Health Financi	al Systems	INC.	In Li	eu of Form CMS-2552-10	
	s required by law (42 USC 1395				
payments made	since the beginning of the co	st reporting period being o	leemed overpayments	s (42 USC 1395g).	OMB NO. 0938-0050
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY			Provider CCN: 1500	D23 Period: From 01/01/201: To 12/31/201:	
PART I - COST	REPORT STATUS				
Provider	 [X] Electronically filed 	cost report		Date: 5/25/2	016 Time: 10:01 am
use only	2. [] Manually submitted co	ost report			
	3.[0] If this is an amended 4.[F] Medicare Utilization.			er resubmitted this	cost report
Contractor	5. [1]Cost Report Status			10.NPR Date:	
use only	(1) As Submitted			11. Contractor's Vend	
		8. [N] Initial Report for 9. [N] Final Report for the	this Provider CCN	12.[0]1T line 5, 0	Column 1 15 4: Enter
	(3) Settled with Audit	3. [N] Fillal Report for the	IIS PIOVIUEI CCN	number of ti	mes reopened = $0-9$.
	(4) Reopened			•	
	(5) Amended				
PART II - CERT	IFICATION				

ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by UNION HOSPITAL, INC. (150023) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 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.

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

Encryption Information
ECR: Date: 5/25/2016 Time: 10:01 am jNknyS9CJagEyRQrmYtub7LEzrA0U0 Kt8wXOPUIuKrObs83fwzsNvz8KdRPC T0181wF.hH0vx71w Date: 5/25/2016 Time: 10:01 am

OaCikFJMtBB5XfWZIhL4tzj1fWYZRO TDbihO5go:7DRHuDi75bmi72uaSSpH

(Signed)

lm Officer or Administrator of Provider(s)

Title

Date

			Title XVIII				
		Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	1,141,310	10,063	-89,638	-456,369	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	-53,823	6		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	1,087,487	10,069	-89,638	-456,369	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: 150023 Period: Worksheet S-2

From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/25/2016 10:01 am 3.00 4. 00 Hospital and Hospital Health Care Complex Address: Street: 1606 NORTH SEVENTH ST 1.00 PO Box: 1.00 State: IN 2.00 Ci ty: TERRE HAUTE Zip Code: 47804-County: VI GO 2.00 Provi der Component Name CCN CBSA Date Payment System (P, Certi fi ed Number Number T, 0, or N) Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 UNION HOSPITAL, INC. 150023 45460 01/01/1966 Ν Р 0 3.00 Hospi tal 1 4.00 Subprovider - IPF 4.00 5.00 Subprovider - IRF MEDICAL REHAR 15T023 45460 5 09/01/1989 N Р 0 5 00 Subprovi der - (Other) 6.00 6.00 7.00 Swing Beds - SNF 7.00 Swing Beds - NF 8.00 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospital-Based NF 10.00 Hospi tal -Based OLTC 11 00 11 00 Hospi tal -Based HHA 12.00 12.00 13.00 Separately Certified ASC 13.00 Hospi tal -Based Hospi ce 14.00 14.00 15.00 Hospital-Based Health Clinic - RHC 15.00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 Renal Dialysis 18.00 18.00 19.00 Other 19.00 From: To: 1.00 2.00 20.00 | Cost Reporting Period (mm/dd/yyyy) 12/31/2015 20 00 01/01/2015 Type of Control (see instructions) 21.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate N 22.00 22.00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y' for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting 22.01 Ν Ν period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care payments to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on in column 2, or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result Ν Ν 22.03 of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 3 Ν 23.00 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2 enter "Y" for yes or "N" fo<u>r no</u>. Out-of Medi cai d Other In-State In-State Out-of Medi cai d Medi cai d Medi cai d State State HMO davs paid days el i gi bl e Medi cai d Medi cai d days paid days el i gi bl e unpai d days unpai d 1.00 2.00 3. 00 4.00 5. 00 6.00 24.00 If this provider is an IPPS hospital, enter the 2. 213 4.865 1, 220 489 5,649 24.00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. If this provider is an IRF, enter the in-state 149 34 0 25.00 163 14 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.

			ΓAL, ΙΝC.		1	n Lieu	of For	m CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ГА	Provi der (eriod: rom 01/01.	/2015	Workshe Part I	eet S-2	2
				To	12/31.	/2015	Date/Ti 5/25/20	me Pre	pared: 01 am
				<u> </u>	Urban/Ru 1.00	ral S	Date of	Geogr	-
26. 00	Enter your standard geographic classification (not wa			inning of the	1.00	1	2. (JU	26. 00
27. 00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or	ge) sta "2" fo	atus at the end or rural. If ap			1			27. 00
35. 00	enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			H status in		0			35. 00
					Begi nni 1. 00		Endi 2. (-
36. 00	Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date		Subscript line	36 for number					36. 00
	If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.	the nu	·			0			37. 00
38. 00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38. 00
					Y/N 1. 00		Y/ 2. (
	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage req)? Ĕnt∈	er in column 1	"Y" for yes	N		N		39. 00
40. 00	CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob	adjust er 1. E	tment? Enter "Y Enter "Y" for y	" for yes or	Y		Υ	•	40. 00
	no in column 2, for discharges on or after October 1.	(see i	IISTFUCTIONS)			V	XVIII	XI X	
	Prospective Payment System (PPS)-Capital					1. 00	2. 00	3.00	
	Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions)					N	Y	N	45. 00
46. 00	Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.					N	N	N	46. 00
	Is this a new hospital under 42 CFR §412.300 PPS capi Is the facility electing full federal capital payment				10.	N N	N N	N N	47. 00 48. 00
56. 00	Teaching Hospitals Is this a hospital involved in training residents in or "N" for no.	approve	ed GME programs	? Enter "Y" f	for yes	Υ			56. 00
57. 00	If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y"N", complete Wkst. D, Parts III & IV and D-2, Pt. II	yes or h of th ", comp	"N" for no in nis cost report Diete Worksheet	column 1. If ing period? E	column 1 Inter "Y"	N			57.00
	If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	ursemer complet	nt for physicia te Wkst. D-5.		IS	N			58. 00
	Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing school and/or allied health					N Y			59. 00 60. 00
	provider-operated criteria under §413.85? Enter "Y"	for yes	or "N" for no	. (see instruc Direct GME	tions)		Di rect	t GMF	
		·							
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in	1. 00 N	2. 00	3. 00	4.00	0.00	5. (61.00
	column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see		0.00	0.00					61. 01
61. 02	instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of		0.00	0.00					61. 02
61. 03	ACA). (see instructions) 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		0. 00	0.00					61. 03
61. 04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0. 00	0.00					61. 04
61. 05	current cost reporting period (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line		0. 00	0.00					61. 05
61 06	61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being		0. 00	0.00					61. 06

Health Financial Systems UNION HOSPITAL, INC. In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 150023 Peri od: Worksheet S-2 From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/25/2016 10:01 am Program Code Unweighted IME Program Name Unwei ghted Direct ĞME FTE FTE Count Count 1.00 2.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0.00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column direct GME FTE unweighted count. 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 62 01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter Υ 63.00 for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions) Unwei ahted Ratio (col. 1/ Unwei ahted **FTES** FTEs in (col . 1 + col Nonprovi der Hospi tal 2)) Si te 1. 00 2.00 3.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents 0.000000 64.00 0.00 n the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Unwei ghted Unwei ghted Ratio (col. 3/ FTĔs FTEs in (col. 3 + col. Nonprovi der Hospi tal 4)) Si te 1.00 3.00 4.00 5.00 UH FAMILY MEDICINE 65.00 Enter in column 1, if line 63 1201711131 0. 91 20. 14 0. 043230 65. 00 is yes, or your facility RESI DENCY trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of

unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 + column 4)). (see instructions)

In Lieu of Form CMS-2552-10 Health Financial Systems UNION HOSPITAL, INC. HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 150023 Peri od: Worksheet S-2 From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/25/2016 10:01 am Unwei ghted Unwei ghted Ratio (col. (col. 1 + col FTEs FTEs in 2)) Nonprovi der Hospi tal Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 66.00 0.000000 66.00 Enter in column 1 the number of unweighted non-primary care resident 0.00 0.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Code Ratio (col. 3/ Program Name Unwei ghted Unwei ahted FTEs FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1 00 3. 00 2 00 4.00 5 00 67.00 Enter in column 1, the program UH FAMILY MEDICINE 1201711131 0.81 6.21 0. 115385 67. 00 name associated with each of RESI DENCY your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4. the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no. 70.00 70.00 Ν If line 70 yes. Column 1: Did the facility have an approved GME teaching program in the most 71.00 0 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF Υ 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most Υ Ν O 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 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 80.00 N 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 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. N 85.00 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 \$413.40(f)(i)(i)? Enter "Y" for yes and "N" for no.
Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" 87.00 N for yes or "N" for no. ٧/ XI X 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 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 Ν Ν 91.00 full or in part? Enter "Y" for yes or "N" for no in the applicable column. 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. 92.00 92.00 N Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. 93 00 Ν N 93 00 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the Ν 94.00 Ν applicable column.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	ITAL, INC. Provi der	CCN: 150023 Pe	In L	_ieu of Form CI Worksheet	
	11011001		om 01/01/20	15 Part I	Prepared:
			V	XI X	10. 01 alli
95.00 If line 94 is "Y", enter the reduction percentage in the ap	anlicable column	<u> </u>	1.00	2.00	. 00 95. 00
96.00 Does title V or XIX reduce operating cost? Enter "Y" for yeapplicable column.	es or "N" for no	o in the	N	N	96. 00
97.00 If line 96 is "Y", enter the reduction percentage in the ap	oplicable column	n.	0.	. 00	97.00
105.00 Does this hospital qualify as a critical access hospital (C 106.00 If this facility qualifies as a CAH, has it elected the all for outpatient services? (see instructions)		hod of payment	N N		105. 00 106. 00
107.00 If this facility qualifies as a CAH, is it eligible for costraining programs? Enter "Y" for yes or "N" for no in colum yes, the GME elimination is not made on Wkst. B, Pt. I, col reimbursed. If yes complete Wkst. D-2, Pt. II.	mn 1. (see insti	ructions) If	N		107. 00
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N		108. 00
	Physi cal 1.00	Occupational 2.00	Speech 3.00	Respirator	ry
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N N	N N	N N	109.00
				1.00	
110.00 Did this hospital participate in the Rural Community Hospit the current cost reporting period? Enter "Y" for yes or "N"		on project (410	A Demo)for	N	110. 00
			1	. 00 2. 00 3.	00
Miscellaneous Cost Reporting Information 115.00 s this an all-inclusive rate provider? Enter "Y" for yes of	on "N" for no is	a caluma 1 lf	column 1	N C	115 00
is yes, enter the method used (A, B, or E only) in column 2 3 either "93" percent for short term hospital or "98" perce psychiatric, rehabilitation and long term hospitals provide Pub. 15-1, chapter 22, §2208.1.	2. If column 2 i ent for long ter	is "E", enter i rm care (includ	n column les	N C	115.00
116.00 s this facility classified as a referral center? Enter "Y" 117.00 s this facility legally-required to carry malpractice insu	•		N" for	Y	116. 00 117. 00
no. 118.00 s the malpractice insurance a claims-made or occurrence po	olicy? Enter 1 i	if the policy i	s	1	118. 00
claim-made. Enter 2 if the policy is occurrence.		Premi ums	Losses	Insurance	5
		1.00	2. 00	3.00	
118.01 List amounts of malpractice premiums and paid losses:		928, 586		0	0 118. 01
			1. 00	2.00	110.00
118.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sche and amounts contained therein.			N		118. 02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that of Hold Harmless provision in ACA §3121 and applicable amendments.	n column 1, "Y' qualifies for th	" for yes or he Outpatient	N	N	119. 00 120. 00
Enter in column 2, "Y" for yes or "N" for no. 121.00Did this facility incur and report costs for high cost implements? Enter "Y" for yes or "N" for no.	antable devices	s charged to	Y		121. 00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" f yes, enter certification date(s) (mm/dd/yyyy) below.			N		125. 00
126.00 If this is a Medicare certified kidney transplant center, ϵ in column 1 and termination date, if applicable, in column		fication date			126. 00
127.00 If this is a Medicare certified heart transplant center, er in column 1 and termination date, if applicable, in column	2.				127. 00
	2.				128. 00
128.00 If this is a Medicare certified liver transplant center, er in column 1 and termination date, if applicable, in column		cation date in	1		129. 00
in column 1 and termination date, if applicable, in column 129.00 If this is a Medicare certified lung transplant center, ent column 1 and termination date, if applicable, in column 2.					105
in column 1 and termination date, if applicable, in column 129.00 If this is a Medicare certified lung transplant center, ent column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in column 2.	enter the ceri	ti fi cati on			
in column 1 and termination date, if applicable, in column 129.00 If this is a Medicare certified lung transplant center, ent column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in column 1.	enter the cert olumn 2. er, enter the ce olumn 2.	tification ertification			130.00
in column 1 and termination date, if applicable, in column 129.00 If this is a Medicare certified lung transplant center, ent column 1 and termination date, if applicable, in column 2.130.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in column 1.131.00 If this is a Medicare certified intestinal transplant center.	enter the cert olumn 2. er, enter the ce olumn 2. nter the certifi 2.	tification ertification ication date			

alth Financial Systems SPITAL AND HOSPITAL HEALTH CARE COMPLEX I		PITAL, INC. Provider C	CN: 15002		:	u of Form CMS Worksheet S	
				From C	1/01/2015 2/31/2015	Part I	repared
					1. 00	2.00	_
All Providers					1.00	2.00	
O.00 Are there any related organization of chapter 10? Enter "Y" for yes or "N" are claimed, enter in column 2 the ho	for no in column 1. ome office chain numb	If yes, and home o er. (see instructi	office co		Υ	15H043	140. 0
1.00 If this facility is part of a chain		2.00	ab 142 +b		3.00	of the	
home office and enter the home office				e name an	a address	or the	
1.00 Name: UNION HOSPITAL, INC.	Contractor's Name:	WISCONSIN PHYSICIA		actor's Nu	ımber: 0810)1	141. (
2.00Street: 1606 NORTH SEVENTH ST	PO Box:	SERVI CES					142.
3. OO Ci ty: TERRE HAUTE	•	IN	Zip Co	ode:	4780)4	143.
						1.00	
4.00 Are provider based physicians' costs	included in Workshee	t A?				1.00 Y	144.
The copies of provided and second project or allowed the contract of the contr	THE GOOD THE WORKSHOO						
E COLE appets for manal complete and all in	mad an Wkat A Lina	74 and the easts	for		1. 00	2.00	145
5.00 If costs for renal services are claim inpatient services only? Enter "Y" fo no, does the dialysis facility inclu- period? Enter "Y" for yes or "N" for	or yes or "N" for no de Medicare utilizati r no in column 2.	in column 1. If co on for this cost r	olumn 1 is reporting	5	Y		145.
6.00 Has the cost allocation methodology of Enter "Y" for yes or "N" for no in co yes, enter the approval date (mm/dd/	olumn 1. (See CMS Pub			lf	N		146.
						1.00	
7.00 Was there a change in the statistical 3.00 Was there a change in the order of al						N N	147. 148.
3.00 was there a change in the order of a 3.00 Was there a change to the simplified				for no.		N N	149.
		Part A	Part	В 1	itle V	Title XIX	
Does this facility contain a provide	r that qualifies for	1.00	2. 00		3.00 f the Lowe	4.00	
or charges? Enter "Y" for yes or "N"							
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		N	N		N	N	159.
D.OO HOME HEALTH AGENCY 1.OO CMHC		N	N N		N N	N N	160. 161.
Mul +i compus						1.00	
Multicampus 5.00 s this hospital part of a Multicampo	us hospital that has	one or more campus	ses in di	fferent CE	BSAs?	N	— 165.
Enter "Y" for yes or "N" for no.		· .					
	Name 0	County 1.00	2. 00	Zi p Code 3.00	4. 00	FTE/Campus 5.00	\dashv
c.00 on the contract of the co	7						00 166.
						1.00	
Hoal th Intormation Lockhology (ULT)	- ,	"Y" for yes or "N	N" for no		the	Y	167. 0168.
7.00 s this provider a meaningful user u 3.00 f this provider is a CAH (line 105)							1
7.00 s this provider a meaningful user un B.00 of this provider is a CAH (line 105) reasonable cost incurred for the HIT	assets (see instruct	i ons)	qual i fv	for a hard	dshi p		168.
7.00 Is this provider a meaningful user un 3.00 If this provider is a CAH (line 105 reasonable cost incurred for the HIT 3.01 If this provider is a CAH and is not exception under §413.70(a)(6)(ii)? El	assets (see instruct a meaningful user, d nter "Y" for yes or " r (line 167 is "Y") a	ions) oes this provider N" for no. (see ir	nstructi o	ns) is "N"), e	enter the		
7.00 Is this provider a meaningful user un 8.00 If this provider is a CAH (line 105 in reasonable cost incurred for the HIT B.01 If this provider is a CAH and is not exception under §413.70(a)(6)(ii)? Even 9.00 If this provider is a meaningful user	assets (see instruct a meaningful user, d nter "Y" for yes or " r (line 167 is "Y") a	ions) oes this provider N" for no. (see ir	nstructi o	ns) is "N"), e	·	0. Endi ng 2.00	168. 50169.

Health Financial Systems	UNION HOSPITAL,	I NC.	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDE	ENTIFICATION DATA	Provi der CCN: 150023	From 01/01/2015		
			To 12/31/2015	Date/Time Pre 5/25/2016 10:	
				1.00	
171.00 If line 167 is "Y", does this provider	have any days for individ	duals enrolled in sect	ion 1876	N	171. 00
Medicare cost plans reported on Wkst. (see instructions)	nd "N" for no.				

	Financial Systems	UNI ON HOSPITAL, INC.	0011 450000		eu of Form CMS-	
HOSPI T.	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE Provi der		Period: From 01/01/2015		
				Го 12/31/2015	Date/Time Pro 5/25/2016 10	
		·		Y/N	Date	
	General Instruction: Enter Y for all YES resp	ponses Enter N for all NO re	senonses Enter	1.00	2.00	
	mm/dd/yyyy format.	onses. Effer in for all no re	sponses. Litter	arr dates in	trie	
	COMPLETED BY ALL HOSPITALS					
1. 00	Provider Organization and Operation Has the provider changed ownership immediate	ly prior to the beginning of	the cost	N	I	1.0
	reporting period? If yes, enter the date of		instructions)			
			1.00	2. 00	V/I 3. 00	
2. 00	Has the provider terminated participation in	the Medicare Program? If	N N	2.00	3.00	2.00
	yes, enter in column 2 the date of termination	on and in column 3, "V" for				
3. 00	voluntary or "I" for involuntary. Is the provider involved in business transac	tions, including management	Y			3. 0
	contracts, with individuals or entities (e.g.	., chain home offices, drug				
	or medical supply companies) that are related officers, medical staff, management personnel					
	of directors through ownership, control, or					
	relationships? (see instructions)		Y/N	Turno	Data	
			1.00	7ype 2. 00	3. 00	
	Financial Data and Reports					
4. 00	Column 1: Were the financial statements pre Accountant? Column 2: If yes, enter "A" for		Y	A		4.00
	or "R" for Reviewed. Submit complete copy or					
- 00	column 3. (see instructions) If no, see instru		N.			F 0/
5. 00	Are the cost report total expenses and total those on the filed financial statements? If		N			5.00
	those on the fired financial statements.	, 30, 30, 30, 30, 30, 30, 30, 30, 30, 30		Y/N	Legal Oper.	
	Approved Educational Activities			1. 00	2. 00	
5. 00	Column 1: Are costs claimed for nursing scho	ool? Column 2: If yes, is th	ne provider is	N		6.00
	the legal operator of the program?		•			
7. 00 3. 00	Are costs claimed for Allied Health Programs' Were nursing school and/or allied health pro		l during the	Y		7. 0
	cost reporting period? If yes, see instruction		r during the	14		
9. 00	Are costs claimed for Interns and Residents i		al education	Υ		9. 00
10. 00	program in the current cost report? If yes, s Was an approved Intern and Resident GME progr		he current	N		10.00
	cost reporting period? If yes, see instruction					1
11. 00	Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see		proved	N		11.00
	reaching frogram on worksheet A: 11 yes, see	Thistructions.			Y/N	
	D-1 D-6+-				1. 00	
12. 00	Bad Debts Is the provider seeking reimbursement for bad	d debts? If ves. see instruct	i ons.		Y	12. 00
13. 00	If line 12 is yes, did the provider's bad del			st reporting	N	13. 00
14 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles a	and/ar so nayments weiged? If	Type soo ins	rueti enc	N	14.00
	Bed Complement	and/or co-payments warveur in	yes, see ms	ir uctrons.	I IN	14.00
15. 00	Did total beds available change from the pri	or cost reporting period? If	ť –		Y	15.00
		D		rt A Date	Part B Y/N	10.00
			I Y/N			10.00
		Description 0	Y/N 1.00	2. 00	3.00	1010
	PS&R Data		1.00	2. 00	3.00	
	Was the cost report prepared using the PS&R					
			1.00	2. 00	3.00	
	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		1.00	2. 00	3.00	
16. 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)		1.00	2. 00	3.00	16. 0
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) Was the cost report prepared using the PS&R Report for totals and the provider's records		1. 00 Y	2. 00	3. 00 Y	16. 0
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) 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		1. 00 Y	2. 00	3. 00 Y	16. 0
16. 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) Was the cost report prepared using the PS&R Report for totals and the provider's records		1. 00 Y	2. 00	3. 00 Y	16. 0
17. 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) 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) If line 16 or 17 is yes, were adjustments		1. 00 Y	2. 00	3. 00 Y	16. 0
17. 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) 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) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional		1. 00 Y	2. 00	3. 00 Y	16. 0
7. 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) 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) If line 16 or 17 is yes, were adjustments		1. 00 Y	2. 00	3. 00 Y	16. 0
6. 007. 008. 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) 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) 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 cost report? If yes, see instructions.		1. 00 Y N	2. 00	3. 00 Y N	16. 00 17. 00 18. 00
6. 007. 008. 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) 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) 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 cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments		1. 00 Y	2. 00	3. 00 Y	16. 0 17. 0
6. 007. 008. 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) 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) 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 cost report? If yes, see instructions.		1. 00 Y N	2. 00	3. 00 Y N	16. 00
16. 00 17. 00 18. 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) 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) 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 cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		1. 00 Y N N	2. 00	3. 00 Y N N	16. 00 17. 00 18. 00
16. 00 17. 00 18. 00 19. 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) 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) 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 cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see		1. 00 Y N	2. 00	3. 00 Y N	16. 00

Health FinancialSystemsUNION HOSPITAL, INC.In Lieu of Form CMS-2552-10HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIREProvider CCN: 150023Period: From 01/01/2015Worksheet S-2

Date/Time Prepared: 12/31/2015 5/25/2016 10:01 am Part A Part B Description Y/N Date Y/N 0 1.00 2.00 3.00 21.00 Was the cost report prepared only using the Ν 21 00 Ν provider's records? If yes, see instructions 1.00 COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost Have assets been relifed for Medicare purposes? If yes, see instructions 22.00 22.00 Ν Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost 23.00 Ν 23.00 reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? Ν 24.00 If ves. see instructions Have there been new capitalized leases entered into during the cost reporting period? If yes, see Ν 25.00 25.00 instructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see Ν 26,00 instructions. 27 00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit Ν 27.00 сору Interest Expense 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting N 28.00 period? If yes, see instructions. Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) Ν 29.00 treated as a funded depreciation account? If yes, see instructions Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see Ν 30.00 instructions. 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see Ν 31.00 instructions. Purchased Services 32.00 Have changes or new agreements occurred in patient care services furnished through contractual N 32.00 arrangements with suppliers of services? If yes, see instructions. If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If Ν 33.00 33.00 no, see instructions. Provi der-Based Physicians Are services furnished at the provider facility under an arrangement with provider-based physicians? Ν 34.00 If yes, see instructions. Iffine 34 is yes, were there new agreements or amended existing agreements with the provider-based Ν 35.00 physicians during the cost reporting period? If yes, see instructions. Y/N Date 1.00 2.00 Home Office Costs 36, 00 Were home office costs claimed on the cost report? 36, 00 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? Υ 37.00 If yes, see instructions. If line 36 is yes, was the fiscal year end of the home office different from that of N 38.00 the provider? If yes, enter in column 2 the fiscal year end of the home office. If line 36 is yes, did the provider render services to other chain components? If yes, 39.00 39.00 N see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see Ν 40.00 instructions. 1.00 2.00 Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position LANDON HACKETT 41.00 held by the cost report preparer in columns 1, 2, and 3, respecti vel y. Enter the employer/company name of the cost report BLUE & CO., LLC 42.00 42.00 preparer. 43.00 Enter the telephone number and email address of the cost 317-713-7929 LHACKETT@BLUEANDCO. COM 43.00 report preparer in columns 1 and 2, respectively.

Heal th F	inancial Systems	UNION HOSPITAL	I NC.	In Lie	u of Form CMS-2552-10
HOSPI TAL	AND HOSPITAL HEALTH CARE REI	BURSEMENT QUESTI ONNAI RE	Provi der CCN: 150023	From 01/01/2015	Worksheet S-2 Part II Date/Time Prepared:

					From 01/01/2015 To 12/31/2015	Part II Date/Time Pre	
						5/25/2016 10:	01 am_
		Part B	1				
		Date	1				
		4. 00					
	PS&R Data						1
16. 00	Was the cost report prepared using the PS&R	03/30/2016					16. 00
	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						
47.00	instructions)						1
17. 00	Was the cost report prepared using the PS&R						17. 00
	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)						
18. 00	,						18. 00
16.00	made to PS&R Report data for additional						18.00
	claims that have been billed but are not						
	included on the PS&R Report used to file						
	this cost report? If yes, see instructions.						
19. 00			İ				19.00
	made to PS&R Report data for corrections of						
	other PS&R Report information? If yes, see						
	instructions.						
20.00							20. 00
	made to PS&R Report data for Other? Describe						
	the other adjustments:						
21. 00	Was the cost report prepared only using the						21. 00
	provi der's records? If yes, see						
	instructions.						
				3. 00	_		
	Cost Report Preparer Contact Information		1	3.00			
41 00	Enter the first name, last name and the title	/nocition	MANAGI	D			41. 00
41.00	held by the cost report preparer in columns 1		IVIAINAGI	-N			41.00
	respectively.	i, 2, and 5,					
42. 00	Enter the employer/company name of the cost r	report	1				42.00
.2. 50	preparer.	-1					12.00
43.00	1	of the cost					43. 00
· · · · · ·	report preparer in columns 1 and 2, respective						
		-	•		•		•

Part I

23.00

24 00

24. 10

25.00

26, 00

26.25

27.00

28.00

29.00

30.00

31.00

32.00

32.01

33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

AMBULATORY SURGICAL CENTER (D. P.)

FEDERALLY QUALIFIED HEALTH CENTER

Employee discount days (see instruction)

Labor & delivery days (see instructions)

Total ancillary labor & delivery room

outpatient days (see instructions)

HOSPICE (non-distinct part)

Total (sum of lines 14-26)

Employee discount days - IRF

23.00

24 00

24. 10

25. 00

26.00

26, 25

27.00

28.00

29.00

30.00

31.00

32.00

32.01

HOSPI CE

CMHC - CMHC

RURAL HEALTH CLINIC

Observation Bed Days

Ambul ance Trips

33.00 LTCH non-covered days

From 01/01/2015 12/31/2015 Date/Time Prepared: 5/25/2016 10:01 am I/P Days / O/P Visits / Trips Component Worksheet A No. of Beds Bed Days CAH Hours Title V Line Number Avai I abl e 5.00 1.00 2.00 3.00 4.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 30.00 19 69, 715 0.00 0 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2 00 HMO and other (see instructions) 2 00 3.00 HMO IPF Subprovider 3.00 HMO IRF Subprovider 4.00 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 5.00 0 Hospital Adults & Peds. Swing Bed NF 6.00 0 6.00 7.00 Total Adults and Peds. (exclude observation 191 69, 715 0.00 0 7.00 beds) (see instructions) INTENSIVE CARE UNIT 31.00 8.00 36 13, 140 0.00 0 8.00 CORONARY CARE UNIT 9.00 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 INTENSIVE NURSERY 35.00 5, 475 0.00 0 15 12.00 13.00 NURSERY 43.00 0 13.00 14.00 Total (see instructions) 242 88, 330 0.00 0 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 16.00 16.00 SUBPROVIDER - IRF 41.00 8,030 17.00 22 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

30.00

264

17

6, 205

| Peri od: | Worksheet S-3 | From 01/01/2015 | Part I | To 12/31/2015 | Date/Time Prepared: Provi der CCN: 150023

				''	0 12/31/2013	5/25/2016 10:	
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	'			Pati ents	& Residents	Payrol I	
		6.00	7. 00	8.00	9. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	24, 539	2, 213	47, 733			1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	3, 394	12, 223				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO IRF Subprovider	0	211				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	24, 539	2, 213	47, 733			7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	5, 360	0	9, 032			8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	I NTENSI VE NURSERY	0	0	3, 528			12.00
13.00	NURSERY		0	3, 606			13.00
14.00	Total (see instructions)	29, 899	2, 213	63, 899	20. 98	1, 413. 75	14.00
15.00	CAH visits	o	0	0			15. 00
16.00	SUBPROVI DER - I PF						16.00
17.00	SUBPROVI DER - I RF	2, 719	149	3, 899	0.00	23. 73	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)	o	0	0			24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 25
27.00	Total (sum of lines 14-26)				20. 98	1, 437. 48	27. 00
28. 00	Observation Bed Days		0	9, 212			28. 00
29.00	Ambul ance Tri ps	o					29. 00
30.00	Employee discount days (see instruction)		1	0			30. 00
31.00	Employee discount days - IRF		1	0			31.00
32.00	Labor & delivery days (see instructions)	О	17	30			32. 00
32. 01	Total ancillary labor & delivery room			346			32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days	О	1				33. 00
	•	. '	'		•	•	•

Provi der CCN: 150023 | Peri od: | Worksheet S-3 | Part I | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | F/35/(2014 10:01 em.

				10) 12/31/2015	5/25/2016 10:0	
		Full Time	<u>'</u>	Di sch	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12.00	13. 00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)		0	6, 646	418	14, 455	1. 00
2. 00 3. 00	HMO and other (see instructions)			674	2, 722 0		2. 00 3. 00
4.00	HMO IRF Subprovider				17		4. 00
5.00					17		5. 00
6.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	, ,						7. 00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
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	INTENSIVE NURSERY						12. 00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0.00	0	6, 646	418	14, 455	14. 00
15. 00	CAH visits	0.00	0	0,040	410	14, 433	15. 00
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF	0.00	0	203	10	294	17. 00
18. 00	SUBPROVI DER	0.00	O	200	10	271	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	ŀ					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						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)				1		30. 00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)				1		32. 00
32. 01	Total ancillary labor & delivery room				1		32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33. 00

| Peri od: | Worksheet S-3 | From 01/01/2015 | Part II | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 Provi der CCN: 150023

					T	o 12/31/2015	Date/Time Prep 5/25/2016 10:0	
		Worksheet A		Reclassi fi cati			Average Hourly	
		Line Number	Reported	on of Salaries (from	Sal ari es (col . 2 ± col .	Related to Salaries in	Wage (col. 4 ÷ col. 5)	
		4.00		Worksheet A-6)		col . 4	ŕ	
	PART II - WAGE DATA	1. 00	2. 00	3. 00	4.00	5. 00	6. 00	
	SALARI ES			_				
1. 00	Total salaries (see instructions)	200. 00	101, 330, 647	0	101, 330, 647	2, 989, 564. 00	33. 89	1. 00
2.00	Non-physician anesthetist Part		0	0	0	0.00	0. 00	2. 00
3. 00	A Non-physician anesthetist Part		0	0	0	0.00	0. 00	3. 00
	В		05.000		05.000			
4. 00	Physician-Part A - Administrative		25, 000	0	25, 000	167. 00	149. 70	4. 00
4. 01	Physicians - Part A - Teaching		1, 061, 414	0				
5. 00 6. 00	Physician-Part B Non-physician-Part B		15, 953, 161 0	0	,	54, 371. 00 0. 00		
7. 00	Interns & residents (in an	21. 00	0	1, 244, 062	1, 244, 062	43, 634. 00		7. 00
7. 01	approved program) Contracted interns and		0	0	0	0.00	0. 00	7. 01
	residents (in an approved							
8. 00	programs) Home office personnel		0	О	0	0. 00	0. 00	8. 00
9.00	SNF	44. 00	0	0	0	0.00		
10. 00	Excluded area salaries (see instructions)		11, 727, 482	-2, 228, 525	9, 498, 957	174, 418. 00	54. 46	10. 00
	OTHER WAGES & RELATED COSTS		5 0/7 050		5 0/7 050	07 (// 00	54.00	
11. 00	Contract Labor: Direct Patient Care		5, 067, 258	0	5, 067, 258	97, 661. 00	51. 89	11. 00
12. 00	Contract labor: Top level		0	0	0	0.00	0. 00	12. 00
	management and other management and administrative							
12.00	servi ces		7/5 /07		7/5 /07	/ 2/5 00	122.20	12.00
13. 00	Contract Labor: Physician-Part A - Administrative		765, 607	0	765, 607	6, 265. 00	122. 20	13. 00
14. 00	Home office salaries & wage-related costs		18, 172, 431	0	18, 172, 431	352, 824. 00	51. 51	14. 00
15. 00	Home office: Physician Part A		0	0	0	0.00	0. 00	15. 00
16. 00	- Administrative Home office and Contract		0	0	0	0.00	0. 00	16. 00
	Physicians Part A - Teaching WAGE-RELATED COSTS							
17. 00	Wage-related costs (core) (see		21, 832, 647	0	21, 832, 647			17. 00
18. 00	instructions) Wage-related costs (other)		0	0	0			18. 00
	(see instructions)		0					
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		2, 204, 213 0	0	2, 204, 213			19. 00 20. 00
	A		-					
21. 00	Non-physician anesthetist Part B		0	0	O O			21. 00
22. 00	Physician Part A - Administrative		5, 024	0	5, 024			22. 00
22. 01	Physician Part A - Teaching		221, 016	0	221, 016			22. 01
23. 00 24. 00	Physician Part B Wage-related costs (RHC/FQHC)		2, 229, 630	0				23. 00 24. 00
25. 00	Interns & residents (in an		367, 199		_			25. 00
	approved program) OVERHEAD COSTS - DIRECT SALARIE	S						
26. 00	Employee Benefits Department	4. 00	275, 653					
27. 00 28. 00	Administrative & General Administrative & General under	5. 00	6, 864, 858 2, 203, 190		6, 439, 569 2, 203, 190			
	contract (see inst.)		_,,	_				
29. 00 30. 00	Maintenance & Repairs Operation of Plant	6. 00 7. 00	915, 499	0	0 915, 499	0. 00 38, 134. 00		
31. 00	Laundry & Linen Service	8. 00	661, 194		661, 194	43, 422. 00	15. 23	
32. 00 33. 00	Housekeeping under contract	9. 00	1, 878, 284 351, 837	0	,	129, 338. 00 28, 588. 00		
	(see instructions)							
34. 00 35. 00	Di etary Di etary under contract (see	10. 00	1, 508, 725 196, 434	-6, 972 0				
	instructions)			_				
36. 00 37. 00	Cafeteria Maintenance of Personnel	11. 00 12. 00	425, 493 0	0		32, 108. 00 0. 00		
38. 00	Nursing Administration	13. 00	1, 259, 863	0	1, 259, 863	28, 218. 00	44. 65	38. 00
39. 00 40. 00	Central Services and Supply Pharmacy	14. 00 15. 00	0	0		0. 00 0. 00		39. 00 40. 00
					, -			

Heal th I	Financial Systems		UNI ON HOSPI	TAL, INC.		In Lie	eu of Form CMS-2	2552-10
HOSPI TA	L WAGE INDEX INFORMATION			Provi der		Peri od:	Worksheet S-3	
						From 01/01/2015		
						To 12/31/2015		
							5/25/2016 10:	01 am_
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2.00	3.00	4. 00	5. 00	6. 00	
41. 00 M	Medical Records & Medical	16. 00	2, 029, 534	. 0	2, 029, 53	90, 945. 00	22. 32	41. 00
1	Records Library							
42.00	Soci al Servi ce	17. 00	144, 181	0	144, 18	1 4, 080. 00	35. 34	42.00
43. 00	Other General Service	18. 00	0) 0		0.00	0.00	43. 00

HOSPITAL WAGE INDEX INFORMATION			Provi der	CCN: 150023	Peri od:	Worksheet S-3
					From 01/01/2015	Part III
					To 12/31/2015	Date/Time Prepared:
						5/25/2016 10:01 am
	Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly
	Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷

							5/25/2016 10:0	01 am
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4	·	
		1.00	2. 00	3.00	4.00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		87, 067, 533	-1, 244, 062	85, 823, 471	2, 939, 683. 00	29. 19	1.00
	instructions)							
2.00	Excluded area salaries (see		11, 727, 482	-2, 228, 525	9, 498, 957	174, 418. 00	54. 46	2.00
	instructions)							
3.00	Subtotal salaries (line 1		75, 340, 051	984, 463	76, 324, 514	2, 765, 265. 00	27. 60	3.00
	minus line 2)							
4.00	Subtotal other wages & related		24, 005, 296	0	24, 005, 296	456, 750. 00	52. 56	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		21, 837, 671	0	21, 837, 671	0.00	28. 61	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		121, 183, 018	984, 463	122, 167, 481	3, 222, 015. 00	37. 92	6.00
7.00	Total overhead cost (see		18, 714, 745	97, 448	18, 812, 193	790, 602. 00	23. 79	7.00
	instructions)							
		•		•	•	•	•	

Health Financial Systems	UNION HOSPITAL, INC.	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 150023	Peri od: Worksheet S-3 From 01/01/2015 Part IV To 12/31/2015 Date/Time Prepared:

		To	12/31/2015	Date/Time Prep 5/25/2016 10:0	
				Amount	
				Reported	
				1. 00	
	PART IV - WAGE RELATED COSTS				
	Part A - Core List				
	RETI REMENT COST				
1.00	401K Employer Contributions			2, 747, 348	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)			7, 500, 781	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		'		
5.00	401K/TSA Plan Administration fees			0	5. 00
6.00	Legal/Accounting/Management Fees-Pension Plan			0	6.00
7.00	Employee Managed Care Program Administration Fees			0	7. 00
	HEALTH AND INSURANCE COST		,		
8.00	Health Insurance (Purchased or Self Funded)			9, 538, 752	8. 00
9.00	Prescription Drug Plan			0	9. 00
10.00	Dental, Hearing and Vision Plan			-163	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)			39, 570	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)			0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)			82, 651	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0	14.00
15. 00	'Workers' Compensation Insurance			116, 331	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraor	dinary accrual required b	y FASB 106.	0	16.00
	Non cumulative portion)		_		
	TAXES				
17. 00	FICA-Employers Portion Only			6, 574, 727	17. 00
18. 00	Medicare Taxes - Employers Portion Only			0	18. 00
	Unemployment Insurance			93, 998	19. 00
20.00	State or Federal Unemployment Taxes			0	20. 00
	OTHER				
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Rep	orted on lines 1 through	4 above. (see	0	21.00
	instructions))				
22. 00	Day Care Cost and Allowances			0	22. 00
	Tuition Reimbursement			165, 735	
24. 00	Total Wage Related cost (Sum of lines 1 -23)			26, 859, 730	24. 00
	Part B - Other than Core Related Cost				
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)			0	25. 00

Heal th	Financial Systems	UNION HOSPITAL,	I NC.		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST		Provi der	CCN: 150023	Period: From 01/01/2015 To 12/31/2015	Worksheet S-3 Part V Date/Time Pre 5/25/2016 10:	pared:
	Cost Center Description				Contract Labor	Benefit Cost	
					1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost						
	Hospital and Hospital-Based Component Identifica	ati on:					
1.00	Total facility's contract labor and benefit cos	t			0	0	1.00
2.00	Hospi tal				0	0	2. 00
3.00	Subprovi der - I PF						3. 00
4 00	Subprovider - IRE				0	0	4 00

Head the Financial Systems										
Sincompensated and Indigent care cost computation 1.00			I NC.		In Li€	u of Form CMS-2	2552-10			
Uncompensated and indigent care cost computation 1.00	HOSPI T	TAL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der	CCN: 150023			0			
							nanad.			
1.00										
Uncompensated and Indigent care cost computation 0.00		7,25,25,5								
1.00 Cost to charge ratio (Worksheet C, Part line 202 column 3 divided by line 202 column 8) 0.251556 1.00 Medicaid (3 (see instructions for each line) 24,705,694 2.00 3.00						1. 00				
Medical d (see Instructions for each line) 24,705,694 2.00 Net revenue from Medicaid 3.00 1f line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid? 4.00 1f line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid? 4.00 1f line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid? 4.00 5.00 1f line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid? 4.00 5.00 1f line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid? 4.00 5.00 1f line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid? 4.00 5.00 135,000,066 6.00										
2.00 Not reverue From Medical 24,705,694 2.00	1.00		ded by li	ne 202 colum	n 8)	0. 251556	1. 00			
3.00 2.00 0.00										
1						24, 705, 694				
1 1 1 1 1 1 1 1 1 1										
135, 060, 966 6, 00		_ '								
1.00 Medicaid cost ((line 1 times line 6) 0.00 0.00 1.00 0.0			Medicai d							
Section Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5: if 9, 269, 702 8.00										
State Children's Heal th Insurance Program (SCHIP) (see instructions for each line) 9,00			7	6 1:	0 1 5 . 1 6					
State Children's Health Insurance Program (SCHIP) (see instructions for each line) 0 0 0 0 0 0 0 0 0	8.00		ine / min	ius sum of II	nes 2 and 5; IT	9, 269, 702	8.00			
Net revenue from stand-alone SGHIP 0 0.00			ons for a	ach line)						
10.00 Stand-al one SCHIP charges 0.10.00 0.	9 00		0113 101 6	acii i i iie)		0	9 00			
11.00 Stand-al one SCHIP cost (line 1 times line 10) 12.00 Difference between net revenue and costs for stand-al one SCHIP (line 11 minus line 9; if < zero then enter zero) 0 Other state or local government indigent care program (see instructions for each line) 13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) 15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 15.00 lines) 18.00 State or local indigent care program cost (line 1 times line 14) 19.00 Private grants, donations, or endowment income restricted to funding charity care 0 17.00 lines (line 1 times line 2 times lin										
12.00 Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero) Other state or local government indigent care program (see instructions for each line) 13.00 Net revenue from state or local indigent care program (Net included on lines 2, 5 or 9) 0 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) 15.00 State or local indigent care program cost (line 1 times line 14) 0 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero) Uncompensated care (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care 17.00 18.00 Overnment grants, appropriations or transfers for support of hospital operations 0 18.00 18.00 Overnment grants, appropriations or transfers for support of hospital operations 0 18.00 18.00 Overnment grants, appropriations or transfers for support of hospital operations 0 18.00 18.00 Overnment grants, appropriations or transfers for support of hospital operations 0 18.00 18.00 Overnment grants, appropriations or transfers for support of hospital operations 0 18.00 18.00 Overnment grants, appropriations or transfers for support of hospital operations 0 18.00 Overnment grants, appropriations or transfers for support of hospital operations 0 18.00 Overnment grants, appropriations or transfers for support of hospital operations 0 18.00 Overnment grants, appropriations or transfers for support of hospital operations 0 18.00 Overnment grants, appropriations or transfers for support of hospital operations 0 18.00 Overnment grants, appropriations or transfers for support grants, appropriations 0 18.00 Overnment grants, appropriations or trans										
enter zero) Other state or local government indigent care program (see instructions for each line) 13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) 15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13: if < zero then enter zero) Uncompensated care (see Instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care 18.00 Government grants, appropriations or transfers for support of hospital operations 19.00 Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 9, 269, 702 19.00 20.00 Total initial obligation of patients approved for charity care (at full 21, 208, 340 0 21, 208, 340			line 11 m	inus line 9	if < zero then					
Other state or local government indigent care program (see instructions for each line) Net revenue from state or local indigent care program (Not included in lines 2, 5 or 9) 13. 00 14. 00 15. 00 16. 00 16. 00 16. 00 16. 00 17. 00 18. 01 18. if < zero then enter zero) Uncompensated care (see instructions for each line) 17. 00 18. 00 18. 00 19. 01	.2.00				20.0		12.00			
14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) 15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero) 17.00 Private grants, donations, or endowment income restricted to funding charity care 18.00 Government grants, appropriations or transfers for support of hospital operations 19.00 Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 9, 269, 702 19.00 8, 12 and 16) 10.00			uctions f	or each line)					
10) State or local indigent care program cost (line 1 times line 14) 16.00 Strate or local indigent care program cost (line 1 times line 14) 17.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13: if < zero then enter zero) Uncompensated care (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care 0 law of lines 0 law	13.00	Net revenue from state or local indigent care program (Not inclu	ded on li	nes 2, 5 or	9)	0	13. 00			
15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13: if < zero then enter zero) Uncompensated care (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care Government grants, appropriations or transfers for support of hospital operations 19.00 Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 9, 269, 702 19.00 18.00 20.00 3.00 20.00 3.00 20.00 3.00 20.00 3.00 21.208, 340 20.00 21.208, 340 20.00 21.208, 340 20.00 21.208, 340 20.00 21.208, 340 20.00 21.208, 340 20.00 21.208, 340 20.00 21.208, 340 20.00 21.208, 340 20.00 21.208, 340 20.00 21.208, 340 20.00 21.208, 340 20.00 22.00 23.00 20.00	14.00	Charges for patients covered under state or local indigent care	program (Not included	in lines 6 or	0	14.00			
16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero) Uncompensated care (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care 0 18.00 Government grants, appropriations or transfers for support of hospital operations 9, 269, 702 18.00 19.00 Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 9, 269, 702 19.00 8, 12 and 16) 10.00 Total initial obligation of patients approved for charity care (at full 21, 208, 340 0 21, 208, 340 20.00 charges excluding non-reimbursable cost centers) for the entire facility 21.00 Cost of initial obligation of patients approved for charity care (line 1 5, 335, 085 0 5, 335, 085 21.00 times line 20) 22.00 Partial payment by patients approved for charity care (line 1 5, 335, 085 0 5, 335, 085 23.00 Cost of charity care (line 21 minus line 22) 5, 335, 085 0 5, 335, 085 23.00 24.00 Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit imposed on patients covered by Medicaid or other indigent care program's length of stay limit imposed on patients covered by Medicaid complex (see instructions) 1, 296, 096 27.00 27.00 Medicare bad debts for the entire hospital complex (see instructions) 2, 26, 434, 988 28.00 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 26, 649, 880 29.00 30.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 11, 984, 965 30.00 11, 984, 965 30.00 11, 984, 965 30.00 11, 984, 965 30.00 11, 984, 965 30.00 11, 984, 965 30.00 11, 984, 965 30.00 11, 984, 965 30.00 11, 984, 965 30.00 11, 984, 965 30.00 11, 984, 965 30.00 11, 984, 965 30.00 11, 984, 965 30.00 11,		10)								
13; If < zero then enter zero) Uncompensated care (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care 18.00 Government grants, appropriations or transfers for support of hospital operations 19.00 Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines patients 1.00	15. 00	State or local indigent care program cost (line 1 times line 14)				0	15. 00			
Uncompensated care (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care Government grants, appropriations or transfers for support of hospital operations Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 9, 269, 702 19.00 8, 12 and 16) Uninsured patients patients Insured patients Ins	16. 00		gent care	program (li	ne 15 minus line	0	16. 00			
17. 00 18. 00 19										
18.00 Government grants, appropriations or transfers for support of hospital operations Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines Uninsured patients Insured patients Hool Local Local	17 00		al!				17.00			
Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16) Uninsured patients patients			9	,						
8, 12 and 16) Uninsured patients District patients Total (col. 1 patients Patie					me (cum of lines	_				
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	31. 00	Total unreimbursed and uncompensated care cost (line 19 plus lin	e 30)			21, 254, 667	31.00			

## CASS FICATION, AMB ADJUSTIFUTION Solidarios Proprietative Cost Centre Proprietative Cost Centre Centr	Heal th	Fi nar	ncial Systems	UNION HOSPITAL	., INC.		In Lie	u of Form CMS-	2552-10
Cost Center Description	RECLAS	SIFIC	ATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der	CCN: 150023 P	eri od:	Worksheet A	
Control Description								Doto/Time Dro	nonod.
Cost Center Description						1	0 12/31/2015		
Color Colo			Cost Center Description	Salaries	Other	Total (col 1	Reclassi fi cati		OT alli
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4.00 00-000 EMPLOYEE REPRET TS DEPARTMENT 275, 653 25, 648 301, 301 30.00 60.00 96.06 96.00 96	1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		12, 369, 614	12, 369, 614	11, 721, 669	24, 091, 283	1. 00
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13.00 01300 MURSINX ADMINISTRATION 1.259, 863 239, 431 1.409, 204 0 1.409, 204 13.00 17.00 01700 SOCIAL SERVICE 144, 181 16, 234 160, 415 17.00 1.301, 187, 187, 187, 187, 187, 187, 187, 18		1							
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66. 01 06601 PSYCHI ATRIC/PSYCHOLOGI CAL SERVICES 0 0 0 0 0 0 66. 01 66. 02 06602 07P PHYSI CAL THERAPY 0 0 0 0 0 0 0 66. 02 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 68. 00 06800 SPECH PATHOLOGY 0 395, 966 395, 966 0 395, 966 68. 00 69. 00 06900 ELECTROCARDI OLOGY 1, 407, 971 550, 612 1, 958, 583 0 1, 958, 583 69. 00 70. 00 06901 CARDIJ AC REHAB 260, 207 49, 171 309, 378 0 309, 378 69. 01 70. 00 07000 ELECTROENCEPHALOGRAPHY 2, 426, 120 789, 893 3, 216, 013 0 3, 216, 013 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 914, 347 914, 347 -43, 836 870, 511 71. 00 71. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 914, 347 914, 347 -43, 836 870, 511 71. 00 71. 00 07300 DRUGS CHARGED TO PATI ENTS 3, 662, 925 31, 960, 534 35, 623, 459 -1, 623, 141 34, 000, 318 73. 00 76. 00 03020 RENAL ACUTE 0 1, 647, 933 1, 647, 933 0 1, 647, 933 76. 00 09000 CLI NI C 232, 418 41, 826 274, 244 0 274, 244 90. 00 79. 00 09000 CLI NI C 324, 461 857, 095 1, 181, 556 0 34, 395 0 79. 00 09000 PATI ENT NUTRI TI ON 303, 885 45, 510 349, 395 0 349, 395 0 79. 00 09000 RATIENT NUTRI TI ON 324, 461 857, 095 1, 181, 556 0 1, 181, 556 90. 07 79. 00 09000 CLI NI C 324, 461 857, 095 1, 181, 556 0 1, 181, 556 90. 07 79. 00 09000 CHREGENCY 4, 647, 665 3, 462, 589 8, 110, 254 0 8, 110, 254 79. 00 09000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1, 29, 693 1, 633, 577 2, 763, 270 67, 730 2, 831, 000 79. 00 194. 00 07950 RIRAL HEALTH 1, 129, 693 1, 633, 577 2, 763, 270 67, 730 2, 831, 000 79. 00 194. 00 07951 RIRAL PROPERTY 83, 1443 156, 453 239, 596 0 0 239, 596 194, 01 794. 00 07955 PHYSI CIAN PRACTICES 4, 419, 748 4, 678, 1	65.00	06500	RESPI RATORY THERAPY	2, 625, 970	1, 081, 609	3, 707, 579	0	3, 707, 579	65. 00
66.02 06602 0/P PHYSICAL THERAPY 0 3, 307, 384 3, 307, 384 0 3, 307, 384 66.02 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 68.00 06800 SPECH PATHOLOGY 0 0 395, 966 0 395, 966 0 395, 966 68.00 69.01 06901 CARDI AC REHAB 260, 207 49, 171 309, 378 0 309, 378 0 70.00 07000 ELECTROCREDIOLOGY 1, 407, 971 550, 612 1, 958, 583 0 1, 958, 583 69. 01 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 914, 347 -43, 836 870, 511 71. 00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 914, 347 914, 347 -43, 836 870, 511 71. 00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 10, 645, 497 10, 645, 497 72. 00 73.00 07300 DRUGS CHARGED TO PATI ENTS 3, 662, 925 31, 960, 534 35, 623, 459 -1, 623, 141 34, 000, 318 73. 00 76.00 03020 RENAL ACUTE 0 1, 647, 933 1, 647, 933 0 1, 647, 933 76. 00 79.00 09000 CLI NI C 232, 418 41, 826 274, 244 0 274, 244 90. 00 79.00 09000 DRUG ENERGENCY 4, 647, 665 3, 462, 589 8, 110, 254 0 8, 110, 254 79.00 079007 WOUND CLI NI C 324, 461 857, 095 1, 181, 556 0 1, 181, 556 90. 07 79.00 07000 DRUG ENERGENCY 4, 647, 665 3, 462, 589 8, 110, 254 0 8, 110, 254 79.00 07900 CURLAN OF ALP AND OF				0	3, 957, 184	3, 957, 184			1
67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 0 67. 00 68. 00 06800 08EECH PATHOLOGY 0 0 395, 966 68. 00 69. 00 06900 ELECTROCARDI OLOGY 1, 407, 971 550, 612 1, 958, 583 0 1, 958, 583 69. 01 70. 00 07000 ELECTROENCEPHALOGRAPHY 2, 426, 120 789, 893 3, 216, 013 0 309, 378 69. 01 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 914, 347 914, 347 -43, 836 870, 511 71. 00 72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 0 914, 347 914, 347 -43, 836 870, 151 71. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 3, 662, 925 31, 960, 534 35, 623, 459 -1, 623, 141 34, 000, 318 73. 00 74. 00 07300 DRUGS CHARGED TO PATIENTS 3, 662, 925 31, 960, 534 35, 623, 459 -1, 623, 141 34, 000, 318 73. 00 75. 00 07300 DRUGS CHARGED TO PATIENTS 3, 662, 925 31, 960, 534 35, 623, 459 -1, 623, 141 34, 000, 318 73. 00 76. 00 03020 RENAL ACUTE 0 1, 647, 933 1, 647, 933 1, 647, 933 0 1, 647, 933 76. 00 79. 00 09000 CLINIC 232, 418 41, 826 274, 244 0 274, 244 79. 00 09000 DRUGS CHARGED TO PATIENTS 303, 885 45, 510 349, 395 0 349, 395 0 0 79. 00 09000 DRUGS CHARGED TO PATIENTS 303, 885 45, 510 349, 395 0 0 79. 00 09000 DRUGS CHARGED TO PATIENTS 303, 885 45, 510 349, 395 0 0 79. 00 09000 DRUGS CHARGED TO PATIENTS 303, 885 45, 510 349, 395 0 0 79. 00 09000 DRUGS CHARGED TO PATIENTS 30, 846, 857 30, 867, 975 1, 181, 556 90. 07 79. 00 09000 DRUGS CHARGED TO PATIENTS 303, 885 45, 510 349, 395 0 0 79. 00 09000 DRUGS CHARGED TO PATIENTS 303, 885 45, 510 349, 395 0 0 79. 00 09000 DRUGS CHARGED TO PATIENTS 30, 840, 850 1, 181, 556 0 1, 181, 556 0 1, 181, 556 0 79. 00 09000 DRUGS CHARGED TO PATIENTS 30, 840, 850 1, 181, 556 0 1, 181, 556 0 1, 181, 556 0 79. 00 09000 DRUGS CHARGED TO PATIENTS 30, 840, 850 1, 1			l control of the cont	0	-	·			1
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70. 00 07000 ELECTROENCEPHALOGRAPHY 2, 426, 120 789, 893 3, 216, 013 0 3, 216, 013 70. 00 71. 00 71000 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 914, 347 914, 347 -43, 836 870, 511 71. 00 72. 00 72. 00 1 MPL. DEV. CHARGED TO PATI ENTS 0 0 10, 645, 497 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 3, 662, 925 31, 960, 534 35, 623, 459 -1, 623, 141 34, 000, 318 73. 00 73. 00 00000 00000 00000 00000 00000 00000 00000 00		1	1						1
71. 00		1	1	· .					1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS				1					1
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90. 00	76.00	03020	RENAL ACUTE	0	1, 647, 933	1, 647, 933	0	1, 647, 933	76. 00
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91. 00									1
92. 00 09200 08SERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 SPECIAL PURPOSE COST CENTERS 91, 362, 625 192, 502, 828 283, 865, 453 3, 637, 079 287, 502, 532 118. 00 NONREI MBURSABLE COST CENTERS 91, 362, 625 192, 502, 828 283, 865, 453 3, 637, 079 287, 502, 532 118. 00 190. 00 1									1
SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) 91,362,625 192,502,828 283,865,453 3,637,079 287,502,532 118.00				4, 047, 005	3, 402, 309	0, 110, 234	U	0, 110, 234	1
118. 00 SUBTOTALS (SUM OF LINES 1-117) 91, 362, 625 192, 502, 828 283, 865, 453 3, 637, 079 287, 502, 532 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 190000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 0 190. 00 190. 00 194. 00 194. 00 1950 RURAL HEALTH 1, 129, 693 1, 633, 577 2, 763, 270 67, 730 2, 831, 000 194. 00 194. 01 07951 RENTAL PROPERTY 83, 143 156, 453 239, 596 0 239, 596 194. 01 194. 02 194. 02 194. 02 194. 04 194. 05 194. 0	,2.00			1		1			1 /2.00
190. 00	118.00			91, 362, 625	192, 502, 828	283, 865, 453	3, 637, 079	287, 502, 532	118. 00
194. 00 07950 RURAL HEALTH 1, 129, 693 1, 633, 577 2, 763, 270 67, 730 2, 831, 000 194. 00 194. 01 07951 RENTAL PROPERTY 83, 143 156, 453 239, 596 0 239, 596 194. 01 194. 02 07954 FAMI LY PRACTI CE 3, 968, 805 1, 713, 456 5, 682, 261 -3, 984, 075 1, 698, 186 194. 02 194. 04 07955 PHYSI CI AN PRACTI CES 4, 419, 748 4, 678, 170 9, 097, 918 0 9, 097, 918 194. 04		NONRE	IMBURSABLE COST CENTERS						
194. 01 07951 RENTAL PROPERTY 83, 143 156, 453 239, 596 0 239, 596 194. 01 194. 02 07954 FAMI LY PRACTI CE 3, 968, 805 1, 713, 456 5, 682, 261 -3, 984, 075 1, 698, 186 194. 02 194. 03 07952 WELLNESS 0 0 360, 134 360, 134 194. 03 194. 04 07955 PHYSI CI AN PRACTI CES 4, 419, 748 4, 678, 170 9, 097, 918 0 9, 097, 918 194. 04				0	-				1
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194. 04 07955 PHYSI CLAN PRACTICES 4, 419, 748 4, 678, 170 9, 097, 918 0 9, 097, 918 194. 04									
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Heal th Financ	ial Systems	UNION HOSPI	TAL, INC.		In Lie	eu of Form CMS-:	2552-10
RECLASSI FI CAT	TION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der		eri od:	Worksheet A	
					rom 01/01/2015 o 12/31/2015	Date/Time Pre	pared:
						5/25/2016 10:	
(Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cati	Reclassi fied	
				+ 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 I	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	355, 333	346, 215	701, 548	-80, 868	620, 680	194. 07
200.00	FOTAL (SUM OF LINES 118-199)	101, 330, 647	201, 731, 059	303, 061, 706	0	303, 061, 706	200. 00

