PART II - CERTIFICATION

(3) Settled with Audit

(4) Reopened (5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by UNION HOSPITAL, INC. (15-0023) for the cost reporting period beginning 01/01/2016 and ending 12/31/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

] I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

Si gned)					
	Offi cer	or	Admi ni strator	of	Provi der(s)
T1 11 1					
Title					
Date					
Date					

number of times reopened = 0-9.

			Title XVIII				
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
	<u> </u>	1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	281, 406	344, 812	1, 937	-728, 383	1.00
2.00	Subprovi der - I PF	0	0	0		0	2.00
3.00	Subprovi der - I RF	0	-18, 868	-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	262, 538	344, 806	1, 937	-728, 383	200.00

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

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

Health Financial Systems UNION HOSPITAL, INC. In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0023 Peri od: Worksheet S-2 From 01/01/2016 Part I Date/Time Prepared: 12/31/2016 11/12/2018 4:13 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1606 NORTH SEVENTH ST 1.00 PO Box: 1.00 Ci ty: TERRE HAUTE State: IN Zip Code: 47804-2.00 County: VIGO 2.00 Component Name CCN CBSA Provi der Date Payment System (P, Certi fi ed T, 0, or N) Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 UNION HOSPITAL, INC. 150023 45460 01/01/1966 Ν Р 0 3.00 Hospi tal 1 Subprovi der - IPF 4.00 4.00 5.00 Subprovi der - IRF MEDICAL REHAB 15T023 45460 5 09/01/1989 N Ρ 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 Hospital -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 Hospi tal -Based OLTC 11 00 11 00 12.00 Hospital -Based HHA 12.00 13.00 Separately Certified ASC 13.00 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 18.00 Renal Dialysis 18 00 19.00 Other 19.00 From To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2016 12/31/2016 20 00 Type of Control (see instructions) 21.00 2 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 for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting Ν Ν 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Is this a newly merged hospital that requires final uncompensated care payments to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result 22.03 Ν of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 3 N 23.00 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method enter "Y" for yes or used in the prior cost reporting period? In column 2 "N" for no In-State In-State Out-of Medi cai d Out-of 0ther Medicai d Medi cai d State State HMO days Medi cai d Medi cai d Medi cai d eligible paid days days unpai d pai d days el i gi bl e days unpai d 1 00 3.00 2.00 4.00 5.00 6.00 24.00 If this provider is an IPPS hospital, enter the 1, 246 2,778 1, 485 331 9, 137 24.00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 55 260 13 13 95 25.00 Medicaid paid days in column 1, the in-state

Medicaid eligible unpaid days in column 2,

out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.

Heal th	Financial Systems UNION	HOSPI ⁻	ΓAL, INC.		In	Lieu	u of For	n CMS-2	2552-10
	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provi der C		eriod: rom 01/01/	2016	Workshe Part I	et S-2	
				T			Date/Ti 11/12/2		
					Urban/Rur 1.00	al S		Geogr	lo piii
26. 00	Enter your standard geographic classification (not wa			eginning of the		1	2. 0		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	ige) st "2" f	atus at the er or rural. If a			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.			SCH status in		0			35. 00
	errect in the cost reporting perrod.				Begi nni r	ng:	Endi		
36.00	Enter applicable beginning and ending dates of SCH st	atus	Subscript line	- 36 for number	1.00		2. 0	00	36. 00
	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter	S.	•			0			37.00
	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for th	ne MDH	transitional p	payment in	N	0			37.00
38. 00	accordance with FY 2016 OPPS final rule? Enter "Y" foinstructions) If line 37 is 1, enter the beginning and ending dates	of MD	H status. If I	ine 37 is					38. 00
	greater than 1, subscript this line for the number of enter subsequent dates.	peri o	ds in excess o	of one and					
					Y/N 1.00		Y/ 2. C		
39. 00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) for yes or "N" for no. Does the facility meet the mil with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column instructions)	or (i eage r	i)? Enter in d equirements in	column 1 "Y" n accordance			N		39.00
40. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob	er 1.	Enter "Y" for		N		N		40. 00
	no in column 2, for discharges on or after October 1.	(See	I nstructions)			V 1. 00	XVIII) 2.00	XI X 3. 00	
45. 00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen	it for	di sproporti ona	ate share in ac	cordance	N	Y	N	45. 00
46. 00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst					N	N	N	46. 00
	Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS c Is the facility electing full federal capital payment					N N	N N	N N	47. 00 48. 00
56. 00	Teaching Hospitals Is this a hospital involved in training residents in	approv	ed GME prograr	ms? Enter "Y"	for yes	Υ			56. 00
57. 00	or "N" for no. If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y	yes o h of t ", com	r "N" for no i his cost repo plete Workshee	in column 1. If rting period?	column 1 Enter "Y"	N			57. 00
58. 00	"N", complete Wkst. D, Parts III & IV and D-2, Pt. II If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	urseme	nt for physici	ans' services	as	N			58.00
59. 00	Are costs claimed on line 100 of Worksheet A? If yes					N			59.00
				NAHE 413.85 Y/N	Workshee Line #		Pass-Th Qualifi Crite Coo	cation rion	
60.00	Are you claiming nursing and allied health education	(NVTE)	costs for	1. 00 Y	2. 00		3. 0		60.00
50.00		see in	structions)	·	LME		Di zoci	CME	50.00
		Y/N	I ME	Direct GME	IME		Di rect		
61. 00	Did your hospital receive FTE slots under ACA	1. 00 N	2. 00	3. 00	4. 00	0. 00	5. C		61.00
	section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care		0. 0	0.00					61.01
	FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		3.0						
61. 02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0. 0	0.00					61. 02
	Enter the base line FTE count for primary care		0. 0	o. oc	4				61.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provi der CC	F	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Pre 11/12/2018 4:	pared:
	Y/N	I ME	Direct GME	I ME	Direct GME	ra pili
	1. 00	2. 00	3. 00	4. 00	5. 00	
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary		0.00	0.0	0		61. 04 61. 05
and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary		0.00	0.0	С		61. 06
care or general surgery. (see instructions)	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1. 00	2. 00	3. 00	4. 00	
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61. 10
0f the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0. 00	61. 20
					1.00	
ACA Provisions Affecting the Health Resources and Ser 62.00 Enter the number of FTE residents that your hospital				rind for which	0.00	62. 00
your hospital received HRSA PCRE funding (see instructed). 2.01 Enter the number of FTE residents that rotated from a	ctions) n Teachi	ing Health Cen	ter (THC) into			62. 01
during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide			ns)			
63.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple					Y	63.00
, , , , , , , , , , , , , , , , , , , ,			Unwei ghted FTEs	Unwei ghted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
			Nonprovi der Si te	nospi tui	COI . 2))	
Cooking FEOA of the ACA D. V. FTF D. 1.1.1.1.1.1.1		dan Catti	Si te 1. 00	2. 00	3. 00	
Section 5504 of the ACA Base Year FTE Residents in No period that begins on or after July 1, 2009 and befor	onprovi re June	der Settings 30, 2010.	Si te 1. 00	2. 00	3. 00	
period that begins on or after July 1, 2009 and before Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted nor resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted	<u>re June</u> Ty train n-priman all non I non-po	30, 2010. ned residents ry care nprovider rimary care	Si te 1. 00	2.00 r is your cost	3.00 reporting	64. 00
period that begins on or after July 1, 2009 and before 64.00 Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted nor resident FTEs attributable to rotations occurring in	re June ry train n-priman all non n column	ned residents ry care nprovider rimary care n 3 the ratio	Site 1.00 This base yea	2.00 r is your cost	3.00 reporting	64. 00
period that begins on or after July 1, 2009 and before Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted nor resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in	re June ry train n-priman all non n column instruc	ned residents ry care nprovider rimary care n 3 the ratio	Site 1.00 This base yea	2.00 r is your cost	3.00 reporting	64.00

Health Financial Systems UNION HOSPITAL, INC. In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 15-0023 Peri od: Worksheet S-2 From 01/01/2016 Part I Date/Time Prepared: 12/31/2016 11/12/2018 4:13 pm Program Name Program Code Unwei ghted Unwei ghted Ratio (col. 3/ (col. 3 + FTEs FTEs in col. 4)) Nonprovi der Hospi tal Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if li is yes, or your facility UH FAMILY MEDICINE 1201711131 0. 91 20. 14 0.043230 65.00 if line 63 RESI DENCY trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ (col . 1 + col . 2)) FTEs in FTFs Hospi tal Nonprovi der Si te 2. 00 3. 00 1 00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0.00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Unwei ghted Unwei ghted Ratio (col. FTEs FTEs in 3/(col. 3 +col. 4)) Nonprovi der Hospi tal Si te 1.00 2.00 3. 00 4. 00 5. 00 67.00 Enter in column 1, the program UH FAMILY MEDICINE 1201711131 2. 30 0. 109524 67. 00 18. 70 name associated with each of RESI DENCY your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 70.00 N Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most 71.00 0 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

75.00

Inpatient Rehabilitation Facility PPS

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

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

SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-002	Peri od:	Worksheet S	S-2552 S-2
5.7.7.2.7.8.2.7.8.2.7.8.2.7.8.2.7.7.2.7.7.3.7.7.3.7.3.7.3.7.3.7.3.7.3	From 01/01/201 To 12/31/201	6 Part I	Prepare
	1	00 2.00 3.0	20
.00 If line 75 is yes: Column 1: Did the facility have an approved GME teaching progra recent cost reporting period ending on or before November 15, 2004? Enter "Y" for no. Column 2: Did this facility train residents in a new teaching program in accor CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 indicate which program year began during this cost reporting period. (see instruct	m in the most yes or "N" for dance with 42 is Y,		
		1. 00	
Long Term Care Hospital PPS .00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. .00 Is this a LTCH co-located within another hospital for part or all of the cost repo "Y" for yes and "N" for no.	rting period? Ente	n N	80. 81.
TEFRA Providers .00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for .00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR S		. N	85. 86.
\$413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 1. Solution 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	ti on	N	87.
[1880(d)(1)(b)(vi): Litter 1 Toll yes of N Toll III.	V 1.00	XI X 2. 00	
Title V and XIX Services	1.00	2.00	
.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" yes or "N" for no in the applicable column.	for N	Y	90.
00 Is this hospital reimbursed for title V and/or XIX through the cost report either full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	91
00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (se instructions) Enter "Y" for yes or "N" for no in the applicable column.	е	N	92
00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? En "Y" for yes or "N" for no in the applicable column.	ter N	N	93
00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94
00 If line 94 is "Y", enter the reduction percentage in the applicable column. 00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	0. 00 N	0. 00 N	95 96
00 If line 96 is "Y", enter the reduction percentage in the applicable column. 00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents po stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no i column 1 for title V, and in column 2 for title XIX.		0. 00 Y	97 98
O1 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 title XIX.		Y	98
O2 Does title V or XIX follow Medicare (title XVIII) for the calculation of observati bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column for title V, and in column 2 for title XIX.		Y	98
O3 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in col for title V, and in column 2 for title XIX.		N	98
O4 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, in column 2 for title XIX.	and	N	98
05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowanc Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, a column 2 for title XIX.		Y	98
O6 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Rural Providers		Y	98
6.00 Does this hospital qualify as a CAH? 6.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of pa	yment N		105 106
1.00 of this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is reimbursed. If yes complete Wkst. D-2, Pt. II.	lf		107
3.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? Se CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	e 42 N		108

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der	F	eriod: rom 01/01/	′2016	Worksheet S Part I	
		Т	o 12/31/		Date/Time F 11/12/2018	
-	Physi cal	Occupati onal		h	Respi rator	
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.	1. 00 N	2. 00 N	3. 00 N		4. 00 N	109.0
					1. 00	
110.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "			110A		N	110.0
			1.00		2. 00	
111.00 If this facility qualifies as a CAH, did it participate in t Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ac for tele-health services.	ost reporting olumn 1 is Y, rticipating i	period? Enter enter the n column 2.	N	1.00	2.00 3.0	111. (
Miscellaneous Cost Reporting Information				1.00	2.00 3.0	00
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percer psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, chapter 22, §2208.1.	If column 2 nt for long rs) based on	2 is "E", enter term care (inclu the definition	in column udes	N	0	115. (
116.00 Is this facility classified as a referral center? Enter "Y" 117.00 Is this facility legally-required to carry malpractice insur no.			"N" for	Y		116. (117. (
118.00 is the malpractice insurance a claims-made or occurrence policial m-made. Enter 2 if the policy is occurrence.	icy? Enter	lif the policy	is	1		118. (
		Premi ums	Losse		Insurance	
 118.01 List amounts of malpractice premiums and paid losses:		1. 00 928, 586	2.00	0	3. 00	0118.
			1.00		2.00	
118.02 Are malpractice premiums and paid losses reported in a cost	center other	than the	1. 00 N		2. 00	118.
Administrative and General? If yes, submit supporting schedand amounts contained therein. 19.00 DO NOT USE THIS LINE	dule listing	cost centers				119.
120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no.	n column 1, ' ualifies for	Y" for yes or the Outpatient	N		N	120.
21.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.	antable devi	ces charged to	Y			121.
22.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.	-	. , . ,	N			122.
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for	or yes and "!	N" for no. If	N			125.
yes, enter certification date(s) (mm/dd/yyyy) below.						
26.00 f this is a Medicare certified kidney transplant center, er in column 1 and termination date, if applicable, in column 2		urreation date				126.
27.00 If this is a Medicare certified heart transplant center, ent in column 1 and termination date, if applicable, in column 2		fication date				127.
28.00 f this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2	ter the certi	fication date				128.
29.00 f this is a Medicare certified lung transplant center, ente column 1 and termination date, if applicable, in column 2.		ication date in	ו			129.
30.00 f this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in col		erti fi cati on				130.
31.00 f this is a Medicare certified intestinal transplant center date in column 1 and termination date, if applicable, in col	r, enter the	certi fi cati on				131.
32.00 f this is a Medicare certified islet transplant center, ent in column 1 and termination date, if applicable, in column 2	ter the certi	fication date				132.
33.00 f this is a Medicare certified other transplant center, ent in column 1 and termination date, if applicable, in column 2	ter the certi	fication date				133.
34.00 If this is an organ procurement organization (OPO), enter the		in column 1				134.
and termination date, if applicable, in column 2. All Providers						

Health Financial Systems UNION HOSPITAL, INC. In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 15-0023 Peri od: Worksheet S-2 From 01/01/2016 Part I Date/Time Prepared: To 12/31/2016 11/12/2018 4:13 pm If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number. Contractor's Name: WISCONSIN PHYSICIANS Contractor's Number: 08101 141.00 141. 00 Name: UNION HOSPITAL, INC. SERVI CES 142.00 Street: 1606 NORTH SEVENTH ST PO Box: 142.00 143.00 City: TERRE HAUTE State: ΙN Zip Code: 47804 143.00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144.00 1.00 2.00 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for 145.00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? Ν 146.00 Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 147 00 N 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. Ν 148.00 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title V Title XIX 3. 00 4.00 1.00 2.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155. 00 Hospi tal N 155.00 N Ν Ν 156.00 Subprovi der - IPF Ν Ν Ν Ν 156.00 157.00 Subprovi der - IRF Ν Ν 157. 00 Ν Ν 158. 00 SUBPROVI DER 158. 00 159, 00 SNF 159 00 Ν Ν Ν Ν 160.00 HOME HEALTH AGENCY Ν Ν Ν Ν 160.00 161.00 CMHC Ν Ν Ν 161.00 1.00 Mul ticampus 165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? 165.00 Enter "Y" for yes or "N" for no. FTE/Campus Name County State Zi p Code **CBSA** 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00166.00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 s this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. 167.00 168.00 of this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the d168. 00 reasonable cost incurred for the HIT assets (see instructions) 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions) 168.01 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the 0. 25 169. 00 transition factor. (see instructions) Endi ng Begi nni ng 1.00 2.00 170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting 01/01/2016 12/31/2016 170.00 peri<u>od respectively (mm/dd/yyyy)</u> 1.00 2.00

Ν

0171.00

171.00|If line 167 is "Y", does this provider have any days for individuals enrolled in

1876 Medicare days in column 2. (see instructions)

section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section

	Financial Systems UNION HOSPI AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider Co		Peri od:	wof Form CMS- Worksheet S-2	
				From 01/01/2016 Fo 12/31/2016		anarac
			<u></u>	12/31/2010	11/12/2018 4:	
				Y/N	Date	
				1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N	l for all NO re	esponses. Ente	er all dates in	the	
	mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation					
00	Has the provider changed ownership immediately prior to the	e beginning of	the cost	N		1.
	reporting period? If yes, enter the date of the change in a					
			Y/N	Date	V/I	
			1. 00	2. 00	3. 00	
00	Has the provider terminated participation in the Medicare F		N			2.
	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	nn 3, V FOF				
00	Is the provider involved in business transactions, including	na management	Y			3.
00	contracts, with individuals or entities (e.g., chain home of		'			5.
	or medical supply companies) that are related to the provide					
	officers, medical staff, management personnel, or members of					
	of directors through ownership, control, or family and other	er similar				
	relationships? (see instructions))/ /h	-	<u> </u>	
			Y/N	Type	Date	-
	Financial Data and Reports		1. 00	2. 00	3. 00	
00	Column 1: Were the financial statements prepared by a Cert	tified Public	Υ	A		4.
00	Accountant? Column 2: If yes, enter "A" for Audited, "C" 1	for Compiled.		, A		7.
	or "R" for Reviewed. Submit complete copy or enter date ava					
	column 3. (see instructions) If no, see instructions.					
00	Are the cost report total expenses and total revenues diffe		N			5.
	those on the filed financial statements? If yes, submit rec	conciliation.				
				Y/N	Legal Oper.	
	Approved Educational Activities			1. 00	2. 00	
00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2:	If you is th	he provider is	N N		6.
00	the legal operator of the program?	11 yes, 15 ti	ne provider 13) IV		0.
00	Are costs claimed for Allied Health Programs? If "Y" see in	nstructi ons.		Υ		7.
00	Were nursing school and/or allied health programs approved		d during the	N		8.
	cost reporting period? If yes, see instructions.		· ·			
00	Are costs claimed for Interns and Residents in an approved		cal education	Υ		9.
	program in the current cost report? If yes, see instruction					10
. 00	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.	or renewed in	the current	N		10.
. 00		& Rin an An	nroved	N		11.
. 00	Teaching Program on Worksheet A? If yes, see instructions.	a K III ali Api	pi oved	14		' ' '
	<u> </u>			•	Y/N	
	· · · · · · · · · · · · · · · · · · ·				1. 00	
	Bad Debts				1. 00	
	Is the provider seeking reimbursement for bad debts? If yes				1. 00 Y	
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p			ost reporting	1. 00	
. 00	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.	oolicy change o	during this co		1. 00 Y N	13.
. 00	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payments.	oolicy change o	during this co		1. 00 Y	13.
. 00	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? I	during this co	structi ons.	1.00 Y N	13. 14.
. 00	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payments.	ents waived? It	during this co	structions.	1. 00 Y N	13. 14.
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	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payme Bed Complement Did total beds available change from the prior cost reporti PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see 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.	ng period? If ng period? If Par Y/N 1.00 Y	during this co	ructions. Par Y/N 3.00 Y	1.00 Y N N Y t B Date 4.00	13. 14. 15. 16. 17.
. 00	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payme Bed Complement Did total beds available change from the prior cost reporti PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see 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	oolicy change of ents waived? If ng period? If Par Y/N 1.00	during this co	ructions. Par Y/N 3.00 Y	1.00 Y N N Y t B Date 4.00	13. 14. 15. 16.

	Financial Systems UNION HOSPIT			In Lie	u of Form CMS	S-2552-1			
HOSPI TAI	L AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CC	CN: 15-0023	Period: From 01/01/2016 To 12/31/2016		repared			
		Descri	ption	Y/N	Y/N	11 10 5			
		C)	1. 00	3. 00				
	f line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.0			
1.	ioport data for striot, besseries the striot day astriionts.	Y/N	Date	Y/N	Date				
21. 00 W	Vas the cost report prepared only using the provider's	1. 00 N	2. 00	3. 00 N	4. 00	21.0			
	records? If yes, see instructions.	14		- 14		21.0			
					1. 00				
_	OMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS H	IOSPI TALS)						
	apital Related Cost				N				
	Have assets been relifed for Medicare purposes? If yes, see Have changes occurred in the Medicare depreciation expense		sals made du	ıring the cost	N N	22. 0 23. 0			
	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases entered into during this cost reporting period?								
1	f yes, see instructions	· ·			N	24.0			
	Have there been new capitalized leases entered into during nstructions.	the cost repor	rting period	f? If yes, see	N	25.0			
	Were assets subject to Sec. 2314 of DEFRA acquired during the nstructions.	ne cost reporti	ng period?	If yes, see	N	26. 0			
27. 00 H	las the provider's capitalization policy changed during the	e cost reportir	ng period? I	f yes, submit	N	27. 0			
	copy. nterest Expense								
	Were new loans, mortgage agreements or letters of credit en period? If yes, see instructions.	ntered into dur	ing the cos	st reporting	N	28. 0			
29. 00 D	00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund)								
80. 00 H	reated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu		debt? If ye	es, see	N	30.0			
31. 00 H	nstructions. Has debt been recalled before scheduled maturity without is nstructions.	ssuance of new	debt? If ye	es, see	N	31.0			
P	urchased Services		lk.la		N				
а	Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru	ıcti ons.			N	32.0			
	fline 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.	olied pertainir	ng to compet	itive bidding? If	N	33.0			
	rovi der-Based Physi ci ans				N.				
	Are services furnished at the provider facility under an ar f yes, see instructions.	rangement witr	n provider-b	based physicians?	N	34.0			
	fline 34 is yes, were there new agreements or amended exichysicians during the cost reporting period? If yes, see in		nts with the	e provi der-based	N	35. C			
				Y/N 1.00	Date 2.00				
H	ome Office Costs			1.00	2.00				
6.00 W	Were home office costs claimed on the cost report?			Y		36.0			
	fline 36 is yes, has a home office cost statement been pr f yes, see instructions.	repared by the	home office	9? Y		37.0			
	fline 36 is yes , was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end			of N		38.0			
9.00	fline 36 is yes, did the provider render services to other			es, N		39.0			
10.00	see instructions. fline 36 is yes, did the provider render services to the	home office?	If yes, see	e N		40.0			
i	nstructions.								
	act Danart Drangrar Contact Information	1. (00	2.	00				
1.00 E		LANDON	HACKETT		41.0				
r	neld by the cost report preparer in columns 1, 2, and 3, respectively.		_						
12.00 E	. , , , , , , , , , , , , , , , , , , ,	BLUE & CO., LL		42.0					
	preparer.					II.			

Heal th	Financial Systems	TAL, INC.		In Lieu of Form CMS-2552-10			
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUES	STI ONNAI RE	Provider CCN: 15-0023		Period: From 01/01/2016	Worksheet S-2 Part II	
				Т	o 12/31/2016	Date/Time Pre 11/12/2018 4:	
			3. 00				
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title.	/position	MANAGER				41.00
	held by the cost report preparer in columns 1	, 2, and 3,					
	respectively.						
42.00	Enter the employer/company name of the cost re	eport					42.00
	preparer.						
43.00	Enter the telephone number and email address	of the cost					43.00
	report preparer in columns 1 and 2, respective	el v.					

| Peri od: | Worksheet S-3 | From 01/01/2016 | Part | To 12/31/2016 | Date/Time Prepared: Heal th Fi nancial SystemsUNIONHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provi der CCN: 15-0023

Component Worksheet A Line Number No. of Beds Red Days Available No. of Beds Red Days Available No. of Beds Red Days Title V No. of Beds Red Days Red Days Red Days No. of Beds Red Days Red Day						Т	o 12/31/2016	Date/Time Pre 11/12/2018 4:	
Component Worksheet A Line Number Trips Title V Line Number Titl									TO PIII
Component									
Line Number									
1.00		Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
1.00 Hospit tal Adult is & Peds. (col umns 5, 6, 7 and 8 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 2 2 2 2 2 3 3 3 3									
8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2. 00 HM and other (see instructions) 3. 00 HM IPF Subprovi der 4. 00 Hospital Adults & Peds. Swing Bed SNF 6. 00 Hospital Adults & Peds. Swing Bed SNF 6. 00 Hospital Adults & Peds. Swing Bed NF 7. 00 Total Adults and Peds. (exclude observation beds) (see instructions) 8. 00 INTENSIVE CARE UNIT 9. 00 CORONARY CARE UNIT 10. 00 BURN INTENSIVE CARE UNIT 11. 00 SURGICAL INTENSIVE CARE UNIT 12. 00 INTENSIVE NERSERY 35. 00 15 5, 490 0.00 0.12. 00 13. 00 NURSERY 43. 00 43. 00 54. 00 O SUBPROVIDER - IPF 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 19. 00 SKILLED NURSING FACILITY 20. 00 O WIRSING FACILITY 20. 00 O WIRSING FACILITY 21. 00 O O O O O O O O O O O O O O O O O O									
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		outpatient days (see instructions)							
33.01 LTCH site neutral days and discharges									
	33. 01	LTCH site neutral days and discharges							33. 01

| Period: | Worksheet S-3 | From 01/01/2016 | Part | To 12/31/2016 | Date/Time Prepared: Provider CCN: 15-0023

Component					Т	o 12/31/2016	Date/Time Pre 11/12/2018 4:	
Component			I/P Days	/ O/P Visits	/ Trips	Full Time F		13 pili
Neglital Adults & Peds. (columns 5, 6, 7 and 8 and 9,00 9,00 10,00 1,00							1	
Neglital Adults & Peds. (columns 5, 6, 7 and 8 and 9,00 9,00 10,00 1,00								
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) 1.00		Component	Title XVIII	Title XIX				
1.00 Hospit tal Adult is & Peds. (columns 5, 6, 7 and 8 24,958 789 48,771			6.00	7 00				
8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2	1 00	Hospital Adults & Peds (columns 5 6 7 and				7.00	10.00	1 00
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For the portion of LDP room avail lable beds) 3, 423 13, 702 2.00								
2.00 HM0 and other (see instructions)								
3.00	2.00		3, 423	13, 702				2.00
4.00			0					3.00
5.00	4.00		0	381				4.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 24,958 789 48,771 8.00 8,314 8.00 9.00 1.	5.00	•	0	o	0			5. 00
Deds) (see instructions)	6.00	Hospital Adults & Peds. Swing Bed NF		O	0			6.00
8. 00 INTENSIVE CARE UNIT 4,836 0 8,314 8. 00 0. 0	7.00	Total Adults and Peds. (exclude observation	24, 958	789	48, 771			7.00
9.00 CORONARY CARE UNIT 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 1		beds) (see instructions)						
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27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 31.00 Total (sum of lines 14-26) 21.00 21.00 22.00 28.00 29.00 29.00 29.00 30.00 30.00 31.00 31.00 32.00 32.00 32.00 32.01 32.01 33.00 33.00 33.00			0	0	0	0.00	0.00	
28.00 Observation Bed Days 28.00 29.00 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 0 31.00 29.00 32.00 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 0 33.00 33.00 33.00				Ÿ.	O			
29.00 Ambulance Trips 0 30.00 Employee discount days (see instruction) 0 31.00 Employee discount days - IRF 0 32.00 Labor & delivery days (see instructions) 0 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 295 33.00 LTCH non-covered days 0				0	9 247		1, 100.07	
30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 31.00 LTCH non-covered days 30.00 31.00 31.00 31.00 32.00 32.00 32.01 32.01			0	Ĭ	772.7			
31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 31.00 32.01 32.00 32.01 32.01 32.01			1		0			
32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 32.00 32 47 295 32.01 33.00								
32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 32.01		. 3	o	32				
outpatient days (see instructions) 33.00 LTCH non-covered days 0 33.00				-				
33.01 LTCH site neutral days and discharges 0 33.01	33.00	LTCH non-covered days	0					33.00
	33. 01	LTCH site neutral days and discharges	0]		33. 01

| Period: | Worksheet S-3 | From 01/01/2016 | Part | To 12/31/2016 | Date/Time Prepared: Provider CCN: 15-0023

				To	12/31/2016	Date/Time Pre 11/12/2018 4:	
		Full Time		Di sch	arges	, , . = , =	
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
	T	11. 00	12. 00	13. 00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		(6, 816	210	14, 901	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)			663	2, 930		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO I RF Subprovi der				27		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation						7. 00
0.00	beds) (see instructions)						0 00
8. 00 9. 00	INTENSIVE CARE UNIT						8. 00 9. 00
	CORONARY CARE UNIT						
10. 00 11. 00	BURN INTENSIVE CARE UNIT						10. 00 11. 00
	SURGICAL INTENSIVE CARE UNIT						
12. 00 13. 00	I NTENSI VE NURSERY NURSERY						12. 00 13. 00
14. 00	Total (see instructions)	0.00	(6, 816	210	14, 901	14.00
15. 00	CAH visits	0.00	(0,010	210	14, 901	15.00
16. 00	SUBPROVIDER - IPF						16.00
17. 00	SUBPROVIDER - I RF	0.00	(185	4	267	
18. 00	SUBPROVI DER	0.00		103	7	207	18.00
19. 00	SKILLED NURSING FACILITY						19.00
20. 00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26, 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27.00	Total (sum of lines 14-26)	0.00					27. 00
28.00	Observation Bed Days						28. 00
29.00	Ambul ance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days			0			33.00
33. 01	LTCH site neutral days and discharges			0			33. 01

	Financial Systems TAL WAGE INDEX INFORMATION		UNI ON HOSPI	Provider C	CN: 15_0022	In Lie Period:	u of Form CMS-2 Worksheet S-3	
10321 1	AL WAGE INDEX INFORMATION					From 01/01/2016 To 12/31/2016	Part II	pared:
		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1. 00	2. 00	3.00	4.00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							1
. 00	Total salaries (see	200. 00	93, 876, 990	0	93, 876, 99	0 3, 023, 677. 00	31. 05	1.00
. 00	instructions) Non-physician anesthetist Part		0	0		0.00	0.00	2.00
00	A Non-physician anesthetist Part		0	0		0.00	0.00	3.00
00	B Physician-Part A -		0	0		0.00	0. 00	4.00
01	Administrative Physicians - Part A - Teaching		807, 200	0	807, 20	0 6, 870. 00	117. 50	4. 01
00	Physician and Non Physician-Part B		5, 060, 801	0			186. 55	
00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0		0. 00	0. 00	6.00
00	Interns & residents (in an approved program)	21. 00	0	1, 332, 004	1, 332, 00	4 43, 680. 00	30. 49	7. 00
01	Contracted interns and residents (in an approved		0	0		0.00	0. 00	7. 01
00	programs) Home office and/or related organization personnel		0	0		0.00	0. 00	8. 00
00	SNF	44.00	0	О		0. 00	0. 00	1
. 00	Excluded area salaries (see instructions)		12, 429, 594	-2, 065, 677	10, 363, 91	7 187, 807. 00	55. 18	10.00
00	OTHER WAGES & RELATED COSTS		E 00E 400		F 005 40	2 444 405 00	FO 74	11.00
. 00	Contract Labor: Direct Patient Care		5, 805, 423				50. 71	
00	Contract labor: Top level management and other management and administrative		0	0		0.00	0. 00	12.00
00	services Contract Labor: Physician-Part		823, 560	0	823, 56	0 7, 508. 00	109. 69	13.00
. 00	A - Administrative Home office and/or related organization salaries and		0	О		0.00	0.00	14.00
. 01	wage-related costs Home office salaries		19, 721, 174	0	19, 721, 17	4 393, 756. 00	50. 08	14. 01
	Related organization salaries		0	0		0.00	0. 00	14. 02
00	Home office: Physician Part A - Administrative		0	0		0.00	0.00	15. 00
00	Physicians Part A - Teaching		0	0		0.00	0. 00	16. 00
. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		26, 118, 014	0	26, 118, 01	4		17. 00
. 00	instructions) Wage-related costs (other)		0	0		0		18. 00
. 00	(see instructions) Excluded areas		2, 692, 024	0	2, 692, 02	4		19.00
. 00	Non-physician anesthetist Part		0	ő	2,072,02	Ö		20.00
. 00	Non-physician anesthetist Part B		0	0		0		21.00
. 00	Physician Part A - Administrative		0	0		0		22.00
01	Physician Part A - Teaching		184, 380					22. 01
00	Physician Part B Wage-related costs (RHC/FQHC)		859, 443 0	0		o		23. 00 24. 00
00	Interns & residents (in an approved program)		442, 324	0	442, 32	4		25.00
50	Home office wage-related (core)		0	0		0		25. 50
51	1 ` ′		0	0		О		25. 51
52			0	0		0		25. 52
	wage-related (core)							

25.53

wage-related (core)
Home office & Contract
Physicians Part A - Teaching wage-related (core)

Provi der CCN: 15-0023

Number N						Te	o 12/31/2016		
Number Reported Salaries (col. 2 ± col. Salaries (col. 2 ± col. Salaries in col. 4 col. 4 col. 4 col. 4 col. 5			Wkst Alina	Amount	Paclassi fi cat	Adiustad	Daid Hours		13 piii
Sal ari es (from Wkst. A-6) Sol ari es in col. 4 col. 5)									
OVERHEAD COSTS - DIRECT SALARIES 26.00 Employee Benefits Department 4.00 290, 388 525, 358 815, 746 31, 712.00 25.72 26.00			IVallibet	керог геа					
1.00 2.00 3.00 4.00 5.00 6.00						`		•	
1.00 2.00 3.00 4.00 5.00 6.00						3)	COI. 4	COI . 3)	
OVERHEAD COSTS - DIRECT SALARIES 26. 00 Employee Benefit s Department 4. 00 290, 388 525, 358 815, 746 31, 712.00 25. 72 26. 00			1. 00	2. 00		4. 00	5. 00	6, 00	
27. 00 Administrative & General 5. 00 7, 315, 674 -455, 386 6, 860, 288 248, 174, 00 27. 64 27. 00 28. 00 Administrative & General under contract (see inst.) 2, 152, 856 0		OVERHEAD COSTS - DIRECT SALARI							
27. 00 Administrative & General 5. 00 7, 315, 674 -455, 386 6, 860, 288 248, 174, 00 27. 64 27. 00 28. 00 Administrative & General under contract (see inst.) 2, 152, 856 0	26.00	Employee Benefits Department	4.00	290, 388	525, 358	815, 746	31, 712. 00	25. 72	26. 00
Contract (see inst.) Contract (see inst.) Contract (see inst.)	27.00	Administrative & General	5. 00	7, 315, 674	-455, 386	6, 860, 288	248, 174. 00	27. 64	27. 00
29.00 Maintenance & Repairs 6.00 0 0 0 0.00 29.00 30.00 Operation of Plant 7.00 1,738,635 0 1,738,635 62,921.00 27.63 30.00 31.00 Laundry & Linen Service 8.00 603,673 0 603,673 39,141.00 15.42 31.00 40.00 15.42 31.00 15.42	28.00	Administrative & General under		2, 152, 856	0	2, 152, 856	15, 858. 00	135. 76	28. 00
30.00 Operation of Plant 7.00 1,738,635 0 1,738,635 62,921.00 27.63 30.00 31.00 Laundry & Linen Service 8.00 603,673 0 603,673 39,141.00 15.42 31.00 32.00 Housekeeping under contract (see instructions) 10.00 1,821,869 -7,008 1,814,861 118,176.00 15.36 34.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		contract (see inst.)							
31. 00 Laundry & Linen Service	29.00	Maintenance & Repairs	6. 00	0	0	0	0. 00	0. 00	29. 00
32. 00 Housekeeping 9. 00 1, 973, 267 0 1, 973, 267 141, 150. 00 13. 98 32. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	30.00	Operation of Plant	7. 00	1, 738, 635	0	1, 738, 635	62, 921. 00	27. 63	30.00
33. 00 Housekeeping under contract (see instructions) 34. 00 Di etary 35. 00 Di etary under contract (see instructions) 36. 00 Cafeteria 37. 00 Maintenance of Personnel 38. 00 Nursing Administration 39. 00 Central Services and Supply 40. 00 Pharmacy 42. 00 Social Service 10. 00 10. 00 10. 00 1, 821, 869 -7, 008 1, 814, 861 118, 176. 00 0 0 0 0 0 0 0 0 0 0 0 0	31.00	Laundry & Linen Service	8. 00	603, 673	0	603, 673	39, 141. 00	15. 42	31.00
(see instructions) 34.00 Di etary 35.00 Di etary under contract (see instructions) 36.00 Cafeteria 37.00 Maintenance of Personnel 38.00 Nursi ng Administrati on 39.00 Central Services and Supply 40.00 Pharmacy 42.00 Social Service 10.00 1,821,869 -7,008 1,814,861 118,176.00 15.36 34.00 0 0 0 0 0.00 12.98 36.00 0 0 0 0 0 0 0.00 0 0 0 0 0 0.00 0 0 0 0	32.00	Housekeepi ng	9. 00	1, 973, 267	0	1, 973, 267	141, 150. 00	13. 98	32.00
34. 00 Di etary Di e	33.00	Housekeeping under contract		0	0	0	0. 00	0. 00	33. 00
35.00 Di etary under contract (see i nstructions) 36.00 Cafeteria 11.00 112,059 0 112,059 8,632.00 12.98 36.00 37.00 Mai ntenance of Personnel 12.00 0 0 0 0 0.00 0.00 37.00 38.00 Nursi ng Administration 13.00 1,427,387 0 1,427,387 30,368.00 47.00 38.00 39.00 Central Services and Supply 14.00 0 0 0 0.00 0.00 39.00 40.00 Pharmacy 15.00 0 0 0 0.00 0.00 0.00 40.00 41.00 Medi cal Records & Medi cal Records & Medi cal Records & Medi cal Service 17.00 0 0 0 0.00 0.00 42.00		(see instructions)							
instructions) 36.00 Cafeteria	34.00	Di etary	10.00	1, 821, 869	-7, 008	1, 814, 861	118, 176. 00	15. 36	34.00
36. 00 Cafeteria 11. 00 112, 059 0 112, 059 8, 632. 00 12. 98 36. 00 37. 00 Maintenance of Personnel 12. 00 0 0 0 0 0. 00 37. 00 38. 00 Nursi ng Admi ni strati on 13. 00 1, 427, 387 0 1, 427, 387 30, 368. 00 47. 00 38. 00 0 0 0 0 0. 00 37. 00 38. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	35.00	Dietary under contract (see		0	0	0	0. 00	0. 00	35.00
37. 00 Maintenance of Personnel 12. 00 0 0 0 0. 00 0. 00 37. 00 38. 00 Nursing Administration 13. 00 1, 427, 387 0 1, 427, 387 30, 368. 00 47. 00 38. 00 39. 00 Central Services and Supply 14. 00 0 0 0 0. 00 0. 00 0. 00 39. 00 40. 00 Pharmacy 15. 00 0 0 0 0. 00 0. 00 0. 00 40. 00 41. 00 Medi cal Records & Medi cal Records Library 16. 00 1, 972, 637 0 1, 972, 637 90, 338. 00 21. 84 41. 00 42. 00 Soci al Service 17. 00 0 0 0 0. 00 0. 00 0. 00 42. 00		instructions)							
38.00 Nursing Administration 13.00 1,427,387 0 1,427,387 30,368.00 47.00 38.00 39.00 Central Services and Supply 14.00 0 0 0 0 0 0 0 0 0 0 39.00 40.00 Pharmacy 15.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	36.00	Cafeteri a	11. 00	112, 059	0	112, 059	8, 632. 00	12. 98	36.00
39. 00 Central Services and Supply 14. 00 0 0 0 0. 00 39. 00 40. 00 Pharmacy 15. 00 0 0 0 0 0. 00 40. 00 41. 00 Medical Records & Medical Records & Medical Records & I harry 42. 00 Social Service 17. 00 0 0 0 0 0 0 0. 00 42. 00 42. 00 0 0 0 0 0 0 0 0 0	37.00	Maintenance of Personnel	12.00	0	0	0			37.00
40. 00 Pharmacy 15. 00 0 0 0. 00 0. 00 40. 00 41. 00 Medi cal Records & Medi cal Records Li brary 42. 00 Soci al Service 17. 00 0 0 0 0 0 0. 00 42. 00	38.00	Nursing Administration	13.00	1, 427, 387	0	1, 427, 387	30, 368. 00	47. 00	38. 00
41. 00 Medi cal Records & Medi cal Records & Medi cal Records Li brary 42. 00 Soci al Servi ce 17. 00 0 0 0 0 0.00 21. 84 41. 00	39.00	Central Services and Supply	14. 00	0	0	0	0. 00	0. 00	39. 00
Records Li brary	40.00	Pharmacy	15. 00	0	0	0	0. 00	0. 00	40.00
42. 00 Soci al Servi ce 17. 00 0 0 0. 00 42. 00	41.00	Medical Records & Medical	16. 00	1, 972, 637	0	1, 972, 637	90, 338. 00	21. 84	41.00
		Records Library							
43.00 Other General Service 18.00 0 0 0 0.00 43.00	42.00	Social Service	17. 00	0	0	0	0.00	0. 00	42.00
	43.00	Other General Service	18. 00	0	0	0	0. 00	0.00	43.00

<u>H</u>	leal th	Financial Systems		UNI ON HOSPI	TAL, INC.		In Lie	u of Form CMS-2	<u> 2552-10</u>
H	HOSPI T	AL WAGE INDEX INFORMATION			Provi der C	CN: 15-0023	Peri od:	Worksheet S-3	
							From 01/01/2016		
							To 12/31/2016		
_							_	11/12/2018 4:	13 pm
			Worksheet A	Amount	Recl assi fi cat	Adj usted	Pai d Hours	Average	
			Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				·	Sal ari es	(col.2 ± col	Salaries in	(col. 4 ÷	
					(from	3)	col. 4	col. 5)	
					Worksheet	,		,	
					A-6)				
			1. 00	2. 00	3.00	4.00	5. 00	6. 00	
		PART III - HOSPITAL WAGE INDEX	SUMMARY						
1	1. 00	Net salaries (see		90, 161, 845	-1, 332, 004	88, 829, 84	1 2, 961, 856. 00	29. 99	1.00
		instructions)							
2	2. 00	Excluded area salaries (see		12, 429, 594	-2, 065, 677	10, 363, 91	7 187, 807. 00	55. 18	2.00
				,	, , .		, , , , , , , , , , , , , , , , , , , ,		

77, 732, 251

26, 350, 157

26, 118, 014

130, 200, 422

19, 408, 445

733, 673

733, 673

62, 964

78, 465, 924

26, 350, 157

26, 118, 014

130, 934, 095

19, 471, 409

2, 774, 049. 00

3, 289, 798. 00

786, 470. 00

515, 749. 00

0.00

28. 29

51.09

33. 29

39. 80

24. 76

3.00

4.00

5.00

6.00

7.00

instructions)

minus line 2)

instructions)

costs (see inst.)

Subtotal salaries (line 1

Subtotal other wages & related

Subtotal wage-related costs

(see inst.)
Total (sum of lines 3 thru 5)
Total overhead cost (see

3.00

4.00

5.00

6. 00

7.00

Health Financial Systems	UNION HOSPITAL, INC.	In Lieu	of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0023	Peri od: From 01/01/2016	Worksheet S-3
			Date/Time Prepared:

	To 12/31/2016	Date/Time Pre 11/12/2018 4:	
		Amount	ГО РІП
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1. 00	401K Employer Contributions	3, 146, 893	1.00
2.00	Tax Shel tered Annui ty (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, 564, 428	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)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	12, 139, 139	8. 02
8. 03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	71, 938	10.00
11.00		40, 321	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)	98, 936	13.00
14.00		0	14.00
15.00	, , , ,	542, 925	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
	Non cumulative portion)		
	TAXES		
17.00	FICA-Employers Portion Only	6, 537, 593	17. 00
18.00	Medicare Taxes - Employers Portion Only	0	18. 00
19.00	Unempl oyment Insurance	32, 409	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21. 00
	instructions))		
22.00	Day Care Cost and Allowances	0	22. 00
23.00	Tuition Reimbursement	121, 535	23. 00
24.00	Total Wage Related cost (Sum of lines 1 -23)	30, 296, 117	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

Health Financial Systems UNION HO	OSPITAL, INC.	In Lie	u of Form CMS-2	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0023	Peri od: From 01/01/2016 To 12/31/2016		pared:
Cost Center Description		Contract Labor	Benefit Cost	
		1. 00	2. 00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital - Based Component I dentification:		E 00E 400	20 20/ 117	1 00
1.00 Total facility's contract labor and benefit cost 2.00 Hospital		5, 805, 423		1.00 2.00
3.00 Subprovider - IPF		5, 805, 423	30, 290, 117	3.00
4.00 Subprovider - IRF		0	0	4.00
5.00 Subprovider - (Other)		0	0	5.00
6.00 Swing Beds - SNF		0	0	6.00
7. 00 Swing Beds - NF		0	0	7.00
8. 00 Hospi tal -Based SNF			O	8.00
9. 00 Hospi tal -Based NF				9.00
10. 00 Hospi tal -Based OLTC				10.00
11.00 Hospi tal -Based HHA				11.00
12.00 Separately Certified ASC				12.00
13.00 Hospi tal -Based Hospi ce				13.00
14.00 Hospital-Based Health Clinic RHC				14.00
15.00 Hospital-Based Health Clinic FQHC				15.00
16.00 Hospi tal -Based-CMHC				16. 00
17.00 Renal Dialysis				17. 00
18.00 Other		0	0	18. 00

Heal th	Financial Systems UNIO	N HOSPITAL, INC.		In lie	u of Form CMS-2	2552-10	
	TAL UNCOMPENSATED AND INDIGENT CARE DATA		CN: 15-0023	Peri od:	Worksheet S-1		
				From 01/01/2016			
				To 12/31/2016	Date/Time Pre 11/12/2018 4:		
					1.00	•	
	Uncompensated and indigent care cost computation				1.00		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 of	column 3 divided by I	ine 202 colum	n 8)	0. 238641	1.00	
	Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid		38, 160, 306	2.00			
3.00	Did you receive DSH or supplemental payments from Me					3.00	
4. 00 5. 00	If line 3 is yes, does line 2 include all DSH and/or If line 4 is no, then enter DSH and/or supplemental			ai d?	0	4. 00 5. 00	
6. 00	Medi cai d charges	payments from medica	Tu		223, 753, 834		
7. 00	Medicaid cost (line 1 times line 6)				53, 396, 839		
8. 00	Difference between net revenue and costs for Medicai	d program (line 7 mi	nus sum of li	nes 2 and 5; if			
	< zero then enter zero)						
	Children's Health Insurance Program (CHIP) (see inst	ructions for each li	ne)				
9.00	Net revenue from stand-alone CHIP				0		
10. 00 11. 00	Stand-alone CHIP charges Stand-alone CHIP cost (line 1 times line 10)				0	10. 00 11. 00	
12.00	Difference between net revenue and costs for stand-a	alone CHIP (line 11 m	inus line 9.	if / zero then		12.00	
12.00	enter zero)	arone onii (iiiic ii iii	irius iriic 7,	TT V ZCTO THEN		12.00	
	Other state or local government indigent care progra	am (see instructions	for each line)			
13.00	Net revenue from state or local indigent care progra				0		
14. 00	Charges for patients covered under state or local in	ndigent care program	(Not included	in lines 6 or	0	14.00	
15 00	10)	1: 14)				15 00	
15. 00 16. 00	State or local indigent care program cost (line 1 till Difference between net revenue and costs for state of		o program (Li	no 15 minus lina	0	15. 00 16. 00	
10.00	13; if < zero then enter zero)	or rocar rhurgent car	e program (11	ne is minus init		10.00	
	Grants, donations and total unreimbursed cost for Me	edicaid, CHIP and sta	te/local indi	gent care progra	ams (see		
17. 00	instructions for each line) Private grants, donations, or endowment income resti	ricted to funding cha	rity care		0	17. 00	
18. 00	Government grants, appropriations or transfers for s				l o	18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and sta-			s (sum of lines	15, 236, 533	19. 00	
	8, 12 and 16)						
			Uni nsured	Insured	Total (col. 1		
			pati ents 1.00	patients 2.00	+ col . 2) 3.00		
	Uncompensated Care (see instructions for each line)		1.00		0.00		
20.00	Charity care charges and uninsured discounts for the	e entire facility	20, 039, 87	71 0	20, 039, 871	20.00	
	(see instructions)						
21. 00	Cost of patients approved for charity care and uning instructions)	sured discounts (see	4, 782, 33	35 0	4, 782, 335	21.00	
22. 00	Payments received from patients for amounts previous	sly written off as		0 0	0	22. 00	
22.00	charity care		4 700 00). 	4 700 005	22.00	
23. 00	Cost of charity care (line 21 minus line 22)		4, 782, 33	35 0	4, 782, 335	23.00	
					1. 00		
24.00	Does the amount on line 20 column 2, include charges			of stay limit	N	24. 00	
25. 00	imposed on patients covered by Medicaid or other inc If line 24 is yes, enter the charges for patient day			m's lenath of	0	25. 00	
	stay limit			J			
26.00	Total bad debt expense for the entire hospital compl	•	•		22, 707, 070	1	
27. 00	Medicare reimbursable bad debts for the entire hospi		1, 851, 473				
27. 01 28. 00	Medicare allowable bad debts for the entire hospital Non-Medicare bad debt expense (see instructions)	comprex (see instru	CTIONS)		2, 848, 420 19, 858, 650	•	
29. 00							
	.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 5,736,03 .00 Cost of uncompensated care (line 23 column 3 plus line 29) 10,518,37						
	Total unreimbursed and uncompensated care cost (line				25, 754, 903		

