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: 15-0023 Worksheet S Peri od: From 01/01/2021 Parts I-III AND SETTLEMENT SUMMARY 12/31/2021 Date/Time Prepared: 5/26/2022 10:49 am PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 5/26/2022 Time: 10:49 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:
[18] 17. Contractor's Vendor Code:
[18] 17. Contractor's Vendor Code:
[18] 18. Contractor's Vendor Code:
[18] 19. NPR Date:
[18] 19. NPR Date:
[18] 19. NPR Date:
[18] 19. NPR Date:
[19] 19. NPR Date: 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, INC. (15-0023) 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	HI T	Title XIX	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	(	508, 219	-900, 206	0	-1, 854, 365	1.00
2.00	Subprovi der - IPF		0	0		0	2. 00
3.00	Subprovi der - IRF		2, 672	5		42, 361	3. 00
5.00	Swing Bed - SNF		0	0		0	5. 00
6.00	Swing Bed - NF					0	6. 00
200.00	Total		510, 891	-900, 201	0	-1, 812, 004	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, INC.

In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 15-0023

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

Date/Time Prepared:
5/26/2022 10: 49 am

Hospital and Hospital Health Care Complex Address:

1.00 Street: 1606 NORTH SEVENTH ST

PO Box:

1.00 In Lieu of Form CMS-2552-10

Worksheet S-2
Part I
Date/Time Prepared:
5/26/2022 10: 49 am

1.00 In Lieu of Form CMS-2552-10

Worksheet S-2
Part I
Date/Time Prepared:
5/26/2022 10: 49 am

1.00 In Lieu of Form CMS-2552-10

From 01/01/2021
In Lieu of Form CMS-2552-10

Worksheet S-2
Part I
Date/Time Prepared:
5/26/2022 10: 49 am

1.00 In Lieu of Form CMS-2552-10

North Seven In Lieu of Form CMS-2552-10

Porvider CCN: 15-0023

Period:
From 01/01/2021
In Lieu of Form CMS-2552-10

North Seven In Lieu of Form CMS-2552-10

Part I
Date/Time Prepared:
5/26/2022 10: 49 am

1.00 In Lieu of Form CMS-2552-10

Part I
Date/Time Prepared:
5/26/2022 10: 49 am

1.00 In Lieu of Form CMS-2552-10

In Lieu of Form CMS-2552-10

Part I
Date/Time Prepared:
5/26/2022 10: 49 am

1.00 In Lieu of Form CMS-2552-10

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Date/Time Prepared:
5/26/2022 10: 49 am

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Part I
Date/Time Prepared:
5/26/2022 10: 49 am

1.00 In Lieu of Form CMS-2552-10

Part I
Date/Time Prepared:
5/26/2022 10: 49 am

1.00 In L

										Date/Ti 5/26/20		
	1.00	malay Adı	2.00		3. 00				1. 00			
1. 00	Hospital and Hospital Health Care Co Street: 1606 NORTH SEVENTH ST	mprex au	PO Box:									1. 00
2. 00	Ci ty: TERRE HAUTE		State: IN	Zi p Cod	e: 478	304-	Count	y: VI GO				2. 00
		Comp	onent Name	CCN	CB:		Provi der	Date		nt Syst		
				Number	Num	ber	Туре	Certi fi ed		0, or		
			1.00	2.00	3. (	00	4. 00	5. 00	V 6. 00	7. 00	XI X 8. 00	
	Hospital and Hospital-Based Componen	t Identii		2.00	] 3.	00	4.00	5.00	0.00	7.00	8.00	
3.00			SPITAL, INC.	150023	454	160	1	01/01/1966	N	Р	0	3. 00
4.00	Subprovider - IPF											4. 00
5.00	· ·	MEDI CAL	REHAB	15T023	454	160	5	09/01/1989	N	P	0	5.00
6. 00 7. 00	Subprovider - (Other) Swing Beds - SNF											6. 00 7. 00
8.00	Swing Beds - NF											8.00
9.00	Hospi tal -Based SNF											9. 00
10.00	Hospi tal -Based NF											10.00
11. 00 12. 00	Hospi tal -Based OLTC Hospi tal -Based HHA											11. 00 12. 00
13. 00	Separately Certified ASC											13.00
	Hospi tal -Based Hospi ce											14. 00
15. 00	Hospital-Based Health Clinic - RHC											15. 00
16.00	Hospital - Based Health Clinic - FQHC											16.00
17. 00 18. 00	Hospital-Based (CMHC) I Renal Dialysis											17. 00 18. 00
19. 00												19. 00
								From:		To		
20.00	Cook Deposit on Depict (may did (may)							1.00	221	2.0		20.00
20.00 Cost Reporting Period (mm/dd/yyyy) 21.00 Type of Control (see instructions)  01/01/20						)21	12/31/	2021	20. 00 21. 00			
200	Trype or control (see their detrone)							_				21100
	I						1. 00	2. 00		3.0	00	
22. 00	Inpatient PPS Information  Does this facility qualify and is it	currentl	v rocelvina no	umonto for			Υ	N				22. 00
22.00	disproportionate share hospital adju	stment. i	n accordance w	ith 42 CFF	}		'					22.00
	§412.106? In column 1, enter "Y" fo											
	facility subject to 42 CFR Section §			endment								
22. 01	hospital?) In column 2, enter "Y" fo Did this hospital receive interim un			ts for thi	S		N	N				22. 01
22.01	cost reporting period? Enter in colu							"				22.01
	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				e		N	N	1			22. 02
	payments to be determined at cost re	port sett	lement? (see i	nstructi or								
	Enter in column 1, "Y" for yes or "N											
	cost reporting period prior to Octob or "N" for no, for the portion of th											
	October 1.	e cost re	sporting perrou	on or an	.eı							
22. 03	Did this hospital receive a geograph						N	N		N		22. 03
	rural as a result of the OMB standar											
	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) ? [	inter in corumn	3, 1 10	וע							
22. 04	Did this hospital receive a geograph	ic reclas	sification from	m urban to	)		N	N		N		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 in column 2, "Y" for yes or "N" for				71							
	reporting period occurring on or aft											
	Does this hospital contain at least			•								
	counted in accordance with 42 CFR 41	2. 105)?	Enter in colum	n 3, "Y" 1	or							
23 00	yes or "N" for no. Which method is used to determine Me	dicaid da	avs on lines 24	and/or 2				3 N				23. 00
_0.00	below? In column 1, enter 1 if date							1 "				_3. 55
	if date of discharge. Is the method				cost							
	reporting period different from the reporting period? In column 2, ente											
	proporting portion: The Condition 2, effice		y 0.3 01 N 10	. 110.		1		1	I			I

N

N

58 00

59.00

58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.

59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.

alth Financial Systems UNION SSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provi der C	F	reriod: rom 01/01/2021 o 12/31/2021	Worksheet S-2 Part I Date/Time Pre 5/26/2022 10:	pared:
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
			1. 00	2.00	3.00	
Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. Instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C adjustement? Enter "Y" for yes or "N" for no in colu If line 60 is yes, complete columns 2 and 3 for each instructions)	85? (s umn 1. CR) NAHE imn 2. progran	see If column 1 E MA payment n. (see	Y	N 23. 00		60.0
0.02 If line 60 is yes, complete columns 2 and 3 for each instructions)	program Y/N	n. (see	Direct GME	23. 01	1 Direct GME	60.0
	1.00	2. 00	3. 00	4.00	5. 00	
1.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 1.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports	N			0.00	0.00	61.0
ending and submitted before March 23, 2010. (see instructions)  1.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of						61. 0
ACA). (see instructions)  .03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61. (
<ul> <li>Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions).</li> <li>Enter the difference between the baseline primary</li> </ul>						61. (
and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)  1.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61. (
	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1. 00	2. 00	3.00	4. 00	
<ul> <li>Of the FTEs in line 61.05, specify each new program 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.</li> <li>Of the FTEs in line 61.05, specify each expanded</li> </ul>				0.00		61. 1
program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	01. 2
			(UDCA)		1.00	
ACA Provisions Affecting the Health Resources and Ser 2.00 Enter the number of FTE residents that your hospital	trai ned			iod for which	0.00	62.0
your hospital received HRSA PCRE funding (see instruction for the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC programmer.	Teachi			your hospital	0.00	62. (
Teaching Hospitals that Claim Residents in Nonprovide 3.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	er Setti ettings	ings during this c	ost reporting		Y	63. (

Health Financial Systems	UNIO	N HOSPITAL	. INC.		In Li∈	eu of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP			Provi der CC	CN: 15-0023	Peri od: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I	pared:
				Unwei ghted FTEs Nonprovi de Si te	FTEs in	Ratio (col. 1/ (col. 1 + col. 2))	
				1. 00	2.00	3.00	
Section 5504 of the ACA Base Yea				This base yea	ar is your cost i	reporting	
period that begins on or after.  64.00 Enter in column 1, if line 63 is in the base year period, the nur resident FTEs attributable to row settings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column 1).	s yes, or your facili mber of unweighted no otations occurring in e number of unweighte our hospital. Enter i	ty trained n-primary all nonpr d non-prim n column 3	residents care covider ary care the ratio	0.	00 0.00	0. 000000	64. 00
	Program Name		am Code	Unwei ghted	Unweighted	Ratio (col. 3/	
				FTEs Nonprovi de Si te	FTEs in r Hospital	(col. 3 + col. 4))	
	1.00	2	2. 00	3. 00	4.00	5. 00	
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTES for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	UH FAMILY MEDICINE RESIDENCY	120171113	1	O.  Unwei ghtec	91 20.14	Ratio (col. 1/	65. 00
				FTEs Nonprovi de Si te	FTEs in	(col. 1 + col. 2))	
				1. 00	2.00	3.00	
Section 5504 of the ACA Current	Year FTE Residents i	n Nonprovi	der Settings				
beginning on or after July 1, 20							
66.00 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospif (column 1 divided by (column 1 divided by (column 1 divided by (column 1 divided by	occurring in all nonp unweighted non-prima tal. Enter in column:	rovider se ry care re 3 the rati	ttings. sident o of	0.	0.00	0. 000000	66. 00
	Program Name	Progr	ram Code	Unwei ghted FTEs Nonprovi de Si te	FTEs in	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00		2. 00	3. 00	4.00	5. 00	
67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	UH FAMILY MEDICINE RESIDENCY	120171113			33 20.53		67.00

Health Financial Systems UNION HOSPITAL, INC. In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0023 Peri od: Worksheet S-2 From 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/26/2022 10:49 am 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS 70.00 70.00 | Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.

If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 75.00 Υ 75.00 Υ 0 Ν 76.00 recent cost reporting period ending on or before November 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)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) 1.00 Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. N 80.00 81.00 | Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter N 81.00 'Y" for yes and "N" for no. TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 85.00 N Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 86.00 \$413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. 87.00 N XIX 1. 00 2.00 Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for Ν Υ 90.00 yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report either in 91.00 Ν Υ 91.00 full or in part? Enter "Y" for yes or "N" for no in the applicable column. 92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. N 92.00 93.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter Ν Ν 93.00 Y" for yes or "N" for no in the applicable column. 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the N N 94.00 applicable column. 95 00 If line 94 is "Y", enter the reduction percentage in the applicable column. 0 00 0 00 95 00 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the 96.00 Ν N 97.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 97.00 98.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post 98.00 Υ stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. 98.01 C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 Υ 98.02 for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) Ν 98.03 reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of Ν 98.04 N outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and

in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on 98.05 Υ Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Υ 98.06 Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Rural Providers 105.00 Does this hospital qualify as a CAH? Ν 105.00 106.00 of this facility qualifies as a CAH, has it elected the all-inclusive method of payment N 106.00 for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) 107.00 Ν Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)

	Provider C		eri od:	Worksheet S-	-2
			rom 01/01/2021 o 12/31/2021	Part I Date/Time Pr	
			V	5/26/2022 10 XI X	): 49 aı
			1.00	2.00	_
08.00 s this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche	edul e? See 42	N		108.
CFR Section 9412.113(c). Enter 1 101 yes of N 101 110.	Physi cal	Occupati onal	Speech	Respi ratory	
	1.00	2.00	3.00	4.00	100
09.00   f 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.	N	N	N	N	109.
				1.00	$\dashv$
IO.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	'Y" for yes or	"N" for no. I	yes,	N	110.
			1. 00	2.00	4
1.00 f this facility qualifies as a CAH, did it participate in t	the Frontier (	Community	1.00 N	2.00	111
Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ac for tele-health services.	ost reporting olumn 1 is Y, rticipating ir	period? Enter enter the column 2.	·		
		1. 00	2. 00	3. 00	+
2.00 Did this hospital participate in the Pennsylvania Rural Heal demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceaparticipation in the demonstration, if applicable.	peri od? s "Y", enter ne	N			112
Miscellaneous Cost Reporting Information  5.00 Is this an all-inclusive rate provider? Enter "Y" for yes or	. "N" for no	N			0115
in column 1. If column 1 is yes, enter the method used (A, E in column 2. If column 2 is "E", enter in column 3 either "9 for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub. 15-1, chapter 22, §2208.1.	3, or E only) 93" percent (includes	IN IN			0113
6.00 s this facility classified as a referral center? Enter "Y" "N" for no.	for yes or	Y			116
7.00 Is this facility legally-required to carry malpractice insur "Y" for yes or "N" for no.		Y			117
8.00 Is the malpractice insurance a claims-made or occurrence pol	,				118
if the policy is claim-made. Enter 2 if the policy is occurr					
μτ the policy is claim-made. Enter 2 if the policy is occuri		Premi ums	Losses	Insurance	
μτ the policy is claim-made. Enter 2 if the policy is occuri					
		1.00 720,644	2.00	3.00	0118
		1.00	2.00	3.00	0118
3.01 List amounts of malpractice premiums and paid losses:	contar other	1. 00 720, 644	2.00	3.00	
3.01 List amounts of malpractice premiums and paid losses:  3.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schedand amounts contained therein.		1.00 720,644	2.00	3.00	118
3.01 List amounts of malpractice premiums and paid losses:  3.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein.  3.00 DO NOT USE THIS LINE  3.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualified Hold Harmless provision in ACA §3121 and applicable amendments.	dule listing of d Harmless pro n column 1, "\ ualifies for t	than the cost centers  ovision in ACA "for yes or the Outpatient"	2.00	3.00	118
3.01 List amounts of malpractice premiums and paid losses:  Administrative and General? If yes, submit supporting schedand amounts contained therein.  3.00 DO NOT USE THIS LINE  3.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.	dule listing of the during the du	than the cost centers  ovision in ACA (" for yes or the Outpatient cructions)	2.00 3 0 1.00 N	3.00	118
3.01 List amounts of malpractice premiums and paid losses:  3.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schedand amounts contained therein.  3.00 DO NOT USE THIS LINE  3.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualified Hold Harmless provision in ACA §3121 and applicable amendments. Hold Harmless provision in ACA §3121 and applicable amendments.  4.00 Did this facility incur and report costs for high cost implay patients? Enter "Y" for yes or "N" for no.  5.00 Does the cost report contain healthcare related taxes as defact? Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.	dule listing of the dule listing of the dumn 1, "Nualifies for the device of the device of the dule line stands of the device of the dule of the dule dule of the	than the cost centers  ovision in ACA " for yes or the Outpatient cructions) es charged to  8(w)(3) of the	2.00 0 1.00 N	3.00	0 118 118 119 120
Are malpractice premiums and paid losses:  Administrative and General? If yes, submit supporting schedand amounts contained therein.  O OD NOT USE THIS LINE  O OI Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter ir "N" for no. Is this a rural hospital with < 100 beds that qualifier in column 2, "Y" for yes or "N" for no.  O OD Did this facility incur and report costs for high cost implainable patients? Enter "Y" for yes or "N" for no.  O OD Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information	dule listing of Harmless produced in column 1, "Yualifies for this? (see instantable devices fined in §1903 is "Y", enter	than the cost centers  ovision in ACA " for yes or the Outpatient cructions) es charged to B(w)(3) of the er in column 2	2.00 1.00 N	3.00 2.00 N	118 119 120
3.01 List amounts of malpractice premiums and paid losses:  3.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schedand amounts contained therein.  3.00 DO NOT USE THIS LINE  3.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA \$3121 and applicable amendments.  4.00 Did this facility incur and report costs for high cost implay patients? Enter "Y" for yes or "N" for no.  5.00 Does the cost report contain healthcare related taxes as defact? Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information  5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.	d Harmless production column 1, "Nualifies for the tarts? (see instantable device fined in §1903 is "Y", enterprogram and "N" the certi	than the cost centers  ovision in ACA " for yes or the Outpatient cructions) es charged to B(w)(3) of the er in column 2	2.00 1.00 N	3.00 2.00 N	118 119 120 121 122
3.01 List amounts of malpractice premiums and paid losses:  3.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schedand amounts contained therein.  3.00 DO NOT USE THIS LINE  3.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments.  4.00 Did this facility incur and report costs for high cost implated patients? Enter "Y" for yes or "N" for no.  5.00 Does the cost report contain healthcare related taxes as defact?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information  5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.  6.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2.	d Harmless produced Harmless produced to the column 1, "Yallifies for the column 1, "Yallifies for the column 1, "Yallifies for the certifies and "N" or yes and "N" of the certifies th	than the cost centers  ovision in ACA "for yes or the Outpatient cructions) es charged to B(w) (3) of the er in column 2  for no. If	2.00 1.00 N	3.00 2.00 N	118 119 120
8.01 List amounts of malpractice premiums and paid losses:  8.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schedand amounts contained therein.  9.00 DO NOT USE THIS LINE  9.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifier in column 2, "Y" for yes or "N" for no.  1.00 Did this facility incur and report costs for high cost implay patients? Enter "Y" for yes or "N" for no.  2.00 Does the cost report contain heal theare related taxes as defact? Enter "Y" for yes or "N" for no.  2.00 Does the cost report contain heal theare related taxes as defact? Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information  5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.  6.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2.	d Harmless produced the column 1, "Yualifies for this? (see instantable deviced fined in §1903 lis "Y", enterpropers and "N" the certification of the certif	than the cost centers  ovision in ACA "for yes or the Outpatient cructions) as charged to B(w)(3) of the er in column 2  for no. If fication date	2.00 1.00 N	3.00 2.00 N	118 119 120 121 122 122
8.01 List amounts of malpractice premiums and paid losses:  8.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schedand amounts contained therein.  9.00 DO NOT USE THIS LINE  0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifier in column 2, "Y" for yes or "N" for no.  1.00 Did this facility incur and report costs for high cost implay patients? Enter "Y" for yes or "N" for no.  2.00 Does the cost report contain healthcare related taxes as defact?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information  5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.  6.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2, only if this is a Medicare certified kidney transplant center, enter the significant center in column 1 and termination date, if applicable, in column 2, only if this is a Medicare certified keart transplant center, enter the column 2 and termination date, if applicable, in column 2, only if this is a Medicare certified keart transplant center, entermination date, if applicable, in column 2, only if this is a Medicare certified keart transplant center, entermination date in the column 2, only if the column 2 and termination date, if applicable, in column 2, only if the column 2 and termination date, if applicable, in column 2, only if the column 2 and termination date, if applicable, in column 2, only if the column 2 and termination date, if applicable, in column 2, only if the column 2 and termination date, if applicable, in column 2, only in the column 2 and termination date and the column 2 and termination date and the column 2 and termination date and the column 2 and	d Harmless production column 1, "Nualifies for the service fined in §1903 is "Y", enterprise and "N" there the certification the certification certification is the certification certification is the certification certification is the certification certification is supported by the certification is supported by	than the cost centers  ovision in ACA " for yes or the Outpatient cructions)  es charged to B(w)(3) of the er in column 2  for no. If fication date Fication date	2.00 1.00 N N	3.00 2.00 N	118 119 120 121 122 126 126

ealth Financial Systems OSPITAL AND HOSPITAL HEALTH CARE COMPLE		SPITAL, INC. Provider CC	N: 15-0023	Peri od:		w of Form CMS Worksheet S	
					1/01/2021 2/31/2021	Part I	repared
					1. 00	2.00	
31.00 If this is a Medicare certified in			erti fi cati on				131. (
date in column 1 and termination of this is a Medicare certified is in column 1 and termination date,	let transplant center,	enter the certifi	cation date				132.
3.00 Removed and reserved 4.00 If this is an organ procurement or and termination date, if applicabl ALI Providers	ganization (OPO), enter		n column 1				133. 134.
O.00 Are there any related organization chapter 10? Enter "Y" for yes or " are claimed, enter in column 2 the	N" for no in column 1. home office chain numb	If yes, and home per. (see instruct	office cost	s	Υ	15H043	140.
1.00 If this facility is part of a chai		<u>2.00</u> on lines 141 throu	 ugh 143 the	name and	3.00 d address	of the	
home office and enter the home off				N.		\1	141
1.00 Name: UNION HOSPITAL, INC.	Contractor's Name:	SERVICES	IANSCONTRAC	tor s Nu	mber: U810	)	141.
12.00 Street: 1606 NORTH SEVENTH ST	PO Box:	1.01	7: 0 1		4700		142.
13.00 City: TERRE HAUTE	State:	I N	Zi p Cod	⊎:	4780	J4	143.
4 00 4	±= !==1! ! ! !	-+ 42				1.00	1
4.00 Are provider based physicians' cos	its included in Workshee	et A?				Y	144.
					1. 00	2.00	
5.00  f costs for renal services are clipatient services only? Enter "Y" no, does the dialysis facility inceperiod? Enter "Y" for yes or "N" 6.00 Has the cost allocation methodology	for yes or "N" for no lude Medicare utilizati for no in column 2.	in column 1. If o ion for this cost	column 1 is reporting		N		145. 146.
Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d		o. 15-2, chapter 4	10, §4020) I	f		1.00	
7.00Was there a change in the statisti	cal basis? Enter "Y" fo	or ves or "N" for	no			1.00 N	147.
8.00 Was there a change in the order of 9.00 Was there a change to the simplifi	allocation? Enter "Y"	for yes or "N" for	or no.			N N	148. 149.
		Part A 1.00	2.00	Т	itle V 3.00	Title XIX 4.00	
Does this facility contain a provi or charges? Enter "Y" for yes or "		an exemption from	n the applic		f the lowe	er of costs	
5.00 Hospi tal		N	N		N	N	155.
6.00 Subprovi der - IPF 7.00 Subprovi der - IRF		N N	N N		N N	N N	156. 157.
8. 00 SUBPROVI DER							158.
9.00 SNF 0.00 HOME HEALTH AGENCY		N N	N N		N N	N N	159. 160.
1.00 CMHC		IN .	N N		N N	N N	161.
						1.00	
Multicampus			!. !! 66		104-0		1/5
5.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	impus nospitai that has	one or more campu	ises in diff	erent CE	SAS?	N	165.
, , , , , , , , , , , , , , , , , , , ,	Name	County		ip Code	CBSA	FTE/Campus	
5.00  fline 165 is yes, for each	0	1. 00	2. 00	3. 00	4. 00	5.00	00 166
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0. (	00 100
						1.00	
Health Information Technology (HIT				ent Act			
7.00 Is this provider a meaningful user 3.00 If this provider is a CAH (line 10 reasonable cost incurred for the H	5 is "Y") and is a mear	ningful user (line		), enter	the	Y	167. 168.
3.01  f this provider is a CAH and is n			qualify fo	r a hard	lshi p		168
exception under §413.70(a)(6)(ii)?					enter the	9	99169.

Health Financial Systems	UNION HOSPITA	L, INC.	In Lieu of Form CMS-2552-10			
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX II	DENTIFICATION DATA	Provider CCN: 15-0023	Peri od:	Worksheet S-2	2	
			From 01/01/2021			
			To 12/31/2021	Date/Time Pre 5/26/2022 10:	epared: 49 am	
			Begi nni ng	Endi ng		
			1. 00	2.00		
170.00 Enter in columns 1 and 2 the EHR begi period respectively (mm/dd/yyyy)			170. 00			
			1. 00	2.00		
171.00 If line 167 is "Y", does this provide	r have any days for indiv	viduals enrolled in	N	C	171. 00	
section 1876 Medicare cost plans repo						
"Y" for yes and "N" for no in column	1. If column 1 is yes, er	nter the number of section	n			
1876 Medicare days in column 2. (see	instructions)					

	Financial Systems UNION HOSPI AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0023	Period: From 01/01/2021		2
	<u> </u>			To 12/31/2021	5/26/2022 10:	
				Y/N 1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	N for all NO re	sponses. Ente			
. 00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	e beginning of	the cost	N		1.0
	reporting period? If yes, enter the date of the change in o	column 2. (see	instructions)			
			1. 00	2. 00	V/I 3. 00	+
. 00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum yoluntary or "I" for involuntary.		N			2.0
. 00	Is the provider involved in business transactions, includir	ith individuals or entities (e.g., chain home offices, drug upply companies) that are related to the provider or its dical staff, management personnel, or members of the board through ownership, control, or family and other similar				3. 00
			Y/N	Type	Date	
	Financial Data and Reports		1.00	2. 00	3. 00	
. 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. Are the cost report total expenses and total revenues difference.	for Compiled, ailable in	Y	A		4.00
	those on the filed financial statements? If yes, submit rec	conciliation.		Y/N 1.00	Legal Oper. 2.00	
	Approved Educational Activities				2.00	
. 00	Column 1: Are costs claimed for a nursing program? Column is the legal operator of the program?	2: If yes, is	the provider	~ N		6. 0
. 00 . 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.		ed during the	e Y		7. 00 8. 00
. 00	Are costs claimed for Interns and Residents in an approved		al education	Υ		9. 0
0. 00	program in the current cost report? If yes, see instruction 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	roved	N		11. 0
					Y/N 1. 00	+
	Bad Debts					
2. 00 3. 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. 0 13. 0
	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement		•		N	14.0
3.00	Did total beds available change from the prior cost reporti		t A		t B	15. 0
		Y/N 1.00	Date	Y/N	Date	
	PS&R Data	1.00	2. 00	3. 00	4. 00	
6. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions)	Y	03/10/2022	Y	03/10/2022	16. 00
7. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17. 0
8. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18. 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	N		N		19. 0

DISPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE  D. 00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:  1. 00 Was the cost report prepared only using the provider's records? If yes, see instructions.    COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT Capital Related Cost Have assets been relifed for Medicare purposes? If yes, see i Have changes occurred in the Medicare depreciation expense dureporting period? If yes, see instructions.  1. 00 Were new leases and/or amendments to existing leases entered If yes, see instructions Have there been new capitalized leases entered into during the instructions.  1. 00 Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.  1. 00 Has the provider's capitalization policy changed during the copy.	instructions ue to apprais into during he cost repor	Date 2.00  OSPITALS)  als made dur this cost re ting period?	eporting period?  If yes, see  f yes, see	Worksheet S-Part II     Date/Time Proceedings	20. 00 21. 00 22. 00 23. 00 24. 00 25. 00
Report data for Other? Describe the other adjustments:  1.00 Was the cost report prepared only using the provider's records? If yes, see instructions.  COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT Capital Related Cost Have assets been relifed for Medicare purposes? If yes, see i Have changes occurred in the Medicare depreciation expense dureporting period? If yes, see instructions.  Were new leases and/or amendments to existing leases entered If yes, see instructions Have there been new capitalized leases entered into during the instructions.  Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.  Has the provider's capitalization policy changed during the copy.	Y/N 1.00 N T CHILDRENS HO instructions ue to apprais into during he cost report	Date 2.00  OSPITALS)  als made dur this cost re ting period? ng period? I	1.00 N Y/N 3.00 N ing the cost eporting period? If yes, see f yes, see	Y/N 3.00 N Date 4.00	20. 00 21. 00 22. 00 23. 00 24. 00 25. 00
Report data for Other? Describe the other adjustments:  1.00 Was the cost report prepared only using the provider's records? If yes, see instructions.  COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT Capital Related Cost Have assets been relifed for Medicare purposes? If yes, see i Have changes occurred in the Medicare depreciation expense dureporting period? If yes, see instructions.  Were new leases and/or amendments to existing leases entered If yes, see instructions Have there been new capitalized leases entered into during the instructions.  Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.  Has the provider's capitalization policy changed during the copy.	Y/N 1.00 N  T CHILDRENS HO instructions ue to apprais into during he cost report	Date 2.00  OSPITALS)  als made dur this cost re ting period? I	N Y/N 3.00 N ing the cost eporting period? If yes, see f yes, see	N Date 4.00	21. 00 22. 00 23. 00 24. 00 25. 00
Report data for Other? Describe the other adjustments:  1.00 Was the cost report prepared only using the provider's records? If yes, see instructions.  COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT Capital Related Cost Have assets been relifed for Medicare purposes? If yes, see i Have changes occurred in the Medicare depreciation expense dureporting period? If yes, see instructions.  Were new leases and/or amendments to existing leases entered If yes, see instructions Have there been new capitalized leases entered into during the instructions.  Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.  Has the provider's capitalization policy changed during the copy.	1.00 N  T CHILDRENS HO instructions ue to appraise into during the cost report	2.00  OSPITALS)  als made dur this cost re ting period? ng period? I	Y/N 3.00 N ing the cost eporting period? If yes, see f yes, see	Date 4.00	21. 00 22. 00 23. 00 24. 00 25. 00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT Capital Related Cost  Have assets been relifed for Medicare purposes? If yes, see i Have changes occurred in the Medicare depreciation expense dureporting period? If yes, see instructions.  Were new leases and/or amendments to existing leases entered If yes, see instructions  Have there been new capitalized leases entered into during the instructions.  Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.  Has the provider's capitalization policy changed during the copy.	1.00 N  T CHILDRENS HO instructions ue to appraise into during the cost report	2.00  OSPITALS)  als made dur this cost re ting period? ng period? I	3.00 N	1. 00 N N N	22. 00 23. 00 24. 00 25. 00
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completed by Cost reimbursed and terra Hospitals only (except Capital Related Cost Have assets been relifed for Medicare purposes? If yes, see i Have changes occurred in the Medicare depreciation expense du reporting period? If yes, see instructions.  Were new leases and/or amendments to existing leases entered If yes, see instructions Have there been new capitalized leases entered into during the instructions.  Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.  Has the provider's capitalization policy changed during the copy.	N  T CHILDRENS HO  instructions ue to apprais  into during he cost report  cost reporting	OSPITALS)  als made dur this cost re ting period? ng period? I	ing the cost sporting period?  If yes, see f yes, see	1. 00 N N N	22. 00 23. 00 24. 00 25. 00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT Capital Related Cost  Have assets been relifed for Medicare purposes? If yes, see i Have changes occurred in the Medicare depreciation expense du reporting period? If yes, see instructions.  Were new leases and/or amendments to existing leases entered If yes, see instructions  Have there been new capitalized leases entered into during the instructions.  Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.  Has the provider's capitalization policy changed during the copy.	instructions ue to apprais into during he cost repor	als made dur this cost re ting period? ng period? I	eporting period?  If yes, see  f yes, see	N N N	23. 00 24. 00 25. 00
Capital Related Cost  Have assets been relifed for Medicare purposes? If yes, see i Have changes occurred in the Medicare depreciation expense du reporting period? If yes, see instructions.  Were new leases and/or amendments to existing leases entered If yes, see instructions Have there been new capitalized leases entered into during the instructions.  Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.  Has the provider's capitalization policy changed during the copy.	instructions ue to apprais into during he cost repor	als made dur this cost re ting period? ng period? I	eporting period?  If yes, see  f yes, see	N N N	23. 00 24. 00 25. 00
Capital Related Cost  Have assets been relifed for Medicare purposes? If yes, see i Have changes occurred in the Medicare depreciation expense du reporting period? If yes, see instructions.  Were new leases and/or amendments to existing leases entered If yes, see instructions Have there been new capitalized leases entered into during the instructions.  Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.  Has the provider's capitalization policy changed during the copy.	instructions ue to apprais into during he cost repor	als made dur this cost re ting period? ng period? I	eporting period?  If yes, see  f yes, see	N N N	23. 00 24. 00 25. 00
Capital Related Cost  Have assets been relifed for Medicare purposes? If yes, see i Have changes occurred in the Medicare depreciation expense du reporting period? If yes, see instructions.  Were new leases and/or amendments to existing leases entered If yes, see instructions Have there been new capitalized leases entered into during the instructions.  Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.  Has the provider's capitalization policy changed during the copy.	instructions ue to apprais into during he cost repor	als made dur this cost re ting period? ng period? I	eporting period?  If yes, see  f yes, see	N N N	23. 00 24. 00 25. 00
Have assets been relifed for Medicare purposes? If yes, see i Have changes occurred in the Medicare depreciation expense du reporting period? If yes, see instructions.  Were new leases and/or amendments to existing leases entered If yes, see instructions Have there been new capitalized leases entered into during the instructions.  Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.  Has the provider's capitalization policy changed during the copy.	ue to appraisa into during he cost reportion	this cost re ting period? ng period? I	eporting period?  If yes, see  f yes, see	N N N	23. 00 24. 00 25. 00
Have changes occurred in the Medicare depreciation expense dureporting period? If yes, see instructions.  Were new leases and/or amendments to existing leases entered If yes, see instructions  Have there been new capitalized leases entered into during the instructions.  Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.  Has the provider's capitalization policy changed during the copy.	ue to appraisa into during he cost reportion	this cost re ting period? ng period? I	eporting period?  If yes, see  f yes, see	N N	24. 00 25. 00
4.00 Were new leases and/or amendments to existing leases entered If yes, see instructions Have there been new capitalized leases entered into during the instructions. Were assets subject to Sec. 2314 of DEFRA acquired during the instructions. To 00 Has the provider's capitalization policy changed during the copy.	he cost reportion	ting period? ng period? I	If yes, see	N	25. 00
If yes, see instructions Have there been new capitalized leases entered into during the instructions.  Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.  Has the provider's capitalization policy changed during the copy.	he cost reportion	ting period? ng period? I	If yes, see	N	25. 00
Have there been new capitalized leases entered into during the instructions.  Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.  Has the provider's capitalization policy changed during the copy.	cost reporti	ng period? I	f yes, see		
instructions.  Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.  Has the provider's capitalization policy changed during the copy.	cost reporti	ng period? I	f yes, see		
Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.  Has the provider's capitalization policy changed during the copy.			_	N	1 _
instructions. 7.00 Has the provider's capitalization policy changed during the cocopy.			_		26.00
сору.	cost reporting	a pariod2 Lf	:		
		g perrous ri	yes, submit	N	27. 00
Interest Expense 3.00 Were new Loans, mortgage agreements or Letters of credit ente	ared into duri	ing the cost	reporting	N	28. 00
period? If yes, see instructions.	erea mito dan	ing the cost	reporting	IN	20.00
9.00 Did the provider have a funded depreciation account and/or bo	ond funds (Del	bt Service R	eserve Fund)	N	29. 00
treated as a funded depreciation account? If yes, see instruc					
0.00 Has existing debt been replaced prior to its scheduled maturi	ity with new o	debt? If yes	s, see	N	30.00
instructions. 1.00 Has debt been recalled before scheduled maturity without issu	uanco of now	dobt2 If you	500	N	31.00
instructions.	uance or new t	debt: II yes	, see	IN	31.00
Purchased Services					
2.00 Have changes or new agreements occurred in patient care servi		d through co	ntractual	N	32.00
arrangements with suppliers of services? If yes, see instruct					
3.00 If line 32 is yes, were the requirements of Sec. 2135.2 appli	ied pertainin	g to competi	tive bidding? If	N	33.00
no, see instructions. Provider-Based Physicians					_
4.00 Are services furnished at the provider facility under an arra	angement with	provi der-ba	sed physicians?	N	34.00
If yes, see instructions.	3				
5.00 If line 34 is yes, were there new agreements or amended exist		ts with the	provi der-based	N	35. 00
physicians during the cost reporting period? If yes, see inst	tructions.		Y/N	Date	
			1. 00	2. 00	
Home Office Costs			11.00	2.00	
6.00 Were home office costs claimed on the cost report?			Y		36.00
7.00 If line 36 is yes, has a home office cost statement been prep	pared by the I	home office?	Y		37. 00
If yes, see instructions.	1. 66				00.00
3.00   If line 36 is yes, was the fiscal year end of the home office the provider? If yes, enter in column 2 the fiscal year end o			N		38. 00
9.00 If line 36 is yes, did the provider render services to other			, N		39.00
see instructions.		, , , , , , , ,	.		
0.00 If line 36 is yes, did the provider render services to the ho	ome office?	lf yes, see	N		40.00
i nstructi ons.					
<del> </del>	1. (	00	2.	00	-
Cost Report Preparer Contact Information	1. (	Ζ.	00		
	AROLYN		CHAPLI N		41.00
held by the cost report preparer in columns 1, 2, and 3,					
respecti vel y.		_			
	LUE & CO., LLO	С			42.00
preparer. 3.00 Enter the telephone number and email address of the cost   31	17-713-7919		CCUADLI NADLUEA	NDCO COM	12.00
report preparer in columns 1 and 2, respectively.	11-113-1414		CCHAPLI N@BLUEAI	NDCU. CUIVI	43.00

Heal th	Financial Systems UNION	N HOSPI	TAL, INC.	In Lieu of Form CMS-2552-10				
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAI	RE	Provi der CCN: 15-0023		riod: om 01/01/2021 12/31/2021	Worksheet S-2 Part II Date/Time Pro 5/26/2022 10:	epared:	
		-	3. 00					
	Cost Report Preparer Contact Information							
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and respectively.		SENI OR MANAGER				41. 00	
42. 00	Enter the employer/company name of the cost report preparer.						42. 00	
43. 00	Enter the telephone number and email address of the creport preparer in columns 1 and 2, respectively.	cost					43. 00	

| Period: | 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: 15-0023

				T	o 12/31/2021	Date/Time Pre 5/26/2022 10:	
						I/P Days / 0/P	49 4111
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
	Component	Line Number	No. of beas	Avai I abl e	OAIT HOUTS	11 11 0 0	
		1.00	2. 00	3.00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	205			0.00	1. 00
1.00	8 exclude Swing Bed, Observation Bed and	50. 00	200	71,020	0.00		1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2. 00
3. 00	HMO IPF Subprovider						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		205	74, 825	0.00		7. 00
	beds) (see instructions)			'', '		_	
8.00	INTENSIVE CARE UNIT	31. 00	24	8, 760	0.00	0	8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	I NTENSI VE NURSERY	35. 00	15	5, 475	0.00	0	12. 00
13. 00	NURSERY	43. 00				0	13. 00
14. 00	Total (see instructions)		244	89, 060	0.00	0	14. 00
15. 00	CAH visits					0	15. 00
16.00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVIDER - IRF	41. 00	15	5, 475		0	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)		259				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						33. 01

Health Financial Systems UNION HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Peri od: | Worksheet S-3 | From 01/01/2021 | Part | To 12/31/2021 | Date/Time Prepared: Provider CCN: 15-0023

				Т	o 12/31/2021	Date/Time Pre 5/26/2022 10:	
		I/P Days	/ O/P Visits .	/ Trips	Full Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
		6. 00	7. 00	Pati ents 8.00	& Residents 9.00	Payrol I 10. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	22, 005	1, 083	53, 989		10.00	1.00
1.00	8 exclude Swing Bed, Observation Bed and	22,003	1,003	33, 707			1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	10, 715	14, 732				2. 00
3.00	HMO IPF Subprovider	O	0				3. 00
4.00	HMO IRF Subprovider	O	730				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6. 00
7.00	Total Adults and Peds. (exclude observation	22, 005	1, 083	53, 989			7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	3, 128	96	8, 117			8. 00
9. 00	CORONARY CARE UNIT						9. 00
10. 00							10.00
11. 00	l e						11. 00
12. 00		0	287	4, 100			12. 00
13.00		05.400	96	2, 814			13.00
14.00	,	25, 133	1, 562	69, 020		1, 432. 37	1
15.00		U	0	0			15.00
16.00	1	1 020	40	4 440	0.00	10.54	16.00
17. 00		1, 920	42	4, 440	0. 00	19. 54	1
18. 00 19. 00	1						18. 00 19. 00
20. 00	i i						20.00
21. 00							21.00
22. 00	l e						22.00
23. 00	1		•				23. 00
24. 00	` ,						24.00
24. 10				34			24. 10
25. 00				0.			25. 00
26. 00	l e						26. 00
26. 25		o	o	0	0.00	0.00	
27. 00					20. 53	1, 451. 91	
28. 00			3, 336	11, 055			28. 00
29. 00	Ambul ance Tri ps	0					29. 00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	134	228			32. 00
32. 01	Total ancillary labor & delivery room		ĺ	153			32. 01
	outpatient days (see instructions)						
33. 00	,	0					33. 00
33. 01	LTCH site neutral days and discharges	0	I				33. 01

| Period: | Worksheet S-3 | From 01/01/2021 | Part | To 12/31/2021 | Date/Time Prepared: Provider CCN: 15-0023

					То	12/31/2021	Date/Time Pre 5/26/2022 10:	
		Full Time Equivalents			Di scha	irges	0, 20, 2022 10.	77 (311)
	Component	Nonpai d	Title V		Title XVIII	Title XIX	Total All	
	·	Workers					Pati ents	
		11.00	12. 00		13.00	14.00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)			0	4, 748	217	14, 508	1. 00
2.00	HMO and other (see instructions)				1, 768	2, 666		2.00
3.00	HMO IPF Subprovider					0		3.00
4.00	HMO IRF Subprovider					49		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF							5. 00
6.00	Hospital Adults & Peds. Swing Bed NF							6. 00
7.00	Total Adults and Peds. (exclude observation							7. 00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT							8. 00
9.00	CORONARY CARE UNIT							9. 00
10.00	BURN INTENSIVE CARE UNIT							10.00
11.00	SURGICAL INTENSIVE CARE UNIT							11.00
12.00	I NTENSI VE NURSERY							12.00
13. 00 14. 00	NURSERY	0. 00		o	4, 748	217	14, 508	13. 00 14. 00
15. 00	Total (see instructions) CAH visits	0.00		U	4, 748	217	14, 508	15. 00
16. 00	SUBPROVIDER - I PF							16. 00
17. 00	SUBPROVIDER - I RF	0. 00		0	137	1	292	17. 00
18. 00	SUBPROVI DER	0.00			137	'	272	18. 00
19. 00	SKILLED NURSING FACILITY							19. 00
20. 00	NURSING FACILITY							20.00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY							22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24.00	HOSPI CE							24. 00
24. 10	HOSPICE (non-distinct part)							24. 10
25.00	CMHC - CMHC							25.00
26.00	RURAL HEALTH CLINIC							26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00						26. 25
27. 00	Total (sum of lines 14-26)	0. 00						27. 00
28. 00	Observation Bed Days							28. 00
29. 00	Ambul ance Tri ps							29. 00
30. 00	Employee discount days (see instruction)							30. 00
31. 00	Employee discount days - IRF							31. 00
32. 00	Labor & delivery days (see instructions)							32. 00
32. 01	Total ancillary labor & delivery room							32. 01
22.00	outpatient days (see instructions)							22.00
	LTCH non-covered days				0			33. 00
33. U I	LTCH site neutral days and discharges				0			33. 01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0023 Peri od: From 01/01/2021 12/31/2021

Part II

Date/Time Prepared:

5/26/2022 10:49 am Adj usted Wkst. A Line Amount Recl assi fi cati Paid Hours Average Hourly Number Reported on of Salaries Sal ari es Related to Wage (col. 4 (col.2 ± col (from Wkst. Salaries in col. 5) A-6)3) col. 4 5.00 6.00 2.00 1.00 3.00 4.00 PART II - WAGE DATA SALARI ES 1.00 Total salaries (see 200. 00 111, 153, 642 111, 153, 642 2, 979, 336. 00 37. 31 1.00 instructions) 2.00 Non-physician anesthetist Part 0 0.00 0.00 2.00 3.00 Non-physician anesthetist Part 0.00 0.00 3.00 4.00 Physician-Part A -130, 669 130, 669 764.00 171. 03 4.00 Administrative 4.01 Physicians - Part A - Teaching 714, 222 714, 222 5, 563.00 128.39 4.01 Physician and Non 3, 484, 763 3, 484, 763 8, 408. 00 414. 46 5.00 5.00 Physician-Part B Non-physician-Part B for 6.00 0.00 0.00 6.00 hospital-based RHC and FQHC servi ces 7.00 Interns & residents (in an 21.00 1, 453, 506 1, 453, 506 42, 702. 00 34.04 7.00 approved program) 7.01 Contracted interns and 0.00 0.00 7.01 residents (in an approved programs) Home office and/or related 8.00 0 0.00 0.00 8.00 organization personnel 9.00 44.00 0.00 0.00 9.00 19, 357, 126 17, 292, 782 62. 99 10.00 Excluded area salaries (see -2, 064, 344 274, 536. 00 10.00 instructions) OTHER WAGES & RELATED COSTS 11.00 Contract labor: Direct Patient 8, 768, 906 8, 768, 906 85, 242. 00 102.87 11.00 0.00 12.00 Contract labor: Top level 0 0.00 12.00 management and other management and administrative servi ces Contract Labor: Physician-Part 13.00 446, 134 446, 134 3, 203. 00 139. 29 13.00 A - Administrative 14.00 Home office and/or related 0.00 0.00 14.00 organization salaries and wage-related costs 14.01 Home office salaries 26, 366, 638 26, 366, 638 626, 816.00 42.06 14.01 14.02 Related organization salaries 6, 317, 908 6, 317, 908 136, 460.00 46. 30 14.02 15.00 Home office: Physician Part A 0.00 0.00 15.00 - Administrative Home office and Contract 0 0.00 0.00 16.00 16.00 Physicians Part A - Teaching 16.01 Home office Physicians Part A 0 0.00 0.00 16.01 Teachi ng 16. 02 Home office contract C 0.00 0.00 16.02 Physicians <u>Part A - Teaching</u> WAGE-RELATED COSTS 21, 929, 493 17.00 Wage-related costs (core) (see 21, 929, 493 17.00 instructions) 18.00 Wage-related costs (other) 18.00 (see instructions) 2, 802, 733 19.00 Excluded areas 2, 802, 733 19.00 Non-physician anesthetist Part 20.00 20.00 21.00 Non-physician anesthetist Part 21.00 22.00 Physician Part A -12, 545 12, 545 22.00 Administrative 22.01 Physician Part A - Teaching 81.715 81.715 22 01 23.00 Physician Part B 220, 826 220, 826 23.00 24.00 Wage-related costs (RHC/FQHC) 24.00 Interns & residents (in an 301, 824 301, 824 25.00 25.00 approved program) 25.50 Home office wage-related 5, 865, 349 0 5, 865, 349 25.50 (core) 25. 51 25.51 Related organization 1, 347, 686 1, 347, 686 wage-related (core) Home office: Physician Part A 0 25, 52 25. 52 0 - Administrative wage-related (core)

Provider CCN: 15-0023

					Т	o 12/31/2021	Date/Time Pre 5/26/2022 10:	
		Wkst. A Line	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col. 5)	
				A-6)	3)	col. 4		
		1.00	2. 00	3.00	4. 00	5. 00	6. 00	
25. 53	Home office: Physicians Part A		0	0	0			25. 53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARIE		25/ 12/	1 7/5 755	1 000 000	25 / 12 22		
26. 00	Employee Benefits Department	4. 00	256, 484			,		26. 00
27. 00	Administrative & General	5. 00	10, 477, 306			i i		
28. 00	Administrative & General under		1, 619, 685	0	1, 619, 685	14, 117. 90	114. 73	28. 00
00.00	contract (see inst.)	, 00				0.00	0.00	00.00
29. 00	Maintenance & Repairs	6.00	70.004	1 000	0 700	0.00		29. 00
30.00	Operation of Plant	7. 00	78, 801			i i		
31.00	Laundry & Linen Service	8. 00	786, 113			i i		
32.00	Housekeepi ng	9. 00	2, 140, 399	52, 212	2, 192, 611	132, 810. 00		
33. 00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33. 00
34.00	Di etary	10. 00	1, 800, 763	-1, 438, 089	362, 674	21, 408. 00	16. 94	34.00
35. 00	Di etary under contract (see instructions)		0	0	0	0.00	0. 00	35. 00
36.00	Cafeteri a	11. 00	0	1, 479, 073	1, 479, 073	87, 219. 00	16. 96	36. 00
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0.00	37. 00
38.00	Nursing Administration	13. 00	1, 274, 234	31, 083	1, 305, 317	21, 876. 00	59. 67	38. 00
39.00	Central Services and Supply	14. 00	0	0	0	0.00	0.00	39. 00
40.00	Pharmacy	15. 00	0	0	0	0.00	0.00	40. 00
41.00	Medical Records & Medical	16. 00	2, 929, 358	71, 458	3, 000, 816	125, 956. 00	23. 82	41. 00
	Records Library							
42.00	Social Service	17. 00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18. 00	0	0	0	0.00	0.00	43. 00

Health Financial Systems In Lieu of Form CMS-2552-10 UNION HOSPITAL, INC. HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 15-0023 Peri od:

Worksheet S-3 Part III Date/Time Prepared: From 01/01/2021 To 12/31/2021 5/26/2022 10:49 am Average Hourly Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 ÷ (col . 2 ± col . col. 5) (from Salaries in Worksheet A-6) 3) col. 4 1.00 5.00 6.00 2.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 108, 574, 342 -1, 453, 506 107, 120, 836 2, 936, 780. 90 1.00 36. 48 instructions) 2.00 19, 357, 126 -2, 064, 344 17, 292, 782 274, 536. 00 62. 99 2.00 Excluded area salaries (see instructions) 3.00 Subtotal salaries (line 1 89, 217, 216 610, 838 89, 828, 054 2, 662, 244. 90 33.74 3.00 minus line 2) 4.00 Subtotal other wages & related 41, 899, 586 41, 899, 586 851, 721. 00 49. 19 4.00 costs (see inst.) Subtotal wage-related costs 5.00 29, 155, 073 C 29, 155, 073 0.00 32. 46 5.00 (see inst.) Total (sum of lines 3 thru 5) 6.00 6.00 160, 271, 875 610, 838 160, 882, 713 3, 513, 965. 90 45 78

-1, 876, 758

19, 486, 385

731, 598. 90

26.64

7.00

21, 363, 143

7.00

Total overhead cost (see

instructions)

Health Financial Systems	UNION HOSPITAL, INC.	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0023	Peri od: Worksheet S-3 From 01/01/2021 Part IV To 12/31/2021 Date/Time Prepared:

	To 12/31/2021	Date/Time Prep 5/26/2022 10:	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		1
	RETI REMENT COST		1
1.00	401K Employer Contributions	4, 196, 086	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		1
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		1
8. 00	Health Insurance (Purchased or Self Funded)	0	8.00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	•
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	12, 951, 723	8. 02
8. 03	Heal th Insurance (Purchased)	0	1
9. 00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	-190	10.00
	Life Insurance (If employee is owner or beneficiary)	36, 075	1
	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13. 00	Disability Insurance (If employee is owner or beneficiary)	209, 621	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	344, 591	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
	Non cumulative portion)		
	TAXES		1
17.00	FICA-Employers Portion Only	7, 401, 616	17. 00
18.00	Medicare Taxes - Employers Portion Only	0	18. 00
19.00	Unemployment Insurance	8, 170	19. 00
20.00	State or Federal Unemployment Taxes	0	20. 00
	OTHER		1
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21. 00
	instructions))		1
22. 00	Day Care Cost and Allowances	0	22. 00
	Tuition Reimbursement	201, 445	1
24. 00	Total Wage Related cost (Sum of lines 1 -23)	25, 349, 137	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00

Health Financial Systems	UNION HOSPITAL, INC.	In Lie	u of Form CMS-2	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0023	Peri od: From 01/01/2021 To 12/31/2021		pared:
Cost Center Description		Contract Labor 1.00	Benefit Cost 2.00	
PART V - Contract Labor and Benefit Cost		1.00	2.00	

			5/26/2022 10:4	49 am_
	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	8, 768, 906	25, 349, 137	1.00
2.00	Hospi tal	8, 768, 906	25, 349, 137	2.00
3.00	Subprovi der - I PF			3.00
4.00	Subprovi der - I RF	0	0	4. 00
5.00	Subprovi der - (Other)	0	0	5. 00
6.00	Swing Beds - SNF	0	0	6. 00
7.00	Swing Beds - NF	0	0	7. 00
8.00	Hospi tal -Based SNF			8. 00
9.00	Hospi tal -Based NF			9. 00
10.00	Hospi tal -Based OLTC			10.00
11. 00	Hospi tal -Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospi tal -Based Hospi ce			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospi tal -Based-CMHC			16.00
17.00	Renal Di al ysi s			17.00
18. 00	Other	0	0	18. 00

Heal th	Financial Systems UNION HOSPIT	AL INC		In lie	eu of Form CMS-2	2552_10		
	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der Co	CN: 15-0023	Peri od:	Worksheet S-1			
	The discount endities while the section of the section		0.1. 10 0020	From 01/01/2021				
				To 12/31/2021	Date/Time Pre 5/26/2022 10:			
	Uncompensated and indigent care cost computation							
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3	divided by li	ne 202 column	1 8)	0. 216956	1. 00		
2. 00	Medicaid (see instructions for each line) Net revenue from Medicaid				69, 813, 593	2. 00		
3.00	Did you receive DSH or supplemental payments from Medicaid?				Y	3. 00		
4. 00	If line 3 is yes, does line 2 include all DSH and/or supplem	nental payment	s from Medica	ni d?	Ň	4. 00		
5.00	If line 4 is no, then enter DSH and/or supplemental payments	from Medicai	d		2, 087, 211	5. 00		
6.00	Medi cai d charges				302, 411, 070			
7. 00 8. 00	Medicaid cost (line 1 times line 6) Difference between net revenue and costs for Medicaid progra	um (lino 7 min	uc cum of Lir	oc 2 and E. if	65, 609, 896 0	7. 00 8. 00		
6.00	<pre> &lt; zero then enter zero)</pre>	ııı (ııne / ııııı	ius suiii 01 111	ies 2 and 5, 11	0	8.00		
	Children's Health Insurance Program (CHIP) (see instructions	for each lin	e)					
9.00	Net revenue from stand-alone CHIP				0	9. 00		
10.00	Stand-allone CHIP charges				0	10. 00		
11.00	Stand-alone CHIP cost (line 1 times line 10)	D (line 11 mi	nuo lino O. i	f . zana than	0	11. 00 12. 00		
12. 00	Difference between net revenue and costs for stand-alone CHI enter zero)	P (TIME IT IIII	nus iine 9; i	i < zero then	0	12.00		
	Other state or local government indigent care program (see i	nstructions f	or each line)					
13.00	Net revenue from state or local indigent care program (Not i	ncluded on li	nes 2, 5 or 9	9)	0	13. 00		
14. 00	Charges for patients covered under state or local indigent of	are program (	Not included	in lines 6 or	0	14. 00		
15. 00	10)   State or local indigent care program cost (line 1 times line	. 14)			0	15. 00		
16. 00	Difference between net revenue and costs for state or local		program (Lir	ne 15 minus line		16. 00		
	13; if < zero then enter zero)	That gone oar o	program (iii			10.00		
	Grants, donations and total unreimbursed cost for Medicaid, instructions for each line)	CHIP and stat	e/local indio	jent care prograi	ms (see			
17. 00	Private grants, donations, or endowment income restricted to	funding char	ity care		0	17. 00		
18. 00	Government grants, appropriations or transfers for support of	of hospital op	erati ons		0	18. 00		
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and Ic	ocal indigent	care programs	(sum of lines	0	19. 00		
	8, 12 and 16)		Uni nsured	Insured	Total (col. 1			
			patients	patients	+ col . 2)			
			1.00	2. 00	3. 00			
	Uncompensated Care (see instructions for each line)	6 1111	15.500.4		15.500.444			
20. 00	Charity care charges and uninsured discounts for the entire (see instructions)	facility	15, 509, 14	14 0	15, 509, 144	20. 00		
21. 00	Cost of patients approved for charity care and uninsured dis	counts (see	3, 364, 80	02	3, 364, 802	21. 00		
22. 00	<pre>instructions) Payments received from patients for amounts previously writt</pre>	en off as		0 0	0	22. 00		
22.00	charity care		2 244 90	02	3, 364, 802	22.00		
23. 00	Cost of charity care (line 21 minus line 22)		3, 364, 80	02	3, 304, 602	23.00		
					1. 00 N	24. 00		
24. 00	24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit							
25. 00	imposed on patients covered by Medicaid or other indigent callfline 24 is yes, enter the charges for patient days beyond		care program	n's length of	0	25. 00		
26. 00	stay limit Total bad debt expense for the entire hospital complex (see	instructions)			25, 648, 655	26. 00		
27. 00	Medicare reimbursable bad debts for the entire hospital comp	,			334, 314	27. 00		
27. 01	Medicare allowable bad debts for the entire hospital complex				514, 328			
28. 00	Non-Medicare bad debt expense (see instructions)				25, 134, 327	28. 00		
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt	expense (see	instructions)		5, 633, 057	29. 00		
30. 00 31. 00	Cost of uncompensated care (line 23 column 3 plus line 29) Total unreimbursed and uncompensated care cost (line 19 plus	· line 20)			8, 997, 859 8, 997, 859			
31.00	Trotal differindulated and uncompensated care cost (fille 19 prus	, iiie 30)			1 0,777,009	31.00		

	FINANCIAI SYSTEMS	UNIUN HUSPII		N. 15 0022		Workshoot A	2332-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CO		Period: From 01/01/2021	Worksheet A	
					To 12/31/2021	Date/Time Pre	
	Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cati	5/26/2022 10: Reclassi fi ed	49 am
	cost center bescription	Sai ai i cs	Other	+ col . 2)	ons (See A-6)	Trial Balance	
				,	, ,	(col. 3 +-	
						col. 4)	
	I	1. 00	2. 00	3. 00	4. 00	5. 00	
1 00	GENERAL SERVICE COST CENTERS OO100 NEW CAP REL COSTS-BLDG & FIXT		14 000 000	14 000 000	( 102 (21	21 0/5 021	1 00
1. 00 2. 00	00200 NEW CAP REL COSTS-BLDG & FIXT		14, 882, 200 10, 283, 779			21, 065, 831 12, 953, 016	1. 00 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	256, 484	26, 178			4, 662, 658	4. 00
5. 01	00540 NONPATI ENT TELEPHONES	444, 773	349, 643			805, 266	5. 01
5.02	00550 DATA PROCESSING	O	0	(	o	0	5. 02
5. 03	00560 PURCHASING RECEIVING AND STORES	0	0	(	0	0	5. 03
5.04	OO570   ADMI TTI NG	1, 193, 931	275, 260	1, 469, 191	29, 124	1, 498, 315	5. 04
5. 05 5. 06	OO580   CASHI ERI NG/ACCOUNTS RECEI VABLE   OO590   OTHER ADMI N AND GENERAL	0 8, 838, 602	23, 712, 739	32, 551, 341	1 -12, 025, 533	0 20, 525, 808	5. 05 5. 06
7. 00	00700 OPERATION OF PLANT	78, 801	481, 044			561, 767	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	786, 113	431, 880			1, 237, 169	8. 00
9.00	00900 HOUSEKEEPI NG	2, 140, 399	1, 287, 527			3, 480, 138	9. 00
10.00	01000 DI ETARY	1, 800, 763	2, 799, 140			913, 797	1
11. 00	01100 CAFETERI A	0	0	(	-, ,	3, 727, 090	
13.00	01300 NURSING ADMINISTRATION 01600 MEDICAL RECORDS & LIBRARY	1, 274, 234	165, 638			1, 470, 955	
16. 00 21. 00	02100   &R SERVI CES-SALARY & FRINGES APPRVD	2, 929, 358	1, 465, 943	4, 395, 301		4, 466, 759 1, 580, 462	
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	O	0			2, 141, 040	
23. 00	02300 PARAMED ED PRGM	Ö	0			92, 944	
23. 01	02341 OTHER MED ED	1, 122, 493	115, 583	1, 238, 076	76, 625	1, 314, 701	23. 01
23. 02	02301 PARAMED ED PRGM	0	0	(	0	0	23. 02
	INPATIENT ROUTINE SERVICE COST CENTERS				1		
30.00	03000 ADULTS & PEDI ATRI CS	22, 657, 429	13, 978, 518			35, 964, 159	
31. 00 35. 00	03100   INTENSIVE CARE UNIT   02040   INTENSIVE NURSERY	5, 475, 124 2, 215, 885	4, 635, 122 1, 329, 738			10, 326, 887 3, 641, 617	31. 00 35. 00
41. 00	04100 SUBPROVI DER – I RF	1, 728, 886	342, 380			2, 158, 863	
43. 00	04300 NURSERY	0	0 12, 000			1, 056, 984	
	ANCILLARY SERVICE COST CENTERS			1			
50.00	05000 OPERATING ROOM	3, 397, 432	19, 940, 562			16, 832, 315	
50. 01	05001 CARDI AC SURGERY	2, 362, 162	2, 621, 047			4, 824, 664	
50. 02 51. 00	05002 WVSC   05100 RECOVERY ROOM	1 412 057	15, 494, 037	15, 494, 037 1, 939, 404		13, 331, 288 1, 978, 774	
51.00	05101 0/P TREATMENT ROOM	1, 613, 957 426, 326	325, 447 179, 421	605, 747		616, 147	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	3, 313, 083	3, 634, 704			7, 038, 459	
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 558, 147	4, 312, 622				
55. 00	05500 RADI OLOGY-THERAPEUTI C	354, 875	5, 274, 743			5, 638, 275	1
56. 00	05600 RADI OI SOTOPE	396, 520	1, 436, 329			1, 842, 522	1
57. 00	05700 CT SCAN	1, 036, 204	1, 064, 934			2, 126, 415	
58. 00 59. 00	05800   MAGNETIC RESONANCE I MAGING (MRI)   05900   CARDIAC CATHETERIZATION	712, 008 2, 433, 040	671, 923 20, 738, 629			1, 401, 300 21, 962, 640	
60. 00	06000 LABORATORY	1, 791, 188	9, 086, 670			10, 921, 552	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1, 702, 823			1, 702, 823	
65.00	06500 RESPI RATORY THERAPY	3, 423, 756	1, 500, 834			5, 037, 670	
66. 00	06600 PHYSI CAL THERAPY	140	5, 346, 066	5, 346, 206	5 3	5, 346, 209	
66. 01	06601 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0 457 00	0	0	66. 01
66. 02	O6602   O/P PHYSI CAL THERAPY   O6700   OCCUPATI ONAL THERAPY	0	3, 457, 307	3, 457, 307	0	3, 457, 307	
67. 00 68. 00	06800 SPEECH PATHOLOGY	0	599, 327	599. 327	7	0 599, 327	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	2, 075, 738	2, 150, 940		1	4, 277, 313	1
69. 01	06901 CARDI AC REHAB	301, 295	44, 647	345, 942		353, 292	1
70.00	07000 ELECTROENCEPHALOGRAPHY	2, 502, 601	1, 765, 453			4, 329, 102	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	985, 411	985, 411		0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		,	11, 105, 511	
73.00	07300 DRUGS CHARGED TO PATIENTS	4, 826, 702	55, 894, 965			56, 661, 679	
76. 00	03020  RENAL ACUTE   OUTPATIENT SERVICE COST CENTERS	0	2, 092, 555	2, 092, 555	0	2, 092, 555	76. 00
90. 00	09000 CLINIC	198, 572	45, 444	244, 016	4. 844	248, 860	90.00
90.05	09005 PATIENT NUTRITION	71, 747	15, 151	86, 898		88, 648	
90. 07	09007 WOUND CLINIC	393, 689	1, 120, 262			1, 511, 203	
91.00	09100 EMERGENCY	5, 515, 438	7, 356, 507	12, 871, 945	144, 396	13, 016, 341	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
						242.054.045	
	SPECIAL PURPOSE COST CENTERS	04 447 005			7 2, 887, 298	342, 956, 265	[118.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	94, 647, 895	245, 421, 072	340, 068, 967			1
	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS		245, 421, 072				190 00
190. 00	SUBTOTALS (SUM OF LINES 1 through 117)  NONREIMBURSABLE COST CENTERS  19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(	0	0	
190. 00 194. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS		245, 421, 072 0 3, 373, 139 25, 273	5, 549, 718	0 3 197, 110		194. 00
190. 00 194. 00 194. 01 194. 02	SUBTOTALS (SUM OF LINES 1 through 117)  NONREI MBURSABLE COST CENTERS  19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN  07950 RURAL HEALTH  07951 RENTAL PROPERTY  07954 FAMILY PRACTICE	0	0 3, 373, 139	5, 549, 718 25, 273 6, 754, 083	0 0 3 197, 110 3 0 3 -3, 599, 084	0 5, 746, 828 25, 273 3, 154, 999	194. 01 194. 02
190. 00 194. 00 194. 01 194. 02 194. 03	SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 07950 RURAL HEALTH 07951 RENTAL PROPERTY 07954 FAMILY PRACTICE 07952 WELLNESS	0 2, 176, 579 0 5, 018, 433 0	0 3, 373, 139 25, 273 1, 735, 650 0	5, 549, 718 25, 273 6, 754, 083	0 0 3 197, 110 3 0 3 -3, 599, 084 0 376, 695	0 5, 746, 828 25, 273 3, 154, 999 376, 695	194. 00 194. 01 194. 02 194. 03
190. 00 194. 00 194. 02 194. 03 194. 04	SUBTOTALS (SUM OF LINES 1 through 117)  NONREI MBURSABLE COST CENTERS  19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN  07950 RURAL HEALTH  07951 RENTAL PROPERTY  07954 FAMILY PRACTICE	0 2, 176, 579 0	0 3, 373, 139 25, 273	5, 549, 718 25, 273 6, 754, 083 ( 33, 380, 328	0 0 3 197, 110 3 0 3 -3, 599, 084 0 376, 695 3 213, 358	0 5, 746, 828 25, 273 3, 154, 999 376, 695 33, 593, 686	194. 00 194. 01 194. 02 194. 03 194. 04

Health Financial Systems	UNION HOSPI	TAL, INC.		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CC		eri od:	Worksheet A	
				rom 01/01/2021 o 12/31/2021	Date/Time Pre	
					5/26/2022 10:	49 am_
Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi 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	
194. 07 07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	546, 003	128, 664	674, 667	-75, 823	598, 844	194. 07
200.00   TOTAL (SUM OF LINES 118 through 199)	111, 153, 642	276, 571, 739	387, 725, 381	0	387, 725, 381	200. 00

Heal th	Financial Systems	UNI ON HOSPI	TAL, INC.		In Lie	u of Form CMS	S-2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CC	N: 15-0023	Peri od:	Worksheet A	
					From 01/01/2021 To 12/31/2021	Date/Time Pi	repared:
						5/26/2022 10	0: 49 am
	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation				
		6.00	7.00				
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT	-5, 052, 645					1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	-706, 900					2.00
4. 00 5. 01	00400 EMPLOYEE BENEFITS DEPARTMENT 00540 NONPATIENT TELEPHONES	17, 835, 057 -52, 769	1				4. 00 5. 01
5. 02	00550 DATA PROCESSING	16, 607, 106					5. 02
5. 03	00560 PURCHASING RECEIVING AND STORES	2, 141, 340					5. 03
5. 04	00570 ADMITTING	0					5. 04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	8, 310, 111					5. 05
5.06	00590 OTHER ADMIN AND GENERAL	14, 661, 304	35, 187, 112				5. 06
7.00	00700 OPERATION OF PLANT	9, 432, 084					7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	-7, 229					8. 00
9.00	00900 HOUSEKEEPI NG	-100, 190					9. 00
10.00	01000 DI ETARY	-721, 893					10.00
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	-900, 630 1, 161, 125					11. 00 13. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	377, 455					16. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0 0					21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	Ö	1				22. 00
23. 00	02300 PARAMED ED PRGM	0	1				23. 00
23. 01	02341 OTHER MED ED	-1, 025, 930	288, 771				23. 01
23. 02	02301 PARAMED ED PRGM	0	0				23. 02
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	-702, 459					30.00
31.00	03100   NTENSIVE CARE UNIT	-97, 769					31.00
35. 00 41. 00	02040   NTENSI VE NURSERY 04100   SUBPROVI DER -   RF	-904, 000 -323, 705					35. 00 41. 00
41.00	04300 NURSERY	-323, 705	1				43.00
43.00	ANCI LLARY SERVI CE COST CENTERS	0	1,030,704				45.00
50.00	05000 OPERATING ROOM	-3, 267, 366	13, 564, 949				50.00
50. 01	05001 CARDI AC SURGERY	-2, 542, 543					50. 01
50. 02	05002 WVSC	-1, 579, 639	11, 751, 649				50. 02
51. 00	05100 RECOVERY ROOM	19, 975					51.00
51. 02	05101 0/P TREATMENT ROOM	0	616, 147				51. 02
52. 00	05200 DELIVERY ROOM & LABOR ROOM	-2, 751, 145					52.00
54. 00	05400 RADI OLOGY - DI AGNOSTI C	107, 665					54.00
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0					55. 00 56. 00
57. 00	05700 CT SCAN	253, 571	., ,				57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	67, 262					58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	21, 170					59. 00
60.00	06000 LABORATORY	-22, 545					60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0					62. 00
65. 00	06500 RESPI RATORY THERAPY	0					65. 00
66. 00	06600 PHYSI CAL THERAPY	-2, 239, 294					66. 00
66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	- 1				66. 01
66. 02	06602 O/P PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	-1, 632, 851	1, 824, 456				66. 02 67. 00
67. 00 68. 00	06800 SPEECH PATHOLOGY	2, 310, 557 317, 277					68.00
69. 00	06900 ELECTROCARDI OLOGY	16, 465	1				69. 00
69. 01	06901 CARDI AC REHAB	299					69. 01
70. 00	07000 ELECTROENCEPHALOGRAPHY	-3, 239, 484	1				70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-14, 055	-14, 055				71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	11, 105, 511				72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 066, 616					73. 00
76. 00	03020 RENAL ACUTE	0	2, 092, 555				76. 00
00.00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC		248, 860				
90. 00 90. 05	09000 PATIENT NUTRITION	0 -1, 475					90. 00 90. 05
90. 03	09007 WOUND CLINIC	19, 040					90. 03
91. 00	09100 EMERGENCY	-3, 582, 577					91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 222, 211	1,,				92. 00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	43, 256, 386	386, 212, 651				118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0					190. 00
	07950 RURAL HEALTH	0					194. 00
	107951 RENTAL PROPERTY	0	25, 273				194. 01
	2 07954 FAMILY PRACTICE 3 07952 WELLNESS	0	3, 154, 999 376, 695				194. 02 194. 03
	4 07955  PHYSI CLAN PRACTI CES	-410, 000	1				194. 03
	07953 SYCAMORE SPORTS MED	-1, 205, 863					194. 04
	7 07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	1				194. 07
200.00		41, 640, 523	1				200. 00

Peri od: From 01/01/2021 To 12/31/2021 Date/Ti me Prepared: 5/26/2022 10:49 am Provider CCN: 15-0023

					5/26/2022 10: 49	am_
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
	A - PARAMED RECLASS					
1. 00	PARAMED ED PRGM	23.00	74, 169	<u> </u>		1. 00
	O FLENESS ASTLUITY PEOLASS		74, 169	16, 966		
1 00	B - FITNESS ACTIVITY RECLASS	4 00	115 404	27.002		1 00
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	115, 404	37, 893		1.00
2. 00	WELLNESS	1 <u>94.</u> 03	27 <u>8, 4</u> 67 393, 871	9 <u>1, 4</u> 35 129, 328		2. 00
	C - CLAY CITY RURAL HEALTH RE	CI ACC	393, 071	129, 320		
1. 00	RURAL HEALTH	194.00	0	47, 567		1. 00
1.00	0			47, 567		1.00
	D - CORK MEDICAL RURAL HEALTH	RECLASS	<u> </u>	17,007		
1.00	RURAL HEALTH	194.00	0	64, 414		1. 00
	0			64, 414		
	E - BRAZIL MEDICAL CENTER REC	LASS	· · · · · · · · · · · · · · · · · · ·			
1.00	RURAL HEALTH	194. 00	0	32, 034		1.00
				32, 034		
	F - HOUSE NURSE ASSISTANT REC	LASS		·		
1.00	INTENSIVE CARE UNIT	31.00	73, 922	7, 357		1.00
2.00	INTENSIVE NURSERY	35.00	37, 316	3, 714	1	2.00
3.00	SUBPROVI DER - I RF	41. 00	4 <u>0, 4</u> 15	4, 022	;	3.00
	0		151, 653	15, 093		
	G - EMPLOYEE ACCESS RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	7 <u>0, 7</u> 45	16,671		1. 00
	0		70, 745	16, 671		
1 00	H - TUBE FEEDING RECLASS	20.00	0.070			1 00
1. 00	ADULTS & PEDI ATRI CS	3000	2, 873	0		1. 00
	U FAMILY MEDICINE DECLASS		2, 873	U <sub> </sub>		
1 00	I - FAMILY MEDICINE RECLASS I&R SERVICES-SALARY &	21 00	1, 418, 894	10/ OF/		1 00
1. 00	FRINGES APPRVD	21. 00	1, 410, 094	126, 956		1. 00
2.00	I &R SERVI CES-OTHER PRGM	22. 00	1, 423, 057	683, 269		2. 00
2.00	COSTS APPRVD	22.00	1, 423, 037	003, 207		2. 00
	0	+	2, 841, 951	810, 225		
	J - LOBBY PHARMACY RECLASS		2/011/701	0.07220		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	555, 264	3, 559, 677		1. 00
			555, 264	3, 559, 677		
	K - IMPLANTABLE DEVICES RECLA	SS				
1.00	IMPL. DEV. CHARGED TO	72.00	0	11, 105, 511	•	1.00
	PATI ENTS					
2.00		0.00	0	0		2. 00
3.00		0.00	0	0	•	3. 00
4.00		0.00	0	0		4. 00
5. 00		0.00	0	0	'	5. 00
	U INTERECT REGIACO		0	11, 105, 511		
1 00	L - INTEREST RECLASS	1 00	ما	( 227 (4/		1 00
1. 00	NEW CAP REL COSTS-BLDG & FLXT	1.00	0	6, 327, 646		1. 00
2. 00	NEW CAP REL COSTS-MVBLE	2.00	o	2, 669, 237		2. 00
2.00	EQUI P	2.00	٩	2,007,237	•	2.00
	0	+		8, 996, 883		
	M - NURSERY RECLASS		<u> </u>	0,7,0,000		
1.00	NURSERY	43.00	854, 255	181, 891		1. 00
			854, 255	181, 891		
	N - PHARMACY PARAMED RECLASS					
1.00	OTHER MED ED	23. 01	44, 573	4, 670		1. 00
	0		44, 573	4, 670		
	O - CAFE RECLASS					
1.00	CAFETERI A	<u>11.</u> 00	<u>1, 443, 8</u> 52	<u>2, 248, 0</u> 17	•	1. 00
	0		1, 443, 852	2, 248, 017		
	P - CENTRAL SUPPLY RECLASS		1			
1.00	OPERATING ROOM	50.00	0	236, 499		1.00
2.00	CARDI AC SURGERY	50. 01	0	19, 708		2.00
3.00	WVSC	50. 02	0	59, 125		3.00
4.00	DELIVERY ROOM & LABOR ROOM	52.00	0	9, 854		4.00
5.00	RADI OLOGY-DI AGNOSTI C	54. 00 59. 00	0	78, 833 541, 076		5.00
6. 00 7. 00	CARDI AC CATHETERI ZATI ON RESPIRATORY THERAPY	65. 00	0	541, 976		6. 00 7. 00
7. 00 8. 00	EMERGENCY THERAPY	91.00		29, 562 9, 854		7. 00 8. 00
0.00	O	71.00		985, 411		J. UU
	Q - BONUS RECLASS		J J	700, 411		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	24, 342	0		1. 00
2. 00	NONPATIENT TELEPHONES	5. 01	10, 850	Ö		2. 00
3. 00	ADMITTING	5. 04	29, 124	Ö		3. 00
4. 00	OTHER ADMIN AND GENERAL	5. 06	205, 998	Ö		4. 00
	. !	-1	• •	-1	<u>'</u>	

Health Financial Systems RECLASSIFICATIONS | Peri od: | Worksheet A-6 | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared: Provider CCN: 15-0023

					5/26/2022 10	
		Increases				
	Cost Center	Li ne #	Sal ary	Other		
	2. 00	3.00	4.00	5. 00		
5.00	OPERATION OF PLANT	7.00	1, 922	0		5. 00
6.00	LAUNDRY & LINEN SERVICE	8.00	19, 176	0		6. 00
7.00	HOUSEKEEPI NG	9.00	52, 212	0		7. 00
8.00	DI ETARY	10.00	8, 636	0		8. 00
9.00	CAFETERI A	11.00	35, 221	0		9. 00
10.00	NURSING ADMINISTRATION	13.00	31, 083	0		10. 00
11.00	MEDICAL RECORDS & LIBRARY	16.00	71, 458	0		11. 00
12.00	I&R SERVICES-SALARY &	21.00	34, 612	0		12. 00
	FRINGES APPRVD					
13.00	I&R SERVICES-OTHER PRGM	22.00	34, 714	0		13. 00
	COSTS APPRVD					
14. 00	PARAMED ED PRGM	23. 00	1, 809	0		14. 00
15. 00	OTHER MED ED	23. 01	27, 382	0		15. 00
16. 00	ADULTS & PEDIATRICS	30.00	528, 231	0		16. 00
17. 00	INTENSIVE CARE UNIT	31.00	135, 362	0		17. 00
18. 00	I NTENSI VE NURSERY	35.00	54, 964	0		18. 00
19. 00	SUBPROVI DER - I RF	41.00	43, 160	0		19. 00
20.00	NURSERY	43. 00	20, 838	0		20. 00
21. 00	OPERATING ROOM	50.00	82, 876	0		21. 00
22. 00	CARDI AC SURGERY	50. 01	57, 622	0		22. 00
23.00	RECOVERY ROOM	51.00	39, 370	0		23. 00
24.00	O/P TREATMENT ROOM	51. 02	10, 400	0		24. 00
25. 00	DELIVERY ROOM & LABOR ROOM	52.00	80, 818	0		25. 00
26. 00	RADI OLOGY-DI AGNOSTI C	54.00	109, 381	0		26. 00
27. 00	RADI OLOGY-THERAPEUTI C	55. 00	8, 657	0		27. 00
28. 00	RADI OI SOTOPE	56.00	9, 673	0		28. 00
29. 00	CT SCAN	57. 00	25, 277	0		29. 00
30.00	MAGNETIC RESONANCE I MAGING	58.00	17, 369	0		30. 00
	(MRI)			_		
31. 00	CARDI AC CATHETERI ZATI ON	59.00	59, 351	0		31.00
32. 00	LABORATORY	60.00	43, 694	0		32. 00
33. 00	RESPI RATORY THERAPY	65. 00	83, 518	0		33. 00
34. 00	PHYSI CAL THERAPY	66. 00	3	0		34. 00
35. 00	ELECTROCARDI OLOGY	69. 00	50, 635	0		35. 00
36. 00	CARDI AC REHAB	69. 01	7, 350	0		36. 00
37. 00	ELECTROENCEPHALOGRAPHY	70.00	61, 048	0		37. 00
38. 00	DRUGS CHARGED TO PATIENTS	73.00	104, 196	0		38. 00
39. 00	CLINIC	90.00	4, 844	0		39. 00
40. 00	PATI ENT NUTRI TI ON	90. 05	1, 750	0		40.00
41. 00	WOUND CLINIC	90. 07	9, 604	0		41. 00
42. 00	EMERGENCY	91. 00	134, 542	0		42. 00
43. 00	RURAL HEALTH	194.00	53, 095	0		43. 00
44. 00	FAMI LY PRACTI CE	194. 02	53, 092	0		44. 00
45. 00	WELLNESS	194. 03	6, 793	0		45. 00
46. 00	PHYSICIAN PRACTICES	194. 04	213, 358	0		46. 00
47. 00	SYCAMORE SPORTS MED	194.06	446	0		47. 00
48. 00	PSYCHI ATRI C/PSYCHOLOGI CAL	194. 07	11, 593	0		48. 00
	SERVICES	<del> </del>		— — <sub>ō</sub>		
E00 00	Crand Total . Increases		2, 711, 449			E00 00
500. 00	Grand Total: Increases	ı l	9, 144, 655	28, 214, 358		500.00

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 UNION HOSPITAL, INC.