Provi der CCN: 150023

Peri od: From 01/01/2015 To 12/31/2015 Date/Ti me Prepared: 5/25/2016 10:01 am

Cost Center Description
G. G. G. G. G. G. G. G.
GENERAL SERVICE COST CENTERS 1.00 OCIO DIRE CAP REL COSTS-HADD & FIXT -1, 361, 416 22, 729, 867 2.0 0.000 DRE CAP REL COSTS-HADD & FIXT -5, 98, 985 9, 691, 895 2.0 0.01 0.000 0.01 0.000 0.00
1.00 00100 AFBY CAP REL COSTSBILDE & FIXT -1, 361, 416 22, 279, 867
2 00 00200 NEW CAP REL COSTS-MARLE EQUIP
4.00 00400 FAM TOUTE STRETCH'S DEPARTMENT 17, 609, 250 19, 283, 374 4.00 5.00 5.00 00500 0047A PROCESSIN N. 11, 189, 026 11, 189, 026 5.00 00500 0047A PROCESSIN N. 11, 189, 026 11, 189, 026 5.00 00500 0047A PROCESSIN N. 11, 189, 026 5.00 00500 0047A PROCESSIN N. 12, 29, 33 1, 159, 320 5.00 00500 0047A PROCESSIN N. 12, 29, 33 1, 159, 320 5.00 00500 0047B ADMIN NA GENERAL 1, 34, 900 5.00 00500 0047B ADMIN NA GENERAL 1, 34, 900 5.00 00500 0047B ADMIN NA GENERAL 1, 34, 900 5.00 00500 0047B ADMIN NA GENERAL 1, 34, 900 5.00 00500 0047B ADMIN NA GENERAL 1, 34, 900 5.00 00500 0047B ADMIN NA GENERAL 1, 34, 900 00500 0047B ADMIN NA GENERAL 1, 34, 900 00500 0047B ADMIN NA GENERAL 1, 34, 900 00500 0047B ADMIN STRATI ON 1, 22, 23, 26, 31 0.00 00500 0047B ADMIN NA GENERAL 1, 34, 900 0, 32, 32, 32, 32, 32, 32, 32, 32, 32, 32
5.01 00540 (ADMAPATIENT TELEPHONES 1.189, 006 5.00 00540 (DIATE PROCESSIA) MS AND STORES 1.189, 006 5.00 00540 (DIATE PROCESSIA) MS AND STORES 1.129, 933 1.129, 933 5.00 00540 (DIATE PROCESSIA) MS AND STORES 1.129, 933 1.129, 933 5.00 00540 (DIATE PROCESSIA) MS AND STORES 1.129, 933 1.129, 933 5.00 00540 (DIATE PROCESSIA) MS AND STORES 1.129, 933 1.129, 933 5.00 00540 (DIATE PROCESSIA) MS AND STORES 1.129, 933 1.129, 933 5.00 00540 (DIATE PROCESSIA) MS AND STORES 1.129, 933 1.129, 933 5.00 00540 (DIATE PROCESSIA) MS AND STORES 1.129, 934 934 935 93 93 93 93 93 93 93 93 93 93 93 93 93
5.02 OSSO DATA PROCESSING 11, 189, 026 11, 189, 026 11, 189, 026 5.00 OSSO OPERA SING RECEIVING AND STORES 1, 120, 933 5.00 OSSO OPERA SING RECEIVING AND STORES 1, 120, 933 5.00 OSSO OPERA SING RECEIVING AND STORES 1, 120, 933 5.00 OSSO OPERA SING RECEIVING AND STORES 1, 200, 930 0.50 OSSO OPERA SING RECEIVING AND STORES 1, 200, 930 0.50 OSSO OPERA SING RECEIVING AND STORES 1, 200, 930 0.50 OSSO OPERA SING RECEIVING AND STORES 1, 200, 930 0.50 OSSO OPERA SING RECEIVING AND STORES 1, 200, 930 0.50 OSSO OPERA SING RECEIVING AND STORES 1, 200, 930 0.50 OSSO OPERA SING RECEIVING AND STORES 1, 200, 930 0.50 OSSO OPERA SING RECEIVING AND STORES 1, 200, 930 0.50 OSSO OPERA SING RECEIVING AND STORES 0.50 OSSO OSSO OPERA SING RECEIVING AND STORES 0.50 OSSO OSSO OPERA SING RECEIVING AND STORES 0.50 OSSO
5.03 0.0560 PURCHASH NIG RECELVING AND STORES 1, 129, 933 1, 129, 933 1, 129, 933 5.0
5.04 00570 ADMITTINS 0 1,759,203 5.0
D. D. DOSED CASHIER IN MS/ACCOUNTS RECEIVABLE 5, 12, 988 5, 11, 2, 988 5, 10, 000 000 COTTER ADMIN IN ALD GENERAL 1, 361, 900 000 COTTER ADMIN IN ALD GENERAL 1, 361, 900 000 COTTER ADMIN IN ALD GENERAL 1, 361, 900 000 COTTER ADMIN IN ALD GENERAL 1, 361, 900 000 COTTER ADMIN IN ALD GENERAL 1, 361, 900 000 COTTER ADMIN IN ALD GENERAL 1, 361, 900 000 COTTER ADMIN IN ALD GENERAL 1, 361, 900 000 COTTER ADMIN IN ALD GENERAL 1, 361, 900 000 COTTER ADMIN IN ALD GENERAL 1, 361, 900 000 COTTER ADMIN IN ALD GENERAL 1, 361, 900 000 COTTER ADMIN IN ALD GENERAL 1, 361, 900 000 COTTER ADMINISTRATION 1, 233, 363 2, 732, 657 13. 00 COTTER ADMINISTRATION 1, 233, 363 2, 732, 657 13. 00 COTTER ADMINISTRATION 1, 233, 363 2, 732, 657 13. 00 COTTER ADMINISTRATION 1, 233, 363 2, 732, 657 13. 00 COTTER ADMINISTRATION 1, 233, 363 2, 732, 657 13. 00 COTTER ADMINISTRATION 1, 233, 363 2, 732, 657 13. 00 COTTER ADMINISTRATION 1, 233, 243, 243, 243, 247 1, 243, 243, 243, 243, 243, 243, 243, 243
5.06 0.0590 OTHER ADMIN AND GENERAL 1,361,900 20,155,829 5.0
7. 00 007000 (DEPARTION OF PLANT) 949, 746 8, 938, 081 7. 0 9. 00 009000 (LAUNDRY & LINEN SERVICE) −224, 402 982, 066 8. 0 9. 00 009000 (HOUSEKEPIN K) −222, 551 3, 929, 804 9. 0 11. 00 01000 (AFTERIA) −1, 486, 927 −74, 166 11. 0 11. 00 01000 (ANESIN GARDIN STRATION) 1, 233, 363 2, 732, 657 13. 0 16. 00 01600 (MEDI CAL RECORGS & LIBRARY) 59, 538 3, 628, 324 16. 0 16. 00 01600 (MEDI CAL RECORGS & LIBRARY) 59, 538 3, 628, 324 16. 0 2. 00 02000 (SOUL) (AS SERVICE) (AS PERVIDE COSTS APPRVID −94, 920 1, 53, 789 22. 0 23. 01 02000 (AS SERVICE) (AS PERVIDE COSTS APPRVID −94, 920 2, 537, 879 22. 0 23. 01 02000 (AS SERVICE) (AS PERVIDE COST CENTERS -1, 488, 674 24, 079, 187 -1 30. 00 03000 (ADULTS & PEDI ATRICS) −1, 488, 674 24, 079, 187 -1 31. 00 0310 (DI HESIA) YE CASER UNIT −1, 488, 674 24, 079, 187 -1
8.00 OBSOD LANDRY & LINEN SERVICE -23, 402 982, 064 9, 00 0900 DISCKEEPIN DOUSEKEEPING 9, 00 10000 DIETARY 137, 121 222, 280, 013 10, 00 10000 DIETARY 137, 121 222, 280, 013 10, 00 10000 DIETARY 137, 121 222, 280, 013 10, 00 10000 DIETARY 137, 121 222, 280, 013 13, 00 13000 NURSING ADMINISTRATION 1, 283, 363 2, 72 7-4, 166 11, 00 11000 DIETAR SERVICE CORDS & LIBRARY 539, 538 3, 628, 327 16, 00 17000 DIETAR SERVICE SALARY & FRINGES APPRVD 0, 160, 415 170, 00 17000 DIETAR SERVICE SOTHER PROM COSTS APPRVD 0, 1, 251, 285 22, 00 176, 639 22, 00 176, 639 22, 00 176, 639 22, 00 176, 639 22, 00 176, 639 23, 00
9.00 009000 HOUSEKEEPING -222, 551 3, 329, 804 9, 0.013 10.00 1100 00 11000 DETARY -137, 121 2, 280, 0.013 10.00 1110.00 1110 00 11000 CAFETERI A -1, 466, 927 -74, 166 111.00 1100 CAFETERI A -1, 466, 927 -74, 166 111.00 1100 CAFETERI A -1, 466, 927 -74, 166 0 115.00 115.00 MISSI MAG ABMINISTRATION 1, 233, 363 2, 732, 667 113.00 1100 MISSI MAG ABMINISTRATION 1, 233, 363 2, 732, 667 113.00 1100 MISSI MAG ABMINISTRATION 1, 233, 363 2, 732, 667 113.00 1100 CAFETERI A -1, 160, 0.01 1100
10 00 010000 DETARY 1-137, 121 2, 280, 013 10.0 11.0 01100 CAFETERIAY 1-1, 486, 227 7-74, 166 11.0 11.0 01100 CAFETERIAY 1.233, 363 2,732, 657 13.0 10.0 0100 MEDI CAL ECORDS & LIBRARY 539, 538 3, 628, 327 16.0 01.70 0100 0100 MEDI CAL ECORDS & LIBRARY 539, 538 3, 628, 327 16.0 01.0 0100 SOCI AL SERVICE 01.0 02100 LAR SERVI CES-SALARY & FRI NGES APPRVD 0 1.50, 415 12.0 02100 LAR SERVI CES-OTHER PREMI COSTS APPRVD -44, 920 2, 537, 870 22.0 02.200 PARAMED ED PREMI 03.0 01.76, 839 23.0 02.200 PARAMED ED PREMI 03.0 01.76, 839 22.5 33.0 02.000 PARAMED ED PREMI 03.0 01.76, 839 22.5 33.0 02.000 PARAMED ED PREMI 03.0 01.76, 839 02.3 02.3 01.0 03.0
11.00 01100 CAFETERIA
13.0 0.1300 NURSING ADMINISTRATION 1,233,363 2,732,657 13.0 16.0 0.1700 MEDICAL RECRODS & LIBRARY 539,538 3,628,327 16.0 0.1700 5001 AL SERVICE 0.0 0.160,415 17.0 0.1700 5001 AL SERVICE 0.0 0.160,415 17.0 0.1700 18R SERVICES-SALARY & FRINGES APPRVD 0.0 1.351,285 22.0 0.2300 128 SERVICES-STHER PREMI COSTS APPRVD 0.0 17.6,839 22.0 0.2300 0.2300 PARAMED ED PROM 0.0 17.6,839 22.0 0.2301 0.2341 0.114F MED ED 0.200,376 22.5 547 23.0 0.2300 0.2500 0.25
16. 00 01600 MEDICAL RECORDS & LI BRARY 539, 538 3, 628, 327 16. 00 17. 00 17.00 017
17. 00 01700 SOCIAL SERVI CE 0 100, 415 21.00 22.00 1200
21.00 02100 18 SERVI CES-SALARY & FRINGES APPRVD 0
22.00 02200 IAR SERVI CES-OTHER PRIGN COSTS APPRVD -94, 920 2, 537, 870 23.00 23
23.00
23.0 2234 OTHER MED ED
INPAT ENT ROUTINE SERVICE COST CENTERS
30.00 03000 ADULTS & PEDIATRICS -1, 488, 674 24, 079, 187 31.00 31.00 31.00 31.00 10.01 INTENSI VE NURSERY -483, 933 2, 101, 793 35.00 02040 INTENSI VE NURSERY -483, 933 2, 101, 793 35.00 0300 NURSERY -1, 711, 517 41.00 41.00 41.00 51
33.00 03100 INTENSI VE CARE UNIT
35. 00
41.00 04100 SUBPROVI DER - I RF 0 1, 711, 517 41.04 43.00 43.0
43. 00
ANCI LLARY SERVICE COST CENTERS 50.00
50.00 05000 05000 CARDI AC SURGERY -2,093,043 2,011,972 50.00 50.01 05001 CARDI AC SURGERY -2,093,043 2,011,972 50.00 50.00 05002 WSC 771 11,328,647 50.00 51.00 05100 RECOVERY ROOM 4,422 1,729,130 51.00 51.02 05101 0/P TREATMENT ROOM 0,2,499,675 51.00 52.00 05200 DELI VERY ROOM & LABOR ROOM -1,294,047 3,426,432 52.00 52.00 05200 DELI VERY ROOM & LABOR ROOM -1,294,047 3,426,432 52.00 52.00 05500 RADIO IOSTOPE -5,375,343 7,210,810 55.00 05500 RADIO IOSTOPE -19,250 1,216,980 55.00 05500 RADIO IOSTOPE -19,250 1,216,980 55.00 05500 RADIO IOSTOPE -19,250 1,216,980 56.00 05500 CT SCAN 203,008 2,206,004 57.00 59.00 05900 CARDI AC CATHETERI ZATI ON 243,088 17,510,278 58.00 05900 CARDI AC CATHETERI ZATI ON 243,088 17,510,278 59.00 05900 CARDI AC CATHETERI ZATI ON 243,088 17,510,278 60.00 06600 PHYSI CAL THERAPY -45,091 9,233,419 60.00 06600 PHYSI CAL THERAPY -1,611,954 2,345,230 66.00 06600 PHYSI CAL THERAPY -1,611,954 2,345,230 66.00 06600 PHYSI CAL THERAPY -1,611,954 2,345,230 66.00 06600 PHYSI CAL THERAPY -1,282,055 0,000 0,000 06600 PHYSI CAL THERAPY -1,282,055 0,000 0
50. 01 05001 CARDI AC SURGERY -2, 093, 043 2, 011, 972 50. 02 05002 WYSC 50. 02 05002 WYSC 50. 03 50. 0
50. 02 05002 WYSC 102,771 11, 328,647 50. 02 51. 03 05100 RECOVERY ROOM 4.422 1, 729, 130 51. 03
51. 00 05100 RECOVERY ROOM 4, 422 1, 729, 130 51. 00 51. 02 05101 0/P TREATMENT ROOM 0 2, 499, 675 51. 00 52. 00 05200 DELI VERY ROOM & LABOR ROOM -1, 294, 047 3, 426, 432 52. 00 55. 00 05500 RADIO LOGY-THERAPEUTI C 0 4, 095, 143 55. 00 05500 RADIO LOGY-THERAPEUTI C 0 4, 095, 143 55. 00 05500 RADIO LOGY-THERAPEUTI C 0 4, 095, 143 55. 00 05500 RADIO LOGY-THERAPEUTI C 0 4, 095, 143 55. 00 05500 RADIO LOGY-THERAPEUTI C 0 4, 095, 143 55. 00 05500 RADIO ISOTOPE -19, 250 1, 216, 980 56. 00 05600 RADIO ISOTOPE 57. 00 05700 CT SCAN 58. 00 05800 MAGNETI C RESONANCE MAGING (MRI) 51, 472 1, 557, 314 58. 00 05800 RADIO RADIO REPORTED RESONANCE MAGING (MRI) 51, 472 1, 557, 314 58. 00 05800 RADIO RADIO REPORTED RESONANCE MAGING 60. 00 06000 LABORATORY -48, 091 9, 233, 419 60. 00 06000 LABORATORY -48, 091 9, 233, 419 60. 00 06000 CABORATORY -48, 091 9, 233, 419 60. 00 06000 PAPICKED RED BLOOD CELLS 0 1, 691, 617 62. 00 06500 RESPIRATORY THERAPY 0, 3, 707, 579 65. 00 06500 RESPIRATORY THERAPY -1, 611, 954 2, 345, 230 066. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 06600 PHYSI CAL THERAPY -1, 262, 055 2, 025, 329 66. 0. 00 06000 CLUPATI IONAL THERAPY 1, 362, 854 1, 362, 854 67. 00 06000 CLUPATI IONAL THERAPY 1, 362, 854 1, 362, 854 67. 00 06000 ELECTROCARDIO LOGY 108, 470 06000 ELECTROCARDIO LOGY 108, 470 06000 ELECTROCARDIO LOGY 108, 470 06000 06000 ELECTROCARDIO LOGY 108, 470 06000 06000 06000 ELECTROCARDIO LOGY 108, 470 06000 06000 06000 06000 06000 06000 06000 06000 06000 060000 0600000000
51.02 05101 0/P TREATMENT ROOM
52. 00 05200 DELI VERY ROOM & LABOR ROOM -1, 294, 047 3, 426, 422 52. 05 54. 00 05400 RADI OLOGY-DI AGNOSTIC -5, 375, 343 7, 210, 810 55. 00 05500 RADI OLOGY-THERAPEUTIC 0 4, 905, 143 55. 00 05600 RADI OLOGY-THERAPEUTIC 0 4, 905, 143 55. 00 05600 RADI OLOGY-THERAPEUTIC 0 4, 905, 143 55. 00 05600 RADI OLOGY-THERAPEUTIC 0 4, 905, 143 56. 00 05600 RADI OLOGY-THERAPEUTIC 2030, 008 2, 206, 004 57. 00 05700 CT SCAN 57. 00 58. 00 05800 MAGNETIC RESONANCE I MAGI NG (MRI) 51, 472 1, 557, 314 59. 00 05900 CARDI AC CATHETERI ZATI ON 243, 088 17, 510, 278 60. 00 06000 LABORATORY -45, 091 9, 233, 419 61. 00 06000 MHOLE BLOOD & PACKED RED BLOOD CELLS 0 1, 691, 617 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 1, 691, 617 63. 00 06500 RESPI RATORY THERAPY 0 3, 707, 579 64. 00 06600 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 66. 02 06600 07 07 07 07 07 07
54. 00 05400 RADI OLOGY-DI AGNOSTI C -5, 375, 343 7, 210, 810 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 4, 905, 143 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 4, 905, 143 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 4, 905, 143 55. 00 05700 CT SCAN 203, 008 2, 206, 004 57. 00 05700 CT SCAN 203, 008 2, 206, 004 57. 00 05900 MORETI C RESONANCE I MAGI NG (MRI) 51, 472 1, 557, 314 58. 00 05900 MORETI C RESONANCE I MAGI NG (MRI) 243, 088 17, 510, 278 59. 00 05900 CARDI AC CATHETERI ZATI ON 243, 088 17, 510, 278 60. 00 05000 LABORATORY -45, 091 9, 233, 419 60. 00 06000 LABORATORY 62. 00 06200 MHOLE BLOOD & PACKED RED BLOOD CELLS 0 1, 691, 617 62. 00 06500 RESPI RATORY THERAPY 0 3, 707, 579 65. 00 06600 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 06600 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 06600 06600 O7000 OCUPATI ONAL THERAPY 1, 362, 854 67. 00 06700 OCUPATI ONAL THERAPY 1, 362, 854 67. 00 06900 ELECTROCARDI OLOGY -48, 616 1, 909, 967 69. 00 06900 ELECTROCARDI OLOGY -48, 616 1, 909, 967 69. 00 06910 CARDI AC REHAB 3, 037 312, 415 69. 00 07000 ELECTROCARDI OLOGY -48, 616 1, 909, 967 69. 00 06910 CARDI AC REHAB 3, 037 312, 415 69. 00 07000 ELECTROCARDI OLOGY -2, 322, 938 893, 075 70. 00 07000 ELECTROCARDI OLOGY -2, 322, 938 893, 075 70. 00 07000 ELECTROCARDED TO PATI ENTS -2, 322, 938 893, 075 70. 00 07000 ELECTROCARDED TO PATI ENTS -2, 322, 938 893, 075 70. 00 07000 DRUGS CHARGED TO PATI ENTS -2, 322, 938 893, 075 70. 00 07000 ELECTROCARDED TO PATI ENTS -13, 607 856, 904 71. 00 07000 DRUGS CHARGED TO PATI ENTS -2, 322, 938 893, 075 72. 00 07000 ELECTROCARDED TO PATI ENTS -2, 322, 938 893, 075 73. 00 07000 DRUGS CHARGED TO PATI ENTS -2, 322, 938 893, 075 73. 00 07000 DRUGS CHARGED TO PATI ENTS -2, 322, 938 893, 075 73.
55. 00 05500 RADI OLOGY-THERAPEUTI C 0 4,905,143 55. 0 56. 00 05600 RADI OLSOTOPE -19,250 1,216,980 55. 0 57. 00 05700 CT SCAN 203,008 2,206,004 57. 0 58. 00 05800 MAGNETI C RESONANCE MAGI NG (MRI) 51,472 1,557,314 58. 0 59. 00 05900 CARDI AC CATHETERI ZATI ON 243,088 17,510,278 59. 0 60. 00 06000 LABORATORY -45,091 9,233,419 60. 0 62. 00 062200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 1,691,617 62. 0 65. 00 06500 RESPI RATORY THERAPY -1,611,954 2,345,230 65. 0 66. 01 06600 PHYSI CAL THERAPY -1,611,954 2,345,230 66. 0 66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 67. 00 06602 PP PHYSI CAL THERAPY -1,282,055 2,205,329 66. 0 67. 00 06600 OP-PHYSI CAL THERAPY 1,362,854 1,362,854 67. 0 68. 00 06600 OSOBO SPEECH PATHOLOGY 108,470 504,436 68. 0 69. 0
56. 00 05600 RADI OI SOTOPE -19, 250 1, 216, 980 56. 00 57. 00 05700 CT SCAN 203, 008 2, 206, 004 57. 00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 51, 472 1, 557, 314 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 243, 088 17, 510, 278 59. 00 60. 00 06000 LABORATORY -45, 091 9, 233, 419 60. 00 65. 00 06500 RESPI RATORY THERAPY 0 1, 691, 617 62. 00 66. 00 06500 RESPI RATORY THERAPY -1, 611, 954 2, 345, 230 66. 01 66. 01 06600 PHYSI CAL THERAPY -1, 611, 954 2, 345, 230 66. 01 66. 02 06602 PHYSI CAL THERAPY -1, 611, 954 2, 345, 230 66. 01 66. 02 06602 PHYSI CAL THERAPY -1, 282, 055 2, 025, 329 66. 01 67. 00 06600 PSCHI ATTI CIPSYCHOLOGI CAL SERVI CES 0 0 66. 01 68. 00 06800 SPEECH PATHOLOGY 108, 470 504, 436 68. 00 6800 SPEECH PATHOLOGY 108, 470 504, 436 68. 00 69. 00 69. 01 69. 01 69.
57. 00 05700 CT SCAN 203,008 2,206,004 57.01 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 51,472 1,557,314 58.00 59. 00 05900 CARDI AC CATHETERI ZATI ON 243,088 17,510,278 59.00 60. 00 06000 LABORATORY -45,091 9,233,419 60.01 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 1,691,617 62.00 65. 00 06500 RESPI RATORY THERAPY 0 3,707,579 65.00 66. 01 06600 PHYSI CAL THERAPY -1,611,954 2,345,230 66.01 66. 02 06600 PHYSI CAL THERAPY -1,282,055 2,025,329 66.00 66. 02 06700 OCCUPATI ONAL THERAPY 1,362,854 1,362,854 67.00 67. 00 06700 OCCUPATI ONAL THERAPY 1,362,854 1,909,967 69.00 69. 01 06900 SPEECH PATHOLOGY 108,470 504,436 69.00 69. 01 06901 CARDI AC REHAB 3,037 312,415 69.00 70. 00 O7000 ELECTROCARDI OLOGY -48,616 1,909,967 69.00 71. 00 O
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 51, 472 1, 557, 314 58. 00 59. 00 05900 CARDIA C CATHETERIZATION 243, 088 17, 510, 278 59. 00 60. 00 06000 LABORATORY -45, 091 9, 233, 419 66. 00 65. 00 06500 RESPIRATORY THERAPY 0 3, 707, 579 65. 00 66. 00 06600 RESPIRATORY THERAPY -1, 611, 954 2, 345, 230 66. 00 66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 66. 00 66. 02 06602 O/P PHYSI CAL THERAPY -1, 282, 055 2, 025, 329 66. 0. 67. 00 06700 OCCUPATI ONAL THERAPY 1, 362, 854 1, 362, 854 67. 00 68. 00 06800 SPEECH PATHOLOGY 108, 470 504, 436 68. 00 69. 01 06901 CARDIA C REHAB 3, 037 312, 415 69. 00 70. 00 07000 ELECTROCARDI OLOGY -48, 616 1, 909, 967 69. 01 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS -13, 607 856, 904 71. 00 72. 00 07200 I IMPL. DEV. CHARGED TO PATI ENTS 0 10, 645, 497 72. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 243, 088 17, 510, 278 60. 00 60000 LABORATORY 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 1, 691, 617 62. 00 66. 00 66500 RESPI RATORY THERAPY 0 3, 707, 579 65. 00 66. 00 66601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 66. 00
60. 00
62. 00
65. 00
66. 00
66. 01 06601 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 0 066. 02 06602 0/P PHYSICAL THERAPY -1, 282, 055 2, 025, 329 66. 02 06700 0CCUPATIONAL THERAPY 1, 362, 854 1, 362, 854 67. 00 06700 0CCUPATIONAL THERAPY 1, 362, 854 1, 362, 854 67. 00 06800 SPEECH PATHOLOGY 108, 470 504, 436 68. 00 06900 ELECTROCARDIOLOGY -48, 616 1, 909, 967 69. 01 06901 CARDIAC REHAB 3, 037 312, 415 69. 00 07000 ELECTROENCEPHALOGRAPHY -2, 322, 938 893, 075 70. 00 07000 ELECTROENCEPHALOGRAPHY -2, 322, 938 893, 075 70. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS -13, 607 856, 904 71. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 10, 645, 497 72. 00 07300 DRUGS CHARGED TO PATIENTS 22, 470 34, 022, 788 73. 00 07300 DRUGS CHARGED TO PATIENTS 22, 470 34, 022, 788 73. 00 07300 DRUGS CHARGED TO PATIENTS 22, 470 34, 022, 788 76. 00 09000 CLI NI C 0 1, 647, 933 76. 00 09000 CLI NI C 0 274, 244 90. 05 09005 PATIENT NUTRITION -3, 279 346, 116 90. 07 09007 WOUND CLI NI C 5, 320 1, 186, 876 90. 07 9007 WOUND CLI NI C 5, 320 1, 186, 876 90. 07 91. 00 09100 EMERGENCY -1, 518, 880 6, 591, 374 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART)
66. 02
67. 00
68. 00
69. 00
69. 01
70. 00
71. 00
72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 22,470 34,022,788 73.00 76.00 03020 RENAL ACUTE 0 1,647,933 76.00 00000 CLI NI C 0 274,244 90.05 09005 PATIENT NUTRITION -3,279 346,116 90.07 09007 WOUND CLI NI C 5,320 1,186,876 90.07 09100 EMERGENCY -1,518,880 6,591,374 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART)
76. 00 03020 RENAL ACUTE 0 1, 647, 933 76. 00 OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 0 274, 244 90. 05 90. 05 09005 PATIENT NUTRITION -3, 279 346, 116 90. 07 09007 WOUND CLINIC 5, 320 1, 186, 876 90. 07 91. 00 09100 EMERGENCY -1, 518, 880 6, 591, 374 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 0 274, 244 90. 00 90. 05 09005 PATIENT NUTRITION -3, 279 346, 116 90. 00 90. 07 09007 WOUND CLINIC 5, 320 1, 186, 876 90. 00 91. 00 09100 EMERGENCY -1, 518, 880 6, 591, 374 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92. 00
90. 00 09000 CLINIC 0 274, 244 90. 00 9000 PATIENT NUTRITION -3, 279 346, 116 90. 00 9000 09000 CUINIC 5, 320 1, 186, 876 90. 00 91. 00 09100 EMERGENCY -1, 518, 880 6, 591, 374 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92. 00 90000 000000
90. 05 09005 PATIENT NUTRITION
90. 07 09007 WOUND CLINIC 5,320 1,186,876 91. 00 09100 EMERGENCY -1,518,880 6,591,374 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92. 00
91. 00 09100 EMERGENCY -1, 518, 880 6, 591, 374 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 92. 00
SPECIAL PURPOSE COST CENTERS
118. 00 SUBTOTALS (SUM OF LINES 1-117) 15, 182, 892 302, 685, 424 118. 00
NONREI MBURSABLE COST CENTERS
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190. 00
194. 00 07950 RURAL HEALTH 0 2, 831, 000 194. 00
194. 01 07951 RENTAL PROPERTY 0 239, 596 194. 0
194. 02 07954 FAMILY PRACTICE 0 1, 698, 186 194. 0:
194. 03 07952 WELLNESS 0 360, 134 194. 0
194. 04 07955 PHYSI CI AN PRACTI CES 0 9, 997, 918 194. 0
194. 06/07953 SYCAMORE SPORTS MED -567, 138 144, 522 194. 0
194. 07 07 97 56 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 620, 680 194. 0
200.00 TOTAL (SUM OF LINES 118-199) 14, 615, 754 317, 677, 460 200.00

Health Financial Systems RECLASSIFICATIONS UNION HOSPITAL, INC. In Lieu of Form CMS-2552-10 Provider CCN: 150023

					10 12/31/20	5/25/2016 10:01 am
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
	B - PARAMED					
1.00	PARAMED ED PRGM	23. 00	14 <u>5, 3</u> 67	3 <u>1, 4</u> 72		1.00
	0		145, 367	31, 472		
	C - FITNESS ACTIVITY					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	170, 966	71, 130		1.00
2.00	WELLNESS	194. 03	254, 323	105, 811		2.00
			425, 289	176, 941		
	D - CLAY CITY RURAL HEALTH		· · · · ·			
1.00	RURAL HEALTH	194. 00	0	44, 500		1.00
	0	``+		44, 500		
	E - CORK MEDICAL RURAL HEALTH		<u> </u>	11,000		
1. 00	RURAL HEALTH	194.00	Ο	23, 230		1.00
1.00	O -		0	23, 230		1.00
	F - HOUSE NURSE ASSISTANT		u u	23, 230		
1 00	INTENSIVE CARE UNIT	31.00	93, 635	10, 780		1 00
1.00						1.00
2.00	I NTENSI VE NURSERY	35.00	36, 575	4, 211		2.00
3.00	SUBPROVI DER - I RF	41.00	40, 421	4,654		3.00
	U SUBJECTED ASSESSED		170, 631	19, 645		
	G - EMPLOYEE ACCESS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	6 <u>8, 3</u> 62	1 <u>2, 5</u> 06		1. 00
	0		68, 362	12, 506		
	H - TUBE FEEDING					
1.00	ADULTS & PEDIATRICS	30.00	6, 972	34, 556		1.00
			6, 972	34, 556		
	I - FAMILY MEDICINE					
1.00	I&R SERVICES-SALARY &	21. 00	1, 244, 062	107, 223		1. 00
	FRINGES APPRVD		, ,			
2.00	I&R SERVICES-OTHER PRGM	22. 00	1, 422, 956	1, 209, 834		2.00
	COSTS APPRVD		, , , , , , ,	, ,		
	0		2, 667, 018	1, 317, 057		
	J - LOBBY PHARMACY			., ,		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	290, 381	1, 259, 478		1.00
	0		290, 381	1, 259, 478		
	K - IMPLANTABLE DEVICES		270, 301	1, 237, 470		
1. 00	I MPL. DEV. CHARGED TO	72.00	O	10, 645, 497		1.00
1.00	PATI ENTS	72.00	٥	10, 043, 477		1.00
2.00	IAITENIS	0.00	o	0		2. 00
3.00		0.00	0	0		3.00
			-	U		
4. 00		0.00	•	U		4. 00
	U		0	10, 645, 497		
	L - INTEREST			44 700		
1.00	NEW CAP REL COSTS-BLDG &	1. 00	0	11, 789, 399		1. 00
	FLXT					
2.00	NEW CAP REL COSTS-MVBLE	2. 00	0	4, 091, 383		2.00
	EQUI P		+			
	0		0	15, 880, 782		
	M - PLUM PUMPS AND OTHER					
1.00	ADULTS & PEDIATRICS	30.00	0	43, 836		1. 00
	0 = = = = = =		0	43, 836		
	N - NURSERY	<u>'</u>		•		
1. 00	NURSERY	43.00	1, 029, 950	36, 356		1.00
		— — †	1, 029, 950	36, 356		
	O - PHARMACY PARAMED		., 02,,,00	55, 555		
1. 00	OTHER MED ED	23. 01	66, 744	6, 538		1. 00
00	0	23.01	66, 744	6, 538		1.00
E00 00	Crand Total: Increases					F00 00
500. O	Grand Total: Increases	1	4, 870, 714	29, 532, 394		500.00

Health Financial Systems RECLASSIFICATIONS UNION HOSPITAL, INC. In Lieu of Form CMS-2552-10 Provi der CCN: 150023

| Peri od: | Worksheet A-6 | From 01/01/2015 | To 12/31/2015 | Date/Time Prepared:

					'	5/25/2016	5 10: 01 am
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
	B - PARAMED						
1.00	RADI OLOGY-DI AGNOSTI C	<u>54.</u> 00	14 <u>5, 3</u> 67	3 <u>1, 4</u> 72			1. 00
	0		145, 367	31, 472			
4 00	C - FITNESS ACTIVITY	5.04	405 000	47/ 044			1.00
1.00	OTHER ADMIN AND GENERAL	5. 06 0. 00	425, 289	176, 941	0		1.00
2.00			425, 289	<u></u> <u>0</u> 176, 941			2.00
	D - CLAY CITY RURAL HEALTH		423, 209	170, 941			
1.00	NEW CAP REL COSTS-BLDG &	1.00	ol	44, 500	ol		1.00
1.00	FIXT	1.00	٩	44, 500	1		1.00
		+		44, 500			ľ
	E - CORK MEDICAL RURAL HEALTH	·	<u>'</u>	·	·		
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	23, 230	9		1.00
	FI XT						
	0		0	23, 230			
	F - HOUSE NURSE ASSISTANT						
1.00	ADULTS & PEDIATRICS	30.00	170, 631	19, 645			1.00
2.00		0. 00	0	0			2. 00
3.00		0.00	0_	0	0		3. 00
	0		170, 631	19, 645			
1 00	G - EMPLOYEE ACCESS	104 07	(0.2(2)	10. 50/			1.00
1. 00	PSYCHI ATRI C/PSYCHOLOGI CAL	194. 07	68, 362	12, 506	0		1.00
	SERVICES	+	68, 362	12, 506	 		
	H - TUBE FEEDING		00, 302	12, 300			
1.00	DI ETARY	10.00	6, 972	34, 556	0		1.00
1.00	0		6, 972	34, 556			1.00
	I - FAMILY MEDICINE		5/ //2	0 1,7 0 0 0			
1.00	FAMILY PRACTICE	194. 02	2, 667, 018	1, 317, 057	0		1.00
2.00		0.00	0	0	0		2.00
			2, 667, 018	1, 317, 057			
	J - LOBBY PHARMACY						
1.00	DRUGS CHARGED TO PATIENTS	73. 00	290, 381	1, 259, 478	0		1. 00
	0		290, 381	1, 259, 478			
	K - IMPLANTABLE DEVICES						
1.00	OPERATING ROOM	50.00	0	6, 080, 789			1.00
2.00	CARDI AC SURGERY	50. 01	0	529, 266			2. 00
3.00	WVSC	50. 02	0	792, 190			3. 00
4.00	CARDI AC CATHETERI ZATI ON	<u>59.</u> 00		3, 243, 252			4. 00
	0		0	10, 645, 497			
4 00	L - INTEREST	5.04		45 000 700	141		1.00
1.00	OTHER ADMIN AND GENERAL	5. 06	0	15, 880, 782			1.00
2.00		0.00	0	00 15, 880, 782	11		2. 00
	M - PLUM PUMPS AND OTHER		UU	15, 880, 782			
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	43, 836	O		1.00
1.00	PATI ENTS	71.00	ď	43, 030	٥		1.00
	<u> </u>	+	-	43, 836	 		
	N - NURSERY		<u> </u>	.5, 666			
1.00	ADULTS & PEDIATRICS	30.00	1, 029, 950	36, 356	0		1.00
	0 +	— — — +	1, 029, 950	36, 356			
	O - PHARMACY PARAMED			,	<u> </u>		
1.00	DRUGS CHARGED TO PATIENTS	73. 00	66, 744	6, 538	0		1.00
		+	66, 744	6, 538			
E00 00	Grand Total: Decreases		4, 870, 714	29, 532, 394			500.00

Health Financial Systems	UNION HOSPITAL,	INC.		In Lieu of Form CMS-2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der CCN: 150023	Peri od:	Worksheet A-7

From 01/01/2015 | Part | To 12/31/2015 | Date/Time Prepared: 5/25/2016 10:01 am Acqui si ti ons Begi nni ng Purchases Total Donati on Di sposal s and Bal ances Retirements 2.00 3.00 4. 00 5. 00 1 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 17, 436, 649 5, 178 1.00 19, 528, 558 0 67, 264 92, 863 2.00 Land Improvements 67, 264 2.00 3.00 326, 258, 727 2, 164, 747 2, 164, 747 14, 497 3.00 Buildings and Fixtures 0 4.00 Building Improvements 1, 526, 209 73, 585 73, 585 4.00 5.00 Fixed Equipment 0 5.00 0 6.00 Movable Equipment 129, 289, 251 6, 367, 585 6, 367, 585 2, 277, 378 6.00 0 7.00 HIT designated Assets 0 7.00 8.00 Subtotal (sum of lines 1-7) 494, 039, 394 8, 673, 181 8, 673, 181 2, 389, 916 8.00 9.00 Reconciling Items 0 9.00 Total (line 8 minus line 9) 494, 039, 394 8, 673, 181 O 2, 389, 916 10.00 8, 673, 181 10.00 Endi ng Bal ance Fully Depreci ated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 17, 431, 471 1.00 2.00 Land Improvements 19, 502, 959 0 2. 00 Buildings and Fixtures 3.00 328, 408, 977 0 3.00 0) 4.00 Building Improvements 1, 599, 794 4.00 5.00 Fixed Equipment 0 5.00 0 6.00 Movable Equipment 133, 379, 458 6.00 7.00 HIT designated Assets 0 7.00 Subtotal (sum of lines 1-7) 8.00 500, 322, 659 0 8.00 9.00 Reconciling Items 9.00

500, 322, 659

10.00

10.00 Total (line 8 minus line 9)

Heal th	Financial Systems	UNI ON HOSPI	TAL, INC.		In Lie	u of Form CMS-2	2552-10
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150023	Peri od:	Worksheet A-7	
					From 01/01/2015 To 12/31/2015	Part II Date/Time Prep	narod:
					10 12/31/2013	5/25/2016 10:0	
			Sl	JMMARY OF CAP	I TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
					instructions)		
		9. 00	10. 00	11. 00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	<u>KSHEET A, COLUM</u>	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FLXT	12, 369, 614	0		0 0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	6, 196, 354	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	18, 565, 968	0		0 0	0	3. 00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	12, 369, 614				1. 00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	6, 196, 354				2. 00
3.00	Total (sum of lines 1-2)	0	18, 565, 968	1			3. 00
		•		•			

Health Financial Systems	UNI ON HOSPI	TAL, INC.		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der		Peri od: From 01/01/2015 To 12/31/2015		pared:
	COME	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance	
	1.00	2. 00	3. 00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		1	070 000 50	0.747040	0	1 00
1.00 NEW CAP REL COSTS-BLDG & FLXT 2.00 NEW CAP REL COSTS-MVBLE EQUIP	373, 900, 584 126, 422, 075	l e	373, 900, 58 126, 422, 07		0	1. 00 2. 00
3.00 Total (sum of lines 1-2)	500, 322, 659		500, 322, 65			3. 00
3.00 Total (sum of fiftee 12)		TION OF OTHER (F CAPITAL	3.00
Cost Center Description	Taxes	Other Capi tal-Relate d Costs	Total (sum o cols. 5 through 7)	f Depreciation	Lease	
	6.00	7. 00	8. 00	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00 NEW CAP REL COSTS-BLDG & FLXT	0			0 11, 087, 695	0	
2. 00 NEW CAP REL COSTS-MVBLE EQUIP	0			0 5, 651, 076	0	
3.00 Total (sum of lines 1-2)	0	·		0 16, 738, 771	0	3. 00
			JMMARY OF CAPI			
Cost Center Description	Interest	Insurance (see instructions)			Total (2) (sum of cols. 9 through 14)	
	11. 00	12. 00	13. 00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		_				
1.00 NEW CAP REL COSTS-BLDG & FLXT	11, 642, 172			0	22, 729, 867	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	4, 040, 776 15, 682, 948			0 0		2. 00 3. 00
3. 00 Total (Suil Of TitleS 1-2)	10,002,948	1	I	O _I O _I	32,421,/19	J 3.00

				To	rom 01/01/2015 o 12/31/2015	Date/Time Prep 5/25/2016 10:0	
				Expense Classification on To/From Which the Amount is			JI alli
				10/11 oill will cit the Allouit 13	to be Aujusteu		
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
1.00	Investment income - NEW CAP	1. 00 B	2. 00 -147, 227	3.00 NEW CAP REL COSTS-BLDG &	4. 00 1. 00	5. 00 11	1. 00
	REL COSTS-BLDG & FIXT (chapter 2)			FIXT			
2. 00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter	В	-50, 607	NEW CAP REL COSTS-MVBLE EQUIP	2. 00	11	2. 00
3.00	2) Investment income - other (chapter 2)		0		0.00	0	3. 00
4. 00	Trade, quantity, and time	В	-4, 628	PURCHASING RECEIVING AND STORES	5. 03	0	4. 00
5.00	di scounts (chapter 8) Refunds and rebates of	В	-70, 537	PURCHASING RECEIVING AND	5. 03	0	5. 00
6.00	expenses (chapter 8) Rental of provider space by		0	STORES	0.00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay stations excluded) (chapter	А	-18, 920	NONPATIENT TELEPHONES	5. 01	0	7. 00
8. 00	21) Tel evi si on and radi o servi ce		0		0. 00	0	8. 00
9. 00 10. 00	(chapter 21) Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -19, 282, 251		0.00	0	9. 00 10. 00
11. 00	adjustment Sale of scrap, waste, etc.	A-0-2	- 17, 202, 251		0. 00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	54, 868, 363			0	12. 00
13. 00	transactions (chapter 10) Laundry and linen service		0		0.00	0	13. 00
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee		-1, 329, 493 0	CAFETERI A	11. 00 0. 00	0	14. 00 15. 00
16. 00	and others Sale of medical and surgical supplies to other than patients	А	-13, 607	MEDICAL SUPPLIES CHARGED TO PATIENTS	71. 00	0	16. 00
17. 00	Sale of drugs to other than patients	A	-37, 521	DRUGS CHARGED TO PATIENTS	73.00	0	17. 00
18. 00	Sale of medical records and abstracts	В	-44, 216	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	Nursing school (tuition, fees,		0		0.00	0	19. 00
20.00	books, etc.) Vendi ng machi nes	A	-12, 849	OPERATION OF PLANT	7. 00	0	20.00
21. 00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0. 00	0	21. 00
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0. 00	0	22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
24. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSICAL THERAPY	66. 00		24. 00
25. 00	limitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
26. 00	(chapter 21) Depreciation - NEW CAP REL			NEW CAP REL COSTS-BLDG &	1. 00	0	26. 00
27. 00	COSTS-BLDG & FIXT Depreciation - NEW CAP REL			FIXT NEW CAP REL COSTS-MVBLE	2. 00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	EQUIP *** Cost Center Deleted ***	19. 00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATIONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	instructions) Adjustment for speech	A-8-3		SPEECH PATHOLOGY	68. 00		31. 00
	pathology costs in excess of limitation (chapter 14)						
32. 00	CAH HIT Adjustment for Depreciation and Interest		0		0. 00	0	32. 00

Health Financial Systems
ADJUSTMENTS TO EXPENSES Provi der CCN: 150023 Peri od: Worksheet A-8 From 01/01/2015
To 12/31/2015 Date/Time Prepared:

				To	o 12/31/2015	Date/Time Pre 5/25/2016 10:	
				Expense Classification on	Worksheet A	572572016 10.	UT alli
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
33. 00	TELEPHONE DEPRECIATION	1. 00 A	2.00	3.00 NEW CAP REL COSTS-MVBLE	4. 00	5. 00	33. 00
00.00	TEEETHONE BETTEOTHTON		200	EQUI P	2.00	ĺ	00.00
34. 00	VENDING HOUSEKEEPING	A		HOUSEKEEPI NG	9. 00	0	
35. 00	MEALS SOLD	В		DIETARY	10.00	0	
36. 00 38. 00	VISITORS MEALS LAB - BLDG	A B		CAFETERIA NEW CAP REL COSTS-BLDG &	11. 00 1. 00	0	36. 00 38. 00
30.00	LAD - BEDG	B	-140, 773	FIXT	1.00	'	30.00
39. 00	LAB - ADMINISTRATION	В		OTHER ADMIN AND GENERAL	5. 06	0	39. 00
40.00	LAB - LAUNDRY	В		LAUNDRY & LINEN SERVICE	8. 00	0	
41.00	LAB - HOUSEKEEPING	В		HOUSEKEEPI NG	9. 00	0	
42. 00 42. 01	LAB - OPERATION OF PLANT HAMILTON CENTER OPERATION OF	B A		OPERATION OF PLANT HOUSEKEEPING	7. 00 9. 00	0	
42.01	PLANT	A	-12, 930	HOUSEKEEPING	9.00	0	42.01
45. 00	HAMILTON CENTER NUTRITION	A	-231, 841	DI ETARY	10.00	0	45. 00
45. 01	FITNESS ACTIVITY	В		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	
45. 02	EQUI PMENT RENTAL	В	-7, 533	NEW CAP REL COSTS-MVBLE	2. 00	9	45. 02
45. 03	UHF - HOUSEKEEPING	A	-960	EQUI P HOUSEKEEPI NG	9. 00	0	45. 03
45. 04	MI SCELLANEOUS	В		OTHER ADMIN AND GENERAL	5. 06	0	
45. 05	CATERI NG	В	•	CAFETERI A	11. 00	0	45. 05
45. 06	MANAGEMENT SERVICES	В	-24,000	OTHER ADMIN AND GENERAL	5. 06	0	45. 06
45. 07	PHYSICIAN MEALS	В		CAFETERI A	11. 00	0	
45. 08	OTHER RENTAL	В		OPERATION OF PLANT	7.00	0	
45. 09 45. 24	PHYSICIAN EQUIPMENT REVENUE UHF - ADMINISTRATION	B B		OPERATION OF PLANT OTHER ADMIN AND GENERAL	7. 00 5. 06	0	
45. 26	LOBBY PHARMACY	В		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	ı
45. 27	LOBBYI NG COSTS	A		OTHER ADMIN AND GENERAL	5. 06	Ö	
45. 29	AP&S REVENUE	В	-68, 175	NONPATIENT TELEPHONES	5. 01	0	45. 29
45. 32	AP&S REVENUE	В		NEW CAP REL COSTS-BLDG &	1. 00	9	45. 32
45. 37	AP&S REVENUE	В		FIXT DATA PROCESSING	5. 02	0	45. 37
45. 38	AP&S REVENUE	В		OTHER ADMIN AND GENERAL	5. 06	0	45. 38
45. 39	COH REVENUE	В		NEW CAP REL COSTS-BLDG &	1.00	9	45. 39
45 40	COLL DEVENUE	, n	4 (50	FLXT	F 01		45 40
45. 40 45. 42	COH REVENUE PHYSICIAN RENTAL	B A		NONPATIENT TELEPHONES NEW CAP REL COSTS-BLDG &	5. 01 1. 00	0	45. 40 45. 42
43. 42	THISTOTAN KENTAL		-337,010	FIXT	1.00	'	45.42
45. 43	PHYSICIAN RENTAL	A	-418, 148	OPERATION OF PLANT	7. 00	0	45. 43
45. 44	ACCELERATED DEPRECIATION	A	· ·	NEW CAP REL COSTS-BLDG &	1. 00	9	45. 44
45. 45	CHILD BIRTH CLASS	В		FIXT DELIVERY ROOM & LABOR ROOM	52. 00	0	45. 45
	CONTINUING EDUCATION	В		OTHER ADMIN AND GENERAL	52.00 5.06	_	•
	EDUCATION SERVICES	В		OTHER ADMIN AND GENERAL	5. 06		
45. 49	TRANSCRI PTI ON	В	-1, 094	MEDICAL RECORDS & LIBRARY	16. 00	0	45. 49
46. 00	VHA	В		DRUGS CHARGED TO PATIENTS	73. 00	0	46. 00
46. 01	EMPLOYEE BENEFITS	В		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	46. 01
46. 02 46. 03	TIME SAVERS HOUSEKEEPING	B B	· ·	EMPLOYEE BENEFITS DEPARTMENT HOUSEKEEPING	4. 00 9. 00	0	
46. 04	LANDSBAUM	В	· ·	OPERATION OF PLANT	7. 00	0	
46. 07	MAPLE CENTER	В	· ·	OTHER ADMIN AND GENERAL	5. 06	0	
46. 08	PROF SUPPORT UHS	В		OTHER ADMIN AND GENERAL	5. 06	0	1
46. 09	AP&S OTHER CHG/LAUNDRY REVENUE			LAUNDRY & LINEN SERVICE	8. 00	0	46. 09
46. 10	AP&S A/P PD SPACE/EQUIP RENT R	! В	-15, 958	NEW CAP REL COSTS-BLDG &	1. 00	9	46. 10
46. 11	CODING CLASS REVENUE	В	_8 850	FIXT MEDICAL RECORDS & LIBRARY	16. 00	0	46. 11
46. 12	WVHC ST ANN/ASH PHARMACY REVEN			DRUGS CHARGED TO PATIENTS	73. 00	0	
46. 13	HAF	A		OTHER ADMIN AND GENERAL	5. 06	Ō	46. 13
46. 14	CRNA S&W/BENEFITS	A	-1, 274, 685	DELIVERY ROOM & LABOR ROOM	52. 00	0	46. 14
50.00	TOTAL (sum of lines 1 thru 49)		14, 615, 754				50. 00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1.(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 150023

Worksheet A-8-1 From 01/01/2015 | Ta 12/31/2015 | Date/Time Prepared:

0	. 60313			To 12/31/2015	Date/Time Prep 5/25/2016 10:0	
	Li ne No.	Cost Center	Expense I tems	Amount of	Amount	, , d
			·	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 (ORGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:	OTHER MED ED	la a a u a		200 074	
1.00		OTHER MED ED	PARAMED	0	302, 376	1. 00
2.00		NEW CAP REL COSTS-BLDG & FIX		0	1, 957, 123	2.00
3.00			HOME OFFICE	0	4, 349, 284	3. 00
4. 00 4. 01		NONPATIENT TELEPHONES OPERATION OF PLANT	HOME OFFICE	0	244, 858	4. 00 4. 01
4. 01		HOUSEKEEPING	HOME OFFICE		1, 073, 186	4. 01
4. 02		NEW CAP REL COSTS-BLDG & FIX		1, 778, 465	467, 409 0	4. 02
4.03			HOME OFFICE	3, 811, 777	0	4. 03
4. 04			HOME OFFICE	18, 079, 302	0	4. 04
4.05		NONPATIENT TELEPHONES	HOME OFFICE	212, 455	0	4. 05
4. 00		DATA PROCESSING	HOME OFFICE	11, 803, 738	0	4. 07
4. 07		PURCHASING RECEIVING AND STO		1, 205, 098	0	4. 07
4. 09		CASHI ERI NG/ACCOUNTS RECEI VAB		6, 412, 988	0	4. 09
4. 10	•	OTHER ADMIN AND GENERAL	HOME OFFICE	15, 102, 023	0	4. 10
4. 10	l l	OPERATION OF PLANT	HOME OFFICE	2, 896, 478	0	4. 10
4. 12	•	HOUSEKEEPI NG	HOME OFFICE	424, 737	0	4. 12
4. 13		DIETARY	HOME OFFICE	143, 077	Ö	4. 13
4. 14		CAFETERI A	HOME OFFICE	231, 027	0	4. 14
4. 15	•	NURSING ADMINISTRATION	HOME OFFICE	1, 233, 363	0	4. 15
4. 16	•	MEDICAL RECORDS & LIBRARY	HOME OFFICE	593, 698	O	4. 16
4. 17	•	OPERATING ROOM	HOME OFFICE	159, 839	0	4. 17
4. 18	•	CARDI AC SURGERY	HOME OFFICE	12, 721	o	4. 18
4. 19	50. 02	s	HOME OFFICE	102, 771	o	4. 19
4. 20	•	RECOVERY ROOM	HOME OFFICE	4, 422	0	4. 20
4. 21	54.00	RADI OLOGY-DI AGNOSTI C	HOME OFFICE	151, 501	o	4. 21
4. 22		CT SCAN	HOME OFFICE	203, 008	O	4. 22
4. 23	58. 00	MAGNETIC RESONANCE IMAGING (HOME OFFICE	51, 472	0	4. 23
4. 24	59. 00	CARDIAC CATHETERIZATION	HOME OFFICE	243, 088	0	4. 24
4. 25	66. 00	PHYSI CAL THERAPY	HOME OFFICE	13, 999	О	4. 25
4. 26	66. 02	O/P PHYSICAL THERAPY	HOME OFFICE	13, 821	0	4. 26
4. 27	67. 00	OCCUPATIONAL THERAPY	HOME OFFICE	14, 216	0	4. 27
4. 28	68. 00	SPEECH PATHOLOGY	HOME OFFICE	4, 313	0	4. 28
4. 29	69. 00	ELECTROCARDI OLOGY	HOME OFFICE	42, 584	0	4. 29
4.30	69. 01	CARDI AC REHAB	HOME OFFICE	3, 037	0	4.30
4.31	70. 00	ELECTROENCEPHALOGRAPHY	HOME OFFICE	21, 331	0	4. 31
4.32	73. 00	DRUGS CHARGED TO PATIENTS	HOME OFFICE	323, 102	0	4. 32
4.33	90. 07	WOUND CLINIC	HOME OFFICE	5, 320	0	4. 33
4. 36	•	PHYSI CAL THERAPY	UNION THERAPIES	2, 124, 884	3, 750, 837	4. 36
4.37		O/P PHYSICAL THERAPY	UNION THERAPIES	1, 311, 120	2, 606, 996	4. 37
4.38		OCCUPATIONAL THERAPY	UNION THERAPIES	1, 348, 638	0	4. 38
4.39		SPEECH PATHOLOGY	UNION THERAPIES	409, 135	304, 978	4. 39
4.41	1	SYCAMORE SPORTS MED	UNION THERAPIES	0	567, 138	4. 41
5.00	0		0	70, 492, 548	15, 624, 185	5. 00

^{*} The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropri ate.