	FINANCIAL SYSTEMS SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	ONI ON HOSPI I	Provider C	N: 15_0023	Peri od:	Worksheet A	2332-10
RECEAS	STITCATION AND ADSOSTMENTS OF TREAD DALANCE O	I EXI ENSES	110videi co	F	rom 01/01/2016		
				1	o 12/31/2016	Date/Time Pre 11/12/2018 4:	pared:
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cat	Reclassi fi ed	13 piii
			2 21.12.	+ col . 2)	i ons (See	Tri al Balance	
					A-6)	(col. 3 +-	
		1.00		0.00		col . 4)	
	CENIEDAL CEDIULCE COCT CENTEDO	1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 NEW CAP REL COSTS-BLDG & FIXT		12, 761, 421	12, 761, 421	9, 748, 190	22, 509, 611	1.00
	00200 NEW CAP REL COSTS-MVBLE EQUIP		5, 647, 288			9, 169, 578	1
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	290, 388	26, 469			2, 320, 430	
5. 01	00540 NONPATIENT TELEPHONES	549, 077	399, 818	948, 895	0	948, 895	5. 01
5. 02	00550 DATA PROCESSING	0	0	C	0	0	
5. 03	00560 PURCHASING RECEIVING AND STORES	1 201 ((1	(47,000	1 000 404	0	1 020 404	
5. 04 5. 05	00570 ADMI TTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	1, 281, 661 0	647, 823	1, 929, 484	1	1, 929, 484 0	5. 04 5. 05
5. 06	00590 OTHER ADMIN AND GENERAL	5, 484, 936	29, 664, 820	1	ا ۱	21, 145, 923	1
7. 00	00700 OPERATION OF PLANT	1, 738, 635	8, 167, 401	9, 906, 036		9, 906, 036	
8. 00	00800 LAUNDRY & LINEN SERVICE	603, 673	401, 216			1, 004, 889	
9. 00	00900 HOUSEKEEPI NG	1, 973, 267	1, 109, 156	3, 082, 423	0	3, 082, 423	9.00
	01000 DI ETARY	1, 821, 869	1, 650, 777			3, 440, 448	1
	01100 CAFETERI A	112, 059	219, 389			331, 448	1
	01300 NURSING ADMINISTRATION 01600 MEDICAL RECORDS & LIBRARY	1, 427, 387 1, 972, 637	284, 529 1, 308, 238			1, 711, 916 3, 280, 875	
	01700 SOCI AL SERVI CE	1, 772, 037	1, 300, 230	3, 200, 073		3, 200, 073	1
21. 00	02100 I&R SERVICES-SALARY & FRINGES APPRVD	o	0	ď	_	1, 433, 559	
	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	C	2, 354, 347	2, 354, 347	
	02300 PARAMED ED PRGM	0	0	C	251, 232	251, 232	
23. 01	02341 OTHER MED ED	447, 626	47, 060	494, 686	73, 035	567, 721	23. 01
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	20, 000, 711	/ 202 722	27 1/2 422	1 27/ 027	25 707 407	20.00
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	20, 880, 711 5, 234, 087	6, 282, 722 1, 513, 066			25, 787, 406 6, 843, 296	
35. 00	02040 I NTENSI VE NURSERY	1, 883, 910	998, 620			2, 927, 074	
	04100 SUBPROVI DER - I RF	1, 283, 839	341, 348			1, 667, 303	
	04300 NURSERY	0	439			1, 225, 861	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	4, 474, 660	16, 730, 413			13, 680, 346	
	05001 CARDI AC SURGERY	2, 076, 844	3, 272, 603			4, 321, 197	
50. 02 51. 00	05002 WVSC	1, 443, 598	13, 166, 417 299, 249			12, 474, 235 1, 742, 847	1
	05101 O/P TREATMENT ROOM	2, 157, 731	339, 804			2, 497, 535	
52.00	05200 DELIVERY ROOM & LABOR ROOM	3, 229, 486	2, 697, 818			5, 927, 304	
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 680, 974	3, 406, 827	7, 087, 801	-251, 232	6, 836, 569	54.00
	05500 RADI OLOGY-THERAPEUTI C	432, 395	4, 604, 899			5, 037, 294	
	05600 RADI OI SOTOPE	335, 648	901, 766			1, 237, 414	
	05700 CT SCAN	1, 055, 004	1, 007, 884			2, 062, 888	1
59. 00	05900 CARDIAC CATHETERIZATION	565, 800 738, 267	910, 759 19, 569, 702			1, 476, 559 16, 920, 371	
	06000 LABORATORY	730, 207	9, 365, 754			9, 365, 754	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1, 286, 409			1, 286, 409	
	06500 RESPI RATORY THERAPY	2, 601, 931	1, 035, 787	3, 637, 718	0	3, 637, 718	65.00
	06600 PHYSI CAL THERAPY	0	4, 547, 718	4, 547, 718		4, 547, 718	1
66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	2 427 407	0	0	66. 01
66. 02 67. 00	06602 0/P PHYSICAL THERAPY 06700 OCCUPATIONAL THERAPY	0	3, 436, 494	3, 436, 494	0	3, 436, 494	66. 02 67. 00
	06800 SPEECH PATHOLOGY	0	521, 922	521, 922	1	521, 922	1
69. 00	06900 ELECTROCARDI OLOGY	1, 463, 570	572, 460			2, 036, 030	1
69. 01	06901 CARDI AC REHAB	283, 175	49, 411	332, 586	0	332, 586	
70.00	07000 ELECTROENCEPHALOGRAPHY	2, 072, 959	774, 248	2, 847, 207	0	2, 847, 207	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	937, 395			937, 395	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(, ,	12, 632, 757	
73.00	ATAGA BRUGA GUARAFR TA BATIFATA			1 /15 11/1 131	-1, 809, 929	43, 304, 202	73.00
	07300 DRUGS CHARGED TO PATIENTS	3, 911, 194	41, 202, 937			1 514 012	1
76.00	03020 RENAL ACUTE	3, 911, 194	1, 516, 013			1, 516, 013	1
76. 00	03020 RENAL ACUTE OUTPATIENT SERVICE COST CENTERS	0	1, 516, 013	1, 516, 013	0		76. 00
76. 00 90. 00	03020 RENAL ACUTE			1, 516, 013 211, 186	0	1, 516, 013 211, 186 326, 099	76. 00 90. 00
76. 00 90. 00 90. 05 90. 07	03020 RENAL ACUTE 0UTPATIENT SERVICE COST CENTERS 09000 CLINIC 09005 PATIENT NUTRITION 09007 WOUND CLINIC	172, 046	1, 516, 013 39, 140	1, 516, 013 211, 186	0 0	211, 186	76. 00 90. 00 90. 05 90. 07
76. 00 90. 00 90. 05 90. 07 91. 00	03020 RENAL ACUTE OUTPATIENT SERVICE COST CENTERS 09000 CLINIC 09005 PATIENT NUTRITION 09007 WOUND CLINIC 09100 EMERGENCY	0 172, 046 287, 190	1, 516, 013 39, 140 38, 909	1, 516, 013 211, 186 326, 099 1, 299, 174	0 0	211, 186 326, 099	76. 00 90. 00 90. 05 90. 07 91. 00
76. 00 90. 00 90. 05 90. 07 91. 00	03020 RENAL ACUTE OUTPATIENT SERVICE COST CENTERS 09000 CLINIC 09005 PATIENT NUTRITION 09007 WOUND CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	172, 046 287, 190 329, 132	1, 516, 013 39, 140 38, 909 970, 042	1, 516, 013 211, 186 326, 099 1, 299, 174	0 0	211, 186 326, 099 1, 299, 174	76. 00 90. 00 90. 05 90. 07 91. 00
76. 00 90. 00 90. 05 90. 07 91. 00 92. 00	03020 RENAL ACUTE OUTPATIENT SERVICE COST CENTERS 09000 CLINIC 09005 PATIENT NUTRITION 09007 WOUND CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS	0 172, 046 287, 190 329, 132 4, 881, 495	1, 516, 013 39, 140 38, 909 970, 042 3, 231, 873	1, 516, 013 211, 186 326, 099 1, 299, 174 8, 113, 368	0 0 0	211, 186 326, 099 1, 299, 174 8, 113, 368	76. 00 90. 00 90. 05 90. 07 91. 00 92. 00
76. 00 90. 00 90. 05 90. 07 91. 00	03020 RENAL ACUTE OUTPATIENT SERVICE COST CENTERS 09000 CLINIC 09005 PATIENT NUTRITION 09007 WOUND CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	172, 046 287, 190 329, 132	1, 516, 013 39, 140 38, 909 970, 042	1, 516, 013 211, 186 326, 099 1, 299, 174 8, 113, 368	0 0 0	211, 186 326, 099 1, 299, 174	76. 00 90. 00 90. 05 90. 07 91. 00 92. 00
76. 00 90. 00 90. 05 90. 07 91. 00 92. 00 118. 00	03020 RENAL ACUTE OUTPATIENT SERVICE COST CENTERS 09000 CLINIC 09005 PATIENT NUTRITION 09007 WOUND CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0 172, 046 287, 190 329, 132 4, 881, 495	1, 516, 013 39, 140 38, 909 970, 042 3, 231, 873	1, 516, 013 211, 186 326, 099 1, 299, 174 8, 113, 368	0 0 0	211, 186 326, 099 1, 299, 174 8, 113, 368 294, 406, 346	76. 00 90. 00 90. 05 90. 07 91. 00 92. 00
76. 00 90. 00 90. 05 90. 07 91. 00 92. 00 118. 00 190. 00 194. 00	03020 RENAL ACUTE OUTPATIENT SERVICE COST CENTERS 09000 CLINIC 09005 PATIENT NUTRITION 09007 WOUND CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 07950 RURAL HEALTH	0 172, 046 287, 190 329, 132 4, 881, 495 83, 178, 861	1, 516, 013 39, 140 38, 909 970, 042 3, 231, 873	1, 516, 013 211, 186 326, 099 1, 299, 174 8, 113, 368 291, 085, 114	3, 321, 232	211, 186 326, 099 1, 299, 174 8, 113, 368 294, 406, 346	76. 00 90. 00 90. 05 90. 07 91. 00 92. 00 118. 00
76. 00 90. 00 90. 05 90. 07 91. 00 92. 00 118. 00 190. 00 194. 00 194. 01	03020 RENAL ACUTE OUTPATIENT SERVICE COST CENTERS 09000 CLINIC 09005 PATIENT NUTRITION 09007 WOUND CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 07950 RURAL HEALTH 07951 RENTAL PROPERTY	0 172, 046 287, 190 329, 132 4, 881, 495 83, 178, 861 0 1, 207, 341 0	1, 516, 013 39, 140 38, 909 970, 042 3, 231, 873 207, 906, 253 0 2, 008, 578 165, 283	1, 516, 013 211, 186 326, 099 1, 299, 174 8, 113, 368 291, 085, 114	3, 321, 232 0 112, 630 0 0	211, 186 326, 099 1, 299, 174 8, 113, 368 294, 406, 346 0 3, 328, 549 165, 283	90. 00 90. 05 90. 07 91. 00 92. 00 118. 00 190. 00 194. 00 194. 01
76. 00 90. 00 90. 05 90. 07 91. 00 92. 00 118. 00 190. 00 194. 00 194. 01 194. 02	03020 RENAL ACUTE OUTPATIENT SERVICE COST CENTERS 09000 CLINIC 09005 PATIENT NUTRITION 09007 WOUND CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 07950 RURAL HEALTH 07951 RENTAL PROPERTY 07954 FAMILY PRACTICE	0 172, 046 287, 190 329, 132 4, 881, 495 83, 178, 861	1, 516, 013 39, 140 38, 909 970, 042 3, 231, 873 207, 906, 253 0 2, 008, 578 165, 283 2, 108, 369	211, 186 326, 099 1, 299, 174 8, 113, 368 291, 085, 114 (3, 215, 919 165, 283 6, 539, 278	3, 321, 232 3, 321, 232 0 112, 630 0 -3, 787, 906	211, 186 326, 099 1, 299, 174 8, 113, 368 294, 406, 346 0 3, 328, 549 165, 283 2, 751, 372	76.00 90.00 90.05 90.07 91.00 92.00 118.00 194.01 194.01 194.01
76. 00 90. 00 90. 05 90. 07 91. 00 92. 00 118. 00 194. 00 194. 01 194. 02 194. 03	03020 RENAL ACUTE OUTPATIENT SERVICE COST CENTERS 09000 CLINIC 09005 PATIENT NUTRITION 09007 WOUND CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 07950 RURAL HEALTH 07951 RENTAL PROPERTY 07952 WELLNESS	0 172, 046 287, 190 329, 132 4, 881, 495 83, 178, 861 0 1, 207, 341 0 4, 430, 909 0	1, 516, 013 39, 140 38, 909 970, 042 3, 231, 873 207, 906, 253 0 2, 008, 578 165, 283 2, 108, 369 0	211, 186 326, 099 1, 299, 174 8, 113, 368 291, 085, 114 3, 215, 919 165, 283 6, 539, 278	3, 321, 232 3, 321, 232 0 112, 630 0 0 3, 787, 906 452, 831	211, 186 326, 099 1, 299, 174 8, 113, 368 294, 406, 346 0 3, 328, 549 165, 283 2, 751, 372 452, 831	76.00 90.00 90.05 90.07 91.00 92.00 118.00 194.01 194.01 194.02 194.03
76. 00 90. 00 90. 05 90. 07 91. 00 92. 00 118. 00 194. 00 194. 01 194. 02 194. 03 194. 04	03020 RENAL ACUTE OUTPATIENT SERVICE COST CENTERS 09000 CLINIC 09005 PATIENT NUTRITION 09007 WOUND CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 07950 RURAL HEALTH 07951 RENTAL PROPERTY 07954 FAMILY PRACTICE	0 172, 046 287, 190 329, 132 4, 881, 495 83, 178, 861 0 1, 207, 341 0	1, 516, 013 39, 140 38, 909 970, 042 3, 231, 873 207, 906, 253 0 2, 008, 578 165, 283 2, 108, 369	1, 516, 013 211, 186 326, 099 1, 299, 174 8, 113, 368 291, 085, 114 0 3, 215, 919 165, 283 6, 539, 278 12, 238, 219	3, 321, 232 3, 321, 232 0 112, 630 0 -3, 787, 906 452, 831	211, 186 326, 099 1, 299, 174 8, 113, 368 294, 406, 346 0 3, 328, 549 165, 283 2, 751, 372	76. 00 90. 00 90. 05 90. 07 91. 00 92. 00 118. 00 194. 01 194. 02 194. 03 194. 03 194. 04

Health Financial Systems UNION HOSPITAL, INC. In Lieu						2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (OF EXPENSES	Provi der CO		Peri od:	Worksheet A	
				From 01/01/2016 o 12/31/2016	Date/Time Pre	paradi
				0 12/31/2010	11/12/2018 4:	
Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
			+ col. 2)	ions (See	Trial Balance	
				A-6)	(col. 3 +-	
					col. 4)	
	1. 00	2.00	3. 00	4. 00	5. 00	
194. 07 07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	384, 570	74, 245	458, 815	-98, 787	360, 028	194.07
200.00 TOTAL (SUM OF LINES 118 through 199)	93, 876, 990	220, 625, 696	314, 502, 686	0	314, 502, 686	200.00

Health Financial Systems UNION HORECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provi der CCN: 15-0023 Peri od: Worksheet A From 01/01/2016 To 12/31/2016 Date/Time Prepared:

Count					To 12/31/2016 Date/Time Pro 11/12/2018 4:	
Company Comp		Cost Center Description	,			
COUNTY C			(See A-8)			
The Part of			6. 00		_	
2 00 00000 DUCOM INTO CAP FILE LOSIS-INVOLE EQUIP -519, 420 8, 66, 158 2, 70		GENERAL SERVICE COST CENTERS	3. 3.			
4.00 DOSOLO DEMONTE EIREM IS DEPARTMENT 2-0, 74, 89.07 3-4, 94.02 5-0, 11 5-0, 10 5-				1		1
5.01 00540 MOMPATIENT TELEPHONES		1 1		1		1
5.02 000000		1 1		1	1	1
5.03 (00560) PURCHASHING RECEIVING AND STORES 1.407, 006 1.407, 006 5.03 1.00500 AUNTT NO. 00500 CASH ENINGACCOURTS RECEIVABLE 6.230, 281 6.230				1	1	
5.05 0.00560 CASHI FINISA/ACCIUNTS RECTUMNIF 6, 230, 243 6, 230, 245 5, 05 0.00560 CORPERA MINI NA BOCKERPAL 2, 846, 201 23, 92, 184 5, 06 0.0000 CORPERATION OF PLANT 5, 000 0.0000 CORPERATION OF PLANT 5, 000 0.0000 0.0000 CETARY 1.72, 973 3, 207, 475 10, 00 0.0000 0.0000 CETARY 1.72, 973 3, 207, 475 10, 00 0.0000 0.0000 CETARY 1.72, 973 3, 207, 475 10, 00 0.0000 0.0000 CETARY 1.72, 973 3, 207, 475 10, 00 0.0000 0.0000 CETARY 1.72, 973 3, 207, 475 10, 00 0.0000 0.0000 CETARY 1.74, 532 3, 126, 448 13, 00 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.00000000		1 1		1		1
5.06 DOSPO] OTHER ADMIN AND CENERAL 2,846,261 23,992,184 5.06 3.07			-			1
7.00 0.0700 OPERATION OF PLANT -5-60, 7-53 9, 345, 283 7.00 8.00 ORDON OUNSEREPING -1-35, 373 2, 947, 056 9.00 0.000 OUNSEREPING -1-35, 373 2, 947, 056 9.00 0.000 OUNSERIES 0.00 OUNSERIES						1
B.O. 0.0800 LANDRY & LINEN SERVICE		1 1				1
9.00 00900 MUSERLEPING		1 1				1
11.00 11.00 (CAFETER A) -1,566,885 -1,235,137 11.00 13.00 (DATE OF A) MIRST NA ZAMAN IN STRATION -1,414,532 -1,205,137 17.00		1 1		l .		
13.00 1300 MURSIN SAMIN STRATION 1, 414, 532 3, 126, 448 13.00 17.00 1		1 1		l		1
16.00 1000 MEDICAL, RECORDS & LIBRARY 219 120 3, 499, 995 10.00 17.00		1 1		1		1
17.00 1700 SOCIAL SERVICE 0		1 1				
21.00			219, 120	1		
23. 00 02300 PARAMED ED PROM 23. 01 0231 THERE TO BY 225. 00 23. 01 0231 THERE TO BY 23. 01 0231 THERE TO BY 23. 01 0231 THERE TO BY 23. 01			0	1, 433, 559		
DATE		1 1	-98, 878			1
			0		•	
30.00	23.01		-295, 121	272, 600)	23.01
35. 00	30.00		-53, 328	25, 734, 078	3	30.00
11. 00 04100 SUBPROVI DER - I RF 0 1,667,303 341,00	31.00					31.00
1,000 0,4300 NURSERY						
ANCILLARY SERVICE COST CENTERS				1		1
50.00 05000 0FEATTING ROOM	43.00		0	1, 225, 801		43.00
50.02 IOSDO2 IWSCC FORT A 1 11, 596, 754 50.02	50.00		-3, 140, 216	10, 540, 130		50.00
51.00 05100 DECOVERY ROOM 2, 401 1, 745, 248 51.00 51.02 DS101 DYP TREATMENT ROOM 0 2, 497, 535 51.02 52.00 05200 DELL VERY ROOM & LABOR ROOM -2, 303, 906 3, 623, 398 52.00 55.00 05500 RADIO LOCY-THERAPEUTI C 0 5, 337, 294 55.00 55.00 05500 RADIO LOCY-THERAPEUTI C 0 5, 337, 294 55.00 55.00 05500 RADIO LOCY-THERAPEUTI C 0 5, 337, 294 55.00 57.00 05700 CT SCAN 217, 629 2, 280, 517 57.00 58.00 05500 RADIO LOCY-THERAPEUTI C 71.46, 50 1, 225, 744 55.00 59.00 05900 CT SCAN 217, 629 2, 280, 517 57.00 59.00 05900 CT SCAN 57.00 57.00 57.00 57.00 59.00 05900 CARDIAC CATHETERI ZATI ON -1, 400, 163 15, 280, 208 59.00 60.00 06600 MROLERI CRESONANCE IMAGING (MRI) -1, 400, 163 15, 280, 208 59.00 60.00 06600 MHOLE BLOOD & PACKED RED BLOOD CELLS 0 1, 286, 409 62.00 60.00 06600 07.00 07.00 07.00 07.00 07.00 07.00 60.00 06600 PNYSI CAL THERAPY -2, 196, 204 2, 351, 514 66.00 60.00 06600 PNYSI CAL THERAPY -1, 351, 349 2, 085, 145 66.00 60.00 06600 PSYSI CAL THERAPY -1, 351, 349 2, 085, 145 66.00 60.00 06600 OFFICH ATRIC CPSYCHOLOGI CAL SERVI CES 0 0 0 60.00 06600 SPECCH PATHOLOGY 77, 901 1, 546, 375 67, 200 60.00 06700 OCCUPATI ORAL THERAPY 1, 546, 375 1, 546, 375 67, 200 60.00 06700 OCCUPATI ORAL THERAPY 1, 546, 375 1, 546, 375 69, 200 60.00 06900 SPEECH PATHOLOGY 77, 901 77				1		1
S1-02 05101 O.P TREATMENT ROOM Commons		1 1		1		
S2.00 05200 DELIVERY ROOM & LABOR ROOM -2, 303, 906 3, 623, 398 52, 20			2, 401 0			
54. 00 05400 RADI OLOGY-DI AGNOSTIC -340, 923 6, 495, 794 55. 00		1 1	-2, 303, 906			1
56. 00 05000 CADIO I SOTOPE -11, 650 1, 225, 764 56. 00 57. 00 65700 CT SCAN 217, 629 2, 280, 517 57. 00 58. 00 5900 CARDIT C RESONANCE I MAGI NG (MRI) 51, 890 1, 528, 449 58. 00 59. 00 05900 CARDIT AC CATHETER I ZATI ON -1, 640, 163 15, 280, 208 59. 00 60. 00 6000 LABORATORY CATHETER I ZATI ON -1, 640, 163 15, 280, 208 60. 00 60. 00 6000 LABORATORY FACE OF THE RAPY -1, 846, 409 62. 00 66. 00		1 1				1
57.00 05700 CT SCAN 217, 629 2, 280, 517 57.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 51,890 1,528,449 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON -1,640, 163 15,280,208 59.00 60.00 06000 LABORATORY -183,070 9,182,684 60.00 60.00 60.00 06000 LABORATORY -183,070 9,182,684 60.00 50.00		1 1	· ·			
58.00 05800 MAGNETIC RESONANCE IMAGINC (MRI) 51, 800 1, 528, 449 58.00 69.00 69.00 65000 CARDIAC CATHETER IZATION -1, 640, 163 15, 280, 208 59, 00 60.00		1 1				1
59.00 05900 CARDIAC CATHETERI ZATION -1,640,163 15,280,208 59,00 600.00 60000 LABORATORY 60.00 60000 LABORATORY 60.00 60.00 60000 LABORATORY 60.00				l		1
60.00 06000 LABORATORY -183,070 9,182,684 60.00 662.00 062000 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 1,286,409 62.00 66.00 66500 RESPI RATORY THERAPY -2,196,204 2,351,514 66.00 66.01 66.00 66.00 PSYCHIATRIC / PSYCHOLOGI CAL SERVI CES 0 0 0 66.01 66.00 66.00 PSYCHIATRIC / PSYCHOLOGI CAL SERVI CES 0 0 0 66.01 66.00			·			
65.00 06500 RESPIRATORY THERAPY 0 3, 637, 718 66.00 66.00 06600 PHYSI CAL THERAPY -2, 196, 204 2, 351, 514 66.00 66.01 66.01 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES 0 0 66.01 66.01 66.02 06602 0/P PHYSI CAL THERAPY -1, 351, 349 2, 085, 145 66.02 66.00 66.01 66.00					l control of the cont	
66. 00 06600 PHYSICAL THERAPY -2, 196, 204 2, 351, 514 066. 00 06601 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 066. 01			0	ľ		
66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 66. 01 66. 02 06602 0/P PHYSI CAL THERAPY 1,546,375 1,546,375 66. 02 67. 00 06700 0CCUPATI ONAL THERAPY 1,546,375 1,546,375 67. 00 68. 00 06800 SPECR PATHOLOGY 77,901 599,823 68. 00 69. 00 06900 ELECTROCARDI OLOGY -73,678 1,962,352 69. 00 69. 01 06901 CARDI AC REHAB 2,101 334,687 69. 01 70. 00 07000 ELECTROENCEPHALOGRAPH -2,232,977 614,230 71. 00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS -6,545 930,850 77. 00 72. 00 07200 IMPL DEV. CHARGED TO PATIENTS -6,545 930,850 77. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS -316,706 42,987,496 73. 00 76. 00 03020 RENAL ACUTE 0 1,516,013 76. 00 0000 CLINI C 0 0 211,186 90. 00 90. 05 09005 PATIENT SURVICE COST CENTERS 90. 05 90. 07 09000 CLINI C 2,758 1,301,932 90. 07 91. 00 09100 MERGENCY 0 8,113,368 90. 07 91. 00 09100 MERGENCY 0 8,113,368 90. 00 92. 00 09200 0SERVATI ON BEDS (NON-DISTINCT PART) 92. 00 92. 00 09200 0SERVATI ON BEDS (NON-DISTINCT PART) 90. 00 92. 00 09200 0SERVATI ON BEDS (NON-DISTINCT PART) 90. 00 92. 00 09200 0SERVATI ON BEDS (NON-DISTINCT PART) 90. 00 94. 00 07950 RURAL HEALTH 0 3,328,549 194. 00 94. 00 07950 RURAL HEALTH 0 45,283 194. 01 94. 00 07950 RURAL HEALTH 0 45,283 194. 01 94. 00 07955 RURAL HEALTH PROPERTY 0 65,283 194. 02 194. 03 07952 WELLNESS 0 452,831 194. 03 194. 04 07955 SYCAMORE SPORTS MED -675,241 124,817 194. 06			0			1
66. 02 06602 0/P PHYSICAL THERAPY			-2, 196, 204 0	ľ		1
67. 00 66700 OCCUPATI ONAL THERAPY 1,546,375 1,546,375 67. 00 68. 00 06800 SPEECH PATHOLOGY 77, 901 599,823 68. 00 69. 00 06900 ELECTROCARDI OLOGY 77, 901 334,687 69. 00 69. 01 06901 CARDI AC REHAB 2,101 334,687 69. 01 70. 00 7000 ELECTROENCEPHALOGRAPHY -2,232,977 614,230 77. 00 77. 00 77. 00 77. 00 77. 00 77. 00 07. 00			-1, 351, 349			
69. 00 06900 CARDI AC REHAB 2, 101 334, 687 69. 00 69. 01 06901 CARDI AC REHAB 2, 101 334, 687 70. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY -2, 232, 977 614, 230 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS -6, 545 930, 850 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 12, 632, 757 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS -316, 706 42, 987, 496 73. 00 76. 00 03002 RENAL ACUTE 0 1, 516, 013 76. 00 00000 CLINIC 0 211, 186 90. 00 90. 05 09000 CLINIC 0 2, 758 1, 301, 932 90. 07 91. 00 09000 CLINIC 2, 758 1, 301, 932 90. 07 91. 00 09000 DEBREGENCY 91. 00 8, 113, 368 91. 00 92. 00 09000 DEBREGENCY 91. 00 92. 00 09000 DEBREGENCY 92. 00 92. 00 09000 OSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 90. 05 O9000 OSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 90. 05 O9000 OSERVATI ON GEDS (ENTERS 91. 00 91.		06700 OCCUPATI ONAL THERAPY				
69. 01 06901 CARDI AC REHAB 2, 101 334, 687 69. 01 70. 00 70000 ELECTROENCEPHALOGRAPHY -2, 232, 977 614, 230 70. 00 71. 00 70. 00 MEDI CAL SUPPLIES CHARGED TO PATIENTS -6, 545 930, 850 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 12, 632, 757 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS -316, 706 42, 987, 496 73. 00 76. 00 00000 RENAL ACUTE 0 1, 516, 013 76. 00 00000 CLI NI C 0 0, 516, 013 76. 00 000000 CLI NI C 0 0, 516, 013 00. 00000 09000 CLI NI C 0, 516, 013 09000 PATIENT NUTRI TI ON -3, 365 322, 734 90. 05 90. 00		1 1				
70. 00 07000 ELECTROENCEPHALOGRAPHY -2, 232, 977 614, 230 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS -6, 545 930, 850 71. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 12, 632, 757 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS -316, 706 42, 987, 496 73. 00 07300 DRUGS CHARGED TO PATIENTS -316, 706 42, 987, 496 73. 00 07300 DRUGS CHARGED TO PATIENTS -316, 706 42, 987, 496 73. 00 07300 DRUGS CHARGED TO PATIENTS -316, 706 42, 987, 496 75. 00 03020 RENAL ACUTE 0 1,516, 013 76. 00 07471 ENT SERVI CE COST CENTERS 90. 00 9000 CLI NI C 90. 05 90005 PATIENT NUTRI TI ON -3, 365 322, 734 90. 05 90. 07 09007 WOUND CLI NI C 2, 758 1, 301, 932 90. 07 09007 WOUND CLI NI C 2, 758 1, 301, 932 90. 07 09000 DRUGS CHARGED TO PATIENT SERVI CE COST CENTERS 91. 00 99000 DRUGS CHORD CONTROL TO PART 92. 00 09100 EMERGENCY 0 8, 113, 368 91. 00 99000 DRUGS CHORD CONTROL TO PART 92. 00 DRUGS CHARGED TO PATIENT SERVI CE COST CENTERS 91. 00 09100 EMERGENCY 0 8, 113, 368 91. 00 99000 DRUGS CHORD CONTROL TO PART 92. 00 DRUGS CHARGED TO PATIENT 93. 00 DRUGS CHARGED TO PATIENT 94. 00 PATIENT 94. 00 PATIENT 94. 00 DRUGS CHARGED TO PATIENT 94. 00 PATIENT 9						
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS -6,545 930,850 71. 00 72. 00 72.00 IMPL. DEV. CHARGED TO PATIENTS 0 12,632,757 72. 00 73. 00 73.0						
73. 00 76. 00 76. 00 77						
76. 00 03020 RENAL ACUTE 0 1,516,013 76. 00 0UTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 0 211,186 90. 05 09005 PATIENT NUTRITION -3, 365 322, 734 90. 05 90. 07 09007 WOUND CLINIC 2,758 1,301,932 90. 07 91. 00 09100 EMERGENCY 0 8, 113, 368 91. 00 92. 00 9200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 26, 741, 444 321, 147, 790 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 194. 00 07950 RURAL HEALTH 0 3, 328, 549 194. 01 07951 RENTAL PROPERTY 0 165, 283 194. 04 07955 PHYSI CIAN PRACTICES -600, 215 11, 638, 004 194. 06 07953 SYCAMORE SPORTS MED -675, 241 124, 817			0	12, 632, 757	,	
OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS OUTPATIENT NUTRITION OUTPATIENT NUTRITION N				1		
90. 00 09000 CLINIC 0 211, 186 90. 00 90. 05 90. 05 90. 05 90. 05 90. 07	76.00		0	1, 516, 013	3	76.00
90. 05 09005 PATI ENT NUTRITION -3, 365 322, 734 90. 05 90. 07 90. 00	90. 00		0	211, 186		90.00
91. 00			-3, 365	l .		
92. 00 9200 0BSERVATI ON BEDS (NON-DISTINCT PART) 92. 00 SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 26, 741, 444 321, 147, 790 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 190. 00 190. 00 194. 00 07950 RURAL HEALTH 0 3, 328, 549 194. 00 194. 00 194. 00 195. 00 1965, 283 194. 00 194. 00 195			2, 758			
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 26,741,444 321,147,790 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0,3,328,549 194.00 194.00 197950 RURAL HEALTH 0 3,328,549 194.00 194.00 194.01 197951 RENTAL PROPERTY 0 165,283 194.01 194.02 197954 FAMILY PRACTICE 0 2,751,372 194.02 194.03 197952 WELLNESS 0 452,831 194.03 194.04 194.06 197955 PHYSI CI AN PRACTICES -600,215 11,638,004 194.04 194.06 194.0			0	8, 113, 368	3	
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 26, 741, 444 321, 147, 790 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0, 3, 328, 549 194. 00 194. 01 07950 RURAL HEALTH 0 165, 283 194. 01 194. 02 07954 FAMILY PRACTICE 0 2, 751, 372 194. 02 194. 03 07952 WELLNESS 0 452, 831 194. 04 194. 04 07955 PHYSI CI AN PRACTICES -600, 215 11, 638, 004 194. 04 194. 06 07953 SYCAMORE SPORTS MED -675, 241 124, 817 194. 06	92.00					92.00
NONRE MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190. 00 194. 00 195. 00 194. 00 194. 00 194. 01 194	118. 00		26, 741. 444	321, 147, 790		118.00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190. 00 194. 00 194. 00 1950 RURAL HEALTH 0 3, 328, 549 194. 00 194. 01 1950 1					·]
194. 01 07951 RENTAL PROPERTY 0 165, 283 194. 01 194. 02 07954 FAMILY PRACTICE 0 2, 751, 372 194. 02 194. 03 07952 WELLNESS 0 452, 831 194. 04 07955 PHYSI CI AN PRACTICES -600, 215 11, 638, 004 194. 06 07953 SYCAMORE SPORTS MED -675, 241 124, 817 194. 06		19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		l e e e e e e e e e e e e e e e e e e e	
194. 02 07954 FAMILY PRACTICE 0 2, 751, 372 194. 02 194. 03 07952 WELLNESS 0 452, 831 194. 03 194. 04 07955 PHYSI CI AN PRACTICES -600, 215 11, 638, 004 194. 04 194. 06 07953 SYCAMORE SPORTS MED -675, 241 124, 817 194. 06			0			
194. 03 07952 WELLNESS 0 452, 831 194. 03 194. 04 07955 PHYSI CI AN PRACTI CES -600, 215 11, 638, 004 194. 06 07953 SYCAMORE SPORTS MED -675, 241 124, 817 194. 06			0			
194. 04 07955 PHYSI CI AN PRACTI CES -600, 215 11, 638, 004 194. 06 07953 SYCAMORE SPORTS MED -675, 241 124, 817 194. 06			0			
194. 06 07953 SYCAMORE SPORTS MED -675, 241 124, 817 194. 06			-600, 215			
404 07 07 07 07 07 07 07 07 07 07 07 07 07	194.06	07953 SYCAMORE SPORTS MED	-675, 241	124, 817	,	194. 06
194. 0/ 0/956 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES 0 360, 028 194. 0/	194. 07	07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	360, 028	3	194. 07

Health Financial Systems	UNI ON HOSPI	UNION HOSPITAL, INC.			In Lieu of Form CMS-2552-10		
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANC	CE OF EXPENSES	Provi der Co	CN: 15-0023	Peri od:	Worksheet A		
				From 01/01/2016			
				To 12/31/2016	Date/Time Pre		
					11/12/2018 4:	13 pm	
Cost Center Description	Adjustments	Net Expenses					
	(See A-8)	For					
		Allocation					
	6. 00	7. 00					
200.00 TOTAL (SUM OF LINES 118 through 199)) 25, 465, 988	339, 968, 674				200.00	

Health Financial Systems RECLASSIFICATIONS UNION HOSPITAL, INC. In Lieu of Form CMS-2552-10 Provider CCN: 15-0023 Peri od: Worksheet A-6 From 01/01/2016 To 12/31/2016 Date/Time Prepared:

					10		1/12/2018 4:13 pm
		Increases				•	
	Cost Center	Li ne #	Sal ary	Other			
	2. 00	3. 00	4. 00	5. 00			
	B - PARAMED						
1.00	PARAMED ED PRGM	2300	19 <u>7, 9</u> 79	5 <u>3, 2</u> 53			1.00
	0		197, 979	53, 253			
	C - FITNESS ACTIVITY						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	123, 172	44, 720			1.00
2.00	WELLNESS	194. 03	332, 214	120, 617			2.00
			455, 386	165, 337			
	D - CLAY CITY RURAL HEALTH						
1.00	RURAL HEALTH	194. 00	0	45, 719			1.00
				45, 719			
	E - CORK MEDICAL RURAL HEALTH	ŀ	•				
1.00	RURAL HEALTH	194. 00	0	22, 235			1.00
				22, 235			
	F - HOUSE NURSE ASSISTANT			·			
1.00	INTENSIVE CARE UNIT	31.00	86, 503	9, 640			1.00
2.00	I NTENSI VE NURSERY	35. 00	40, 078	4, 466			2.00
3.00	SUBPROVI DER I RF	41. 00	37, 893	4, 223			3.00
	0		164, 474	18, 329			
	G - EMPLOYEE ACCESS		,	, 02 /			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	82, 801	15, 986			1.00
	0		82, 801	15, 986			
	H - TUBE FEEDING		02/00.1	107 700			
1.00	ADULTS & PEDIATRICS	30.00	7, 008	25, 190			1.00
1.00	0		7,008				1.00
	I - FAMILY MEDICINE		7,000	23, 170			
1.00	I &R SERVICES-SALARY &	21. 00	1, 332, 004	101, 555			1.00
1.00	FRI NGES APPRVD	21.00	1, 332, 004	101, 333			1.00
2. 00	I&R SERVICES-OTHER PRGM	22. 00	1, 285, 702	1, 068, 645			2.00
2.00	COSTS APPRVD	22.00	1, 203, 702	1,000,043			2.00
	0	+	2, 617, 706	1, 170, 200			
	J - LOBBY PHARMACY		2,017,700	1, 170, 200			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	319, 385	1, 417, 509			1.00
1.00	O DENETT 13 DEL ARTIMENT		319, 385	1, 417, 509			1.00
	K - IMPLANTABLE DEVICES		317, 303	1, 417, 307			
1. 00	IMPL. DEV. CHARGED TO	72. 00	O	12, 632, 757			1.00
1.00	PATI ENTS	72.00	٥	12, 032, 737			1.00
2. 00	IAITENIS	0. 00	0	0			2.00
3. 00		0.00	0	0			3.00
4. 00		0.00	0	0			4.00
4.00			— — o	12, 632, 757			4.00
	L - INTEREST		- υ	12, 032, 737			
1. 00	NEW CAP REL COSTS-BLDG &	1. 00	O	9, 860, 820			1.00
1.00	FIXT	1.00	٩	7, 000, 620			1.00
2. 00	NEW CAP REL COSTS-MVBLE	2. 00	o	2 522 200			2.00
2.00	EQUIP	2.00	۷	3, 522, 290			2.00
		+					
	N - NURSERY		U _I	13, 303, 110			
1 00		42.00	1 021 722	202 400			1 00
1. 00	NURSERY	43.00	1, 021, 732	203, 690			1.00
	O DUADMACY DADAMED		1, 021, 732	203, 690			
1 00	O - PHARMACY PARAMED	22 04	// 7,4	/ 001			1 00
1. 00	OTHER MED ED	<u>23.</u> 01	66, 744	<u>6, 291</u>			1.00
	U D DDAZILI MEDI GAL GENTES		66, 744	6, 291			
4 00	P - BRAZIL MEDICAL CENTER	40. 6-1	=1				
1. 00	RURAL HEALTH	1 <u>94.</u> 00	•	4 <u>4, 6</u> 76			1.00
F00 01	TOTALS		0	44, 676			500 00
500.00	Grand Total: Increases		4, 933, 215	29, 204, 282			500.00

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

| Peri od: | Worksheet A-6 | From 01/01/2016 | To 12/31/2016 | Date/Time Prepared:

					_	10 12	11/12/201	8 4: 13 pr
		ecreases						
Cost Cer	iter	Li ne #	Sal ary	0ther	Wkst. A-7 Ref	f <u>.</u>		
6. 00		7. 00	8. 00	9. 00	10.00			
B - PARAMED	T. 0	54.00	107.070	50.05	_			
00 RADI OLOGY-DI AGNOS	NIC	5400	19 <u>7, 9</u> 79	5 <u>3, 2</u> 53		<u>o</u>		1.
C - FITNESS ACTI	/I TV		197, 979	53, 253	3			
OO OTHER ADMIN AND		5. 06	455, 386	165, 33	7	0		1.
00 OTHER ADMIN AND O	JENERAL	0.00	455, 360	100, 33.		0		2.
			455, 386	165, 33		٩		2.
D - CLAY CITY RU	או שבאו דש		400, 300	100, 33	/			
OO NEW CAP REL COSTS		1.00	ol	45, 719		9		1.
FLXT	J-DLDG &	1.00	٥	45, 71		7		'.'
0		+		45, 719	9	4		
E - CORK MEDICAL	RURAL HEALTH		<u></u>	10, 71	,			
OO NEW CAP REL COSTS		1. 00	0	22, 23!	5	9		1.
FLXT	DEDG W	1. 00	Ĭ	22, 200				''
0		+		22, 23!	<u> </u>	1		•
F - HOUSE NURSE	ASSISTANT				=1	1		
00 ADULTS & PEDIATRI		30. 00	164, 474	18, 329	9	0		1.
00		0.00	0	, (o		2.
00		0.00	0	(o		3.
0 — — —		— +	164, 474	18, 329		7		
G - EMPLOYEE ACC	ESS				- 1	_		
DO PSYCHI ATRI C/PSYCI		194. 07	82, 801	15, 986	5	0		1.
SERVI CES				•				
0			82, 801	15, 986	5	7		
H - TUBE FEEDING	•		· •		,			
OO DI ETARY		10.00	7, 008	25, 190)	0		1
0 — — —			7, 008	25, 190		7		
I - FAMILY MEDIC	NE		<u> </u>					
OO FAMILY PRACTICE		194. 02	2, 617, 706	1, 170, 200)	0		1.
00		0. 00	O	(O	o		2.
0 — — —			2, 617, 706	1, 170, 200	<u> </u>	7		
J - LOBBY PHARMA	CY							
DO DRUGS CHARGED TO		73. 00	319, 385	1, 417, 50	9	0		1
0 — — —		- $ +$	319, 385	1, 417, 50	9	7		
K - IMPLANTABLE	DEVI CES							
OO OPERATING ROOM		50. 00	0	7, 524, 72	7	0		1
OO CARDIAC SURGERY		50. 01	0	1, 028, 250	O	0		2
OO WVSC		50. 02	0	692, 182	2	0		3
OO CARDIAC CATHETER	ZATION	59. 00	0	3, 387, 598	3	0		4
0			0	12, 632, 75	7			
L - INTEREST								
OO OTHER ADMIN AND	GENERAL	5. 06	0	13, 383, 110)	11		1
00		0.00	0	()	l <u>1</u>		2
0			0	13, 383, 110)			
N - NURSERY								
DO ADULTS & PEDIATRI	CS	30.00	<u>1, 021, 7</u> 32	203, 690		ol		1.
0			1, 021, 732	203, 690	D			
O - PHARMACY PARA								
DO DRUGS CHARGED TO	PATI ENTS	73. 00	66, 744	<u>6, 2</u> 91		O		1.
0			66, 744	6, 29	1			
P - BRAZIL MEDICA								
OO NEW CAP REL COST:	S-BLDG &	1. 00	0	44, 676	5	9		1.
FI XT					<u> </u>	_		
TOTALS			0	44, 670				
0.00 Grand Total: Deci	reases		4, 933, 215	29, 204, 282	2	- 1		500.

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

| Peri od: | Worksheet A-7 | From 01/01/2016 | Part | To 12/31/2016 | Date/Time Prepared:

				10	12/31/2016	Date/lime Pre 11/12/2018 4:	
				Acqui si ti ons		117 127 2010 4.	15 piii
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	17, 431, 472	469, 267		469, 267	377, 196	1. 00
2.00	Land Improvements	19, 502, 959	93, 623		93, 623	· ·	2.00
3.00	Buildings and Fixtures	328, 408, 977	2, 225, 380		2, 225, 380		3. 00
4.00	Building Improvements	1, 599, 793	8, 085	0	8, 085	0	4. 00
5.00	Fixed Equipment	0	0	0	0	0	5. 00
6.00	Movable Equipment	133, 379, 458	21, 259, 343	0	21, 259, 343	8, 727, 136	6. 00
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	500, 322, 659	24, 055, 698	0	24, 055, 698	9, 307, 415	8. 00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	500, 322, 659	24, 055, 698	0	24, 055, 698	9, 307, 415	10.00
		Endi ng	Ful I y				
		Bal ance	Depreci ated				
			Assets				
	T	6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1. 00	Land	17, 523, 543	0				1. 00
2.00	Land Improvements	19, 486, 903	0				2.00
3.00	Buildings and Fixtures	330, 540, 953	0				3.00
4.00	Building Improvements	1, 607, 878	0				4. 00
5. 00	Fi xed Equi pment	0	0				5.00
6. 00	Movable Equipment	145, 911, 665	0				6. 00
7. 00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	515, 070, 942	0				8. 00
9. 00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	515, 070, 942	0				10.00

Heal th	n Financial Systems	UNION HOSPITAL, INC.			In Lieu of Form CMS-2552-10			
RECON	RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der Co	CN: 15-0023	Period: From 01/01/2016 To 12/31/2016			
					10 12/31/2010	11/12/2018 4:		
		SUMMARY OF CAPITAL						
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see		
					(see instructions)	instructions)		
		9. 00	10. 00	11. 00	12.00	13.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WOR			and 2				
1. 00	NEW CAP REL COSTS-BLDG & FIXT	12, 761, 421			0	0	1.00	
2. 00	NEW CAP REL COSTS-MVBLE EQUIP	5, 647, 288			0 0	0	2.00	
3.00	Total (sum of lines 1-2)	18, 408, 709			0 0	0	3.00	
		SUMMARY 0	F CAPITAL					
	Cost Center Description	0ther	Total (1)					
		Capi tal -Rel at						
		ed Costs (see	9 through 14)					
		instructions)						
		14. 00	15. 00					
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLU		and 2				
1. 00	NEW CAP REL COSTS-BLDG & FIXT	0	12, 761, 421				1.00	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	5, 647, 288				2.00	
3. 00	Total (sum of lines 1-2)	0	18, 408, 709				3. 00	

Health Financial Systems	UNI ON HOSPI	TAL, INC.		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Period: From 01/01/2016 To 12/31/2016	Worksheet A-7 Part III Date/Time Pre 11/12/2018 4:	pared:
	COMI	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	•
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
		Leases	for Ratio	instructions)		
			(col. 1 -			
	1. 00	2.00	col . 2) 3.00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS C		2.00	3.00	4.00	5.00	
1. 00 NEW CAP REL COSTS-BLDG & FLXT	369, 159, 277	0	369, 159, 27	7 0. 716715	0	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	145, 911, 665	0			0	2.00
3.00 Total (sum of lines 1-2)	515, 070, 942	0	515, 070, 94	2 1. 000000	0	3.00
	ALLOCA ⁻	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel at				
		ed Costs	through 7)	0.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	6. 00	7. 00	8.00	9. 00	10. 00	
1.00 NEW CAP REL COSTS-BLDG & FIXT	ENTERS	1		0 10, 573, 354	0	1. 00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0		0 5, 159, 556		2.00
3.00 Total (sum of lines 1-2)	0	0		0 15, 732, 910		3. 00
(Sl	JMMARY OF CAPI		-	7.75
Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)	
		(see	instructions)	Capi tal -Rel at	(sum of cols.	
		instructions)		ed Costs (see	9 through 14)	
				instructions)		
DART III DECONCILIATION OF CARLTAL COCTO C	11. 00	12. 00	13. 00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CI	9, 772, 108	0		0 0	20, 345, 462	1. 00
2. 00 NEW CAP REL COSTS-BLDG & FIXT	3, 490, 602		1	0 0		2.00
3.00 Total (sum of lines 1-2)	13, 262, 710			0 0		
5. 55 1.5 ta. (5dill 61 111165 1 2)	10,202,710	1	ı	91	20, 770, 020	0.00

				To	12/31/2016	Date/Time Pre 11/12/2018 4:	
				Expense Classification on		11/12/2010 4.	13 piii
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2) 1. 00	2. 00	3.00	4.00	Ref. 5. 00	
1. 00	Investment income - NEW CAP	B		NEW CAP REL COSTS-BLDG &	1.00	5.00	1.00
	REL COSTS-BLDG & FIXT (chapter			FIXT			
2. 00	2) Investment income - NEW CAP	В	-31, 688	NEW CAP REL COSTS-MVBLE	2. 00	11	2. 00
	REL COSTS-MVBLE EQUIP (chapter			EQUI P			
3. 00	2) Investment income - other		0		0. 00	0	3.00
4 00	(chapter 2)	D	0.024	DUDGUACING DECELVANC AND	F 03		4 00
4. 00	Trade, quantity, and time discounts (chapter 8)	В	-8, 834	PURCHASING RECEIVING AND STORES	5. 03	0	4. 00
5. 00	Refunds and rebates of expenses (chapter 8)	В	-230, 946	PURCHASING RECEIVING AND	5. 03	0	5. 00
6. 00	Rental of provider space by		0	STORES	0.00	0	6. 00
7 00	suppliers (chapter 8)		10 21/	NONDATI ENT. TELEDUONES	F 01		7.00
7. 00	Tel ephone services (pay stations excluded) (chapter	А	-18, 216	NONPATI ENT TELEPHONES	5. 01	0	7. 00
0.00	21)		0		0.00	0	0.00
8. 00	Television and radio service (chapter 21)		U		0. 00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21)	402	14 041 440		0. 00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-14, 841, 668			O	10.00
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0. 00	0	11. 00
12. 00	Related organization	A-8-1	63, 021, 037			0	12.00
13. 00	transactions (chapter 10) Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	В	-1, 383, 343	CAFETERI A	11. 00	Ö	14. 00
15. 00	Rental of quarters to employee and others		0		0. 00	0	15.00
16. 00	Sale of medical and surgical	Α	-6, 545	MEDICAL SUPPLIES CHARGED TO	71. 00	0	16. 00
	supplies to other than patients			PATI ENTS			
17. 00	Sale of drugs to other than	Α	-17, 394	DRUGS CHARGED TO PATIENTS	73. 00	0	17. 00
18. 00	patients Sale of medical records and	В	-23, 436	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	abstracts Nursing and allied health		0		0. 00	0	19. 00
17.00	education (tuition, fees,		O		0.00	0	19.00
20. 00	books, etc.) Vending machines	А	-12 564	OPERATION OF PLANT	7. 00	0	20. 00
21. 00	Income from imposition of	Λ	12, 304	STERVITOR OF TEARIN	0.00	0	
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0. 00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00		A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
	(chapter 21)						
26. 00	Depreciation - NEW CAP REL COSTS-BLDG & FLXT		0	NEW CAP REL COSTS-BLDG & FLXT	1. 00	0	26. 00
27. 00	Depreciation - NEW CAP REL		0	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	Physicians' assistant	4.6.5	0		0. 00	0	29. 00
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30.00
20.00	limitation (chapter 14)			ADULTS & DEDLATELOS	20.00		20.00
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30. 00		30. 99
	· ·	'		'	,	'	

Heal th	Financial Systems		UNION HOSPIT	AL. INC.	In Lieu	u of Form CMS-2	2552-10
	MENTS TO EXPENSES			Provider CCN: 15-0023 F	Peri od:	Worksheet A-8	
					rom 01/01/2016 o 12/31/2016	Date/Time Pre 11/12/2018 4:	
				Expense Classification on	Worksheet A	117 127 2010 4.	13 piii
			т	o/From Which the Amount is			
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	·	(2)				Ref.	
		1. 00	2. 00	3. 00	4. 00	5. 00	
31. 00	Adjustment for speech	A-8-3	0 S	SPEECH PATHOLOGY	68. 00		31.00
	pathology costs in excess of limitation (chapter 14)						
32. 00	CAH HIT Adjustment for		o		0.00	0	32.00
32.00	Depreciation and Interest				0.00	O	32.00
33.00	TELEPHONE DEPRECIATION	Α	-672 N	IEW CAP REL COSTS-MVBLE	2.00	9	33.00
			l I	QUI P			
34.00	VENDI NG HOUSEKEEPI NG	A	· .	IOUSEKEEPI NG	9. 00	0	ł
35.00	MEALS SOLD	В	-44, 043 D		10.00	0	35.00
36.00	VISITORS MEALS LAB - BLDG	A B	-372, 311 C		11.00	0	36.00
38. 00	בחט - טבטט	D		IEW CAP REL COSTS-BLDG &	1. 00	9	38.00
39. 00	LAB - ADMINISTRATION	В		THER ADMIN AND GENERAL	5. 06	0	39. 00
40.00	LAB - LAUNDRY	В		AUNDRY & LINEN SERVICE	8. 00	0	40.00
41. 00	LAB - HOUSEKEEPING	В		IOUSEKEEPI NG	9. 00	0	41.00
42.00	LAB - OPERATION OF PLANT	В		PERATION OF PLANT	7. 00	0	42.00
42. 01	HAMILTON CENTER OPERATION OF	A	-82, 052 0	PERATION OF PLANT	7. 00	0	42. 01
45. 00	PLANT HAMILTON CENTER NUTRITION	А	-249, 501 D	NI FTADV	10.00	0	45.00
45. 01	FITNESS ACTIVITY	В	l	MPLOYEE BENEFITS DEPARTMENT	1	0	45. 01
45. 02	EQUI PMENT RENTAL	В	l	IEW CAP REL COSTS-MVBLE	2. 00	9	45. 02
				QUI P			
45. 03	UHF - HOUSEKEEPING	А		IOUSEKEEPI NG	9. 00	0	45. 03
45. 04	MI SCELLANEOUS	В		OTHER ADMIN AND GENERAL	5. 06	0	45. 04
45. 05	CATERING	B B		CAFETERIA	11. 00	0	45.05
45. 06 45. 08	MANAGEMENT SERVICES OTHER RENTAL	В	1 I	OTHER ADMIN AND GENERAL OPERATION OF PLANT	5. 06 7. 00	0	45. 06 45. 08
45. 09	PHYSICIAN EQUIPMENT REVENUE	В	1 I	PERATION OF PLANT	7. 00	0	45. 09
45. 24	UHF - ADMINISTRATION	В		THER ADMIN AND GENERAL	5. 06	0	45. 24
45. 26	LOBBY PHARMACY	В	-235, 645 E	MPLOYEE BENEFITS DEPARTMENT	4.00	0	45. 26
45. 27	LOBBYI NG COSTS	А		THER ADMIN AND GENERAL	5. 06	0	45. 27
45. 29	AP&S REVENUE	В	· · ·	IONPATI ENT TELEPHONES	5. 01	0	45. 29
45. 32	AP&S REVENUE	В		IEW CAP REL COSTS-BLDG &	1.00	9	45. 32
45. 37	AP&S REVENUE	В	l l	OATA PROCESSING	5. 02	0	45. 37
	AP&S REVENUE	В		THER ADMIN AND GENERAL	5. 06	0	l
45. 39	COH REVENUE	В		IEW CAP REL COSTS-BLDG &	1.00	9	45. 39
45 40	COLL DEVENUE	D		TIXT	F 01	0	45 40
45. 40 45. 42	COH REVENUE PHYSICIAN RENTAL	B A		IONPATIENT TELEPHONES IEW CAP REL COSTS-BLDG &	5. 01 1. 00	0	45. 40 45. 42
43.42	THISTOTAN KENTAL	^		IXT	1.00	7	45.42
45. 43	PHYSICIAN RENTAL	А	-533, 067 0	PERATION OF PLANT	7. 00	0	45. 43
45. 44	ACCELERATED DEPRECIATION	А		IEW CAP REL COSTS-BLDG &	1. 00	9	45. 44
4E 4E	CILL D. DI DTIL CLASS	D	l I	TIXT	F2 00	0	45 45
45. 45 45. 47	CHILD BIRTH CLASS CONTINUING EDUCATION	B B		DELIVERY ROOM & LABOR ROOM OTHER ADMIN AND GENERAL	52. 00 5. 06	0	45. 45 45. 47
45. 48	EDUCATION SERVICES	В		OTHER ADMIN AND GENERAL	5. 06	0	45. 48
45. 49	TRANSCRI PTI ON	В	· · ·	MEDICAL RECORDS & LIBRARY	16. 00	0	45. 49
46. 00	VHA	В	1 I	RUGS CHARGED TO PATIENTS	73. 00	0	46. 00
46. 02	TIME SAVERS	В	I I	MPLOYEE BENEFITS DEPARTMENT	1	0	46. 02
46. 03	HOUSEKEEPI NG	B B		NOUSEKEEPING	9.00	0	46. 03 46. 04
46. 04 46. 07	LANDSBAUM MAPLE CENTER	В	I I	PERATION OF PLANT OTHER ADMIN AND GENERAL	7. 00 5. 06	0	46. 04
46. 08	PROF SUPPORT UHS	В	l	OTHER ADMIN AND GENERAL	5. 06	0	46.08
46. 10	AP&S A/P PD SPACE/EQUIP RENT R		I I	IEW CAP REL COSTS-BLDG &	1. 00	9	46. 10
		_	I I	IXT			
46. 11	CODING CLASS REVENUE	В	I I	MEDICAL RECORDS & LIBRARY	16.00	0	1
46. 12 46. 13	WVHC ST ANN/ASH PHARMACY REVEN	B A		DRUGS CHARGED TO PATIENTS OTHER ADMIN AND GENERAL	73. 00 5. 06	0	46. 12 46. 13
46. 14	CRNA S&W/BENEFITS	A		DELIVERY ROOM & LABOR ROOM	52. 00	0	46. 14
50. 00	TOTAL (sum of lines 1 thru 49)		25, 465, 988			_	50.00
	(Transfer to Worksheet A				1		I

⁽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.