Peri od: From 01/01/2021 To 12/31/2021 Date/Ti me Prepared: 5/26/2022 10:49 am Provider CCN: 15-0023

						26/2022 10: 49 am
	2 1 2 1	Decreases	0.1	0.11		
	Cost Center 6.00	Li ne # 7.00	Sal ary 8.00	0ther 9.00	Wkst. A-7 Ref. 10.00	
	A - PARAMED RECLASS	7.00	0.00	7.00	10.00	
1.00	RADI OLOGY-DI AGNOSTI C	54.00	74, 169	16, 966	0	1. 00
	0		74, 169	16, 966		
1. 00	B - FITNESS ACTIVITY RECLASS OTHER ADMIN AND GENERAL	5. 06	393, 871	129, 328	0	1.00
2.00	OTHER ADMIN AND GENERAL	0.00	393, 6/1	129, 320	0	2.00
			393, 871	129, 328		
	C - CLAY CITY RURAL HEALTH REC					
1. 00	NEW CAP REL COSTS-BLDG &	1. 00	0	47, 567	9	1. 00
	FIXT	+		— — <sub>47, 56</sub> 7		
	D - CORK MEDICAL RURAL HEALTH	RECLASS		,		
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	64, 414	9	1. 00
	FIXT	+		64, 414		
	E - BRAZIL MEDICAL CENTER RECI	LASS	ΟĮ	04, 414		
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	32, 034	9	1. 00
	FI XT	+				
	O   F - HOUSE NURSE ASSISTANT REC	100	0	32, 034		
1.00	ADULTS & PEDIATRICS	30.00	151, 653	15, 093	0	1. 00
2.00	nische a resimme	0.00	0	0		2. 00
3.00		0.00	0_	0	0	3. 00
	0		151, 653	15, 093		
1. 00	G - EMPLOYEE ACCESS RECLASS PSYCHI ATRI C/PSYCHOLOGI CAL	194. 07	70, 745	16, 671	0	1.00
1.00	SERVI CES	174.07	70, 743	10, 07 1		1.00
	0		70, 745	16, 671		
	H - TUBE FEEDING RECLASS	40.00	0.070			
1. 00	DI ETARY		<u>2, 873</u> 2, 873	0	0	1.00
	I - FAMILY MEDICINE RECLASS		2,073	0		
1.00	FAMILY PRACTICE	194. 02	2, 841, 951	810, 225	0	1. 00
2.00		0.00	0	0		2. 00
	J - LOBBY PHARMACY RECLASS		2, 841, 951	810, 225		
1.00	DRUGS CHARGED TO PATIENTS	73.00	555, 264	3, 559, 677	0	1. 00
			555, 264	3, 559, 677		
	K - IMPLANTABLE DEVICES RECLA					
1.00	OPERATING ROOM	50. 00 50. 01	0	6, 825, 054		1.00
2. 00 3. 00	CARDI AC SURGERY WVSC	50. 01	0	235, 875 2, 221, 874		2. 00 3. 00
4. 00	CARDIAC CATHETERIZATION	59.00	Ö	1, 810, 356		4. 00
5.00	WOUND CLINIC	<u>90.</u> 07	o	1 <u>2, 3</u> 52		5. 00
	0		0	11, 105, 511		
1. 00	L - INTEREST RECLASS OTHER ADMIN AND GENERAL	5. 06	0	8, 996, 883	11	1.00
2. 00	OTTER ADMIN AND GENERAL	0.00	ő	0, 770, 663		2.00
				8, 996, 883		
	M - NURSERY RECLASS					
1. 00	ADULTS & PEDI ATRI CS	3000	85 <u>4, 2</u> 55 854, 255	18 <u>1, 891</u> 181, 891		1.00
	N - PHARMACY PARAMED RECLASS		654, 255	101, 091		
1.00	DRUGS CHARGED TO PATIENTS	73.00	44, 573	4, 670	0	1. 00
	0		44, 573	4, 670		
4 00	0 - CAFE RECLASS	40.00	4 442 050	0.040.047		1.00
1. 00	DI ETARY	1000	1, 44 <u>3, 8</u> 52 1, 443, 852	<u>2, 248, 017</u> 2, 248, 017		1.00
	P - CENTRAL SUPPLY RECLASS		1, 443, 632	2, 240, 017		
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	985, 411	0	1. 00
2.00	PATI ENTS	0.00		^		2.00
2. 00 3. 00		0. 00 0. 00	0	0		2. 00 3. 00
4. 00		0.00	ő	0		4. 00
5.00		0.00	О	0	0	5. 00
6.00		0.00	0	0	0	6.00
7. 00 8. 00		0. 00 0. 00	O	0	0	7. 00 8. 00
0.00	+			00 985, 411	<del> </del>	8.00
	Q - BONUS RECLASS		<u> </u>	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
1.00	OTHER ADMIN AND GENERAL	5. 06	2, 711, 449	0		1.00
2. 00 3. 00		0. 00 0. 00	0	0		2. 00 3. 00
3. 00 4. 00		0.00	0	0		4. 00
	1	-:1	۹			1 00

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

Period: Worksheet A-6
From 01/01/2021
To 12/31/2021 Date/Time Prepared: 5/26/2022 10:49 am Provider CCN: 15-0023

							5/26/2022 10:	49 am
		Decreases				1		
	Cost Center	Li ne #	Sal ary		Wkst. A-7 Ref.			
	6. 00	7. 00	8. 00	9. 00	10. 00			
5.00		0.00	0	0				5. 00
6.00		0.00	0	0				6. 00
7. 00		0.00	0	0				7. 00
8.00		0.00	0	0				8. 00
9.00		0.00	0	0				9. 00
10. 00		0.00	0	0				10. 00
11. 00		0.00	0	0				11. 00
12.00		0.00	0	0				12.00
13.00		0.00	0	0				13. 00
14.00		0.00	0	0				14. 00
15. 00		0.00	0	0				15. 00
16.00		0.00	0	0				16. 00
17. 00		0.00	0	0				17. 00
18. 00		0.00	0	0	0			18. 00
19. 00		0.00	0	0				19. 00
20.00		0.00	0	0				20. 00
21. 00		0.00	0	0				21. 00
22. 00		0.00	0	0				22. 00
23.00		0.00	0	0				23. 00
24. 00		0.00	0	0				24. 00
25. 00		0.00	0	0				25. 00
26.00		0.00	0	0				26. 00
27.00		0.00	0	0				27. 00
28. 00		0.00	0	0				28. 00
29. 00		0.00	0	0				29. 00
30.00		0.00	0	0	0			30.00
31. 00		0.00	0	0				31. 00
32.00		0.00	0	0	0			32. 00
33.00		0.00	0	0				33. 00
34.00		0.00	0	0				34. 00
35. 00		0.00	0	0				35. 00
36. 00		0.00	0	0				36. 00
37. 00		0.00	0	0				37. 00
38. 00		0.00	0	0				38. 00
39. 00		0.00	0	0				39. 00
40. 00		0.00	0	0				40. 00
41. 00		0.00	0	0				41. 00
42.00		0.00	0	0				42. 00
43. 00		0.00	0	0				43. 00
44.00		0.00	0	0				44. 00
45. 00		0.00	0	0				45. 00
46. 00		0.00	0	0				46. 00
47. 00		0.00	0	0				47. 00
48. 00		0.00		0		1		48. 00
E00.00	0		2, 711, 449	0		1		F00 00
500.00	Grand Total: Decreases		9, 144, 655	28, 214, 358	1			500.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS UNION HOSPITAL, INC. Provider CCN: 15-0023

				To	o 12/31/2021	Date/Time Pre 5/26/2022 10:	
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	17, 860, 235	1, 714, 177	0	1, 714, 177		1. 00
2.00	Land Improvements	20, 535, 875	310, 706	0	310, 706	l	2. 00
3.00	Buildings and Fixtures	402, 841, 063	0	0	0	94, 858, 610	3. 00
4.00	Building Improvements	2, 288, 759	102, 156, 333	0	102, 156, 333	0	4. 00
5.00	Fixed Equipment	0	0	0	0	0	5. 00
6.00	Movable Equipment	177, 458, 926	13, 569, 454	0	13, 569, 454	0	6. 00
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	620, 984, 858	117, 750, 670	0	117, 750, 670	94, 858, 610	8. 00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	620, 984, 858	117, 750, 670	0	117, 750, 670	94, 858, 610	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	19, 574, 412	0				1. 00
2.00	Land Improvements	20, 846, 581	0				2. 00
3.00	Buildings and Fixtures	307, 982, 453	0				3. 00
4.00	Building Improvements	104, 445, 092	0				4. 00
5.00	Fixed Equipment	0	0				5. 00
6.00	Movable Equipment	191, 028, 380	0				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	643, 876, 918	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	643, 876, 918	0				10. 00

Heal th	n Financial Systems	UNI ON HOSPI	TAL, INC.		In Lieu of Form CMS-2552-10		
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der CO	CN: 15-0023	Peri od:	Worksheet A-7	
					From 01/01/2021 To 12/31/2021	Part II   Date/Time Pre	nared·
					12, 01, 2021	5/26/2022 10:	
			SU	IMMARY OF CAF	PITAL		
	Cost Contor Description	Depreciation	Lease	Interest	Insurance (see	Tayos (soo	
	Cost Center Description	Depi eci ati on	Lease	Tillerest	instructions)		
		9. 00	10.00	11.00	12. 00	13. 00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	14, 882, 200	0		0 0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	10, 283, 779	0		0 0	0	2. 00
3.00	Total (sum of lines 1-2)	25, 165, 979	0		0 0	0	3. 00
		SUMMARY 0	F CAPITAL				
	Cook Cooker Doorsinties	0+1	T-+-1 (1) (				
	Cost Center Description		Total (1) (sum of cols. 9				
		Capi tal -Relate d Costs (see	through 14)				
		instructions)	till ough 14)				
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK			nd 2			
1.00	NEW CAP REL COSTS-BLDG & FLXT	0	14, 882, 200				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	10, 283, 779				2. 00
3.00	Total (sum of lines 1-2)	0	25, 165, 979				3. 00

Heal th	Health Financial Systems		TAL, INC.		In Lieu of Form CMS-2552-10		
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der CO	F	Period: From 01/01/2021 To 12/31/2021	Worksheet A-7 Part III Date/Time Prep	
		COMI	L PUTATION OF RAT	108	ALLOCATION OF	5/26/2022 10: 2 OTHER CAPITAL	19 am_
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE		T			_	
1.00	NEW CAP REL COSTS-BLDG & FIXT	452, 848, 538				0	1. 00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	191, 028, 380		, ,		0	2.00
3.00	Total (sum of lines 1-2)	643, 876, 918		010/070/710		0	3. 00
		ALLOCATION OF OTHER CAPITAL SUM				F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate	col s. 5			
			d Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS					
1.00	NEW CAP REL COSTS-BLDG & FLXT	0	0	(	9, 906, 302	0	1. 00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	(	9, 705, 626	0	2.00
3.00	Total (sum of lines 1-2)	0	0	(	19, 611, 928	0	3. 00
			SL	JMMARY OF CAPI	ΓAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
	oost content beschiptron	Tittorost	instructions)		Capi tal -Rel ate		
			Tristractions)	Tristractions)	d Costs (see	through 14)	
					instructions)	in ough 11)	
		11. 00	12. 00	13. 00	14.00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00	NEW CAP REL COSTS-BLDG & FIXT	6, 106, 884	0	(	0	16, 013, 186	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2, 540, 490			0	12, 246, 116	2.00
3.00	Total (sum of lines 1-2)	8, 647, 374	0	(	0	28, 259, 302	3.00

From 01/01/2021 12/31/2021 Date/Time Prepared: 5/26/2022 10:49 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Cost Center Line # Wkst. A-7 Ref. Amount 1.00 2.00 3.00 4.00 5.00 1.00 Investment income - NEW CAP -220, 762 NEW CAP REL COSTS-BLDG & 1. 00 В 1.00 11 REL COSTS-BLDG & FLXT (chapter lf i xt 2.00 Investment income - NEW CAP В -128, 747 NEW CAP REL COSTS-MVBLE 2.00 11 2.00 REL COSTS-MVBLE EQUIP (chapter FOUI P 3 00 Investment income - other 3 00 0 00 0 (chapter 2) 4 00 Trade, quantity, and time В -2, 361 OTHER ADMIN AND GENERAL 5.06 4.00 di scounts (chapter 8) Refunds and rebates of -205, 668 PURCHASING RECEIVING AND 5.00 В 5.03 5.00 expenses (chapter 8) STORES Rental of provider space by 6.00 0.00 6.00 suppliers (chapter 8) -21, 419 NONPATIENT TELEPHONES 7.00 Tel ephone services (pay Α 5.01 7.00 stations excluded) (chapter 21) 8.00 Tel evision and radio service 0 0.00 8.00 0 (chapter 21) Parking Lot (chapter 21) 9.00 0.00 9.00 0 -19, 995, 964 10.00 Provider-based physician A-8-2 10.00 adj ustment 11.00 Sale of scrap, waste, etc. 0.00 11.00 (chapter 23) 12.00 Related organization A-8-1 82, 209, 756 12.00 transactions (chapter 10) 13.00 Laundry and linen service 0.00 13.00 14.00 Cafeteria-employees and guests В -1, 286, 820 CAFETERI A 11.00 14.00 15.00 Rental of quarters to employee 0.00 15.00 and others -14, 055 MEDI CAL SUPPLI ES CHARGED TO 16.00 Sale of medical and surgical 71.00 16.00 supplies to other than PATI ENTS pati ents -412 DRUGS CHARGED TO PATIENTS 17.00 Sale of drugs to other than 73.00 17.00 Α pati ents -59, 280 MEDI CAL RECORDS & LI BRARY Sale of medical records and 18.00 В 16 00 18 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 -13, 224 OPERATION OF PLANT 20.00 Α 7.00 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) Utilization review -0 \*\*\* Cost Center Deleted \*\*\* 25.00 114.00 25.00 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 instructions) 31.00 Adjustment for speech A-8-3 OSPEECH PATHOLOGY 68.00 31.00

pathology costs in excess of limitation (chapter 14) Provider CCN: 15-0023 Peri od: Worksheet A-8 From 01/01/2021 | To 12/31/2021 | Date/Time Prepared:

				To	12/31/2021	Date/Time Pre 5/26/2022 10:	
				Expense Classification on	Worksheet A	1 37 207 2022 10.	47 4111
				To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	,	1.00	2. 00	3. 00	4. 00	5. 00	
32.00	CAH HIT Adjustment for		0		0.00	0	32. 00
	Depreciation and Interest						
33.00	TELEPHONE DEPRECIATION	A	-53	NEW CAP REL COSTS-MVBLE	2. 00	9	33. 00
				EQUI P			
34. 00	VENDING HOUSEKEEPING	A	·	HOUSEKEEPI NG	9. 00	0	
36. 00	LAB - BLDG	В	-80, 184	NEW CAP REL COSTS-BLDG &	1. 00	9	36. 00
		_		FLXT			
38. 00	LAB - ADMINISTRATION	В		OTHER ADMIN AND GENERAL	5. 06	0	38. 00
39. 00	LAB - LAUNDRY	В		LAUNDRY & LINEN SERVICE	8. 00	0	
40. 00	LAB - HOUSEKEEPING	В		HOUSEKEEPI NG	9. 00	0	
41. 00	LAB - OPERATION OF PLANT	В		OPERATION OF PLANT	7. 00	0	
42. 00	HAMILTON CENTER OPERATION OF	A	-114, 309	OPERATION OF PLANT	7. 00	0	42. 00
	PLANT						
42. 01	HAMILTON CENTER NUTRITION	A	-237, 056		10. 00	0	
45. 00	FITNESS ACTIVITY	В		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	
45. 01	UHF - HOUSEKEEPING	A	·	HOUSEKEEPI NG	9. 00	0	
45. 02	MI SCELLANEOUS	В		OTHER ADMIN AND GENERAL	5. 06	0	
45. 03	CATERI NG	В		CAFETERI A	11. 00	0	
45. 04	PHYSICIAN MEALS	В		CAFETERI A	11. 00	0	
45. 06	PHYSICIAN EQUIPMENT REVENUE	В		OPERATION OF PLANT	7. 00	0	
45. 08	LOBBY PHARMACY	В		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	
45. 09	LOBBYI NG COSTS	A	·	OTHER ADMIN AND GENERAL	5. 06	0	
45. 24	AP&S REVENUE	В	-120, 773	NEW CAP REL COSTS-BLDG &	1. 00	9	45. 24
				FLXT			
45. 26	AP&S REVENUE	В	·	DATA PROCESSING	5. 02	0	45. 26
45. 27	COH REVENUE	В	-17, 276	NEW CAP REL COSTS-BLDG &	1. 00	9	45. 27
		_		FIXT		_	
45. 29	COH REVENUE	В	·	NONPATIENT TELEPHONES	5. 01	0	1 .0.27
45. 32	PHYSICIAN RENTAL	A	-377, 769	NEW CAP REL COSTS-BLDG &	1. 00	9	45. 32
	DUNGLOLAN DENTAL		070 7/0	FIXT	7.00		45 07
45. 37	PHYSICIAN RENTAL	A		OPERATION OF PLANT	7. 00	0	
45. 38	ACCELERATED DEPRECIATION	A	13, 280	NEW CAP REL COSTS-BLDG &	1. 00	9	45. 38
4E 20	CONTINUING FOUGATION	В	2 000	FLXT	F 0/	_	45 20
45. 39	CONTINUING EDUCATION			OTHER ADMIN AND GENERAL	5. 06	0	
45. 40	EDUCATION SERVICES	В	·	OTHER ADMIN AND GENERAL	5.06	0	45. 40
45. 42	TRANSCRI PTI ON	В		MEDICAL RECORDS & LIBRARY	16.00	0	
45. 43	LAUNDRY	B B		LAUNDRY & LINEN SERVICE	8. 00	0	
45. 44	HOUSEKEEPI NG			HOUSEKEEPI NG	9.00	0	
45. 45	LANDSBAUM	В		OPERATION OF PLANT	7. 00	0	
45. 47	MAPLE CENTER	В	·	OTHER ADMIN AND GENERAL	5. 06	0	
45. 48	AP&S A/P PD SPACE/EQUIP RENT R	В В	-4, 067, 138	NEW CAP REL COSTS-BLDG &	1. 00	9	45. 48
4E 40	HAF		10 424 402	FLXT	E 0/	_	45 40
45. 49		A		OTHER ADMIN AND GENERAL	5.06	0	
46. 00	DI ETARY EXPENSES	A	-798, 681	NURSING ADMINISTRATION	10.00	0	46. 00
46. 01 50. 00	RECUITMENT EXPENSE	A	·		13. 00	0	46. 01
ou. uu	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A,		41, 640, 523	1			50. 00
	column 6, line 200.)						
(4) 5	COTUME O, TIME 200. )			0110 D 1 15 1			L

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

<sup>(2)</sup> Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 15-0023 Period: From 01/01/2021 To 12/31/2021 Date/Time Prepar

OTTTOL	50313			To 12/31/2021	Date/Time Pre 5/26/2022 10:	
	Li ne No.	Cost Center	Expense I tems	Amount of	Amount	
			'	Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	RGANIZATIONS OR	CLAIMED	
4 00	HOME OFFICE COSTS:	OTHER MED ED	DADAMED	1 0	4 005 000	4 00
1.00	•	OTHER MED ED	PARAMED	0	1, 025, 930	1.00
2.00		NEW CAP REL COSTS-BLDG & FIX		0	1, 875, 379	2.00
3.00	•	NEW CAP REL COSTS-MVBLE EQUI NONPATIENT TELEPHONES	HOME OFFICE	0	6, 557, 942	3.00
4. 00 4. 01		OPERATION OF PLANT	HOME OFFICE		208, 201 66, 173	4. 00 4. 01
4. 01		HOUSEKEEPING	HOME OFFICE		398, 672	4. 01
4. 02		NEW CAP REL COSTS-BLDG & FIX		1, 693, 356	370, 072	4. 02
4. 04			HOME OFFICE	5, 979, 842	0	4. 04
4. 05		EMPLOYEE BENEFITS DEPARTMENT	l	18, 310, 460	Ö	4. 05
4. 06		NONPATI ENT TELEPHONES	HOME OFFICE	181, 501	Ö	4. 06
4. 07		DATA PROCESSING	HOME OFFICE	16, 825, 959	Ö	4. 07
4. 08	•	PURCHASING RECEIVING AND STO		2, 347, 008	o	4. 08
4. 09		CASHI ERI NG/ACCOUNTS RECEI VAB		8, 310, 111	0	4. 09
4. 10	•	OTHER ADMIN AND GENERAL	HOME OFFICE	25, 699, 221	0	4. 10
4. 11	7. 00	OPERATION OF PLANT	HOME OFFICE	10, 150, 838	0	4. 11
4. 12	9. 00	HOUSEKEEPI NG	HOME OFFICE	359, 977	o	4. 12
4. 13	10.00	DI ETARY	HOME OFFICE	313, 844	o	4. 13
4. 14	11.00	CAFETERI A	HOME OFFICE	445, 546	o	4. 14
4. 15	13. 00	NURSING ADMINISTRATION	HOME OFFICE	1, 580, 630	0	4. 15
4. 16		MEDICAL RECORDS & LIBRARY	HOME OFFICE	450, 202	0	4. 16
4. 17	50.00	OPERATING ROOM	HOME OFFICE	315, 148	0	4. 17
4. 18	•	CARDI AC SURGERY	HOME OFFICE	11, 560	0	4. 18
4. 19	50. 02	1	HOME OFFICE	225, 583	0	4. 19
4. 20	•	RECOVERY ROOM	HOME OFFICE	19, 975	0	4. 20
4. 21		RADI OLOGY-DI AGNOSTI C	HOME OFFICE	278, 398	0	4. 21
4. 22		CT SCAN	HOME OFFICE	253, 571	0	4. 22
4. 23	•		HOME OFFICE	67, 262	0	4. 23
4. 24	•	CARDI AC CATHETERI ZATI ON	HOME OFFICE	21, 170	0	4. 24
4. 25 4. 26	•	PHYSI CAL THERAPY  0/P PHYSI CAL THERAPY	HOME OFFICE	199, 762	0	4. 25 4. 26
4. 20		OCCUPATIONAL THERAPY	HOME OFFICE	98, 628 160, 591	0	4. 20
4. 27		SPEECH PATHOLOGY	HOME OFFICE	56, 788	0	4. 27
4. 29		ELECTROCARDI OLOGY	HOME OFFICE	17, 825	0	4. 29
4. 30		CARDI AC REHAB	HOME OFFICE	299	0	4. 30
4. 31		ELECTROENCEPHALOGRAPHY	HOME OFFICE	1, 240	0	4. 31
4. 32		DRUGS CHARGED TO PATIENTS	HOME OFFICE	1, 067, 028	0	4. 32
4. 33		WOUND CLINIC	HOME OFFICE	19, 040	Ö	4. 33
4. 34	•	OPERATING ROOM	HOME OFFICE	255, 633	Ö	4. 34
4. 36	•	PHYSI CAL THERAPY	UNI ON THERAPI ES	2, 674, 761	5, 113, 817	4. 36
4. 37	•	O/P PHYSI CAL THERAPY	UNI ON THERAPI ES	1, 320, 421	3, 051, 900	4. 37
4. 38	•	OCCUPATIONAL THERAPY	UNION THERAPIES	2, 149, 966	0	4. 38
4.39		SPEECH PATHOLOGY	UNION THERAPIES	760, 272	499, 783	4. 39
4.40	194. 04	PHYSICIAN PRACTICES	UNION THERAPIES	0	410, 000	4.40
4.41	194. 06	SYCAMORE SPORTS MED	UNION THERAPIES	0	1, 205, 863	4. 41
5.00	0		0	102, 623, 416	20, 413, 660	5. 00

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

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

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

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

6. 00	G	0. 00 UNI ON HOSPI TAL 100. 00	6. 00
7. 00	G	0. 00 UNI ON THERAPY 100. 00	7.00
8. 00		0.00	8.00
9. 00		0.00	9.00
10. 00		0.00	10.00

STATEME OFFI CE		RELATED ORGANI ZATI ONS AND HO	ME Provider (	CCN: 15-0023	Peri od: From 01/01/2021 To 12/31/2021		epared:
				Related Organ	or Home Office		
	Symbol (1)	Name	Percentage of Ownership	1	Name	Percentage of Ownership	
	1. 00	2. 00	3.00	4	4. 00	5. 00	
	G. Other (financial or non-financial) specify:	OTHER					100. 00

UNION HOSPITAL, INC.

In Lieu of Form CMS-2552-10

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

Health Financial Systems

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
  B. Corporation, partnership, or other organization has financial interest in provider.
  C. Provider has financial interest in corporation, partnership, or other organization.
  D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der.

					10 12/01/2021	5/26/2022 10: 49 am
	Net	Wkst. A-7 Ref.				
	Adjustments					
	(col. 4 minus					
	col. 5)*					
	6. 00	7. 00				
	A. COSTS INCUR	RED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF TRAI	NSACTIONS WITH RELATED O	RGANIZATIONS OR C	CLAIMED
	HOME OFFICE CO					
1.00	-1, 025, 930					1.00
2.00	-1, 875, 379					2.00
3.00	-6, 557, 942					3.00
4.00	-208, 201	0				4. 00
4.01	-66, 173					4. 0
4.02	-398, 672					4. 02
4. 03	1, 693, 356					4. 03
4.04	5, 979, 842					4. 04
4.05	18, 310, 460					4. 0
4.06	181, 501	0				4. 00
4. 07	16, 825, 959					4. 0
4.08	2, 347, 008					4. 08
4. 09	8, 310, 111	0				4. 0
4. 10	25, 699, 221					4. 10
4. 11	10, 150, 838					4. 1
4. 12	359, 977					4. 12
4. 13	313, 844					4. 1:
4. 14	445, 546	1				4. 14
4. 15	1, 580, 630					4. 1!
4. 16	450, 202					4. 10
4. 17	315, 148	1				4. 1
4. 18	11, 560					4. 18
4. 19	225, 583					4. 19
4. 20	19, 975					4. 20
4. 21	278, 398					4. 2
4. 22	253, 571					4. 22
4. 23 4. 24	67, 262 21, 170					4. 2.
4. 25	199, 762					4. 2.
4. 26	98, 628					4. 20
4. 27	160, 591	o				4. 2
4. 28	56, 788					4. 28
4. 29	17, 825					4. 20
4. 30	299					4. 30
4. 31	1, 240					4. 3
4. 32	1, 067, 028					4. 32
4. 33	19, 040					4. 33
4. 34	255, 633					4. 34
4. 36	-2, 439, 056					4. 30
4. 37	-1, 731, 479					4. 3
4. 38	2, 149, 966					4. 38
4. 39	260, 489					4. 39
4. 40	-410, 000					4. 40
4. 41	-1, 205, 863					4. 4
5 00	82 209 756					5.00

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

Related Organization(s)		
and/or Home Office		
Type of Business		
6. 00		
B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

	HOME OFFICE	6.00	
	THERAPI ES	7.00	
8.00		8. 00 9. 00	
9.00		9.00	
8. 00 9. 00 10. 00		10.00	
100.00		100.00	

Health Financial Systems	UNION HOSPITA	L, INC.	In Lie	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOME	Provi der CCN: 15-0023	Peri od:	Worksheet A-8-1
OFFICE COSTS			From 01/01/2021 To 12/31/2021	Date/Time Prepared: 5/26/2022 10:49 am
Related Organization(s) and/or Home Office				
Type of Business				
6. 00				

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

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
  B. Corporation, partnership, or other organization has financial interest in provider.
  C. Provider has financial interest in corporation, partnership, or other organization.
  D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.

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

Peri od: From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/26/2022 10:49 am

							5/26/2022 10:	49 am
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1. 00	2.00	3.00	4.00	5. 00	6. 00	7. 00	
1.00		ADULTS & PEDIATRICS	702, 459			169, 700		1. 00
2. 00		INTENSIVE CARE UNIT	97, 769	97, 769		169, 700		2. 00
3.00		I NTENSI VE NURSERY	904, 000			169, 700		3.00
4. 00		SUBPROVI DER - I RF	323, 705			211, 500	0	4. 00
5. 00		OPERATING ROOM	3, 849, 282	3, 813, 282	· ·	246, 400	94	5. 00
6. 00		CARDI AC SURGERY	2, 554, 103	2, 554, 103		246, 400		6. 00
7. 00	50. 02		1, 805, 222	1, 805, 222		246, 400		7. 00
8. 00		DELIVERY ROOM & LABOR ROOM	2, 751, 145	2, 751, 145	0	237, 100	0	8. 00
9. 00	54. 00	RADI OLOGY-DI AGNOSTI C	192, 563	167, 563	25, 000	271, 900	167	9. 00
10.00		LABORATORY	308, 500	0	308, 500	260, 300	2, 285	10.00
11. 00	69. 00	ELECTROCARDI OLOGY	1, 360	1, 360	0	271, 900	0	11.00
12.00	70. 00	ELECTROENCEPHALOGRAPHY	3, 240, 724	3, 240, 724	0	179, 000	0	12.00
13. 00	90. 05	PATIENT NUTRITION	2, 250	0	2, 250	179, 000	9	13.00
14. 00	91. 00	EMERGENCY	3, 656, 961	3, 582, 577	74, 384	179, 000	2, 369	14.00
200. 00			20, 390, 043	19, 943, 909	446, 134		4, 924	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Limit		Memberships &	Component	of Mal practice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2.00	8.00	9. 00	12.00	13.00	14.00	
1.00		ADULTS & PEDIATRICS	0	0		0		1. 00
2. 00		INTENSIVE CARE UNIT	l o	l o	0	0	o	2. 00
3.00		I NTENSI VE NURSERY	0	0		0	1	3. 00
4. 00		SUBPROVIDER - IRF	0	0	0	0	o	4. 00
5. 00		OPERATING ROOM	11, 135	557	0	0	Ö	5. 00
6. 00		CARDI AC SURGERY	0	007	0	0	ő	6. 00
7. 00	50. 01		0	ľ	0	0	Ö	7. 00
8. 00		DELIVERY ROOM & LABOR ROOM			0	0	Ö	8. 00
9. 00		RADI OLOGY-DI AGNOSTI C	21, 830	1, 092	_	0	o	9. 00
10. 00		LABORATORY	285, 955				0	10. 00
11. 00		ELECTROCARDI OLOGY	200, 400	14, 270	0	0	0	11. 00
		l .				0	0	
12.00		ELECTROENCEPHALOGRAPHY	_		_	0		12.00
13.00		PATIENT NUTRITION	775	39		0	0	13.00
14. 00	91.00	EMERGENCY	203, 871	10, 194		0	0	14. 00
200.00	14/1 1 A 1 . //	0 1 0 1 (8)	523, 566			0	0	200. 00
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1. 00	2.00	14 15. 00	16. 00	17. 00	18. 00		
1.00		ADULTS & PEDIATRICS	15.00			702, 459		1. 00
2. 00		INTENSIVE CARE UNIT	Ö		0	97, 769		2. 00
3.00		INTENSIVE CARE ON T				904, 000		3. 00
4. 00		SUBPROVI DER – I RF	0		0	323, 705		4. 00
		OPERATING ROOM		11, 135	U	3, 838, 147		5. 00
5.00		CARDI AC SURGERY		11, 133		2, 554, 103		6. 00
6.00				0	0			
7.00	50. 02		0		0	1, 805, 222		7. 00
8.00		DELIVERY ROOM & LABOR ROOM	0		0	2, 751, 145		8. 00
9.00		RADI OLOGY-DI AGNOSTI C	0	21, 830		170, 733		9. 00
10.00		LABORATORY	0	285, 955		22, 545	1	10.00
11. 00		ELECTROCARDI OLOGY	0	0	0	1, 360	1	11. 00
12. 00		ELECTROENCEPHALOGRAPHY	0		0	3, 240, 724		12. 00
13. 00		PATIENT NUTRITION	0	775		1, 475	1	13.00
14. 00	91. 00	EMERGENCY	0	203, 871	0	3, 582, 577		14. 00
200.00			0	523, 566	52, 055	19, 995, 964		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 Provi der CCN: 15-0023

						o 12/31/2021	Date/Time Pre	pared:
				CAPI TAL REL	ATED COSTS		5/26/2022 10:	49 am
		Cost Contor Description	Not Eypopeos	NEW BLDG &	NEW MVBLE	EMPLOYEE	NONPATI ENT	
		Cost Center Description	Net Expenses for Cost	FIXT	EQUI P	BENEFI TS	TELEPHONES	
			Allocation			DEPARTMENT		
			(from Wkst A col. 7)					
	CENED	AL CEDILOE COCT CENTEDO	0	1. 00	2. 00	4. 00	5. 01	
1. 00		AL SERVICE COST CENTERS NEW CAP REL COSTS-BLDG & FIXT	16, 013, 186	16, 013, 186				1. 00
2.00		NEW CAP REL COSTS-MVBLE EQUIP	12, 246, 116	04 -0-	12, 246, 116			2. 00
4. 00 5. 01	1	EMPLOYEE BENEFITS DEPARTMENT NONPATIENT TELEPHONES	22, 497, 715 752, 497	91, 727 10, 716			945, 643	4. 00 5. 01
5.02	00550	DATA PROCESSING	16, 607, 106	0	C	0	0	5. 02
5. 03 5. 04		PURCHASING RECEIVING AND STORES ADMITTING	2, 141, 340 1, 498, 315	0 49, 941	1		0 34, 290	5. 03 5. 04
5. 05	00580	CASHI ERI NG/ACCOUNTS RECEI VABLE	8, 310, 111	0			01, 2,0	5. 05
5. 06 7. 00		OTHER ADMIN AND GENERAL OPERATION OF PLANT	35, 187, 112 9, 993, 851	283, 874 5, 461, 791			88, 392 54, 102	5. 06 7. 00
8. 00		LAUNDRY & LINEN SERVICE	1, 229, 940	97, 664			13, 716	8. 00
9.00		HOUSEKEEPI NG	3, 379, 948	25, 248			6, 096	9.00
10. 00 11. 00	1	DI ETARY CAFETERI A	191, 904 2, 826, 460	179, 017 127, 739			4, 572 18, 288	10. 00 11. 00
13.00	01300	NURSING ADMINISTRATION	2, 632, 080	38, 752	83	270, 064	6, 858	13.00
16. 00 21. 00		MEDICAL RECORDS & LIBRARY I &R SERVICES-SALARY & FRINGES APPRVD	4, 844, 214 1, 580, 462	86, 165 0	1		22, 860 0	16. 00 21. 00
22. 00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	2, 141, 040	0	C	301, 606	0	22. 00
23. 00 23. 01		PARAMED ED PRGM OTHER MED ED	92, 944 288, 771	0 11, 743	1		0	23. 00 23. 01
23. 01		PARAMED ED PRGM	200, 771	0			0	23. 01
20.00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	25 2/1 700	2 127 075	825, 503	4, 589, 442	130, 303	20.00
30. 00 31. 00	1	INTENSIVE CARE UNIT	35, 261, 700 10, 229, 118	3, 137, 975 374, 965			22, 098	30. 00 31. 00
35. 00		I NTENSI VE NURSERY	2, 737, 617	64, 131			13, 716	
41. 00 43. 00	1	SUBPROVIDER - IRF  NURSERY	1, 835, 158 1, 056, 984	251, 548 12, 363			23, 622 3, 048	41. 00 43. 00
	ANCI L	LARY SERVICE COST CENTERS						
50. 00 50. 01	1	OPERATING ROOM CARDIAC SURGERY	13, 564, 949 2, 282, 121	686, 744 31, 217			62, 484 4, 572	50. 00 50. 01
50. 02	05002	WVSC	11, 751, 649	495, 348	795, 226		0	50. 02
51. 00 51. 02	1	RECOVERY ROOM O/P TREATMENT ROOM	1, 998, 749 616, 147	23, 356 390, 231			13, 716 20, 574	51. 00 51. 02
52. 00	1	DELIVERY ROOM & LABOR ROOM	4, 287, 314	387, 230			17, 526	
54.00		RADI OLOGY - DI AGNOSTI C	9, 075, 513	522, 520			82, 296	
55. 00 56. 00		RADI OLOGY-THERAPEUTI C RADI OI SOTOPE	5, 638, 275 1, 842, 522	430, 467 143, 527			31, 242 0	55. 00 56. 00
57. 00		CT SCAN	2, 379, 986	35, 425			5, 334	
58. 00 59. 00		MAGNETIC RESONANCE IMAGING (MRI) CARDIAC CATHETERIZATION	1, 468, 562 21, 983, 810	42, 292 589, 342			3, 048 25, 908	58. 00 59. 00
60.00	06000	LABORATORY	10, 899, 007	0			6, 096	60. 00
62. 00 65. 00		WHOLE BLOOD & PACKED RED BLOOD CELLS  RESPIRATORY THERAPY	1, 702, 823 5, 037, 670	0 83, 947	363, 809	0 725, 637	0 10, 668	
66. 00	06600	PHYSI CAL THERAPY	3, 106, 915	165, 545			17, 526	
66. 01 66. 02		PSYCHIATRIC/PSYCHOLOGICAL SERVICES  0/P PHYSICAL THERAPY	0 1, 824, 456	0			0 762	66. 01 66. 02
67. 00		OCCUPATIONAL THERAPY	2, 310, 557	27, 042		0	3, 810	
68. 00		SPEECH PATHOLOGY	916, 604	53, 627		420, 024	762	
69. 00 69. 01	1	ELECTROCARDI OLOGY CARDI AC REHAB	4, 293, 778 353, 591	51, 882 106, 569			3, 048 4, 572	69. 00 69. 01
70. 00	07000	ELECTROENCEPHALOGRAPHY	1, 089, 618	0	68, 734	530, 406	12, 954	70. 00
71. 00 72. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS	-14, 055 11, 105, 511	0	0	0	0	71. 00 72. 00
73.00	07300	DRUGS CHARGED TO PATIENTS	57, 728, 295	337, 859			38, 100	73. 00
76. 00		RENAL ACUTE TIENT SERVICE COST CENTERS	2, 092, 555	57, 492	6, 211	0	3, 048	76. 00
90. 00		CLINIC	248, 860	11, 384	C	42, 086	0	90. 00
90. 05 90. 07		PATIENT NUTRITION WOUND CLINIC	87, 173	31, 478			0	90. 05 90. 07
91.00	1	EMERGENCY	1, 530, 243 9, 433, 764	146, 006 393, 525			9, 906 48, 006	91.00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
118. 00	-	AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	386, 212, 651	15, 549, 414	11, 986, 387	19, 649, 486	867, 919	118. 00
	NONRE	IMBURSABLE COST CENTERS						
		GIFT, FLOWER, COFFEE SHOP & CANTEEN RURAL HEALTH	0 5, 746, 828	0				190. 00 194. 00
194.0	1 07951	RENTAL PROPERTY	25, 273	0	2, 520	0	0	194. 01
194. 02	2 07954	FAMILY PRACTICE	3, 154, 999	195, 719	78, 062	461, 288	54, 102	194. 02

Health Financial Systems	UNION HOSPI	TAL, INC.		In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CO		Peri od: Worksheet B			
				From 01/01/2021 To 12/31/2021	Part     Date/Time Pre	narod:	
				10 12/31/2021	5/26/2022 10:	49 am	
		CAPI TAL REL	ATED COSTS				
Cost Center Description	Net Expenses	NEW BLDG &	NEW MVBLE	EMPLOYEE	NONPATI ENT		
	for Cost	FLXT	EQUI P	BENEFITS	TELEPHONES		
	Allocation			DEPARTMENT			
	(from Wkst A						
	col . 7)						
	0	1. 00	2. 00	4. 00	5. 01		
194. 03 07952 WELLNESS	376, 695	221, 309		0 59, 019	0	194. 03	
194. 04 07955 PHYSICIAN PRACTICES	33, 183, 686	0	113, 41	0 1, 853, 736	16, 764	194. 04	
194.06 07953 SYCAMORE SPORTS MED	66, 928	0		0 3, 878	0	194. 06	
194. 07 07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	598, 844	46, 744	78	8 100, 727	6, 096	194. 07	
200.00 Cross Foot Adjustments						200. 00	
201.00 Negative Cost Centers		0		0	0	201.00	
202.00   TOTAL (sum lines 118 through 201)	429, 365, 904	16, 013, 186	12, 246, 11	6 22, 589, 442	945, 643	202. 00	

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2021	Part
To 12/31/2021	Date/Time Prepared:
5/26/2022	10:49 am

Delicable Service Description					'	0 12/31/2021	5/26/2022 10:	
Select   S		Cost Center Description	DATA	PURCHASI NG	ADMITTING	CASHI ERI NG/ACC		
CHARLAN SERVICE COST CAMENDS   5.00   5.03   5.04   5.05   5.05   5.05   5.00			PROCESSI NG					
DEFINITE SERVICE OOS CENTERS   1 00 0000 DAY CAD BY COSTS. \$10 0.000 DAY CAD BY COST			F 00		F 04		FA 05	
0.000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.00000		CENEDAL CEDVICE COST CENTEDS	5. 02	5.03	5.04	5. 05	5A. U5	
2.00	1 00							1 00
0.000   DIGNO   DIAMPORT INFT TETRIFIENTS   16, 607, TOA   2, 1141, 340   5.0								1
0.046  WARAPTI ENT TELEPHONES								1
0.00500   DATA PRODESSING   10,007.10								1
5.03   0.0560   PURCHASING RECEIVING AND STORES   0   2.141, 340   1, 946, 667   1, 500   1			16 607 106					1
0.0570   ARMITTINE   0.0570								
5. 05   0.00990   DOSSID CRINICACOUNTS RECEIVABLE   0   0   0   8, 310, 111   37, 107, 241   7. 00   7				1	1 945 667	,		
0.000   0.000   CHER ADMIN AND SERVICE			0	0		I I		1
0 00700 (DPERATION OF PLANT 0 0 0000 (LUNDIN FETPING 0 7, 658 2, 401 0 0 0000 (LUNDIN FETPING 0 7, 658 2, 401 0 0 0000 (LUNDIN FETPING 1 30, 122 1 0 0 0 0 0 1, 706, 48 8 8.0 0 1, 706, 48 1, 791 0 0 0 0 0 1, 706, 48 8 8.0 1 30, 700 (LUNDIN FETPING 1 30			369.047	132	Ċ		37, 197, 241	
0.00   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.000					d	ol		1
0.000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.00000000		1	37, 658	2, 401	C	o		1
11.00 0 10100 (AFETRIA ) 115, 568 0 0 0 0 3, 470, 075 1 10.00 16.00 0 1600 (MISH NA ADMINISTRATION ) 7, 532 0 0 0 0 2, 6, 569, 569 13.00 16.00 0 1600 (MISH NA ADMINISTRATION ) 7, 532 0 0 0 0 0 0 0 0 0 0 1, 31, 3155 12.00 12.00 12.00 12.00 12.00 12.00 12.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00	00900 HOUSEKEEPI NG	67, 784	1, 391	c	o	3, 959, 478	9. 00
13.00   01300   NURSING ADMINISTRATION   7.522   0   0   0   2,955,309   13.00	10.00	01000 DI ETARY	30, 126	237	C	o	635, 516	10.00
16.00   01000   MEDICAL RECORDS & LIBRARY   149,552   183   0   0   0,072,919   16.00   22.00   02200   188 SERVICES-CHIER PROM COSTS APPRVD   0   0   0   0   0   0   2,442,646   22.00   23.01   23.00   2	11. 00	01100 CAFETERI A	135, 568	0	C	0	3, 420, 075	11. 00
21.00   02100   LAR SERVICES-SALARY & FRINCES APPRVD   0   0   0   0   1,881,185   21.00   0220   02200   02200   LAR SERVICES-OFTHER PREMICOSTS APPRVD   0   0   0   0   0   0   0   0   0	13.00	01300 NURSING ADMINISTRATION	7, 532	0	C	0	2, 955, 369	13. 00
22.00   02000   RAS SERVICES-OTHER PROM COSTS APPRVID   0   0   0   0   0   0   0   0   0	16. 00		489, 552	183	C	0		
23.00   02300  PARAMED ED PREM   0   0   0   0   0   31,56,63   23.00   23.01   02341  OTHER MED ED PREM   0   0   0   0   0   0   0   0   0			0	0	C	0		1
23.01   02341   OTHER NED FOD   0   0   0   0   0   0   0   0   0					_	1		1
23.02			_	1	· · · · · · · · · · · · · · · · · · ·	1 1		1
INPATI ENT ROUTINE SERVICE COST CENTERS   4,451,155					_			1
30.00   03000   ADULTS & PEDIATRICS   4.451,155   481,309   307,109   6.65,107   49,925,603   30.00   30.00   03100   INTENSIN EACRE IMIT   7.75,251   797,470   111,790   116,0555   12,900,278   31.00   31.00   31.00   03100   INTENSIN EACRE IMIT   7.75,751   03.00   0.10	23. 02		0	0		0	0	23. 02
31.00   03100   INTENSI WE CARE UNIT   7, 522   197, 470   111, 798   166, 555   12, 960, 278   31.05   35.00   0240   INTENSIS WE INVESTEY   143, 100   26, 933   61, 24   791, 244   791, 244   3, 911, 315   35.00   041.00   SUBPROVI DER - I RF   0   0   9, 402   14, 000   1, 227, 107   43.00   43.00   43200   NURSERY   0   0   9, 402   14, 000   1, 227, 107   43.00   43.00   43200   NURSERY   75.316   60, 955   1811, 729   866, 462   19, 191, 897   50.00   50.00   05000   OPERATI ING ROOM   775, 751   60, 955   1811, 729   866, 462   19, 191, 897   50.00   50.00   05000   OPERATI ING ROOM   37, 558   88, 599   478, 814   343   621, 883   14, 998, 862   50.00   50.00   05000   OPERATI ING ROOM   331, 386   47, 526   10, 734   35, 066   2, 877, 639   51.00   05100   RECOVERY ROOM   331, 386   84, 546   274   170, 063   1, 236, 465   51.00   51.00   05100   RECOVERY ROOM   406, 705   818, 456   274   470, 603   1, 236, 465   51.00   52.00   052000   DELI VERY ROOM & LABOR ROOM   406, 705   76, 472   63, 964   115, 520   63, 321, 347   52.00   052000   DELI VERY ROOM & LABOR ROOM   406, 705   76, 472   63, 964   115, 520   63, 321, 347   52.00   05500   RADI OLOGY - INCADE LINE AND ROOM   406, 705   2, 201, 201, 201, 201, 201, 201, 201, 2	20.00		4 451 155	401 200	207 100	/51 107	40,025,702	20.00
143, 100   02040   INTENSIVE NURSERY   143, 100   26, 933   61, 247   91, 244   3, 911, 315   35, 00   43.00   04300   NURSERY   0   0   0, 402   14, 006   1, 277, 107   43, 00   1, 277, 107   43, 00   1, 277, 107   43, 00   1, 277, 107   43, 00   1, 277, 107   43, 00   05000								1
14. 00   04100   SUBPROVIDER - I FF   0   18, 264   16, 452   24, 510   2, 558, 684   41. 00   43. 00   43.0								1
A3. 00   04300   NURSERY   0   0   0   9, 402   14, 006   1, 277, 107   43, 00								1
ANCILLARY SERVICE COST CENTERS					· ·			1
50.00   0500	43.00		0	U	7, 402	14,000	1, 277, 107	43.00
50.00	50 00		775 751	60 955	181 729	868 462	19 191 897	50.00
SOLD   05002   WSC   SOLD   WSC								1
51.00								
15.1 02   05.101   0.PT TREATMENT ROOM   ALABOR ROOM   A.06, 705   76, 472   33, 964   115, 520   6, 321, 347   52. 00   05.								1
S2-00   05200   DELIVERY ROOM & LABOR ROOM   406, 705   76, 472   63, 964   115, 520   6 , 321, 347   \$2. 00		1						1
55.00   05500   RADIOLOGY-THERAPEUTIC   482,020   1,047   9,139   246,572   7,147,563   55.00     55.00   05500   RADIOLOGY-THERAPEUTIC   60,253   2,071   4,266   58,244   2,544,675   60     57.00   05700   CT SCAN   0   0   67,324   55,710   275,449   3,412,814   57.00     58.00   05500   CARDIAC CATHETERIZATION   723,030   14,673   116,433   527,128   24,799,942   59.00     60.00   06000   LABORATORY   0   2,825   182,362   504,245   12,004,252   60.00     60.00   06000   WHOLE BLOOD & PACKED RED BLOOD CELLS   0   0   9,850   17,510   1,730,183   62.00     60.00   06000   WHOLE BLOOD & PACKED RED BLOOD CELLS   0   0   9,850   17,510   1,730,183   62.00     60.00   06000   WHOLE BLOOD & PACKED RED BLOOD CELLS   0   0   9,850   17,510   1,730,183   62.00     60.00   06000   WHOLE BLOOD & PACKED RED BLOOD CELLS   0   0   0   9,850   17,510   1,730,183   62.00     60.00   06000   WHOLE BLOOD & PACKED RED BLOOD CELLS   0   0   0   9,850   17,510   1,730,183   62.00     60.00   06000   WHOLE BLOOD & PACKED RED BLOOD CELLS   0   0   0   0   0   0   0     60.01   06000   WHOLE BLOOD & PACKED RED BLOOD CELLS   0   0   0   0   0   0   0     60.01   06000   WHOLE BLOOD & PACKED RED BLOOD CELLS   0   0   0   0   0   0   0   0     60.01   06000   WHOLE BLOOD & PACKED RED BLOOD CELLS   0   0   0   0   0   0   0   0     60.01   06000   WHOLE BLOOD & PACKED RED BLOOD CELLS   0   0   0   0   0   0   0   0     60.01   06000   WHOLE BLOOD & PACKED RED BLOOD CELLS   0   0   0   0   0   0   0   0     60.01   06000   WHOLE BLOOD & PACKED RED BLOOD CELLS   0   0   0   0   0   0   0   0     60.01   06000   WHOLE BLOOD & PACKED RED BLOOD CELLS   0   0   0   0   0   0   0   0     60.01   06000   WHOLE BLOOD CELLS   0   0   0   0   0   0   0   0   0	52.00	1			63, 964			1
56.00   05600 RADIO I SOTOPE   60, 253   2, 071   4, 266   55, 824   2, 534, 467   56.00     57.00   05700   CT SCAN   0 0 67, 324   55, 710   275, 449   3, 412, 814   57, 00     58.00   05800   MAGNETI C RESONANCE I MAGI NG (MRI )   15, 063   2, 826   8, 505   73, 065   2, 657, 773   58.00     59.00   05900   CARDITA C CATHETERI ZATI ON   723, 030   14, 673   116, 433   527, 128   24, 799, 942   59.00     60.00   06000   LABORATORY   20, 04, 252   60.00     60.00   06000   LABORATORY   PACKED RED BLOOD CELLS   0 0 0 9, 850   17, 510   1, 730, 183   62.00     60.00   06000   RESPI RATIORY   THERAPY   361, 515   1, 245   32, 257   75, 105   3, 773, 171   66.00     60.01   0600   PSYCHI ATRIC / PSYCHOLOGI CAL SERVI CES   0 0 0 0 0 0 0 0 0 0 0   0 66.01     60.01   0600   PSYCHI ATRIC / PSYCHOLOGI CAL SERVI CES   0 0 0 4, 772   21, 349   997, 114   68.00     60.00   06000   OFPHYS CAL THERAPY   0 0 0 4, 772   21, 349   997, 114   68.00     60.00   06000   OFPHYS CAL THERAPY   0 0 0 4, 772   21, 349   997, 114   68.00     60.00   06000   OFPHYS CAL THERAPY   0 0 0 4, 772   21, 349   997, 114   68.00     60.01   06000   OFPHYS CAL THERAPY   0 0 0 4, 772   21, 349   997, 114   68.00     60.01   06000   OFPHYS CAL THERAPY   0 0 0 4, 772   21, 349   997, 114   68.00     60.01   06000   OFPHYS CAL THERAPY   0 0 0 4, 772   21, 349   997, 114   68.00     60.01   06000   OFPHYS CAL THERAPY   0 0 0 4, 772   21, 349   997, 114   68.00     60.01   06000   OFPHYS CAL THERAPY   0 0 0 44, 752   21, 349   997, 114   68.00     60.01   06000   OFPHYS CAL THERAPY   0 0 0 44, 752   21, 349   997, 114   68.00     06.01   06000   OFPHYS CAL THERAPY   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	54.00	05400 RADI OLOGY-DI AGNOSTI C	497, 083	31, 088	64, 208	367, 374	13, 344, 806	54.00
57.00   05700   CT SCAN   0   05700   CT SCAN   0   06.00   05800   MAGNETI C RESONANCE I MAGI NG (MRI )   15.06.3   2.826   8.5.05   73.065   2.657, 773   58.00	55.00	05500 RADI OLOGY-THERAPEUTI C	482, 020	1, 047	9, 139	246, 572	7, 147, 563	55. 00
S8.00   OSBOO   MAGNETIC RESONANCE IMAGIN (MRI)   15,063   2,826   8,505   73,065   2,657,773   58.00	56.00	05600 RADI OI SOTOPE	60, 253	2, 071	4, 206	55, 824	2, 534, 467	56. 00
59.00   05900   CARDIAC CATHETERIZATION   723,030   14,673   116,433   527,128   24,799,942   59,00	57.00	05700 CT SCAN	0	67, 324	55, 710	275, 449	3, 412, 814	57. 00
60.00   06000   LABORATORY   0   2,825   182,362   504,245   12,004,252   60,00   62.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   0   0   0   9,850   17,510   1,730,183   62.00   65.00   06500   RESPIRATORY THERAPY   165,694   80,907   118,965   193,032   6,780,329   65.00   66.01   06600   PHYSI CAL THERAPY   361,515   1,245   32,257   75,105   3,773,117   66.00   66.01   06601   PSYCHI ATRIC C/PSYCHOLOGI CAL SERVI CES   0   0   0   0   0   0   0   0   66.02   06602   O/P PHYSI CAL THERAPY   0   0   0   24,348   60,373   2,013,855   66.02   67.00   06700   0CCUPATI ONAL THERAPY   0   0   0   4,772   21,349   997,114   68.00   68.00   06800   SPEECH PATHOLOGY   0   0   4,772   21,349   997,114   68.00   69.00   06900   ELECTROCARDI OLOGY   369,047   86   58,900   444,268   6,736,864   69.00   69.01   06901   CARDIAC REHAB   30,126   471   411   7,462   631,377   69.00   67.00   07000   ELECTROCARDI OLOGY   263,605   806   2,903   20,164   1,989,190   70.00   67.00   07100   MBUC LAS SUPPLIES CHARGED TO PATI ENTS   0   0   44,593   249,089   11,399,193   72.00   67.00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   44,593   249,089   11,399,193   72.00   67.00   07200   LINI C   22,595   230   5   4,266   329,426   90.00   67.00   07000   DESERVATION DEDS (NON-DISTINS   0   31,779   13,781   22,480   2,227,346   67.00   07000   DESERVATION BEDS (NON-DISTINCT PART)   14,031,310   2,129,435   1,945,667   8,310,111   379,883,769   67.00   07900   MBURSABLE COST CENTERS   0   0   0   0   0   7,084,027   194.00   67.01   09705   RURAL HEALTH   805,878   4,302   0   0   0   4,356,031   194.00   67.01   097951   RURAL HEALTH   805,878   4,302   0   0   0   0   0   0   0   0   67.02   097954   FAIR TYPROCE FORTY   0   0   0   0   0   0   0   0   0			15, 063	2, 826	8, 505	73, 065	2, 657, 773	58. 00
62.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   0   0   9,850   17,510   1,730,183   62.00   65.00   06500   RESPI RATORY THERAPY   165,694   80,907   118,965   193,032   6,780,329   65.00   66.01   06600   PHYSI CAL THERAPY   361,515   1,245   32,257   75,105   3,773,117   66.00   66.01   06601   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   0   0   0   0   0   0   66.00   66.02   06600   OF PHYSI CAL THERAPY   67,784   1,782   0   37,079   2,013,855   66.02   67.00   06700   0CCUPATI ONAL THERAPY   67,784   1,782   0   37,079   2,013,855   66.02   68.00   06800   SPEECH PATHOLOGY   0   0   0   4,772   21,349   997,114   68.00   69.01   06900   ELECTROCARDI OLOGY   369,047   86   58,900   444,268   6,736,864   69.00   69.01   06901   CARDI AC REHAB   30,126   471   411   7,462   631,937   69.01   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   4,792   249,089   11,399,193   720.00   72.00   07200   IMPL DEV CHARGED TO PATI ENTS   0   0   44,593   249,089   11,399,193   720.00   73.00   07300   DRUGS CHARGED TO PATI ENTS   1,468,656   45,133   191,580   1,697,416   62,546,715   73.00   74.00   07300   DRUGS CHARGED TO PATI ENTS   1,468,656   45,133   191,580   1,697,416   62,546,715   73.00   75.00   07400   MEDI CAL SUPPLIES CHORED TO PATI ENTS   0   31,779   13,781   22,480   2,227,346   76.00   07400   DRUGS CHARGED TO PATI ENTS   1,468,656   45,133   191,580   1,697,416   62,546,715   73.00   76.00   07400   DRUGS CHARGED TO PATI ENTS   1,468,656   45,133   191,580   1,697,416   62,546,715   73.00   76.00   07400   MEDI CAL SUPPLIES CHORED TO PATI ENTS   1,468,656   45,133   191,580   1,697,416   62,546,715   73.00   77.00   07900   DRUGS CHARGED TO PATI ENTS   1,468,656   45,133   191,580   1,697,416   62,546,715   73.00   78.00   07900   DRUGS CHARGED TO PATI ENTS   1,468,656   45,133   191,580   1,697,416   62,546,715   73.00   79.00   09000   CLI NIC   128,037   31,831   0   52,489   2,017,939   90.07   79.00   09000   05000   05000   05000   05000   05000   05000   05000   05		1 1	723, 030	14, 673				1
65.00   06500   RESPIRATORY THERAPY   165,694   80,907   118,965   193,032   6,780,329   65.00   66.01   06601   PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								1
66. 00   06600   PHYSICAL THERAPY   361, 515   1, 245   32, 257   75, 105   3, 773, 117   66. 00   66. 01   06601   PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES   0 0 0 0 0 0 0 0 0 0   66. 02   06602   O/P PHYSICAL THERAPY   67, 784   1, 782   0 37, 079   2, 013, 855   66. 02   06602   O/P PHYSICAL THERAPY   0 0 0 24, 348   60, 373   2, 426, 130   67. 00   06700   OCCUPATI ONAL THERAPY   0 0 0 4, 772   21, 349   997, 114   68. 00   06800   SPECH PATHOLOGY   369, 047   86   58, 900   444, 268   6, 736, 864   69. 01   06901   CARDI AC REHAB   30, 126   471   411   7, 462   631, 937   69. 01   06901   CARDI AC REHAB   30, 126   471   411   7, 462   631, 937   69. 01   06901   CARDI AC REHAB   30, 126   471   411   7, 462   631, 937   69. 01   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0 0 44, 593   249, 089   11, 399, 193   72, 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0 0 44, 593   249, 089   11, 399, 193   72, 00   72. 00   07200   IMPL DEV. CHARGED TO PATI ENTS   0 0 31, 779   13, 781   22, 480   2, 227, 346   76. 00   03020   RENAL ACUTE   0 31, 779   13, 781   22, 480   2, 227, 346   77. 00   07000   CENTRE OFFERS   0 0 31, 779   13, 781   22, 480   2, 227, 346   78. 00   07000   07000   07000   07000   07000   07000   79. 00   09000   CLINI C   22, 595   230   5 4, 266   329, 426   90. 00   79. 00   09000   07000   07000   07000   07000   07000   79. 00   09000   07000   07000   07000   07000   07000   79. 00   09000   07000   07000   07000   07000   07000   79. 00   09000   07000   07000   07000   07000   07000   79. 00   09000   07000   07000   07000   07000   07000   79. 00   09000   07000   07000   07000   07000   07000   79. 00   09000   07000   07000   07000   07000   07000   79. 00   09000   07000   07000   07000   07000   07000   79. 00   09000   07000   07000   07000   07000   07000   07000   79. 00   09000   07000   07000   07000   07000   07000   07000   79. 00   09000   07000   07000   07000   07000   07000   07000   79. 00   09000   07000   07000   07000   07000   07000   070			_	1				1
66. 01   06601   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   0   0   0   0   0   0   0   66. 01   66. 02   06602   07P PHYSI CAL THERAPY   67, 784   1, 782   0   37, 079   2, 013, 855   66. 02   67. 00   06700   0CCUPATI ONAL THERAPY   0   0   0   24, 348   60, 373   2, 426, 130   67. 00   68. 00   06800   SPEECH PATHOLOGY   0   0   0   4, 772   21, 349   997, 114   68. 00   69. 00   06900   ELECTROCARDI OLOGY   369, 047   86   58, 900   444, 268   6, 736, 684   69. 00   69. 01   06901   CARDI AC REHAB   30, 126   471   411   7, 462   631, 937   69. 01   70. 00   07000   ELECTROENCEPHALOGRAPHY   263, 605   806   2, 903   20, 164   1, 989, 190   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   0   -14, 055   71. 00   72. 00   07200   IMPL DEV. CHARGED TO PATI ENTS   0   0   0   44, 593   249, 089   11, 399, 193   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   1, 468, 656   45, 133   191, 580   1, 697, 416   62, 546, 715   76. 00   90. 05   09000   CLIN C   0   0   0   0   0   0   0   90. 05   09000   CLIN C   0   0   0   0   0   90. 05   09000   DATI ENT SERVICE COST CENTERS   0   0   31, 779   13, 781   22, 480   2, 227, 346   90. 07   09000   CLIN C   0   0   0   0   0   0   91. 00   09000   CLIN C   0   0   0   0   0   92. 00   09000   DATI ENT SERVICE COST CENTERS   0   0   0   0   0   0   92. 00   09000   DATI ENT SERVICE COST CENTERS   0   0   0   0   0   0   92. 00   09000   DATI ENT SERVICE COST CENTERS   0   0   0   0   0   0   92. 00   09000   DATI ENT SERVICE COST CENTERS   0   0   0   0   0   0   0   94. 00   09000   DATI ENT SERVICE COST CENTERS   0   0   0   0   0   0   94. 00   09000   DATI ENT SERVICE COST CENTERS   0   0   0   0   0   0   0   0   94. 00   09000   DATI ENT SERVICE COST CENTERS   0   0   0   0   0   0   0   0   94. 00   09000   DATI ENT SERVICE COST CENTERS   0   0   0   0   0   0   0   0   0   94. 00   09000   DATI ENT SERVICE COST CENTERS   0   0   0   0   0   0   0   0   0		1						1
66.02   06602   0/P PHYSICAL THERAPY   67,784   1,782   0   37,079   2,013,855   66.02   67.00   06700   0CCUPATI ONAL THERAPY   0   0   0   24,348   60,373   2,426,130   68.00   06800   SPEECH PATHOLOGY   0   0   0   4,772   69.01   06900   ELECTROCARDI OLOGY   369,047   86   58,900   444,268   6,736,864   69.01   06901   CARDI AC REHAB   30,126   471   411   7,462   631,937   70.00   07000   ELECTROCARDI OLOGY   263,605   806   2,903   20,164   1,989,190   70.00   07000   ELECTROCARDI CLORAPHY   263,605   806   2,903   20,164   1,989,190   70,00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   -14,055   71,00   72.00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   44,593   249,089   11,399,193   72,00   73.00   07300   DRUGS CHARGED TO PATI ENTS   1,468,656   45,133   191,580   1,697,416   62,546,715   73,00   74.00   03020   RENAL ACUTE   0   31,779   13,781   22,480   2,227,346   75.00   09005   PATI ENT SERVICE COST CENTERS   79.07   09007   WOUND CLI NI C   22,595   230   5   4,266   329,426   90.00   79.07   09007   MUND CLI NI C   128,037   31,831   0   52,489   2,017,939   90.00   79.08   09008   PATI ENT NUTRI TI ON BEDS (NON-DISTINCT PART)   1,016,762   182,962   128,379   700,114   13,254,798   91.00   79.00   09009   OBSERVATI ON BEDS (NON-DISTINCT PART)   805,878   4,302   0   0   0   7,084,027   194.00   794.00   19900   OBSERVATI ON BEDS (NON-DISTINCT PART)   805,878   4,302   0   0   0   7,084,027   194.00   794.00   19900   OFFICE SHOPERY   0   0   0   0   0   0   0   0   0   794.00   19900   OFFICE SHOPERY   0   0   0   0   0   0   0   0   0   794.00   19900   OFFICE SHOPERY   0   0   0   0   0   0   0   0   0   794.00   07950   RURAL HEALTH   805,878   4,302   0   0   0   0   0   0   0   0   794.00   07950   RURAL HEALTH   805,878   4,302   0   0   0   0   0   0   0   0   0				1				
67.00   06700   OCCUPATI ONAL THERAPY   0   0   24, 348   60, 373   2, 426, 130   67. 00   68.00   06800   SPEECH PATHOLOGY   369, 047   86   58, 900   444, 228   67, 36, 864   69. 00   69.01   06901   CARDI AC REHAB   30, 126   471   411   7, 462   631, 937   69. 01   70.00   07000   ELECTROENCEPHALOGRAPHY   263, 605   806   2, 903   20, 164   1, 989, 190   70. 00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   -14, 055   71. 00   73.00   07300   DRUGS CHARGED TO PATIENTS   1, 468, 656   45, 133   191, 580   1, 697, 416   62, 546, 715   73. 00   73.00   07300   DRUGS CHARGED TO PATIENTS   1, 468, 656   45, 133   191, 580   1, 697, 416   62, 546, 715   73. 00   70.00   07000   CLINI C   22, 595   230   5   4, 266   329, 426   90. 00   90.00   09000   CLINI C   22, 595   230   5   4, 266   329, 426   90. 00   90.00   09000   CLINI C   22, 595   230   5   4, 266   329, 426   90. 00   90.00   09000   CLINI C   128, 037   31, 831   0   52, 489   2, 017, 939   90. 07   91.00   09000   EMERGENCY   1, 016, 762   182, 962   128, 379   700, 114   13, 254, 798   91. 00   92.00   09000   DEMERGENCY   1, 016, 762   182, 962   128, 379   700, 114   13, 254, 798   91. 00   92.00   09000   GIFT, FLOWER COST CENTERS			_					1
68.00   06800   SPEECH PATHOLOGY   0   0   4,772   21,349   997,114   68.00   69.01   06901   CARDI AC REHAB   30,126   471   411   7,462   631,937   69.01   70.00   07000   ELECTROENCEPHALOGRAPHY   263,605   806   2,903   20,164   1,989,190   70.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   44,593   249,089   11,399,193   72.00   72.00   07200   IMPL DEV. CHARGED TO PATIENTS   0   0   44,593   249,089   11,399,193   72.00   73.00   07300   DRUGS CHARGED TO PATIENTS   0   0   44,593   249,089   11,399,193   72.00   76.00   07300   DRUGS CHARGED TO PATIENTS   0   0   31,779   13,781   22,480   2,227,346   76.00   07200   IMPL DEV. CHARGED TO PATIENTS   0   0   31,779   13,781   22,480   2,227,346   76.00   07300   DRUGS CHARGED TO PATIENTS   0   31,779   13,781   22,480   2,227,346   77.00   07900   CLI NI C   22,595   230   5   4,266   329,426   90.00   79.00   09000   CLI NI C   22,595   230   5   4,266   329,426   90.00   79.00   09000   CLI NI C   28,037   31,831   0   52,489   2,017,93   90.07   79.00   09000   DRUGS CHARGED TO PATIENTS   1,016,762   182,962   128,379   700,114   13,254,798   91.00   79.00   09000   DRUGS CHARGED TO PATIENT   1411			67, 784	1, /82				
69. 00   06900   ELECTROCARDI OLOGY   369, 047   86   58, 900   444, 268   6, 736, 864   69. 00   69. 01   06901   CARDI AC REHAB   30, 126   471   411   7, 462   631, 937   69. 01   70. 00   70000   ELECTROENCEPHALOGRAPHY   263, 605   806   2, 903   20, 164   1, 989, 190   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   44, 593   249, 089   11, 399, 193   72. 00   73. 00   07300   DRIGGS CHARGED TO PATI ENTS   0   0   44, 593   249, 089   11, 399, 193   72. 00   73. 00   07300   DRIGGS CHARGED TO PATI ENTS   0   0   44, 593   249, 089   11, 399, 193   72. 00   76. 00   03020   RENAL ACUTE   0   31, 779   13, 781   22, 480   2, 227, 346   76. 00   03020   RENAL ACUTE   0   31, 779   13, 781   22, 480   2, 227, 346   76. 00   09000   CLI NI C   22, 595   230   5   4, 266   329, 426   90. 00   79. 00   09000   CLI NI C   128, 037   31, 831   0   52, 489   2, 017, 939   90. 07   791. 00   09007   WOUND CLI NI C   128, 037   31, 831   0   52, 489   2, 017, 939   90. 07   792. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   14, 031, 310   2, 129, 435   1, 945, 667   8, 310, 111   379, 883, 769   118. 00   NONREI MBURSABLE COST CENTERS   140, 00   0   0   0   0   0   194. 00   07950   RURAL HEALTH   805, 878   4, 302   0   0   0   0   0   0   0   194. 00   07951   RURAL PROPERTY   0   0   0   0   0   0   0   0   194. 01   07951   RURAL PROPERTY   0   0   0   0   0   0   0   0   194. 02   07954   FAMILLY PRACTICE   451, 894   27   0   0   0   0   0   0   194. 03   07952   WELL NESS   0   0   0   0   0   0   0   657, 023   194. 06   194. 04   07955   PKINSI CI AN PRACTICES   1, 280, 366   7, 536   0   0   0   0   70, 806   194. 06   194. 06   07953   SYCAMORE SPORTS MED   0   0   0   0   0   0   70, 806   194. 06   194. 06   07953   SYCAMORE SPORTS MED   0   0   0   0   0   0   70, 806   194. 06   194. 06   07953   SYCAMORE SPORTS MED   0   0   0   0   0   0   0   0   194. 08   07953   SYCAMORE SPORTS MED   0   0   0   0   0   0   0   0   0			0	0				
69. 01   06901   CARDI AC REHAB   30, 126   471   411   7, 462   631, 937   69. 01			260 047	1			•	1
70. 00   07000   ELECTROENCEPHALOGRAPHY   263, 605   806   2, 903   20, 164   1, 989, 190   70. 00   71. 00   71. 00   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   0   1-14, 055   71. 00   72. 00   70200   MPL. DEV. CHARGED TO PATI ENTS   0   0   0   44, 593   249, 089   11, 399, 193   72. 00   73. 00								
71. 00								
72. 00								
73. 00					_	1		
76. 00			_	-				
OUTPATIENT SERVICE COST CENTERS   OUTPATIENT NUTRITION   OUTPATIENT								
90. 00   09000   CLINIC   22,595   230   5   4,266   329,426   90. 00   90. 05   09005   PATIENT NUTRITION   37,658   8   0   976   173,174   90. 05   90. 07   09007   WOUND CLINIC   128,037   31,831   0   52,489   2,017,939   90. 07   91. 00   09100   EMERGENCY   1,016,762   182,962   128,379   700,114   13,254,798   91. 00   92.00   OBSERVATION BEDS (NON-DISTINCT PART)   92. 00   OSSERVATION BEDS (NON-DISTINC	70.00			0.17777	10,70	227 100	2,227,010	70.00
90. 05   09005   PATI ENT NUTRITION   37, 658   8   0   976   173, 174   90. 05   90. 07   90	90.00		22, 595	230	5	4, 266	329, 426	90.00
90. 07   09007   WOUND CLINIC   128,037   31,831   0   52,489   2,017,939   90.07   91.00   09100   EMERGENCY   1,016,762   182,962   128,379   700,114   13,254,798   91.00   92.00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART)   0   92.00   0   0   0   0   0   0   0   0   0					C			1
91. 00   09100   EMERGENCY   1, 016, 762   182, 962   128, 379   700, 114   13, 254, 798   91. 00   92. 00   SERVATI ON BEDS (NON-DI STINCT PART)   92. 00	90. 07	09007 WOUND CLINIC			C		2, 017, 939	
SPECIAL PURPOSE COST CENTERS   SUBTOTALS (SUM OF LINES 1 through 117)   14, 031, 310   2, 129, 435   1, 945, 667   8, 310, 111   379, 883, 769   118. 00   NONREI MBURSABLE COST CENTERS	91.00	09100 EMERGENCY	1, 016, 762		128, 379	700, 114	13, 254, 798	91.00
118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   14, 031, 310   2, 129, 435   1, 945, 667   8, 310, 111   379, 883, 769   118. 00   NONREI MBURSABLE COST CENTERS   190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   0   194. 00   194. 00   194. 01   07951   RURAL HEALTH   805, 878   4, 302   0   0   0   0   7, 084, 027   194. 01   194. 02   07954   FAMILY PRACTICE   451, 894   27   0   0   0   4, 396, 091   194. 02   194. 03   07952   WELLNESS   0   0   0   0   657, 023   194. 03   194. 04   07955   PHYSI CI AN PRACTICES   1, 280, 366   7, 536   0   0   36, 455, 498   194. 04   194. 06   07953   SYCAMORE SPORTS MED	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
NONREI MBURSABLE COST CENTERS   190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   190. 00   194. 00   07950   RURAL HEALTH   805, 878   4, 302   0   0   7, 084, 027   194. 00   194. 01   07951   RENTAL PROPERTY   0   0   0   0   27, 793   194. 01   194. 02   07954   FAMI LY PRACTICE   451, 894   27   0   0   4, 396, 091   194. 02   194. 03   07952   WELLNESS   0   0   0   657, 023   194. 03   194. 04   07955   PHYSI CI AN PRACTICES   1, 280, 366   7, 536   0   0   36, 455, 498   194. 04   194. 06   07953   SYCAMORE SPORTS MED   0   0   0   0   70, 806   194. 06		SPECIAL PURPOSE COST CENTERS						
190. 00   1900   1900   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   190. 00   190. 00   194. 00   194. 00   194. 00   194. 01   194. 01   194. 01   194. 01   194. 01   194. 01   194. 01   194. 01   194. 01   194. 01   194. 01   194. 02   194. 01   194. 02   194. 03   194. 04   194. 05   194. 06   194. 06   194. 06   19793   SYCAMORE SPORTS MED   0   0   0   0   0   190. 00	118.00		14, 031, 310	2, 129, 435	1, 945, 667	8, 310, 111	379, 883, 769	118. 00
194. 00     07950     RURAL HEALTH     805, 878     4, 302     0     0     7, 084, 027     194. 00       194. 01     07951     RENTAL PROPERTY     0     0     0     0     27, 793     194. 01       194. 02     07954     FAMI LY PRACTICE     451, 894     27     0     0     4, 396, 091     194. 02       194. 03     07952     WELLNESS     0     0     0     657, 023     194. 03       194. 04     07955     PHYSI CI AN PRACTICES     1, 280, 366     7, 536     0     0     36, 455, 498     194. 04       194. 06     07953     SYCAMORE SPORTS MED     0     0     0     70, 806     194. 06								1
194. 01   07951   RENTAL PROPERTY   0   0   0   27, 793   194. 01   194. 02   07954   FAMI LY PRACTICE   451, 894   27   0   0   4, 396, 091   194. 02   194. 03   07952   WELLNESS   0   0   0   657, 023   194. 03   194. 04   07955   PHYSI CI AN PRACTICES   1, 280, 366   7, 536   0   0   36, 455, 498   194. 04   194. 06   07953   SYCAMORE SPORTS MED   0   0   0   0   0   0   0   70, 806   194. 06					C	0		1
194. 02     07954     FAMILY PRACTICE     451, 894     27     0     0     4, 396, 091     194. 02       194. 03     07952     WELLNESS     0     0     0     657, 023     194. 03       194. 04     07955     PHYSI CI AN PRACTICES     1, 280, 366     7, 536     0     0     36, 455, 498     194. 04       194. 06     07953     SYCAMORE SPORTS MED     0     0     0     70, 806     194. 06			805, 878	4, 302				
194. 03 07952 WELLNESS 0 0 0 0 657, 023 194. 03 194. 04 07955 PHYSI CI AN PRACTI CES 1, 280, 366 7, 536 0 0 36, 455, 498 194. 04 194. 06 07953 SYCAMORE SPORTS MED 0 0 0 0 70, 806 194. 06			0	0	_	1		
194. 04 07955 PHYSI CI AN PRACTI CES 1, 280, 366 7, 536 0 0 36, 455, 498 194. 04 194. 06 07953 SYCAMORE SPORTS MED 0 0 0 70, 806 194. 06			451, 894	27	C	이		
194. 06 07953 SYCAMORE SPORTS MED 0 0 0 70, 806 194. 06			0	0	<u> </u>			
			1, 280, 366	7, 536				
194. U/ U/900 P31CHIATKIC/P31CHULUGICAL SEKVICES   37, 008  40  0  0  /90, 897 194. 07			0 27 /50	0	_			
	194.0	1017300 POTONI ATKI C/POTONULUGI CAL SEKVI CES	37,658	1 40	1	<u>ار</u>	190, 897	1174.07