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

Shoul	Should be indicated in column 4 of this part.					
				Related Organization(s) and/	or Home Office	
				= g= == (=, =		
	Symbol (1)	Name	Percentage of	Name	Percentage of	
	J		Ownershi p		Ownershi p	
			Owner Sili p		OWNER SITE	
	1. 00	2.00	3.00	4. 00	5. 00	
B INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE						

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

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

6.00	G		O. OO UNI ON HOSPI TAL	100.00	6. 00
7.00	G		O. OO UNI ON THERAPY	100.00	7.00
8.00			0. 00	0. 00	8.00
9.00			0. 00	0. 00	9.00
10.00			0. 00	0. 00	10.00
		•	·	· ·	

STATEME OFFICE		RELATED ORGANIZATIONS AND HO	ME Provi der	CCN: 150023	Peri od: From 01/01/2015	Worksheet A-8	3-1
OTTICE	60313					Date/Time Pre 5/25/2016 10:	
				Related Organ	nization(s) and/o	or Home Office	
	Symbol (1)	Name	Percentage of	N	lame	Percentage of	
			Ownershi p			Ownershi p	
	1. 00	2.00	3.00	4	. 00	5. 00	
100.00	G. Other (financial or	OTHER					100.00

UNION HOSPITAL, INC.

In Lieu of Form CMS-2552-10

non-financial) specify: (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 12/31/2015	5/25/2016 10:01 am
	Net	Wkst. A-7 Ref.				3/23/2010 10. 01 aiii
	Adjustments					
	(col. 4 minus					
	col. 5)*					
	6. 00	7. 00				
	A. COSTS INCUR	RED AND ADJUSTM	ENTS REQUIRED AS A RESULT OF TRANS	ACTIONS WITH RELATED O	RGANIZATIONS OR C	LAI MED
	HOME OFFICE CO	STS:				
1.00	-302, 376					1.00
2.00	-1, 957, 123					2. 00
3.00	-4, 349, 284					3. 00
4.00	-244, 858					4. 00
4. 01	-1, 073, 186					4. 01
4. 02	-467, 409					4. 02
4.03	1, 778, 465					4. 03
4.04	3, 811, 777	9				4. 04
4. 05	18, 079, 302					4. 05
4. 06	212, 455					4. 06
4. 07	11, 803, 738					4. 07
4. 08	1, 205, 098					4. 08
4. 09	6, 412, 988					4. 09
4. 10	15, 102, 023	0				4. 10
4. 11	2, 896, 478					4. 11
4. 12	424, 737					4. 12
4. 13	143, 077	0				4. 13
4. 14	231, 027	0				4. 14 4. 15
4. 15 4. 16	1, 233, 363 593, 698					4. 16
4. 10	159, 839					4. 17
4. 17	12, 721	0				4. 18
4. 19	102, 771	0				4. 19
4. 20	4, 422	o				4. 20
4. 21	151, 501	o				4. 21
4. 22	203, 008	0				4. 22
4. 23	51, 472					4. 23
4. 24	243, 088					4. 24
4. 25	13, 999					4. 25
4. 26	13, 821	Ō				4. 26
4. 27	14, 216					4. 27
4. 28	4, 313					4. 28
4. 29	42, 584					4. 29
4.30	3, 037	0				4. 30
4.31	21, 331	0				4. 31
4.32	323, 102					4. 32
4.33	5, 320					4. 33
4.36	-1, 625, 953					4. 36
4.37	-1, 295, 876					4. 37
4.38	1, 348, 638					4. 38
4. 39	104, 157	0				4. 39
4.41	-567, 138					4. 41
5.00	54, 868, 363					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		
and/or nome office		
Type of Pusiness		
Type of Business		
6. 00		
B. INTERRELATIONSHIP TO RELAT	FED 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 10. 00 100. 00		9.00
10.00		10.00
100.00		100.00

Health Financial Systems	UNION HOSPITAL,	In Lieu of Form CMS-2552-10		
STATEMENT OF COSTS OF SERVICES FROM	Provider CCN: 150023	Peri od:	Worksheet A-8-1	
OFFICE COSTS			From 01/01/2015 To 12/31/2015	Date/Time Prepared: 5/25/2016 10:01 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
- 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 01/01/2015 To 12/31/2015 Date/Time Prepared: Provi der CCN: 150023

								5/25/2016 10:	
	Wkst. A Line #	Cost Center/Physician	Total	Profession	nal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Compone	nt	Component		ider Component	
							Hours		
	1. 00	2. 00	3. 00	4.00		5. 00	6. 00	7. 00	
1.00	22. 00	I&R SERVICES-OTHER PRGM	1, 061, 414		C	1, 061, 414	211, 500	9, 505	1. 00
		COSTS APPRVD							
2.00		ADULTS & PEDIATRICS	1, 496, 147					65	2. 00
3.00		I NTENSI VE NURSERY	483, 933	483	3, 933		237, 100	0	3. 00
4.00	41.00	SUBPROVIDER - IRF	97, 500	1	C	97, 500	211, 500	1, 300	4. 00
5.00	50.00	OPERATING ROOM	5, 560, 147	5, 560), 147	0	246, 400	0	5. 00
6.00	50. 01	CARDI AC SURGERY	2, 105, 764	2, 10!	5, 764	0	246, 400	0	6.00
7.00	54.00	RADI OLOGY-DI AGNOSTI C	5, 549, 119	5, 52	1, 119	25, 000	271, 900	167	7. 00
8.00	56.00	RADI OI SOTOPE	19, 250	19	9, 250	0	271, 900	0	8. 00
9.00	60.00	LABORATORY	617, 000	1	C	617, 000	260, 300	4,570	9. 00
10.00		ELECTROCARDI OLOGY	102, 000		1, 200	10, 800		120	10.00
11. 00		ELECTROENCEPHALOGRAPHY	2, 344, 269				1	0	
12. 00		PATIENT NUTRITION	5, 000		0			20	
13. 00		EMERGENCY	1, 537, 936		880	·			
200.00	700	Z.IIIZ. TO I	20, 979, 479					16, 375	
200.00	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE			Cost of	Provi der	Physician Cost	200.00
	INCSC. A EITHE #	I denti fi er	Li mi t			Memberships &		of Malpractice	
		Tuchti i ci	Li iiii t	Li mi t		Continuing	Share of col.	Insurance	
						Educati on	12	i i i i i i i i i i i i i i i i i i i	
	1. 00	2.00	8.00	9. 00		12. 00	13. 00	14. 00	
1.00		I &R SERVI CES-OTHER PRGM	966, 494		3, 325				1. 00
		COSTS APPRVD	,,,,,		, 020		Ĭ		
2.00	30.00	ADULTS & PEDIATRICS	6, 609	,	330	0	0	79, 587	2. 00
3.00		INTENSIVE NURSERY	0,007	,	000	0		0	3. 00
4. 00		SUBPROVI DER - I RF	132, 188		5, 609	1	1	0	
5. 00		OPERATING ROOM	0	1), UU) (110, 731	5. 00
6. 00		CARDI AC SURGERY		ł	0			67, 847	6. 00
7. 00		RADI OLOGY-DI AGNOSTI C	21, 830	1	I, 092		0	98, 843	
8. 00		RADI OLOGI - DI AGNOSTI C	21,030		1, 092 0		0	0,043	
9. 00		LABORATORY	571. 909	20	3, 595	1	0	0	
10. 00		ELECTROCARDI OLOGY	11, 394	1	570 570		0	0	10.00
11. 00		ELECTROCARDI OLOGI ELECTROENCEPHALOGRAPHY	11, 394		370	1	0	118, 936	
			1 701		-	_	_		
12.00		PATIENT NUTRITION	1, 721		86		0	0	12.00
13.00	91.00	EMERGENCY	63, 857		3, 193			0	
200.00	14(1 1 0 1 1 //	0 1 0 1 (8)	1, 776, 002		3, 800		-	475, 944	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adj usted		RCE	Adjustment		
		l denti fi er	Component	Limit		Di sal I owance			
			Share of col.						
	1. 00	2.00	14 15. 00	16, 00		17.00	10.00	1	
1. 00		2.00 I &R SERVI CES-OTHER PRGM	15.00		5, 494	17. 00 94, 920	18. 00 94, 920		1, 00
1.00	22.00	COSTS APPRVD	0	900	0, 494	94, 920	94, 920		1.00
2. 00	20.00	ADULTS & PEDIATRICS	864		7, 473	8, 777	1, 488, 674		2. 00
3. 00		INTENSIVE NURSERY	0 804	1	7,473 O				3. 00
				1	_	,	483, 933		
4.00		SUBPROVI DER - I RF	0	1	2, 188		U F F (0 1 4 7		4. 00
5.00		OPERATING ROOM	0	1	0	1	5, 560, 147		5. 00
6.00		CARDI AC SURGERY	0	1	0	,	,		6.00
7.00		RADI OLOGY-DI AGNOSTI C	445	1	2, 275	2, 725			7. 00
8.00		RADI OI SOTOPE	0	1	C	0	19, 250		8. 00
9.00		LABORATORY	0		1, 909	·	45, 091		9. 00
10.00		ELECTROCARDI OLOGY	0	1	1, 394				10. 00
11. 00		ELECTROENCEPHALOGRAPHY	0	1	C	1	2, 344, 269		11. 00
12.00		PATIENT NUTRITION	0	1	۱, 721				12. 00
13.00	91.00	EMERGENCY	0	1	3, 857		1, 518, 880	•	13. 00
200.00			1, 309	1, 77	7, 311	154, 792	19, 282, 251		200. 00

| Peri od: | Worksheet B | From 01/01/2015 | Part | | To | 12/31/2015 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 150023

				To	12/31/2015	Date/Time Prep 5/25/2016 10:0		
				CAPI TAL REI	ATED COSTS		3/23/2010 10.	or alli
		Not Evpopos	NEW BLDG &	NEW MVDLE	EMDL OVEE	NONDATI ENT		
Cost Center Description		Net Expenses for Cost	FLXT	NEW MVBLE EQUIP	EMPLOYEE BENEFITS	NONPATI ENT TELEPHONES		
			Allocation			DEPARTMENT		
			(from Wkst A					
			col. 7) 0	1. 00	2.00	4. 00	5. 01	
		AL SERVICE COST CENTERS						
1.00		NEW CAP REL COSTS-BLDG & FIXT	22, 729, 867	22, 729, 867				1.00
2. 00 4. 00		NEW CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT	9, 691, 852 19, 783, 374	179, 482	9, 691, 852 0	19, 962, 856		2. 00 4. 00
5. 01		NONPATI ENT TELEPHONES	839, 460	15, 282		109, 027	1, 026, 489	5. 01
5.02	1	DATA PROCESSING	11, 189, 026	0		0	0	5. 02
5.03		PURCHASING RECEIVING AND STORES	1, 129, 933	71 225		0	0	5. 03
5. 04 5. 05	1	ADMITTING CASHIERING/ACCOUNTS RECEIVABLE	1, 758, 203 6, 412, 988	71, 225 0		232, 914 0	36, 689 0	5. 04 5. 05
5. 06		OTHER ADMIN AND GENERAL	20, 155, 829	431, 979	·	940, 541	94, 577	5. 06
7.00		OPERATION OF PLANT	8, 938, 081	7, 873, 741		182, 328	57, 888	7. 00
8. 00 9. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING	982, 066 3, 929, 804	139, 287 123, 585		131, 681 374, 073	14, 676 6, 523	8. 00 9. 00
10.00	1	DI ETARY	2, 280, 013	255, 312		299, 084	24, 460	•
11. 00	01100	CAFETERI A	-74, 166	182, 180	24, 114	84, 740	0	11. 00
13.00		NURSING ADMINISTRATION	2, 732, 657	55, 268		250, 910	7, 338	
16. 00 17. 00		MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	3, 628, 327 160, 415	122, 888 4, 559		404, 195 28, 715	24, 460 3, 261	16. 00 17. 00
21. 00		I &R SERVICES-SALARY & FRINGES APPRVD	1, 351, 285	0		247, 763	0, 201	21. 00
22. 00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	2, 537, 870	0	0	283, 391	0	22. 00
23. 00		PARAMED ED PRGM	176, 839		I -	9, 650	0	23. 00
23. 01		OTHER MED ED IENT ROUTINE SERVICE COST CENTERS	225, 547	16, 748	2, 549	46, 675	0	23. 01
30.00		ADULTS & PEDIATRICS	24, 079, 187	4, 374, 131	1, 148, 128	3, 930, 761	139, 422	30. 00
31.00		INTENSIVE CARE UNIT	7, 093, 546			1, 083, 832	23, 644	
35.00		INTENSIVE NURSERY SUBPROVIDER - IRF	2, 101, 793	66, 992		350, 113	14, 676	
41. 00 43. 00		NURSERY	1, 711, 517 1, 104, 484	458, 729 91, 346		274, 270 205, 121	25, 275 3, 261	43.00
10.00		LARY SERVICE COST CENTERS	17 10 17 10 1	7.70.10	77.10	2007 121	0,201	10.00
50.00		OPERATING ROOM	10, 875, 589	947, 535		1, 700, 535	66, 856	
50. 01 50. 02	05001	CARDI AC SURGERY	2, 011, 972 11, 328, 647	41, 870 698, 480		439, 928 8, 285	4, 892 0	50. 01 50. 02
51. 00		RECOVERY ROOM	1, 729, 130	33, 310		283, 093	14, 676	
51. 02	1	O/P TREATMENT ROOM	2, 499, 675	496, 482	189, 782	423, 711	22, 014	51. 02
52.00		DELIVERY ROOM & LABOR ROOM	3, 426, 432	483, 944		778, 844	18, 752	•
54. 00 55. 00		RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C	7, 210, 810 4, 905, 143	806, 225 613, 857		1, 704, 624 76, 800	88, 055 33, 428	•
56.00	1	RADI OI SOTOPE	1, 216, 980			67, 634	00, 120	56. 00
57. 00	1	CT SCAN	2, 206, 004	50, 523		204, 377	5, 707	57. 00
58. 00 59. 00		MAGNETIC RESONANCE IMAGING (MRI) CARDIAC CATHETERIZATION	1, 557, 314 17, 510, 278	60, 316 388, 318		98, 315 128, 695	3, 261 27, 721	•
60.00	1	LABORATORY	9, 233, 419	300, 310		128, 693	6, 523	
62.00		WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 691, 617	0	0	0	0	•
65. 00		RESPI RATORY THERAPY	3, 707, 579	49, 639		522, 979	11, 414	
66. 00 66. 01		PHYSI CAL THERAPY PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	2, 345, 230	236, 099 0		0	18, 752 0	66. 00 66. 01
66. 02	1	0/P PHYSI CAL THERAPY	2, 025, 329	0		0	815	
67. 00		OCCUPATI ONAL THERAPY	1, 362, 854	38, 567		0	4, 077	67. 00
68. 00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	504, 436 1, 909, 967	76, 482 30, 356		290 407	815	
69. 00 69. 01		CARDI AC REHAB	312, 415	167, 479		280, 407 51, 822	3, 261 4, 892	69. 00 69. 01
70. 00		ELECTROENCEPHALOGRAPHY	893, 075	35, 008		483, 178	13, 860	
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	856, 904	132, 867	198, 765	0	11, 414	71. 00
72. 00 73. 00	1	IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	10, 645, 497 34, 022, 788	0 298, 717		0 651, 726	0 40, 766	72. 00 73. 00
76. 00		RENAL ACUTE	1, 647, 933	81, 995		031, 720	3, 261	•
		TIENT SERVICE COST CENTERS					·	
90.00	1	CLINIC	274, 244	5, 071	0	46, 288	0	90.00
90. 05 90. 07		PATIENT NUTRITION WOUND CLINIC	346, 116 1, 186, 876	44, 894 90, 694		60, 521 64, 619	0 10, 599	90. 05 90. 07
91. 00		EMERGENCY	6, 591, 374	559, 915		925, 613	51, 365	
92. 00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
110 00		AL PURPOSE COST CENTERS	202 405 424	21 522 020	0 115 777	10 471 770	042.224	110 00
118.00		SUBTOTALS (SUM OF LINES 1-117) IMBURSABLE COST CENTERS	302, 685, 424	21, 533, 928	9, 115, 667	18, 471, 778	943, 326	1 1 δ. UU
	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190. 00
		RURAL HEALTH	2, 831, 000	0		224, 986		194. 00
		RENTAL PROPERTY FAMILY PRACTICE	239, 596 1, 698, 186			16, 558 259, 259		194. 01 194. 02
174.02	- 07754	TIME LI TRACTICE	1,070,100	002, 307	1 415, 705	257, 259	57,000	1 74. UZ

Health Financial Systems	UNION HOSPI	TAL, INC.		In Lie	eu of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Period: From 01/01/2015 To 12/31/2015		pared: 01 am
		CAPI TAL REL	ATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW BLDG & FIXT	NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	NONPATI ENT TELEPHONES	
	0	1.00	2.00	4. 00	5. 01	
194. 03 07952 WELLNESS	360, 134	266, 966		0 50, 650	0	194. 03
194. 04 07955 PHYSI CLAN PRACTI CES	9, 097, 918	0	75, 23	3 880, 222	17, 937	194. 04
194.06 07953 SYCAMORE SPORTS MED	144, 522	0	7, 96	5 2, 251	0	194. 06
194. 07 07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	620, 680	66, 666	6, 93	8 57, 152	6, 523	194. 07
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers		0		0 0	0	201. 00
202.00 TOTAL (sum lines 118-201)	317, 677, 460	22, 729, 867	9, 691, 85	2 19, 962, 856	1, 026, 489	202. 00

Provi der CCN: 150023

					'	0 12/31/2015	Date/lime Pre 5/25/2016 10:	
		Cost Center Description	DATA	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/ACC	Subtotal	J
			PROCESSI NG	RECEIVING AND		OUNTS		
			5. 02	STORES 5. 03	5. 04	RECEI VABLE 5. 05	5A. 05	
	GENER	AL SERVICE COST CENTERS	3.02	5.03	5.04	5.05	5A. 05	
1.00		NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	1	NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01 5. 02	1	NONPATI ENT TELEPHONES DATA PROCESSI NG	11 100 024					5. 01 5. 02
5. 02	1	PURCHASING RECEIVING AND STORES	11, 189, 026	1, 129, 933				5. 02
5. 04		ADMITTING	125, 955		1			5. 04
5.05		CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0	0	6, 412, 988		5. 05
5.06		OTHER ADMIN AND GENERAL	671, 761	49			22, 422, 275	5. 06
7.00	1	OPERATION OF PLANT	199, 429			0	17, 541, 224	7. 00
8. 00 9. 00	1	LAUNDRY & LINEN SERVICE HOUSEKEEPING	41, 985 10, 496				1, 495, 542 4, 650, 809	1
10. 00	1	DI ETARY	146, 948				3, 331, 446	1
11. 00	1	CAFETERI A	52, 481	2		0	269, 351	11. 00
13. 00		NURSING ADMINISTRATION	0	0			3, 059, 081	13. 00
16.00		MEDICAL RECORDS & LIBRARY	608, 784	54	0	0	4, 807, 505	1
17. 00 21. 00		SOCIAL SERVICE I&R SERVICES-SALARY & FRINGES APPRVD	31, 489	0		0	228, 439 1, 599, 048	1
22. 00		I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0		0	2, 821, 261	1
23. 00		PARAMED ED PRGM	Ö	Ö			186, 489	ı
23. 01	02341	OTHER MED ED	0	0	0	0	291, 519	23. 01
		IENT ROUTINE SERVICE COST CENTERS						
30.00	1	ADULTS & PEDIATRICS	1, 910, 324				36, 730, 734	
31. 00 35. 00		INTENSIVE CARE UNIT INTENSIVE NURSERY	251, 911 52, 481	141, 372 14, 879			9, 852, 132 2, 872, 422	•
41. 00	1	SUBPROVI DER - I RF	451, 340				3, 023, 463	1
43. 00	1	NURSERY	41, 985		23, 073		1, 505, 794	1
	ANCI L	LARY SERVICE COST CENTERS						
50.00	1	OPERATING ROOM	440, 843				17, 431, 507	50. 00
50. 01	1	CARDI AC SURGERY	41, 985				3, 100, 652	
50. 02 51. 00	05002	RECOVERY ROOM	73, 474	8, 914 25, 581	0 8, 071		12, 890, 977 2, 240, 073	1
51. 02		O/P TREATMENT ROOM	0	26, 194			3, 726, 973	1
52.00		DELIVERY ROOM & LABOR ROOM	52, 481	62, 919			5, 300, 533	1
54.00	1	RADI OLOGY-DI AGNOSTI C	818, 709				11, 926, 196	1
55. 00		RADI OLOGY-THERAPEUTI C	41, 985				6, 365, 172	1
56. 00 57. 00		RADI OI SOTOPE CT SCAN	0	1, 245 39, 416			1, 427, 104 2, 910, 448	1
58. 00	1	MAGNETIC RESONANCE IMAGING (MRI)	41, 985				1, 904, 285	1
59. 00		CARDI AC CATHETERI ZATI ON	199, 429				19, 093, 581	1
60.00	06000	LABORATORY	20, 993	0	170, 404	424, 298	9, 855, 637	60.00
62.00		WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	,		1, 717, 894	1
65. 00		RESPI RATORY THERAPY PHYSI CAL THERAPY	73, 474				4, 847, 088	1
66. 00 66. 01	1	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	230, 918	446			2, 956, 059 0	1
		O/P PHYSI CAL THERAPY	83, 970				2, 209, 155	
67. 00		OCCUPATIONAL THERAPY	0				1, 471, 938	
68. 00	1	SPEECH PATHOLOGY	10, 496				609, 899	1
69.00	1	ELECTROCARDI OLOGY	125, 955				2, 745, 227	1
69. 01 70. 00		CARDI AC REHAB ELECTROENCEPHALOGRAPHY	20, 993 41, 985				603, 945 1, 599, 939	l
71. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	41, 763				1, 227, 121	1
72. 00		IMPL. DEV. CHARGED TO PATIENTS	Ö	0			10, 645, 497	1
73.00	07300	DRUGS CHARGED TO PATIENTS	167, 940	12, 898	295, 105	994, 744	36, 545, 614	1
76. 00		RENAL ACUTE	0	7, 645	15, 359	20, 326	1, 777, 579	76. 00
00.00		TIENT SERVICE COST CENTERS				2.012	220 (25	00.00
90. 00 90. 05		CLINIC PATIENT NUTRITION	0	0		3, 013 1, 625	328, 625 454, 876	1
90. 03		WOUND CLINIC	41, 985			27, 966	1, 450, 103	
91. 00		EMERGENCY	1, 773, 870				10, 990, 673	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92. 00
		AL PURPOSE COST CENTERS		1				
118.00		SUBTOTALS (SUM OF LINES 1-117)	8, 900, 839	1, 121, 965	2, 239, 871	6, 412, 988	297, 042, 904	1118. 00
100 00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	31, 489	0	0	O	31, 489	100 00
		RURAL HEALTH	650, 769				3, 767, 496	1
		RENTAL PROPERTY	0	0	0	o	268, 579	194. 01
194. 02	07954	FAMILY PRACTICE	1, 175, 582			0	4, 470, 000	194. 02
		WELLNESS	0	0	1	0	677, 750	1
		PHYSICIAN PRACTICES SYCAMORE SPORTS MED	346, 377	4, 860 0		0	10, 422, 547 154, 738	
		PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	83, 970				841, 957	
	,			, 20		, <u> </u>	2, .0.	

Hea	l th Financial	Systems		UNION HOSPIT	AL,	INC.				In Lieu	u of Form CMS	-2552-10
COS	ST ALLOCATION	- GENERAL SERVICE C	OSTS			Provi der	CCN:		Period: From 01/0 To 12/3	1/2015	Worksheet B Part I Date/Time Pr 5/25/2016 10	
	Cost	Contor Doscription	,	DATA	DHE	CHVCINC	ΔDI	METTENC	CVCHLEDI	NG /ACC	Subtotal	

						5/25/2016 10): 01 am
	Cost Center Description	DATA	PURCHASI NG	ADMI TTI 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 118-201)	11, 189, 026	1, 129, 933	2, 239, 871	6, 412, 988	317, 677, 46	0 202. 00

| Peri od: | Worksheet B | From 01/01/2015 | Part | | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Provi der CCN: 150023

	Cost Center Description	OTHER ADMIN	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	Date/Time Prep 5/25/2016 10:0 DIETARY	
	·	AND GENERAL 5.06	PLANT 7. 00	LINEN SERVICE 8.00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS	1					
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT						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 ADMI TTI NG						5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	22 422 275					5. 05
5. 06 7. 00	00590 OTHER ADMIN AND GENERAL 00700 OPERATION OF PLANT	22, 422, 275 1, 332, 116					5. 06 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	113, 574					8. 00
9. 00	00900 HOUSEKEEPI NG	353, 192	164, 744		5, 172, 229		9. 00
10.00	01000 DI ETARY	252, 997	340, 341		95, 035		10.00
11. 00	01100 CAFETERI A	20, 455			67, 813		11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	232, 313	73, 674		20, 572		13.00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	365, 092 17, 348			45, 742 1, 697	0	16. 00 17. 00
21. 00	02100 &R SERVICES-SALARY & FRINGES APPRVD	121, 435		1	1, 697	0	21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	214, 252	0		0	ő	22. 00
23. 00	02300 PARAMED ED PRGM	14, 162	0	0	0	0	23. 00
23. 01	02341 OTHER MED ED	22, 139	22, 326	0	6, 234	0	23. 01
	INPATIENT ROUTINE SERVICE COST CENTERS	0.700.400		T = 0, 000	4 (00 477	0.000.500	
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	2, 789, 408 748, 191	5, 830, 875 712, 867		1, 628, 177 199, 057		30. 00 31. 00
35. 00	02040 I NTENSI VE NURSERY	218, 137	89, 302		24, 936		35. 00
41. 00	04100 SUBPROVI DER – I RF	229, 608			170, 752		41. 00
43. 00	04300 NURSERY	114, 353	121, 767		34, 002	0	43. 00
	ANCILLARY SERVICE COST CENTERS			,			
50.00	05000 OPERATING ROOM	1, 323, 784			352, 700		50.00
50. 01 50. 02	05001 CARDI AC SURGERY 05002 WVSC	235, 470			15, 585		50. 01 50. 02
51. 00	05100 RECOVERY ROOM	978, 967 170, 116	931, 100 44, 403		259, 995 12, 399		51. 00
51. 02	05101 0/P TREATMENT ROOM	283, 034			184, 805		51. 02
52.00	05200 DELIVERY ROOM & LABOR ROOM	402, 533			180, 138		52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	905, 699	1, 074, 727	61, 524	300, 100	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	483, 384	818, 294		228, 495		55.00
56.00	05600 RADI OI SOTOPE	108, 377	90, 356		25, 231	0	56. 00
57. 00 58. 00	05700 CT SCAN	221, 025			18, 806	0	57. 00 58. 00
59. 00	05800 MAGNETI C RESONANCE I MAGING (MRI) 05900 CARDI AC CATHETERI ZATI ON	144, 615 1, 450, 005	80, 403 517, 643		22, 451 144, 543	· · · · · · · · · · · · · · · · · · ·	59. 00
60. 00	06000 LABORATORY	748, 457	0 0		0	0	60. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	130, 460	0	0	0	0	62.00
65. 00	06500 RESPI RATORY THERAPY	368, 098	66, 170	0	18, 477	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	224, 489			87, 883		66. 00
66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0		66. 01
66. 02 67. 00	06602 0/P PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	167, 768 111, 782			0 14, 356		66. 02 67. 00
68. 00	06800 SPEECH PATHOLOGY	46, 317	101, 953		28, 469		68. 00
69. 00	06900 ELECTROCARDI OLOGY	208, 478			11, 299		69. 00
69. 01	06901 CARDI AC REHAB	45, 865	223, 256	964	62, 341	0	69. 01
70. 00	07000 ELECTROENCEPHALOGRAPHY	121, 503	46, 667		13, 031		70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	93, 190			49, 457		71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	808, 440 2, 775, 347	0 398, 201		0 111, 191		72. 00 73. 00
76. 00	03020 RENAL ACUTE	134, 993			30, 521		76. 00
70.00	OUTPATIENT SERVICE COST CENTERS	1017770	1077 002	0,700	30, 32.1	<u> </u>	70.00
90.00	09000 CLI NI C	24, 956	6, 760	0	1, 888	0	90.00
90. 05	09005 PATIENT NUTRITION	34, 544			16, 711	0	90. 05
90. 07	09007 WOUND CLINIC	110, 124	120, 899		33, 759		90. 07
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	834, 654	746, 387	281, 695	208, 417	0	91. 00 92. 00
92.00	SPECIAL PURPOSE COST CENTERS						92.00
118.00		20, 855, 246	17, 279, 109	1, 783, 843	4, 727, 065	4, 019, 819 1	118. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 391	0		0		190. 00
	07950 RURAL HEALTH	286, 111	0	1, 399	0		194. 00
	07951 RENTAL PROPERTY	20, 396		1 045	220 07/		194. 01
	07954 FAMILY PRACTICE 07952 WELLNESS	339, 461 51, 470	1, 149, 487 355, 876		320, 976 99, 373		194. 02 194. 03
	107955 PHYSI CI AN PRACTI CES	791, 509		7, 703	99, 373		194. 03 194. 04
	07953 SYCAMORE SPORTS MED	11, 751	Ö	0,703	0		194. 06
194. 07	07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	63, 940	88, 868		24, 815	0 1	194. 07
200.00	Cross Foot Adjustments		<u> </u>			2	200. 00

Health Financial Systems	UNION HOSPI	TAL, INC.		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Period: From 01/01/2015 To 12/31/2015	Worksheet B Part I Date/Time Pre 5/25/2016 10:	
Cost Center Description	OTHER ADMIN AND GENERAL	OPERATION OF PLANT	LINEN SERVICE		DI ETARY	

0 18, 873, 340

0 22, 422, 275

0 1, 794, 790

0 5, 172, 229 0 201. 00 4, 019, 819 202. 00

201. 00

Negative Cost Centers TOTAL (sum lines 118-201)

Provi der CCN: 150023

	INTERNS &	
Cost Center Description CAFETERIA NURSING MEDICAL SOCIAL SERVICEISE	RESI DENTS	
	Y & FRINGES	
LI BRARY		
11. 00 13. 00 16. 00 17. 00	21. 00	
GENERAL SERVICE COST CENTERS 1. 00 00100 NEW CAP REL COSTS-BLDG & FIXT		1. 00
2. 00 00200 NEW CAP REL COSTS-BLDG & TTAT		2. 00
4.00 OO400 EMPLOYEE BENEFITS DEPARTMENT		4. 00
5. 01 O0540 NONPATI ENT TELEPHONES		5. 01
5. 02 00550 DATA PROCESSING		5. 02
5. 03 00560 PURCHASING RECEIVING AND STORES		5. 03 5. 04
5. 05 O0580 CASHI ERI NG/ACCOUNTS RECEI VABLE		5. 05
5. 06 O0590 OTHER ADMIN AND GENERAL		5. 06
7.00 00700 OPERATI ON OF PLANT		7. 00
8. 00 00800 LAUNDRY & LI NEN SERVI CE		8. 00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY		9. 00 10. 00
11. 00 01100 CAFETERI A 600, 471		11. 00
13.00 01300 NURSI NG ADMINI STRATI ON 7, 240 3, 392, 880		13.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 23, 263 0 5, 405, 416		16.00
17. 00 01700 SOCIAL SERVICE	1 721 022	17. 00
21. 00 02100 1 &R SERVI CES-SALARY & FRINGES APPRVD 11, 339 0 0 0 0 22. 00 02200 1 &R SERVI CES-OTHER PRGM COSTS APPRVD 2, 875 0 0 0 0 0 0 0 0 0	1, 731, 822	21. 00 22. 00
23. 00 02300 PARAMED ED PRGM		23. 00
23. 01 02341 OTHER MED ED 2, 449 16, 377 0 0		23. 01
INPATIENT ROUTINE SERVICE COST CENTERS	222 222	
30. 00 03000 ADULTS & PEDI ATRI CS 185, 622 1, 364, 710 436, 601 151, 052 31. 00 03100 I NTENSI VE CARE UNI T 44, 982 354, 825 125, 828 19, 615	839, 933 0	30. 00 31. 00
35. 00 02040 INTENSIVE CARE ONLY 44, 762 354, 025 125, 026 17, 015 35. 00 02040 INTENSIVE NURSERY 13, 841 109, 177 56, 723 12, 649	22, 514	35. 00
41.00 O4100 SUBPROVI DER - I RF 12,616 99,519 17,493 0	0	41. 00
43. 00 04300 NURSERY 9, 316 73, 484 23, 073 33, 364	0	43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM 34, 123 228, 432 756, 764 367	119, 496	50. 00
50. 00 05000 0PERATI NG ROOM 34, 123 228, 432 756, 764 367 50. 01 05001 CARDI AC SURGERY 4, 365 21, 415 60, 613 0	119, 490	50. 00
50. 02 05002 WYSC 532 4, 199 461, 754 0	Ö	50. 02
51. 00 05100 RECOVERY ROOM 11, 818 93, 220 19, 595 0	0	51.00
51. 02 05101 0/P TREATMENT ROOM 19, 696 155, 367 51, 055 12, 466 155, 367 31, 055 12, 466 155, 367 17, 466 17, 4	0	51. 02
52. 00 05200 DELI VERY ROOM & LABOR ROOM 25, 126 177, 622 86, 494 917 54. 00 05400 RADI OLOGY-DI AGNOSTI C 34, 602 0 251, 335 0	173, 182 25, 977	52. 00 54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C 3, 088 0 151, 538 183	13, 855	55. 00
56. 00 05600 RADI 0I SOTOPE 3, 141 0 48, 546 183	0	56.00
57. 00 05700 CT SCAN 6, 920 0 274, 763 0	0	57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 3, 300 0 69, 660 0 59. 00 05900 CARDIAC CATHETERIZATION 5, 110 0 459, 633 367	0	58. 00 59. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 5, 110 0 459, 633 367 60. 00 06000 LABORATORY 0 0 357, 596 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 13, 208 0	0	62. 00
65. 00 06500 RESPI RATORY THERAPY 21, 506 169, 644 65, 629 0	24, 246	
66. 00 06600 PHYSI CAL THERAPY 0 47, 690 0 66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0	64, 077 0	
66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0	66. 01 66. 02
67. 00 06700 OCCUPATI ONAL THERAPY 0 0 29, 931 0	Ö	67. 00
68. 00 06800 SPEECH PATHOLOGY 0 0 9, 080 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY 14, 160 0 75, 980 0 0 0 0 0 0 0 0 0	34, 636	69. 00
69. 01 06901 CARDI AC REHAB 2, 023 0 5, 418 0 70. 00 07000 ELECTROENCEPHALOGRAPHY 4, 578 0 38, 059 0	0	69. 01 70. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 11,886 0	Ö	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 22, 518 152, 848 838, 957 0	3, 464	73. 00
76. 00 03020 RENAL ACUTE 0 0 17, 130 0	0	76. 00
90. 00 09000 CLI NI C 1, 011 7, 978 2, 539 0	0	90.00
90. 05 09005 PATI ENT NUTRI TI ON 2, 502 19, 736 1, 369 0	0	90. 05
90. 07 09007 WOUND CLINIC 2, 662 20, 996 23, 570 0	12, 123	90. 07
91. 00 09100 EMERGENCY	187, 037	91. 00 92. 00
SPECIAL PURPOSE COST CENTERS		72.00
118. 00 SUBTOTALS (SUM OF LINES 1-117) 580, 774 3, 392, 880 5, 405, 416 254, 444	1, 520, 540	118. 00
NONREI MBURSABLE COST CENTERS	_	100.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 194. 00 07950 RURAL HEALTH 0 0 0 0		190. 00 194. 00
194. 00 07950 RORAL HEALTH 0 0 0 0 0 0 0 0		194. 00 194. 01
194. 02 07954 FAMILY PRACTICE 9, 582 0 0	211, 282	
194. 03 07952 WELLNESS 0 0 0 0	0	194. 03
194. 04 07955 PHYSI CI AN PRACTI CES 7, 932 0 0 183	0	194. 04

Health Financial Systems	UNION HOSPITAL,	I NC.		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 150023	From 01/01/2015	Worksheet B Part I Date/Time Pre 5/25/2016 10:	
		•			INTERNS &	

						5/25/2016 10:	<u>uı am</u>
						INTERNS &	
						RESI DENTS	
	Cost Center Description	CAFETERI A	NURSI NG	MEDI CAL	SOCIAL SERVICE	SERVI CES-SALAR	
			ADMI NI STRATI ON	RECORDS &		Y & FRINGES	
				LI BRARY			
		11. 00	13. 00	16.00	17. 00	21.00	
194. 06 07953	SYCAMORE SPORTS MED	0	0	0	0	0	194. 06
194. 07 07956	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	2, 183	0	0	0	0	194. 07
200. 00	Cross Foot Adjustments					0	200. 00
201. 00	Negative Cost Centers	0	0	0	0	0	201. 00
202. 00	TOTAL (sum lines 118-201)	600, 471	3, 392, 880	5, 405, 416	254, 627	1, 731, 822	202. 00

	n Financial Systems ALLOCATION - GENERAL SERVICE COSTS	UNI ON HOSPI			eriod: com 01/01/2015	u of Form CMS-2 Worksheet B Part I Date/Time Pre 5/25/2016 10:	pared:
	Cost Center Description	I NTERNS & RESI DENTS SERVI CES-OTHER PRGM COSTS	PARAMED ED PRGM	OTHER MED ED	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	OFNEDAL CEDILIOS COCT OFNEDO	22. 00	23. 00	23. 01	24. 00	25. 00	
1 00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT						1 00
1. 00 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 5. 06 7. 00 8. 00 10. 00 11. 00 11. 00 21. 00 22. 00 23. 00 23. 00	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 011000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 02100 I&R SERVICES-SALARY & FRINGES APPRVD 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	3, 038, 388	201, 875	361, 044			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 17. 00 21. 00 22. 00 23. 01
	INPATIENT ROUTINE SERVICE COST CENTERS			·			
30. 00 31. 00 35. 00 41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	1, 473, 618 0 39, 499 0 0	0 0 0 0	0 0 0	55, 039, 352 12, 679, 540 3, 468, 830 4, 412, 569 1, 915, 153	-2, 313, 551 0 -62, 013 0	31. 00
50. 00 50. 01 50. 02	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05001 CARDIAC SURGERY 05002 WVSC	209, 649 0 0	0 0	0	21, 835, 187 3, 494, 028 15, 675, 007	-329, 145 0 0	50. 00 50. 01 50. 02
51. 00 51. 02 52. 00 54. 00 55. 00 57. 00 59. 00 60. 00 65. 00 66. 01 66. 02 67. 00 68. 00 69. 01 70. 00	05600 RADI OI SOTOPE 05700 CT SCAN 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 06602 0/P PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB	0 0 303, 839 45, 576 24, 307 0 0 0 0 42, 537 112, 420 0 0 0 60, 768 0	0 0 0 201, 875 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0	2, 664, 840 5, 403, 527 7, 385, 978 14, 827, 611 8, 120, 247 1, 714, 095 3, 499, 332 2, 279, 192 21, 707, 037 10, 961, 690 1, 861, 562 5, 623, 395 3, 823, 918 0 2, 442, 264 1, 679, 418 795, 718 3, 205, 251 943, 812 1, 826, 899	0 0 -477, 021 -71, 553 -38, 162 0 0 0 0 0 0 -66, 783 -176, 497 0 0 0 0 -95, 404	54. 00 55. 00 56. 00 57. 00 58. 00 60. 00 62. 00 65. 00 66. 01 66. 01 66. 02 67. 00 68. 00
71. 00 72. 00 73. 00 76. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 03020 RENAL ACUTE	0 0 6, 077 0	0 0 0 0	0 0 361, 044 0	1, 558, 770 11, 453, 937 41, 215, 261 2, 078, 458	0 0 -9, 541 0	71. 00 72. 00
90. 00 90. 05 90. 07 91. 00 92. 00	09005 PATIENT NUTRITION 09007 WOUND CLINIC 09100 EMERGENCY	0 0 21, 269 328, 146	0 0 0 0	0 0 0 0	373, 757 589, 583 1, 815, 881 14, 452, 589	0 0 -33, 392 -515, 183 0	
118. 0	SUBTOTALS (SUM OF LINES 1-117)	2, 667, 705	201, 875	361, 044	292, 823, 688	-4, 188, 245	118. 00
190. 0 194. 0	NONREIMBURSABLE COST CENTERS D 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN D 07950 RURAL HEALTH	0 0	0	0 0	33, 880 4, 055, 006	0	190. 00 194. 00
	1 07951 RENTAL PROPERTY 2 07954 FAMILY PRACTICE	0 370, 683	0	0	288, 975 6, 873, 316		194. 01 194. 02

Health Financial Systems	UNION HOSPI	ΓAL, INC.		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 150023	Peri od: From 01/01/2015	Worksheet B Part I	·
				To 12/31/2015	Date/Time Pre	
	INTERNS &				5/25/2016 10:	01 am
	RESI DENTS					
Cost Center Description	SERVI CES-OTHER	PARAMED ED	OTHER MED ED	Subtotal	Intern &	
	PRGM COSTS	PRGM			Residents Cost	
					& Post	
					Stepdown	
					Adjustments	
	22. 00	23. 00	23. 01	24. 00	25. 00	
194. 03 07952 WELLNESS	0	0		0 1, 184, 469	0	194. 03
194.04 07955 PHYSICIAN PRACTICES	0	0		0 11, 229, 874	0	194. 04
194.06 07953 SYCAMORE SPORTS MED	0	0		0 166, 489	0	194. 06
194. 07 07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 1, 021, 763	0	194. 07
200.00 Cross Foot Adjustments	0	0		0 0	0	200. 00
201.00 Negative Cost Centers	0	0		0 0	0	201. 00
202.00 TOTAL (sum lines 118-201)	3, 038, 388	201, 875	361, 04	317, 677, 460	-4, 770, 210	202. 00

| Period: | Worksheet B | From 01/01/2015 | Part | To 12/31/2015 | Date/Time Prepared: | 5/25/2016 10: 01 am Provi der CCN: 150023

		5/25/2016 10: 01 am
Cost Center Description	Total	, , , , , , , , , , , , , , , , , , ,
OFFICE OF	26. 00	
GENERAL SERVICE COST CENTERS		1.00
1.00 OO100 NEW CAP REL COSTS-BLDG & FIXT 2.00 OO200 NEW CAP REL COSTS-MVBLE EQUIP		1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT		4.00
5. 01 00540 NONPATIENT TELEPHONES		5. 01
5. 02 00550 DATA PROCESSING		5. 02
5. 03 00560 PURCHASING RECEIVING AND STORES		5. 02
5. 04 00570 ADMITTING		5.03
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 00900 HOUSEKEEPI NG		9.00
10. 00 01000 DI ETARY		10.00
11. 00 01100 CAFETERI A		11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON		13.00
16. 00 01600 MEDICAL RECORDS & LIBRARY		16. 00
17. 00 01700 SOCIAL SERVICE		17. 00
21. 00 02100 &R SERVI CES-SALARY & FRI NGES APPRVD		21.00
22. 00 02200 &R SERVI CES-OTHER PRGM COSTS APPRVD		21.00
23. 00 02300 PARAMED ED PRGM		22.00
23. 01 02341 OTHER MED ED		23. 00
I NPATIENT ROUTINE SERVICE COST CENTERS		25. 01
30. 00 03000 ADULTS & PEDI ATRI CS	52, 725, 801	30, 00
31. 00 03100 NTENSI VE CARE UNI T	12, 679, 540	30.00
35. 00 02040 NTENSI VE NURSERY	3, 406, 817	35.00
41. 00 04100 SUBPROVI DER - I RF	4, 412, 569	41.00
43. 00 04300 NURSERY	1, 915, 153	41.00
ANCI LLARY SERVI CE COST CENTERS	1, 715, 155	43.00
50. 00 05000 OPERATING ROOM	21, 506, 042	50.00
50. 01 05001 CARDI AC SURGERY	3, 494, 028	50. 00
50. 02 05002 WVSC	15, 675, 007	50. 02
51. 00 05100 RECOVERY ROOM	2, 664, 840	51.00
51. 02 05101 0/P TREATMENT ROOM	5, 403, 527	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	6, 908, 957	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	14, 756, 058	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	8, 082, 085	55.00
56. 00 05600 RADI OI SOTOPE	1, 714, 095	56. 00
57. 00 05700 CT SCAN	3, 499, 332	57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	2, 279, 192	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	21, 707, 037	59. 00
60. 00 06000 LABORATORY	10, 961, 690	60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 861, 562	62.00
65. 00 06500 RESPIRATORY THERAPY	5, 556, 612	65. 00
66. 00 06600 PHYSI CAL THERAPY	3, 647, 421	66.00
66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	3,047,421	66. 01
66. 02 06602 0/P PHYSI CAL THERAPY	2, 442, 264	66.02
67. 00 06700 OCCUPATI ONAL THERAPY	1, 679, 418	67. 00
68. 00 06800 SPEECH PATHOLOGY	795, 718	68.00
69. 00 06900 ELECTROCARDI OLOGY	3, 109, 847	69.00
69. 01 06901 CARDI AC REHAB	943, 812	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 826, 899	70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 558, 770	70.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	11, 453, 937	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	41, 205, 720	72.00
76. 00 03020 RENAL ACUTE	2, 078, 458	76. 00
OUTPATIENT SERVICE COST CENTERS	2,070,430	70.00
90. 00 09000 CLINIC	373, 757	90.00
90. 05 09005 PATI ENT NUTRI TI ON	589, 583	90. 05
90. 07 09007 WOUND CLINIC	1, 782, 489	90.07
91. 00 09100 EMERGENCY	13, 937, 406	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	13, 737, 400	92.00
SPECIAL PURPOSE COST CENTERS		72.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	288, 635, 443	118.00
NONREI MBURSABLE COST CENTERS	200,000,440	110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	33, 880	190. 00
194.00 07950 RURAL HEALTH	4, 055, 006	190.00
194. 01 07951 RENTAL PROPERTY	288, 975	194.00
194.02 07954 FAMILY PRACTICE	6, 291, 351	194.01
194. 03 07952 WELLNESS	1, 184, 469	194. 02
194. 04 07955 PHYSI CLAN PRACTICES	11, 229, 874	194.03
194.04 07955 PHYSICIAN PRACTICES 194.06 07953 SYCAMORE SPORTS MED	166, 489	194.04
194. 00 07953 SYCAMORE SPORTS MED 194. 07 07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	1, 021, 763	194.06
	1, 021, 763	194.07
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers	0	200.00
201. 00 Negative Cost Centers	ı U	201.00

Health Financial Systems	UNION HOSPITA	AL, INC.	In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CCN: 150023	From 01/01/2015	Date/Time Pre	
				5/25/2016 10:	01 am
Cost Center Description	Total				
	26. 00				
202.00 TOTAL (sum lines 118-201)	312, 907, 250				202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 150023