Health Financial Systems	UNI ON HOSPI	TAL, INC.	In Lieu of Form CMS-2552-10			
ADJUSTMENTS TO EXPENSES				Peri od: From 01/01/2016	Worksheet A-8	
					Date/Time Pre 11/12/2018 4:	pared: 13 pm
			Expense Classification o	n Worksheet A		
			To/From Which the Amount is	to be Adjusted		
Cost Center Description	Basis/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	(2)				Ref.	
	1. 00	2. 00	3.00	4. 00	5. 00	

B. Amount Received - if cost cannot be determined.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider CCN: 15-0023 Period: From 01/01/2016 To 12/31/2016 Date/Time Prepared: 11/12/2018 4-13 pm

					10 12/31/2010	11/12/2018 4:	
	Li ne No.	Cost Center	Expense	Items	Amount of	Amount	
					Allowable Cost	Included in	
						Wks. A, column	
	1 00	0.00				5	
	1.00	2. 00	3. 0		4.00	5. 00	
	OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS W	I IH KELATED O	RGANI ZATI UNS UR	CLAIMED HOME	
1. 00		OTHER MED ED	PARAMED		0	295, 121	1. 00
2. 00		NEW CAP REL COSTS-BLDG & FIX			0	1, 794, 533	2. 00
3.00		NEW CAP REL COSTS-MVBLE EQUI			0	4, 015, 654	3.00
4. 00		NONPATI ENT TELEPHONES	HOME OFFICE		0	228, 082	4. 00
4. 01		OPERATION OF PLANT	HOME OFFICE		0	1, 640, 162	4. 01
4. 02		HOUSEKEEPI NG	HOME OFFICE		0	318, 635	4. 02
4. 03	1.00	NEW CAP REL COSTS-BLDG & FIX	HOME OFFICE		1, 636, 458	0	4.03
4.04		NEW CAP REL COSTS-MVBLE EQUI			3, 536, 127	0	4.04
4.05	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE		25, 137, 966	0	4.05
4.06	5. 01	NONPATIENT TELEPHONES	HOME OFFICE		197, 899	0	4.06
4.07	5. 02	DATA PROCESSING	HOME OFFICE		12, 292, 272	0	4.07
4.08	5. 03	PURCHASING RECEIVING AND STO	HOME OFFICE		1, 647, 386	0	4.08
4.09	5. 05	CASHI ERI NG/ACCOUNTS RECEI VAB	HOME OFFICE		6, 230, 243	0	4.09
4. 10	5. 06	OTHER ADMIN AND GENERAL	HOME OFFICE		18, 061, 639	0	4. 10
4. 11	7. 00	OPERATION OF PLANT	HOME OFFICE		3, 012, 638	0	4. 11
4. 12	9. 00	HOUSEKEEPI NG	HOME OFFICE		290, 567	0	4. 12
4. 13	1	DI ETARY	HOME OFFICE		120, 571	0	4. 13
4. 14		CAFETERI A	HOME OFFICE		193, 475	0	4. 14
4. 15		NURSING ADMINISTRATION	HOME OFFICE		1, 414, 532	0	4. 15
4. 16	I	MEDICAL RECORDS & LIBRARY	HOME OFFICE		267, 607	0	4. 16
4. 17		OPERATING ROOM	HOME OFFICE		75, 730	0	4. 17
4. 18		CARDI AC SURGERY	HOME OFFICE		5, 670	0	4. 18
4. 19	50. 02		HOME OFFICE		49, 246	0	4. 19
4. 20	1	RECOVERY ROOM	HOME OFFICE		2, 401	0	4. 20
4. 21	•	RADI OLOGY-DI AGNOSTI C	HOME OFFICE		162, 326	0	4. 21
4. 22		CT SCAN	HOME OFFICE		217, 629	0	4. 22
4. 23			HOME OFFICE		51, 890	0	4. 23
4. 24	1	CARDI AC CATHETERI ZATI ON	HOME OFFICE		156, 707	0	4. 24
4. 25		PHYSI CAL THERAPY	HOME OFFICE		-175, 243	0	4. 25
4. 26		O/P PHYSICAL THERAPY	HOME OFFICE		8, 774	0	4. 26
4. 27 4. 28		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	HOME OFFICE HOME OFFICE		9, 985	0	4. 27 4. 28
4. 20		ELECTROCARDI OLOGY	HOME OFFICE		1, 586 29, 477	0	4. 20 4. 29
4. 29	I	CARDI AC REHAB	HOME OFFICE		2, 101	0	4. 29
4. 31	1	ELECTROENCEPHALOGRAPHY	HOME OFFICE		12, 038	0	4. 30
4. 32	I	DRUGS CHARGED TO PATIENTS	HOME OFFICE		323, 461	0	4. 32
4. 33	I	WOUND CLINIC	HOME OFFICE		2, 758	0	4. 33
4. 34		OPERATION OF PLANT	PLANT SALARIES		2, 730	618, 857	4. 34
4. 36		PHYSI CAL THERAPY	UNION THERAPIES		2, 299, 725	4, 320, 686	4. 36
4. 37	1	O/P PHYSICAL THERAPY	UNION THERAPIES		1, 350, 071	2, 710, 194	4. 37
4. 38	1	OCCUPATI ONAL THERAPY	UNION THERAPIES		1, 536, 390	0	4. 38
4. 39	1	SPEECH PATHOLOGY	UNION THERAPIES		505, 127	428, 812	4. 39
4.40	1	PHYSICIAN PRACTICES	UNION THERAPIES		0	600, 215	4.40
4. 41	1	SYCAMORE SPORTS MED	UNION THERAPIES		o	675, 241	4.41
5.00	0		0		80, 667, 229	17, 646, 192	5.00

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

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

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

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

6.00	G	0.00 UNI ON HOSPI TAL 100.00	6. 00
7.00	G	0.00 UNI ON THERAPY 100.00	7.00
8. 00		0.00	8.00
9. 00		0.00	9.00
10.00		0.00 0.00	10.00

Health Financial Systems	UNI ON HOSP	PITAL, INC.		In Lie	u of Form CMS-	2552-10
STATEMENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO	ME Provider (CCN: 15-0023	Period: From 01/01/2016	Worksheet A-8	3-1
OFFICE COSTS				To 12/31/2016		
			Related Orga	nization(s) and/o	or Home Office	
Symbol (1)	Name	Percentage of		Vame	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
non-financial) specify:						

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

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

	Financial Syste		UNI ON HOSPI TA			u of Form CMS-	
		SERVICES FROM	RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-0023	Peri od: From 01/01/2016	Worksheet A-	8-1
OFFICE	COSTS				To 12/31/2016	Date/Time Pro 11/12/2018 4	
	Net	Wkst. A-7 Ref.					
	Adjustments						
	(col. 4 minus						
	col. 5)*	7.00					
	6. 00	7.00	l MENTS REQUIRED AS A RESULT OF TR	ANSACTIONS WITH DELATED	ODCANI ZATI ONE OD	CLAIMED HOME	
	OFFICE COSTS:	KED AND ADJUSTI	MENTS REQUIRED AS A RESULT OF TR	ANSACTIONS WITH RELATED	URGANI ZATI UNS UR	CLAIMED HOME	
1.00	-295, 121	0					1.00
2. 00	-1, 794, 533						2.00
3.00	-4, 015, 654	9					3.00
4. 00	-228, 082	Ó	1				4.00
4. 01	-1, 640, 162	0	1				4. 01
4. 02	-318, 635						4. 02
4. 03	1, 636, 458	9					4. 03
4. 04	3, 536, 127	9					4. 04
4.05	25, 137, 966	0					4. 05
4.06	197, 899						4.06
4.07	12, 292, 272	0					4.07
4.08	1, 647, 386	0					4.08
4.09	6, 230, 243	0					4. 09
4. 10	18, 061, 639	0					4. 10
4. 11	3, 012, 638						4. 11
4. 12	290, 567	0					4. 12
4. 13	120, 571	0					4. 13
4. 14	193, 475	0					4. 14
4. 15	1, 414, 532						4. 15
4. 16	267, 607	0	I .				4. 16
4. 17	75, 730		I .				4. 17
4. 18	5, 670	0					4. 18
4. 19	49, 246		I .				4. 19
4. 20	2, 401	0					4. 20
4. 21 4. 22	162, 326 217, 629		I and the second				4. 21 4. 22
4. 22	51, 890		I .				4. 22
4. 24	156, 707	0	1				4. 24
4. 25	-175, 243						4. 25
4. 26	8,774	0					4. 26
4. 27	9, 985		1				4. 27
4. 28	1, 586		1				4. 28
4. 29	29, 477	0	1				4. 29
4.30	2, 101	0					4. 30
4. 31	12, 038	0					4. 31
4. 32	323, 461	0					4. 32
4. 33	2, 758	0					4. 33
4.34	-618, 857	0					4. 34
4. 36	-2, 020, 961	0					4. 36
4. 37	-1, 360, 123	0					4. 37
4. 38	1, 536, 390						4. 38
4. 39	76, 315	0					4. 39
4. 40	-600, 215						4. 40
4.41	-675, 241	0					4.41

* 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.

5.00

	Related Organization(s)				
	and/or Home Office				
	Type of Business				
	6. 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.

Termbar Sement ander tritle AVIII.						
6. 00	HOME OFFICE	6.00				
7.00	THERAPI ES	7.00				
8.00		8.00				
9.00		9.00				
10.00		10.00				
100.00		100.00				

5.00

63, 021, 037

Health Financial Systems	UNION HOSPITAL	In Lieu of Form CMS-2552-10		
STATEMENT OF COSTS OF SERVICES FRO	M RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-0023	Peri od: From 01/01/2016	Worksheet A-8-1
				Date/Time Prepared: 11/12/2018 4:13 pm
Related Organization(s) and/or Home Office				
Type of Business	_			
6.00				

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0023

Peri od: Worksheet A-8-2 From 01/01/2016 To 12/31/2016 Date/Time Prepared:

11/12/2018 4:13 pm

Wkst. A Line # Cost Center/Physician Total Professi onal Provi der RCE Amount Physi ci an/Prov I denti fi er der Component Remuneration Component Component Hours 2.00 3. 00 5. 00 1 00 4 00 6 00 7 00 1.00 22. 00 & SERVICES-OTHER PRGM 807, 200 0 807, 200 211,500 6,966 1.00 COSTS APPRVD 30. 00 ADULTS & PEDIATRICS 2.00 53, 328 53, 328 211,500 2.00 237, 100 3.00 35. 00 I NTENSI VE NURSERY 539.067 539, 067 0 3.00 41. 00 SUBPROVI DER - I RF 99, 375 99, 375 211, 500 993 4.00 4 00 5.00 50.00 OPERATING ROOM 3, 269, 646 3, 215, 946 246, 400 537 5.00 53,700 50. 01 CARDI AC SURGERY 6.00 2, 808, 597 2, 808, 597 0 246, 400 0 6.00 50. 02 WVSC 0 246, 400 7.00 926, 727 926, 727 7.00 0 52. 00 DELIVERY ROOM & LABOR ROOM 8.00 1, 928, 333 1, 928, 333 0 246, 400 8.00 9.00 54. 00 RADI OLOGY-DI AGNOSTI C 503, 249 503, 249 0 271, 900 0 9.00 10.00 56. 00 RADI OI SOTOPE 11,650 11, 650 271, 900 0 10.00 59. 00 CARDI AC CATHETERI ZATI ON 1, 796, 870 260, 300 11.00 1, 796, 870 Ω 11.00 60. 00 LABORATORY 12.00 617,000 617,000 197, 500 4, 570 12.00 13.00 69. 00 ELECTROCARDI OLOGY 113,830 103, 155 10,675 197, 500 120 13.00 14.00 70. 00 ELECTROENCEPHALOGRAPHY 2, 245, 015 179,000 14.00 2, 245, 015 Ω 0 73.00 DRUGS CHARGED TO PATIENTS 211, 500 15.00 424, 418 424, 418 0 15.00 16.00 90. 05 PATIENT NUTRITION 5,500 5,500 211,500 21 16.00 91. 00 EMERGENCY 17.00 37, 310 37, 310 211, 500 1, 178 17.00 16, 187, 115 14, 556, 355 14, 385 200.00 200.00 1, 630, 760 Wkst. A Line # Cost Center/Physician Unadjusted RCE 5 Percent of Cost of Provi der Physician Cost I denti fi er Unadjusted RCE Memberships & Component of Malpractice Limit Conti nui ng Limit Share of col Insurance Educati on 12 9.00 13.00 14. 00 1.00 2.00 8. 00 12.00 22.00 I &R SERVI CES-OTHER PRGM 1.00 708. 322 35, 416 C 1.00 COSTS APPRVD 30. 00 ADULTS & PEDIATRICS 2.00 0 27, 495 2.00 0 3.00 35. 00 NTENSIVE NURSERY 0 0 55 3.00 0 41. 00 SUBPROVI DER - I RF 100, 971 0 4.00 5,049 0 4.00 50. 00 OPERATING ROOM 5.00 63, 614 3, 181 153, 593 5.00 0 0 6.00 50. 01 CARDI AC SURGERY 75.653 6.00 0 50. 02 WVSC 0 0 7.00 0 0 C 7.00 52. 00 DELIVERY ROOM & LABOR ROOM 8.00 0 0 8.00 54. 00 RADI OLOGY-DI AGNOSTI C 9.00 0 0 35, 511 9.00 56. OORADI OI SOTOPE 10 00 0 10 00 0 59. 00 CARDI AC CATHETERI ZATI ON 11.00 Λ 0 11.00 12.00 60. 00 LABORATORY 433, 930 21, 697 0 0 0 12.00 13.00 69. 00 ELECTROCARDI OLOGY 11, 394 570 0 0 602 13.00 70. 00 ELECTROENCEPHALOGRAPHY 0 0 14 00 118, 091 14 00 0 73.00 DRUGS CHARGED TO PATIENTS 15.00 0 0 0 0 15.00 16.00 90. 05 PATIENT NUTRITION 2, 135 107 16.00 17.00 91. 00 EMERGENCY 119, 782 5, 989 213 17.00 C 411, 213 1, 440, 148 72 009 200.00 200.00 Wkst. A Line # Cost Center/Physician Provi der Adjusted RCE RCF Adjustment Di sal I owance I denti fi er Component Limit Share of col. 14 2.00 1.00 15.00 16.00 17.00 18.00 1.00 22. 00 I &R SERVICES-OTHER PRGM 708, 322 98,878 98,878 1.00 COSTS APPRVD 2.00 30. 00 ADULTS & PEDI ATRI CS 53, 328 2.00 0 3 00 35. 00 I NTENSI VE NURSERY 0 0 539,067 3 00 0 4.00 41. 00 SUBPROVI DER - I RF 100, 971 0 4.00 5.00 50.00 OPERATING ROOM 3, 215, 946 2.523 66, 137 5.00 6.00 50. 01 CARDI AC SURGERY 0 2, 808, 597 6.00 0 0 50. 02 WVSC 7.00 0 926, 727 0 0 7 00 52. 00 DELIVERY ROOM & LABOR ROOM 8.00 0 0 1, 928, 333 8.00 54. 00 RADI OLOGY-DI AGNOSTI C 503, 249 9.00 0 0 9.00 10.00 56. 00 RADI OI SOTOPE 0 0 11, 650 10.00 0 59. 00 CARDI AC CATHETERI ZATI ON 11.00 0 O 1, 796, 870 11.00 12.00 60. 00 LABORATORY 0 433, 930 183,070 183,070 12.00 13.00 69. 00 ELECTROCARDI OLOGY 56 11, 450 103, 155 13.00 70. 00 ELECTROENCEPHALOGRAPHY 2, 245, 015 14.00 14.00 0 0 0 73.00 DRUGS CHARGED TO PATIENTS 15.00 0 0 Λ 424, 418 15.00 16.00 90. 05 PATIENT NUTRITION 0 2, 135 3, 365 3, 365 16.00 91. 00 EMERGENCY 119, 995 17.00 17.00 213 200.00 2 792 1, 442, 940 285, 313 14, 841, 668 200.00

| Period: | Worksheet B | From 01/01/2016 | Part | To | 12/31/2016 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-0023

						o 12/31/2016	Date/Time Pre	pared:
				CAPITAL REI	_ATED COSTS		11/12/2018 4:	13 pm
		Cost Contor Description	Not Exposes	NEW BLDG &	NEW MVBLE	EMPLOYEE	NONPATI ENT	
		Cost Center Description	Net Expenses for Cost	FIXT	EQUI P	BENEFI TS	TELEPHONES	
			Allocation			DEPARTMENT		
			(from Wkst A col. 7)					
			0	1. 00	2.00	4. 00	5. 01	
1 00		AL SERVICE COST CENTERS	00.045.440	00.045.440	I			4 00
1. 00 2. 00		NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-MVBLE EQUIP	20, 345, 462 8, 650, 158	20, 345, 462	8, 650, 158			1. 00 2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT	27, 066, 239	109, 282				4. 00
5. 01		NONPATI ENT TELEPHONES	844, 921	13, 831			1, 079, 636	5. 01
5. 02 5. 03		DATA PROCESSING PURCHASING RECEIVING AND STORES	11, 672, 578 1, 407, 606	0			0	5. 02 5. 03
5. 04		ADMI TTI NG	1, 929, 484	64, 462			38, 712	5. 04
5. 05		CASHI ERI NG/ACCOUNTS RECEI VABLE	6, 230, 243	300.040	122.074		00.701	5.05
5. 06 7. 00		OTHER ADMIN AND GENERAL OPERATION OF PLANT	23, 992, 184 9, 345, 283	390, 960 7, 049, 869			99, 791 61, 079	5. 06 7. 00
8. 00	00800	LAUNDRY & LINEN SERVICE	999, 910	126, 060			15, 485	8. 00
9.00		HOUSEKEEPI NG	2, 947, 050	111, 850			6, 882	9.00
10. 00 11. 00		DI ETARY CAFETERI A	3, 267, 475 -1, 235, 137	231, 069 164, 881			25, 808 0	10. 00 11. 00
13.00	01300	NURSING ADMINISTRATION	3, 126, 448	50, 020	12, 355	418, 149	7, 742	13.00
16.00	1	MEDICAL RECORDS & LIBRARY	3, 499, 995	111, 219			25, 808	16.00
17. 00 21. 00		SOCIAL SERVICE I&R SERVICES-SALARY & FRINGES APPRVD	1, 433, 559	0			0	17. 00 21. 00
22. 00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	2, 255, 469	0		376, 642	0	22.00
23. 00		PARAMED ED PRGM OTHER MED ED	251, 232	15 150		-/	0	23. 00
23. 01		I ENT ROUTINE SERVICE COST CENTERS	272, 600	15, 158	2, 439	64, 228	0	23. 01
30.00	03000	ADULTS & PEDIATRICS	25, 734, 078	3, 958, 779			147, 107	30. 00
31. 00 35. 00		INTENSIVE CARE UNIT INTENSIVE NURSERY	6, 843, 296 2, 388, 007	483, 990 60, 630			24, 948	31. 00 35. 00
41.00		SUBPROVI DER - I RF	1, 667, 303	312, 014			15, 485 26, 668	41.00
43.00	04300	NURSERY	1, 225, 861	82, 672			3, 441	
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	10, 540, 130	857, 561	1, 796, 919	1, 310, 838	70, 542	50. 00
50.00	1	CARDI AC SURGERY	1, 518, 270	37, 894			5, 162	50.00
50.02	05002		11, 596, 754	632, 155		0	0	50. 02
51. 00 51. 02		RECOVERY ROOM O/P TREATMENT ROOM	1, 745, 248 2, 497, 535	30, 147 449, 338			15, 485 23, 227	51. 00 51. 02
52.00	1	DELIVERY ROOM & LABOR ROOM	3, 623, 398	437, 991			19, 786	
54.00	1	RADI OLOGY-DI AGNOSTI C	6, 495, 646	687, 038			92, 909	54.00
55. 00 56. 00		RADI OLOGY-THERAPEUTI C RADI OI SOTOPE	5, 037, 294 1, 225, 764	555, 630 61, 346			35, 271 0	55. 00 56. 00
57. 00		CT SCAN	2, 280, 517	45, 725			6, 022	57. 00
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	1, 528, 449	54, 588			3, 441	58. 00
59. 00 60. 00		CARDI AC CATHETERI ZATI ON LABORATORY	15, 280, 208 9, 182, 684	351, 445 0			29, 249 6, 882	59. 00 60. 00
62.00		WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 286, 409	0	1		0, 002	
65.00		RESPI RATORY THERAPY	3, 637, 718	44, 925	1		12, 044	
66. 00 66. 01	1	PHYSI CAL THERAPY PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	2, 351, 514 0	213, 680 0	1		19, 786 0	66. 00 66. 01
66. 02		0/P PHYSICAL THERAPY	2, 085, 145	0			860	66. 02
67.00	1	OCCUPATIONAL THERAPY	1, 546, 375	34, 905			4, 301	67.00
68. 00 69. 00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	599, 823 1, 962, 352	69, 220 27, 473			860 3, 441	68. 00 69. 00
69. 01		CARDI AC REHAB	334, 687	151, 576			5, 162	69. 01
70.00		ELECTROENCEPHALOGRAPHY	614, 230	31, 684			14, 625	70.00
71. 00 72. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS	930, 850 12, 632, 757	120, 250 0			12, 044 0	71. 00 72. 00
73. 00		DRUGS CHARGED TO PATIENTS	42, 987, 496	270, 352			43, 013	
76. 00		RENAL ACUTE	1, 516, 013	74, 209	1, 015	0	3, 441	76. 00
90. 00		TIENT SERVICE COST CENTERS CLINIC	211, 186	4, 589		50, 400	0	90. 00
90.05		PATIENT NUTRITION	322, 734	40, 631			0	90.05
90. 07		WOUND CLINIC	1, 301, 932	82, 082			11, 183	90. 07
91. 00 92. 00		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)	8, 113, 368	506, 747	259, 653	1, 430, 019	54, 197	91. 00 92. 00
72. UU		AL PURPOSE COST CENTERS			I			72. UU
118.00)	SUBTOTALS (SUM OF LINES 1 through 117)	321, 147, 790	19, 209, 927	8, 102, 178	24, 735, 320	991, 889	118. 00
190 0		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	ol	0		O	0	190. 00
194.00	07950	RURAL HEALTH	3, 328, 549	0				190.00
		RENTAL PROPERTY	165, 283	0				194. 01
194. 02	∠ U/954	FAMILY PRACTICE	2, 751, 372	780, 426	398, 141	531, 173	61, 079	194. 02

Health Financial Systems	UNI ON HOSPI	UNION HOSPITAL, INC.			In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CO		Peri od:	Worksheet B			
				From 01/01/2016 To 12/31/2016	Date/Time Pre	pared:		
		CADITAL DEL	ATED COCTO		11/12/2018 4:	13 pm		
		CAPI TAL REL	LATED COSTS					
Cost Center Description	Net Expenses	NEW BLDG &	NEW MVBLE	EMPLOYEE	NONPATI ENT			
	for Cost	FLXT	EQUI P	BENEFI TS	TELEPHONES			
	Allocation			DEPARTMENT				
	(from Wkst A							
	col. 7)							
	0	1. 00	2. 00	4. 00	5. 01			
194. 03 07952 WELLNESS	452, 831	294, 773		97, 321	0	194. 03		
194. 04 07955 PHYSI CI AN PRACTI CES	11, 638, 004	0	72, 01	1, 366, 762	18, 926	194. 04		
194.06 07953 SYCAMORE SPORTS MED	124, 817	0	7, 62	3 2, 856	0	194.06		
194. 07 07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	360, 028	60, 336	6, 64	0 88, 402	6, 882	194. 07		
200.00 Cross Foot Adjustments						200.00		
201.00 Negative Cost Centers		0		0 0	0	201.00		
202.00 TOTAL (sum lines 118 through 201)	339, 968, 674	20, 345, 462	8, 650, 15	8 27, 175, 521	1, 079, 636	202. 00		

| Peri od: | Worksheet B | From 01/01/2016 | Part I | To 12/31/2016 | Date/Time Prepared: | 11/12/2018 | 4:13 pm

CORREGAL SERVICE COSTS BLOG AT THE PROCESSING A CONTINUE COSTS BLOG AT THE PROCESSING A CONTINUE COSTS BLOG AT THE PROCESSING A CONTINUE COSTS BLOG AT THE PROCESSING ACCORDANCE COSTS BLOG ACCORDANCE COSTS BLO					'	0 12/31/2016	Date/lime Pre 11/12/2018 4:	
STORYS		Cost Center Description	DATA	PURCHASI NG	ADMITTI NG	CASHI ERI NG/AC		, o p
STRIPTION STRIPTION CONTYCENTERS 5,02 5,03 5,04 5,09 5,00			PROCESSI NG					
DEFENSE SERVICE COST CENTERS 1			5.02		5.04		5A 05	
1.00 000000 MOR CAP REL COSTS - NUMBER 2011 0 0 0 0 0 0 0 0 0		GENERAL SERVICE COST CENTERS	5. 02	5.05	5. 04	5.05	5A. U5	
4.00 0.0000 DEPROYTE PRIMET IS DEPARTMENT	1.00							1.00
5.01 0.0044 NORMATIENT TELEPHONES	2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
5.02 0.00500 DATA PROCESS NO	4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.03 0.00560 PURCHASIN IR RECEIV IN 6A MD STORES 0 1.407, Cold 0.005600 0.005600 0.005600 0.005600 0.005600 0.005600 0.005600 0.005600 0.005600 0.005600 0.005600 0.005600 0.005600 0.005600 0.005600 0.005600 0.005600 0.005600 0.005600 0.005600 0								1
0.0070 ADMITTING 0.0070		1		4 407 (0)				1
DOSBBO CASHIFFEN CACCULARTS REFORM CORPERAL 20,770 50			1		2 422 202			1
5.00 DOSPO] OTHER ADMIN AND ERRERAL 20,770 556 0 0 2,6,099,277 5,06 8.00 DOSECUL LAMBORY & LI NEN SERVICE 0 1,651 0 0 1,246,868 10,00 8.00 DOSECUL LAMBORY & LI NEN SERVICE 0 1,651 0 0 1,466,868 10,00 9.00 DOSECUL LAMBORY & LI NEN SERVICE 0 1,651 0 0 0 0 1,246,868 10,00 9.00 DOSECUL LAMBORY & LI NEN SERVICE 0 0 0 0 0 0 0 1,465,00 9.00 DOSECUL LAMBORY & LI NEN SERVICE 0 0 0 0 0 0 0 0 0			0					1
0.00760 OPERATION OF PEANT 0 556 0 0 1,7,248,895 7,000 0 0 0 0 0 0 0 0 0			20, 770	- 1	-	0	26, 099, 227	1
9.00 0.0900 NULSEEEPIN 1	7.00	00700 OPERATION OF PLANT	0	556	0	0		7.00
10.00 01000 DETARY			0		0	0	1, 496, 866	1
11.00 0 1100 (AFETERIA 0 0 0 -1,014,348 11.00 10.0			ŭ		_	-		1
13.00 01300 NIPSI INC. ADMINISTRATION 0 0 0 0 3,614,714 13.00								
16.00 1600 MEDI CAL RECORDS & LIBRARY 417, 703 25			=		_	-		
17.00 01700 SOCIAL SERVICES - SALARY & FRINGES APPRVD 0 0 0 0 0 0 17.00 22.00 02000 LAR SERVICES-OTHER PROM COSTS APPRVD 0 0 0 0 0 0 2.632, 111 22.00 2230 07.00 PARABEL DE D PROM 0 0 0 0 0 0 2.632, 111 22.00 2230 07.00 PARABEL DE D PROM 0 0 0 0 0 0 3.34, 425 23.01 07.00 PARABEL DE D PROM 0 0 0 0 0 3.34, 425 23.01 07.00 PARABEL DE D PROM 0 0 0 0 0 3.34, 425 23.01 07.00 PARABEL DE D PROM 0 0 0 0 0 3.34, 425 23.01 07.00 PARABEL DE D PROM 0 0 0 0 0 3.34, 425 23.01 07.00 PARABEL DE D PROM 0 0 0 0 0 3.34, 425 23.01 07.00 PARABEL DE D PROM 0 0 0 0 0 3.34, 425 23.01 07.00 PARABEL DE D PROM 0 0 0 0 0 3.34, 425 23.01 07.00 PARABEL DE D PROM 0 0 0 0 0 3.34, 425 23.01 07.00 PARABEL DE D PROM 0 0 0 0 0 0 3.34, 425 23.01 07.00 07.00 PARABEL DE D PROM 0 0 0 0 0 0 0 24.00 07.00 07.00 PARABEL DE D PROM 0 0 0 0 0 0 24.00 07.00 07.00 PARABEL DE D PROM 0 0 0 0 0 0 25.00 07.00 07.00 PARABEL DE D PROM 0 0 0 0 0 0 25.00 07.00 07.00 PARABEL DE D PROM 0 0 0 0 0 0 25.00 07.00 07.00 PARABEL DE D PROM 0 0 0 0 0 0 25.00 07.00 07.00 07.00 PARABEL DE D PROM 0 0 0 0 0 25.00 07.00 07.00 07.00 PARABEL DE D PROM 0 0 0 0 0 25.00 07.00 07.00 07.00 PARABEL DE D PROM 0 0 0 0 0 25.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 25.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 25.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 25.00 07.			ŭ					1
21.00			0		0	0		1
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INPATI ENT ROUTINE SERVICE COST CENTERS		1				0	· ·	1
0.000 0.0000 ADULTS & PEDIATRICS 6,532,074 317,336 416,309 477,693 414,386,863 30.00 30.00 0.010 INTENSIVE CARE INIT 768,479 166,293 116,888 120,495 0.514,817 31.00 31.00 0.010 0.0	23. 01		0	0]	0	0	354, 425	23. 01
31.00 03100 INTENSIVE CARE UNIT 788. 479 169. 292 116. 888 120. 495 10. 514. 817 31. 00 31.00 03200 INTENSIVE WINDSKERY 166. 158 129. 896 70. 465 72. 556 3. 497. 72 35. 00 41.00 04100 SUBPROVI DER - I RF 0 12. 014 16. 785 17. 286 2. 490. 029 41. 000 41.00 41.00 41.00 41.00 42.00	30 00		6 532 074	317 336	416 309	477 693	44 386 863	30 00
16.6, 158 21, 889 70, 465 72, 550 3, 499, 720 35, 00 43, 00 4300 345								1
A3. DO 04300 NURSERY DO 0 24, 293 25, 012 1, 669, 346 42, 00								1
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50.00 050000 0FEATH ING ROOM	43.00		0	0	24, 293	25, 012	1, 669, 346	43.00
50.00	50.00		222 215	57 170	440 506	900 977	16 215 050	50 00
50.00 05000 05000 05000 0500 0500 0500 0500 0500 0500 0500 0500 0500 0500 0500 0500 0500 0500 0500 0500 0510 070 07000 0510 070 07000 0510 070 07000 0510 070 0700 0510 070 0700 0510 070 0700 0510 070 0700 0510 070 0700 0510 070 0700 07								1
51 02 05 101 OF TREATMENT ROOM 0 29, 870 6, 407 49, 401 3, 869, 529 51, 02 52, 00 05 00 05			-					1
S2.00 05200 DELIVERY ROOM & LABOR ROOM 311, 546 78, 938 69, 539 93, 684 5, 890, 252 52, 00 540, 00 05400 RADIOLOGY-THERAPPUTIC 0 695 7, 190 184, 693 6, 383, 211 55, 00 650, 00 05500 RADIOLOGY-THERAPPUTIC 0 695 7, 190 184, 693 6, 383, 211 55, 00 650, 00 05500 RADIOLOGY-THERAPPUTIC 0 52, 552 75, 176 274, 167 3, 043, 842 7, 00 670, 00 057, 00 05700 CT SCAN 0 0 52, 552 75, 176 274, 167 3, 043, 842 7, 00 650, 00 05600 MAGNETIC RESONANCE IMAGING (MRI) 0 1, 134 11, 933 65, 384 1, 1973, 414 58, 00 650, 00 05900 CARDIAC CATHETERIZATION 353, 085 9, 535 147, 456 528, 571 17, 065, 714 59, 00 060, 00 06000 LABORATORY 0 0 0 0, 00	51.00	05100 RECOVERY ROOM	31, 155		9, 182			1
54.00 05400 RADIOLOGY-DIAGNOSTIC 654, 246 18, 214 54, 645 256, 950 10, 232, 096 54, 00 550.00 05500 RADIOLOGY-THERAPPUTIC 0 695 7, 190 184, 693 6, 383, 211 55.00 05600 RADIOLOGY-THERAPPUTIC 20, 770 1, 517 4, 836 42, 999 1, 466, 011 56, 00 057.00 05700 CTSCAN 0 52, 552 75, 176 274, 147 3, 043, 842 57, 00 58.00 05800 MAGNETI C RESONANCE IMAGING (MRI) 30 1, 134 11, 933 65, 384 1, 873, 414 58, 00 0.0			-					
55.00 05500 RADIO LOGY-THERAPEUTI C 0 6.95 7, 100 184, 6.93 6, 383, 211 55.00								1
56.00 05000 RADIO I SOTOPE 20,770 1,517 4,836 42,989 1,466 015 56.00 57.00 05700 CT SCAN 0 52,552 75,176 274,167 3,043,842 57.00 58.00 05800 MAGNETIC RESONANCE I MAGI NG (MRI) 0 1,134 11,933 65.384 1,873,414 58.00 05900 CARDIA C CATHETERI ZATI ON 353,085 9,535 147,456 528,571 17,065,714 59.00 06.00 06000 LABORATORY RODO LABORATORY 0 0 0 200,187 439,785 9,829,538 60.00 06000 LABORATORY RODO 12,025 15,338 1,313,772 62.00 06.00 RODO RESPIRATORY RODO RESPIRATOR RO			654, 246					1
57.00 05700 CT SCAN 0 05800 MAGNETI C RESONANCE I MAGI NG (MRI)			20 770					1
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59.00 059000 059			0					1
62.00 06200 MHOILE BLOOD & PACKED RED BLOOD CELLS 0 0 12, 025 15, 338 1, 313, 772 62, 00 65.00 06500 RESPI RATORY THERAPY 238, 852 718 50, 067 55, 329 2, 968, 578 66, 00 66.01 06601 PSYCHI ATRI C/PSYCHOLGI CAS SERVI CES 0 0 0 0 0 0 66.02 06602 07P PHYSI CAL THERAPY 0 0 0 0 32, 481 2, 180, 143 66, 02 66.02 06602 07P PHYSI CAL THERAPY 0 0 0 0 32, 481 2, 180, 143 66, 02 66.02 06602 07P PHYSI CAL THERAPY 0 0 0 0 32, 481 2, 180, 143 66, 02 66.02 06602 07P PHYSI CAL THERAPY 0 0 0 0 32, 481 2, 180, 143 66, 02 67.00 06700 05CUIPATI ONAL THERAPY 0 0 0 0 5, 461 12, 153 689, 701 68, 00 68.00 06800 SPEECH PATHOLOGY 197, 312 5, 029 50, 838 95, 092 2, 819, 038 69, 00 69.01 06901 CARDI AC REHAB 31, 155 222 712 6, 778 650, 431 69, 00 69.01 06901 CARDI AC REHAB 31, 155 222 712 6, 778 650, 431 69, 00 71.00 07000 ELECTROCARDI OLOGY 197, 312 5, 029 50, 838 95, 092 2, 819, 038 69, 00 71.00 07000 ELECTROCECPHALGGRAPHY 0 997 14, 971 38, 837 1, 390, 811 70, 01 71.00 07000 ELECTROCECPHALGGRAPHY 0 997 14, 971 38, 837 1, 390, 811 70, 01 71.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 3, 449 11, 041 12, 100 1, 168, 263 71, 00 71.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 12, 632, 757 72, 00 71.00 07200 DRUGS CHARGED TO PATI ENTS 218, 082 22, 727 315, 686 1, 183, 160 46, 131, 492 73, 00 71.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 13, 173 16, 327 18, 932 1, 643, 110 71.00 07200 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 0 71.00 07200 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 71.00 07200 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 0 71.00 07200 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 0 71.00 07200 DRUGS CHARGED TO PATI ENTS 0 0 0	59.00	05900 CARDI AC CATHETERI ZATI ON	353, 085	9, 535	147, 456	528, 571	17, 065, 714	59.00
66. 00 06500 RESPI RATORY THERAPY 145, 388 31, 180 50, 944 57, 947 5, 025, 165 65, 006 66. 00 06600 PHYSI CAL THERAPY 238, 852 718 50, 067 55, 329 2, 968, 578 66. 00 060 07			0					
66. 01 06600 PHYSICAL THERAPY			0	-				1
66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 0 66. 01 66. 02 06602 0/P PHYSI CAL THERAPY 0 0 715 0 32, 481 2, 180, 143 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 22, 942 36, 964 1, 657, 832 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 5, 461 12, 153 68. 00 06800 SPECH PATHOLOGY 0 0 0 5, 461 12, 153 689, 701 68. 00 06900 ELECTROCARDI OLOGY 197, 312 69. 00 06900 ELECTROCARDI OLOGY 197, 312 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 997 14, 971 38, 837 1, 390, 811 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATI ENTS 0 3, 449 11, 041 12, 100 1, 168, 263 71. 00 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 0 0 0 0 12, 632, 757 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 218, 082 22, 727 315, 666 1, 183, 160 46, 131, 492 76. 00 03020 RENAL ACUTE 0 13, 173 16, 327 18, 932 1, 643, 110 79. 0. 07 09000 LUI C 0 0 0 5 3, 803 269, 983 90. 00 79. 0. 09000 CLINI C 0 0 5 3, 803 269, 983 90. 00 79. 00 09000 CLINI C 0 16, 331 0 27, 751 1, 555, 957 90. 07 79. 00 09000 CLINI C 0 16, 331 0 27, 751 1, 555, 957 90. 07 79. 00 09000 DRIFICENCY 913, 867 163, 399 135, 923 594, 816 12, 171, 89 91. 00 79. 00 09000 SERVATI ON BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS 118. 00 NONEE IMBURSABLE COST CENTERS 0 0 0 0 0 0 0 79. 00 09000 GLINI EN SILVENCE COST CENTERS 0 0 0 0 0 0 79. 00 09000 01 01 02, 04 02, 04 02, 04 79. 00 07950 RURAL HEALTH 0 0 0 0 0 0 0 0 0 79. 00 07950 RURAL HEALTH 0 0 0 0 0 0 0 0 0 79. 00 07950 RURAL HEALTH 0 0 0 0 0 0 0 0 0 79. 00 07950 SURVAL HEALTH 0 0 0 0 0 0 0 0 0 79. 00 07950 SURVAL HEALTH 0 0 0 0 0 0 0 0 0 79. 00 07950 SURVAL HEALTH 0 0 0								
66.02 06602 0/P PHYSICAL THERAPY 0 715 0 32,481 2,180,143 66.02 67.00 06700 0CUPATI ONAL THERAPY 0 0 0 22,942 36,964 1,657,832 67.00 69.00 06800 SPEECH PATHOLOGY 0 0 5,461 12,153 689,701 68.00 69.00 06900 ELECTROCARDI OLOGY 197,312 5,029 50,838 95,092 2,819,038 69.00 69.01 CARDI AC REHAB 31,155 222 712 6,778 650,431 69.01 70.00 70.00 ELECTROCARDI OLOGY 0 997 14,971 38,837 1,390,811 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 3,449 11,041 12,100 1,168,263 71.00 72.00 07300 MPL. DEV. CHARGED TO PATIENTS 0 3,449 11,041 12,100 1,168,263 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 218,082 22,727 315,686 1,183,160 46,131,492 73.00 73.00 07300 RUGS CHARGED TO PATIENTS 218,082 22,727 315,686 1,183,160 46,131,492 73.00 70.0					·	33, 329		1
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69. 01 06901 CARDI AC REHAB 31, 155 222 712 6, 778 650, 431 69. 01 70. 00 7000 ELECTROENCEPHALOGRAPHY 0 997 14, 971 38, 837 1, 390, 811 70. 00 71. 00 7010 MEDIC ALL SUPPLIES CHARGED TO PATIENTS 0 3, 449 11, 041 12, 100 1, 168, 263 71. 00			-	-				
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90. 00	76.00	03020 RENAL ACUTE						
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90. 07 09007 WOUND CLINIC 0 16, 331 0 27, 751 1, 555, 957 90. 07 91. 00 09100 EMERGENCY 913, 867 163, 399 135, 923 594, 816 12, 171, 989 91. 00 92. 00 SERVATION BEDS (NON-DISTINCT PART) 0 92. 00 SERVATION BEDS (NON-DISTINCT PART) 0 92. 00 0920 093000 0930000 0930000 0930000 0930000 0930000 09300000 093000000 0930000000000			0		5			1
91. 00			0		0			1
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 92. 00 SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 11,610,269 1,399,369 2,422,283 6,230,243 316,865,781 118. 00 NONREI MBURSABLE COST CENTERS 190. 00			913 867		135 923			1
SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 11,610,269 1,399,369 2,422,283 6,230,243 316,865,781 118. 00 NONREI MBURSABLE COST CENTERS			710,007	.00,077	100,720	371,313		
NONRE MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190. 00 194. 00 07950 RURAL HEALTH 0 2,943 0 0 3,741,227 194. 00 194. 01 07951 RENTAL PROPERTY 0 0 0 0 173, 661 194. 01 194. 02 07954 FAMI LY PRACTI CE 0 13 0 0 4,522, 204 194. 02 194. 03 07952 WELLNESS 0 0 0 844, 925 194. 03 194. 04 07955 PHYSI CI AN PRACTI CES 20,770 5,240 0 0 13, 121, 712 194. 04 194. 06 07953 SYCAMORE SPORTS MED 0 0 0 135, 296 194. 06								
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190. 00 194. 00 07950 RURAL HEALTH 0 2, 943 0 0 3, 741, 227 194. 00 194. 01 07951 RENTAL PROPERTY 0 0 0 0 173, 661 194. 01 194. 02 07954 FAMILY PRACTICE 0 13 0 0 4, 522, 204 194. 02 194. 03 07952 WELLNESS 0 0 0 844, 925 194. 03 194. 04 07955 PHYSI CI AN PRACTICES 20, 770 5, 240 0 0 13, 121, 712 194. 04 194. 06 07953 SYCAMORE SPORTS MED 0 0 0 135, 296 194. 06	118.00	, ,	11, 610, 269	1, 399, 369	2, 422, 283	6, 230, 243	316, 865, 781	118. 00
194. 00 07950 RURAL HEALTH 0 2, 943 0 0 3, 741, 227 194. 00 194. 01 07951 RENTAL PROPERTY 0 0 0 0 173, 661 194. 01 194. 02 07954 FAMI LY PRACTICE 0 13 0 0 4, 522, 204 194. 02 194. 03 07952 WELLNESS 0 0 0 844, 925 194. 03 194. 04 07955 PHYSI CI AN PRACTI CES 20, 770 5, 240 0 0 13, 121, 712 194. 04 194. 06 07953 SYCAMORE SPORTS MED 0 0 0 135, 296 194. 06	100 00		ما	ما	0		^	100 00
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194. 02 07954 FAMILY PRACTICE 0 13 0 0 4, 522, 204 194. 02 194. 03 07952 WELLNESS 0 0 0 0 844, 925 194. 03 194. 04 07955 PHYSI CI AN PRACTICES 20, 770 5, 240 0 0 13, 121, 712 194. 04 194. 06 07953 SYCAMORE SPORTS MED 0 0 0 135, 296 194. 06			o	2, 743	0			1
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194.06 07953 SYCAMORE SPORTS MED 0 0 0 135, 296 194.06			О	O	0	0		
			20, 770		0	0		1
194. U/U/930 P31CHIAIRIC/P31CHULUGICAL SERVICES 41, 339 41 U U 563, 868 194. U/			41 530	-	_	-		
	174.07	107730 1 31011 ATM 0/F310110L001 CAL 3ERVI CES	41, 039	41	0	<u>ı</u> 0	503, 608	1174.07

Health Financial Systems	UNI ON HOSPI	TAL, INC.		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der Co		From 01/01/2016		
				To 12/31/2016	Date/Time Pre 11/12/2018 4:	
Cost Center Description	DATA PROCESSI NG	PURCHASING RECEIVING AND	ADMITTI NG	CASHI ERI NG/AC COUNTS	Subtotal	

						11/12/2018 4:	13 pm
	Cost Center Description	DATA	PURCHASI NG	ADMITTI NG	CASHI ERI NG/AC	Subtotal	
		PROCESSI NG	RECEIVING AND		COUNTS		
			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	0	0	0	201.00
202. 00	TOTAL (sum lines 118 through 201)	11, 672, 578	1, 407, 606	2, 422, 283	6, 230, 243	339, 968, 674	202.00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2016 Part I
To 12/31/2016 Date/Time Prepared:
11/12/2018 4:13 pm

2 00 00200 KER CAP REL COSTS-MAREL EQUIP 4 00 00MOS LINE THE THE FINDERS 5 01 00-600 (MINNEY) THE THE FINDERS 5 01 00-600 (MINNEY) THE THE FINDERS 5 02 00-600 (MINNEY) THE THE FINDERS 5 03 00-600 (MINNEY) THE THE FINDERS 5 04 00-600 (MINNEY) THE THE FINDERS 5 05 00-600 (MINNEY) THE THE FINDERS 5 06 00-600 (MINNEY) THE THE FINDERS 5 06 00-600 (MINNEY) THE THE FINDERS 5 07 00-600 (MINNEY) THE THE FINDERS 5 08 00-600 (MINNEY) THE THE FINDERS 5 09 00-600 (MINNEY) THE THE FINDERS 5 09 00-600 (MINNEY) THE THE FINDERS 5 09 00-600 (MINNEY) THE THE FINDERS 6 00-600 (MINNEY) THE						12/31/2010	11/12/2018 4:	
		Cost Center Description				HOUSEKEEPI NG	DI ETARY	
EXPERIENCE SERVICE COST CENTERS 1. 00 00100 MEN CAR PEL COSTS-MULE CENT 2. 0 1. 00 00100 MEN CAR PEL COSTS-MULE CENT 2. 0 1. 00 00100 MEN CAR PEL COSTS-MULE CENT 2. 0 1. 00 00100 MEN CAR PEL COSTS-MULE CENT 2. 0 1. 00 00100 MEN CAR PEL COSTS-MULE CENT 2. 0 1. 00 00100 MEN CAR PEL COSTS-MULE CENT 2. 0 1. 00 00100 MEN CAR PEL COSTS-MULE CENT 2. 0 1. 00 00100 MEN CAR PEL COSTS-MULE CENT 2. 0 1. 00 00100 MEN CAR PEL COSTS-MULE 2. 0 1. 00 00100 MEN CAR PEL COSTS MEN CHARLES 3. 0 1. 00 00100 MEN CAR PEL COSTS MEN CHARLES 3. 0 1. 00 00100 MEN CAR PEL COSTS MEN CHARLES 3. 0 1. 00 00100 MEN CAR PEL COSTS MEN CHARLES 3. 0 1. 00 00100 MEN CAR PEL COSTS MEN CHARLES 3. 0 1. 00 00100 MEN CAR PEL COSTS MEN CHARLES 3. 0 1. 00 00100 MEN CAR PEL COSTS MEN CHARLES 3. 0 1. 00 00100 MEN CAR PEL COSTS MEN CHARLES 3. 0 1. 00 00100 MEN CAR PEL COSTS MEN CHARLES 3. 0 1. 00 00100 MEN CAR PEL COSTS MEN CHARLES 3. 0 1. 00 00100 MEN CAR PEL COSTS CHARLES 3. 0 1. 00 00100 MEN CAR PEL COST						9 00	10.00	
1.00 00000 IMPLICATES - BILLE & FIXT		GENERAL SERVICE COST CENTERS	5. 00	7.00	8.00	9.00	10.00	
0.000 DIPLOYER BEREFITS DEPARTEINT	1.00							1.00
5.01 0.0540 MOREAT ITELEPHONES	2.00							2.00
0.0050 OATA PROCESSING	4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 03 00660 PURCHASH NO. RECELVING AND STORES 5.00 00070 000	5. 01	00540 NONPATIENT TELEPHONES						5. 01
5.00 DOSPO (CASH ICEN INSTACCOUNTS RECEIVABLE 5.00 DOSPO (CHIEF RADIA CONTINUE) 7.7 1.428 5.11 18.663 4.604 7.7 1.428 5.11 18.663 4.604 7.7 1.428 5.11 18.663 4.604 7.7 1.428 5.11 18.663 4.604 7.7 1.428 5.11	5. 02	00550 DATA PROCESSING						5. 02
5.0 OGSHO CASHIFER INK-/ACCIDINTS RECEIVABLE 26,009,227 7.00 OTFO OFTER ADMIN AND GERBAL 26,009,227 7.00 OTFO OFTER ADMIN AND GERBAL 26,009,227 7.00 OTFO OFTER ADMIN AND GERBAL 26,009,227 7.00 0.00 OFTER ADMIN AND GERBAL 26,009,227 7.00 0.00 OTFO OFTER ADMIN AND GERBAL 26,009,227 7.00 0.00								5. 03
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9.00 00900 HOUSEKEEPING 314, 696 104, 150 129, 392 4, 404, 979 9. 11.00 01000 DITEARY 378, 373 339, 114 9, 609 0 15, 201 0110 11.00 01000 DITEARY 90, 609 0 58, 201 0 11, 201 11.00 01000 MIRSI NA ADMINISTRATION 90, 606 73, 409 0 58, 201 0 17, 656 0 13, 300 130 0 1000 MIRSI NA ADMINISTRATION 90, 606 73, 409 0 77, 656 0 13, 300 1000 MIRSI NA ADMINISTRATION 90, 606 73, 409 0 77, 656 0 13, 300 1000 MIRSI NA ADMINISTRATION 90, 606 73, 409 0 77, 656 0 13, 300 1000 MIRSI NA ADMINISTRATION 90, 600 10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 1						7.00
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13.00 01300 NURSING ADMINISTRATION 299, 606 73, 409 0 17, 656 0 13.								11.00
16. 00 01600 MEDICAL RECORDS & LIBRARY 390, 433 163, 223 0 39, 259 0 16.			-					13.00
17.00 01700 SOCIAL SERVICE 0 0 0 0 0 0 0 0 0								16.00
22.00 02700 ARS SERVICES-SALARY & FRINCES APPRVD 151, 163 0 0 0 0 0 0 22.		1 1	370, 1 33	103, 223	1	07, 237		17.00
22.00 02200 IAR SERVICES-OTHER PROM COSTS APPRVO 218, 163 0 0 0 0 0 23. 23.01 02341 OTHER MED ED 29, 377 22, 248 0 0 5, 350 0 23. 10 10 10 10 10 10 10			151 163	0	0	0		21.00
23. 00 02300 PARMED ED PREM 21,006 0 0 0 0 0 0 0 23. 31 32. 301 02310 OTHER MED ED 29,377 22,245 0 5,550 0 23. 31. 00 0300 AURITS & PEDIATRIC S 3,679,005 5,809,861 559,012 1,397,399 4,015,892 31. 00 0300 AURITS & PEDIATRIC S 3,679,005 5,809,861 559,012 1,397,399 4,015,892 31. 00 0300 AURITS & PEDIATRIC S 30. 00 2300 AURITS & PEDIATRIC S 290,074 88,980 90,000 21,402 298,892 35. 41. 00 04100 SUBPROVI DER - 1 RF 206,386 457,909 15,417 110,137 041. 41. 30. 04300 MINESTEY 290,000 12,417,298 20. 29,182 0. 30. 41. 00 04100 SUBPROVI DER - 1 RF 206,386 457,909 15,417 110,137 041. 41. 43. 00 4300 MINESTEY 290,193 44. 051 1,258,547 115,851 302,708 0. 50. 00 SOOO OPERATING ROOM 1,344,051 1,258,547 15,417 223,143 0. 50. 00 SOOO OPERATING ROOM 1,079,905 927,744 135,174 223,143 0. 50. 01. 0500 WNSC 10,079,905 927,744 135,174 223,143 0. 50. 01. 0500 WNSC 200,000 WNSC 200,000 WNSC 200,000 WNSC 200,000 WNSC 200,000 200,0				0	0	0		22.00
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30.00 03000 ADULTS & PEDIATRICS 3, 679, 005 5, 809, 801 559, 012 1, 397, 399 4, 015, 882 30, 300 3310 01500 NITEMSIVE CAME UNIT 871, 521 710, 298 102, 918 170, 842 682, 288 31, 35, 00 02040 INTEMSIVE NURSERY 290, 074 88, 980 9, 000 21, 402 298, 882 35, 410, 00 410, 00 9100 SUBPROVIDER - IRF 206, 386 467, 900 161, 101, 137 04, 11, 430 04, 100 04300 NURSERY 138, 364 121, 328 0 29, 182 0 43, 43, 44, 44, 45, 45, 45, 45, 45, 45, 46, 46, 46, 46, 46, 46, 46, 46, 46, 46	23. 01			22, 245	0	5, 350	0	23. 01
33.00 03100 INTERSIVE CARE UNIT 871, 521 710, 298 102, 918 170, 842 682, 298 81 83.00 0200 INTERSIVE VUNISERY 290, 074 88, 980 9,000 21, 402 298, 882 35 41.00 04100 SUBPROVI DER - IRF 206, 386 457, 999 15, 417 110, 137 041, 430 041,		INPATIENT ROUTINE SERVICE COST CENTERS						
35.00	30.00	03000 ADULTS & PEDIATRICS	3, 679, 005	5, 809, 861	559, 012	1, 397, 399	4, 015, 882	30.00
41.00 04100 SUBPROVI DER - IRF 206, 386 457, 909 15, 417 110, 137 0 41. 43.00 04300 NURSERY 138, 364 121, 328 0 29, 182 0 43. ANCILLARY SERVICE COST CENTERS	31.00	03100 INTENSIVE CARE UNIT	871, 521	710, 298	102, 918	170, 842	682, 258	31.00
ABOOD QASOON QASENTICE COST CENTERS ABOOD AB	35.00	02040 I NTENSI VE NURSERY	290, 074	88, 980	9, 000	21, 402	298, 882	35.00
ANCILLARY SERVICE COST CENTERS	41.00	04100 SUBPROVI DER - I RF	206, 386	457, 909	15, 417			41.00
50.00 0500	43.00		138, 364	121, 328	0	29, 182	0	43.00
50.01 GDD1 CARDI AC SURGERY 229, 793 55, 613 96 13, 376 0 50. 02 50.02 WSC 1, 079, 905 927, 744 135, 174 223, 143 0 50. 50. 02 50.00 EDD0 WSC 10, 641 0 51. 100 10, 641 0 51. 100 10, 641 0 51. 100 10, 641 0 51. 100 10, 641 0 51. 100 10, 641 0 10, 641 0 51. 100 10, 641 0 51. 100 10, 641 0 51. 100 10, 641 0 51. 100 10, 641 0 10, 641								
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51.00								50. 01
51.02 05101 OPT TREATMENT ROOM 320, 726 659, 443 58, 938 158, 611 352, 017 51. 52. 00 50200 DELI VERY ROOM & LABOR ROOM 487, 385 642, 790 81, 724 154, 605 17 52. 54. 00 05400 RADI OLOGY-DI ACNOSTI C 848, 087 1, 008, 289 54, 835 242, 516 0 54. 55. 00 05500 RADI OLOGY-THERAPEUTI C 529, 072 815, 437 29, 518 196, 130 0 55. 56. 00 05600 RADI OLOGY-THERAPEUTI C 529, 072 815, 437 29, 518 196, 130 0 55. 56. 00 05600 RADI OLOGY-THERAPEUTI C 529, 072 815, 437 29, 518 196, 130 0 55. 56. 00 05600 RADI OLOGY-THERAPEUTI C 529, 072 815, 437 29, 518 196, 130 0 55. 56. 00 05600 RADI OLOGY-THERAPEUTI C 529, 072 815, 437 29, 518 196, 130 0 55. 56. 00 05600 RADI OLOGY-THERAPEUTI C 529, 072 815, 437 29, 518 196, 130 0 57. 58. 00 05800 MAGNETI C RESONANCE IMAGI NG (MRI) 155, 278 80, 113 58, 947 19, 269 0 58. 59. 00 05900 CARDI ACC CATHETERI ZATI ON 1, 414, 492 515, 777 16, 919 124, 056 24, 531 59. 60. 00 0 0 0 0 0 0 0 0							_	50.02
52.00 05200 DELIVERY ROOM & LABOR ROOM 487, 385 642, 790 811, 724 154, 605 117 52, 540 00 5000 RADIO CY-DI AGNOSTI C 848, 087 1, 008, 289 54, 835 242, 516 00 54, 550 00 00 00 00 00 00 00		1 1						
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66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 0 66. 66. 02 06602 0/P PHYSI CAL THERAPY 180, 701 0 31, 614 0 0 66. 67. 00 06700 00 00 00 00 00 0	65.00	06500 RESPI RATORY THERAPY	416, 511	65, 932	0	15, 858	0	65.00
66. 02 06602 0/P PHYSICAL THERAPY 180, 701 0 31, 614 0 0 66. 67. 00 06700 0CCUPATI ONAL THERAPY 137, 409 51, 225 0 12, 321 0 67. 68. 00 06800 SPECH PATHOLOGY 57, 166 101, 586 0 24, 434 0 68. 69. 00 06900 ELECTROCARDI OLOGY 233, 656 40, 319 10, 443 9, 698 0 69. 69. 01 06901 CARDI AC REHAB 53, 911 222, 451 749 53, 504 0 69. 70. 00 07000 ELECTROENCEPHALOGRAPHY 115, 277 46, 498 3, 144 111, 184 0 70. 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 96, 831 176, 478 0 42, 447 0 71. 72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 1, 047, 066 0 0 0 0 0 72. 73. 00 07300 DRUGS CHARGED TO PATIENTS 3, 823, 692 396, 766 0 95, 431 0 73. 76. 00 03020 RENAL ACUTE 136, 189 108, 908 9, 031 26, 195 0 76. 0UTPATIENT SERVICE COST CENTERS 90. 00 09000 CLI NI C 22, 378 6, 735 0 1, 620 0 90. 90. 07 09007 WOUND CLI NI C 128, 965 120, 463 19, 022 28, 974 0 90. 91. 00 09100 EMERGENCY 1, 008, 875 743, 696 252, 430 178, 875 0 91. 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 24, 184, 343 16, 996, 912 1, 795, 917 4, 004, 150 5, 373, 687 118. 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 24, 184, 343 16, 996, 912 1, 795, 917 4, 004, 150 5, 373, 687 118. 190. 00 19000 GIFT, ELOWER, COFFEE SHOP & CANTEEN 0 0 1, 427 0 0 194. 194. 01 07951 RENTAL PROPERTY 14, 394 0 0 0 0 0 0 1994.	66.00	06600 PHYSI CAL THERAPY	246, 051	313, 594	15, 594	75, 426	0	66.00
67. 00	66. 01		0	0	0	0	_	66. 01
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70. 00 07000 ELECTROENCEPHALOGRAPHY 115, 277 46, 498 3, 144 11, 184 0 70. 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 96, 831 176, 478 0 42, 447 0 71. 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 1, 047, 066 0 0 0 0 0 72. 73. 00 07300 DRUGS CHARGED TO PATI ENTS 3, 823, 692 396, 766 0 95, 431 0 73. 76. 00 03020 RENAL ACUTE 136, 189 108, 908 9, 031 26, 195 0 76. 00 00000 CLI NI C 22, 378 6, 735 0 1, 620 0 90. 90. 00 09000 CLI NI C 22, 378 59, 629 0 14, 342 0 90. 90. 00 09000 EMERGENCY 1, 28, 965 120, 463 19, 022 28, 974 0 90. 90. 00 09100 EMERGENCY 1, 008, 875 743, 696 252, 430 178, 875 0 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) SPECI AL PURPOSE COST CENTERS 18. 00 SUBTOTALS (SUM OF LI NES 1 through 117) 24, 184, 343 16, 996, 912 1, 795, 917 4, 004, 150 5, 373, 687 118. 00 19000 GI FT., FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 194. 01 07951 RENTAL PROPERTY 14, 394 0 0 0 0 0 194.								69.00
71. 00		l I						69. 01
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OUTPATIENT SERVICE COST CENTERS OUTPATIENT SUBJECT CONTEST OUTPATIENT SERVICE COST CENTERS OUTPATIENT SUBJECT COST CENTERS OUTPATIEN								76.00
90. 00 09000 CLINIC 22, 378 6, 735 0 1, 620 0 90. 90. 90. 05 09005 PATIENT NUTRITION 37, 318 59, 629 0 14, 342 0 90. 90. 90. 07 09007 WOUND CLINIC 128, 965 120, 463 19, 022 28, 974 0 90. 91. 00 09100 EMERGENCY 1, 008, 875 743, 696 252, 430 178, 875 0 91. 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.	70.00		130, 104	100, 700	7,031	20, 175	U	70.00
90. 05	90 00		22 378	6 735	1 0	1 620	0	90.00
90. 07 09007 WOUND CLINIC 128, 965 120, 463 19, 022 28, 974 0 90.								90.05
91. 00 09100 EMERGENCY 1, 008, 875 743, 696 252, 430 178, 875 0 91. 92. 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 92. SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 24, 184, 343 16, 996, 912 1, 795, 917 4, 004, 150 5, 373, 687 118. 118. 10 10 10 10 10 10 10 1								90.07
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 92. SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 24, 184, 343 16, 996, 912 1, 795, 917 4, 004, 150 5, 373, 687 118. NONREI MBURSABLE COST CENTERS 100. 00 1900		1 1						91.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 24, 184, 343 16, 996, 912 1, 795, 917 4, 004, 150 5, 373, 687 118.			, , .	,	,	, , ,		92.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190. 190. 194. 00 07950 RURAL HEALTH 310, 092 0 1, 427 0 0 194. 194. 01 07951 RENTAL PROPERTY 14, 394 0 0 0 0 194.								
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190. 190. 194. 00 07950 RURAL HEALTH 310, 092 0 1, 427 0 0 194. 194. 01 07951 RENTAL PROPERTY 14, 394 0 0 0 0 194.	118.00	SUBTOTALS (SUM OF LINES 1 through 117)	24, 184, 343	16, 996, 912	1, 795, 917	4, 004, 150	5, 373, 687	118.00
194. 00 07950 RURAL HEALTH 310, 092 0 1, 427 0 0 194. 01 07951 RENTAL PROPERTY 14, 394 0 0 0 0 194.		NONREI MBURSABLE COST CENTERS						
194. 01 07951 RENTAL PROPERTY 14, 394 0 0 0 0 194.	190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
			310, 092	0	1, 427	0		194. 00
				0	0	0		194. 01
		07954 FAMILY PRACTICE	374, 823	1, 145, 344				194. 02
				432, 605		104, 051		194. 03
				0		0		194.04
				0		0		194.06
194. 07 07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 46, 736 88, 548 0 21, 298 0 194.	194. 07	U/956 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES	46, 736	88, 548	0	21, 298	0	194. 07
200.00 Cross Foot Adjustments 200.	200.00				<u> </u>			200. 00