Heal th Financial	Systems	UNION HOSPITA	AL, INC.	In Lie	u of Form CMS-2552-10
COST ALLOCATION	- GENERAL SERVICE COSTS		Provider Co		Worksheet B Part I Date/Time Prepared: 5/26/2022 10:49 am

						5/26/2022 10	: 49 am_
	Cost Center Description	DATA	PURCHASI NG	ADMITTI NG	CASHI ERI NG/ACC	Subtotal	
		PROCESSI NG	RECEIVING AND		OUNTS		
			STORES		RECEI VABLE		
		5. 02	5. 03	5. 04	5. 05	5A. 05	
200.00	Cross Foot Adjustments						0 200. 00
201. 00	Negative Cost Centers	0	0	C	0		0 201. 00
202.00	TOTAL (sum lines 118 through 201)	16, 607, 106	2, 141, 340	1, 945, 667	8, 310, 111	429, 365, 90	4 202. 00

				1	0 12/31/2021	Date/lime Pre 5/26/2022 10:	
	Cost Center Description	OTHER ADMIN	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		AND GENERAL 5.06	PLANT 7. 00	LINEN SERVICE 8.00	9. 00	10. 00	
	GENERAL SERVICE COST CENTERS	3.00	7.00	0.00	7. 00	10.00	
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 5. 04	00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING						5. 03 5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5. 06	00590 OTHER ADMIN AND GENERAL	37, 197, 241					5. 06
7. 00	00700 OPERATION OF PLANT	1, 473, 405	17, 007, 947				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	161, 855	164, 215				8. 00
9.00	00900 HOUSEKEEPI NG	375, 545	42, 452	160, 329	4, 537, 804		9. 00
10.00	01000 DI ETARY	60, 277	301, 006			1, 085, 951	1
11. 00	01100 CAFETERI A	324, 384	214, 785		,	0	11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	280, 308	65, 160	1	,	0	13.00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	575, 998	144, 881 0	0	39, 130	0	16.00
21. 00 22. 00	O2100   I &R SERVICES-SALARY & FRINGES APPRVD   O2200   I &R SERVICES-OTHER PRGM COSTS APPRVD	178, 425 231, 678	0	0	0	0	21. 00 22. 00
23. 00	02300 PARAMED ED PRGM	10, 306	0	0	0	0	23. 00
23. 01	02341 OTHER MED ED	33, 341	19, 745	1	5, 333	0	23. 01
23. 02	02301 PARAMED ED PRGM	0	0	Ö	0	0	23. 02
	INPATIENT ROUTINE SERVICE COST CENTERS	'					
30. 00	03000 ADULTS & PEDIATRICS	4, 735, 294	5, 276, 303		1, 425, 059	825, 146	30. 00
31. 00	03100 INTENSIVE CARE UNIT	1, 229, 243	630, 479		170, 284	123, 460	1
35. 00	02040 I NTENSI VE NURSERY	370, 976	107, 831		29, 124	0	35. 00
41. 00	04100 SUBPROVI DER - I RF	242, 684	422, 961	23, 758		67, 531	1
43. 00	04300 NURSERY	121, 130	20, 787	0	5, 614	0	43.00
50. 00	ANCILLARY SERVICE COST CENTERS    O5000   OPERATING ROOM	1, 820, 294	1, 154, 716	128, 647	311, 874	0	50.00
50. 00	05001 CARDI AC SURGERY	326, 660	52, 490			0	
50. 02	05002 WVSC	1, 422, 597	832, 895			0	50. 02
51.00	05100 RECOVERY ROOM	272, 935	39, 271	99, 097		0	51.00
51. 02	05101 O/P TREATMENT ROOM	117, 274	656, 147			65, 245	51. 02
52.00	05200 DELIVERY ROOM & LABOR ROOM	599, 561	651, 101	87, 631	175, 854	22	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 265, 715	878, 584	60, 715		0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	677, 925	723, 803			0	55. 00
56. 00	05600 RADI OI SOTOPE	240, 387	241, 331	10, 027	65, 180	0	56. 00
57. 00	05700 CT SCAN	323, 695	59, 565		16, 088	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	252, 082	71, 111		l '	0	58. 00 59. 00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	2, 352, 200 1, 138, 567	990, 940 0		267, 640	4, 547 0	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	164, 103	0	0	0	0	62.00
65. 00	06500 RESPIRATORY THERAPY	643, 094	141, 152		38, 123	0	65.00
66. 00	06600 PHYSI CAL THERAPY	357, 869	278, 354			Ö	66.00
66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0	0	0	66. 01
66. 02	06602 0/P PHYSI CAL THERAPY	191, 008	0	33, 845	0	0	66. 02
67. 00	06700 OCCUPATI ONAL THERAPY	230, 111	45, 469	0		0	67. 00
68. 00	06800 SPEECH PATHOLOGY	94, 573	90, 170	•	,	0	1
69. 00	06900 ELECTROCARDI OLOGY	638, 971	87, 236			0	69. 00
69. 01	06901 CARDI AC REHAB	59, 937	179, 189			0	69. 01
70. 00 71. 00	07000   ELECTROENCEPHALOGRAPHY   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS	188, 669	0	7, 313	0	0	70.00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0 1, 081, 179	0		0	0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	5, 932, 253	568, 089	3, 354	153, 433	0	73.00
76. 00	03020 RENAL ACUTE	211, 257	96, 670			0	76.00
70.00	OUTPATIENT SERVICE COST CENTERS	211/20/	70,070	10,027	20, 107		7 0. 00
90.00	09000 CLI NI C	31, 245	19, 142	0	5, 170	0	90.00
90. 05	09005 PATIENT NUTRITION	16, 425	52, 928	0	14, 295	0	90. 05
90. 07	09007 WOUND CLINIC	191, 395	245, 500	18, 660	66, 306	0	90. 07
91. 00	09100 EMERGENCY	1, 257, 178	661, 687	265, 272	178, 713	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
440.00	SPECIAL PURPOSE COST CENTERS	00 504 000	44 000 445			1 005 051	
118.00		32, 504, 008	16, 228, 145	2, 020, 444	4, 327, 190	1, 085, 951	118. 00
100.00	NONREI MBURSABLE COST CENTERS	٥	0		٥	0	100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN  07950 RURAL HEALTH	0 671, 899	0	0 1, 369	_		190. 00 194. 00
	07951 RENTAL PROPERTY	2, 636	0	1, 309			194. 00
	07954 FAMILY PRACTICE	416, 956	329, 088	1, 568	88, 882		194. 01
	07952 WELLNESS	62, 317	372, 117		100, 504		194. 03
	07955 PHYSICIAN PRACTICES	3, 457, 695	0	9, 174			194. 04
194. 06	07953 SYCAMORE SPORTS MED	6, 716	0	0	o	0	194. 06
	07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	75, 014	78, 597	0	21, 228	0	194. 07
200.00	Cross Foot Adjustments						200. 00

Heal th Financial	Systems		UNION HOSPI	TAL, INC.		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION	- GENERAL SERVICE (	COSTS		Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Pre 5/26/2022 10:	
Cost	Center Description	n	OTHER ADMIN	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	

						5/26/2022 10:	49 am_
	Cost Center Description	OTHER ADMIN	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		AND GENERAL	PLANT	LINEN SERVICE			
		5. 06	7. 00	8. 00	9. 00	10.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	37, 197, 241	17, 007, 947	2, 032, 555	4, 537, 804	1, 085, 951	202. 00

						INTERNS &	RESI DENTS	49 am
		Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON		SERVI CES-SALAR Y & FRI NGES	SERVICES-OTHER PRGM COSTS	
	1		11.00	13.00	16. 00	21. 00	22. 00	
1.00 2.00 4.00 5.01	00100 00200 00400 00540	NAL SERVICE COST CENTERS  NEW CAP REL COSTS-BLDG & FIXT  NEW CAP REL COSTS-MVBLE EQUIP  EMPLOYEE BENEFITS DEPARTMENT  NONPATIENT TELEPHONES						1. 00 2. 00 4. 00 5. 01
5. 02 5. 03 5. 04 5. 05 5. 06	00560 00570 00580 00590	DATA PROCESSING PURCHASING RECEIVING AND STORES ADMITTING CASHIERING/ACCOUNTS RECEIVABLE OSTHER ADMIN AND GENERAL						5. 02 5. 03 5. 04 5. 05 5. 06
7. 00 8. 00 9. 00 10. 00 11. 00	00800 00900 01000	OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA	4, 017, 255					7. 00 8. 00 9. 00 10. 00 11. 00
13. 00 16. 00 21. 00 22. 00	01300 01600 02100	NURSING ADMINISTRATION MEDICAL RECORDS & LIBRARY LAR SERVICES-SALARY & FRINGES APPRVD LAR SERVICES-OTHER PRGM COSTS APPRVD	36, 891 212, 914 72, 025 15, 108	3, 355, 327 0 0	7, 045, 842 0	2, 131, 635	2, 689, 432	13. 00 16. 00 21. 00 22. 00
23. 00 23. 01 23. 02	02300 02341 02301	PARAMED ED PRGM OTHER MED ED PARAMED ED PRGM I ENT ROUTINE SERVICE COST CENTERS	4, 567 31, 621	0 39, 734	0 0 0		2, 007, 432	23. 00 23. 01 23. 02
30.00	03000	ADULTS & PEDIATRICS	1, 036, 812		552, 075		964, 824	
31. 00 35. 00		INTENSIVE CARE UNIT INTENSIVE NURSERY	233, 994 101, 187		141, 222 77, 366	3, 440 30, 669	4, 340 38, 694	
41. 00 43. 00		SUBPROVI DER – I RF NURSERY	72, 377		20, 782	0	0	41. 00 43. 00
43.00	ANCI L	LARY SERVICE COST CENTERS	43, 215		11, 876	O O	O	43.00
50. 00 50. 01	1	OPERATING ROOM CARDIAC SURGERY	211, 157 27, 756		736, 370 27, 020	159, 364 0	201, 066 0	50. 00 50. 01
50. 02	05002	WVSC	27,730		527, 295	ő	Ö	50. 02
51. 00 51. 02		RECOVERY ROOM O/P TREATMENT ROOM	83, 268 17, 216		46, 691 14, 468	0	0	51. 00 51. 02
52. 00		DELIVERY ROOM & LABOR ROOM	164, 780		97, 949	196, 912	248, 439	
54. 00 55. 00		RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C	241, 373 17, 567	1	311, 497 209, 069	20, 064 22, 357	25, 314 28, 207	
56.00		RADI OI SOTOPE	17, 216	1	47, 334	0	20, 207	56. 00
57. 00 58. 00		CT SCAN MAGNETIC RESONANCE IMAGING (MRI)	45, 675 30, 567	1	233, 553 61, 952		0	57. 00 58. 00
59. 00	05900	CARDI AC CATHETERI ZATI ON	100, 133	1	446, 953		1, 085	
60.00		LABORATORY	120, 862	0	427, 550	0	0	60.00
62. 00 65. 00		WHOLE BLOOD & PACKED RED BLOOD CELLS RESPIRATORY THERAPY	145, 807		14, 847 163, 673	30, 096	37, 971	62. 00 65. 00
66. 00 66. 01		PHYSI CAL THERAPY PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	C	0	63, 682 0	0	0	
66. 02		0/P PHYSICAL THERAPY	C		31, 439	<u>۱</u>	0	66. 01 66. 02
67. 00 68. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	C	0	51, 190 18, 102	0	0	67. 00 68. 00
69.00	06900	ELECTROCARDI OLOGY	121, 565	- 1	376, 695	0	0	69. 00
69. 01 70. 00	1	CARDI AC REHAB ELECTROENCEPHALOGRAPHY	14, 756 36, 540		6, 327 17, 097	0	0	69. 01 70. 00
71. 00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	30, 340	0	0	o O	0	71. 00
72. 00 73. 00	1	IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	165, 834	0 183, 219	211, 203 1, 438, 925	0 7, 452	0 9, 402	72. 00 73. 00
76. 00	03020	RENAL ACUTE	C	0	19, 061	0	0	
90. 00		TIENT SERVICE COST CENTERS	7, 378	9, 271	3, 617	342, 804	432, 508	90. 00
90. 05	09005	PATIENT NUTRITION	3, 162	3, 973	828	0	0	90. 05
90. 07 91. 00		WOUND CLINIC  EMERGENCY	20, 027 264, 561		44, 506 593, 628	52, 739 218, 409	66, 540 275, 561	90. 07 91. 00
92. 00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				_,,,,,,,,,		92. 00
118.00		AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	3, 717, 911	3, 355, 327	7, 045, 842	1, 849, 882	2, 333, 951	118. 00
190 00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	^	ol	0	0	0	190. 00
194.00	07950	RURAL HEALTH	C	Ö	0	o o	0	194. 00
		RENTAL PROPERTY FAMILY PRACTICE	93, 106		0	0 281, 753	0 355, 481	194. 01 194. 02
194. 03	07952	WELLNESS	C	o	0	O	0	194. 03
194.04	η07955	PHYSICIAN PRACTICES	184, 806	o  O	0	0	0	194. 04

Health Financial Systems

UNION HOSPITAL, INC.

In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0023
From 01/01/2021
To 12/31/2021
Date/Time Prepared:

						5/26/2022 10:	49 am
					INTERNS &	RESI DENTS	
Co	ost Center Description	CAFETERI A	NURSI NG	MEDI CAL	SERVI CES-SALAR	SERVI CES-OTHER	
	·		ADMI NI STRATI ON	RECORDS &	Y & FRINGES	PRGM COSTS	
				LI BRARY			
		11. 00	13. 00	16. 00	21.00	22. 00	
194.06 07953 SY	CAMORE SPORTS MED	0	0	C	0	0	194. 06
194. 07 07956 PS	SYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	21, 432	0	l c	0	0	194. 07
200. 00 Cr	ross Foot Adjustments				0	0	200. 00
201.00 Ne	egative Cost Centers	0	0	C	0	0	201. 00
202.00 TO	OTAL (sum lines 118 through 201)	4, 017, 255	3, 355, 327	7, 045, 842	2, 131, 635	2, 689, 432	202. 00

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

Charlest Centre Description					To	12/31/2021	Date/Time Pre 5/26/2022 10:	
Sensitive		Cost Center Description		OTHER MED ED	PARAMED ED PRGM	Subtotal		
CHEBBL SERVICE DOT CENTERS   23.00   23.01   23.02   24.00   25.00			T KOM		T KGIII		& Post	
DEMINSING STRUCTC DOST CENTRES							•	
1.00   00000   MORE CAP MEL COSIS SHUGE STIXT		OFNEDAL CEDIU OF COCT OFNEDO	23. 00	23. 01	23. 02	24. 00		
2.00   DOZDO   INN CAP HEL COSTS-WISE LEQUIP	1.00							1.00
0.0040   MORPATIENT TELEPROMES	2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						1
5.0.2 00050 DATA PROCESSING		1 I						ı
5.03   00560   PURCHASTING RECEIV INC AND STORES   5.03		l						1
5.05   0.0580   CASHIERING ACCOUNTS RECEIVABLE     5.06   7.00   0.0700   OPERATION OF PLANT     7.00   7		l						1
0.0090   OTHER ADMIN AND CENERAL								1
0.0000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000000								1
9.00   00900    0015016   FPI PN								1
10.00   01000   DETARY								1
11.00   01100   CAFETERIA								1
10.00   10.00   INEDICAL, RECORDS & LUBRARY								1
21.00		1						1
22.00								1
23.01								1
33.00			123, 536					1
IMPATI ENT ROUTINE SERVICE COST CENTERS   0   0   0   0   7, 387, 056   -1, 729, 540   30. 00   30. 00   300, 00   301, 00   310, 310, 300   310, 00   310, 310, 310, 310, 310, 310, 310, 310,		1		481, 298				1
31.00   03100   INTENSIVE CARE UNIT	23. 02				<u> </u>			23.02
35.00   02040   INTENSIVE NURSERY   0   0   0   1, 534,032   0   41.00   41.00   410.00   03.0   03.0   04.000   03.0   03.0   04.000   04.000   04.000   04.000   04.000   04.000   04.000   04.000   04.000   04.000   04.000   04.000   04.000   04.000   05.0000   05.000   05.000   05.000   05.0000   05.0000   05.000   05.0000   05.0000   05.0000   05.		1	0					1
41.00   04100   SUBPROVI DER - I RF			0	-	-			
MOLILLARY SERVICE COST CENTERS			Ö					1
50.00	43. 00		0	0	0	1, 534, 032	0	43. 00
50.01   05001   CARDI AC SURGERY   0   0   0   3, 909, 524   0   50. 01	50. 00		0	0	0	24, 180, 721	-360, 430	50.00
51.00   05100   RECOVERY ROOM		05001 CARDI AC SURGERY	0		-			1
51.02   05101   O/P TREATMENT ROOM   Color			0					1
52.00			0		_			1
55.00   05500   RADIO LOGY-THERAPEUTI C		05200 DELIVERY ROOM & LABOR ROOM	0	0	0		-445, 351	1
56.00   05600   RADI OI SOTOPE   0   0   0   3, 155, 942   0   56.00		1	123, 536	0				1
57.00   05700   CT SCAN   0   0   0   0   0   0   0   0   0			0	0	_			1
59.00   05000   CARDIAC CATHETERIZATION   0   0   0   29.023, 189   -1, 945   59.00	57. 00	05700 CT SCAN	0	0	0			1
60.00   06000   LABORATORY   0   0   0   13,691,231   0   60.00			0	0	-			1
62. 00   06.200   WHOLE BLOOD & PACKED RED BLOOD CELLS   0   0   0   1,909,133   0   62. 00   65. 00   06500   RESPI RATORY THERAPY   0   0   0   0   8,151, 985   -68,067   66. 01   06600   PSYCHI ATRI C/PSYCHOLGGI CAL SERVI CES   0   0   0   0   0   0   66. 01   06601   PSYCHI ATRI C/PSYCHOLGGI CAL SERVI CES   0   0   0   0   0   66. 02   06602   0/P PHYSI CAL THERAPY   0   0   0   0   0   0   66. 02   06602   0/P PHYSI CAL THERAPY   0   0   0   0   0   67. 00   06700   0CCUPATI ONAL THERAPY   0   0   0   0   2,765,181   0   0   68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   1,224,313   0   68. 00   69. 01   06901   CARDI AC REHAB   0   0   0   0   8,174,899   0   69. 01   69. 01   06901   CARDI AC REHAB   0   0   0   0   0   8,174,899   0   69. 01   69. 01   06901   CARDI AC REHAB   0   0   0   0   0   2,259,118   0   70. 00   69. 01   07000   ELECTROENCEPHALOGRAPHY   0   0   0   0   2,259,118   0   70. 00   71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   12,691,575   0   72. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   481,298   0   71,489,974   -16,854   73. 00   73. 00   07300   RRUGS CHARGED TO PATIENTS   0   481,298   0   71,489,974   -16,854   73. 00   76. 00   30020   RENAL ACUTE   0   0   0   2,748,777   -119,279   90. 07   79. 00   09005   PATIENT NUTRI TION   0   0   0   2,748,777   -119,279   90. 07   79. 00   09005   PATIENT NUTRI TION   0   0   0   0   2,748,777   -119,279   90. 07   79. 00   09000   DESERVATI ON BEDS (NON-DISTINCT PART)   SPECIAL PURPOSE COST CENTERS   79. 00   19000   090000   09000   09000   09000   09000   09000   09000   09000   090			0	0				1
66. 00   06600   PHYSICAL THERAPY   0   0   0   4,556,979   0   66. 00   66. 01   06601   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   0   0   0   0   0   0   66. 02   06602   07P PHYSICAL THERAPY   0   0   0   0   0   2,270,147   0   66. 02   67. 00   06602   07P PHYSICAL THERAPY   0   0   0   0   2,270,147   0   66. 02   68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   1,224,313   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   0   8,174,899   0   69. 00   69. 01   06901   CARDI AC REHAB   0   0   0   0   959,576   0   69. 01   69. 01   06901   CARDI AC REHAB   0   0   0   0   959,576   0   69. 01   71. 00   07000   ELECTROCEPHALOGRAPHY   0   0   0   0   2,259,118   0   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   12,691,575   0   71. 00   72. 00   07200   IMPL DEV. CHARGED TO PATI ENTS   0   0   0   12,691,575   0   72. 00   73. 00   07300   RURGS CHARGED TO PATI ENTS   0   481,298   0   71,489,974   -16,854   73. 00   76. 00   03020   RENAL ACUTE   0   0   0   0   2,590,970   0   76. 00   79. 00   09000   CLINI C   0   0   0   0   2,748,777   -119,279   90. 07   90. 05   09005   PATI ENT NUTRI TI ON   0   0   0   2,748,777   -119,279   90. 07   90. 07   09000   000   000   000   000   000   000   000   91. 00   09000   DESERVATI ON BEDS (NON-DISTINCT PART)  SPECIAL PURPOSE COST CENTERS  18. 00   NONREI MBURSABLE COST CENTERS   0   0   0   0   0   0   0   91. 00   09000   000   000   000   000   000   000   000   000   000   91. 00   000   000   000   000   000   000   000   000   000   91. 00   000   000   000   000   000   000   000   000   000   91. 00   000   000   000   000   000   000   000   000   000   000   91. 00   000   000   000   000   000   000   000   000   000   000   000   91. 00   000		1	Ö	0				1
66. 01   06601   0890CH   ATRI C/PSYCHOLOGI CAL SERVI CES   0   0   0   0   0   0   66. 01   66. 02   066002   07P PHYSI CAL THERAPY   0   0   0   0   0   2, 765, 181   0   67. 00   67. 00   067000   0CCUPATI ONAL THERAPY   0   0   0   0   2, 765, 181   0   67. 00   68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   1, 224, 313   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   0   1, 224, 313   0   68. 00   69. 01   06900   ELECTROCARDI OLOGY   0   0   0   0   959, 576   0   69. 00   70. 00   07000   ELECTROCARDI OLOGY   0   0   0   0   0   959, 576   0   69. 01   70. 00   07000   ELECTROCARDI OLOGY   0   0   0   0   0   0   71. 00   07000   ELECTROENCEPHALOGRAPHY   0   0   0   0   0   2, 259, 118   0   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   0   1, 489, 974   -16, 854   73. 00   72. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   2, 590, 970   0   76. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   2, 590, 970   0   76. 00   74. 00   03020   RENAL ACUTE   0   0   0   0   1, 180, 561   -775, 312   75. 00   09000   ENAL ACUTE   0   0   0   0   1, 180, 561   -775, 312   90. 00   76. 00   09000   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   76. 00   09000   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   76. 00   09000   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   76. 00   09000   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   76. 00   09000   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   76. 00   09000   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   76. 00   09000   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   76. 00   09000   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   77. 00   07000   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   77. 00   07000   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   77. 00   07000   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   77. 00   07000   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   78. 00   07000   DRUGS CHARG			0	0				
66. 02   06602   0/P PHYSICAL THERAPY   0   0   0   2, 270, 147   0   66. 02   67. 00   0   0   0   0   0   2, 765, 181   0   67. 00   68. 00   0   0   0   0   0   0   0   0   0			0	0	ı			
68. 00   06800   SPEECH PATHOLOGY   0   0   0   1,224,313   0   68. 00   69. 00   6900   ELECTROCARDI OLOGY   0   0   0   0   8,174,899   0   69. 00   0   0   0   0   0   0   0   0   0			Ö	0	-			
69. 00   06900   ELECTROCARDI OLOGY   0   0   0   8, 174, 899   0   69. 00   69. 01   06901   CARDI AC REHAB   0   0   0   959, 576   0   69. 01   07. 00   07.000   ELECTROENCEPHALOGRAPHY   0   0   0   2, 259, 118   0   70. 00   07.000   ELECTROENCEPHALOGRAPHY   0   0   0   0   2, 259, 118   0   70. 00   07.000   ELECTROENCEPHALOGRAPHY   0   0   0   0   0   0   0   0   0			0	0	0			
69. 01 06901 CARDI AC REHAB 0 0 0 0 959, 576 0 69. 01 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 2, 259, 118 0 70. 00 710. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 12, 691, 575 0 72. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0 0 0 12, 691, 575 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 481, 298 0 71, 489, 974 -16, 854 73. 00 76. 00 03020 RENAL ACUTE 0 0 0 0 2, 590, 970 0 76. 00 0000 CLI NI C 0 0 0 1, 180, 561 -775, 312 90. 00 09000 CLI NI C 0 0 0 1, 180, 561 -775, 312 90. 00 90000 PATI ENT NUTRI TI ON 0 0 0 1, 180, 561 -775, 312 90. 00 09000 PATI ENT NUTRI TI ON 0 0 0 0 2, 748, 777 -119, 279 90. 07 91. 00 09100 EMERGENCY 0 0 0 0 17, 302, 249 -493, 970 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) SPECI AL PURPOSE COST CENTERS  118. 00 SUBTOTALS (SUM OF LI NES 1 through 117) 123, 536 481, 298 0 373, 251, 431 -4, 183, 833 18. 00 194. 00 19900 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 7, 757, 295 0 194. 00 194. 00 07950 RURAL HEALTH 0 0 0 0 0 5, 962, 925 -637, 234 194. 02 194. 01 07951 RENTAL PROPERTY 0 0 0 0 5, 962, 925 -637, 234 194. 02 194. 03 07952 WELLNESS 0 0 0 0 1, 191, 961 0 194. 03			0	0	0			
71. 00			0	0	Ö			
72. 00			0	0	0			
73. 00			0	0	0			
90. 00   OPATI ENT SERVI CE COST CENTERS   O   O   O   O   O   O   O   O   O			0	481, 298				1
90. 00	76. 00		0	0	0	2, 590, 970	0	76. 00
90. 05	90. 00		0	0	O	1, 180, 561	-775, 312	90.00
91. 00	90. 05	09005 PATIENT NUTRITION	0	0	0	264, 785	0	90. 05
92. 00			0	0				
118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   123,536   481,298   0   373,251,431   -4,183,833   118. 00   NONREI MBURSABLE COST CENTERS   0   0   0   0   190. 0			0		Ŭ	17, 302, 247		1
NONREI MBURSABLE COST CENTERS  190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190. 00 190. 00 194. 00 194. 00 194. 00 07,757, 295 0 194. 00 194. 01 194. 01 07951 RENTAL PROPERTY 0 0 0 0 30, 429 0 194. 01 194. 02 07954 FAMI LY PRACTI CE 0 0 0 5, 962, 925 -637, 234 194. 02 194. 03 07952 WELLNESS 0 0 0 0 1, 191, 961 0 194. 03	110 00		122 E24	491 209		272 251 421	4 102 022	110 00
194. 00     07950     RURAL HEALTH     0     0     7,757,295     0     194. 00       194. 01     07951     RENTAL PROPERTY     0     0     0     30,429     0     194. 01       194. 02     07954     FAMI LY PRACTI CE     0     0     0     5,962,925     -637, 234     194. 02       194. 03     07952     WELLNESS     0     0     0     1,191,961     0     194. 03	110.00	<u> </u>	123, 530	401, 290	0	373, 231, 431	-4, 103, 033	]116.00
194. 01   07951   RENTAL PROPERTY 0 0 0 30, 429 0   194. 01 194. 02   194. 02   07954   FAMI LY PRACTI CE 0 0 0 5, 962, 925 -637, 234   194. 02   194. 03   07952   WELLNESS 0 0 0 1, 191, 961 0   194. 03			0	0				1
194. 02 07954 FAMILY PRACTICE 0 0 0 5, 962, 925 -637, 234 194. 02 194. 03 07952 WELLNESS 0 0 0 1, 191, 961 0 194. 03			0	0				
	194. 02	07954 FAMILY PRACTICE	o o	Ö		5, 962, 925	-637, 234	194. 02
174. 04 0/700 PRITOLLIAN PRACTICES   U  U  U  40, 107, 173  0 194. 04			0	0				
	194. 04	+ U/7550 PHISICIAN PRACTICES	0	0	ı O	40, 107, 173	1 0	1174. 04

Heal th Finar	ncial Systems	UNI ON HOSPI	TAL, INC.		In Lie	eu of Form CMS-2	2552-10
COST ALLOCA	TION - GENERAL SERVICE COSTS		Provi der CO	CN: 15-0023	Peri od:	Worksheet B	
					From 01/01/2021		
					To 12/31/2021		
						5/26/2022 10: 4	19 am_
	Cost Center Description	PARAMED ED	OTHER MED ED	PARAMED ED	Subtotal	Intern &	
		PRGM		PRGM		Residents Cost	
						& Post	
						Stepdown	
						Adjustments	
		23. 00	23. 01	23. 02	24. 00	25. 00	
194. 06 07953	SYCAMORE SPORTS MED	0	0		0 77, 522	0	194. 06
194. 07 07956	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 987, 168	0	194. 07
200.00	Cross Foot Adjustments	0	0		0 0	0	200. 00
201.00	Negative Cost Centers	0	0		0	0	201. 00
202. 00	TOTAL (sum lines 118 through 201)	123, 536	481, 298		0 429, 365, 904	-4, 821, 067	202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2021 | Part | | To 12/31/2021 | Date/Time Prepared: | From 12/31/2021 | Date/Time Prepared: | From 12/31/2021 | Prepar Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0023

SERIOR COST CONTROL PICTURES   7.00					
DO     DO   DO   DO   DO   DO   DO		Cost Center Description			
1.00   0000   MEN CAP REL CISIS-BLIDG A FIXT		GENERAL SERVICE COST CENTERS	26. 00		
4. 00 00-000 PARP OVER PRIMET IS DEPARTMENT 5. 00 00-000 PARP OVER PRIMET IS DEPARTMENT 5. 00 00-000 PARP PARP OVER AND STORPS 5. 00 00-000 PARP PARP OVER AND STORPS 5. 00 00-000 PARP PARP OVER PA	1. 00				1.00
5.01   OSCIAI) MORPATIFITY TETERINES   5.01   S.02   OSCIAI AND RECEISTING AND STORES   5.02   OSCIAI AND RECEISTING AND STORES   5.03   S.04   S.05   S.05   S.05   S.06   S.06	2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP			2. 00
5.00   0.0050   JATA FROCESSI NO   5.00   5.					1
0.0560   PURCHASING RECEI VINS AND STORES   5.03		1 1			1
0.0750   ZAMITTING   5.04		1 1			1
0.0890   CASHI ERINKY-ACQUISTS RECEIVABLE   5.05		1 1			1
5.06   0.0090   OTHER ADUIN AND CEMERAL					1
9.00					1
9.00   00900   MUSEREEP NO   10 001   11 12 12 12 12 12 12 12 12 12 12 12 12		1 1			1
10.00   01000   DETARY		1 1			1
11.00   01100   CAFETERIA     11.00   13.00		1 1			1
13.00   01300   MIRSH MG ADM IN STRATION     16.00		1 1			1
21.00     2020       AS SERVICES-SALARY & FENNES APPRVD		1 1			1
22.00   20200   IAR SERVICES-OTHER PROM COSTS APPRVD   23.00   23.01	16.00	01600 MEDICAL RECORDS & LIBRARY			16. 00
23.00					1
23.00		1			1
23. 02   PARAMED FD PROM					1
INVADIT   INVADIT   INVADIT   SERVICE COST CENTERS   30,00		1			1
13.1 0.0   03100   INTENSI WE CARE UNIT   15, 862, 754   3.3 0.0   0.410   DATES   D					1
35.00	30.00	03000 ADULTS & PEDIATRICS	65, 657, 516		30. 00
1.1					1
A3. 00   A3.00   NURSERY   1, 534, 032					1
MOLILLARY SERVICE COST CENTERS		1 1			1
50. 00   050000   OFERATI NG ROOM   23, 820, 291   50. 00   50.	43.00		1, 554, 052		43.00
50.00   05000   RECOVERY ROOM   0.3544, 141   51.00   51.00   051.00   RECOVERY ROOM   0.3544, 141   51.00   51.00   051.00   RECOVERY ROOM   0.3544, 141   51.00   51.00   051.00   RECOVERY ROOM   0.3544, 141   51.00   51.00   054.00	50.00		23, 820, 291		50. 00
51.00   OSTOO   RECOVERY ROOM   3, 534, 141   51.00   52.00   OSZOO	50. 01	05001 CARDI AC SURGERY	3, 909, 524		50. 01
51.02   05101   0/P TREATMENT ROOM   2.313.123   51.025   52.00   05200   DELL'VERY ROOM & LABOR ROOM   8.291.176   52.00   52.00   05400   05400   RADIOLOGY-DI AGNOSTIC   16.463.520   55.00   05500   RADIOLOGY-THERAPEUTIC   8.996, 834   55.50   05500   RADIOLOGY-THERAPEUTIC   8.996, 834   55.00   05500   RADIOLOGY-THERAPEUTIC   8.904, 834   55.00   05500   RADIOLOGY-THERAPEUTIC   8.904, 834   55.00   05500   MACHETIC RESONANCE IMAGING (MRI ) 3. 16.91, 231   60.00   05000   MACHETIC RESONANCE IMAGING (MRI ) 3. 16.91, 231   60.00   05000   MACHETIC RESONANCE IMAGING (MRI ) 3. 16.91, 231   60.00   05000   MACHETIC RESONANCE IMAGING (MRI ) 3. 16.91, 231   60.00   05000   MACHETIC RESONANCE IMAGING (MRI ) 3. 16.91, 231   60.00   05000   MACHETIC RESONANCE IMAGING (MRI ) 3. 16.91, 231   60.00   05000   MACHETIC RESONANCE IMAGING (MRI ) 3. 16.91, 231   60.00   05000   MACHETIC RESONANCE IMAGING (MRI ) 3. 16.91, 231   60.00   05000   MRI LEREAPY 4.566, 979   60.00   050		1 1			1
S2.0   0   0   0   0   0   0   0   0   0		1 1			1
54. 00   05400   RADI DLOGY-DI AGNOSTIC   16, 463, 520   55. 00   05500   RADI DLOGY-THERAPPUTIC   8, 996, 834   55. 00   05500   RADI DLOGY-THERAPPUTIC   8, 996, 834   55. 00   05700   CSTONOCT SCAN   4, 091, 390   57. 00   05700   CSTONOCT SCAN   57. 00   05700   CSTONOCT SCAN   58. 00   05800   MAGNETIC RESONANCE I MAGING (MRI )   3, 169, 984   58. 00   05900   DAGINA CATHETERI ZATION   29, 021, 244   59, 00   05900   CLABORATORY   13, 691, 231   62. 00   05000   LABORATORY   13, 691, 231   62. 00   05000   RESPIRATORY THERAPY   8, 083, 918   62. 00   05000   RESPIRATORY THERAPY   4, 556, 979   66. 00   06000   PSYCHIA TRIC CPSYCHOLOGI CAL SERVI CES   06. 00   06000   PSYCHIA TRIC CPSYCHOLOGI CAL SERVI CES   06. 00   06000   PSYCHIA TRIC CPSYCHOLOGI CAL SERVI CES   06. 00   06000   PSYCHIA TRIC CPSYCHOLOGI CAL SERVI CES   06. 00   06000   PSYCHIA TRIC CPSYCHOLOGI CAL SERVI CES   06. 00   06000   PSYCHIA TRIC CPSYCHOLOGI CAL SERVI CES   06. 00   06000   PSYCHIA TRIC CPSYCHOLOGI CAL SERVI CES   06. 00   06000   PSYCHIA TRIC CPSYCHOLOGI CAL SERVI CES   06. 00   06000   PSYCHIA TRIC CPSYCHOLOGI CAL SERVI CES   06. 00   06000   PSYCHIA TRIC CPSYCHOLOGI CAL SERVI CES   06. 00   06000   PSYCHIA TRIC CPSYCHOLOGI CAL SERVI CES   06. 00   06000   PSYCHIA TRIC CPSYCHOLOGI CAL SERVI CES   07. 00   07. 00   00000   0000   000000					1
55. 00   05.00   ADJO LOGY-THERAPEUTIC   8, 996, 834   55. 00   65. 00   05.00   ADJO LOGY-THERAPEUTIC   8, 155, 942   55. 00   65. 00   05.		1 1			1
57.00   05700   05700   05700   0580		1 1			1
58. 00   050000   050000   050000   050000   050000   050000   050000   0500	56.00	05600 RADI OI SOTOPE	3, 155, 942		56. 00
59.00   05900   05900   CARDIAC CATHETERI ZATI ON   29.021, 244   06.00   06000   LABORATORY   13.691, 231   06.00   06000   LABORATORY   13.691, 231   062.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   1,909, 133   062.00   065.00   06500   RESPI RATORY THERAPY   8.083, 918   065.00   066.01   06600   PHYSI CAL THERAPY   4.556, 979   066.01   06601   PSYCHI ATRIC CPSYCHOLOGI CAL SERVI CES   066.01   06601   PSYCHI ATRIC CPSYCHOLOGI CAL SERVI CES   066.01   06601   06000   06000   079900   07000		1 1			1
60.00   06000   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   1,909,133   62.00		1 1			1
62.00   06200   MPIOLE BLOOD & PACKED RED BLOOD CELLS   1,909,133   65.00		1 1			1
65. 00   06500   RESPI RATORY THERAPY   8,083,918   66.00   666.00   06600   PHYSI CAL THERAPY   4,556,979   66.00   66.01   08600   PHYSI CAL THERAPY   2,270,147   66.01   66.02   06602   07P PHYSI CAL THERAPY   2,270,147   66.02   06602   07P PHYSI CAL THERAPY   2,765,181   67.00   67.00   0600700   0000000000000000000000000		l i			1
66. 01 06601   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 06602 0/600 06600   O66002 0/60 P PHYSI CAL THERAPY 2, 765, 181 66. 02 67. 00 06700 0 CCUPATI ONAL THERAPY 2, 765, 181 67. 00 68. 00 06800   O66700 0 CCUPATI ONAL THERAPY 2, 765, 181 67. 00 68. 00 06800   SPEECH PATHOLOGY 1, 224, 313 68. 00 06900   ELECTROCARDI OLOGY 8, 174, 899 69. 00 06901   CARDI AC REHAB 959, 576 70. 00 07000   CLECTROCARDI OLOGY 9, 17, 18, 899 69. 01 06901   CARDI AC REHAB 959, 576 70. 00 07000   ELECTROENCEPHALOGRAPHY 2, 259, 118 70. 00 07100   MEDI CAL SUPPLIE S CHARGED TO PATI ENTS 12, 691, 575 71. 00 07200   IMPL DEV. CHARGED TO PATI ENTS 71, 473, 120 73. 00 07300   DRUGS CHARGED TO		1			
66. 02 06602 0/P PHYSICAL THERAPY 2, 270, 147 67.00 06700 0CCUPATIONAL THERAPY 2, 2765, 181 66. 02 67.00 06700 0CCUPATIONAL THERAPY 2, 765, 181 66. 02 67.00 06800 SPEECH PATHOLOGY 1, 224, 313 68. 00 69. 00 06900 ELECTROCARDI OLOGY 8, 174, 899 69. 01 06901 CARDI ACREHAB 959, 576 70. 00 07000 ELECTROCARDI OLOGY 2, 259, 118 70. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 71. 00 07300 DRUGS CHARGED TO PATIENTS 71. 473, 120 73. 00 07300 DRUGS CHARGED TO PATIENTS 71. 473, 120 07300	66. 00		4, 556, 979		66. 00
67. 00   06700   OCCUPATI ONAL THERAPY   2, 765, 181   67. 00   68. 00   06800   SPECH PATHOLOGY   1, 224, 313   68. 00   06900   SLECTROCARDI OLOGY   8, 174, 899   69. 01   06901   CARDI AC REHAB   959, 576   69. 01   07. 00   07. 000   ELECTROCROPI ALLOGRAPHY   2, 259, 118   71. 00   71. 00   07. 00   07. 000   ELECTROCROPI ALLOGRAPHY   2, 259, 118   71. 00   71. 00   07. 00			-		1
68. 00   668.00   SPEECH PATHOLOGY		1			•
69. 00   6900   ELECTROCARDI OLOGY   8, 174, 899   69. 01   69. 01   06901   CARDI AC REHAB   959, 576   69. 01   69. 01   06901   CARDI AC REHAB   959, 576   69. 01   70. 00   07000   ELECTROENCEPHALOGRAPHY   2, 259, 118   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   -14, 055   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   12, 691, 575   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   71, 473, 120   73. 00   76. 00   03020   RENAL ACUTE   2, 590, 970   76. 00   79. 00   09000   CLI NI C   405, 249   90. 00   79. 00   09000   CLI NI C   2, 629, 498   90. 05   79. 00   09000   PATI ENT SURVICE COST CENTERS   90. 07   79. 00   09100   EMERGENCY   16, 808, 279   91. 00   79. 00   09100   EMERGENCY   91. 00   79. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   92. 00   79. 00   SPECI AL PURPOSE COST CENTERS   18. 00   79. 00   09000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   90. 00   79. 00   09000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   90. 00   79. 00   09000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   194. 00   79. 00   09000   GIFT, FLOWER, COFFEE SHOP & SANTEEN   194. 00   79. 00   09000   GIFT, FLOWER, COFFEE SHOP & SANTEEN   194. 00   79. 00   09000   GIFT, FLOWER, COFFEE SHOP & SANTEEN   194. 00   79. 00   09000   GIFT, FLOWER, COFFEE SHOP & SANTEEN   194. 00   79. 00   09000   GIFT, FLOWER, COFFEE SHOP & SANTEEN   194. 00   79. 00   09000   GIFT, FLOWER, COFFEE SHOP & SANTEEN   194. 00   79. 00   09000   GIFT, FLOWER, COFFEE SHOP & SANTEEN   194. 00   79. 00   09000   GIFT, FLOWER, COFFEE SHOP & T., 757, 295   194. 00   79. 00   09000   GIFT, FLOWER, COFFEE SHOP & T., 757, 295   194. 00   79. 00   09000   GIFT, FLOWER, COFFEE SHOP & T., 752, 295   194. 00   79. 00   09000   GIFT, FLOWER, COFFEE SHOP & T., 522   194. 00   79. 00   09000   09000   GIFT, CORD & T., 522   194. 00   79. 00   09000   09000   GIFT, TRICPPSYCHOLOGI CAL SERVI CES   987. 168   194. 00   79. 00   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000					1
69.01   06901   CARDI AC REHAB   959,576   70.00   7000   ELECTROENCEPHALOGRAPHY   2,259,118   70.00   7000   ELECTROENCEPHALOGRAPHY   2,259,118   70.00   7000   ELECTROENCEPHALOGRAPHY   2,259,118   70.00   7000   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   14,055   72.00   73.00   7300   DRUGS CHARGED TO PATI ENTS   71,473,120   73.00   7300   DRUGS CHARGED TO PATI ENTS   71,473,120   73.00   76.00   0000   CLINI C   2,590,970   76.00   0000   CLINI C   405,249   90.05   00005   PATI ENT NUTRI TI ON   264,785   90.05   90.07   90007   WOUND CLI NI C   2,629,498   90.07   91.00   9000   EMERGENCY   16,808,279   91.00   92.00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   8PECI AL PURPOSE COST CENTERS   118.00   SUBTOTALS (SUM OF LINES 1 through 117)   369,067,598   194.00   194.01   07950   RURAL HEALTH   7,757,295   194.00   194.01   07951   RENTAL PROPERTY   30,429   194.01   194.01   107952   FAMILY PRACTI CE   5,325,691   194.02   194.03   07952   FAMILY PRACTI CE   5,325,691   194.02   194.03   194.04   07955   PYSYCI ATRIC PSYCHOLOGI CAL SERVI CES   40,107,173   194.04   194.06   07953   SYCAMORE SPORTS MED   77,522   194.06   194.07   07956   PSYCHI ATRIC /PSYCHOLOGI CAL SERVI CES   987,168   194.07   200.00   Cross Foot Adjustments   0   200.00   0   0   0   0   0   0   0   0					1
71. 00					
72. 00 07200   IMPL. DEV. CHARGED TO PATIENTS 12, 691, 575 73. 00 07300   DRUGS CHARGED TO PATIENTS 71, 473, 120 73. 00 07300   DRUGS CHARGED TO PATIENTS 71, 473, 120 75. 00 07300   DRUGS CHARGED TO PATIENTS 71, 473, 120 75. 00 073020   RENAL ACUTE 2, 590, 970   000 00000   CLINIC 0					
73. 00   07300   DRUGS CHARGED TO PATIENTS   71, 473, 120   2,590,970   76. 00   03020   RENAL ACUTE   2,590,970   76. 00   76. 00   09000   CLI NI C   405,249   90. 00   90. 00   90. 00   90. 00   PATIENT NUTRITION   264,785   90. 05   90. 07   90907   WOUND CLI NI C   2,629,498   90. 07   91. 00   99100   EMERGENCY   16,808,279   91. 00   9200   OBSERVATION BEDS (NON-DISTINCT PART)   92. 00   9					
76. 00 03020 RENAL ACUTE 0UTPATI ENT SERVI CE COST CENTERS  90. 00 90. 0					
OUTPATIENT SERVICE COST CENTERS   O9000   O9005   O9005   OPATIENT NUTRITION   C64, 785   O9005   O9005   O9005   O9005   OPATIENT NUTRITION   C64, 785   O90. 05   O9005					
90. 00	, 5. 66		2, 370, 770		1 , 5. 55
90. 07	90. 00		405, 249		90. 00
91. 00   09100   EMERGENCY   16, 808, 279   91. 00   92. 00					
92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART)   92. 00   SPECI AL PURPOSE COST CENTERS   118. 00   SUBTOTALS (SUM OF LI NES 1 through 117)   369, 067, 598   118. 00   190. 00   190. 00   GI FT, FLOWER, COFFEE SHOP & CANTEEN   190. 00   194. 00   07950   RURAL HEALTH   7, 757, 295   194. 00   194. 01   195. 01   19		1 1			
SPECIAL PURPOSE COST CENTERS   118.00   SUBTOTALS (SUM OF LINES 1 through 117)   369,067,598   118.00   NONREI MBURSABLE COST CENTERS   190.00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   190.00   194.00   19500		1 1	16, 808, 279		
118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   369, 067, 598   118. 00	72. UU				72.00
NONRE   MBURSABLE   COST   CENTERS   190. 00   19000   GI FT   FLOWER, COFFEE SHOP & CANTEEN   0   190. 00   194. 00   194. 00   194. 00   194. 01   194. 01   194. 01   194. 02   194. 02   194. 02   194. 03   197. 05   194. 02   194. 03   197. 05   194. 04   197. 07   197.	118. 00		369, 067, 598		118. 00
194. 00   07950   RURAL HEALTH   7,757,295   194. 00   194. 01   194. 02   194. 02   194. 03   194. 02   194. 03   194. 04   1950   196. 07955   196	-	9 /			
194. 01 07951 RENTAL PROPERTY 30, 429 194. 01 194. 02 07954 FAMI LY PRACTI CE 5, 325, 691 194. 03 07952 WELLNESS 1, 191, 961 194. 03 194. 04 07955 PHYSI CI AN PRACTI CES 40, 107, 173 194. 06 07953 SYCAMORE SPORTS MED 77, 522 194. 07 07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 987, 168 200. 00					
194. 02     07954     FAMILY PRACTICE     5, 325, 691       194. 03     07952     WELLNESS     1, 191, 961       194. 04     07955     PHYSI CI AN PRACTICES     40, 107, 173       194. 06     07953     SYCAMORE SPORTS MED     77, 522       194. 07     07956     PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES     987, 168       200. 00     Cross Foot Adjustments     0					
194. 03     07952     WELLNESS     1, 191, 961       194. 04     07955     PHYSI CI AN PRACTI CES     40, 107, 173       194. 06     07953     SYCAMORE SPORTS MED     77, 522       194. 07     07956     PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES     987, 168       200. 00     Cross Foot Adjustments     0					
194. 04     07955     PHYSI CI AN PRACTI CES     40, 107, 173     194. 04       194. 06     07953     SYCAMORE SPORTS MED     77, 522     194. 06       194. 07     07956     PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES     987, 168     194. 07       200. 00     Cross Foot Adjustments     0     200. 00					
194. 06       07953       SYCAMORE SPORTS MED       77, 522       194. 06         194. 07 07956       PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES       987, 168       194. 07         200. 00       Cross Foot Adjustments       0       200. 00					
194. 07   07956   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES       987, 168   194. 07         200. 00   Cross Foot Adjustments       0					
					1
201.00   Negative Cost Centers   0   201.00		1 1			
	201.00	Negative Cost Centers	0		201.00

Heal th Finan	cial Systems	UNION HOSPITA	AL, INC.			In Lie	u of Form CMS-:	2552-10
COST ALLOCAT	ION - GENERAL SERVICE COSTS		Provi der	CCN:	15-0023	Peri od: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Pre 5/26/2022 10:	
	Cost Center Description	Total						
		26. 00						
202 00	TOTAL (sum Lines 119 through 201)	121 511 027						202 00