Cost Center Description						Io	12/31/2015	Date/lime Pre 5/25/2016 10:	
PRINTED Company Comp					CAPI TAL REI	ATED COSTS		072072010 10.	OT GIII
PRIMERIA Service OST Centres Telestate Costs 1, 00 2, 00 2A 4, 00			Coot Conton Decement on	Di manti v	NEW DLDC 0	NEW MVDLE	Cubtatal	EMDL OVEE	
PRINTED NOT COMPINE COST COMPINES Deliver Costs 1.00			cost center bescription				Subtotai		
CREMAL SERVICE COST CENTERS						2231.			
DEBRICAL SERVICE COST CENTERS						0.00			
1.00		CENED	AL SEDVICE COST CENTEDS	0	1.00	2.00	2A	4.00	
2.00 DODGO LEND CAP MELL COSIS-MANULE CIGUITY 0.00 0.0	1 00								1 00
5.01 0.0564 MONINATIENT TELEPHONES 0 15, 282 0.2, 720 78, 002 0.95 0.50									
5.00 000000 000000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 000000				0					
5.03 0.00500 DOSCO PURICIUSS INS REPER IN ING AND STORES 0 0.007 0.008				0					
0.0070 AZMITTING		1	l e e e e e e e e e e e e e e e e e e e	0			0		
5.05 0.00580 CASH LERINKY/ACCOUNTS RECEIVABLE 0 0 0 0 0.5 0.5 0.5 0.5 0.00590 CHER ADMIN AND GENERAL 0.0 C.2 0.47 131,779 127,539 0.21,505 8.445 5.0 0.00500 CHER ADMIN AND GENERAL 0.0 1.00 0.00 0.00 0.00 0.00 0.00 0.00				6, 012	-	_	90, 983	-	
0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000000		00580	CASHI ERI NG/ACCOUNTS RECEI VABLE	0			0		5. 05
8.00 0.0800 AJMIDEY & LINEN SERVICE 0 139,287 184,522 323,809 1.184 8.00 0.00 0.00 0.00 0.161APY 3,505 255,317 3,502 9.00 0.00 0.00 0.161APY 3,505 255,317 3,525 574 594,439 2.688 10.00 10.00 10.00 0.00				1 ' 1					
9.00 0.0000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000000		1	l .	1 1					
10.00 01000 DETARY 3.553 25, 312 325, 514 504, 439 2.608 10.00				1 -1					
13.00 01300 IMPSI NX AMM NI STRATION 3, 290 55, 268 12, 908 17, 466 2, 255 13.00 17.00 01070 DOI OLT AL SERVICE 0 4, 559 0 4, 559 288 17.00 17.00 01070 SOCIAL SERVICE 0 4, 559 0 4, 559 288 17.00 17.00 01070 SOCIAL SERVICE 0 0 0 0 0 0 2, 227 21.00 17.00 01070 RS SERVICES-GHER PREW COST SAPREWD 0 0 0 0 0 0 2, 227 21.00 17.00 01070 RS SERVICES-GHER PREW COST SAPREWD 0 0 0 0 0 0 2, 247 22.00 17.00 01070 RS SERVICES-GHER PREW COST SAPREWD 0 0 0 0 0 0 2, 247 22.00 17.00 01070 RS SERVICES-GHER PREW COST SAPREWD 0 0 0 0 0 0 0 2, 247 22.00 17.00 01070 RS SERVICES-GOST CENTERS 0 0 0 0 0 0 0 0 0				1					
16.00 10-600 MEDICAL, RECORDS & LIBRARY 7, 248 122, 888 18, 797 144, 933 3, 633 16. 00 21. 00 2010 18F SERVICES-SALARY & FRINCES APPRVD 0 0 0 0 2, 227 21. 00 2200 02200 18F SERVICES-SALARY & FRINCES APPRVD 0 0 0 0 2, 227 21. 00 220 220 02200 18F SERVICES-SALARY & FRINCES APPRVD 0 0 0 0 2, 237 22. 00 220 02200 18F SERVICES-SALARY & FRINCES APPRVD 0 0 0 0 2, 257 22. 00 220		1	ł .	١					
17.00 01700 SOCIAL SERVICE STALRY & FRINGES APPRVD 0 4,559 0 4,559 258 17.00 2210 02200 LAS SERVICES-SALRY & FRINGES APPRVD 0 0 0 0 0 0 2,227 21.00 2210 02200 LAS SERVICES-OTHER PROBLEOSTS APPRVD 0 0 0 0 0 0 0 2,227 21.00 22.00 23.00				1					•
21.00 0200 IAB SERVICES-SALARY & FRINKES APPRVD 0 0 0 0 2,247 21.00				7, 248					•
22.00 02000 RAS SERVI CES. OTHICE PROM COSTS APPRVD 0 0 0 0 0 87 23 00 030 03000 PARAMEP ED PROM 0 16, 748 2, 849 19, 297 420 23 01		1	•			1			
0.341 OTHER NED FD 0.241 0.341				o	0	O	o		
INPATT ENT ROUTINE SERVICE COST CENTERS 119,837				0	0	0	0		
30.00	23. 01			0	16, 748	2, 549	19, 297	420	23. 01
31.00	30 00			119 837	4 374 131	1 148 128	5 642 096	35 377	30 00
1.00 04100 SUBPROVIDER - I I I I I I I I I I I I I I I I I I		1	•	1					
	35. 00			2, 221	66, 992	147, 462	216, 675	3, 147	35. 00
MOLILLARY SERVICE COST CENTERS 50.00				1					•
50.00 050000000 0500000000	43.00			3, 409	91, 346	9, 146	103, 901	1, 844	43.00
50.00 05000 CARDIA CA SURGERY 75, 474 41,870 718, 445 295, 789 3,954 50.01 50.00 05000 WSCC 436,693 486,698 480 298,766 1,433,839 74 50.02 50.00 05100 RECOVERY ROOM 1,601 33,310 49,488 84,399 2,545 51.00 51.00 05100 DETERMENT ROOM 1,586 486,482 189,782 687,850 3,809 51.02 52.00 05200 DELIVERY ROOM & LABOR ROOM 23,135 483,944 312,702 819,781 7,001 52.00 52.00 05400 RADI LOGY-DI AGROSTIC 837,242 613,857 505,263 1,961,362 650 55.00 05500 RADI DISOT-DIFE 1,805 67,782 10,931 80,518 608 56.00 50.00 05500 RADI DISOTOPE 1,805 67,782 10,931 80,518 608 56.00 50.00 05500 CARDIAC CATHETERIZATION 1,054,561 388,318 44,649 777,237 884 58.00 50.00 05600 MADI ELIOST-LETERIZATION 1,054,561 388,318 600 0,0 0 0 0 0 60.00 06000 LABORATORY 62.00 62.00 6200 MHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 0 0 0	50. 00			830, 380	947, 535	2, 018, 972	3, 796, 887	15. 285	50.00
51.00 05100 RECOVERY ROOM 1.601 33, 310 49, 488 84, 399 2, 545 51.00	50. 01						· · · · · · · · · · · · · · · · · · ·		50. 01
51.02 05101 07 PREATMENT ROOM 1.586 494, 482 189, 782 687, 850 3, 809 51.02 52.00 05200 DELL'VERY ROOM & LABOR ROOM 23.135 483, 944 312, 702 819, 781 7, 001 52.0 52.00 05200 DELL'VERY ROOM & LABOR ROOM 23.135 483, 944 312, 702 819, 781 7, 001 52.0 55.00 05500 RADIO LOGY-THERAPEUTI C 837, 242 613, 857 505, 263 1, 956, 362 660 55.00 05500 RADIO LOGY-THERAPEUTI C 837, 242 613, 857 505, 263 1, 956, 362 660 55.00 05500 RADIO LOGY-THERAPEUTI C 837, 242 613, 857 505, 263 1, 956, 362 660 55.00 05500 RADIO LOGY-THERAPEUTI C 837, 242 613, 857 505, 263 1, 956, 362 660 55.00 05500 RADIO LOGY-THERAPEUTI C 837, 242 60, 316 44, 649 777, 237 884 58.00 650.00 840, 600 RADIO LOGY-THERAPEUTI C 833, 340 1, 837 57.00 65.00 65000 MROHETI C RESONANCE I MAGING (MRI) 672, 272 60, 316 44, 649 777, 237 884 58.00 650.00 65000 MAGNETI C RESONANCE I MAGING (MRI) 1, 054, 561 388, 318 156, 602 1, 599, 481 1, 157 59.00 62.00							· · · · · · · · · · · · · · · · · · ·		
52.00 0520		1	•						
54.00 OS400 RADI OLOGY-DIAGNOSTIC 538, 499 806, 225 936, 446 2, 281, 170 15, 322 54.00 55.00 OS500 RADI OLOGY-THERAPEUTIC 837, 242 613, 857 505, 263 1, 966, 362 690 55.00 56.00 OS600 RADI OLOGY-THERAPEUTIC 1, 805 67, 782 10, 931 80, 518 608 56.00 57.00 OS700 CT SCAN 303, 166 50, 523 651 354, 340 1, 837 57.00 58.00 OS800 MAGNETIC RESONANCE IMAGING (MRI) 672, 272 60, 316 44, 649 777, 237 884 58.00 59.00 OS900 CARDIAC CATHETERI ZATI ON 1, 054, 561 388, 318 156, 602 1, 599, 481 1, 157 59.00 60.00 OS000 LABORATORY APACED RED BLOOD CELLS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1	•	1					
56.00 05600 RADIO I SOTOPE 1,805 67,782 10,931 80,518 608 56.00 57.00 05700 CT SCAN 303,166 50,523 651 354,340 1,837 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 672,272 60,316 44,649 777,237 884 58.00 05900 CARDIA C CATHETERI ZATI ON 1,054,561 388,318 156,602 1,599,481 1,157 59.00 60				1					
57, 00 05700 CT SCAN 303, 166 50, 523 651 354, 340 1, 837 57, 00 5800 05800 MAGNETIC RESONANCE IMAGING (MRI) 672, 272 60, 316 44, 649 777, 237 884 58. 00 5900 CARDIA C CATHETERI ZATION 1, 054, 561 388, 318 156, 602 1, 599, 481 1, 157 59. 00 60. 00 00 00 00 00 00				1 ' 1					
58.00 05900 MAGNETIC RESONANCE IMAGING (MRI) 672,272 60,316 44,649 777,237 884 58.00									
59, 00 05900 CARDI AC CATHETERI ZATI ON 1, 054, 561 388, 318 156, 602 1, 599, 481 1, 157 59, 00 06.00 06000 LABORATORY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				1					
60. 00 06000 LABORATORY 0 0 0 0 0 0 0 0 0				1					
65. 00 06500 RESPIRATORY THERAPY 302, 052 49, 639 317, 969 669, 660 4, 701 65. 00 66. 00 06600 PHYSI CAL THERAPY 3, 984 236, 099 40, 362 280, 445 0 66. 00 0 0 0 0 0 0 0 66. 01 66. 01 06601 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 0 0 0 66. 01 66. 02 06602 0/P PHYSI CAL THERAPY 340, 244 0 63, 671 403, 915 0 66. 02 067. 00 000				0			O		
66. 00 06600 PHYSI CAL THERAPY 3, 984 236, 099 40, 362 280, 445 0 66. 00 66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 0 66. 01 066. 01 06602 0/P PHYSI CAL THERAPY 340, 244 0 63, 671 403, 915 0 66. 02 0/P PHYSI CAL THERAPY 0 38, 567 12, 897 51, 464 0 67. 00 0 0 0 0 0 0 0 0 0				0			-1		
66. 01 06601 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 0 66. 01 66. 02 06602 06700 06002 067P PHYSI CAL THERAPY 340, 244 0 0 38, 567 12, 897 51, 464 0 67. 00 68. 00 06700 06002 06000 06002 060000 060000 060000 060000 060000 060000 060000 060000 060000 060000 0600000 060000000 0600000000		1	•	1 ' 1				•	
66. 02 06602 0/P PHYSI CAL THERAPY 340, 244 0 63, 671 403, 915 0 66. 02 67. 00 06700 0CCUPATI ONAL THERAPY 0 38, 567 12, 897 51, 464 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 38, 509 76, 482 2, 282 117, 273 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 102, 035 30, 356 259, 324 391, 715 2, 520 69. 00 69. 01 06901 CARDI AC REHAB 1, 999 167, 479 38, 848 208, 326 466 69. 01 70. 00 7000 ELECTROENCEPHALOGRAPHY 12, 061 35, 008 71, 254 118, 323 4, 343 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 16 132, 867 198, 765 331, 648 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 73. 00 07300 RURGS CHARGED TO PATI ENTS 748, 093 298, 717 60, 930 1, 107, 740 5, 858 73. 00 76. 00 03020 RENAL ACUTE 1, 301 81, 995 1, 060 84, 356 0 76. 00 0000 CLI NIC 0 0 5, 071 0 79. 00 09000 CLI NIC 0 0 5, 071 0 79. 00 09000 CLI NIC 0 0 5, 071 79. 00 09000 CLI NIC 2, 164 90, 694 21, 167 114, 025 581 90. 07 79. 00 09000 MERIGENCY 25, 336 559, 915 288, 618 873, 869 8, 320 79. 00 09000 MERIGENCY 25, 336 559, 915 288, 618 873, 869 8, 320 79. 00 09200 DESERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 79. 00 09000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 794. 00 07950 RURAL HEALTH 209, 151 0 57, 659 266, 810 2, 022 194, 00 794. 00 07950 RENAL LACTHE 534 0 12, 425 12, 959 149 194, 01 794. 01 07951 RENTAL PROPERTY 534 0 12, 425 12, 959 149 194, 01 794. 02 07954 FAMILY PRACTI CE 16, 785 862, 307 415, 965 1, 295, 057 2, 330 194, 02 795. 00 07950 RURAL HEALTH 200, 07951 RENTAL PROPERTY 534 0 12, 425 12, 959 149, 01 794. 02 07954 FAMILY PRACTI CE 16, 785 862, 307 415, 965 1, 295, 057 2, 330 194, 02				0		1	200, 443		
68. 00 06800 SPECH PATHOLOGY 38, 509 76, 482 2, 282 117, 273 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 102, 035 30, 356 259, 324 391, 715 2, 520 69. 00 69. 01 69. 0	66. 02			340, 244	0			0	66. 02
69. 00 06900 ELECTROCARDI OLOGY 102, 035 30, 356 259, 324 391, 715 2, 520 69. 00 69. 01 06901 CARDI AC REHAB 1, 999 167, 479 38, 848 208, 326 466 69. 01 70. 00 07000 ELECTROENCEPHALOGRAPHY 12, 061 35, 008 71, 254 118, 323 4, 343 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 16 132, 867 198, 765 331, 648 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 748, 093 298, 717 60, 930 1, 107, 740 5, 858 73. 00 76. 00 0000 RENAL ACUTE 1, 301 81, 995 1, 060 84, 356 0 76. 00 0000 CLI NI C 0 5, 071 0 5, 071 416 90. 00 79. 05 09005 PATI ENT SERVICE COST CENTERS 1618 44, 894 1, 708 48, 220 544 90. 05 90. 07 09007 WOUND CLI NI C 2, 164 90, 694 21, 167 114, 025 581 90. 07 91. 00 09100 EMERGENCY 25, 336 559, 915 288, 618 873, 869 8, 320 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) SPECIAL PURPOSE COST CENTERS 18. 00 NONREI MBURSABLE COST CENTERS 190. 00 0 0 0 0 0 194. 00 07950 RENAL HEALTH 209, 151 0 57, 659 266, 810 2, 022 194. 00 194. 00 07951 RENTAL PROPERTY 534 0 12, 425 12, 959 149 194. 01 194. 01 07951 RENTAL PROPERTY 534 0 12, 425 12, 959 149 194. 01 194. 02 07954 FAMIL LY PRACTICE 16, 785 862, 307 415, 965 1, 295, 057 2, 330 194. 01 194. 02 07954 FAMIL LY PRACTICE 16, 785 862, 307 415, 965 1, 295, 057 2, 330 194. 01 194. 02 07954 FAMIL LY PRACTICE 16, 785 862, 307 415, 965 1, 295, 057 2, 330 194. 01 194. 02 07954 FAMIL LY PRACTICE 16, 785 862, 307 415, 965 1, 295, 057 2, 330 194. 01 194. 02 07954 FAMIL LY PRACTICE 16, 785 862, 307 415, 965 1, 295, 057 2, 330 194. 01 194. 02 07954 FAMIL LY PRACTICE 16, 785 862, 307 415, 965 1, 295, 057 2, 330 194. 01 195. 00 00 0				0	·				•
69. 01 06901 CARDI AC REHAB 1,999 167,479 38,848 208,326 466 69. 01 70. 00 70000 ELECTROENCEPHALOGRAPHY 12,061 35,008 71,254 118,323 4,343 70. 00 71. 00 71. 00 71.00 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 16 132,867 198,765 331,648 0 71. 00 72. 00 0 0 0 0 0 0 0 0 0									•
70. 00 07000 ELECTROENCEPHALOGRAPHY 12, 061 35, 008 71, 254 118, 323 4, 343 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 16 132, 867 198, 765 331, 648 0 71. 00 72. 00 1MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 748, 093 298, 717 60, 930 1, 107, 740 5, 858 73. 00 76. 00 03020 RENAL ACUTE 1, 301 81, 995 1, 060 84, 356 0 76. 00 000									•
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 748, 093 298, 717 60, 930 1, 107, 740 5, 858 73. 00 76. 00 03000 RENAL ACUTE 1, 301 81, 995 1, 060 84, 356 0 OUTPATIENT SERVICE COST CENTERS	70. 00						118, 323	4, 343	
73. 00 07300 DRUGS CHARGED TO PATIENTS 748,093 298,717 60,930 1,107,740 5,858 73.00 76. 00 03020 RENAL ACUTE 1,301 81,995 1,060 84,356 0 76.00 0UTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 5,071 0 5,071 416 90.00 90. 05 09005 PATIENT NUTRITION 1,618 44,894 1,708 48,220 544 90.07 90. 07 09007 WOUND CLINIC 2,164 90.694 21,167 114,025 581 90.07 91. 00 09100 EMERGENCY 25,336 559,915 288,618 873,869 8,320 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) 6,760,234 21,533,928 9,115,667 37,409,829 166,080 190. 00 190.00 190.00 194.00 07950 RURAL HEALTH 209,151 0 57,659 266,810 2,022 194.00 194. 01 07951 RENTAL PROPERTY 534 0 12,425 12,959 149 194.01 194. 02 07954 FAMILY PRACTICE 16,785 862,307 415,965 1,295,057 2,330 194.02			•	16			331, 648		
76. 00 03020 RENAL ACUTE 1, 301 81, 995 1, 060 84, 356 0 76. 00				748 003			1 107 740		
OUTPATIENT SERVICE COST CENTERS O O O O O O O O O		03020	RENAL ACUTE	1 ' 1					
90. 05				.,,		.,	2.,, 222		
90. 07 09007 WOUND CLINIC 2, 164 90, 694 21, 167 114, 025 581 90. 07 91. 00 09100 EMERGENCY 25, 336 559, 915 288, 618 873, 869 8, 320 91. 00 92. 00 SPECIAL PURPOSE COST CENTERS		1	•	1					
91. 00 09100 EMERGENCY 25, 336 559, 915 288, 618 873, 869 8, 320 91. 00 92. 00 9200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 SPECI AL PURPOSE COST CENTERS									1
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0 92. 00									
SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) 6,760,234 21,533,928 9,115,667 37,409,829 166,080 118.00				20,000	007, 710	200, 010	0	0, 020	•
NONREI MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190.00 194.00 194.00 07950 RURAL HEALTH 209, 151 0 57, 659 266, 810 2, 022 194.00 194.01 194.02 07951 RENTAL PROPERTY 534 0 12, 425 12, 959 149 194.01 194.02 07954 FAMI LY PRACTICE 16, 785 862, 307 415, 965 1, 295, 057 2, 330 194.02 194.0			AL PURPOSE COST CENTERS						
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 190. 00 194. 00 194. 00 07950 RURAL HEALTH 209, 151 0 57, 659 266, 810 2, 022 194. 00 194. 01 07951 RENTAL PROPERTY 534 0 12, 425 12, 959 149 194. 01 194. 02 07954 FAMILY PRACTICE 16, 785 862, 307 415, 965 1, 295, 057 2, 330 194. 02	118.00			6, 760, 234	21, 533, 928	9, 115, 667	37, 409, 829	166, 080	118. 00
194. 00 07950 RURAL HEALTH 209, 151 0 57, 659 266, 810 2, 022 194. 00 194. 01 07951 RENTAL PROPERTY 534 0 12, 425 12, 959 149 194. 01 194. 02 07954 FAMI LY PRACTI CE 16, 785 862, 307 415, 965 1, 295, 057 2, 330 194. 02	190 00				0		ام	0	190 00
194. 01 07951 RENTAL PROPERTY 534 0 12, 425 12, 959 149 194. 01 194. 02 07954 FAMI LY PRACTI CE 16, 785 862, 307 415, 965 1, 295, 057 2, 330 194. 02							- 1		
	194. 01	07951	RENTAL PROPERTY	534		12, 425	12, 959	149	194. 01
194. U3 U/952 WELLINE55 U 266, 966 U 266, 966 455 194. U3				1 1					
	194.03	o ₁ 07952	MELLINESS	ı O	200, 966	ı O	200, 906	455	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		Peri od:	Worksheet B	
				From 01/01/2015 To 12/31/2015		nared:
				10 12/31/2013	5/25/2016 10:	
		CAPI TAL REL	_ATED COSTS			
Cost Center Description	Di rectly	NEW BLDG &	NEW MVBLE	Subtotal	EMPLOYEE	
	Assigned New	FLXT	EQUI P		BENEFI TS	
	Capi tal				DEPARTMENT	
	Related Costs					
	0	1.00	2.00	2A	4. 00	
194. 04 07955 PHYSI CI AN PRACTI CES	444, 169	0	75, 23	33 519, 402	7, 912	194. 04
194.06 07953 SYCAMORE SPORTS MED	0	0	7, 96	7, 965	20	194. 06
194. 07 07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	2, 259	66, 666	6, 93	75, 863	514	194. 07
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers		0		0 0	0	201. 00
202 00 TOTAL (cum Lines 119 201)	7 422 122	22 720 047	0 401 00	20 054 051	170 402	202 00

9, 691, 852

39, 854, 851

179, 482 202. 00

7, 433, 132

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

200.00 201.00 202.00

Provi der CCN: 150023

				11	0 12/31/2013	Date/lime Pre 5/25/2016 10:	
	Cost Center Description	NONPATI ENT	DATA	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/ACC	O I GIII
		TELEPHONES	PROCESSI NG	RECEIVING AND		OUNTS	
		5. 01	5. 02	STORES 5. 03	5. 04	RECEI VABLE 5. 05	
	GENERAL SERVICE COST CENTERS	3.01	3.02	3.03	3. 04	J. 03	
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	78, 982					5. 01
5. 02	OO550 DATA PROCESSING OO560 PURCHASING RECEIVING AND STORES	0	0	l .			5. 02
5. 03 5. 04	00570 ADMITTING	2, 823	0		95, 900		5. 03 5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	2,029	Ö		75, 760	0	5. 05
5. 06	00590 OTHER ADMIN AND GENERAL	7, 277	Ö	o o	0	Ö	5. 06
7.00	00700 OPERATION OF PLANT	4, 454	0	0	0	0	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 129	0	_	0	0	8. 00
9. 00	00900 HOUSEKEEPI NG	502	0	_	0	0	
10.00	01000 DI ETARY	1, 882	0		0	0	
11. 00 13. 00	O1100 CAFETERIA O1300 NURSI NG ADMINISTRATION	0 565	0	· -	0	0	11. 00 13. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	1, 882	0		0	0	16. 00
	01700 SOCIAL SERVICE	251	0	o o	0	Ö	17. 00
21. 00	02100 I&R SERVICES-SALARY & FRINGES APPRVD	O	O	o	0	0	21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	o	0	0	0	0	22. 00
23. 00	02300 PARAMED ED PRGM	0	0		0	0	23. 00
23. 01	02341 OTHER MED ED	0	0	0	0	0	23. 01
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	10.720	0	1 0	17 204		20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	10, 728 1, 819	0		16, 394 5, 391	0	30. 00 31. 00
35. 00	02040 I NTENSI VE NURSERY	1, 129	0	_	2, 431	0	35. 00
41. 00	04100 SUBPROVI DER - I RF	1, 945	0	· -	750	Ö	41. 00
	04300 NURSERY	251	0		989	1	43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	5, 144	0		18, 421	0	50. 00
50. 01	05001 CARDI AC SURGERY	376	0		2, 492	0	50. 01
50. 02	05002 WVSC	0	0		0	0	50. 02
51. 00 51. 02	O5100 RECOVERY ROOM O5101 O/P TREATMENT ROOM	1, 129	0		346 366	0	51. 00 51. 02
51. 02	05200 DELIVERY ROOM & LABOR ROOM	1, 694 1, 443	0		2, 650	0	52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	6, 775	0		2, 030	0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	2, 572	Ö	o o	360	l	55. 00
56. 00	05600 RADI OI SOTOPE	o	0	0	211	0	56. 00
57. 00	05700 CT SCAN	439	0	0	3, 333	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	251	0	1	640	l .	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	2, 133	0	0	5, 509	0	59.00
60. 00 62. 00	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	502	0		7, 304 455	0	60. 00 62. 00
65. 00	06500 RESPIRATORY THERAPY	878	0		2, 573	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	1, 443	Ö		1, 186	0	66. 00
66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	o	0	Ō	66. 01
66. 02	06602 0/P PHYSI CAL THERAPY	63	0	0	0	0	66. 02
	06700 OCCUPATI ONAL THERAPY	314	0	0	773	l	
68. 00	06800 SPEECH PATHOLOGY	63	0	0	198	l	68. 00
	06900 ELECTROCARDI OLOGY	251	0	0	1, 798	l	69.00
	06901 CARDI AC REHAB 07000 ELECTROENCEPHALOGRAPHY	376 1, 066	0		39 676	1	69. 01 70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	878	0		479	1	70.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0,0	0		0	Ö	1
	07300 DRUGS CHARGED TO PATIENTS	3, 137	0	o o	12, 648		1
	03020 RENAL ACUTE	251	O	o	658	0	1
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	0	0	0	0	
	09005 PATIENT NUTRITION	0	0	0	0	0	
	09007 WOUND CLINIC	816	0	0	0	0	90. 07 91. 00
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 952	U	0	4, 652	0	91.00
72.00	SPECIAL PURPOSE COST CENTERS	L					72.00
118. 00		72, 583	C	0	95, 900	0	118. 00
20	NONREI MBURSABLE COST CENTERS			·	2, 100]
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	O	0	0		190. 00
	07950 RURAL HEALTH	63	0	0	0		194. 00
	07951 RENTAL PROPERTY	0	0	0	0	•	194. 01
	07954 FAMILY PRACTICE	4, 454	0	0	0	•	194. 02
	07952 WELLNESS 07955 PHYSI CLAN PRACTICES	1 200	0	0	0	•	194. 03 194. 04
	07953 SYCAMORE SPORTS MED	1, 380	0	0	0		194. 04
	07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	502	0	0	0		194. 00
	, , , , , , , , , , , , , , , , , , , ,					<u>. </u>	

Health Financial Systems	UNION HOSPI	AL, INC.		In Lie	eu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi d	er CCN: 150023	Peri od: From 01/01/2015 To 12/31/2015	Worksheet B Part II Date/Time Prepared: 5/25/2016 10:01 am

						5/25/2016 10:	01 am_
	Cost Center Description	NONPATI ENT	DATA	PURCHASI NG	ADMITTI 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	201. 00
202.00	TOTAL (sum lines 118-201)	78, 982	C	0	95, 900	0	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150023 | Period: From 01/01/201

| Period: | Worksheet B | From 01/01/2015 | Part II | To 12/31/2015 | Date/Time Prepared: | 5/25/2016 10: 01 am

		Cook Cooking Decoration	OTHER ARMIN	ODEDATI ON OF	LAUNDDY 0	HOUSE/EEDLAG	5/25/2016 10:	
		Cost Center Description	OTHER ADMIN AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
	OENED	AL CERVICE COST OFNITERS	5. 06	7. 00	8. 00	9. 00	10. 00	
1. 00		AL SERVICE COST CENTERS NEW CAP REL COSTS-BLDG & FIXT						1. 00
2.00		NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	1	NONPATI ENT TELEPHONES						5. 01
5. 02 5. 03	1	DATA PROCESSING PURCHASING RECEIVING AND STORES						5. 02 5. 03
5. 04		ADMITTING						5. 04
5.05		CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5.06		OTHER ADMIN AND GENERAL	637, 296	0 004 757				5. 06
7. 00 8. 00	1	OPERATION OF PLANT LAUNDRY & LINEN SERVICE	37, 854 3, 227	8, 231, 757 80, 983				7. 00 8. 00
9. 00	1	HOUSEKEEPI NG	10, 036	71, 854		381, 788		9. 00
10.00	1	DI ETARY	7, 189	148, 442		7, 015	751, 655	•
11.00	1	CAFETERI A	581	105, 922		5, 006	0	11. 00
13. 00 16. 00	1	NURSING ADMINISTRATION MEDICAL RECORDS & LIBRARY	6, 601 10, 375	32, 134 71, 449		1, 519 3, 376	0	13. 00 16. 00
17. 00		SOCIAL SERVICE	493	2, 651		125	0	17. 00
21. 00	1	I&R SERVICES-SALARY & FRINGES APPRVD	3, 451	0	-	0	0	21. 00
22. 00		I &R SERVICES-OTHER PRGM COSTS APPRVD	6, 088	0	-	0	0	22. 00
23. 00 23. 01	1	PARAMED ED PRGM OTHER MED ED	402 629	9, 737	0	0 460	0	23. 00 23. 01
23. 01		IENT ROUTINE SERVICE COST CENTERS	027	7, 131	<u> </u>	+00		25.01
30.00	03000	ADULTS & PEDI ATRI CS	79, 402	2, 543, 181		120, 185	565, 189	30. 00
31. 00		INTENSIVE CARE UNIT	21, 261	310, 923		14, 693	96, 124	•
35. 00 41. 00		INTENSIVE NURSERY SUBPROVIDER - IRF	6, 199 6, 525	38, 950 266, 712		1, 841 12, 604	0 41, 494	35. 00 41. 00
43. 00	1	NURSERY	3, 250	53, 110		2, 510	0	43. 00
	ANCI L	LARY SERVICE COST CENTERS						
50.00	1	OPERATI NG ROOM	37, 617	550, 911		26, 035	0	50.00
50. 01 50. 02	05001	CARDI AC SURGERY	6, 691 27, 819	24, 344 406, 106		1, 150 19, 191	0	50. 01 50. 02
51. 00		RECOVERY ROOM	4, 834	19, 367		915	0	51. 00
51. 02	05101	O/P TREATMENT ROOM	8, 043	288, 662	14, 667	13, 641	45, 652	51. 02
52. 00		DELIVERY ROOM & LABOR ROOM	11, 439	281, 372		13, 297	15	
54. 00 55. 00	1	RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C	25, 737 13, 736	468, 751 356, 905		22, 152 16, 866	0	54. 00 55. 00
56. 00	1	RADI OLOGI - MEKAFEOTI C	3, 080	39, 410		1, 862	0	56.00
57. 00	1	CT SCAN	6, 281	29, 375		1, 388	0	57. 00
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	4, 109	35, 068		1, 657	0	58. 00
59. 00 60. 00		CARDI AC CATHETERI ZATI ON LABORATORY	41, 204 21, 268	225, 774 0		10, 669 0	3, 181 0	59. 00 60. 00
62. 00	1	WHOLE BLOOD & PACKED RED BLOOD CELLS	3, 707	0		0	0	62.00
65.00	1	RESPI RATORY THERAPY	10, 460	28, 861	0	1, 364	0	65. 00
66.00		PHYSI CAL THERAPY	6, 379	137, 271	1	6, 487	0	66.00
66. 01 66. 02	1	PSYCHIATRIC/PSYCHOLOGICAL SERVICES 0/P PHYSICAL THERAPY	0 4, 767	0	1	0	0	66. 01 66. 02
67. 00	1	OCCUPATIONAL THERAPY	3, 176	22, 423		1, 060	0	
68.00	1	SPEECH PATHOLOGY	1, 316	44, 468		2, 101	0	
69. 00		ELECTROCARDI OLOGY	5, 924	17, 649		834	0	
69. 01 70. 00		CARDI AC REHAB ELECTROENCEPHALOGRAPHY	1, 303 3, 453	97, 375 20, 354		4, 602 962	0	69. 01 70. 00
71.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 648	77, 251	0	3, 651	0	71.00
72. 00		IMPL. DEV. CHARGED TO PATIENTS	22, 973	0	0	0	0	72. 00
73.00	1	DRUGS CHARGED TO PATIENTS	78, 865	173, 679		8, 208	0	73.00
76. 00		RENAL ACUTE TIENT SERVICE COST CENTERS	3, 836	47, 673	2, 042	2, 253	0	76. 00
90. 00		CLINIC	709	2, 948	O	139	0	90. 00
90. 05		PATIENT NUTRITION	982	26, 102		1, 234	0	90. 05
90. 07		WOUND CLINIC	3, 129	52, 731		2, 492	0	90. 07
91.00		EMERGENCY	23, 718	325, 542	64, 402	15, 384	0	91.00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART) AL PURPOSE COST CENTERS						92. 00
118. 00		SUBTOTALS (SUM OF LINES 1-117)	592, 766	7, 536, 420	407, 829	348, 928	751, 655	118. 00
		MBURSABLE COST CENTERS						
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	68	0		0		190. 00
		RURAL HEALTH RENTAL PROPERTY	8, 130 580	0		0		194. 00 194. 01
		FAMILY PRACTICE	9, 646	501, 358	1	23, 693		194. 01
194. 03	07952	WELLNESS	1, 463	155, 218		7, 335	0	194. 03
	1	PHYSICIAN PRACTICES	22, 492	0		0		194. 04
	1	SYCAMORE SPORTS MED PSYCHIATRIC/PSYCHOLOGICAL SERVICES	334 1, 817	0 38, 761	0	0 1, 832		194. 06 194. 07
200.00	1	Cross Foot Adjustments	1,017	30, 701		1, 032	O	200. 00

Health Financial Systems		UNION HOSPI	TAL, I	INC.		In Lie	eu of Form CMS	-2552-10
ALLOCATION OF CAPITAL RELATED CO	OSTS			Provi der	CCN: 150023	Peri od:	Worksheet B	
						From 01/01/2015		
						To 12/31/2015	Date/Time Pr	
							5/25/2016 10	: 01 am_
Cost Center Descrip	tion	OTHER ADMIN	OPER/	ATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		AND GENERAL	P	PLANT	LINEN SERVIC	E		
		5.06		7. 00	8. 00	9. 00	10.00	
201.00 Negative Cost Cente	rs	0		0		0 0		0 201. 00
202.00 TOTAL (sum lines 11	8-201)	637, 296	8	8, 231, 757	410, 33	381, 788	751, 65	5 202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

| Peri od: | Worksheet B | From 01/01/2015 | Part | I | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015

					Т	o 12/31/2015	Date/Time Pre 5/25/2016 10:	
							INTERNS &	
		Cost Center Description	CAFETERI A	NURSI NG	MEDI CAL	SOCIAL SERVICE	RESI DENTS SERVI CES-SALAR	
				ADMI NI STRATI ON	RECORDS &		Y & FRINGES	
			11.00	13. 00	LI BRARY 16. 00	17. 00	21. 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	1	EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01		NONPATIENT TELEPHONES						5. 01
5. 02		DATA PROCESSING						5. 02
5. 03 5. 04		PURCHASING RECEIVING AND STORES ADMITTING						5. 03 5. 04
5. 05	1	CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5.06		OTHER ADMIN AND GENERAL						5. 06
7.00		OPERATION OF PLANT						7.00
8. 00 9. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING						8. 00 9. 00
10.00		DI ETARY						10. 00
11. 00	1	CAFETERI A	283, 544					11.00
13. 00 16. 00		NURSING ADMINISTRATION MEDICAL RECORDS & LIBRARY	3, 419 10, 985					13. 00 16. 00
17. 00	1	SOCIAL SERVICE	503					17. 00
21. 00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	5, 354		C		11, 032	21. 00
22. 00	1	I&R SERVICES-OTHER PRGM COSTS APPRVD	1, 357			0		22. 00
23. 00 23. 01		PARAMED ED PRGM OTHER MED ED	578 1, 156					23. 00 23. 01
20.01		TENT ROUTINE SERVICE COST CENTERS	1,100	307				20.01
30. 00	1	ADULTS & PEDIATRICS	87, 653			1		30. 00
31. 00 35. 00	1	INTENSIVE CARE UNIT	21, 241	12, 336				31. 00 35. 00
41. 00		I NTENSI VE NURSERY SUBPROVI DER - I RF	6, 536 5, 957					41.00
43. 00	1	NURSERY	4, 399					43. 00
FO 00		LARY SERVICE COST CENTERS	4, 440	7.040	05.000	10		F0 00
50. 00 50. 01	1	OPERATING ROOM CARDIAC SURGERY	16, 113 2, 061	7, 942 745				50. 00 50. 01
50. 02	05001	l e e e e e e e e e e e e e e e e e e e	251	146				50. 02
51. 00		RECOVERY ROOM	5, 580		908			51. 00
51. 02 52. 00	1	O/P TREATMENT ROOM	9, 301	5, 402				51. 02 52. 00
54. 00		DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	11, 865 16, 339		1			54. 00
55. 00	1	RADI OLOGY-THERAPEUTI C	1, 458					55. 00
56.00		RADI OI SOTOPE	1, 483					56.00
57. 00 58. 00		CT SCAN MAGNETIC RESONANCE IMAGING (MRI)	3, 268 1, 558					57. 00 58. 00
59. 00	1	CARDI AC CATHETERI ZATI ON	2, 413					59. 00
60.00	1	LABORATORY	0	0				60. 00
62. 00 65. 00	1	WHOLE BLOOD & PACKED RED BLOOD CELLS RESPIRATORY THERAPY	10 155	0 5. 898				62.00
66. 00		PHYSICAL THERAPY	10, 155	3, 696	2, 211			65. 00 66. 00
66. 01		PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0				66. 01
66. 02	1	O/P PHYSI CAL THERAPY	0	0	1, 349			66. 02
67. 00 68. 00	1	OCCUPATIONAL THERAPY SPEECH PATHOLOGY		0	1, 388 421			67. 00 68. 00
69. 00		ELECTROCARDI OLOGY	6, 686	Ö	3, 522			69. 00
69. 01		CARDI AC REHAB	955		251			69. 01
70. 00 71. 00		ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 162	0	1, 764 551			70. 00 71. 00
72. 00		IMPL. DEV. CHARGED TO PATIENTS	Ö	Ö	0			72.00
73. 00		DRUGS CHARGED TO PATIENTS	10, 633					73. 00
76. 00		RENAL ACUTE TIENT SERVICE COST CENTERS	0	0	794	. 0		76. 00
90. 00		CLINIC	478	277	118	0		90. 00
90. 05		PATIENT NUTRITION	1, 181					90. 05
90. 07	1	WOUND CLINIC	1, 257					90. 07
91. 00 92. 00		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)	19, 908	11, 241	22, 568	808		91. 00 92. 00
		AL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	274, 243	117, 959	250, 633	8, 834	0	118. 00
190 00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190. 00
		RURAL HEALTH	0	Ö		o o		194. 00
		RENTAL PROPERTY	0	0	C	0		194. 01
		FAMILY PRACTICE WELLNESS	4, 525	0		0		194. 02 194. 03
		PHYSICIAN PRACTICES	3, 745	0		6		194. 03
				'				

Health Financial Systems	UNI ON HOSPI	TAL,	I NC.		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS			Provi der	CCN: 150023	Peri od: From 01/01/2015	Worksheet B	
						Date/Time Pre 5/25/2016 10:	
						I NTERNS &	UT alli
						RESI DENTS	
Cost Center Description	CAFETERI A		IURSI NG	MEDI CAL	SOCIAL SERVICE	SERVI CES-SALAR	

						INTERNS &	
						RESI DENTS	
	Cost Center Description	CAFETERI A	NURSI NG	MEDI CAL	SOCIAL SERVICE	SERVI CES-SALAR	
	·		ADMI NI STRATI ON	RECORDS &		Y & FRINGES	
				LI BRARY			
		11. 00	13. 00	16. 00	17. 00	21. 00	
194.06 07953	SYCAMORE SPORTS MED	0	0	0	0		194. 06
194.07 07956	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	1, 031	0	0	0		194. 07
200.00	Cross Foot Adjustments					11, 032	200. 00
201. 00	Negative Cost Centers	35, 021	o	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	318, 565	117, 959	250, 633	8, 840	11, 032	202. 00
'	'	'	'			•	•

	Financial Systems TION OF CAPITAL RELATED COSTS	UNI ON HOSPI			eri od:	u of Form CMS-2 Worksheet B	2552-10
				Fi To	rom 01/01/2015 o 12/31/2015	Part II Date/Time Pre 5/25/2016 10:	pared:
	Cost Center Description	I NTERNS & RESI DENTS SERVI CES-OTHER PRGM COSTS	PARAMED ED PRGM	OTHER MED ED	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	or am
		22. 00	23. 00	23. 01	24. 00	25. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 NEW CAP REL COSTS-BLDG & FIXT			1			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 17. 00 21. 00 22. 00 23. 00 23. 01	OO200 NEW CAP REL COSTS-BUG & PIAT OO200 NEW CAP REL COSTS-MVBLE EQUIP OO400 EMPLOYEE BENEFITS DEPARTMENT OO540 NONPATIENT TELEPHONES OO550 DATA PROCESSING OO560 PURCHASING RECEIVING AND STORES OO570 ADMITTING OO580 CASHIERING/ACCOUNTS RECEIVABLE OO590 OTHER ADMIN AND GENERAL OO700 OPERATION OF PLANT OO800 LAUNDRY & LINEN SERVICE OO900 HOUSEKEEPING O1000 DIETARY O1100 CAFETERIA O1300 NURSING ADMINISTRATION O1600 MEDICAL RECORDS & LIBRARY O1700 SOCIAL SERVICE O2100 I &R SERVICES-OTHER PRGM COSTS APPRVD O2300 PARAMED ED PRGM O2341 OTHER MED ED	9, 992	1, 067	32, 268			2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 5. 06 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 16. 00 17. 00 21. 00 22. 00 23. 00 23. 01
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00 35. 00 41. 00 43. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 02040 INTENSIVE NURSERY 04100 SUBPROVIDER - IRF 04300 NURSERY				9, 307, 115 1, 660, 133 285, 975 874, 774 175, 037	0 0 0 0	30. 00 31. 00 35. 00 41. 00 43. 00
50. 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM				4, 535, 804	0	50.00
50. 01 50. 02 51. 00 51. 02 52. 00 54. 00 55. 00 56. 00 67. 00 68. 00 66. 01 66. 02 67. 00 68. 00 69. 01 70. 00 71. 00 72. 00 73. 00 76. 00 90. 05 90. 05 90. 05 90. 07 91. 00	OSOO1 CARDI AC SURGERY OSOO2 WVSC OS100 RECOVERY ROOM OS101 O/P TREATMENT ROOM OS200 DELI VERY ROOM & LABOR ROOM OS400 RADI OLOGY-DI AGNOSTI C OS500 RADI OLOGY-THERAPEUTI C OS600 RADI OLOGY-THERAPEUTI C OS600 MAGNETI C RESONANCE IMAGI NG (MRI) OS900 CARDI AC CATHETERI ZATI ON O6000 LABORATORY O6200 WHOLE BLOOD & PACKED RED BLOOD CELLS O6500 RESPIRATORY THERAPY O6601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES O6602 O/P PHYSI CAL THERAPY O6600 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES O6602 O/P PHYSI CAL THERAPY O6600 SPEECH PATHOLOGY O6900 ELECTROCARDI OLOGY O6901 CARDI AC REHAB O7000 ELECTROENCEPHALOGRAPHY O7100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS O7200 IMPL. DEV. CHARGED TO PATI ENTS O7300 DRUGS CHARGED TO PATI ENTS O7300 DRUGS CHARGED TO PATI ENTS O7300 CLI NI C O9005 PATI ENT NUTRI TI ON O9007 WOUND CLI NI C O9100 EMERGENCY				340, 438 1, 942, 550 140, 003 1, 081, 887 1, 179, 747 2, 864, 142 2, 363, 280 131, 980 413, 004 837, 088 1, 917, 218 45, 652 4, 774 737, 593 439, 211 0 418, 380 80, 598 165, 840 434, 154 313, 913 153, 817 417, 106 22, 973 1, 445, 018 141, 863	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	50. 01 50. 02 51. 00 51. 02 52. 00 54. 00 55. 00 56. 00 57. 00 58. 00 60. 00 62. 00 66. 00 66. 01 66. 02 67. 00 68. 00 69. 01 70. 00 71. 00 72. 00 73. 00 76. 00 90. 05 90. 05 90. 07 91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS					0	92. 00
118. 00	SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	0	0	0	36, 516, 111	0	118. 00
194. 00 194. 01	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 07950 RURAL HEALTH 07951 RENTAL PROPERTY 07954 FAMILY PRACTICE				68 277, 345 13, 688 1, 841, 485	0	190. 00 194. 00 194. 01 194. 02

Health Financial Systems	UNION HOSPI	TAL, INC.		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der	CCN: 150023	Peri od:	Worksheet B	
				From 01/01/2015 To 12/31/2015	Part II Date/Time Pre	pared:
					5/25/2016 10:	
	INTERNS &					
Cook Cooks Doors at to	RESI DENTS	DADAMED ED	OTHER MED E	C	1 + 0	
Cost Center Description	SERVI CES-OTHER	PARAMED ED	OTHER MED ED		Intern &	
	PRGM COSTS	PRGM			Residents Cost	
					& Post	
					Stepdown	
					Adjustments	
	22.00	23. 00	23. 01	24.00	25. 00	
194. 03 07952 WELLNESS				431, 437	0	194. 03
194. 04 07955 PHYSI CI AN PRACTI CES				556, 698	0	194. 04
194.06 07953 SYCAMORE SPORTS MED				8, 319	0	194. 06
194. 07 07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES				120, 320	0	194. 07
200.00 Cross Foot Adjustments	9, 992	1, 067	32, 26	54, 359	0	200. 00
201.00 Negative Cost Centers	0	0		0 35, 021	0	201. 00
202.00 TOTAL (sum lines 118-201)	9, 992	1, 067	32, 26	39, 854, 851	0	202. 00

	ATION OF CAPITAL RELATED COSTS	ONI ON TIOSI I TAL	Provi der CCN: 150023	Peri od:	Worksheet B
				From 01/01/2015	Part II Date/Time Prepared:
	Cost Center Description	Total			5/25/2016 10: 01 am
	·	26. 00			
1. 00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT				1.00
2. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP				2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4. 00
5. 01	00540 NONPATI ENT TELEPHONES				5. 01
5. 02	00550 DATA PROCESSING				5. 02
5. 03	00560 PURCHASING RECEIVING AND STORES				5. 03
5.04	00570 ADMI TTI NG				5. 04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	İ			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	00900 HOUSEKEEPI NG				9. 00
10. 00	1				10.00
11.00					11. 00
	01300 NURSING ADMINISTRATION				13.00
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE				16. 00 17. 00
	02100 I &R SERVI CES-SALARY & FRINGES APPRVD				21. 00
22. 00					22. 00
	02300 PARAMED ED PRGM				23. 00
	02341 OTHER MED ED				23. 01
20.0.	I NPATIENT ROUTINE SERVICE COST CENTERS				20.01
30.00	03000 ADULTS & PEDIATRICS	9, 307, 115			30.00
	03100 INTENSIVE CARE UNIT	1, 660, 133			31.00
35.00	02040 I NTENSI VE NURSERY	285, 975			35. 00
41.00	04100 SUBPROVI DER - I RF	874, 774			41.00
43.00		175, 037			43.00
	ANCILLARY SERVICE COST CENTERS	. 505 004			50.00
	05000 OPERATI NG ROOM	4, 535, 804			50.00
50. 01	05001 CARDI AC SURGERY 05002 WVSC	340, 438 1, 942, 550			50. 01 50. 02
51. 00	1 I	140,003			51. 00
	05101 0/P TREATMENT ROOM	1, 081, 887			51. 02
	05200 DELIVERY ROOM & LABOR ROOM	1, 179, 747			52. 00
54. 00	1 1	2, 864, 142			54. 00
	05500 RADI OLOGY-THERAPEUTI C	2, 363, 280			55. 00
56.00	05600 RADI OI SOTOPE	131, 980			56. 00
57.00	05700 CT SCAN	413, 004			57. 00
58. 00	` '	837, 088			58. 00
59. 00	1	1, 917, 218			59. 00
60.00	1	45, 652			60.00
62. 00		4, 774			62. 00
65. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	737, 593			65. 00
66. 00 66. 01		439, 211			66. 00 66. 01
	06602 0/P PHYSI CAL THERAPY	418, 380			66. 02
	06700 OCCUPATI ONAL THERAPY	80, 598			67. 00
68. 00		165, 840			68. 00
69. 00		434, 154			69. 00
69. 01		313, 913			69. 01
70.00		153, 817			70.00
71. 00		417, 106			71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	22, 973			72. 00
	07300 DRUGS CHARGED TO PATIENTS	1, 445, 018			73. 00
76. 00	03020 RENAL ACUTE	141, 863			76. 00
00.00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	10 15/			00.00
90. 00 90. 05		10, 156 79, 012			90. 00 90. 05
90. 05		181, 512			90.05
91.00		1, 374, 364			90.07
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,074,004			92. 00
	SPECIAL PURPOSE COST CENTERS				00
118.00		36, 516, 111			118. 00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	68			190. 00
	007950 RURAL HEALTH	277, 345			194. 00
	1 07951 RENTAL PROPERTY	13, 688			194. 00
	207954 FAMILY PRACTICE	1, 841, 485			194. 02
	3 07952 WELLNESS	431, 437			194. 03
	4 07955 PHYSICIAN PRACTICES	556, 698			194. 04
	07953 SYCAMORE SPORTS MED	8, 319			194. 06
194. 07	7 07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	120, 320			194. 07

54, 359 35, 021

200. 00 201. 00

194. 07 07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES
200. 00 Cross Foot Adjustments
201. 00 Negative Cost Centers

Heal th Finar	cial Systems	UNION HOSPITA	AL, INC.		In Lie	u of Form CMS-	2552-10
ALLOCATI ON	OF CAPITAL RELATED COSTS		Provi der CC	N: 150023	From 01/01/2015	Worksheet B Part II Date/Time Pre 5/25/2016 10:	
	Cost Center Description	Total					
		26. 00					
202.00	TOTAL (sum lines 118-201)	39, 854, 851					202. 00

	1 Financial Systems	UNI UN HUSPI I		0011 450000 0		u of Form CMS	
COST	ALLOCATION - STATISTICAL BASIS		Provi der	F	eriod: rom 01/01/2015 o 12/31/2015	Worksheet B-1 Date/Time Pre	
		OADLTAL DEL	ATED COCTO		0 12/31/2013	5/25/2016 10:	
	Cost Center Description	NEW BLDG & FIXT (NEW TOTAL SQ FT)	NEW MVBLE EQUIP (NEW EQUIP DEPRN)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATI ENT TELEPHONES (PHONES)	DATA PROCESSING (DEVICES)	
		1.00	2.00	4.00	5. 01	5. 02	
4 00	GENERAL SERVICE COST CENTERS	077.4(0		1			1 00
1. 00 2. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP	977, 168	3, 528, 877				1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	7, 716	0,020,077	1			4. 00
5. 01	00540 NONPATI ENT TELEPHONES	657	22, 837	549, 018			5. 01
5. 02 5. 03	00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES	0	0	0	0	1, 066 0	5. 02 5. 03
5. 03	00570 ADMITTING	3, 062	5, 005	1, 172, 869	_	12	5. 04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0	0	0	0	5. 05
5.06	00590 OTHER ADMIN AND GENERAL	18, 571	46, 438			64	5. 06
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	338, 496 5, 988	105, 444 67, 186			19 4	7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	5, 313	60, 934			1	9. 00
10.00	01000 DI ETARY	10, 976	118, 544			14	10.00
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	7, 832 2, 376	8, 780 4, 700			5 0	11. 00 13. 00
16. 00		5, 283	6, 844			58	1
17. 00		196	0	144, 596		3	17. 00
21. 00 22. 00	I I	0	0	1, 247, 642 1, 427, 051		0	21. 00 22. 00
23. 00	02300 PARAMED ED PRGM	0	0	48, 595		0	23. 00
23. 01	02341 OTHER MED ED	720	928	235, 038	0	0	23. 01
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	188, 046	418, 042	19, 793, 650	171	182	30.00
31. 00		22, 990	163, 110			24	ı
35. 00	I I	2, 880	53, 692			5	
41. 00 43. 00	1	19, 721 3, 927	18, 930 3, 330			43	41. 00 43. 00
43.00	ANCILLARY SERVICE COST CENTERS	3, 721	3, 330	1,032,714	4	4	43.00
50.00	I I	40, 735	735, 124			42	•
50. 01 50. 02	05001 CARDI AC SURGERY 05002 WVSC	1, 800 30, 028	64, 973 108, 783			4	50. 01 50. 02
51. 00		1, 432	18, 019			7	51.00
51. 02	05101 O/P TREATMENT ROOM	21, 344	69, 101			0	51. 02
52. 00 54. 00	· · · · · · · · · · · · · · · · · · ·	20, 805 34, 660	113, 857 340, 967			5 78	52. 00 54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	26, 390	183, 970			4	55.00
56. 00	05600 RADI OI SOTOPE	2, 914	3, 980			0	56. 00
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	2, 172 2, 593	237 16, 257			0 4	57. 00 58. 00
59. 00		16, 694	57, 020	1		19	ı
60.00	06000 LABORATORY	0	0	0		2	60.00
62. 00 65. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	115 775	0 422 527	0	0	
66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	2, 134 10, 150	115, 775 14, 696		14	7 22	65. 00 66. 00
66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0	0	0	66. 01
66. 02	I I	0	23, 183		1	8	66. 02
67. 00 68. 00	1	1, 658 3, 288	4, 696 831		1	1	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	1, 305	94, 422	1, 412, 023		12	69. 00
69. 01	06901 CARDI AC REHAB	7, 200	14, 145			2	
70. 00 71. 00	I I	1, 505 5, 712	25, 944 72, 372			4	70. 00 71. 00
72. 00	1 1	0,712	0			0	1
73. 00		12, 842	22, 185			16	
76. 00	03020 RENAL ACUTE OUTPATIENT SERVICE COST CENTERS	3, 525	386	0	4	0	76. 00
90. 00	09000 CLINIC	218	0	233, 087	0	0	90.00
90. 05	I I	1, 930	622			0	90. 05
90. 07 91. 00	09007 WOUND CLINIC 09100 EMERGENCY	3, 899 24, 071	7, 707 105, 088			4 169	90. 07 91. 00
91.00	1 1	24,071	100,000	4, 001, 041	03	109	92.00
	SPECIAL PURPOSE COST CENTERS	· · · · · · · · · · · · · · · · · · ·		T -			
118. 00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	925, 754	3, 319, 084	93, 016, 774	1, 157	848	118. 00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	3	190. 00
194.00	07950 RURAL HEALTH	0	20, 994			62	194. 00
	1 07951 RENTAL PROPERTY 2 07954 FAMILY PRACTICE	0 37, 071	4, 524 151, 456				194. 01 194. 02
1 74. 02	E TO THE PUBLIC TO THE POPULATION OF THE POPULAT	37,071	151, 450	1, 505, 555	71	112	1174.02

Health Financial Systems	UNION HOSPITAL,	I NC.		In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der	CCN: 150023	Peri od: From 01/01/2015	Worksheet B-1	
					Date/Time Pre 5/25/2016 10:	
	CAPITAL RELATED	COSTS				
			-			

						5/25/2016 10:	UT alli
		CAPITAL REL	ATED COSTS				
	Cost Center Description	NEW BLDG &	NEW MVBLE	EMPLOYEE	NONPATI ENT	DATA	
		FLXT	EQUI P	BENEFITS	TELEPHONES	PROCESSI NG	
		(NEW TOTAL	(NEW EQUIP	DEPARTMENT	(PHONES)	(DEVICES)	
		SQ FT)	DEPRN)	(GROSS			
				SALARI ES)			
		1. 00	2.00	4. 00	5. 01	5. 02	
194. 03 07952	WELLNESS	11, 477	0	255, 055	0	0	194. 03
194. 04 07955	PHYSICIAN PRACTICES	0	27, 393	4, 432, 468	22	33	194. 04
194. 06 07953	SYCAMORE SPORTS MED	0	2, 900	11, 333	0	0	194. 06
194. 07 07956	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	2, 866	2, 526	287, 797	8	8	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)	22, 729, 867	9, 691, 852	19, 962, 856	1, 026, 489	11, 189, 026	202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	23. 260961	2. 746441	0. 198585	815. 320890	10, 496. 272045	203. 00
204. 00	Cost to be allocated (per Wkst. B,			179, 482	78, 982	0	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part			0. 001785	62. 733916	0. 000000	205. 00
	11)						

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 UNION HOSPITAL, INC. Provi der CCN: 150023 | Peri od: | Worksheet B-1 | From 01/01/2015 | To 12/31/2015 | Date/Time Prepared:

					То	12/31/2015	Date/Time Pre 5/25/2016 10:	
		Cost Center Description	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/ACCR	econciliation	OTHER ADMIN	
			RECEIVING AND	(I NPATI ENT	OUNTS RECEI VABLE		AND GENERAL	
			STORES (REQUISITIO)	REVENUE)	(TOTAL		(ACCUM. COST)	
			(1.245151115)		REVENUE)			
	OFNED	AL CERVI OF COCT OFNITERS	5. 03	5. 04	5. 05	5A. 06	5. 06	
1. 00		AL SERVICE COST CENTERS NEW CAP REL COSTS-BLDG & FIXT						1. 00
2.00		NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00		EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01		NONPATIENT TELEPHONES						5. 01
5. 02		DATA PROCESSING PURCHASING RECEIVING AND STORES	F 220 (2)					5. 02
5. 03 5. 04	1	ADMITTING	5, 230, 626 5, 272	489, 819, 937				5. 03 5. 04
5. 05	1	CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0	1, 181, 905, 691			5. 05
5.06		OTHER ADMIN AND GENERAL	228	0	0	-22, 422, 275	295, 255, 185	5. 06
7.00	1	OPERATION OF PLANT	746	0	I - 1	0	17, 541, 224	7. 00
8. 00 9. 00	1	LAUNDRY & LINEN SERVICE HOUSEKEEPING	6, 134 180, 427	0		0	1, 495, 542 4, 650, 809	8. 00 9. 00
10.00	1	DI ETARY	256	0		o	3, 331, 446	
11. 00	1	CAFETERI A	9	0	0	0	269, 351	
13. 00	1	NURSING ADMINISTRATION	0	0		0	3, 059, 081	13. 00
16.00		MEDICAL RECORDS & LIBRARY	252	0	I - 1	0	4, 807, 505	16. 00
17. 00 21. 00		SOCIAL SERVICE I&R SERVICES-SALARY & FRINGES APPRVD		0		0	228, 439 1, 599, 048	17. 00 21. 00
22. 00		I &R SERVICES-OTHER PRGM COSTS APPRVD		0		0	2, 821, 261	22. 00
23. 00		PARAMED ED PRGM	0	0	0	0	186, 489	23. 00
23. 01	_	OTHER MED ED	0	0	0	0	291, 519	23. 01
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	1, 149, 146	83, 642, 871	95, 473, 679	o	36, 730, 734	30. 00
31. 00		INTENSIVE CARE UNIT	654, 430	27, 506, 456		0	9, 852, 132	
35.00		I NTENSI VE NURSERY	68, 877	12, 403, 588		0	2, 872, 422	35. 00
41. 00		SUBPROVIDER - IRF	55, 996	3, 824, 601		0	3, 023, 463	•
43. 00		NURSERY LARY SERVICE COST CENTERS	4	5, 045, 579	5, 045, 579	0	1, 505, 794	43. 00
50. 00		OPERATING ROOM	236, 451	94, 522, 204	165, 485, 314	0	17, 431, 507	50. 00
50. 01	1	CARDI AC SURGERY	1, 164, 270	12, 712, 123		O	3, 100, 652	
50. 02	05002	l control of the cont	41, 266	0		0	12, 890, 977	50. 02
51.00		RECOVERY ROOM	118, 418	1, 764, 978		0	2, 240, 073	•
51. 02 52. 00	1	O/P TREATMENT ROOM DELIVERY ROOM & LABOR ROOM	121, 254 291, 261	1, 866, 560 13, 520, 978		0	3, 726, 973 5, 300, 533	•
54. 00		RADI OLOGY-DI AGNOSTI C	56, 925	11, 111, 623		Ö	11, 926, 196	
55.00		RADI OLOGY-THERAPEUTI C	2, 326	1, 834, 422		0	6, 365, 172	55. 00
56.00	1	RADI OI SOTOPE	5, 765	1, 078, 231		0	1, 427, 104	
57. 00 58. 00	1	CT SCAN MAGNETIC RESONANCE IMAGING (MRI)	182, 462 3, 943	17, 003, 384 3, 266, 853		0	2, 910, 448 1, 904, 285	
59. 00		CARDI AC CATHETERI ZATI ON	39, 952	28, 108, 248		o	19, 093, 581	59. 00
60.00		LABORATORY	0	37, 262, 967		0	9, 855, 637	1
62.00	1	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	2, 319, 106		0	1, 717, 894	•
65. 00 66. 00		RESPI RATORY THERAPY PHYSI CAL THERAPY	120, 950 2, 066	13, 128, 148 6, 049, 999		0	4, 847, 088 2, 956, 059	
66. 01		PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	2,000	0, 049, 999		o	2, 930, 039	
66. 02		O/P PHYSI CAL THERAPY	3, 903	0	6, 363, 160	0	2, 209, 155	•
67. 00		OCCUPATI ONAL THERAPY	0	3, 942, 563		0	1, 471, 938	
68.00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	17 940	1, 009, 073		0	609, 899	•
69. 00 69. 01		CARDI AC REHAB	17, 840 721	9, 173, 498 199, 376		0	2, 745, 227 603, 945	
70. 00		ELECTROENCEPHALOGRAPHY	3, 019	3, 448, 101		O	1, 599, 939	
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	8, 736	2, 444, 939		0	1, 227, 121	•
72. 00 73. 00	1	IMPL. DEV. CHARGED TO PATIENTS	0 59, 706	0		0	10, 645, 497	
76.00	1	DRUGS CHARGED TO PATIENTS RENAL ACUTE	35, 388	64, 532, 054 3, 358, 594		0	36, 545, 614 1, 777, 579	•
70.00		TIENT SERVICE COST CENTERS	00,000	0,000,071	577.107700	<u> </u>	.,,,,,,,,	70.00
90.00	1	CLINIC	0	1, 962		0	328, 625	90.00
90. 05 90. 07		PATIENT NUTRITION WOUND CLINIC	55	0	·	0	454, 876 1, 450, 103	
91.00		EMERGENCY	28, 686 526, 603	23, 736, 858		0	10, 990, 673	
92. 00	1	OBSERVATION BEDS (NON-DISTINCT PART)	323, 333	20, 700, 000	100, 102, 000	J	10,770,070	92. 00
		AL PURPOSE COST CENTERS						
118. 00		SUBTOTALS (SUM OF LINES 1-117) IMBURSABLE COST CENTERS	5, 193, 743	489, 819, 937	1, 181, 905, 691	-22, 422, 275	274, 620, 629	118. 00
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	0	0	0	31, 489	190. 00
194.00	07950	RURAL HEALTH	10, 495	0		o	3, 767, 496	1
		RENTAL PROPERTY	. 0	0	0	0	268, 579	
		FAMILY PRACTICE WELLNESS	3, 762	0		0	4, 470, 000 677, 750	
		PHYSICIAN PRACTICES	22, 496	0		0	10, 422, 547	
				<u>-</u>	1			·