Heal th Fina	ncial Systems	UNION HOSPITAL, INC.			In Lieu of Form CMS-2552-10			
COST ALLOCA	TION - GENERAL SERVICE COSTS		Provi der Co	CN: 15-0023	Peri od:	Worksheet B		
					From 01/01/2016	Part I		
					To 12/31/2016	Date/Time Pre		
						11/12/2018 4:	13 pm	
	Cost Center Description	OTHER ADMIN	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY		
		AND GENERAL	PLANT	LINEN SERVICE				
		5. 06	7. 00	8. 00	9. 00	10.00		
201.00	Negative Cost Centers	0	0		0 0	0	201.00	
202.00	TOTAL (sum lines 118 through 201)	26, 099, 227	18, 663, 409	1, 805, 93	9 4, 404, 979	5, 373, 687	202.00	

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS | Peri od: | Worksheet B | From 01/01/2016 | Part I | To 12/31/2016 | Date/Time Prepared: Provider CCN: 15-0023

			То	12/31/2016	Date/Time Pre	
					INTERNS &	
Cost Center Description	CAFETERI A	NURSI NG	MEDI CAL	SOCI AL	RESI DENTS SERVI CES-SALA	
cost center bescription	CALLIENIA	ADMI NI STRATI O	RECORDS &	SERVI CE	RY & FRI NGES	
		N	LI BRARY			
GENERAL SERVICE COST CENTERS	11. 00	13. 00	16. 00	17. 00	21. 00	
1. 00 O0100 NEW CAP REL COSTS-BLDG & FLXT						1.00
2. 00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01 00540 NONPATI ENT TELEPHONES 5. 02 00550 DATA PROCESSI NG						5. 01 5. 02
5. 03 00560 PURCHASING RECEIVING AND STORES						5. 03
5. 04 00570 ADMI TTI NG						5. 04
5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5. 06 00590 OTHER ADMIN AND GENERAL 7. 00 00700 OPERATION OF PLANT						5. 06 7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY	714 170					10.00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	-714, 170					11. 00 13. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY		0				16.00
17. 00 01700 SOCI AL SERVI CE	0	0	0	0	l l	17. 00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0		1
22.00 02200 1&R SERVICES-OTHER PRGM COSTS APPRVD 23.00 02300 PARAMED ED PRGM		0	0	0	1	22. 00 23. 00
23. 01 02341 OTHER MED ED	0	13, 256		0	l	23. 01
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	.,,		0	1	1
31. 00 03100 I NTENSI VE CARE UNI T 35. 00 02040 I NTENSI VE NURSERY		372, 651 126, 672	102, 578 61, 761	0	1	
41. 00 04100 SUBPROVI DER - I RF		108, 506		Ö		
43. 00 04300 NURSERY	0	82, 975	21, 292	0	0	43.00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	1 0	265, 618	681, 787	0	84, 922	50.00
50. 00 05000 OPERATTING ROOM 50. 01 05001 CARDI AC SURGERY		24, 058		0	1	1
50. 02 05002 WVSC	0	0		0	1	1
51. 00 05100 RECOVERY ROOM	0	110, 470		0	1	51.00
51. 02 05101 0/P TREATMENT ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	179, 697 211, 120		0	1	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		211, 120	218, 741	0		1
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	157, 229	0		1
56. 00 05600 RADI OI SOTOPE	0	0	36, 596	0	1	56.00
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	233, 399 55, 662	0	1	1
59. 00 05900 CARDI AC CATHETERI ZATI ON		Ö	449, 972	0	1	
60. 00 06000 LABORATORY	0	0	374, 389	0	0	1
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	100 400	13, 057	0	1	
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY		190, 499	49, 330 47, 101	0	29, 624	65. 00 66. 00
66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	Ö	0	0		1
66. 02 06602 0/P PHYSI CAL THERAPY	0	0	27, 651	0		66. 02
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	0	31, 467	0	0	1
69. 00 06900 SPEECH PATHOLOGY		0	10, 346 80, 952	0	0 1, 975	1
69. 01 06901 CARDI AC REHAB	0	0	5, 770	0	0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	33, 062	0	5, 925	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 MPL. DEV. CHARGED TO PATIENTS	0	0	10, 301	0	0	1
73. 00 07300 DRUGS CHARGED TO PATIENTS		177, 242		0	l I	1
76. 00 03020 RENAL ACUTE	0	0		0		1
OUTPATIENT SERVICE COST CENTERS	1	0.000	2 222		200 000	00.00
90. 00 09000 CLINIC 90. 05 09005 PATIENT NUTRITION	0	9, 820 22, 585		0		1
90. 07 09007 WOUND CLINIC		25, 531		0		1
91. 00 09100 EMERGENCY	0	404, 074		0		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	4, 005, 385	5, 303, 450	0	1, 757, 687	118 00
NONREI MBURSABLE COST CENTERS		1, 000, 300	0, 505, 450		1,757,007	1.10.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	_		0		190. 00
194. 00 07950 RURAL HEALTH	0	0	T.	0	1	194.00
194. 01 07951 RENTAL PROPERTY 194. 02 07954 FAMI LY PRACTI CE		0	0	0		194. 01 194. 02
194. 03 07952 WELLNESS	0	Ö	0	Ö	0	194. 03
194. 04 07955 PHYSI CI AN PRACTI CES	0	0	0	0	0	194. 04

Health Financial Systems	UNION HOSPITAL, INC.			In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CC		Peri od: From 01/01/2016	Worksheet B Part I		
				To 12/31/2016	Date/Time Pre 11/12/2018 4:	pared: 13 pm	
					INTERNS &		
					RESI DENTS		
Cost Center Description	CAFETERI A	NURSI NG	MEDI CAL	SOCI AL	SERVI CES-SALA		
		ADMI NI STRATI O	RECORDS &	SERVI CE	RY & FRINGES		
		N	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	0	0		0	0	194. 07	
200.00 Cross Foot Adjustments					0	200.00	
201.00 Negative Cost Centers	-714, 170	o		0	0	201.00	
202.00 TOTAL (sum lines 118 through 201)	-714, 170	4, 005, 385	5, 303, 45	50 0	1, 974, 929	202. 00	

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0023 Peri od: Worksheet B From 01/01/2016 Part I Date/Time Prepared: 12/31/2016 11/12/2018 4:13 pm INTERNS & **RESI DENTS** SERVI CES-OTHE PARAMED ED OTHER MED ED Subtotal Intern & Cost Center Description R PRGM COSTS Residents PRGM Cost & Post Stepdown Adjustments 22. 00 23. 00 23. 01 24.00 25.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00540 NONPATIENT TELEPHONES 5.01 5.01 5.02 00550 DATA PROCESSING 5.02 5.03 00560 PURCHASING RECEIVING AND STORES 5.03 00570 ADMITTING 5 04 5 04 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.05 5.05 5.06 00590 OTHER ADMIN AND GENERAL 5.06 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8 00 8 00 00900 HOUSEKEEPI NG 9.00 9.00 01000 DI ETARY 10.00 10.00 01100 CAFETERI A 11.00 11.00 01300 NURSING ADMINISTRATION 13 00 13 00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 17.00 01700 SOCIAL SERVICE 17.00 02100 | &R SERVICES-SALARY & FRINGES APPRVD 21 00 21.00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 2, 850, 274 22.00 274, 441 02300 PARAMED ED PRGM 23.00 23.00 23.01 02341 OTHER MED ED 424.653 23.01 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 1,046,050 63, 706, 140 -1, 770, 847 30.00 0 03100 INTENSIVE CARE UNIT 0 13, 527, 883 31.00 0 31.00 02040 INTENSIVE NURSERY 0 4, 439, 917 35.00 25, 652 0 -43, 426 35.00 04100 SUBPROVI DER - I RF 0 3, 403, 100 41.00 0 0 41.00 43.00 04300 NURSERY 0 2, 062, 487 43.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 122, 562 0 20, 391, 904 -207.484 50.00 05001 CARDI AC SURGERY 0 50.01 C 3.144.871 Λ 50.01 05002 WVSC 15, 825, 560 50.02 50.02 0 0 05100 RECOVERY ROOM 51.00 0 0 0 2, 806, 866 0 51.00 05101 0/P TREATMENT ROOM 0 5, 641, 016 51.02 0 0 0 51.02 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 279, 327 8, 010, 616 -472, 870 52.00 42, 754 54.00 05400 RADI OLOGY-DI AGNOSTI C 274.441 12, 951, 383 -72, 378 54.00 05500 RADI OLOGY-THERAPEUTI C 19, 952 8, 144, 374 -33, 777 55.00 55.00 05600 RADI OI SOTOPE 0 56,00 0 C 1, 744, 285 Ω 56,00 57.00 05700 CT SCAN 0 C 3, 612, 776 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 2, 242, 683 0 58.00 05900 CARDIAC CATHETERIZATION 0 59.00 14.251 0 19, 635, 587 -24, 126 59.00 06000 LABORATORY 0 60.00 11, 018, 648 Ω 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 1, 435, 721 62.00 06500 RESPIRATORY THERAPY 42, 754 0 5, 835, 673 -72, 378 65.00 65.00 06600 PHYSI CAL THERAPY 0 66.00 2,850 3, 671, 169 -4, 825 66.00 66.01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 66.01 06602 0/P PHYSICAL THERAPY 2, 574, 516 66.02 91, 209 -154, 407 66.02 06700 OCCUPATIONAL THERAPY 1, 890, 254 67.00 0 67.00 06800 SPEECH PATHOLOGY 68.00 883, 233 68.00 69.00 06900 ELECTROCARDI OLOGY 2,850 3, 198, 931 -4,825 69.00 69.01 06901 CARDI AC REHAB 986, 816 69.01 70 00 07000 ELECTROENCEPHALOGRAPHY 0 1, 614, 452 -14, 476 70 00 8 551 Ω 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 C 1, 494, 320 0 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 0 13, 679, 823 72.00 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 39, 904 0 424, 653 52, 123, 698 -67, 553 73.00 03020 RENAL ACUTE 1, 939, 550 76.00 0 0 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 0 0 1, 066, 506 -752, 732 90.00 09000 CLI NI C 444, 643 90.05 90.05 09005 PATIENT NUTRITION 5.701 0 0 594, 671 -9.651 90.07 1.984,565 09007 WOUND CLINIC 0 -82, 029 90 07 48, 455 C 91.00 09100 EMERGENCY 299, 279 0 15, 772, 953 -506, 647 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 SPECIAL PURPOSE COST CENTERS
SUBTOTALS (SUM OF LINES 1 through 117) 2, 536, 744 118.00 274, 441 424, 653 313, 056, 947 -4, 294, 431 118. 00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 194.00 07950 RURAL HEALTH 0 0 190 00 0 4, 052, 746 0 194, 00 0 0 194. 01 07951 RENTAL PROPERTY 0 0 188, 055 0 194. 01 194. 02 07954 FAMILY PRACTICE 313, 530 0 6, 850, 526 -530, 772 194. 02

Health Financial Systems	UNI ON HOSPI	TAL, INC.		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der C	CN: 15-0023	Peri od:	Worksheet B	
				From 01/01/2016 To 12/31/2016		nared:
				10 12/31/2010	11/12/2018 4:	13 pm
	INTERNS &					
	RESI DENTS					
Cost Center Description	SERVI CES-OTHE	PARAMED ED	OTHER MED E	Subtotal	Intern &	
	R PRGM COSTS	PRGM			Resi dents	
					Cost & Post	
					Stepdown	
					Adjustments	
	22. 00	23. 00	23. 01	24. 00	25. 00	
194. 03 07952 WELLNESS	0	0		0 1, 451, 613	0	194. 03
194. 04 07955 PHYSICIAN PRACTICES	0	0		0 14, 215, 997	0	194. 04
194.06 07953 SYCAMORE SPORTS MED	0	0		0 146, 510	0	194.06
194. 07 07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 720, 450	0	194. 07
200.00 Cross Foot Adjustments	0	0		0 0	0	200.00
201.00 Negative Cost Centers	0	0		0 -714, 170	0	201.00
202.00 TOTAL (sum lines 118 through 201)	2, 850, 274	274, 441	424, 6	339, 968, 674	-4, 825, 203	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS UNION HOSPITAL, INC.

| In Lieu of Form CMS-2552-10 | Period: Worksheet B | From 01/01/2016 | Part | | To 12/31/2016 | Date/Time Prepared: 11/12/2018 4: 13 pm Provider CCN: 15-0023

			11/12/2018 4:	13 pm
	Cost Center Description	Total		
		26. 00		
GENEI	RAL SERVICE COST CENTERS			
	O NEW CAP REL COSTS-BLDG & FIXT			1.00
	NEW CAP REL COSTS-MVBLE EQUIP			2. 00
	O EMPLOYEE BENEFITS DEPARTMENT			4.00
	O NONPATI ENT TELEPHONES			5. 01
	D DATA PROCESSING			5. 02
	1			5. 02
•	O PURCHASING RECEIVING AND STORES			•
	O ADMITTING			5. 04
	O CASHI ERI NG/ACCOUNTS RECEI VABLE			5. 05
	OOTHER ADMIN AND GENERAL			5. 06
7. 00 0070	O OPERATION OF PLANT			7. 00
8.00 0080	O LAUNDRY & LINEN SERVICE			8. 00
9.00 0090	O HOUSEKEEPI NG			9. 00
10.00 0100	O DI ETARY			10.00
11.00 0110	O CAFETERI A			11.00
	O NURSING ADMINISTRATION			13.00
	O MEDICAL RECORDS & LIBRARY			16.00
	O SOCIAL SERVICE			17. 00
	0 &R SERVICES-SALARY & FRINGES APPRVD			21. 00
	O I &R SERVICES-OTHER PRGM COSTS APPRVD			22.00
	O PARAMED ED PRGM			23. 00
	1 OTHER MED ED			23. 01
	TIENT ROUTINE SERVICE COST CENTERS			
30.00 0300	O ADULTS & PEDIATRICS	61, 935, 293		30.00
31.00 0310	O INTENSIVE CARE UNIT	13, 527, 883		31.00
35. 00 0204	O I NTENSI VE NURSERY	4, 396, 491		35.00
	O SUBPROVI DER - I RF	3, 403, 100		41.00
	O NURSERY	2, 062, 487		43.00
	LLARY SERVICE COST CENTERS	2,002,407		43.00
	O OPERATING ROOM	20, 184, 420		50.00
				1
	1 CARDI AC SURGERY	3, 144, 871		50. 01
	2 WVSC	15, 825, 560		50. 02
	O RECOVERY ROOM	2, 806, 866		51.00
51. 02 0510	1 O/P TREATMENT ROOM	5, 641, 016		51.02
52.00 0520	O DELIVERY ROOM & LABOR ROOM	7, 537, 746		52.00
54.00 0540	O RADI OLOGY-DI AGNOSTI C	12, 879, 005		54.00
	O RADI OLOGY-THERAPEUTI C	8, 110, 597		55.00
	O RADI OI SOTOPE	1, 744, 285		56.00
	O CT SCAN	3, 612, 776		57.00
	O MAGNETIC RESONANCE IMAGING (MRI)	2, 242, 683		58.00
	1			•
	O CARDI AC CATHETERI ZATI ON	19, 611, 461		59.00
	O LABORATORY	11, 018, 648		60.00
	O WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 435, 721		62. 00
	O RESPI RATORY THERAPY	5, 763, 295		65. 00
66. 00 0660	O PHYSI CAL THERAPY	3, 666, 344		66. 00
66. 01 0660	1 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0		66. 01
66. 02 0660	2 O/P PHYSICAL THERAPY	2, 420, 109		66. 02
67. 00 0670	O OCCUPATI ONAL THERAPY	1, 890, 254		67.00
	O SPEECH PATHOLOGY	883, 233		68.00
1	O ELECTROCARDI OLOGY	3, 194, 106		69.00
	1 CARDI AC REHAB	986, 816		69. 01
	O ELECTROENCEPHALOGRAPHY	1, 599, 976		70.00
		1, 494, 320		
	O MEDICAL SUPPLIES CHARGED TO PATIENTS			71.00
•	O IMPL. DEV. CHARGED TO PATIENTS	13, 679, 823		72.00
	O DRUGS CHARGED TO PATIENTS	52, 056, 145		73.00
	O RENAL ACUTE	1, 939, 550		76. 00
	ATIENT SERVICE COST CENTERS			
90.00 0900	1	313, 774		90.00
90. 05 0900	5 PATIENT NUTRITION	585, 020		90. 05
	7 WOUND CLINIC	1, 902, 536		90. 07
91.00 0910	1	15, 266, 306		91.00
	O OBSERVATION BEDS (NON-DISTINCT PART)	2, 223, 330		92.00
	TAL PURPOSE COST CENTERS			1
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	308, 762, 516		118. 00
	EIMBURSABLE COST CENTERS	300, 702, 310		1 10.00
		0		100.00
	O GIFT, FLOWER, COFFEE SHOP & CANTEEN	-1		190.00
	O RURAL HEALTH	4, 052, 746		194.00
	1 RENTAL PROPERTY	188, 055		194. 01
	4 FAMILY PRACTICE	6, 319, 754		194. 02
194. 03 0795	2 WELLNESS	1, 451, 613		194. 03
194. 04 0795	5 PHYSICIAN PRACTICES	14, 215, 997		194. 04
	3 SYCAMORE SPORTS MED	146, 510		194.06
	6 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	720, 450		194. 07
200. 00	1	720, 430		200. 00
	Cross Foot Adjustments	- 1		
201. 00	Negative Cost Centers	-714, 170		201. 00

Health Financial Systems	UNION HOSPITA	L, INC.	In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0023	Peri od:	Worksheet B
			From 01/01/2016	Part
			To 12/31/2016	Date/Time Prepared:
				11/12/2018 4:13 pm
Cost Center Description	Total			
	26. 00			
202.00 TOTAL (sum lines 118 through 201)	335, 143, 471			202. 00

| Peri od: | Worksheet B | From 01/01/2016 | Part II | To 12/31/2016 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0023

				То	12/31/2016	Date/Time Pre 11/12/2018 4:	
			CAPI TAL REI	LATED COSTS		1 117 127 20 10 11	, o p
	Cost Center Description	Directly	NEW BLDG &	NEW MVBLE	Subtotal	EMPLOYEE	
	oost denter bescription	Assigned New	FLXT	EQUI P	oubtotai	BENEFI TS	
		Capi tal Rel ated Costs				DEPARTMENT	
		0	1. 00	2.00	2A	4. 00	
1 00	GENERAL SERVI CE COST CENTERS	1					1 00
1. 00 2. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	О	109, 282	О	109, 282	109, 282	4.00
5. 01	00540 NONPATI ENT TELEPHONES	0	13, 831		73, 864		5. 01
5. 02 5. 03	00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES	0	0	_	0	0	5. 02 5. 03
5. 04	00570 ADMITTING	63, 966	64, 462	-	141, 585	-	
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	o	0	0	0	0	5. 05
5. 06 7. 00	00590 OTHER ADMIN AND GENERAL 00700 OPERATION OF PLANT	27, 394 16, 605	390, 960 7, 049, 869		540, 428 7, 335, 254	5, 923 2, 048	5. 06 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	5, 764	126, 060		308, 440	· ·	8.00
9. 00	00900 HOUSEKEEPI NG	-1, 952	111, 850		258, 862		9. 00
10.00	01000 DI ETARY	3, 543	231, 069		546, 235		
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	0 3, 412	164, 881 50, 020		187, 961 65, 787	132 1, 681	11. 00 13. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	8, 939	111, 219		138, 065		16.00
17.00	01700 SOCIAL SERVICE	0	0	0	0	0	17.00
21. 00 22. 00	02100 &R SERVICES-SALARY & FRINGES APPRVD 02200 &R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	1, 569 1, 514	21. 00 22. 00
23. 00	02300 PARAMED ED PRGM	l o	0	Ö	0	9	23. 00
23. 01	02341 OTHER MED ED	0	15, 158	2, 439	17, 597	258	23. 01
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	137, 298	3, 958, 779	1, 032, 024	5, 128, 101	23, 235	30.00
31.00	03100 INTENSIVE CARE UNIT	197, 391	3, 936, 779 483, 990		1, 110, 158		
35. 00	02040 I NTENSI VE NURSERY	12, 270	60, 630	140, 909	213, 809	2, 266	35.00
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	13, 921 0	312, 014 82, 672		375, 697		41. 00 43. 00
43.00	ANCI LLARY SERVICE COST CENTERS	ı o	02,072	8, 754	91, 426	1, 203	43.00
50.00	05000 OPERATING ROOM	825, 649	857, 561		3, 480, 129	5, 270	50.00
50. 01 50. 02	05001 CARDI AC SURGERY 05002 WVSC	59, 624 425, 969	37, 894 632, 155		268, 316 1, 344, 088		50. 01 50. 02
51.00	05100 RECOVERY ROOM	1, 709	30, 147		75, 903		1
51. 02	05101 O/P TREATMENT ROOM	1, 470	449, 338	181, 650	632, 458	2, 541	51.02
52.00	05200 DELIVERY ROOM & LABOR ROOM	15, 520	437, 991		752, 813		
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	483, 367 877, 783	687, 038 555, 630		2, 066, 725 1, 869, 182		
56.00	05600 RADI OI SOTOPE	20, 117	61, 346		91, 925		
57.00	05700 CT SCAN	322, 656	45, 725		369, 004		
58. 00 59. 00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	545, 225 136, 708	54, 588 351, 445		642, 549 638, 045		
60.00	06000 LABORATORY	2, 813	0		2, 813		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0		62.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	298, 812	44, 925 213, 680		327, 716 551, 124	3, 064 0	
66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0		1
66. 02	06602 O/P PHYSICAL THERAPY	3, 948	0		64, 890		66.02
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	349, 704	34, 905 69, 220		47, 250 421, 108		67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	39, 504	27, 473		115, 730		
69. 01	06901 CARDI AC REHAB	102, 751	151, 576		291, 511	334	
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	778 21, 351	31, 684 120, 250		100, 662 220, 130		70. 00 71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0		72.00
	07300 DRUGS CHARGED TO PATIENTS	-602	270, 352		328, 069		
76. 00	03020 RENAL ACUTE OUTPATIENT SERVICE COST CENTERS	784, 889	74, 209	1, 015	860, 113	0	76.00
90. 00	09000 CLI NI C	0	4, 589	0	4, 589	203	90.00
90.05	09005 PATIENT NUTRITION	1, 301	40, 631		43, 567	338	
90. 07 91. 00	09007 WOUND CLINIC 09100 EMERGENCY	0 2, 164	82, 082 506, 747		102, 342 768, 564	388 5, 749	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 104	300, 747	237, 003	768, 364	5, 749	92.00
440.00	SPECIAL PURPOSE COST CENTERS	5 044 7/4	40,000,007	0.400.470	22 422 27	00.470	440.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	5, 811, 761	19, 209, 927	8, 102, 178	33, 123, 866	99, 473	Ji 18. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190. 00
	0/07950 RURAL HEALTH 07951 RENTAL PROPERTY	26, 027 216, 060	0	55, 188 8, 378	81, 215 224, 438		194. 00 194. 01
	207954 FAMILY PRACTICE	534	780, 426		1, 179, 101		194.01
	07952 WELLNESS	0	294, 773		294, 773		194. 03

Health Financial Systems	UNI ON HOSPI	TAL, INC.		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CO		Peri od:	Worksheet B	·
				From 01/01/2016 To 12/31/2016		nared:
				10 12/31/2010	11/12/2018 4:	
		CAPI TAL REL	ATED COSTS			
Cost Center Description	Di rectl y	NEW BLDG &	NEW MVBLE	Subtotal	EMPLOYEE	
	Assigned New	FLXT	EQUI P		BENEFITS	
	Capi tal				DEPARTMENT	
	Related Costs					
	0	1. 00	2. 00	2A	4. 00	
194. 04 07955 PHYSI CI AN PRACTI CES	49, 429	0	72, 01	0 121, 439	5, 495	194. 04
194.06 07953 SYCAMORE SPORTS MED	0	0	7, 62	3 7, 623	11	194.06
194. 07 07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	575, 813	60, 336	6, 64	0 642, 789	355	194. 07
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0		0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	6, 679, 624	20, 345, 462	8, 650, 15	8 35, 675, 244	109, 282	202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2016 Part II
To 12/31/2016 Date/Time Prepared:
11/12/2018 4:13 pm

					7 127 317 2010	11/12/2018 4:	
	Cost Center Description	NONPATI ENT	DATA	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/AC	
		TELEPHONES	PROCESSI NG	RECEIVING AND STORES		COUNTS RECEI VABLE	
		5. 01	5. 02	5. 03	5. 04	5. 05	
	GENERAL SERVICE COST CENTERS						
	00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
	DO400 EMPLOYEE BENEFITS DEPARTMENT DO540 NONPATIENT TELEPHONES	74, 511					4. 00 5. 01
	00550 DATA PROCESSING	74, 311	0				5.01
	00560 PURCHASING RECEIVING AND STORES						5.02
	00570 ADMITTING	2, 672	C		145, 766		5. 04
1	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	C	ol ol	0	0	5. 05
	00590 OTHER ADMIN AND GENERAL	6, 887	C	0	0	0	5.06
7.00	00700 OPERATION OF PLANT	4, 215	C	o	0	0	7. 00
	00800 LAUNDRY & LINEN SERVICE	1, 069	C	0	0	0	8. 00
	00900 HOUSEKEEPI NG	475	C	0	0	0	9. 00
1	D1000 DI ETARY	1, 781	C	0	0	0	10.00
	D1100 CAFETERI A	0	C	0	0	0	11.00
1	01300 NURSI NG ADMINI STRATI ON	534 1, 781	C		0	0	13.00
	D1600 MEDICAL RECORDS & LIBRARY D1700 SOCIAL SERVICE	1, 781			0	0	16. 00 17. 00
	02100 I&R SERVICES-SALARY & FRINGES APPRVD				0	0	21.00
	D2200 I&R SERVICES-OTHER PRGM COSTS APPRVD		0		0	0	22.00
	D2300 PARAMED ED PRGM	l ol	C	ol ol	0	0	23.00
	02341 OTHER MED ED	o	C		0	0	23. 01
I	NPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	10, 155	C	0	25, 081	0	30.00
1	03100 INTENSIVE CARE UNIT	1, 722	C	0	7, 042	0	31.00
	02040 I NTENSI VE NURSERY	1, 069	C	-	4, 245	0	35.00
	04100 SUBPROVI DER – I RF	1, 841	C	-	1, 011	0	41.00
	04300 NURSERY	237	C	0	1, 464	0	43.00
	ANCILLARY SERVICE COST CENTERS D5000 OPERATING ROOM	4, 868	C	ol	26, 916	0	50.00
	05000 OFERATTING ROOM	356	C		3, 286	0	50.00
	05002 WVSC	0	0		0, 200	0	50.01
	D5100 RECOVERY ROOM	1, 069	C	ol ol	553	0	51.00
	05101 O/P TREATMENT ROOM	1, 603	C	o	386	0	51.02
52.00	D5200 DELIVERY ROOM & LABOR ROOM	1, 366	C	o	4, 189	0	52.00
	D5400 RADI OLOGY-DI AGNOSTI C	6, 412	C	0	3, 292	0	54.00
	D5500 RADI OLOGY-THERAPEUTI C	2, 434	C	0	433	0	55.00
	D5600 RADI OI SOTOPE	0	C	0	291	0	56.00
1	D5700 CT SCAN	416	C	0	4, 529	0	57.00
	D5800 MAGNETIC RESONANCE IMAGING (MRI)	237	C	0	719	0	58.00
1	05900 CARDI AC CATHETERI ZATI ON	2, 019	C		8, 884	0	59.00
	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	475			12, 060 724	0	60. 00 62. 00
	06500 RESPI RATORY THERAPY	831			3, 069	0	65.00
	06600 PHYSI CAL THERAPY	1, 366	0		3, 016	0	66.00
	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	C	ol ol	0, 0.10	0	66. 01
	06602 O/P PHYSICAL THERAPY	59	C	o	0	0	66. 02
	06700 OCCUPATI ONAL THERAPY	297	C	0	1, 382	0	67.00
68.00	06800 SPEECH PATHOLOGY	59	C	0	329	0	68. 00
	06900 ELECTROCARDI OLOGY	237	C	0	3, 063	0	69. 00
	06901 CARDI AC REHAB	356	C	0	43	0	69. 01
	07000 ELECTROENCEPHALOGRAPHY	1, 009	C	0	902	0	70.00
1	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	831	C	0	665	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		10.010	0	72.00
	07300 DRUGS CHARGED TO PATIENTS 03020 RENAL ACUTE	2, 969 237	C	-	19, 019 984	0	73. 00 76. 00
	DUTPATIENT SERVICE COST CENTERS	237		η σ	704	U	70.00
	09000 CLINIC	O	C	ol ol	0	0	90.00
	09005 PATIENT NUTRITION	l ol	C	ol ol	0	0	90.05
	09007 WOUND CLINIC	772	C	o	0	0	90. 07
91.00	09100 EMERGENCY	3, 740	C	o	8, 189	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
_	SPECIAL PURPOSE COST CENTERS						
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	68, 456	C	0	145, 766	0	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C	-	0		190.00
	07950 RURAL HEALTH	59	C	0	0		194. 00 194. 01
	D7951 RENTAL PROPERTY D7954 FAMILY PRACTICE	4 215	C		0		194.01
	07954 FAMILY PRACTICE	4, 215	(0		194. 02
	07955 PHYSI CI AN PRACTI CES	1, 306			0		194. 03
	07953 SYCAMORE SPORTS MED	1, 330	C		n		194. 06
	07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	475	C	-	0		194. 07
		1				•	

Health Financial Systems	UNI ON HOSPI	TAL, INC.		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der C		Peri od: From 01/01/2016	Worksheet B	
				To 12/31/2016		
Cost Center Description	NONPATI ENT TELEPHONES	DATA PROCESSI NG	PURCHASING RECEIVING AN		CASHI ERI NG/AC COUNTS	

						11/12/2018 4:	13 pm
	Cost Center Description	NONPATI ENT	DATA	PURCHASI NG	ADMITTI NG	CASHI ERI NG/AC	
		TELEPHONES	PROCESSI NG	RECEIVING AND		COUNTS	
				STORES		RECEI VABLE	
		5. 01	5. 02	5. 03	5. 04	5. 05	
200.00	Cross Foot Adjustments						200.00
201. 00	Negative Cost Centers	0	0	0	0	0	201.00
202. 00	TOTAL (sum lines 118 through 201)	74, 511	0	0	145, 766	0	202.00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2016 Part II
To 12/31/2016 Date/Time Prepared:
11/12/2018 4:13 pm

			'		11/12/2018 4:	
Cost Center Description	OTHER ADMIN	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	AND GENERAL 5.06	PLANT 7. 00	LINEN SERVICE 8.00	9. 00	10.00	
GENERAL SERVICE COST CENTERS	5.00	7.00	0.00	9.00	10.00	
1.00 O0100 NEW CAP REL COSTS-BLDG & FLXT						1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01 00540 NONPATI ENT TELEPHONES						5. 01
5. 02 00550 DATA PROCESSING						5.02
5. 03 00560 PURCHASING RECEIVING AND STORES 5. 04 00570 ADMITTING						5. 03 5. 04
5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.04
5. 06 00590 OTHER ADMIN AND GENERAL	553, 238					5.06
7.00 00700 OPERATION OF PLANT	30, 282	7, 371, 799				7.00
8.00 00800 LAUNDRY & LINEN SERVICE	2, 630	73, 074	385, 924			8.00
9. 00 00900 HOUSEKEEPI NG	6, 671	64, 837	1			9. 00
10. 00 01000 DI ETARY	8, 021	133, 946	1		700, 855	10.00
11. 00 01100 CAFETERI A	0	95, 578	1	4, 767	0	11.00
13.00 O1300 NURSING ADMINISTRATION 16.00 O1600 MEDICAL RECORDS & LIBRARY	6, 351 8, 276	28, 995 64, 471	0	1, 446 3, 216	0	13. 00 16. 00
17. 00 01700 SOCIAL SERVICE	0,270	04,471	1	3, 210	0	17.00
21. 00 02100 I &R SERVICES-SALARY & FRINGES APPRVE	- I	l ő	Ö	o o	0	21.00
22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRVE		Ö	Ō	Ö	0	22. 00
23.00 02300 PARAMED ED PRGM	445	0	0	0	0	23. 00
23. 01 02341 OTHER MED ED	623	8, 787	0	438	0	23. 01
INPATIENT ROUTINE SERVICE COST CENTERS	77.000		110 150		500 7/7	
30. 00 03000 ADULTS & PEDI ATRI CS	77, 988		1		523, 767	30.00
31. 00 03100 INTENSIVE CARE UNIT 35. 00 02040 INTENSIVE NURSERY	18, 475 6, 149				88, 982 38, 981	31. 00 35. 00
41. 00 04100 SUBPROVI DER - I RF	4, 375		1		30, 901	41.00
43. 00 04300 NURSERY	2, 933	47, 923			0	43.00
ANCILLARY SERVICE COST CENTERS				, , , , , , , , , , , , , , , , , , , ,		
50. 00 05000 OPERATING ROOM	28, 491	497, 109	24, 757	24, 795	0	50.00
50. 01 05001 CARDI AC SURGERY	4, 871	21, 966	1		0	50. 01
50. 02 05002 WVSC	22, 892	366, 446			0	50.02
51. 00 05100 RECOVERY ROOM	4, 142	17, 475	1		0 45 011	51.00
51.02 05101 0/P TREATMENT ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	6, 799 10, 332	260, 471 253, 894	1		45, 911 15	51. 02 52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	17, 978	l '	1		0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	11, 215		1		0	55.00
56. 00 05600 RADI OI SOTOPE	2, 576	i '	1		0	56.00
57.00 05700 CT SCAN	5, 348	26, 506	0	1, 322	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	3, 292	31, 644			0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	29, 984	203, 725	1	·	3, 199	
60. 00 06000 LABORATORY	17, 270	0		0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 65.00 06500 RESPIRATORY THERAPY	2, 308 8, 829	26, 042	0	1, 299	0	62. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY	5, 216	123, 865			0	66.00
66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0,210	0		0, 170	0	66. 01
66. 02 06602 0/P PHYSI CAL THERAPY	3, 831	0	6, 756	O	0	66.02
67. 00 06700 OCCUPATI ONAL THERAPY	2, 913		0	1, 009	0	67.00
68.00 06800 SPEECH PATHOLOGY	1, 212		1	2, 001	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	4, 953	l			0	69.00
69. 01 06901 CARDI AC REHAB	1, 143		1		0	69. 01
70.00 O7000 ELECTROENCEPHALOGRAPHY 71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 444 2, 053	18, 366 69, 706	1	916 3, 477	0	70. 00 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	22, 196		1	3,477	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	81, 037	156, 717	_	7, 817	0	73.00
76. 00 03020 RENAL ACUTE	2, 887	43, 017	1		0	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	474	2, 660	1	133	0	90.00
90. 05 09005 PATI ENT NUTRI TI ON	791	23, 553	1	1, 175	0	90.05
90. 07 09007 WOUND CLINIC	2, 734	l '	1		0	90.07
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART)	21, 386	293, 750	53, 944	14, 652	0	91. 00 92. 00
SPECIAL PURPOSE COST CENTERS						72.00
118.00 SUBTOTALS (SUM OF LINES 1 through 11	7) 512, 645	6, 713, 555	383, 782	327, 979	700, 855	118.00
NONREI MBURSABLE COST CENTERS	, 3.2,310				. 10, 000	1
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
194.00 07950 RURAL HEALTH	6, 573		305	0		194. 00
194. 01 07951 RENTAL PROPERTY	305	l e	0	0		194. 01
194. 02 07954 FAMILY PRACTICE	7, 946		1	22, 565		194. 02
194. 03 07952 WELLNESS 194. 04 07955 PHYSI CLAN PRACTI CES	1, 485 23, 055		1, 430	8, 523		194. 03 194. 04
194.06 07953 SYCAMORE SPORTS MED	23, 055	l e	1, 430			194.04
194. 07 07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	991	34, 975		1, 744		194.00
200.00 Cross Foot Adjustments]		.,	Ü	200.00
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Heal th Fina	ncial Systems	UNI ON HOSPI	UNION HOSPITAL, INC.			In Lieu of Form CMS-2552-10		
ALLOCATI ON	OF CAPITAL RELATED COSTS		Provi der C	CN: 15-0023	Peri od:	Worksheet B		
					From 01/01/2016	Part II		
					To 12/31/2016	Date/Time Pre		
						11/12/2018 4:	13 pm	
	Cost Center Description	OTHER ADMIN	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY		
		AND GENERAL	PLANT	LINEN SERVICE				
		5. 06	7. 00	8. 00	9. 00	10.00		
201. 00	Negative Cost Centers	0	0		0 0	0	201.00	
202.00	TOTAL (sum lines 118 through 201)	553, 238	7, 371, 799	385, 92	4 360, 811	700, 855	202.00	