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

Cost Center Description					Io	12/31/2021	Date/lime Pre 5/26/2022 10:	
COMPAND   CONTRIBUTE   COST CENTERS   COST CENTER				CAPI TAL REI	LATED COSTS		7 0, 20, 2022 10.	7 (3.11)
CHINGE STRUCT COST CHATES   0   1.00   2.00   24   4.00		Cost Center Description	Assigned New Capital			Subtotal	BENEFI TS	
Company   Comp				1 00	2 00	2A	4 00	
1.00		GENERAL SERVICE COST CENTERS		1.00	2.00	ZN	4.00	
A.D.   DOSCOOL INFLOVES INFELLIS DEPARTMENT   0   91,777   8,104   91,777   4,05   5.05   5	1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
0.0560   DIRCHARS IN CRECEI VI NO AND STORES   0   0   0   0   0   5   0.05	4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0					4. 00
5.05   0.0580  CASHIERING/ACCOUNTS RECEIVABLE   0   0   0   0   5.05   0.00500  ODTER ADMIN AND GERBAL   46,701   283,974   39,877   5,933,888   688   7.00   0.00500  DEFEARTION OF FLANT   24,000   5,461,791   8,097   5,933,888   688   7.00   0.00500  DEFEARTION OF FLANT   24,000   5,461,791   8,097   5,933,888   688   7.00   0.00500  DEFEARTION OF FLANT   2,781   179,017   154,622   336,423   305   10.00   0.0050  DEFEARTION OF FLANT   2,781   179,017   154,622   336,423   305   10.00   0.0050  DEFEARTION OF FLANT   1,741   1,741   1,741   1,741   1,741   1,741   0.0071000  DEFEARTION OF FLANT   1,741   1,741   1,741   1,741   1,741   0.0071000  DEFEARTION OF FLANT   1,741   1,741   1,741   1,741   1,741   0.0071000  DEFEARTION OF FLANT   1,741   1,741   1,741   1,741   1,741   0.0071000  DEFEARTION OF FLANT   1,741   1,741   1,741   1,741   1,741   0.0071000  DEFEARTION OF FLANT   1,741   1,741   1,741   1,741   1,741   0.0071000  DEFEARTION OF FLANT   1,741   1,741   1,741   1,741   1,741   0.0071000  DEFEARTION OF FLANT   1,741   1,741   1,741   1,741   1,741   1,741   0.0071000  DEFEARTION OF FLANT   1,741   1,7	5.03	00560 PURCHASING RECEIVING AND STORES	0 0	0	0	0	0	5. 03
2,00			0					l
8.00   00800   LANIDRY & LINEN SERVICE   17.047   97.664   138.496   273,207   676   8 0.0     9.00   00900   DUELTARY   2,781   179,017   154.625   336.423   305   10.00     10.00   10100   CHETERIA   1.293   25,248   179,017   154.625   336.423   305   10.00     10.00   10100   CHETERIA   1.293   25,248   179,017   154.625   336.423   305   10.00     10.00   10100   CHETERIA   1.293   25,248   179,017   154.625   336.423   305   10.00     10.00   10100   CHETERIA   1.293   305   10.00     22.00   14000   CHETERIA   1.293   305   10.00     22.00   10200   148 SERVICES-OHIER PROM COSTS APPRVID   0   0   0   0   0   0     22.00   10200   148 SERVICES-OHIER PROM COSTS APPRVID   0   0   0   0   0   0   0     23.01   10230   TORNAMED ED PROM COST CENTERS   0   0   0   0   0   0   0     23.01   10230   TORNAMED ED PROM COST CENTERS   0   0   0   0   0   0   0     23.01   10230   TORNAMED ED PROM COST CENTERS   0   0   0   0   0   0     23.01   10230   TORNAMED ED PROM COST CENTERS   0   0   0   0   0   0   0     23.01   10230   TORNAMED ED PROM COST CENTERS   0   0   0   0   0   0   0   0     23.01   10230   TORNAMED ED PROM COST CENTERS   0   0   0   0   0   0   0   0   0     23.01   10230   TORNAMED ED PROM COST CENTERS   0   0   0   0   0   0   0   0   0	5.06	00590 OTHER ADMIN AND GENERAL	46, 701	283, 874	39, 877	370, 452	4, 989	5. 06
9.00   0.0900   IOUSEKEPING   1,973   25,248   25,371   51,912   1,942   9.00   11.00   0.0100   DETARY   2,781   179,017   154,625   33,6423   305   10.00   1300   0.076   MESING ADMINISTRATION   0   127,739   6.007   133,746   1,242   11.00   13.00   1300   MESING ADMINISTRATION   1,247   38,752   80   0.07   133,746   1,242   11.00   13.00   1300   MESING ADMINISTRATION   1,247   10.07   13.00   1300   MESING ADMINISTRATION   1,247   10.07   13.00   1300   MESING ADMINISTRATION   1,247   10.00   10.00   0   0   0   0   0   0   0   0   0			1					•
10.00   OLOGO   CETARY   2,781   179, 017   154, 625   336, 423   305   10.00								l .
11-00 0 1100 (CAFETERIA   0 127,739 6,007 133,746   1,242 11:00 13.00 1300 (MESIN MESIN ME			1					•
13.00   01300   NURSIN CADMINISTRATION   1, 247   38, 752   38   40, 082   1, 096   13.00   12.00			1					•
21.00   02100   IAS SERVICES-SALARY & FRINGES APPRVD   0   0   0   0   0   1,225   22.00   02200   IAS SERVICES-COTTER PREGUESTS   0   0   0   0   0   0   0   0   0		1	1					•
22.00   02200   RASSERVICES-OTHER PROX COSTS APPRVD   0   0   0   0   0   0   0   64   23   00   0300   0301   07   07   03.01   03.			1		1			16. 00
23.00   02300   PARAMED ED PRICM   0   1.74   3   44   11,787   207   23.01   23.01   02341   01HER NED ED   0   1.74   3   44   11,787   207   23.01   23.01   23.01   02341   01HER NED ED   0   0   0   0   0   0   0   0   0			0			- 1		•
23.01   02341   DTHER MED ED   0   11, 743   44   11, 787   207   23.01			0	0		0		1
23. 02 02301 PARAMED ED PRIGNI			0	U 11 7/2		11 707		
INPATI ENT ROUTINE SERVICE COST CENTERS   283,840   3,137,975   825,503   4,247,318   18,646   30.00   31.00   30.00   ADULTS & PEDITATICS   283,840   3,137,975   825,503   4,247,318   18,646   30.00   31.00   31.00   INTENSIVE CARE UNIT   1,116,544   374,965   674,666   2,166,175   4,775   31.00   34.00   40.00   1   1   1   1   1   1   1   1   1		· ·			i l			1
31.00   03100   INTENSIVE CARE UNIT   1,116,544   374,965   674,666   2,166,175   4,775   31.00   30.00   2000   INTENSIVE NURSERY   4,039   64.131   297,779   363,494   1,939   35.00   2000   INTENSIVE NURSERY   0   12,638   252   12,615   735   43.00   4300   NURSERY   0   10,000   NURSERY   0   10,0	20.02		<u> </u>		<u> </u>	<u> </u>		20.02
15.00   02040   INTERSIVE NURSERY			283, 840	3, 137, 975	825, 503		18, 646	30. 00
1.0   0.4100   SUBPROVI DER - I I I F   11, 159   251, 548   14, 141   276, 848   1, 522   41. 00			1					1
13, 00   04300   NURSERY   0   12, 363   252   12, 615   735   43, 00			1					ł
ANCIL LARY SERVICE COST CENTERS   So. 00   So. 00   GPEATIN ROOM   927, 608   686, 744   2, 270, 765   3, 885, 117   2, 923   50, 00   50, 00   GOOD   GERATIN ROOM   927, 608   686, 744   42, 270, 765   3, 885, 117   2, 923   50, 00   50, 00   50, 00   600002   WSC   483, 942   495, 348   31, 217   286, 351   353, 586   2, 033   50, 01   50, 00   50,			1					ł
SO. 01   OSDOT   CARDIA & SURGERY   36, 018   31, 217   266, 351   353, 586   2, 033   50. 01	.0.00		<u> </u>	12, 000	202	127 0 10	7.00	10.00
50.02   05002   WSC   05002   WSC   1,774,516   0 50.02	50.00					3, 885, 117	2, 923	50. 00
10								•
S1-10   OSTO1   O.P. TREATMENT ROOM   1.092   390, 231   45, 691   437, 014   367   51.02			I I					•
S2.00   05200   DELIVERY ROOM & LABOR ROOM   14, 985   387, 230   264, 435   666, 650   2, 851   52, 00			· · · · · · · · · · · · · · · · · · ·					1
54.00   05400   RADIOLOGY-DIAGNOSTIC   566, 396   522, 520   1, 754, 381   2, 843, 297   3, 858   54.00   55.00   05500   RADIOLOGY-THERAPEUTIC   874, 389   430, 672, 23, 588   1, 588, 444   305   55.00   05500   RADIOLOGY-THERAPEUTIC   227, 439   143, 527   342, 025   712, 991   341   56.00   57.00   05700   CT SCAN   90, 778   35, 425   373, 971   500, 174   892   57.00   68.00   05800   MAGNETIC RESONANCE IMAGING (MRI)   495   42, 292   893, 508   936, 295   613   58.00   59.00   05800   MAGNETIC RESONANCE IMAGING (MRI)   202, 373   589, 342   303, 955   1, 095, 670   2, 094   59.00   69.00   60.00   6								•
56. 00   05700   CT SCAN   05700   CT SCAN   90,778   35,425   373,971   500,174   892   57. 00   57. 00   05800   MAGNETI C RESONANCE I MAGI NG (MRI )   495   42,292   893,508   936,295   613   58. 00   05800   MAGNETI C RESONANCE I MAGI NG (MRI )   495   42,292   893,508   936,295   613   58. 00   05800   CARDI AC CATHETERI ZATI ON   202, 373   589, 342   303,955   1,095,670   2,094   59. 00   60. 00   6000   LABORATORY   1,411   0   30,089   31,500   1,541   60. 00   6000   LABORATORY   1,411   0   30,089   31,500   1,541   60. 00   6000   LABORATORY   1,411   0   30,089   31,500   1,541   60. 00   60.	54.00		1					54. 00
57.00   05700   CT SCAN   90,778   35,425   373,971   500,174   892   57.00			1					l .
S8.00   05800   MAGNETIC RESONANCE I MACI NG (MRI )   495   42, 292   893, 508   936, 295   613   58.00			1					•
59.00   05900   CARDI AC CATHETERI ZATION   202, 373   589, 342   303, 955   1, 095, 670   2, 094   59. 00								•
60.00   06000   LABORATORY   1,411   0   30,089   31,500   1,541   60.00   62.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   0   0   0   0   0   0   65.00   06500   RESPIRATORY THERAPY   88,015   83,947   363,809   535,771   2,946   65.00   66.01   06600   PHYSI CAL THERAPY   990   165,545   12,979   179,514   0   66.00   66.01   06601   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   0   0   0   0   66.01   66.02   06602   O/P PHYSI CAL THERAPY   2,219   0   81,992   84,211   0   66.02   66.03   06602   O/P PHYSI CAL THERAPY   0   27,042   0   27,042   0   67.00   67.00   06700   OCCUPATI ONAL THERAPY   0   27,042   0   27,042   0   67.00   68.00   06600   PEECH PATHOLOGY   0   53,627   0   53,627   0   53,627   0   68.00   69.01   06900   ELECTROCARDI OLOGY   488,923   51,882   1,075,919   1,616,724   1,786   69.00   69.01   06901   CARDI AC REHAB   0   106,569   64,878   171,447   259   69.01   69.01   06901   CARDI AC REHAB   0   106,569   64,878   171,447   259   69.01   69.01   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   0   0   68,734   89,415   2,153   70.00   67.00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   0   0   0   67.00   07300   DRUGS CHARGED TO PATI ENTS   826,232   337,859   143,801   1,307,692   3,638   73.00   69.00   09000   CLI NI C   0   11,384   0   11,384   171   90.00   69.01   09000   CLI NI C   0   11,384   0   11,384   171   90.00   69.02   09000   DRIFIENT SERVICE COST CENTERS   12,474   57,492   6,211   64,950   339   90.07   69.00   09000   CLI NI C   0   11,384   0   11,384   171   90.00   69.00   09000   DRIFIENT NUTRI TI ON   0   31,478   675   32,153   62   90.05   69.00   09000   DRIFIENT SERVICE COST CENTERS   182,333   625,807   4,746   91.00   69.00   09000   DRIFIENT SERVICE COST CENTERS   182,333   625,807   4,746   91.00   69.00   09000   DRIFIENT SERVICE COST CENTERS   182,333   183,500   190,00   69.00   09000   DRIFIENT SERVICE COST CENTERS   180,000   190,00   190,00   190,00   69.00   09000   01,000   01,000   01,000   01,000   01,000   01,			1					•
65. 00   06500   RESPI RATORY THERAPY   88, 015   83, 947   363, 809   535, 771   2, 946   65. 00   66. 00   06600   PHYSI CAL THERAPY   990   165, 545   12, 979   179, 514   0   66. 00   0   0   0   0   0   0   0   66. 01   66. 01   66. 02   06602   O/P PHYSI CAL THERAPY   2, 219   0   81, 992   84, 211   0   66. 02   06700   0CCUPATI ONAL THERAPY   0   27, 042   0   27, 042   0   67. 00   06800   SPEECH PATHOLOGY   0   53, 627   0   68. 00   06800   SPEECH PATHOLOGY   0   53, 627   0   68. 00   06900   ELECTROCARDI OLOGY   488, 923   51, 882   1, 075, 919   1, 616, 724   1, 786   69. 00   06900   ELECTROCARDI OLOGY   488, 923   51, 882   1, 075, 919   1, 616, 724   1, 786   69. 00   06900   ELECTROCARDI OLOGY   488, 923   51, 882   1, 075, 919   1, 616, 724   1, 786   69. 00   07000   ELECTROCARDI OLOGY   20, 681   0   68, 734   89, 415   2, 153   70. 00   07000   ELECTROCARDI OLOGY   20, 681   0   68, 734   89, 415   2, 153   70. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   0   0   0   0   0								60. 00
66. 00   06600   PHYSI CAL THERAPY   990   165, 545   12, 979   179, 514   0   66. 00   66. 01   06601   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   0   0   0   0   0   67. 00   06700   06002   07P PHYSI CAL THERAPY   2, 21   9   0   81, 992   84, 211   0   66. 02   67. 00   06700   0CCUPATI ONAL THERAPY   0   27, 042   0   27, 042   0   67. 00   68. 00   06800   SPEECH PATHOLOGY   0   53, 627   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   488, 923   51, 882   1,075, 919   1,616, 724   1,786   69. 00   69. 01   06901   CARDI AC REHAB   0   106, 569   64, 878   171, 447   259   69. 01   70. 00   07000   ELECTROENCEPHALOGRAPHY   20, 681   0   68, 734   89, 415   2,153   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   826, 232   337, 859   143, 601   1, 307, 692   3, 638   73. 00   76. 00   03000   RUGS CHARGED TO PATI ENTS   826, 232   337, 859   143, 601   1, 307, 692   3, 638   73. 00   76. 00   03000   RUGS CHARGED TO PATI ENTS   826, 232   337, 859   143, 601   1, 307, 692   3, 638   73. 00   76. 00   03000   RUGS CHARGED TO PATI ENTS   826, 232   337, 859   143, 601   1, 307, 692   3, 638   73. 00   76. 00   03000   RUGS CHARGED TO PATI ENTS   826, 232   337, 859   143, 601   1, 307, 692   3, 638   73. 00   76. 00   00700   CLI INI C   0   11, 384   0   11, 384   171   90. 00   77. 00   07000   CLI INI C   0   11, 384   0   11, 384   171   90. 00   79. 00   09000   CLI INI C   4, 546   146, 006   35, 988   186, 540   339   90. 07   791. 00   09100   EMERGENCY   49, 949   393, 525   182, 333   625, 807   4, 746   91. 00   792. 00   09000   CLI INI C   0   0   0   0   0   0   792. 00   09000   CHERGENCY   49, 949   393, 525   182, 333   625, 807   4, 746   91. 00   794. 00   09000   CHERGENCY   0   0   0   0   0   0   0   794. 00   09000   CHERGENCY   0   0   0   0   0   0   794. 00   09000   CHERGENCY   0   0   0   0   0   0   0   794. 00		· ·	1		- 1	-		
66. 01   06601   PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES   0   0   0   0   0   0   0   66. 01   66. 02   06602   0/P PHYSI CAL THERAPY   2, 219   0   81, 992   84, 211   0   66. 02   67. 00   06700   06CCUPATI ONAL THERAPY   0   27, 042   0   27, 042   0   67. 00   68. 00   06800   SPEECH PATHOLOGY   0   53, 627   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   488, 923   51, 882   1, 075, 919   1, 616, 724   1, 786   69. 00   69. 01   06901   CARDI ACRIBAR   0   106, 569   64, 878   171, 447   259   69. 01   70. 00   07000   ELECTROENCEPHALOGRAPHY   20, 681   0   68, 734   89, 415   2, 153   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   826, 232   337, 859   143, 601   1, 307, 692   3, 638   73. 00   76. 00   007200   ENAL ACUTE   1, 247   57, 492   6, 211   64, 950   0   79. 05   09005   ENAL ACUTE   1, 247   57, 492   6, 211   64, 950   0   79. 05   09005   PATI ENT NUTRI TI ON   0   31, 478   675   32, 153   62   90. 05   79. 07   09007   WOUND CLI NI C   4, 546   146, 006   35, 988   186, 540   339   90. 07   79. 00   09000   EMERGENCY   49, 949   393, 525   182, 333   625, 807   4, 746   91. 00   79. 00   09000   DSERVATI ON BEDS (NON-DI STI NCT PART)   SPECI AL PURPOSE COST CENTERS    118. 00   SUBSTOTALS (SUM OF LI NES 1 through 117)   6, 434, 577   15, 549, 414   11, 986, 387   33, 970, 378   79, 790   118. 00   194. 00   07950   RURAL HEALTH   166, 433   0   64, 949   231, 382   1, 873   194. 00   194. 00   07951   RENTAL PROPERTY   0   0   2, 520   2, 520   0, 194. 01   194. 01   07951   RENTAL PROPERTY   0   0   0   2, 520   2, 520   0, 194. 01   194. 02   07954   FAMIL LY PRACTICE   9, 776   195, 719   78, 062   283, 557   1, 873   194. 02   194. 02   07954   FAMIL LY PRACTICE   9, 776   195, 719   78, 062   283, 557   1, 873   194. 02   194. 02   07954   FAMIL LY PRACTICE   9, 776   195, 719   78, 062   283, 557   1, 873   194. 02		· ·	1					
66. 02   06602   0/P PHYSI CAL THERAPY   2, 219   0   81, 992   84, 211   0   66, 02   67. 00   06700   OCCUPATI ONAL THERAPY   0   27, 042   0   27, 042   0   67. 00   68. 00   06800   SPEECH PATHOLOGY   0   53, 627   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   488, 923   51, 882   1, 075, 919   1, 616, 724   1, 786   69. 01   06901   CARDI AC REHAB   0   106, 559   64, 878   171, 447   259   69. 01   07000   OCCUPATI ONAL THERAPY   20, 681   0   68, 734   89, 415   2, 153   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   826, 232   337, 859   143, 601   1, 307, 692   3, 638   76. 00   03020   RENAL ACUTE   1, 247   57, 492   6, 211   64, 950   0   76. 00   00000   CLINIC   0   11, 384   0   11, 384   171   790. 05   090005   PATI ENT SURI ITION   0   31, 478   675   32, 153   62, 900   791. 00   09000   CLINIC   4, 546   146, 006   35, 988   186, 540   339   90. 07   791. 00   09000   OUTO BERGENCY   49, 949   393, 525   182, 333   625, 807   4, 746   791. 00   09000   OUTO BERGENCY   49, 949   393, 525   182, 333   625, 807   4, 746   792. 00   09200   OUTO BERGENCY   49, 949   393, 525   182, 333   33, 970, 378   79, 790   791. 00   09000   CLINIC   0   0   0   0   0   792. 00   09200   OUTO BERGENCY   49, 949   393, 525   182, 333   625, 807   4, 746   791. 00   09100   BURGERNCY   500000   50000   500000   500000   500000   500000   500000   500000   500000   500000   500000			990	165, 545	12, 979	179, 314		
67. 00   06700   OCCUPATIONAL THERAPY   0   27, 042   0   27, 042   0   67. 00   68. 00   06800   SPEECH PATHOLOGY   0   53, 627   0   53, 627   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   488, 923   51, 882   1, 075, 919   1, 616, 724   1, 786   69. 00   69. 01   06901   CARDI AC REHAB   0   106, 569   64, 878   171, 447   259   69. 01   70. 00   07000   ELECTROCROEPHALOGRAPHY   20, 681   0   68, 734   89, 415   2, 153   70. 00   71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   0   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   826, 232   337, 859   143, 601   1, 307, 692   3, 638   73. 00   76. 00   03020   RENAL ACUTE   1, 247   57, 492   6, 211   64, 950   0   79. 00   09000   CLI NI C   0   11, 384   0   11, 384   171   79. 00   09000   PATI ENT SERVI CE COST CENTERS   79. 00   09000   PATI ENT NUTRI TI ON   0   31, 478   675   32, 153   62   90. 05   79. 00   09100   DRUGS CHARGED TO PATI ENTS   49, 949   393, 525   182, 333   625, 807   4, 746   91. 00   79. 00   09100   DRUGS CHARGED TO PATI ENTS   0   0   0   0   79. 00   09100   DRUGS CHARGED TO PATI ENTS   0   0   0   79. 00   09100   DRUGS CHARGED TO PATI ENTS   0   0   79. 00   09000   CLETROST CENTERS   0   0   0   0   79. 00   09000   DRUGS CHARGED TO PATI ENTS   0   0   79. 00   09000   DRUGS CHARGED TO PATI ENTS   0   0   79. 00   09100   DRUGS CHARGED TO PATI ENTS   0   0   79. 00   09100   DRUGS CHARGED TO PATI ENTS   0   0   79. 00   09100   DRUGS CHARGED TO PATI ENTS   0   0   79. 00   09100   DRUGS CHARGED TO PATI ENTS   0   0   79. 00   09100   DRUGS CHARGED TO PATI ENTS   0   0   79. 00   09100   DRUGS CHARGED TO PATI ENTS   0   0   79. 00   09100   DRUGS CHARGED TO PATI ENTS   0   0   79. 00   09100   DRUGS CHARGED TO PATI ENTS   0   0   79. 00   09100   DRUGS CHARGED TO PATI ENTS   0   0   79. 00   09100   DRUGS CHARGED TO PATI ENTS   0   0   79. 00   09100   DRUGS CHARGED TO PATI ENTS   0   0   79. 00   09100   DRUGS CHARGED TO PATI			2, 219	0	81, 992	84, 211		1
69. 00 06900   ELECTROCARDI OLOGY	67. 00		0				0	67. 00
69. 01   06901   CARDI AC REHAB   0   106, 569   64, 878   171, 447   259   69. 01   70. 00   07000   ELECTROENCEPHALOGRAPHY   20, 681   0   68, 734   89, 415   2, 153   70. 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   0   0   0   73. 00   07300   DRUGS CHARGED TO PATIENTS   826, 232   337, 859   143, 601   1, 307, 692   3, 638   73. 00   76. 00   03020   RENAL ACUTE   1, 247   57, 492   6, 211   64, 950   0   76. 00    OUTPATIENT SERVICE COST CENTERS			0					
70.00   07000   ELECTROENCEPHALOGRAPHY   20, 681   0   68, 734   89, 415   2, 153   70.00   71.00   71.00   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   71.00   72.00   1MPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   72.00   72.00   1MPL. DEV. CHARGED TO PATIENTS   826, 232   337, 859   143, 601   1, 307, 692   3, 638   73.00   76.00   03020   RENAL ACUTE   1, 247   57, 492   6, 211   64, 950   0   76.00   00   0   76.00   00   0   76.00   00   00   0   76.00   00   00   00   00   00   00   00			488, 923					1
71. 00			20 681	_				1
72. 00			0	0				
76. 00	72. 00		0	0	0	0	0	72. 00
OUTPATI ENT SERVI CE COST CENTERS   OUTPATI ENT NUTRI TI ON								1
90. 00	76. 00		1, 247	57, 492	6, 211	64, 950	0	76. 00
90. 05	90 00			11 39/		11 20/	171	l an nn
90. 07   09007   WOUND CLINIC   4,546   146,006   35,988   186,540   339   90. 07   91. 00   09100   EMERGENCY   49,949   393,525   182,333   625,807   4,746   91. 00   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0   0   0   0   0   0   0   0   0			0					1
92. 00			4, 546					1
SPECIAL PURPOSE COST CENTERS   SUBTOTALS (SUM OF LINES 1 through 117)   6,434,577   15,549,414   11,986,387   33,970,378   79,790   118.00   NONREI MBURSABLE COST CENTERS			49, 949	393, 525	182, 333	625, 807	4, 746	91. 00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 6, 434, 577 15, 549, 414 11, 986, 387 33, 970, 378 79, 790 118. 00 NONREI MBURSABLE COST CENTERS  190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190. 00 190. 00 194. 00 07950 RURAL HEALTH 166, 433 0 64, 949 231, 382 1, 873 194. 00 194. 01 07951 RENTAL PROPERTY 0 0 0 2, 520 2, 520 0 194. 01 194. 02 07954 FAMILY PRACTICE 9, 776 195, 719 78, 062 283, 557 1, 873 194. 02	92. 00					0		92. 00
NONREI MBURSABLE COST CENTERS   190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   190. 00   190. 00   194. 00   194. 01   07951   RENTAL PROPERTY   0   0   2, 520   2, 520   0   194. 01   194. 02   07954   FAMILY PRACTICE   9, 776   195, 719   78, 062   283, 557   1, 873   194. 02   194. 02   194. 02   195, 719   19	110 00		4 424 577	15 540 414	11 007 207	22 070 270	70. 700	110 00
190. 00     190.00     GIFT, FLOWER, COFFEE SHOP & CANTEEN     0     0     0     0     0     190. 00       194. 00     07950     RURAL HEALTH     166, 433     0     64, 949     231, 382     1, 873 194. 00       194. 01     07951     RENTAL PROPERTY     0     0     2, 520     2, 520     0 194. 01       194. 02     07954     FAMILY PRACTICE     9, 776     195, 719     78, 062     283, 557     1, 873 194. 02	1 18. UC		0,434,5//	13, 549, 414	11, 900, 38/	აა, <del>9</del> 10, 3/8	19, 190	ji 16. UU
194. 00     07950     RURAL HEALTH     166, 433     0     64, 949     231, 382     1, 873 194. 00       194. 01     07951     RENTAL PROPERTY     0     0     2, 520     2, 520     0 194. 01       194. 02     07954     FAMI LY PRACTICE     9, 776     195, 719     78, 062     283, 557     1, 873 194. 02	190.00		O	0	0	ol	0	190. 00
194. 02 07954 FAMILY PRACTICE 9, 776 195, 719 78, 062 283, 557 1, 873 194. 02	194.00	07950 RURAL HEALTH	166, 433	0	64, 949		1, 873	194. 00
			0	0				
174. 00 01702 WELENEOS   U  221, 304  U  221, 304  240 194. 03			1					
	174. U	0/07 732  WLLLINL33	<u>ı</u>	221, 309	ı o	221, 309	240	1174. U3

Health Financial Systems	UNION HOSPI	TAL, INC.		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CO		Peri od:	Worksheet B	
				From 01/01/2021 To 12/31/2021	Part II   Date/Time Pre	nared:
				10 12/31/2021	5/26/2022 10:	
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Di rectly	NEW BLDG &	NEW MVBLE	Subtotal	EMPLOYEE	
	Assigned New	FLXT	EQUI P		BENEFI TS	
	Capi tal				DEPARTMENT	
	Related Costs					
	0	1.00	2.00	2A	4. 00	
194. 04 07955 PHYSICIAN PRACTICES	820, 388	0	113, 41	0 933, 798	7, 526	194. 04
194.06 07953 SYCAMORE SPORTS MED	0	0		0 0	16	194. 06
194. 07 07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	3, 654	46, 744	78	8 51, 186	409	194. 07
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers		0		ol ol	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	7, 434, 828	16, 013, 186	12, 246, 11	6 35, 694, 130	91, 727	202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2021 | Part II | To 12/31/2021 | Date/Time Prepared: | 5/26/2022 | 10: 49 am

						72/31/2021	5/26/2022 10:	49 am
		Cost Center Description	NONPATIENT TELEPHONES	DATA PROCESSI NG	PURCHASING RECEIVING AND	ADMI TTI NG	CASHI ERI NG/ACC	
SERIONAL SERVICE COST CENTERS			TEEETHONES	11002001110				
1.00   00100  AER CAP HEL COSTS-PELICA & INT   2.00   2.		CENEDAL CEDULCE COCT CENTERS	5. 01	5. 02	5. 03	5. 04	5. 05	
2 0.0 0.0000 LINE LYSE PERMITT ST EMPRISES 09.263 0.0 0.0000 LINES SERVICES TOMATIVETY 09.263 0.0 0.0000 LINES SERVICES STREET SERVICE SER	1 00							1 00
5.01   0.0540   NOWNATHER!   TELEPHONES   9.0   0   0   5.7492   0   5.01   5.01   5.02   5.0550   5.00		1 1						•
5.02   0.0550   DATA PROCESSING   0								ł
0.0560   PURCHASING RECEIVING AND STORES   0   0   0   0   0   0   0   57,492   5.03		1 1	1	_				•
0.0070  ADMITTING		1 1	_	(				•
5.05   0.0580   CASHI ERINKA/ACQUATT RECEI WALE		1 1		(		57 492		•
0.000   0.0700   0.0FERATION OF PLANT		1 1	0	Č	o o	0	0	•
B.O.   0.0800  LANIBURY & LINEN SERVICE			1	C	0	0		•
9.00   0.900  MUSISEEPING				C	0	0		•
10.00   01000   DETARY		1 1		(		0		1
11.00   0100 (CAFETERIA   1.970   0 0 0 0 0 11.00   11.00   13				(		0		1
16.00   1600   MEDICAL RECORDS & LIBRARY   2.400   0   0   0   0   0   0   0   0   22.00   22.00   20200   Las SERVICES-OTHER PROM COSTS APPRVD   0   0   0   0   0   0   0   0   23.01   02300   02300   DANAMED ED PROM COSTS APPRVD   0   0   0   0   0   0   0   23.01   0231   OTHER MD ED   0   0   0   0   0   0   0   23.01   0231   OTHER MD ED   0   0   0   0   0   0   0   23.01   0231   OTHER MD ED   0   0   0   0   0   0   0   23.01   0231   OTHER MD ED   0   0   0   0   0   0   0   23.01   0231   OTHER MD ED   0   0   0   0   0   0   0   23.01   0231   OTHER MD ED   0   0   0   0   0   0   0   0   23.01   02300   OTHER MD ED   0   0   0   0   0   0   0   0   23.01   02300   OTHER MD ED   0   0   0   0   0   0   0   0   23.01   02300   OTHER MD ED   0   0   0   0   0   0   0   0   23.01   02300   OTHER MD ED   0   0   0   0   0   0   0   0   0   23.01   02300   OTHER MD ED   0   0   0   0   0   0   0   0   0		1 1		Č	o	0		1
21 00 0200   LAR SERVICES-SALAKY & FRINCES APPRVD 0 0 0 0 0 0 0 0 22 00 23 00 0200   LAR SERVICES-OTHER PROM COSTS APPRVD 0 0 0 0 0 0 0 0 0 0 22 00 23 00 02300   PARAMED ED PROM 0 0 0 0 0 0 0 0 0 0 22 00 0 23 00 0 23 00 0 23 00 0 23 00 0 23 00 0 23 00 0 0 0			l l	C	0	0		
22 00   02200   IAR SERVICES-OTHER PROM COSTS APPRVD   0   0   0   0   0   0   22 0   0   0		1 1	2, 400	C	0	0		
23.00   02300   PARAMED ED PROM		1 1	0	(		0	-	1
23.01   02341   OTHER NED ED   0   0   0   0   0   23.01		1 1	0	(		0		1
INPATI ENT ROUTINE SERVICE COST CENTERS   30.00   30			O	Č	o	0		1
30.00	23. 02		0		0	0	0	23. 02
31.00	20.00		12 (72			11 (05	0	1 20 00
135.00   02040   INTENSIVE NURSERY   1.440   0   0   4.87   0.41.00   0.43.00   0.4300   0.500   0.4300   0.4300   0.4300   0.4300   0.500   0.4300   0.4300   0.4300   0.500   0.4300   0.4300   0.500   0.4300   0.4300   0.500   0.4300   0.500   0.4300   0.500   0.4300   0.500   0.4300   0.500   0.4300   0.500   0.4300   0.500   0.4300   0.500   0.500								•
11.00   04100   SUBROVI DER - I RF   2,480   0   0   27E   0,41.00   430   04300   MIRSERY   320   0   0   27E   0,42.00   630   65.00   65.		1 1	· · · · · · · · · · · · · · · · · · ·	(	-		-	
ANCILLARY SERVICE COST CENTERS		1 1		Č	o			•
50.00   05000   05000   076000   076000   0   0   0   0   0   0   0   0   0	43.00		320		0	278	0	43. 00
50.00	F0 00		, 550			5.07/		 
50.02   OSDO2   WSC		1 1						•
51.00   05100   DECOVERY ROOM   1, 440   0   0   318   0   51.02   51.02   0510   07   TREATMENT ROOM   2, 160   0   0   8   0   51.02   52.00   05200   DELLYERY ROOM & LABOR ROOM   1, 840   0   0   1, 892   0   52.00   55.00   055.00   DELLYERY ROOM & LABOR ROOM   1, 840   0   0   1, 892   0   54.00   55.00   055.00   DELLYERY ROOM & LABOR ROOM   1, 840   0   0   0   1, 892   0   55.00   055.00   055.00   DELLYERY ROOM & LABOR ROOM   1, 840   0   0   0   1, 892   0   55.00   055.00			l l	(				•
S2.00   05200   DELLYVERY ROOM & LABOR ROOM   1, 840   0   0   1, 892   0   52.00		1 1	1, 440	C	0		0	•
54. 00   05400   RADI OLOGY-DI AGNOSTIC   8, 639   0   0   1, 899   0   54. 00			1	C	0	8	-	
55.00   05500   RADIO LOGY-THERAPEUTI C   3, 279   0   0   270   0   55.00		1 1	1	C	0			
56.00   05000   RADIO I SOTOPE   0 0 0 0 124 0 56.00		1 1		(				•
57.00   05700   CT SCAN   56.0   0   1,648   0   57.00		1 1	1	(				1
59.00   05900   CARDIAC CATHETERI ZATION   2,720   0   0   3,444   0   59,00			560	C	0			1
60.00   06000   LABORATORY   640   0   0   5,395   0   60,00   62.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   0   0   0   0   291   0   62.00   62.00   06500   RESPIRATORY THERAPY   1,120   0   0   3,519   0   65.00   66.00   06600   PHYSI CAL THERAPY   1,840   0   0   954   0   66.00   66.01   06601   PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES   0   0   0   0   0   0   0   66.02   06602   O/P PHYSI CAL THERAPY   80   0   0   0   0   0   0   66.02   06602   O/P PHYSI CAL THERAPY   80   0   0   0   0   0   0   66.02   06602   O/P PHYSI CAL THERAPY   400   0   0   720   0   67.00   67.00   06700   OCCUPATI ONAL THERAPY   400   0   0   0   141   0   68.00   68.00   06800   SPECEH PATHOLOGY   80   0   0   141   0   68.00   69.00   06900   ELECTROCARDI OLOGY   320   0   0   1,742   0   69.00   69.01   06901   CARDIAC REHAB   480   0   0   1,742   0   69.00   70.00   07000   ELECTROCARDI OLOGY   320   0   0   1,742   0   69.00   71.00   07000   ELECTROENCEPHALOGRAPHY   1,360   0   0   86   0   70.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   0   0   72.00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATI ENTS   3,999   0   0   5,667   0   73.00   76.00   03020   RENAL ACUTE   320   0   0   0   0   0   0   79.00   09005   PATI ENT NUTRI TI ON   0   0   0   0   0   0   79.00   09005   PATI ENT NUTRI TI ON   0   0   0   0   0   0   79.00   09005   PATI ENT NUTRI TI ON   0   0   0   0   0   79.00   09000   EMERGENCY   5,039   0   0   57,492   0   79.00   09100   EMERGENCY   5,039   0   0   57,492   0   79.00   09100   EMERGENCY   5,039   0   0   0   0   0   79.00   09100   09100   00   00   00   00			l l	C	-			1
62.00   06.200   WHOLE BLOOD & PACKED RED BLOOD CELLS   0   0   0   0   291   0   62.00			1	C	0	•		1
65. 00   06500   RESPIRATORY THERAPY   1, 120   0   0   3,519   0   65. 00   66. 00   06600   PHYSI CAL THERAPY   1, 840   0   0   0   954   0   66. 00   66. 01   06601   PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES   0   0   0   0   0   0   66. 02   06602   07P PHYSI CAL THERAPY   80   0   0   0   0   0   66. 02   06602   07P PHYSI CAL THERAPY   80   0   0   0   0   0   67. 00   06700   0CCUPATI ONAL THERAPY   400   0   0   720   0   68. 00   06800   SPECH PATHOLOGY   80   0   0   141   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   320   0   0   1, 742   0   69. 00   69. 01   06901   CARDI AC REHAB   480   0   0   12   0   69. 01   70. 00   07000   ELECTROCARDI ALCORAPHY   1, 360   0   0   86   0   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   1, 319   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   3, 999   0   0   5, 667   0   73. 00   74. 00   07300   DRUGS CHARGED TO PATI ENTS   3, 999   0   0   5, 667   0   73. 00   75. 00   07000   CLINI C   0   0   0   0   0   0   76. 00   03002   RENAL ACUTE   320   0   0   408   0   76. 00   79. 00   09000   CLINI C   0   0   0   0   0   0   79. 00   09000   PATI ENT SERVI CE COST CENTERS   0   0   0   0   0   0   79. 00   09000   DRUGS CHARGED TO PATI ENT S   0   0   0   0   0   79. 00   09000   DRUGS CHARGED TO PATI ENT S   0   0   0   0   0   79. 00   09000   PATI ENT NUTRI TI ON   0   0   0   0   0   79. 00   09000   PATI ENT NUTRI TI ON   0   0   0   0   0   79. 00   09000   PATI ENT SERVI CE COST CENTERS   0   0   0   0   0   79. 00   09000   DRUGS CHARGED COST CENTERS   0   0   0   0   0   79. 00   09000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   0   79. 00   07900   RURAL HEALTH   80   0   0   0   0   0   79. 00   07900   RURAL HEALTH   RURAL HEALTH   80   0   0   0   0   0   79. 00   07900   WINDEL SENTAL PROPERTY   0   0   0   0   0   0   79. 00   07900   WINDEL SENTAL PROPERTY   0   0   0   0   0   0   79. 00   07900   07			1	(				1
66. 00   06600   PHYSICAL THERAPY   1,840   0   0   954   0   66. 00   66. 01   06601   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   0   0   0   0   0   66. 02   06602   07P PHYSI CAL THERAPY   80   0   0   0   0   0   67. 00   06700   0CCUPATI ONAL THERAPY   400   0   0   720   0   67. 00   68. 00   06800   SPEECH PATHOLOGY   80   0   0   141   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   320   0   0   1,742   0   69. 00   69. 01   06901   CARDI AC REHAB   480   0   0   12   0   69. 00   69. 01   06901   CARDI AC REHAB   480   0   0   12   0   69. 00   71. 00   07000   ELECTROCROPHALOGRAPHY   1,360   0   0   86   0   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   1,319   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   3,999   0   0   5,667   0   73. 00   76. 00   03020   RENAL ACUTE   320   0   0   0   0   0   0   76. 00   03020   RENAL ACUTE   320   0   0   0   0   0   0   79. 00   09000   CLINI IC   0   0   0   0   0   0   0   79. 05   09005   PATI ENT NUTRI TI 10 N   0   0   0   0   0   0   79. 07   09007   WOUND CLI NI C   1,040   0   0   0   0   0   79. 00   09100   EMERGENCY   5,039   0   0   3,798   0   79. 00   09200   DSSERVATI ON BEDS (NON-DI STI NCT PART)   SPECIAL PURPOSE COST CENTERS    118. 00   NONREI MBURSABLE COST CENTERS    119. 00   NONREI MBURSABLE COST CENTERS   0   0   0   0   0   0   194. 00   07950   RURAL HEALTH   80   0   0   0   0   0   194. 00   07950   RURAL HEALTH   80   0   0   0   0   0   194. 00   07950   RURAL HEALTH   80   0   0   0   0   0   194. 01   07951   REINTAL PROPERTY   0   0   0   0   0   0   194. 02   07955   PHYSI CIA N PRACTICES   1,760   0   0   0   0   194. 03   07952   WELLINESS   0   0   0   0   0   0   194. 04   07955   PHYSI CIA N PRACTICES   1,760   0   0   0   0   0   194. 06   07953   SYCANORE SPORTS MED				(				1
66.02   06602   0/P PHYSICAL THERAPY		06600 PHYSI CAL THERAPY	1	C	0		0	1
67.00   06700   OCCUPATIONAL THERAPY   400   0   0   720   0   67.00   68.00   06800   SPEECH PATHOLOGY   80   0   0   141   0   68.00   69.00   06900   CLECTROCARDI OLOGY   320   0   0   1,742   0   69.00   69.01   06901   CARDI AC REHAB   480   0   0   1,742   0   69.00   70.00   07000   CLECTROENCEPHALOGRAPH   1,360   0   0   86   0   70.00   71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   1,319   0   72.00   73.00   07300   DRUGS CHARGED TO PATIENTS   3,999   0   0   5,667   0   73.00   76.00   03020   RENAL ACUTE   320   0   0   408   0   76.00   76.00   03020   RENAL ACUTE   320   0   0   0   0   0   79.05   09005   PATIENT SERVICE COST CENTERS   79.00   09005   PATIENT NUTRI TI ON   0   0   0   0   0   0   79.05   09005   PATIENT NUTRI TI ON   0   0   0   0   0   79.06   09005   DESERVATI ON BEDS (NON-DI STI NCT PART)   79.00   09000   OSERVATI ON BEDS (NON-DI STI NCT PART)   79.00   09000   OSERVATI ON BEDS (NON-DI STI NCT PART)   79.00   09000   OSERVATI ON BEDS COST CENTERS   79.00   09000   OSERVATI ON BEDS (NON-DI STI NCT PART)   79.00   09000   OSERVATI ON BEDS (NON-DI STI NCT PART)   79.00   09000   OSERVATI ON BEDS (NON-DI STI NCT PART)   79.00   09000   OSERVATI ON BEDS (NON-DI STI NCT PART)   79.00   09000   OSERVATI ON BEDS (NON-DI STI NCT PART)   79.00   09000   OSERVATI ON BEDS (NON-DI STI NCT PART)   79.00   09000   OSERVATI ON BEDS (NON-DI STI NCT PART)   79.00   09000   OSERVATI ON BEDS (NON-DI STI NCT PART)   79.00   09000   OSERVATI ON BEDS (NON-DI STI NCT PART)   79.00   09000   OSERVATI ON BEDS (NON-DI STI NCT PART)   79.00   09000   OSERVATI ON BEDS (NON-DI STI NCT PART)   79.00   09000   OSERVATI ON BEDS (NON-DI STI NCT PART)   79.00   09000   OSERVATI ON BEDS (NON-DI STI NCT PART)   79.00   09000   OSERVATI ON BEDS (NON-DI STI NCT PART)   79.00   09000   OSERVATI ON BEDS (NON-DI STI NCT PART)   79.00   09000   OSERVATI ON BEDS (NON-DI STI NCT PART)   79.00   09000   OSERVATI ON BEDS (NON			· ·	C	0	0		
68.00   06800   SPEECH PATHOLOGY   80   0   0   1411   0   68.00   69.00   06900   ELECTROCARDIOLOGY   320   0   0   1,742   0   69.00   70.00   06901   CARDI AC REHAB   480   0   0   12   0   69.00   70.00   07000   ELECTROENCEPHALOGRAPHY   1,360   0   0   86   0   70.00   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   1,319   0   72.00   07300   DRUGS CHARGED TO PATIENTS   3,999   0   0   5,667   0   73.00   76.00   07300   DRUGS CHARGED TO PATIENTS   320   0   0   408   0   76.00   77.00   07300   RENAL ACUTE   320   0   0   408   0   76.00   78.00   07300   DRUGS CHARGED TO PATIENTS   3,999   0   0   5,667   0   73.00   79.00   09000   CLINIC   0   0   0   0   0   0   0   79.00   09000   CLINIC   0   0   0   0   0   0   0   79.00   09000   CLINIC   0   0   0   0   0   0   0   79.00   09000   PATIENT NUTRITION   0   0   0   0   0   0   79.00   09000   DRUGS CHARGED TO PATIENT   TIRITION   0   0   0   0   0   79.00   09000   DRIBERSENCY   5,039   0   0   3,798   0   91.00   79.00   09000   DEBERVATION BEDS (NON-DISTINCT PART)   SPECIAL PURPOSE COST CENTERS    118.00   SUBTOTALS (SUM OF LINES 1 through 117)   91,104   0   0   0   57,492   0   194.00   19400   19400   19400   19400   194.01   19751   RENTAL PROPERTY   0   0   0   0   0   194.02   07954   FAMILY PRACTICE   5,679   0   0   0   0   194.03   07952   WELLNESS   0   0   0   0   0   194.04   07955   PHYSI CIAN PRACTICES   1,760   0   0   0   194.04   07955   PHYSI CIAN PRACTICES   1,760   0   0   0   194.04   07955   SYCAMORE SPORTS MED   0   0   0   194.05   07940   0   0   0   0   0   194.06   07950   07950   00   0   0   0   194.06   07950   07950   07950   00   0   0   194.06   07955   07950   0   0   0   0   194.06   07955   07950   00   0   0   0   194.06   07955   07950   0   0   0   0   194.06   07955   07950   0   0   0   0   194.06   07955   07950   00   0   0   0   194.06   07955   07950   07950   07950   00   0   0   194.06   07950   07950   0			l l	C	_	0		•
69. 00   06900   CARDI AC REHAB   320   0   0   1,742   0   69. 00   69. 01   06901   CARDI AC REHAB   480   0   0   12   0   69. 01   70. 00   07000   ELECTROENCEPHALOGRAPHY   1,360   0   0   86   0.70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   1,319   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   3,999   0   0   5,667   0   73. 00   76. 00   03020   RENAL ACUTE   320   0   0   408   0   76. 00   0000   OUTPATI ENT SERVICE COST CENTERS   0   0   0   0   0   0   90. 05   09005   PATI ENT NUTRI TI ON   0   0   0   0   0   0   90. 05   09005   PATI ENT NUTRI TI ON   0   0   0   0   0   0   91. 00   09000   CLINIC   1,040   0   0   0   0   0   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   92. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   92. 00   92. 00   09200   OSSERVATI ON BEDS (NON-DI STI NCT PART)   92. 00   90. 00   09400   CIFT, FLOWER, COFFEE SHOP & CANTEEN   80   0   0   0   0   194. 00   194. 00   07950   RURAL HEALTH   80   0   0   0   0   0   194. 00   194. 00   07951   RENTAL PROPERTY   0   0   0   0   0   0   194. 00   194. 02   07954   FANILY PRACTI CE   5,679   0   0   0   0   0   0   194. 03   07952   WELLNESS   0   0   0   0   0   0   194. 01   194. 04   07955   PHYSI CI AN PRACTI CES   1,760   0   0   0   0   0   194. 02   194. 04   07955   PHYSI CI AN PRACTI CES   1,760   0   0   0   0   0   194. 04   194. 04   07955   PHYSI CI AN PRACTI CES   1,760   0   0   0   0   0   0   194. 05   194. 04   07955   PHYSI CI AN PRACTI CES   1,760   0   0   0   0   0   0   194. 05   194. 06   07953   SYCAMORE SPORTS MED   0   0   0   0   0   194. 05   194. 06   07953   SYCAMORE SPORTS MED   0   0   0   0   0   0   194. 05   194. 06   07953   SYCAMORE SPORTS MED   0   0   0   0   0   0   0   0   0				(	_			
69. 01   06901   CARDIAC REHAB				(	ol ol			
71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   1,319   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   3,999   0   0   5,667   0   73. 00   76. 00   03020   RENAL ACUTE   320   0   0   4088   0    0   0   0   0   4088   0   76. 00    0   0   0   0   0   0   0    0   0	69. 01			C	0		0	
72. 00   07200   IMPL   DEV. CHARGED TO PATIENTS   0   0   0   1,319   0   72. 00			l	C	0	86		
73. 00		1 1		(	0	1 210		•
76. 00				(				•
OUTPATIENT SERVICE COST CENTERS   O				(				
90. 05								
90. 07		1 1	0	C	0	0		
91. 00   09100   EMERGENCY   5, 039   0   0   3, 798   0   91. 00   92. 00   92. 00   SPECIAL PURPOSE COST CENTERS			0	C	0	0		
92. 00   9200   0BSERVATI ON BEDS (NON-DISTINCT PART)   92. 00     SPECIAL PURPOSE COST CENTERS   118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   91, 104   0   0   57, 492   0     NONREI MBURSABLE COST CENTERS   190. 00   190. 00   190. 00     194. 00   07950   RURAL HEALTH   80   0   0   0   0   194. 00     194. 01   07951   RENTAL PROPERTY   0   0   0   0   0   194. 01     194. 02   07954   FAMILY PRACTICE   5, 679   0   0   0   0   194. 01     194. 04   07955   PHYSI CI AN PRACTICES   1, 760   0   0   0   194. 04     194. 06   07953   SYCAMORE SPORTS MED   0   0   0   194. 06     194. 06   07953   SYCAMORE SPORTS MED   0   0   0   0   194. 06     195. 06   195. 07   195. 07   195. 07     195. 07   195. 07   195. 07     195. 08   195. 08   195. 08     195. 08   195. 08   195. 08     195. 08   195. 08   195. 08     195.		1 1	1	(		0 3 708		
SPECIAL PURPOSE COST CENTERS   SUBTOTALS (SUM OF LINES 1 through 117)   91, 104   0   0   57, 492   0   118. 00   NONREI MBURSABLE COST CENTERS     190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   190. 00   194. 00   194. 00   194. 01   195. 01			3,037		)	3, 770		•
NONREIMBURSABLE COST CENTERS   190. 00 19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   190. 00   194. 00 07950   RURAL HEALTH   80   0   0   0   0   194. 00   194. 01 07951   RENTAL PROPERTY   0   0   0   0   0   194. 01   194. 02 07954   FAMILY PRACTICE   5,679   0   0   0   0   194. 02   194. 03 07952   WELLNESS   0   0   0   0   0   194. 02   194. 04 07955   PHYSI CI AN PRACTICES   1,760   0   0   0   0   194. 06 07953   SYCAMORE SPORTS MED   0   0   0   0   194. 06								
190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   190. 00   194. 00   194. 00   194. 00   194. 00   194. 01   194.	118.00		91, 104	C	0	57, 492	0	118. 00
194. 00 07950 RURAL HEALTH 80 0 0 0 0 194. 00 194. 01 07951 RENTAL PROPERTY 0 0 0 0 0 194. 01 194. 02 07954 FAMILY PRACTICE 5, 679 0 0 0 0 194. 02 194. 03 07952 WELLNESS 0 0 0 0 0 194. 03 194. 04 07955 PHYSI CI AN PRACTICES 1, 760 0 0 0 194. 04 194. 06 07953 SYCAMORE SPORTS MED 0 0 0 0 194. 06	100.00				J 51			100 00
194. 01 07951 RENTAL PROPERTY 0 0 0 0 0 194. 01 194. 02 194. 02 07954 FAMILY PRACTICE 5, 679 0 0 0 0 194. 02 194. 03 07952 WELLNESS 0 0 0 0 0 194. 03 194. 04 07955 PHYSI CI AN PRACTICES 1, 760 0 0 0 0 194. 04 194. 06 07953 SYCAMORE SPORTS MED 0 0 0 0 194. 06			· · · · · · · · · · · · · · · · · · ·	(	1	0		
194. 02     07954     FAMILY PRACTICE     5, 679     0     0     0     194. 02       194. 03     07952     WELLNESS     0     0     0     0     194. 03       194. 04     07955     PHYSI CI AN PRACTICES     1, 760     0     0     0     0     194. 04       194. 06     07953     SYCAMORE SPORTS MED     0     0     0     0     194. 06			0	(		0		
194. 04 07955 PHYSI CI AN PRACTI CES 1, 760 0 0 0 194. 04 194. 06 07953 SYCAMORE SPORTS MED 0 0 0 194. 06			5, 679	C	o	0		
194.06 07953 SYCAMORE SPORTS MED 0 0 0 194.06	194. 03	07952 WELLNESS	0	C	0	0		
			1	C	0	0		
171. 07 07700 1 010111 071 011010E001 07E DERIVIOED   040  0  0  0  0  174. 07		1 1		(	-	0		
		12	1 340		· i		<u> </u>	1.707

Health Financial Systems

UNION HOSPITAL, INC.

In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0023
From 01/01/2021
To 12/31/2021
Date/Time Prepared:
E/2/4/2023 10:40 em

						5/26/2022 10:	49 am_
	Cost Center Description	NONPATI ENT	DATA	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/ACC	
		TELEPHONES	PROCESSI NG	RECEIVING AND		OUNTS	
				STORES		RECEI VABLE	
		5. 01	5. 02	5. 03	5. 04	5. 05	
200.00	Cross Foot Adjustments						200.00
201. 00	Negative Cost Centers	0	0	0	0	0	201. 00
202. 00	TOTAL (sum lines 118 through 201)	99, 263	0	0	57, 492	0	202. 00

Section   Sect			Cost Contor Description	OTHER ADMIN	ODERATION OF	I ALINDDY «	HOUSEKEEDI NO	5/26/2022 10:	49 am
			Cost Center Description	OTHER ADMIN AND GENERAL	OPERATION OF PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
1.00 DOUGHER CAFFEL COSTS-BLOG S FIXT 0.00 DOOGHE WORNER CAFFEL COSTS-BLOG S FIXT 0.00 DOOGHE WORNER CAFFEL COSTS-BLOW S FIXT 0.00 DOOGHE WORNER CAFFEL THE PROVIDER 0.00 DOOGHE WORNER CAFFEL THE PROVIDER 0.00 DOOGHE WORNER BLOW THE WAR WAS DIGES 0.00 DOOGHE WORNER BLOW THE WAS DIGES 0.00 DOOGHE WORNER BLOW THE WAR WAS DIGES 0.00 DOOGHE WORNER BLOW THE WORNER BLOW THE WAR WAS DIGES 0.00 DOOGHE WORNER BLOW THE WAR WAS DIGES 0.00 DOOGHE WORNER BLOW THE WORNER BLOW THE WAR WAS DIGES 0.00 DOOGHE WORNER BLOW THE WORNER BLOW THE WAR WAS DIGES 0.00 DOOGHE WORNER BLOW THE WORNER BLOW THE WAR WAS DIGES 0.00 DOOGHE WORNER BLOW THE WORNER BLOW THE WORNER BLOW THE WAR WAS DIGES 0.00 DOOGHE WORNER BLOW THE WORNER BLOW THE WAR WAS DIGES 0.00 DOOGHE WORNER BLOW THE WORNER BLOW THE WAR WAS DIGES 0.00 DOOGHE WORNER BLOW THE WORNER BLOW THE WAR WAS DIGES 0.00 DOOGHE WORNER BLOW THE WORNER BL							9. 00	10.00	
2.00 000000 INST CAP INCL COSTS-AVEILE BOULT P 5.01 000000 INDURY SERVERT PET TELEPRISMS 5.02 000000 INDURS SERVERT TELEPRISMS 5.03 000000 INDURS SERVERT PET TELEPRISMS 5.04 000000 INDURS SERVERT PET SERVERT P 5.05 000000 INDURS SERVERT P 5.06 000000 INDURS SERVERT P 5.07 00000 INDURS SERVERT P 5.07 00000 INDURS SERVERT P 5.08 000000 INDURS SERVERT P 5.09 00000 INDURS SERVERT P 5.00 00000 INDURS SERVERT P 5.00 00000 INDURS SERVERT P 5.00 000000 INDURS SERVERT P 5.00 00000 INDURS SERVERT P 5.00 000000 INDURS SERVERT P 5.00 00000 INDURS SERVERT P 5.00 00000 INDURS SERVERT P 5.00 00000 INDURS SERVERT P 5.00 000000 INDURS SERVERT P 5.00 00000000000 INDURS SERVERT P 5.00 0000000000000000000000000000000000									
4.00   0.0000   PRIVED PRIFE TS EPPARTRENT									
5.01 000500 MARCH ENT ILLEHMOLS 5.02 000500 MARCH ENT ILLEHMOLS 5.03 000500 MARCH ENT ILLEHMOLS 5.04 000500 MARCH ENT ILLEHMOLS 5.05 000500 MARCH ENT ILLEHMOLS 5.06 000500 MARCH ENT ILLEHMOLS 5.07 000500 MARCH ENT ILLEHMOL		1	l i						
5.02   000560   DIATA PROCESSING   5.02   5.03   000560   DIATA PROCESSING   5.03   000560   DIATA PROCESSING   5.04   5.05   5.									
5.03   00560   PURCURSINE RECEIVED NO AD STRIKES   5.03   5.01   5.05   5.06   5.05									
5.06   DOSING CASH I PER KAYACCIUMIST STCT WALLE   5.06   0.09070 (PERATION OF PLANT   15,239   5.514,874   3.00   1.00   0.00   DOSING CHERATION OF PLANT   15,239   5.514,874   3.00   0.00   0.00   DOSING CHERATION OF PLANT   1.00   0.00   DISCONDINEST ENDING STREET   1.00   0.00									
5.06 00090 OTHER AMIN AND CENERAL 384,770	5.04	00570	ADMITTING						5. 04
7.00   000000   000000   00000   00000   00000   000000									
0.00   0.000   JAUNDRY & LI NEN SERVICE   1.674   53,247   330,246   99,053   9,007   9,00   90,007   1,000   1000   DIETARY   3.23   97,002   1,276   1,777   1,788   46,010   1000   1000   DIETARY   3.23   97,002   1,276   1,777   1,788   46,010   1000   1000   DIETARY   3.288   46,042   1,276   1,787   1,788   1,000   1000									
9.00   0.000		1	l .						
10.00   01000   DETARY							00.002		
11.00   01100   CAFETERIA   3,850   69,045   0   1,255   0   13.00   03.00   03.00   1		1	l .					120 166	
13.00   01300   NURSINO ADMINISTRATION   2,899   21,128   0   380   0   13.00									•
16.00 0 10400 MEDICAL RECORDS & LIBRARY   5,958   46,978   0   846   0   10.00   22.00 0 2200 0 187 SERVICES-OTHER PROMICOSTS APPRIVD   2,930   0   0   0   0   0   22.00   23.01 0 2230 0 187 SERVICES-OTHER PROMICOSTS APPRIVD   2,930   0   0   0   0   0   22.00   23.01 0 2230 0 187 SERVICES-OTHER PROMICOSTS APPRIVD   2,930   0   0   0   0   0   0   23.01 0 2230 0 187 SERVICES-OTHER PROMICOSTS APPRIVD   2,930   0   0   0   0   0   23.01 0 2230 0 10   0   0   0   0   0   0   23.01 0 2230 0 187 SERVICES-OTHER PROMICOSTS APPRIVD   2,930   0   0   0   23.01 0 2231 0 10 THE MOLT BE SERVICE OST CENTERS									
22.00   0.0200   IAR SERVICES-OTHER PROM COSTS APPRVD   2,304								0	
23 00   03000   PARAMED ED PROM	21. 00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	1, 845	0	0	0	0	21. 00
23.01   02341   OTHER MED ED   345   0.402   0   115   0   23.07						-	0	-	
						-	-1	-	
INPATIENT ROUTINE SERVICE COST CENTERS		1	l .						
0.000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.00000000	23. 02			U	0	l o	υĮ	0	23.02
31.00   03100   INTENSI VE CARE UNIT	30 00			48 977	1 710 859	105 812	30.808	333 163	30 00
35.00   02040  INTENSI VE NURSERY   3, 837   34, 965   1, 396   2. 469   27, 267   41, 00   43.00   04300 (NURSERY   1, 253   6, 740   0   121   0   0   43.00   121   0   0   43.00   121   0   0   43.00   121   0   0   43.00   121   0   0   43.00   121   0   0   43.00   121   0   0   43.00   121   0   0   43.00   121   0   0   43.00   121   0   0   43.00   121   0   0   43.00   121   0   0   43.00   121   0   0   43.00   121   0   0   0   0   0   0   0   0   0									
1,25    6,740   0   12    0   43,00	35.00						630		•
MINITERIARY SERVICE COST CENTERS	41.00	04100	SUBPROVI DER - I RF	2, 510	137, 146	3, 860	2, 469	27, 267	41.00
50. 00   05000   0FEATH INC ROOM   18, 827   374, 420   20, 902   6.742   0   50. 00   10.	43.00			1, 253	6, 740	0	121	0	43. 00
50.00   OSCOD   CARDIAC SURGERY   3, 379   17, 020   21   300   0   50.01	F0 00			40.007	074 400	1 00 000	( 740		F0 00
50.00   05000   WINCE   14, 714   270, 069   24, 064   4, 863   0   50.00   051.00   051.00   05100   0FEODERRY ROOM   2, 823   12, 734   10.101   229   0   51.00   051.00			l i						
51.00   05100   RECOVERY ROOM									
51.00			l .						
52.00   05200   DELIVERY ROOM & LABOR ROOM   6,201   211,121   14,238   3,801   9   52.00   54.00   0540   00   RADI DUCKY-THERAPEUTI C   7,012   234,695   4,130   4,226   0,54.00   55.00   05500   RADI DUCKY-THERAPEUTI C   7,012   234,695   4,130   4,226   0,55.00   05600   RADI DUCKY-THERAPEUTI C   7,012   234,695   4,130   4,226   0,55.00   05700   RADI DUCKY-THERAPEUTI C   7,012   234,695   4,130   4,226   0,55.00   05700   RADI DUCKY-THERAPEUTI C   7,012   234,695   4,130   4,226   0,55.00   05700   RADI ROLE ROLE ROLE ROLE ROLE ROLE ROLE ROLE									
55.00	52.00	1	l .						
56.00   0.5600   RADIO I SOTOPE	54.00	05400	RADI OLOGY-DI AGNOSTI C	13, 091	284, 883	9, 865	5, 130	0	54. 00
57 00   05700   CT SCAN   3,348   19,314   0   348   0   57.00									
S8 00   OSBOO MAGNETI C RESONANCE I IMAGI NG (MRI )   2, 607   23, 058   12, 558   415   0   58. 00   59. 00   6900   CARDIAC CATHETERI ZATI ON   24, 329   321, 315   9, 568   5, 766   1, 836   59. 00   60. 0									
59.00   05900   CARDIA C CATHETERI ZATION   24, 329   321, 315   9, 568   5, 766   1, 836   59. 00		1	l I						
60.00   060000   06000   06000   06000   06000   06000   06000   06000   060000   06000   06000   0600000   0600000   0600000   0600000   0600000   0600000   0600000000									
62.00   06200   06200   MPOLE BLOOD & PACKED RED BLOOD CELLS   1,697   0   0   0   62.00									•
6.500   06500   06500   06500   06500   06500   06500   06600		1	l I			-	- 1		
66.01		1	l I			-	- 1		•
66. 02   06602   0/P PHYSICAL THERAPY   1,976   0   5,499   0   0   66. 02   67. 00   06700   0CCUPATI ONAL THERAPY   2,380   14,743   0   265   0   67. 00   68. 00   06800   SPEECH PATHOLOGY   978   29,238   0   526   0   68. 00   69. 00   06800   SPEECH PATHOLOGY   6,609   28,286   6,052   509   0   69. 00   69. 01   06901   CARDIA C REHAB   620   58,102   80   1,046   0   69. 01   70. 00   07000   ELECTROCARDI OLOGY   1,951   0   1,188   0   0   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   11,183   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATIENTS   11,183   0   0   0   0   0   74. 00   03020   RENAL ACUTE   2,185   31,345   1,710   564   0   76. 00   03020   RENAL ACUTE   2,185   31,345   1,710   564   0   79. 00   09000   CLI NI C   323   6,207   0   112   0   90. 00   79. 00   09000   DATIENT NUTRI TION   17, 162   0   309   0   90. 05   79. 00   09000   WOUND CLI NI C   1,980   79,604   3,032   1,433   0   90. 07   79. 00   09000   BATEINT NUTRI TION   17,000   17,162   0   309   0   90. 07   79. 00   09000   CRINIC   1,980   79,604   3,032   1,433   0   90. 07   79. 00   09000   BATEINT NUTRI TION   13,003   214,554   43,101   3,863   0   91. 00   79. 00   09000   SATIENT NUTRI TO BEDS (NON-DISTINCT PART)   SUBTOTALS (SUM OF LINES 1 through 117)   336,177   5,262,021   328,276   93,540   438,466   18. 00   79. 00   19000   1917, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   0   79. 00   194. 00   07950   RIRAL HEALTH   6,949   0   222   0   0   194. 00   79. 01   194. 02   07954   FAMILY PRACTI CE   4,313   106,708   255   1,921   0   194. 01   79. 04   04,007955   PHYSICI AN PRACTI CES   35,763   0   1,491   0   0   194. 01   79. 04   07956   PSYCHIATRI C/PSYCHOLOGICAL SERVICES   776   25,485   0   459   0   194. 07   79. 00   09905   00000	66.00			3, 701	90, 257	1, 426	1, 625	0	66. 00
67. 00   06700   0CCUPATI ONAL THERAPY   2, 380   14, 743   0   265   0   67. 00   68. 00   06800   SPEECH PATHOLOGY   978   29, 238   0   526   0   68. 00   69. 01   06900   CLECTROCARDI OLOGY   6, 609   28, 286   6, 052   509   0   69. 00   69. 01   06901   CARDI AC REHAB   620   58, 102   80   1, 046   0   69. 01   70. 00   07000   ELECTROCEPHALOGRAPHY   1, 951   0   1, 188   0   0   70. 00   71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   0   0   0   0   0   0   72. 00   07200   IMPL DEV. CHARGED TO PATI ENTS   11, 183   0   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   61, 347   184, 204   545   3, 317   0   73. 00   76. 00   03020   RENAL ACUTE   2, 185   31, 345   1, 710   564   0   76. 00   79. 00   09000   CLI NI C   323   6, 207   0   112   0   90. 00   79. 00   09000   CLI NI C   1, 980   79, 604   3, 332   1, 433   0   90. 07   79. 00   09000   DRIF ON ONE ONE ONE ONE ONE ONE ONE ONE ONE				0				0	
68.00   06800   SPEECH PATHOLOGY   9.78   29,238   0   526   0   68.00   69.00   06900   ELECTROCARDIOLOGY   6.609   28,286   6.052   509   0   69.00   70.00   07000   ELECTROENCEPHALOGRAPHY   1,951   0   1,188   0   0   0   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   72.00   07200   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATIENTS   11,183   0   0   0   0   74.00   07300   DRUGS CHARGED TO PATIENTS   11,183   0   0   0   0   75.00   07300   DRUGS CHARGED TO PATIENTS   61,347   184,204   545   3,317   0   73.00   76.00   03020   RENAL ACUTE   2,185   31,345   1,710   564   0   76.00   79.00   09000   CLINIC   323   6,207   0   112   0   90.00   79.00   09000   DRUGS CHARGED TO PATIENTS   17,080   79,604   3,032   1,433   0   90.07   79.00   09000   DRUGS CHARGED TO PATIENTS   13,003   214,554   43,101   3,863   0   91.00   79.00   09000   DRUGS CHARGED TO PATIENTS   13,003   214,554   43,101   3,863   0   91.00   79.00   09000   DRUGS CHARGED TO PATIENTS   13,003   214,554   43,101   3,863   0   91.00   79.00   09000   DRUGS CHARGED TO PATIENTS   13,003   214,554   43,101   3,863   0   91.00   79.00   09000   DRUGS CHARGED TO PATIENTS   13,003   214,554   43,101   3,863   0   91.00   79.00   09000   DRUGS CHARGED TO PATIENTS   13,003   214,554   43,101   3,863   0   91.00   79.00   09000   DRUGS CHARGED TO PATIENTS   13,003   214,554   43,101   3,863   0   91.00   79.00   09000   DRUGS CHARGED TO PATIENTS   13,003   214,554   43,101   3,863   0   91.00   79.00   09000   DRUGS CHARGED TO PATIENTS   13,003   214,554   43,101   3,863   0   91.00   79.00   09000   DRUGS CHARGED TO PATIENTS   13,003   214,554   43,101   3,863   0   91.00   79.00   09000   DRUGS CHARGED TO PATIENTS   13,003   214,554   43,101   3,863   0   91.00   79.00   09000   DRUGS CHARGED TO PATIENTS   13,003   214,554   43,101   3,863   0   91.00   79.00   09000   DRUGS CHARGED TO PATIENTS   13,003   214,554   43,101   3,863   0   91.00   79.00   09000   DRUGS		1	l .						
69.00   06900   ELECTROCARDI OLOGY   6, 609   28, 286   6, 052   509   0   69.00   69.01   06901   CARDI AC REHAB   620   58, 102   80   1, 046   0   69.01   70.00   07000   ELECTROENCEPHALOGRAPHY   1, 951   0   1, 188   0   0   70.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   11, 183   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATIENTS   11, 183   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATIENTS   11, 183   0   0   0   0   76.00   03020   RENAL ACUTE   2, 185   31, 345   1, 710   564   0   76.00   09000   CLI NI C   323   6, 207   0   112   0   90.00   7905   09005   PATIENT SERVICE COST CENTERS   7900   09000   DRUGS CHARGED TO PATIENT   17, 162   0   309   0   90.05   7900   09000   DRUGS CHARGED TO PATIENT   17, 162   0   309   0   90.05   7900   09000   DRUGS CHARGED TO PATIENT   17, 162   0   309   0   90.05   7900   09000   DRUGS CHARGED TO PATIENT   17, 162   0   309   0   90.05   7900   09000   DRUGS CHARGED TO PATIENT   17, 162   0   309   0   90.05   7900   09000   DRUGS CHARGED TO PATIENT   17, 162   0   309   0   90.05   7900   09000   DRUGS CHARGED TO PATIENT   17, 162   0   309   0   90.05   7900   09000   DRUGS CHARGED TO PATIENT   17, 162   0   309   0   90.05   7900   09000   DRUGS CHARGED TO PATIENT   17, 162   0   309   0   90.05   7900   09000   DRUGS CHARGED TO PATIENT   17, 162   0   309   0   90.05   7900   09000   DRUGS CHARGED TO PATIENT   17, 162   0   309   0   90.05   7900   09000   DRUGS CHARGED TO PATIENT   17, 162   0   309   0   90.05   7900   09000   DRUGS CHARGED TO PATIENT   17, 162   0   309   0   90.05   7900   09000   DRUGS CHARGED TO PATIENT   17, 162   0   309   0   90.05   7900   09000   DRUGS CHARGED TO PATIENT   17, 162   0   309   0   90.05   7900   09000   DRUGS CHARGED TO PATIENT   17, 162   0   309   0   90.05   7900   09000   DRUGS CHARGED TO PATIENT   17, 162   0   309   0   90.05   7900   09000   DRUGS CHARGED TO				·					
69. 01   06901   CARDI AC REHAB   1.00   58, 102   80   1.046   0   69. 01									
70. 00   07000   ELECTROENCEPHALOGRAPHY   1, 951   0   1, 188   0   0   70. 00   170. 00   170. 00   170. 00   170. 00   170. 00   170. 00   0   0   0   0   0   0   0   0		1	l i						
71. 00									•
73. 00	71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1	0	0	71. 00
76. 00 03020 RENAL ACUTE 00TPATIENT SERVICE COST CENTERS  90. 00 09000 CLI NI C 323 6, 207 0 112 0 90. 00  90. 05 09005 PATIENT NUTRITION 170 17, 162 0 309 0 90. 05  90. 07 09007 WOUND CLI NI C 1, 980 79, 604 3, 032 1, 433 0 90. 07  91. 00 09100 EMERGENCY 13, 003 214, 554 43, 101 3, 863 0 91. 00  92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 92. 00  SPECIAL PURPOSE COST CENTERS  118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 336, 177 5, 262, 021 328, 276 93, 540 438, 466 118. 00  NONRE! MBURSABLE COST CENTERS  190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 194. 00  194. 00 07950 RURAL HEALTH 6, 949 0 222 0 0 0 194. 00  194. 01 07951 RENTAL PROPERTY 27 0 0 0 0 0 194. 01  194. 02 07954 FAMILY PRACTICE 4, 313 106, 708 255 1, 921 0 194. 02  194. 03 07955 WELLNESS 645 120, 660 0 2, 173 0 194. 03  194. 04 07955 PHYSI CI AN PRACTICES 35, 763 0 1, 491 0 0 194. 03  194. 07 07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVICES 776 25, 485 0 459 0 194. 07					0	-	٧,		
90. 00   09000  CLI NI C   323   6, 207   0   112   0   90. 00									
90. 00	76. 00			2, 185	31, 345	1, 710	564	0	76. 00
90. 05	90 00			323	6 207		112	0	
90. 07   09007   WOUND CLINIC   1,980   79,604   3,032   1,433   0   90.07   91.00   09100   EMERGENCY   13,003   214,554   43,101   3,863   0   91.00   92.00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART)   92.00   SUBTOTALS (SUM OF LINES 1 through 117)   336,177   5,262,021   328,276   93,540   438,466   118.00   NONREI MBURSABLE COST CENTERS   190.00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   6,949   0   222   0   0   194.00   194.00   194.01   107951   RENTAL PROPERTY   27   0   0   0   0   194.01   194.02   194.02   07954   FAMILY PRACTICE   4,313   106,708   255   1,921   0   194.02   194.03   07952   WELNESS   645   120,660   0   2,173   0   194.02   194.04   194.06   07953   SYCAMORE SPORTS MED   69   0   0   0   0   194.06   194.07   194.07   194.07   07956   PSYCHIATRIC/PSYCHOLOGICAL SERVICES   776   25,485   0   459   0   194.07									
91. 00									
SPECIAL PURPOSE COST CENTERS   SUBTOTALS (SUM OF LINES 1 through 117)   336, 177   5, 262, 021   328, 276   93, 540   438, 466   118. 00   NONREI MBURSABLE COST CENTERS	91.00							0	91.00
118.00   SUBTOTALS (SUM OF LINES 1 through 117)   336, 177   5, 262, 021   328, 276   93, 540   438, 466   118.00	92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
NONREL MBURSABLE COST CENTERS   190. 00   19000   GI FT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   0   190. 00     194. 00   07950   RURAL HEALTH   6,949   0   222   0   0   194. 00     194. 01   07951   RENTAL PROPERTY   27   0   0   0   0   194. 01     194. 02   07954   FAMI LY PRACTI CE   4,313   106,708   255   1,921   0   194. 02     194. 03   07952   WELLNESS   645   120,660   0   2,173   0   194. 03     194. 04   07955   PHYSI CI AN PRACTI CES   35,763   0   1,491   0   0   194. 04     194. 06   07953   SYCAMORE SPORTS MED   69   0   0   0   0     194. 07   07956   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   776   25,485   0   459   0   194. 07     190. 00   190. 00   0   194. 07     190. 00   190. 00   190. 00   190. 00     190. 00   190. 00   190. 00     190. 00   190. 00     190. 00   190. 00     190. 00   190. 00     190. 00   190. 00     190. 00   190. 00     190. 00   190. 00     190. 00   190. 00     190. 00   190. 00     190. 00   190. 00     190. 00   190. 00     190. 00     190. 00   190. 00     1									
190. 00	118.00			336, 177	5, 262, 021	328, 276	93, 540	438, 466	118. 00
194. 00     07950     RURAL HEALTH     6, 949     0     222     0     0     194. 00       194. 01     07951     RENTAL PROPERTY     27     0     0     0     0     194. 01       194. 02     07954     FAMI LY PRACTI CE     4, 313     106, 708     255     1, 921     0     194. 02       194. 03     07952     WELNESS     645     120, 660     0     2, 173     0     194. 03       194. 04     07955     PHYSI CI AN PRACTI CES     35, 763     0     1, 491     0     0     194. 04       194. 06     07953     SYCAMORE SPORTS MED     69     0     0     0     0     194. 06       194. 07     07956     PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES     776     25, 485     0     459     0     194. 07	100.00			٥	0		ما	0	100 00
194. 01     07951     RENTAL PROPERTY     27     0     0     0     0     194. 01       194. 02     07954     FAMI LY PRACTI CE     4, 313     106, 708     255     1, 921     0     194. 02       194. 03     07952     WELLNESS     645     120, 660     0     2, 173     0     194. 03       194. 04     07955     PHYSI CI AN PRACTI CES     35, 763     0     1, 491     0     0     194. 04       194. 06     07953     SYCAMORE SPORTS MED     69     0     0     0     0     194. 06       194. 07     07956     PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES     776     25, 485     0     459     0     194. 07				-			- 1		
194. 02     07954     FAMI LY PRACTI CE     4, 313     106, 708     255     1, 921     0 194. 02       194. 03     07952     WELLNESS     645     120, 660     0     2, 173     0 194. 03       194. 04     07955     PHYSI CI AN PRACTI CES     35, 763     0     1, 491     0     0     194. 04       194. 06     07953     SYCAMORE SPORTS MED     69     0     0     0     0     194. 06       194. 07     07956     PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES     776     25, 485     0     459     0     194. 07					0	1	- 1		
194. 03     07952     WELLNESS     645     120, 660     0     2, 173     0     194. 03       194. 04     07955     PHYSI CI AN PRACTICES     35, 763     0     1, 491     0     0     194. 04       194. 06     07953     SYCAMORE SPORTS MED     69     0     0     0     0     194. 06       194. 07     07956     PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES     776     25, 485     0     459     0     194. 07		1	l I		106, 708	-	~  		
194. 06   07953   SYCAMORE SPORTS MED     69     0     0     0     0     194. 06       194. 07   07956   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES     776     25, 485     0     459     0   194. 07									
194. 07 07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 776 25, 485 0 459 0 194. 07							0		
						-	-		
200.00   Cross Foot Adjustments			i i	776	25, 485	0	459		
	200.00	기	CLOSS FOOT Adjustments						<u> </u> ∠00. 00

Health Financial Systems	UNI ON HOSPI	TAL, INC.		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der Co		Peri od:	Worksheet B	
				From 01/01/2021	Part II	
				To 12/31/2021	Date/Time Pre	pared:
					5/26/2022 10:	49 am
Cost Center Description	OTHER ADMIN	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	AND GENERAL	PLANT	LINEN SERVIC	E		

0 5, 514, 874

0 384, 719 0 330, 244

0 98, 093 0 201. 00 438, 466 202. 00

201. 00 202. 00 Negative Cost Centers TOTAL (sum lines 118 through 201)

| Period: | Worksheet B | From 01/01/2021 | Part II | Date/Time Prepared: | 5/26/2022 | 10: 49 am |

					INTERNS &	5/26/2022 10: RESI DENTS	
	Cost Center Description	CAFETERI A	NURSI NG	MEDI CAL	SERVI CES-SALAR	SERVI CES-OTHER	
			ADMI NI STRATI ON	RECORDS &	Y & FRINGES	PRGM COSTS	
		11.00	13. 00	LI BRARY 16. 00	21. 00	22. 00	
1. 00	GENERAL SERVICE COST CENTERS O0100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 5. 01	OO400						4. 00 5. 01
5. 02 5. 03	00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES						5. 02 5. 03
5. 04	00570 ADMITTING						5. 04
5. 05 5. 06	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00590 OTHER ADMI N AND GENERAL						5. 05 5. 06
7.00	00700 OPERATION OF PLANT						7. 00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						8. 00 9. 00
10.00	01000 DI ETARY	211 1/2					10. 00
11. 00 13. 00	O1100   CAFETERI A   O1300   NURSI NG   ADMI NI STRATI ON	211, 162 1, 939	1				11. 00 13. 00
16. 00 21. 00	01600 MEDICAL RECORDS & LIBRARY 02100 I &R SERVICES-SALARY & FRINGES APPRVD	11, 192	1	175, 827	4 050		16.00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	3, 786 794	0	0	·	4, 415	21. 00 22. 00
23. 00 23. 01	O2300   PARAMED ED PRGM   O2341   OTHER MED ED	240 1, 662		0			23. 00 23. 01
23. 02	02301 PARAMED ED PRGM	0	l	0			23. 02
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	54, 498	25, 017	13, 729			30.00
31.00	03100 INTENSIVE CARE UNIT	12, 300	5, 980	3, 512			31. 00
35. 00 41. 00	02040   I NTENSI VE NURSERY   04100   SUBPROVI DER -   I RF	5, 319 3, 804	l	1, 924 517			35. 00 41. 00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	2, 272	1, 104	295			43. 00
50. 00	05000 OPERATING ROOM	11, 099		18, 311			50. 00
50. 01 50. 02	05001 CARDI AC SURGERY 05002 WVSC	1, 459 0	350 0	672 13, 112			50. 01 50. 02
51.00	05100 RECOVERY ROOM	4, 377	2, 128	1, 161			51. 00
51. 02 52. 00	05101   0/P TREATMENT ROOM   05200   DELIVERY ROOM & LABOR ROOM	905 8, 661	440 3, 924	360 2, 436			51. 02 52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	12, 687	O	7, 746			54. 00
55. 00 56. 00	05500  RADI OLOGY - THERAPEUTI C   05600  RADI OI SOTOPE	923 905	l .	5, 199 1, 177			55. 00 56. 00
57. 00 58. 00	05700 CT SCAN   05800 MAGNETIC RESONANCE IMAGING (MRI)	2, 401 1, 607	0	5, 808 1, 541			57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	5, 263	0	11, 114			59. 00
60. 00 62. 00	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	6, 353 0	0	10, 632 369			60. 00 62. 00
65.00	06500 RESPI RATORY THERAPY	7, 664		4, 070			65. 00
66. 00 66. 01	06600  PHYSI CAL THERAPY   06601  PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	l	1, 584 0			66. 00 66. 01
66. 02 67. 00	06602 0/P PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	o	782 1 272			66. 02 67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	1, 273 450			68. 00
69. 00 69. 01	O6900   ELECTROCARDI OLOGY   O6901   CARDI AC REHAB	6, 390 776	l	9, 367 157			69. 00 69. 01
70. 00	07000 ELECTROENCEPHALOGRAPHY	1, 921	413	425			70. 00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0 5, 252			71. 00 72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	8, 717	3, 726	36, 398			73. 00
76. 00	03020   RENAL ACUTE   OUTPATIENT SERVICE COST CENTERS	0	0	474			76. 00
90. 00 90. 05	09000 CLINIC 09005 PATIENT NUTRITION	388	i i	90 21			90. 00 90. 05
90. 03	09007 WOUND CLINIC	166 1, 053	l .	1, 107			90. 07
91. 00 92. 00	O9100   EMERGENCY   O9200   OBSERVATION   BEDS (NON-DISTINCT PART)	13, 906	6, 762	14, 762			91. 00 92. 00
	SPECIAL PURPOSE COST CENTERS			.== -			
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)   NONREIMBURSABLE COST CENTERS	195, 427	68, 244	175, 827	0	0	118. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			190. 00
	07950 RURAL HEALTH  07951 RENTAL PROPERTY	0	0 0	0			194. 00 194. 01
	07954 FAMILY PRACTICE	4, 894	0	0			194. 02 194. 03
	07955 PHYSI CI AN PRACTI CES	9, 714		0		<u> </u>	194. 03

Health Financial Systems

UNION HOSPITAL, INC.