Health Financial Systems	UNION HOSPITAL,	I NC.	In Lie	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der CCN: 150023		Worksheet B-1
			From 01/01/2015	Dato/Timo Propared

				Ţ	o 12/31/2015	Date/Time Pre 5/25/2016 10:	
	Cost Center Description	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/ACC	Reconciliation		
		RECEIVING AND	(I NPATI ENT	OUNTS		AND GENERAL	
		STORES	REVENUE)	RECEI VABLE		(ACCUM.	
		(REQUISITIO)		(TOTAL		COST)	
				REVENUE)			
		5. 03	5. 04	5. 05	5A. 06	5. 06	
194. 06 0795	SYCAMORE SPORTS MED	0	0	0	0	154, 738	194. 06
194. 07 0795	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	130	0	0	0	841, 957	194. 07
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B,	1, 129, 933	2, 239, 871	6, 412, 988		22, 422, 275	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 216023	0. 004573	0.005426		0. 075942	203. 00
204.00	Cost to be allocated (per Wkst. B,	0	95, 900	0		637, 296	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000196	0.000000		0. 002158	205. 00
	11)						

Heal t	n Financial Systems	UNION HOSPI	TAL, INC.		In lie	u of Form CMS-	2552-10
	ALLOCATION - STATISTICAL BASIS	5.00 5.00 11551		CCN: 150023	Peri od: From 01/01/2015 To 12/31/2015	Worksheet B-1 Date/Time Pre 5/25/2016 10:	pared:
	Cost Center Description	OPERATION OF PLANT (NEW TOTAL SQ FT)	LAUNDRY & LINEN SERVICE (LINEN)	HOUSEKEEPING (NEW TOTAL SQ FT)		CAFETERI A (FTE)	
	Torner or and or armino	7. 00	8. 00	9. 00	10.00	11. 00	
1.00	GENERAL SERVICE COST CENTERS O0100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 5. 06 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 17. 00 21. 00 22. 00 23. 01	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 01700 SOCIAL SERVICE 02100 I&R SERVICES-SALARY & FRINGES APPRVD 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	608, 666 5, 988 5, 313 10, 976 7, 832 2, 376 5, 283 196 0 0	1, 009, 613 1, 960 0 0 0 0 0 0 0 0	597, 36 10, 9' 7, 8' 2, 3 5, 26	76 197, 758 32 0 76 0	11, 280 136 437 20 213 54 23	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 17. 00 21. 00 22. 00 23. 00
30. 00		188, 046	329, 653	188, 0	148, 699	3, 487	30.00
31.00	1	22, 990	1	1		845	1
35. 00 41. 00		2, 880 19, 721	1	1		260 237	
43.00		3, 927	0	3, 9:	27 0	175	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	40, 735	64, 840	40, 7	35 0	641	50.00
50. 01 50. 02	1 I	1, 800 30, 028				82 10	1
51. 00	1 1	1, 432	41, 186	1, 4:		222	
51. 02 52. 00	• • •	21, 344 20, 805				370 472	1
54. 00	1 I	34, 660	1	1		650	1
55. 00 56. 00		26, 390 2, 914		1		58 59	1
57. 00	05700 CT SCAN	2, 172	12	2, 1	72 0	130	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	2, 593 16, 694				62 96	
60.00	06000 LABORATORY	0,074			0 0	0	60. 00
62. 00 65. 00	1	2, 134	0	2, 1:	0 0	0 404	
66.00	06600 PHYSI CAL THERAPY	10, 150	9, 322		50 0	0	66. 00
66. 01 66. 02		0			0 0	0	1
67. 00	06700 OCCUPATI ONAL THERAPY	1, 658	0	1, 6!		0	67. 00
68. 00 69. 00		3, 288 1, 305		-, -		0 266	
69. 01	1	7, 200	542	7, 20	00	38	1
70.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 505 5, 712	1	1		86 0	1
	07200 IMPL. DEV. CHARGED TO PATIENTS	12.042	1	12.0	0 0	0	
76. 00	07300 DRUGS CHARGED TO PATIENTS 03020 RENAL ACUTE	12, 842 3, 525	1	12, 8, 3, 5:		423 0	1
90. 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	218	0	J 2:	18 0	19	90.00
	09000 PATIENT NUTRITION	1, 930		1, 9:		47	1
90. 07	09007 WOUND CLINIC 09100 EMERGENCY	3, 899 24, 071	1	1		50 792	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	21,071	100, 100	21,0		,,,2	92. 00
118.0	SPECIAL PURPOSE COST CENTERS O SUBTOTALS (SUM OF LINES 1-117)	557, 252	1, 003, 455	545, 9	51 197, 758	10 910	118. 00
	NONREI MBURSABLE COST CENTERS		1				
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 07950 RURAL HEALTH	0		1	0 0		190. 00 194. 00
194. C	1 07951 RENTAL PROPERTY	0	0		0	0	194. 01
	2 07954 FAMILY PRACTICE 3 07952 WELLNESS	37, 071 11, 477	1	37, 0 ⁻¹ 11, 4 ⁻¹			194. 02 194. 03
194. C	4 07955 PHYSI CI AN PRACTI CES	0	4, 333		0 0	149	194. 04
194.0	6 07953 SYCAMORE SPORTS MED	0	0	1	0 0	0	194. 06

Health Financial Systems	UNI ON HOSPI	TAL, INC.		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od: From 01/01/2015	Worksheet B-1	
				To 12/31/2015	Date/Time Pre 5/25/2016 10:	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NO	DI ETARY	CAFETERI A	
	PLANT	LINEN SERVICE	(NEW TOTAL	(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	41	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)	18, 873, 340	1, 794, 790	5, 172, 22	4, 019, 819	600, 471	202. 00
203.00 Unit cost multiplier (Wkst. B, Part I) 31. 007712	1. 777701	8. 65840	7 20. 326960	53. 233245	203. 00
204.00 Cost to be allocated (per Wkst. B,	8, 231, 757	410, 332	381, 78	8 751, 655	318, 565	204. 00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	13. 524260	0. 406425	0. 63912	3. 800883	25. 136879	205. 00
11)						

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 150023

					INTERNS &	5/25/2016 10: RESI DENTS	01 am
	Cook Cookin Doorsi ati on	NUDCING	MEDICAL	COCLAL CEDVICE			
	Cost Center Description	NURSI NG ADMI NI STRATI ON	MEDICAL RECORDS &	SOCIAL SERVICE	Y & FRINGES	PRGM COSTS	
		(TIME	LI BRARY (TOTAL	(# REFERRALS)	(INTERNS)	(INTERNS)	
		SPENT)	REVENUE)	ŕ			
	GENERAL SERVI CE COST CENTERS	13. 00	16. 00	17. 00	21. 00	22. 00	
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 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 ADMIN 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						10. 00
11. 00 13. 00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	8, 080					11. 00 13. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0,000	1, 181, 905, 691				16. 00
17. 00 21. 00	01700 SOCIAL SERVICE 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	1, 389 0	1, 000		17. 00 21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0	ő	1, 000	1, 000	22. 00
23. 00 23. 01	02300 PARAMED ED PRGM 02341 OTHER MED ED	0 39	0	0			23. 00 23. 01
23.01	INPATIENT ROUTINE SERVICE COST CENTERS	37	0				23.01
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	3, 250 845	95, 473, 679 27, 515, 511		485 0	485 0	30. 00 31. 00
35. 00	02040 I NTENSI VE NURSERY	260	12, 403, 926	1	13	13	35. 00
41.00	04100 SUBPROVI DER - I RF	237	3, 825, 199		0	0	41.00
43. 00	04300 NURSERY ANCI LLARY SERVICE COST CENTERS	175	5, 045, 579	182	U _I	0	43. 00
50. 00 50. 01	05000 OPERATI NG ROOM 05001 CARDI AC SURGERY	544 51	165, 485, 314 13, 254, 589	1	69 0	69 0	50. 00 50. 01
50. 01	05001 CARDI AC SURGERT	10	100, 973, 931	1	0	0	50. 01
51. 00 51. 02	O5100 RECOVERY ROOM O5101 O/P TREATMENT ROOM	222 370	4, 284, 852 11, 164, 539	1	0	0	51. 00 51. 02
52. 00	05200 DELIVERY ROOM & LABOR ROOM	423	18, 914, 134	1	100	100	52.00
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	0	54, 960, 691 33, 137, 611		15 8	15 8	54. 00 55. 00
56. 00	05600 RADI OLOGI - ITIERAFEUTT C	0	10, 615, 720	1	0	0	56.00
57. 00 58. 00	05700 CT SCAN	0	60, 083, 693	1	0	0	57. 00 58. 00
59. 00	05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION	0	15, 232, 957 100, 510, 197	1	0	0	59. 00
60.00	06000 LABORATORY	0	78, 197, 163		0	0	60. 00 62. 00
62. 00 65. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06500 RESPIRATORY THERAPY	404	2, 888, 286 14, 351, 416		14		1
66. 00	06600 PHYSI CAL THERAPY 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	10, 428, 502 0	1	37	37	66.00
66. 01 66. 02	06602 0/P PHYSI CAL THERAPY	0	6, 363, 160	-	0 0	0	66. 01 66. 02
67. 00 68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	0	6, 545, 242	0	0	0	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	1, 985, 621 16, 614, 970		20	20	69. 00
69. 01 70. 00	06901 CARDI AC REHAB 07000 ELECTROENCEPHALOGRAPHY	0	1, 184, 752		0	0	69. 01 70. 00
70.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8, 322, 640 2, 599, 216		0	0	70.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	102 225 227		0	0	72.00
73. 00 76. 00	07300 DRUGS CHARGED TO PATIENTS 03020 RENAL ACUTE	364	183, 335, 327 3, 745, 966	1	0	2	73. 00 76. 00
00.00	OUTPATIENT SERVICE COST CENTERS	10	EEE 20/			0	00.00
90. 00 90. 05	09000 CLINIC 09005 PATIENT NUTRITION	19 47	555, 296 299, 412	1	0	0	90. 00 90. 05
90. 07	09007 WOUND CLINIC	50	5, 154, 094	1	7	7	90. 07
91. 00 92. 00	O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART)	770	106, 452, 506	127	108	108	91. 00 92. 00
110 0	SPECIAL PURPOSE COST CENTERS	0.000	1 101 005 /01	1 200	070	070	110 00
118. 00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	8,080	1, 181, 905, 691	1, 388	878	8/8	118. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 07950 RURAL HEALTH	0	0	1	0		190. 00 194. 00
194.0	07951 RENTAL PROPERTY	0	0		0	0	194. 01
194. 02	2 07954 FAMILY PRACTICE	0	0	0	122	122	194. 02

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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150023 | Period: From 01/01/2015 | To 12/31/2015 | Date/Time Prepared: Date/Time Prepared: F425/2014 10:01 on F425/

						5/25/2016 10:	01 am_
					INTERNS &	RESI DENTS	
	Cost Center Description	NURSI NG	MEDI CAL	SOCIAL SERVICE	SERVI CES-SALAR	SERVI CES-OTHER	
		ADMI NI STRATI ON	RECORDS &		Y & FRINGES	PRGM COSTS	
			LI BRARY	(#	(INTERNS)	(INTERNS)	
		(TIME	(TOTAL	REFERRALS)			
		SPENT)	REVENUE)				
		13. 00	16. 00	17. 00	21. 00	22. 00	
194. 03 07952	WELLNESS	0	0	0	0	0	194. 03
194. 04 07955	PHYSICIAN PRACTICES	0	0	1	0	0	194. 04
194. 06 07953	SYCAMORE SPORTS MED	0	0	0	0	0	194. 06
194. 07 07956	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	194. 07
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B,	3, 392, 880	5, 405, 416	254, 627	1, 731, 822	3, 038, 388	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	419. 910891	0. 004573	183. 316775	1, 731. 822000	3, 038. 388000	203. 00
204. 00	Cost to be allocated (per Wkst. B,	117, 959	250, 633	8, 840	11, 032	9, 992	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	14. 598886	0. 000212	6. 364291	11. 032000	9. 992000	205. 00
	11)						

UNION HOSPITAL, INC.

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 Provi der CCN: 150023

				25/2016 10:01 am
	Cost Center Description	PARAMED ED	OTHER MED ED	
		PRGM	(ASSI GNED	
		(PARAMED RADI OLOGY)	TIME)	
		23. 00	23. 01	
	GENERAL SERVICE COST CENTERS			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT			1. 00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4.00
5. 01	00540 NONPATI ENT TELEPHONES 00550 DATA PROCESSI NG			5. 01
5. 02 5. 03	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	00900 HOUSEKEEPI NG			9. 00
10.00	01000 DI ETARY			10.00
11. 00 13. 00	01100 CAFETERI A			11. 00
16. 00	01300 NURSING ADMINISTRATION 01600 MEDICAL RECORDS & LIBRARY			16. 00
17. 00	01700 SOCIAL SERVICE			17. 00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD			21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD			22. 00
23. 00	02300 PARAMED ED PRGM	100		23. 00
23. 01	02341 OTHER MED ED		100	23. 01
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDI ATRI CS	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	0	41. 00 43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	0	U U	43.00
50. 00	05000 OPERATI NG ROOM	0	0	50.00
50. 01	05001 CARDI AC SURGERY	0	o	50. 01
50. 02	05002 WVSC	0	o	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	100		54.00
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	0	55. 00 56. 00
57. 00	05700 CT SCAN	0	o	57.00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	Ö	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	o	59. 00
60.00	06000 LABORATORY	0	o	60. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62. 00
65. 00	06500 RESPI RATORY THERAPY	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	66.00
66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	66. 01
66. 02 67. 00	06602 0/P PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	0	66. 02 67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	Ö	69. 00
69. 01	06901 CARDI AC REHAB	0	ol	69. 01
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	O	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	o	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	100	73.00
76. 00	03020 RENAL ACUTE OUTPATIENT SERVICE COST CENTERS	0	0	76. 00
gn nn	09000 CLINIC		O	90.00
90.05	09005 PATIENT NUTRITION	0	0	90.05
90. 07	09007 WOUND CLINIC	0	0	90. 07
91. 00		0	ol	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			 92. 00
	SPECIAL PURPOSE COST CENTERS			
118.00		100	100	118. 00
100.00	NONREI MBURSABLE COST CENTERS			100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 07950 RURAL HEALTH		0	190. 00 194. 00
	07950 RUKAL HEALTH			194. 00
	207954 FAMILY PRACTICE			194. 02
	07952 WELLNESS	0	0	194. 03
	07955 PHYSICIAN PRACTICES	0	ő	194. 04
	07953 SYCAMORE SPORTS MED	0	o	194. 06
		•		 · · · · · · · · · · · · · · · · · · ·

Health Financial Systems	UNI ON HOSPI	TAL, INC.		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi de	r CCN: 150023	Peri od: From 01/01/2015	Worksheet B-1	
				To 12/31/2015	Date/Time Pre	
					5/25/2016 10:	01 am
Cost Center Description	PARAMED ED	OTHER MED EI				
	PRGM	(ASSI GNED				
	(PARAMED	TIME)				
	RADI OLOGY)					
	23. 00	23. 01				
194. 07 07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0		0			194. 07

201, 875

1, 067

10. 670000

2, 018. 750000

361, 044

32, 268

3, 610. 440000

322. 680000

Cross Foot Adjustments Negative Cost Centers

Part I)

Part II)

11)

Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part I)
Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part

200. 00 201. 00 202. 00

203.00

204.00

205.00

200. 00 201. 00 202. 00

203. 00 204. 00

205. 00

Peri od: Worksheet C From 01/01/2015 Part I To 12/31/2015 Date/Time Prepared: 5/25/2016 10:01 am

					12, 01, 2010	5/25/2016 10:	01 am
			Ti tl	e XVIII	Hospi tal	PPS	
	·				Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	·	(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	52, 725, 801		52, 725, 8)1 8, 777	52, 734, 578	30. 00
31.00	03100 INTENSIVE CARE UNIT	12, 679, 540		12, 679, 5	10 0	12, 679, 540	31. 00
35.00	02040 I NTENSI VE NURSERY	3, 406, 817		3, 406, 8	7 0	3, 406, 817	35. 00
41.00	04100 SUBPROVI DER - I RF	4, 412, 569		4, 412, 5	9 0	4, 412, 569	41.00
43.00	04300 NURSERY	1, 915, 153		1, 915, 1			
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATI NG ROOM	21, 506, 042		21, 506, 0	12 0	21, 506, 042	50. 00
50. 01	05001 CARDI AC SURGERY	3, 494, 028		3, 494, 0			
50. 02	05002 WVSC	15, 675, 007		15, 675, 0			50. 02
51. 00	05100 RECOVERY ROOM	2, 664, 840		2, 664, 8		2, 664, 840	1
51. 02	05101 0/P TREATMENT ROOM	5, 403, 527		5, 403, 5			51. 02
52. 00	05200 DELIVERY ROOM & LABOR ROOM	6, 908, 957		6, 908, 9			
54. 00	05400 RADI OLOGY-DI AGNOSTI C	14, 756, 058		14, 756, 0			
55. 00	05500 RADI OLOGY-THERAPEUTI C	8, 082, 085		8, 082, 0			
56. 00	05600 RADI OI SOTOPE	1, 714, 095		1, 714, 0			
57. 00	05700 CT SCAN	3, 499, 332		3, 499, 3		3, 499, 332	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	2, 279, 192		2, 279, 1			
59. 00	05900 CARDI AC CATHETERI ZATI ON	21, 707, 037		21, 707, 0		21, 707, 037	
60. 00	06000 LABORATORY	10, 961, 690		10, 961, 6		11, 006, 781	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 861, 562		1, 861, 5		l	62.00
65. 00	06500 RESPIRATORY THERAPY	5, 556, 612	C			1	1
66. 00	06600 PHYSI CAL THERAPY	3, 647, 421		-,, -			66.00
66. 01	06601 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES	3,047,421			0 0		66. 01
66. 02	06602 0/P PHYSI CAL THERAPY	2, 442, 264		1			66. 02
67. 00	06700 OCCUPATI ONAL THERAPY	1, 679, 418	_	1, 679, 4			
68. 00	06800 SPEECH PATHOLOGY	795, 718		795, 7			
69. 00	06900 ELECTROCARDI OLOGY	3, 109, 847		3, 109, 8			
69. 00	06901 CARDI AC REHAB	943, 812		943, 8		-, ,	
70. 00	07000 ELECTROENCEPHALOGRAPHY	1, 826, 899		1, 826, 8			
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 558, 770		1, 558, 7		1,020,077	
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	11, 453, 937		11, 453, 9			
73. 00	07300 DRUGS CHARGED TO PATIENTS	41, 205, 720		41, 205, 7			
		1 ' '					
76. 00	03020 RENAL ACUTE OUTPATIENT SERVICE COST CENTERS	2, 078, 458		2, 078, 4	08 0	2, 078, 458	76. 00
00.00		272 757		272.7	.7	272 757	00.00
90.00	09000 CLINIC	373, 757		373, 7			1
90.05	09005 PATIENT NUTRITION	589, 583		589, 5			
90. 07	09007 WOUND CLINIC	1, 782, 489		1, 782, 4			
91.00	09100 EMERGENCY	13, 937, 406		13, 937, 4			
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	8, 530, 865		8, 530, 8		8, 530, 865	
200.00		297, 166, 308		2777 .0070			
201.00		8, 530, 865		8, 530, 8		8, 530, 865	
202.00	Total (see instructions)	288, 635, 443	C	288, 635, 4	59, 872	288, 695, 315	1202. UU

Peri od: Worksheet C From 01/01/2015 Part I To 12/31/2015 Date/Time Prepared: 5/25/2016 10:01 am

INPATIENT ROUTINE SERVICE COST CENTERS 1, 20, 10, 10, 10, 10, 10, 10, 10, 10, 10, 1							5/25/2016 10:	01 am_
Inpatient				Ti tl	e XVIII	Hospi tal	PPS	
INPATIENT ROUTINE SERVICE COST CENTERS 3.0 0.0 7.0 0 8.0 0 9.0 0 10.0 0				Charges				
INPATIENT ROUTINE SERVICE COST CENTERS		Cost Center Description	I npati ent	Outpati ent	Total (col.	Cost or Other	TEFRA	
INPATI ENT ROUTINE SERVICE COST CENTERS 82,210,774 82,210,774 30.00		·	·	·	+ col . 7)	Ratio	Inpati ent	
INPATI ENT ROUTI NE SERVICE COST CENTERS 82, 210, 974 82, 210, 974 30, 00 30, 00 3010 ADULTS & PEDIATRIC SS 82, 210, 974 82, 210, 974 30, 00 310 310 ADULTS & PEDIATRIC SS 31, 00 310 ADULTS & PEDIATRIC SS 32, 40, 01 33, 824, 601 41, 00					,		Rati o	
30.00 03000 ADULTS & PEDI ATRI CS 82, 210, 974 82, 210, 974 31, 00 310, 00 3100 NITERSI VE CARE UNIT 27, 506, 456 27, 506, 456 31, 00 310, 00 3100 03000 NITERSI VE NURSERY 12, 403, 588 12, 403, 588 35, 00 41, 00 4100 04100 04100 SUSPROVI DER - I RF 3, 824, 601 3, 824, 601 41, 00 43, 00 43, 00 43, 00 43, 00 43, 00 43, 00 43, 00 43, 00 43, 00 43, 00 43, 00 43, 00 44, 00 44, 10			6.00	7. 00	8. 00	9. 00	10.00	
31.00 03100 INTERSIVE CARE UNIT 27,506,456 27,506,456 31.00 03100 INTERSIVE WURSERY 12,403,588 12,403,		INPATIENT ROUTINE SERVICE COST CENTERS						
31.00 03100 INTERSIVE CARE UNIT 27,506,456 27,506,456 31.00 03100 INTERSIVE WURSERY 12,403,588 12,403,	30.00	03000 ADULTS & PEDI ATRI CS	82, 210, 974		82, 210, 97	4		30.00
25. 00 02040 INTERSIVE NURSERY 12, 403, 588 24, 601 3, 824, 601 41, 00 4100 4100 5400	31.00	1	1					31. 00
14. 00 04100 SUBPROVI DER - IFF 3, 824, 601 3, 824, 601 41. 00 43. 0			1					1
A3. 00 A3.00 NURSERY 5, 045, 579 5, 045, 579 43. 00 A3.00 A3.0		1						1
ANCILLARY SERVICE COST CENTERS SINCE COST CENTE		1	1 ' ' 1					
50.00	10.00		0,010,017		0,010,01	<u>' </u>		10.00
50.00 OSDO1 CARDI AC SURGERY 9,255,548 0 9,255,548 0 377506 0 000000 50.02 000000 50.02 000000 000000 50.02 000000 50.02 000000 000000 50.02 000000000000000000000000000000000	50 00		81 785 375	61 717 187	143 502 56	2 0 149865	0.00000	50 00
50, 02 05002 WSC 250, 000 99, 335, 206 99, 585, 206 0, 157403 0, 000000 50, 025 00 51, 00 05100 REOVERY ROOM 1, 764, 978 2, 519, 874 4, 284, 852 0, 621921 0, 000000 51, 00 51, 00 52, 00 520 05200 DELIVERY ROOM 1, 2795, 491 1, 247, 070 14, 042, 561 0, 492001 0, 000000 54, 00 55, 00 05500 RADIO ILOGY-THERAPEUTI C 1, 834, 422 31, 303, 189 33, 331, 100 47, 342, 383 0, 311668 0, 000000 54, 00 56, 00 05600 RADIO ILOGY-THERAPEUTI C 1, 834, 422 31, 303, 189 33, 331, 611 0, 243895 0, 000000 55, 00 057, 00 05700 CT SCAN 17, 003, 384 43, 080, 309 60, 083, 693 0, 058241 0, 000000 57, 00 05700 CT SCAN 17, 003, 384 43, 080, 309 60, 083, 693 0, 058241 0, 000000 57, 00 05900 CARDIAC CATHETERIZATION 26, 518, 270 68, 306, 442 94, 824, 712 0, 228918 0, 000000 59, 00 05900 CARDIAC CATHETERIZATION 26, 518, 270 68, 306, 442 94, 824, 712 0, 228918 0, 000000 59, 00 050000 050000 050000 05000 05000 050000 050000 05000 050000 050000 050000 05								1
S1 00 05100 RECOVERY ROOM			1	~				1
S1 02 05101 O/P TREATMENT ROOM								
S2.00 05200 05200 05200 05200 05400 Xabor Room 12,795,491 1,247,070 14,042,651 0.492001 0.000000 52.00 54.00 05400 RADI OLOGY-THERAPEUTI C 1,834,422 31,303,189 33,137,611 0.243895 0.000000 54.00 05500 RADI OLOGY-THERAPEUTI C 1,834,422 31,303,189 33,137,611 0.243895 0.000000 55.00 05500 RADI OLOGY-THERAPEUTI C 1,834,422 31,303,189 33,137,611 0.243895 0.000000 55.00 05500 RADI OLOGY-THERAPEUTI C 1,078,231 9,537,489 10,615,720 0.161468 0.000000 55.00 0.000000 0.00000 0.00000 0.00000 0.00000 0.00000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000		1	1					1
54.00 05400 RADI OLOGY-DI AGNOSTIC 10, 011, 283 37, 331, 100 47, 342, 383 0, 311468 0, 000000 54, 00 05500 RADI OLOGY-THERAPEUTI C 1, 834, 422 31, 303, 189 33, 137, 611 0, 243895 0, 000000 56, 00 05600 RADI OLOGY-THERAPEUTI C 1, 078, 231 9, 537, 489 10, 615, 720 0, 161468 0, 000000 56, 00 05600 RADIO I SOTOPE 1, 078, 231 9, 537, 489 10, 615, 720 0, 161468 0, 000000 56, 00 057, 00 07, 00 07, 00 0, 0000000 0, 000000 0, 000000 0, 000000 0, 000000 0, 000000 0, 000000 0, 000000 0, 000000 0, 000000 0, 000000 0, 000000 0, 000000 0, 000000 0, 000000 0, 000000 0, 0000000 0, 0000000 0, 0000000 0, 00000000								1
55.00 05500 RADI OLOGY-THERAPEUTI C 1, 834, 422 31, 303, 189 33, 137, 611 0, 243895 0, 000000 55.00 05600 05600 RADI OLOGY-THERAPEUTI C 1, 078, 231 9, 537, 489 10, 615, 720 0, 161468 0, 000000 57.00 05700 CT SCAN 17, 003, 384 43, 080, 309 60, 083, 693 0, 058241 0, 000000 57.00 05800 MARGNETI C RESONANCE I MAGI NG (MRI) 3, 266, 853 11, 966, 104 15, 232, 957 0, 149622 0, 000000 59.00 0, 000000 0, 000000 0, 000000 0, 000000 0, 000000 0, 000000 0, 000000 0, 000000 0, 000000 0, 0000000 0, 000000 0, 000000 0, 000000 0, 000000 0, 000000 0, 000000 0, 000000 0, 000000 0, 000000 0, 00000000								1
56. 00 05600 RABI OI SOTOPE 1, 078, 231 9, 537, 489 10, 615, 720 0. 1611468 0. 000000 55. 00 05700 CT SCAN 17, 003, 384 43, 080, 309 60, 083, 693 0. 058241 0. 000000 55. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 3, 266, 853 11, 966, 104 15, 232, 957 0. 149622 0. 000000 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 3, 266, 853 11, 966, 104 15, 232, 957 0. 149622 0. 000000 59. 00 0. 000000 CARDI AC CATHETERI ZATI ON 26, 518, 270 68, 306, 442 94, 824, 712 0. 228918 0. 000000 69. 00 0. 000000 62. 00 0. 000000 62. 00 0. 000000 62. 00 0. 000000 62. 00 0. 000000 0. 000000 62. 00 0. 000000 0. 000000 62. 00 0. 000000 0. 000000 62. 00 0. 000000 0. 000000 62. 00 0. 000000 0. 000000 62. 00 0. 000000 0. 000000 63. 00 0. 000000 0. 000000 0. 000000 64. 00 0. 000000								
57. 00 05700 CT SCAN 17, 003, 384 43,080, 309 60,083, 693 0. 058241 0. 000000 57. 00 58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 3, 266, 853 11, 966, 104 15, 232, 957 0. 149622 0. 000000 58. 00 05900 CARDIJAC CATHETERI ZATION 26, 518, 270 68, 306, 442 94, 824, 712 0. 228918 0. 000000 59. 00 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 00000								1
58.00 05800 MAGNETIC RESONANCE I MAGI NG (MRI) 3, 266, 853 11, 966, 104 15, 232, 957 0. 149622 0. 000000 58.00 05900 CARDI AC CATHETERI ZATI ON 26, 518, 270 68, 306, 442 94, 824, 712 0. 228918 0. 0000000 59.00 0. 0000000 0. 0000000 0. 00000000								1
59.00 05900 CARDI AC CATHETERIZATION 26, 518, 270 68, 306, 442 94, 824, 712 0. 228918 0. 000000 59.00 60.0			1 ' ' 1					1
60.00 06000 LABORATORY 37, 262, 967 40, 934, 196 78, 197, 163 0. 140180 0. 000000 60. 00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 2, 319, 106 569, 180 2, 888, 286 0. 644521 0. 000000 62. 00 65.00 06500 RESPI RATORY THERAPY 6, 049, 999 4, 378, 503 10, 428, 502 0. 349755 0. 000000 66. 00 66.01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0. 000000 0. 000000 66. 01 66.02 06602 OP PHYSI CAL THERAPY 0, 6, 363, 160 6, 363, 160 0. 383813 0. 000000 66. 01 67.00 06700 0CCUPATI ONAL THERAPY 3, 942, 563 2, 602, 679 6, 545, 242 0. 256586 0. 000000 67. 00 68.00 06800 SPEECH PATHOLOGY 1, 009, 073 976, 548 1, 985, 621 0. 400740 0. 000000 68. 00 69.01 06901 CARDI ACREHAB 199, 376 985, 376 1, 184, 752 0. 796633 0. 000000 69. 01 70.00 07000 ELECTROENCEPHALOGRAPHY 1, 200, 919 3, 344, 517 4, 545, 436 0. 401919 0. 000000 70. 00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 2, 444, 939 154, 277 2, 599, 216 0. 599708 0. 000000 71. 00 72.00 07200 DRUGS CHARGED TO PATI ENTS 8, 568, 470 10, 093, 295 18, 661, 765 0. 613765 0. 000000 76. 00 72.00 07200 DRUGS CHARGED TO PATI ENTS 8, 568, 470 10, 093, 295 18, 661, 765 0. 554852 0. 000000 76. 00 76.00 07000 DRUGS CHARGED TO PATI ENTS 8, 568, 470 10, 093, 295 18, 661, 765 0. 554852 0. 000000 76. 00 77.00 07000 DRUGS CHARGED TO PATI ENTS 8, 568, 470 10, 093, 295 18, 661, 765 0. 554852 0. 000000 76. 00 78.00 07000 DRUGS CHARGED TO PATI ENTS 8, 568, 470 10, 093, 295 18, 661, 765 0. 554852 0. 000000 76. 00 78.00 07000 DRUGS CHARGED TO PATI ENTS 8, 568, 470 10, 093, 295 18, 661, 765 0. 599708 0. 000000 76. 00 78.00 07000 DRUGS CHARGED TO PATI ENTS 3, 358, 594 387, 372 3, 745, 966 0. 554852 0. 000000 90. 00 78.00 07000 07000 07000 07000 07000 07000 07000 07000 07000			1 ' ' 1					
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 2, 319, 106 569, 180 2, 888, 286 0. 644521 0. 000000 62. 00 65. 00 06500 RESPIRATORY THERAPY 13, 128, 148 1, 223, 268 14, 351, 416 0. 387182 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 OCCUPATI ONAL THERAPY 0 6, 363, 160 6, 363, 160 0. 383813 0. 000000 66. 01 67. 00 06700 0CCUPATI ONAL THERAPY 3, 942, 563 2, 602, 679 6, 545, 242 0. 256586 0. 000000 67. 00 69. 00 06900								
65. 00 06500 RESPI RATORY THERAPY 13, 128, 148 1, 223, 268 14, 351, 416 0. 387182 0. 000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 6, 049, 999 4, 378, 503 10, 428, 502 0. 349755 0. 000000 66. 00 66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0. 000000 66. 01 66. 02 06602 0/P PHYSI CAL THERAPY 0 6, 363, 160 6, 363, 160 0. 383813 0. 000000 66. 02 67. 00 06700 0CCUPATI ONAL THERAPY 3, 942, 563 2, 602, 679 6, 545, 242 0. 256586 0. 000000 67. 00 68. 00 06800 SPECH PATHOLOGY 1, 009, 073 976, 548 1, 985, 621 0. 400740 0. 000000 68. 00 69. 01 06901 CARDI AC REHAB 199, 376 985, 376 1, 184, 752 0. 796633 0. 000000 69. 01 70. 00 07000 ELECTROENCEPHALOGRAPHY 1, 200, 919 3, 344, 517 4, 545, 436 0. 401919 0. 000000 71. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 2, 444, 939 154, 277 2, 599, 216 0. 599708 0. 000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 8, 568, 470 10, 093, 295 18, 661, 765 0. 613765 0. 000000 73. 00 74. 00 07300 DRUGS CHARGED TO PATI ENTS 64, 532, 054 117, 249, 817 181, 781, 871 0. 226677 0. 000000 73. 00 74. 00 07000 CLI NI C 0. 000000 0. 000000 0. 000000 0. 0000000 0. 00000000				40, 934, 196				
66. 00 06600 PHYSI CAL THERAPY 6, 049, 999 4, 378, 503 10, 428, 502 0. 349755 0. 000000 66. 00 0. 0000000 0. 0000000 66. 01 0. 0000000 0. 0000000 66. 01 0. 0000000 0. 0000000 66. 01 0. 0000000 0. 0000000 66. 01 0. 0000000 0. 0000000 66. 01 0. 0000000 0. 0000000 66. 01 0. 0000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000	62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	2, 319, 106	569, 180	2, 888, 28	6 0. 644521	0. 000000	62. 00
66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 0 0 0 0	65.00	06500 RESPI RATORY THERAPY	13, 128, 148	1, 223, 268	14, 351, 41			65. 00
66. 02 06602 0/P PHYSI CAL THERAPY 0 6, 363, 160 0.383813 0.000000 66. 02 67. 00 06700 0CCUPATI ONAL THERAPY 3, 942, 563 2, 602, 679 6, 545, 242 0.256586 0.000000 67. 00 680.0 06800 SPEECH PATHOLOGY 1, 009, 073 976, 548 1, 985, 621 0.400740 0.000000 68. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 01 06901 CARDI AC REHAB 199, 376 985, 376 1, 184, 752 0.796633 0.00000 69. 01 70. 00 07000 ELECTROEARDI OLOGY 9, 010, 862 7, 309, 543 16, 320, 405 0.190550 0.00000 69. 01 70. 00 07000 ELECTROENCEPHALOGRAPHY 1, 200, 919 3, 344, 517 4, 545, 436 0.401919 0.000000 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 2, 444, 939 154, 277 2, 599, 216 0.599708 0.000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 8, 568, 470 10, 093, 295 18, 661, 765 0.613765 0.000000 73. 00 07300 DRUGS CHARGED TO PATI ENTS 64, 532, 054 117, 249, 817 181, 781, 871 0.226677 0.000000 73. 00 07300 DRUGS CHARGED TO PATI ENTS 64, 532, 054 117, 249, 817 181, 781, 871 0.226677 0.000000 73. 00 07300 DRUGS CHARGED TO PATI ENTS 64, 532, 054 117, 249, 817 181, 781, 871 0.226677 0.000000 73. 00 07300 DRUGS CHARGED TO PATI ENTS 64, 532, 054 117, 249, 817 181, 781, 871 0.226677 0.000000 73. 00 07300 DRUGS CHARGED TO PATI ENTS 64, 532, 054 117, 249, 817 181, 781, 871 0.226677 0.000000 73. 00 07300 DRUGS CHARGED TO PATI ENTS 64, 532, 054 117, 249, 817 181, 781, 871 0.226677 0.000000 73. 00 07300 DRUGS CHARGED TO PATI ENTS 64, 532, 054 117, 249, 817 181, 781, 871 10.226677 0.000000 73. 00 07300 DRUGS CHARGED TO PATI ENTS 64, 532, 054 117, 249, 817 181, 781, 871 10.226677 0.000000 90. 00 00 00 00 00 00 00 00 00 00 00 00 0	66.00	06600 PHYSI CAL THERAPY	6, 049, 999	4, 378, 503	10, 428, 50	2 0. 349755	0.000000	66.00
67. 00	66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0)	0. 000000	0.000000	66. 01
68. 00 06800 SPEECH PATHOLOGY 1,009,073 976,548 1,985,621 0.400740 0.000000 68. 00 69. 00 69. 00 69. 00 69. 01 6	66. 02	06602 0/P PHYSI CAL THERAPY	0	6, 363, 160	6, 363, 16	0. 383813	0.000000	66. 02
68. 00 06800 SPEECH PATHOLOGY 1,009,073 976,548 1,985,621 0.400740 0.000000 68. 00 69. 00 69. 00 69. 00 69. 01 6	67.00	06700 OCCUPATI ONAL THERAPY	3, 942, 563	2, 602, 679	6, 545, 24	2 0. 256586	0.000000	67. 00
69. 00	68.00	06800 SPEECH PATHOLOGY		976, 548	1, 985, 62	1 0. 400740	0. 000000	68. 00
69. 01	69. 00	06900 FLECTROCARDI OLOGY	9, 010, 862				0. 000000	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 1, 200, 919 3, 344, 517 4, 545, 436 0. 401919 0. 000000 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 2, 444, 939 154, 277 2, 599, 216 0. 599708 0. 000000 71. 00 72. 00 07200 MPL. DEV. CHARGED TO PATI ENTS 8, 568, 470 10, 093, 295 18, 661, 765 0. 613765 0. 000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 64, 532, 054 117, 249, 817 181, 781, 871 0. 226677 0. 000000 73. 00 03020 RENAL ACUTE 0. 000000 74. 00 03020 RENAL ACUTE 0. 0000000 74. 00 0. 000000 75. 00 09000 CLI NI C 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 0000000 0. 00000000								
71. 00			1					1
72. 00			1					1
73. 00 07300 DRUGS CHARGED TO PATIENTS 64,532,054 117,249,817 181,781,871 0.226677 0.000000 73.00 03020 RENAL ACUTE 3,358,594 387,372 3,745,966 0.554852 0.000000 76.0								
76. 00 03020 RENAL ACUTE 3, 358, 594 387, 372 3, 745, 966 0. 554852 0. 000000 76. 00								
90. 00 OPO00 CLINIC OP000 CLINIC OP000 OP0000 OP00000 OP00000 OP00000 OP00000 OP000000 OP000000 OP000000 OP0000000 OP0000000 OP0000000 OP0000000 OP0000000 OP0000000000								
90. 00 09000 CLINIC 1,962 553,331 555,293 0.673081 0.000000 90.00 90	76.00		3, 330, 394	301, 312	3, 743, 90	0, 334632	0.000000	76.00
90. 05 09005 PATI ENT NUTRI TI ON 0 299, 412 299, 412 1.969136 0.000000 90. 05 90. 07 90. 07 90. 07 90. 07 90. 07 90. 07 90. 07 90. 07 90. 07 90. 07 90. 07 90. 07 90. 07 90. 07 90. 07 90. 07 90. 07 90. 00 90. 07 90. 0	00 00		1 0/3	EE2 221	FEE 20	2 0 (72001	0.000000	00 00
90. 07 09007 WOUND CLINIC 10,000 5,068,016 5,078,016 0.351021 0.000000 90.07 91.00 09100 EMERGENCY 23,736,858 82,715,648 106,452,506 0.130926 0.000000 91.00 92.00 09200 09500			1 ' 1					1
91. 00 09100 EMERGENCY 23,736,858 82,715,648 106,452,506 0.130926 0.000000 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 1,806,126 475,197,483 672,205,006 1,147,402,489 201. 00 2			1					
92. 00 09200 085ERVATI ON BEDS (NON-DISTINCT PART) 1,806,126 17,034,922 18,841,048 0.452781 0.000000 92.00 200.00 201.00 Less Observation Beds 475,197,483 672,205,006 1,147,402,489 201.00		1	1 ' 1					1
200.00 Subtotal (see instructions) 475, 197, 483 672, 205, 006 1, 147, 402, 489 200.00 Less Observation Beds 200.00								
201.00 Less Observation Beds 201.00			1 ' ' 1				0. 000000	
			475, 197, 483	672, 205, 006	1, 147, 402, 48	9		
202.00 Total (see instructions) 475, 197, 483 672, 205, 006 1, 147, 402, 489 202.00		1						
	202.00	Total (see instructions)	475, 197, 483	672, 205, 006	1, 147, 402, 48	9		202. 00

Health Financial Systems	UNION HOSPITAL,	I NC.	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 150023	Peri od: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepared: 5/25/2016 10:01 am

				5/25/2016 10:01 am
		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				
50. 00 05000 0PERATING ROOM	0. 149865			50.00
50. 01 05001 CARDI AC SURGERY	0. 377506			50. 01
50. 02 05002 WVSC	0. 157403			50. 02
51. 00 05100 RECOVERY ROOM	0. 621921			51.00
51. 02 05100 RECOVERT ROOM 51. 02 05101 0/P TREATMENT ROOM	1			51.00
	1. 468984			
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0. 492001			52.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0. 311746			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 243895			55. 00
56. 00 05600 RADI OI SOTOPE	0. 161468			56. 00
57. 00 05700 CT SCAN	0. 058241			57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 149622			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 228918			59. 00
60. 00 06000 LABORATORY	0. 140757			60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 644521			62. 00
65. 00 06500 RESPI RATORY THERAPY	0. 387182			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 349755			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. 383813			66. 02
67. 00 06700 OCCUPATI ONAL THERAPY	0. 256586			67. 00
68.00 06800 SPEECH PATHOLOGY	0. 400740			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 190550			69. 00
69. 01 06901 CARDI AC REHAB	0. 796633			69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 401919			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 599708			71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 613765			72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 226677			73.00
76. 00 03020 RENAL ACUTE	0. 554852			76. 00
OUTPATIENT SERVICE COST CENTERS	0.007002			75. 60
90. 00 09000 CLINIC	0. 673081			90.00
90. 05 09005 PATI ENT NUTRI TI ON	1. 980088			90.05
90. 07 09007 WOUND CLINIC	0. 351021			90.03
1 I	1			90.07
91. 00 09100 EMERGENCY	0. 130926			
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART)	0. 452781			92.00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)	I I			202. 00

					10 12/31/2015	5/25/2016 10:	
			Tit	le XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	μ	(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	52, 725, 801		52, 725, 80	1 8, 777	52, 734, 578	30. 00
	03100 INTENSIVE CARE UNIT	12, 679, 540		12, 679, 54		12, 679, 540	
	02040 I NTENSI VE NURSERY	3, 406, 817	l e	3, 406, 81		3, 406, 817	35. 00
	04100 SUBPROVI DER - I RF	4, 412, 569		4, 412, 56		4, 412, 569	
	04300 NURSERY	1, 915, 153		1, 915, 15		1, 915, 153	
	ANCILLARY SERVICE COST CENTERS	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		., ., ., .,		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
50.00	05000 OPERATING ROOM	21, 506, 042		21, 506, 04	2 0	21, 506, 042	50. 00
50. 01	05001 CARDI AC SURGERY	3, 494, 028	l e	3, 494, 02		3, 494, 028	50. 01
50. 02	05002 WVSC	15, 675, 007	l e	15, 675, 00		15, 675, 007	50. 02
51. 00	05100 RECOVERY ROOM	2, 664, 840		2, 664, 84		2, 664, 840	
51. 02	05101 0/P TREATMENT ROOM	5, 403, 527	l e	5, 403, 52		5, 403, 527	51. 02
52. 00	05200 DELIVERY ROOM & LABOR ROOM	6, 908, 957	l e	6, 908, 95		6, 908, 957	52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	14, 756, 058		14, 756, 05		14, 758, 783	
55. 00	05500 RADI OLOGY-THERAPEUTI C	8, 082, 085	l	8, 082, 08		8, 082, 085	55. 00
56. 00	05600 RADI OI SOTOPE	1, 714, 095	l .	1, 714, 09		1, 714, 095	56. 00
	05700 CT SCAN	3, 499, 332	l .	3, 499, 33		3, 499, 332	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	2, 279, 192		2, 279, 19		2, 279, 192	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	21, 707, 037		21, 707, 03		21, 707, 037	59. 00
60. 00	06000 LABORATORY	10, 961, 690		10, 961, 69		11, 006, 781	60. 00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 861, 562		1, 861, 56		1, 861, 562	62. 00
65. 00	06500 RESPIRATORY THERAPY	5, 556, 612				5, 556, 612	65. 00
66. 00	06600 PHYSI CAL THERAPY	3, 647, 421	0			3, 647, 421	66. 00
66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	3,047,421	1		0 0	0,047,421	66. 01
66. 02	06602 O/P PHYSI CAL THERAPY	2, 442, 264			-	2, 442, 264	
67. 00	06700 OCCUPATI ONAL THERAPY	1, 679, 418	l e	, , , , ,		1, 679, 418	67. 00
68. 00	06800 SPEECH PATHOLOGY	795, 718				795, 718	
69. 00	06900 ELECTROCARDI OLOGY	3, 109, 847	0	3, 109, 84		3, 109, 847	69. 00
69. 01	06901 CARDI AC REHAB	943, 812		943, 81		943, 812	69. 01
	07000 ELECTROENCEPHALOGRAPHY	1, 826, 899	l e	1, 826, 89		1, 826, 899	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 558, 770		1, 558, 77		1, 558, 770	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	11, 453, 937		11, 453, 93		11, 453, 937	71.00
	07300 DRUGS CHARGED TO PATIENTS	41, 205, 720		41, 205, 72		41, 205, 720	
	03020 RENAL ACUTE	2, 078, 458	l e	2, 078, 45		2, 078, 458	
70.00	OUTPATIENT SERVICE COST CENTERS	2,070,430		2,070,43	0	2,070,430	70.00
90. 00	09000 CLINIC	373, 757		373, 75	7 0	373, 757	90. 00
	09005 PATIENT NUTRITION	589, 583	l e	589, 58		592, 862	90.00
90. 03	09007 WOUND CLINIC	1, 782, 489		1, 782, 48	•	1, 782, 489	
	09100 EMERGENCY	13, 937, 406		13, 937, 40		13, 937, 406	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	8, 530, 865		8, 530, 86		8, 530, 865	
200.00		297, 166, 308	l .			297, 226, 180	
200.00		8, 530, 865		8, 530, 86		8, 530, 865	
201.00		288, 635, 443					
202.00		200, 000, 440	1	200, 000, 44	J7, J72	200, 070, 010	202.00

						5/25/2016 10:	01 am
			Ti t	le XIX	Hospi tal	Cost	
	·		Charges				
	Cost Center Description	Inpati ent	Outpati ent	Total (col.	Cost or Other	TEFRA	
	'	'	•	+ col. 7)	Ratio	Inpati ent	
				<u> </u>		Rati o	
		6.00	7. 00	8.00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	·		•	<u>'</u>		
30.00	03000 ADULTS & PEDIATRICS	82, 210, 974		82, 210, 97	4		30.00
31.00	03100 INTENSIVE CARE UNIT	27, 506, 456		27, 506, 45	6		31.00
35. 00	02040 I NTENSI VE NURSERY	12, 403, 588		12, 403, 58			35. 00
41. 00	04100 SUBPROVI DER - I RF	3, 824, 601		3, 824, 60			41.00
43.00	04300 NURSERY	5, 045, 579		5, 045, 57			43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	81, 785, 375	61, 717, 187	143, 502, 56	2 0. 149865	0.000000	50.00
50. 01	05001 CARDI AC SURGERY	9, 255, 548	0			0.000000	1
50. 02	05002 WVSC	250,000	99, 335, 206			0.000000	1
51. 00	05100 RECOVERY ROOM	1, 764, 978	2, 519, 874			0.000000	1
51. 02	05101 O/P TREATMENT ROOM	60, 434	3, 617, 976			0.000000	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	12, 795, 491	1, 247, 070			0.000000	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	10, 011, 283	37, 331, 100			0. 000000	•
55. 00	05500 RADI OLOGY-THERAPEUTI C	1, 834, 422	31, 303, 189			l	•
56. 00	05600 RADI OI SOTOPE	1, 078, 231	9, 537, 489			0. 000000	
57. 00	05700 CT SCAN	17, 003, 384	43, 080, 309			0. 000000	1
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	3, 266, 853	11, 966, 104			0. 000000	ł
59. 00	05900 CARDI AC CATHETERI ZATI ON	26, 518, 270	68, 306, 442			•	1
60. 00	06000 LABORATORY	37, 262, 967	40, 934, 196			0. 000000	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	2, 319, 106	569, 180			0. 000000	1
65. 00	06500 RESPIRATORY THERAPY	13, 128, 148	1, 223, 268			0. 000000	1
66. 00	06600 PHYSI CAL THERAPY	6, 049, 999	4, 378, 503			0. 000000	
66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0,047,777	4, 370, 303		0.000000	0. 000000	1
66. 02	06602 0/P PHYSI CAL THERAPY		6, 363, 160	1		0. 000000	1
67. 00	06700 OCCUPATIONAL THERAPY	3, 942, 563	2, 602, 679			0. 000000	1
68. 00	06800 SPEECH PATHOLOGY	1, 009, 073	976, 548			0. 000000	1
69. 00	06900 ELECTROCARDI OLOGY	9, 010, 862	7, 309, 543			0. 000000	•
69. 01	06901 CARDI AC REHAB	199, 376	985, 376			0.000000	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	1, 200, 919	3, 344, 517			l	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 444, 939	154, 277			0.000000	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	8, 568, 470	10, 093, 295			0. 000000	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	64, 532, 054	117, 249, 817			0.00000	
76. 00	03020 RENAL ACUTE	3, 358, 594	387, 372			0.00000	1
70.00	OUTPATIENT SERVICE COST CENTERS	3, 330, 374	307, 372	. 3, 743, 70	0. 554652	0.000000	70.00
90. 00	09000 CLINIC	1, 962	553, 331	555, 29	3 0. 673081	0.000000	90.00
90.00	09005 PATIENT NUTRITION	1, 962	299, 412			0.00000	1
90.03	09007 WOUND CLINIC	10,000	5, 068, 016			0.00000	1
91.00	09100 EMERGENCY	23, 736, 858	82, 715, 648			0.00000	1
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 806, 126	17, 034, 922			0.00000	1
200.00	,	475, 197, 483		1, 147, 402, 48		0.00000	200.00
200.00	, ,	4/3, 197, 483	072, 200, 000	1, 147, 402, 48	7		200.00
201.00	1	475, 197, 483	672 205 004	1, 147, 402, 48	0		201.00
202.00	Tiorai (See Histiactions)	4/3, 19/, 483	012, 200, 000	η ι, ι47, 402, 48	7	I	₁ 202.00

Health Financial Systems	UNION HOSPITAL,	I NC.	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150023	From 01/01/2015	Worksheet C Part I Date/Time Prepared: 5/25/2016 10:01 am

			, , , , , , , , , , , , , , , , , , , ,	5/25/2016 10:01 am
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31. 00 03100 I NTENSI VE CARE UNIT				31.00
35. 00 02040 I NTENSI VE NURSERY				35. 00
41. 00 04100 SUBPROVI DER - RF				41.00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 000000			50.00
50. 01 05001 CARDI AC SURGERY	0. 000000			50. 01
50. 02 05002 WVSC	0. 000000			50. 02
51. 00 05100 RECOVERY ROOM	0. 000000			51.00
51. 02 05101 0/P TREATMENT ROOM	0. 000000			51. 02
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			55. 00
56. 00 05600 RADI OI SOTOPE	0. 000000			56.00
57. 00 05700 CT SCAN	0. 000000			57.00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.00
60. 00 06000 LABORATORY	0. 000000			60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			62.00
65. 00 06500 RESPIRATORY 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 PATI ENT NUTRI TI ON	0. 000000			90. 05
90. 07 09007 WOUND CLI NI C	0. 000000			90. 07
91. 00 09100 EMERGENCY	0. 000000			91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00
	į į			,202. 0

Heal th	Financial Systems	UNION HOSPI	TAL, INC.		In Lie	u of Form CMS-2	2552-10
APPORTI	ONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS		!	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part I Date/Time Prep 5/25/2016 10:0	
				e XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient		
		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						
	ADULTS & PEDIATRICS	9, 307, 115	0	9, 307, 11		163. 44	
31.00	INTENSIVE CARE UNIT	1, 660, 133		1, 660, 13	9, 032	183. 81	31. 00
35. 00	INTENSIVE NURSERY	285, 975		285, 97	5 3, 528	81. 06	35. 00
41.00	SUBPROVI DER - I RF	874, 774	0	874, 77	4 3, 899	224. 36	41.00
43.00	NURSERY	175, 037		175, 03	7 3, 606	48. 54	43.00
200.00	Total (lines 30-199)	12, 303, 034		12, 303, 03	4 77, 010		200. 00
	Cost Center Description	I npati ent	I npati ent				
		Program days	Program				
			Capital Cost				
			(col. 5 x col.				
			6)				
		6.00	7. 00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDI ATRI CS	24, 539	4, 010, 654				30. 00
31.00	INTENSIVE CARE UNIT	5, 360	985, 222				31.00
35. 00	I NTENSI VE NURSERY	0	0				35. 00
41.00	SUBPROVI DER - I RF	2, 719	610, 035				41.00
43.00	NURSERY	0	0				43.00
200. 00	Total (lines 30-199)	32, 618	5, 605, 911				200. 00