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

The control pasceription						lo	12/31/2016	Date/lime Pre 11/12/2018 4:	
CAPITERIA ANIMEN INSTITUTION SERVICE S								INTERNS &	•
ADMINISTRATIO RECORDS SERVICE DOT CENTERS 11.00 13.00 16.00 17.00 21.00			Cost Contor Description	CAEETEDIA	MITEST NC	MEDICAL	SOCIAL		
N			cost center bescription	CAFETERIA					
CREATER SENVICE COST CENTERS					N				
1.00 00100 NEW CAP REL COSTS-BUDG & FIXT		CENED	AN CERVICE COCT CENTERS	11. 00	13. 00	16. 00	17. 00	21.00	
2.00 ODDOD INW CAP BETL CRISTS MAN IF TOUR P	1 00								1 00
5 - 01 00-0500 NORMATIENT TELEPHONES 5 - 07 5 - 02 00-0500 PURCHASIN RECEIV NOR AMD STORES 5 - 07 5 - 03 00-0500 PURCHASIN RECEIV NOR AMD STORES 5 - 08 5 - 04 00-0500 PURCHASIN RECEIV NOR AMD STORES 5 - 08 5 - 05 00-0500 PURCHASIN RECEIV NOR AMD STORES 5 - 08 5 - 05 00-0500 PURCHASIN RECEIV NOR AMD STORES 5 - 08 5 - 05 00-0500 PURCHASIN RECEIV NOR AMD STORES 5 - 08 5 - 05 00-0500 PURCHASIN RECEIV NOR AMD STORES 5 - 08 5 - 05 00-0500 PURCHASIN AMD SENDRAL 5 - 08 6 - 05 00-0500 PURCHASIN AMD SENDRAL 5 - 08 6 - 05 00-0500 PURCHASIN AMD SENDRAL 5 - 08 7 - 05 00-0500 PURCHASIN AMD SENDRAL 5 - 08									
5 0.0 00050 DATA PROCESSING 5 0.0	4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.03 0.0560 PURCHASING RECEIVING AND STORES 5.04 5.05 5.		1	ł ·						
0.070 ADMITTING									
5.05 00589 CASH LERING ACCOUNTS RECEIVABLE 5.06 00590 CHERA ADMIN AND GENERAL 7.00 00720 CHERA ADMIN AND SERVICE 8.00 0.00 0000 CHERA ADMIN AND SERVICE 8.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0									
0.0000 OPERATION OF PLANT									
8. 00 00000 CANIDATY & LINEN SERVICE 8. 00 0. 000 0.		1	1						
9. 00 00900 MUSENEEPIN		1	1						
10.00 01000 DETARY		1	1						
11.00 11.00 (AFETERIA 288, 438 11.00 10.00 (ANSIN AC MINS INS ALD NURS INS ADMINISTRATION 13.00 10.00 (ANSIN AC MINS INS ADMINISTRATION 16.00 10.00		1	1						
16.00 1600 MEDICAL RECORDS & LIBRARY 0 0 0 218,132 16.00 17.		1	1	288, 438					
17.00 01700 IAS PERVICES-SALARY & FRINGES APPRVD 0 0 0 0 0 0 17.7 21.00 22.00 18R SERVICES-SALARY & FRINGES APPRVD 0 0 0 0 0 0 0 22.00 22.00 23.	13.00	01300	NURSING ADMINISTRATION	0	104, 794				13.00
21.00 2020 RA SERVICES-SALARY & FRINCES APPRVD 0 0 0 0 0 0 22 20		1	l e e e e e e e e e e e e e e e e e e e	0	0		_		
22.00 02000 AR SERVICES-OTHER PROM COSTS APPRVD 0 0 0 0 0 22.00 03				0	0		0	4 772	
23.00 02300 PARAMED ED PROM 0 0 347 0 0 23.00		1		0	0		_	4,773	
INPART ENT ROUTINE SERVICE COST CENTERS				0	0	Ö	0		
30.00 30000 ADULTS & PEDIATRICS 0 43.971 10.731 0 30.00 31.00 31.00 31.00 35.00 20240 INTENSI VE NURSERY 0 3.514 2.541 0 35.00 43.00 43.00 INTENSI VE NURSERY 0 2.839 605 0 41.0	23. 01			0	347	0	0		23. 01
31.00 03100 NTENSI VE CARE UNIT 0 9,750 4,220 0 31.00	20.00			0	42 071	1/ 701			20.00
35.00		1	ł ·	0					
1.0 0.410.0 SUBPROVI DER - IRF 0 2,839 605 0 41.00 0.43.00 0.50.00		1	1	0			-		
ANCIL LARY SERVICE COST CENTERS		1	1	0			0		
50. 00 050000 0FERATI NG ROOM 0 6,949 28,051 0 50. 00	43.00	-		0	2, 171	876	0		43.00
Social Cardin C	50 00			0	6 0/10	28 051	0		50 00
50.02 OSDO2 WNSC 0		1		0					
STOCK STOTO O.P TREATMENT ROOM		05002	WVSC	0					
52.00 05200 DELI VERY ROOM & LABOR ROOM 0 5,524 3,281 0 52.00		1	1	0		1	0		
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 0 54. 00		1	l e e e e e e e e e e e e e e e e e e e	0			0		
55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 6, 469 0 55.00		1	1	0			0		
57.00 05700 07500 07500 07 SCAN 0 0 0 0 9,603 0 57.00		1	l e	0			0		
S8.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 2,290 0 58.00				0	0		0		
59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 18, 513 0 59.00				0			0		
60. 00 06000 LABORATORY 0 0 15, 404 0 60. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 537 0 62. 00 065. 00 65500 RESPIRATORY THERAPY 0 4, 984 2, 030 0 65. 00 66. 00 66. 01		1		0	0		0		
65. 00 06500 RESPI RATORY THERAPY 0 4,984 2,030 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 1,938 0 66. 00 66. 01 66. 01 PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 0 66. 01 66. 01 66. 01 PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 0 66. 01 66. 01 66. 01 PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 0 0 66. 02 66. 02 66. 02 67. 00 6700 0 0 0 0 0 0 0 0 1,138 0 66. 02 67. 00 6700 0 0 0 0 0 0 0 0 0				0	0		0		
66. 00 06600 PHYSI CAL THERAPY 0 0 0 1, 938 0 66. 00 66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 66. 01 06602 0/P PHYSI CAL THERAPY 0 0 0 0 0 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 1, 138 0 68. 00 06800 SPEECH PATHOLOGY 0 0 0 426 0 68. 00 06800 SPEECH PATHOLOGY 0 0 0 3, 331 0 69. 01 06901 CARDI AC REHAB 0 0 0 3, 331 0 69. 01 06901 CARDI AC REHAB 0 0 0 237 0 69. 01 06901 CARDI AC REHAB 0 0 0 1, 360 0 71. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 1, 360 0 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 4, 637 41, 356 0 76. 00 03020 RENAL ACUTE 0 0 663 0 76. 00 00TPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 0 257 133 0 90. 05 90. 07 9007 WOUND CLI NI C 0 668 972 0 99. 07 91. 00 09100 DEBERGENCY 0 10, 572 20, 834 0 91. 00 92. 00 DSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 SUBTOTALS (SUM OF LINES 1 through 117) 0 104, 794 218, 132 0 0 194. 00 07950 RUBRAL HEALTH 0 0 0 0 194. 00 07950 RUBRAL HEALTH 0 0 0 0 194. 00 07950 RUBRAL HEALTH 0 0 0 0 194. 00 07950 RUBRAL HEALTH 0 0 0 0 194. 00 07950 RUBRAL HEALTH 0 0 0 0 0 194. 00 07950 RUBRAL HEALTH 0 0 0 0 0 194. 00 07950 RUBRAL HEALTH 0 0 0 0 0 194. 00 07950 RUBRAL HEALTH 0 0 0 0 0 194. 00 07950 RUBRAL HEALTH 0 0 0 0 0 194. 00 07950 RUBRAL HEALTH 0 0 0 0 0 194. 00 07950 RUBRAL HEALTH 0 0 0 0 0 194. 00 07950 RUBRAL HEALTH 0 0 0 0 0 194. 00 07950 RUBRAL HEALTH 0 0 0 0 0 194. 00 07950 RUBRAL HEALTH 0 0 0 0 0 194. 00 07950 RUBRAL HEALTH 0 0	62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	537	0		62.00
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 1,138 0 66. 02 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 1,295 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 426 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 3,331 0 69. 00 69. 01 06901 CARDI AC REHAB 0 0 0 237 0 69. 01 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 1,360 0 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 424 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 4,637 41,356 0 73. 00 76. 00 03020 RENAL ACUTE 0 0 663 0 76. 00 0017PATI ENT SERVI CE COST CENTERS 90. 05 09005 PATI ENT NUTRI TI ON 0 591 37 0 90. 05 90. 07 09007 WOUND CLI NI C 0 668 972 0 90. 05 90. 07 09007 WOUND CLI NI C 0 668 972 0 90. 07 91. 00 09200 DEBERGENCY 0 10,572 20,834 0 91. 00 92. 00 SPECI AL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LI NES 1 through 117) 0 104,794 218,132 0 0 194. 00 07900 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 194. 00 07950 RURAL HEALTH 0 0 0 0 0 194. 00 07950 RURAL HEALTH 0 0 0 0 194. 00 07950 RURAL HEALTH 0 0 0 0 0 194. 00 07950 RURAL HEALTH 0 0 0 0 0 194. 00 07950 RURAL HEALTH 0 0 0 0 0 194. 00 07950 RURAL HEALTH 0 0 0 0 0 194. 00 07950 RURAL HEALTH 0 0 0 0 0 194. 00 07950 RURAL HEALTH 0 0 0 0 0 194. 00 07950 RURAL HEALTH 0 0 0 0 0 194. 00 07950 RURAL HEALTH 0 0 0 0 0 194. 00 07950 RURAL HEALTH 0 0 0 0 0 194. 00 07950 RURAL HEALTH 0 0 0 0 0 19500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500				0					
66. 02 06602 0/P PHYSICAL THERAPY 0 0 0 1,138 0 66. 02 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 1,295 0 67. 00 68. 00 06800 SPECH PATHOLOGY 0 0 0 426 0 69. 01 06800 SPECH PATHOLOGY 0 0 0 3,331 0 69. 00 69. 01 06901 CARDI AC REHAB 0 0 0 237 0 69. 01 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 1,360 0 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 424 0 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 4,637 41,356 0 73. 00 74. 00 03020 RENAL ACUTE 0 0 663 0 75. 00 03020 RENAL ACUTE 0 0 663 0 76. 00 09000 CLINIC 0 591 37 0 79. 05 09005 PATIENT NUTRITION 0 591 37 0 79. 07 09007 WOUND CLINIC 0 668 972 0 90. 05 79. 07 09007 WOUND CLINIC 0 668 972 0 90. 05 79. 07 09007 WOUND CLINIC 0 668 972 0 90. 07 791. 00 09100 EMERGENCY 0 10,572 20,834 0 91. 00 792. 00 DESERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 0 104,794 218,132 0 0 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 194. 00 07950 RURAL HEALTH 0 0 0 0 0 194. 00 07950 RURAL HEALTH 0 0 0 0 194. 00 07950 RURAL HEALTH 0 0 0 0 194. 00 07950 RURAL HEALTH 0 0 0 0 194. 00 07950 RURAL HEALTH 0 0 0 0 0 194. 00 07950 RURAL HEALTH 0 0 0 0 0 194. 00 07950 RURAL HEALTH 0 0 0 0 0 194. 00 07950 RURAL HEALTH 0 0 0 0 0 194. 00 07950 RURAL HEALTH 0 0 0 0 0 0 194. 00 07950 RURAL HEALTH 0 0 0 0 0 0 195. 00 07050 07050 07050 07050 07050 07050 07050 07050 07050 07050 07050 07050 07050 07050 07050 07050 070500 07050 070500 070500 07050 07050				0			_		
67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 1, 295 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 426 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 3, 331 0 69. 00 69. 01 06901 CARDI AC REHAB 0 0 0 237 0 69. 01 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 1, 360 0 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 424 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 4, 637 41, 356 0 73. 00 76. 00 03020 RENAL ACUTE 0 0 0 663 0 76. 00 09000 CLI NI C 0 257 133 0 79. 00 09000 CLI NI C 0 591 37 0 79. 00 09000 CLI NI C 0 668 972 0 79. 00 09000 MOUND CLI NI C 0 668 972 0 79. 00 09000 DRERSENCY 0 10, 572 20, 834 0 79. 00 09200 DRERSENCY 0 10, 572 20, 834 0 79. 00 09200 DRERSENCY 0 10, 572 20, 834 0 79. 00 09200 DRERSENCY 0 10, 572 20, 834 0 79. 00 09200 DRESEVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 0 104, 794 218, 132 0 0 790. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 790. 00 190. 00 194. 00 791. 00 09750 RURAL HEALTH 0 0 0 0 791. 00 0 194. 00 792. 00 00 00 0 0 793. 00 00 0 0 794. 00 00 00 0 794. 00 00 00 0 795. 00 194. 00 794. 00 00 00 0 794. 00 00 00 0 795. 00 00 0 794. 00 00 00 0 795. 00 00 00 0 795. 00 00 00 0 795. 00 00 00 0 795. 00 00 00 0 795. 00 00 00 0 795. 00 00 00 00 795. 00 00 00 00 795. 00 00 00 00 795. 00 00 00 00 795. 00 00 00 00 795. 00 00 00 00 795. 00 00 00 00 795. 00 00 00 00 795. 00 00 00 00 795. 00 00 00 00 795. 00 00 00 795. 00 00 00 795. 00 00		1	1	0	0		0		
69. 00 06900 ELECTROCARDI OLOGY 0 0 0 3, 331 0 69. 00 69. 00 69. 01 06901 CARDI AC REHAB 0 0 0 0 237 0 69. 01 70. 00 7000 ELECTROENCEPHALOGRAPHY 0 0 0 1, 360 0 70. 00 71. 00 7100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 424 0 71. 00				0	0		0		
69. 01 06901 CARDI AC REHAB 0 0 0 0 237 0 0 69. 01 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 1, 360 0 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 424 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 72.00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 4, 637 41, 356 0 733. 00 76. 00 03020 RENAL ACUTE 0 0 0 663 0 76. 00 0UTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 0 0 257 133 0 90. 05 90. 05 99005 PATI ENT NUTRI TI ON 0 0 591 37 0 90. 05 90. 07 09007 WOUND CLI NI C 0 0 668 972 0 90. 05 91. 00 09100 EMERGENCY 0 0 10, 572 20, 834 0 91. 00 92. 00 09200 DESERVATI ON BEDS (NON-DI STI NCT PART) SPECI AL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LI NES 1 through 117) 0 104, 794 218, 132 0 118. 00 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190. 00 194. 00 07950 RURAL HEALTH		1		0	0		0		
70. 00		1	1	0	0		0		
71. 00		1	1	0	0		0		
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 4,637 41,356 0 73. 00 76. 00 03020 RENAL ACUTE 0 0 663 0 76. 00 OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 0 257 133 0 90. 00 90. 05 09005 PATIENT NUTRITION 0 591 37 0 90. 05 90. 07 09007 WOUND CLINIC 0 668 972 0 90. 07 91. 00 09100 EMERGENCY 0 10,572 20,834 0 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92. 00 SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 0 104,794 218,132 0 0 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 194. 00 07950 RURAL HEALTH 0 0 0 0 194. 00 07950 RURAL HEALTH 0 0 0 0 173. 00 73. 00 73. 00 73. 00 76. 00 194. 00 079750 RURAL HEALTH 0 0 0 0 173. 00 73. 00 73. 00 75. 00 174. 00 07950 RURAL HEALTH 0 0 0 0 175. 00 76. 00 76. 00 175. 00 76. 00 76. 00 175. 00 76. 00 76. 00 175. 00 76. 00 76. 00 187. 00 76. 00 189. 00 76. 00 190. 00 190. 00 190. 00 190. 00 190. 00 190. 00 190		1		0	0		0		
76. 00 03020 RENAL ACUTE 0 0 663 0 76. 00 0UTPATIENT SERVICE COST CENTERS 90. 00 90000 CLI NI C 0 257 133 0 90. 00 90. 05 09005 PATIENT NUTRITION 0 591 37 0 90. 05 90. 07 09007 WOUND CLI NI C 0 668 972 0 90. 07 91. 00 09100 EMERGENCY 0 10, 572 20, 834 0 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 SPECI AL PURPOSE COST CENTERS 100, 00 104, 794 218, 132 0 0 118. 00 NONREI MBURSABLE COST CENTERS 100, 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 194. 00 07950 RURAL HEALTH 0 0 0 0 0 194. 00 07950 RURAL HEALTH 0 0 0 0 0 194. 00 0000 0000 0000 0000 0000 0000 10000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 000000		1		0			0		
OUTPATI ENT SERVI CE COST CENTERS O				0	4, 637	1	-		
90. 00	76.00			U	U	003	0		76.00
90. 07 09007 WOUND CLINIC 0 668 972 0 90. 07 91. 00 91. 00 92. 0		09000	CLINIC	0	257	133	0		90. 00
91. 00 09100 EMERGENCY 0 10, 572 20, 834 0 91. 00 92. 00				0		1	0		
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 92. 00				0		1	-		
SPECIAL PURPOSE COST CENTERS				U	10, 572	20, 634	0		
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190. 00 194. 00 07950 RURAL HEALTH 0 0 0 0 194. 00	72.00								72.00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190. 00 194. 00 07950 RURAL HEALTH 0 0 0 0 0 194. 00	118.00			0	104, 794	218, 132	0	0	118. 00
194.00 07950 RURAL HEALTH 0 0 0 0 0 194.00	100 00			0	0		^		100 00
				0	0		0		
				0	Ö	Ö	0		194. 01
194. 02 07954 FAMILY PRACTICE 0 0 0 0 194. 02	194. 02	2 07954	FAMILY PRACTICE	0	0	0	0		194. 02
194. 03 07952 WELLNESS 0 0 0 0 194. 03 194. 04 07955 PHYSI CI AN PRACTI CES 0 0 0 0 194. 04		3 07952		0	0	0	0		
194. 04 07955 PHYSI CI AN PRACTI CES 0 0 0 0 194. 04		107055	SIDHVSICIAN DDACTICES	^	Λ.	[//	^		194.04

Health Financial Systems	UNI ON HOSPI	TAL, INC.		In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provi der Co		Peri od:	Worksheet B		
				From 01/01/2016 To 12/31/2016		narod.	
				10 12/31/2010	11/12/2018 4:		
					INTERNS &		
					RESI DENTS		
Cost Center Description	CAFETERI A	NURSI NG	MEDI CAL	SOCI AL	SERVI CES-SALA		
		ADMI NI STRATI O	RECORDS &	SERVI CE	RY & FRINGES		
		N	LI BRARY				
	11. 00	13. 00	16. 00	17. 00	21. 00		
194.06 07953 SYCAMORE SPORTS MED	0	0		0		194. 06	
194. 07 07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 0		194. 07	
200.00 Cross Foot Adjustments					4, 773	200.00	
201.00 Negative Cost Centers	288, 438	0		0 0	0	201.00	
202.00 TOTAL (sum lines 118 through 201)	288, 438	104, 794	218, 13	32 0	4, 773	202. 00	

From 01/01/2016 Part II Date/Time Prepared: 12/31/2016 11/12/2018 4:13 pm INTERNS & **RESI DENTS** Cost Center Description SERVI CES-OTHE PARAMED ED OTHER MED ED Subtotal Intern & R PRGM COSTS PRGM Residents Cost & Post Stepdown Adjustments 22. 00 23. 00 23. 01 24.00 25.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.01 00540 NONPATIENT TELEPHONES 5.01 5.02 00550 DATA PROCESSING 5.02 5.03 00560 PURCHASING RECEIVING AND STORES 5.03 00570 ADMITTING 5 04 5 04 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.05 5.05 5.06 00590 OTHER ADMIN AND GENERAL 5.06 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8 00 8 00 00900 HOUSEKEEPI NG 9.00 9.00 01000 DI ETARY 10.00 10.00 01100 CAFETERI A 11.00 11.00 01300 NURSING ADMINISTRATION 13 00 13 00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 17.00 02100 | &R SERVICES-SALARY & FRINGES APPRVD 21 00 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 6, 139 22.00 02300 PARAMED ED PRGM 23.00 454 23.00 02341 OTHER MED ED 23.01 28, 050 23.01 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 8, 377, 767 0 30.00 03100 INTENSIVE CARE UNIT 0 31.00 1, 563, 160 31.00 02040 INTENSIVE NURSERY 311, 196 35.00 35.00 0 04100 SUBPROVI DER - I RF 41.00 581, 109 0 41.00 04300 NURSERY 43.00 150, 623 0 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 4, 127, 335 0 50.00 05001 CARDI AC SURGERY 50.01 305, 023 0 50.01 05002 WVSC 1, 798, 308 0 50.02 50.02 05100 RECOVERY ROOM 51.00 120,002 0 51.00 05101 0/P TREATMENT ROOM 51.02 982, 187 51.02 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 1, 065, 345 0 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 2, 537, 576 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 2, 234, 702 55.00 0 56.00 05600 RADI OI SOTOPE 135, 841 56.00 0 57.00 05700 CT SCAN 417, 971 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 695, 572 0 58.00 05900 CARDI AC CATHETERI ZATI ON 919, 015 0 59.00 59.00 06000 LABORATORY 60.00 48,022 0 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 3, 569 62.00 06500 RESPIRATORY THERAPY 65.00 377, 864 0 65.00 06600 PHYSI CAL THERAPY 66.00 696, 035 0 66.00 66.01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 66.01 06602 0/P PHYSICAL THERAPY 66.02 76, 674 0 66.02 06700 OCCUPATIONAL THERAPY 67.00 74.379 67.00 0 06800 SPEECH PATHOLOGY 68.00 465, 260 0 68.00 69.00 06900 ELECTROCARDI OLOGY 147, 990 0 69.00 69.01 06901 CARDI AC REHAB 386, 032 0 69.01 70 00 07000 ELECTROENCEPHALOGRAPHY 128, 772 Ω 70 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 297, 286 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 22, 196 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 645, 773 0 73.00 03020 RENAL ACUTE 911, 977 76.00 76.00 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 8, 449 09005 PATIENT NUTRITION 90.05 70,052 0 90.05 09007 WOUND CLINIC 161, 895 90 07 90.07 0 91.00 09100 EMERGENCY 1, 201, 380 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 0 SPECIAL PURPOSE COST CENTERS
SUBTOTALS (SUM OF LINES 1 through 117) 0 118.00 0 0 32, 046, 337 0 118.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 194.00 07950 RURAL HEALTH 0 190 00 0 194.00 89, 574 194. 01 07951 RENTAL PROPERTY 224, 743 0 194. 01 194. 02 07954 FAMILY PRACTICE 1, 668, 765 0 194.02

Health Financial Systems	UNI ON HOSPI	TAL, INC.		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der C		Peri od: Worksheet B		
				From 01/01/2016 To 12/31/2016		pared:
					11/12/2018 4:	13 pm
	INTERNS &					
	RESI DENTS					
Cost Center Description	SERVI CES-OTHE	PARAMED ED	OTHER MED ED	Subtotal	Intern &	
	R PRGM COSTS	PRGM			Resi dents	
					Cost & Post	
					Stepdown	
					Adjustments	
	22. 00	23. 00	23. 01	24. 00	25.00	
194. 03 07952 WELLNESS				476, 045	0	194. 03
194. 04 07955 PHYSI CI AN PRACTI CES				152, 725	0	194.04
194.06 07953 SYCAMORE SPORTS MED				7, 872	0	194. 06
194. 07 07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES				681, 329	0	194. 07
200.00 Cross Foot Adjustments	6, 139	454	28, 05	39, 416	0	200.00
201.00 Negative Cost Centers	o	0		0 288, 438	0	201.00
202.00 TOTAL (sum lines 118 through 201)	6, 139	454	28, 05	35, 675, 244	0	202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2016 Part II
To 12/31/2016 Date/Time Prepared:
11/12/2018 4:13 pm Provider CCN: 15-0023

				10 12/31/2016 Date/Time Pre	
		Cost Center Description	Total		
	OFNED	ALL OFFICE OF STATE O	26. 00		
1 00		AL SERVICE COST CENTERS			1 00
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	1	NONPATI ENT TELEPHONES			5. 01
5.02	00550	DATA PROCESSING			5. 02
5.03	00560	PURCHASING RECEIVING AND STORES			5. 03
5.04	1	ADMI TTI NG			5. 04
5. 05		CASHI ERI NG/ACCOUNTS RECEI VABLE			5. 05
5.06	1	OTHER ADMIN AND GENERAL			5.06
7. 00 8. 00		OPERATION OF PLANT LAUNDRY & LINEN SERVICE			7. 00 8. 00
9. 00	1	HOUSEKEEPI NG			9. 00
10.00	1	DI ETARY			10.00
11.00	1	CAFETERI A			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
16.00	1	MEDICAL RECORDS & LIBRARY			16. 00
17. 00	1	SOCIAL SERVICE			17. 00
21.00		I&R SERVICES-SALARY & FRINGES APPRVD I&R SERVICES-OTHER PRGM COSTS APPRVD			21.00
22. 00 23. 00	1	PARAMED ED PRGM			22. 00 23. 00
23. 00		OTHER MED ED			23. 00
		TENT ROUTINE SERVICE COST CENTERS	1		
30.00		ADULTS & PEDIATRICS	8, 377, 767		30.00
31.00	03100	INTENSIVE CARE UNIT	1, 563, 160		31.00
35. 00		I NTENSI VE NURSERY	311, 196		35. 00
41.00	1	SUBPROVI DER - I RF	581, 109		41.00
43. 00		NURSERY LARV SERVICE COST CENTERS	150, 623		43. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	4, 127, 335		50.00
50. 01	1	CARDI AC SURGERY	305, 023		50. 00
50. 02	05002	•	1, 798, 308		50.02
51.00	05100	RECOVERY ROOM	120, 002		51.00
51. 02	1	O/P TREATMENT ROOM	982, 187		51.02
52.00	1	DELIVERY ROOM & LABOR ROOM	1, 065, 345		52.00
54.00	1	RADI OLOGY THE PARELLE C	2, 537, 576		54.00
55. 00 56. 00	1	RADI OLOGY-THERAPEUTI C RADI OI SOTOPE	2, 234, 702 135, 841		55. 00 56. 00
57.00	1	CT SCAN	417, 971		57.00
58. 00	1	MAGNETIC RESONANCE IMAGING (MRI)	695, 572		58.00
59.00	1	CARDI AC CATHETERI ZATI ON	919, 015		59.00
60.00		LABORATORY	48, 022		60.00
62.00	1	WHOLE BLOOD & PACKED RED BLOOD CELLS	3, 569		62.00
65.00	1	RESPI RATORY THERAPY	377, 864		65.00
66. 00 66. 01		PHYSI CAL THERAPY PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	696, 035 0		66. 00 66. 01
66. 02		0/P PHYSICAL THERAPY	76, 674		66. 02
		OCCUPATIONAL THERAPY	74, 379		67.00
		SPEECH PATHOLOGY	465, 260		68.00
		ELECTROCARDI OLOGY	147, 990		69. 00
69. 01		CARDI AC REHAB	386, 032		69. 01
70.00		ELECTROENCEPHALOGRAPHY	128, 772		70.00
71. 00 72. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	297, 286		71.00
73.00	1	IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	22, 196 645, 773		72. 00 73. 00
76.00		RENAL ACUTE	911, 977		76.00
		TIENT SERVICE COST CENTERS	, ,		1
90.00		CLINIC	8, 449		90.00
90. 05		PATIENT NUTRITION	70, 052		90. 05
90. 07		WOUND CLINIC	161, 895		90. 07
91.00	1	EMERGENCY	1, 201, 380		91.00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART) AL PURPOSE COST CENTERS			92.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	32, 046, 337		118. 00
		IMBURSABLE COST CENTERS	02/0/0/00/		1
	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190. 00
		RURAL HEALTH	89, 574		194. 00
		RENTAL PROPERTY	224, 743		194. 01
		FAMILY PRACTICE	1, 668, 765		194. 02
	1	WELLNESS DHYSI CLAN DDACTI CES	476, 045 152, 725		194. 03
		PHYSICIAN PRACTICES SYCAMORE SPORTS MED	152, 725 7, 872		194. 04 194. 06
	1	PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES	681, 329		194. 00
200.00		Cross Foot Adjustments	39, 416		200.00
201.00	1	Negative Cost Centers	288, 438		201. 00

Heal th Finar	ncial Systems	UNI ON HOSPITA	AL, INC.		In Lie	u of Form CMS-	2552-10
ALLOCATI ON	OF CAPITAL RELATED COSTS		Provi der	CCN: 15-0023	Peri od: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Pro 11/12/2018 4:	
	Cost Center Description	Total					
		26. 00					
202.00	TOTAL (sum lines 118 through 201)	35, 675, 244					202.00

COST	ALLOCATION - STATISTICAL BASIS		Provi der CO	CN: 15-0023	Peri od: From 01/01/2016 To 12/31/2016	Worksheet B-1 Date/Time Pre	
		CAPITAL RELA	ATED COSTS		10 12/31/2010	11/12/2018 4:	
	Cost Center Description	NEW BLDG &	NEW MVBLE EQUI P	EMPLOYEE BENEFITS	NONPATI ENT TELEPHONES	DATA PROCESSI NG	
		(NEW TOTAL SQ FT)	(NEW EQUIP DEPRN)	DEPARTMENT (GROSS	(PHONES)	(DEVICES)	
		1.00	2. 00	SALARI ES) 4. 00	5. 01	5. 02	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	966, 430	2 200 507				1.00
2. 00 4. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	5, 191	3, 290, 587 0	93, 061, 25	56	•	2. 00 4. 00
5. 01	00540 NONPATI ENT TELEPHONES	657	22, 837	550, 82			5. 01
5. 02	00550 DATA PROCESSING	0	0		0 0	1, 124	1
5. 03	00560 PURCHASING RECEIVING AND STORES	0	0		0 0	0	
5.04	00570 ADMITTING	3, 062	5, 005	1, 285, 73	39 45 0 0	0	
5. 05 5. 06	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00590 OTHER ADMIN AND GENERAL	18, 571	46, 438	5, 045, 55		2	5. 05 5. 06
7. 00	00700 OPERATION OF PLANT	334, 876	102, 246	1, 744, 16		0	
8.00	00800 LAUNDRY & LINEN SERVICE	5, 988	67, 186	605, 59		0	8. 00
9. 00	00900 HOUSEKEEPI NG	5, 313	56, 667	1, 979, 54		0	9. 00
10.00		10, 976	118, 544 8, 780	1, 820, 63		19	
11. 00 13. 00	l l	7, 832 2, 376	8, 780 4, 700	112, 41 1, 431, 92		0	
16. 00		5, 283	6, 812	1, 978, 91		46	
17.00		0	0		0 0	0	1
21. 00		0	0	1, 336, 24		0	
22.00		0	0	1, 289, 79			
23. 00 23. 01		0 720	0 928	7, 54 219, 94		0	23. 00 23. 01
23.01	INPATIENT ROUTINE SERVICE COST CENTERS	720	720	217, 7-	0	0	23.01
30.00	03000 ADULTS & PEDIATRICS	188, 046	392, 590	19, 764, 19	171	629	30.00
31.00	1	22, 990	163, 110	5, 337, 51		74	
35. 00 41. 00	1 1	2, 880	53, 603			16 0	1
43.00		14, 821 3, 927	18, 930 3, 330	1, 325, 93 1, 024, 98			1
10.00	ANCILLARY SERVICE COST CENTERS	0,727	0,000	1,021,70			1
50.00	1	40, 735	683, 560	4, 488, 89		32	1
50. 01	1	1, 800	64, 973	2, 083, 45		0	
50. 02 51. 00	1	30, 028 1, 432	108, 783 16, 756	1, 448, 19	0 0 11 18	0	50. 02 51. 00
51.00	1 1	21, 344	69, 101	2, 164, 59		0	1
52.00		20, 805	113, 857	3, 239, 76		30	
54. 00		32, 635	340, 967	3, 685, 14		63	1
55. 00 56. 00		26, 393	165, 770	433, 77		0	55. 00 56. 00
57.00		2, 914 2, 172	3, 980 237	336, 71 1, 058, 3 <i>6</i>		2	57.00
58. 00		2, 593	16, 257	567, 60		Ö	1
	05900 CARDI AC CATHETERI ZATI ON	16, 694	57, 020	740, 61	6 34	34	1
	06000 LABORATORY	0	0		0 8	0	
62. 00 65. 00		2, 134	0 107, 576	2, 610, 20	0 0	0 14	
66. 00	l l	10, 150	14, 696	2,010,20	0 23	23	
66. 01		0	0		0 0	0	1
66. 02		0	23, 183		0 1	0	
67.00		1, 658	4, 696		0 5	0	67.00
68. 00 69. 00	1	3, 288 1, 305	831 18, 546	1, 468, 22	26 4	0 19	68. 00 69. 00
69. 01	1 1	7, 200	14, 145	284, 07		3	1
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 505	25, 944			0	1
71. 00		5, 712	29, 873		0 14	0	71.00
72.00		12 043	0	2 524 20	0 0	0	
73. 00 76. 00		12, 842 3, 525	22, 185 386	3, 536, 28	50 0 4	21 0	1
70.00	OUTPATIENT SERVICE COST CENTERS	0,020	000		<u> </u>		70.00
	09000 CLI NI C	218	0	172, 59	0	0	90.00
90.05	1	1, 930	622	288, 10		0	
90. 07 91. 00		3, 899 24, 071	7, 707 98, 774	330, 17 4, 897, 02		0 88	
91.00	i i	24, 071	90, 774	4, 097, 02	25 05	00	92.00
,2.00	SPECIAL PURPOSE COST CENTERS	l l					72.00
118.0	SUBTOTALS (SUM OF LINES 1 through 117)	912, 491	3, 082, 131	84, 704, 91	9 1, 153	1, 118	118.00
100.0	NONREI MBURSABLE COST CENTERS					^	100.00
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 07950 RURAL HEALTH	0	20, 994	1, 211, 18	0 0		190. 00 194. 00
	1 07951 RENTAL PROPERTY		3, 187	.,	0 0		194. 01
	2 07954 FAMILY PRACTICE	37, 071	151, 456	1, 818, 97	72 71		194. 02

Health Financial Systems	UNI ON HOSPIT	AL, INC.		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
				From 01/01/2016		
				To 12/31/2016	Date/Time Pre	pared:
					11/12/2018 4:	13 pm_
	CAPI TAL RELA	ATED COSTS				
Cost Center Description	NEW BLDG &	NEW MVBLE	EMPLOYEE	NONPATI ENT	DATA	

						11/12/2018 4:	13 pm
		CAPITAL REL	ATED COSTS				
	Cost Center Description	NEW BLDG &	NEW MVBLE EQUIP	EMPLOYEE BENEFITS	NONPATI ENT TELEPHONES	DATA PROCESSI NG	
		(NEW TOTAL	(NEW EQUIP	DEPARTMENT	(PHONES)	(DEVICES)	
		`	,		(PHUNES)	(DEVICES)	
		SQ FT)	DEPRN)	(GROSS			
		1.00	2.00	SALARI ES)	F 01	F 00	
104 00 07050	WELLNESS	1.00	2.00	4. 00	5. 01	5. 02	101.00
194. 03 07952		14, 002	0	333, 271	0	l e	194. 03
	PHYSICIAN PRACTICES	0	27, 393			l e	194. 04
	SYCAMORE SPORTS MED	0	2, 900				194. 06
	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	2, 866	2, 526	302, 729	8	4	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)	20, 345, 462	8, 650, 158	27, 175, 521	1, 079, 636	11, 672, 578	202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	21. 052184	2. 628758	0. 292018	860. 267729	10, 384. 855872	203.00
204.00	Cost to be allocated (per Wkst. B,			109, 282	74, 511	0	204.00
	Part II)				·		
205. 00	Unit cost multiplier (Wkst. B, Part			0. 001174	59. 371315	0. 000000	205. 00
	[1]						
206. 00	NAHE adjustment amount to be allocated						206.00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207.00
	Parts III and IV)						

COST	ALLOCA	ITON - STATISTICAL BASIS		Provider C	F	rom 01/01/2016 o 12/31/2016	Worksheet B-1 Date/Time Pre	pared:
		Cost Center Description	PURCHASI NG RECEI VI NG AND STORES (REQUI SI TI 0)	ADMITTING (INPATIENT REVENUE)	COUNTS RECEI VABLE (TOTAL	Reconciliatio n	11/12/2018 4: OTHER ADMIN AND GENERAL (ACCUM. COST)	13 pm
			5. 03	5. 04	REVENUE) 5. 05	5A. 06	5. 06	
1. 00 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04	00100 00200 00400 00540 00550 00560	AL SERVICE COST CENTERS NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT NONPATIENT TELEPHONES DATA PROCESSING PURCHASING RECEIVING AND STORES ADMITTING	5, 147, 315 3, 690	523, 033, 103				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	00580 00590 00700 00800 00900 01000 01100	CASHI ERI NG/ACCOUNTS RECEI VABLE OTHER ADMIN AND GENERAL OPERATION OF PLANT LAUNDRY & LI NEN SERVI CE HOUSEKEEPI NG DI ETARY CAFETERI A	0 205 2, 032 7, 135 14, 526 305 5	0 0 0 0 0 0	1, 306, 588, 269 0 0 0 0 0 0 0	-26, 099, 227 0 0 0 0	314, 883, 795 17, 234, 895 1, 496, 866 3, 796, 781 4, 565, 028 0	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	01600 01700 02100 02200 02300 02341	NURSING ADMINISTRATION MEDICAL RECORDS & LIBRARY SOCIAL SERVICE I&R SERVICES-SALARY & FRINGES APPRVD I&R SERVICES-OTHER PRGM COSTS APPRVD PARAMED ED PRGM OTHER MED ED IENT ROUTINE SERVICE COST CENTERS	0 93 0 0 0 0	0 0 0 0 0 0	000000000000000000000000000000000000000	0 0 0 0	3, 614, 714 4, 710, 535 0 1, 823, 766 2, 632, 111 253, 435 354, 425	13. 00 16. 00 17. 00 21. 00 22. 00 23. 00 23. 01
30. 00 31. 00 35. 00 41. 00 43. 00	03100 02040 04100 04300	ADULTS & PEDIATRICS INTENSIVE CARE UNIT INTENSIVE NURSERY SUBPROVIDER - IRF NURSERY LARY SERVICE COST CENTERS	1, 160, 430 619, 067 80, 044 47, 591 0	89, 896, 038 25, 240, 315 15, 215, 931 3, 624, 414 5, 245, 733	25, 271, 663 15, 215, 931 3, 625, 454	0 0 0	44, 386, 863 10, 514, 817 3, 499, 720 2, 490, 029 1, 669, 346	30. 00 31. 00 35. 00 41. 00 43. 00
50. 00 50. 01 50. 02 51. 00 51. 02 52. 00 54. 00 55. 00 58. 00 60. 00 62. 00 66. 01 66. 02 67. 00 68. 00 69. 01 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00 77. 00 78. 00 79. 00 79. 00 79. 00 79. 00	05000 05001 05002 05100 05101 05200 05400 05500 05700 06800 06600 06600 06600 06600 06600 06600 06600 06900 07100 07100 07200 07300 03020 007000	OPERATING ROOM CARDIAC SURGERY WYSC RECOVERY ROOM O/P TREATMENT ROOM DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC RADIOLOGY-THERAPEUTIC RESONANCE IMAGING (MRI) CARDIAC CATHETERIZATION LABORATORY WHOLE BLOOD & PACKED RED BLOOD CELLS RESPIRATORY THERAPY PHYSICAL THERAPY PSYCHIATRIC/PSYCHOLOGICAL SERVICES O/P PHYSICAL THERAPY OCCUPATIONAL THERAPY SPEECH PATHOLOGY ELECTROCARDIOLOGY CARDIAC REHAB ELECTROCARDIOLOGY CARDIAC REHAB ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS TENT SERVICE COST CENTERS ICLINIC PATIENT NUTRITION	209, 058 1, 167, 270 30, 059 128, 507 109, 230 288, 661 66, 605 2, 542 5, 547 192, 171 4, 147 34, 866 0 0 114, 019 2, 626 2, 616 0 18, 391 811 3, 644 12, 613 0 83, 109 48, 171	97, 039, 847 11, 777, 952 0 1, 982, 640 1, 383, 483 15, 016, 066 11, 799, 799 1, 552, 505 1, 044, 317 16, 233, 170 2, 576, 870 2, 596, 659 11, 000, 711 10, 811, 304 0 4, 953, 921 1, 179, 232 10, 977, 783 153, 720 3, 232, 715 2, 384, 150 0 68, 167, 958 3, 525, 499	12, 195, 737 106, 095, 052 5, 065, 446 10, 360, 970 19, 648, 524 53, 890, 466 38, 735, 923 9, 016, 112 57, 501, 526 13, 713, 140 110, 857, 918 92, 236, 841 3, 216, 828 12, 153, 254 11, 604, 203 0 6, 812, 335 7, 752, 483 2, 548, 823 19, 943, 720 1, 421, 475 8, 145, 340 2, 537, 728 0 248, 055, 913 3, 970, 688		16, 215, 858 2, 772, 433 13, 028, 954 2, 357, 456 3, 869, 529 5, 880, 252 10, 232, 096 6, 383, 211 1, 466, 011 3, 043, 842 1, 873, 414 17, 065, 714 9, 829, 538 1, 313, 772 5, 025, 165 2, 968, 578 0 2, 180, 143 1, 657, 832 689, 701 2, 819, 038 650, 431 1, 390, 811 1, 168, 263 12, 632, 757 46, 131, 492 1, 643, 110	51. 02 52. 00 54. 00 55. 00 56. 00 57. 00 58. 00 60. 00 62. 00 65. 00 66. 01 66. 02 67. 00 68. 00 69. 01 70. 00 71. 00 72. 00 73. 00
90. 07 91. 00 92. 00	09007 09100 09200 SPECI	WOUND CLINIC EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART) AL PURPOSE COST CENTERS	59, 719 597, 517	0 29, 350, 678	5, 820, 246 124, 751, 734	0	1, 555, 957 12, 171, 989	90. 07 91. 00 92. 00
118.00	NONRE	SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	5, 117, 192	5∠3, U33, 1U3	1, 306, 588, 269	-25, 084, 879	291, 780, 902	
194. 00 194. 01 194. 02 194. 03	07950 07951 07954 07952	GIFT, FLOWER, COFFEE SHOP & CANTEEN RURAL HEALTH RENTAL PROPERTY FAMILY PRACTICE WELLNESS PHYSICIAN PRACTICES	0 10, 761 0 49 0 19, 163	0 0 0 0 0	000000000000000000000000000000000000000	0 0 0 0	0 3, 741, 227 173, 661 4, 522, 204 844, 925 13, 121, 712	194. 01 194. 02 194. 03

Health Financial Systems	UNION HOSPI	TAL, INC.		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
				rom 01/01/2016		
				Γο 12/31/2016		
Cost Center Description	PURCHASI NG	ADMITTING	CASHLEDI NC /AC	Reconciliatio	11/12/2018 4: OTHER ADMIN	13 pili
Cost Center Description	RECEIVING AND	(I NPATI ENT	COUNTS		AND GENERAL	
	STORES	•	RECEI VABLE	n		
		REVENUE)			(ACCUM.	
	(REQUISITIO)		(TOTAL		COST)	
	F 02	F 04	REVENUE)	FA 0/	F 0/	
10.1.0.(07050 0)(0.11005 000070 1150	5. 03	5. 04	5. 05	5A. 06	5. 06	404.04
194. 06 07953 SYCAMORE SPORTS MED	0	0	9	0	135, 296	•
194. 07 07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	150	0	(0	563, 868	1
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B,	1, 407, 606	2, 422, 283	6, 230, 24	3	26, 099, 227	202. 00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 273464	0. 004631	0.00476	3	0. 082885	203.00
204.00 Cost to be allocated (per Wkst. B,	0	145, 766			553, 238	204.00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000279	0.00000		0. 001757	205.00
206.00 NAHE adjustment amount to be allocated						206. 00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,						207. 00
Parts III and IV)						
	1		1	1	ı	'

COST	ALLOCATION - STATISTICAL BASIS		Provi der C	F	eriod: rom 01/01/2016 o 12/31/2016	Worksheet B-1 Date/Time Pre	
	Cost Center Description	OPERATION OF PLANT (NEW TOTAL SQ FT)	LAUNDRY & LI NEN SERVI CE (LI NEN)	HOUSEKEEPING (NEW TOTAL SQ FT)	DI ETARY (DI ETARY)	11/12/2018 4: CAFETERI A (FTE)	13 pm
		7. 00	8.00	9. 00	10.00	11. 00	
1 00	GENERAL SERVICE COST CENTERS						1 00
1. 00 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 5. 06 7. 00 10. 00 11. 00 13. 00 17. 00 21. 00 22. 00 23. 00	01100 CAFETERIA 01300 NURSING ADMINISTRATION 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 02100 &R SERVICES-SALARY & FRINGES APPRVD 02200 &R SERVICES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM 02341 OTHER MED ED	604, 073 5, 988 5, 313 10, 976 7, 832 2, 376 5, 283 0 0 0	1, 111, 064 79, 581 5, 912 0 0 0 0 0 0	592, 772 10, 976 7, 832 2, 376 5, 283 0 0	183, 353 0 0 0 0 0 0 0	11, 284 146 434 0 210 46 256 43	13. 00 16. 00 17. 00 21. 00 22. 00 23. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	188, 046	343, 919	188, 046	137, 024	3, 629	30.00
31. 00 35. 00 41. 00 43. 00	03100 INTENSIVE CARE UNIT 02040 INTENSIVE NURSERY 04100 SUBPROVIDER - IRF	22, 990 2, 880 14, 821 3, 927	63, 318 5, 537 9, 485	22, 990 2, 880 14, 821	23, 279 10, 198		31.00 35.00 41.00
FO 00	ANCILLARY SERVICE COST CENTERS	40. 725	71 275	40.725		F(0	FO 00
50. 00 50. 01 50. 02 51. 00 51. 02 52. 00 55. 00 56. 00 57. 00 58. 00 60. 00 62. 00 66. 01 66. 02 67. 00 68. 00 69. 01 70. 00 71. 00 72. 00 73. 00 76. 00	05001 CARDI AC SURGERY 05002 WVSC 05100 RECOVERY ROOM 05101 O/P TREATMENT ROOM 05200 DELI VERY ROOM & LABOR ROOM 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05600 MAGNETI C RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON 06900 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 O/P PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06901 CARDI AC REHAB 07000 ELECTROCARDI OLOGY 06901 CARDI AC REHAB 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 03020 RENAL ACUTE	40, 735 1, 800 30, 028 1, 432 21, 344 20, 805 32, 635 26, 393 2, 914 2, 172 2, 593 16, 694 0 0 2, 134 10, 150 0 1, 658 3, 288 1, 305 7, 200 1, 505 5, 712 0 12, 842 3, 525	59 83, 163 41, 895 36, 260 50, 279 33, 736 18, 160 5, 219 0 36, 266 10, 409 0 0 9, 594 0 19, 450 0 6, 425 461 1, 934 0 0 0 5, 556	1, 800 30, 028 1, 432 21, 344 20, 805 32, 635 26, 393 2, 914 2, 172 2, 593 16, 694 0 0 2, 134 10, 150 0 1, 658 3, 288 1, 305 7, 200 1, 505 5, 712 0 12, 842 3, 525	0 0 12,011 4 0 0 0 0 0 837 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	560 77 0 225 366 443 384 62 51 146 70 0 388 0 0 0 0 0 0 267 44 77 0 0 437	50. 01 50. 02 51. 00 51. 02 52. 00 54. 00 55. 00 56. 00 57. 00 60. 00 62. 00 66. 01 66. 02 67. 00 68. 00 69. 01 70. 00 71. 00 72. 00 73. 00
90.00	09000 CLI NI C	218	1	218		20	
90. 05 90. 07 91. 00 92. 00	09007 WOUND CLINIC 09100 EMERGENCY	1, 930 3, 899 24, 071	11, 703			46 52 823	90.07
118. 00		550, 134	1, 104, 898	538, 833	183, 353	10, 810	118. 00
194. 00 194. 00 194. 00 194. 00	NONKEIMBURSABLE COST CENTERS 0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 07950 RURAL HEALTH 1 07951 RENTAL PROPERTY 2 07954 FAMILY PRACTICE 3 07952 WELLNESS 4 07955 PHYSICIAN PRACTICES 6 07953 SYCAMORE SPORTS MED	0 0 0 37, 071 14, 002 0	0 1, 171 0 4, 117	0 37, 071 14, 002 0	0	0 0 143 0 287	190. 00 194. 00 194. 01 194. 02 194. 03 194. 04 194. 06

Heal th Finar	ncial Systems	UNION HOSPITAL, INC.			In Lieu of Form CMS-2552-10			
COST ALLOCA	TION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1		
					From 01/01/2016 To 12/31/2016	Date/Time Pre 11/12/2018 4:	pared: 13 pm_	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG		CAFETERI A		
		PLANT	LI NEN SERVI CE	(NEW TOTAL	(DI ETARY)	(FTE)		
		(NEW TOTAL	(LI NEN)	SQ FT)				
		SQ FT)						
		7. 00	8. 00	9. 00	10.00	11. 00		
	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	2, 866	0	2, 86	6 0		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, 663, 409	1, 805, 939	4, 404, 97	5, 373, 687	-714, 170	202. 00	
203. 00	Unit cost multiplier (Wkst. B, Part I)	30. 895950	1. 625414	7. 43115	29. 307876	0.000000	203.00	
204. 00	Cost to be allocated (per Wkst. B, Part II)	7, 371, 799	385, 924	360, 81	1 700, 855	288, 438	204. 00	
205. 00	Unit cost multiplier (Wkst. B, Part	12. 203490	0. 347346	0. 60868	3. 822435	25. 561680	205. 00	
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00	
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00	
l l	1. 4. 10 11. 4.14 11.		'		1 1		1	

| Peri od: | Worksheet B-1 | | To | 12/31/2016 | Date/Time Prepared: | Provider CCN: 15-0023

N LI BRARY (# (I NTERNS) (I N		
ADMINISTRATIO RECORDS & SERVICE RY & FRINGES R PRO N LIBRARY (# (INTERNS) (IN	GM COSTS	
N LI BRARY (# (I NTERNS) (I N		
SPENT) REVENUE) 13.00 16.00 17.00 21.00 2	2. 00	
GENERAL SERVICE COST CENTERS	2.00	
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP		1.00 2.00
4. 00 O0400 EMPLOYEE BENEFITS DEPARTMENT		4.00
5. 01 00540 NONPATIENT TELEPHONES		5. 01
5. 02 00550 DATA PROCESSING 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 7. 00 00700 OPERATION OF PLANT		5. 06 7. 00
8.00 00800 LAUNDRY & LINEN SERVICE		8. 00
9. 00 00900 HOUSEKEEPI NG		9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A		10.00 11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 8, 158		13.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY		16.00 17.00
21. 00 02100 1 &R SERVI CES-SALARY & FRI NGES APPRVD 0 0 0 1,000		21.00
22. 00 02200 1 &R SERVICES-OTHER PRGM COSTS APPRVD 0 0 0	1, 000	1
23. 00 02300 PARAMED ED PRGM		23. 00 23. 01
INPATIENT ROUTINE SERVICE COST CENTERS		25.01
30. 00 03000 ADULTS & PEDI ATRI CS 3, 423 100, 187, 261 0 367	367	30.00
31. 00 03100 I NTENSI VE CARE UNI T 759 25, 271, 663 0 0 35. 00 02040 I NTENSI VE NURSERY 258 15, 215, 931 0 9	0	31.00 35.00
41. 00 04100 SUBPROVI DER - I RF 221 3, 625, 454 0 0	0	41.00
43. 00 04300 NURSERY 169 5, 245, 733 0 0 0	0	43.00
50. 00 05000 OPERATING ROOM 541 167, 969, 127 0 43	43	50.00
50. 01 05001 CARDI AC SURGERY 49 12, 195, 737 0	0	50. 01
50. 02 05002 WVSC	0	50. 02 51. 00
51. 02 05101 0/P TREATMENT ROOM 366 10, 360, 970 0 0	0	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 430 19, 648, 524 0 98	98	52.00
54. 00 05400 RADI 0LOGY-DI AGNOSTI C	15 7	54. 00 55. 00
56. 00 05600 RADI 0I SOTOPE 0 9, 016, 112 0	0	56.00
57. 00 05700 CT SCAN	0	57.00
58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI)	0 5	58. 00 59. 00
60. 00 06000 LABORATORY 0 92, 236, 841 0	0	60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 3, 216, 828 0 0 0 65. 00 06500 RESPIRATORY THERAPY 388 12, 153, 254 0 15	0	62.00
65. 00 06500 RESPI RATORY THERAPY 388 12, 153, 254 0 15 66. 00 06600 PHYSI CAL THERAPY 0 11, 604, 203 0 1	15 1	65. 00 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 6, 812, 335 0 32 67. 00 06700 0CCUPATI ONAL THERAPY 0 7, 752, 483 0 0	32 0	66. 02 67. 00
68. 00 06800 SPEECH PATHOLOGY 0 2,548,823 0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY 0 19, 943, 720 0 1	1	69.00
69. 01 06901 CARDI AC REHAB 0 1, 421, 475 0 0 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 8, 145, 340 0 3	0	69. 01 70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 2,537,728 0 0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 361 248, 055, 913 0 14	0	72.00
73. 00 07300 DRUGS CHARGED TO PATI ENTS 361 248, 055, 913 0 14 76. 00 03020 RENAL ACUTE 0 3, 970, 687 0 0	14 0	73. 00 76. 00
OUTPATIENT SERVICE COST CENTERS		
90. 00 09000 CLINIC 20 797, 668 0 156 90. 05 09005 PATIENT NUTRITION 46 223, 008 0 2	156 2	90. 00 90. 05
90. 03 09003 PATTENT NOTRETTON 40 225, 008 0 2 9 9 0. 07 09007 WOUND CLINIC 52 5, 820, 246 0 17	17	1
91. 00 09100 EMERGENCY 823 124, 751, 734 0 105	105	
92.00 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS		92.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 8,158 1,306,588,269 0 890	890	118. 00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0	0	190. 00
194. 00 07950 RURAL HEALTH 0 0 0 0	0	194. 00
194. 01 07951 RENTAL PROPERTY 0 0 0 0		194. 01
194. 02 07954 FAMILY PRACTICE 0 0 110	110	194. 02

Health Financial Systems	UNION HOSPITAL, INC.	In Lieu	of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0023	From 01/01/2016 To 12/31/2016	Worksheet B-1 Date/Time Prepared:

Cost Center Description NURSI NG ADMINISTRATIO RECORDS & LI BRARY (# REFERRALS) SERVI CES-SALA SERVI CES-OTHE RY & FRI NGES (I NTERNS) (I NTERNS)	m_
ADMINISTRATIO RECORDS & SERVICE RY & FRINGES (INTERNS) REFERALS) REFERALS RE	
ADMINISTRATIO RECORDS & SERVICE RY & FRINGES (INTERNS) REFERALS) REFERALS RE	
N (TIME SPENT) REFERRALS) (INTERNS) (INTERNS)	
CTIME SPENT) REFERRALS) SPENT) REVENUE SPENT) REVENUE SPENT) REVENUE SPENT) REVENUE SPENT) SPENT S	
SPENT REVENUE	
13. 00 16. 00 17. 00 21. 00 22. 00 194. 03 07952 WELLNESS 0 0 0 0 0 194. 04 194. 04 07955 PHYSI CI AN PRACTICES 0 0 0 0 0 0 194. 04 194. 06 07953 SYCAMORE SPORTS MED 0 0 0 0 0 0 194.	
194. 03 07952 WELLNESS 0 0 0 0 0 194. 194. 04 07955 PHYSI CI AN PRACTI CES 0 0 0 0 0 0 194. 194. 06 07953 SYCAMORE SPORTS MED 0 0 0 0 0 0 194.	
194. 04 07955 PHYSI CI AN PRACTI CES 0 0 0 0 194. 194. 06 07953 SYCAMORE SPORTS MED 0 0 0 0 194.	
194. 06 07953 SYCAMORE SPORTS MED 0 0 0 194.	
200.00 Cross Foot Adjustments 200.	
201.00 Negative Cost Centers 201.	
202.00 Cost to be allocated (per Wkst. B, 4,005,385 5,303,450 0 1,974,929 2,850,274 202.	00
203.00 Unit cost multiplier (Wkst. B, Part I) 490.976342 0.004059 0.000000 1,974.929000 2,850.274000 203.	
204.00 Cost to be allocated (per Wkst. B, 104,794 218,132 0 4,773 6,139 204.	00
205. 00 Unit cost multiplier (Wkst. B, Part 12. 845550 0. 000167 0. 000000 4. 773000 6. 139000 205.	00
206.00 NAHE adjustment amount to be allocated 206.	00
(per Wkst. B-2)	
207.00 NAHE unit cost multiplier (Wkst. D, 207.	00
Parts III and IV)	

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

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

					11/12/2018 4:	13 pm
		Cost Center Description	PARAMED ED	OTHER MED ED		
			PRGM (PARAMED	(ASSI GNED		
			RADI OLOGY)	TIME)		
			23. 00	23. 01		
	GENER	AL SERVICE COST CENTERS				
1.00	1	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	1	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4. 00 5. 01	1	EMPLOYEE BENEFITS DEPARTMENT NONPATIENT TELEPHONES				4. 00 5. 01
5. 02		DATA PROCESSING				5. 02
5. 03	00560	PURCHASING RECEIVING AND STORES				5. 03
5.04		ADMITTING				5.04
5. 05		CASHI ERI NG/ACCOUNTS RECEI VABLE				5. 05
5. 06 7. 00	1	OTHER ADMIN AND GENERAL OPERATION OF PLANT				5. 06 7. 00
8. 00	1	LAUNDRY & LINEN SERVICE				8.00
9. 00	1	HOUSEKEEPI NG				9.00
10. 00	1	DI ETARY				10.00
11.00	1	CAFETERI A				11.00
13. 00 16. 00	1	NURSING ADMINISTRATION MEDICAL RECORDS & LIBRARY				13. 00 16. 00
17. 00	1	SOCIAL SERVICE				17. 00
21. 00		I&R SERVICES-SALARY & FRINGES APPRVD				21.00
22. 00		I&R SERVICES-OTHER PRGM COSTS APPRVD				22. 00
23. 00		PARAMED ED PRGM	100			23.00
23. 01		OTHER MED ED I ENT ROUTINE SERVICE COST CENTERS		100		23. 01
30. 00		ADULTS & PEDIATRICS	0	0		30.00
31. 00		INTENSIVE CARE UNIT	0	0		31.00
35. 00	1	INTENSIVE NURSERY	0	0		35.00
41.00	1	SUBPROVI DER - I RF	0	0		41. 00
43.00		NURSERY	0	0		43.00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	0	0		50.00
50. 00	1	CARDI AC SURGERY	0	0		50.00
50. 02	05002		o O	0	·	50.02
51.00		RECOVERY ROOM	0	0		51.00
51. 02	1	O/P TREATMENT ROOM	0	0	1	51.02
52.00	1	DELIVERY ROOM & LABOR ROOM	0	0	1	52.00
54. 00 55. 00	1	RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C	100	0	·	54. 00 55. 00
56. 00	1	RADI OI SOTOPE	0	0	·	56.00
57.00	1	CT SCAN	0	0		57.00
58. 00	1	MAGNETIC RESONANCE IMAGING (MRI)	0	0	·	58. 00
59.00		CARDI AC CATHETERI ZATI ON	0	0	1	59.00
60. 00 62. 00	1	LABORATORY WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	1	60. 00 62. 00
65. 00	1	RESPIRATORY THERAPY	0	0	1	65.00
66. 00		PHYSI CAL THERAPY	O	0	1	66.00
66. 01	1	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		66. 01
	1	O/P PHYSICAL THERAPY	0	0	·	66.02
67. 00 68. 00		OCCUPATI ONAL THERAPY SPEECH PATHOLOGY	0	0	·	67. 00 68. 00
69. 00	1	ELECTROCARDI OLOGY	0	0		69.00
69. 01	1	CARDI AC REHAB	Ö	Ö		69. 01
	07000	ELECTROENCEPHALOGRAPHY	0	0		70. 00
71.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71. 00
		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0	0	·	72. 00 73. 00
76.00	1	RENAL ACUTE	0	100 0	·	76.00
70.00		TIENT SERVICE COST CENTERS	<u> </u>	0		70.00
90.00	09000	CLI NI C	0	0		90.00
90. 05		PATIENT NUTRITION	0	0	1	90. 05
90. 07		WOUND CLINIC	0	0	1	90.07
91.00	1	EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)		0		91. 00 92. 00
,2.00		AL PURPOSE COST CENTERS	1			,2.00
118.00)	SUBTOTALS (SUM OF LINES 1 through 117)	100	100		118. 00
		IMBURSABLE COST CENTERS				
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
	1	RURAL HEALTH RENTAL PROPERTY	0	0		194. 00 194. 01
	1	FAMILY PRACTICE		0		194.01
		WELLNESS	o	Ö		194. 03
	1	PHYSI CI AN PRACTI CES	0	0		194. 04
194.06	07953	SYCAMORE SPORTS MED	0	0		194. 06

Health Financial Systems	UNION HOSPITAL, INC.	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0023	Period: Worksheet B-1 From 01/01/2016
		To 12/31/2016 Date/Time Prepared