In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0023
Period:
From 01/01/2021
To 12/31/2021
Vorksheet B
Part II
Date/Time Prepared:
5/26/2022 10: 49 am

					5/26/2022 10:	49 am_
				INTERNS &	RESI DENTS	
Cost Center Description	CAFETERI A	NURSI NG	MEDI CAL	SERVI CES-SALAR	SERVI CES-OTHER	
		ADMI NI STRATI ON	RECORDS &	Y & FRINGES	PRGM COSTS	
			LI BRARY			
	11. 00	13. 00	16. 00	21.00	22.00	
194.06 07953 SYCAMORE SPORTS MED	0	0	(	)		194. 06
194. 07 07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	1, 127	0				194. 07
200.00 Cross Foot Adjustments				6, 852	4, 415	200. 00
201.00 Negative Cost Centers	0	0	(	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	211, 162	68, 244	175, 827	6, 852	4, 415	202. 00

UNION HOSPITAL, INC.

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

				11	0 12/31/2021	5/26/2022 10:	
	Cost Center Description	PARAMED ED	OTHER MED ED	PARAMED ED	Subtotal	Intern &	
		PRGM		PRGM		Residents Cost	
						& Post	
						Stepdown	
		23. 00	23. 01	23. 02	24. 00	Adjustments 25.00	
	GENERAL SERVICE COST CENTERS	20.00	20.01	20.02	21100	20.00	
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 5. 03	00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES						5. 02 5. 03
5. 04	00570 ADMITTING						5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5.06	00590 OTHER ADMIN AND GENERAL						5.06
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY						9. 00 10. 00
11. 00	01100 CAFETERI A						10.00
13. 00	01300 NURSI NG ADMI NI STRATI ON						13. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY						16. 00
21. 00	02100 I&R SERVICES-SALARY & FRINGES APPRVD						21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD						22. 00
23. 00	02300 PARAMED ED PRGM	411					23. 00
23. 01	02341 OTHER MED ED		21, 326				23. 01
23. 02	02301 PARAMED ED PRGM INPATIENT ROUTINE SERVICE COST CENTERS			0			23. 02
30. 00	03000 ADULTS & PEDIATRICS				6, 614, 185	0	30. 00
31. 00	03100   NTENSI VE CARE UNI T				2, 482, 005		31. 00
35. 00	02040 I NTENSI VE NURSERY				419, 797	0	35. 00
41. 00	04100 SUBPROVI DER - I RF				460, 760	0	41. 00
43. 00	04300 NURSERY				25, 733	0	43. 00
FO 00	ANCILLARY SERVICE COST CENTERS				4 255 (72		FO 00
50. 00 50. 01	05000 OPERATI NG ROOM 05001 CARDI AC SURGERY				4, 355, 673 379, 936	0	50. 00 50. 01
50. 01	05002 WVSC				2, 101, 348		50. 01
51. 00	05100 RECOVERY ROOM				123, 740	Ö	51. 00
51. 02	05101 0/P TREATMENT ROOM				686, 613	0	51. 02
52.00	05200 DELIVERY ROOM & LABOR ROOM				923, 624	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C				3, 191, 095		54. 00
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE				1, 798, 483	0	55. 00 56. 00
57. 00	05700 CT SCAN				799, 314 534, 493		57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)				979, 266	Ö	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON				1, 483, 139	0	59. 00
60.00	06000 LABORATORY				67, 837	0	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS				2, 357	0	62.00
65. 00	06500 RESPIRATORY THERAPY				611, 828		65. 00
	06600 PHYSI CAL THERAPY 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES				280, 901 0	0	66. 00 66. 01
66. 02	1 1				92, 548		66. 02
67. 00	06700 OCCUPATI ONAL THERAPY				46, 823		67. 00
68. 00	06800 SPEECH PATHOLOGY				85, 040		68. 00
69. 00	06900 ELECTROCARDI OLOGY				1, 680, 892		69. 00
69. 01	06901 CARDI AC REHAB				233, 356		69. 01
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS				98, 912 0	0	70. 00 71. 00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS				17, 754		71.00 72.00
	07300 DRUGS CHARGED TO PATIENTS				1, 619, 250		73. 00
76. 00					101, 956		76. 00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC				18, 864	0	90.00
	09005 PATIENT NUTRITION				50, 124		90. 05 90. 07
90. 07 91. 00					276, 640 949, 341	0	90. 07 91. 00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				747, 341		91.00
72.00	SPECIAL PURPOSE COST CENTERS						72.00
118.00		0	0	0	33, 593, 627	0	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN				240 504		190.00
	07950 RURAL HEALTH 07951 RENTAL PROPERTY				240, 506 2, 547		194. 00 194. 01
	207951 RENTAL PROPERTY				409, 200		194. 01
	07952 WELLNESS				345, 027		194. 03
	07955 PHYSICIAN PRACTICES				990, 052		194. 04

Health Financial Systems	UNI ON HOSPI	TAL, INC.		In Lieu of Form CMS-2552-10		
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-			Peri od: From 01/01/2021	Worksheet B Part II	
				To 12/31/2021	Date/Time Pre 5/26/2022 10:	pared: 49 am
Cost Center Description	PARAMED ED	OTHER MED ED	PARAMED ED	Subtotal	Intern &	
	PRGM		PRGM		Residents Cost	
					& Post	
					Stepdown	
					Adjustments	
	23. 00	23. 01	23. 02	24. 00	25. 00	
194.06 07953 SYCAMORE SPORTS MED				85	0	194. 06
194. 07 07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES				80, 082	0	194. 07
200.00 Cross Foot Adjustments	411	21, 326		0 33, 004	0	200. 00
201.00 Negative Cost Centers	0	0		0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	411	21, 326		0 35, 694, 130	0	202. 00

| Period: | Worksheet B | From 01/01/2021 | Part II | Date/Time Prepared: | 5/26/2022 | 10: 49 am | Provider CCN: 15-0023

			10 12	5/26/2022 10: 4	
Cost C	Center Description	Total		972972322 1911	7 (3.11)
		26. 00			
	/ICE COST CENTERS				
	AP REL COSTS-BLDG & FIXT				1.00
, ,	AP REL COSTS-MVBLE EQUIP				2.00
1 1	YEE BENEFITS DEPARTMENT				4. 00
	TIENT TELEPHONES				5. 01
5. 02 00550 DATA F					5. 02
	ASING RECEIVING AND STORES				5. 03
5. 04   00570 ADMI TT					5. 04
	ERING/ACCOUNTS RECEIVABLE				5. 05
	ADMIN AND GENERAL				5. 06
	TION OF PLANT				7. 00
	RY & LINEN SERVICE				8. 00
9. 00 00900 HOUSEK					9.00
10. 00 01000 DI ETAR					10.00
11. 00   01100   CAFETE					11.00
	IG ADMINISTRATION				13.00
	AL RECORDS & LIBRARY				16.00
	ERVI CES-SALARY & FRI NGES APPRVD				21. 00
	ERVICES-OTHER PRGM COSTS APPRVD				22. 00
23. 00   02300 PARAME					23. 00
23. 01   02341 OTHER 23. 02   02301 PARAME					23. 01
	DUTINE SERVICE COST CENTERS				23. 02
	S & PEDIATRICS	4 414 10E			30. 00
1 1		6, 614, 185			
	SIVE CARE UNIT	2, 482, 005			31.00
35. 00   02040   I NTENS 41. 00   04100   SUBPRO		419, 797			35. 00 41. 00
43. 00 04300 NURSER		460, 760 25, 733			41.00
	ERVICE COST CENTERS	25, 755			43.00
50. 00 05000 OPERAT		4, 355, 673			50. 00
50. 01   05000 GPERAT		379, 936			50. 00
50. 01   05001 CARDI A	AC SUNGENT	2, 101, 348			50. 01
51. 00   05100   RECOVE	DV DOOM	123, 740			50.02
1 1	REATMENT ROOM				
	ERY ROOM & LABOR ROOM	686, 613			51. 02 52. 00
	LOGY-DI AGNOSTI C	923, 624 3, 191, 095			54. 00
1 1	LOGY-THERAPEUTI C	1, 798, 483			55. 00
56. 00   05600 RADI 01		799, 314			56.00
57. 00   05700 CT SCA		534, 493			57. 00
	TIC RESONANCE IMAGING (MRI)	979, 266			58. 00
1 1	AC CATHETERIZATION	1, 483, 139			59. 00
60. 00   06000 LABORA		67, 837			60.00
	BLOOD & PACKED RED BLOOD CELLS	2, 357			62. 00
1 1	RATORY THERAPY	611, 828			65. 00
66. 00   06600 PHYSI 0		280, 901			66. 00
I I	ATRI C/PSYCHOLOGI CAL SERVI CES	200, 701			66. 01
	HYSI CAL THERAPY	92, 548			66. 02
I I	ATIONAL THERAPY	46, 823			67. 00
68. 00 06800 SPEECH		85, 040			68. 00
69. 00   06900   ELECTR		1, 680, 892			69. 00
69. 01 06901 CARDI A		233, 356			69. 01
	ROENCEPHALOGRAPHY	98, 912			70. 00
	AL SUPPLIES CHARGED TO PATIENTS	0			71. 00
	DEV. CHARGED TO PATIENTS	17, 754			72. 00
	CHARGED TO PATIENTS	1, 619, 250			73. 00
76. 00 03020 RENAL		101, 956			76. 00
	SERVICE COST CENTERS	,			
90. 00 09000 CLINIC		18, 864			90.00
90. 05 09005 PATIEN		50, 124			90. 05
90. 07 09007 WOUND		276, 640			90. 07
91. 00 09100 EMERGE		949, 341			91. 00
	/ATION BEDS (NON-DISTINCT PART)	, , 5			92.00
	POSE COST CENTERS				
	TALS (SUM OF LINES 1 through 117)	33, 593, 627		1	118. 00
	ABLE COST CENTERS				
	FLOWER, COFFEE SHOP & CANTEEN	0		1	190. 00
194. 00 07950 RURAL		240, 506			194. 00
194. 01 07951 RENTAL		2, 547			194. 01
194. 02 07954 FAMI LY		409, 200			194. 02
194. 03 07952 WELLNE		345, 027			194. 03
194. 04 07955 PHYSI C		990, 052			194. 04
194. 06 07953 SYCAMO		85			194. 06
	ATRI C/PSYCHOLOGI CAL SERVI CES	80, 082			194. 07
	Foot Adjustments	33, 004			200. 00
	ve Cost Centers	0			201. 00
		<u> </u>			

Health Financial Systems	UNION HOSPITA	L, INC.	In Lie				
ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0023	Peri od:				
			From 01/01/2021				
			To 12/31/2021	Date/Time Prepared:			
				5/26/2022 10:49 am			
Cost Center Description	Total						
	26. 00						
202.00 TOTAL (sum lines 118 through 201)	35, 694, 130			202. 00			

	ALLOCATION - STATISTICAL BASIS	0111 011 11031 1 1	Provi der CC	CN: 15-0023 P	eri od:	Worksheet B-1	
					rom 01/01/2021 o 12/31/2021	Date/Time Pre	pared:
		CAPITAL RELA	ATED COSTS			5/26/2022 10:	49 am
		CAPITAL RELA	ATED COSTS				
	Cost Center Description	NEW BLDG & FLXT	NEW MVBLE EQUIP	EMPLOYEE BENEFITS	NONPATI ENT TELEPHONES	DATA PROCESSING	
		(NEW TOTAL	(NEW EQUIP	DEPARTMENT	(PHONES)	(DEVICES)	
		SQ FT)	DEPRN)	(GROSS	, ,	, ,	
		1.00	2. 00	SALARI ES) 4. 00	5. 01	5. 02	
	GENERAL SERVICE COST CENTERS				2.2.		
1. 00 2. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP	981, 808	5, 004, 495				1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	5, 624	5, 004, 445	109, 183, 292			4.00
5. 01	00540 NONPATIENT TELEPHONES	657	36, 029	455, 623	l '		5. 01
5. 02 5. 03	00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES	0	0	0	0	2, 205 0	5. 02 5. 03
5. 04	00570 ADMITTING	3, 062	20	1, 223, 055	1	13	5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0	0	0	0	5. 05
5. 06 7. 00	00590 OTHER ADMIN AND GENERAL 00700 OPERATION OF PLANT	17, 405 334, 876	16, 296 3, 309	5, 939, 280 80, 723		49 0	5. 06 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	5, 988	64, 771	805, 289		5	8. 00
9.00	00900 HOUSEKEEPI NG 01000 DI ETARY	1, 548	10, 368	2, 192, 611		9	9.00
10. 00 11. 00	01100 CAFETERI A	10, 976 7, 832	63, 189 2, 455	362, 674 1, 479, 073		4 18	10. 00 11. 00
13. 00	01300 NURSING ADMINISTRATION	2, 376	34	1, 305, 317	9	1	13. 00
16.00	01600 MEDI CAL RECORDS & LI BRARY	5, 283	3, 715	3, 000, 816		65 0	16. 00 21. 00
21.00	02100   &R SERVICES-SALARY & FRINGES APPRVD   02200   &R SERVICES-OTHER PRGM COSTS APPRVD		0	1, 453, 506 1, 457, 771	0	0	21.00
23. 00	02300 PARAMED ED PRGM	O	0	75, 978		0	23. 00
23. 01 23. 02	O2341 OTHER MED ED   O2301 PARAMED ED PRGM	720	18 0	246, 337 0		0	
23. 02	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	<u> </u>	0	U U	0	23.02
30.00		192, 397	337, 350	22, 182, 625		591	
35.00	03100   NTENSI VE CARE UNIT 02040   NTENSI VE NURSERY	22, 990 3, 932	275, 709 120, 873	5, 684, 408 2, 308, 165		19	31. 00 35. 00
	04100 SUBPROVI DER – I RF	15, 423	5, 779	1, 812, 461		0	
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	758	103	875, 093	4	0	43. 00
50. 00	05000 OPERATING ROOM	42, 106	927, 969	3, 480, 308	82	103	50.00
50. 01	05001 CARDI AC SURGERY	1, 914	117, 020	2, 419, 784		10	
50. 02 51. 00	05002 WVSC 05100 RECOVERY ROOM	30, 371 1, 432	324, 977 22, 492	0 1, 653, 327	1	114 44	1
51. 02	05101 O/P TREATMENT ROOM	23, 926	18, 672	436, 726	27	5	51. 02
52. 00 54. 00	05200   DELIVERY ROOM & LABOR ROOM   05400   RADIOLOGY-DIAGNOSTIC	23, 742 32, 037	108, 064 716, 945	3, 393, 901 4, 593, 359		54 66	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	26, 393	95, 458	4, 593, 559 363, 532		64	1
56. 00	05600 RADI OI SOTOPE	8, 800	139, 772	406, 193	O	8	
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	2, 172 2, 593	152, 827 365, 141	1, 061, 481 729, 377	7	0 2	
	05900 CARDI AC CATHETERI ZATI ON	36, 134	124, 214	2, 492, 391	34	96	ł
	06000 LABORATORY	0	12, 296	1, 834, 882	8	0	
62. 00 65. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06500 RESPI RATORY THERAPY	5, 147	148, 674	3, 507, 274		22	
66. 00	06600 PHYSI CAL THERAPY	10, 150	5, 304	143	23	48	ı
66. 01 66. 02	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 06602 0/P PHYSI CAL THERAPY	0	0 33, 507	0	0	0	66. 01 66. 02
67. 00	06700 OCCUPATI ONAL THERAPY	1, 658	33, 307	0	5	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	3, 288	0	0	1	0	68. 00
69. 00 69. 01	06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB	3, 181 6, 534	439, 685 26, 513	2, 126, 373 308, 645		49	69. 00 69. 01
	07000 ELECTROENCEPHALOGRAPHY	0,334	28, 089	2, 563, 649		35	
71. 00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	0	0	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	20, 715	58, 684	4, 331, 061	50	0 195	
76. 00	03020 RENAL ACUTE	3, 525	2, 538	0	l .	0	•
90. 00	OUTPATIENT SERVICE COST CENTERS  O9000 CLINIC	698	ol	203, 416	O	3	90.00
90.05	1 1	1, 930	276	73, 497		5	•
90. 07	09007 WOUND CLINIC	8, 952	14, 707	403, 293		17	
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	24, 128	74, 512	5, 649, 980	63	135	91. 00 92. 00
72.00	SPECIAL PURPOSE COST CENTERS						72.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	953, 373	4, 898, 354	94, 973, 397	1, 139	1, 863	118. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	O	0	O	0	190. 00
	07950 RURAL HEALTH	0	26, 542	2, 229, 674	1		194.00
	07951   RENTAL PROPERTY   07954   FAMILY PRACTICE	12, 000	1, 030 31, 901	0 2, 229, 574	71		194. 01 194. 02
		. , , , , , , , , ,					•

Health Financial Systems	UNION HOSPITAL, INC.	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0023	Peri od: Worksheet B-1 From 01/01/2021
		To 12/31/2021 Date/Time Prepared:

				''	0 12/31/2021	5/26/2022 10:	
		CAPITAL REL	ATED COSTS				
	Cost Center Description	NEW BLDG &	NEW MVBLE	EMPLOYEE	NONPATI ENT	DATA	
		FIXT	EQUI P	BENEFITS	TELEPHONES	PROCESSI NG	
		(NEW TOTAL	(NEW EQUIP	DEPARTMENT	(PHONES)	(DEVI CES)	
		SQ FT)	DEPRN)	(GROSS			
		1.00	2.00	SALARI ES) 4. 00	5. 01	5. 02	
194. 03 0795	2 WELLNESS	13, 569	2.00	285, 260			194. 03
	5 PHYSICIAN PRACTICES	0	46, 346	·			194. 04
	3 SYCAMORE SPORTS MED	0	0	18, 746			194. 06
	6 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	2, 866	322	·			194. 07
200.00	Cross Foot Adjustments			·			200. 00
201. 00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B,	16, 013, 186	12, 246, 116	22, 589, 442	945, 643	16, 607, 106	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	16. 309896	2. 447023				1
204. 00	Cost to be allocated (per Wkst. B,			91, 727	99, 263	0	204. 00
005 00	Part II)			0 000040	70.00/004	0 000000	005 00
205. 00	Unit cost multiplier (Wkst. B, Part			0. 000840	79. 986301	0. 000000	205.00
206. 00	NAHE adjustment amount to be allocated						206. 00
200.00	(per Wkst. B-2)						200.00
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						
	·			•	'	'	

	Financial Systems	UNI UN HUSPI I		011 45 0000 5		U OT FORM CMS	
COSTA	NLLOCATION - STATISTICAL BASIS		Provider C		eriod: rom 01/01/2021 o 12/31/2021	Worksheet B-1 Date/Time Pre	
						5/26/2022 10:	
	Cost Center Description	PURCHASI NG	ADMITTING	CASHI ERI NG/ACC	Reconciliation		
		RECEIVING AND STORES	(I NPATI ENT CHARGES)	OUNTS RECEI VABLE		AND GENERAL (ACCUM.	
		(REQUISITIO)	CHARGES)	(GROSS		COST)	
		(110)		CHARGES)		0001)	
		5. 03	5. 04	5. 05	5A. 06	5. 06	
	GENERAL SERVICE COST CENTERS	T		I			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 01	00540 NONPATI ENT TELEPHONES						5. 01
5. 02	00550 DATA PROCESSING						5. 02
5.03	00560 PURCHASING RECEIVING AND STORES	7, 844, 106					5. 03
5.04	00570 ADMI TTI NG	44, 389	593, 387, 735				5. 04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0	1, 701, 185, 298	27 107 241	202 102 710	5. 05
5. 06 7. 00	00590 OTHER ADMIN AND GENERAL 00700 OPERATION OF PLANT	484	0	0	-37, 197, 241 0	392, 182, 718 15, 534, 542	1
8. 00	00800 LAUNDRY & LINEN SERVICE	8, 797	0	0	o	1, 706, 485	1
9.00	00900 HOUSEKEEPI NG	5, 094	0	0	o	3, 959, 478	1
10.00	01000 DI ETARY	870	0	· ·	0	635, 516	
11. 00	01100 CAFETERI A	0	0	-	0	3, 420, 075	
13.00	01300 NURSI NG ADMI NI STRATI ON	0	0	0	0	2, 955, 369	1
16. 00 21. 00	01600 MEDICAL RECORDS & LIBRARY 02100 I&R SERVICES-SALARY & FRINGES APPRVD	672	0	0	0	6, 072, 919 1, 881, 185	1
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD		0	o	o	2, 442, 646	
23. 00	02300 PARAMED ED PRGM	o	0	0	Ō	108, 663	
23. 01	02341 OTHER MED ED	0	0	0	0	351, 524	
23. 02		0	0	0	0	0	23. 02
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	1 742 117	121 122 700	122 207 070	ol	40 025 402	30.00
30. 00 31. 00	03100 INTENSIVE CARE UNIT	1, 763, 117 723, 369	121, 122, 799 34, 095, 203		0	49, 925, 603 12, 960, 278	
35. 00	02040 I NTENSI VE NURSERY	98, 660	18, 678, 475		ő	3, 911, 315	
41.00	04100 SUBPROVI DER - I RF	66, 903	5, 017, 326		o	2, 558, 684	
43.00	04300 NURSERY	0	2, 867, 220	2, 867, 220	0	1, 277, 107	43. 00
	ANCILLARY SERVICE COST CENTERS		55 400 050		ما	40 404 007	
50. 00 50. 01	05000 OPERATI NG ROOM 05001 CARDI AC SURGERY	223, 290 771, 758	55, 422, 053 6, 498, 308		0	19, 191, 897 3, 444, 072	1
50. 01	05002 WVSC	1, 742, 992	104, 600		o	14, 998, 862	
51. 00	05100 RECOVERY ROOM	174, 096	3, 273, 710		o	2, 877, 639	1
51. 02	05101 O/P TREATMENT ROOM	67, 609	83, 558		O	1, 236, 450	51. 02
52.00	05200 DELIVERY ROOM & LABOR ROOM	280, 132	19, 507, 049		0	6, 321, 347	
54.00	05400  RADI OLOGY-DI AGNOSTI C   05500  RADI OLOGY-THERAPEUTI C	113, 881	19, 581, 576		0	13, 344, 806	1
55. 00 56. 00	05600 RADI OI SOTOPE	3, 835 7, 586	2, 786, 997 1, 282, 581		0	7, 147, 563 2, 534, 467	1
57. 00	05700 CT SCAN	246, 620	16, 989, 921		o	3, 412, 814	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	10, 353	2, 593, 631		0	2, 657, 773	
59. 00	05900 CARDI AC CATHETERI ZATI ON	53, 749	35, 508, 688		0	24, 799, 942	1
	06000 LABORATORY	10, 350	55, 615, 051		0	12, 004, 252	
62. 00 65. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06500 RESPIRATORY THERAPY	296, 378	3, 004, 102 36, 280, 957		0	1, 730, 183 6, 780, 329	62. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	4, 560	9, 837, 574		o	3, 773, 117	
66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	O	0	0	Ō	0	1
66. 02	06602 0/P PHYSI CAL THERAPY	6, 527	0	7, 590, 297	0	2, 013, 855	
67. 00	06700 OCCUPATI ONAL THERAPY	0	7, 425, 538		0	2, 426, 130	
68. 00 69. 00	O6800   SPEECH PATHOLOGY   O6900   ELECTROCARDI OLOGY	315	1, 455, 269 17, 962, 862		0	997, 114 6, 736, 864	
69. 01	06901 CARDI AC REHAB	1, 724	125, 353		0	631, 937	
70. 00	07000 ELECTROENCEPHALOGRAPHY	2, 953	885, 315		o	1, 989, 190	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	O	0	1	14, 055	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	13, 599, 443		0	11, 399, 193	1
73.00	07300 DRUGS CHARGED TO PATIENTS	165, 331	58, 426, 429		0	62, 546, 715	
76.00	03020   RENAL ACUTE   OUTPATIENT SERVICE COST CENTERS	116, 411	4, 202, 926	4, 601, 901	0	2, 227, 346	76. 00
90.00	09000 CLINIC	843	1, 400	873, 307	ol	329, 426	90.00
90. 05	09005 PATIENT NUTRITION	28	0	199, 814	o	173, 174	1
90. 07	09007 WOUND CLINIC	116, 602	0	10, 744, 937	0	2, 017, 939	1
91.00	09100 EMERGENCY	670, 221	39, 151, 821	143, 319, 207	0	13, 254, 798	1
92. 00	O9200   OBSERVATION BEDS (NON-DISTINCT PART)   SPECIAL PURPOSE COST CENTERS						92.00
118. 00		7, 800, 499	593 387 735	1, 701, 185, 298	-37, 183, 186	342, 700, 583	118 00
	NONREI MBURSABLE COST CENTERS	7,000,177	07070077700	1,7,01,7100,7270	077 1007 100	012/700/000	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
	07950 RURAL HEALTH	15, 758	0	-	0	7, 084, 027	
	07951 RENTAL PROPERTY	0	0	0	0		194. 01
	07954 FAMILY PRACTICE 07952 WELLNESS	99	0	0	0	4, 396, 091 657, 023	1
	107955 PHYSI CLAN PRACTICES	27, 604	0	1	-	36, 455, 498	
				1			•

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

					rom 01/01/2021		
				T	o 12/31/2021	Date/Time Pre	
	Coot Conton Decement on	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/ACC	Daganailiatian	5/26/2022 10:	49 alli
	Cost Center Description				Reconciliation		
		RECEIVING AND	(I NPATI ENT	OUNTS		AND GENERAL	
		STORES	CHARGES)	RECEI VABLE		(ACCUM.	
		(REQUISITIO)		(GROSS		COST)	
				CHARGES)			
		5. 03	5. 04	5. 05	5A. 06	5. 06	
194. 06 079	53 SYCAMORE SPORTS MED	0	0	0	0	70, 806	194. 06
194. 07 079	56 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	146	0	0	0	790, 897	194. 07
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	2, 141, 340	1, 945, 667	8, 310, 111		37, 197, 241	202. 00
	Part I)		,				
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 272987	0. 003279	0. 004885		0. 094847	203. 00
204.00	Cost to be allocated (per Wkst. B,	0	57, 492	0		384, 719	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000097	0.000000		0. 000981	205. 00
	11)						
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

	FINANCIAL SYSTEMS	UNI UN HUSPI		CN 15 0000 D		Waster to D. 1	
COST	ALLOCATION - STATISTICAL BASIS		Provi der C	F	eriod: rom 01/01/2021 o 12/31/2021	Worksheet B-1 Date/Time Pre 5/26/2022 10:	pared:
	Cost Center Description	OPERATION OF PLANT (NEW TOTAL SQ FT)	LAUNDRY & LINEN SERVICE (LINEN)	HOUSEKEEPING (NEW TOTAL SQ FT)	DI ETARY (DI ETARY)	CAFETERI A (FTE)	T) diii
		7. 00	8. 00	9. 00	10.00	11. 00	
1 00	GENERAL SERVICE COST CENTERS		1				1 00
1.00 2.00 4.00 5.01 5.02 5.03 5.04 5.05 5.06 7.00 8.00 9.00 11.00 13.00 16.00 21.00 22.00 23.00 23.01 23.02	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00540 NONPATIENT TELEPHONES 00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE 00590 OTHER ADMIN AND GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01600 MEDICAL RECORDS & LIBRARY 02100 I &R SERVICES-SALARY & FRINGES APPRVD 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 02301 PARAMED ED PRGM 02301 PARAMED ED PRGM	620, 184 5, 988 1, 548 10, 976 7, 832 2, 376 5, 283 0 0 0 720	1, 183, 383 93, 346 4, 573 0 0 0 0 0 0	612, 648 10, 976 7, 832 2, 376 5, 283 0 0 0	199, 915 0 0 0 0 0 0 0	11, 434 105 606 205 43 13 90	13. 00 16. 00 21. 00 22. 00 23. 00 23. 01
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	100 207	270 157	100 207	151 000	2.051	20.00
30. 00 31. 00 35. 00 41. 00 43. 00	03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNIT 02040 I NTENSI VE NURSERY 04100 SUBPROVI DER - I RF 04300 NURSERY	192, 397 22, 990 3, 932 15, 423 758	46, 438 5, 002 13, 832	22, 990 3, 932 15, 423	22, 728 0 12, 432	2, 951 666 288 206 123	31. 00 35. 00 41. 00
	ANCILLARY SERVICE COST CENTERS						1
50. 00 50. 01	05000 OPERATING ROOM 05001 CARDIAC SURGERY	42, 106 1, 914	76	1, 914	0	601 79	50. 01
50. 02 51. 00	05002 WVSC 05100 RECOVERY ROOM	30, 371 1, 432	86, 231 57, 696			0 237	
51. 02	05101 0/P TREATMENT ROOM	23, 926	l	1		49	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	23, 742	51, 020			469	
54.00	05400 RADI OLOGY - DI AGNOSTI C	32, 037	l			687	1
55. 00 56. 00	05500  RADI OLOGY-THERAPEUTI C   05600  RADI OI SOTOPE	26, 393 8, 800				50 49	1
57. 00	05700 CT SCAN	2, 172	l	1		130	1
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	2, 593				87	
59. 00	05900 CARDI AC CATHETERI ZATI ON	36, 134	1			285	1
60.00	06000 LABORATORY	0	l .		_	344 0	1
62. 00 65. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06500 RESPIRATORY THERAPY	5, 147		5, 147		415	1
66.00	06600 PHYSI CAL THERAPY	10, 150				0	
66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0	0	0	1
66. 02 67. 00	06602 0/P PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0 1, 658	19, 705 0		0	0	
68. 00	06800 SPEECH PATHOLOGY	3, 288		3, 288		0	
69. 00	06900 ELECTROCARDI OLOGY	3, 181	21, 688	3, 181	0	346	1
69. 01	06901 CARDI AC REHAB	6, 534			0	42	1
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4, 258 0	0	0	104 0	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	Ö	Ö	0	0	1
73.00	07300 DRUGS CHARGED TO PATIENTS	20, 715	l			472	1
76. 00	03020 RENAL ACUTE OUTPATIENT SERVICE COST CENTERS	3, 525	6, 129	3, 525	0	0	76. 00
90. 00	09000 CLINIC	698	0	698	0	21	90.00
90. 05	09005 PATIENT NUTRITION	1, 930	О	1, 930	0	9	
90. 07	09007 WOUND CLINIC	8, 952	l			57	
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	24, 128	154, 445	24, 128	0	753	91. 00 92. 00
118. 00	SPECIAL PURPOSE COST CENTERS	591, 749	1, 176, 332	584, 213	199, 915	10, 582	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000  GIFT, FLOWER, COFFEE SHOP & CANTEEN   07950  RURAL HEALTH	0	0 797		0		190. 00 194. 00
	07950 RURAL HEALTH	0	/9/	0	0		194. 00
194. 02	07954 FAMILY PRACTICE	12, 000		12, 000	Ö	265	194. 02
194.03	07952 WELLNESS	13, 569	l n	13, 569	0	0	194. 03
			l				
194. 04	07955 PHYSICIAN PRACTICES 07953 SYCAMORE SPORTS MED	0	5, 341		0	526	194. 04 194. 06

Health Finar	ncial Systems	UNION HOSPI	TAL, INC.		In Lieu of Form CMS-2552-10		
COST ALLOCA	TION - STATISTICAL BASIS		Provider CO		Peri od:	Worksheet B-1	
					From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 10:	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE	· `	(DI ETARY)	(FTE)	
		(NEW TOTAL	(LI NEN)	SQ FT)			
		SQ FT)					
		7. 00	8. 00	9. 00	10.00	11. 00	
194. 07 07956	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	2, 866	0	2, 86	6 0	61	194. 07
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	17, 007, 947	2, 032, 555	4, 537, 80	4 1, 085, 951	4, 017, 255	202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	27. 424034	1. 717580	7. 40687	5. 432064	351. 342925	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	5, 514, 874	330, 244	98, 09	3 438, 466	211, 162	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	8. 892319	0. 279068	0. 16011	3 2. 193262	18. 467903	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NÄHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

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

					''	0 12/31/2021	Date/lime Pre   5/26/2022 10:	
					INTERNS &	RESI DENTS		
		Cost Center Description	NURSI NG	MEDI CAL	SERVICES_SALAR	SERVI CES-OTHER	PARAMED ED	
		cost center bescriptron	ADMI NI STRATI ON	RECORDS &	Y & FRINGES	PRGM COSTS	PRGM	
				LI BRARY	(INTERNS)	(INTERNS)	(PARAMED	
			(TIME SPENT)	(GROSS CHARGES)			RADI OLOGY)	
			13. 00	16. 00	21.00	22. 00	23. 00	
		AL SERVICE COST CENTERS						
1. 00 2. 00		NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	1	NONPATI ENT TELEPHONES						5. 01
5.02	1	DATA PROCESSING						5. 02
5. 03 5. 04	1	PURCHASING RECEIVING AND STORES   ADMITTING						5. 03 5. 04
5. 05	1	CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5.06	1	OTHER ADMIN AND GENERAL						5. 06
7. 00 8. 00	1	OPERATION OF PLANT LAUNDRY & LINEN SERVICE						7. 00 8. 00
9.00	1	HOUSEKEEPI NG						9. 00
10.00	01000	DI ETARY						10. 00
11.00		CAFETERIA NURSING ADMINISTRATION	7 (00					11.00
13. 00 16. 00		MEDICAL RECORDS & LIBRARY	7, 600	1, 701, 185, 298				13. 00 16. 00
21. 00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	O	0	1			21. 00
22. 00	1	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0		7, 437	100	22. 00
23. 00 23. 01		PARAMED ED PRGM OTHER MED ED	90	0			100	23. 00 23. 01
23. 02	1	PARAMED ED PRGM	0	0				23. 02
		TENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	2, 786 666	133, 287, 079 34, 095, 203		2, 668 12	0	1
35. 00		I NTENSI VE NURSERY	288	18, 678, 475		107	0	1
41. 00	1	SUBPROVI DER - I RF	206	5, 017, 326		O	0	41. 00
43. 00		NURSERY LARY SERVICE COST CENTERS	123	2, 867, 220	0	0	0	43. 00
50.00		OPERATING ROOM	601	177, 781, 273	556	556	0	50. 00
50. 01		CARDI AC SURGERY	39	6, 523, 308		0	0	
50. 02 51. 00	1	WVSC RECOVERY ROOM	0 237	127, 304, 538 11, 272, 532	1	0	0	
51. 02	1	O/P TREATMENT ROOM	49	3, 492, 941		o	0	51. 02
52. 00		DELIVERY ROOM & LABOR ROOM	437	23, 647, 835		687	0	
54. 00 55. 00	1	RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C	0	75, 204, 498 50, 475, 353		70 78	100 0	
56. 00	1	RADI OLOGI - MERAFLUTT C	0	11, 427, 698	•	0	0	1
57. 00	1	CT SCAN	o	56, 386, 648		o	0	
58. 00 59. 00	1	MAGNETIC RESONANCE IMAGING (MRI)   CARDIAC CATHETERIZATION	0	14, 957, 083 107, 907, 486		0	0	
60.00		LABORATORY	0	107, 307, 480		0	0	
62.00		WHOLE BLOOD & PACKED RED BLOOD CELLS	0	3, 584, 444	0	o	0	
65. 00 66. 00		RESPI RATORY THERAPY PHYSI CAL THERAPY	389	39, 515, 350		105	0	65. 00 66. 00
66. 01		PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES	0	15, 374, 673 0			0	66. 01
66. 02	06602	0/P PHYSICAL THERAPY	0	7, 590, 297	0	o	0	66. 02
67.00		OCCUPATIONAL THERAPY	0	12, 358, 849		0	0	
68. 00 69. 00		SPEECH PATHOLOGY   ELECTROCARDI OLOGY	346	4, 370, 343 90, 945, 266			0	69.00
69. 01	06901	CARDI AC REHAB	42	1, 527, 525		o	0	69. 01
70.00		ELECTROENCEPHALOGRAPHY	46	4, 127, 715	0	0	0	70.00
71. 00 72. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS   IMPL. DEV. CHARGED TO PATIENTS	0	50, 990, 681	0	0	0	71. 00 72. 00
73. 00		DRUGS CHARGED TO PATIENTS	415	347, 511, 386		26	0	1
76. 00		RENAL ACUTE	0	4, 601, 901	0	0	0	76. 00
90. 00		TIENT SERVICE COST CENTERS	21	873, 307	1, 196	1, 196	0	90.00
90. 05		PATIENT NUTRITION	9	199, 814		0	0	1
90. 07		WOUND CLINIC	57	10, 744, 937		184	0	
91. 00 92. 00		EMERGENCY   OBSERVATION BEDS (NON-DISTINCT PART)	753	143, 319, 207	762	762	0	91. 00 92. 00
,2.00		AL PURPOSE COST CENTERS						72.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7, 600	1, 701, 185, 298	6, 454	6, 454	100	118. 00
190.00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	0	0	ol	0	190. 00
194.00	07950	RURAL HEALTH	O	0	0	o	0	194. 00
		RENTAL PROPERTY FAMILY PRACTICE	0	0		0 983		194. 01 194. 02
174.02	101754	TITUM ET TIMOTIOE	<u> </u>		1 703	1 703	0	1174.02

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

						5/26/2022 10:	49 am
				INTERNS &	RESI DENTS		
	Cost Center Description	NURSI NG		SERVI CES-SALAR		PARAMED ED	
		ADMI NI STRATI ON	RECORDS &	Y & FRINGES	PRGM COSTS	PRGM	
		(T1115	LI BRARY	(INTERNS)	(INTERNS)	(PARAMED	
		(TIME	(GROSS			RADI OLOGY)	
		SPENT) 13.00	CHARGES) 16. 00	21.00	22.00	23. 00	
104 02 070	52 WELLNESS	13.00	10.00	21.00	22.00		194. 03
	55 PHYSICIAN PRACTICES		0		0		194. 03
	53 SYCAMORE SPORTS MED	0	0		0		194. 04
	56 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0		194. 00
200. 00	Cross Foot Adjustments		0	1	U	Ü	200. 00
201.00	Negative Cost Centers						201.00
202. 00	Cost to be allocated (per Wkst. B,	3, 355, 327	7, 045, 842	2, 131, 635	2, 689, 432		
202.00	Part I)	3, 333, 327	7,043,042	2, 131, 033	2, 007, 432	123, 330	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	441. 490395	0. 004142	286. 625656	361. 628614	1, 235. 360000	203. 00
204.00	Cost to be allocated (per Wkst. B,	68, 244	175, 827	6, 852	4, 415	411	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	8. 979474	0. 000103	0. 921339	0. 593653	4. 110000	205. 00
	[11]						
206.00	NAHE adjustment amount to be allocated					0	206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,					0.000000	207. 00
	Parts III and IV)						

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

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

				'	0 12/31/2021	Date/lime Prepared:   5/26/2022 10:49 am
	Cost Center Description	OTHER MED ED	PARAMED ED	<u>'</u>		
		(ASSI GNED	PRGM			
		TIME)	(PARAMED RADI OLOGY)			
		23. 01	23. 02			
	GENERAL SERVICE COST CENTERS					
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
2. 00 4. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT					2. 00 4. 00
5. 01	00540 NONPATIENT TELEPHONES					5. 01
5. 02	00550 DATA PROCESSING					5. 02
5.03	00560 PURCHASING RECEIVING AND STORES					5. 03
5. 04	00570 ADMITTING					5. 04
5. 05 5. 06	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00590 OTHER ADMI N AND GENERAL					5. 05 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 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON					11. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY					16. 00
21. 00	02100 I&R SERVICES-SALARY & FRINGES APPRVD					21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD					22. 00
23. 00	O2300   PARAMED ED   PRGM   O2341   OTHER   MED   ED	100				23. 00
23. 01 23. 02	02301 PARAMED ED PRGM	100	100			23. 01
20.02	INPATIENT ROUTINE SERVICE COST CENTERS		100			20.02
30. 00	03000 ADULTS & PEDIATRICS	0	0			30.00
31. 00	03100 I NTENSI VE CARE UNI T	0	0			31. 00
35. 00	02040 I NTENSI VE NURSERY	0	0			35. 00
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY		0			41. 00 43. 00
10.00	ANCILLARY SERVICE COST CENTERS	<u> </u>	<sub> </sub>			10.00
50.00	05000 OPERATING ROOM	0	0			50. 00
50. 01	05001 CARDI AC SURGERY	0	0			50. 01
50. 02 51. 00	05002 WVSC 05100 RECOVERY ROOM	0	0			50. 02 51. 00
51.00	05101 O/P TREATMENT ROOM		0			51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	l o	Ö			52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	100			54. 00
55. 00	05500   RADI OLOGY-THERAPEUTI C	0	0			55. 00
56. 00 57. 00	05600	0	0			56. 00 57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)		o			58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	o	o			59. 00
60.00	06000 LABORATORY	0	0			60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0			62.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY		0			65. 00 66. 00
	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	O	o			66. 01
	06602 0/P PHYSI CAL THERAPY	o	o			66. 02
67. 00	06700 OCCUPATI ONAL THERAPY	0	0			67. 00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	0			68. 00 69. 00
69. 01	06901 CARDI AC REHAB		0			69. 01
70. 00	07000 ELECTROENCEPHALOGRAPHY		ő			70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	o			71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0			72.00
	07300 DRUGS CHARGED TO PATIENTS 03020 RENAL ACUTE	100	0			73. 00 76. 00
, 0. 00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	U			70.00
	09000 CLI NI C	0	0			90.00
	09005 PATIENT NUTRITION	0	0			90. 05
	09007 WOUND CLINIC	0	0			90. 07
91.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	ا ا	o			91. 00 92. 00
, 2. 00	SPECIAL PURPOSE COST CENTERS					/2.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	100	100			118. 00
40	NONREI MBURSABLE COST CENTERS					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN   07950 RURAL HEALTH	0	0			190. 00 194. 00
	07950 RUKAL HEALTH		O O			194. 00
	07954 FAMILY PRACTICE		o			194. 02
194. 03	07952 WELLNESS	0	o			194. 03
	07955 PHYSI CI AN PRACTI CES	0	0			194. 04
194.06	07953 SYCAMORE SPORTS MED	0	0			194. 06

Heal th Financial Systems

UNION HOSPITAL, INC.

In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0023
From 01/01/2021
To 12/31/2021
Date/Time Prepared:

				5/26/2022 10: 49 am	
	Cost Center Description	OTHER MED ED (ASSIGNED TIME)	PARAMED ED PRGM (PARAMED RADI OLOGY)		
		23. 01	23. 02		
194. 07 079	956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	194. 07	7
200.00	Cross Foot Adjustments			200.00	)
201.00	Negative Cost Centers			201.00	)
202. 00	Cost to be allocated (per Wkst. B, Part I)	481, 298	0	202. 00	)
203.00	Unit cost multiplier (Wkst. B, Part I)	4, 812. 980000	0. 000000	203.00	Э
204. 00	Cost to be allocated (per Wkst. B, Part II)	21, 326	0	204. 00	)
205.00	Unit cost multiplier (Wkst. B, Part	213. 260000	0. 000000	205. 00	)
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)	0	0	206. 00	)
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)	0. 000000	0. 000000	207. 00	)

NOAT EAR BOUTINE SERVICE COST CENTERS   NOAT   NOAT   NOAT EAR BOUTINE SERVICE COST CENTERS   NOAT						10 12/31/2021	5/26/2022 10:	
Total Cost Center Description				Title	XVIII	Hospi tal		,, d
INPATIENT ROUTINE SERVICE COST CENTERS				<u> </u>				
Part 1		Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
NPATI ENT ROUTI NE SERVICE COST CENTERS		·	(from Wkst. B,	Adj .		Di sal I owance		
INPATIENT ROUTINE SERVICE COST CENTERS   1.00   2.00   3.00   4.00   5.00			Part I, col.					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00   0300			1. 00	2. 00	3. 00	4. 00	5. 00	
33.00   03100   INTENSI VE CARE UNIT   15, 862, 754   15, 862, 754   31. 00   15, 862, 754   35. 00   03. 01   INTENSI VE UNISERY   4, 733, 539   4, 733, 539   04, 733, 539   35. 00   04100   SUBPROVI DER - 1 RF   3, 613, 960   3, 613, 960   0 3, 613, 960   41. 00   04100   SUBPROVI DER - 1 RF   3, 613, 960   0 3, 613, 960   0 1, 534, 032   0 1, 53								
15. 00   02040   INTENSIVE NURSERY   4, 733, 539   4, 733, 539   0   4, 733, 539   35, 00     41. 00   04300   SUBPROVID ER - IRF   3, 613, 960   0   3, 613, 960   0   3, 613, 960   0     41. 00   04300   NURSERY   1, 534, 032   1, 534, 032   0   1, 534, 032   3, 00     50. 01   05000   CARDIA C SURGERY   3, 909, 524   3, 909, 524   0   3, 909, 524   50, 00     50. 01   05000   CARDIA C SURGERY   3, 909, 524   3, 909, 524   0   18, 154, 712   0   18, 154, 712   50, 00     50. 02   05000   WSC   18, 154, 712   18, 154, 712   0   18, 154, 712   50, 00     50. 02   05000   WSC   18, 154, 712   0   18, 154, 712   50, 00     50. 02   05000   CARDIA C SURGERY   3, 399, 524   3, 399, 524   50, 01     50. 02   05000   CARDIA C SURGERY   3, 34, 141   3, 534, 141   0   3, 534, 141   5, 00     50. 02   05000   CARDIA C SURGERY   3, 34, 141   3, 534, 141   0   3, 534, 141   10, 03, 53								1
41 .00								
ABOOD   MARCHEAPY SERVICE COST CENTERS		l I						•
ANCILLARY SERVICE COST CENTERS			1					
SOLO	43.00		1, 534, 032		1, 534, 03	2 0	1, 534, 032	43.00
So. 01   OSDO1   CARDI AC SURGERY   3, 909, 524   3, 909, 524   50, 01   50, 02   5002   WYSC   18, 154, 712   18, 154, 712   0   18, 154, 712   50, 02   51, 00   5100   RECOVERY ROOM   3, 534, 141   3, 534, 141   0   3, 534, 141   51, 00   51, 00   5100   RECOVERY ROOM   2, 313, 123   2, 313, 123   0   2, 313, 123	FO 00		22 020 201		22 020 20	1 24.0/5	22 045 454	
Solid   Soli								
51.00   05100   RECOVERY ROOM   3,534,141   3,534,141   0   3,534,141   51.00   05100   APP TREATMENT ROOM   2,313,123   2,313,123   0   2,313,123   51.00   52.00   05200   DELIVERY ROOM & LABOR ROOM   8,291,176   8,291,176   0   8,291,176   0   8,291,176   52.00   05200   DELIVERY ROOM & LABOR ROOM   8,291,176   0   0   0   0   0   0   0   0   0								
51.02   05101   O/P TREATMENT ROOM   2, 313, 123   2, 313, 123   0   2, 313, 123   51.02								ł
52.00   05200   DELIVERY ROOM & LABOR ROOM   8, 291, 176   8, 291, 176   0   8, 291, 176   52.00								ł
54.00   05400   RADI OLOGY-DI AGNOSTI C   16, 463, 520   16, 463, 520   3, 170   16, 466, 690   54.00   05500   RADI OLOGY-THERAPEUTI C   8, 996, 834   8, 996, 834   0   8, 996, 834   55.00   05600   RADI OLOGY-THERAPEUTI C   8, 996, 834   3, 996, 834   0   8, 996, 834   55.00   05600   RADI OLOGY-THERAPEUTI C   3, 155, 942   0   3, 155, 942   0   3, 155, 942   56.00   05700   CT SCAN   4, 091, 390   4, 091, 390   0   2, 091, 244   0   29, 021, 244   29		l						1
55.00   05500   RADI OLOGY-THERAPEUTI C   8, 996, 834   8, 996, 834   0   8, 996, 834   55.00   05600   RADI OLOGY-THERAPEUTI C   3, 155, 942   3, 155, 942   0   3, 155, 942   50.00   05700   CT SCAN   4, 091, 390   4, 091, 390   0   4, 091, 390   57.00   05700   CT SCAN   4, 091, 390   4, 091, 390   0   4, 091, 390   57.00   05900   CARDI AC CATHETERI ZATI ON   29, 021, 244   29, 021, 244   0   29, 021, 244   0   05900   CARDI AC CATHETERI ZATI ON   29, 021, 244   29, 021, 244   0   29, 021, 244   0   29, 021, 244   0   00000   CABORATIORY   13, 691, 231   13, 691, 231   22, 545   13, 713, 776   60.00   06000   LABORATIORY   AND ACKED RED BLOOD CELLS   1, 909, 133   1, 909, 133   0   0, 900, 100, 100, 100, 100, 100, 100, 1								1
56. 00   05600   RADIOI SOTOPE   3, 155, 942   3, 155, 942   0   3, 155, 942   56. 00								
57. 00   05700   CT SCAN								1
58. 00   05800   MAGNETIC RESONANCE I MAGI NG (MRI)   3, 169, 984   3, 169, 984   0   3, 169, 984   59. 00   05900   CARDI AC CATHETERI ZATI ON   29, 021, 244   29, 021, 244   0   29, 021, 244   59. 00   05900   CARDI AC CATHETERI ZATI ON   29, 021, 244   29, 021, 244   0   29, 021, 244   59. 00   06. 00   06000   LABORATORY   13, 691, 231   13, 691, 231   22, 545   13, 713, 776   60. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   1, 909, 133   1, 909, 133   0   0   0, 000   0   0   0   0   0								
59.00   05900   CARDI AC CATHETERIZATION   29,021,244   00   29,021,244   50,00								1
60. 00   06000   LABORATORY   13, 691, 231   13, 691, 231   22, 545   13, 713, 776   60. 00								l
62.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   1,909, 133   1,909, 133   0   1,909, 133   62.00   65.00   06500   RESPI RATORY THERAPY   8,083,918   0   8,083,918   0   66.00   06600   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   0   0   66.01   06601   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   0   0   66.02   06602   O/P PHYSI CAL THERAPY   2,270,147   0   2,270,147   0   2,270,147   0   67.00   06700   OCCUPATI ONAL THERAPY   2,765,181   0   2,765,181   0   2,765,181   0   68.00   06800   SPEECH PATHOLOGY   1,224,313   0   1,224,313   0   69.00   06900   ELECTROCARDI OLOGY   8,174,899   8,174,899   0   69.01   06901   CARDI AC REHAB   959,576   959,576   0   69.01   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   67.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   12,691,575   12,691,575   0   67.00   07200   IMPL. DEV. CHARGED TO PATI ENTS   71,473,120   71,473,120   0   67.00   07200   DRUGS CHARGED TO PATI ENTS   71,473,120   71,473,120   0   67.00   07000   CLI INI C   2,590,970   2,590,970   0   67.00   09000   CLI INI C   2,694,785   1,475   266,260   90.05   67.00   09000   CLI INI C   2,629,498   2,629,498   0   2,629,498   0   67.00   09000   DRUGS CHARGED TO BEDS (NON-DISTINCT PART)   11,159,249   11,159,2								l
65. 00   06500   RESPI RATORY THERAPY   8, 083, 918   0   8, 083, 918   0   06600   9HYSI CAL THERAPY   4, 556, 979   0   4, 556, 979   0   0   0   0   0   0   0   0   0								1
66. 00 06600 PHYSI CAL THERAPY				0				1
66. 01   06601   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   0   0   0   0   0   66. 01   66. 02   06602   07P PHYSI CAL THERAPY   2, 270, 147   0   2, 270, 147   0   2, 270, 147   67. 00   06700   0CCUPATI ONAL THERAPY   2, 765, 181   0   2, 765, 181   0   2, 765, 181   0   68. 00   06800   SPEECH PATHOLOGY   1, 224, 313   0   1, 224, 313   1, 475   266, 260   90. 05   1, 259, 249   10, 259, 249, 240   10, 259, 249, 240								
66. 02			1				l	
67. 00			2, 270, 147	0	2, 270, 14	7 0	2, 270, 147	•
69. 00   06900   CARDI AC REHAB   959, 576   959, 576   0 959, 576   69. 01   70. 00   07000   CARDI AC REHAB   959, 576   959, 576   0 959, 576   69. 01   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	67.00		2, 765, 181	0				67. 00
69. 01 06901 CARDI AC REHAB 959, 576 959, 576 0 959, 576 69. 01 70. 00 07000 ELECTROENCEPHALOGRAPHY 2, 259, 118 2, 259, 118 0 2, 259, 118 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 71. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 12, 691, 575 12, 691, 575 0 12, 691, 575 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 71, 473, 120 71, 473, 120 0 71, 473, 120 73. 00 76. 00 03020 RENAL ACUTE 2, 590, 970 2, 590, 970 0 2, 590, 970  90. 00 09000 CLI NI C 405, 249 405, 249 0 405, 249 90. 00 90. 05 09005 PATI ENT NUTRI TI ON 264, 785 266, 260 90. 05 90. 07 09007 WOUND CLI NI C 2, 629, 498 2, 629, 498 0 2, 629, 498 90. 07 91. 00 09200 DREGENCY 16, 808, 279 11, 159, 249 11, 159, 249 200. 00 200. 00 Subtotal (see instructions) 380, 240, 902 11, 159, 249 11, 159, 249 201. 00 201. 00 Less Observation Beds 11, 159, 249 11, 159, 249 11, 159, 249 201. 00	68.00			0				68. 00
70. 00	69.00	06900 ELECTROCARDI OLOGY	8, 174, 899		8, 174, 89	9 0	8, 174, 899	69. 00
71. 00	69. 01	06901 CARDI AC REHAB	959, 576		959, 57	6 0	959, 576	69. 01
72. 00	70.00	07000 ELECTROENCEPHALOGRAPHY	2, 259, 118		2, 259, 11	8 0	2, 259, 118	70. 00
73. 00   07300   DRUGS CHARGED TO PATIENTS   71, 473, 120   71, 473, 120   0   71, 473, 120   73. 00   76. 00   03020   RENAL ACUTE   2,590,970   2,590,970   0   2,590,970   76. 00   0000   CLI NI C   405, 249   405, 249   0   405, 249   90. 00   90. 005   PATIENT NUTRI TI ON   264, 785   264, 785   264, 785   1, 475   266, 260   90. 05   90. 07   9000   CLI NI C   2, 629, 498   2, 629, 498   0   2, 629, 498   90. 07   90. 00   90. 00   EMERGENCY   16, 808, 279   16, 808, 279   17, 159, 249   11, 159, 249   11, 159, 249   11, 159, 249   11, 159, 249   200. 00   200. 00   Subtotal (see i nstructions)   380, 240, 902   0   380, 240, 902   52, 055   380, 292, 957   200. 00   201. 00   Less Observation Beds   11, 159, 249   11, 159, 249   201. 00   200. 00   2	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0	0	71. 00
76. 00 03020 RENAL ACUTE 2, 590, 970 2, 590, 970 0 2, 590, 970 76. 00 00TPATI ENT SERVICE COST CENTERS  90. 00 09000 CLINIC 405, 249 405, 249 0 405, 249 90. 00 9000 PATI ENT NUTRITION 264, 785 264, 785 1, 475 266, 260 90. 05 90. 07 09007 WOUND CLINIC 2, 629, 498 2, 629, 498 0 2, 629, 498 0 2, 629, 498 0 2, 629, 498 91. 00 09100 EMERGENCY 16, 808, 279 100 09200 OBSERVATION BEDS (NON-DISTINCT PART) 11, 159, 249 201. 00	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	12, 691, 575		12, 691, 57	5 0	12, 691, 575	72.00
OUTPATIENT SERVICE COST CENTERS           90. 00         09000         CLINIC         405, 249         405, 249         0         405, 249         90. 00           90. 05         09005         PATIENT NUTRITION         264, 785         264, 785         1, 475         266, 260         90. 05           90. 07         09007         WOUND CLINIC         2, 629, 498         2, 629, 498         0         2, 629, 498         0         2, 629, 498         0         70         00			71, 473, 120		71, 473, 12	0	71, 473, 120	73. 00
90. 00	76.00		2, 590, 970		2, 590, 97	0	2, 590, 970	76. 00
90. 05   09005   PATI ENT NUTRITION   264, 785   264, 785   264, 785   90. 07   09007   WOUND CLINIC   2, 629, 498   0   2, 629, 498   90. 07   09100   EMERGENCY   16, 808, 279   16, 808, 279   11, 159, 249   11, 159, 249   11, 159, 249   200. 00   200. 00   Subtotal (see i nstructions)   380, 240, 902   11, 159, 249   11, 159, 249   201. 00   201. 00   201. 00   202. 00   203. 00   203. 00   203. 00   204. 00								
90. 07   09007   WOUND CLINIC   2,629,498   2,629,498   0   2,629,498   90. 07   91. 00   09100   EMERGENCY   16,808,279   16,808,279   0   16,808,279   91. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   11,159,249   11,159,249   11,159,249   201. 00   201. 00   Less Observation Beds   11,159,249   11,159,249   11,159,249   201. 00   11,159,249   201. 00   2,629,498   90. 07   16,808,279   91. 00   16,808,279   91. 00   11,159,249   200. 00   2,629,498   90. 07   16,808,279   91. 00   11,159,249   92. 00   380,240,902   52,055   380,292,957   200. 00   11,159,249   201. 00   11,159,249   201. 00   11,159,249   201. 00   2,629,498   90. 07   16,808,279   91. 00   16,808,279   91. 00   11,159,249   92. 00   11,159,249   11,159,249   11,159,249   11,159,249   201. 00   11,159,249   201. 00   11,159,249   201. 00   2,629,498   90. 07   202. 00								1
91. 00   09100   EMERGENCY   16, 808, 279   16, 808, 279   11, 159, 249   11, 159, 249   11, 159, 249   200. 00   201. 00   Less Observation Beds   11, 159, 249   11, 159, 249   11, 159, 249   201. 00   201								1
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART)   11, 159, 249   11, 159, 249   200. 00   200. 00   Less Observation Beds   11, 159, 249   11, 159, 249   201. 00   11, 159, 249   201. 00								1
200. 00 Subtotal (see instructions) 380, 240, 902 0 380, 240, 902 52, 055 380, 292, 957 200. 00 201. 00 Less Observation Beds 11, 159, 249 11, 159, 249								
201. 00 Less Observation Beds 11, 159, 249 11, 159, 249 201. 00								
				0				
202.00    10Tal (see Instructions)   369,081,653  0  369,081,653  52,055  369,133,708 202.00				-				1
	202.00	(see instructions)	369, 081, 653	0	369, 081, 65	اد 52, 055 اد 52, 055	369, 133, 708	J202. 00

| Peri od: | Worksheet C | From 01/01/2021 | Part | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Da Provider CCN: 15-0023