				From 01/01/2015 Fo 12/31/2015	Part II Date/Time Pre 5/25/2016 10:	pared: 01 am
			e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges		I npati ent	Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		(col. 1 ÷ col.	Charges	column 4)	
	Part II, col.	8)	2)			
	26)	0.00		1.00		
ANOLLI ADV. CEDIU OF COCT. OFNITEDO	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	4 525 004	142 502 5/2	0.001/0	41 500 (10	1 214 5/5	
	4, 535, 804					1
50. 01 05001 CARDI AC SURGERY 50. 02 05002 WVSC	340, 438					50. 01
	1, 942, 550					50. 02
	140, 003					1
	1, 081, 887				1	51. 02
52. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 179, 747		0. 084013		164, 456	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 864, 142					1
55. 00 05500 RADI OLOGY-THERAPEUTI C	2, 363, 280					55. 00
56. 00 05600 RADI OI SOTOPE	131, 980					56.00
57. 00 05700 CT SCAN	413, 004					57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	837, 088			, ,		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 917, 218					59.00
60. 00 06000 LABORATORY	45, 652					60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	4, 774					62.00
65. 00 06500 RESPI RATORY THERAPY	737, 593					65.00
66. 00 06600 PHYSI CAL THERAPY	439, 211					66. 00
66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	ļ	0.0000			66. 01
66. 02 06602 0/P PHYSI CAL THERAPY	418, 380				0	66. 02
67. 00 06700 OCCUPATI ONAL THERAPY	80, 598					67.00
68. 00 06800 SPEECH PATHOLOGY	165, 840		0. 083520		36, 386	68. 00
69. 00 06900 ELECTROCARDI OLOGY	434, 154					69.00
69. 01 06901 CARDI AC REHAB	313, 913					69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	153, 817				24, 139	70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	417, 106					71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	22, 973					72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 445, 018					73.00
76. 00 03020 RENAL ACUTE OUTPATIENT SERVICE COST CENTERS	141, 863	3, 745, 966	0. 03787	2, 209, 392	83, 672	76. 00
	10.15/	TEE 202	0.01000			00.00
	10, 156					90.00
90. 05 09005 PATI ENT NUTRI TI ON	79, 012					90.05
90. 07 09007 WOUND CLINIC 91. 00 09100 EMERGENCY	181, 512 1, 374, 364					90. 07 91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						ł
	1, 505, 612					92.00
200.00 Total (lines 50-199)	25, / 18, 689	1, 016, 411, 291	l	175, 475, 543	4, 021, 597	J∠UU. UU

Health Financial Customs	TINI ON TIOSDI	TAL LNC		ا ما	eu of Form CMS-2	DEED 10
Health Financial Systems APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	UNI ON HOSPI		CCN: 150023	Period:	Worksheet D	2552-10
APPORTIONWENT OF INPATTENT ROUTINE SERVICE OTHER PA	33 THROUGH CUS	13 Provider		From 01/01/2015		
				To 12/31/2015	Date/Time Pre	
					5/25/2016 10:	01 am_
	L		e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health		Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos		1 through 3,	
	1. 00	2.00	3.00	4. 00	minus col. 4) 5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00 03000 ADULTS & PEDIATRICS			1		0	30.00
31. 00 03100 NTENSI VE CARE UNI T	0			0	0	31.00
35. 00 02040 NTENSI VE NURSERY	0			0	0	35.00
41. 00 04100 SUBPROVI DER - I RF	0			0	0	41. 00
43. 00 04300 NURSERY	0			0	0	43.00
200.00 Total (lines 30-199)	0			0	_	200.00
Cost Center Description	Total Patient	Per Diem (col.	Inpati ent	Inpati ent	U	200.00
cost center bescription	Days	5 ÷ col. 6)	Program Days			
	Days	J + COI . 0)	Trogram bays	Pass-Through		
				Cost (col. 7 x		
				col. 8)		
	6, 00	7.00	8. 00	9, 00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	56, 945	0.00	24, 53	9 0		30.00
31.00 03100 INTENSIVE CARE UNIT	9, 032	0.00	5, 36	0 0		31.00
35. 00 02040 I NTENSI VE NURSERY	3, 528		1	o o		35. 00
41. 00 04100 SUBPROVI DER - RF	3, 899	l .	l	9 0		41.00
43. 00 04300 NURSERY	3, 606			o o		43. 00
200.00 Total (lines 30-199)	77, 010		32, 61	8 0		200. 00
	•	•	•	•	•	•

Health Financial Systems	UNION HOSPITAL, INC.	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS Provider CCN: 150023	Peri od: Worksheet D From 01/01/2015 Part IV To 12/31/2015 Date/Time Prepared:

Non Physician Anesthetist Non Physician Anesthetist Non Physician Anesthetist Cost Center Description Non Physician Anesthetist Non Physician Anesthetist Cost Allied Health Anesthetist Cost				'	0 12/31/2013	5/25/2016 10:	
ANCILLARY SERVICE COST CENTERS			Ti tl	e XVIII	Hospi tal	PPS	
ANCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00	Cost Center Description	Non Physician I	Nursing School	Allied Health	All Other	Total Cost	
ANCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00		Anesthetist	Ŭ		Medi cal	(sum of col 1	
NOCLLARY SERVICE COST CENTERS		Cost			Education Cost	through col.	
ANCILLARY SERVICE COST CENTERS						4)	
50.00 05000 05000 05000 0 0 0		1.00	2.00	3. 00	4. 00	5. 00	
50. 01 05001 CARDI AC. SURGERY 0 0 0 0 0 50. 01	ANCILLARY SERVICE COST CENTERS						
50. 02 05002 WYSC	50. 00 05000 OPERATING ROOM	0	0	0	0	0	50.00
51. 00 05100 RECOVERY ROOM 0 0 0 0 0 0 51. 00	50. 01 05001 CARDI AC SURGERY	0	0	0	0	0	50. 01
51.02 OS101 O/P TREATMENT ROOM	50. 02 05002 WVSC	0	0	0	o	0	50. 02
52.00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 0 0 0 52.00	51.00 05100 RECOVERY ROOM	0	0	0	o	0	51.00
54.00 05400 RADI OLOGY-DI AGNOSTIC 0 0 0 0 201,875 0 201,875 54.00 05500	51.02 05101 0/P TREATMENT ROOM	0	0	0	o	0	51. 02
55.00 05500 RADI OLOGY_THERAPEUTI C	52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	o	0	52. 00
55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 55.00	54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	201, 875	o	201, 875	54.00
57. 00 05700 CT SCAN 0 0 0 0 0 0 0 57. 00 58. 00 05800 MAGNETII C RESONANCE I MAGI NG (MRI) 0 0 0 0 0 0 0 58. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 0 0 0 59. 00 06. 00 06000 LABORATORY 0 0 0 0 0 0 0 0 0	55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0	o	0	55. 00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 0 0 58. 00 59. 00 05900 CARDIAC CATHETERIZATION 0 0 0 0 0 59. 00 60. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 0 62. 00 65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 66. 00 66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 0 0 66. 01 66. 02 06602 PPSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 0 66. 01 66. 02 06602 JP PHYSI CAL THERAPY 0 0 0 0 0 0 0 66. 01 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0	56. 00 05600 RADI 0I SOTOPE	0	0	0	o	0	56. 00
59.00 05900 CARDI AC CATHETERI ZATION 0 0 0 0 0 0 0 0 0	57. 00 05700 CT SCAN	o	0	0	o	0	57. 00
59.00 05900 CARDI AC CATHETERI ZATION 0 0 0 0 0 0 0 0 0	58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	o	0	0	o	0	58. 00
60. 00 06000 LABORATORY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		o	0	0	o	0	
62. 00		o	0	0	o	0	
65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 0 0 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 66. 00 066. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		o	0	0	o	0	62.00
66. 00		o	0	0	o	0	
66. 01		o	0	0	o	0	
66. 02 06602 0/P PHYSI CAL THERAPY 0 0 0 0 0 0 0 66. 02 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 68. 00 69. 00 69. 00 69. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		o	0	0	o	0	
67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 67. 00 68. 00 68. 00 69. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 68. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 0 0 0 0 0 0 69. 00 69. 00 69. 01		o	0	0	o	0	
68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 68. 00 69. 00 6		o	0	0	o	0	
69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 69. 00 69. 01 06901 CARDI AC REHAB 0 0 0 0 0 0 69. 01 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 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 0 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 361, 044 73. 00 76. 00 03020 RENAL ACUTE 0 0 0 0 0 0UTPATIENT SERVICE COST CENTERS 90. 00 09000 CLI NI C 0 0 0 0 0 90. 05 09005 PATIENT NUTRI TI ON 0 0 0 0 0 90. 07 09007 WOUND CLI NI C 0 0 0 0 90. 07 09007 WOUND CLI NI C 0 0 0 91. 00 09100 EMERGENCY 0 0 0 0 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART)	68. 00 06800 SPEECH PATHOLOGY	o	0	0	ol	0	68. 00
69. 01		0	0	0	0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 70. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 72. 00 72. 00 73.		o	0	0	o	0	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 72. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 361, 044 0 361, 044 73. 00 076. 00 0 0 0 0 0 0 0 0 0		o	0	0	o	0	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 72. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 361, 044 0 361, 044 73. 00 076. 00 0 0 0 0 0 0 0 0 0	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0	0	o	0	71. 00
76. 00 03020 RENAL ACUTE 0 0 0 0 0 0 76. 00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	o	0	0	o	0	72. 00
76. 00 03020 RENAL ACUTE 0 0 0 0 0 0 76. 00	73.00 07300 DRUGS CHARGED TO PATIENTS	o	0	361, 044	o	361, 044	73. 00
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 0 0 0 90.00		o	0		o	•	76. 00
90. 00 09000 CLINIC 0 0 0 0 0 90. 00 90					-1		
90. 05 09005 PATIENT NUTRITION		0	0	0	0	0	90.00
91. 00 09100 EMERGENCY	90. 05 09005 PATIENT NUTRITION	o	0	0	o	0	90. 05
91. 00 09100 EMERGENCY	90. 07 09007 WOUND CLINIC	o	0	0	ol	0	90. 07
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 92.00			0	0	ol	0	
		0	0	0	o	0	
		0	0	562, 919	o	562, 919	

Health Financial Systems	UNION HOSPITAL,	INC.	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 150023	Peri od: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/25/2016 10:01 am

TTIKOOC	00313			j	To 12/31/2015	Date/Time Pre 5/25/2016 10:	pared: 01 am
			Ti tl	e XVIII	Hospi tal	PPS	<u> </u>
	Cost Center Description	Total	Total Charges	Ratio of Cost	Outpati ent	Inpati ent	
		Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
		Cost (sum of	Part I, col.	(col. 5 ÷ col.	to Charges	Charges	
		col. 2, 3 and	8)	7)	(col. 6 ÷ col.	, and the second	
		4)			7)		
		6.00	7. 00	8. 00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0					1
50. 01	05001 CARDI AC SURGERY	0	9, 255, 548			5, 473, 300	50. 01
50. 02	05002 WVSC	0	99, 585, 206			78, 559	50. 02
51.00	05100 RECOVERY ROOM	0	4, 284, 852	0.000000	0. 000000	1, 008, 905	51.00
51. 02	05101 O/P TREATMENT ROOM	0	3, 678, 410	0. 000000	0. 000000	26, 237	51. 02
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	14, 042, 561	0.000000	0. 000000	1, 957, 527	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	201, 875	47, 342, 383	0. 004264	0. 004264	5, 867, 596	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	33, 137, 611	0.000000	0.000000	922, 109	55. 00
56.00	05600 RADI OI SOTOPE	0	10, 615, 720	0.000000	0.000000	489, 874	56.00
57.00	05700 CT SCAN	0	60, 083, 693	0.000000	0.000000	9, 167, 068	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	15, 232, 957	0.000000	0.000000	1, 557, 309	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	94, 824, 712	0.000000	0.000000	12, 639, 846	59. 00
60.00	06000 LABORATORY	0	78, 197, 163	0.000000	0.000000	20, 736, 804	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	2, 888, 286	0. 000000	0. 000000	1, 297, 779	62.00
65.00	06500 RESPIRATORY THERAPY	0	14, 351, 416		0. 000000	6, 540, 634	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	10, 428, 502	1		2, 693, 095	66. 00
66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0			0	66. 01
66. 02	06602 O/P PHYSI CAL THERAPY	0	6, 363, 160	1		0	66. 02
67. 00	06700 OCCUPATI ONAL THERAPY	0	6, 545, 242	1		1, 299, 340	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	1, 985, 621			435, 654	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	16, 320, 405			5, 302, 220	ł
69. 01	06901 CARDI AC REHAB	0	1, 184, 752	1		114, 694	69. 01
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	4, 545, 436	1		713, 341	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 599, 216	1		1, 363, 509	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	18, 661, 765			4, 439, 855	
73. 00	07300 DRUGS CHARGED TO PATIENTS	361, 044		1			
76. 00	03020 RENAL ACUTE	0				2, 209, 392	
70.00	OUTPATIENT SERVICE COST CENTERS		0,710,700	0.00000	0.00000	2,207,072	70.00
90. 00	09000 CLINI C	0	555, 293	0.000000	0.00000	0	90. 00
90. 05	09005 PATIENT NUTRITION	0	299, 412			0	90.05
90. 07	09007 WOUND CLINIC	0	5, 078, 016	1		4, 729	90. 07
91. 00	09100 EMERGENCY	0		l .			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1 0	18, 841, 048	1			
200.00		562 919	1, 016, 411, 291		0.00000	175, 475, 543	
200.00	1.000. (11100.00.177)	002,717	1 ., 510, 111, 271	ı	ı	170, 170, 040	1-50.00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

THROUGH COSTS

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

Period: From 01/01/2015 To 12/31/2015 To 12/31/2015

5/25/2016 10:01 am

72.00

73.00

76.00

90.00

90.05

90.07

91.00

92.00

200.00

Title XVIII Hospi tal PPS Outpati ent Cost Center Description I npati ent Outpati ent Program Program Program Pass-Through Pass-Through Charges Costs (col. Costs (col. x col. 10) x col. 12) 11.00 12.00 13.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 18, 281, 387 0 50.00 05001 CARDI AC SURGERY 0 50.01 25, 183 50.01 05002 WVSC 0 31, 608, 719 0 50.02 50.02 51.00 05100 RECOVERY ROOM 0 0 14, 822 51.00 05101 0/P TREATMENT ROOM 0 0 51.02 1, 218, 992 51.02 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 269, 594 0 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 25, 019 9, 083, 822 38, 733 54.00 15, 377, 501 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 55.00 05600 RADI OI SOTOPE 0 0 56.00 3, 249, 733 56.00 57.00 05700 CT SCAN 0 14, 993, 593 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 000000000000000 3, 582, 935 58.00 05900 CARDIAC CATHETERIZATION 0 25, 043, 709 59 00 59 00 60.00 06000 LABORATORY 10, 626, 320 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 434, 405 62.00 06500 RESPIRATORY THERAPY 0 352, 969 65 00 65 00 0 66.00 06600 PHYSI CAL THERAPY 7, 771 66.00 66.01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 66.01 06602 0/P PHYSICAL THERAPY 66.02 66.02 06700 OCCUPATIONAL THERAPY 67 00 729 0 67 00 68.00 06800 SPEECH PATHOLOGY 1, 770 68.00 69.00 06900 ELECTROCARDI OLOGY 3, 172, 087 69.00 0 69.01 06901 CARDI AC REHAB 561, 396 69.01 857, 243 07000 ELECTROENCEPHALOGRAPHY 0 70.00 70 00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 70, 900 71.00

0

0

0

0

92, 024

67,005

6, 118, 791

60, 546, 990

2, 850, 146

17, 994, 944

5, 251, 913

231, 728, 734

130, 370

0

0

0

0

0

0

158, 979

120, 246

07200 IMPL. DEV. CHARGED TO PATIENTS

09200 OBSERVATION BEDS (NON-DISTINCT PART)

07300 DRUGS CHARGED TO PATIENTS

OUTPATIENT SERVICE COST CENTERS

Total (lines 50-199)

03020 RENAL ACUTE

09007 WOUND CLINIC

09100 EMERGENCY

09005 PATIENT NUTRITION

09000 CLI NI C

72.00

73.00

76.00

90.00 90.05

90 07

91.00

92.00

200.00

| Peri od: | Worksheet D | From 01/01/2015 | Part V | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Provi der CCN: 150023

					0 12/31/2015	5/25/2016 10:	
			Ti tl	e XVIII	Hospi tal	PPS	OT am
			1	Charges	noopi tui	Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	oost content boson per on	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Servi ces Not	(300 11131.)	
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0. 149865	18, 281, 387	(0	2, 739, 740	50. 00
50. 01	05001 CARDI AC SURGERY	0. 377506		1	0	9, 507	
50. 02	05002 WVSC	0. 157403	31, 608, 719		0	4, 975, 307	50. 02
51.00	05100 RECOVERY ROOM	0. 621921	14, 822		0	9, 218	51.00
51. 02	05101 0/P TREATMENT ROOM	1. 468984		1	0	1, 790, 680	51. 02
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 492001	269, 594	1	0	132, 641	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 311688	· ·	1		2, 831, 318	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 243895			0	3, 750, 496	1
56. 00	05600 RADI OI SOTOPE	0. 161468			0	524, 728	
57. 00	05700 CT SCAN	0. 058241		1	_	873, 242	1
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 149622			1	536, 086	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 228918			_	5, 732, 956	1
60.00	06000 LABORATORY	0. 140180				1, 489, 598	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 644521	434, 405			279, 983	
65. 00	06500 RESPIRATORY THERAPY	0. 387182		1	_	136, 663	
66. 00	06600 PHYSI CAL THERAPY	0. 349755		1	o o	2, 718	
66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000		1	o o	0	
66. 02	06602 0/P PHYSI CAL THERAPY	0. 383813			0	0	66. 02
67. 00	06700 OCCUPATI ONAL THERAPY	0. 256586				187	
68. 00	06800 SPEECH PATHOLOGY	0. 400740		l .	_	709	1
69. 00	06900 ELECTROCARDI OLOGY	0. 190550				604, 441	
69. 01	06901 CARDI AC REHAB	0. 796633			-	447, 227	69. 01
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 401919		1		344, 542	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 599708				42, 519	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 613765				3, 755, 500	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 226677		1	-	13, 724, 610	
76. 00	03020 RENAL ACUTE	0. 554852		l .		72, 336	
	OUTPATIENT SERVICE COST CENTERS				-		
90.00	09000 CLI NI C	0. 673081	0		0	0	90.00
90. 05	09005 PATIENT NUTRITION	1. 969136	0		0	0	90. 05
90. 07	09007 WOUND CLINIC	0. 351021			0	1, 000, 461	90. 07
91. 00	09100 EMERGENCY	0. 130926			_	2, 356, 006	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 452781				2, 377, 966	1
200.00			231, 728, 734			50, 541, 385	
201.00			,, , , , ,	(0	12, 2, 000	201. 00
	Only Charges]			
202.00			231, 728, 734	15, 857	84, 254	50, 541, 385	202. 00

 Heal th Financial Apportionment of Medical, Other Health Services AND VACCINE COST
 UNION HOSPITAL, INC. In Lieu of Form CMS-2552-10 Provi der CCN: 150023

					10 12/31/2013	5/25/2016 10:	
			Ti tl	e XVIII	Hospi tal	PPS	
	·	Cos	sts				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Reimbursed				
		Servi ces	Servi ces Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7. 00				
_	NCILLARY SERVICE COST CENTERS	1		1			
	5000 OPERATING ROOM	0	l ~				50.00
	5001 CARDI AC SURGERY	0	ľ	1			50. 01
	5002 WVSC	0	0	1			50. 02
	5100 RECOVERY ROOM	0	0				51. 00
	5101 O/P TREATMENT ROOM	0	0				51. 02
	5200 DELIVERY ROOM & LABOR ROOM	0	0	1			52. 00
	5400 RADI OLOGY-DI AGNOSTI C	0	0				54. 00
1	5500 RADI OLOGY-THERAPEUTI C	0	0				55. 00
	5600 RADI OI SOTOPE	0	0				56. 00
	5700 CT SCAN	0	0				57. 00
	5800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58. 00
1	5900 CARDI AC CATHETERI ZATI ON	0	0				59. 00
	6000 LABORATORY	1, 739	ł				60.00
	6200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62. 00
	6500 RESPI RATORY THERAPY	0	0	1			65. 00
	6600 PHYSI CAL THERAPY	0	0	1			66. 00
	6601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0				66. 01
	6602 O/P PHYSI CAL THERAPY	0	0	1			66. 02
	6700 OCCUPATI ONAL THERAPY	0	0				67. 00
1	6800 SPEECH PATHOLOGY	0	0	1			68. 00
	6900 ELECTROCARDI OLOGY	0	0	1			69. 00
	6901 CARDI AC REHAB	539	l e	1			69. 01
	7000 ELECTROENCEPHALOGRAPHY	0	0				70.00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
	7200 I MPL. DEV. CHARGED TO PATIENTS	0	0				72.00
	7300 DRUGS CHARGED TO PATIENTS	0	19, 098				73.00
	3020 RENAL ACUTE	0	0	1			76. 00
	UTPATIENT SERVICE COST CENTERS 9000 CLINIC						00.00
		0	0	1			90.00
	9005 PATIENT NUTRITION	0	_	1			90.05
	9007 WOUND CLINIC	0	0	1			90. 07
	9100 EMERGENCY	18		1			91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 195	l				92.00
200.00	Subtotal (see instructions)	3, 491	19, 098	1			200. 00
201. 00	Less PBP Clinic Lab. Services-Program Only Charges	0					201. 00
202. 00	Net Charges (line 200 +/- line 201)	3, 491	19, 098				202. 00
202.00	inet charges (Title 200 +/ - Title 201)	3, 491	17,090	'1			1202.00

∐oal +b	Financial Systems	UNION HOSPI	TAL, INC.		In Lie	u of Form CMS-:	2552 10
	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA			CCN: 150023	Peri od:	Worksheet D	2332-10
ALLOKI	TORMENT OF THE ATTENT ANOTEENT SERVICE OATTE	(E 00313	Trovide	CON. 130023	From 01/01/2015	Part II	
			· ·	nt CCN: 15T023	To 12/31/2015	Date/Time Pre 5/25/2016 10:	
				le XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	Capi tal		Ratio of Cos		Capital Costs	
			(from Wkst. C		Program	(column 3 x	
		(from Wkst. B,		(col . 1 ÷ col	. Charges	column 4)	
		Part II, col.	8)	2)			
		26)	0.00	2.00	4.00	F 00	
	ANOLILIADY CERVICE COCT CENTERS	1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	4 505 004	440 500 57	0 004/	100 5//	0.470	F0 00
50.00	05000 OPERATI NG ROOM	4, 535, 804				3, 179	1
50. 01	05001 CARDI AC SURGERY	340, 438				519	
50. 02	05002 WVSC	1, 942, 550				3	50. 02
51.00	05100 RECOVERY ROOM	140, 003				57	51.00
51. 02	05101 0/P TREATMENT ROOM	1, 081, 887				5	51. 02
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 179, 747				253	
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 864, 142				3, 473	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	2, 363, 280				2, 155	
56. 00	05600 RADI OI SOTOPE	131, 980				11	56. 00
57.00	05700 CT SCAN	413, 004				477	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	837, 088		•		1, 549	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	1, 917, 218		•		1, 041	59. 00
60.00	06000 LABORATORY	45, 652		•		175	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	4, 774		•		41	62. 00
65.00	06500 RESPI RATORY THERAPY	737, 593				6, 857	65. 00
66. 00	06600 PHYSI CAL THERAPY	439, 211	10, 428, 50			55, 325	66. 00
66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0		0. 00000		0	66. 01
66. 02	06602 0/P PHYSI CAL THERAPY	418, 380	6, 363, 16	0. 0657	50 0	0	66. 02
67.00	06700 OCCUPATI ONAL THERAPY	80, 598	6, 545, 24	2 0. 0123 ⁻	14 1, 236, 442	15, 226	67. 00
68. 00	06800 SPEECH PATHOLOGY	165, 840	1, 985, 62	1 0. 0835	20 269, 767	22, 531	68. 00
69. 00	06900 ELECTROCARDI OLOGY	434, 154	16, 320, 40	0. 02660	02 27, 372	728	69. 00
69. 01	06901 CARDI AC REHAB	313, 913	1, 184, 75	2 0. 2649	61 0	0	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	153, 817	4, 545, 43	6 0. 0338	40 15, 679	531	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	417, 106	2, 599, 21	6 0. 1604 ⁻	74 9, 375	1, 504	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	22, 973	18, 661, 76	5 0. 0012	31 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 445, 018	181, 781, 87	1 0.00794	49 831, 890	6, 613	73.00
76.00	03020 RENAL ACUTE	141, 863	3, 745, 96	6 0. 0378 ⁻	71 125, 997	4, 772	76. 00
	OUTPATIENT SERVICE COST CENTERS			•			1
90.00	09000 CLI NI C	10, 156	555, 29	3 0. 0182	39 0	0	90.00
90. 05	09005 PATIENT NUTRITION	79, 012			91 0	0	90. 05
90. 07	09007 WOUND CLINIC	181, 512	5, 078, 01	6 0. 0357	45 0	0	90. 07
91.00	09100 EMERGENCY	1, 374, 364				171	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				0	92.00
200.00		24, 213, 077	1, 016, 411, 29		4, 658, 997	127, 196	200.00
			•	•		•	•

	Financial Systems	UNI ON HOSPI				In Lie	u of Form CMS-	2552-10
	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	S Provi	der	CCN: 150023	Peri od: From 01/01/2015	Worksheet D Part IV	
THROUG	H COSTS		Compo	nent	CCN: 15T023			pared: 01 am
			-	Ti tI	e XVIII	Subprovi der – I RF	PPS	
	Cost Center Description	Non Physician	Nursing Sch	hool	Allied Healt		Total Cost	
		Anesthetist				Medi cal	(sum of col 1	
		Cost				Education Cost	,	
		1.00	2. 00		3.00	4. 00	4) 5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00		0.00	1. 00	0.00	
50.00	05000 OPERATI NG ROOM	0		0		0 0	0	50. 00
50. 01	05001 CARDI AC SURGERY	0		0		0 0	0	50. 01
50. 02	05002 WVSC	0		0		0	0	50. 02
51. 00	05100 RECOVERY ROOM	0		0		0 0	0	51.00
51. 02	05101 O/P TREATMENT ROOM	0		0		0 0	0	51. 02
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		0		0 0	0	52.00
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	0		0		0 0	201, 875 0	54. 00 55. 00
56. 00	05600 RADI OLOGY - THERAPEUTI C	0		0		0 0	0	56.00
57. 00	05700 CT SCAN	0		0		0 0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0		0		0 0	0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0		0		0 0	0	59. 00
60.00	06000 LABORATORY	0		0		0 0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0		0 0	0	62.00
65.00	06500 RESPI RATORY THERAPY	0		0		0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0		0		0 0	0	66. 00
66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0		0		0 0	0	66. 01
66. 02	06602 0/P PHYSI CAL THERAPY	0		0		0 0	0	66. 02
67.00	06700 OCCUPATIONAL THERAPY	0		0		0 0	0	67.00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0		0			0	68. 00 69. 00
69. 01	06901 CARDI AC REHAB	0		0		0 0	0	69. 01
70. 00	07000 ELECTROENCEPHALOGRAPHY	0		0		0 0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0		0 0	Ö	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0		0	361, 0	44 0	361, 044	73. 00
76. 00	03020 RENAL ACUTE OUTPATIENT SERVICE COST CENTERS	0		0		0 0	0	76. 00
90.00	09000 CLINI C	0		0		0 0	0	90.00
90. 05	09005 PATIENT NUTRITION	0		0		0 0	0	90. 05
90. 07	09007 WOUND CLINIC	0		0		0 0	0	90. 07
91.00	09100 EMERGENCY	0		0		0 0	0	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0 0	0	92. 00
200.00	Total (lines 50-199)	0		0	562, 9 ⁻	19 0	562, 919	200. 00

Health Financial Systems	UNI ON HOSPI	TAL, INC.		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PAS	S Provi der	CCN: 150023	Peri od:	Worksheet D	
THROUGH COSTS		Componen	t CCN: 15T023	From 01/01/2015 To 12/31/2015	Part IV Date/Time Pre	
		T: +	e XVIII	Subprovi der -	5/25/2016 10:0 PPS	01 am
				. I RF	PPS	
Cost Center Description	Total		Ratio of Cos		Inpati ent	
	Outpati ent	(from Wkst. C		Ratio of Cost	Program	
	Cost (sum of		(col . 5 ÷ col		Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)	7.00	0.00	7)	10.00	
ANOLLI ADV. CEDVI OF COCT. CENTEDO	6. 00	7. 00	8. 00	9. 00	10. 00	
ANCILLARY SERVICE COST CENTERS		142 502 50	0.0000	0.000000	100 577	F0 60
50. 00 05000 OPERATING ROOM	0		1		100, 566	
50. 01 05001 CARDI AC SURGERY	0		1		14, 099	1
50. 02 05002 WVSC	0		1		174	
51. 00 05100 RECOVERY ROOM	0		1		1, 730	
51. 02 05101 0/P TREATMENT ROOM	0		1		18	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0				3, 015	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	201, 875		1		57, 410	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0		1		30, 223	
56. 00 05600 RADI 0I SOTOPE	0		1		907	56. 00
57.00 05700 CT SCAN	0		1		69, 450	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0		1		28, 196	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0		0. 00000	0. 000000	51, 472	59. 00
60. 00 06000 LAB0RAT0RY	0		0. 00000		299, 839	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0. 00000	0. 000000	25, 074	62. 00
65. 00 06500 RESPI RATORY THERAPY	0	.,	0. 00000		133, 418	65. 00
66. 00 06600 PHYSI CAL THERAPY	0		0. 00000		1, 313, 634	66. 00
66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0)	0. 00000		0	66. 01
66. 02 06602 0/P PHYSI CAL THERAPY	0	6, 363, 16	0. 00000		0	66. 02
67. 00 06700 OCCUPATIONAL THERAPY	0	6, 545, 24	0.00000	0. 000000	1, 236, 442	67.00
68. 00 06800 SPEECH PATHOLOGY	0	1, 985, 62	0.00000	0. 000000	269, 767	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	16, 320, 40	0. 00000	0. 000000	27, 372	69.00
69. 01 06901 CARDI AC REHAB	0	1, 184, 75	0. 00000	0. 000000	0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	4, 545, 43	0.00000	0. 000000	15, 679	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 599, 21	0. 00000	0. 000000	9, 375	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	18, 661, 76	0. 00000	0. 000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	361, 044	181, 781, 87	0. 00198	0. 001986	831, 890	73.00
76. 00 03020 RENAL ACUTE	0	3, 745, 96	0. 00000	0. 000000	125, 997	76. 00
OUTPATIENT SERVICE COST CENTERS					·	
90. 00 09000 CLINIC	0	555, 29	0.00000	0. 000000	0	90.00
90. 05 09005 PATI ENT NUTRI TI ON	0				Ö	
90. 07 09007 WOUND CLINIC	0		1		Ö	
91. 00 09100 EMERGENCY	0	-,,	1		13, 250	
	-		1		· ·	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	18, 841, 04	0.00000	0. 000000	0	92.00

Health Financial Systems	UNION HOSPITAL,	I NC.	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILITHROUGH COSTS	LARY SERVICE OTHER PASS	Provi der CCN: 150023 Component CCN: 15T023	From 01/01/2015	
		Title XVIII	Subprovi der -	PPS

			liti	e XVIII	Subprovider - IRF	PPS	
	Cost Center Description	Inpati ent	Outpati ent	Outpati ent	INI		
	oost center bescription	Program	Program	Program			
		Pass-Through	Charges	Pass-Through	1		
		Costs (col. 8	g	Costs (col.			
		x col. 10)		x col. 12)			
		11.00	12.00	13.00			
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0		50.00
50. 01	05001 CARDI AC SURGERY	0	0)	0		50. 01
50. 02	05002 WVSC	0	0)	0		50. 02
51.00	05100 RECOVERY ROOM	0	0)	0		51.00
51. 02	05101 O/P TREATMENT ROOM	0	0)	0		51. 02
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0)	0		52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	245	0)	0		54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0)	0		55. 00
56.00	05600 RADI OI SOTOPE	0	0)	0		56. 00
57.00	05700 CT SCAN	0	0)	0		57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0)	0		58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	o	0)	0		59. 00
60.00	06000 LABORATORY	0	0)	0		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	o	0)	0		62. 00
65.00	06500 RESPI RATORY THERAPY	0	0)	0		65. 00
66.00	06600 PHYSI CAL THERAPY	o	0)	0		66. 00
66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	o	0)	0		66. 01
66. 02	06602 0/P PHYSI CAL THERAPY	o	0)	0		66. 02
67.00	06700 OCCUPATI ONAL THERAPY	o	0)	0		67. 00
68.00	06800 SPEECH PATHOLOGY	o	0)	0		68. 00
69.00	06900 ELECTROCARDI OLOGY	o	0)	0		69. 00
69. 01	06901 CARDI AC REHAB	O	0)	0		69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	O	0)	0		70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	O	0)	0		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	O	0)	0		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 652	0)	0		73. 00
76.00	03020 RENAL ACUTE	o	0	1	0		76. 00
	OUTPATIENT SERVICE COST CENTERS						1
90.00	09000 CLI NI C	0	0		0		90. 00
90.05	09005 PATIENT NUTRITION	0	0)	0		90. 05
90. 07	09007 WOUND CLINIC	o	0)	0		90. 07
91.00	09100 EMERGENCY	o	108		0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	O	0)	0		92.00
200.00	Total (lines 50-199)	1, 897	108		0		200. 00

Health Financial Systems	UNION HOSPITAL,	I NC.	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVI	ICES AND VACCINE COST	Provider CCN: 150 Component CCN: 15	D23 Period: From 01/01/2015 T023 To 12/31/2015	
		T: +L o V/// L I	Cubanavi dan	DDC

					5/25/2016 10:	01 am
		Ti tl	e XVIII	Subprovi der -	PPS	
				I RF		
			Charges		Costs	
Cost Center Description		PPS Reimbursed		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.			
			(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. 149865			0		
50. 01 05001 CARDI AC SURGERY	0. 377506	ł .		0		50. 01
50. 02 05002 WVSC	0. 157403	0		0		50. 02
51. 00 05100 RECOVERY ROOM	0. 621921	0		0	0	51. 00
51.02 05101 0/P TREATMENT ROOM	1. 468984	0		0	0	51. 02
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 492001	0		0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 311688	0		0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 243895	0		0 0	0	55.00
56. 00 05600 RADI OI SOTOPE	0. 161468	0		0 0	0	56. 00
57. 00 05700 CT SCAN	0. 058241	0		0 0	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 149622	0		0 0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 228918	0		0 0	0	59. 00
60. 00 06000 LABORATORY	0. 140180	0		0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 644521	0		0 0	0	62. 00
65. 00 06500 RESPIRATORY THERAPY	0. 387182	0		0 0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 349755	0		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. 383813	0		0 0	0	66. 02
67. 00 06700 OCCUPATI ONAL THERAPY	0. 256586	0		0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 400740			0 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 190550			0	0	69. 00
69. 01 06901 CARDI AC REHAB	0. 796633			0 0	0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 401919			0 0	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 599708			0 0	1	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 613765			0 0	1	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 226677	ł .		0 215	1	73. 00
76. 00 03020 RENAL ACUTE	0. 554852			0 0		1
OUTPATIENT SERVICE COST CENTERS	0. 334032			0		70.00
90. 00 09000 CLINIC	0. 673081	0		0 0	0	90.00
90. 05 09005 PATIENT NUTRITION	1. 969136			0 0		90.05
90. 07 09007 WOUND CLI NI C	0. 351021			0	0	
91. 00 09100 EMERGENCY	0. 130926	l e		0	14	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 452781			0 0		1
200.00 Subtotal (see instructions)	0.432761	108		٥	1	200. 00
	1	108		0 215		
				٥		201. 00
Only Charges (Line 200 // Line 201)	-	100		0 215	1.4	202 00
202.00 Net Charges (line 200 +/- line 201)	I	108	I	0 215	1 14	202. 00

Health Financial Systems	UNI ON HOSPI TAL,	I NC.	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL, OTHER	R HEALTH SERVICES AND VACCINE COST		From 01/01/2015	
		Title XVIII	Subprovi der -	5/25/2016 10: 01 am PPS

			Title XV	III Subprovi		PPS	
	Co	sts		INI	,		
Cost Center Description	Cost	Cos	t				
	Rei mbursed	Rei mbui					
	Servi ces	Servi ces					
	Subject To	Subj ec					
	Ded. & Coins. (see inst.)	Ded. & C					
	6.00	7.00					
ANCILLARY SERVICE COST CENTERS	0.00	7.0	<u> </u>				
50. 00 05000 OPERATING ROOM	C		0				50.00
50. 01 05001 CARDI AC SURGERY		o	o			ļ	50. 01
50. 02 05002 WVSC	C		0			ļ	50. 02
51.00 05100 RECOVERY ROOM	C		0			ļ	51.00
51.02 05101 O/P TREATMENT ROOM	C		0			ļ	51. 02
52. 00 05200 DELI VERY ROOM & LABOR ROOM	C		O			ļ	52.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	C		0			ļ	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	C		0			ļ	55.00
56. 00 05600 RADI 01 SOTOPE 57. 00 05700 CT SCAN			0			ļ	56. 00 57. 00
58.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE MAGING (MRI)		-	0			ļ	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		-	0			ļ	59.00
60. 00 06000 LABORATORY		-	Ö			ļ	60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS			o			l	62.00
65. 00 06500 RESPIRATORY THERAPY	d		o			l	65. 00
66. 00 06600 PHYSI CAL THERAPY	C		o			ļ	66. 00
66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	C		o			l	66. 01
66. 02 06602 0/P PHYSI CAL THERAPY	C	o	0			ļ	66. 02
67. 00 06700 OCCUPATI ONAL THERAPY	C		0			ļ	67. 00
68.00 06800 SPEECH PATHOLOGY	C		0			ļ	68. 00
69. 00 06900 ELECTROCARDI OLOGY	C		O			ļ	69. 00
69. 01 06901 CARDI AC REHAB	C	- 1	0			ļ	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	C	- 1	0			ļ	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	C		0			ļ	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS		-	49			l	73.00
76. 00 03020 RENAL ACUTE		•	0			ļ	76.00
OUTPATIENT SERVICE COST CENTERS		1	91				70.00
90. 00 09000 CLI NI C	C	ol	0				90.00
90. 05 09005 PATI ENT NUTRI TI ON	C		o			l	90. 05
90. 07 09007 WOUND CLINIC	C)	0			l	90. 07
91. 00 09100 EMERGENCY	C		0			ļ	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	C		0			ļ	92.00
200.00 Subtotal (see instructions)	C		49			ļ	200. 00
201.00 Less PBP Clinic Lab. Services-Program	C	ال				ļ	201. 00
0nly Charges 202.00 Net Charges (line 200 +/- line 201)	C		49			ļ	202. 00
202.00 Net Charges (Title 200 +/- Title 201)	1	4	47			l	₁ 202.00

Health Financial Systems	UNION HOSPITAL,	I NC.	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 150023	Peri od: From 01/01/2015	Worksheet D-1
				Date/Time Prepared: 5/25/2016 10:01 am
		Title XVIII	Hospi tal	PPS

PART 1 ALL PROVIDER CREPORNITS PART 1 ALL PROVIDER CREPORNITS			T: +1 - \0/111	11	5/25/2016 10:0	01 am	
DART 1 - ALL PROVIDER COMPONENTS		Cost Center Description	Title XVIII	Hospi tal	PPS		
Impartient days (including private room days and saing-bed days, excluding newborn) 56,945 2.00 Inpartient days (including private room days, excluding swing-bed and newborn days) 56,945 2.00 Inpartient days (including private room days, excluding swing-bed and observation bed days) 17 you have only private room days 56,945 2.00					1. 00		
Impattent days (including private room days and swing-bed days, excluding newborn) 50,945 1.00							
Impatient days (including private room days, excluding swing-bed and nebborn days) 50,945 2.00 3.00 Private room days (secularing swing-bed and observation bed days) 1.79 uhave only private room days (secularing swing-bed and observation bed days) 1.79 uhave only private room days 1.70 3.00	1 00		oveluding newbern)		E4 04E	1 1 00	
Private room days (excluding swing-bed and observation bed days). If you have only private room days, decluding swing-bed and observation bed days). A 0 Semi-private room days (excluding swing-bed and observation bed days). A 0 Semi-private room days (accluding private room days) through December 31 of the cost room trip open down the private room days). Through December 31 of the cost room trip open down t							
do not complete this line. 4.00 Semi-private room days (excluding swing-bed and observation bed days) Total swing-bed SPE type inpatient days (including private room days) after December 31 of the cost reporting period (if culendar year, enter 0 on this line) 7.00 Total swing-bed SPE type inpatient days (including private room days) after December 31 of the cost reporting period (if culendar year, enter 0 on this line) 7.00 Total swing-bed SPE type inpatient days (including private room days) through December 31 of the cost reporting period 8.00 Total swing-bed SPE type inpatient days (including private room days) after December 31 of the cost reporting period 8.00 Total swing-bed SPE type inpatient days (including private room days) after December 31 of the cost reporting period 1.00 Swing-bed SPE type inpatient days applicable to the Program (excluding swing-bed and newborn days) 1.00 Swing-bed SPE type inpatient days applicable to title XVIII only (including private room days) 1.00 Swing-bed SPE type inpatient days applicable to title XVIII only (including private room days) 1.00 Swing-bed SPE type inpatient days applicable to title XVIII only (including private room days) 1.00 Swing-bed SPE type inpatient days applicable to title XVIII only (including private room days) 1.00 Swing-bed SPE type inpatient days applicable to title XVIII only (including private room days) 1.00 Swing-bed SPE type inpatient days applicable to title XVIII only (including private room days) 1.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) 1.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) 1.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) 1.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) 1.00 Swing-bed NF type inpatient days applicable to swing-bed XVII only (including private room days) 1.01 Swing-bed NF type inpatient d				ivate room davs.			
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost of Potal swing-bed SNF type inpatient days (including private room days) after December 31 of the cost of Potal swing-bed NF type inpatient days (including private room days) through December 31 of the cost of Potal swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) or local line inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) or local line inpatient days including private room days applicable to the Program (excluding swing-bed and nextorm days) including private room days applicable to the Program (excluding swing-bed and patient of the cost reporting period (if calendar year, enter 0 on this line) or local patient days applicable to the Program (excluding private room days) or local December 31 of the cost reporting period (if calendar year, enter 0 on this line) or local patient days applicable to title swill only (including private room days) or local patients of the cost reporting period (if calendar year, enter 0 on this line) or local patients of the cost reporting period (if calendar year, enter 0 on this line) or local patients of the cost reporting period (if calendar year, enter 0 on this line) or local patients of the cost reporting period (if calendar year, enter 0 on this line) or local patients of the cost reporting period (if calendar year, enter 0 on this line) or local patients of the cost reporting period (if calendar year, enter 0 on this line) or local patients of the cost reporting period (if calendar year, enter 0 on this line) or local patients of the cost patients of the cost patients of the cost patients of the cost patients of the cost patients of the cost patients of the cost patients of the cost patients of the cost patients of the cost patients of the cost patients of the cost patients of the cost	0.00		γ youανο σ y p.	. varo i com dayo,	١	0.00	
reporting period (if calendar year, enter 0 on this line) 7.00 Total sing-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) 8.00 Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10.00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and newborn days) 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 through December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 12.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 15.00 Total nursery days (title V or XIX only) 16.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 17.00 Total nursery days (title V or XIX only) 18.00 Medically necessary private room days applicable to services through December 31 of the cost reporting period (see instructions) 18.00 Medically necessary private room days applicable to services through December 31 of the cost reporting period (line 8 or special private room of the private room of the private room of the private room of the private room of the private room of the private r	4.00				47, 733		
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 swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) Power of the cost reporting period (if calendar year, enter 0 on this line) Power of the cost reporting period (if calendar year, enter 0 on this line) Power of the cost reporting period (if calendar year, enter 0 on this line) Power of the cost reporting period (if calendar year, enter 0 on this line) Power of the cost reporting period (if calendar year, enter 0 on this line) Power of the cost reporting period (see instructions) Power of the cost reporting period (if calendar year, enter 0 on this line) Power of the cost reporting period (if calendar year, enter 0 on this line) Power of the cost reporting period (if calendar year, enter 0 on this line) Power of the cost reporting period (if calendar year, enter 0 on this line) Power of the cost reporting period (if calendar year, enter 0 on this line) Power of the cost reporting period (if calendar year, enter 0 on this line) Power of the cost reporting period (if calendar year, enter 0 on this line) Power of the cost reporting period (if calendar year, enter 0 on this line) Power of the cost reporting period Power of the period Power of the period Power of the period Power of the	5. 00		days) through Decembe	r 31 of the cost	0	5. 00	
reporting period (if calendar year, enter 0 on this iline) 7.00 Total swing-bed Mr type inpatient days (including private room days) through December 31 of the cost reporting period 8.00 Total swing-bed Mr type inpatient days (including private room days) after December 31 of the cost 9.00 Total inpatient days including private room days apricable to the Program (excluding swing-bed and newborn days) 9.00 Swing-bed SMr type inpatient days applicable to title XVIII only (including private room days) after 0 through December 31 of the cost reporting period (including private room days) after 0 through December 31 of the cost reporting period (including private room days) after 0 through December 31 of the cost reporting period (including private room days) after 0 through December 31 of the cost reporting period (including private room days) after 0 through December 31 of the cost reporting period (including private room days) after 0 through 0				21 -6		/ 00	
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7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	24.00	1	24	(1:		24.00	
25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 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) 27. 00 FRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 30. 00 Average private room per diem charge (line 29 ÷ line 3) 30. 00 Average per vate 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 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 35) 31. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 52, 734, 578) 32. 00 Average per diem private room cost differential (see instructions) 33. 00 Average per diem private room cost differential (see instructions) 34. 00 Average per diem cost differential (see instructions) 35. 00 General inpatient routine service cost per diem (see instructions) 36. 00 Private room cost differential (see instructions) 37. 00 General inpatient routine service cost per diem (see instructions) 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 39. 00 Program general inpatient routine service cost (line 9 x line 38) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	24.00		31 of the cost reporti	ng period (iine	U	24.00	
Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.00 PRI VATE ROOM DIFFERNTI AL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Pri vate room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Average private room per diem charge (line 29 + line 3) 30.00 Average semi-private room per diem charge (line 30 + line 4) 30.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 32.00 Average per diem private room cost differential (line 34 x line 31) 33.00 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 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Ajusted general inpatient routine service cost per diem (see instructions) 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 do 0.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	25. 00	1	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) 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) 0							
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 9.00 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) 31.00 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) 33.00 Average per diem private room cost differential (line 34 x line 31) 34.00 Average per diem private room cost differential (line 34 x line 35) 35.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 52, 734, 578) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 52, 734, 578) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 926.06 38.00 Program general inpatient routine service cost per diem (see instructions) 926.06 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 926.06 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 926.06 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 926.06 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 926.06 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 926.06 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 926.06 38.00 Adjusted general inpatient routine service cost per diem (see instructions)			i 21 -i 1 i 24)				
28. 00 29. 00 29. 00 Private room charges (excluding swing-bed and observation bed charges) Oprivate room charges (excluding swing-bed charges) Oprivate room comper diem charge (line 27 ÷ line 28) Oprivate room per diem charge (line 30 ÷ line 4) Oprivate room comper diem charge (line 30 ÷ line 4) Oprivate room comper diem charge (line 30 ÷ line 4) Oprivate room cost differential (line 32 minus line 33) (see instructions) Oprivate room cost differential (line 34 x line 31) Oprivate room cost differential djustment (line 3 x line 35) Oprivate room cost differential adjustment (line 3 x line 35) Oprivate room cost differential (line 32 minus line 36) Oprivate room cost differential oprivate room cost differential (line 52, 734, 578) Oprivate room cost differential (line 52, 734, 578) Oprivate room cost differential (line 52, 734, 578) Oprivate room cost differential (line 52, 734, 578) Oprivate room cost differential (line 52, 734, 578) Oprivate room cost differential (line 52, 734, 578) Oprivate room cost differential (line 52, 734, 578) Oprivate room cost differential (line 52, 734, 578) Oprivate room cost differential (line 52, 734, 578) Oprivate room cost differential (line 52, 734, 578) Oprivate room cost differential (line 52, 734, 578) Oprivate room cost differential (line 52, 734, 578) Oprivate room cost differential (line 52, 734, 578) Oprivate room cost differential (line 52, 734, 578) Oprivate room cost differential (line 52, 734, 578) Oprivate room cost differential (line 32 minus line 33) Oprivate room cost differential (line 32 minus line 33) Oprivate room cost differential (line 32 minus lin	27.00		ine 21 minus iine 26)		52, 734, 578	27.00	
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 52, 734, 578 and 52, 734, 578 and 53, 734, 578 and 54, 734, 578 and 54, 734, 735 and 54, 734, 735 and 54, 734, 735 and 735, 734, 736 and 735, 734, 736 and 735, 734, 736 and 735, 734, 737 and 735, 735, 735, 735, 735, 735, 735, 735,	28. 00		and observation bed ch	arges)	0	28. 00	
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 52, 734, 578) 37.00 PART II - HOSPITAL AND SUBPROVI DERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 926.06 38.00 920.06 38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 0.00 32.00 0.00 32.00 0.00 32.00 32.00 32.00 32.00 32.00 34.00 35.00 36.00 36.00 37.00 37.00 38.00 39.00 40.00					0		
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 52, 734, 578) 37.00 PART II - HOSPITAL AND SUBPROVI DERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00	30.00	Semi-private room charges (excluding swing-bed charges)			0	30. 00	
33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 52, 734, 578) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	31.00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0.000000	31.00	
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 52, 734, 578 and 52, 734, 578 and 52, 734, 578 and 53, 734, 578 and 54, 734, 578 and 54, 734, 735 and 54, 734, 735 and 54, 734, 735 and 54, 734, 735 and 54, 734, 735 and 54, 734, 735 and 54, 734, 735 and 735, 734, 736 and 735, 735, 734, 736 and 735, 735, 734, 736 and 735, 735, 735, 735, 735, 735, 735, 735,	32.00				0.00	32. 00	
35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 52, 734, 578 and 57, 700) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
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 52, 734, 578 27, 734, 738 27, 734, 738 27, 734, 738 27, 734, 738 27, 734, 738 27, 734, 738 27, 734, 738 27, 734, 738 27, 734, 738 27, 738, 738, 738, 738, 738, 738, 738, 73	34. 00	Average per diem private room charge differential (line 32 minu	s line 33)(see instruc	tions)	0. 00		
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27, 734, 578 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) 926.06 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							
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) 926.06 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		, , , , , , , , , , , , , , , , , , ,				1	
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 926.06 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	37. 00		d private room cost di	fferential (line	52, 734, 578	37. 00	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 926.06 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							
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 926.06 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) 926.06 22,724,586 39.00 40.00			TMENTS				
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) 22,724,586 39.00 40.00	38. 00				926. 06	38. 00	
		' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	,			1	
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 22,724,586 41.00							
	41. 00	Total Program general inpatient routine service cost (line 39 +	line 40)		22, 724, 586	41.00	

Heal th	Financial Systems	UNION HOSPI	TAL, I	NC.		In Li	eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST			Provi der	CCN: 150023	Peri od: From 01/01/2015		
						To 12/31/2015	5/25/2016 10:	
	Cost Center Description	Total	Т	<u>Ti tl</u> otal	e XVIII Average Per	Hospital Program Days	PPS Program Cost	
	oost center beserveron	Inpatient Cost					(col . 3 x col . 4)	
		1.00		2. 00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0		0	0.	00 (0 0	42. 00
43. 00	INTENSIVE CARE UNIT	12, 679, 540		9, 032	1, 403.	85 5, 360	7, 524, 636	43. 00
44. 00	CORONARY CARE UNIT							44. 00
45. 00	BURN INTENSIVE CARE UNIT							45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT	3, 406, 817		3, 528	965.	65 (o	46. 00 47. 00
	Cost Center Description						1.00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3, line	e 200)			39, 094, 073	48. 00
49. 00	Total Program inpatient costs (sum of lines - PASS THROUGH COST ADJUSTMENTS	41 through 48)((see i	nstructio	ons)		69, 343, 295	49. 00
50.00	Pass through costs applicable to Program inpulli	atient routine	servi	ces (from	n Wkst. D, su	m of Parts I and	4, 995, 876	50. 00
51. 00	Pass through costs applicable to Program inp	atient ancillar	y ser	vices (fr	om Wkst. D,	sum of Parts II	4, 113, 621	51.00
52. 00	and IV) Total Program excludable cost (sum of lines!	50 and 51)					9, 109, 497	52. 00
53. 00	Total Program inpatient operating cost exclu		el ated	non-phy	sician anest	hetist, and	60, 233, 798	53. 00
	medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION	52)						1
	Program di scharges						0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)						0.00	1
57. 00	Difference between adjusted inpatient operation	0						
58. 00	Bonus payment (see instructions)	0						
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	0.00	59. 00					
60.00								60.00
61. 00	.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target							61. 00
	amount (line 56), otherwise enter zero (see							
62.00								62. 00 63. 00
63.00	B. 00 Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST 0							
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions) (title XVIII only)	ts through Dece	ember :	31 of the	cost report	ing period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	oer 31	of the c	ost reportin	g period (See	0	65. 00
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routing</pre>	ne costs (line	64 pl	us 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	n Decer	mber 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 D	Decembe	er 31 of	the cost rep	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs ((line (57 + line	e 68)		0	69. 00
70.00	PART III - SKILLED NURSING FACILITY, OTHER NU					`	T	70.00
70. 00 71. 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service of	,			•)		70. 00 71. 00
72. 00	Program routine service cost (line 9 x line	71)			,			72. 00
73. 00 74. 00	Medically necessary private room cost applications and program general inpatient routine services.							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							77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		orovi de	er record	ls)			78. 00 79. 00
80. 00	Total Program routine service costs for compa	arison to the c				nus line 79)		80.00
81. 00 82. 00								81. 00 82. 00
82.00								83.00
84. 00	Program inpatient ancillary services (see in	structions)						84. 00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum			85)				85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST	. Jugit	/				
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	: line	2)			9, 212 926. 06	1
	Observation bed cost (line 87 x line 88) (see	•		-/			8, 530, 865	

Health Financial Systems	UNION HOSPI	TAL, INC.		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2015 To 12/31/2015	Date/Time Pre 5/25/2016 10:	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	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	9, 307, 115	52, 734, 578	0. 17649	0 8, 530, 865	1, 505, 612	90. 00
91.00 Nursing School cost	0	52, 734, 578	0.00000	0 8, 530, 865	0	91.00
92.00 Allied health cost	0	52, 734, 578	0.00000	0 8, 530, 865	0	92. 00
93.00 All other Medical Education	0	52, 734, 578	0. 00000	0 8, 530, 865	0	93. 00

Health Financial Systems	UNION HOSPITAL,	I NC.	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 150023	Peri od: From 01/01/2015	Worksheet D-1
		Component CCN: 15T023		
		Title XVIII	Subprovi der -	PPS
			IRF	