					11/12/2018 4: 13 pm
		Cost Center Description	PARAMED ED PRGM (PARAMED RADIOLOGY)	OTHER MED ED (ASSI GNED TIME)	
			23. 00	23. 01	
		PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	194. 07
	200. 00	Cross Foot Adjustments			200.00
	201. 00	Negative Cost Centers			201.00
	202. 00	Cost to be allocated (per Wkst. B, Part I)	274, 441	424, 653	202.00
	203. 00	Unit cost multiplier (Wkst. B, Part I)	2, 744. 410000	4, 246. 530000	203.00
	204. 00	Cost to be allocated (per Wkst. B, Part II)	454	28, 050	204. 00
	205. 00	Unit cost multiplier (Wkst. B, Part II)	4. 540000	280. 500000	205. 00
	206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)	0	0	206. 00
	207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)	0. 000000	0. 000000	207. 00

Health Financial Systems	UNION HOSPITAL, INC.	In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0023		Worksheet C	
		From 01/01/2016		

				o 12/31/2016	Date/Time Pre 11/12/2018 4:	pared:
·		Title	XVIII	Hospi tal	PPS	то ріп
			7,,,,,	Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
5551 5511ton 55551 Pt 1 511	(from Wkst.	Adj.	1014. 00010	Di sal I owance	.014. 00010	
	B, Part I,					
	col . 26)					
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	•	<u> </u>				
30. 00 03000 ADULTS & PEDI ATRI CS	61, 935, 293		61, 935, 293	O	61, 935, 293	30.00
31. 00 03100 INTENSIVE CARE UNIT	13, 527, 883		13, 527, 883		13, 527, 883	
35. 00 02040 I NTENSI VE NURSERY	4, 396, 491		4, 396, 491	o	4, 396, 491	35.00
41. 00 04100 SUBPROVI DER - I RF	3, 403, 100		3, 403, 100		3, 403, 100	
43. 00 04300 NURSERY	2, 062, 487		2, 062, 487		2, 062, 487	43.00
ANCILLARY SERVICE COST CENTERS	<u> </u>	<u> </u>				1
50. 00 05000 OPERATING ROOM	20, 184, 420		20, 184, 420	0	20, 184, 420	50.00
50. 01 05001 CARDI AC SURGERY	3, 144, 871		3, 144, 871	o	3, 144, 871	50. 01
50. 02 05002 WVSC	15, 825, 560		15, 825, 560		15, 825, 560	
51.00 05100 RECOVERY ROOM	2, 806, 866		2, 806, 866	o	2, 806, 866	51.00
51.02 05101 0/P TREATMENT ROOM	5, 641, 016		5, 641, 016	o	5, 641, 016	51.02
52.00 05200 DELIVERY ROOM & LABOR ROOM	7, 537, 746		7, 537, 746		7, 537, 746	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	12, 879, 005		12, 879, 005	o	12, 879, 005	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	8, 110, 597		8, 110, 597	o	8, 110, 597	55.00
56. 00 05600 RADI 0I SOTOPE	1, 744, 285		1, 744, 285	o	1, 744, 285	56.00
57. 00 05700 CT SCAN	3, 612, 776		3, 612, 776	o	3, 612, 776	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	2, 242, 683		2, 242, 683	o	2, 242, 683	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	19, 611, 461		19, 611, 461	o	19, 611, 461	59.00
60. 00 06000 LABORATORY	11, 018, 648		11, 018, 648		11, 201, 718	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 435, 721		1, 435, 721	o	1, 435, 721	62.00
65. 00 06500 RESPIRATORY THERAPY	5, 763, 295	0	5, 763, 295	o	5, 763, 295	65.00
66. 00 06600 PHYSI CAL THERAPY	3, 666, 344	0	3, 666, 344	o	3, 666, 344	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	2, 420, 109	0	2, 420, 109	0	2, 420, 109	66. 02
67. 00 06700 OCCUPATI ONAL THERAPY	1, 890, 254	0	1, 890, 254	0	1, 890, 254	67.00
68. 00 06800 SPEECH PATHOLOGY	883, 233	0	883, 233	O	883, 233	68.00
69. 00 06900 ELECTROCARDI OLOGY	3, 194, 106		3, 194, 106	0	3, 194, 106	69.00
69. 01 06901 CARDI AC REHAB	986, 816		986, 816	0	986, 816	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 599, 976		1, 599, 976	0	1, 599, 976	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 494, 320		1, 494, 320	0	1, 494, 320	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	13, 679, 823		13, 679, 823	0	13, 679, 823	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	52, 056, 145		52, 056, 145	0	52, 056, 145	73.00
76. 00 03020 RENAL ACUTE	1, 939, 550		1, 939, 550	0	1, 939, 550	76.00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	313, 774		313, 774	0	313, 774	90.00
90. 05 09005 PATIENT NUTRITION	585, 020		585, 020	3, 365	588, 385	90.05
90. 07 09007 WOUND CLINIC	1, 902, 536		1, 902, 536	0	1, 902, 536	90. 07
91. 00 09100 EMERGENCY	15, 266, 306		15, 266, 306	o	15, 266, 306	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	9, 871, 357		9, 871, 357		9, 871, 357	92.00
200.00 Subtotal (see instructions)	318, 633, 873	0	318, 633, 873	186, 435	318, 820, 308	200.00
201.00 Less Observation Beds	9, 871, 357		9, 871, 357		9, 871, 357	201.00
202.00 Total (see instructions)	308, 762, 516	0	308, 762, 516	186, 435	308, 948, 951	202.00
				·		

| Peri od: | Worksheet C | From 01/01/2016 | Part | To 12/31/2016 | Date/Time Prepared:

					10 12/31/2010	11/12/2018 4:	
			Title	XVIII	Hospi tal	PPS	
			Charges				
	Cost Center Description	Inpatient	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col . 7)	Ratio	I npati ent	
				' ' ' ' ' ' ' '	1.2.1.2	Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
LN	NPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03	3000 ADULTS & PEDIATRICS	89, 896, 038		89, 896, 03	3		30.00
	3100 INTENSIVE CARE UNIT	25, 240, 315		25, 240, 31			31.00
	2040 INTENSIVE NURSERY	15, 215, 931		15, 215, 93			35.00
	4100 SUBPROVI DER - I RF	3, 624, 414		3, 624, 41			41.00
	4300 NURSERY	5, 245, 733		5, 245, 73			43.00
	NCILLARY SERVICE COST CENTERS	5, = .5, .55			-		
	5000 OPERATING ROOM	90, 256, 022	66, 748, 464	157, 004, 486	0. 128560	0.000000	50.00
50. 01 05	5001 CARDI AC SURGERY	9, 481, 312	417, 785			0. 000000	50. 01
	5002 WVSC	87, 966	103, 807, 278			0.000000	1
	5100 RECOVERY ROOM	1, 982, 640	3, 082, 806			0.000000	
	5101 O/P TREATMENT ROOM	37, 907	2, 710, 425			0. 000000	
	5200 DELIVERY ROOM & LABOR ROOM	15, 016, 066	3, 149, 164			0. 000000	•
	5400 RADI OLOGY-DI AGNOSTI C	11, 796, 754	41, 550, 645			0. 000000	1
	5500 RADI OLOGY-THERAPEUTI C	1, 552, 505	37, 131, 616			0. 000000	1
	5600 RADI OI SOTOPE	1, 044, 317	7, 971, 795			0. 000000	1
	5700 CT SCAN	16, 233, 170	41, 268, 356			0. 000000	1
	5800 MAGNETIC RESONANCE IMAGING (MRI)	2, 576, 870	11, 136, 270			0. 000000	1
	5900 CARDI AC CATHETERI ZATI ON	31, 038, 154	75, 040, 061			0. 000000	1
	6000 LABORATORY	43, 227, 570	49, 009, 271			0. 000000	1
	6200 WHOLE BLOOD & PACKED RED BLOOD CELLS	2, 596, 659	620, 169			0.000000	
	6500 RESPIRATORY THERAPY	11, 000, 711	1, 152, 543			0.000000	1
	6600 PHYSI CAL THERAPY	10, 811, 304	792, 899			0.000000	1
	6601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0,011,304	772,077		0.000000	0.000000	1
	6602 O/P PHYSI CAL THERAPY		6, 812, 335			0. 000000	
	6700 OCCUPATI ONAL THERAPY	4, 953, 921	2, 798, 562			0.000000	
	6800 SPEECH PATHOLOGY	1, 179, 232	1, 369, 591			0.000000	1
	6900 ELECTROCARDI OLOGY	10, 977, 783	8, 623, 229			0.000000	1
	6901 CARDI AC REHAB	1 ' ' 1				0.000000	1
	7000 ELECTROENCEPHALOGRAPHY	153, 720 3, 232, 715	1, 267, 755 1, 331, 312			0.000000	
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 384, 150				0.000000	1
			153, 578				1
	7200 IMPL. DEV. CHARGED TO PATIENTS 7300 DRUGS CHARGED TO PATIENTS	7, 827, 041	7, 548, 071			0. 000000 0. 000000	72.00
	3020 RENAL ACUTE	68, 167, 958	178, 146, 392				73.00
		3, 525, 499	445, 188	3, 970, 68	0. 488467	0. 000000	76. 00
	JTPATIENT SERVICE COST CENTERS 9000 CLINIC	1 104	70/ F/4	707 (4)	0.202244	0.000000	00 00
		1, 104	796, 564			0.000000	1
	9005 PATIENT NUTRITION	F 000	223, 008			0.000000	•
	9007 WOUND CLINIC	5,000	5, 773, 097			0.000000	90.07
	9100 EMERGENCY	29, 350, 678	95, 401, 056			0.000000	1
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 345, 576	16, 492, 131			0. 000000	
200.00	Subtotal (see instructions)	521, 066, 735	112, 111, 416	1, 293, 838, 15 ⁻			200.00
201. 00	Less Observation Beds	F21 0// 725	770 771 447	1 202 020 45			201.00
202. 00	Total (see instructions)	521, 066, 735	112, 111, 416	1, 293, 838, 15	I		202. 00

Health Financial Systems	UNION HOSPITAL, INC.	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0023	Peri od: Worksheet C Part I To 12/31/2016 Date/Time Prepared: 11/12/2019 4-13 pm

			10 12/31/2010	11/12/2018 4:13 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
· ·	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS	<u>'</u>			
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 - RF				41.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS	'			
50. 00 05000 OPERATING ROOM	0. 128560			50.00
50. 01 05001 CARDI AC SURGERY	0. 317693			50. 01
50. 02 05002 WVSC	0. 152322			50. 02
51. 00 05100 RECOVERY ROOM	0. 554120			51.00
51.02 05101 0/P TREATMENT ROOM	2. 052523			51. 02
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 414955			52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 241418			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 209662			55.00
56. 00 05600 RADI OI SOTOPE	0. 193463			56.00
57. 00 05700 CT SCAN	0. 062829			57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 163543			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 184877			59.00
60. 00 06000 LABORATORY	0. 121445			60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 446316			62.00
65. 00 06500 RESPIRATORY THERAPY	0. 474218			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 315950			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. 355254			66. 02
67. 00 06700 OCCUPATI ONAL THERAPY	0. 243826			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 346526			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 162956			69.00
69. 01 06901 CARDI AC REHAB	0. 694220			69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 350562			70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 588842			71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 889738			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 211340			73.00
76. 00 03020 RENAL ACUTE	0. 488467			76.00
OUTPATIENT SERVICE COST CENTERS	0. 100 107			76.66
90. 00 09000 CLINIC	0. 393364			90.00
90. 05 09005 PATI ENT NUTRI TI ON	2. 638403			90.05
90. 07 09007 WOUND CLINIC	0. 329267			90.07
91. 00 09100 EMERGENCY	0. 122373			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 553398			92.00
200.00 Subtotal (see instructions)	3. 333370			200.00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00
	1			_{[=12} , 00

			T	0 12/31/2016	Date/Time Pre	pared:
		Ti +I	e XIX	Hospi tal	Cost	13 piii
		11 (1	I I	Costs	0031	
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
5551 5511611 55551 Pt 1511	(from Wkst.	Adj.	1014. 00010	Di sal I owance	.014. 00010	
	B, Part I,	,				
	col. 26)					
	1. 00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30. 00 03000 ADULTS & PEDIATRICS	61, 935, 293		61, 935, 293	0	61, 935, 293	30.00
31.00 03100 INTENSIVE CARE UNIT	13, 527, 883		13, 527, 883	0	13, 527, 883	
35. 00 02040 I NTENSI VE NURSERY	4, 396, 491		4, 396, 491	0	4, 396, 491	
41. 00 04100 SUBPROVI DER - I RF	3, 403, 100		3, 403, 100	0	3, 403, 100	41.00
43. 00 04300 NURSERY	2, 062, 487		2, 062, 487	0	2, 062, 487	43.00
ANCILLARY SERVICE COST CENTERS						1
50. 00 05000 OPERATING ROOM	20, 184, 420		20, 184, 420	0	20, 184, 420	50.00
50. 01 05001 CARDI AC SURGERY	3, 144, 871		3, 144, 871	0	3, 144, 871	50. 01
50. 02 05002 WVSC	15, 825, 560		15, 825, 560	0	15, 825, 560	50. 02
51.00 05100 RECOVERY ROOM	2, 806, 866		2, 806, 866	0	2, 806, 866	51.00
51.02 05101 0/P TREATMENT ROOM	5, 641, 016		5, 641, 016	0	5, 641, 016	51.02
52.00 05200 DELIVERY ROOM & LABOR ROOM	7, 537, 746		7, 537, 746	0	7, 537, 746	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	12, 879, 005		12, 879, 005	0	12, 879, 005	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	8, 110, 597		8, 110, 597	0	8, 110, 597	55.00
56. 00 05600 RADI 0I SOTOPE	1, 744, 285		1, 744, 285	0	1, 744, 285	56.00
57. 00 05700 CT SCAN	3, 612, 776		3, 612, 776	0	3, 612, 776	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	2, 242, 683		2, 242, 683	0	2, 242, 683	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	19, 611, 461		19, 611, 461	0	19, 611, 461	59.00
60. 00 06000 LABORATORY	11, 018, 648		11, 018, 648	183, 070	11, 201, 718	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 435, 721		1, 435, 721	0	1, 435, 721	62.00
65. 00 06500 RESPIRATORY THERAPY	5, 763, 295	0	5, 763, 295	0	5, 763, 295	65.00
66. 00 06600 PHYSI CAL THERAPY	3, 666, 344	0	3, 666, 344	0	3, 666, 344	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	2, 420, 109	0	2, 420, 109	0	2, 420, 109	66. 02
67. 00 06700 OCCUPATI ONAL THERAPY	1, 890, 254	0	1, 890, 254	0	1, 890, 254	67.00
68.00 06800 SPEECH PATHOLOGY	883, 233	0	883, 233	0	883, 233	68. 00
69. 00 06900 ELECTROCARDI OLOGY	3, 194, 106		3, 194, 106	0	3, 194, 106	69. 00
69. 01 06901 CARDI AC REHAB	986, 816		986, 816	0	986, 816	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 599, 976		1, 599, 976	0	1, 599, 976	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 494, 320		1, 494, 320	0	1, 494, 320	
72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS	13, 679, 823		13, 679, 823	0	13, 679, 823	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	52, 056, 145		52, 056, 145	0	52, 056, 145	
76. 00 03020 RENAL ACUTE	1, 939, 550		1, 939, 550	0	1, 939, 550	76. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	313, 774		313, 774	0	313, 774	
90. 05 09005 PATI ENT NUTRI TI ON	585, 020		585, 020	3, 365	588, 385	
90. 07 09007 WOUND CLI NI C	1, 902, 536		1, 902, 536	0	1, 902, 536	
91. 00 09100 EMERGENCY	15, 266, 306		15, 266, 306	0	15, 266, 306	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	9, 871, 357	_	9, 871, 357		9, 871, 357	
200.00 Subtotal (see instructions)	318, 633, 873	0	,	186, 435	318, 820, 308	
201.00 Less Observation Beds	9, 871, 357	_	9, 871, 357	40/ 105	9, 871, 357	
202.00 Total (see instructions)	308, 762, 516	0	308, 762, 516	186, 435	308, 948, 951	1202.00

Date/Time Prepared: 12/31/2016 11/12/2018 4:13 pm Title XIX Hospi tal Cost Charges Total (col. 6 Cost or Other Cost Center Description Inpati ent Outpati ent TEFRA + col. 7) Ratio Inpati ent Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 89 896 038 89, 896, 038 30.00 31.00 03100 INTENSIVE CARE UNIT 25, 240, 315 25, 240, 315 31.00 02040 INTENSIVE NURSERY 35.00 15, 215, 931 15, 215, 931 35.00 41.00 04100 SUBPROVI DER - I RF 3, 624, 414 3, 624, 414 41.00 04300 NURSERY 5, 245, 733 43.00 5, 245, 733 43.00 ANCILLARY SERVICE COST CENTERS 157, 004, 486 50 00 05000 OPERATING ROOM 90, 256, 022 66, 748, 464 0 128560 0.000000 50.00 05001 CARDI AC SURGERY 9, 481, 312 417, 785 9, 899, 097 0. 317693 50.01 0.000000 50.01 103, 895, 244 103, 807, 278 0.000000 50.02 05002 WVSC 87, 966 0.152322 50 02 51.00 05100 RECOVERY ROOM 1, 982, 640 3, 082, 806 5, 065, 446 0.554120 0.000000 51.00 51.02 05101 0/P TREATMENT ROOM 37, 907 2, 710, 425 2, 748, 332 2.052523 0.000000 51.02 3, 149, 164 18, 165, 230 05200 DELIVERY ROOM & LABOR ROOM 52 00 15, 016, 066 0.414955 0.000000 52 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 11, 796, 754 41, 550, 645 53, 347, 399 0. 241418 0.000000 54.00 05500 RADI OLOGY-THERAPEUTI C 1, 552, 505 0. 209662 55 00 37, 131, 616 38, 684, 121 0.000000 55.00 05600 RADI OI SOTOPE 9, 016, 112 0. 193463 0.000000 56,00 1,044,317 7, 971, 795 56,00 05700 CT SCAN 57, 501, 526 57 00 16, 233, 170 41, 268, 356 0.062829 0.000000 57 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 2, 576, 870 11, 136, 270 13, 713, 140 0.163543 0.000000 58.00 58.00 05900 CARDI AC CATHETERI ZATI ON 59.00 31, 038, 154 75, 040, 061 106, 078, 215 0.184877 0.000000 59.00 06000 LABORATORY 49, 009, 271 0.119460 60.00 43, 227, 570 92, 236, 841 0.000000 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 2, 596, 659 620, 169 3, 216, 828 0. 446316 0.000000 62.00 11, 000, 711 65.00 06500 RESPIRATORY THERAPY 1, 152, 543 12, 153, 254 0.474218 0.000000 65.00 06600 PHYSI CAL THERAPY 10, 811, 304 792, 899 11, 604, 203 0.315950 0.000000 66.00 66.00 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 66.01 0.000000 0.000000 66.01 66.02 06602 0/P PHYSI CAL THERAPY 0 6, 812, 335 6, 812, 335 0.355254 0.000000 66.02 06700 OCCUPATI ONAL THERAPY 4, 953, 921 2, 798, 562 7, 752, 483 67.00 0.243826 0.000000 67.00 06800 SPEECH PATHOLOGY 1, 179, 232 1, 369, 591 2, 548, 823 0.000000 68.00 0.346526 68.00 06900 ELECTROCARDI OLOGY 10, 977, 783 19, 601, 012 69.00 8, 623, 229 0.162956 0.000000 69.00 69. 01 06901 CARDI AC REHAB 153, 720 1, 267, 755 1, 421, 475 0.694220 0.000000 69.01 70.00 07000 ELECTROENCEPHALOGRAPHY 3, 232, 715 1, 331, 312 4, 564, 027 0.350562 0.000000 70.00 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 2 384 150 153 578 2, 537, 728 0.588842 0.000000 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 7, 827, 041 7, 548, 071 15, 375, 112 0.889738 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 68, 167, 958 178, 146, 392 246, 314, 350 0.211340 0.000000 73.00 73.00 03020 RENAL ACUTE 76.00 3, 525, 499 445, 188 3, 970, 687 0. 488467 0.000000 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 797, 668 09000 CLI NI C 1, 104 796, 564 0.393364 0.000000 90.00 09005 PATIENT NUTRITION 90.05 223,008 223,008 2.623314 0.000000 90.05 90 07 09007 WOUND CLINIC 5.000 5, 773, 097 5. 778. 097 0.329267 0.000000 90 07 91.00 09100 EMERGENCY 29, 350, 678 95, 401, 056 124, 751, 734 0.122373 0.000000 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1, 345, 576 16, 492, 131 17, 837, 707 0. 553398 0.000000 92.00 200.00 Subtotal (see instructions) 521, 066, 735 772, 771, 416 1, 293, 838, 151 200.00 201 00 Less Observation Reds 201. 00

521, 066, 735

772, 771, 416 1, 293, 838, 151

202.00

202.00

Total (see instructions)

Health Financial Systems	UNION HOSPITAL, INC.	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0023	Peri od: From 01/01/2016 To 12/31/2016 Worksheet C Part I Date/Time Prepared:

Title XIX Hospital Cost				10 12/31/2016	11/12/2018 4:	
NPATI ENT ROUTINE SERVICE COST CENTERS 11.00			Ti tle XIX	Hospi tal		то ріп
INPATI ENT ROUTINE SERVICE COST CENTERS 11.00	Cost Center Description	PPS Inpatient		<u> </u>		
NPATIENT ROUTINE SERVICE COST CENTERS 30.00 31.00 03100 001700 NUTES & PEDIATRIC S 31.00 31.00 03100 NUTES VARE UNIT 31.00 31.00 03100 NUTES VARE UNIT 35.00 20300 NUTES VARE VARE VARE VARE VARE VARE VARE VARE	·	Ratio				
30.00 0.0000 ADULTS & PEDIATRICS 31.00		11. 00				
31.00 03100 INTENSIVE CARE UNIT						
35. 00						30.00
41.00						31.00
43. 00 0.300 NURSERY						35.00
ANCILLARY SERVICE COST CENTERS	41. 00 04100 SUBPROVI DER - I RF					41.00
50.00 05000 05000 05001 0ARDI AC SURGERY 0.000000 50.01 05001						43.00
50. 01 05001 CARDI AC. SURGERY 0.000000 50. 02 05002 WSCC 0.000000 51. 00 05100 RECOVERY ROOM 0.000000 51. 00 05100 RECOVERY ROOM 0.000000 51. 00 05100 RECOVERY ROOM 0.000000 51. 00 052. 00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 54. 00 05400 RADIO LOGY - IDEAPAPEUTI C 0.000000 55. 00 05500 RADIO LOGY - IDEAPAPEUTI C 0.000000 55. 00 05500 RADIO LOGY - IDEAPAPEUTI C 0.000000 55. 00 05500 RADIO LOGY - IDEAPAPEUTI C 0.000000 55. 00 05500 RADIO LOGY - IDEAPAPEUTI C 0.000000 55. 00 05500 RADIO LOGY - IDEAPAPEUTI C 0.000000 55. 00 05500 RADIO LOGY - IDEAPAPEUTI C 0.000000 55. 00 05500 RADIO LOGY - IDEAPAPEUTI C 0.000000 55. 00 05500 RADIO LOGY - IDEAPAPEUTI C 0.000000 55. 00 05500 RADIO LOGY - IDEAPAPEUTI C 0.000000 55. 00 05500 RADIO LOGY - IDEAPAPEUTI C 0.000000 55. 00 05500 RADIO LOGY - IDEAPAPEUTI C 0.000000 55. 00 05500 RADIO LOGY - IDEAPAPEUTI C 0.000000 55. 00 05500 RADIO LOGY - IDEAPAPEUTI C 0.000000 55. 00 05500 RADIO LOGY - IDEAPAPEUTI C 0.000000 55. 00 05500 RADIO LOGY - IDEAPAPEUTI C 0.000000 65. 00 05500 RADIO LOGY - IDEAPAPEUTI C 0.000000 65. 00 05500 RADIO LOGY - IDEAPAPEUTI C 0.000000 65. 00 05500 RADIO LOGY - IDEAPAPEUTI C 0.000000 65. 00 055000 055000 055000 055000 055000 055000 055000						
50.02 05002 WYSC 05100 RECOVERY ROOM 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000		1				50.00
51.00 05100 RECOVERY ROOM 0.000000 51.00 51.00 52.00 05101 0/P TREATMENT ROOM 0.000000 52.00 05200 DELI VERY ROOM & LABOR ROOM 0.000000 52.00 05200 DELI VERY ROOM & LABOR ROOM 0.000000 52.00 05200 DELI VERY ROOM & LABOR ROOM 0.000000 55.00 05500 RADIO LOGY-THERAPEUTI C 0.000000 55.00 0.000000 55.0		1				50. 01
51.02 05101 0/P TREATMENT ROOM		1				50. 02
52. 00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 55. 00 05400 RADI OLOGY-DI AGNOSTIC 0.000000 55. 00 05500 RADI OLOGY-THERAPEUTIC 0.000000 55. 00 05500 RADIOLOGY-THERAPEUTIC 0.000000 55. 00 05500 RADIOLOGY-THERAPEUTIC 0.000000 55. 00 05500 CADIOLOGY-THERAPEUTIC 0.000000 55. 00 05500 CADIOLOGY-THERAPEUTIC 0.000000 55. 00 05800 MAGNETIC RESONANCE IMAGI NG (MRI) 0.000000 58. 00 05800 MAGNETIC RESONANCE IMAGI NG (MRI) 0.000000 59. 00 05900 CARDI AC CATHETERI ZATI ON 0.000000 59. 00 05900 CARDI AC CATHETERI ZATI ON 0.000000 60. 00 06000 LABORATORY 0.000000 60. 00 06000 LABORATORY 0.000000 60. 00 06500 RESPI RATORY THERAPY 0.000000 65. 00 06500 RESPI RATORY THERAPY 0.000000 66. 00 06600 PHYSI CAL THERAPY 0.000000 66. 00 06600 0600 DESCHIATRI C/PSYCHOLOGI CAL SERVI CES 0.000000 66. 00 0600 DESCHIATRI C/PSYCHOLOGI CAL SERVI CES 0.000000 66. 00 0600 0600 DEECTROCARDI OLOGY 0.000000 67. 00 06000 DEECTROCARDI OLOGY 0.000000 68. 00 0600 DEECTROCARDI OLOGY 0.000000 69. 00 0600 DEECTROCARDI OLOGY 0.000000 0.00000 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				51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 000000 55. 00 05500 RADI OLOGY-THERAPEUTI C 0. 000000 55. 00 05600 RADI OLOGY-THERAPEUTI C 0. 000000 55. 00 05600 RADI OLOGY-THERAPEUTI C 0. 000000 55. 00 05600 RADI OLOGY-THERAPEUTI C 0. 000000 55. 00 05700 CT SCAN 0. 000000 55. 00 05700 CT SCAN 0. 000000 55. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0. 000000 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0. 000000 59. 00 05900 CARDI AC CATHETERI ZATI ON 0. 000000 66. 00 06000 LABORATORY 0. 000000 66. 00 06000 LABORATORY 0. 000000 060. 00 06000 ESPI RATORY THERAPY 0. 000000 060. 00 06000 ESPI RATORY THERAPY 0. 000000 060. 00 06000 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0. 000000 060. 00 06000 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0. 000000 060. 00 060000 060000 060000 060000 060000 060000 0600000 0600000 06000000 06000000 060000000 0600000000	· · · · · · · · · · · · · · · · · · ·	1				51.02
55. 00	· · · · · · · · · · · · · · · · · · ·	1				52.00
56. 00 05600 RADI OI SOTOPE 0.000000 57. 00 57. 00 05700 CT SCAN 0.000000 57. 00 05800 MAGNETI C RESONANCE IMAGI NG (MRI) 0.000000 58. 00 05900 CARDI AC CATHETERI ZATI ON 0.000000 59. 00 06. 00 06000 LABORATORY 0.000000 06. 00 06000 LABORATORY 0.000000 06. 00 06000 LABORATORY 0.000000 06. 00 06500 RESPI RATORY THERAPY 0.000000 06. 00 06500 RESPI RATORY THERAPY 0.000000 06. 00 06600 PHYSI CAL THERAPY 0.000000 06. 00 06600 060000 060000 060000 060000 060000 060000 060000 060000 060000 060000 0600000 0600000 0600000 0600000 06000000 060000000 0600000000		0. 000000				54.00
57. 00 05700 CT SCAN 0.000000 557.00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 58. 00 59. 00 05900 CARDI AC CATRITERI ZATI ON 0.000000 59. 00 60. 00 06000 LABORATORY 0.000000 60. 00 62. 00 06500 MFOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 65. 00 65. 00 06500 RESPI RATORY THERAPY 0.000000 66. 00 66. 00 06600 PHYSI CAL THERAPY 0.000000 66. 00 66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0.000000 66. 00 66. 02 06602 O/P PHYSI CAL THERAPY 0.000000 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0.000000 67. 00 68. 00 06800 SPECH PATHOLOGY 0.000000 67. 00 69. 01 06901 CARDI AC REHAB 0.000000 69. 00 69. 01 06901 CARDI AC REHAB 0.000000 69. 00 69. 01 06901 CARDI AC REHAB 0.000000 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 72. 00 73. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 0.000000 72. 00 73. 00 07200 DRUGS CHARGED TO PATI ENTS 0.000000 72. 00 74. 00 07000 CLINIC 0.000000 72. 00 75. 00 07000 CLINIC 0.000000 90. 00 76. 00 09000 CLINIC 0.000000 90. 00 79. 00 09000 09000 09000 090000 090. 00 79. 00 09000 09000 090000 090000 090000 79. 00 09000 0900000000 090000000 0900000000	· · · · · · · · · · · · · · · · · · ·	1				55.00
58. 00	· · · · · · · · · · · · · · · · · · ·	1				56.00
59. 00 05900 CARDIAC CATHETERIZATION 0.000000 59. 06 60. 00 06000 LABORATORY 0.000000 60.00 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. 00 66. 02 06602 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0.000000 66. 00 67. 00 06600 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0.000000 66. 00 68. 00 06600 SPECH PATHOLOGY 0.000000 67. 00 68. 00 06800 SPECH PATHOLOGY 0.000000 68. 00 69. 01 06901 CARDI AC REHAB 0.000000 69. 01 69. 01 06901 CARDI AC REHAB 0.000000 69. 01 70. 00 07000 ELECTROCARDI OLOGY 0.000000 69. 01 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 72. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 72. 00 74. 00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 72. 00 07401 INTL. DEV. CHARGED TO PATI ENTS 0.000000 72. 00 07501 DRUGS CHARGED TO PATI ENTS 0.000000 73. 00 76. 00 07000 ELECTRO COST CENTERS 90. 00 09000 CLI NI C 0.000000 90. 00 90. 05 09005 PATI ENT NUTRI TI ON 0.000000 90. 00 90. 07 09007 WOUND CLI NI C 0.000000 90. 00 90. 07 09007 WOUND CLI NI C 0.000000 90. 00 90. 07 09000 BERGGENCY 0.000000 90. 00 90. 07 09000 BERGGENCY 0.000000 90. 00 90. 00 90. 00 09200 BERGGENCY 0.000000 90. 00	57. 00 05700 CT SCAN	0. 000000				57.00
60. 00 06000 LABORATORY 0. 000000 62. 00 62. 00 66. 00		1				58. 00
62. 00		1				59.00
65. 00	60. 00 06000 LABORATORY	0. 000000				60.00
66. 00		1				62.00
66. 01		1				65.00
66. 02		1				66.00
67. 00 06700 OCCUPATI ONAL THERAPY		1				66. 01
68. 00		1				66. 02
69. 00		1				67.00
69. 01		1				68. 00
70. 00		1				69.00
71. 00		1				
72. 00		1				1
73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 76. 00 03020 RENAL ACUTE 0.000000 76. 00 000000 76. 00 000000 000000 000000 000000 000000	· · · · · · · · · · · · · · · · · · ·	1				71.00
76. 00 03020 RENAL ACUTE 0.000000 76. 00		1				
OUTPATIENT SERVICE COST CENTERS		1				
90. 00 09000 CLINIC 0. 000000 90. 00 9		0. 000000				76.00
90. 05 09005 PATI ENT NUTRITION 0. 000000 90. 07 09007 WOUND CLINIC 0. 000000 91. 00 09100 EMERGENCY 0. 000000 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 000000 92. 00 09200 09						4
90. 07 09007 WOUND CLINIC 0. 000000 91. 00 91. 00 09100 EMERGENCY 0. 000000 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 000000 92. 00 092	· · · · · · · · · · · · · · · · · · ·	1				
91. 00 09100 EMERGENCY 0. 000000 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 000000 92. 00 09200		1				
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0. 000000 92. 00		1				1
	i i	1				1
200.001		0. 000000				
	1 1					1
	+ I					201.00
202.00 Total (see instructions)	202.00 TOTAL (See INSTRUCTIONS)					202. 00

Health Financial Systems	UNION HOSPI	TAL, INC.		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Period: From 01/01/2016 To 12/31/2016	Worksheet D Part I Date/Time Pre 11/12/2018 4:	pared: 13 pm
			XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst.	Swing Bed Adjustment	Reduced Capital Related Cost	Total Patient Days	Per Diem (col. 3 / col. 4)	
	B, Part II, col. 26)		(col. 1 - col. 2)		,	
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	8, 377, 767		8, 377, 76		144. 40	
31.00 INTENSIVE CARE UNIT	1, 563, 160		1, 563, 16		188. 02	
35. 00 I NTENSI VE NURSERY	311, 196	ł .	311, 19	· ·	80. 79	
41. 00 SUBPROVI DER - I RF	581, 109		581, 10	· ·	159. 56	
43. 00 NURSERY	150, 623		150, 62	· ·	42. 25	
200.00 Total (lines 30 through 199)	10, 983, 855		10, 983, 85	5 77, 391		200.00
Cost Center Description	I npati ent	Inpatient				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
	/ 00	col. 6)				
INDATION DOUTING CERVICE COCT CENTERS	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 ADULTS & PEDIATRICS	24, 958	2 (02 025				30.00
31. 00 INTENSIVE CARE UNIT	4, 836					31.00
35. 00 INTENSIVE CARE UNIT	4, 830	909, 265				35.00
41. 00 SUBPROVI DER - I RF	2, 511	400, 655				41.00
43. 00 NURSERY	2,311	400, 655				43.00
200.00 Total (lines 30 through 199)	32, 305	4, 913, 855				200.00

				rom 01/01/2016 o 12/31/2016		pared: 13 pm
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal		Ratio of Cost	I npati ent	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col . 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)			
	col . 26)					
ANOUGH ARM REPUM OF ROOT RENTERS	1. 00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1 107 005	157.004.404	1 000000		4.4.5.004	
50. 00 05000 OPERATING ROOM	4, 127, 335					
50. 01 05001 CARDI AC SURGERY	305, 023					
50. 02 05002 WVSC	1, 798, 308		•	·		
51. 00 05100 RECOVERY ROOM	120, 002					
51. 02 05101 O/P TREATMENT ROOM	982, 187			·		
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 065, 345			2, 093, 333		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 537, 576					
55. 00 05500 RADI OLOGY-THERAPEUTI C	2, 234, 702					
56. 00 05600 RADI 01 SOTOPE	135, 841					56.00
57. 00 05700 CT SCAN	417, 971			· · ·		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	695, 572			· · ·		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	919, 015			· · ·		59.00
60. 00 06000 LABORATORY	48, 022			23, 453, 438		•
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	3, 569					
65. 00 06500 RESPI RATORY THERAPY	377, 864				176, 762	65.00
66. 00 06600 PHYSI CAL THERAPY	696, 035			3, 053, 409		66.00
66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	· · · · · · · · · · · · · · · · · · ·			0	66. 01
66. 02 06602 0/P PHYSI CAL THERAPY	76, 674				0	66. 02
67. 00 06700 OCCUPATI ONAL THERAPY	74, 379					
68. 00 06800 SPEECH PATHOLOGY	465, 260		•	·		68.00
69. 00 06900 ELECTROCARDI OLOGY	147, 990		•		48, 042	69.00
69. 01 06901 CARDI AC REHAB	386, 032					1
70. 00 07000 ELECTROENCEPHALOGRAPHY	128, 772			·		70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	297, 286					1
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	22, 196					72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	645, 773					
76. 00 03020 RENAL ACUTE	911, 977	3, 970, 687	0. 229677	2, 461, 881	565, 437	76. 00
OUTPATIENT SERVICE COST CENTERS		707 ((0	1 0 040500	1		
90. 00 09000 CLI NI C	8, 449				0	90.00
90. 05 09005 PATI ENT NUTRI TI ON	70, 052				0	
90. 07 09007 WOUND CLINIC	161, 895					90.07
91. 00 09100 EMERGENCY	1, 201, 380				156, 142	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 335, 259			·	1, 539	
200.00 Total (lines 50 through 199)	22, 397, 741	1, 154, 615, 720	1	188, 966, 265	3, 675, 216	200.00

Health Financial Systems	UNION HOSPI	TAL, INC.		In Li∈	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS Provider CO		Period: From 01/01/2016 To 12/31/2016		
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng School	Allied Health Cost	All Other Medical Education	Swing-Bed Adjustment Amount (see	Total Costs (sum of cols. 1 through 3,	
			Cost		minus col. 4)	
	1. 00	2.00	3. 00	4. 00	5. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	31.00
35. 00 02040 I NTENSI VE NURSERY	0	0		0	0	35.00
41. 00 04100 SUBPROVI DER - I RF	0	0		0 0	0	41.00
43. 00 04300 NURSERY	0	0		0	0	43.00
200.00 Total (lines 30 through 199)	0	0		0	0	200.00
Cost Center Description	Total Pati ent	Per Diem	Inpatient	I npati ent		
	Days	(col. 5 ÷	Program Days			
		col. 6)		Pass-Through		
				Cost (col. 7		
	6. 00	7. 00	8.00	x col. 8) 9.00	-	
INPATIENT ROUTINE SERVICE COST CENTERS	6.00	7.00	8.00	9.00		
30. 00 03000 ADULTS & PEDIATRICS	58, 018	0.00	24, 95	ol c		30.00
31. 00 03100 NTENSI VE CARE UNI T	8, 314	0.00				31.00
35. 00 02040 NTENSI VE NURSERY	3, 852			0		35.00
41. 00 04100 SUBPROVI DER - I RF	3, 642	0.00		1		41.00
43. 00 04300 NURSERY	3, 565					43.00
200.00 Total (lines 30 through 199)	77, 391	0.00	32, 30	٥	,	200. 00

Health Financial Systems	UNION HOSPITAL, INC.	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT A	ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0023	Peri od: Worksheet D
TUDOLIOU COSTS		Erom 01/01/2016 Part IV

THROUGH COSTS From 01/01/2016 | Part IV To 12/31/2016 | Date/Time Prepared: 11/12/2018 4:13 pm Title XVIII Hospi tal PPS Cost Center Description Non Physician Allied Health All Other Total Cost Nursi ng Anestheti st Medi cal (sum of cols. School 1, 2, 3, and Cost Educati on 4) Cost 1. 00 2.00 3.00 4. 00 5.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 50 00 0 000000000000000000000000000 0 05001 CARDI AC SURGERY 0 50.01 0 0 50.01 50.02 05002 WVSC 0 0 50.02 0 0 0 05100 RECOVERY ROOM 0 0 51.00 0 51.00 05101 0/P TREATMENT ROOM 0 0 51.02 51.02 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 274, 441 274, 441 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 0 55.00 0 0 0 05600 RADI OI SOTOPE 0 56.00 56.00 0 57.00 05700 CT SCAN 0 0 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 05900 CARDIAC CATHETERIZATION 0 0 59.00 59.00 0 0 0 60.00 06000 LABORATORY 0 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 06500 RESPIRATORY THERAPY 0 0 65.00 0 65.00 0 06600 PHYSI CAL THERAPY 66.00 0 0 66.00 66.01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 66.01 06602 0/P PHYSICAL THERAPY 0 66.02 66.02 0 06700 OCCUPATI ONAL THERAPY 67.00 67.00 06800 SPEECH PATHOLOGY 0 68.00 0 0 68.00 0 69.00 06900 ELECTROCARDI OLOGY 0 69.00 06901 CARDI AC REHAB 69.01 69.01 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 Ω 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 C 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 o 73.00 0 424, 653 424.653 73.00 03020 RENAL ACUTE 0 76.00 0 0 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLI NI C 000000 0 0 0 09005 PATIENT NUTRITION 0 90.05 0 0 90.05 09007 WOUND CLINIC 0 90.07 90.07 0 0 91.00 09100 EMERGENCY 0 0 0 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 92.00 699, 094 200. 00 200.00 Total (lines 50 through 199) 0 699, 094 o

Health Financial Systems	UNI ON HOSPI TAL,	I NC.	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS F			Worksheet D
THROUGH COSTS			From 01/01/2016	Part IV

	THOMMENT OF IMPATTENT/OUTPATTENT ANCILLARY SET GH COSTS	RVICE UTHER PAS	5 Provider C		From 01/01/2016	Part IV	
11111001	311 00010				To 12/31/2016		pared:
				\0.00 L		11/12/2018 4:	13 pm
				XVIII	Hospi tal	PPS	
	Cost Center Description	Total	Total Charges			I npati ent	
		Outpati ent	(from Wkst.	to Charges	Ratio of Cost	Program	
		Cost (sum of	C, Part I,	(col. 5 ÷	to Charges	Charges	
		col s. 2, 3	col. 8)	col. 7)	(col. 6 ÷		
		and 4)	7.00	0.00	col . 7)	10.00	
	ANCILLARY SERVICE COST CENTERS	6. 00	7. 00	8. 00	9. 00	10. 00	
EO 00	05000 OPERATING ROOM	0	157, 004, 486	0. 00000	0. 000000	44, 324, 653	E0 00
50.00							50.00
50. 01	05001 CARDI AC SURGERY	0	9, 899, 097			5, 883, 938	50.01
50. 02	05002 WVSC	0	103, 895, 244			85, 384	50.02
51.00	05100 RECOVERY ROOM	0	5, 065, 446			1, 106, 860	51.00
51. 02	05101 0/P TREATMENT ROOM	0	2, 748, 332			22, 432	51.02
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	18, 165, 230			2, 093, 333	
54.00	05400 RADI OLOGY-DI AGNOSTI C	274, 441	53, 347, 399			6, 651, 442	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	38, 684, 121	0. 00000		783, 933	55.00
56.00	05600 RADI OI SOTOPE	0	9, 016, 112			476, 378	
57. 00	05700 CT SCAN	0	57, 501, 526			8, 996, 678	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	13, 713, 140			1, 224, 230	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	106, 078, 215			12, 889, 976	59.00
60.00	06000 LABORATORY	0	92, 236, 841	0.00000	0. 000000	23, 453, 438	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	3, 216, 828	0.00000	0. 000000	1, 519, 853	62.00
65.00	06500 RESPIRATORY THERAPY	0	12, 153, 254	0.00000	0. 000000	5, 685, 131	65.00
66.00	06600 PHYSI CAL THERAPY	0	11, 604, 203	0.00000	0. 000000	3, 053, 409	66.00
66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0.00000	0. 000000	0	66. 01
66. 02	06602 0/P PHYSI CAL THERAPY	0	6, 812, 335	0.00000	0. 000000	0	66. 02
67.00	06700 OCCUPATI ONAL THERAPY	0	7, 752, 483	0.00000	0. 000000	1, 858, 388	67.00
68. 00	06800 SPEECH PATHOLOGY	0	2, 548, 823			453, 057	68.00
69. 00	06900 ELECTROCARDI OLOGY	0	19, 601, 012	0. 00000		6, 363, 222	69.00
69. 01	06901 CARDI AC REHAB	0	1, 421, 475			80, 992	ł
70.00	07000 ELECTROENCEPHALOGRAPHY	0	4, 564, 027			592, 574	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 537, 728			1, 513, 959	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	o o	15, 375, 112			6, 279, 338	
73. 00	07300 DRUGS CHARGED TO PATIENTS	424, 653	246, 314, 350			34, 872, 784	73.00
76. 00	· ·	0	3, 970, 687			2, 461, 881	76.00
70.00	OUTPATIENT SERVICE COST CENTERS		3, 710, 007	0.00000	0. 000000	2, 401, 001	70.00
90.00		0	797, 668	0.00000	0. 000000	0	90.00
90. 05	09005 PATIENT NUTRITION	ő	223, 008			0	90.05
90. 03	09007 WOUND CLINIC	0	5, 778, 097			4, 324	1
91. 00	09100 EMERGENCY	0	124, 751, 734			16, 214, 121	91.00
92.00		0	17, 837, 707			20, 557	
200.00	,	-	1, 154, 615, 720		0.000000	188, 966, 265	1
200.00	p Total (Titles 50 till bugli 177)	077, 094	1, 154, 015, 720	I	1	100, 700, 200	200.00

11/12/2018 4:13 pm Title XVIII Hospi tal PPS Outpati ent Outpati ent Cost Center Description Inpatient 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 O5000 OPERATING ROOM 18, 789, 094 50 00 50.01 05001 CARDI AC SURGERY 0 26, 121 50.01 05002 WVSC 0 32, 351, 362 0 50.02 50.02 05100 RECOVERY ROOM 0 0 51.00 51.00 10, 353 05101 0/P TREATMENT ROOM 0 878, 978 0 51.02 51.02 05200 DELIVERY ROOM & LABOR ROOM 295, 282 0 52.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 34, 215 9, 613, 009 49, 449 54.00 18, 148, 750 05500 RADI OLOGY-THERAPEUTI C 55.00 0 0 55.00 0 56.00 05600 RADI OI SOTOPE 0 2, 606, 189 56.00 57.00 05700 CT SCAN 0 0 0 14, 480, 535 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 3, 239, 644 58.00 05900 CARDI AC CATHETERI ZATI ON 0 27, 041, 640 59.00 59.00 60. 00 | 06000 | LABORATORY 11, 371, 571 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 0000000000 456, 688 62.00 0 06500 RESPIRATORY THERAPY 65.00 939, 990 65.00 66.00 06600 PHYSI CAL THERAPY 100, 924 66.00 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 66.01 66.01 06602 0/P PHYSI CAL THERAPY 66.02 66.02 06700 OCCUPATI ONAL THERAPY 67.00 0 50, 613 67.00 68.00 06800 SPEECH PATHOLOGY 16, 181 68.00 06900 ELECTROCARDI OLOGY 4, 225, 814 69.00 69.00 698, 302 0 69 01 06901 CARDI AC REHAB 69 01 07000 ELECTROENCEPHALOGRAPHY 897, 828 0 70.00 70.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 75, 195 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 6, 274, 575 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 60, 121 62, 143, 086 107, 135 73 00 03020 RENAL ACUTE 76.00 172, 431 0 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 90.00 09005 PATIENT NUTRITION 0 90.05 0 90.05 0 90.07 09007 WOUND CLINIC 0 2, 647, 355 90.07 91. 00 09100 EMERGENCY 0 21, 012, 709 0 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 5, 268, 145 0 92.00

94, 336

243, 832, 364

156, 584

200.00

Total (lines 50 through 199)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0023 Peri od: Worksheet D From 01/01/2016 Part V Date/Time Prepared: 12/31/2016 11/12/2018 4:13 pm Title XVIII Hospi tal **PPS** Charges Costs PPS Services Cost Center Description Cost to PPS Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) Services (see From Servi ces Services Not Worksheet C, inst.) Subject To Subject To Part I, col. Ded. & Coins. Ded. & Coins. 9 (see inst.) (see inst.) 2.00 5.00 1.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 0. 128560 18, 789, 094 2, 415, 526 50.00 05001 CARDI AC SURGERY 0 50.01 0.317693 0 8, 298 50.01 26, 121 0 50.02 05002 WVSC 0. 152322 32, 351, 362 4, 927, 824 50.02 51.00 05100 RECOVERY ROOM 0.554120 10, 353 0 0 5, 737 51.00 05101 0/P TREATMENT ROOM 2.052523 878, 978 0 0 1, 804, 123 51.02 51.02 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 414955 295, 282 0 122, 529 52.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 241418 9, 613, 009 2, 320, 753 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0. 209662 18, 148, 750 0 0 0 0 3, 805, 103 55.00 56.00 05600 RADI OI SOTOPE 0. 193463 0 504, 201 2, 606, 189 56.00 05700 CT SCAN 0 909, 798 57.00 0.062829 14, 480, 535 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.163543 3, 239, 644 0 529, 821 58.00 05900 CARDI AC CATHETERI ZATI ON 4, 999, 377 59.00 0.184877 27, 041, 640 0 0 0 59.00 11, 371, 571 06000 LABORATORY 60 00 0 119460 3 120 1, 358, 448 60 00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.446316 456, 688 0 203, 827 62.00 65.00 06500 RESPIRATORY THERAPY 0. 474218 939, 990 0 0 445, 760 65.00 0 66.00 06600 PHYSI CAL THERAPY 0.315950 100, 924 0 31, 887 66.00 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0.000000 O 66 01 C 0 66 01 0 66.02 06602 0/P PHYSI CAL THERAPY 0.355254 0 0 66.02 06700 OCCUPATI ONAL THERAPY 0. 243826 50, 613 0 12, 341 67.00 67.00 0 68.00 06800 SPEECH PATHOLOGY 0.346526 16, 181 0 5, 607 68.00 06900 ELECTROCARDI OLOGY 0.162956 4, 225, 814 0 688, 622 69 00 69 00 0 o 69.01 06901 CARDI AC REHAB 0.694220 698, 302 484, 775 69.01 07000 ELECTROENCEPHALOGRAPHY 897, 828 0 0 70.00 0.350562 314, 744 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.588842 0 71.00 75. 195 0 44, 278 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 5, 582, 728 0.889738 72.00 6, 274, 575 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 211340 62, 143, 086 0 59, 426 13, 133, 320 73.00 76.00 03020 RENAL ACUTE 0. 488467 172, 431 0 0 84, 227 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0. 393364 0 0 90.00 2. 623314 09005 PATIENT NUTRITION 0 90.05 0 0 90.05 2, 647, 355 90.07 09007 WOUND CLINIC 0. 329267 0 0 871, 687 90.07 0 91.00 91. 00 | 09100 | EMERGENCY 0. 122373 21, 012, 709 0 2, 571, 388 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 553398 5, 268, 145 2, 915, 381 92.00 0 200.00 Subtotal (see instructions) 243, 832, 364 3, 120 59, 426 51, 102, 110 200. 00 Less PBP Clinic Lab. Services-Program 201. 00 201.00 0 Only Charges

243, 832, 364

3, 120

59, 426

51, 102, 110 202. 00

202.00

Net Charges (line 200 - line 201)

Health Financial Systems	UNION HOSPITAL,	INC.	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST PI	Provider CCN: 15-0023	From 01/01/2016	Worksheet D Part V

				To 12/31/2016	Date/Time Pro 11/12/2018 4:	epared:
		Title	XVIII	Hospi tal	PPS	
	Cos	sts			<u> </u>	
Cost Center Description	Cost	Cost				
, , , , , , , , , , , , , , , , , , ,	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0				50.00
50. 01 05001 CARDI AC SURGERY	0	0				50. 01
50. 02 05002 WVSC	0	0				50. 02
51.00 05100 RECOVERY ROOM	0	0				51.00
51.02 05101 0/P TREATMENT ROOM	0	0				51.02
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55.00
56. 00 05600 RADI OI SOTOPE	0	0				56.00
57.00 05700 CT SCAN	0	0				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60. 00 06000 LABORATORY	373	0				60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62.00
65. 00 06500 RESPIRATORY 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 06602 0/P PHYSI CAL THERAPY	0	0				66. 02
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68.00 06800 SPEECH PATHOLOGY	0	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
69. 01 06901 CARDI AC REHAB	0	0				69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0					72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	12, 559				73.00
76. 00 03020 RENAL ACUTE	0	0				76. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0				90.00
90. 05 09005 PATI ENT NUTRI TI ON	0	0				90.05
90. 07 09007 WOUND CLINIC	0	0				90. 07
91. 00 09100 EMERGENCY	0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		1			92.00
200.00 Subtotal (see instructions)	373	12, 559				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						1
202.00 Net Charges (line 200 - line 201)	373	12, 559	l			202.00