Inpatient   Outpatient   Outpatient   Total (col. 6   e. col. 7)						10 12/31/2021	5/26/2022 10:	
Inpatient				Title	XVIII	Hospi tal		77 aiii
Inpatient   Outpatient   Total (col. 6   Lost or Other Ratio								
INPATIENT ROUTINE SERVICE COST CENTERS   117, 856, 189   117, 856, 189   30.00   30.00   30.00   30.00   31.		Cost Center Description	Inpatient		Total (col. 6	Cost or Other	TEFRA	
INPATIENT ROUTINE SERVICE COST CENTERS   117, 856, 189   117, 856, 189   30, 00		<b>'</b>	'	'			Inpati ent	
INPATI ENT ROUTI NE SERVICE COST CENTERS   30.00					ŕ		Rati o	
30.00   03000   ADULTS & PEDIATRICS   117,856,189     117,856,189   31.00   3300   02040   INTENSIVE CARE UNIT   34,095,203   34,095,203   34,095,203   34,005,			6.00	7. 00	8. 00	9. 00	10.00	
31.00   03100   INTERSIVE CARE LINIT   34.095, 203   34.095, 203   34.095, 203   35.00   35.00   35.00   36.00   INTERSIVE WURSERY   18.678, 475   18.678, 475   35.00   36.00   36.00   INTERSIVE WURSERY   2.867, 220   2.867, 220   41.00   36.00								
35. 00   02040   INTENSIVE NURSERY   18, 678, 475   18, 678, 475   18, 678, 475   18, 678, 475   41. 00   041000   04100   04100   04100   04100   0		1 1						•
11.00   0410								
A3. 00   A3.00   NURSERY   C. COST CENTERS		1 1						•
ANCILLARY SERVICE COST CENTERS		1 1						1
50. 0	43. 00		2, 867, 220		2, 867, 22	)		43. 00
50.00   OSDO1   CARDI AC SURGERY   6, 498, 308   25, 000   6, 523, 308   0, 599316   0, 000000   50, 01   50, 02   5000   0   5000   217, 199, 88   227, 310, 538   0, 142609   0, 000000   50, 01   50, 02   51, 00   0   5100   RECOVERY ROOM   3, 273, 710   7, 998, 822   11, 272, 532   0, 313518   0, 000000   51, 02   51, 00   0   5000   0   5000   0   5000   0				100 050 000	477 704 07	0.400007		
50. Q   05002   WSC   104,600   127, 199, 938   127, 304, 538   0, 142609   0, 000000   50, 02   51. 00   51. 00   51. 00   51. 01   51. 00   51. 01   51. 00   51. 01   7, 998   22, 31, 227, 304, 538   0, 31518   0, 000000   51. 02   51. 02   51. 02   51. 01   7, 998, 31, 558   3, 409, 383   3, 492, 941   0, 662228   0, 000000   51. 02   52. 00   05200   DELIVERY ROOM & LABOR ROOM   19, 507, 049   4, 140, 786   23, 647, 835   0, 350610   0, 000000   54. 00   54. 00   5400   6400								1
S1 00   05100   RECOVERY ROOM   3, 273, 710   7, 998, 822   11, 272, 532   0, 313518   0, 000000   51, 00   51, 00   51, 00   52, 00   05200   DELI VERY ROOM & LABOR ROOM   19, 507, 049   4, 140, 786   23, 647, 835   0, 313518   0, 000000   52, 00   54, 00   05200   DELI VERY ROOM & LABOR ROOM   19, 507, 049   4, 140, 786   23, 647, 835   0, 350610   0, 000000   52, 00   55, 00   05500   ROID IOLOGY-THERAPEUTI C   19, 581, 576   56, 562, 922   75, 204, 498   0, 218917   0, 000000   55, 00   55, 00   5500   ROID IOLOGY-THERAPEUTI C   2, 786, 997   47, 688, 356   50, 475, 353   0, 178242   0, 000000   55, 00   56, 00   05700   CT SCAN   16, 989, 921   39, 396, 727   56, 386, 648   0, 072560   0, 000000   57, 00   05700   CT SCAN   16, 989, 921   39, 396, 727   56, 386, 648   0, 072560   0, 000000   57, 00   05800   MAGNETI C RESONANCE I MAGI NG (MRI )   2, 593, 631   12, 363, 452   14, 957, 083   0, 211939   0, 000000   58, 00   05900   CARDITORY   CAR								
S1 00   05200   05200   DELI YERY ROOM & LABOR ROOM   19,507,049   4,140,786   23,647,835   0.350610   0.000000   52.00   05400   RADI OLOGY-DI AGNOSTI C   19,581,576   55,622,922   75,204,498   0.218917   0.000000   52.00   05400   RADI OLOGY-DI AGNOSTI C   2,786,997   47,688,356   50,475,353   0.178242   0.000000   55.00   05500   RADI OLOGY-THERAPEUTI C   2,786,997   47,688,356   50,475,353   0.178242   0.000000   55.00   05500   RADI OLOGY-THERAPEUTI C   2,786,997   47,688,356   50,475,353   0.178242   0.000000   55.00   05500   RADI OLOGY-THERAPEUTI C   2,786,997   47,688,356   50,475,353   0.178242   0.000000   55.00   05500   RADI OLOGY-THERAPEUTI C   2,583,631   1.45,117   11,427,698   0.276166   0.000000   55.00   05500   RADI OLOGY-THERAPEUTI C   2,593,631   12,363,452   14,957,083   0.211939   0.000000   55.00   055000   05500   055000   05500   055000   055000   055000   055000   055000   055000   055000   055000   055000   055000   055000   055000   055000   05								1
52.00   0520								
54.00   05400   RADI OLOGY-DI AGNOSTIC   19, 581, 576   55, 622, 922   75, 204, 498   0. 218917   0. 000000   54. 00   55.00   05500   RADI OLOGY-THERAPEUTI C   2, 786, 997   47, 688, 356   50, 475, 353   0. 178242   0. 000000   55. 00   57.00   05600   RADIO IOSOTOPE   1, 282, 581   10, 145, 117   11, 427, 698   0. 276166   0. 000000   56. 00   57.00   05700   CT SCAN   16, 989, 921   39, 396, 727   56, 386, 648   0. 072560   0. 000000   57. 00   58.00   05800   MAGNETI C RESONANCE I IMAGING (MRI )   2, 593, 631   12, 363, 452   14, 957, 083   0. 211939   0. 000000   58. 00   59.00   05600   CARDI AC CATHETERI ZATI ON   35, 508, 688   72, 398, 798   107, 907, 486   0. 268946   0. 000000   59. 00   60.00   066001   LaBORATORY   55, 615, 051   47, 608, 056   103, 223, 107   0. 132637   0. 000000   60. 00   65.00   06500   RESPI RATORY THERAPY   36, 280, 957   3, 234, 393   39, 515, 350   0. 204577   0. 000000   65. 00   66.01   06601   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   0. 000000   0. 000000   66. 01   66.02   06602   079 PHYSI CAL THERAPY   7, 425, 538   4, 933, 311   12, 358, 489   0. 223741   0. 000000   66. 00   66.01   06901   CARDITI ONAL THERAPY   7, 425, 538   4, 933, 311   12, 358, 489   0. 223741   0. 000000   67. 00   69.01   06901   CARDI AC REHAB   125, 353   1, 402, 172   1, 527, 525   0. 628190   0. 000000   69. 01   69.01   06901   CARDI AC REHAB   125, 353   1, 402, 172   1, 527, 525   0. 628190   0. 000000   70. 00   70.00   07000   ELECTROCARDI OLOGY   17, 902, 904   39, 915, 374, 511, 386   0. 205671   0. 000000   70. 00   71.00   07000   TINIC SERVI CES   0   0   0   0   0   0. 000000   0. 000000   70. 00   71.00   07000   TINIC SERVI CE COST CENTERS   1, 400   871, 907   873, 507   873, 507   90, 90. 681   0. 248900   0. 000000   90. 07   72.00   09000   CLI NI C   0   0   0   0   0   0   0   0   0								1
55. 00   05500   RADI OLOGY-THERAPEUTI C   2, 786, 997   47, 688, 356   50, 475, 353   0. 178242   0. 000000   55. 00   56. 00   05600   RADI OLOGY-THERAPEUTI C   1, 282, 581   10, 145, 117   11, 427, 698   0. 276166   0. 000000   55. 00   57. 00   57. 00   05700   CT SCAN   16, 989, 921   39, 396, 727   56, 386, 648   0. 072560   0. 000000   57. 00   58. 00   05700   CT SCAN   16, 989, 921   39, 396, 727   56, 386, 648   0. 072560   0. 000000   57. 00   58. 00   05900   CARDI AC CATHETERI ZATI ON   35, 508, 688   72, 398, 798   107, 907, 486   0. 268946   0. 000000   59. 00   0. 00000								1
56. 00   05600   RADI OI SOTOPE   1, 282, 581   10, 145, 177   11, 427, 698   0. 276166   0. 000000   56. 00   57. 00   05700   CT SCAN   16, 989, 921   39, 396, 727   56, 386, 648   0. 072560   0. 000000   57. 00   58. 00   05800   MAGNETI C RESONANCE I MAGI NG (MRI )   2, 593, 631   12, 363, 452   14, 957, 083   0. 211939   0. 000000   58. 00   59. 00   05900   CARDI AC CATHETERI ZATI ON   35, 508, 688   72, 398, 798   107, 907, 486   0. 268946   0. 000000   69. 00   60. 00   60000   LABDRATORY   55, 615, 051   47, 608, 056   103, 223, 107   0. 132637   0. 000000   62. 00   65. 00   06500   RESPI RATORY THERAPY   36, 280, 957   3, 234, 393   39, 515, 350   0. 204577   0. 000000   66. 00   66. 00   06600   PSYCHI ATRI C/PSYCHOLGGI CAL SERVI CES   0   0   0   0. 000000   0. 000000   66. 01   66. 02   06602   079   PHYSI CAL THERAPY   7, 425, 538   4, 933, 311   12, 358, 849   0. 223741   0. 000000   67. 00   68. 00   06700   0CCUPATI ONAL THERAPY   7, 425, 538   4, 933, 311   12, 358, 849   0. 223741   0. 000000   67. 00   69. 00   06900   ELECTROCARDI OLOGY   17, 962, 862   2, 915, 074   4, 370, 343   0. 280141   0. 000000   69. 01   69. 01   06901   CARDI AC REHAB   125, 353   1, 402, 172   1, 527, 525   0. 628190   0. 000000   69. 01   69. 01   0700   MEDICAL SUPPLIES CHARGED TO PATI ENTS   58, 426, 429   289, 084, 957   347, 511, 386   0. 248900   0. 000000   70. 00   69. 00   07000   DRUGS CHARGED TO PATI ENTS   58, 426, 429   289, 084, 957   347, 511, 386   0. 248900   0. 000000   70. 00   69. 00   07000   DRUGS CHARGED TO PATI ENTS   58, 426, 429   289, 084, 957   347, 511, 386   0. 248900   0. 000000   70. 00   69. 00   07000   DRUGS CHARGED TO PATI ENTS   58, 426, 429   289, 084, 957   347, 511, 386   0. 248720   0. 000000   70. 00   69. 00   07000   DRUGS CHARGED TO PATI ENTS   58, 426, 429   289, 084, 957   347, 511, 386   0. 248720   0. 000000   70. 00   69. 00   07000   DRUGS CHARGED TO PATI ENTS   58, 426, 429   289, 084, 957   347, 511, 386   0. 248720   0. 000000   70. 00   69. 00   07000   0700								
57. 00   05700   CT SCAN   16, 989, 921   39, 396, 727   56, 386, 648   0. 072560   0. 000000   57. 00   58. 00   05800   MAGNETIT C RESONANCE I MAGI NG (MRI )   2, 593, 631   12, 363, 452   14, 957, 633   0. 211939   0. 000000   58. 00   0. 0000000   0. 0000000   0. 00								1
58. 00   05800   MAGNETIC RESONANCE IMAGING (MRI )   2, 593, 631   12, 363, 452   14, 957, 083   0. 211939   0. 000000   58. 00   05900   CARDIAC CATHETERIZATION   35, 508, 688   72, 398, 798   107, 907, 486   0. 268946   0. 0000000   0. 0000000   0. 000000   0. 000000   0. 000000   0. 0000000   0. 0000000   0. 0000000   0. 0000								
59. 00   05900   CARDI AC CATHETERI ZATION   35, 508, 688   72, 398, 798   107, 907, 486   0.268946   0.000000   59. 00   60. 00   06000   LABORATORY   55, 615, 051   47, 608, 056   103, 223, 107   0.132637   0.000000   60. 00   62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   3, 004, 102   580, 342   3, 584, 444   0.532616   0.000000   62. 00   65. 00   06500   RESPI RATORY THERAPY   36, 280, 957   3, 234, 393   39, 515, 350   0.204577   0.000000   65. 00   66. 01   06601   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   0   0   0.000000   0.000000   66. 00   66. 02   06602   O/P PHYSI CAL THERAPY   7, 425, 538   4, 933, 311   12, 358, 849   0.223741   0.000000   68. 00   68. 00   06800   SPEECH PATHOLOGY   1, 455, 569   2, 915, 074   4, 370, 343   0.280141   0.000000   68. 00   69. 00   06900   ELECTROCARDI OLOGY   17, 962, 862   72, 982, 404   90, 945, 266   0.089888   0.000000   69. 00   69. 01   06900   CARDIA CARDIA CREHAB   125, 353   1, 402, 172   1, 527, 525   0.628190   0.000000   71. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   13, 599, 443   37, 391, 238   50, 990, 681   0.248900   0.000000   73. 00   72. 00   07300   DRUGS CHARGED TO PATI ENTS   13, 599, 443   37, 391, 238   50, 990, 681   0.248900   0.000000   73. 00   74. 00   07000   CLICTROT SERVICE COST CENTERS   14, 202, 926   398, 975   4, 601, 901   0.563022   0.000000   74. 00   75. 00   07000   CLI NI C   0   0.000000   0.0								1
60. 00   06000   LABORATORY   55, 615, 051   47, 608, 056   103, 223, 107   0. 132637   0. 000000   60. 00   62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   3, 004, 102   580, 342   3, 584, 444   0. 532616   0. 000000   62. 00   65. 00   06500   RESPIR RATORY THERAPY   36, 280, 957   3, 234, 393   39, 515, 350   0. 204577   0. 000000   65. 00   66. 01   06601   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   0   0. 000000   0. 000000   0. 000000   66. 01   66. 02   06602   O/P PHYSI CAL THERAPY   7, 425, 538   4, 933, 311   12, 358, 849   0. 223741   0. 00000   67. 00   67. 00   06700   0CCUPATI ONAL THERAPY   7, 425, 538   4, 933, 311   12, 358, 849   0. 223741   0. 000000   67. 00   68. 00   06800   SPECCH PATHOLOGY   17, 455, 269   2, 915, 074   4, 370, 343   0. 280141   0. 000000   67. 00   69. 00   06900   CARDI AC REHAB   125, 353   1, 402, 172   1, 527, 525   0. 628190   0. 000000   69. 01   70. 00   07000   ELECTROENCEPHALOGRAPHY   885, 315   3, 242, 400   4, 127, 715   0. 547305   0. 000000   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   13, 599, 443   37, 391, 238   50, 990, 681   0. 248900   0. 000000   72. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   13, 599, 443   37, 391, 238   50, 990, 681   0. 248900   0. 000000   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   13, 599, 443   37, 391, 238   50, 990, 681   0. 248900   0. 000000   72. 00   74. 00   07300   DRUGS CHARGED TO PATI ENTS   13, 599, 443   37, 391, 238   50, 990, 681   0. 248900   0. 000000   72. 00   75. 00   07000   ELECTROENCEDI COST CENTERS   14, 400   871, 907   873, 307   0. 464040   0. 000000   72. 00   76. 00   09000   DRUGS CHARGED TO PATI ENTS   58, 426, 429   289, 084, 957   347, 511, 386   0. 205671   0. 000000   70. 00   76. 00   09000   DRUGS CHARGED TO PATI ENTS   14, 400   871, 907   873, 307   0. 464040   0. 000000   70. 00   76. 00   09000   DRUGS CHARGED TO PATI ENTS   14, 400   871, 907   873, 307   0. 464040   0. 000000   70. 00   77. 00   09000   DRUGS CHARGED TO PATI ENTS								1
62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   3, 004, 102   580, 342   3, 584, 444   0. 532616   0. 000000   62. 00   65. 00   06500   RESPIRATORY THERAPY   36, 280, 957   3, 234, 393   39, 515, 350   0. 204577   0. 000000   65. 00   66. 01   06601   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   0   0. 000000   0. 000000   0. 000000   66. 01   06601   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   0   0. 000000   0. 000000   0. 000000   66. 02   06602   O/P PHYSI CAL THERAPY   0   7, 590, 297   7, 590, 297   0. 299085   0. 000000   66. 01   66. 02   06602   O/P PHYSI CAL THERAPY   7, 425, 538   4, 933, 311   12, 358, 849   0. 223741   0. 000000   67. 00   67. 00   06700   0CCUPATI ONAL THERAPY   7, 425, 538   4, 933, 311   12, 358, 849   0. 223741   0. 000000   67. 00   68. 00   06800   SPEECH PATHOLOGY   1, 455, 269   2, 915, 074   4, 370, 343   0. 280141   0. 000000   68. 00   69. 01   06901   CARDI AC REHAB   125, 353   1, 402, 172   1, 527, 525   0. 628190   0. 000000   69. 01   70. 00   07000   CARDI AC REHAB   125, 353   1, 402, 172   1, 527, 525   0. 628190   0. 000000   69. 01   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   13, 599, 443   37, 391, 238   50, 990, 681   0. 248900   0. 000000   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   58, 426, 429   289, 084, 957   347, 511, 386   0. 205671   0. 000000   73. 00   74. 00   07000   CLI NI C   0   07000   0		1 1						1
65. 00   06500   RESPIRATORY THERAPY   36, 280, 957   3, 234, 393   39, 515, 350   0. 204577   0. 000000   65. 00   66. 00   06600   PHYSI CAL THERAPY   9, 837, 574   5, 537, 099   15, 374, 673   0. 296395   0. 000000   66. 00   0   0. 000000   0. 000000   66. 01   0. 0000000   0. 0000000   0. 00000000		1 1						•
66. 00   06600   PHYSI CAL THERAPY   9, 837, 574   5, 537, 099   15, 374, 673   0. 296395   0. 000000   66. 00   66. 01   06601   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   0   0   0. 000000   0. 000000   66. 01   67. 00   06700   0CCUPATI ONAL THERAPY   7, 425, 538   4, 933, 311   12, 358, 849   0. 223741   0. 000000   67. 00   68. 00   06800   SPEECH PATHOLOGY   1, 455, 269   2, 915, 074   4, 370, 343   0. 280141   0. 000000   68. 00   69. 00   06900   ELECTROCARDI OLOGY   17, 962, 862   72, 982, 404   90, 945, 266   0. 089888   0. 000000   69. 00   69. 01   06901   06901   CARDI AC REHAB   125, 353   1, 402, 172   1, 527, 525   0. 628190   0. 000000   69. 01   69. 01   07000   ELECTROENCEPHALOGRAPHY   885, 315   3, 242, 400   4, 127, 715   0. 547305   0. 000000   70. 00   69. 01   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   13, 599, 443   37, 391, 238   50, 990, 681   0. 248900   0. 000000   72. 00   73. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   58, 426, 429   289, 084, 957   347, 511, 386   0. 205671   0. 000000   73. 00   74. 00   09000   CLI NI C   4, 202, 926   398, 975   4, 601, 901   0. 563022   0. 000000   79. 00   75. 00   09000   CLI NI C   0   199, 814   1. 325157   0. 000000   90. 05   75. 00   09000   CLI NI C   0   10, 744, 937   0. 244720   0. 000000   90. 07   75. 00   09000   EMERGENCY   39, 151, 821   104, 167, 386   143, 319, 207   0. 117279   0. 000000   91. 00   75. 00   09000   DEES (NON-DISTINCT PART)   3, 266, 610   12, 164, 280   15, 430, 890   0. 723176   0. 000000   92. 00   75. 00   200. 00   Subtotal (see instructions)   593, 387, 735   1, 107, 797, 563   1, 701, 185, 298   201. 00   75. 00   201. 00   Less Observation Beds   201. 00								1
66. 01 06601 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 0 0 7,590,297 7,590,297 0.299085 0.000000 66. 01 66. 02 06602 0/P PHYSICAL THERAPY 0 7,425,538 4,933,311 12,358,849 0.223741 0.000000 67. 00 069. 00 06900 069. 00 06900 069. 00 06900 069. 01 06901 0		1 1						1
66. 02 06602 0/P PHYSICAL THERAPY 0 7, 590, 297 7, 590, 297 0. 299085 0. 000000 66. 02 67. 00 06700 0CCUPATI ONAL THERAPY 7, 425, 538 4, 933, 311 12, 358, 849 0. 223741 0. 000000 67. 00 68. 00 06800 SPEECH PATHOLOGY 1, 455, 269 2, 915, 074 4, 370, 343 0. 280141 0. 000000 69. 00 69. 00 06900 ELECTROCARDI OLOGY 17, 962, 862 72, 982, 404 90, 945, 266 0. 089888 0. 000000 69. 00 69. 01 06901 CARDI AC REHAB 125, 353 1, 402, 172 1, 527, 525 0. 628190 0. 000000 69. 01 70. 00 07000 ELECTROENCEPHALOGRAPHY 885, 315 3, 242, 400 4, 127, 715 0. 547305 0. 000000 70. 00 71. 00 07000 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0.000000 70. 00 0. 0000000 71. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 13, 599, 443 37, 391, 238 50, 990, 681 0. 248900 0. 000000 72. 00 073. 00 07300 DRUGS CHARGED TO PATI ENTS 58, 426, 429 289, 084, 957 347, 511, 386 0. 205671 0. 000000 73. 00 07300 DRUGS CHARGED TO PATI ENTS 58, 426, 429 289, 084, 957 347, 511, 386 0. 205671 0. 000000 73. 00 07300 DRUGS CHARGED TO PATI ENTS 58, 426, 429 289, 084, 957 347, 511, 386 0. 205671 0. 000000 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 58, 426, 429 289, 084, 957 347, 511, 386 0. 205671 0. 000000 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 58, 426, 429 289, 084, 957 347, 511, 386 0. 205671 0. 000000 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 000000 0. 000000 0. 000000 0. 000000			0					
67. 00			0	7. 590. 297	7, 590, 29			1
68.00   06800   SPEECH PATHOLOGY   1, 455, 269   2, 915, 074   4, 370, 343   0. 280141   0. 000000   68.00   69.00   69.00   69.00   69.00   69.00   69.00   69.01   6		1 1	7, 425, 538					1
69. 00								l
70. 00	69. 00						0. 000000	69. 00
70. 00	69. 01	06901 CARDI AC REHAB	125, 353	1, 402, 172	1, 527, 52	0. 628190	0. 000000	69. 01
71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   0   0   0	70.00	07000 ELECTROENCEPHALOGRAPHY					0. 000000	70. 00
73. 00   07300   DRUGS CHARGED TO PATIENTS   58, 426, 429   289, 084, 957   347, 511, 386   0. 205671   0. 000000   73. 00   76. 00   03020   RENAL ACUTE   0.000000   74. 000   75. 00	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0. 000000	0.000000	71. 00
76. 00 03020 RENAL ACUTE 4, 202, 926 398, 975 4, 601, 901 0.563022 0.000000 76. 00 00000 0000 CLI NI C 1, 400 871, 907 873, 307 0.464040 0.000000 90. 00 09005 PATI ENT NUTRI TI ON 0 199, 814 1.325157 0.000000 90. 05 90. 07 990.07 90007 WOUND CLI NI C 0 10, 744, 937 10, 744, 937 0.244720 0.000000 90. 07 91. 00 99100 EMERGENCY 39, 151, 821 104, 167, 386 143, 319, 207 0.117279 0.000000 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 3, 266, 610 12, 164, 280 15, 430, 890 0.723176 0.000000 92. 00 201. 00 Less Observation Beds 593, 387, 735 1, 107, 797, 563 1, 701, 185, 298 201. 00	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	13, 599, 443	37, 391, 238	50, 990, 68	0. 248900	0.000000	72. 00
90. 00   09000   CLINIC   1,400   871,907   873,307   0.464040   0.000000   90.00   90	73.00	07300 DRUGS CHARGED TO PATIENTS	58, 426, 429	289, 084, 957	347, 511, 38	0. 205671	0.000000	73. 00
90. 00	76.00	03020 RENAL ACUTE	4, 202, 926	398, 975	4, 601, 90	0. 563022	0.000000	76. 00
90. 05   09005   PATI ENT NUTRI TI ON   0   199, 814   199, 814   199, 814   1   325157   0   000000   90. 05   09007   09007   09007   09007   09100   09100   09100   09100   09100   09200								
90. 07   09007   WOUND CLINIC   0   10, 744, 937   10, 744, 937   0. 244720   0. 000000   90. 07   09100   EMERGENCY   39, 151, 821   104, 167, 386   143, 319, 207   0. 117279   0. 000000   91. 00   09200		1 1	1, 400	871, 907				1
91. 00   09100   EMERGENCY   39, 151, 821   104, 167, 386   143, 319, 207   0. 117279   0. 000000   91. 00   92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART)   3, 266, 610   12, 164, 280   15, 430, 890   0. 723176   0. 000000   92. 00   201. 00   201. 00   Less Observation Beds   593, 387, 735   1, 107, 797, 563   1, 701, 185, 298   201. 00   201			1 -1					
92. 00   09200   08SERVATI ON BEDS (NON-DISTINCT PART)   3, 266, 610   12, 164, 280   15, 430, 890   0. 723176   0. 000000   92. 00   200. 00   201. 00   Less Observation Beds   593, 387, 735   1, 107, 797, 563   1, 701, 185, 298   201. 00   201.		1 1	1 "1					1
200.00   Subtotal (see instructions)   593,387,735   1,107,797,563   1,701,185,298   200.00   201.00   Less Observation Beds   201.00		1 1						1
201.00 Less Observation Beds 201.00							0.000000	
			593, 387, 735	1, 107, 797, 563	1, 701, 185, 29	3		
- 202 00   LLOTAL (See INSTRUCTIONS)   593-387-7351-1-107-797-5631-1-701-185-2981   1202-00		1 1	F02 207 705	1 107 707 510	1 701 405 00			
252.55] [1513. (555 1.151 351 5115) [275, 367, 765] [1,777, 365] [1,777, 365] [1,777, 365]	202.00	p   rotal (see instructions)	593, 387, 735	1, 107, 797, 563	1, 701, 185, 29	기	l	J202. 00

Heal th Financial Systems

UNION HOSPITAL, INC.

In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0023
Form 01/01/2021
To 12/31/2021
Date/Time Prepared:

				10 12/31/2021	5/26/2022 10:	
			Title XVIII	Hospi tal	PPS	
	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
35.00	02040 I NTENSI VE NURSERY					35. 00
41.00	04100 SUBPROVI DER - I RF					41.00
43.00	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS	<u> </u>				1
50.00	05000 OPERATING ROOM	0. 134126				50.00
50. 01	05001 CARDI AC SURGERY	0. 599316				50. 01
50.02	05002 WVSC	0. 142609				50. 02
51.00	05100 RECOVERY ROOM	0. 313518				51.00
51. 02	05101 0/P TREATMENT ROOM	0. 662228				51. 02
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 350610				52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 218959				54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 178242				55. 00
56.00	05600 RADI 0I SOTOPE	0. 276166				56.00
57.00	05700 CT SCAN	0. 072560				57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 211939				58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 268946				59. 00
60.00	06000 LABORATORY	0. 132856				60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 532616				62.00
65.00	06500 RESPI RATORY THERAPY	0. 204577				65. 00
66.00	06600 PHYSI CAL THERAPY	0. 296395				66. 00
66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000				66. 01
66. 02	06602 0/P PHYSI CAL THERAPY	0. 299085				66. 02
67.00	06700 OCCUPATI ONAL THERAPY	0. 223741				67.00
68.00	06800 SPEECH PATHOLOGY	0. 280141				68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 089888				69. 00
69. 01	06901 CARDI AC REHAB	0. 628190				69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 547305				70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 248900				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 205671				73.00
76.00	03020 RENAL ACUTE	0. 563022				76. 00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLI NI C	0. 464040				90. 00
90.05	09005 PATIENT NUTRITION	1. 332539				90. 05
90. 07	09007 WOUND CLINIC	0. 244720				90. 07
91.00	09100 EMERGENCY	0. 117279				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 723176				92.00
200.00	Subtotal (see instructions)					200.00
201.00	Less Observation Beds					201. 00
202.00	Total (see instructions)					202. 00
						•

					0 12/31/2021	5/26/2022 10:	
			Ti tl	e XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	<b>'</b>	(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	65, 657, 516		65, 657, 516	0	65, 657, 516	30.00
31.00	03100 INTENSIVE CARE UNIT	15, 862, 754		15, 862, 754	. 0	15, 862, 754	31. 00
35.00	02040 I NTENSI VE NURSERY	4, 733, 539		4, 733, 539	o	4, 733, 539	35. 00
41.00	04100 SUBPROVI DER - I RF	3, 613, 960		3, 613, 960	o	3, 613, 960	41.00
43.00	04300 NURSERY	1, 534, 032		1, 534, 032	el ol	1, 534, 032	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	23, 820, 291		23, 820, 291	24, 865	23, 845, 156	50.00
50. 01	05001 CARDI AC SURGERY	3, 909, 524		3, 909, 524	. 0	3, 909, 524	50. 01
50.02	05002 WVSC	18, 154, 712		18, 154, 712	el ol	18, 154, 712	50. 02
51.00	05100 RECOVERY ROOM	3, 534, 141		3, 534, 141	o	3, 534, 141	51.00
51. 02	05101 0/P TREATMENT ROOM	2, 313, 123		2, 313, 123		2, 313, 123	51. 02
52.00	05200 DELIVERY ROOM & LABOR ROOM	8, 291, 176		8, 291, 176	o	8, 291, 176	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	16, 463, 520		16, 463, 520	3, 170	16, 466, 690	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	8, 996, 834		8, 996, 834	o	8, 996, 834	55. 00
56.00	05600 RADI OI SOTOPE	3, 155, 942		3, 155, 942	el ol	3, 155, 942	56. 00
57.00	05700 CT SCAN	4, 091, 390		4, 091, 390		4, 091, 390	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	3, 169, 984		3, 169, 984	. o	3, 169, 984	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	29, 021, 244		29, 021, 244		29, 021, 244	
60.00	06000 LABORATORY	13, 691, 231		13, 691, 231		13, 713, 776	60. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 909, 133		1, 909, 133		1, 909, 133	62. 00
65.00	06500 RESPI RATORY THERAPY	8, 083, 918	0	1		8, 083, 918	65. 00
66.00	06600 PHYSI CAL THERAPY	4, 556, 979	0			4, 556, 979	66. 00
66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0			0	66. 01
66. 02	06602 0/P PHYSI CAL THERAPY	2, 270, 147	0	2, 270, 147	ol	2, 270, 147	66. 02
67. 00	06700 OCCUPATI ONAL THERAPY	2, 765, 181	0			2, 765, 181	67. 00
68. 00	06800 SPEECH PATHOLOGY	1, 224, 313	0	1, 224, 313		1, 224, 313	
69.00	06900 ELECTROCARDI OLOGY	8, 174, 899		8, 174, 899		8, 174, 899	69. 00
69. 01	06901 CARDI AC REHAB	959, 576		959, 576		959, 576	
70. 00	07000 ELECTROENCEPHALOGRAPHY	2, 259, 118		2, 259, 118	1	2, 259, 118	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0				0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	12, 691, 575		12, 691, 575	o	12, 691, 575	
73.00	07300 DRUGS CHARGED TO PATIENTS	71, 473, 120		71, 473, 120	1	71, 473, 120	
76. 00	03020 RENAL ACUTE	2, 590, 970		2, 590, 970		2, 590, 970	
	OUTPATIENT SERVICE COST CENTERS	, , , , , ,			-1	, , , , , ,	
90.00	09000 CLI NI C	405, 249		405, 249	ol	405, 249	90. 00
90. 05	09005 PATIENT NUTRITION	264, 785		264, 785		266, 260	
90. 07	09007 WOUND CLINIC	2, 629, 498		2, 629, 498		2, 629, 498	
91. 00	09100 EMERGENCY	16, 808, 279		16, 808, 279		16, 808, 279	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	11, 159, 249		11, 159, 249		11, 159, 249	
200.00		380, 240, 902	0			380, 292, 957	
201.00	1	11, 159, 249		11, 159, 249		11, 159, 249	
202.00		369, 081, 653	0			369, 133, 708	
				,,		- , ,	

| Peri od: | Worksheet C | From 01/01/2021 | Part | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Da Provider CCN: 15-0023

					0 12/31/2021	5/26/2022 10:	
			Ti tl	e XIX	Hospi tal	Cost	.,
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Rati o	
		6. 00	7. 00	8. 00	9. 00	10. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	117, 856, 189		117, 856, 189			30. 00
31. 00	03100 I NTENSI VE CARE UNI T	34, 095, 203		34, 095, 203			31. 00
35. 00	02040 I NTENSI VE NURSERY	18, 678, 475		18, 678, 475			35. 00
41. 00	04100 SUBPROVI DER - I RF	5, 017, 326		5, 017, 326			41.00
43. 00	04300 NURSERY	2, 867, 220		2, 867, 220	)		43. 00
	ANCILLARY SERVICE COST CENTERS		100 050 000		0.400007	0.00000	
50.00	05000 OPERATING ROOM	55, 422, 053	122, 359, 220			0.000000	
50. 01	05001 CARDI AC SURGERY	6, 498, 308	25, 000			0.000000	
50. 02	05002 WVSC	104, 600	127, 199, 938			0.000000	
51.00	05100 RECOVERY ROOM	3, 273, 710	7, 998, 822			0.000000	
51. 02	05101 0/P TREATMENT ROOM	83, 558	3, 409, 383			0.000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	19, 507, 049	4, 140, 786			0.000000	
54.00	05400 RADI OLOGY - DI AGNOSTI C	19, 581, 576	55, 622, 922			0.000000	
55. 00	O5500   RADI OLOGY-THERAPEUTI C	2, 786, 997	47, 688, 356			0.000000	
56.00	05600 RADI OI SOTOPE	1, 282, 581	10, 145, 117			0.000000	
57. 00	05700 CT SCAN	16, 989, 921	39, 396, 727			0.000000	
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	2, 593, 631	12, 363, 452			0.000000	
59.00	05900   CARDI AC   CATHETERI ZATI ON   06000   LABORATORY	35, 508, 688	72, 398, 798			0.000000	59. 00 60. 00
60. 00 62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	55, 615, 051	47, 608, 056			0. 000000 0. 000000	62.00
65. 00	06500 RESPIRATORY THERAPY	3, 004, 102 36, 280, 957	580, 342			0. 000000	65.00
66. 00	06600 PHYSI CAL THERAPY	9, 837, 574	3, 234, 393 5, 537, 099			0. 000000	66. 00
66. 01	06601 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES	9,037,374	5, 557, 099		0. 296393	0. 000000	66. 01
66. 02	06602 0/P PHYSI CAL THERAPY	0	7, 590, 297			0. 000000	66. 02
67. 00	06700 OCCUPATIONAL THERAPY	7, 425, 538	4, 933, 311			0. 000000	67. 00
68. 00	06800 SPEECH PATHOLOGY	1, 455, 269	2, 915, 074			0. 000000	
69.00	06900 ELECTROCARDI OLOGY	17, 962, 862	72, 982, 404			0. 000000	69.00
69. 01	06901 CARDI AC REHAB	125, 353	1, 402, 172			0. 000000	
70. 00	07000 ELECTROENCEPHALOGRAPHY	885, 315	3, 242, 400			0. 000000	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	065, 315	3, 242, 400			0. 000000	
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	13, 599, 443	37, 391, 238			0. 000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	58, 426, 429	289, 084, 957			0. 000000	
76. 00	03020 RENAL ACUTE	4, 202, 926	398, 975		1	0. 000000	76.00
70.00	OUTPATIENT SERVICE COST CENTERS	4, 202, 920	370, 773	4,001,90	0. 303022	0.000000	70.00
90. 00	09000 CLINI C	1, 400	871, 907	873, 307	0. 464040	0. 000000	90.00
90. 05	09005 PATIENT NUTRITION	1, 100	199, 814			0. 000000	
90. 07	09007 WOUND CLINIC		10, 744, 937			0. 000000	
91. 00	09100 EMERGENCY	39, 151, 821	104, 167, 386			0. 000000	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 266, 610	12, 164, 280			0. 000000	
200.00				1, 701, 185, 298		2.000000	200.00
201.00	1 / /		, 21,111,000				201. 00
202.00	1 1	593, 387, 735	1, 107, 797, 563	1, 701, 185, 298	<sub>3</sub>		202. 00
						'	

Health Financial Systems

UNION HOSPITAL, INC.

In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0023
From 01/01/2021
To 12/31/2021
Date/Time Prepared:

				10 12/31/2021	Date/IIMe Pre   5/26/2022 10:	
			Title XIX	Hospi tal	Cost	47 (1111
	Cost Center Description	PPS Inpatient	THE XIX	nospi tui	0031	
	0001 00mtor 200011 pt 10m	Ratio				
		11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS					30.00
	03100 INTENSIVE CARE UNIT					31.00
35.00	02040 I NTENSI VE NURSERY					35. 00
41.00	04100 SUBPROVI DER - I RF					41.00
43.00	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS					1
50.00	05000 OPERATING ROOM	0.000000				50.00
50. 01	05001 CARDI AC SURGERY	0. 000000				50. 01
50. 02	05002 WVSC	0. 000000				50. 02
51.00	05100 RECOVERY ROOM	0. 000000				51.00
51. 02	05101 0/P TREATMENT ROOM	0. 000000				51. 02
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000				55.00
56.00	05600 RADI 0I SOTOPE	0. 000000				56.00
57.00	05700 CT SCAN	0. 000000				57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000				58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000				59. 00
60.00	06000 LABORATORY	0. 000000				60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000				62.00
65.00	06500 RESPI RATORY THERAPY	0. 000000				65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000				66.00
66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000				66. 01
66. 02	06602 0/P PHYSI CAL THERAPY	0. 000000				66. 02
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
68. 00	06800 SPEECH PATHOLOGY	0. 000000				68.00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000				69.00
69. 01	06901 CARDI AC REHAB	0. 000000				69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000				70.00
71. 00	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
76.00	03020 RENAL ACUTE	0. 000000				76.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLI NI C	0. 000000				90.00
90.05	09005 PATIENT NUTRITION	0. 000000				90. 05
90.07	09007 WOUND CLINIC	0. 000000				90. 07
91.00	09100 EMERGENCY	0. 000000				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92. 00
200.00	Subtotal (see instructions)					200. 00
201.00	Less Observation Beds					201. 00
202.00	Total (see instructions)					202. 00

Health Financial Systems	UNI ON HOSPI	TAL, INC.		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part I Date/Time Pre 5/26/2022 10:	pared: 49 am
		Titl∈	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26)		2)			
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	-					
30. 00 ADULTS & PEDI ATRI CS	6, 614, 185		-, ,			
31.00   INTENSIVE CARE UNIT	2, 482, 005		2, 482, 00			
35. 00   I NTENSI VE NURSERY	419, 797		419, 79			35. 00
41. 00   SUBPROVI DER - I RF	460, 760	0	460, 76			
43. 00 NURSERY	25, 733		25, 73	3 2, 814	9. 14	43.00
200.00 Total (lines 30 through 199)	10, 002, 480		10, 002, 48	0 84, 515		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)	1			
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	22, 005					30. 00
31.00 INTENSIVE CARE UNIT	3, 128	956, 480	)			31. 00
35. 00   I NTENSI VE NURSERY	0	0	1			35. 00
41. 00 SUBPROVI DER - I RF	1, 920	199, 238	3			41.00
43. 00 NURSERY	0	1	)			43. 00
200.00 Total (lines 30 through 199)	27, 053	3, 393, 406				200. 00

1, 680, 892

233, 356

98, 912

17, 754

101, 956

18,864

50, 124

276, 640

949, 341

24, 715, 307 1, 522, 670, 885

1, 124, 160

1, 619, 250

90, 945, 266

1, 527, 525

4, 127, 715

50, 990, 681

4, 601, 901

873, 307

199, 814

10.744.937

143, 319, 207

15, 430, 890

347, 511, 386

0.018482

0.152767

0.023963

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0.022155

0.021601

0.250853

0.025746

0.006624

0.072851

7, 641, 970

59, 046

379, 271

6, 202, 181

21, 708, 519

2, 057, 254

15, 787, 645

1, 585, 215

160, 488, 309

0

0

141, 239

9,020

9,088

2, 158

101, 162

104, 577

115, 484

45, <u>5</u>78

0 71.00

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0 90.07

2, 377, 479 200. 00

69.00

69.01

70.00

72.00

73.00

76.00

90 00

90.05

91.00

92.00

06900 ELECTROCARDI OLOGY

09005 PATIENT NUTRITION

07000 ELECTROENCEPHALOGRAPHY

07300 DRUGS CHARGED TO PATIENTS

OUTPATIENT SERVICE COST CENTERS

07100 MEDICAL SUPPLIES CHARGED TO PATIENTS

09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (lines 50 through 199)

07200 IMPL. DEV. CHARGED TO PATIENTS

06901 CARDI AC REHAB

03020 RENAL ACUTE

09007 WOUND CLINIC

09100 EMERGENCY

09000 CLI NI C

69.00

69.01

70. 00 71. 00

72.00

73.00

76.00

90 00

90.05

90 07

91.00

92.00

200.00

Health Financial Systems	UNION HOSPI	TAL, INC.		In Lie	eu of Form CMS	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA		S Provider CO		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part III Date/Time Pre 5/26/2022 10:	pared:
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Post-Stepdow Adjustments		All Other Medical Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   INTENSIVE CARE UNIT 35. 00   02040   INTENSIVE NURSERY 41. 00   04100   SUBPROVIDER - IRF	0 0	0 0 0		0 0 0 0 0 0	0 0 0 0	31. 00 35. 00
43. 00   04300   NURSERY 200. 00   Total (Lines 30 through 199)	0	0		0 0	0	
Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patien Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   INTENSIVE CARE UNIT 35. 00   02040   INTENSIVE NURSERY 41. 00   04100   SUBPROVI DER -   RF 43. 00   04300   NURSERY	0	0 0 0 0	8, 11 4, 10 4, 44	7 0.00 0 0.00 0 0.00	3, 128 0 1, 920	31. 00 35. 00 41. 00
200.00 Total (lines 30 through 199)		0				200.00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						1
30. 00   03000   ADULTS & PEDI ATRI CS 31. 00   03100   INTENSI VE CARE UNI T 35. 00   02040   INTENSI VE NURSERY 41. 00   04100   SUBPROVI DER -   IRF	0 0 0					30. 00 31. 00 35. 00 41. 00
43.00   04300   NURSERY 200.00   Total (lines 30 through 199)	0					43. 00 200. 00

Health Financial Systems	UNION HOSPITAL, INC.	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT A	ANCILLARY SERVICE OTHER PASS   Provider CCN: 15-0023	Peri od: Worksheet D

From 01/01/2021 Part IV
To 12/31/2021 Date/Time Prepared: THROUGH COSTS 5/26/2022 10:49 am Title XVIII Hospi tal PPS Nursi ng Cost Center Description Non Physician Nursi ng Allied Health Allied Health Anestheti st Post-Stepdown Program Program Post-Stepdown Cost Adi ustments Adjustments 1.00 3. 00 2A 2.00 ЗА ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 0 0000000000000000000000000000000 0 50.01 05001 CARDI AC SURGERY 50.01 0 0 50.02 05002 WVSC 0 50.02 05100 RECOVERY ROOM 0 0 51.00 0 51.00 05101 0/P TREATMENT ROOM 0 0 51.02 51.02 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 123, 536 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 55.00 01 05600 RADI OI SOTOPE 0 56.00 56.00 0 57.00 05700 CT SCAN 0 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 05900 CARDIAC CATHETERIZATION 0 0 59.00 59.00 0 0 06000 LABORATORY 0 60.00 60.00 0 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 62.00 06500 RESPIRATORY THERAPY 0 0 65.00 65.00 0 06600 PHYSI CAL THERAPY 0 0 66 00 66 00 0 66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 66.01 66.02 06602 0/P PHYSI CAL THERAPY 0 0 0 66.02 06700 OCCUPATIONAL THERAPY 67.00 67.00 06800 SPEECH PATHOLOGY 0 0 68.00 68 00 0 06900 ELECTROCARDI OLOGY 0 69.00 0 0 69.00 06901 CARDI AC REHAB 69.01 69.01 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 481, 298 73.00 73.00 03020 RENAL ACUTE 0 76.00 0 0 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 0 0 90.00

0 0 0

0

0

0

0

0

0

0

0

0

0 91.00

604, 834 200. 00

90.05

0 90.07

92.00

0 0 0

0

0

09005 PATIENT NUTRITION

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

Total (lines 50 through 199)

09007 WOUND CLINIC

09100 EMERGENCY

90.05

90.07

91.00

200.00

Health Financial Systems	Ith Financial Systems UNION HOSPITAL,				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEITHROUGH COSTS	RVICE OTHER PASS	Provi der Co		Period: From 01/01/2021	Worksheet D Part IV	
111100011 00313				To 12/31/2021	Date/Time Prep 5/26/2022 10:	oared: 49 am
		Title	: XVIII	Hospi tal	PPS	
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)	
					,	

						3/20/2022 10.	47 4111
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total		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 OPERATING ROOM	0	0	(	177, 781, 273	0.000000	50.00
50. 01	05001 CARDI AC SURGERY	0	0	(	6, 523, 308	0.000000	50. 01
50. 02	05002 WVSC	0	0	(	127, 304, 538	0.000000	50. 02
51.00	05100 RECOVERY ROOM	0	0	(	11, 272, 532	0.000000	51.00
51. 02	05101 O/P TREATMENT ROOM	0	0	(	3, 492, 941	0.000000	51. 02
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(	23, 647, 835	0.000000	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	123, 536	123, 536	75, 204, 498	0.001643	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		50, 475, 353		55. 00
56. 00	05600 RADI OI SOTOPE	0	0				
57. 00	05700 CT SCAN	0	0		56, 386, 648		1
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		14, 957, 083		
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	(	107, 907, 486		
60.00	06000 LABORATORY	0	0				
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		3, 584, 444		
65. 00	06500 RESPI RATORY THERAPY	0	0	(	39, 515, 350		
66. 00	06600 PHYSI CAL THERAPY	0	0		15, 374, 673		
66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0	0. 000000	
66. 02	06602 O/P PHYSI CAL THERAPY	0	0		7, 590, 297	1	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0				
68. 00	06800 SPEECH PATHOLOGY	0	l o		4, 370, 343		
69. 00	06900 ELECTROCARDI OLOGY	0	l ő		90, 945, 266		
69. 01	06901 CARDI AC REHAB	0	0	ì	1, 527, 525		
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	ì	4, 127, 715		
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	ì	1, 127, 710	0. 000000	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	l o	ì	50, 990, 681	0. 000000	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	481, 298	l .			
76. 00	03020 RENAL ACUTE	0	0			0.000000	
70.00	OUTPATIENT SERVICE COST CENTERS		<u> </u>		7, 001, 701	0.000000	70.00
90. 00		0	0		873, 307	0.000000	90.00
90.05	09005 PATIENT NUTRITION				199, 814		
90. 03	09007 WOUND CLINIC				10, 744, 937		
91. 00	09100 EMERGENCY						1
91.00							
200.00			604, 834		15, 430, 890		200.00
200.00	of frotal (Tries 50 till ough 199)	1	1 004, 034	1 004, 034	1, 322, 070, 003	I	<sub>1</sub> 200.00

	Financial Systems	UNION HOSPITA				eu of Form CMS-2	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER CH COSTS	RVICE OTHER PASS	Provi der Co		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Pre	
-			T	V0.01.1		5/26/2022 10:	<u>49 am</u>
	Cook Cooker Decorientian	0		XVIII	Hospi tal	PPS	
	Cost Center Description	Outpatient Ratio of Cost	Inpatient Program	Inpatient Program	Outpatient Program	Outpatient Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.	chai ges	Costs (col. 8		Costs (col. 9	
		7)				,	
		9, 00	10. 00	x col. 10) 11.00	12.00	x col . 12) 13.00	
	ANCILLARY SERVICE COST CENTERS	9.00	10.00	11.00	12.00	13.00	
50. 00	05000 OPERATING ROOM	0. 000000	23, 641, 982		0 30, 369, 981	0	50.00
50. 00	05001 CARDI AC SURGERY	0.000000	2, 622, 674		0 24, 056	1	
50. 01	05002 WVSC	0. 000000	103, 800		0 29, 741, 298		
51. 00	05100 RECOVERY ROOM	0. 000000	1, 385, 846		0 2, 098, 816		51.00
51. 00	05101 0/P TREATMENT ROOM	0. 000000	7, 676		0 1, 256, 615		
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	57, 941		0 1, 250, 615		
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 001643	8, 306, 149				
55. 00	05500 RADI OLOGY-THERAPEUTI C	0.001043	876, 870		0 19, 361, 582		
56. 00	05600 RADI OLOGI - ITIERAF LUTT C	0. 000000	758, 463		0 4, 053, 979	<b>l</b>	
57. 00	05700 CT SCAN	0. 000000	7, 417, 049		0 11, 131, 425		
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0.000000	959, 410		0 2, 907, 748		58.00
59. 00	05900 CARDIAC CATHETERIZATION	0. 000000	15, 886, 313		0 31, 830, 644		
60.00	06000 LABORATORY	0. 000000	22, 094, 565		0 7, 802, 166		
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	1, 186, 786		0 266, 574	l	
65. 00	06500 RESPIRATORY THERAPY	0. 000000	13, 766, 416		0 697, 703	l	65.00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	3, 415, 001		0 135, 762	l	66.00
66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	3, 413, 001		0 135, 762		
66. 02	06602 0/P PHYSICAL THERAPY	0. 000000	0		0 0	0	66. 02
67. 00	06700 OCCUPATIONAL THERAPY	0. 000000	2, 091, 045		0 60, 886		67.00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	489, 222		0 44, 178	l e	
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	7, 641, 970		0 24, 886, 308		
69. 00	06901 CARDI AC REHAB	0. 000000	7, 641, 970 59, 046		0 24, 666, 306		69. 01
70. 00	07000 ELECTROENCEPHALOGRAPHY	1					70.00
70.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000 0. 000000	379, 271 0		0 641, 276 0 0	l	
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	6, 202, 181		0 11, 435, 637		1
72.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	6, 202, 181 21, 708, 519				73.00
76.00	03020 RENAL ACUTE	0.001385				1	
70.00	OUTPATIENT SERVICE COST CENTERS	0.000000	2, 057, 254	l	0 121, 652	1 0	1 /6.00
00 00	001PATTENT SERVICE COST CENTERS	0.000000	0		0 /13 793	0	90 00

0.000000

0. 000000 0. 000000

0. 000000

0.000000

90.00

90. 05 90. 07

91.00

0

0

0 92.00

197, 714 200. 00

413, 783

3, 742, 248

17, 040, 020

2, 335, 545

343, 535, 535

0

0

0

43, 713

0

15, 787, 645

1, 585, 215

160, 488, 309

90.00

200.00

09000 CLI NI C

91. 00 09100 EMERGENCY

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

Total (lines 50 through 199)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0023 Peri od: Worksheet D From 01/01/2021 Part V Date/Time Prepared: 12/31/2021 5/26/2022 10:49 am Title XVIII Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From 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 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 133987 30, 369, 981 4, 069, 183 50.00 50.01 05001 CARDI AC SURGERY 0.599316 24, 056 0 0 14, 417 50.01 05002 WVSC 29, 741, 298 0 0 4, 241, 377 50 02 0 142609 50 02 0 0 51.00 05100 RECOVERY ROOM 0. 313518 2,098,816 658, 017 51.00 51.02 05101 0/P TREATMENT ROOM 0.662228 1, 256, 615 832, 166 51.02 05200 DELIVERY ROOM & LABOR ROOM 0.350610 0 0 52 00 1 107 388 52 00 |05400| RADI OLOGY-DI AGNOSTI C 11, 949, 115 0 54.00 0.218917 2, 615, 864 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.178242 19, 361, 582 3, 451, 047 55.00 0 56.00 05600 RADI OI SOTOPE 0. 276166 4, 053, 979 0 1, 119, 571 56.00 0 05700 CT SCAN 807, 696 57 00 0.072560 11, 131, 425 57 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0. 211939 2, 907, 748 616, 265 58.00 05900 CARDIAC CATHETERIZATION 0. 268946 31, 830, 644 0 0 0 0 0 0 0 0 0 0 0 8, 560, 724 59.00 59.00 06000 LABORATORY 7, 802, 166 0 1, 034, 856 60.00 0.132637 60.00 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 0.532616 266, 574 141, 982 62.00 65.00 06500 RESPIRATORY THERAPY 0. 204577 697, 703 0 142, 734 65.00 06600 PHYSI CAL THERAPY 0. 296395 40, 239 66.00 135, 762 66.00 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0.000000 0 66, 01 C 66.01 0 0 06602 0/P PHYSI CAL THERAPY 0.299085 66.02 0 66.02 67.00 06700 OCCUPATIONAL THERAPY 0. 223741 60,886 13, 623 67.00 06800 SPEECH PATHOLOGY 0 68.00 0. 280141 44, 178 12, 376 68.00 06900 ELECTROCARDI OLOGY 0 69.00 0.089888 24, 886, 308 2, 236, 980 69.00 0 06901 CARDI AC REHAB 381, 078 69.01 0.628190 606, 628 69 01 07000 ELECTROENCEPHALOGRAPHY 0.547305 641, 276 0 0 350, 974 70.00 70.00 o 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.248900 11, 435, 637 0 2, 846, 330 72.00 72.00 0 452, 247 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 205671 128, 578, 803 26, 444, 931 73.00 03020 RENAL ACUTE 0.563022 68, 493 76.00 121, 652 0 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0.464040 90.00 413, 783 0 192, 012 0 90.05 09005 PATIENT NUTRITION 1. 325157 0 90.05 09007 WOUND CLINIC 0 90.07 0. 244720 3, 742, 248 0 915, 803 90.07 09100 EMERGENCY 0 0.117279 17, 040, 020 0 1, 998, 437 91.00 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0. 723176 2, 335, 545 1, 689, 010 92.00 200.00 Subtotal (see instructions) 343, 535, 535 0 452, 247 65, 496, 573 200.00 Less PBP Clinic Lab. Services-Program 0 201.00 201.00 Only Charges

0

452, 247

343, 535, 535

65, 496, 573 202. 00

202.00

Net Charges (line 200 - line 201)

 
 Heal th Financial
 Systems
 UNION HOSPI

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

					10 12/31/2021	5/26/2022 10:	
			Title	XVIII	Hospi tal	PPS	
		Cos	sts				
	Cost Center Description	Cost	Cost	1			
		Rei mbursed	Rei mbursed				
		Servi ces	Servi ces Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00	1			İ
A	ANCILLARY SERVICE COST CENTERS	•	<u> </u>				
	05000 OPERATING ROOM	0	0				50.00
50. 01	05001 CARDI AC SURGERY	0	0				50. 01
	05002 WVSC	0	0				50. 02
	05100 RECOVERY ROOM	0	0				51. 00
	05101 O/P TREATMENT ROOM	0	0				51. 02
	05200 DELIVERY ROOM & LABOR ROOM	0	0	1			52. 00
	05400 RADI OLOGY-DI AGNOSTI C	0	1				54. 00
	05500 RADI OLOGY-THERAPEUTI C		0	1			55. 00
	05600 RADI OI SOTOPE	0	0	l .			56.00
	05700 CT SCAN		0	1			57.00
1	05800 MAGNETIC RESONANCE IMAGING (MRI)		0	1			58.00
1	05900 CARDI AC CATHETERI ZATI ON			1			59.00
	06000 LABORATORY	0	0	•			60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		1	1			62.00
	06500 RESPIRATORY THERAPY	0					65. 00
	06600 PHYSI CAL THERAPY		1	1			66.00
1	· ·	0		1			1
1	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0		1			66. 01
	06602 O/P PHYSI CAL THERAPY	0		1			66. 02
	06700 OCCUPATI ONAL THERAPY	0	1	1			67. 00
	06800 SPEECH PATHOLOGY	0	0	1			68. 00
	06900 ELECTROCARDI OLOGY	0	0				69. 00
	06901 CARDI AC REHAB	0	0				69. 01
	07000 ELECTROENCEPHALOGRAPHY	0	0	•			70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	•			71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0		1			72. 00
	07300 DRUGS CHARGED TO PATIENTS	0		1			73. 00
	03020 RENAL ACUTE	0	0				76. 00
	OUTPATIENT SERVICE COST CENTERS						- 00 00
	09000 CLINIC	0					90.00
	09005 PATIENT NUTRITION	0	1	1			90. 05
	09007 WOUND CLINIC	0	1	ł			90. 07
	09100 EMERGENCY	0	0	1			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	1			92.00
200.00	Subtotal (see instructions)	0	93, 014				200. 00
201. 00	Less PBP Clinic Lab. Services-Program	0					201. 00
000 60	Only Charges		00.01.				000 00
202. 00	Net Charges (line 200 - line 201)	0	93, 014				202. 00

Heal th	Financial Systems	UNION HOSPI	TAL. INC.		In Lie	eu of Form CMS-:	2552-10
	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA			CN: 15-0023	Peri od:	Worksheet D	
					From 01/01/2021	Part II	
			·	CCN: 15-T023	To 12/31/2021	Date/Time Pre 5/26/2022 10:	pared: 49 am
				e XVIII	Subprovi der – I RF	PPS	
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,			. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
	T	1. 00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						1
50. 00	05000 OPERATI NG ROOM	4, 355, 673				796	
50. 01	05001 CARDI AC SURGERY	379, 936				207	50. 01
50. 02	05002 WVSC	2, 101, 348	127, 304, 538	0. 01650	159	3	50. 02
51.00	05100 RECOVERY ROOM	123, 740	11, 272, 532	0. 01097	7 0	0	51. 00
51. 02	05101 O/P TREATMENT ROOM	686, 613	3, 492, 941	0. 19657	2 0	0	51. 02
52.00	05200 DELIVERY ROOM & LABOR ROOM	923, 624	23, 647, 835	0. 03905	57 26	1	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 191, 095	75, 204, 498	0.04243	79, 265	3, 363	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	1, 798, 483	50, 475, 353	0. 03563	0	0	55.00
56.00	05600 RADI OI SOTOPE	799, 314	11, 427, 698	0. 06994	5 0	0	56.00
57.00	05700 CT SCAN	534, 493	56, 386, 648	0.00947	49, 561	470	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	979, 266	14, 957, 083	0.06547	2 5, 325	349	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	1, 483, 139	107, 907, 486	0. 01374	5 22, 464	309	59.00
60.00	06000 LABORATORY	67, 837	103, 223, 107	0.00065	342, 026	225	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	2, 357	3, 584, 444	0.00065	13, 007	9	62.00
65. 00	06500 RESPIRATORY THERAPY	611, 828		1		5, 524	65.00
66. 00	06600 PHYSI CAL THERAPY	280, 901				20, 037	66.00
66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0				0	
66. 02	06602 0/P PHYSI CAL THERAPY	92, 548	_	1		Ö	
67. 00	06700 OCCUPATI ONAL THERAPY	46, 823		1		4, 200	
68. 00	06800 SPEECH PATHOLOGY	85, 040		1		4, 017	
69. 00	06900 ELECTROCARDI OLOGY	1, 680, 892		1		426	1
69. 01	06901 CARDI AC REHAB	233, 356		1		0	
70. 00	07000 ELECTROENCEPHALOGRAPHY	98, 912		1		27	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	70, 712		1		0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	17, 754	_			0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 619, 250				981	
76. 00	03020 RENAL ACUTE			1			
76.00		101, 956	4, 601, 901	0.02213	55 114, 115	2, 528	76.00
00.00	OUTPATIENT SERVICE COST CENTERS	10.074	070 007	0.00446	11	_	00.00
90.00	09000 CLINIC	18, 864				0	
90.05	09005 PATIENT NUTRITION	50, 124				0	
90. 07	09007 WOUND CLINIC	276, 640				0	
91.00	09100 EMERGENCY	949, 341		1		102	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	00 501 117				0	
200.00	Total (lines 50 through 199)	23, 591, 147	1, 522, 670, 885	1	3, 680, 683	43, 574	200. 00

APPORT	Financial Systems IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF H COSTS	UNION HOSPI RVICE OTHER PASS	Provi der Co	CN: 15-0023 CCN: 15-T023	Peri od: From 01/01/202 To 12/31/202		pared:
			Title	XVIII	Subprovider -	PPS	
	Cost Center Description		Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Post-Stepdowr Adjustments		
	ANOLLI ADV. CEDVI CE. COCT. CENTEDO	1.00	2A	2.00	3A	3. 00	
EO 00	ANCILLARY SERVICE COST CENTERS    05000   OPERATING ROOM	l ol	^		0	0 (	50.00
50. 00 50. 01	05000 OPERATING ROOM 05001 CARDI AC SURGERY	0	0		-	0 0	
50. 01	05002 WVSC		0		0		
51. 00	05100 RECOVERY ROOM		0		0		51.00
51. 02	05101 0/P TREATMENT ROOM		0		0		
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0			o o	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	o	0		-	123, 536	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	1
56. 00	05600 RADI 0I SOTOPE	0	0		0	0	56.00
57. 00	05700 CT SCAN	0	0		0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	59. 00
60.00	06000 LABORATORY	0	0		9	0	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	0	
65.00	06500 RESPI RATORY THERAPY	0	0		9	0	
66.00	06600 PHYSI CAL THERAPY	0	0		0	0	
66. 01 66. 02	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 06602 0/P PHYSI CAL THERAPY	0	0		0	0 0	1
67. 00	06700 OCCUPATIONAL THERAPY		0		0		
68. 00	06800 SPEECH PATHOLOGY		0		0		
69. 00	06900 ELECTROCARDI OLOGY		0		0		
69. 01	06901 CARDI AC REHAB		0		0		
70. 00	07000 ELECTROENCEPHALOGRAPHY	o	0		ō	ol o	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	481, 298	73.00
76. 00	03020 RENAL ACUTE	0	0		0	0 0	76. 00
	OUTPATIENT SERVICE COST CENTERS						
90. 00	09000 CLINIC	0	0			0	
90. 05	09005 PATI ENT NUTRI TI ON	0	0		-	0	
90. 07	09007 WOUND CLINIC	0	0		-	0	
91. 00 92. 00	09100 EMERGENCY	0	0		0	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1 01		I	O	1 0	92.00

	Financial Systems    ONMENT OF   NPATIENT/OUTPATIENT ANCILLARY SE	UNI ON HOSPI		CN. 1E 0022	In Lie	u of Form CMS-2 Worksheet D	2552-10
	H COSTS	RVICE UTHER PASS		CCN: 15-T023	From 01/01/2021 Part IV To 12/31/2021 Date/Ti me 5/26/2022		pared: 49 am
			Title	· XVIII	Subprovider - IRF	PPS	.,
	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 OPERATING ROOM	0		l .	0 177, 781, 273	0. 000000	
50. 01	05001 CARDI AC SURGERY	0	0		0 6, 523, 308	0. 000000	1
50. 02	05002 WVSC	0	0		0 127, 304, 538	0. 000000	
51. 00	05100 RECOVERY ROOM	0	0		0 11, 272, 532	0. 000000	1
51. 02	05101 0/P TREATMENT ROOM	0	0		0 3, 492, 941	0. 000000	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 23, 647, 835	0. 000000	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	123, 536	123, 53		0. 001643	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 50, 475, 353	0. 000000	
56. 00	05600 RADI OI SOTOPE	0	0		0 11, 427, 698	0. 000000	1
57. 00	05700 CT SCAN	0	0		0 56, 386, 648	0. 000000	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 14, 957, 083	0. 000000	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 107, 907, 486	0. 000000	
60.00	06000 LABORATORY	0	0		0 103, 223, 107	0. 000000	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 3, 584, 444	0. 000000	
65.00	06500 RESPI RATORY THERAPY	0	0		0 39, 515, 350	0. 000000	
66.00	06600 PHYSI CAL THERAPY	0	0		0 15, 374, 673	0. 000000	1
66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 0	0.000000	1
66. 02	06602 O/P PHYSI CAL THERAPY	0	0		0 7, 590, 297	0.000000	
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 12, 358, 849	0.000000	1
68. 00	06800 SPEECH PATHOLOGY	0	0		0 4, 370, 343	0.000000	
69. 00	06900 ELECTROCARDI OLOGY	0	0		0 90, 945, 266 0 1 527 525	0.000000	1
69. 01	06901 CARDI AC REHAB	0	0		., 02,, 020	0.000000	1
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 4, 127, 715	0.000000	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 50, 990, 681	0.000000	1
	07300 DRUGS CHARGED TO PATIENTS	0	401 200	401 20		0.000000	1
	03020 RENAL ACUTE	0			98 347, 511, 386 0 4, 601, 901	0. 001385 0. 000000	
76.00	OUTPATIENT SERVICE COST CENTERS		0		0 4, 601, 901	0.000000	76.00
90. 00	09000 CLINIC	0	0		0 873, 307	0. 000000	90.00
90.00	09005 PATIENT NUTRITION	0		1	0 199, 814		
90.03	09007 WOUND CLINIC	0			0 10, 744, 937	0.000000	
90.07	09100 EMERGENCY	0	0		0 143, 319, 207	0. 000000	1
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	_		0 15, 430, 890	0.000000	
	O / ZOO   ODGERVATION DEDG (NON-DIGITNOI FARI)		ı	1	0, 10, 400, 070	0.00000	1 72.00

	5					6.5	
	Financial Systems	UNI ON HOSPITA	<u>i</u>			eu of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	Provi der Co	UN: 15-0023	Peri od: From 01/01/2021	Worksheet D	
THROUG	H COSTS		Component	CCN: 15-T023	To 12/31/2021	Part IV Date/Time Pre 5/26/2022 10:	pared: 49 am
			Title	· XVIII	Subprovider - IRF	PPS	
	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	n Charges	Pass-Through	
		(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10.00	11. 00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0.000000	32, 470		0 0	0	50.00
50. 01	05001 CARDI AC SURGERY	0. 000000	3, 549		0 0	0	50. 01
50. 02	05002 WVSC	0. 000000	159		0 0	0	
51. 00	05100 RECOVERY ROOM	0. 000000	0	•		Ö	
51. 00	05101 0/P TREATMENT ROOM	0. 000000	0	l .	0 530	0	51.00
52. 00	1 I	0. 000000	-		0 0		
	05200 DELIVERY ROOM & LABOR ROOM	1	26	l .		0	1
54.00	05400 RADI OLOGY - DI AGNOSTI C	0. 001643	79, 265	1		0	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0	l .	0	0	1
56. 00	05600 RADI OI SOTOPE	0. 000000	0		0 0	0	56. 00
57. 00	05700 CT SCAN	0. 000000	49, 561	•	0	0	1
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	5, 325	•	0	0	58. 00
59. 00	05900  CARDI AC CATHETERI ZATI ON	0. 000000	22, 464	l .	0	0	
60.00	06000 LABORATORY	0. 000000	342, 026		0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	13, 007		0 0	0	62.00
65.00	06500 RESPI RATORY THERAPY	0. 000000	356, 798		0 0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000	1, 096, 720		0 0	0	66. 00
66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	0		0 0	0	66. 01
66. 02	06602 0/P PHYSI CAL THERAPY	0. 000000	0		0 0	0	66. 02
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	1, 108, 487		0 0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	206, 450	•	0 0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	23, 061	•	0 0	Ö	69. 00
69. 01	06901 CARDI AC REHAB	0. 000000	20, 001		0 0	Ö	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	1, 133		0 0	Ö	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	1, 133		0 0		
71.00	l	0. 000000	0		0 0		
	07200 I MPL. DEV. CHARGED TO PATIENTS	l I	210 502	20	-		
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 001385	210, 593	•		0	1
76. 00	03020 RENAL ACUTE	0. 000000	114, 115		0 0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS			ı			
90. 00	09000 CLI NI C	0. 000000	0	•	0		
90. 05	09005 PATIENT NUTRITION	0. 000000	0	•	0	0	
90. 07	09007 WOUND CLINIC	0. 000000	0		0	0	
91. 00	09100 EMERGENCY	0. 000000	15, 474		0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92.00
200.00	Total (lines 50 through 199)		3, 680, 683	42	22 530	0	200. 00
		·					

Health Financial Systems	UNION HOSPITAL	In Lieu of Form CMS-2552-1		
APPORTIONMENT OF MEDICAL, OTHER H	HEALTH SERVICES AND VACCINE COST	Provi der CCN: 15-0023 Component CCN: 15-T023	From 01/01/2021 To 12/31/2021	
		T: +1 a V/// / /	Cubasavidas	DDC

					5/26/2022 10:	49 am
		Title	XVIII	Subprovi der - I RF	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	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						1
50. 00   05000   OPERATI NG ROOM	0. 133987	0		0		
50. 01  05001   CARDI AC SURGERY	0. 599316	0		0	0	50. 01
50. 02  05002  WVSC	0. 142609	0	(	0	0	50. 02
51.00  05100 RECOVERY ROOM	0. 313518	0	(	0	0	51. 00
51.02  05101 0/P TREATMENT ROOM	0. 662228	530	(	0	351	1
52.00  05200   DELIVERY ROOM & LABOR ROOM	0. 350610	0	(	0	0	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 218917	0	(	0	0	54.00
55. 00   05500   RADI OLOGY-THERAPEUTI C	0. 178242	0	(	0	0	55. 00
56. 00   05600   RADI 0I SOTOPE	0. 276166	0	(	0	0	56. 00
57.00  05700 CT SCAN	0. 072560	0	(	0	0	57. 00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0. 211939	0	(	0	0	58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0. 268946	0	(	0	0	59. 00
60. 00  06000 LABORATORY	0. 132637	0	(	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 532616	0	(	0	0	62. 00
65. 00  06500 RESPIRATORY THERAPY	0. 204577	0	(	0	0	65. 00
66. 00  06600 PHYSI CAL THERAPY	0. 296395	0	(	0	0	66. 00
66. 01   06601   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	0	(	0	0	66. 01
66. 02   06602   0/P PHYSI CAL THERAPY	0. 299085	0	(	0	0	66. 02
67. 00  06700 OCCUPATI ONAL THERAPY	0. 223741	0	(	0	0	67. 00
68. 00  06800 SPEECH PATHOLOGY	0. 280141	0	(	0	0	68. 00
69. 00  06900  ELECTROCARDI OLOGY	0. 089888	0	(	0	0	69. 00
69. 01  06901  CARDI AC REHAB	0. 628190	0	(	0	0	69. 01
70. 00   07000   ELECTROENCEPHALOGRAPHY	0. 547305	0	(	0	0	70. 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. 248900	0		0	-	72. 00
73.00   07300   DRUGS CHARGED TO PATIENTS	0. 205671	0	(	934	0	73. 00
76. 00 03020 RENAL ACUTE	0. 563022	0	(	0	0	76. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00  09000  CLI NI C	0. 464040	0		0	0	90.00
90. 05   09005   PATIENT NUTRITION	1. 325157	0	(	0	0	90. 05
90. 07  09007   WOUND CLINIC	0. 244720	0	(	0	0	90. 07
91. 00  09100 EMERGENCY	0. 117279	0	(	0	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 723176	0	(	0	0	92. 00
200.00 Subtotal (see instructions)		530		934	351	200. 00
201.00 Less PBP Clinic Lab. Services-Program				0		201. 00
Only Charges						
202.00   Net Charges (line 200 - line 201)		530	(	934	351	202. 00

Health Financial Systems		UNION HOSPITAL	, INC.	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND	VACCINE COST	Provider CCN: 15-0023	Peri od: From 01/01/2021	Worksheet D Part V
			Component CCN: 15-T023	To 12/31/2021	Date/Time Prepared: 5/26/2022 10:49 am
			Title XVIII	Subprovi der -	PPS

		Title	· XVIII	Subprovi der - I RF	PPS	
	Cos	sts		TIM		
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Servi ces Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.) 6.00	(see inst.) 7.00				
ANCI LLARY SERVI CE COST CENTERS	6.00	7.00				
50. 00 05000 OPERATING ROOM	0	0				50.00
50. 01   05001   CARDI AC SURGERY	0					50. 01
50. 02   05002   WVSC	0		1			50. 02
51.00 05100 RECOVERY ROOM	0	0				51.00
51.02 05101 0/P TREATMENT ROOM	0	0				51. 02
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0				52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0				54. 00
55. 00   05500   RADI OLOGY-THERAPEUTI C	0	0				55. 00
56. 00   05600   RADI 0I SOTOPE	0	0				56. 00
57. 00   05700   CT   SCAN	0	1				57. 00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	1				59. 00
60. 00   06000   LABORATORY	0		•			60.00
62.00   06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 65.00   06500 RESPIRATORY THERAPY	0	1				62. 00 65. 00
66. 00   06600   PHYSI CAL THERAPY			•			66.00
66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	-				66. 01
66. 02 06602 0/P PHYSI CAL THERAPY	0	1				66. 02
67. 00 06700 OCCUPATI ONAL THERAPY	0	1	1			67. 00
68. 00 06800 SPEECH PATHOLOGY	0	Ö				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69. 00
69. 01 06901 CARDI AC REHAB	0	0				69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	_	I			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0		1			73. 00
76. 00 03020 RENAL ACUTE	0	0				76. 00
OUTPATIENT SERVICE COST CENTERS	_		1			
90. 00   09000   CLINIC	0		1			90.00
90. 05   09005   PATI ENT NUTRI TI ON 90. 07   09007   WOUND CLI NI C	0	0	1			90. 05 90. 07
91. 00   09100   EMERGENCY	0	0	1			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		ł			92.00
200.00 Subtotal (see instructions)		192	1			200.00
201.00 Less PBP Clinic Lab. Services-Program	0	1				201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	192				202. 00
	•	•				•

Health Financial Systems	In Lieu of Form CMS-2552-10				
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0023	Peri od: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Preps/26/2022 10:4	pared:	
	Title XVIII	Hospi tal	PPS	.,	
Cost Center Description					
			1. 00		

		Title XVIII	Hospi tal	5/26/2022 10: PPS	49 am_
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS				
1. 00 2. 00 3. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-leprivate room days (excluding swing-bed and observation bed day do not complete this line.	ped and newborn days)	vate room days,	65, 044 65, 044 0	1. 00 2. 00 3. 00
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roof reporting period		r 31 of the cost	53, 989 0	4. 00 5. 00
6. 00	Total swing-bed SNF type inpatient days (including private rooreporting period (if calendar year, enter 0 on this line)		0	6. 00	
7. 00	Total swing-bed NF type inpatient days (including private roor reporting period	m days) through December	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)			0	8. 00
9. 00	Total inpatient days including private room days applicable to newborn days) (see instructions)	o the Program (excluding	swi ng-bed and	22, 005	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruc-	tions)		0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, en	nter O on this line)	3 /	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	only (including private	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI) after December 31 of the cost reporting period (if calendar ye	ear, enter O on this line	e)	0	13. 00
14. 00 15. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	0	14. 00 15. 00		
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT	0	16. 00		
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	0.00	17. 00		
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	0. 00	18. 00		
19. 00	Medical d rate for swing-bed NF services applicable to services reporting period	0.00	19. 00		
20. 00	Medical d rate for swing-bed NF services applicable to services reporting period	0. 00	20. 00		
21. 00 22. 00	Total general inpatient routine service cost (see instructions $Swing$ -bed cost applicable to $SNF$ type services through December $S$ x line 17)	65, 657, 516 0	21. 00 22. 00		
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00
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	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December (x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 65, 657, 516	26. 00 27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)		9/	0	29. 00
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	: line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	==,		0.00	1
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	+!>	0.00	1	
34. 00 35. 00	Average per diem private room charge differential (line 32 min Average per diem private room cost differential (line 34 x lin	0. 00 0. 00	1		
36.00	Private room cost differential adjustment (line 3 x line 35)	0.00	36. 00		
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	and private room cost di	fferential (line	65, 657, 516	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTMENTS			
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see			1, 009. 43	38. 00
39. 00	Program general inpatient routine service cost per dreim (see	*		22, 212, 507	39. 00
40.00	Medically necessary private room cost applicable to the Progra			0	40.00
41.00	Total Program general inpatient routine service cost (line 39	+ IINE 4U)		22, 212, 507	41.00

<u>Hea</u> l th	Financial Systems	UNION HOSPITA	AL, INC.		In Lie	u of Form CMS-2	<u> 1552-10</u>
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der CCI		Period: From 01/01/2021	Worksheet D-1	
					Γο 12/31/2021	Date/Time Prep 5/26/2022 10:4	
			Title	XVIII	Hospi tal	PPS	+7 alli
	Cost Center Description	Total Inpatient Costlr	Total	Average Per	Program Days	Program Cost (col. 3 x col.	
		Impatrent costin	ipati eiit bayst	col. 2)	-	4)	
42.00	NUDGEDY (4: 41 - V 0 VIV1.)	1.00	2. 00	3. 00	4. 00	5. 00	42.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.00	0	U	42. 00
43. 00	INTENSIVE CARE UNIT	15, 862, 754	8, 117	1, 954. 26	3, 128	6, 112, 925	43. 00
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
46. 00	SURGI CAL INTENSIVE CARE UNIT						46. 00
47. 00	INTENSIVE NURSERY  Cost Center Description	4, 733, 539	4, 100	1, 154. 52	2 0	0	47. 00
	cost center bescription					1. 00	
48.00	Program inpatient ancillary service cost (Wk			>		31, 513, 277	48. 00
49.00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(Se	ee instruction	18)		59, 838, 709	49. 00
50.00	Pass through costs applicable to Program inp	atient routine se	ervices (from	Wkst. D, sum	of Parts I and	3, 194, 168	50. 00
51. 00		atient ancillary	services (fro	om Wkst. D. si	ım of Parts II	2, 421, 192	51. 00
	and IV)	,					
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		ated non-phys	ician anestha	atist and	5, 615, 360 54, 223, 349	52. 00 53. 00
33. 00	medical education costs (line 49 minus line	9 1	ateu, non phys	are are arestric	trot, and	34, 223, 347	33. 00
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. 00
55. 00	, 3					0.00	
56.00	Target amount (line 54 x line 55)	:+		5/! !	: 52)	0	56. 00
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and targ	get amount (11	ne 56 minus i	The 53)	0	57. 00 58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period er	ndi ng 1996, up	dated and con	npounded by the	0.00	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year		0. 00	60. 00			
61. 00	1.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by						61. 00
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see						
62. 00	62.00 Relief payment (see instructions)						
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instruct	tions)			0	63. 00
64.00	Medicare swing-bed SNF inpatient routine cos	ts through Decemb	ber 31 of the	cost reportir	ng period (See	0	64.00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after December	r 31 of the co	st renorting	neriod (See	o	65. 00
	instructions)(title XVIII only)			, 3			
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line 64	4 plus line 65	5)(title XVIII	only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through [	December 31 of	the cost rep	oorting period	0	67. 00
68. 00	<pre>(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin</pre>	e costs after Dec	rember 31 of t	he cost renor	rting period	0	68. 00
	(line 13 x line 20)			·	tring portion		
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69. 00
70.00	Skilled nursing facility/other nursing facil						70. 00
71. 00 72. 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ne 70 ÷ line 2	2)			71. 00 72. 00
73. 00	Medically necessary private room cost applic		(line 14 x lin	ne 35)			73. 00
74. 00 75. 00	Total Program general inpatient routine serv	•	,	orkohoot B. Dr	ort II. column		74. 00 75. 00
75.00	Capital-related cost allocated to inpatient 26, line 45)	Toutine Service (	COSTS (110III WC	JI KSHEEL B, Pa	int II, Corullii		75.00
76.00	Per diem capital-related costs (line 75 ÷ li						76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00 78. 00
79. 00	O Aggregate charges to beneficiaries for excess costs (from provider records)						79. 00
80. 00 81. 00	,						80. 00 81. 00
82. 00	Inpatient routine service cost limitation (	ine 9 x line 81)					82.00
83. 00 84. 00	Reasonable inpatient routine service costs ( Program inpatient ancillary services (see in		)				83. 00 84. 00
85. 00	Utilization review - physician compensation		s)				85. 00
86. 00	Total Program inpatient operating costs (sum	of lines 83 thro					86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					11, 055	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷ l	line 2)			1, 009. 43	88. 00
89. UU	Observation bed cost (line 87 x line 88) (se	e instructions)				11, 159, 249	64. UU

Health Financial Systems	UNION HOSPI	ΓAL, INC.		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 10:4	
		Title	XVIII	Hospi tal	PPS	49 alli
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(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	6, 614, 185	65, 657, 516	0. 10073	8 11, 159, 249	1, 124, 160	90.00
91.00 Nursing Program cost	0	65, 657, 516	0.00000	0 11, 159, 249	0	91.00
92.00 Allied health cost	0	65, 657, 516	0.00000	0 11, 159, 249	0	92.00
93.00 All other Medical Education	0	65, 657, 516	0.00000	0 11, 159, 249	0	93.00

Health Financial Systems	UNION HOSPITAL, INC.	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0023	Peri od: From 01/01/2021	Worksheet D-1
	Component CCN: 15-T023	To 12/31/2021	Date/Time Prepared: 5/26/2022 10:49 am
	Title XVIII	Subprovider -	PPS
		IRF	I