			I RF		
	Cost Center Description		-	1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,			3, 899	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-bed Private room days (excluding swing-bed and observation bed days)		soom dave	3, 899 0	2. 00 3. 00
3.00	do not complete this line.	i. It you have only private i	oom days,	U	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed	days)		3, 899	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room	days) through December 31 of	the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room	days) after December 31 of t	he cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	days) arter becember 31 or t	The Cost	O	0.00
7.00	Total swing-bed NF type inpatient days (including private room	days) through December 31 of	the cost	0	7. 00
0.00	reporting period	Java) after December 21 of th		0	0.00
8. 00	Total swing-bed NF type inpatient days (including private room (reporting period (if calendar year, enter 0 on this line)	days) after becember 31 of the	ie cost	U	8. 00
9.00	Total inpatient days including private room days applicable to	the Program (excluding swing-	bed and	2, 719	9. 00
40.00	newborn days)		,		40.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only through December 31 of the cost reporting period (see instruction		/S)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only		s) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, enter	er O on this line)			
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX (only (including private 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 XIX of	only (including private room	days)	0	13. 00
	after December 31 of the cost reporting period (if calendar year	, enter 0 on this line)	uayo,		
14. 00	Medically necessary private room days applicable to the Program	(excluding swing-bed days)		0	14. 00
15.00	Total nursery days (title V or XIX only)			0	15. 00 16. 00
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			U	16.00
17. 00	Medicare rate for swing-bed SNF services applicable to services	through December 31 of the c	cost	0.00	17. 00
40.00	reporting period	6. 6			40.00
18. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	after December 31 of the cos	st	0.00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of the co	st	0. 00	19. 00
	reporting period				
20. 00	Medicaid rate for swing-bed NF services applicable to services a reporting period	0. 00	20. 00		
21. 00	Total general inpatient routine service cost (see instructions)			4, 412, 569	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	31 of the cost reporting per	iod (line	0	
22.00	5 x line 17)		-	0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 3 x line 18)	or the cost reporting perio	a (Tine 6	0	23. 00
24.00	Swing-bed cost applicable to NF type services through December :	31 of the cost reporting peri	od (line	0	24.00
	7 x line 19)			_	
25. 00	Swing-bed cost applicable to NF type services after December 31 x line 20)	of the cost reporting period	I (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 (1)	ne 21 minus line 26)		4, 412, 569	27. 00
20 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	and observation had charges)		0	28. 00
28.00	General inpatient routine service charges (excluding swing-bed a Private room charges (excluding swing-bed charges)	and observation bed charges)		0	
30. 00	Semi -pri vate room charges (excluding swing-bed charges)			0	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ 1	i ne 28)		0.000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus	s line 33)(see instructions)		0. 00 0. 00	
35. 00	Average per diem private room cost differential (line 34 x line	, ,		0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and	d private room cost different	ial (line	4, 412, 569	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST	MENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see in	nstructions)		1, 131. 72	
39. 00	Program general inpatient routine service cost (line 9 x line 3)			3, 077, 147	
40. 00 41. 00	Medically necessary private room cost applicable to the Program Total Program general inpatient routine service cost (line 39 +	•		0 3, 077, 147	
11.00	1.02a ogram gonorar impatront routino sorvice cost (fille 37 +		ı	5, 577, 147	11.00

Heal th	Financial Systems	UNION HOSPITAL,	I NC.		In Lie	u of Form CMS-2	2552-10	
	ATION OF INPATIENT OPERATING COST		Provi der CCN: 15	0023 Pe	eriod: com 01/01/2015	Worksheet D-1		
			Component CCN: 1			Date/Time Pre		
			Title XVIII		Subprovi der -	5/25/2016 10: (PPS	01 am_	
					' I RF			
	Cost Center Description	Total		ge Per	Program Days	Program Cost (col. 3 x col.		
		npatient Cost Inpa		. 2)		4)		
		1.00		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	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	0	0.00	0	0		
	Cost Center Description					1. 00		
48. 00	Program inpatient ancillary service cost (Wks	t. D-3, col. 3, li	ne 200)			1, 340, 653	48. 00	
49. 00	Total Program inpatient costs (sum of lines 4					4, 417, 800	49. 00	
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	tient routine serv	rices (from Wkst	D SUM O	of Parts L and	610, 035	50. 00	
00.00	III)	tront routino sor v	rees (rrom mest.	D, Sam C	, raits raina	010, 000	00.00	
51. 00	Pass through costs applicable to Program inpa and IV)	tient ancillary se	ervices (from Wkst	. D, sum	of Parts II	129, 093	51. 00	
52. 00	Total Program excludable cost (sum of lines 5	0 and 51)				739, 128	52. 00	
53. 00	Total Program inpatient operating cost exclud		ed, non-physician	anesthet	ist, and	3, 678, 672	53. 00	
	medical education costs (line 49 minus line 5 TARGET AMOUNT AND LIMIT COMPUTATION	2)						
54.00	Program di scharges					0		
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 target	amount (line 56	minus li	ne 53)	0	56. 00 57. 00	
58. 00	Bonus payment (see instructions)	0 0. 00	58. 00 59. 00					
59. 00	00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket							
60.00								
61. 00	.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target							
	amount (line 56), otherwise enter zero (see i		Thes 54 x 60), or	1% OI L	ne target			
	00 Relief payment (see instructions)							
63. 00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	nt (see instructio	ns)			0	63. 00	
64. 00	Medicare swing-bed SNF inpatient routine cost	s through December	31 of the cost r	eporting	period (See	0	64. 00	
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost	s after December 3	11 of the cost ron	ortina n	port od (Soo	0	65. 00	
03.00	instructions)(title XVIII only)		·		·	U	03.00	
66. 00	Total Medicare swing-bed SNF inpatient routin	e costs (line 64 p	lus line 65)(titl	e XVIII	only). For	0	66. 00	
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine	costs through Dec	ember 31 of the c	ost repo	rtina period	0	67. 00	
	(line 12 x line 19)	· ·		•				
68. 00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	costs after Decem	ber 31 of the cos	st report	ing period	0	68. 00	
69. 00	Total title V or XIX swing-bed NF inpatient r	outine costs (line	e 67 + line 68)			0	69. 00	
70.00	PART III - SKILLED NURSING FACILITY, OTHER NU			no 27)			70.00	
70. 00 71. 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co	•	•	ne 37)			70. 00 71. 00	
72. 00	Program routine service cost (line 9 x line 7	1)	ŕ				72. 00	
73. 00 74. 00	Medically necessary private room cost applica Total Program general inpatient routine servi						73. 00 74. 00	
75. 00	Capital -related cost allocated to inpatient r	•		et B, Par	t II, column		75. 00	
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ lin	2)					76. 00	
77. 00	Program capital -related costs (line 9 x line						77. 00	
	Inpatient routine service cost (line 74 minus	line 77)					78. 00 79. 00	
79. 00 80. 00								
81. 00	Inpatient routine service cost per diem limit						80. 00 81. 00	
82. 00 83. 00	Inpatient routine service cost limitation (li	· · · · · · · · · · · · · · · · · · ·					82. 00 83. 00	
84. 00	Reasonable inpatient routine service costs (s Program inpatient ancillary services (see ins						84. 00	
85. 00	5.00 Utilization review - physician compensation (see instructions)							
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		n 85)				86. 00	
87. 00	Total observation bed days (see instructions)					0	87. 00	
88. 00	Adjusted general inpatient routine cost per d	•	e 2)				88. 00 89. 00	
07. UU	Observation bed cost (line 87 x line 88) (see	THISTI UCTI UNS)			I	υĮ	U7. UU	

Health Financial Systems	UNI ON HOSPI	TAL, INC.		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
		Component	CCN: 15T023	From 01/01/2015 To 12/31/2015		
		Ti tl	e XVIII	Subprovi der - I RF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	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	874, 774	4, 412, 569	0. 19824	16 0	0	90. 00
91.00 Nursing School cost	0	4, 412, 569	0.00000	0 0	0	91. 00
92.00 Allied health cost	0	4, 412, 569	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	4, 412, 569	0.00000	00	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: 150023	From 01/01/2015		
			To 12/31/2015	Date/Time Pre 5/25/2016 10:	
		Title XIX	Hospi tal	Cost	
C+ C+ D					

-		Title XIX	Hospi tal	5/25/2016 10: Cost	JI am_	
	Cost Center Description	THE WAR	nospi tui	0031		
	E			1. 00		
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days,	excluding newborn)		56, 945	1. 00	
2.00	Inpatient days (including private room days, excluding swing-be			56, 945	2. 00	
3.00	Private room days (excluding swing-bed and observation bed days)). If you have only pri	vate room days,	0	3. 00	
4 00	do not complete this line.	daya)		47 722	4 00	
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation bed Total swing-bed SNF type inpatient days (including private room		31 of the cost	47, 733 0	4. 00 5. 00	
0.00	reporting period	days) thi oagh becomber	01 01 110 0031	o o	0.00	
6.00	Total swing-bed SNF type inpatient days (including private room	days) after December 3	31 of the cost	0	6. 00	
7 00	reporting period (if calendar year, enter 0 on this line)	daya) through Dagamhar	21 of the cost	0	7 00	
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	days) till odgir becelliber	31 Of the Cost	0	7. 00	
8.00	Total swing-bed NF type inpatient days (including private room	days) after December 31	l of the cost	0	8. 00	
	reporting period (if calendar year, enter 0 on this line)					
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	2, 213	9. 00	
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII only	v (includina private ro	oom davs)	0	10. 00	
	through December 31 of the cost reporting period (see instruction		, ,			
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only		oom days) after	0	11. 00	
12. 00	December 31 of the cost reporting period (if calendar year, ent- Swing-bed NF type inpatient days applicable to titles V or XIX		room days)	0	12. 00	
12.00	through December 31 of the cost reporting period	only (merdaring private	z room days)		12.00	
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13. 00	
14. 00	after December 31 of the cost reporting period (if calendar yea			0	14. 00	
15. 00	Medically necessary private room days applicable to the Program Total nursery days (title V or XIX only)	(excluding swing-bed t	lays)		15. 00	
16. 00	Nursery days (title V or XIX only)			0		
	SWING BED ADJUSTMENT					
17. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	through December 31 of	the cost	0.00	17. 00	
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of t	the cost	0.00	18. 00	
	reporting period					
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	0.00	19. 00			
20. 00						
	reporting period					
21. 00 22. 00	· · · · · · · · · · · · · · · · · · ·					
22.00	5 x line 17)	31 of the cost reporti	ng perrou (Trie	0	22. 00	
23. 00	Swing-bed cost applicable to SNF type services after December 3	1 of the cost reporting	g period (line 6	0	23. 00	
24.00	x line 18)	24 -6 +6++!-			24.00	
24. 00	Swing-bed cost applicable to NF type services through December 17 x line 19)	3) of the cost reportir	ng period (iine	0	24. 00	
25. 00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25. 00	
0, 00	x line 20)				0, 00	
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (I	ine 21 minus line 26)		0 52, 725, 801	26. 00 27. 00	
27.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	THE 21 IIITHUS TITHE 20)		32, 723, 001	27.00	
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)	0	28. 00	
29. 00	Pri vate room charges (excluding swing-bed charges)			0		
30.00	Semi-private room charges (excluding swing-bed charges)	line 20)		0 000000	30. 00 31. 00	
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 ÷ Average private room per diem charge (line 29 ÷ line 3)	TTHE 28)		0. 000000 0. 00		
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00		
34. 00	Average per diem private room charge differential (line 32 minus	s line 33)(see instruct	tions)	0.00		
35. 00	Average per diem private room cost differential (line 34 x line		11 0113)	0.00		
36. 00	Private room cost differential adjustment (line 3 x line 35)	0.,		0	36. 00	
37. 00	General inpatient routine service cost net of swing-bed cost and	d private room cost dif	ferential (line	52, 725, 801	37. 00	
	27 minus line 36)	· · · · · · · · · · · · · · · · · · ·				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	EMENTO				
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST			025 01	20 00	
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see in Program general inpatient routine service cost (line 9 x line 3)			925. 91 2, 049, 039		
40. 00	Medically necessary private room cost applicable to the Program	,		2, 049, 039		
	Total Program general inpatient routine service cost (line 39 +	•		2, 049, 039		
			·			

Heal th	Financial Systems	UNION HOSPI	TAL, I	NC.		In Lie	eu of Form CMS-:	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST			Provi der	CCN: 150023	Peri od: From 01/01/2015 To 12/31/2015		pared:
				Ti t	le XIX	Hospi tal	Cost	
	Cost Center Description	Total Inpatient Cost		otal ent Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2	2. 00	3.00	4. 00	5. 00	
42.00	NURSERY (title V & XIX only)	1, 915, 153	3	3, 606	531.	10 0	0	42. 00
40.00	Intensive Care Type Inpatient Hospital Units	10 (70 540	J	0.000	4 400	٥٦		40.00
43.00	INTENSIVE CARE UNIT CORONARY CARE UNIT	12, 679, 540	7	9, 032	1, 403.	85 C	0	
44. 00 45. 00	BURN INTENSIVE CARE UNIT							44. 00 45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT							46.00
47. 00		3, 406, 817	,	3, 528	965.	65 C	0	47. 00
	Cost Center Description		•				1. 00	
48. 00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3	3. line	200)			2, 560, 310	48. 00
	Total Program inpatient costs (sum of lines a PASS THROUGH COST ADJUSTMENTS				ons)		4, 609, 349	1
50.00	Pass through costs applicable to Program inpa	atient routine	servi	ces (from	n Wkst. D, su	m of Parts I and	0	50. 00
51. 00	Pass through costs applicable to Program inpa	atient ancillar	ry serv	/ices (fr	om Wkst. D,	sum of Parts II	0	51. 00
52. 00	and IV) Total Program excludable cost (sum of lines!	50 and 51)					0	52. 00
53. 00	Total Program inpatient operating cost exclusions medical education costs (line 49 minus line 9	ding capital re	el ated,	non-phy	sician anest	hetist, and	0	
	TARGET AMOUNT AND LIMIT COMPUTATION	32)						1
54.00	Program di scharges						0	54. 00
55.00	Target amount per discharge						0.00	1
56.00	Target amount (line 54 x line 55)				! 5/ -!	1: 52)	0	
57. 00 58. 00	Difference between adjusted inpatient operati Bonus payment (see instructions)	Tine 53)	0 0	1				
59. 00	Lesser of lines 53/54 or 55 from the cost re		1					
	market basket							
60.00	Lesser of lines 53/54 or 55 from prior year						0.00	1
61. 00	.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 than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)							
62.00								62. 00
63.00	3.00 Allowable Inpatient cost plus incentive payment (see instructions)							
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 3	31 of the	cost report	ing period (See	0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	ber 31	of the c	ost reportin	a period (See	0	65. 00
	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi						0	
	CAH (see instructions)	•	•		, ,	3,	0	
67. 00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	· ·						
	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)				·	orting period	0	
69. 00	Total title V or XIX swing-bed NF inpatient I PART III - SKILLED NURSING FACILITY, OTHER NU	JRSING FACILITY	, AND	ICF/IID	ONLY		0	1
70.00	Skilled nursing facility/other nursing facili	,			•)		70.00
71. 00 72. 00	Adjusted general inpatient routine service of		line 70) ÷ line	2)			71.00
73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applications)		m (line	e 14 x li	ne 35)			72. 00 73. 00
74. 00	Total Program general inpatient routine servi							74. 00
75. 00	Capital-related cost allocated to inpatient (26, line 45)	routine service	e costs	s (from W	lorksheet B,	Part II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)						76. 00
77. 00	Program capital-related costs (line 9 x line							77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		arovi d	ar rocard	le)			78. 00 79. 00
80.00	Total Program routine service costs for compa					nus line 79)		80.00
81. 00								81.00
82. 00								82. 00
83.00								83.00
84. 00 85. 00	Program inpatient ancillary services (see insultilization review - physician compensation		ons)					84. 00 85. 00
	Total Program inpatient operating costs (sum			85)				86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	THROUGH COST	<u> </u>					
87.00	Total observation bed days (see instructions)		Line	2)			9, 212	1
88. 00 89. 00	Adjusted general inpatient routine cost per of Observation bed cost (line 87 x line 88) (see	•		۷)			925. 91 8, 529, 483	1
	(30)		•				1 2, 22,7, 100	

Health Financial Systems	UNION HOSPI	TAL, INC.		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2015 To 12/31/2015	Date/Time Pre 5/25/2016 10:	
		Ti t	le XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	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	9, 307, 115	52, 725, 801	0. 17651	9 8, 529, 483	1, 505, 616	90. 00
91.00 Nursing School cost	0	52, 725, 801	0.00000	0 8, 529, 483	0	91.00
92.00 Allied health cost	0	52, 725, 801	0.00000	0 8, 529, 483	0	92. 00
93.00 All other Medical Education	0	52, 725, 801	0.00000	0 8, 529, 483	0	93. 00

Health Financial Systems	UNION HOSPITAL,	LNC		Inlie	u of Form CMS-2	2552_10
I NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	ONT ON TIOSITI TAL,			Peri od:	Worksheet D-3	
				From 01/01/2015 To 12/31/2015	Date/Time Prep 5/25/2016 10:0	
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description			Ratio of Cos	t Inpatient	Inpati ent	
			To Charges	Program	Program Costs	

				10 12/31/2015	5/25/2016 10:	
		Ti tl (e XVIII	Hospi tal	PPS	OT dill
	Cost Center Description	11 (1	Ratio of Cost		Inpati ent	
	oost oontor bescriptron		To Charges	Program	Program Costs	
			. o onal goo	Charges	(col . 1 x col .	
				onal goo	2)	
		İ	1. 00	2. 00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	'				
30.00	03000 ADULTS & PEDI ATRI CS			43, 877, 524		30.00
31.00	03100 I NTENSI VE CARE UNI T			16, 178, 900	1	31. 00
35.00	02040 I NTENSI VE NURSERY			0	l	35. 00
41.00	04100 SUBPROVI DER - I RF			0		41.00
43.00	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS			<u>'</u>	'	
50.00	05000 OPERATI NG ROOM		0. 14986	5 41, 589, 619	6, 232, 828	50.00
50. 01	05001 CARDI AC SURGERY		0. 37750	6 5, 473, 300	2, 066, 204	50. 01
50. 02	05002 WVSC		0. 15740	3 78, 559	12, 365	50. 02
51.00	05100 RECOVERY ROOM		0. 62192	1, 008, 905	627, 459	51.00
51. 02	05101 0/P TREATMENT ROOM		1. 46898	4 26, 237	38, 542	51. 02
52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 49200	1, 957, 527	963, 105	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 31174	6 5, 867, 596	1, 829, 200	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C		0. 24389	922, 109	224, 898	55. 00
56.00	05600 RADI OI SOTOPE		0. 16146	8 489, 874	79, 099	56. 00
57.00	05700 CT SCAN		0. 05824	1 9, 167, 068	533, 899	57. 00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 14962	2 1, 557, 309	233, 008	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON		0. 22891	8 12, 639, 846	2, 893, 488	59. 00
60.00	06000 LABORATORY		0. 14075	7 20, 736, 804	2, 918, 850	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	ĺ	0. 64452	1, 297, 779	836, 446	62. 00
65.00	06500 RESPI RATORY THERAPY		0. 38718	2 6, 540, 634	2, 532, 416	65. 00
66.00	06600 PHYSI CAL THERAPY	ĺ	0. 34975			66. 00
66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0.00000			66. 01
66. 02	06602 0/P PHYSI CAL THERAPY		0. 38381	3 0	0	66. 02
67.00	06700 OCCUPATI ONAL THERAPY		0. 25658		333, 392	67. 00
68.00	06800 SPEECH PATHOLOGY	ĺ	0.40074	0 435, 654	174, 584	68. 00
69.00	06900 ELECTROCARDI OLOGY	ĺ	0. 19055	5, 302, 220	1, 010, 338	69. 00
69. 01	06901 CARDI AC REHAB	ĺ	0. 79663	3 114, 694	91, 369	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	ĺ	0. 40191	9 713, 341	286, 705	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 59970	1, 363, 509	817, 707	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 61376	5 4, 439, 855	2, 725, 028	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 22667	7 33, 738, 679		
76.00	03020 RENAL ACUTE		0. 55485	2, 209, 392	1, 225, 886	76. 00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLI NI C		0. 67308	1 0	0	90.00
90.05	09005 PATIENT NUTRITION		1. 98008	8 0	0	90. 05
90. 07	09007 WOUND CLINIC		0. 35102	1 4, 729	1, 660	90. 07
91.00	09100 EMERGENCY	l	0. 13092	6 13, 782, 757	1, 804, 521	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	l	0. 45278	1 25, 112		92.00
200.00	Total (sum of lines 50-94 and 96-98)	l		175, 475, 543	39, 094, 073	200. 00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0)	201. 00
202.00	Net Charges (line 200 minus line 201)	l		175, 475, 543	i	202. 00

ealth Financial Systems UNION HOSPITAL NPATIENT ANCILLARY SERVICE COST APPORTIONMENT		CCN: 150023	Peri od:	u of Form CMS-3 Worksheet D-3	
NPATTENT ANGILLARY SERVICE COST APPORTIONWENT	Provider	CCN. 130023	From 01/01/2015	WOLKSHEET D-3	'
	Component	CCN: 15T023		Date/Time Pre 5/25/2016 10:	pared: 01 am
	Ti tl	e XVIII	Subprovi der - I RF	PPS	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
		1.00	2. 00	2) 3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS			0		30.00
81. 00 03100 NTENSI VE CARE UNI T			0		31.00
85. 00 02040 I NTENSI VE NURSERY			0		35. 00
11. 00 04100 SUBPROVI DER - I RF			2, 666, 449		41.00
13. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM		0. 1498	65 100, 566	15, 071	50.00
50. 01 05001 CARDI AC SURGERY		0. 3775	· ·	5, 322	
50. 02 05002 WVSC		0. 1574	03 174	27	
51. 00 05100 RECOVERY ROOM		0. 6219	· ·	1, 076	
51.02 05101 O/P TREATMENT ROOM		1. 4689		26	
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 4920		1, 483	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 3117		17, 897	
55. 00 O5500 RADI OLOGY-THERAPEUTI C		0. 2438		7, 371	1
66. 00 05600 RADI OI SOTOPE		0. 1614		146	
67.00 05700 CT SCAN 68.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0.0582		4, 045	
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 59. 00 05900 CARDIAC CATHETERIZATION		0. 1496 0. 2289	· ·	4, 219 11, 783	
50. 00 06000 LABORATORY		0. 2269		42, 204	
22. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 1407		16, 161	1
55. 00 06500 RESPIRATORY THERAPY		0. 3871	· ·	51, 657	1
66. 00 06600 PHYSI CAL THERAPY		0. 3497		459, 450	
66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 0000		0	1
66. 02 06602 0/P PHYSI CAL THERAPY		0. 3838		Ō	1
57. 00 06700 OCCUPATI ONAL THERAPY		0. 2565		317, 254	
98. 00 06800 SPEECH PATHOLOGY		0. 4007		108, 106	
99. 00 06900 ELECTROCARDI OLOGY		0. 1905	50 27, 372	5, 216	69.00
99. 01 06901 CARDI AC REHAB		0. 7966	33 0	0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 4019	19 15, 679	6, 302	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 5997	08 9, 375	5, 622	71.00
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 6137		0	1
73.00 O7300 DRUGS CHARGED TO PATIENTS		0. 2266	· ·	188, 570	
76. 00 03020 RENAL ACUTE		0. 5548	52 125, 997	69, 910	76.00
OUTPATIENT SERVICE COST CENTERS		0 (700	0.1		00.00
00. 00 09000 CLINI C		0. 6730		0	
00.05 09005 PATLENT NUTRITION 00.07 09007 WOUND CLINIC		1. 9800 0. 3510		0	
70. 07 09007 WOUND CLINIC 21. 00 09100 EMERGENCY		0. 3510		0	90.07
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 1309	· ·	1, 735	1
200.00 Total (sum of lines 50-94 and 96-98)		0.4327	4, 658, 997	1, 340, 653	
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		4, 050, 497	1, 340, 033	201. 00
202.00 Net Charges (line 200 minus line 201)	(1110 01)	I	4, 658, 997		202. 00

Health Financial Systems	UNION HOSPITAL,	I NC.		In Lieu	u of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN:	150023	Peri od: From 01/01/2015	Worksheet D-3
					Date/Ti me Prepared: 5/25/2016 10:01 am
		Title XI	Χ	Hospi tal	Cost

				From 01/01/2015 To 12/31/2015	Date/Ti me Pre 5/25/2016 10:	
		Ti t	le XIX	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	2.00	2) 3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3.00	
30. 00	03000 ADULTS & PEDIATRICS			2, 465, 401		30.00
31. 00	03100 I NTENSI VE CARE UNI T			974, 181		31. 00
35. 00	02040 I NTENSI VE NURSERY			0		35. 00
41. 00	04100 SUBPROVI DER - I RF			121, 569		41. 00
43. 00	04300 NURSERY			857, 633		43. 00
10.00	ANCILLARY SERVICE COST CENTERS			007,000		10.00
50.00	05000 OPERATING ROOM		0. 14986	5 2, 046, 146	306, 646	50. 00
50. 01	05001 CARDI AC SURGERY		0. 37750		0	50. 01
50. 02	05002 WVSC		0. 15740			50. 02
51. 00	05100 RECOVERY ROOM		0. 62192		38, 669	51. 00
51. 02	05101 0/P TREATMENT ROOM		1. 46898		0	51. 02
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 49200		107, 893	52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 31168		116, 987	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C		0. 24389			55. 00
56. 00	05600 RADI OI SOTOPE		0. 16146		5, 652	56.00
57. 00	05700 CT SCAN		0. 05824			57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 14962		l	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON		0. 22891		12, 171	59. 00
60. 00	06000 LABORATORY		0. 14018			60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 64452		l	62. 00
65. 00	06500 RESPIRATORY THERAPY		0. 38718		l	65. 00
66. 00	06600 PHYSI CAL THERAPY		0. 34975		51, 876	66.00
66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 00000		0	66. 01
66. 02	06602 0/P PHYSI CAL THERAPY		0. 38381		0	66. 02
67. 00	06700 OCCUPATI ONAL THERAPY		0. 25658			67. 00
68. 00	06800 SPEECH PATHOLOGY		0. 40074		15, 537	68. 00
69. 00	06900 ELECTROCARDI OLOGY		0. 19055			69. 00
69. 01	06901 CARDI AC REHAB		0. 79663		3, 641	69. 01
70. 00	07000 ELECTROENCEPHALOGRAPHY		0. 40191		l	•
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 59970		l	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 61376		l	•
73. 00	07300 DRUGS CHARGED TO PATIENTS		0. 22667		l	1
76. 00	03020 RENAL ACUTE		0. 55485		25, 535	
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLI NI C		0. 67308	1, 907	1, 284	90.00
90. 05	09005 PATIENT NUTRITION		1. 96913	0	0	90. 05
90. 07	09007 WOUND CLINIC		0. 35102	.1 0	0	90. 07
91.00	09100 EMERGENCY		0. 13092	790, 460	103, 492	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 45278		53, 708	92.00
200.00	Total (sum of lines 50-94 and 96-98)			10, 524, 048	2, 560, 310	200. 00
201.00	Less PBP Clinic Laboratory Services-Program only charges (I	ine 61)		0		201. 00
202.00	Net Charges (line 200 minus line 201)			10, 524, 048		202. 00

				0 12/31/2015	Date/lime Pre 5/25/2016 10:	
		Ti tl	e XVIII	Hospi tal	PPS	<u> </u>
			0	1 00	2.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		0	1. 00	2. 00	
1.00	DRG Amounts Other than Outlier Payments			0		1.00
1.01	DRG amounts other than outlier payments for discharges occurring	g prior		41, 808, 508		1. 01
1. 02	to October 1 (see instructions) DRG amounts other than outlier payments for discharges occurring	a on or		14 200 207		1. 02
1.02	after October 1 (see instructions)	y on or		14, 390, 387		1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for			0		1. 03
4 04	discharges occurring prior to October 1 (see instructions)					1 04
1. 04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)			0		1. 04
2.00	Outlier payments for discharges. (see instructions)			666, 583		2. 00
2.01	Outlier reconciliation amount			O		2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instruction	ns)		0		2. 02
3. 00 4. 00	Managed Care Simulated Payments Bed days available divided by number of days in the cost report	i na		6, 272, 454 232. 81		3. 00 4. 00
1. 00	period (see instructions)	1119		202.01		1.00
	Indirect Medical Education Adjustment					
5. 00	FTE count for allopathic and osteopathic programs for the most cost reporting period ending on or before 12/31/1996. (see instructions)			12. 22		5. 00
6. 00	FTE count for allopathic and osteopathic programs which meet the			0.00		6. 00
	criteria for an add-on to the cap for new programs in accordance					
7 00	CFR 413.79(e)			0.00		7.00
7. 00	MMA Section 422 reduction amount to the IME cap as specified uni $CFR \S 412.105(f)(1)(iv)(B)(1)$	der 42		0.00		7. 00
7. 01	ACA Section 5503 reduction amount to the IME cap as specified u	nder 42		0.00		7. 01
	CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July					
0.00	then see instructions.	i a and		0.00		0.00
8. 00	Adjustment (increase or decrease) to the FTE count for allopath osteopathic programs for affiliated programs in accordance with			0.00		8. 00
	413. 75(b), 413. 79(c) (2) (i v), 64 FR 26340 (May 12, 1998), and 67					
	(August 1, 2002).					
8. 01	The amount of increase if the hospital was awarded FTE cap slot- section 5503 of the ACA. If the cost report straddles July 1, 2			0.00		8. 01
	instructions.	orr, see				
8.02	The amount of increase if the hospital was awarded FTE cap slots	s from a		0.00		8. 02
0.00	closed teaching hospital under section 5506 of ACA. (see instru			12.22		0.00
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines and 8,02) (see instructions)	(8, 8,01		12. 22		9. 00
10.00	FTE count for allopathic and osteopathic programs in the curren	t year		20. 98		10.00
	from your records					
11. 00 12. 00	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)			0. 00 12. 22		11. 00 12. 00
13. 00	Total allowable FTE count for the prior year.			12. 22		13.00
14.00	Total allowable FTE count for the penultimate year if that year	ended on		12. 22		14. 00
45.00	or after September 30, 1997, otherwise enter zero.			10.00		45.00
15. 00 16. 00	Sum of lines 12 through 14 divided by 3. Adjustment for residents in initial years of the program			12. 22 0. 00		15. 00 16. 00
	Adjustment for residents displaced by program or hospital closu	re		0.00		17. 00
18. 00	Adjusted rolling average FTE count			12. 22		18. 00
	Current year resident to bed ratio (line 18 divided by line 4).			0. 052489		19.00
20. 00 21. 00	Prior year resident to bed ratio (see instructions) Enter the lesser of lines 19 or 20 (see instructions)			0. 053693 0. 052489		20.00
22. 00	IME payment adjustment (see instructions)			1, 588, 293		22. 00
22. 01	IME payment adjustment - Managed Care (see instructions)			177, 272		22. 01
00.00	Indirect Medical Education Adjustment for the Add-on for Section		he MMA	0.45		00.00
23. 00	Number of additional allopathic and osteopathic IME FTE residen slots under 42 Sec. 412.105 (f)(1)(iv)(C).	т сар		8. 45		23. 00
24. 00	IME FTE Resident Count Over Cap (see instructions)			8. 76		24. 00
25. 00	If the amount on line 24 is greater than -O-, then enter the lo	wer of		8. 45		25. 00
26. 00	line 23 or line 24 (see instructions)			0.034304		24 00
27. 00	Resident to bed ratio (divide line 25 by line 4) IME payments adjustment factor. (see instructions)			0. 036296 0. 009599		26. 00 27. 00
28. 00	IME add-on adjustment amount (see instructions)			539, 453		28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)			60, 209		28. 01
29. 00	Total IME payment (sum of lines 22 and 28)			2, 127, 746		29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment			237, 481		29. 01
30. 00	Percentage of SSI recipient patient days to Medicare Part A pat	ient days		5. 35		30. 00
	(see instructions)	-				
31.00	Percentage of Medicaid patient days (see instructions)			22. 61		31. 00 32. 00
32. 00 33. 00	Sum of lines 30 and 31 Allowable disproportionate share percentage (see instructions)			27. 96 12. 28		32.00
	Disproportionate share adjustment (see instructions)			1, 725, 306		34. 00
				·		

From 01/01/2015 Part A Date/Time Prepared: 12/31/2015 5/25/2016 10:01 am Title XVIII Hospi tal Prior to On/After October 1 October 1 n 2 00 1 00 Uncompensated Care Adjustment 35.00 7, 647, 644, 885 6, 406, 145, 534 Total uncompensated care amount (see instructions) 35.00 35. 01 Factor 3 (see instructions) 0.000462085 0.000460744 35.01 Hospital uncompensated care payment (If line 34 is zero, 3, 533, 862 2, 951, 593 35.02 35.02 enter zero on this line) (see instructions) Pro rata share of the hospital uncompensated care payment 2, 643, 134 741, 930 35.03 amount (see instructions) 36.00 Total uncompensated care (sum of columns 1 and 2 on line 3, 385, 064 36.00 35 ()3) Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46) Total Medicare discharges on Worksheet S-3, Part I 0 40.00 excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions) 41.00 Total ESRD Medicare discharges excluding MS-DRGs 652, 41.00 0 682, 683, 684 an 685. (see instructions) Total ESRD Medicare covered and paid discharges excluding 41.01 0 41.01 MS-DRGs 652, 682, 683, 684 an 685. (see instructions) Divide line 41 by line 40 (if less than 10%, you do not 42.00 0.00 42.00 qualify for adjustment) 43.00 Total Medicare ESRD inpatient days excluding MS-DRGs 652, 0 43.00 682, 683, 684 an 685. (see instructions) 44.00 Ratio of average length of stay to one week (line 43 0.000000 44 00 divided by line 41 divided by 7 days) 45.00 Average weekly cost for dialysis treatments (see 0.00 45.00 instructions) 46.00 Total additional payment (line 45 times line 44 times line 0 46, 00 41.01) 47 00 Subtotal (see instructions) 64, 103, 594 47 00 Hospital specific payments (to be completed by SCH and 48.00 48.00 MDH, small rural hospitals only. (see instructions) 49.00 Total payment for inpatient operating costs (see 49.00 64, 341, 075 instructions) Payment for inpatient program capital (from Wkst. L, Pt. I 50.00 50.00 5, 164, 745 and Pt. II, as applicable) 51.00 Exception payment for inpatient program capital (Wkst. L, 51.00 0 Pt. III, see instructions) Direct graduate medical education payment (from Wkst. E-4, 52.00 771, 748 52.00 line 49 see instructions) Nursing and Allied Health Managed Care payment 53.00 2.691 53.00 54.00 Special add-on payments for new technologies 8, 278 54.00 55.00 Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, 55.00 line 69) 56 00 Cost of physicians' services in a teaching hospital (see O 56 00 intructions) 57.00 Routine service other pass through costs (from Wkst. D, 0 57 00 Pt. III, column 9, lines 30 through 35) 58.00 Ancillary service other pass through costs from Wkst. D, 92, 024 58.00 Pt. IV, col. 11 line 200) Total (sum of amounts on lines 49 through 58) 70, 380, 561 59 00 59 00 60.00 Primary payer payments 33, 762 60.00 Total amount payable for program beneficiaries (line 59 70, 346, 799 61.00 61.00 minus line 60) 5, 766, 108 62.00 Deductibles billed to program beneficiaries 62.00 Coinsurance billed to program beneficiaries 63.00 166, 276 63.00 64.00 Allowable bad debts (see instructions) 681, 245 64.00 65.00 Adjusted reimbursable bad debts (see instructions) 442.809 65.00 Allowable bad debts for dual eligible beneficiaries (see 66.00 207, 808 66.00 instructions) 67.00 Subtotal (line 61 plus line 65 minus lines 62 and 63) 64, 857, 224 67.00 Credits received from manufacturers for replaced devices 68.00 68.00 for applicable to MS-DRGs (see instructions) 69.00 Outlier payments reconciliation (sum of lines 93, 95 and 69.00 96). (For SCH see instructions) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 70.00 70 00 RURAL DEMONSTRATION PROJECT 0 70.50 70.50 70.89 Pioneer ACO demonstration payment adjustment amount (see 70.89 instructions) HSP bonus payment HVBP adjustment amount (see 70.90 70.90 0 instructions) 70.91 HSP bonus payment HRR adjustment amount (see instructions) 0 70.91 Bundled Model 1 discount amount (see instructions) 70.92 HVBP payment adjustment amount (see instructions) 176, 209 70.93 70.93 HRR adjustment amount (see instructions) 70.94 70 94 -417, 862 70.95 Recovery of accelerated depreciation 70.95

alth Financial Systems UNION HOSPITA NLCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150023		u of Form CMS-	2332-1
ALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150023	Peri od: From 01/01/2015	Worksheet E Part A	
		To 12/31/2015	Date/Time Pre 5/25/2016 10:	
	Title XVIII	Hospi tal	PPS	<u> </u>
		Prior to	On/After	
		October 1	October 1	-
0.96 Low volume adjustment for federal fiscal year (yyyy)	0	0 1.00	2. 00	70. 9
(Enter in column 0 the corresponding federal year for the				70. 9
period prior to 10/1)				
0.97 Low volume adjustment for federal fiscal year (yyyy)		o o		70. 9
(Enter in column 0 the corresponding federal year for the				
period ending on or after 10/1)				
0.98 Low Volume Payment-3		o		70. 9
). 99 HAC adjustment amount (see instructions)		o		70. 9
1.00 Amount due provider (line 67 minus lines 68 plus/minus		64, 615, 571		71.0
lines 69 & 70)				
.01 Sequestration adjustment (see instructions)		1, 292, 311		71. C
2.00 Interim payments		62, 181, 950		72. C
3.00 Tentative settlement (for contractor use only)		0		73. C
H.00 Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		1, 141, 310		74.0
5.00 Protested amounts (nonallowable cost report items) in		639, 095		75.0
accordance with CMS Pub. 15-2, chapter 1, §115.2				
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
0.00 Operating outlier amount from Wkst. E, Pt. A, line 2 (see		0		90.0
instructions)				
.00 Capital outlier from Wkst. L, Pt. I, line 2		0		91.0
2.00 Operating outlier reconciliation adjustment amount (see instructions)		0		92.0
3.00 Capital outlier reconciliation adjustment amount (see		0		93.0
instructions)				
1.00 The rate used to calculate the time value of money (see		0.00		94.0
instructions)		_		l
5.00 Time value of money for operating expenses (see		0		95. C
instructions)				
5.00 Time value of money for capital related expenses (see		U U		96.0
instructions)		Prior to 10/1	On/Aftor 10/1	_
		1.00	2.00	
HSP Bonus Payment Amount		1.00	2.00	
00.00 HSP bonus amount (see instructions)		0	0	100. c
HVBP Adjustment for HSP Bonus Payment		٩		1.00.0
01.00 HVBP adjustment factor (see instructions)		0.0000000000	0. 0000000000	1101.0
02.00 HVBP adjustment amount for HSP bonus payment (see instruction	is)	0.000000000		102. C
HRR Adjustment for HSP Bonus Payment	/	<u> </u>		1
03.00 HRR adjustment factor (see instructions)		0.0000	0. 0000	1103 C
04.00 HRR adjustment amount for HSP bonus payment (see instructions	.)	0.0000		104. 0

Provi der CCN: 150023

						5/25/2016 10:		
						Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4. 00	5. 00	
1. 00	DRG amounts other than outlier	1. 00	0	0	0		0	1. 00
1. 01	payments DRG amounts other than outlier	1. 01	41, 808, 508	0	41, 808, 508	0	41, 808, 508	1. 01
1. 02	payments for discharges occurring prior to October 1 DRG amounts other than outlier	1. 02	14, 390, 387	0	0	14, 390, 387	14, 390, 387	1. 02
1.02	payments for discharges occurring on or after October	1. 02	14, 370, 307	0	O	14, 370, 307	14, 370, 367	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	0	0	0	0	0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0	0	O	0	1. 04
2.00	Outlier payments for discharges (see instructions)	2. 00	666, 583	0	486, 066	180, 518	666, 584	2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	0	0	0	2. 01
3. 00	Operating outlier reconciliation	2. 01	0	0	0	0	0	3. 00
4. 00	Managed care simulated payments Indirect Medical Education Adju	3. 00	6, 272, 454	0	4, 766, 128	1, 506, 327	6, 272, 455	4. 00
5. 00	Amount from Worksheet E, Part	21. 00	0. 052489	0. 052489	0. 052489	0. 052489		5. 00
6. 00	A, line 21 (see instructions) IME payment adjustment (see	22. 00	1, 588, 293	0	1, 181, 592		1, 588, 293	6. 00
6. 01	instructions) IME payment adjustment for	22. 01	177, 272	0	134, 700	42, 572	177, 272	6. 01
	managed care (see instructions)							
7 00	Indirect Medical Education Adju IME payment adjustment factor				ne MMA 0.009599	0. 009599		7 00
7. 00	(see instructions)	27. 00	0. 009599	0. 009599	0.009599	0.009599		7. 00
8. 00	IME adjustment (see	28. 00	539, 453	0	401, 320	138, 133	539, 453	8. 00
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	60, 209	O	45, 750	14, 459	60, 209	8. 01
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	2, 127, 746	0	1, 582, 912	544, 834	2, 127, 746	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	237, 481	0	180, 450	57, 031	237, 481	9. 01
	Disproportionate Share Adjustme							
10. 00	Allowable disproportionate share percentage (see instructions)	33. 00	0. 1228	0. 1228	0. 1228	0. 1228		10.00
11. 00	Disproportionate share adjustment (see instructions)	34. 00	1, 725, 306	0	1, 283, 521	441, 785	1, 725, 306	11. 00
11. 01	Uncompensated care payments	36. 00	3, 385, 064	0	2, 643, 134	741, 930	3, 385, 064	11. 01
10.00	Additional payment for high per		RD beneficiary		_			10.00
12. 00	Total ESRD additional payment (see instructions)	46. 00	0	0	0		0	
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47. 00 48. 00	64, 103, 594 0	0	47, 804, 140 0	16, 299, 454 0	64, 103, 594 0	13. 00 14. 00
15. 00	(see instructions) Total payment for inpatient operating costs (see	49. 00	64, 341, 075	0	47, 984, 590	16, 356, 485	64, 341, 075	15. 00
16. 00	instructions) Payment for inpatient program	50. 00	5, 164, 745	0	3, 829, 695	1, 335, 050	5, 164, 745	16. 00
17. 00	capital Special add-on payments for new technologies	54.00	8, 278	0	8, 278	О	8, 278	17. 00
17. 01 17. 02	Net organ aquisition cost Credits received from	55. 00 68. 00	0	0	0		0	17. 01 17. 02
18. 00	manufacturers for replaced devices for applicable MS-DRGs Capital outlier reconciliation	93. 00	0	0	0		0	
	adjustment amount (see instructions)							

							o 12/31/2015	Date/Time Pre 5/25/2016 10:	pared:		
					Ti tl	e XVIII	Hospi tal	PPS			
		W/S E, Part A	Amounts (from Pre/		/S E, Part A Amounts (from F		ost	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitle	ement	to 10/01	On/After 10/01	through 4)			
		0	1.00	2.00	0	3.00	4. 00	5. 00			
19.00	SUBTOTAL				0	51, 822, 563	17, 691, 535	69, 514, 098	19. 00		
		W/S L, line	(Amounts from								
			L)								
		0	1.00	2.00	0	3.00	4. 00	5. 00			
20.00	Capital DRG other than outlier	1. 00	4, 507, 840		0	3, 341, 168	1, 166, 672	4, 507, 840	20. 00		
20. 01	Model 4 BPCI Capital DRG other	1. 01	0		0	(0	0	20. 01		
	than outlier										
21.00	Capital DRG outlier payments	2. 00	232, 718		0	232, 718	58, 594	291, 312	21. 00		
21. 01	Model 4 BPCI Capital DRG	2. 01	0		0	(0	0	21. 01		
	outlier payments										
22.00	Indirect medical education	5. 00	0. 0359	(0. 0359	0. 0359	0. 0359		22. 00		
	percentage (see instructions)										
23.00	Indirect medical education	6. 00	161, 831		0	119, 947	41, 884	161, 831	23. 00		
	adjustment (see instructions)										
24.00	Allowable disproportionate	10.00	0. 0582	(0. 0582	0. 0582	0. 0582		24. 00		
	share percentage (see										
	instructions)										
25.00	Di sproporti onate share	11. 00	262, 356		0	194, 456	67, 900	262, 356	25. 00		
	adjustment (see instructions)										
26.00	Total prospective capital	12.00	5, 164, 745		0	3, 829, 695	1, 335, 050	5, 164, 745	26. 00		
	payments (see instructions)										
		W/S E, Part A	(Amounts to E,								
		line	Part A)								
		0	1. 00	2.00	0	3.00	4. 00	5. 00			
27.00	Low volume adjustment factor					0. 000000	0.000000		27. 00		
28.00	Low volume adjustment	70. 96				(0	28. 00		
	(transfer amount to Wkst. E,										
	Pt. A, line)										
29.00	Low volume adjustment	70. 97					0	0	29. 00		
	(transfer amount to Wkst. E,										
	Pt. A, line)										
100.00	Transfer low volume		Y						100. 00		
	adjustments to Wkst. E, Pt. A.										

Heal th Financial SystemsUNION HOSPIHOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 Provi der CCN: 150023

						0 12/31/2015	5/25/2016 10:	
				Ti tl	e XVIII	Hospi tal	PPS	
		Wkst. E, Pt.	Amt	. from	Period to	Peri od on	Total (cols. 2	
		A, line		E, Pt.	10/01	after 10/01	and 3)	
				A)				
		0	1	. 00	2. 00	3. 00	4. 00	
1.00	DRG amounts other than outlier payments	1. 00						1. 00
1. 01	DRG amounts other than outlier payments for	1. 01	41	, 808, 508	41, 808, 508		41, 808, 508	1. 01
	discharges occurring prior to October 1							
1. 02	DRG amounts other than outlier payments for	1. 02	14	1, 390, 387		14, 390, 387	14, 390, 387	1. 02
	discharges occurring on or after October 1			_	_		_	
1.03	DRG for Federal specific operating payment	1. 03		O	0		0	1. 03
	for Model 4 BPCI occurring prior to October							
1. 04	DRG for Federal specific operating payment	1. 04		0		0	0	1. 04
1.04	for Model 4 BPCI occurring on or after	1.04		U		0	0	1.04
	October 1							
2.00	Outlier payments for discharges (see	2. 00		666, 583	486, 066	180, 518	666, 584	2. 00
	instructions)			,	,	,		
2. 01	Outlier payments for discharges for Model 4	2. 02		o	0	0	0	2. 01
	BPCI							
3.00	Operating outlier reconciliation	2. 01		0	0	0	0	3. 00
4.00	Managed care simulated payments	3. 00	1 6	, 272, 454	4, 766, 128	1, 506, 327	6, 272, 455	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21	21. 00		0. 052489	0. 052489	0. 052489		5. 00
	(see instructions)							
6.00	IME payment adjustment (see instructions)	22. 00	1	, 588, 293	1, 181, 592		1, 588, 293	6.00
6. 01	IME payment adjustment for managed care (see	22. 01		177, 272	134, 700	42, 572	177, 272	6. 01
	instructions)			422 - 6 +	1414.0			
7. 00	Indirect Medical Education Adjustment for the IME payment adjustment factor (see	27.00	T	0. 009599	0. 009599	0. 009599		7. 00
7.00	instructions)	27.00		0.009399	0.009399	0.009399		7.00
8. 00	IME adjustment (see instructions)	28. 00		539, 453	401, 320	138, 133	539, 453	8. 00
8. 01	IME payment adjustment add on for managed	28. 01		60, 209	45, 750			8. 01
0.0.	care (see instructions)	20.01		00,20,	107 700	,,	00,20,	0.0.
9.00	Total IME payment (sum of lines 6 and 8)	29. 00		2, 127, 746	1, 582, 912	544, 834	2, 127, 746	9. 00
9. 01	Total IME payment for managed care (sum of	29. 01		237, 481	180, 450		237, 481	9. 01
	lines 6.01 and 8.01)			.				
	Disproportionate Share Adjustment							
10. 00	Allowable disproportionate share percentage	33. 00		0. 1228	0. 1228	0. 1228		10. 00
	(see instructions)							
11. 00	Di sproporti onate share adjustment (see	34.00	1	, 725, 306	1, 283, 521	441, 785	1, 725, 306	11. 00
11. 01	instructions) Uncompensated care payments	36. 00		205 044	2 642 124	741, 930	2 205 044	11. 01
11.01	Additional payment for high percentage of ESF			3, 385, 064	2, 643, 134	741, 930	3, 385, 064	11.01
12. 00	Total ESRD additional payment (see	46.00	ui scrie	0	0	0	0	12. 00
12.00	instructions)	40.00		O	0	0	٥	12.00
13. 00	Subtotal (see instructions)	47. 00	64	I, 103, 594	47, 804, 140	16, 299, 454	64, 103, 594	13. 00
14. 00	Hospital specific payments (completed by SCH	48. 00		0	0	0	0.,,0	14. 00
	and MDH, small rural hospitals only.) (see					_		
	instructions)							
15.00	Total payment for inpatient operating costs	49. 00	64	1, 341, 075	47, 984, 590	16, 356, 485	64, 341, 075	15. 00
	(see instructions)							
16.00	Payment for inpatient program capital	50. 00	5	5, 164, 745	3, 888, 289			
17. 00	Special add-on payments for new technologies	54.00		8, 278	8, 278		8, 278	
17. 01	Net organ aquisition cost	55. 00		0	0	0		17. 01
17. 02	Credits received from manufacturers for	68. 00		0	0	0	0	17. 02
40.05	replaced devices for applicable MS-DRGs	00.00		_	=	_	_	40.00
18. 00	Capital outlier reconciliation adjustment	93. 00		0	0	0	0	18. 00
10.00	amount (see instructions)				E1 001 1F7	17 422 044	40 E14 000	10 00
19.00	SUBTOTAL		1		51, 881, 157	17, 632, 941	69, 514, 098	I 19.00

Heal th	Financial Systems	UNION HOSPI	TAL, INC.		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5			Period: From 01/01/2015 To 12/31/2015	Date/Time Pre 5/25/2016 10:	pared:
				e 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, 507, 840	3, 341, 16	1, 166, 672	4, 507, 840	20. 00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0)	0	0	20. 01
21.00	Capital DRG outlier payments	2.00	232, 718	232, 71	8 0	232, 718	21. 00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0)	0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0359	0. 035	0. 0359		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	161, 831	119, 94	41, 884	161, 831	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0582	0. 058	0. 0582		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11.00	262, 356	194, 45	67, 900	262, 356	25. 00
26. 00	1	12.00	5, 164, 745	3, 888, 28	1, 276, 456	5, 164, 745	26. 00
		Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt.				
			A)				
		0	1.00	2. 00	3. 00	4. 00	
27. 00							27. 00
28. 00	Low volume adjustment prior to October 1	70. 96	0)	0	0	28. 00
29. 00	Low volume adjustment on or after October 1	70. 97	0	1	0	0	29. 00
30.00	HVBP payment adjustment (see instructions)	70. 93	176, 209	142, 21	1 33, 998	176, 209	
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	C		0 0	0	30. 01
31.00	HRR adjustment (see instructions)	70. 94	-417, 862	-338, 71	5 -79, 147	-417, 862	31. 00
31. 01	HRR adjustment for HSP bonus payment (see	70. 91	О		0	0	31. 01

0

70. 99

1.00

Ν

516, 847

3. 00

175, 878

2.00

692, 725

(Amt. to Wkst. E, Pt. A)

4.00

32. 00

100. 00

instructions)

32.00 HAC Reduction Program adjustment (see

instructions)

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

Health Financial Systems	UNION HOSPITAL,	I NC.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 150023	Peri od: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 5/25/2016 10:01 am
		Ti +Lo VVIII	Hospi tal	DDC