50. 01 05001 CARDI AC SURGERY 305, 023 9, 899, 097 0. 030813 12, 221 377 50. 02 05002 WYSC 1, 798, 308 103, 895, 244 0. 017309 148 3 51. 00 05100 RECOVERY ROOM 120, 002 5, 065, 446 0. 023690 3, 190 76 51. 02 05101 O/P TREATMENT ROOM 982, 187 2, 748, 332 0. 357376 0 0 0 0 0 0 144 5 0					III LI E	u of Form CMS-2	2552-10
Capital Related Cost (from Wist. B, Part II, col. 26) 1.00 2.00 3.00 4.00 5.00	F INPATIENT ANCILLARY SERVICE CAPITAL	COSTS			From 01/01/2016	Part II	pared:
Rel ated Cost (from Wkst. B, Part II, col. 26) 1.00 2.00 3.00 4.00 5.00			Title	XVIII		PPS	10 piii
Crow	t Center Description						
B, Part II, col. 26 Col. 20 Col. 20 Col. 20 Col. 20 Col. 20 Col. 26 Col. 26							
ANCI LLARY SERVICE COST CENTERS					Charges	column 4)	
1.00 2.00 3.00 4.00 5.00			COI. 8)	(01. 2)			
ANCILLARY SERVICE COST CENTERS			2 00	3 00	4 00	5 00	
50. 00 05000 OFERATI NG ROOM 4,127,335 157,004,486 0.026288 95,828 2,519 50.01 05001 CARDI AC SURGERY 305,023 9,899,097 0.030813 12,221 377 375	SERVI CE COST CENTERS		2.00	0.00	11.00	0.00	
50. 02 05002 WVSC 1,798,308 103,895,244 0.017309 148 3 51. 00 05100 RECOVERY ROOM 120,002 5,065,446 0.023690 3,190 76 51. 02 05101 O/P TREATMENT ROOM 982,187 2,748,332 0.357376 0 0 0 52. 00 05200 DELI VERY ROOM & LABOR ROOM 1,065,345 18,165,230 0.058647 1,936 114 54. 00 05400 RADI OLOGY-DI AGNOSTI C 2,537,576 53,347,399 0.047567 58,609 2,788 55. 00 05500 RADI OLOGY-THERAPEUTI C 2,234,702 38,684,121 0.05768 20,158 1,164 56. 00 05600 RADI OLSOTOPE 135,841 9,016,112 0.015066 3,475 52 57. 00 05700 CT SCAN 417,971 57,501,526 0.007269 79,257 576 58. 00 05800 MAGNETI C RESONANCE IMAGI NG (MRI) 919,015 106,078,215 0.008664 59,768 518 <td></td> <td>4, 127, 335</td> <td>157, 004, 486</td> <td>0. 02628</td> <td>95, 828</td> <td>2, 519</td> <td>50.00</td>		4, 127, 335	157, 004, 486	0. 02628	95, 828	2, 519	50.00
51. 00 05100 RECOVERY ROOM 120,002 5,065,446 0.023690 3,190 76 5 51. 02 05101 0/P TREATMENT ROOM 982,187 2,748,332 0.357376 0 0 0 5 52. 00 05200 DELIVERY ROOM & LABOR ROOM 1,065,345 18,165,230 0.058647 1,936 114 9 54. 00 05400 RADI OLOGY-DI AGNOSTI C 2,537,576 53,347,399 0.047567 58,609 2,788 2 788 55.00 0.05500 RADI OLOGY-THERAPEUTI C 2,234,702 38,684,121 0.057768 20,158 1,164 9 9 9,016,112 0.05768 20,158 1,164 9 9 9,016,112 0.015066 3,475 52 9 9 9,016,112 0.015066 3,475 52 9 9 79,257 576 9 9 9,016,112 0.007269 79,257 576 9 9 9,016,112 0.007269 79,257 576 9 9 9,016,112 0.005723 6,040 306 9 9 9,057 9	DI AC SURGERY	305, 023	9, 899, 097	0. 03081	3 12, 221	377	50. 01
51. 02 05101 0/P TREATMENT ROOM 982, 187 2, 748, 332 0. 357376 0 0 5 5 0 0 5 0 0 5 0 0		1, 798, 308	103, 895, 244	0. 01730		3	50. 02
52. 00 05200 DELI VERY ROOM & LABOR ROOM 1, 065, 345 18, 165, 230 0. 058647 1, 936 114 54. 00 05400 RADI OLOGY-DI AGNOSTI C 2, 537, 576 53, 347, 399 0. 047567 58, 609 2, 788 55. 00 05500 RADI OLOGY-THERAPEUTI C 2, 234, 702 38, 684, 121 0. 057768 20, 158 1, 164 56. 00 05600 RADI OI SOTOPE 135, 841 9, 016, 112 0. 015066 3, 475 52 57. 00 05700 CT SCAN 417, 971 57, 501, 526 0. 007269 79, 257 576 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 695, 572 13, 713, 140 0. 050723 6, 040 306 59. 00 05900 CARDI AC CATHETERI ZATI ON 919, 015 106, 078, 215 0. 008664 59, 768 518 56. 00 06000 LABORATORY 48, 022 92, 236, 841 0. 000521 335, 769 175 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 3, 569 3, 216, 828 0. 001109 11, 500 13 66. 00 06600 PHYSI CAL THERAPY 696, 035 11, 604, 203 0. 059981 1, 303, 528 78, 187 66. 01 06602 0/P PHYSI CAL THERAPY 76, 674 6, 812, 335 0. 011255 0 0 67. 00 06600 00000 0 000000 0 0						76	51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 2, 537, 576 53, 347, 399 0. 047567 58, 609 2, 788 55. 00 05500 RADI OLOGY-THERAPEUTI C 2, 234, 702 38, 684, 121 0. 057768 20, 158 1, 164 56. 00 05600 RADI OLOGY-THERAPEUTI C 135, 841 9, 016, 112 0. 015066 3, 475 52 57. 00 05700 CT SCAN 417, 971 57, 501, 526 0. 007269 79, 257 576 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 695, 572 13, 713, 140 0. 050723 6, 040 306 59. 00 05900 CARDI AC CATHETERI ZATI ON 919, 015 106, 078, 215 0. 008664 59, 768 518 56. 00 06000 LABORATORY 48, 022 92, 236, 841 0. 000521 335, 769 175 66. 00 06500 RESPI RATORY THERAPY 48, 022 92, 236, 841 0. 001109 11, 500 13 66. 00 06600 PHYSI CAL THERAPY 696, 035 11, 604, 203 0. 059981 1, 303, 528 78, 187 66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0. 000000 0 0 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 0000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000						-	51.02
55. 00 05500 RADI OLOGY-THERAPEUTI C 2, 234, 702 38, 684, 121 0. 057768 20, 158 1, 164 56. 00 05600 RADI OLOGY-THERAPEUTI C 135, 841 9, 016, 112 0. 015066 3, 475 52 57. 00 05700 CT SCAN 417, 971 57, 501, 526 0. 007269 79, 257 576 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 695, 572 13, 713, 140 0. 050723 6, 040 306 59. 00 05900 CARDI AC CATHETERI ZATI ON 919, 015 106, 078, 215 0. 008664 59, 768 518 50. 00 06000 LABORATORY 48, 022 92, 236, 841 0. 000521 335, 769 175 66. 00 06500 RESPI RATORY THERAPY 377, 864 12, 153, 254 0. 031092 95, 116 2, 957 66. 00 06600 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0. 000000 0. 000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000							
56. 00							54.00
57. 00 05700 CT SCAN 417, 971 57, 501, 526 0.007269 79, 257 576 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 695, 572 13, 713, 140 0.050723 6, 040 306 59. 00 05900 CARDI AC CATHETERI ZATI ON 919, 015 106, 078, 215 0.008664 59, 768 518 518 50. 00 06000 LABORATORY 48, 022 92, 236, 841 0.000521 335, 769 175 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 3, 569 3, 216, 828 0.001109 11, 500 13 65. 00 06500 RESPI RATORY THERAPY 377, 864 12, 153, 254 0.031092 95, 116 2, 957 66. 00 06600 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0.000000 0 0 0 0 0							
58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 695, 572 13, 713, 140 0.050723 6, 040 306 59. 00 05900 CARDI AC CATHETERI ZATI ON 919, 015 106, 078, 215 0.008664 59, 768 518 518 50. 00 06000 LABORATORY 48, 022 92, 236, 841 0.000521 335, 769 175 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 3, 569 3, 216, 828 0.001109 11, 500 13 66. 00 06500 RESPI RATORY THERAPY 377, 864 12, 153, 254 0.031092 95, 116 2, 957 66. 00 06600 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0.000000 0 0 0.000000 0							56. 00 57. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 919, 015 106, 078, 215 0.008664 59, 768 518 90. 00 06000 CARDI AC CATHETERI ZATI ON 919, 015 106, 078, 215 0.008664 59, 768 518 90. 000000000000000000000000000000000							58.00
60. 00 06000 LABORATORY 48, 022 92, 236, 841 0. 000521 335, 769 175 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 3, 569 3, 216, 828 0. 001109 11, 500 13 65. 00 06500 RESPI RATORY THERAPY 696, 035 11, 604, 203 0. 059981 1, 303, 528 78, 187 66. 01 06600 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0. 000000 0 0 0 0 0 0							
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 3, 569 3, 216, 828 0. 001109 11, 500 13 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							60.00
65. 00							62.00
66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0.000000 0 0.000000 0 0							65.00
66. 02 06602 0/P PHYSICAL THERAPY 76, 674 6, 812, 335 0. 011255 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SI CAL THERAPY	696, 035	11, 604, 203	0. 05998	1, 303, 528	78, 187	66.00
67. 00 06700 0CCUPATI ONAL THERAPY 74, 379 7, 752, 483 0. 009594 1, 252, 733 12, 019 0		0	0	0. 00000	0 0	0	66. 01
68. 00 06800 SPEECH PATHOLOGY 465, 260 2, 548, 823 0. 182539 318, 937 58, 218 0		76, 674	6, 812, 335	0. 01125		0	66. 02
							67.00
		147, 990	19, 601, 012	0. 00755		345	69.00
						-	69. 01
							70. 00 71. 00
							72.00
						-	
OUTPATIENT SERVICE COST CENTERS		711, 777	0, 770, 007	0. 22707	202,007	10, 100	70.00
		8, 449	797, 668	0. 01059	0	0	90.00
						0	90.05
90. 07 09007 WOUND CLINIC 161, 895 5, 778, 097 0. 028019 0 0			5, 778, 097	0. 02801		0	90. 07
		1, 201, 380					
							92.00
200.00 Total (Lines 50 through 199) 21,062,482 1,154,615,720 4,645,836 210,533 20	al (lines 50 through 199)	21, 062, 482	1, 154, 615, 720		4, 645, 836	210, 533	200.00

llool +b	Financial Systems	LIND ON LICEDITA	LING		la li o	u of Form CMC	2552 10
	<u>Financial Systems</u> TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	UNI ON HOSPI TA	· · · · · · · · · · · · · · · · · · ·	CCN: 15-0023	Period:	u of Form CMS-2 Worksheet D	2552-10
	SH COSTS	KVICE OTHER TASS	Trovider	CN. 13-0023	From 01/01/2016		
			· ·	CCN: 15-T023	To 12/31/2016	11/12/2018 4:	
			Title	e XVIII	Subprovi der -	PPS	
	Cost Center Description	Non Physician	Nursi ng	Allied Heal	IRF h All Other	Total Cost	
	cost center bescription	Anesthetist	School	Airred near	Medi cal	(sum of cols.	
		Cost	3011001		Education	1, 2, 3, and	
		0031			Cost	4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	O5000 OPERATING ROOM	0	(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 0/P TREATMENT ROOM	0	()	0	0	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	(0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	(274, 4		274, 441	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	(0	0	
56. 00	05600 RADI OI SOTOPE	0	(0 0	0	
57. 00	05700 CT SCAN	0	(0	0	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	(0	0	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	(0 0	0	
60. 00 62. 00	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	(0 0	0	60.00
65.00	06500 RESPIRATORY THERAPY		(0	0	
66. 00	06600 PHYSI CAL THERAPY		(0 0	0	66.00
66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		(0	
66. 02	06602 0/P PHYSICAL THERAPY		(0	66.02
67. 00	06700 OCCUPATI ONAL THERAPY	o o	Č	ő	0 0	ő	1
68. 00	06800 SPEECH PATHOLOGY	0	(0 0	Ö	
69.00	06900 ELECTROCARDI OLOGY	0	(0 0	0	1
69. 01	06901 CARDI AC REHAB	0	(0 0	0	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	(0 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	(0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	(0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	(424, 6	53 0	424, 653	73.00
76.00	03020 RENAL ACUTE	0	(0 0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	()	0	0	
90. 05	09005 PATIENT NUTRITION	0	()	0 0	0	
90. 07	09007 WOUND CLINIC	0	(0 0	0	1
	09100 EMERGENCY	0	(0	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	(1	0	0	92.00
200.00	Total (lines 50 through 199)	0	(0 699, 0	94 0	699, 094	1200.00

Health Financial Systems	UNI ON HOSPI	TAL INC		In lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SI			CN: 15-0023	Peri od:	Worksheet D	2002 10
THROUGH COSTS	in or other the			From 01/01/2016	Part IV	
		·		To 12/31/2016	11/12/2018 4:	pared: 13 pm
			XVIII	Subprovi der - I RF	PPS	
Cost Center Description	Total	Total Charges			I npati ent	
	Outpati ent	(from Wkst.	to Charges	Ratio of Cost	Program	
	Cost (sum of	C, Part I,	(col. 5 ÷	to Charges	Charges	
	col s. 2, 3	col. 8)	col. 7)	(col. 6 ÷		
	and 4)			col. 7)		
	6. 00	7. 00	8. 00	9. 00	10. 00	
ANCILLARY SERVICE COST CENTERS	_					
50. 00 05000 OPERATING ROOM	C				95, 828	
50. 01 05001 CARDI AC SURGERY	C		•		12, 221	50. 01
50. 02 05002 WVSC	C		•		148	
51. 00 05100 RECOVERY ROOM	C	.,	•		3, 190	
51. 02 05101 0/P TREATMENT ROOM	C	2, 748, 332	0.00000	0. 000000	0	51.02
52.00 05200 DELIVERY ROOM & LABOR ROOM	C	18, 165, 230	0.00000		1, 936	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	274, 441	53, 347, 399	0.00514	4 0. 005144	58, 609	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	C	38, 684, 121	0.00000		20, 158	55.00
56. 00 05600 RADI 0I SOTOPE	C	9, 016, 112	0.00000	0. 000000	3, 475	56.00
57. 00 05700 CT SCAN	C	57, 501, 526	0.00000	0. 000000	79, 257	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	C	13, 713, 140	0.00000	0. 000000	6, 040	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	C	106, 078, 215	0.00000	0. 000000	59, 768	59.00
60. 00 06000 LABORATORY	C	92, 236, 841	0.00000	0. 000000	335, 769	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	C	3, 216, 828	0.00000	0. 000000	11, 500	62.00
65. 00 06500 RESPIRATORY THERAPY	C	12, 153, 254	0.00000	0. 000000	95, 116	65.00
66. 00 06600 PHYSI CAL THERAPY	C	11, 604, 203	0.00000	0. 000000	1, 303, 528	66.00
66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0	0. 00000	0. 000000	0	66. 01
66. 02 06602 0/P PHYSI CAL THERAPY	0	6, 812, 335	0. 00000		0	66. 02
67. 00 06700 OCCUPATI ONAL THERAPY	0			0. 000000	1, 252, 733	67.00
68. 00 06800 SPEECH PATHOLOGY	0	2, 548, 823	0. 00000	0. 000000	318, 937	
69. 00 06900 ELECTROCARDI OLOGY	0	19, 601, 012	0. 00000	0. 000000	45, 678	69.00
69. 01 06901 CARDI AC REHAB					0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY					15, 613	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS					10, 813	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	i c				0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	424, 653				701, 468	
76. 00 03020 RENAL ACUTE	12.7,555				202, 309	
OUTPATIENT SERVICE COST CENTERS	,	5,7,0,007	3. 00000	3. 000000	202, 007	1 . 5. 55
90. 00 09000 CLINIC		797, 668	0.00000	0. 000000	0	90.00
90. 05 09005 PATI ENT NUTRI TI ON			•		0	
90. 07 09007 WOUND CLINIC			•		0	
91. 00 09100 EMERGENCY		-,,			11, 742	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					11, 742	
200.00 Total (lines 50 through 199)	_	1, 154, 615, 720		5. 000000	4, 645, 836	
200.00 [Total (Tries 50 till ough 177)	077,074	1 1, 154, 515, 720	ı	1	1 4, 040, 000	1200.00

Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	UNI ON HOSPI		CN. 1E 0000	Period:	u of Form CMS- Worksheet D	-2002-10
THROUGH COSTS	RVICE UTHER PASS	S Provider C	CN: 15-0023	From 01/01/2016		
THROUGH COSTS		Component	CCN: 15-T023	To 12/31/2016		epared:
		<u>'</u>			11/12/2018 4	
		Title	: XVIII	Subprovi der -	PPS	
Cook Cooker Doorwinking		0	0	I RF		
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program	.b		
	Pass-Through	Charges	Pass-Throug			
	Costs (col. 8 x col. 10)		Costs (col.			
		12. 00	x col. 12)	_		
ANCILLARY SERVICE COST CENTERS	11.00	12.00	13. 00			
50. 00 05000 OPERATING ROOM		0		0		50.00
50. 01 05000 0FERATTING ROOM 50. 01 05001 CARDI AC SURGERY	0	0		0		50.00
50. 02 05002 WVSC		0		0		50.01
51. 00 05100 RECOVERY ROOM		0		0		51.00
51. 02 05101 0/P TREATMENT ROOM		0		0		51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM		0		0		52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	301	0		0		54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0		55.00
56. 00 05600 RADI OI SOTOPE		0		0		56.00
57. 00 05700 CT SCAN		0		0		57.00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0		58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0		59.00
60. 00 06000 LABORATORY	0	0		0		60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0		62.00
65. 00 06500 RESPIRATORY THERAPY	0	0		0		65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0		66.00
66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0		66. 01
66. 02 06602 0/P PHYSI CAL THERAPY	0	0		0		66. 02
67. 00 06700 OCCUPATI ONAL THERAPY		0		o		67.00
68. 00 06800 SPEECH PATHOLOGY		0		0		68.00
69. 00 06900 ELECTROCARDI OLOGY		0		0		69.00
69. 01 06901 CARDI AC REHAB		0		0		69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY		0		0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0		0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0		0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 209	0		0		73.00
76. 00 03020 RENAL ACUTE	0	0		0		76.00

0 0 0

1, 510

0

212

212

76.00

90. 00 90. 05

90.07

91.00

92.00

200.00

03020 RENAL ACUTE

OUTPATIENT SERVICE COST CENTERS

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

90. 00 | 09000 | CLINIC | 90. 05 | 09005 | PATIENT NUTRITION

90. 07 09007 WOUND CLINIC

91. 00 09100 EMERGENCY

	Financial Systems IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	UNI ON HOSPI VACCI NE COST	Provi der C		Period: From 01/01/2016 To 12/31/2016	wof Form CMS-2 Worksheet D Part V Date/Time Pre 11/12/2018 4:	pared:
			Title	: XVIII	Subprovi der - I RF	PPS	
				Charges	110	Costs	
	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col.	PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	(see inst.)	PPS Services (see inst.)	
	ANGLI LADV CEDVI CE COCT CENTEDO	1. 00	2. 00	3. 00	4. 00	5. 00	
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0. 128560	0	1	0 0	0	50.00
50. 00 50. 01 50. 02 51. 00 51. 02 52. 00 54. 00 55. 00	05000 DEPARTING ROOM 05001 CARDI AC SURGERY 05002 WVSC 05100 RECOVERY ROOM 05101 O/P TREATMENT ROOM 05200 DELI VERY ROOM & LABOR ROOM 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	0. 12330 0. 317693 0. 152322 0. 554120 2. 052523 0. 414955 0. 241418 0. 209662	000000000000000000000000000000000000000			0 0 0 0 0	50. 00 50. 01 50. 02 51. 00 51. 02 52. 00 54. 00 55. 00
56. 00 57. 00 58. 00 59. 00 60. 00 62. 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	0. 193463 0. 062829 0. 163543 0. 184877 0. 119460 0. 446316	000000000000000000000000000000000000000		0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0	56. 00 57. 00 58. 00 59. 00 60. 00 62. 00
65. 00 66. 00 66. 01 66. 02 67. 00 68. 00	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	0. 474218 0. 315950 0. 000000 0. 355254 0. 243826 0. 346526	000000000000000000000000000000000000000		0 0 0 0 0 0 0 0 0 0	0 0 0 0 0	65. 00 66. 00 66. 01 66. 02 67. 00 68. 00
	06900 ELECTROCARDIOLOGY 06901 CARDIAC REHAB 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 03020 RENAL ACUTE 0UTPATIENT SERVICE COST CENTERS	0. 162956 0. 694220 0. 350562 0. 588842 0. 889738 0. 211340 0. 488467	0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0 0 295 0 0	0 0 0 0 0 0	69. 00 69. 01 70. 00 71. 00 72. 00 73. 00 76. 00
90. 00 90. 05 90. 07 91. 00 92. 00 200. 00 201. 00	09000 CLINIC 09005 PATIENT NUTRITION 09007 WOUND CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) Subtotal (see instructions)	0. 393364 2. 623314 0. 329267 0. 122373 0. 553398	0 0 0 212 0 212		0 0 0 0 0 0 0 0 0 0 0 0 0 295 0 0		90. 00 90. 05 90. 07 91. 00 92. 00 200. 00 201. 00

212

295

26 202.00

202.00

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

	E		UNI ON HOSPI	TAL 11				G F 0110	0550 40
		cial Systems JT OF MEDICAL, OTHER HEALTH SERVICES ANI	UNI ON HOSPI D VACCINE COST			CN: 15-0023	Period:	u of Form CMS- Worksheet D	2552-10
						CCN: 15-T023	From 01/01/2016 To 12/31/2016	Part V	
					Title	XVIII	Subprovi der - I RF	PPS	10 piii
			Cos	sts			I I KF		
		Cost Center Description	Cost Reimbursed Services Subject To	Co Rei ml Servi o Subje Ded. & (see	ost oursed ces Not ect To Coins. inst.)				
		LARY SERVICE COST CENTERS							
50. 02 51. 00 51. 02 52. 00 54. 00 55. 00 56. 00 57. 00 60. 00 62. 00 66. 01 66. 02 67. 00 68. 00 69. 01 70. 00 71. 00 73. 00 73. 00	05001 05002 05100 05101 05200 05400 05500 05600 05700 06800 06600 06601 06602 06700 06800 06901 07000 07100 07300 07300	OPERATING ROOM CARDIAC SURGERY WVSC RECOVERY ROOM O/P TREATMENT ROOM DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC RADIOLOGY-THERAPEUTIC RADIOLOGY-THERAPEUTIC RADIOLOGY-THERAPEUTIC RADIOLOGY-THERAPEUTIC RADIOLOGY-THERAPEUTIC RADIOLOGY-THERAPEUTIC RADIOLOGY-THERAPEUTIC RADIOLOGY-THERAPEUTIC RADIOLOGY CARDIAC CATHETERIZATION LABORATORY WHOLE BLOOD & PACKED RED BLOOD CELLS RESPIRATORY THERAPY PHYSICAL THERAPY PSYCHIATRIC/PSYCHOLOGICAL SERVICES O/P PHYSICAL THERAPY SPECH PATHOLOGY CLUPATIONAL THERAPY SPECH PATHOLOGY CARDIAC REHAB ELECTROCARDIOLOGY CARDIAC REHAB ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS RENAL ACUTE TIENT SERVICE COST CENTERS	000000000000000000000000000000000000000		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				50. 00 50. 01 50. 02 51. 00 54. 00 55. 00 56. 00 57. 00 58. 00 69. 00 66. 00 66. 00 66. 00 66. 00 66. 00 67. 00 68. 00 69. 00 69. 00 70. 00 71. 00 72. 00 73. 00 76. 00
91.00	09000 09005 09007 09100 09200	CLINIC PATIENT NUTRITION WOUND CLINIC EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART) Subtotal (see instructions) Less PBP Clinic Lab. Services-Program Only Charges	0 0 0 0 0 0		0 0 0 0 0 62				90.00 90.05 90.07 91.00 92.00 200.00 201.00

202.00

202.00

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

COMPUT	Financial Systems UNION HOSPITAL ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0023	Peri od:	u of Form CMS-2 Worksheet D-1	
			From 01/01/2016 To 12/31/2016		pared:
		Title XVIII	Hospi tal	PPS	15 piii
	Cost Center Description			4 00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day			58, 018	
2. 00 3. 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed days)		rivata room days	58, 018 0	
3.00	do not complete this line.	iys). II you have only p	iivate room days,	U	3.00
4. 00	Semi-private room days (excluding swing-bed and observation be			48, 771	4.00
5. 00	Total swing-bed SNF type inpatient days (including private re	oom days) through Decemb	er 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)	3		_	
7. 00	Total swing-bed NF type inpatient days (including private room	om days) through Decembe	r 31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private roo	um days) after December	31 of the cost	0	8.00
0.00	reporting period (if calendar year, enter 0 on this line)	iii days) arter becember	or the cost	O	0.00
9. 00	Total inpatient days including private room days applicable t	o the Program (excludin	g swing-bed and	24, 958	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private	room days)	0	10.00
10.00	through December 31 of the cost reporting period (see instruc		room days)	· ·	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, ϵ Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12.00
12.00	through December 31 of the cost reporting period	X only (Therdaing priva	te room days)	O	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13.00
14. 00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr			0	14.00
15. 00	Total nursery days (title V or XIX only)	all (excluding swing-bed	uays)	0	
16.00	Nursery days (title V or XIX only)			0	16. 00
17 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	ess through Dosember 21	of the cost	0.00	 17. 00
17.00	reporting period	es till ough becelliber 31	or the cost	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
10 00	reporting period	so through Docombor 21 o	f +bo ooo+	0.00	10.00
19.00	Medicaid rate for swing-bed NF services applicable to service reporting period	s through becember 31 o	i the cost	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	0.00	20.00
21 00	reporting period	>		/1 DOE 202	01.00
21. 00 22. 00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ting period (line	61, 935, 293 0	
	5 x line 17)	·		_	
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporti	ng period (line 6	0	23.00
24. 00	x line 18) Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost report	ing period (line	0	24.00
	7 x line 19)	·			
25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reportin	g period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		61, 935, 293	
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT				
28. 00 29. 00	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	ed and observation bed c	harges)	0	
30.00	Semi -pri vate room charges (excluding swing-bed charges)			0	
31. 00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	nus line 33)(see instru	ctions)	0. 00 0. 00	
35. 00	Average per diem private room cost differential (line 34 x li	, ,	Í	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	and and out of the second		0	
37. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost d	ıırerentıal (line	61, 935, 293	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ		,		
38.00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line	•		1, 067. 52 26, 643, 164	
30 00					

40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)
41.00 Total Program general inpatient routine service cost (line 39 + line 40)

26, 643, 164 41. 00

42. 00 NURSERY Intensi 43. 00 INTENSI 44. 00 CORONAF 45. 00 BURN IN 46. 00 SURGI CO 47. 00 INTENSI 50. 00 Program 50. 00 Pass th 111) 51. 00 Pass th 111) 52. 00 Total Factor 53. 00 Total Factor 54. 00 Total Factor 55. 00 Total Factor 56. 00 Target 56. 00 Target 57. 00 Difference 58. 00 Bonus 59. 00 Lesser 60. 00 Lesser 61. 00 If line 62. 00 Medicar 63. 00 Allowate 64. 00 Medicar 65. 00 Medicar 66. 00 Total Medicar 66. 00 Total Medicar 67. 00 Title 68. 00 Title 69. 00 Total 69. 00 Total 70. Total	EY CARE UNIT ITENSIVE CARE UNIT LINTENSIVE CARE UNIT VE NURSERY Dist Center Description In inpatient ancillary service cost (Wk Program inpatient costs (sum of lines ROUGH COST ADJUSTMENTS ITTOUGH costs applicable to Program inpatient operating cost exclused and inpatient operating cost exclused education costs (line 49 minus line AMOUNT AND LIMIT COMPUTATION In discharges ITTOUGH COST ADJUSTMENTS ITTOUGH COST ADJUSTM	13,527,883 4,396,491 st. D-3, col. 3 41 through 48)(matient routine matient ancillar 50 and 51) ding capital re 52) ing cost and ta	Total Inpatient Days 2.00 0 8,314 3,852 . Line 200) see instructic services (from y services (from elated, non-phy	XVIII Average Per Diem (col. 1 ÷ col. 2) 3.00 0.00 1,627.1. 1,141.3. Dons) Tom Wkst. D, sun Tom Wkst. D, sun Tom Wkst. D, sun	4,836 Tof Parts I and sum of Parts II metist, and	Date/Time Prep 11/12/2018 4: 1 PPS Program Cost (col. 3 x col. 4) 5.00 0	42.00 43.00 44.00 45.00 46.00 47.00 50.00 51.00 52.00 53.00 54.00 55.00 56.00						
42. 00 NURSERN Intensi 43. 00 INTENSI 44. 00 CORONAF 45. 00 BURN I N 46. 00 SURGI CA 47. 00 INTENSI 48. 00 Program 49. 00 Total F PASS TH 50. 00 Pass th 111) 51. 00 Pass th 111) 52. 00 Total F 53. 00 Total F 53. 00 Total F 54. 00 Program 55. 00 Target 56. 00 Target 57. 00 Differe 58. 00 Bonus F 59. 00 Lesser 60. 00 Lesser 61. 00 If line 63. 00 Allowate 64. 00 Medicar 65. 00 Medicar 66. 00 Total M 66. 00 Total M 67. 00 Title N 68. 00 Title N 69. 00 Total M 69. 00 Total M 70. 00 Skilled 70. 00 Total M 70. 00 Total M	Ve Care Type Inpatient Hospital Units VE CARE UNIT MY CARE UNIT MY CARE UNIT MITENSIVE CARE UNIT LINTENSIVE CARE UNIT VE NURSERY Dest Center Description Inipatient ancillary service cost (Wk Program inpatient costs (sum of lines ROUGH COST ADJUSTMENTS MITENSIVE CARE UNIT VE NURSERY Dest Center Description Inipatient ancillary service cost (Wk Program inpatient costs (sum of lines ROUGH COST ADJUSTMENTS MITENSIVE COST ADJ	Inpatient Cost 1.00 0 13,527,883 4,396,491 st. D-3, col. 3 41 through 48)(atient routine atient ancillar 50 and 51) ding capital re 52) ing cost and ta	Total Inpatient Days 2.00 0 8,314 3,852 . Line 200) see instructic services (from y services (from elated, non-phy	XVIII Average Per Di em (col. 1 + col. 2) 3.00 0.00 1,627.1. 1,141.3 DOIS) TOM Wkst. D, sun Tom Wkst. D, sun ysician anesth	Hospital Program Days 4.00 0 4,836 5 0 n of Parts I and sum of Parts II hetist, and	Date/Time Pret 11/12/2018 4: 1 PPS Program Cost (col. 3 x col. 4) 5.00 0	13 pm 42.00 43.00 44.00 45.00 46.00 47.00 50.00 51.00 52.00 53.00 54.00 55.00 56.00						
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52. 00 Total F medical TARGET 54. 00 Program 55. 00 Target 56. 00 Differe 58. 00 Bonus F 59. 00 Lesser market 60. 00 Lesser 61. 00 Allowate PROGRAM 64. 00 Medicar instruc 65. 00 Medicar instruc 66. 00 Total M 67. 00 Title M (line 1 68. 00 Title M (line 1 69. 00 Skilled	Program excludable cost (sum of lines Program inpatient operating cost exclueducation costs (line 49 minus line AMOUNT AND LIMIT COMPUTATION of discharges amount per discharge amount (line 54 x line 55) ence between adjusted inpatient operatory asyment (see instructions) of lines 53/54 or 55 from the cost rebasket of lines 53/54 or 55 from prior year	ding capital re 52) ing cost and ta porting period cost report, up	rget amount (I			66, 495, 014 0 0. 00 0 0	54. 00 55. 00 56. 00						
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medical TARGET	education costs (line 49 minus line AMOUNT AND LIMIT COMPUTATION of discharges amount per discharge amount (line 54 x line 55) and the symmetric see instructions) of lines 53/54 or 55 from the cost rebasket of lines 53/54 or 55 from prior year	ing cost and ta	rget amount (I			0 0.00 0 0	54. 00 55. 00 56. 00						
54.00 Program 55.00 Target 56.00 Target 57.00 Differe 58.00 Bonus p 59.00 Lesser market 60.00 Lesser 61.00 If line which c amount 62.00 Relief 63.00 Allowab PROGRAM 64.00 Medicar instruc 65.00 Medicar instruc 66.00 Total M CAH (se 67.00 Title V (line 1 68.00 Total M 69.00 Total I FART II 70.00 Skilled	AMOUNT AND LIMIT COMPUTATION I discharges amount per discharge amount (line 54 x line 55) nnce between adjusted inpatient operate ayment (see instructions) of lines 53/54 or 55 from the cost re basket of lines 53/54 or 55 from prior year	ing cost and ta porting period cost report, up		ine 56 minus	line 53)	0. 00 0 0	55. 00 56. 00						
55. 00 Target 56. 00 Target 57. 00 Differe 58. 00 Bonus p 59. 00 Lesser market 60. 00 Lesser 61. 00 If line which c amount 62. 00 Relief 63. 00 Medicar instruc 65. 00 Medicar instruc 66. 00 Total h CAH (se 67. 00 Title N (line 1 68. 00 Title N (line 1 69. 00 Skilled	amount per discharge amount (line 54 x line 55) ance between adjusted inpatient operat asyment (see instructions) of lines 53/54 or 55 from the cost re basket of lines 53/54 or 55 from prior year	porting period		ine 56 minus	line 53)	0. 00 0 0	55. 00 56. 00						
56. 00 Target 57. 00 Differe 58. 00 Bonus p 59. 00 Lesser market 60. 00 Lesser 61. 00 If line which coamount 62. 00 Relief 63. 00 Allowak PROGRAM 64. 00 Medicar instruc 65. 00 Medicar instruc 66. 00 Total M CAH (se 67. 00 Title M (line 1 68. 00 Title M (line 1 69. 00 Skilled	amount (line 54 x line 55) ence between adjusted inpatient operat payment (see instructions) of lines 53/54 or 55 from the cost re basket of lines 53/54 or 55 from prior year	porting period		ine 56 minus	line 53)	0	56.00						
57. 00 Difference 58. 00 Bonus processer market 60. 00 Lesser 61. 00 If line 162. 00 Relief 63. 00 Allowate FROGRAM 64. 00 Medicar instruct 65. 00 Medicar instruct 66. 00 Total Medicar instruct 68. 00 Title Medicar instruct 68. 00 Total Medicar instruction for instruction f	ence between adjusted inpatient operat payment (see instructions) of lines 53/54 or 55 from the cost re basket of lines 53/54 or 55 from prior year	porting period		ine 56 minus	line 53)	0							
58. 00 Bonus properties for the state of the	payment (see instructions) of lines 53/54 or 55 from the cost re basket of lines 53/54 or 55 from prior year	porting period											
market Lesser 61.00 If line which c amount 62.00 Relief 63.00 Allowab PROGRAM 64.00 Medicar instruc 65.00 Medicar instruc 66.00 Total M CAH (se 67.00 Title M (line 1 68.00 Title M (line 1 69.00 Skilled	basket of lines 53/54 or 55 from prior year	cost report, up	endi ng 1996, ι										
60.00 Lesser 61.00 If line which camount 62.00 Relief 63.00 Allowad PROGRAM 64.00 Medicar instruc 65.00 Medicar instruc 66.00 Total M CAH (se 67.00 Title M (line 1 68.00 Title M (line 1 69.00 Skilled	of lines 53/54 or 55 from prior year		Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket										
61.00 If line which canount 62.00 Relief 63.00 Allowak PROGRAM 64.00 Medicar instruct 65.00 Total March (line 168.00 Title March (line 169.00 Skilled			da+ad by +ba m	ankat baakat		0.00	60.00						
which canount Allowate													
62.00 Relief 63.00 Allowak PROGRAM 64.00 Medicar instruc 65.00 Medicar instruc 66.00 Total M CAH (se 67.00 Title M (line 1 68.00 Title M (line 1 70.00 Skilled	perating costs (line 53) are less tha					0	61.00						
63. 00 Allowate PROGRAM 64. 00 Medicar instruct 65. 00 Medicar instruct 66. 00 Total Mark CAH (see 67. 00 Title Mark CH (line 168. 00 Title Mark CH (line 169. 00 Total Mark CH (line 169. 00 Skilled	(line 56), otherwise enter zero (see	instructions)				o	62.00						
64. 00 Medicar instruct 65. 00 Medicar instruct 66. 00 Total M CAH (see 67. 00 Title M (line 1 68. 00 Title M (line 1 69. 00 Total Total M PART II 70. 00 Skilled	00 Relief payment (see instructions) 00 Allowable Inpatient cost plus incentive payment (see instructions)												
64.00 Medicar instruct 65.00 Medicar instruct 66.00 Total Mark 67.00 Title Mark 68.00 Title Mark 69.00 Total Total 70.00 Skilled	INPATIENT ROUTINE SWING BED COST	ent (see mstru	ctrons)			0	63.00						
65.00 Medicar instruct 66.00 Total March (see 1.00) 67.00 Title March (line 1.00) 68.00 Title March (line 1.00) 69.00 Total 1.00 70.00 Skilled	e swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	e cost reporti	ng period (See	0	64.00						
instruct 66.00	tions)(title XVIII only)					_							
66.00 Total M CAH (see 67.00 Title N (line 1 68.00 Title N (line 1 69.00 Total 1 PART II 70.00 Skilled	re swing-bed SNF inpatient routine cos ctions)(title XVIII only)	ts after Decemb	er 31 of the c	cost reporting	period (See	0	65.00						
CAH (see 67.00 Title \(\) (line 1 \) (88.00 Title \(\) (line 1 \) 69.00 PART 1 \) 70.00 Skilled	ledicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	55)(title XVII	I only). For	0	66.00						
68.00 Title \(\)(line 1\) 69.00 Total 1\(\) PART II 70.00 Skilled	e instructions)	•	•	, ,	3,								
68.00 Title \(\(\) (line 1 \) 69.00 Total t \(\) PART II 70.00 Skilled	or XIX swing-bed NF inpatient routin	e costs through	December 31 c	of the cost re	eporting period	0	67.00						
69.00 (line 1 Total to PART II 70.00 Skilled	2 x line 19) ′or XIX swing-bed NF inpatient routin	a costs after N	ecember 31 of	the cost rend	orting period	o	68.00						
70.00 PART II	3 x line 20)	e costs arter b	ecember 31 or	the cost repo	iting period	i I	00.00						
70. 00 Skilled	itle V or XIX swing-bed NF inpatient					0	69.00						
	I - SKILLED NURSING FACILITY, OTHER N						70.0						
	I nursing facility/other nursing facil ed general inpatient routine service c						70.00						
72.00 Program	routine service cost (line 9 x line			-/			72.00						
73.00 Medi cal	ly necessary private room cost applic						73.00						
1	Program general inpatient routine serv	•	,		lost II - I		74.00						
75.00 Capital 26, lir	-related cost allocated to inpatient ne 45)	routine service	COSIS (Trom W	worksneet B, F	art II, Column		75.00						
	em capital-related costs (line 75 ÷ li	ne 2)					76.00						
77.00 Program	capital-related costs (line 9 x line	76)					77.00						
	ent routine service cost (line 74 minu		roul don re	46)			78.00						
	ite charges to beneficiaries for exces				nus line 79)		79.00						
1				. (, , ,		81.00						
82.00 Inpatie	Program routine service costs for comp ent routine service cost per diem limi	tation					82.00						
1	Program routine service costs for comp ent routine service cost per diem limi ent routine service cost limitation (I	ine 9 x line 81	* .			1 1	83.00						
	Program routine service costs for comp ent routine service cost per diem limi ent routine service cost limitation (I able inpatient routine service costs (ine 9 x line 81 see instruction	* .				1040						
	Program routine service costs for compent routine service cost per diem limient routine service cost limitation (luble inpatient routine service costs (a inpatient ancillary services (see in	ine 9 x line 81 see instruction structions)	s)				84.00						
	Program routine service costs for compent routine service cost per diem limient routine service cost limitation (luble inpatient routine service costs (a inpatient ancillary services (see in ition review - physician compensation	ine 9 x line 81 see instruction structions) (see instructio	ns)				84. 00 85. 00 86. 00						
	Program routine service costs for compent routine service cost per diem limient routine service cost limitation (luble inpatient routine service costs (a inpatient ancillary services (see in	ine 9 x line 81 see instruction structions) (see instructio of lines 83 th	ns)				85.00						
88.00 Adjuste 89.00 Observa	Program routine service costs for compent routine service cost per diem limient routine service cost limitation (I while inpatient routine service costs (In inpatient ancillary services (see in ition review - physician compensation program inpatient operating costs (sum	ine 9 x line 81 see instruction structions) (see instructio of lines 83 th S THROUGH COST	ns) nrough 85)			9, 247 1, 067, 52	85. 00 86. 00 87. 00						

Health Financial Systems	UNI ON HOSPI	TAL, INC.		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2016 To 12/31/2016	Date/Time Pre 11/12/2018 4:	pared: 13 pm_
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	8, 377, 767	61, 935, 293	0. 13526	6 9, 871, 357	1, 335, 259	90.00
91.00 Nursing School cost	0	61, 935, 293	0.00000	0 9, 871, 357	0	91.00
92.00 Allied health cost	0	61, 935, 293	0.00000	0 9, 871, 357	0	92.00
93.00 All other Medical Education	0	61, 935, 293	0.00000	0 9, 871, 357	0	93.00

Heal th	Financial Systems	UNION HOSPITAL	, INC.	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CCN: 15-0023	Peri od:	Worksheet D-1	
			Component CCN: 15-T023	From 01/01/2016 To 12/31/2016	Date/Time Pre 11/12/2018 4:	
			Title XVIII	Subprovi der -	PPS	•
	Cost Center Description			I RF		
	cost center bescription				1. 00	
	PART I - ALL PROVIDER COMPONENTS					
	INPATIENT DAYS					
1. 00	Inpatient days (including private room days				3, 642	
2.00	Inpatient days (including private room days,				3, 642	
3. 00	Private room days (excluding swing-bed and do not complete this line.	observation bed day	ys). If you have only pr	rivate room days,	0	3.00
4. 00	Semi-private room days (excluding swing-bed	and observation be	ed days)		3, 642	4.00
5. 00	Total swing-bed SNF type inpatient days (inc			er 31 of the cost	0,0.2	
	reporting period	5 F				
6. 00	Total swing-bed SNF type inpatient days (increporting period (if calendar year, enter 0		om days) after December	31 of the cost	0	6.00
7. 00	Total swing-bed NF type inpatient days (incl		m days) through December	r 31 of the cost	0	7.00
7.00	reporting period	rading private roof	adys) thi dagn becomber	01 01 110 0031	Ü	7.00
8.00	Total swing-bed NF type inpatient days (incl		n days) after December 3	31 of the cost	0	8. 00
	reporting period (if calendar year, enter 0		5		0.544	
9. 00	Total inpatient days including private room newborn days)	days applicable to	the Program (excluding	g swing-bed and	2, 511	9. 00
10.00	Swing-bed SNF type inpatient days applicable	e to title XVIII or	nly (including private d	room days)	0	10.00
.0.00	through December 31 of the cost reporting pe	ū	10.00			
11.00	Swing-bed SNF type inpatient days applicable			room days) after	0	11.00
40.00	December 31 of the cost reporting period (i					40.00
12. 00	Swing-bed NF type inpatient days applicable through December 31 of the cost reporting pe		Conly (including privat	te room days)	0	12.00
13. 00	Swing-bed NF type inpatient days applicable		Conty (including privat	te room days)	0	13.00
.0.00	after December 31 of the cost reporting peri				ū	10.00
14.00	Medically necessary private room days applic				0	14.00
15.00	Total nursery days (title V or XIX only)				0	
16. 00	Nursery days (title V or XIX only)				0	16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services app	nlicable to service	os through Docombor 21 (of the cost	0.00	17. 00
17.00	reporting period	pricable to service	es through becember 51 to	of the cost	0.00	17.00
18.00	Medicare rate for swing-bed SNF services app	plicable to service	es after December 31 of	the cost	0.00	18.00
	reporting period					
19. 00	Medicaid rate for swing-bed NF services appl	licable to services	s through December 31 of	f the cost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services appl	licable to complete	after December 21 of	the cost	0. 00	20.00
20.00	reporting period	ilicable to services	s after becember 31 of	the cost	0.00	20.00
21. 00	Total general inpatient routine service cos	t (see instructions	5)		3, 403, 100	21.00
22.00	Swing-bed cost applicable to SNF type service	ces through Decembe	er 31 of the cost report	ting period (line	0	22.00
	5 x line 17)	C1 - 1				00 -
23. 00	Swing-bed cost applicable to SNF type servior x line 18)	ces after December	31 of the cost reporting	ng period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type service	es through December	- 31 of the cost reporti	na period (line	0	24.00
24.00	7 x line 19)	cs through becember	or or the cost reporti	ing period (inte	O	24.00
25. 00	Swing-bed cost applicable to NF type service	es after December 3	31 of the cost reporting	g period (line 8	0	25. 00
04 05	x line 20)				_	0, 5-
26.00	Total swing-bed cost (see instructions)				0	26.00

1. 00 2. 00 3. 00	Inpatient days (including private room days and swing-bed days, excluding newborn) Inpatient days (including private room days, excluding swing-bed and newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private room days,	3, 642 3, 642 0	1. 00 2. 00 3. 00
4. 00 5. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed days) Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	3, 642	4. 00 5. 00
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8. 00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2, 511	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11. 00
	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12.00
	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	
	Medically necessary private room days applicable to the Program (excluding swing-bed days) Total nursery days (title V or XIX only)	0	
	Nursery days (title V or XIX only) SWING BED ADJUSTMENT	0	
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0. 00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0. 00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5×1)	3, 403, 100	21. 00 22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line α x line 18)	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 \times line 19)	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 \times line 20)	0	25. 00
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	3, 403, 100	26. 00 27. 00
	General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges)	0	
	Semi -private room charges (excluding swing-bed charges)	0	
	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	31.00
	Average private room per diem charge (line 29 ÷ line 3)		32.00
	Average semi-private room per diem charge (line 30 ÷ line 4)		33.00
	Average per diem private room charge differential (line 32 minus line 33)(see instructions) Average per diem private room cost differential (line 34 x line 31)	0.00	34. 00 35. 00
	Private room cost differential adjustment (line 3 x line 35)	0.00	36.00
	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		
	Adjusted general inpatient routine service cost per diem (see instructions)	934. 40	
	Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35)	2, 346, 278 0	
	Total Program general inpatient routine service cost (line 39 + line 40)	2, 346, 278	

COMPLIT	Financial Systems ATION OF INPATIENT OPERATING COST	UNION HOSPIT		CCN: 15-0023	Peri od:	u of Form CMS-2 Worksheet D-1	
001111 01	ATTOM OF THE ATTEM OF ENTITIES GOOT			CCN: 15-T023	From 01/01/2016 To 12/31/2016		pared:
			Titl	e XVIII	Subprovi der -	PPS	
	Cost Center Description	Total	Total	Average Pe	IRF r Program Days	Program Cost	
	good gonton good (pt. c.)	I npati ent	Inpatient	Diem (col.		(col . 3 x	
		Cost	Days	÷ col . 2)		col . 4)	
42 NO	NURSERY (title V & XIX only)	1. 00	2. 00	3.00	4. 00 00 0	5. 00	42.00
42.00	Intensive Care Type Inpatient Hospital Units	<u> </u>	`	5] 0.	00 0	0	42.00
43.00	INTENSIVE CARE UNIT	0	(0.	00 0	0	
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT						46.00
	I NTENSI VE NURSERY	0	(0.	00 0	0	
	Cost Center Description					1 00	
48. 00	Program inpatient ancillary service cost (Wk	st D_3 col 3	line 200)			1. 00 1, 241, 487	48. 00
49. 00		41 through 48)(see instructi	ons)		3, 587, 765	
	PASS THROUGH COST ADJUSTMENTS						
50. 00	Pass through costs applicable to Program inpa	atient routine :	services (fro	om Wkst. D, s	um of Parts I and	400, 655	50.00
51. 00		atient ancillar	v services (f	rom Wkst. D.	sum of Parts II	212, 043	51.00
	and IV)		, (.				
52.00	Total Program excludable cost (sum of lines!					612, 698	
53. 00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line !	9 1	lated, non-pr	nysician anes	thetist, and	2, 975, 067	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION	32)					
54.00	Program di scharges					0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0. 00 0	1
57. 00	Difference between adjusted inpatient operati	ing cost and ta	raet amount (Tine 56 minu	s line 53)	0	
58. 00	Bonus payment (see instructions)	g	. g	(0	
59. 00	Lesser of lines 53/54 or 55 from the cost rep	porting period o	endi ng 1996,	updated and	compounded by the	0.00	59.00
60.00	market basket Lesser of lines 53/54 or 55 from prior year	rost renort un	dated by the	market haske	†	0. 00	60.00
61.00	If line 53/54 is less than the lower of lines					0.00	
	which operating costs (line 53) are less than		s (lines 54 >	(60), or 1%	of the target		
62. 00	amount (line 56), otherwise enter zero (see i Relief payment (see instructions)	instructions)				0	62.00
63.00	Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Dece	mber 31 of th	ne cost repor	ting period (See	0	64.00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the	cost reporti	na period (See	0	65.00
	instructions)(title XVIII only)			·			
66. 00	Total Medicare swing-bed SNF inpatient routing	ne costs (line o	64 plus line	65)(title XV	III only). For	0	66.00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through	December 31	of the cost	reporting period	0	67.00
	(line 12 x line 19)						
68. 00	Title V or XIX swing-bed NF inpatient routing	e costs after De	ecember 31 of	the cost re	porting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + lir	ne 68)		0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER NU	JRSING FACILITY,	AND ICF/IID	ONLY			
70.00	Skilled nursing facility/other nursing facili				7)		70.00
71. 00 72. 00	Adjusted general inpatient routine service co Program routine service cost (line 9 x line	,	ine /U ÷ IIne	÷ 2)			71.00
73. 00	Medically necessary private room cost applica		(line 14 x l	ine 35)			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	costs (from	Worksheet 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		rovi der recor	rds)			78. 00 79. 00
80.00	Total Program routine service costs for compa			,	inus line 79)		80.00
81.00	Inpatient routine service cost per diem limi				•		81.00
82. 00 83. 00	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (:						82. 00 83. 00
84. 00	Program inpatient ancillary services (see in		3)				84.00
85. 00	Utilization review - physician compensation	(see instructio					85.00
86. 00			rough 85)				86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					0	87. 00
	Adjusted general inpatient routine cost per of		line 2)			0. 00	88. 00
	Observation bed cost (line 87 x line 88) (see						89.00

Health Financial Systems	UNI ON HOSPI	TAL, INC.		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od: From 01/01/2016	Worksheet D-1	
С		Component (Component CCN: 15-T023		Date/Time Pre 11/12/2018 4:	
		Title	XVIII	Subprovi der -	PPS	
				I RF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	581, 109	3, 403, 100	0. 17075	59 0	0	90.00
91.00 Nursing School cost	0	3, 403, 100	0.00000	00	0	91.00
92.00 Allied health cost	0	3, 403, 100	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	3, 403, 100	0. 00000	00	0	93. 00

	Financial Systems UNION HOSPITATION OF INPATIENT OPERATING COST	TAL, INC. Provider CCN: 15-0023	Peri od:	u of Form CMS-2 Worksheet D-1	
			From 01/01/2016 To 12/31/2016	Date/Time Pre 11/12/2018 4:	
		Title XIX	Hospi tal	Cost	10 piii
	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 of			58, 018	
2. 00 3. 00	Inpatient days (including private room days, excluding swir Private room days (excluding swing-bed and observation bed		orivato room days	58, 018 0	
3.00	do not complete this line.	days). If you have only p	orrvate room days,	U	3.00
4.00	Semi-private room days (excluding swing-bed and observation			48, 771	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private	room days) through Decemb	per 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 the cost	0	6.00
0.00	reporting period (if calendar year, enter 0 on this line)	. com dayo, a. to. boodingo.	0. 0. 1.10 0001	· ·	0.00
7. 00	Total swing-bed NF type inpatient days (including private r	room days) through Decembe	er 31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private r	coom days) after December	21 of the cost	0	8.00
8.00	reporting period (if calendar year, enter 0 on this line)	dolli days) al tel beceliber	31 of the cost	U	8.00
9. 00	Total inpatient days including private room days applicable	e to the Program (excludir	ng swing-bed and	789	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII	only (including private	room days)	0	10.00
10.00	through December 31 of the cost reporting period (see instr		1 doill days)	U	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII	only (including private	room days) after	0	11. 00
12.00	December 31 of the cost reporting period (if calendar year, Swing-bed NF type inpatient days applicable to titles V or		ata maam daya)	0	12.00
12. 00	through December 31 of the cost reporting period	XIX only (Including priva	ate room days)	U	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or		0	13. 00	
14.00	after December 31 of the cost reporting period (if calendar		0	14.00	
14. 00 15. 00	Medically necessary private room days applicable to the Pro Total nursery days (title V or XIX only)	0 3, 565			
16. 00	Nursery days (title V or XIX only)			292	1
	SWI NG BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	vices through December 31	of the cost	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to serv	vices after December 31 of	f the cost	0. 00	18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to servi reporting period	ces through December 31 o	of the cost	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to servi	ces after December 31 of	the cost	0. 00	20.00
	reporting period				
21. 00 22. 00	Total general inpatient routine service cost (see instructi Swing-bed cost applicable to SNF type services through Dece		sting period (line	61, 935, 293	1
22.00	5 x line 17)	silber 31 of the cost repor	ting period (iiile	. 0	22.00
23. 00	Swing-bed cost applicable to SNF type services after Decemb	oer 31 of the cost reporti	ng period (line 6	0	23. 00
24 00	x line 18) Swing-bed cost applicable to NF type services through Decem	when 21 of the cost report	ting pariod (line	0	24.00
24. 00	7 x line 19)	liber 31 of the cost report	tring period (trine	U	24.00
25. 00	Swing-bed cost applicable to NF type services after December	er 31 of the cost reportin	ng period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cos	st (line 21 minus line 26))	61, 935, 293	1
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28. 00	General inpatient routine service charges (excluding swing-	-bed and observation bed o	charges)	0	
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	
31. 00	General inpatient routine service cost/charge ratio (line 2	27 ÷ line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)	- /		0. 00	1
33.00	Average semi-private room per diem charge (line 30 ÷ line 4	1)		0. 00	1
34.00	Average per diem private room charge differential (line 32		uctions)	0. 00	
35. 00 36. 00	Average per diem private room cost differential (line 34 x	line 31)		0.00	35.00