		II the XVIII	I RF	FF3	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			4, 440	1. 00
2.00	Inpatient days (including private room days, excluding swing-b			4, 440	
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	/s). If you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		4, 440	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo		31 of the cost	0	5. 00
4 00	reporting period	om dovo) often December 3	)1 of the cost	0	4 00
6. 00	Total swing-bed SNF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	om days) after becember 3	or the cost	0	6. 00
7.00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7. 00
	reporting period			_	
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 31	of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	1, 920	9. 00
	newborn days) (see instructions)	0 ,			
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII or		nom days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, er	nter 0 on this line)	Join days) ares.		00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	( only (including private	e room days)	0	12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI)	( only (including private	room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar ye			Ö	13.00
14.00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed o	ays)	0	14. 00
15.00	Total nursery days (title V or XIX only)			0	15.00
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	the cost	0.00	17. 00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
	reporting period	g			
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	:)		3, 613, 960	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	0, 010, 700	22. 00
	5 x line 17)				
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportir	ng period (line	0	24. 00
	7 x line 19)	·			
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (	(line 21 minus line 26)		3, 613, 960	
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT		,		
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	d and observation bed cha	arges)	0	28. 00 29. 00
30.00	Semi - pri vate room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27 -	- line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	nus lina 22) (saa instruct	i onc)	0.00	
34. 00 35. 00	Average per diem private room charge differential (line 32 mir Average per diem private room cost differential (line 34 x line		.1 0115)	0. 00 0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	- **/		0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost dif	ferential (line	3, 613, 960	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			813. 95	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line			1, 562, 784	
40.00	Medically necessary private room cost applicable to the Program general inpatient routine service cost (Line 30)	,		1 562 794	40.00
41. 00	Total Program general inpatient routine service cost (line 39	T IIIIC 40)	I	1, 562, 784	41.00

	Financial Systems	UNION HOSPI				eu of Form CMS-2	
COMPUI	ATION OF INPATIENT OPERATING COST		Provi der C		Peri od: From 01/01/2021	Worksheet D-1	
			Component	CCN: 15-T023	To 12/31/2021	Date/Time Pre 5/26/2022 10:	
			Titl∈	× XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	Total Inpatient Costl	Total npatient Days		Program Days	Program Cost (col. 3 x col.	
		1.00	2. 00	col. 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	0	O	0.	00 0	0	42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0	0	0.	00 0	0	43.00
44.00	CORONARY CARE UNIT						44. 00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	INTENSIVE NURSERY	0	C	0.	00 0	0	47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wks					902, 979	1
49. 00	Total Program inpatient costs (sum of lines 4 PASS THROUGH COST ADJUSTMENTS	11 through 48)(	see instructio	ons)		2, 465, 763	49.00
50.00	Pass through costs applicable to Program inpa	atient routine :	services (from	n Wkst. D, su	m of Parts I and	199, 238	50. 00
51. 00	III)  Pass through costs applicable to Program inpa	atient ancillar	v services (fr	om Wkst. D.	sum of Parts II	43, 996	51.00
	and IV)		, (				
52. 00 53. 00	Total Program excludable cost (sum of lines ! Total Program inpatient operating cost exclud		ated, non-phy	sician anest	hetist, and	243, 234 2, 222, 529	1
	medical education costs (line 49 minus line 5					_,,	
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55.00	Target amount per discharge						55. 00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operati	ng cost and ta	rget amount (L	ine 56 minus	line 53)	0	
58. 00	Bonus payment (see instructions)	· ·			•	0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost repmarket basket	porting period	ending 1996, ι	ipdated and c	ompounded by the	0.00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year of	cost report, upo	dated by the m	narket basket		0.00	60.00
61. 00	If line 53/54 is less than the lower of lines which operating costs (line 53) are less than					0	61. 00
	amount (line 56), otherwise enter zero (see i		s (TITIES 54 X	60), 01 1% 0	i the target		
62.00	Relief payment (see instructions)		-+:>				62.00
63. 00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST					0	63.00
64. 00	Medicare swing-bed SNF inpatient routine cost	ts through Dece	mber 31 of the	cost report	ing period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decemb	er 31 of the c	ost reportin	g period (See	0	65. 00
66. 00	instructions) (title XVIII only)	no costs (lino	64 plus lino 6	.E) (+i +l o V/I	II only) For	_	66. 00
88.00	Total Medicare swing-bed SNF inpatient routing CAH (see instructions)	ie costs (Title i	54 prus rine d	os)(title xvi	ii diliy). Fdi		00.00
67. 00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31 c	of the cost r	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routine ((ine 13 x line 20)	e costs after Do	ecember 31 of	the cost rep	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient	•				0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili				)		70. 00
71. 00	Adjusted general inpatient routine service co		ne 70 ÷ line	2)			71. 00
72. 00 73. 00	Program routine service cost (line 9 x line 3 Medically necessary private room cost applications)		(line 14 x li	ne 35)			72. 00 73. 00
74.00	Total Program general inpatient routine servi	ce costs (line	72 + line 73)	,			74. 00
75. 00	Capital-related cost allocated to inpatient (26, line 45)	routine service	costs (from W	lorksheet B,	Part II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ lin						76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for excess		rovi der record	ls)			79. 00
80. 00 81. 00	Total Program routine service costs for compa		ost limitation	ı (line 78 mi	nus line 79)		80. 00 81. 00
81.00	Inpatient routine service cost per diem limit Inpatient routine service cost limitation (li		)				82.00
83.00	Reasonable inpatient routine service costs (		s)				83.00
84. 00 85. 00	Program inpatient ancillary services (see ins Utilization review - physician compensation		ns)				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum	of lines 83 th					86.00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)					0	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			0.00	88. 00
89. 00	Observation bed cost (line 87 x line 88) (see	e instructions)				0	89. 00

Health Financial Systems	UNION HOSPI	TAL, INC.		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Peri od:	Worksheet D-1	
		Component (		From 01/01/2021 To 12/31/2021	Date/Time Prep 5/26/2022 10:	pared: 49 am_
		Title	XVIII	Subprovider - IRF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(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	460, 760	3, 613, 960	0. 12749	4 0	0	90. 00
91.00 Nursing Program cost	0	3, 613, 960	0.00000	0 0	0	91.00
92.00 Allied health cost	0	3, 613, 960	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	3, 613, 960	0. 00000	0 0	0	93. 00

Health Financial Systems	UNION HOSPITAL, INC.	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0023	Peri od: From 01/01/2021	Worksheet D-1	
			Date/Time Pre 5/26/2022 10:	pared: 49 am
	Title XIX	Hospi tal	Cost	
Cost Center Description				
			1 00	

		Title XIX	Hospi tal	Cost	+7 diii
	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			65, 044	1. 00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-berivate room days (excluding swing-bed and observation bed day		voto room dave	65, 044 0	2. 00 3. 00
3.00	do not complete this line.	75). IT you have only pri	vate room days,	U	3.00
4.00	Semi-private room days (excluding swing-bed and observation be			53, 989	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through December	31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private roo	om days) after December 3	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)	•			
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	n days) through December	31 of the cost	0	7. 00
8.00	Total swing-bed NF type inpatient days (including private room	n days) after December 31	of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	the December (evaluating	owing had and	1 002	0.00
9. 00	Total inpatient days including private room days applicable to newborn days) (see instructions)	the Program (excluding	Swing-bed and	1, 083	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII or		nom davs) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, er	nter O on this line)			
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI) through December 31 of the cost reporting period	only (including private	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)	an (exertaining swring bea c	lays)	2, 814	
16. 00	Nursery days (title V or XIX only)			96	16. 00
17. 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to service	s through December 31 of	the cost	0.00	17. 00
17.00	reporting period	3 thi dugit becember 31 of	the cost	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
20.00	reporting period	£1 D 21 -£ +1		0.00	20.00
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	saiter becember 31 of th	ie cost	0.00	20. 00
21. 00	Total general inpatient routine service cost (see instructions			65, 657, 516	
22. 00	Swing-bed cost applicable to SNF type services through December $5 \times 1$ line 17)	er 31 of the cost reporti	ng period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	31 of the cost reportir	na period (line	0	24. 00
	7 x line 19)	·		_	
25. 00	Swing-bed cost applicable to NF type services after December $(x,y)$	31 of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		65, 657, 516	27. 00
28 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	d and observation bed cha	urges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)		900)	0	
30.00	Semi -private room charges (excluding swing-bed charges)			0	
31. 00	General inpatient routine service cost/charge ratio (line 27 -	- line 28)		0.000000	
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	
34. 00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruct	ions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x lin		.1 5.13)	0.00	35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)	,		0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost dif	ferential (line	65, 657, 516	
	27 minus line 36)		`		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTMENTS			
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			1, 009. 43	38. 00
39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 009, 43	39.00
40. 00	Medically necessary private room cost applicable to the Progra			1, 073, 213	40. 00
41. 00	Total Program general inpatient routine service cost (line 39	,		1, 093, 213	
			·		

	Financial Systems	UNION HOSPI			In Li€	eu of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der CC	:N: 15-0023	Period: From 01/01/2021 To 12/31/2021		pared:
			Ti tl	e XIX	Hospi tal	Cost	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
42.00	NURSERY (title V & XIX only)	1, 534, 032	2, 814	545. 1	4 96	52, 333	42. 00
40.00	Intensive Care Type Inpatient Hospital Units	45.0/0.754	0 447	4.054.6		107 (00	1 40 00
43.00	INTENSIVE CARE UNIT	15, 862, 754	8, 117	1, 954. 2	96	187, 609	
44. 00 45. 00	BURN INTENSIVE CARE UNIT						44. 00 45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00		4, 733, 539	4, 100	1, 154. 5	2 287	331, 347	
	Cost Center Description					1. 00	
48 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	line 200)			1, 199, 164	48. 00
	Total Program inpatient costs (sum of lines a PASS THROUGH COST ADJUSTMENTS			ns)		2, 863, 666	1
50. 00	Pass through costs applicable to Program inpa	atient routine	services (from	Wkst. D, sum	of Parts I and	0	50.00
51. 00	Pass through costs applicable to Program inpa and IV)	atient ancillar	y services (fr	om Wkst. D, s	um of Parts II	0	51.00
52. 00	Total Program excludable cost (sum of lines!					0	
53. 00	Total Program inpatient operating cost excluded medical education costs (line 49 minus line !		lated, non-phys	sician anesth	etist, and	0	53.00
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	   E4 00
55. 00	Target amount per discharge					0.00	
56. 00	Target amount (line 54 x line 55)					0.00	•
57.00	Difference between adjusted inpatient operati	ng cost and ta	rget amount (I	ne 56 minus	line 53)	0	57. 00
58. 00	Bonus payment (see instructions)					0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost reparted backet	porting period	endi ng 1996, u <sub>l</sub>	odated and co	mpounded by the	0.00	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	rost renort un	dated by the m	arket hasket		0.00	60.00
	If line 53/54 is less than the lower of lines				the amount by	0.00	61.00
	which operating costs (line 53) are less than		s (lines 54 x	60), or 1% of	the target		
(2.00	amount (line 56), otherwise enter zero (see i	nstructions)					(2.00
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paymo	ent (see instru	ctions)			0	
00.00	PROGRAM INPATIENT ROUTINE SWING BED COST	sir (300 riistru	011 0113)				00.00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	cost reporti	ng period (See	0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost	ts after Decemb	er 31 of the c	ost reporting	period (See	0	65. 00
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routing</pre>	ne costs (line	64 plus line 6	5)(title XVII	l only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 o	f the cost re	porting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 of	the cost repo	rting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili						70.00
71. 00	Adjusted general inpatient routine service co	•		, ,			71.00
72.00	Program routine service cost (line 9 x line	71)					72. 00
73.00	Medically necessary private room cost applica			ne 35)			73.00
74. 00 75. 00	Total Program general inpatient routine servi Capital -related cost allocated to inpatient		74. 00 75. 00				
76. 00	26, line 45)  Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital related costs (line 9 x line	. *					77. 00
78. 00	Inpatient routine service cost (line 74 minus	s line 77)					78. 00
79.00	Aggregate charges to beneficiaries for excess				1: 70)		79.00
80. 00 81. 00	Total Program routine service costs for compa Inpatient routine service cost per diem limi		ust limitation	(iine /8 min	us line /9)		80. 00 81. 00
82. 00	Inpatient routine service cost per drem rim		)				82.00
83. 00	Reasonable inpatient routine service costs (		•				83. 00
84.00	Program inpatient ancillary services (see ins		,				84.00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
00.00	PART IV - COMPUTATION OF OBSERVATION BED PASS		rough 65)				, 55.00
87. 00	Total observation bed days (see instructions)	)				11, 055	1
88. 00	Adjusted general inpatient routine cost per (		line 2)			1, 009. 43	
07.00	Observation bed cost (line 87 x line 88) (see	= ilisti ucti ulis)				11, 159, 249	J 07. UU

Health Financial Systems	UNION HOSPI	TAL, INC.		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 Pre	oared:
					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	6, 614, 185	65, 657, 516	0. 10073	8 11, 159, 249	1, 124, 160	90.00
91.00 Nursing Program cost	0	65, 657, 516	0.00000	0 11, 159, 249	0	91.00
92.00 Allied health cost	o	65, 657, 516	0.00000	0 11, 159, 249	0	92.00
93.00 All other Medical Education	o	65, 657, 516	0.00000	0 11, 159, 249	0	93.00

UNION HOSPITAL, INC.	In Lie	u of Form CMS-2552-10
Provider CCN: 15-0023		Worksheet D-1
Component CCN: 15-T023		
Title XIX	Subprovi der -	Cost
	Component CCN: 15-T023	Provider CCN: 15-0023   Period: From 01/01/2021   To 12/31/2021

Description   1.00			Title XIX	I RF	Cost	
		Cost Center Description				
PRATERT MAYS		DADT I ALL DDOVIDED COMPONENTS			1. 00	
Impationt days (including private room days and seing-bed days, excluding newborn)						
Private room days (excluding swing-bed and observation bed days)   Tryou have only private room days   do   3.00   do not complete this line   4.40   4.00   do not complete this line   4.40   4.00   do not complete this line   4.40   4.00   do   4.00   do   4.40   4.	1.00		, excluding newborn)		4, 440	1. 00
do not complete finis Line.  4. 4.00 Sell-private room days (excluding swing-bed and observation bed days)  1.00 Iotal swing bed SNI type inpatient days (including private room days) after December 31 of the cost  7.00 reporting period (if calendar year, enter 0 on this 1 ine)  7.00 Total swing-bed RY type inpatient days (including private room days) after December 31 of the cost  8.00 Total swing-bed RY type inpatient days (including private room days) after December 31 of the cost  8.00 Total swing-bed RY type inpatient days (including private room days) after December 31 of the cost  8.00 Total swing-bed RY type inpatient days (including private room days) after December 31 of the cost  8.00 Total swing-bed SNI type inpatient days applicable to the Program (excluding swing-bed and instructions)  8.00 Saing-bed SNI type inpatient days applicable to 11 to XVIII only (including private room days)  8.00 Saing-bed SNI type inpatient days applicable to 11 to XVIII only (including private room days)  8.00 Saing-bed SNI type inpatient days applicable to 11 to XVIII only (including private room days)  8.01 Saing-bed SNI type inpatient days applicable to 11 to XVIII only (including private room days)  8.01 Saing-bed SNI type inpatient days applicable to 11 to XVIII only (including private room days)  8.01 Saing-bed SNI type inpatient days applicable to 11 to XVIII only (including private room days)  8.02 Saing-bed SNI type inpatient days applicable to 11 to XVIII only (including private room days)  8.01 Saing-bed SNI type inpatient days applicable to XVII only (including private room days)  8.02 Saing-bed SNI type inpatient days applicable to XVII only (including private room days)  8.01 Saing-bed SNI type inpatient days applicable to XVII only (including private room days)  8.01 Saing-bed SNI type inpatient days applicable to XVII only (including private room days)  8.01 Saing-bed NY type inpatient days applicable to XVII only (including private room days)  8.01 Saing-bed NY type inpatient on SNI only (including priv						
	3.00	, , , , ,	rs). If you have only pri	vate room days,	0	3.00
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost of Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  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)  Total inpatient days including private room days applicable to the Program (excluding swing-bed and days) including private room days applicable to the Program (excluding swing-bed and days) including private room days (including private room days) including private room days) including private room days) including private room days (including private room days) including December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Swing-bed SNF type inpatient days applicable to title SVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days)  Interport of type inpatient days applicable to the Program (excluding swing-bed days)  Interport of type inpatient days applicable to services after December 31 of the cost reporting period (including private room days)  Swing-bed NF type inpatient days applicable to services through December 31 of the cost reporting period (including private room days)  Swing-bed AF type inpatient routine services applicable to services after December 31 of the cost reporting period (including private room days)  Swing-bed cost applicable to SWF type	4.00		ed davs)		4, 440	4. 00
10tal swingbed SNF type inpatient days (including private room days) after December 31 of the cost				31 of the cost		
reporting period (if calendar year, enter 0 on this line)  7.00 Total swing-bed MF type inpatient days (including private room days) through December 31 of the cost on properting period (if calendar year, enter 0 on this line)  8.00 Total swing-bed MF type inpatient days (including private room days) after December 31 of the cost on properting period (if calendar year, enter 0 on this line)  10.00 Swing-bed SMF type inpatient days applicable to the Program (excluding swing-bed and newborn days) (see instructions)  11.00 Swing-bed SMF type inpatient days applicable to the Itle 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 MF 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 MF type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  15.00 Total nursery days (title V or XIX only)  16.00 Miscrept days (title V or XIX only)  17.00 Medicare rate for swing-bed SMF services applicable to services after December 31 of the cost reporting period (including swing-bed swing-bed swing-bed swing-bed swing-bed SMF services applicable to services after December 31 of the cost reporting period (including swing-bed swing-bed SMF services applicable to services after December 31 of the cost reporting period (including swing-bed SMF services applicable to services after December 31 of the cost reporting period (including swing-bed SMF services applicable to services after December 31 of the cost reporting period (including swing-bed SMF services after December 31 of the cost reporting period (including swing-bed cost applicable to SMF type services after December 31 of the cost reporting period (including swing-bed cost applicable to SMF type services after December 31 of th				24 6 11		, 00
1.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period 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)  1.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and total inpatient days) applicable to the Intervention of the program (excluding swing-bed and total patient days) applicable to the Program (excluding swing-bed and 10.00 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)  12.00 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)  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 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days)  15.00 Total nursery days (title V or XIX only)  16.00 Nursery days (title V or XIX only)  17.00 Nursery days (title V or XIX only)  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (line or patient days applicable to services after December 31 of the cost (line 2)  18.00 Nursery days (title V or XIX only)	6.00		om days) after December .	31 of the cost	0	6.00
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)   10.00	7.00		n days) through December	31 of the cost	0	7. 00
reporting period (if Calendar year, énter 0 on this line) 10.00 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 days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 13.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 10 12.00 through Becember 31 of the cost reporting period (ir calendar year, enter 0 on this line) 11.00 through Becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 11.00 through Becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 11.00 through Becember 31 of the cost period 11.00 through Becember 31 of the cost period 11.00 through University 11.00 through SNF services applicable to services through Becember 31 of the cost 10.00 through 11.00 throug						
10.00   Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days)   0.00	8. 00		n days) after December 3°	1 of the cost	0	8. 00
newborn days  (see Instructions)   0   10.00	9. 00		the Program (excluding	swing-bed and	42	9. 00
through December 31 of the cost reporting period (see instructions)  1.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 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)  1.01 Total nursery days (title V or XIX only)  1.02 Ned Indexer days (inter V or XIX only)  1.03 Ned Indexer days (inter V or XIX only)  1.04 Ned Indexer arts for swing-bed SNF services applicable to services through December 31 of the cost reporting period  1.00 Ned Indexer arts for swing-bed SNF services applicable to services after December 31 of the cost reporting period  1.00 Ned Indexer arts for swing-bed NF services applicable to services after December 31 of the cost reporting period  1.00 Ned Indexer arts for swing-bed NF services applicable to services after December 31 of the cost reporting period of reporting period of the system of the cost reporting period (line 6 to XII in 19)  1.00 Ned Industry Nedexer (see applicable to SNF type services through December 31 of the cost reporting period (line 6 to XII in 19)  1.01 Ned Industry Nedexer (see applicable to SNF type services through December 31 of the cost reporting period (line 8 to XII in 19)  1.01 Ned Industry Nedexer (see applicable to SNF type services after December 31 of the cost reporting period (line		newborn days) (see instructions)		· ·		
11.00 Swing-bed SNF type Inpatient days applicable to title XVIII only (Including private room days) after December 31 of the cost reporting period (I fealendar year, enter 0 on this Iine)  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)  14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  16.00 Nursery days (Ititle V or XIX only)  17.00 Nursery days (Ititle V or XIX only)  18.00 SMIN BED ADUSTMENT  19.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 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  20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost  20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost  20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost  20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost  20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (IIne 5 x Iine 17)  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 (IIne 6 x IIne 18)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (IIne 6 x IIne 18)  24.00 Swing-bed cost a	10.00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private ro	oom days)	0	10. 00
December 31 of the cost reporting period (if calendar year, enter 0 on this line)   12.00	11 00			nom days) after	0	11 00
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 Swing-bed NF type inpatient 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 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 19.00 Medicald rate for swing-bed SNF services applicable to services through December 31 of the cost 19.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Nowlp-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 19.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 19.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18) 19.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 28) 19.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 28) 19.00 Swing-bed cost applicable to NF type services after Dece	11.00			Join days) arter		11.00
13.00   Swing-bed NF type inpatient days applicable to titles V or XIX only (Including private room days)   0   13.00	12.00	Swing-bed NF type inpatient days applicable to titles V or XI>		e room days)	0	12. 00
after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  14.00 Modically necessary private room days applicable to the Program (excluding swing-bed days)  15.00 Total nursery days (title V or XIX only)  16.00 Norsery days (title V or XIX only)  17.00 Modicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (line dare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (line dare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (line dare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (line dare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line dare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line dare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line dare reporting december dare line line line dare line line line line line line line lin	12 00		( only (including private	a maam daya)	0	12.00
14.00   Medically necessary private room days applicable to the Program (excluding swing-bed days)   0   14.00   16.00   Nursery days (title V or XIX only)   96   16.00   17.00   17.00   17.00   17.00   17.00   18.00   18.00   19.00   1	13.00				0	13.00
16.00   Nursery days (title V or XIX only)   90   16.00   18	14.00				0	14. 00
SWING BED ADJUSTMENT  1. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period reporting repo						
17. 00   Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost   0.00   17. 00   18. 00   18. 00   19.	16. 00				96	16. 00
reporting period  19. 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 through December 31 of the cost 0.00 19.00 reporting period  20. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20.00 reporting period  21. 00 Total general inpatient routine service cost (see instructions)  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 2 23.00 x line 18)  24. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 2 23.00 x line 18)  25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 18)  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 Total swing-bed cost (see instructions)  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 perivate room per diem charge (line 29 + line 3)  30. 00 Average peri-private room per diem charge (line 30 + line 4)  30. 00 Average peri dem private room cost differential (line 32 minus line 33) (see instructions)  30. 00 Average peri dem private room cost differential (line 32 minus line 33) (see instructions)  30. 00 Average peri dem private room cost differential (line 32 minus line 30)  30. 00 Average peri dem private room cost differential (line 32 minus line 36)  20. 00 Average peri dem private room cost differential (line 32 minus line 36)  20. 00 Av	17 00		es through December 31 of	f the cost	0.00	17 00
reporting period Medicald rate for swing-bed NF services applicable to services through December 31 of the cost cost of the cost reporting period reporting reporting period reporting re	17.00		s through becomber of or	the cost	0.00	17.00
9. 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		es after December 31 of	the cost	0.00	18. 00
reporting period  20. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (20. 00 Total general inpatient routine service cost (see instructions)  21. 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 18)  25. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 18)  26. 00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  27. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  28. 00 Total swing-bed cost (see instructions)  29. 00 Total swing-bed cost (see instructions)  20. 00 Total swing-bed cost (see instructions)	10 00		through Docombor 21 of	the cost	0.00	10.00
20. 00   Medical d rate for swing-bed NF services applicable to services after December 31 of the cost reporting period   20. 00   20. 0	17.00		till odgir becelliber 31 or	the cost	0.00	19.00
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 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)   24. 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 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)   0 2 5. 00   26. 00   Total swing-bed cost (see instructions)   0 2 6. 00   27. 00   PRIVATE ROOM DIFFERENTIAL ADJUSTMENT   28. 00   PRIVATE ROOM DIFFERENTIAL ADJUSTMENT   29. 00   Private room charges (excluding swing-bed charges)   0 29. 00   29. 00	20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of th	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 18)   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)   0 26.00   27.00   General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)   3,613,960   27.00   FRIVATE ROMD DIFFERENTIAL ADJUSTMENT   0 29.00   28.00   Semi-private 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   32.00   Average private room per diem charge (line 29 + line 3)   0.00   33.00   Average per diem private room cost differential (line 30 + line 4)   0.00   34.00   Average per diem private room cost differential (line 34 x line 31)   0.00   35.00   Average per diem private room cost differential (line 34 x line 31)   0.00   36.00   Private room cost differential adjustment (line 3 x line 35)   0 36.00   37.00   Private room cost differential adjustment (line 3 x line 35)   0.00   37.00   Private room cost differential eservice cost net of swing-bed cost and private room cost differential (line 3, 613, 960   38.00   Adjusted general inpatient routine service cost per diem (see instructions)   813.95   38.00   Adjusted general inpatient routine service cost (line 9 x line 38)   0.00   39.00   Program general inpatient routine service cost (line 9 x line 38)   0.00   30.00   0.00   0.00   0.00   30.00   0.00   0.00   0.00   0.00   30.00   0.00   0.00   0.00   0.00   30.00   0.00   0.00   0.00   0.00   30.00   0.00   0.00   0.00   30.00   0.00   0.00   0.00   0.00   30.	21 00				2 412 040	21 00
5 x line 17)  23.00				ng period (line		
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)  30.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Private room cost differential adjustment (line 3 x line 35)  30.00 Private room cost differential distance (line 34 x line 31)  30.00 Private room cost differential distance (line 34 x line 35)  30.00 Private room cost differential distance (line 35 x line 35)  30.00 Private room cost differential (line 35 x line 35)  30.00 Provate room cost differential (line 35 x line 35)  30.00 Provate room cost differential (line 35 x line 35)  30.00 Provate room cost differential (line 35 x line 35)  30.00 Provate room cost differential (line 35 x line 35)  30.00 Provate room cost differential (line 35 x line 35)  30.00 Provate room cost differential (line 35 x line 35)  30.00 Provate room cost differential (line 35 x line 35)  30.00 Provate room cost differential (line 35 x line 35)  30.00 Provate room cost differential (line 35 x line 35)  30.00 Provate room cost differential (line 35 x line 35)  30.00 Provate room cost differential (line 35 x line 35)  30.00 Provate room cost differential (line 35 x line 35)  30.00 Provate room cost differential (line 35 x	22.00		0. 0 0001 1000	ng period (iiiie		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) 26.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.00 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 34 x line 31) 36.00 Private room cost differential (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 613, 960) 37.00 Average per diem private room cost differential (line 3 x line 35) 38.00 Average per diem private room cost differential (line 3 x line 35) 38.00 Average per diem private room cost differential (line 3 x line 35) 38.00 Average per diem private room cost differential (line 3 x line 35) 38.00 Average per diem private room cost differential (line 3 x line 35) 38.00 Average per diem private room cost differential (line 3 x line 35) 38.00 Average per diem private room cost differential (line 3 x line 35) 38.00 Average per diem private room cost differential (line 3 x line 35) 38.00 Average per diem private room cost differential (line 3 x line 35) 38.00 Average per diem private room cost differential (line 3 x line 35) 38.00 Average per diem private room cost differential (line 3 x line 35) 38.00 Average per diem private room cost dif	23. 00		31 of the cost reporting	g period (line 6	0	23. 00
7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 vine 20)  26.00 Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) General inpatient routine service charges (excluding swing-bed and observation bed charges)  9.00 Private room charges (excluding swing-bed charges)  10.00 Semi-private room charges (excluding swing-bed charges)  10.00 Semi-private room charges (excluding swing-bed charges)  10.00 Semi-private room per diem charge (line 27 ÷ line 28)  10.00 Average private room per diem charge (line 29 ÷ line 3)  10.00 Average perivate room per diem charge (line 30 ÷ line 4)  10.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  10.00 34.00  10.00 Average per diem private room cost differential (line 34 x line 31)  10.00 Seneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 613, 960)  10.00 Seneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 613, 960)  10.00 Average per diem private room cost differential (line 3 x line 35)  10.00 Seneral inpatient routine service cost per diem (see instructions)  10.00 Average per diem private room cost differential (line 3 x line 35)  10.00 Seneral inpatient routine service cost per diem (see instructions)  10.00 Average per diem private room cost differential (line 3, 613, 960)  10.00 Average per diem private room cost differential (line 3, 613, 960)  10.00 Average per diem private room cost differential (line 3 x line 35)  10.00 Average per diem private room cost differential (line 3 x line 35)  10.00 Average per diem private room cost differential (line 3 x line 35)  10.00 Average per diem private room cost differential (line 3 x line 35)  10.00 Average per diem	24 00		31 of the cost reporting	na period (line	0	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) Ceneral 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 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 34 x line 31) 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 3, 613, 960) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 613, 960) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 613, 960) 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 (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	24.00	] 3.	31 of the cost reportin	ig perrou (Trile	0	24.00
26.00 Total swing-bed cost (see instructions)  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and observation bed charges)  Private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  Average private room per diem charge (line 29 ÷ line 3)  Average semi-private room per diem charge (line 30 ÷ line 4)  Average per diem private room cost differential (line 34 x line 31)  Average per diem private room cost differential (line 34 x line 31)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 31)  Average per diem private room cost differential (line 3 x line 31)  Average per diem private room cost differential (line 3 x line 31)  Average per diem private room cost differential (line 3 x line 31)  Average per diem private room cost differential (line 3 x line 31)  Average per diem private room cost differential (line 3 x line 31)  Average per diem private room cost differential (line 3 x line 31)  Average per diem private room cost differential (line 3 x line	25.00		31 of the cost reporting	period (line 8	0	25. 00
27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29. 00 Private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  30. 00 General inpatient routine service cost/charge ratio (line 27 + line 28)  30. 00 Average private room per diem charge (line 29 + line 3)  30. 00 Average semi-private room per diem charge (line 30 + line 4)  30. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  30. 00 Average per diem private room cost differential (line 34 x line 31)  30. 00 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 SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38. 00 Adj usted general inpatient routine service cost (line 9 x line 38)  38. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  27. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  28. 00 Alayerage per diem private room cost applicable to the Program (line 14 x line 35)  39. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	24 00				0	24 00
PRI VATE ROOM DIFFERENTI AL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and observation bed charges)  9.00 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 private room cost differential (line 3, 613, 960)  37.00 Average per diem private room cost differential (line 3 x line 35)  38.00 Average per diem private room cost differential (line 3 x line 35)  38.00 Average per diem private room cost differential (line 3 x line 35)  38.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 3, 613, 960)  37.00 Frogram 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)  34, 186 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)			line 21 minus line 26)			
29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  31.00 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 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 3 x line 35)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 613, 960)  37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  38.00 Program 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 29.00 29.					5/ 5 / 5 / 5 / 5	
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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)  32.00 Average semi-private room per diem charge (line 30 ÷ line 4)  32.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  32.00 Average per diem private room cost differential (line 34 x line 31)  32.00 Average per diem private room cost differential (line 34 x line 31)  32.00 Private room cost differential adjustment (line 3 x line 35)  33.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 613, 960)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 613, 960)  37.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  38.00 Program 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)  0.00 00000000000000000000000000000000						
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33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 613, 960)  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)  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			11116 20)			
35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 613, 960)  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)  0.00 35.00 36.00 37.00						
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 3,613,960 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)  36.00 37.00			, ,	tions)		
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3,613,960 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  37.00 37.			ne 31)			
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)  813.95 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 40.00			and private room cost di	fferential (line		
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  813.95 38.00  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)  0 40.00	200	27 minus line 36)			2, 3.3, 700	
38.00 Adjusted general inpatient routine service cost per diem (see instructions)  813.95 38.00  92.00 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)  813.95 38.00 39.00			CTMENTS			
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) 34,186 39.00 40.00	38 00				Q12 OE	38 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			•			
41.00   Total Program general inpatient routine service cost (line 39 + line 40)   34,186   41.00						
	41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		34, 186	41. 00

	Financial Systems	UNION HOSPIT				eu of Form CMS-	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider C		Peri od: From 01/01/2021	Worksheet D-1	
			Component	CCN: 15-T023	To 12/31/2021	Date/Time Pre 5/26/2022 10:	
			Ti tl	e XIX	Subprovi der - I RF	Cost	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	npatient 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	0	0	0.	00 0	0	42.00
43.00	INTENSIVE CARE UNIT	0	C	0.	00 0	0	43.00
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT				00		46. 00
47.00	Cost Center Description	0	0	<u>U.</u>	00 0	0	47. 00
49.00	Program inpatient ancillary service cost (Wk:	2+ D 2 col 2	Line 200)			1.00	48. 00
48. 00 49. 00				ons)			49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program input	atient routine s	earvices (from	Wket D eu	m of Darts I and	Ι ο	50.00
30.00							
51. 00	Pass through costs applicable to Program inpand IV)	atient ancillary	/ services (fr	om Wkst. D,	sum of Parts II	0	51.00
52. 00	Total Program excludable cost (sum of lines					0	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line !		ated, non-phy	sician anest	hetist, and	0	53. 00
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges	·				0	54.00
54. 00 55. 00	Target amount per discharge						55. 00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ng cost and tar	caet amount (1	ing 56 minus	line 53)	0 0	
58. 00	Bonus payment (see instructions)	· ·			•	0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period e	ending 1996, u	ıpdated and c	ompounded by the	0.00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year					0.00	
61. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less than					0	61. 00
42.00	amount (line 56), otherwise enter zero (see		•	,.	3		(2.00
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instrud	ctions)				62. 00 63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Decem	nher 31 of the	cost report	ing period (See	1 0	64. 00
	instructions)(title XVIII only)						
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts after Decembe	er 31 of the c	ost reportin	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	64 plus line 6	5)(title XVI	II only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 c	of the cost r	eporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after De	ecember 31 of	the cost ren	orting period	0	68. 00
	(line 13 x line 20)			•	or tring period		
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU					0	69. 00
70.00	Skilled nursing facility/other nursing facil	ty/ICF/IID rout	tine service d	cost (line 37	)		70.00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ne /U ÷ IIne	2)			71. 00 72. 00
73. 00 74. 00	Medically necessary private room cost applications and Program general inpatient routine services.	9	•	,			73. 00 74. 00
75. 00	Capital -related cost allocated to inpatient	•			Part II, column		75. 00
76. 00	26, line 45)   Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line	76)					77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess	.*	rovi der record	ls)			78. 00 79. 00
80.00	Total Program routine service costs for compa	arison to the co			nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		)				81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (	see instructions					83. 00
84. 00 85. 00	Program inpatient ancillary services (see in: Utilization review - physician compensation		ns)				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS	of lines 83 thr					86. 00
87. 00	Total observation bed days (see instructions)	)				0	1
88. 00 89. 00	Adjusted general inpatient routine cost per observation bed cost (line 87 x line 88) (see	•	line 2)			l .	88. 00 89. 00
57.00	(30)					1	, 57. 00

Health Financial Systems	UNION HOSPI	TAL, INC.		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Peri od:	Worksheet D-1	
		Component (		From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 10:	pared: 49 am_
		Ti tl	e XIX	Subprovi der - I RF	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(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	460, 760	3, 613, 960	0. 12749	4 0	0	90. 00
91.00 Nursing Program cost	0	3, 613, 960	0.00000	0 0	0	91.00
92.00 Allied health cost	0	3, 613, 960	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	3, 613, 960	0. 00000	0 0	0	93. 00

Heal th							
NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Heal th	Financial Systems	UNION HOSPITAL, INC.		In Lie	eu of Form CMS-2	2552-10
Title XVIII			Provi der Co			Worksheet D-3	
NPATIENT ROUTINE SERVICE COST CENTERS   1.00   2.00   3.00							
INPATI ENT ROUTI NE SERVI CE COST CENTERS   1.00   2.00   3.00			Ti tl e	XVIII	Hospi tal	PPS	
INPATI ENT ROUTINE SERVICE COST CENTERS   1.00   2.00   3.00		Cost Center Description					
INPATI ENT ROUTI NE SERVI CE COST CENTERS				To Charges			
INPATI ENT ROUTI NE SERVI CE COST CENTERS					Charges		
INPATI ENT ROUTI NE SERVI CE COST CENTERS   49, 536, 249   30. 00   30. 0				4.00	0.00		
30. 00   03000   ADULTS & PEDIATRICS   49, 536, 249   30. 00   03100   03100   INTENSI VE CARE UNIT   13, 124, 154   31. 00   35. 00   20240   INTENSI VE NURSERY   0   35. 00   35. 00   41. 00   04100   SUBPROVI DER - I RF   0   0   41. 00   43. 00   04300   NURSERY   0   05. 00   00. 00.		INDATIENT DOUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
31. 00   03100   NTENSI VE CARE UNI T   13, 124, 154   0   35. 00   02040   NTENSI VE NURSERY   0   41. 00   35. 00   02040   NTENSI VE NURSERY   0   41. 00   35. 00   02040   NTENSI VE NURSERY   0   41. 00   41. 00   04. 00   02040   NTENSI VE NURSERY   0   41. 00   04. 00   02040   NTENSI VE NURSERY   0   41. 00   02040   NTENSI VE NURSERY   0    20 00				10 526 240		20.00	
35. 00   02040   INTENSI VE NURSERY   0   0   41. 00   41. 00   41. 00   41. 00   41. 00   41. 00   41. 00   41. 00   41. 00   42. 00   42. 00   43. 00							
41. 00					13, 124, 134		
43. 00   04300   NURSERY   NOIL LLARY SERVICE COST CENTERS					0		
NOTES   Service Cost Centers   Society   Service Cost Centers   Society							
50. 00         05000   OFERATI NG ROOM         0. 134126         23, 641, 982   3, 171, 004   50. 00         50. 00           50. 01   OS001   CARDI AC SURGERY         0. 599316   2, 622, 674   1, 571, 810   50. 01         50. 01           50. 02   OS002   WVSC   VVSC   V						L	
50. 02         05002         WVSC         0.142609         103,800         14,803         50.02           51. 00         05100         RECOVERY ROOM         0.313518         1,385,846         434,488         51.00           51. 02         05101         O/P TREATMENT ROOM         0.662228         7,676         5,083         51.02           52. 00         05200         DELI VERY ROOM & LABOR ROOM         0.350610         57,941         20,315         52.00           54. 00         05400         RADI OLOGY-DI AGNOSTI C         0.218959         8,306,149         1,818,706         54.00           55. 00         05500         RADI OLOGY-THERAPEUTI C         0.178242         876,870         156,295         55.00           56. 00         05600         RADI OL SOTOPE         0.276166         758,463         209,462         56.00           57. 00         05700         CT SCAN         0.072560         7,417,049         538,181         57.00           59. 00         OS900         CARDI AC CATHETEI ZATI ON         0.219939         959,410         203,336         58.00           60. 00         O6000         LABORATORY         0.132856         22,094,565         2,935,396         60.00           65. 00 <td< td=""><td>50.00</td><td></td><td></td><td>0. 13412</td><td>6 23, 641, 982</td><td>3, 171, 004</td><td>50.00</td></td<>	50.00			0. 13412	6 23, 641, 982	3, 171, 004	50.00
51. 00       05100 RECOVERY ROOM       0. 313518       1, 385, 846       434, 488       51. 00         51. 02       05101 O/P TREATMENT ROOM       0. 662228       7, 676       5, 083       51. 02         52. 00       05200 DELI VERY ROOM & LABOR ROOM       0. 350610       57, 941       20, 315       52. 00         54. 00       05400 RADI OLOGY-DI AGNOSTI C       0. 218959       8, 306, 149       1, 818, 706       54. 00         55. 00       05500 RADI OLOGY-THERAPEUTI C       0. 178242       876, 870       156, 295       55. 00         56. 00       05600 RADI OLOGY-THERAPEUTI C       0. 276166       758, 463       209, 462       56. 00         57. 00       05700 CT SCAN       0. 072560       7, 417, 049       538, 181       57. 00         58. 00       05800 MAGNETI C RESONANCE I MAGI NG (MRI)       0. 211939       959, 410       203, 336       58. 00         59. 00       05900 CARDI AC CATHETERI ZATI ON       0. 268946       15, 886, 313       4, 272, 560       59. 00         60. 00       06000 LABORATORY       0. 132856       22, 094, 565       2, 935, 396       60. 00         65. 00       06500 RESPI RATORY THERAPY       0. 296395       3, 415, 001       1, 012, 189       66. 00         66. 01       0660	50. 01	05001 CARDI AC SURGERY		0. 59931	6 2, 622, 674	1, 571, 810	50. 01
51. 02       05101       0/P TREATMENT ROOM       0. 662228       7, 676       5, 083       51. 02         52. 00       05200       DELI VERY ROOM & LABOR ROOM       0. 350610       57, 941       20, 315       52. 00         54. 00       05400       RADI OLOGY-DI AGNOSTI C       0. 218959       8, 306, 149       1, 818, 706       54. 00         55. 00       05500       RADI OLOGY-THERAPEUTI C       0. 178242       876, 870       156, 295       55. 00         56. 00       05600       RADI OLOGY-THERAPEUTI C       0. 276166       758, 463       209, 462       56. 00         57. 00       05700       CT SCAN       0. 072560       7, 417, 049       538, 181       57. 00         58. 00       05800       MAGNETI C RESONANCE I MAGI NG (MRI)       0. 211939       959, 410       203, 336       58. 00         59. 00       05900       CARDI AC CATHETERI ZATI ON       0. 268946       15, 886, 313       4, 272, 560       59. 00         60. 00       06000       LABORATORY       0. 132856       22, 094, 565       2, 935, 396       60. 00         65. 00       06500       RESPI RATORY THERAPY       0. 204577       13, 766, 416       2, 816, 292       65. 00         66. 01       06600       PSYCHI	50. 02	05002 WVSC		0. 14260	9 103, 800	14, 803	50. 02
52. 00       05200 DELI VERY ROOM & LABOR ROOM       0. 350610 S7, 941 D. 20, 315 S2. 00       20, 315 S2. 00       52. 00         54. 00       05400 RADI OLOGY-DI AGNOSTI C       0. 218959 R, 306, 149 D. 218959 R, 306,	51.00	05100 RECOVERY ROOM		0. 31351	8 1, 385, 846	434, 488	51.00
54. 00       05400 RADI OLOGY-DI AGNOSTI C       0. 218959       8, 306, 149       1, 818, 706       54. 00         55. 00       05500 RADI OLOGY-THERAPEUTI C       0. 178242       876, 870       156, 295       55. 00         56. 00       05600 RADI OLOGY-THERAPEUTI C       0. 276166       758, 463       209, 462       56. 00         57. 00       05700 CT SCAN       0. 072560       7, 417, 049       538, 181       57. 00         58. 00       05800 MAGNETI C RESONANCE I MAGI NG (MRI)       0. 211939       959, 410       203, 336       58. 00         59. 00       05900 CARDI AC CATHETERI ZATI ON       0. 268946       15, 886, 313       4, 272, 560       59. 00         60. 00       06000 LABORATORY       0. 132856       22, 094, 565       2, 935, 396       60. 00         62. 00       06200 WHOLE BLOOD & PACKED RED BLOOD CELLS       0. 532616       1, 186, 786       632, 101       62. 00         65. 00       06500 RESPI RATORY THERAPY       0. 204577       13, 766, 416       2, 816, 292       65. 00         66. 01       06601 PHYSI CAL THERAPY       0. 296395       3, 415, 001       1, 012, 189       66. 00         66. 02       06602 O/P PHYSI CAL THERAPY       0. 299085       0       0       66. 01         67. 00	51. 02	05101   O/P TREATMENT ROOM		0. 66222	8 7, 676	5, 083	51. 02
55. 00       05500 RADI OLOGY-THERAPEUTI C       0. 178242       876, 870       156, 295       55. 00         56. 00       05600 RADI OL SOTOPE       0. 276166       758, 463       209, 462       56. 00         57. 00       05700 CT SCAN       0. 072560       7, 417, 049       538, 181       57. 00         58. 00       05800 MAGNETI C RESONANCE I MAGI NG (MRI)       0. 211939       959, 410       203, 336       58. 00         59. 00       05900 CARDI AC CATHETERI ZATI ON       0. 268946       15, 886, 313       4, 272, 560       59. 00         60. 00       06000 LABORATORY       0. 132856       22, 094, 565       2, 935, 396       60. 00         62. 00       06200 WHOLE BLOOD & PACKED RED BLOOD CELLS       0. 532616       1, 186, 786       632, 101       62. 00         65. 00       06500 RESPI RATORY THERAPY       0. 204577       13, 766, 416       2, 816, 292       65. 00         66. 01       06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES       0. 000000       0       0       0       66. 01         66. 02       06602 O/P PHYSI CAL THERAPY       0. 299085       0       0       66. 01         66. 02       06600 O/F OO OCCUPATI ONAL THERAPY       0. 223741       2, 091, 045       467, 852       67. 00		1		1	•		
56. 00       05600 RADI OI SOTOPE       0. 276166       758, 463       209, 462       56. 00         57. 00       05700 CT SCAN       0. 072560       7, 417, 049       538, 181       57. 00         58. 00       05800 MAGNETI C RESONANCE I MAGI NG (MRI)       0. 211939       959, 410       203, 336       58. 00         59. 00       05900 CARDI AC CATHETERI ZATI ON       0. 268946       15, 886, 313       4, 272, 560       59. 00         60. 00       06000 LABORATORY       0. 132856       22, 094, 565       2, 935, 396       60. 00         62. 00       06200 WHOLE BLOOD & PACKED RED BLOOD CELLS       0. 532616       1, 186, 786       632, 101       62. 00         65. 00       06500 RESPI RATORY THERAPY       0. 204577       13, 766, 416       2, 816, 292       65. 00         66. 01       06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES       0. 000000       0       0       0       66. 01         66. 02       06602 O/P PHYSI CAL THERAPY       0. 299085       0       0       66. 02         67. 00       06700 OCCUPATI ONAL THERAPY       0. 223741       2, 091, 045       467, 852       67. 00				1			
57. 00       05700       CT SCAN       0.072560       7, 417, 049       538, 181       57. 00         58. 00       05800       MAGNETI C RESONANCE I MAGI NG (MRI)       0.211939       959, 410       203, 336       58. 00         59. 00       05900       CARDI AC CATHETERI ZATI ON       0.268946       15, 886, 313       4, 272, 560       59. 00         60. 00       06000       LABORATORY       0.132856       22, 094, 565       2, 935, 396       60. 00         62. 00       06500       RESPI RATORY THERAPY       0.532616       1, 186, 786       632, 101       62. 00         65. 00       06600       PHYSI CAL THERAPY       0.296395       3, 415, 001       1, 012, 189       66. 00         66. 01       06601       PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES       0.000000       0       0       66. 01         66. 02       06602       O/P PHYSI CAL THERAPY       0.299085       0       0       66. 02         67. 00       06700       0CCUPATI ONAL THERAPY       0.223741       2, 091, 045       467, 852       67. 00				1	•		
58. 00       05800 MAGNETI C RESONANCE I MAGI NG (MRI)       0. 211939       959, 410       203, 336       58. 00         59. 00       05900 CARDI AC CATHETERI ZATI ON       0. 268946       15, 886, 313       4, 272, 560       59. 00         60. 00       06000 LABORATORY       0. 132856       22, 094, 565       2, 935, 396       60. 00         62. 00       06200 WHOLE BLOOD & PACKED RED BLOOD CELLS       0. 532616       1, 186, 786       632, 101       62. 00         65. 00       06500 RESPI RATORY THERAPY       0. 204577       13, 766, 416       2, 816, 292       65. 00         66. 01       06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES       0. 000000       0       0       66. 01         66. 02       06602 O/P PHYSI CAL THERAPY       0. 299085       0       0       66. 01         66. 02       067. 00       06700 OCCUPATI ONAL THERAPY       0. 223741       2, 091, 045       467, 852       67. 00				1	•		
59. 00       05900       CARDI AC CATHETERI ZATI ON       0. 268946       15, 886, 313       4, 272, 560       59. 00         60. 00       06000       LABORATORY       0. 132856       22, 094, 565       2, 935, 396       60. 00         62. 00       06200       WHOLE BLOOD & PACKED RED BLOOD CELLS       0. 532616       1, 186, 786       632, 101       62. 00         65. 00       06500       RESPI RATORY THERAPY       0. 204577       13, 766, 416       2, 816, 292       65. 00         66. 00       06600       PHYSI CAL THERAPY       0. 296395       3, 415, 001       1, 012, 189       66. 00         66. 02       06602       0/P PHYSI CAL THERAPY       0. 299085       0       0       66. 01         67. 00       06700       0CCUPATI ONAL THERAPY       0. 223741       2, 091, 045       467, 852       67. 00				1			
60. 00 06000 LABORATORY 0. 132856 22, 094, 565 2, 935, 396 60. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0. 532616 1, 186, 786 632, 101 62. 00 65. 00 06500 RESPI RATORY THERAPY 0. 204577 13, 766, 416 2, 816, 292 65. 00 66. 00 06600 PHYSI CAL THERAPY 0. 296395 3, 415, 001 1, 012, 189 66. 00 66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0. 000000 0 0 0 66. 02 66. 02 06602 0/P PHYSI CAL THERAPY 0. 299085 0 0 0 66. 02 67. 00 06700 0CCUPATI ONAL THERAPY 0. 223741 2, 091, 045 467, 852 67. 00							
62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   0.532616   1, 186, 786   632, 101   62. 00   65. 00   06500   RESPIRATORY THERAPY   0.204577   13, 766, 416   2, 816, 292   65. 00   66. 01   06601   PHYSI CAL THERAPY   0.296395   3, 415, 001   1, 012, 189   66. 00   66. 01   06601   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0.000000   0   0   66. 01   66. 02   06602   0/P PHYSI CAL THERAPY   0.299085   0   0   66. 02   66. 02   06700   0CCUPATI ONAL THERAPY   0.223741   2, 091, 045   467, 852   67. 00   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000							
65. 00   06500   RESPI RATORY THERAPY   0. 204577   13, 766, 416   2, 816, 292   65. 00   66. 00   06600   PHYSI CAL THERAPY   0. 296395   3, 415, 001   1, 012, 189   66. 00   66. 01   06601   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0. 000000   0   0   66. 01   66. 02   06602   0/P PHYSI CAL THERAPY   0. 299085   0   0   66. 02   67. 00   06700   0CCUPATI ONAL THERAPY   0. 223741   2, 091, 045   467, 852   67. 00   0. 000000   0. 0000000   0. 0000000   0. 0000000   0. 00000000							
66. 00   06600   PHYSI CAL THERAPY   0. 296395   3, 415, 001   1, 012, 189   66. 00   66. 01   06601   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0. 000000   0   0   66. 01   66. 02   06602   0/P PHYSI CAL THERAPY   0. 299085   0   0   66. 02   67. 00   06700   0CCUPATI ONAL THERAPY   0. 223741   2, 091, 045   467, 852   67. 00   06700   0   0   0   0   0   0   0   0   0						l	
66. 01   06601   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0.000000   0   0   66. 01   66. 02   06602   0/P PHYSI CAL THERAPY   0.299085   0   0   66. 02   06700   0CCUPATI ONAL THERAPY   0.223741   2,091,045   467,852   67. 00   06700   0   0   0   0   0   0   0   0   0		1		1			
66. 02   06602   0/P PHYSI CAL THERAPY   0. 299085   0   0   66. 02   67. 00   06700   0CCUPATI ONAL THERAPY   0. 223741   2, 091, 045   467, 852   67. 00		1		1			
67. 00   06700   0CCUPATI ONAL THERAPY   0. 223741   2, 091, 045   467, 852   67. 00							
				1			

7, 641, 970

59, 046

379, 271

6, 202, 181

21, 708, 519

2, 057, 254

15, 787, 645

1, 585, 215

160, 488, 309

160, 488, 309

0

0.089888

0.628190

0.547305

0.000000

0. 248900

0. 205671

0.563022

0.464040

1. 332539

0.244720

0.117279

0. 723176

686, 921

37, 092

207, 577

1, 543, 723

4, 464, 813

1, 158, 279

1, 851, 559

1, 146, 389

31, 513, 277

0

69.00

69.01

70.00

71.00

72.00

73.00

76.00

90.00

90.05

90.07

91.00

92.00

200.00

201. 00 202. 00

69. 00 06900 ELECTROCARDI OLOGY

03020 RENAL ACUTE

09007 WOUND CLINIC

09005 PATIENT NUTRITION

09000 CLI NI C

91. 00 09100 EMERGENCY

06901 CARDI AC REHAB

07000 ELECTROENCEPHALOGRAPHY

07300 DRUGS CHARGED TO PATIENTS

OUTPATIENT SERVICE COST CENTERS

71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Net charges (line 200 minus line 201)

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

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

69.01

73.00

76.00

90.00

90.05

90.07

200.00

201.00

202.00

Health Financial Systems UNION H INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		HOSPITAL, INC.  Provider CCN: 15-0023  Component CCN: 15-T023		Peri od:	worksheet D-3  Date/Time Prepared 5/26/2022 10:49 am	
				From 01/01/2021 To 12/31/2021		
		Title	· XVIII	Subprovi der - I RF	PPS	
	Cost Center Description		Ratio of Cos To Charges	t Inpatient	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
31. 00 35. 00 41. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 02040 INTENSIVE NURSERY 04100 SUBPROVIDER - IRF 04300 NURSERY			2, 146, 089		30. 00 31. 00 35. 00 41. 00 43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000  OPERATING ROOM		0 1241	22 470	4 255	50.0
50. 01	05001 CARDI AC SURGERY		0. 1341 0. 5993	16 3, 549	4, 355 2, 127	50.0
	05002 WVSC 05100 RECOVERY ROOM		0. 1426 0. 3135		23	
	05101 0/P TREATMENT ROOM		0. 6622		0	
	05200 DELIVERY ROOM & LABOR ROOM		0. 3506		9	52. C
	05400 RADI OLOGY-DI AGNOSTI C		0. 2189	59 79, 265	17, 356	54.0
	05500 RADI OLOGY-THERAPEUTI C		0. 1782		0	
	05600 RADI OI SOTOPE		0. 2761		0	
57. 00 58. 00	05700 CT SCAN		0.0725		3, 596	
59. 00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION		0. 2119 0. 2689		1, 129 6, 042	
	06000 LABORATORY		0. 1328		45, 440	
52. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 5326		6, 928	1
	06500 RESPI RATORY THERAPY		0. 2045		72, 993	
6. 00	06600 PHYSI CAL THERAPY		0. 2963	95 1, 096, 720	325, 062	66. (
	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0.0000		0	
	06602 0/P PHYSI CAL THERAPY		0. 2990		0	
57. 00	06700 OCCUPATI ONAL THERAPY		0. 2237		248, 014	1
	06800  SPEECH PATHOLOGY 06900  ELECTROCARDI OLOGY		0. 2801 0. 0898		57, 835 2, 073	
	06901 CARDI AC REHAB		0. 6281		2,073	1
	07000 ELECTROENCEPHALOGRAPHY		0. 5473		620	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0000		0	ı
2. 00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2489		0	1
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 2056	71 210, 593	43, 313	73. 0
6. 00	03020 RENAL ACUTE		0. 5630	22 114, 115	64, 249	76. (
	OUTPATIENT SERVICE COST CENTERS					
	09000 CLINIC		0. 4640		0	
	09005 PATIENT NUTRITION 09007 WOUND CLINIC		1. 3325 0. 2447		0	
	09100 EMERGENCY		0. 2447		1, 815	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 1172	· ·	1, 613	1
2.00			0. 7231	3, 680, 683	902, 979	
201. 00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0, 555, 565	,52, ,77	201. (
202.00		,		3, 680, 683		202.

Health Financial Systems	UNION HOSPITAL, INC.	In Lieu of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CCN: 15-0023	Period: Worksheet D-3

Health Financial Systems UNION HOSPITAL	_, INC.		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der Co	CN: 15-0023	Peri od:	Worksheet D-3	
			From 01/01/2021		
			To 12/31/2021	Date/Time Pre	
-	T: +1	e XIX	Hooni tal	5/26/2022 10:	49 am_
Cook Cooker December 1	1111		Hospi tal	Cost	
Cost Center Description		Ratio of Cos	•	Inpatient	
		To Charges	Program	Program Costs (col. 1 x col.	
			Charges	2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS			2, 116, 042		30. 00
31. 00   03100   NTENSI VE CARE UNI T			930, 950		31. 00
35. 00   02040   I NTENSI VE   NURSERY			730, 730		35. 00
41. 00   04100   SUBPROVI DER -   I RF			27, 891		41. 00
43. 00   04300   NURSERY			1, 652, 934		43.00
ANCILLARY SERVICE COST CENTERS			1, 032, 734		43.00
50. 00   05000   0PERATI NG ROOM		0. 13398	816, 908	109, 455	50.00
50. 01   05001   CARDI AC SURGERY		0. 5993		0 107, 433	50. 00
50. 02   05002   WVSC		0. 14260		0	50. 01
51. 00   05100   RECOVERY ROOM		0. 14200		11, 843	
51. 02   05100   REGOVERT   ROOM   51. 02   05101   0/P   TREATMENT   ROOM		0. 66222	-	0	51.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM		0. 3506		68, 256	
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 3300		60, 969	ł
55. 00   05500   RADI OLOGY-THERAPEUTI C		0. 17824	-	6, 240	ł
56. 00   05600   RADI 01 SOTOPE		0. 17622		8, 230	1
57. 00   05700   CT   SCAN		0. 07256	· ·	21, 447	57. 00
58. 00   05800   MAGNETI C RESONANCE   MAGING (MRI)		0. 07230		9, 129	1
59. 00   05900   CARDI AC CATHETERI ZATI ON		0. 26894		20, 648	1
60. 00   06000   LABORATORY		0. 13263		164, 029	60.00
62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 1326.		45, 693	•
65. 00   06500   RESPI RATORY THERAPY		0. 20457		181, 897	65.00
66. 00   06600   PHYSI CAL THERAPY		0. 29639		32, 767	66.00
66. 01   06601   PSYCHI ATRI C/PSYCHOLOGI CAL   SERVI CES		0. 00000		32,767	•
66. 02   06602   0/P PHYSI CAL THERAPY		0. 29908		0	66. 01 66. 02
67. 00   06700   0CCUPATI ONAL THERAPY				_	•
68. 00   06800   SPEECH PATHOLOGY		0. 22374 0. 28014		21, 288 7, 056	
69. 00   06900   ELECTROCARDI OLOGY		0. 08988	-	29, 238	•
69. 01   06901   CARDI AC   REHAB		0. 62819	-	79	•
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 54730		22, 742	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 00000		22, 742	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 24890		1, 296	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 20567		265, 174	1
75. 00   07300   DR0G3 CHARGED TO PATTENTS 76. 00   03020   RENAL ACUTE		0. 56302		39, 910	
OUTPATIENT SERVICE COST CENTERS		0. 30302	70,000	37, 710	70.00
90. 00 09000 CLINIC		0. 46404	10 0	0	90.00
90. 05   09005   PATI ENT   NUTRI TI ON		1. 32515		0	90.05
90. 07   09007   WOUND CLINIC		0. 24472		0	90. 03
91. 00   09100   EMERGENCY		0. 1172		71, 778	1
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)		0. 72317		71,778	1
200.00 Total (sum of lines 50 through 94 and 96 through 98)		0. 7231	6, 594, 972	1, 199, 164	ł
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0, 374, 772	1, 177, 104	201. 00
202.00 Net charges (line 200 minus line 201)	(.1110 01)		6, 594, 972		202. 00
		1	0,07.,772	I	

Health Financial Systems UNION HOST INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der CCN: 15-0023		Peri od:	eu of Form CMS-2552-1 Worksheet D-3	
	C	Component CCN: 15-T023		From 01/01/2021 To 12/31/2021	Date/Time Prepare 5/26/2022 10:49 a	
		Ti tl	e XIX	Subprovi der - I RF	Cost	
	Cost Center Description		Ratio of Cos To Charges	t Inpatient	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
	PATIENT ROUTINE SERVICE COST CENTERS					4
31. 00 03 35. 00 02 41. 00 04 43. 00 04	000 ADULTS & PEDIATRICS 100 INTENSIVE CARE UNIT 040 INTENSIVE NURSERY 100 SUBPROVIDER - IRF 300 NURSERY			190		30. 00 31. 00 35. 00 41. 00 43. 00
	CILLARY SERVICE COST CENTERS OOD OPERATING ROOM		0. 1339	87 5, 569	746	50.00
50. 01 05	001 CARDI AC SURGERY 002 WYSC		0. 1334 0. 5993 0. 1426	16	0	50. 0°
	100 RECOVERY ROOM		0. 1420		1	1
	101 0/P TREATMENT ROOM		0. 6622		1	
52. 00   05	200 DELIVERY ROOM & LABOR ROOM		0. 3506	10 1, 327	465	52. 0
54. 00   05	400 RADI OLOGY-DI AGNOSTI C		0. 2189	17 1, 899	416	54.0
	500 RADI OLOGY-THERAPEUTI C		0. 1782	42 239	43	55. 0
	600 RADI OI SOTOPE		0. 2761			
	700 CT SCAN		0. 0725		1	
	800 MAGNETIC RESONANCE IMAGING (MRI)		0. 2119			
	900 CARDI AC CATHETERI ZATI ON 000 LABORATORY		0. 2689		1	1
	200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 1326 0. 5326			1
	500 RESPIRATORY THERAPY		0. 3320		1	1
	600 PHYSI CAL THERAPY		0. 2963			1
	601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0.0000		1	1
	602 0/P PHYSI CAL THERAPY		0. 2990		o o	66.0
57. 00   06	700 OCCUPATI ONAL THERAPY		0. 2237	41 649	145	67.0
	800 SPEECH PATHOLOGY		0. 2801		•	
	900 ELECTROCARDI OLOGY		0. 0898			
	901 CARDI AC REHAB		0. 6281		1	
	000 ELECTROENCEPHALOGRAPHY		0. 5473			1
71. 00   07 72. 00   07	100 MEDICAL SUPPLIES CHARGED TO PATIENTS 200 IMPL. DEV. CHARGED TO PATIENTS		0. 0000 0. 2489		1	
	300 DRUGS CHARGED TO PATIENTS		0. 2489			1
	020 RENAL ACUTE		0. 5630		1	1
	TPATIENT SERVICE COST CENTERS		0.0000	22 100	7 272	1 /0. (
	000 CLI NI C		0. 4640	40 (	0	90.0
	005 PATIENT NUTRITION		1. 3251		0	90.0
	007 WOUND CLINIC		0. 2447		0	
4	100 EMERGENCY		0. 1172			1
	200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 7231		0	1
200.00	Total (sum of lines 50 through 94 and 96 through 98)			44, 96	8, 175	
201. 00	Less PBP Clinic Laboratory Services-Program only charges (	line 61)	I	1 (	JI	201. 0

Health Financial Systems	UNION HOSPITAL, INC.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0023	Peri od: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/26/2022 10:49 am

		Title XVIII	Hospi tal	5/26/2022 10: PPS	49 am_
		II LI E AVIII	поѕрі таі	PPS	
				1. 00	
4 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		-		4 00
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring	prior to October 1 (s	see	0 39, 868, 042	1. 00 1. 01
1. 02	instructions) DRG amounts other than outlier payments for discharges occurring	on or after October 1	(see	13, 272, 361	1. 02
1. 03	instructions) DRG for federal specific operating payment for Model 4 BPCI for c	lischarges occurring p	orior to October	0	1. 03
1. 04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for c October 1 (see instructions)	lischarges occurring o	on or after	0	1. 04
2.00	Outlier payments for discharges. (see instructions)				2. 00
2. 01	Outlier reconciliation amount			0	2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instructions	•		0	2. 02
2.03	Outlier payments for discharges occurring prior to October 1 (see			292, 444	2. 03
2.04	Outlier payments for discharges occurring on or after October 1 (	see instructions)		60, 801	2. 04 3. 00
3. 00 4. 00	Managed Care Simulated Payments Bed days available divided by number of days in the cost reporting	ng poriod (soo instru	stions)	20, 800, 798 213. 20	
4.00	Indirect Medical Education Adjustment	ig perrou (see mistruc	, ti ons)	213. 20	4.00
5.00	FTE count for allopathic and osteopathic programs for the most re or before 12/31/1996. (see instructions)	ecent cost reporting p	period ending on	12. 22	5. 00
6. 00	FTE count for allopathic and osteopathic programs that meet the c new programs in accordance with 42 CFR 413.79(e)	riteria for an add-or	n to the cap for	0. 00	6. 00
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified under ACA § 5503 reduction amount to the IME cap as specified under 42 cost report straddles July 1, 2011 then see instructions.			0. 00 0. 00	7. 00 7. 01
8. 00	Adjustment (increase or decrease) to the FTE count for allopathic affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c) 1998), and 67 FR 50069 (August 1, 2002).			0. 00	8. 00
8. 01	The amount of increase if the hospital was awarded FTE cap slots report straddles July 1, 2011, see instructions.	under § 5503 of the A	ACA. If the cost	0. 00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slots under § 5506 of ACA. (see instructions)	from a closed teachir	ng hospital	0. 00	8. 02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (instructions)	8, 8,01 and 8,02) (s	see	12. 22	9. 00
10.00	FTE count for allopathic and osteopathic programs in the current	year from your record	ls	20. 53	10. 00
11. 00	FTE count for residents in dental and podiatric programs.			0.00	
	Current year allowable FTE (see instructions)				12.00
13. 00	Total allowable FTE count for the prior year.			12. 22	
14. 00	Total allowable FTE count for the penultimate year if that year e	ended on or after Sept	ember 30, 1997,	12. 22	14. 00
15. 00	otherwise enter zero. Sum of lines 12 through 14 divided by 3.			12 22	15. 00
16. 00	Adjustment for residents in initial years of the program				16. 00
	Adjustment for residents displaced by program or hospital closure	<b>.</b>			17. 00
	Adjusted rolling average FTE count			12. 22	
	Current year resident to bed ratio (line 18 divided by line 4).			0. 057317	
20.00	Prior year resident to bed ratio (see instructions)			0. 056935	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0. 056935	21.00
22. 00	IME payment adjustment (see instructions)			1, 627, 053	
22. 01	IME payment adjustment - Managed Care (see instructions)			636, 879	22. 01
23. 00	Indirect Medical Education Adjustment for the Add-on for § 422 of Number of additional allopathic and osteopathic IME FTE resident		FR 412. 105	8. 45	23. 00
24. 00	(f)(1)(iv)(C ).  IME FTE Resident Count Over Cap (see instructions)			8. 31	24. 00
	If the amount on line 24 is greater than -0-, then enter the lower instructions)	er of line 23 or line	24 (see	8. 31	25. 00
26. 00	Resident to bed ratio (divide line 25 by line 4)			0. 038977	26. 00
	IME payments adjustment factor. (see instructions)			0. 010300	
28.00	IME add-on adjustment amount (see instructions)			547, 346	28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)			214, 248	28. 01
	Total IME payment ( sum of lines 22 and 28)			2, 174, 399	
	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment			851, 127	
	Percentage of SSI recipient patient days to Medicare Part A patie	ent days (see instruct	i ons)	4. 33	30.00
31. 00	Percentage of Medicaid patient days (see instructions)			23. 72	
	Sum of lines 30 and 31			28. 05	
33.00	Allowable disproportionate share percentage (see instructions)			12.36	
34.00	Disproportionate share adjustment (see instructions)		ı	1, 642, 039	34.00

CALCUI	Financial Systems UNION HOSPITA ATION OF REIMBURSEMENT SETTLEMENT	AL, INC. Provider CCN: 15-0023	Peri od: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Pre 5/26/2022 10:4	
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1		
	Uncomposited Core Adjustment		1. 00	2. 00	
35. 00	Uncompensated Care Adjustment Total uncompensated care amount (see instructions)		8 200 014 521	7, 192, 008, 710	35. 00
35. 00	Factor 3 (see instructions)		0. 000409962	0. 000544339	
35. 02	Hospital uncompensated care payment (If line 34 is zero, ento	er zero on this line) (see		3, 914, 891	35. 02
00.02	instructions)	20.0 01. 11.0 11.10) (30.	3,0,0,0,1	0, , , , , 0, ,	00.02
35. 03	Pro rata share of the hospital uncompensated care payment amount	ount (see instructions)	2, 541, 959	986, 768	35. 03
36. 00			3, 528, 727		36. 00
	Additional payment for high percentage of ESRD beneficiary di	scharges (lines 40 through			
40. 00	Total Medicare discharges (see instructions)		0		40.00
41. 00	Total ESRD Medicare discharges (see instructions)		0		41.00
41. 01	Total ESRD Medicare covered and paid discharges (see instruc-		0		41. 01
42. 00	Divide line 41 by line 40 (if less than 10%, you do not quali	ry for adjustment)	0.00		42.00
43. 00 44. 00	Total Medicare ESRD inpatient days (see instructions) Ratio of average length of stay to one week (line 43 divided	by Line 41 divided by 7	0. 000000		43. 00 44. 00
44. 00	days)	by Title 41 divided by 7	0.00000		44.00
45. 00	Average weekly cost for dialysis treatments (see instructions	s)	0.00		45. 00
46. 00	Total additional payment (line 45 times line 44 times line 4		0		46. 00
47. 00	Subtotal (see instructions)		60, 838, 813		47. 00
48. 00	Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	0		48. 00
	only. (see instructions)				
				Amount	
40.00	Total narment for innations appraising costs (see instruction	-)		1. 00 61, 689, 940	49. 00
49. 00 50. 00	Total payment for inpatient operating costs (see instructions Payment for inpatient program capital (from Wkst. L, Pt. I and			4, 488, 200	
51. 00	Exception payment for inpatient program capital (Wkst. L, Pt. 1 al			4, 488, 200	1
52. 00	Direct graduate medical education payment (from Wkst. E-4, li			687, 693	
53. 00	Nursing and Allied Health Managed Care payment	The Ty see Thisti detroils).		9, 352	
54. 00	Special add-on payments for new technologies			485, 883	
54. 01	Islet isolation add-on payment			0	54. 01
55. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of	69)		0	55. 00
56. 00	Cost of physicians' services in a teaching hospital (see into	ructi ons)		0	56. 00
57. 00	Routine service other pass through costs (from Wkst. D, Pt.	III, column 9, lines 30 th	rough 35).	0	57. 00
58. 00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 11 line 200)		43, 713	1
59. 00	Total (sum of amounts on lines 49 through 58)			67, 404, 781	59. 00
60.00	Primary payer payments			16, 831	1
61.00	Total amount payable for program beneficiaries (line 59 minus	s line 60)		67, 387, 950	
62.00	Deductibles billed to program beneficiaries			4, 750, 672	
63. 00 64. 00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)			143, 054 131, 287	1
65. 00	Adjusted reimbursable bad debts (see instructions)			85, 337	1
66. 00	Allowable bad debts for dual eligible beneficiaries (see ins	tructions)		05, 337	1
67. 00	,	tructrons)		62, 579, 561	
	Credits received from manufacturers for replaced devices for	applicable to MS-DRGs (se	ee instructions)	02, 07 7, 001	
69. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96).			0	
70. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	•	,	0	
70. 50	Rural Community Hospital Demonstration Project (§410A Demons	tration) adjustment (see i	nstructions)	0	70. 50
70. 87	Demonstration payment adjustment amount before sequestration			0	70. 87
70. 88	SCH or MDH volume decrease adjustment (contractor use only)			0	70. 88
70. 89	Pioneer ACO demonstration payment adjustment amount (see ins	tructions)			70. 89
70. 90	HSP bonus payment HVBP adjustment amount (see instructions)			0	
70. 91	HSP bonus payment HRR adjustment amount (see instructions)			0	
	Bundled Model 1 discount amount (see instructions)			0	
70. 92	LINDD assument additional annual Control of the Con				
70. 92 70. 93 70. 94	HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions)			-165, 687 -403, 467	1

Health Financial Systems	UNION HOSPITAL, INC.		Inlie	eu of Form CMS-:	2552_1
CALCULATION OF REIMBURSEMENT SETTLEMENT	i		eriod: rom 01/01/2021	Worksheet E Part A Date/Time Pre	pared:
	Ti +L	> V//	Heeni tel	5/26/2022 10:	49 am
		e XVIII	Hospi tal	PPS	
		FFY (		Amount 1.00	
70.96 Low volume adjustment for federal fiscal	year (yyyy) (Enter in column O			1.00	70. 9
the corresponding federal year for the pe			,		70. 70
70. 97 Low volume adjustment for federal fiscal			)	0	70. 9
the corresponding federal year for the pe					/ / /
70. 98 Low Volume Payment-3	strod charing on or direct 10/1/			0	70. 9
70. 99 HAC adjustment amount (see instructions)				o o	1 , 0, ,
71.00 Amount due provider (line 67 minus lines	68 nlus/minus lines 69 % 70)			62, 010, 407	
71.01 Sequestration adjustment (see instruction				02,010,107	
71. 02 Demonstration payment adjustment amount a	,			o o	
71. 03 Sequestration adjustment-PARHM pass-through				Ĭ	71. 0
72.00 Interim payments	29.13			61, 502, 188	
72.01   Interim payments-PARHM				01,002,100	72. 0
73.00 Tentative settlement (for contractor use	onl v)			0	
73. 01 Tentative settlement-PARHM (for contractor				ı	73.0
74.00 Balance due provider/program (line 71 mi)	37			508, 219	
73)				300, 217	
74.01 Balance due provider/program-PARHM (see					74. 0
75.00 Protested amounts (nonallowable cost reports) CMS Pub. 15-2, chapter 1, §115.2	ort items) in accordance with			1, 086, 087	75. 00
TO BE COMPLETED BY CONTRACTOR (lines 90	through 96)				1
90.00 Operating outlier amount from Wkst. E, P				0	90.0
plus 2.04 (see instructions)					
91.00 Capital outlier from Wkst. L, Pt. I, line	e 2			0	91.0
92.00 Operating outlier reconciliation adjustm				0	92.0
93.00 Capital outlier reconciliation adjustmen				0	93.0
94.00 The rate used to calculate the time value	e of money (see instructions)			0.00	94.0
95.00 Time value of money for operating expense	es (see instructions)			0	95.00
96.00 Time value of money for capital related	expenses (see instructions)			0	96.0
*			Prior to 10/1	On/After 10/1	
			1. 00	2. 00	
HSP Bonus Payment Amount					
100.00 HSP bonus amount (see instructions)			0	0	100. 00
HVBP Adjustment for HSP Bonus Payment					
101.00 HVBP adjustment factor (see instructions)	)		0.0000000000	0.0000000000	101. 00
102.00 HVBP adjustment amount for HSP bonus pay	ment (see instructions)		0	0	102. 00
HRR Adjustment for HSP Bonus Payment					
103.00 HRR adjustment factor (see instructions)			0. 0000	0.0000	103.00
104.00 HRR adjustment amount for HSP bonus payment			0	0	104. 00
Rural Community Hospital Demonstration Pr	roject (§410A Demonstration) Adju	ıstment			
200.00 Is this the first year of the current 5-	year demonstration period under t	the 21st			200. 00
Century Cures Act? Enter "Y" for yes or	"N" for no.				]
Cost Reimbursement					
201.00 Medicare inpatient service costs (from W	kst. D-1, Pt. II, line 49)				201. 00
202.00 Medicare discharges (see instructions)					202.00

102.00 HVBP adjustment amount for HSP bonus payment (see instructions)	0	0 102. 00
HRR Adjustment for HSP Bonus Payment		
103.00 HRR adjustment factor (see instructions)	0.0000	0. 0000 103. 00
104.00 HRR adjustment amount for HSP bonus payment (see instructions)	0	0 104. 00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment		
200.00 Is this the first year of the current 5-year demonstration period under the 21st		200. 00
Century Cures Act? Enter "Y" for yes or "N" for no.		
Cost Reimbursement		
201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)		201. 00
202.00 Medicare discharges (see instructions)		202. 00
203.00 Case-mix adjustment factor (see instructions)		203. 00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current	5-year demonstration	on
peri od)		
204.00 Medicare target amount		204. 00
205.00 Case-mix adjusted target amount (line 203 times line 204)		205. 00
206.00 Medicare inpatient routine cost cap (line 202 times line 205)		206. 00
Adjustment to Medicare Part A Inpatient Reimbursement		
207.00 Program reimbursement under the §410A Demonstration (see instructions)		207. 00
208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)		208. 00
209.00 Adjustment to Medicare IPPS payments (see instructions)		209. 00
210.00 Reserved for future use		210. 00
211.00 Total adjustment to Medicare IPPS payments (see instructions)		211. 00
Comparision of PPS versus Cost Reimbursement		
212.00 Total adjustment to Medicare Part A IPPS payments (from line 211)		212. 00
213.00 Low-volume adjustment (see instructions)		213. 00
218.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)		218. 00
(line 212 minus line 213) (see instructions)		

Provider CCN: 15-0023

				T' 11	NA /1 1 1		5/26/2022 10: 4	49 am_
		W/S F Part A	Amounts (from	Pre/Post	Period Prior	Hospi tal Peri od	PPS Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01		
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	DRG amounts other than outlier	1. 00	0	0	(	0	0	1. 00
1. 01	DRG amounts other than outlier payments for discharges	1. 01	39, 868, 042	О	39, 868, 042	2	39, 868, 042	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	13, 272, 361	0		13, 272, 361	13, 272, 361	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to	1. 03	0	0	(		0	1. 03
1. 04	October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0		0	0	1. 04
2.00	Outlier payments for discharges (see instructions)	2. 00						2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	(	0	0	2. 01
2. 02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2. 03	292, 444	0	292, 444	1	292, 444	2. 02
2. 03	Outlier payments for discharges occurring on or after October 1 (see	2. 04	60, 801	0		60, 801	60, 801	2. 03
3. 00	instructions) Operating outlier reconciliation	2. 01	0	0	(	0	0	3. 00
4. 00	Managed care simulated payments	3. 00	20, 800, 798	0	15, 198, 646	5, 602, 152	20, 800, 798	4. 00
	Indirect Medical Education Adju				1			
5. 00	Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 056935	0. 056935	0. 056935	0. 056935		5. 00
6. 00	IME payment adjustment (see instructions)	22. 00	1, 627, 053	0	1, 220, 680	406, 373	1, 627, 053	6. 00
6. 01	IME payment adjustment for managed care (see instructions)	22. 01	636, 879	0	465, 352	171, 527	636, 879	6. 01
7. 00	Indirect Medical Education Adju IME payment adjustment factor	ustment for the	e Add-on for Se 0.010300			0. 010300		7. 00
8. 00	(see instructions)  IME adjustment (see	28. 00	547, 346					8. 00
	instructions)							
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	214, 248	0	156, 546	57, 702	214, 248	8. 01
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	2, 174, 399	0	1, 631, 321	543, 078	2, 174, 399	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	851, 127	0	621, 898	229, 229	851, 127	9. 01
	Disproportionate Share Adjustme							
10. 00	Allowable disproportionate share percentage (see instructions)	33. 00	0. 1236	0. 1236	0. 1236	0. 1236		10. 00
11. 00	Disproportionate share adjustment (see instructions)	34. 00	1, 642, 039	0	1, 231, 923	410, 116	1, 642, 039	11. 00
11. 01	Uncompensated care payments  Additional payment for high per	36.00 rcentage of ESR	3,528,727 RD beneficiary	0 di scharges	2, 541, 959	986, 768	3, 528, 727	11. 01
12. 00	Total ESRD additional payment	46.00	0	0	(	0	0	12. 00
13. 00 14. 00	(see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47. 00 48. 00	60, 838, 813 0	0	45, 565, 689 (	9 15, 273, 124 0 0	60, 838, 813 0	13. 00 14. 00
15. 00	(see instructions) Total payment for inpatient operating costs (see instructions)	49. 00	61, 689, 940	0	46, 187, 587	15, 502, 353	61, 689, 940	15. 00
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	4, 488, 200	0	3, 389, 870	1, 098, 330	4, 488, 200	16. 00

12/31/2021 Date/Time Prepared: 5/26/2022 10:49 am Title XVIII Hospi tal W/S E, Part A Amounts (from Pre/Post Period Prior Total (Col 2 Peri od E, Part A) to 10/01 On/After 10/01 line Entitlement through 4) 0 1 00 2 00 3 00 4.00 5 00 17.00 Special add-on payments for 54.00 485, 883 328, 533 157, 350 485, 883 17.00 new technologies 17.01 Net organ aquisition cost 17.01 17.02 Credits received from 68.00 17.02 0 0 0 manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation 93.00 0 0 18.00 adjustment amount (see instructions) 66, 664, 023 19.00 SUBTOTAL 49, 905, 990 16, 758, 033 19.00 W/S L, line (Amounts from 0 1.00 2.00 3.00 4. 00 5.00 Capital DRG other than outlier 20.00 1.00 4, 053, 223 3, 056, 918 996, 305 4, 053, 223 20.00 Model 4 BPCI Capital DRG other 20.01 1 01 20.01 than outlier 21.00 Capital DRG outlier payments 2.00 67, 350 55, 690 11,660 67, 350 21.00 Model 4 BPCI Capital DRG 21.01 2.01 21.01 outlier payments Indirect medical education 22 00 5.00 0.0323 0.0323 0.0323 0.0323 22.00 percentage (see instructions) 23.00 Indirect medical education 6.00 130, 919 98, 738 32, 181 130, 919 23.00 adjustment (see instructions) 24.00 Allowable disproportionate 10.00 0.0584 0.0584 0.0584 0.0584 24.00 share percentage (see instructions) 25.00 Di sproporti onate share 11.00 236, 708 Ω 178.524 58. 184 236, 708 25.00 adjustment (see instructions) 26.00 Total prospective capital 12.00 4, 488, 200 3, 389, 870 1, 098, 330 4, 488, 200 26.00 payments (see instructions) W/S E, Part A (Amounts to E, line Part A) 2. 00 5. 00 1.00 3.00 4.00 0 27.00 Low volume adjustment factor 0.000000 0.000000 27.00 28.00 Low volume adjustment 70.96 28.00 (transfer amount to Wkst. E, Pt. A. line) 29.00 Low volume adjustment 29.00 70.97 0 (transfer amount to Wkst. E, Pt. A, line) 100.00 Transfer low volume 100.00

adjustments to Wkst. E, Pt. A.