Part R With Call _ AMD_CTIMED _ IMPLES 1.00				10 12/31/2015	5/25/2016 10:	oarea: Olam
Deat B			Title XVIII	Hospi tal		JI alli
PART B - INDICAL AND OTHER HEALTH SERVICES 1.00 Medical and other services (see instructions) 22,589 1.00 1.00 Medical and other services (see instructions) 52,005,306 2.00			I to a account	110001 141	1.0	
Medical and other services (see instructions)					1. 00	
Medical and other services relatured under OPPS (see instructions)		PART B - MEDICAL AND OTHER HEALTH SERVICES				
DPS payments		· · · · · · · · · · · · · · · · · · ·				
0.00 Continue Co		· · · · · · · · · · · · · · · · · · ·	ons)			
Enter the hospital specific payment to cost ratio (see instructions) 0.000 5.00		1 1				
Line 2 times line 5						
7.00 Sum of Time 3 plus line 4 divided by line 6 0.00 7.00 8.00 Transitional corridor payment (see instructions) 0.80 0.80 9.00 Ancillary service other pass through costs from fikst. D. Pt. IV, col. 13, line 200 158, 979 9.00 11.00 Organ acquisitions 22, 589 11.00 11.00 Total cost (sum of Time 1 and 10) (see instructions) 22, 589 11.00 12.00 Ancillary service charges 100, 111 12, 00 Ancillary service charges 100, 111 12, 00 14.00 Intellary service charges 100, 111 12, 00 Ancillary service charges 100, 111 12, 00 15.00 Ancillary service charges 100, 111 12, 00 100, 111 14, 00 11, 00 11, 11 100 11, 10 11, 10 11, 10 11, 10 11, 10 11, 10 11, 10 11, 10 11, 10 11, 10 11, 10 11, 10 11, 10 11, 10 11, 10 11, 10 11, 10 11, 10 11, 11 11, 11 11, 10 11, 11 11, 10 11, 11<			i ons)			
8.00 Anounts tional corridor payment (see instructions) 18.00 Anounts tional cort (sum of lines 1 and 10) (see instructions) 22,569 10.00						
9,00						
0.00 Organ acquisitions 0.10.00 Computations 0.10.00 Comput						
1.00 Total cost (sum of lines 1 and 10) (see instructions) 22,889 11,00			, col. 13, line 200		158, 979	
COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges Reasonable charges 10,111 12,01 13,00 Cogna acquisit tin charges (from Wkst. D-4, Pt. 111, col. 4, 11ne 69) 0,13,00 13,00 13,00 10,111 14,00 13,00 13,00 10,111 14,00 13,00 13,00 10,111 14,00 10,111 14,00 10,111 14,00 10,111 14,00 10,111 14,00 10,111 14,00 10,111 14,00 10,111 14,00 10,111 14,00 10,111 14,00 10,111 14,00 10,111 14,00 10,111 14,00 10,111 14,00 10,111 14,00 15,00 16,		· ·			22 500	
Reasonable charges 100, 111 12.00 20.00 101 13.00	11.00				22, 589	11.00
2.00 Ancil lary service charges 100, 111 12.00 101 102.00 103 103 101 103 101 103 101 103 101 103 101 103 101 103 101 103 101 103 101 103 101 103 101 103 101 103 101 103 101 103						
13.00 Organ acquisition charges (from West. D-4, Pt. III, col. 4, line 69)	12 00				100 111	12 00
1.0 Total reasonable charges (sum of lines 12 and 13) 14.00			e 69)			
Customary charges Customary charges O 15.00 Agrogate amount actually collected from patients liable for payment for services on a charge basis O 15.00 Amounts that would have been realized from patients liable for payment for services on a charge basis O 16.00 Amounts that would have been realized from patients liable for payment for services on a charge basis O 16.00 Amounts that would have been realized from patients liable for payment for services on a charge basis O 16.00 Amounts that would have been realized from patients liable for payment for services on a charge basis O 16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis O 16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis O 16.00 Amounts that would have been realized from patients liable for payment for services in structions 10.0111 Illinois 10.00000 Illinois 10.000000 Illinois 10.000000 Illinois 10.000000 Illinois 10.0000000 Illinois 10.00000000 Illinois 10.0000000000000000000000000000000000			07)			
15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 16.00					100/ 111	
16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment theen made in accordance with 42 CFR \$41.313(e) 0.000000 17.00 17.00 18.10 19.00 19.10 19.00 19.10 19.00 19.10 19.00 19.10 19.00 19.10 19.00 19.10 19.00 19.10 19.00 19.10 19.00 19.10 19.00 19.10 19.00 19.10 19.00 19.10 19.00 19.10 1	15.00		yment for services on	a charge basis	0	15. 00
17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 17.00 17.00 18.00 17.00 18.00 17.00 18.00	16.00				0	16. 00
18.00 Total customary charges (see instructions) 100, 111 18.00 100, 111 100,		had such payment been made in accordance with 42 CFR §413.13(e)	. 3	Ü		
19. 00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 77, 522 19. 00	17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17.00
Instructions	18.00	Total customary charges (see instructions)			100, 111	18. 00
20. 00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0 20. 00 1 1 1 1 1 1 1 1 1	19. 00		if line 18 exceeds li	ne 11) (see	77, 522	19. 00
Instructions						
1.00 Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions) 0 22, 589 21, 00 22, 00 23, 00 20 20 20 20 20 20 20	20. 00		if line 11 exceeds li	ne 18) (see	0	20. 00
22.00 Interns and residents (see instructions) 0.23.00 0.23.00 0.25 tof physic lans' services in a teaching hospital (see instructions) 0.23.00 0.23.00 0.23.00 0.23.00 0.25 tof physic lans' services in a teaching hospital (see instructions) 0.23.00 0.23.00 0.23.00 0.23.00 0.23.00 0.23.00 0.23.00 0.23.00 0.25 tof physic lans' services 0.25 tof physic lans	21 00		i notrusti spo)		22 500	21 00
23. 00 Cost of physicians' services in a teaching hospital (see instructions) 52,576,028 24. 00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 52. 00 Deductible sand Coinsurance (for CAH, see instructions) 9,958,940 26. 00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 9,958,940 26. 00 Computation and Coinsurance relating to amount on line 24 (for CAH, see instructions) 9,958,940 26. 00 Computation and Coinsurance relating to amount on line 24 (for CAH, see instructions) 9,958,940 26. 00 Computation and Coinsurance relating to amount on line 24 (for CAH, see instructions) 9,958,940 26. 00 Computation and Coinsurance relating to amount on line 24 (for CAH, see instructions) 7,905 28. 00 Computation and Coinsurance relating to amount on line 24 (for CAH, see instructions) 7,907 28. 00 Computation and Coinsurance relating to amount on line 24 (for CAH, see instructions) 7,907 28. 00 Computation and Coinsurance (for Mwkst. E-4, line 30) 7,908 28. 00 7,909 28. 00 29. 00		, , ,	instructions)			
Total prospective payment (sum of lines 3, 4, 8 and 9) 52,576,028 24,00		· · · · · · · · · · · · · · · · · · ·	ections)			
COMPUTATION OF RELIMBURSEMENT SETTLEMENT Deductibles and coinsurance (for CAH, see instructions) 163 25			Ctrons)		-	
25.00 Deductibles and coinsurance (for CAH, see instructions) Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions) 9,958,940 26.00 26.00 Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions) 29,958,940 26.00 27.00 28.00 29.00 2	24.00				32, 370, 020	24.00
26.00 Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions) 9,988,940 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) 42,639,514 27.00 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 529,075 28.00 30.00 Subtotal [(line 30 minus line 37) 43,188,589 30.00 31.00 Primary payer payments 19,938 31.00 32.00 Subtotal [(line 30 minus line 31) 43,148,651 32.00 31.00 Primary payer payments 19,938 31.00 32.00 Subtotal (line 30 minus line 31) 43,148,651 32.00 34.00 Composite rate ESRD (from Wkst. I-5, line 11) 0 33.00 34.00 Allowable bad debts (see instructions) 15,312,749 34.00 35.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 780,539 36.00 36.00 MSUDIAL (SEE INSTRUCTIONS) (SPECIFY) -552 38.00 39.00 MSP-LCC reconciliation amount from PS&R -552 38.00	25 00				163	25 00
27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see linstructions) 1			CAH. see instructions)			
Instructions Direct graduate medical education payments (from Wkst. E-4, line 50) 1 cett graduate medical education costs (from Wkst. E-4, line 36) 29,00 29,00 20						
29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 0 29.00 30.00				, ,		
30.00 Subtotal (sum of lines 27 through 29) 31.00 Primary payer payments 19.938 31.00 31.00 Primary payer payments 19.938 31.00 31.00 AULDWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 32.00 Allowable bad debts (see instructions) 1, 312, 749 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 853, 287 35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 780, 539 36.00 37.00 Subtotal (see instructions) 44.001,938 37.00 38.00 MSP-LCC reconciliation amount from PS&R -552 38.00 39.90 Primery ACO demonstration payment adjustment (see instructions) 39.90 Primer ACO demonstration payment adjustment (see instructions) 39.90 Primer ACO demonstration payment adjustment (see instructions) 39.90 39.90 Primer ACO demonstration payment adjustment (see instructions) 39.90 Primer ACO demonstration payment adjustme	28. 00	Direct graduate medical education payments (from Wkst. E-4, lin	e 50)		529, 075	28. 00
31.00 Primary payer payments 19,938 31.00 32.00 Subtotal (Line 30 minus line 31) 43,148,651 32.00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 1,312,749 34.00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 1,312,749 34.00 34.00 ALLOWABLE BAD DEBTS (ese instructions) 853,287 35.00 35.00 Adjusted reimbursable bad debts (see instructions) 853,287 35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 780,539 36.00 37.00 Subtotal (see instructions) 44.001,938 37.00 37.00 Subtotal (see instructions) 589,100 599,100	29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
32.00 Subtotal (line 30 minus line 31) AlLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Wkst. 1-5, line 11) 0 33.00 34.00 Allowable bad debts (see instructions) 1, 312, 749 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 853, 287 36.00 37.00 38.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 780, 539 36.00 37.00 38.00 MSP-LCC reconciliation amount from PS&R -552 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 13.100 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Sequestration adjustment (see instructions) 44,002,490 40.00 40.01 Interim payments 43,112,377 41.00 41.00 Interim payments 43,112,377 41.00 42.00 Tentative settlement (for contractors use only) 40.00 Protested amounts (nonall lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 Frotested amounts (nonall owable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 0 0 0 0 0 0 0 0		,				
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33. 00 Composite rate ESRD (from Wkst. I-5, Iine 11) 0 33. 00 34. 00 All lowable bad debts (see instructions) 1, 312,749 35. 00 Adjusted reimbursable bad debts (see instructions) 780, 539 36. 00 All owable bad debts for dual eligible beneficiaries (see instructions) 780, 539 36. 00 All owable bad debts for dual eligible beneficiaries (see instructions) 44, 001, 938 37. 00 Subtotal (see instructions) 44, 001, 938 38. 00 MSP-LCC reconciliation amount from PS&R -552 38. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39. 00 39. 90 Partial or full credits received from manufacturers for replaced devices (see instructions) 13, 100 39. 99 Partial or full credits received from manufacturers for replaced devices (see instructions) 13, 100 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 98 40. 00 Subtotal (see instructions) 44, 002, 490 40. 01 Sequestration adjustment (see instructions) 43, 112, 377 41. 00 Interim payments 43, 112, 377 42. 00 Tentative settlement (for contractors use only) 43, 00 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 50 BE COMPLETED BY CONTRACTOR 0 90. 00 90. 00 Original outlier amount (see instructions) 0 91. 00 91. 00 Outlier reconciliation adjustment amount (see instructions) 0 91. 00 92. 00 The rate used to calculate the Time Value of Money 0 93. 00						
33. 00 Composite rate ESRD (from Wkst. I - 5, line 11)	32. 00				43, 148, 651	32. 00
34.00 Allowable bad debts (see instructions) 1,312,749 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 853,287 35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 780,539 36.00 37.00 Subtotal (see instructions) 44,001,938 37.00 38.00 MSP-LCC reconciliation amount from PS&R -552 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 39.50 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 13,100 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 99.99 44,002,490 40.00 40.01 Sequestration adjustment (see instructions) 44,002,490 40.00 40.01 Interim payments 43,112,377 41.00 42.00 Tentative settlement (for contractors use only) 43,102,377 41.00 43.00 Bal ance due provider/program (see instructions) 10,063 43.00 44.00 Protested amounts (nonallowable cost report items) in accordance w	22.00		5)			22.00
35.00						
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39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39. 50 Pioneer ACO demonstration payment adjustment (see instructions) 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 98 RECOVERY OF ACCELERATED DEPRECIATION 39. 99 Subtotal (see instructions) 40. 01 Sequestration adjustment (see instructions) 40. 01 Interim payments 42. 00 Interim payments 42. 00 Tentative settlement (for contractors use only) 43. 00 Balance due provider/program (see instructions) 44. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115. 2 TO BE COMPLETED BY CONTRACTOR 90. 00 Outlier reconciliation adjustment amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money 93. 00 Time Value of Money (see instructions) 93. 00 Outlier reconciliation adjustment amount (see instructions) 93. 00 Outlier reconciliation adjustment amount (see instructions) 93. 00 Outlier reconciliation adjustment amount (see instructions) 94. 00 Outlier reconciliation adjustment amount (see instructions) 95. 00 Outlier reconciliation adjustment amount (see instructions) 96. 00 Outlier reconciliation adjustment amount (see instructions) 97. 00 Outlier reconciliation adjustment amount (see instructions) 97. 00 Outlier reconciliation adjustment amount (see instructions) 98. 00 Outlier reconciliation adjustment amount (see instructions) 99. 00 Outlier reconciliation adjustment amount (see instructions) 99. 00 Outlier reconciliation adjustment amount (see instructions) 99. 00 Outlier reconciliation adjustment amount (see instructions) 99. 00 Outlier reconciliation adjustment amount (see instructions) 99. 00 Outlier reconciliation adjustment amount (see instructions) 99. 00 Outlier reconciliation adjustment amount (see instructions)						
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39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Subtotal (see instructions) 44,002,490 40.00 40.01 41.00 Interim payments 43,112,377 41.00 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 10,063 43.00 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 8115.2 0 0 0 0 0 0 0 0 0				tions)	13, 100	
40.01 Sequestration adjustment (see instructions) 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Time Value of Money (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions)		·	·	ĺ		
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42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions)	40. 01	· · · · · · · · · · · · · · · · · · ·			880, 050	40. 01
43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 Utilier reconciliation adjustment amount (see instructions) 72.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 93.00	41.00				43, 112, 377	41.00
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{5115.2}{10.8E.COMPLETED.BY.CONTRACTOR}\$ 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions)	42.00	Tentative settlement (for contractors use only)			0	42.00
\$115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions)	43.00	Balance due provider/program (see instructions)			10, 063	43.00
TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions)	44. 00		e with CMS Pub. 15-2,	chapter 1,	0	44.00
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 90.00 91.00 92.00 93.00						
91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 91.00 92.00 93.00	00.05					00.00
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93.00 Time Value of Money (see instructions) 0 93.00		1				
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74. 00 10 tai (Suiii 01 11 1165 71 aliu 73)		• · · · · · · · · · · · · · · · · · · ·				
	74. UU	Tiotal (Suil of Titles 71 and 73)			U	74.00

Health Financial Systems	UNION HOSPITAL,	I NC.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150023		Worksheet E
			From 01/01/2015	
		Component CCN: 15T023	To 12/31/2015	
				5/25/2016 10:01 am
		Title XVIII	Subprovi der -	PPS

	II TI E	e xviii	Subprovider -	PPS	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
1.00	Medical and other services (see instructions)			49	1. 00
2.00	Medical and other services reimbursed under OPPS (see instructions)			14	2. 00
3.00	PPS payments			102	3. 00
4. 00 5. 00	Outlier payment (see instructions) Enter the hospital specific payment to cost ratio (see instructions)			0. 000	4. 00 5. 00
6. 00	Line 2 times line 5			0.000	6. 00
7.00	Sum of line 3 plus line 4 divided by line 6			0. 00	
8.00	Transitional corridor payment (see instructions)	1: 200		0	8. 00
9. 00 10. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, Organ acquisitions	Tine 200		0	9. 00 10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			49	
	COMPUTATION OF LESSER OF COST OR CHARGES				
12 00	Reasonable charges			215	12.00
12. 00 13. 00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			215	12. 00 13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)			-	14. 00
	Customary charges				
15. 00 16. 00	Aggregate amount actually collected from patients liable for payment for s Amounts that would have been realized from patients liable for payment for			0	
10.00	had such payment been made in accordance with 42 CFR §413.13(e)	services o	on a chargebasis	U	10.00
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)			215	
19. 00	Excess of customary charges over reasonable cost (complete only if line 18 instructions)	3 exceeds li	ne 11) (see	166	19. 00
20. 00	Excess of reasonable cost over customary charges (complete only if line 11	1 exceeds li	ne 18) (see	0	20. 00
	instructions)		, ,		
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instruction	ns)		49 0	
22. 00 23. 00	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instructions)			0	22. 00 23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)			102	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00 26. 00	Deductibles and coinsurance (for CAH, see instructions) Deductibles and Coinsurance relating to amount on line 24 (for CAH, see in	netrueti one)		0	25. 00 26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum	,	l l	151	
	instructions)		- `		
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0	28. 00
29. 00 30. 00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)			151	29. 00 30. 00
31. 00	Primary payer payments			0	31. 00
32. 00	Subtotal (line 30 minus line 31)			151	32. 00
33. 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11)		1	0	33. 00
34. 00	Allowable bad debts (see instructions)			0	34. 00
35. 00	· · · · · · · · · · · · · · · · · · ·			0	35. 00
36.00				0	36. 00
37. 00 38. 00				151 0	
				0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	
39. 98	Partial or full credits received from manufacturers for replaced devices ((see instruc	ctions)	0	39. 98
39. 99 40. 00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 151	39. 99 40. 00
40. 01	Sequestration adjustment (see instructions)			3	40. 01
41. 00	Interim payments			142	
42. 00 43. 00	Tentative settlement (for contractors use only) Balance due provider/program (see instructions)			0	42. 00 43. 00
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS	Pub. 15-2.	chapter 1.	6	44. 00
	§115. 2				
00.00	TO BE COMPLETED BY CONTRACTOR		1		00.00
90. 00 91. 00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	
92.00	The rate used to calculate the Time Value of Money				92. 00
93. 00	Time Value of Money (see instructions)			0	93.00
94. 00	Total (sum of lines 91 and 93)		l	0	94. 00

Health Financial Systems UI
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED UNION HOSPITAL, INC.

Title XVIII Hospital PPS						5/25/2016 10:0	01 am_
1.00					Hospi tal	PPS	
1.00			Inpatien	t Part A	Par	⁻t B	
1.00							
Interim payments payable on Individual bills, either subtractor for services rendered in the cost reporting period. If none, write "NONE" or neter a zero.			1. 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							
Services rendered in the cost reporting period. If none, write "NONE" or netre a zero.	2.00			(D	0	2.00
### Write "NONE" or enter a zero 3. 00 Write "NONE" or enter a zero 3. 00 Write Separately each retroactive lump sum adjustment amount based on subsequent revision of the interin 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 12/31/2015 1. 313, 474 12/31/2015 1. 313, 474 12/31/2015 1. 313, 474 12/31/2015 1. 30, 40 3. 00 3. 00 3. 00 3. 01 3. 00 3. 01 3. 01 ADJUSTMENTS TO PROVIDER 1. 12/31/2015 1. 313, 474 1. 2/31/2015 1. 313, 474 1. 2/31/2015 1. 313, 474 1. 2/31/2015 1. 313, 474 1. 314, 100 3. 30 3							
List separately each retroactive lump sum adjustment amount based on subsequent revision of the interin rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider							
amount based on subsequent revision of the interin 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 3.02 3.03 3.04 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROVIDER 3.50 Provider to Program 3.51 3.51 3.52 4.00 4.00 4.00 4.00 4.00 5.51 3.53 3.54 4.00 4.00 4.00 4.00 4.00 5.55 4.00 4.00	2 00						2 00
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 1,313,474 12/31/2015 1,368,168 3.01 3.02 0.03/11/2015 25,900 3.02 0.03/11/2015 123,800 3.03 0.05 0.03/11/2015 123,800 3.05 0.03/11/2015 123,800 3.05 0.03/11/2015 123,800 3.05 0.03/11/2015 123,800 3.05 0.03/11/2015 123,800 3.05 0.03/11/2015 123,800 3.05 0.03/11/2015 123,800 3.05 0.03/11/2015 123,800 3.05 0.03/11/2015 123,800 3.05 0.03/11/2015 123,800 3.05 0.03/11/2015 123,800 3.05 0.03/11/2015 123,800 3.05 0.03/11/2015 123,800 3.05 0.03/11/2015 123,800 3.05 0.03/11/2015 123,800 3.05 0.03/11/2015 123,800 3.05 0.03/11/2015 123,800 3.05 0.03/11/2015 123,800 3.05 0.03/11/2015 0.	3.00						3.00
Dayment. If none, write "NONE" or enter a zero. (1) Program to Provider 12/31/2015 1,313,474 12/31/2015 1,368,168 3.01 0 0 0 3.02 0 0 0 0 0 0 0 0 0		for the cost reporting period. Also show date of each					
Program to Provider							
ADJUSTMENTS TO PROVIDER							
3.02 07/15/2015 104,100 07/15/2015 123,800 3.02 3.03 3.04 3.05 123,800 3.03 3.04 3.05 123,800 3.03 3.04 3.05 123,800 3.05 3.0	3. 01		12/31/2015	1, 313, 47,	12/31/2015	1, 368, 168	3. 01
3.03 3.04 3.05 3.06							
3. 04			07/15/2015	104, 10			
Provider to Program ADJUSTMENTS TO PROGRAM 0 0 3.50							3. 04
ADJUSTMENTS TO PROGRAM	3.05					0	3. 05
3.51 3.52 3.53 0 0 0 3.51 3.52 3.53 3.53 0 0 0 3.53 3.53 3.54 0 0 0 3.53 3.54 3.59 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 1,417,574 1,517,868 3.99 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 62,181,950 43,112,377 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 62,181,950 43,112,377 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 62,181,950 43,112,377 4.00		Provider to Program					
3.52 3.53 3.54 3.99 3.50	3.50	ADJUSTMENTS TO PROGRAM		(D	0	3.50
3.53 3.54 0 0 0 0 3.53 3.54 3.59 3.50-3.98 1,417,574 1,517,868 3.99 3.50-3.98 1,417,574 1,517,868 3.99 3.50-3.98 1,417,574 1,517,868 3.99 62,181,950 43,112,377 4.00 10	3. 51					·	
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 1,417,574 1,517,868 3.99 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 62,181,950 43,112,377 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR							
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 1,417,574 1,517,868 3.99 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 62,181,950 43,112,377 4.00 43,112,377 40,112,377 40,112,377 40,112,377 40,112,377 40,112,377 40							
3.50-3.98 Total interim payments (sum of lines 1, 2, and 3.99)					-	1	
A 0.0	3. 99			1, 417, 57	1	1, 517, 868	3. 99
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR	4 00			(0.404.05		40 440 077	4 00
appropriate To BE COMPLETED BY CONTRACTOR	4.00			62, 181, 950)	43, 112, 377	4.00
TO BE COMPLETED BY CONTRACTOR							
List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	5 00						5 00
Write "NONE" or enter a zero. (1) Program to Provider	0.00						0.00
TENTATI VE TO PROVIDER							
5.02 0 0 5.02		Program to Provider					
5.03 Provider to Program S.50 TENTATIVE TO PROGRAM O	5.01	TENTATI VE TO PROVI DER					5. 01
Provider to Program							
TENTATI VE TO PROGRAM 0	5.03			(D	0	5. 03
5.51 0							
5.52 0 0 5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 1,141,310 10,063 6.01 6.02 SETTLEMENT TO PROGRAM 0 0 6.02 7.00 Total Medicare program liability (see instructions) 63,323,260 43,122,440 7.00 7.00		TENTATIVE TO PROGRAM					
5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 1, 141, 310 10, 063 6. 01 6. 02 SETTLEMENT TO PROGRAM 0 0 0 6. 02 7. 00 Total Medicare program liability (see instructions) 63, 323, 260 43, 122, 440 7. 00 Contractor NPR Date (Mo/Day/Yr) 0 1. 00 2. 00							
5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1. 00 2. 00		Cultural (
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	5. 99	`		·)	0	5. 99
the cost report. (1) SETTLEMENT TO PROVIDER 6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1. 00 2. 00	6 00						6 00
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00	0.00						0.00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	6. 01			1, 141, 310		10, 063	6. 01
7.00 Total Medicare program liability (see instructions) 63,323,260 43,122,440 7.00 Contractor Number (Mo/Day/Yr) 0 1.00 2.00							
Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00					-	1	
Number (Mo/Day/Yr) 0 1.00 2.00				, , ,			
8.00 Name of Contractor 8.00			()	1. 00	2. 00	
	8.00	Name of Contractor					8. 00

Health Financial Systems U UNION HOSPITAL, INC.

		Ti tl	e XVIII	Subprovi der -	PPS	
		I npati en	t Part A	_	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		4, 165, 429		142	1. 00
2.00	Interim payments payable on individual bills, either		C)	0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
0.04	Program to Provider					0.04
3. 01 3. 02	ADJUSTMENTS TO PROVIDER				0	3. 01 3. 02
3.02					0	3. 02
3. 04					0	3. 04
3. 05			d		o	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		C		0	3. 50
3. 51			C		0	3. 51
3. 52					0	3. 52
3. 53 3. 54					0	3. 53 3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines				0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		4, 165, 429)	142	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate) TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5. 00
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		C		0	5. 01
5. 02 5. 03			(0	5. 02 5. 03
5.03	Provider to Program			/	U	3.03
5. 50	TENTATI VE TO PROGRAM		C		0	5. 50
5. 51)	0	5. 51
5. 52			C)	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		C)	0	5. 99
6. 00	5.50-5.98) Determined net settlement amount (balance due) based on					6. 00
0.00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER				6	6. 01
6. 02	SETTLEMENT TO PROGRAM		53, 823	3	0	6. 02
7.00	Total Medicare program liability (see instructions)		4, 111, 606		148	7. 00
				Contractor	NPR Date	
		,)	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor		<i>.</i>	1.00	2.00	8. 00
5. 55	Tham of solition			1		0.00

Heal th	Financial Systems UNION HOSPITAL	_, INC.	In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 150023	Peri od: From 01/01/2015 To 12/31/2015		
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst.		14	14, 455	1. 00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	-12		29, 899	2. 00
3. 00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3, 394	3. 00
4. 00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	-12		60, 293	4. 00
5. 00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			1, 147, 402, 489	5. 00
6. 00	Total hospital charity care charges from Wkst. S-10, col. 3 I			21, 208, 340	6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of ciline 168	ertified HII technology	Wkst. S-2, Pt. I	0	7. 00
8.00	Calculation of the HIT incentive payment (see instructions)			1, 311, 196	8. 00
9.00	Sequestration adjustment amount (see instructions)			26, 224	9. 00
10.00					
10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 1,284,97 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)			1, 374, 610	30.00
31.00				0	31. 00
32. 00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	s)	-89, 638	32. 00

Health Financial Systems	UNION HOSPITAL,	I NC.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150023		Worksheet E-3
			From 01/01/2015	
		Component CCN: 15T023	To 12/31/2015	Date/Time Prepared:
		•		5/25/2016 10:01 am
		Title XVIII	Subprovi der -	PPS
			IDE	

		THE CONTIN	I RF	113	
	DART ALL MEDICARE DART A OFFICE AND DROP			1. 00	
1 00	PART III - MEDICARE PART A SERVICES - IRF PPS			2 055 000	1 00
1.00	Net Federal PPS Payment (see instructions)			3, 955, 980	1. 00 2. 00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0306	
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			148, 349	3. 00
4. 00 5. 00	Outlier Payments	manarting paried an	dina an an anian	132, 760	4. 00
5.00	Unweighted intern and resident FTE count in the most recent cost to November 15, 2004 (see instructions)	reporting period en	iding on or prior	20. 98	5. 00
5. 01	Cap increases for the unweighted intern and resident FTE count fo	r residents that wer	e displaced by	0.00	5. 01
	program or hospital closure, that would not be counted without a				
	CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)	. 3 . 3			
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 p	eriod of a "new	0. 00	7. 00
	teaching program" (see instructions)				
8. 00	Current year's unweighted I&R FTE count for residents within the	new program growth p	eriod of a "new	0. 00	8. 00
	teaching program" (see instructions)				
9.00	Intern and resident count for IRF PPS medical education adjustmen	t (see instructions)		0.00	
10.00	Average Daily Census (see instructions)			10. 682192	
11.00	Teaching Adjustment Factor (see instructions)			0.000000	
12.00	Teaching Adjustment (see instructions)			0	12.00
13.00	Total PPS Payment (see instructions)			4, 237, 089	
14. 00	Nursing and Allied Health Managed Care payments (see instruction)			0	14.00
15. 00	Organ acquisition (DO NOT USE THIS LINE)	i ana)		0	15. 00 16. 00
16. 00 17. 00	Cost of physicians' services in a teaching hospital (see instruct	10115)			
18. 00	Subtotal (see instructions) Primary payer payments			4, 237, 089 0	18.00
19. 00	Subtotal (line 17 less line 18).			4, 237, 089	
20. 00	Deductibles			26, 460	
21. 00	Subtotal (line 19 minus line 20)			4, 210, 629	
22. 00	Coi nsurance			17, 010	
23. 00	Subtotal (line 21 minus line 22)			4, 193, 619	
24. 00	Allowable bad debts (exclude bad debts for professional services)	(see instructions)		0	24. 00
25. 00	Adjusted reimbursable bad debts (see instructions)	(555 111511 4511 5115)		0	25. 00
26. 00	Allowable bad debts for dual eligible beneficiaries (see instruct	i ons)		0	26. 00
27. 00	Subtotal (sum of lines 23 and 25)	,		4, 193, 619	
28. 00	Direct graduate medical education payments (from Wkst. E-4, line	49)		0	
29. 00	Other pass through costs (see instructions)	,		1, 897	29. 00
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. 50
31. 99	Recovery of Accelerated Depreciation			0	31. 99
32.00	Total amount payable to the provider (see instructions)			4, 195, 516	32.00
32. 01	Sequestration adjustment (see instructions)			83, 910	32. 01
33.00	Interim payments			4, 165, 429	33.00
34.00	Tentative settlement (for contractor use only)			0	34.00
35. 00	Balance due provider/program (line 32 minus lines 32.01, 33, and	-		-53, 823	
36. 00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub. 15-2,	chapter 1,	11, 189	36. 00
	§115. 2				
EO 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount from Wkst. E-3, Pt. III, line 4			122 7/0	EO 00
50. 00 51. 00	Outlier reconciliation adjustment amount (see instructions)			132, 760 0	50.00
52. 00	The rate used to calculate the Time Value of Money			0. 00	
	Time Value of Money (see instructions)				53. 00
55. 55	1.1. 1.2. 2.3 of money (300 first dottons)		I	۷۱	33.00

Health Financial Systems	UNION HOSPITAL,	I NC.		In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN:	150023		Worksheet E-3 Part VII Date/Time Prepared: 5/25/2016 10:01 am

			10 12/31/2013	5/25/2016 10:	01 am
		Title XIX	Hospi tal	Cost	
			Inpati ent	Outpati ent	
			1. 00	2.00	
-	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	ICES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		4, 609, 349		1.00
2.00	Medical and other services			0	2. 00
3.00	Organ acquisition (certified transplant centers only)		0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		4, 609, 349	0	4. 00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	6. 00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		4, 609, 349	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8.00	Routi ne servi ce charges		0		8. 00
9.00	Ancillary service charges		10, 524, 048	0	9. 00
10.00	Organ acquisition charges, net of revenue		0		10.00
11. 00	Incentive from target amount computation		0		11. 00
12.00	Total reasonable charges (sum of lines 8 through 11)		10, 524, 048	0	12. 00
	CUSTOMARY CHARGES				
13. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
	basis				
14. 00	Amounts that would have been realized from patients liable for		0	0	14. 00
45.00	a charge basis had such payment been made in accordance with 42	! CFR §413.13(e)			45.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	
16.00	Total customary charges (see instructions)		10, 524, 048	0	
17. 00	Excess of customary charges over reasonable cost (complete only	/ IT line 16 exceeds	5, 914, 699	0	17. 00
10 00	line 4) (see instructions)	ifling 4 ayaaada lina	0	0	10.00
18. 00	Excess of reasonable cost over customary charges (complete only	rifiline 4 exceeds line	0	0	18. 00
19. 00	16) (see instructions) Interns and Residents (see instructions)		0	0	19. 00
	Cost of physicians' services in a teaching hospital (see instru	uctions)	0	0	
21. 00	Cost of covered services (enter the lesser of line 4 or line 16		4, 609, 349	0	
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be c			U	21.00
22 00	Other than outlier payments	ompreted for 113 provid	0	0	22. 00
			0	0	
	Program capital payments		0	O	24. 00
25. 00			0		25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	
27. 00	Subtotal (sum of lines 22 through 26)		0	0	
			0	0	
29. 00	Titles V or XIX (sum of lines 21 and 27)		4, 609, 349	0	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		., ., .,		
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		4, 609, 349	0	
32. 00	Deducti bl es		0	0	32. 00
33.00	Coinsurance		0	0	33. 00
34.00			0	0	
35. 00	Utilization review		0		35. 00
36.00			4, 609, 349	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37. 00
38.00	Subtotal (line 36 ± line 37)		4, 609, 349	0	38. 00
	Direct graduate medical education payments (from Wkst. E-4)		O		39. 00
40.00			4, 609, 349	0	40.00
41.00	Interim payments		5, 065, 718	0	41.00
42.00			-456, 369	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				
	1		'		

DIRECT GANDIATE HERIOCAL FORCATION (GMF) & FSRD OUTPATIENT DIRECT Provider COL 150002 Perform 01/01/2015 To 12/31/2015	Heal th	Financial Systems UNION HOSPITAL,	I NC.		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF TOTAL DIRECT SME_ARDUNT 1.00 1	DI RECT	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT			Period: From 01/01/2015	Worksheet E-4 Date/Time Pre	pared:
COMPUTATION OF TOTAL DIRECT GNE ANDUNT			Ti tl	e XVIII	Hospi tal		
1.00 Unweighted resident FTE count for all opathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996. 1.00 2.00 3.01 3						1. 00	
ending on or before December 31, 1996. 2. 00 Unwighted FTE rosident cap add-on for new programs per 42 CFR 413, 79(e)(1) (see instructions) 3. 00 Amount of reduction to Direct OME cap under section 422 of MMA 3. 00 3.							
3.00 Anount of reduction to Direct GME cap under section 422 of MMA 0.00 3.00	1. 00	ending on or before December 31, 1996.	J	·		14. 92	1. 00
0.00 0.00			413.79(e)(1) (see instr	uctions)		2.00
Instructions for cost reporting periods straddling 7/1/2011)			with 42 CER	8413 79 (m)	(500		
Outside affiliation agreement (42 CFR §413.75(b) and §413.79 (T))	3.01		VI (II 42 OI N	3413.77 (111).	(300	0.00	3.01
ACA Section 5503 increase to the Direct OME FTE Cap (see instructions for cost reporting periods straddling 77/12011)	4.00		steopathi c	programs due	to a Medicare	0. 00	4. 00
4.02 ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddil ing 771/2011) 5.00 FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts 6.00 Unwelghted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions) 7.00 Enter the lesser of line 5 or line 6 8.00 Weighted FTE count for physicians in an allopathic and osteopathic programs for the current year from your records (see instructions) 8.00 Weighted FTE count for physicians in an allopathic and osteopathic program for the current year. 9.00 If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.00 Weighted dental and podiatric resident FTE count for the current year 10.00 Weighted dental and podiatric resident FTE count for the current year 11.00 Owner for the subscription of the penultimate cost reporting year (see 114.92 0.00 11.00 1	4. 01	• •	uctions for	cost reporti	ng periods	0. 00	4. 01
FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts 4.02 plus applicable subscripts 5.00 4.02 plus applicable subscripts 5.00 14.92 7.00 14.92 7.00 14.92 7.00 14.92 7.00 14.92 7.00 14.92 7.00 14.92 7.00 14.92 7.00 14.92 7.00 14.92 7.00 14.92 7.00 14.92 7.00 14.92 7.00 14.92 7.00 14.92 7.00	4. 02	ACA Section 5506 number of additional direct GME FTE cap slots	(see inst	ructions for	cost reporting	0. 00	4. 02
Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions) 14.92	5. 00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus	s or minus	line 4 plus l	ines 4.01 and	14. 92	5. 00
14.92 7.00	6. 00	Unweighted resident FTE count for allopathic and osteopathic pr	rograms for	the current	year from your	20. 98	6. 00
1.00 2.00 3.00	7. 00					14. 92	7. 00
Section Weighted FTE count for physicians in an allopathic and osteopathic program for the current year							
program for the current year.	8. 00	Weighted FTE count for physicians in an allopathic and osteopat	thi c				8. 00
6.		program for the current year.		14. 9		14. 92	
11.00 Total weighted FTE count 11.00 Total weighted resident FTE count for the prior cost reporting year (see instructions) 12.00 12.00 12.00 13.00		multiply line 8 times the result of line 5 divided by the amour	nt on line				
12.00 Total weighted resident FTE count for the prior cost reporting year (see 14.92 0.00 12.00 13.00 13.00 10.00 14.92 0.00 13.00 14.92 0.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 15.00 15.00 15.00 15.00 16.0	10.00	Weighted dental and podiatric resident FTE count for the currer	nt year		0.00		10. 00
13.00 Total weighted resident FTE count for the penultimate cost reporting 14.92 0.00 13.00 year (see instructions) 14.00 Rolling average FTE count (sum of lines 11 through 13 divided by 3). 14.92 0.00 14.00 15.00 Adjustment for residents in initial years of new programs 0.00 0.00 0.00 16.00 16.00 Adjustment for residents displaced by program or hospital closure 0.00 0.00 0.00 16.00 17.00 Adjustment for residents displaced by program or hospital closure 0.00 0.00 17.00 18.00 Per resident amount 120,634.07 0.00 18.00 Per resident amount 17.00 18.00 Per resident amount 17.00 18.00 Per resident amount 17.00 Per resident costs 1,799,860 0 1,799,860 19.00 Per resident costs 1,799,860 0 1,799,860 19.00 Per cost dent costs 1,799,860 0 1,799,860 19.00 Per cost dent costs 1,00 Per cost dent cost			,				11.00
13.00 Total weighted resident FTE count for the penultimate cost reporting year (see instructions) 14.92 0.00 13.00 14.00	12. 00		year (see	14. 9	2 0.00		12. 00
14. 00 Rolling average FTE count (sum of lines 11 through 13 divided by 3). 14. 92 0.00 14. 00 15. 00 Adjustment for residents in initial years of new programs 0.00 0.00 0.00 15. 00 16. 00 Adjustment for residents displaced by program or hospital closure 0.00 0.00 16. 00 17. 00 Adjusted rolling average FTE count 14. 92 0.00 17. 00 18. 00 Per resident amount 120,634.07 0.00 18. 00 19. 00 Approved amount for resident costs 1,799,860 0 1,799,860 19. 00 17. 00 18. 00 19. 0	13. 00	Total weighted resident FTE count for the penultimate cost repo	orting	14. 9	2 0.00		13. 00
16.00	14. 00	Rolling average FTE count (sum of lines 11 through 13 divided b	oy 3).	14. 9	I I		14. 00
14. 92 0. 00 17. 00 18. 00 19							15. 00
18.00 Per resident amount 120,634.07 0.00 1,799,860 1,000 2,			ure				
1,799,860 0 1,799,860 19.00					l I		
20.00 Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 5.75 20.00					l I	1, 799, 860	
20.00 Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 5.75 20.00							
Sec. 413.79(c) (4) Direct GME FTE unweighted resident count over cap (see instructions) 6.06 21.00	20.00	Additional unweighted allegathic and esteemathic direct CME ETE	- roeidont	can slots roc	oi vod undor 42		20.00
21.00 Direct GME FTE unweighted resident count over cap (see instructions) 6.06 21.00	20.00		i esi dent	cap sidts reci	erved under 42	5. 75	20.00
23.00 Enter the locally adjustment national average per resident amount (see instructions) 24.00 Multiply line 22 time line 23 25.00 Total direct GME amount (sum of lines 19 and 24) 25.00 Inpatient Part A 1.00 2.00 3.00 COMPUTATION OF PROGRAM PATIENT LOAD 26.00 Inpatient Days (see instructions) 27.00 Total Inpatient Days (see instructions) 28.00 Ratio of inpatient days to total inpatient days 29.00 Program direct GME amount Reduction for direct GME payments for Medicare Advantage 20.00 Ratio of of direct GME payments for Medicare Advantage 20.00 Ratio of inpatient Days (see instructions) 21.00 Sover A 22.00 Sover A 23.00 Sover A 24.00 Sover A 25.00 Sover A 26.00 Sover A 27.00 Sover A 28.00 Ratio of inpatient days to total inpatient days 29.00 Reduction for direct GME payments for Medicare Advantage	21.00		tions)			6. 06	21. 00
24. 00 Multiply line 22 time line 23 25. 00 Total direct GME amount (sum of lines 19 and 24) Inpatient Part Managed care A 1.00 2.00 3.00							
Total direct GME amount (sum of lines 19 and 24) 2, 351, 134 25.00		1	unt (see in	structions)		., .	
Inpatient Part Managed care A 1.00 2.00 3.00							
1.00 2.00 3.00	23.00	Total direct own amount (Sum of Times 17 and 24)		Inpatient Par	t Managed care	2, 331, 134	23.00
COMPUTATION OF PROGRAM PATIENT LOAD 26.00 Inpatient Days (see instructions) 32,618 3,394 26.00 27.00 Total Inpatient Days (see instructions) 64,222 64,222 27.00 28.00 Ratio of inpatient days to total inpatient days 0.507894 0.052848 28.00 29.00 Program direct GME amount 1,194,127 124,253 29.00 30.00 Reduction for direct GME payments for Medicare Advantage 17,557 30.00					2.00	2 00	
26.00 Inpatient Days (see instructions) 32,618 3,394 26.00 27.00 Total Inpatient Days (see instructions) 64,222 64,222 27.00 28.00 Ratio of inpatient days to total inpatient days 0.507894 0.052848 28.00 29.00 Program direct GME amount 1,194,127 124,253 29.00 30.00 Reduction for direct GME payments for Medicare Advantage 17,557 30.00		COMPUTATION OF PROGRAM PATIENT LOAD		1.00	2.00	3.00	
27. 00 Total Inpatient Days (see instructions) 64, 222 64, 222 27. 00 28. 00 Ratio of inpatient days to total inpatient days 0. 507894 0. 052848 28. 00 29. 00 Program direct GME amount 1, 194, 127 124, 253 29. 00 30. 00 Reduction for direct GME payments for Medicare Advantage 17, 557 30. 00	26, 00			32, 61	8 3. 394		26. 00
28.00 Ratio of inpatient days to total inpatient days 29.00 Program direct GME amount 30.00 Reduction for direct GME payments for Medicare Advantage 0.507894 1,194,127 124,253 29.00 30.00		, , , , , , , , , , , , , , , , , , , ,					27. 00
30.00 Reduction for direct GME payments for Medicare Advantage 17,557 30.00							28. 00
	29. 00			1, 194, 12			29. 00
31.00 Net Program direct GME amount 1,300,823 31.00					17, 557		30. 00
	31. 00	Net Program direct GME amount		I	1	1, 300, 823	31. 00

Heal th	Financial Systems UNION HOSPITAL,	LNC	Inlie	u of Form CMS-2	2552-10
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provi der CCN: 150023	Peri od:	Worksheet E-4	
	L EDUCATION COSTS		From 01/01/2015 To 12/31/2015	Date/Time Pre	pared:
		Title XVIII	Hospi tal	PPS	
				1. 00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE EDUCATION COSTS)	XVIII ONLY (NURSING SC	HOOL AND PARAMEDI	CAL	
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt	. I, sum of col. 20 an	d 23, lines 74	0	32. 00
	and 94)				
33. 00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I,		74 and 94)	0	
34. 00	Ratio of direct medical education costs to total charges (line	32 ÷ line 33)		0. 000000	
	Medicare outpatient ESRD charges (see instructions)			0	
36. 00	Medicare outpatient ESRD direct medical education costs (line 3			0	36. 00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII O	INLY			
07.00	Part A Reasonable Cost			70 7/4 005	07.00
37. 00				73, 761, 095	1
38. 00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)	+!		0	38. 00 39. 00
39. 00 40. 00	Cost of physicians' services in a teaching hospital (see instru	ictions)		0 33. 762	
	Primary payer payments (see instructions) Total Part A reasonable cost (sum of lines 37 through 39 minus	Line 40)		73, 727, 333	
41.00	Part B Reasonable Cost	111le 40)		13, 121, 333	41.00
42 00	Reasonable cost (see instructions)			50, 564, 037	42 00
	Primary payer payments (see instructions)			19, 938	1
	Total Part B reasonable cost (line 42 minus line 43)			50, 544, 099	
	Total reasonable cost (sum of lines 41 and 44)			124, 271, 432	1
46. 00	, , ,	41 ÷ line 45)		0. 593277	1
47. 00	Ratio of Part B reasonable cost to total reasonable cost (line	,		0. 406723	1
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART				
48.00	Total program GME payment (line 31)			1, 300, 823	48. 00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		771, 748	49. 00
	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (529, 075	1
		· · · · · · · · · · · · · · · · · · ·	'		•

Health Financial Systems

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

Provi der CCN: 150023 Peri od: Worksheet G From 01/01/2015 To 12/31/2015 Date/Time Prepared:

			'	0 12/31/2013	5/25/2016 10:0	
		General Fund	Speci fi c	Endowment Fund		
			Purpose Fund			
	AUDDENT ASSETS	1.00	2.00	3. 00	4. 00	
1 00	CURRENT ASSETS	41 042 177		0	0	1 00
1. 00 2. 00	Cash on hand in banks Temporary investments	41, 043, 177	1			1. 00 2. 00
3.00	Notes recei vabl e	0		0	Ö	3. 00
4. 00	Accounts receivable	48, 931, 360	1	0	l o	4. 00
5. 00	Other recei vable	0	Ö	0	Ö	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6. 00
7.00	Inventory	4, 244, 838	0	0	0	7. 00
8.00	Prepai d expenses	-18, 444, 178	0	0	0	8. 00
9.00	Other current assets	0	_	0	0	9. 00
10.00	Due from other funds	7, 525, 824	1		0	10.00
11. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	83, 301, 021	0	0	0	11. 00
12. 00	Land	37, 906, 704	0	0	0	12. 00
13. 00	Land improvements	37, 900, 704				13. 00
14. 00	Accumulated depreciation	0	i o		o o	14. 00
15. 00	Bui I di ngs	330, 008, 770	Ö	0	Ö	15. 00
16.00	Accumulated depreciation	-247, 747, 409	0	0	0	16. 00
17. 00	Leasehold improvements	0	0	0	0	17. 00
18. 00	Accumul ated depreciation	0	0	0	0	18. 00
19. 00	Fi xed equipment	0	0	ı -	0	19. 00
20.00	Accumulated depreciation	0	0	0	0	20.00
21. 00	Automobiles and trucks	0		0	0	21. 00
22. 00 23. 00	Accumulated depreciation Major movable equipment	132, 407, 186		0	0	22. 00 23. 00
24. 00	Accumulated depreciation	132, 407, 180		0	0	24. 00
25. 00	Mi nor equi pment depreci abl e	0		0	Ö	25. 00
26. 00	Accumulated depreciation	Ö	Ö	0	Ö	26. 00
27. 00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	0	0	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	0	-	0	29. 00
30. 00	Total fixed assets (sum of lines 12-29)	252, 575, 251	0	0	0	30. 00
21 00	OTHER ASSETS		J			21 00
31. 00 32. 00	Investments Deposits on Leases	0			0	31. 00 32. 00
33. 00	Due from owners/officers	0		0	0	33.00
34. 00	Other assets	93, 399, 412		0	Ö	34. 00
35. 00	Total other assets (sum of lines 31-34)	93, 399, 412			Ö	35. 00
36.00	Total assets (sum of lines 11, 30, and 35)	429, 275, 684	1		0	36. 00
	CURRENT LIABILITIES					
37. 00	Accounts payable	23, 643, 619	1	0	0	37. 00
38. 00	Salaries, wages, and fees payable	18, 757, 598	0	0	0	38. 00
39. 00	Payroll taxes payable	0	0	0	0	39. 00
40.00	Notes and Loans payable (short term)	0		0	0	40.00
41. 00 42. 00	Deferred income Accel erated payments	0	0	0	0	41. 00 42. 00
43. 00	Due to other funds	0	o	0	0	
	Other current liabilities	12, 432, 619	1			
45.00	Total current liabilities (sum of lines 37 thru 44)	54, 833, 836		0	0	
	LONG TERM LIABILITIES					
46. 00	Mortgage payable	0			0	
47. 00	Notes payable	0				
48. 00	Unsecured Loans	074 544 (04	0		0	48. 00
49. 00	Other long term liabilities	271, 541, 621	l .		0	49. 00
50. 00 51. 00	Total long term liabilities (sum of lines 46 thru 49 Total liabilites (sum of lines 45 and 50)	271, 541, 621 326, 375, 457	l .		0	50. 00 51. 00
31.00	CAPITAL ACCOUNTS	320, 373, 437		0	0	31.00
52. 00	General fund balance	102, 900, 227				52. 00
53.00	Specific purpose fund		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	
58. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58. 00
59. 00	Total fund balances (sum of lines 52 thru 58)	102, 900, 227	0	0	0	59. 00
60. 00	Total liabilities and fund balances (sum of lines 51 and	429, 275, 684	l .	0	Ö	
	59)	, , , , , , , , , , , , , , , , , , ,				
				•	•	

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

					То	12/31/2015	Date/Time Prep 5/25/2016 10:0	pared: 01 am_
		General	Fund	Speci al	Purp	oose Fund	Endowment Fund	
	T	1. 00	2. 00	3. 00		4. 00	5. 00	
1.00	Fund balances at beginning of period		96, 042, 997			0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		6, 857, 230			0		2.00
3. 00 4. 00	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)		102, 900, 227		0	0	0	3. 00 4. 00
4. 00 5. 00	Additions (credit adjustments) (specify)				0		0	4. 00 5. 00
6. 00					0		0	6. 00
7. 00					0		Ö	7. 00
8.00		0			0		Ö	8. 00
9. 00		o			0		Ö	9. 00
10.00	Total additions (sum of line 4-9)		0			0		10.00
11. 00	Subtotal (line 3 plus line 10)		102, 900, 227			0		11. 00
12.00	Deductions (debit adjustments) (specify)	O			0		0	12.00
13.00		0			0		0	13.00
14.00		0			0		0	14.00
15. 00		0			0		0	15. 00
16. 00		0			0		0	16. 00
17. 00	T	0			0		0	17. 00
18. 00	Total deductions (sum of lines 12-17)		100 000 007			0		18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)		102, 900, 227			0		19. 00
	Janeet (Title 11 millida 11 lie 10)	Endowment Fund	PI ant	Fund				
	Taran Sanara and American Sanara	6. 00	7. 00	8. 00				
1.00	Fund balances at beginning of period	0			0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				0			2.00
3. 00 4. 00	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	U	0		0			3. 00 4. 00
4. 00 5. 00	Additions (credit adjustments) (specify)		0					4. 00 5. 00
6. 00			0					6. 00
7. 00			0					7. 00
8.00			0					8. 00
9.00			0					9. 00
10.00	Total additions (sum of line 4-9)	0			0			10.00
11.00	Subtotal (line 3 plus line 10)	0			0			11.00
12.00	Deductions (debit adjustments) (specify)		0					12.00
13.00			0					13.00
14. 00			0					14. 00
15. 00			0					15. 00
16.00			0					16. 00
17. 00	Total deductions (cum -f li 12 17)		O					17. 00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance	0			0			18. 00 19. 00
19.00	sheet (line 11 minus line 18)	١			U			19.00
	I shoot (Time II millius IIIIe 10)	1	l	1	- 1			l .

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provi der CCN: 150023

			T	o 12/31/2015	Date/Time Prep 5/25/2016 10:0	
	Cost Center Description	Inpa	ti ent	Outpati ent	Total	JT dill
	<u> </u>		00	2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal	82,	210, 974		82, 210, 974	1. 00
2.00	SUBPROVI DER - I PF					2.00
3.00	SUBPROVI DER - I RF	3,	824, 601		3, 824, 601	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	0,4	025 575		04 025 575	9.00
10. 00	Total general inpatient care services (sum of lines 1-9) Intensive Care Type Inpatient Hospital Services	00,	035, 575		86, 035, 575	10. 00
11. 00	INTENSIVE CARE UNIT	27	506, 456		27, 506, 456	11. 00
12. 00	CORONARY CARE UNIT	27,	300, 430		27, 300, 430	12. 00
13. 00	BURN INTENSIVE CARE UNIT					13. 00
14. 00	SURGICAL INTENSIVE CARE UNIT					14. 00
15. 00	I NTENSI VE NURSERY	12.	403, 588		12, 403, 588	15. 00
16. 00	Total intensive care type inpatient hospital services (sum of li		910, 044		39, 910, 044	16. 00
	11-15)		•			
17.00	Total inpatient routine care services (sum of lines 10 and 16)	125,	945, 619		125, 945, 619	17.00
18.00	Ancillary services	323,	696, 918	566, 533, 675	890, 230, 593	18.00
19. 00	Outpati ent servi ces	26,	937, 999	120, 003, 656	146, 941, 655	19.00
20.00	RURAL HEALTH CLINIC		0	0	0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21.00
22. 00	HOME HEALTH AGENCY					22. 00
23. 00	AMBULANCE SERVICES					23. 00
24. 00	CMHC					24.00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)					25. 00
26. 00	HOSPI CE	15	072 550	20 104 520	25 170 000	26. 00 27. 00
27. 00 28. 00	PRO FEES/ LOBBY PHARMACY Total patient revenues (sum of lines 17-27)(transfer column 3 to		073, 559 654, 095		35, 178, 089 1, 198, 295, 956	28. 00
20.00	G-3, line 1)) WKSL. 491,	034, 093	700, 041, 001	1, 190, 290, 900	26.00
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			303, 061, 706		29. 00
30. 00	HOME OFFICE	63,	845, 825			30. 00
31. 00			0			31.00
32.00			0			32.00
33.00			0			33.00
34.00			0			34.00
35. 00			0			35.00
36. 00	Total additions (sum of lines 30-35)			63, 845, 825		36. 00
37. 00	DEDUCT (SPECIFY)		0			37. 00
38. 00			0			38. 00
39. 00			0			39. 00
40. 00			0			40.00
41. 00	T-t-1 d-d-t-t (27 41)		0			41.00
42. 00 43. 00	Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer		0 366, 907, 531		42. 00 43. 00
43.00	to Wkst. G-3, line 4)	(ri alisi ei		300, 907, 331		43.00
	1					

	Financial Systems UNION HOSPITAL, ENT OF REVENUES AND EXPENSES	Provider CCN: 150023	Peri od:	u of Form CMS-2 Worksheet G-3	2552-10
	ENT OF REVENUES THIS EXICES	11001461 001. 100020	From 01/01/2015 To 12/31/2015		
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line			1, 198, 295, 956	1. 00
2.00	Less contractual allowances and discounts on patients' account	S		813, 323, 723	2.00
3.00	Net patient revenues (line 1 minus line 2)	2)		384, 972, 233	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 4	3)		366, 907, 531	4. 00
5. 00	Net income from service to patients (line 3 minus line 4) OTHER INCOME			18, 064, 702	5. 00
6. 00	Contributions, donations, bequests, etc			0	6. 00
7. 00	Income from investments			0	7. 00
8. 00	Revenues from telephone and other miscellaneous communication:	servi ces		0	8. 00
9. 00	Revenue from television and radio service	361 11 663		o o	9. 00
10.00	Purchase di scounts			Ö	10. 00
11. 00	Rebates and refunds of expenses			ő	11. 00
12. 00				ol	12. 00
13. 00				ol	13. 00
14. 00	1			0	14.00
15. 00				o	15.00
16.00	Revenue from sale of medical and surgical supplies to other the	an patients		0	16.00
17.00	Revenue from sale of drugs to other than patients	·		o	17.00
18.00	Revenue from sale of medical records and abstracts			0	18.00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21. 00	Rental of vending machines			0	21.00
22. 00	Rental of hospital space			0	22.00
23. 00	Governmental appropriations			0	23.00
24. 00	OTHER			12, 664, 978	
24. 01	NON EXPENSE			1, 889, 649	24. 01
25. 00	Total other income (sum of lines 6-24)			14, 554, 627	25. 00
26. 00				32, 619, 329	26. 00
27. 00				25, 762, 099	
	Total other expenses (sum of line 27 and subscripts)			25, 762, 099	
29. 00	Net income (or loss) for the period (line 26 minus line 28)		l	6, 857, 230	29. 00

CALCII	Financial Systems UNION HOSPITA			u of Form CMS-2	2552-10
071200	ATION OF CAPITAL PAYMENT	Provi der CCN: 150023	Peri od: From 01/01/2015 To 12/31/2015	Worksheet L Parts I-III Date/Time Prep 5/25/2016 10:0	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD			1.00	
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			4, 507, 840	1.00
1.01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2.00	Capital DRG outlier payments			232, 718	2. 00
2. 01	Model 4 BPCI Capital DRG outlier payments			0	2. 01
3.00	Total inpatient days divided by number of days in the cost re	ructions)	165. 27	3.00	
4. 00 5. 00	Number of interns & residents (see instructions) Indirect medical education percentage (see instructions)	20. 67 3. 59	4. 00 5. 00		
6. 00	Indirect medical education percentage (see instructions)	sum of lines 1 and 1 01	columns 1 and	161, 831	6.00
0.00	1.01) (see instructions)	Sum of Tries Fand 1.01	, cordiins rand	101, 031	0.00
7.00	Percentage of SSI recipient patient days to Medicare Part A p	atient days (Worksheet E	, part A line	5. 35	7. 00
	30) (see instructions)	,			
8.00	Percentage of Medicaid patient days to total days (see instru	ctions)		22. 61	
9.00	Sum of lines 7 and 8			27. 96	
10.00	Allowable disproportionate share percentage (see instructions	.)		5. 82	
11. 00 12. 00	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			262, 356 5, 164, 745	
12.00	Total prospective capital payments (see instructions)			5, 104, 745	12.00
				1.00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)			0	1. 00
2.00	Program inpatient ancillary capital cost (see instructions)			0	
3. 00 4. 00	Total inpatient program capital cost (line 1 plus line 2)			0	
5.00	Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4)				4. 00 5. 00
3.00	Total Tripatrent program capital cost (Trie 3 x Trie 4)				
				0	0.00
				1.00	0.00
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			1.00	
	Program inpatient capital costs (see instructions)			1.00	1. 00
2.00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance	es (see instructions)		1.00	1. 00 2. 00
2. 00 3. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstanc Net program inpatient capital costs (line 1 minus line 2)	es (see instructions)		1. 00 0 0 0	1. 00 2. 00 3. 00
2. 00 3. 00 4. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstanc Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions)	es (see instructions)		1.00 0 0 0 0 0.00	1. 00 2. 00 3. 00 4. 00
2. 00 3. 00 4. 00 5. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstanc Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)			1.00 0 0 0 0.00	1. 00 2. 00 3. 00 4. 00 5. 00
2. 00 3. 00 4. 00 5. 00 6. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstanc Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions)	structions)	line 6)	1.00 0 0 0 0 0.00	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstanc Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in	structions)	line 6)	1.00 0 0 0 0.00 0.00	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appli	structions) circumstances (line 2 x	,	1.00 0 0 0.00 0.00 0.00	1. 000 2. 000 3. 000 4. 000 5. 000 6. 000 7. 000 8. 000 9. 000
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appli Current year comparison of capital minimum payment level to c	structions) circumstances (line 2 x cable) apital payments (line 8	less line 9)	1.00 0 0 0.00 0.00 0.00 0.00	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appli Current year comparison of capital minimum payment level to c Carryover of accumulated capital minimum payment level over c Worksheet L, Part III, line 14)	structions) circumstances (line 2 x cable) apital payments (line 8 apital payment (from pri	less line 9) or year	1.00 0 0 0.00 0.00 0.00 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appli Current year comparison of capital minimum payment level to c Carryover of accumulated capital minimum payment level over c Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital pa	structions) circumstances (line 2 x cable) apital payments (line 8 apital payment (from pri yments (line 10 plus lin	less line 9) or year e 11)	1.00 0 0 0.00 0.00 0.00 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00
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