Provider CCN: 15-0023 Peri od: Worksheet E From 01/01/2021 Part A Exhibit 5 Date/Time Prepared: 12/31/2021 5/26/2022 10:49 am Hospi tal Title XVIII Period to Total (cols. 2 Wkst. E, Pt. Amt. from Peri od on 10/01 A. line Wkst. E, Pt. after 10/01 and 3) A) 2.00 3. 00 0 4.00 1.00 1.00 DRG amounts other than outlier payments 1.00 1. 00 DRG amounts other than outlier payments for 1.01 1.01 39, 868, 042 39, 868, 042 39, 868, 042 1.01 discharges occurring prior to October 1 1.02 DRG amounts other than outlier payments for 13, 272, 361 1.02 13, 272, 361 13, 272, 361 1.02 discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment 1.03 C 1.03 0 for Model 4 BPCI occurring prior to October DRG for Federal specific operating payment 1.04 1.04 0 1.04 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 2.01 **BPCI** 292, 444 2 02 Outlier payments for discharges occurring 2 03 292 444 292 444 2 02 prior to October 1 (see instructions) Outlier payments for discharges occurring on 2.03 2.04 60, 801 60, 801 60, 801 2.03 or after October 1 (see instructions) 3.00 Operating outlier reconciliation 2.01 3.00 Managed care simulated payments 20, 800, 798 15, 198, 646 5, 602, 152 20, 800, 798 4.00 3.00 4.00 Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.056935 0.056935 0.056935 5.00 (see instructions) IME payment adjustment (see instructions) 6.00 22.00 1,627,053 1, 220, 680 406, 373 1,627,053 6.00 6.01 IME payment adjustment for managed care (see 22.01 636, 879 465, 352 171, 527 636, 879 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 IME payment adjustment factor (see 27. 00 0. 010300 0.010300 0. 010300 7.00 instructions) 8 00 IME adjustment (see instructions) 28 00 547 346 547, 346 8 00 410, 641 136, 705 8.01 IME payment adjustment add on for managed 28.01 214, 248 156, 546 57, 702 214, 248 8.01 care (see instructions) Total IME payment (sum of lines 6 and 8) 29.00 9.00 2, 174, 399 1, 631, 321 543.078 2, 174, 399 9.00 Total IME payment for managed care (sum of 621, 898 9.01 29.01 851, 127 229, 229 851, 127 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage 0. 1236 10.00 33.00 0.1236 0.1236 10.00 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 1.642.039 1, 231, 923 410, 116 1.642.039 11.00 instructions) 11.01 3, 528, 727 2, 541, 959 Uncompensated care payments 36, 00 986, 768 3, 528, 727 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see 46. 00 12.00 instructions) 47.00 13 00 60, 838, 813 45, 565, 689 Subtotal (see instructions) 15, 273, 124 60, 838, 813 13 00 14.00 Hospital specific payments (completed by SCH 48.00 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 49.00 61, 689, 940 46, 187, 587 15, 502, 353 61, 689, 940 15.00 15.00 (see instructions) 3, 389, 870 16.00 50 00 4, 488, 200 1 098 330 4, 488, 200 16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 485, 883 328, 533 157, 350 485, 883 17.00 17.01 Net organ acquisition cost 17.01 Credits received from manufacturers for 68.00 0 17.02 17.02 C 0 0 replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment 93.00 0 0 18.00 amount (see instructions)

49, 905, 990

16, 758, 033

66, 664, 023

19.00

19.00

**SUBTOTAL** 

Health Financial Systems	UNI ON HOSPI	TAL INC		ln lie	eu of Form CMS-2	2552 10
Health Financial Systems HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA		Provider CO		Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Exhibi	t 5 pared:
		Title	XVIII	Hospi tal	PPS	
	Wkst. L, line	(Amt. from				
		Wkst. L)				
	0	1.00	2.00	3. 00	4. 00	
20.00 Capital DRG other than outlier	1.00	4, 053, 223	3, 056, 9	996, 305	4, 053, 223	20.00
20.01 Model 4 BPCI Capital DRG other than outlier	1. 01	0		0 0	0	20. 01
21.00 Capital DRG outlier payments	2.00	67, 350	55, 69	11, 660	67, 350	21. 00
21.01 Model 4 BPCI Capital DRG outlier payments	2. 01	0		0 0	0	21. 01
22.00 Indirect medical education percentage (see	5.00	0. 0323	0. 032	0. 0323		22. 00
instructions)						
23.00 Indirect medical education adjustment (see	6. 00	130, 919	98, 73	32, 181	130, 919	23. 00
instructions)			,			
24.00 Allowable disproportionate share percentage	10, 00	0.0584	0. 058	0. 0584		24.00
(see instructions)						
25. 00 Disproportionate share adjustment (see	11.00	236, 708	178, 52	58, 184	236, 708	25. 00
instructions)			,			
26.00 Total prospective capital payments (see	12.00	4, 488, 200	3, 389, 87	1, 098, 330	4, 488, 200	26.00
instructions)		.,,	,,,,,,,	1, 212, 222	.,,	
	Wkst. E. Pt.	(Amt. from				
	A, Line	Wkst. E, Pt.				
		A)				
	0	1.00	2.00	3. 00	4. 00	
27. 00						27. 00
28.00 Low volume adjustment prior to October 1	70. 96	0		o	l o	28. 00
29.00 Low volume adjustment on or after October 1	70. 97	0		0	0	29.00
30.00 HVBP payment adjustment (see instructions)	70. 93	-165, 687	-165, 68	87	-165, 687	
30. 01 HVBP payment adjustment for HSP bonus	70. 90	0	.00,00	0 0	0	1
payment (see instructions)	70170	Ĭ		٦		00.0.
31.00 HRR adjustment (see instructions)	70. 94	-403, 467	-333, 63	-69, 835	-403, 467	31.00
31.01 HRR adjustment for HSP bonus payment (see	70. 91	0	000,00	0 0,7000	0	31. 01
instructions)	70.71				Ĭ	31.01
THIS CLUSTED SHOW					(Amt. to Wkst.	
					E, Pt. A)	
	0	1.00	2.00	3. 00	4. 00	
32.00 HAC Reduction Program adjustment (see	70, 99	1.00	2.00	0 0		32. 00
instructions)	, , , ,			٦		] 32.00
100.00 Transfer HAC Reduction Program adjustment to		l N				100.00
Wkst. E, Pt. A.						
1	i .	1	1	į	1	

Health Financial Systems	UNION HOSPITAL, INC.	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0023	From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 5/26/2022 10: 49 am

		Title XVIII	Hospi tal	5/26/2022 10: PPS	49 am_
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			93, 014	1. 00
2. 00 3. 00	Medical and other services reimbursed under OPPS (see instruct	i ons)		65, 298, 859	2. 00 3. 00
4. 00	OPPS payments Outlier payment (see instructions)			62, 234, 876 25, 046	1
4. 01	Outlier reconciliation amount (see instructions)			0	1
5.00	Enter the hospital specific payment to cost ratio (see instruc	tions)		0. 000	5. 00
6.00	Line 2 times line 5			0	6. 00
7. 00 8. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7. 00 8. 00
9. 00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. I	V col 13 line 200		197, 714	9. 00
10.00	Organ acqui si ti ons	.,		0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			93, 014	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
12. 00	Reasonable charges Ancillary service charges			452, 247	12.00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 69)		452, 247	1
	Total reasonable charges (sum of lines 12 and 13)			452, 247	•
	Customary charges				
15.00	Aggregate amount actually collected from patients liable for p	3	0	0	
16. 00	Amounts that would have been realized from patients liable for had such payment been made in accordance with 42 CFR §413.13(e		n a chargebasis	0	16. 00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	,		0. 000000	17. 00
18. 00	Total customary charges (see instructions)			452, 247	18. 00
19. 00	Excess of customary charges over reasonable cost (complete onl	y if line 18 exceeds lin	ne 11) (see	359, 233	19. 00
20. 00	instructions)	v if line 11 everede liv	20 10) (000		20.00
20.00	Excess of reasonable cost over customary charges (complete onlinstructions)	y II II'ne II exceeds III	ie 18) (See	0	20. 00
21.00	Lesser of cost or charges (see instructions)			93, 014	21. 00
	Interns and residents (see instructions)			0	22. 00
	Cost of physicians' services in a teaching hospital (see instr	uctions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			62, 457, 636	24. 00
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions	)		0	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line	•	uctions)	11, 000, 991	•
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p	lus the sum of lines 22	and 23] (see	51, 549, 659	27. 00
28. 00	instructions)	no FO)		724 270	20.00
29. 00	Direct graduate medical education payments (from Wkst. E-4, li ESRD direct medical education costs (from Wkst. E-4, line 36)	ne 50)		724, 379	ı
	Subtotal (sum of lines 27 through 29)			52, 274, 038	1
31.00	Primary payer payments			11, 585	
32. 00	Subtotal (line 30 minus line 31)	FC)		52, 262, 453	32. 00
33 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC Composite rate ESRD (from Wkst. I-5, line 11)	ES)		1 0	33. 00
	Allowable bad debts (see instructions)			383, 041	•
	Adjusted reimbursable bad debts (see instructions)			248, 977	1
	Allowable bad debts for dual eligible beneficiaries (see instr	uctions)		0	
	Subtotal (see instructions)			52, 511, 430	•
38.00	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			-88 0	•
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	)			39. 50
39. 97	Demonstration payment adjustment amount before sequestration	•		0	39. 97
39. 98	Partial or full credits received from manufacturers for replac	ed devices (see instruc	tions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	
40. 00 40. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)			52, 511, 518	1
40. 02	Demonstration payment adjustment amount after sequestration			0	
40. 03	Sequestration adjustment-PARHM pass-throughs				40. 03
	Interim payments			53, 411, 724	
41. 01	Interim payments-PARHM				41. 01 42. 00
42. 00	Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)			0	42.00
43. 00	Balance due provider/program (see instructions)			-900, 206	
43. 01	Balance due provider/program-PARHM (see instructions)				43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordan	ce with CMS Pub. 15-2, o	chapter 1,	0	44. 00
	\$115. 2				
90 00	TO BE COMPLETED BY CONTRACTOR  Original outlier amount (see instructions)			0	90.00
91. 00	Outlier reconciliation adjustment amount (see instructions)			0	
92. 00	The rate used to calculate the Time Value of Money			0.00	92. 00
93. 00	Time Value of Money (see instructions)			0	
94.00	Total (sum of lines 91 and 93)			1	94. 00

Health Financial Systems	UNION HOSPITAL, INC.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0023 Component CCN: 15-T023	From 01/01/2021	Worksheet E Part B Date/Time Prepared: 5/26/2022 10:49 am
	Title XVIII	Subprovi der -	PPS

	I itle XVIII Subprovider -	PPS	
	DADT D. HEDLON AND OTHER HEALTH CERVILORS	1. 00	
1. 00	PART B - MEDICAL AND OTHER HEALTH SERVICES  Medical and other services (see instructions)	192	1. 00
2.00	Medical and other services reimbursed under OPPS (see instructions)	351	2.00
3.00	OPPS payments	372	3. 00
4.00	Outlier payment (see instructions)	0	
4. 01 5. 00	Outlier reconciliation amount (see instructions)	0. 000	4. 01 5. 00
6.00	Enter the hospital specific payment to cost ratio (see instructions) Line 2 times line 5	0.000	6. 00
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	
8.00	Transitional corridor payment (see instructions)	0	8. 00
9. 00 10. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
11. 00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)	0 192	10. 00 11. 00
11.00	COMPUTATION OF LESSER OF COST OR CHARGES	172	
	Reasonabl e charges		
12.00	Ancillary service charges	934	
13. 00 14. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) Total reasonable charges (sum of lines 12 and 13)	0 934	13. 00 14. 00
11.00	Customary charges	701	
15. 00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	
16. 00	Amounts that would have been realized from patients liable for payment for services on a chargebasis	0	16. 00
17. 00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)	0. 000000	17. 00
18. 00	Total customary charges (see instructions)	934	1
19. 00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	742	19. 00
20.00	instructions)  Exercise of responsible cost over sustembly charges (complete only if line 11 exercise line 19) (see	0	20. 00
20. 00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	U	20.00
21. 00	Lesser of cost or charges (see instructions)	192	21. 00
22. 00	Interns and residents (see instructions)	0	22. 00
23. 00 24. 00	Cost of physicians' services in a teaching hospital (see instructions) Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0 372	23. 00 24. 00
24.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	372	24.00
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25. 00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	0	26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	564	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29. 00
30.00	Subtotal (sum of lines 27 through 29)	564	
31. 00 32. 00	Primary payer payments Subtotal (line 30 minus line 31)	0 564	
32.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	304	32.00
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33. 00
34.00	Allowable bad debts (see instructions)	0	34. 00
35. 00 36. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions)	0	35. 00 36. 00
37. 00	Subtotal (see instructions)	564	
38. 00	MSP-LCC reconciliation amount from PS&R		38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	
39. 50 39. 97	Pioneer ACO demonstration payment adjustment (see instructions)  Demonstration payment adjustment amount before sequestration	0	39. 50 39. 97
39. 98	Partial or full credits received from manufacturers for replaced devices (see instructions)	Ö	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	0	39. 99
40.00	Subtotal (see instructions)	564	•
40. 01 40. 02	Sequestration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration	0	40. 01 40. 02
40. 03	Sequestration adjustment-PARHM pass-throughs		40. 03
41. 00	Interim payments	559	41. 00
41. 01	Interim payments-PARHM		41. 01
42. 00 42. 01	Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)	0	42. 00 42. 01
43. 00	Balance due provider/program (see instructions)	5	
43. 01	Balance due provider/program-PARHM (see instructions)		43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	44. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR		I
90. 00	Original outlier amount (see instructions)	0	90. 00
91. 00	Outlier reconciliation adjustment amount (see instructions)	0	91. 00
92.00	The rate used to calculate the Time Value of Money		92.00
93. 00 94. 00	Time Value of Money (see instructions) Total (sum of lines 91 and 93)	0	
55	1 (	١	00

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

| Peri od: | Worksheet E-1 | From 01/01/2021 | Part I | To 12/31/2021 | Date/Time Prepared: Provider CCN: 15-0023

				10 12/31/2021		
		Ti tl	e XVIII	Hospi tal	PPS	
		Inpatie	nt Part A	Pai	5/26/2022 10: 49 PPS t B  Amount 4.00 51, 329, 458 0  2, 082, 266 0 0 0 0 0 0 2, 082, 266 53, 411, 724  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4.00	
1.00	Total interim payments paid to provider		60, 387, 83	1	51, 329, 458	1. 00
2.00	Interim payments payable on individual bills, either			0	o	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	12/31/2021	1, 114, 35			3. 01
3.02			l	0		3. 02
3.03			•	0		3. 03
3.04			II.	0		3. 04
3.05				0	0	3. 05
	Provi der to Program					
3.50	ADJUSTMENTS TO PROGRAM		1	0	1	3. 50
3. 51			1	0	1	3. 51
3. 52			1	0		3. 52
3. 53			1	0		3. 53
3.54	Subtatal (sum of lines 2 01 2 40 minus sum of lines		1	0		3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		1, 114, 35		2, 082, 266	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		61, 502, 18	Ω	53 /11 72/	4. 00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		01, 302, 10		33, 411, 724	4.00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR	1	1			
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5.01	TENTATI VE TO PROVI DER			0	0	5. 01
5.02				0	0	5. 02
5.03				0	0	5. 03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM		1	0		5. 50
5. 51			1	0		5. 51
5. 52				0		5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on		1			6. 00
. 01	the cost report. (1)		F00 04			/ 01
6. 01	SETTLEMENT TO PROVIDER	1	508, 21		1	6. 01
6. 02	SETTLEMENT TO PROGRAM	1	1	0		6. 02
7. 00	Total Medicare program liability (see instructions)		62, 010, 40			7. 00
				Contractor Number	(Mo/Day/Yr)	
			0	1. 00	2. 00	
8. 00	Name of Contractor			1.00	2.00	8. 00
5. 50	The second secon	1		1	1 1	0.00

Provider CCN: 15-0023 Component CCN: 15-T023 Title XVIII Subprovi der -

		litie	XVIII	Subprovi der - I RF	PPS	
		Innatien	t Part A		rt B	
		mpatron		rui		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		3, 151, 591		559	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2. 00
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
0.00	amount based on subsequent revision of the interim rate					0.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 02			0		0	3. 02
3.03			0		0	3. 03
3.04			0		0	3. 04
3. 05	Provider to Program		0		0	3. 05
3. 50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51	ADJUSTINIENTS TO TROUBLAND		0			3. 51
3. 52			0		l ő	3. 52
3. 53			l o		l ol	3. 53
3.54			Ö		0	3. 54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		3, 151, 591		559	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5. 00
3.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5.01	TENTATI VE TO PROVI DER		0		0	5. 01
5.02			0		0	5. 02
5.03			0		0	5. 03
F F0	Provi der to Program					F F0
5. 50 5. 51	TENTATI VE TO PROGRAM		0		0	5. 50 5. 51
5. 51						5. 51
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
3. 77	5. 50-5. 98)				١	3. 77
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6.01	SETTLEMENT TO PROVIDER		2, 672		5	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		0	6. 02
7.00	Total Medicare program liability (see instructions)		3, 154, 263		564	7. 00
				Contractor	NPR Date	
			)	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor		)	1.00	2.00	8. 00
0.00	Thame of Sofit detoi	I		ļ	ı l	0.00

Heal th	Financial Systems UNION HOSPITAL	_, INC.	In Lie	u of Form CMS-:	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0023	Peri od:	Worksheet E-1	
			From 01/01/2021 To 12/31/2021	Part II   Date/Time Pre	nared:
			10 12/31/2021	5/26/2022 10:	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				-
1 00	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION Total hospital discharges as defined in AARA §4102 from Wkst.	C 2 D+ L col 15 Line	14		1.00
1. 00 2. 00	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8	-			2.00
2.00	reporting periods beginning on or after 10/01/2013, line 32)	6 through 12, and prus i	oi cost		2.00
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	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 li				6. 00
7.00	CAH only - The reasonable cost incurred for the purchase of co	ertified HIT technology	Wkst. S-2, Pt. I		7. 00
	line 168				
8. 00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	Sequestration adjustment amount (see instructions)				9.00
10. 00	Calculation of the HIT incentive payment after sequestration INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	(see instructions)			10.00
20.00	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)				31.00
	Balance due provider (line 8 (or line 10) minus line 30 and li	ine 31) (see instruction	s)		32.00
32.00	parameter due provider (Time 6 (or Time 10) militas Time 50 and Ti	The 31) (See Thisti detroit	)		1 32.00

Health Financial Systems	UNION HOSPITAL, INC.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0023	Peri od: From 01/01/2021	Worksheet E-3
	Component CCN: 15-T023		Date/Time Prepared: 5/26/2022 10:49 am
	Title XVIII	Subprovi der -	PPS

	IRF	113	
		1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	3, 039, 435	•
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0. 0168	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	173, 248	•
4. 00 5. 00	Outlier Payments	692 20. 53	4. 00 5. 00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	20. 53	3.00
5. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by	0.00	5. 01
0.01	program or hospital closure, that would not be counted without a temporary cap adjustment under 42	0.00	1
	CFR \$412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		
6.00	New Teaching program adjustment. (see instructions)	0.00	6. 00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new	0.00	7. 00
	teaching program" (see instructions)		l
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new	0. 00	8. 00
	teaching program" (see instructions)		
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	
10.00	Average Daily Census (see instructions)	12. 164384	
11.00	Teaching Adjustment Factor (see instructions)	0. 000000	
12.00	Teaching Adjustment (see instructions)	0	12.00
13. 00 14. 00	Total PPS Payment (see instructions)  Nursing and Allied Health Managed Care payments (see instruction)	3, 213, 375 0	13. 00 14. 00
15. 00	Organ acquisition (DO NOT USE THIS LINE)	U U	15. 00
16. 00	Cost of physicians' services in a teaching hospital (see instructions)	0	
17. 00	Subtotal (see instructions)	3, 213, 375	
18. 00	Primary payer payments	30, 225	
19. 00	Subtotal (line 17 less line 18).	3, 183, 150	
20. 00	Deducti bl es	23, 744	
21. 00	Subtotal (line 19 minus line 20)	3, 159, 406	
22. 00	Coinsurance	5, 565	
23.00	Subtotal (line 21 minus line 22)	3, 153, 841	23. 00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	24. 00
25.00	Adjusted reimbursable bad debts (see instructions)	0	25. 00
26. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26. 00
27. 00	Subtotal (sum of lines 23 and 25)	3, 153, 841	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	
29. 00	Other pass through costs (see instructions)	422	•
30. 00	Outlier payments reconciliation	0	30. 00
31. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	
31. 98	Recovery of accelerated depreciation.	0	
31. 99 32. 00	Demonstration payment adjustment amount before sequestration  Total amount payable to the provider (see instructions)	3, 154, 263	
32. 00	Sequestration adjustment (see instructions)	3, 154, 203	32. 00
32. 01	Demonstration payment adjustment amount after sequestration	0	32. 02
33. 00	Interim payments	3, 151, 591	
34. 00	Tentative settlement (for contractor use only)	0, 101, 0,1	
35. 00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	2, 672	
36. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	-, 0	•
	§115. 2		
	TO BE COMPLETED BY CONTRACTOR		I
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	692	50. 00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	1
53. 00	Time Value of Money (see instructions)	0	53. 00
00.05	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19		00.00
99. 00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0.000000	
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0. 000000	99. UT

Health Financial Systems	ancial Systems UNION HOSPITAL, INC.	
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0023	Peri od: Worksheet E-3 From 01/01/2021 Part VII To 12/31/2021 Date/Time Prepared:

PART_VII _ CALCULATION OF REINBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				To 12/31/2021	Date/Time Pre 5/26/2022 10:	
Inpatt ent			Title XIX	Hospi tal		.,
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES						
DART VII - CALCULATION OF RETUBUISEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES						
COMPUTATION OF NET COST OF COVERED SERVICES   1.00   1.0		PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	/ICES FOR TITLES V OR XIX			
Inpatient hospital/SNF/MF services						1
Medical and other services   0   2.00	1 00			2 863 666		1 00
Organ acquisition (certified transplant centers only)		'		2,000,000	0	
Subtotal (sum of lines 1, 2 and 3)				0	_	
Inpatient primary payer payments   0   6.00   0.000   0.0000   0.0000   0				2 863 666	0	
0				0	_	
3.00   Subtotal (line 4 less sum of lines 5 and 6)   2,863,666   0   7.00					0	
COMPUTATION OF LESSER OF COST OR CHARGES   Reasonable Charges   8.00   Routine service charges   4.727,817   8.00   8.00   8.00   7.00   Another service charges   6.594,972   0.90   0.00				2, 863, 666		
Reasonable Charges   8.00   Routine service charges   4,727,817   8.00   Routine service charges   6,594,972   0 9.00   10.00   11.00   10.00   11.0				,		
8.00   Routine service charges   4, 1727, 817   8.00   9.00   Anciliary service charges, net of revenue   6, 594, 972   0, 9, 00   0.		Reasonabl e Charges				1
9.00   Ancillary service charges   6,594,972   0 9.00	8.00			4, 727, 817		8.00
11.00   Incentive from target amount computation   11.00   11.00   12.00   CUSTOMARY CHARGES   0   12.00   CUSTOMARY CHARGES   0   12.00   CUSTOMARY CHARGES   0   13.00   Amounts citually collected from patients Ii able for payment for services on a charge basis   0   0   14.00   15.00   Rounts citually collected from patients Ii able for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)   0   0.000000   0.000000   0.000000   15.00   Rounds of Ii to of Iine 13 to I line 14 (not to exceed 1.000000)   13.00   Rounds of customary charges (see instructions)   0   0.000000   0.000000   0.000000   15.00   Rounds of customary charges over reasonable cost (complete only if I line 16 exceeds   11.322,789   0   16.00   17.00   Rounds of customary charges over reasonable cost (complete only if I line 16 exceeds   11.322,789   0   17.00   18.00   Rounds of customary charges over reasonable cost (complete only if I line 16 exceeds   11.322,789   0   17.00   18.00	9.00	Ancillary service charges		6, 594, 972	0	9. 00
12. 00   Total reasonable charges (sum of lines 8 through 11)   11, 322, 789   0   12. 00   12. 00   13. 00   20. 00	10.00	Organ acquisition charges, net of revenue		0		10.00
CUSTOMARY CHARGES	11. 00	Incentive from target amount computation		0		11. 00
13.00   Amount actually collected from patients liable for payment for services on a charge   0   0   13.00	12.00	Total reasonable charges (sum of lines 8 through 11)		11, 322, 789	0	12.00
basis   14,00		CUSTOMARY CHARGES				
14.00   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 42 CFR §413.13(e)   0.000000   0.000000   15.00   16.00   17.00   18.00	13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
a charge basis had such payment been made in accordance with 42 CFR \$413.13(e)  16. 00 Ritio of line 13 to line 14 (not to exceed 1.000000)  17. 00 Total customary charges (see instructions)  18. 00 Excess of customary charges (see instructions)  18. 00 Excess of reasonable cost over reasonable cost (complete only if line 16 exceeds 8, 459, 123 0 17. 00 17.						
15.00	14. 00			0	0	14. 00
16. 00   Total customary charges (see instructions)   11, 322, 789   0   16. 00   Excess of customary charges over reasonable cost (complete only if line 16 exceeds   8, 459, 123   0   17. 00   17. 00   17. 00   18. 0			2 CFR §413.13(e)			
17. 00   Excess of customary charges over reasonable cost (complete only if line 16 exceeds   8, 459, 123   0   17. 00						
18.00   Excess of reasonable cost over customary charges (complete only if line 4 exceeds line   0   0   18.00   16) (see instructions)   0   0   10   100					-	
18.00   Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	17.00		y IT line 16 exceeds	8, 459, 123	0	17.00
16) (see instructions)	10 00		wifling 4 avecade line		0	10 00
19.00	18.00		y II IIIne 4 exceeds IIIne	0	U	18.00
20.00   Cost of physicians' services in a teaching hospital (see instructions)   0   2,863,666   0   2.00	10 00			0	0	10 00
21.00   Cost of covered services (enter the lesser of line 4 or line 16)   2,863,666   0   21.00			uctions)	١	-	
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.						
22.00   Other than outlier payments   0   0   22.00	21.00					21.00
23.00       Outlier payments       0       0       23.00         24.00       Program capital payments       0       24.00         25.00       Capital exception payments (see instructions)       0       25.00         26.00       Routine and Ancillary service other pass through costs       0       0.26.00         27.00       Subtotal (sum of lines 22 through 26)       0       0       27.00         28.00       Customary charges (title V or XIX PPS covered services only)       0       0       28.00         29.00       Titles V or XIX (sum of lines 21 and 27)       2,863,666       0       29.00         COMPUTATION OF REIMBURSEMENT SETTLEMENT         31.00       Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)       2,863,666       0       31.00         31.00       Deductibles       0       0       32.00         32.00       Coinsurance       0       0       33.00         34.00       Allowable bad debts (see instructions)       0       0       35.00         35.00       Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)       2,863,666       0       36.00         37.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       0       37.00         3	22.00		56p. 6.64.04		0	22. 00
24.00       Program capital payments       0       24.00         25.00       Capital exception payments (see instructions)       0       0       25.00         26.00       Routine and Ancillary service other pass through costs       0       0       26.00         27.00       Subtotal (sum of lines 22 through 26)       0       0       27.00         28.00       Customary charges (title V or XIX PPS covered services only)       0       0       28.00         29.00       Titles V or XIX (sum of lines 21 and 27)       2, 863, 666       0       29.00         COMPUTATION OF REIMBURSEMENT SETTLEMENT         30.00       Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)       2, 863, 666       0       31.00         31.00       Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)       2, 863, 666       0       31.00         32.00       Deductibles       0       0       32.00         33.00       Coinsurance       0       0       33.00         34.00       Allowable bad debts (see instructions)       0       0       34.00         35.00       Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)       2, 863, 666       0       36.00         37.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)				1		
25.00 Capital exception payments (see instructions)  26.00 Routine and Ancillary service other pass through costs  27.00 Subtotal (sum of lines 22 through 26)  28.00 Customary charges (title V or XIX PPS covered services only)  29.00 Titles V or XIX (sum of lines 21 and 27)  COMPUTATION OF REIMBURSEMENT SETTLEMENT  20.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)  20.00 Deductibles  20.00 Allowable bad debts (see instructions)  30.00 Allowable bad debts (see instructions)  30.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)  30.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)  30.00 Subtotal (line 36 ± line 37)  30.00 THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  30.00 Total amount payable to the provider (sum of lines 38 and 39)  40.00 Total amount payable to the provider (sum of lines 38 and 39)  40.00 Total amount payable to the provider (sum of lines 38 and 39)  40.00 Balance due provider/program (line 40 minus line 41)  40.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  25.00 Co. 0 26.00  27.00 Co. 0 26.00  28.00 Co. 0 28.00  29.00 Customary charges (title V or XIX PPS covered services only)  29.00 Customary charges (title V or XIX PPS covered services only)  29.00 Customary charges (title V or XIX PPS covered services only)  29.00 Customary charges (title V or XIX PPS covered services only)  29.00 Customary charges (title V or XIX PPS covered services only)  29.00 Customary charges (title V or XIX PPS covered services only)  29.00 Customary charges (title V or XIX PPS covered services only)  29.00 Customary charges (title V or XIX PPS covered services only)  29.00 Customary charges (title V or XIX PPS covered services only)  29.00 Customary charges (title V or XIX PPS covered services only)  29.00 Customary charges (title V or XIX PPS covered services only)  29.00 Customary charges (title Vor XIX PPS covered services only)  29.00 Customary charges (title Vor XIX PPS covered services only)  29.00 Customar				0		
26.00 Routine and Ancillary service other pass through costs  27.00 Subtotal (sum of lines 22 through 26)  28.00 Customary charges (title V or XIX PPS covered services only)  29.00 Titles V or XIX (sum of lines 21 and 27)  COMPUTATION OF REIMBURSEMENT SETTLEMENT  30.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)  20.00 Deductibles  30.00 Litilization review  30.00 Allowable bad debts (see instructions)  30.00 Utilization review  30.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  30.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  30.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  30.00 Subtotal (line 36 ± line 37)  30.00 OTHER adjustment endical education payments (from Wkst. E-4)  40.00 Total amount payable to the provider (sum of lines 38 and 39)  40.00 Allowable cost report items) in accordance with CMS Pub 15-2,  20.00 Customary charges (title V or XIX PPS covered services only)  30.00 27.00  30.00 28.00  30.00 29.00  30.00				0		
27. 00 Subtotal (sum of lines 22 through 26) 0 27. 00 28. 00 Customary charges (title V or XIX PPS covered services only) 0 28. 00 29. 00 Titles V or XIX (sum of lines 21 and 27) 2,863,666 0 2,863,666 0 2,863,666 0 31. 00  20. 00 Excess of reasonable cost (from line 18) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0	0	26. 00
29.00 Titles V or XIX (sum of lines 21 and 27)  2, 863, 666  0 29.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT  30.00 Excess of reasonable cost (from line 18)  30.00 Deductibles  30.00 Coinsurance  30.00 Allowable bad debts (see instructions)  31.00 Utilization review  32.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)  35.00 UTILER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  38.00 Subtotal (line 36 ± line 37)  39.00 Direct graduate medical education payments (from Wkst. E-4)  40.00 Total amount payable to the provider (sum of lines 38 and 39)  42.00 Balance due provider/program (line 40 minus line 41)  Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  0 29.00  29.00  29.00  29.00  29.00  29.00  30.00				0	0	27. 00
Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)   Coinsurance   Coins	28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
30.00 Excess of reasonable cost (from line 18) 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32.00 Deductibles 33.00 Coinsurance 34.00 Allowable bad debts (see instructions) 35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 36.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	29. 00	Titles V or XIX (sum of lines 21 and 27)		2, 863, 666	0	29. 00
31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)  2, 863, 666  32.00 Deductibles  3.00 Coinsurance  3.00 Allowable bad debts (see instructions)  3.00 Utilization review  3.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)  3.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  3.00 Subtotal (line 36 ± line 37)  3.00 Direct graduate medical education payments (from Wkst. E-4)  4.00 Total amount payable to the provider (sum of lines 38 and 39)  4.00 Balance due provider/program (line 40 minus line 41)  4.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  0 0 32.00  0 32.00  0 32.00  0 32.00  0 32.00  0 32.00  0 33.00  0 34.00  0 35.00  0 36.00  37.00  38.00  39.00  2,863,666  0 38.00  39.00  40.00 Total amount payable to the provider (sum of lines 38 and 39)  41.00 Balance due provider/program (line 40 minus line 41)  42.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,		COMPUTATION OF REIMBURSEMENT SETTLEMENT				
32. 00 Deductibles 0 0 32. 00 33. 00 Coinsurance 0 0 0 33. 00 34. 00 Allowable bad debts (see instructions) 0 0 34. 00 35. 00 Utilization review 0 0 35. 00 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 2, 863, 666 0 36. 00 37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37. 00 38. 00 Subtotal (line 36 ± line 37) 2, 863, 666 0 38. 00 39. 00 Direct graduate medical education payments (from Wkst. E-4) 0 39. 00 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 2, 863, 666 0 40. 00 41. 00 Interim payments 4, 718, 031 0 41. 00 42. 00 Balance due provider/program (line 40 minus line 41) -1, 854, 365 0 42. 00 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43. 00	30.00	Excess of reasonable cost (from line 18)		0	0	30. 00
33. 00   Coinsurance   0   0   33. 00   34. 00   Allowable bad debts (see instructions)   0   34. 00   35. 00   Utilization review   0   35. 00   35. 00   Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)   2,863,666   0   36. 00   37. 00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   0   37. 00   38. 00   Subtotal (line 36 ± line 37)   2,863,666   0   38. 00   39. 00   Direct graduate medical education payments (from Wkst. E-4)   0   Total amount payable to the provider (sum of lines 38 and 39)   2,863,666   0   40. 00   41. 00   Interim payments   4,718,031   0   41. 00   42. 00   Balance due provider/program (line 40 minus line 41)   -1,854,365   0   42. 00   43. 00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,   0   0   43. 00				2, 863, 666	-	
34. 00   Allowable bad debts (see instructions)				0	-	
35. 00 Utilization review 0 35. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 2, 863, 666 0 36. 00 0THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37. 00 38. 00 Subtotal (line 36 ± line 37) 2, 863, 666 0 38. 00 0THER adduate medical education payments (from Wkst. E-4) 0 39. 00 0THER adduate medical education payments (from Wkst. E-4) 0 39. 00 0THER adduate medical education payments (from Wkst. E-4) 0 39. 00 0THER amount payable to the provider (sum of lines 38 and 39) 2, 863, 666 0 40. 00 0THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 37. 00 0THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 37. 00 0 38. 00 0THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 37. 00 0 38. 00 0THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 37. 00 0 38. 00 0THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 37. 00 0 37. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0	-	
36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)  2, 863, 666  0 36.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  38.00 Subtotal (line 36 ± line 37)  2, 863, 666  0 37.00  2, 863, 666  0 38.00  39.00 Direct graduate medical education payments (from Wkst. E-4)  40.00 Total amount payable to the provider (sum of lines 38 and 39)  41.00 Interim payments  42.00 Balance due provider/program (line 40 minus line 41)  43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,		· · · · · · · · · · · · · · · · · · ·		0	0	0 00
37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  38. 00 Subtotal (line 36 ± line 37)  39. 00 Direct graduate medical education payments (from Wkst. E-4)  40. 00 Total amount payable to the provider (sum of lines 38 and 39)  41. 00 Interim payments  42. 00 Balance due provider/program (line 40 minus line 41)  43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  0 37. 00  2, 863, 666  0 40. 00  41. 00  41. 00  42. 00  43. 00  9 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  0 43. 00				0		
38.00   Subtotal (line 36 ± line 37)   2,863,666   0   38.00   39.00   Direct graduate medical education payments (from Wkst. E-4)   0   39.00   40.00   Total amount payable to the provider (sum of lines 38 and 39)   2,863,666   0   40.00   41.00   Interim payments   4,718,031   0   41.00   42.00   Balance due provider/program (line 40 minus line 41)   -1,854,365   0   42.00   43.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,   0   43.00			33)	2, 863, 666		
39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  39.00 2,863,666 4,718,031 0,41.00 41.00 42.00 0,43.00				0		
40.00 Total amount payable to the provider (sum of lines 38 and 39)  41.00 Interim payments  42.00 Balance due provider/program (line 40 minus line 41)  43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  0 40.00  41.00  42.00  43.00		,		2, 863, 666	0	
41.00 Interim payments 4,718,031 0 41.00 42.00 Balance due provider/program (line 40 minus line 41) -1,854,365 0 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00				0	_	
42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 42.00					-	
43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 43.00		, ,				
			1 II ONO B 1 45 0			
Cliapter   1,	43.00		ce wrth CMS Pub 15-2,	0	0	43.00
		Chapter 1, 9110.2		1		I

Health Financial Systems	UNION HOSPITAL, INC.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0023 Component CCN: 15-T023	From 01/01/2021	Worksheet E-3 Part VII Date/Time Prepared: 5/26/2022 10:49 am
	Title XIX	Subprovi der -	Cost

		II tie xix	I RF	COST	
			Inpatient	Outpati ent	
			1.00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVI	CES END TITLES V ND YIX		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	CES TOR TITLES V OR ATA	SERVICES		
1.00	Inpati ent hospital/SNF/NF services		42, 361		1. 00
2. 00	Medical and other services		42, 301	0	2. 00
3.00	Organ acquisition (certified transplant centers only)		0	O	3. 00
4. 00	Subtotal (sum of lines 1, 2 and 3)		42, 361	0	4. 00
5. 00	Inpatient primary payer payments		0	Ö	5. 00
6. 00	Outpatient primary payer payments			0	6. 00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		42, 361	0	7. 00
7.00	COMPUTATION OF LESSER OF COST OR CHARGES		12,001	Ü	7.00
	Reasonable Charges				
8.00	Routine service charges		190		8. 00
9. 00	Ancillary service charges		44, 961	0	9. 00
10. 00	Organ acquisition charges, net of revenue		0	· ·	10.00
11. 00	Incentive from target amount computation		o		11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		45, 151	0	12. 00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for s	services on a charge	0	0	13. 00
	basis	3			
14.00	Amounts that would have been realized from patients liable for p	payment for services on	0	0	14.00
	a charge basis had such payment been made in accordance with 42	CFR §413.13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16. 00	Total customary charges (see instructions)		45, 151	0	16.00
17. 00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	2, 790	0	17. 00
	line 4) (see instructions)				
18. 00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	0	0	18. 00
40.00	16) (see instructions)				40.00
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)		42, 361	U	21. 00
22. 00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co Other than outlier payments	mipreted for PPS provide	0	0	22. 00
23. 00	Outlier payments		0	0	23. 00
24. 00	Program capital payments		0	O	24. 00
25. 00	Capital exception payments (see instructions)		0		25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	26. 00
27. 00	Subtotal (sum of lines 22 through 26)		Ö	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		Ö	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		42, 361	0	29. 00
27.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		12,001	0	27.00
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)		42, 361	0	31. 00
32. 00	Deducti bl es		0	0	32. 00
33. 00	Coinsurance		o	0	33. 00
34.00	Allowable bad debts (see instructions)		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)	42, 361	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37. 00
38.00	Subtotal (line 36 ± line 37)		42, 361	0	38. 00
39. 00	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		42, 361	0	40.00
41. 00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		42, 361	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				

	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT L EDUCATION COSTS	Provider Co	CN: 15-0023	Peri od: From 01/01/2021	Worksheet E-4	
EDICA	L EDUCATION COSTS			To 12/31/2021	Date/Time Prep 5/26/2022 10:4	
		Title	XVIII	Hospi tal	PPS	
					1. 00	
00	COMPUTATION OF TOTAL DIRECT GME AMOUNT				14.00	1 0
. 00	Unweighted resident FTE count for allopathic and osteopathic ending on or before December 31, 1996.	programs for	cost reporti	ng periods	14. 92	1.0
. 00	Unweighted FTE resident cap add-on for new programs per 42 CF		1) (see instr	ructions)	0.00	2.0
. 00 . 01	Amount of reduction to Direct GME cap under section 422 of MM Direct GME cap reduction amount under ACA §5503 in accordance		§413.79 (m).	(see	0. 00 0. 00	3. 0 3. 0
. 00	instructions for cost reporting periods straddling 7/1/2011) Adjustment (plus or minus) to the FTE cap for allopathic and			•	0. 00	4.0
	GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)	)				
. 01	ACA Section 5503 increase to the Direct GME FTE Cap (see inst straddling 7/1/2011)	ructions for	cost reporti	ng periods	0. 00	4. C
. 02	ACA Section 5506 number of additional direct GME FTE cap slot	s (see inst	ructions for	cost reporting	0. 00	4.0
. 00	periods straddling 7/1/2011) FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 pl	us or minus	line 4 plus l	ines 4.01 and	14. 92	5. 0
. 00	4.02 plus applicable subscripts Unweighted resident FTE count for allopathic and osteopathic	nrograms for	the current	vear from vour	20. 53	6.0
. 00	records (see instructions)	programs ron	the current	year rrom your	20. 33	0.0
. 00	Enter the lesser of line 5 or line 6		Primary Care	e Other	14. 92 Total	7.0
			1. 00	2.00	3. 00	
. 00	Weighted FTE count for physicians in an allopathic and osteop	oathi c	20. 5	0.00	20. 53	8. 0
. 00	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amo		14. 9	0.00	14. 92	9. C
	6.					
0. 00 0. 01	Weighted dental and podiatric resident FTE count for the curr Unweighted dental and podiatric resident FTE count for the cu	,		0. 00 0. 00		10. C
1. 00	Total weighted FTE count	,	14. 9	0.00		11.0
2. 00	Total weighted resident FTE count for the prior cost reportin instructions)	ng year (see	14. 9	0.00		12. C
3. 00	Total weighted resident FTE count for the penultimate cost re year (see instructions)	eporting	14. 9	0.00		13. C
4. 00	Rolling average FTE count (sum of lines 11 through 13 divided	l by 3).	14. 9			14.0
5. 00 5. 01	Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new p	rograms	0. 0 0. 0			15. C
6. 00	Adjustment for residents displaced by program or hospital clo		0.0	1		16.0
6. 01	Unweighted adjustment for residents displaced by program or h	nospi tal	0.0	0.00		16.0
7. 00	closure Adjusted rolling average FTE count		14. 9	0.00		17. C
8. 00	Per resident amount		138, 338. 0	138, 338. 04		18. C
9. 00	Approved amount for resident costs		2, 064, 00	0 0	2, 064, 004	19. C
					1. 00	
). 00	Additional unweighted allopathic and osteopathic direct GME F Sec. 413.79(c)(4)	TE resident	cap slots red	eived under 42	5. 75	20. 0
1. 00	Direct GME FTE unweighted resident count over cap (see instru	ıcti ons)			5. 61	21.0
2. 00	Allowable additional direct GME FTE Resident Count (see instr				5. 61	22.0
3. 00 4. 00	Enter the locality adjustment national average per resident a Multiply line 22 time line 23	amount (see i	nstructions)		109, 943. 97	1
5. 00	, ,				616, 786 2, 680, 790	•
				t Managed Care	Total	
			1. 00	2. 00	3. 00	
5. 00	COMPUTATION OF PROGRAM PATIENT LOAD Inpatient Days (see instructions) (Title XIX - see S-2 Part I	X, line	27, 05			26. 0
	3. 02, col umn 2)					
7. 00 8. 00	Total Inpatient Days (see instructions) Ratio of inpatient days to total inpatient days		70, 87 0. 38170			27. C 28. C
9. 00	Program direct GME amount		1, 023, 27		1, 428, 567	29. 0
	Percent reduction for MA DGME			4. 07	·	29.0
9. 01 0. 00	Reduction for direct GME payments for Medicare Advantage			16, 495	16, 495	30.0

	Fi	1.110		u of Form CMS-2	2550 40
	L EDUCATION COSTS	Provider CCN. 15-0025	From 01/01/2021	Worksheet E-4	
WILDI CA	L EDUCATION COSTS		To 12/31/2021	Date/Time Prep 5/26/2022 10:4	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE EDUCATION COSTS)	E XVIII ONLY (NURSING PR	OGRAM AND PARAMED	)I CAL	
32. 00	Renal dialysis direct medical education costs (from Wkst. B, I and 94)	Pt. I, sum of col. 20 an	d 23, lines 74	0	32. 00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt.	I, col. 8, sum of lines	74 and 94)	اه	33. 00
34.00	Ratio of direct medical education costs to total charges (line	e 32 ÷ line 33)	,	0. 000000	34. 00
35.00	Medicare outpatient ESRD charges (see instructions)			0	35. 00
36.00	Medicare outpatient ESRD direct medical education costs (line	34 x line 35)		0	36. 00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	ONLY			
	Part A Reasonable Cost				
	Reasonable cost (see instructions)			62, 304, 472	
	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)			0	
	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	
	Primary payer payments (see instructions)	11 40		47, 056	
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus Part B Reasonable Cost	s line 40)		62, 257, 416	41.00
42. 00				65, 590, 130	42.00
43. 00	,			11, 585	
	Total Part B reasonable cost (line 42 minus line 43)			65, 578, 545	
	Total reasonable cost (sum of lines 41 and 44)			127, 835, 961	
	Ratio of Part A reasonable cost to total reasonable cost (line	e 41 ÷ line 45)		0. 487010	
	Ratio of Part B reasonable cost to total reasonable cost (line			0. 512990	
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PAR	,			
48.00	Total program GME payment (line 31)			1, 412, 072	48. 00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only)	(see instructions)		687, 693	49. 00
	Part B Medicare GME payment (line 47 x 48) (title XVIII only)			724, 379	50.00

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

Health Financial Systems

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

Worksheet G 21 21 Date/Time Prepared: 5/26/2022 10:49 am

Offi y)					5/26/2022 10:	49 am
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	I	1.00	2.00	3. 00	4. 00	
1. 00	CURRENT ASSETS Cash on hand in banks	78, 176, 679	0	0	0	1.00
2. 00	Temporary investments	76, 176, 679		_	-	
3.00	Notes receivable			_	0	3.00
4. 00	Accounts recei vabl e	69, 441, 176	Ō	Ō	0	
5.00	Other recei vable	0	0	0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6. 00
7.00	Inventory	6, 289, 601		0	0	
8. 00 9. 00	Prepaid expenses Other current assets	-38, 239, 108	0	0	0	
10.00	Due from other funds			_	0	10.00
11. 00	Total current assets (sum of lines 1-10)	115, 668, 348	1	_	•	11.00
00	FIXED ASSETS	11070007010	,			1 00
12.00	Land	19, 574, 412	! 0	0	0	12. 00
13. 00	Land improvements	20, 846, 581	0	0		13. 00
14. 00	Accumulated depreciation	0	0	0	1	14. 00
15.00	Bui I di ngs	307, 982, 453	1	0	0	15.00
16.00	Accumulated depreciation	-365, 641, 965	1	0	0	16.00
17. 00 18. 00	Leasehold improvements Accumulated depreciation	104, 445, 092	0	_	0	17. 00 18. 00
19. 00	Fi xed equi pment			_	0	19.00
20. 00	Accumulated depreciation	0		0	Ö	20.00
21. 00	Automobiles and trucks	0	Ö	Ō	0	21. 00
22. 00	Accumulated depreciation	0	0	0	0	22. 00
23. 00	Maj or movable equipment	191, 028, 380	0	0	0	23. 00
24. 00	Accumulated depreciation	0	0	0	0	24. 00
25. 00	Mi nor equi pment depreci abl e	0	0	0	0	25. 00
26. 00	Accumulated depreciation	0	0	0	0	26. 00
27. 00 28. 00	HIT designated Assets Accumulated depreciation	0		0	0	27. 00 28. 00
29. 00	Mi nor equi pment-nondepreci abl e			_	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	278, 234, 953	1	_		30.00
	OTHER ASSETS					
31. 00	Investments	0	0	0	-	31. 00
32. 00	Deposits on Leases	0	0	_	-	32. 00
33. 00	Due from owners/officers	0	0	_	0	33. 00
34. 00	Other assets	278, 055, 338			0	34. 00
35. 00 36. 00	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	278, 055, 338 671, 958, 639	1	_	0	35. 00 36. 00
30.00	CURRENT LIABILITIES	071, 730, 037	1			30.00
37. 00	Accounts payable	39, 700, 683	0	0	0	37. 00
38.00	Salaries, wages, and fees payable	27, 015, 604	0	0	0	38. 00
39. 00	Payroll taxes payable	0	0	0	0	
40. 00	Notes and Loans payable (short term)	0	0	0	0	1
41. 00	Deferred income	0	0	0	0	41.00
42. 00	Accel erated payments	0		0	0	42.00
43. 00 44. 00	Due to other funds Other current liabilities	2, 859, 337	0	0	0	43. 00 44. 00
45. 00	Total current liabilities (sum of lines 37 thru 44)	69, 575, 624		_		
10.00	LONG TERM LIABILITIES	07/070/021				10.00
46.00	Mortgage payable	54, 736, 969	0	0	0	46. 00
47. 00	Notes payable	0	0	_	-	
48. 00	Unsecured Loans	0	0	_		1
49. 00	Other long term liabilities	239, 399, 122	1	_	-	49. 00
50. 00 51. 00	Total long term liabilities (sum of lines 46 thru 49)	294, 136, 091		_	1	50. 00 51. 00
31.00	Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS	363, 711, 715	0	0	0	31.00
52. 00	General fund balance	308, 246, 924				52. 00
53. 00	Specific purpose fund	000/210/721	0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55. 00
56.00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	308, 246, 924	_	_	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	671, 958, 639			0	
_ 5. 55	[59]					-3.00
		•	•	•	•	•

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES UNION HOSPITAL, INC.

Period: Worksheet G-1
From 01/01/2021
To 12/21/2021 Provider CCN: 15-0023

					To	o 12/31/2021	Date/Time Pro 5/26/2022 10:	
		General	Fund	Speci al	Pu	rpose Fund	Endowment Fund	
		1.00	2. 00	3. 00		4. 00	5. 00	
1.00	Fund balances at beginning of period		240, 910, 795			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	67, 336, 129 308, 246, 924			0		2. 00
4. 00	Additions (credit adjustments) (specify)	0	300, 240, 724		0	_		1
5.00		0			0		c	
6.00		0			0			
7. 00 8. 00					0			
9. 00		l ő			0			
10.00	Total additions (sum of line 4-9)		0			0		10. 00
11.00	Subtotal (line 3 plus line 10)		308, 246, 924		0	0		11.00
12. 00 13. 00	Deductions (debit adjustments) (specify)	0			0			
14. 00		0			0			
15. 00		0			0		c	
16.00		0			0			
17. 00 18. 00	Total deductions (sum of lines 12-17)		0		U	0	C	17. 00 18. 00
19. 00	Fund balance at end of period per balance		308, 246, 924			0		19. 00
	sheet (line 11 minus line 18)	Fraderina and Francis	DI	Frank				
		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		O			4. 00
5.00			0					5. 00
6. 00 7. 00			0					6. 00 7. 00
8. 00			0					8.00
9.00			0					9. 00
10.00	Total additions (sum of line 4-9)	0			0			10.00
11. 00 12. 00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	O	0		0			11. 00 12. 00
13. 00	beddetrons (debrt adjustments) (specify)	1	0					13. 00
14.00			0					14. 00
15.00			0					15. 00
16. 00 17. 00			0					16. 00 17. 00
18. 00	Total deductions (sum of lines 12-17)	0	J		0			18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0			19. 00

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

			1	o 12/31/2021	Date/lime Prep 5/26/2022 10:	
	Cost Center Description		Inpati ent	Outpati ent	Total	77 GIII
	300 C 3011 C 300 C 1 P 1 C 1		1. 00	2. 00	3. 00	
	PART I - PATIENT REVENUES	'				
	General Inpatient Routine Services					
1.00	Hospi tal		123, 610, 413		123, 610, 413	1.00
2.00	SUBPROVI DER - I PF					2.00
3.00	SUBPROVI DER - I RF		5, 248, 776		5, 248, 776	3.00
4.00	SUBPROVI DER					4.00
5.00	Swing bed - SNF		0		0	5.00
6.00	Swing bed - NF		0		0	6. 00
7.00	SKILLED NURSING FACILITY					7. 00
8.00	NURSING FACILITY					8. 00
9.00	OTHER LONG TERM CARE					9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)		128, 859, 189		128, 859, 189	10. 00
	Intensive Care Type Inpatient Hospital Services					
11. 00	INTENSIVE CARE UNIT		34, 480, 940		34, 480, 940	11.00
12.00	CORONARY CARE UNIT					12.00
13. 00	BURN INTENSIVE CARE UNIT					13.00
14. 00	SURGICAL INTENSIVE CARE UNIT		10 704 005		10 704 005	14.00
15. 00	INTENSIVE NURSERY	Limos	18, 724, 925		18, 724, 925	15. 00
16. 00	Total intensive care type inpatient hospital services (sum of 11-15)	Times	53, 205, 865		53, 205, 865	16. 00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)		182, 065, 054		182, 065, 054	17. 00
18. 00	Ancillary services		371, 939, 896		1, 363, 403, 064	18. 00
19. 00	Outpati ent servi ces		39, 215, 725			19. 00
20. 00	RURAL HEALTH CLINIC		07, 213, 729		0	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	_	Ö	21. 00
22. 00	HOME HEALTH AGENCY		O	J	o l	22. 00
23. 00	AMBULANCE SERVI CES					23. 00
24. 00	CMHC					24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P. )					25. 00
26. 00	HOSPI CE					26. 00
27.00	RURAL HEALTH		0	5, 500, 432	5, 500, 432	27. 00
27. 01	RENTAL PROPERTY		0	0	0	27. 01
27. 02	FAMILY PRACTICE		0	1, 158, 774	1, 158, 774	27. 02
27. 03	WELLNESS		0	0	0	27. 03
27. 04	PHYSI CI AN PRACTI CES		839, 391	21, 713, 483	22, 552, 874	27. 04
27. 05	SYCAMORE SPORTS MED		0	0	0	27. 05
27. 06	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		275, 408	454, 964	730, 372	27. 06
27. 07	PRO FEES		3, 309, 460	1, 642, 433	4, 951, 893	27. 07
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	597, 644, 934	1, 138, 434, 709	1, 736, 079, 643	28. 00
	G-3, line 1)					
00.00	PART II - OPERATING EXPENSES			207 705 204		00.00
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		07 005 057	387, 725, 381		29. 00
30.00	HOME OFFICE		97, 085, 257			30. 00
31. 00 32. 00			0			31. 00
			0			32. 00
33. 00 34. 00			0			33. 00 34. 00
35. 00			0			35. 00
	Total additions (sum of lines 30-35)		U	97, 085, 257		36. 00
37.00	DEDUCT (SPECIFY)		0			37. 00
38. 00	SECTION		0			38. 00
39. 00			0			39. 00
40. 00			0			40. 00
41. 00			0			41. 00
42.00	Total deductions (sum of lines 37-41)		Ü	0		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42	)(transfer		484, 810, 638		43. 00
.0. 00	to Wkst. G-3, line 4)	/ (3. 4		.5.,5.5,666		.0.00
		'		'	'	1

	Financial Systems	UNION HOSPITAL, INC.		u of Form CMS-2	
STATEMEN	NT OF REVENUES AND EXPENSES	Provi der CCN: 15-0023	Peri od: From 01/01/2021	Worksheet G-3	
			To 12/31/2021	Date/Time Pre 5/26/2022 10:	
				1. 00	
1.00 T	Total patient revenues (from Wkst. G-2, Part I,	column 3 line 28)		1, 736, 079, 643	1. 00
	Less contractual allowances and discounts on pa			1, 730, 079, 043	2.00
	Net patient revenues (line 1 minus line 2)	trents accounts		528, 187, 939	•
	Less total operating expenses (from Wkst. G-2,	Part II lino 42)		484, 810, 638	
	Net income from service to patients (line 3 min			43, 377, 301	ł
	NET FICOME FROM SERVICE TO PATTERITS (TIME 3 MIT)	us ittle 4)		43, 377, 301	3.00
_	Contributions, donations, bequests, etc			0	6. 00
	ncome from investments			0	7. 00
	Revenues from telephone and other miscellaneous	communication convices		0	ı
	Revenue from television and radio service	Communication Services		0	ı
	Purchase di scounts				10.00
				0	
	Rebates and refunds of expenses			ū	11.00
	Parking lot receipts			0	12.00
	Revenue from laundry and linen service			0	13.00
	Revenue from meals sold to employees and guests			0	14.00
	Revenue from rental of living quarters			0	
	Revenue from sale of medical and surgical suppl			0	
	Revenue from sale of drugs to other than patien			0	17. 00
	Revenue from sale of medical records and abstra			0	18. 00
	Tuition (fees, sale of textbooks, uniforms, etc	•		0	19. 00
	Revenue from gifts, flowers, coffee shops, and	canteen		0	20.00
	Rental of vending machines			0	21. 00
4	Rental of hospital space			0	22. 00
	Governmental appropriations			0	23. 00
4	OTHER OPERATING INCOME			32, 785, 744	1
4	FRANSFERS AND OTHER ALLOCATED			2, 318, 964	1
4	NTEREST I NCOME			21, 420, 738	ı
	FRANSFER FOR PROPERTY AND EQUIPENT			0	24. 03
	JNREALIZED GAIN/LOSS ON INVESTMENTS			0	24. 04
	OTHER INCOME AND EXPENSE			-7, 809	ł
	OTHER INCOME AND EXPENSE			1, 891, 000	
24 50 0	COVED 10 DHE Funding			0	24 50

0

58, 408, 637 25. 00 101, 785, 938 26. 00 34, 449, 809 27. 00 34, 449, 809 28. 00

67, 336, 129 29. 00

24.50

24. 50 COVI D-19 PHE Funding

25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)
27.00 ALLOCATED COSTS

28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

		PITAL, INC.	In Lie	u of Form CMS-2	2552-10
CALCU	LATION OF CAPITAL PAYMENT	Provi der CCN: 15-0023	Peri od: From 01/01/2021 To 12/31/2021	Worksheet L Parts I-III Date/Time Pre 5/26/2022 10:	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD			1.00	
	CAPI TAL FEDERAL AMOUNT				1
1.00	Capital DRG other than outlier	4, 053, 223	1.00		
1. 01				0	1. 01
2.00				67, 350	
2.01	Model 4 BPCI Capital DRG outlier payments	0	2. 01		
3. 00 4. 00	Total inpatient days divided by number of days in the cost reporting period (see instructions)			182. 01 20. 53	3. 00 4. 00
5. 00	Number of interns & residents (see instructions)  Indirect medical education percentage (see instructions)			3. 23	
6. 00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and			130, 919	
	1.01) (see instructions)		,	,	
7.00	Percentage of SSI recipient patient days to Medicare Part	A patient days (Worksheet E	, part A line	4. 33	7. 00
	30) (see instructions)				
8.00				23. 72	
9.00				28. 05	
10. 00 11. 00				5. 84 236, 708	
12. 00				4, 488, 200	
12.00	Total prospective capital payments (see misti detrois)			4, 400, 200	12.00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)			0	1.00
2. 00 3. 00	Program inpatient ancillary capital cost (see instruction: Total inpatient program capital cost (line 1 plus line 2)	S)		0	
4. 00	Capital cost payment factor (see instructions)			0	
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	
0.00	Trocal Tripactions program captical cost (Trib o x Trib 1)				0.00
	DART III COMPUTATION OF EVERTION DAYWENTS			1. 00	
1. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions)			0	1.00
2. 00	Program inpatient capital costs (see instructions)  Program inpatient capital costs for extraordinary circums	tances (see instructions)		0	
3.00	Net program inpatient capital costs (line 1 minus line 2)	,		0	
4. 00	Applicable exception percentage (see instructions)			0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)			0	5. 00
6. 00	Percentage adjustment for extraordinary circumstances (see			0.00	
7.00	Adjustment to capital minimum payment level for extraordi	nary circumstances (line 2 >	(line 6)	0	
8.00	Capital minimum payment level (line 5 plus line 7)			0	
9. 00	Current year capital payments (from Part I, line 12, as a		1 aaa 1; ma ()	0	9.00
	Current year comparison of capital minimum payment level of Carryover of accumulated capital minimum payment level over			0	11.00
10. 00	IWantabaat I Dant III II aa 14)				
10. 00 11. 00	Worksheet L, Part III, line 14)		o 111	0	12.00
10. 00 11. 00 12. 00	Net comparison of capital minimum payment level to capita			_	1000
10. 00 11. 00 12. 00 13. 00	Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, en	nter the amount on this line	e)	0	13.00
10. 00 11. 00 12. 00 13. 00	Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, e Carryover of accumulated capital minimum payment level over	nter the amount on this line	e)	_	
10. 00 11. 00 12. 00	Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, el Carryover of accumulated capital minimum payment level over (if line 12 is negative, enter the amount on this line)	nter the amount on this line er capital payment for the f	e)	0	
10. 00 11. 00 12. 00 13. 00 14. 00	Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, electory construction of accumulated capital minimum payment level over (if line 12 is negative, enter the amount on this line) Current year allowable operating and capital payment (see	nter the amount on this line er capital payment for the finstructions)	e)	0	14. 00