	·	1. 00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS	50.010	4 00
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	58, 018	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	58, 018 0	2. 00 3. 00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	U	3.00
4. 00	Semi-private room days (excluding swing-bed and observation bed days)	48, 771	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost		5. 00
3.00	reporting period	O	3.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)	_	
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
	reporting period		
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)		
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	789	9. 00
	newborn days)		
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
44.00	through December 31 of the cost reporting period (see instructions)		44 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
12 00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	12. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	U	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	U	13.00
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
15. 00	Total nursery days (title V or XIX only)		15. 00
16. 00	Nursery days (title V or XIX only)	292	
	SWING BED ADJUSTMENT	: =	
17.00		0.00	17.00
	reporting period		
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18.00
	reporting period		
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19.00
	reporting period		
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20.00
	reporting period		
21. 00	, , , , , , , , , , , , , , , , , , , ,	61, 935, 293	
22. 00		. 0	22. 00
23. 00	5 x line 17)	0	23. 00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	·	23.00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
24.00	7 x line 19)	O	24.00
25 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
	x line 20)	_	
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	61, 935, 293	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29. 00	Private room charges (excluding swing-bed charges)	0	29. 00
30.00	Semi -pri vate room charges (excluding swing-bed charges)	0	
31.00		0.000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)	0. 00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00	
35.00	Average per diem private room cost differential (line 34 x line 31)	0. 00	
36.00	Private room cost differential adjustment (line 3 x line 35)	(1.025.202	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	61, 935, 293	37. 00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY DDOCDAM INDATIENT OPERATING COST REFORE DASS THROUGH COST AD HISTMENTS		
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions)	1 047 50	38 00
39. 00		1, 067. 52 842, 273	
	Medically necessary private room cost applicable to the Program (line 14 x line 35)	042, 273	
	Total Program general inpatient routine service cost (line 39 + line 40)	842, 273	
00	g-mar g-mar	312,273	

Heal th	Financial Systems	UNI ON HOSPI	TAL, INC.		In Lie	u of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST		Provi der C		Period: From 01/01/2016	Worksheet D-1	
					To 12/31/2016	11/12/2018 4:	
	Cost Center Description	Total	Ti tl Total	e XIX Average Per	Hospital Program Days	Cost Program Cost	
	cost center bescription	Inpati ent	Inpatient	Diem (col. 1	Pi Ogi alli Days	(col. 3 x	
		Cost	Days	÷ col . 2)		col . 4)	
40.00	MUDCEDY (+: +1 - V 0 VIV1)	1. 00	2.00	3.00	4. 00	5. 00	42.00
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	2, 062, 487	3, 565	578. 5	4 292	168, 934	42.00
43.00	INTENSIVE CARE UNIT	13, 527, 883	8, 314	1, 627. 1	2 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	4, 396, 491	3, 852	1, 141. 3	5 162	184, 899	1
	Cost Center Description		<u> </u>	· ·		1. 00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3. col. :	3. line 200)			1, 056, 043	48. 00
49. 00	Total Program inpatient costs (sum of lines - PASS THROUGH COST ADJUSTMENTS			ons)		2, 252, 149	ı
50. 00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sur	n of Parts I and	0	50.00
51. 00	Pass through costs applicable to Program inp.	atient ancilla	ry services (f	rom Wkst. D, s	sum of Parts II	0	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				0	52.00
53. 00	Total Program inpatient operating cost exclu	ding capital re	elated, non-ph	ysician anestl	netist, and	0	53. 00
	medical education costs (line 49 minus line 1 TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54.00	Program di scharges					0	54.00
55.00	Target amount per discharge					0. 00	55.00
56.00	Target amount (line 54 x line 55)	: +		li F/!	1: 52)	0	56.00
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	arget amount (illie so minus	11 ne 53)	0	57. 00 58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and co	ompounded by the		1
	market basket		. 1. 1 . 1			0.00	,,,,,,,
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of lines				the amount by	0.00	60. 00 61. 00
01.00	which operating costs (line 53) are less than					O	01.00
	amount (line 56), otherwise enter zero (see instructions)						,,,,,,,
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instr	uctions)			0	62. 00 63. 00
	PROGRAM INPATIENT ROUTINE SWING BED COST				ng noriad (Coo		
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Dece	ember 31 of th	e cost reporti	ng period (see	0	64.00
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts after Decemb	ber 31 of the	cost reportino	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routil CAH (see instructions)	ne costs (line	64 plus line	65)(title XVII	I only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through	h December 31	of the cost re	eporting period	0	67. 00
68. 00	1 1	e costs after I	December 31 of	the cost repo	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NI		<u> </u>			0	69.00
70. 00	Skilled nursing facility/other nursing facil						70.00
71. 00	Adjusted general inpatient routine service co	ost per diem (I					71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applications)		m (lina 14 v l	ine 35)			72. 00 73. 00
74.00	Total Program general inpatient routine serv						74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)				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	,	nrovider recor	ds)			78. 00 79. 00
80.00							80.00
81.00							81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (*				82. 00 83. 00
84. 00	Program inpatient ancillary services (see in		10)				84.00
85.00	Utilization review - physician compensation	(see instruction					85.00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		hrough 85)				86.00
87. 00	Total observation bed days (see instructions					9, 247	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 -				1, 067. 52	
89.00	Observation bed cost (line 87 x line 88) (see	e instructions,)			9, 871, 357	84.00

Health Financial Systems	UNI ON HOSPI	TAL, INC.		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2016 To 12/31/2016	Date/Time Pre 11/12/2018 4:	pared: 13 pm_
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	8, 377, 767	61, 935, 293	0. 13526	6 9, 871, 357	1, 335, 259	90.00
91.00 Nursing School cost	0	61, 935, 293	0.00000	0 9, 871, 357	0	91.00
92.00 Allied health cost	0	61, 935, 293	0. 00000	0 9, 871, 357	0	92.00
93.00 All other Medical Education	0	61, 935, 293	0.00000	0 9, 871, 357	0	93.00

Health Financial Systems UNION HOSPIT		CN. 1E 0022		u of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0023	Peri od: From 01/01/2016	Worksheet D-3	3
			To 12/31/2016	11/12/2018 4:	
	Titl∈	XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col. 2)	
		1.00	2.00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS			47, 151, 378		30.00
31. 00 03100 NTENSI VE CARE UNI T			14, 533, 965		31.00
35. 00 02040 I NTENSI VE NURSERY			0		35.00
41. 00 04100 SUBPROVI DER - I RF			0		41.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM		0. 1285		5, 698, 377	
50. 01 05001 CARDI AC SURGERY		0. 3176	5, 883, 938	1, 869, 286	50. 01
50. 02 05002 WVSC		0. 1523		13, 006	
51. 00 05100 RECOVERY ROOM		0. 55412		613, 333	
51. 02 05101 0/P TREATMENT ROOM		2. 0525		46, 042	1
52. 00 O5200 DELIVERY ROOM & LABOR ROOM		0. 4149!		868, 639	
54. 00 O5400 RADI OLOGY - DI AGNOSTI C		0. 2414		1, 605, 778	1
55. 00 O5500 RADI OLOGY-THERAPEUTI C		0. 2096		164, 361	1
56. 00 05600 RADI 0I SOTOPE 57. 00 05700 CT SCAN		0. 1934 0. 0628		92, 162	1
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 0626		565, 252 200, 214	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 1848		2, 383, 060	
60. 00 06000 LABORATORY		0. 1214			1
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 4463		678, 335	
65. 00 06500 RESPIRATORY THERAPY		0. 4742		2, 695, 991	
66. 00 06600 PHYSI CAL THERAPY		0. 3159			1
66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0.0000		0	1
66. 02 06602 0/P PHYSI CAL THERAPY		0. 3552		0	66. 02
67. 00 06700 OCCUPATI ONAL THERAPY		0. 24382	26 1, 858, 388	453, 123	67.00
68. 00 06800 SPEECH PATHOLOGY		0. 3465	26 453, 057	156, 996	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 1629	6, 363, 222	1, 036, 925	69.00
69. 01 06901 CARDI AC REHAB		0. 6942	20 80, 992	56, 226	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 3505		207, 734	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 5888			1
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 88973		5, 586, 966	1
73. 00 O7300 DRUGS CHARGED TO PATIENTS		0. 2113		7, 370, 014	1
76. 00 O3020 RENAL ACUTE		0. 4884	2, 461, 881	1, 202, 548	76. 00
OUTPATIENT SERVICE COST CENTERS		0.2022	(4)	^	00.00
90. 00 09000 CLI NI C 90. 05 09005 PATI ENT NUTRI TI ON		0. 3933		0 0	
90. 05 09005 PATIENT NUTRITION 90. 07 09007 WOUND CLINIC		2. 63840 0. 32920		1, 424	1
91. 00 09100 EMERGENCY		0. 32920		1, 424	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 1223			92.00
200 00 Total (sum of Lines 50 through 94 and 96 through 98)		0.5555	188, 966, 265		

40, 265, 850 200. 00 201. 00 202. 00

188, 966, 265

188, 966, 265

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

200.00

201. 00 202. 00

	Financial Systems UNION HOSPITAL, ENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-0023	Peri od:	wof Form CMS- Worksheet D-3	
			CCN: 15-T023	From 01/01/2016 To 12/31/2016		pared:
		Title	: XVIII	Subprovi der - I RF	PPS	•
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges	Program Charges	Program Costs (col. 1 x col. 2)	
	ANDATI ENT. DOUTINE CEDIU DE COCT. CENTEDO		1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS		I	0	I	30.00
	03100 INTENSIVE CARE UNIT					31.00
	02040 I NTENSI VE NURSERY					35.00
	04100 SUBPROVI DER – I RF			2, 498, 110	•	41.00
	04300 NURSERY			27 1707 110		43.00
	ANCILLARY SERVICE COST CENTERS		•		•	
	05000 OPERATING ROOM		0. 1285	50 95, 828	12, 320	50.00
	05001 CARDI AC SURGERY		0. 3176		3, 883	
	05002 WVSC		0. 15232			
	05100 RECOVERY ROOM		0. 55412	· ·		
	05101 O/P TREATMENT ROOM		2. 05252			
	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC		0. 41495 0. 2414			
	05500 RADI OLOGY-THERAPEUTI C		0. 2096			
	05600 RADI OI SOTOPE		0. 19346			1
	05700 CT SCAN		0. 06282			
	05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 16354			
59.00	05900 CARDI AC CATHETERI ZATI ON		0. 1848	77 59, 768	11, 050	59.00
	06000 LABORATORY		0. 1214	· ·		
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 4463	· ·		
	06500 RESPI RATORY THERAPY		0. 4742	· ·		
	06600 PHYSI CAL THERAPY		0. 3159			
	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 06602 0/P PHYSI CAL THERAPY		0. 00000 0. 35525		1	
	06700 OCCUPATIONAL THERAPY		0. 33323			
	06800 SPEECH PATHOLOGY		0. 34652			
	06900 ELECTROCARDI OLOGY		0. 1629!	· ·		
	06901 CARDI AC REHAB		0. 69422			
70.00	07000 ELECTROENCEPHALOGRAPHY		0. 35056	52 15, 613	5, 473	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 58884	10, 813	6, 367	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 88973		1	
	07300 DRUGS CHARGED TO PATIENTS		0. 21134	· ·		
	03020 RENAL ACUTE		0. 48846	57 202, 309	98, 821	76. 00
	DUTPATIENT SERVICE COST CENTERS 09000 CLINIC		0. 39336	54 0	0	90.00
	09000 PATIENT NUTRITION		2. 63840			
	09007 WOUND CLINIC		0. 32920		1	
	09100 EMERGENCY		0. 1223			
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 55339		0	
200.00	Total (sum of lines 50 through 94 and 96 through 98)			4, 645, 836	1, 241, 487	
201.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		I	4, 645, 836	I	202.00

Heal th	Financial Systems	UNION HOSPITAL, INC.		In Lie	u of Form CMS-2	2552-10
	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	
				From 01/01/2016 To 12/31/2016		
		Ti tl	e XIX	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos		Inpatient	
			To Charges	Program Charges	Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS		•	<u> </u>		
30.00	03000 ADULTS & PEDIATRICS			1, 307, 153		30.00
				365, 262		31.00
	02040 I NTENSI VE NURSERY			0	l	35.00
41. 00	04100 SUBPROVI DER - I RF			82, 905	l e	41.00
43. 00	04300 NURSERY			1, 123, 107		43.00
F0 00	ANCILLARY SERVICE COST CENTERS		0.4005/	755 070	07.400	
50.00	O5000 OPERATI NG ROOM O5001 CARDI AC SURGERY		0. 12856	· ·	l ' .	1
50. 01	05001 CARDI AC SURGERY		0. 31769 0. 15232		0	
	05100 RECOVERY ROOM		0. 15232		1	1
	05101 0/P TREATMENT ROOM		2. 05252	· ·	13, 774	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 41495		1	
	05400 RADI OLOGY-DI AGNOSTI C		0. 24141	· ·		1
55. 00	05500 RADI OLOGY-THERAPEUTI C		0. 20966	· ·		
56.00	I I		0. 19346	· ·		1
57.00	05700 CT SCAN		0. 06282	9 169, 177	10, 629	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 16354	33, 750	5, 520	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON		0. 18487	7 94, 264	17, 427	59.00
60.00	06000 LABORATORY		0. 11946	0 693, 307	82, 822	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 44631	· ·		1
65.00	06500 RESPI RATORY THERAPY		0. 47421			
66.00	06600 PHYSI CAL THERAPY		0. 31595	· ·		
66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0.00000		0	
			0. 35525		0	
67. 00	06700 OCCUPATI ONAL THERAPY		0. 24382	· ·		1
68.00	06800 SPEECH PATHOLOGY		0. 34652			
	06900 ELECTROCARDI OLOGY		0. 16295	· ·		1
69. 01	06901 CARDI AC REHAB		0. 69422	· ·		1
70.00	07000 ELECTROENCEPHALOGRAPHY		0. 35056		13, 704	

242, 308

1, 182, 745

58, 440

42, 300

382, 899

4, 637, 983

4, 637, 983

143

142, 681

249, 961

51, 996

20, 662

46, 856

0

47

0

1, 056, 043 200. 00

71.00

72.00

73.00

76.00

90.00

90.05

90.07

91.00

92.00

201.00

202.00

0.588842

0.889738

0. 211340

0. 488467

0. 393364

2.623314

0. 329267

0. 122373

0. 553398

71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

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

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net charges (line 200 minus line 201)

72.00 07200 IMPL. DEV. CHARGED TO PATIENTS
73.00 07300 DRUGS CHARGED TO PATIENTS

OUTPATIENT SERVICE COST CENTERS

03020 RENAL ACUTE

90. 05 09005 PATIENT NUTRITION

09007 WOUND CLINIC

09000 CLI NI C

91. 00 09100 EMERGENCY

76.00

90.00

90.07

200.00

201.00

Health Financial Systems	UNION HOSPITAL, INC.	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0023	Peri od: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 11/12/2018 4:13 pm
	Title XVIII	Hosni tal	PPS

		Title XVIII	Hospi tal	11/12/2018 4: PPS	13 pm
				1. 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00	
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring pri	or to October 1 ('see	0 45, 706, 728	1. 00 1. 01
	instructions)				
1. 02	DRG amounts other than outlier payments for discharges occurring on instructions)	or after October	1 (see	13, 897, 449	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for disc 1 (see instructions)	charges occurring	prior to October	0	1. 03
1. 04	DRG for federal specific operating payment for Model 4 BPCI for disc October 1 (see instructions)	charges occurring	on or after	0	1. 04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			574, 758 0	2. 00 2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instructions)			0	2. 02
3. 00 4. 00	Managed Care Simulated Payments Bed days available divided by number of days in the cost reporting p	period (see instru	uctions)	6, 465, 509 215. 60	3. 00 4. 00
5. 00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most recer	nt cost reporting	peri od endi ng on	12. 22	5. 00
6. 00	or before 12/31/1996. (see instructions) FTE count for allopathic and osteopathic programs which meet the cri for new programs in accordance with 42 CFR 413.79(e)	teria for an add-	on to the cap	0.00	6. 00
7. 00	MMA Section 422 reduction amount to the IME cap as specified under 4			0.00	7.00
7. 01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFF cost report straddles July 1, 2011 then see instructions.	≀ §412. 105(f)(1)(i	v)(B)(2) If the	0. 00	7. 01
8. 00	Adjustment (increase or decrease) to the FTE count for allopathic ar affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2			0. 00	8. 00
8. 01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slots uncreport straddles July 1, 2011, see instructions.	der § 5503 of the	ACA. If the cost	0. 00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slots frounder § 5506 of ACA. (see instructions)	om a closed teachi	ng hospi tal	0.00	8. 02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, instructions)	8,01 and 8,02) ((see	12. 22	9. 00
10. 00 11. 00	FTE count for allopathic and osteopathic programs in the current year FTE count for residents in dental and podiatric programs.	ır from your recor	-ds	21. 00 0. 00	10. 00 11. 00
12.00	Current year allowable FTE (see instructions)			12. 22	
	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that year ende otherwise enter zero.	ed on or after Sep	otember 30, 1997,	12. 22 12. 22	
15.00	Sum of lines 12 through 14 divided by 3.				15. 00
	Adjustment for residents in initial years of the program				16. 00 17. 00
	Adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count			12. 22	
	Current year resident to bed ratio (line 18 divided by line 4).			0. 056679	
	Prior year resident to bed ratio (see instructions)			0. 052489	
	Enter the lesser of lines 19 or 20 (see instructions)			0. 052489	
	, , , , , , , , , , , , , , , , , , , ,			1, 684, 533	
22. 01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 422 of th	ne MMA		182, 728	22.01
23. 00	-		CFR 412. 105	8. 45	23. 00
	IME FTE Resident Count Over Cap (see instructions)			8. 78	
25. 00	If the amount on line 24 is greater than -O-, then enter the lower c instructions)	of line 23 or line	e 24 (see	8. 45	
	Resident to bed ratio (divide line 25 by line 4)			0. 039193	
	IME payments adjustment factor. (see instructions)			0.010357	27. 00
	IME add-on adjustment amount (see instructions)			617, 320	
	IME add-on adjustment amount - Managed Care (see instructions)			66, 963	
29. 00 29. 01	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			2, 301, 853 249, 691	
30 00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A patient	days (see instru	rtions)	4. 52	30. 00
	Percentage of Medicaid patient days (see instructions)	adys (SCC THSTIUC	5113)	23. 20	
	Sum of lines 30 and 31			27. 72	
	Allowable disproportionate share percentage (see instructions)				33.00
	Disproportionate share adjustment (see instructions)			1, 800, 046	

Health Financial Systems CALCULATION OF REIMBURSEMENT SETTLEMENT UNION HOSPITAL, INC. Provider CCN: 15-0023 Period:				In Lieu of Form CMS-255		
CALCUI	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0023	From 01/01/2016	Part A		
			To 12/31/2016	Date/Time Pre 11/12/2018 4:		
		Title XVIII	Hospi tal	PPS	тэ рііі	
			Prior to 10/1			
	Uncompensated Care Adjustment		1. 00	2. 00		
35. 00			6, 406, 145, 534	5, 977, 483, 147	35.00	
35. 01	, ,	0. 000460744 ee 2, 951, 593	0. 000431893	1		
35. 02	Hospital uncompensated care payment (If line 34 is zero, er instructions)	2, 581, 633	35.02			
35. 03	*	650, 714	35.03			
36. 00	Total uncompensated care (sum of columns 1 and 2 on line 35	5. 03)	2, 209, 663 2, 860, 377	·	36.00	
40.00	Additional payment for high percentage of ESRD beneficiary		ugh 46)		40.00	
40. 00	Total Medicare discharges on Worksheet S-3, Part I excludin 652, 682, 683, 684 and 685 (see instructions)	ig discharges for MS-DRGS	0		40.00	
41. 00		683, 684 an 685. (see	0		41.00	
44 04	instructions)	IC DD0			44.04	
41. 01	Total ESRD Medicare covered and paid discharges excluding N an 685. (see instructions)	15-DRGS 652, 682, 683, 68	4 0		41.01	
42. 00	Divide line 41 by line 40 (if less than 10%, you do not qua	alify for adjustment)	0.00		42.00	
43. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652,	682, 683, 684 an 685. (se	e 0		43.00	
44. 00	instructions) Ratio of average length of stay to one week (line 43 divide	ed by line 41 divided by 7	0. 000000		44.00	
11.00	days)	a by Time II di Vided by 7	0.00000		11.00	
45. 00			0.00		45.00	
46. 00 47. 00	1		46.00			
48. 00	Hospital specific payments (to be completed by SCH and MDH,		48.00			
	only. (see instructions)	· · · · · · · · · · · · · · · · · · ·				
				Amount 1.00		
49. 00	Total payment for inpatient operating costs (see instruction	ons)		67, 390, 902	49.00	
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I	and Pt. II, as applicable		5, 414, 836		
51. 00 52. 00	Exception payment for inpatient program capital (Wkst. L, F Direct graduate medical education payment (from Wkst. E-4,			0 781, 724	1	
53. 00	Nursing and Allied Health Managed Care payment	Title 47 See Thistructions)	•	4, 107		
54. 00	Special add-on payments for new technologies			3, 107	•	
54. 01	Islet isolation add-on payment	(0)		0		
55. 00 56. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see in			0	55.00	
57. 00	Routine service other pass through costs (from Wkst. D, Pt.	through 35).	0			
58.00	Ancillary service other pass through costs from Wkst. D, Pt	. IV, col. 11 line 200)		94, 336	•	
59. 00 60. 00	Total (sum of amounts on lines 49 through 58) Primary payer payments			73, 689, 012 65, 912	•	
61. 00	Total amount payable for program beneficiaries (line 59 min	73, 623, 100				
62.00	Deductibles billed to program beneficiaries				62.0	
63.00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)				63.00	
65. 00	Adjusted reimbursable bad debts (see instructions)	978, 788 636, 212				
66. 00	Allowable bad debts for dual eligible beneficiaries (see in	nstructions)		353, 041		
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	on anni aghi a ta MC DDCa (ooo i notruotiono)	68, 139, 023		
68. 00 69. 00	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96			0	1	
70. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	.,. (,	0	1	
70. 50	Rural Community Hospital Demonstration Project (§410A Demon	, ,	instructions)	0	1	
70. 87 70. 88	Demonstration payment adjustment amount before sequestratic SCH or MDH volume decrease adjustment (contractor use only)			0		
70. 89	Pioneer ACO demonstration payment adjustment amount (see in			0		
70. 90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70. 90	
70. 91	HSP bonus payment HRR adjustment amount (see instructions)			0		
70. 92 70. 93	Bundled Model 1 discount amount (see instructions) HVBP payment adjustment amount (see instructions)			0 116, 038		
70. 73	HRR adjustment amount (see instructions)			-294, 486	•	
	Recovery of accelerated depreciation				70. 9	

Health Financial Systems UNION HOSPITA	I INC		Inlie	u of Form CMS-2	2552_10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		CN: 15-0023	Peri od: From 01/01/2016 To 12/31/2016	Worksheet E 6 Part A		
	Title	e XVIII Hospi tal		PPS		
		FFY	(yyyy)	Amount		
			0	1. 00		
70.96 Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period prior to 10/1)	n column 0		0	0	70. 96	
	volume adjustment for federal fiscal year (yyyy) (Enter in column 0 e corresponding federal year for the period ending on or after 10/1)				70. 97	
70.98 Low Volume Payment-3				0	70. 98	
70.99 HAC adjustment amount (see instructions)				0	70. 99	
71.00 Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			67, 960, 575	71.00	
71.01 Sequestration adjustment (see instructions)				1, 359, 212	71.01	
71.02 Demonstration payment adjustment amount after sequestration				0	71. 02	
72.00 Interim payments				66, 319, 957	72.00	
73.00 Tentative settlement (for contractor use only)				0	73.00	
74.00 Balance due provider/program (line 71 minus lines 71.01, 71.073)	02, 72, and			281, 406	74.00	
75.00 Protested amounts (nonallowable cost report items) in accorda CMS Pub. 15-2, chapter 1, §115.2	ance with			792, 445	75. 00	
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)						
90.00 Operating outlier amount from Wkst. E, Pt. A, line 2 (see ins	structions)			0	90.00	
91.00 Capital outlier from Wkst. L, Pt. I, line 2				0	91.00	
92.00 Operating outlier reconciliation adjustment amount (see insti	ructions)			0	92.00	
93.00 Capital outlier reconciliation adjustment amount (see instruc	ctions)			0	93.00	
94.00 The rate used to calculate the time value of money (see insti				0.00	94.00	
95.00 Time value of money for operating expenses (see instructions)				0	95. 00	
96.00 Time value of money for capital related expenses (see instruc	ctions)			0	96.00	
			Prior to 10/1			
			1. 00	2. 00		
HSP Bonus Payment Amount					100. 00	
HVBP Adjustment for HSP Bonus Payment						
101.00 HVBP adjustment factor (see instructions) 0.000000000					101. 00 102. 00	
HRR Adjustment for HSP Bonus Payment						
103.00 HRR adjustment factor (see instructions)			0.0000	0. 0000		
104.00 HRR adjustment amount for HSP bonus payment (see instructions	5)		0	0	104. 00	

ow vo	nancial Systems ME CALCULATION EXHIBIT 4		UNI ON HOSPI	Provi der CO		Period: From 01/01/2016 To 12/31/2016		
		W/S E, Part A line	Amounts (from E, Part A)	Title Pre/Post Entitlement	XVIII Period Prior to 10/01	On/After	PPS Total (Col 2 through 4)	
		0	1. 00	2. 00	3. 00	10/01 4. 00	5. 00	
00	DRG amounts other than outlier	1. 00	0	0		0 0	0.00	1
01	payments DRG amounts other than outlier payments for discharges	1. 01	45, 706, 728	0	45, 706, 72	8	45, 706, 728	1
02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	13, 897, 449	0		13, 897, 449	13, 897, 449	,
03	1 DRG for Federal specific operating payment for Model 4 BPCI occurring prior to	1. 03	O	0		0	0	
04	October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after	1. 04	0	0		0	0	
00	October 1 Outlier payments for discharges (see instructions)	2. 00	574, 758	0	452, 56	0 122, 198	574, 758	:
01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0		0 0	0	
00	Operating outlier reconciliation Managed care simulated	2. 01 3. 00	0 6, 465, 509	0		0 0 6, 465, 509	0 6, 465, 509	
	payments		, , , , , , , , , , , , , , , , , , , ,			2, 132, 221	2, 122, 221	
	Indirect Medical Education Adju		0.053400	0.052400	0.05040	0 053400		
00	Amount from Worksheet E, Part A, line 21 (see instructions) IME payment adjustment (see	21. 00 22. 00	0. 052489 1, 684, 533	0. 052489	0. 05248 1, 291, 76		1, 684, 533	
)1	instructions) IME payment adjustment for managed care (see	22. 01	182, 728	0	182, 72	8 0	182, 728	
	instructions)							
00	Indirect Medical Education Adjustment factor	ustment for th 27.00	e Add-on for Se 0.010357	oction 422 of 1 0.010357	the MMA 0.01035	7 0. 010357		
00	(see instructions) IME adjustment (see	28. 00	617, 320	0.010337	473, 38		617, 320	
)1	instructions) IME payment adjustment add on for managed care (see	28. 01	66, 963	0		0 66, 963	66, 963	
00	instructions) Total IME payment (sum of lines 6 and 8)	29. 00	2, 301, 853	0	1, 765, 14	7 536, 706	2, 301, 853	
)1	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	249, 691	0	182, 72	8 66, 963	249, 691	
00	Disproportionate Share Adjustman Allowable disproportionate share percentage (see instructions)	ant 33. 00	0. 1208	0. 1208	0. 120	8 0. 1208		1
00	Disproportionate share adjustment (see instructions)	34. 00	1, 800, 046	0	,		1, 800, 046	
01	Uncompensated care payments Additional payment for high per Total ESRD additional payment	36.00 rcentage of ES 46.00	2, 860, 377 RD beneficiary 0	di scharges 0	, , , , ,	3 650, 714 0 0	2, 860, 377	
00 00	(see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47. 00 48. 00	67, 141, 211 0	0	51, 514, 44	1 15, 626, 770 0 0	67, 141, 211 0	
00	(see instructions) Total payment for inpatient operating costs (see instructions)	49. 00	67, 390, 902	0	51, 697, 16	9 15, 693, 733	67, 390, 902	1
00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	5, 414, 836	0	4, 150, 18	5 1, 264, 651	5, 414, 836	1
00	Special add-on payments for new technologies	54. 00	3, 107	0	3, 10	7 0	3, 107	
. 01 . 02	Net organ aquisition cost Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	0		0 0	0	1

Health Financial Systems UNION HOSPITAL, INC. In Lieu of Form CMS-2552-10								
LOW VOLUME CALCULATION EXHIBIT 4			Provi der CCN: 15-0023		Peri od: From 01/01/2016 To 12/31/2016	Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/12/2018 4:13 pm		
				Title	XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prio	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	0n/After 10/01	through 4)	
		0	1. 00	2.00	3. 00	4. 00	5. 00	
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	0		0 0	0	18. 00
19. 00	SUBTOTAL			0	55, 850, 46	16, 958, 384	72, 808, 845	19. 00
		W/S L, line	(Amounts from L)					
		0	1. 00	2.00	3. 00	4. 00	5. 00	
20. 00	Capital DRG other than outlier	1. 00	4, 787, 082	0	3, 661, 80	1, 125, 278	4, 787, 082	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0		0	0	20. 01
21.00	Capital DRG outlier payments	2. 00	181, 119	0	146, 73	34, 384	181, 119	21.00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0		0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0356	0. 0356	0. 03!	0. 0356		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	170, 420	0	130, 30	40, 060	170, 420	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0577	0. 0577	0. 05	0. 0577		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	276, 215	0	211, 28	64, 929	276, 215	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	5, 414, 836	0	4, 150, 18	1, 264, 651	5, 414, 836	26. 00
		W/S E, Part A	`					
		line	E, Part A)					
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
27. 00	Low volume adjustment factor				0. 00000	0. 000000		27.00
28. 00	Low volume adjustment (transfer amount to Wkst. E,	70. 96				0	0	28. 00
29. 00	Pt. A, line) Low volume adjustment (transfer amount to Wkst. E,	70. 97				0	o	29. 00
100.00	Pt. A, line) Transfer low volume		Υ					100. 00
	adjustments to Wkst. E, Pt. A.							l

HUSPII	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ATTON EXHIBIT S		F	rom 01/01/2016 o 12/31/2016		pared:
			Title	XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2. 00	3. 00	4. 00	
1. 00 1. 01	DRG amounts other than outlier payments DRG amounts other than outlier payments for discharges occurring prior to October 1	1. 00 1. 01	45, 706, 728	45, 706, 728		45, 706, 728	1. 00 1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	13, 897, 449		13, 897, 449	13, 897, 449	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1. 03	O	0		0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	O		0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2. 00	574, 758	452, 560	122, 198	574, 758	2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	0	0	2. 01
3. 00 4. 00	Operating outlier reconciliation Managed care simulated payments	2. 01 3. 00	0 6, 465, 509	0 0	0 6, 465, 509	0 6, 465, 509	3. 00 4. 00
	Indirect Medical Education Adjustment						
5. 00	Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 052489	0. 052489	0. 052489		5. 00
6. 00 6. 01	IME payment adjustment (see instructions) IME payment adjustment for managed care (see	22. 00 22. 01	1, 684, 533 182, 728		392, 770 182, 728	1, 684, 533 182, 728	6. 00 6. 01
0.01	instructions)				102, 720	102, 720	0.01
	Indirect Medical Education Adjustment for the						
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 010357	0. 010357	0. 010357		7. 00
8.00	IME adjustment (see instructions)	28. 00	617, 320	473, 384	143, 936	617, 320	8. 00
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	66, 963	0	66, 963	66, 963	8. 01
9.00	Total IME payment (sum of lines 6 and 8)	29. 00	2, 301, 853	1, 765, 147	536, 706	2, 301, 853	9.00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	249, 691	0	249, 691	249, 691	9. 01
40.00	Disproportionate Share Adjustment			0.1000	0.4000		40.00
10. 00	Allowable disproportionate share percentage (see instructions)	33. 00	0. 1208				10.00
11. 00	Disproportionate share adjustment (see instructions)	34. 00	1, 800, 046	1, 380, 343	419, 703	1, 800, 046	11. 00
11. 01	Uncompensated care payments	36.00	2, 860, 377	2, 209, 663	650, 714	2, 860, 377	11. 01
12. 00	Additional payment for high percentage of ESI Total ESRD additional payment (see	46. 00	di scharges 0	0	0	0	12.00
	instructions) Subtotal (see instructions)	47. 00	47 141 211	51, 514, 441	15 424 770	67, 141, 211	13. 00
13. 00 14. 00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)		67, 141, 211	0 0	15, 626, 770 0	07, 141, 211	14. 00
15. 00	Total payment for inpatient operating costs (see instructions)	49. 00	67, 390, 902	51, 514, 441	15, 876, 461	67, 390, 902	15. 00
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	5, 414, 836	4, 150, 185	1, 264, 651	5, 414, 836	16. 00
17. 00 17. 01	Special add-on payments for new technologies Net organ acquisition cost	54. 00	3, 107	3, 107	0	3, 107	17. 00 17. 01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	0	0	0	
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	0	0	0	18. 00
19. 00	SUBTOTAL			55, 667, 733	17, 141, 112	72, 808, 845	19. 00

HOSPI T	Financial Systems AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	UNION HOSPI TION EXHIBIT 5		CN: 15-0023	Peri od:	u of Form CMS-2 Worksheet E	
					From 01/01/2016 To 12/31/2016		pared:
			Title	XVIII	Hospi tal	PPS	
	·	Wkst. L, line	(Amt. from				
			Wkst. L)				
		0	1. 00	2. 00	3. 00	4. 00	
20. 00	Capital DRG other than outlier	1. 00	4, 787, 082	3, 661, 80			
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	181, 119	146, 73	34, 384	181, 119	
	Model 4 BPCI Capital DRG outlier payments	2. 01	0		0 0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0356	0. 035	0. 0356		22.00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	170, 420	130, 30	40, 060	170, 420	23.00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0577	0. 05	0. 0577		24.00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	276, 215	211, 28	64, 929	276, 215	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	5, 414, 836	4, 150, 18	1, 264, 651	5, 414, 836	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		0	0	29.00
30. 00	HVBP payment adjustment (see instructions)	70. 93	116, 038	107, 99	91 8, 047	116, 038	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0 0	0	30. 01
31. 00	HRR adjustment (see instructions)	70. 94	-294, 486	-251, 40	-43, 083	-294, 486	31.00
31. 01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 0	0	31. 01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2. 00	3. 00	4. 00	
32. 00	HAC Reduction Program adjustment (see	70. 99			0 0	0	32.00
100 00	instructions) Transfer HAC Reduction Program adjustment to		N				100.00

Health Financial Systems	UNION HOSPITAL, INC.	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0023	From 01/01/2016	Worksheet E Part B Date/Time Prepared: 11/12/2018 4:13 pm
	Title XVIII	Hospi tal	PPS

			0 12/01/2010	11/12/2018 4:	
		Title XVIII	Hospi tal	PPS	
			·		
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			12, 932	1.00
2.00	Medical and other services reimbursed under OPPS (see instruc	tions)		50, 945, 526	2.00
3.00	OPPS payments			50, 749, 981	3.00
4.00	Outlier payment (see instructions)			101, 159	4.00
4.01	Outlier reconciliation amount (see instructions)				4. 01
5.00	Enter the hospital specific payment to cost ratio (see instru	ctions)		0.000	5.00
6.00	Line 2 times line 5			0	6. 00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0. 00	7. 00
8.00	Transitional corridor payment (see instructions)			0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		156, 584	9. 00
10.00	Organ acqui si ti ons			0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			12, 932	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
12.00	Ancillary service charges			62, 546	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			62, 546	14.00
	Customary charges				
15.00	Aggregate amount actually collected from patients liable for	payment for services on a	charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable fo	r payment for services on	a chargebasis	0	16.00
	had such payment been made in accordance with 42 CFR §413.13(Ŭ		
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)			62, 546	18.00
19.00	Excess of customary charges over reasonable cost (complete on	ly if line 18 exceeds line	e 11) (see	49, 614	19.00
	instructions)	-			
20.00	Excess of reasonable cost over customary charges (complete on	ly if line 11 exceeds line	e 18) (see	0	20.00
	instructions)				
21.00	Lesser of cost or charges (see instructions)			12, 932	21.00
22.00	Interns and residents (see instructions)			0	22.00
23.00	Cost of physicians' services in a teaching hospital (see inst	ructi ons)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			51, 007, 724	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (fo	r CAH, see instructions)		9, 618, 473	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	plus the sum of lines 22 a	and 23] (see	41, 402, 183	27.00
	instructions)				
28.00	Direct graduate medical education payments (from Wkst. E-4, I	ine 50)		510, 269	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			41, 912, 452	30.00
31.00	Primary payer payments			5, 276	
32. 00	Subtotal (line 30 minus line 31)			41, 907, 176	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)			
	Composite rate ESRD (from Wkst. I-5, line 11)			0	
	Allowable bad debts (see instructions)			1, 869, 632	
35. 00	Adjusted reimbursable bad debts (see instructions)			1, 215, 261	
36. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructi ons)		1, 182, 635	
	Subtotal (see instructions)			43, 122, 437	
38. 00	MSP-LCC reconciliation amount from PS&R			-115	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)		0	
39. 97	Demonstration payment adjustment amount before sequestration			0	39. 97
39. 98	Partial or full credits received from manufacturers for repla	ced devices (see instructi	ons)	50, 665	
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	
40.00	Subtotal (see instructions)			43, 122, 552	
40. 01	Sequestration adjustment (see instructions)			862, 451	
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
41. 00	Interim payments			41, 915, 289	
42.00	Tentative settlement (for contractors use only)			0	42.00
43.00	Balance due provider/program (see instructions)			344, 812	
44. 00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2, ch	napter 1,	0	44.00
	§115. 2				
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)				90.00
91. 00	Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money				92.00
	Time Value of Money (see instructions)			0	
94. 00	Total (sum of lines 91 and 93)			0	94.00

Health Financial Systems	UNION HOSPITAL, INC.	In Lie	u of Form CMS-2	552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0023	Peri od:	Worksheet E	
	Component CCN: 15-T023	From 01/01/2016 To 12/31/2016		
	Title XVIII	Subprovi der -	PPS	<u>s piii</u>
		I RF		

		Title XVIII	Subprovi der - I RF	PPS	
			7100	1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			62	1.00
2. 00	Medical and other services reimbursed under OPPS (see instruc		26	2.00	
3. 00 4. 00	OPPS payments			116	3. 00 4. 00
4. 00	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)		١	4.00	
5. 00	Enter the hospital specific payment to cost ratio (see instru		0. 000	5.00	
6.00	Line 2 times line 5			0	6. 00
7. 00 8. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7. 00 8. 00
9. 00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt.	IV col 13 line 200		0	9.00
10.00	Organ acquisitions	,		Ö	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			62	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
12 00	Reasonable charges Ancillary service charges			295	12. 00
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0	
14.00	Total reasonable charges (sum of lines 12 and 13)			295	14.00
45.00	Customary charges				45.00
15. 00 16. 00	Aggregate amount actually collected from patients liable for Amounts that would have been realized from patients liable fo			0	15. 00 16. 00
10.00	had such payment been made in accordance with 42 CFR §413.13(. 9	on a chargebasis	١	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)			295	
19. 00	Excess of customary charges over reasonable cost (complete on instructions)	Ty if line 18 exceeds I	ine 11) (see	233	19. 00
20. 00	Excess of reasonable cost over customary charges (complete on	ly if line 11 exceeds I	ine 18) (see	0	20. 00
	instructions)	3	, , , , , , , , , , , , , , , , , , ,		
	Lesser of cost or charges (see instructions)			62	
22. 00 23. 00	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see inst	ructions)		0	22. 00 23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	ructions)			24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance (for CAH, see instructions)			0	25.00
26. 00 27. 00	Deductibles and Coinsurance relating to amount on line 24 (fo Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)			0 178	26. 00 27. 00
27.00	instructions)	prus the sum of filles 2	2 and 25] (366	170	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, I	ine 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30. 00 31. 00	Subtotal (sum of lines 27 through 29) Primary payer payments			178 0	30. 00 31. 00
	Subtotal (line 30 minus line 31)			178	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)			
	Composite rate ESRD (from Wkst. I-5, line 11)			0	33.00
35. 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			0	34. 00 35. 00
36. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	36.00
37. 00	Subtotal (see instructions)			178	
	MSP-LCC reconciliation amount from PS&R			0	38.00
39. 00 39. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction	5)		0	39. 00 39. 50
39. 97	Demonstration payment adjustment amount before sequestration	3)		0	39. 97
39. 98	Partial or full credits received from manufacturers for repla	ced devices (see instru	ctions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40. 00 40. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)			178 4	40. 00 40. 01
40. 01	Demonstration payment adjustment amount after sequestration			0	40. 02
41.00	Interim payments			180	
42.00	Tentative settlement (for contractors use only)			0	42.00
43. 00 44. 00	Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accorda	nce with CMS Dub 15 2	chanter 1	-6 0	43. 00 44. 00
44.00	§115. 2	nce with ows Pub. 15-2,	chapter I,	١	44.00
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	90.00
	Outlier reconciliation adjustment amount (see instructions)			0 00	91. 00 92. 00
	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	
	Total (sum of lines 91 and 93)			Ö	
			·	•	

Provider CCN: 15-0023

				10 12/31/2010	11/12/2018 4:	
		Ti tl e	e XVIII	Hospi tal	PPS	
		Inpatier	nt Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4. 00	
1.00	Total interim payments paid to provider		65, 027, 65	8	40, 407, 896	1.00
2.00	Interim payments payable on individual bills, either			0	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	12/31/2016	1, 292, 29		1, 507, 393	3. 01
3. 02			l .	0	0	3. 02
3. 03			1	0	0	3. 03
3. 04				0	0	3.04
3.05				0	0	3.05
	Provider to Program			_	_	
3. 50	ADJUSTMENTS TO PROGRAM		1	0	0	3.50
3. 51				0	0	3. 51
3. 52				0	0	3. 52
3. 53			1	0	0	3.53
3. 54	C.ht-t-1 (6 lines 2 01 2 10 minus6 lines			0	0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		1, 292, 29	9	1, 507, 393	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		66, 319, 95	7	41, 915, 289	4. 00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		00, 319, 93	'	41, 910, 209	4.00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR		1			
5. 00	List separately each tentative settlement payment after					5.00
0.00	desk review. Also show date of each payment. If none,					0.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5. 02				0	o	5. 02
5.03				0	o	5.03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM			0	0	5.50
5. 51				0	0	5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		281, 40	6	344, 812	6. 01
6. 02	SETTLEMENT TO PROGRAM		201, 40	o l	0	6. 02
7.00	Total Medicare program liability (see instructions)		66, 601, 36	3	42, 260, 101	7. 00
, . 50			25,001,00	Contractor	NPR Date	,. 00
				Number	(Mo/Day/Yr)	
			0	1.00	2.00	
8. 00	Name of Contractor					8. 00

	n Financial Systems UNION HOSPI SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der C	CN: 15-0023	Peri od:	u of Form CMS-2 Worksheet E-1	
		Component	CCN: 15-T023	From 01/01/2016 To 12/31/2016	Part I Date/Time Prep 11/12/2018 4:	pared:
		Title	e XVIII	Subprovi der -	PPS	10 p
		I npati en	nt Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
1 00	Table to be a second and the second as	1. 00	2.00	3.00	4. 00	1.0
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		3, 804, 5	0	180 0	1. 00 2. 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3. 00
3. 01	Program to Provider ADJUSTMENTS TO PROVIDER		I	0	0	3. 01
3. 01	ADJUSTIMENTS TO FROVIDER			0	0	3. 0
3. 03				o l	ő	3. 0
3. 04				0	0	3. 0
3. 05				0	0	3.0
	Provider to Program		1			
3. 50	ADJUSTMENTS TO PROGRAM			0	0	3.5
3. 51 3. 52				0	0	3. 5 3. 5
3. 52				0	0	3. 5
3. 54				o I	ő	3. 5
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3. 9
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3, 804, 5	19	180	4. 0
5. 00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after		T			5. 0
3.00	desk review. Also show date of each payment. If none,					3.0
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			0	0	5.0
5. 02				0	0	5. 0
5. 03	Drawi day to Draway			0	0	5.0
5. 50	Provider to Program TENTATIVE TO PROGRAM		I	0	0	5. 5
5. 50	TENTATIVE TO PROGRAM			0	0	5. 5
5. 52				0	0	5. 5
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5. 9
5. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 0
6. 01	SETTLEMENT TO PROVIDER			o	0	6. 0
6. 02	SETTLEMENT TO PROGRAM		18, 8	68	6	6.0
7 00	Total Medicare program liability (see instructions)		3 785 6		174	7.0

18, 868 3, 785, 651

0

Contractor Number

1. 00

7. 00

8. 00

NPR Date (Mo/Day/Yr)

2. 00

6. 02 7. 00

8.00 Name of Contractor

Total Medicare program liability (see instructions)

Heal th	Financial Systems UNION HOSPITA	AL, INC.	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 15-0023	Peri od: From 01/01/2016	Worksheet E-1 Part II	
			To 12/31/2016		
		Title XVIII	Hospi tal	PPS	13 piii
			inopi tai		
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATIO	N			
1.00	Total hospital discharges as defined in AARA §4102 from Wkst	. S-3, Pt. I col. 15 lin	e 14	14, 901	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1,	8-12		29, 794	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3, 423	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1,	8-12		60, 937	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			1, 293, 838, 151	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3			20, 039, 871	6.00
7. 00	CAH only - The reasonable cost incurred for the purchase of	certified HIT technology	Wkst. S-2, Pt. I	0	7. 00
	line 168			, 	
8. 00	Calculation of the HIT incentive payment (see instructions)			657, 574	8.00
9.00	Sequestration adjustment amount (see instructions)			13, 151	9.00
10. 00	Calculation of the HIT incentive payment after sequestration	(see instructions)		644, 423	10. 00
00.00	I NPATI ENT HOSPI TAL SERVI CES UNDER THE I PPS & CAH			(40,40)	00.00
	Initial/interim HIT payment adjustment (see instructions)			642, 486	
31.00	Other Adjustment (specify)	line 21) (occ inct	no)	1 027	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see Instructio	ns)	1, 937	32. 00

Heal th	Financial Systems UNION HOSPITAL	. INC.	In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0023	Peri od:	Worksheet E-3	
			From 01/01/2016		
		Component CCN: 15-T023	To 12/31/2016		
		Title XVIII	Subprovi der -	11/12/2018 4: PPS	13 pm
		II the Aviii	I RF	FFS	
				1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			3, 497, 144	1
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0336	1
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			162, 267	
4. 00	Outlier Payments			246, 746	1
5. 00	Unweighted intern and resident FTE count in the most recent c to November 15, 2004 (see instructions)	ost reporting period e	nding on or prior	21.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE coun	t for residents that we	re displaced by	0. 00	5. 01
	program or hospital closure, that would not be counted withou	t a temporary cap adjus	tment under 42	 -	
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			 -	
6.00	New Teaching program adjustment. (see instructions)			0. 00	1
7. 00	Current year's unweighted FTE count of I&R excluding FTEs in	the new program growth	period of a "new	0. 00	7. 00
0.00	teaching program" (see instructions)	*h	:	0.00	0.00
8. 00	Current year's unweighted I&R FTE count for residents within	the new program growth	period of a new	0. 00	8. 00
9. 00	teaching program" (see instructions) Intern and resident count for IRF PPS medical education adjus	tmont (soo instructions	`	0. 00	9.00
10.00	Average Daily Census (see instructions)	tillett (see tilstructions	,	9. 950820	
11. 00	Teaching Adjustment Factor (see instructions)			0. 000000	1
12. 00	Teaching Adjustment (see instructions)			0.000000	ı
13. 00	Total PPS Payment (see instructions)			3, 906, 157	
14. 00	Nursing and Allied Health Managed Care payments (see instruct	i on)		0,700,107	ı
15. 00	Organ acquisition (DO NOT USE THIS LINE)			·	15.00
16. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	16.00
17.00	Subtotal (see instructions)	,		3, 906, 157	17.00
18.00	Primary payer payments			0	1
19.00	Subtotal (line 17 less line 18).			3, 906, 157	19.00
20.00	Deducti bl es			6, 440	20.00
21.00	Subtotal (line 19 minus line 20)			3, 899, 717	
22. 00	Coinsurance			38, 318	1
	Subtotal (line 21 minus line 22)			3, 861, 399	1
24.00	,	ces) (see instructions)		0	
25. 00	, , , , , , , , , , , , , , , , , , , ,			0	
26.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructi ons)		0	
	Subtotal (sum of lines 23 and 25)			3, 861, 399	
28. 00	Direct graduate medical education payments (from Wkst. E-4, I	ine 49)		0	
29. 00	Other pass through costs (see instructions)			1, 510	1
30.00	Outlier payments reconciliation			0	
31. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction	c)		0	
31. 99	Recovery of Accel erated Depreciation	5)		0	
32. 00	Total amount payable to the provider (see instructions)			3, 862, 909	
32. 00	Sequestration adjustment (see instructions)			77, 258	
32. 01	Demonstration payment adjustment amount after sequestration			77,230	•
33. 00	Interim payments			3, 804, 519	1
34. 00	Tentative settlement (for contractor use only)			0,001,017	ı
35. 00	Balance due provider/program (line 32 minus lines 32.01, 32.0	2, 33, and 34)		-18, 868	
36.00	Protested amounts (nonallowable cost report items) in accorda		chapter 1,	1, 169	ł
	§115. 2	•		·	

246, 746

50.00 0 51.00 0.00 52.00

0 53.00

§115.2 TO BE COMPLETED BY CONTRACTOR

53.00 Time Value of Money (see instructions)

50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4
51.00 Outlier reconciliation adjustment amount (see instructions)

52.00 The rate used to calculate the Time Value of Money

Health Financial Systems	UNION HOSPITAL, INC.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0023	From 01/01/2016	Worksheet E-3 Part VII Date/Time Prepared: 11/12/2018 4:13 pm

			10 12/31/2010	11/12/2018 4:	13 pm
		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
1.00	Inpatient hospital/SNF/NF services		2, 252, 149		1.00
2.00	Medical and other services		, , , , ,	0	
3. 00	Organ acquisition (certified transplant centers only)		0		3.00
4. 00	Subtotal (sum of lines 1, 2 and 3)		2, 252, 149	0	
5. 00	Inpatient primary payer payments		2,202,119	Ü	5.00
6. 00	Outpatient primary payer payments			0	
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		2, 252, 149	0	
7.00	COMPUTATION OF LESSER OF COST OR CHARGES		2, 252, 147		7.00
	Reasonable Charges				+
8. 00			2, 878, 428		- 00
	Routine service charges			0	8.00
9.00	Ancillary service charges		4, 637, 983	Ü	
	Organ acquisition charges, net of revenue		0		10.00
	Incentive from target amount computation		0	_	11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		7, 516, 411	0	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13.00
	basi s				
14.00	Amounts that would have been realized from patients liable for		ן ר	0	14.00
	a charge basis had such payment been made in accordance with 43	2 CFR §413.13(e)			
	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	
	Total customary charges (see instructions)		7, 516, 411	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only	y if line 16 exceeds	5, 264, 262	0	17.00
	line 4) (see instructions)				
18.00	Excess of reasonable cost over customary charges (complete only	y if line 4 exceeds line	e 0	0	18.00
	16) (see instructions)				
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instr	uctions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 1	5)	2, 252, 149	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provid	ders.		
22.00	Other than outlier payments		0	0	22.00
	Outlier payments		o	0	23.00
	Program capital payments		0		24.00
	Capital exception payments (see instructions)		0		25. 00
	Routine and Ancillary service other pass through costs		0	0	
	Subtotal (sum of lines 22 through 26)		0	0	
	Customary charges (title V or XIX PPS covered services only)			0	
	Titles V or XIX (sum of lines 21 and 27)		2, 252, 149	0	
29.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		2, 232, 147	0	29.00
30. 00	Excess of reasonable cost (from line 18)		ol	0	30.00
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		2, 252, 149	0	
	Deducti bl es		0	0	
	Coinsurance		0	0	
	Allowable bad debts (see instructions)		0	0	
	Utilization review		0		35.00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	2, 252, 149	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
	Subtotal (line 36 ± line 37)		2, 252, 149	0	
	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		2, 252, 149	0	40.00
41.00	Interim payments		2, 980, 532	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		-728, 383	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub 15-2,	0	0	43.00
73.00					

TRECT	Financial Systems UNION HOSPITAL GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	L, INC. Provider C	CN: 15-0023	In Lieu Period:	Worksheet E-4	
	L EDUCATION COSTS			From 01/01/2016 To 12/31/2016	Date/Time Pre	pared
		Title	XVIII	Hospi tal	PPS	15 piii
					1. 00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT					
. 00	Unweighted resident FTE count for allopathic and osteopathic ending on or before December 31, 1996.	. 0	•		14. 92	1. C
. 00	Unweighted FTE resident cap add-on for new programs per 42 CF Amount of reduction to Direct GME cap under section 422 of MM		(1) (see inst	ructions)	0. 00 0. 00	2. C
. 01					0.00	3. (
. 00	Adjustment (plus or minus) to the FTE cap for allopathic and GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)		programs due	e to a Medicare	0. 00	4. (
01	ACA Section 5503 increase to the Direct GME FTE Cap (see instant straddling 7/1/2011)		r cost report	ing periods	0. 00	4.0
. 02	ACA Section 5506 number of additional direct GME FTE cap slot periods straddling 7/1/2011)	•			0. 00	4.0
. 00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 pl 4.02 plus applicable subscripts	us or minus	line 4 plus	lines 4.01 and	14. 92	5.0
. 00	Unweighted resident FTE count for allopathic and osteopathic records (see instructions)	programs for	r the current	year from your	21. 00	6. (
. 00	Enter the lesser of line 5 or line 6				14. 92	7. (
			Primary Card	e 0ther 2.00	Total 3. 00	
. 00	Weighted FTE count for physicians in an allopathic and osteopprogram for the current year.	oathi c	21. (21. 00	8. (
00	If line 6 is less than 5 enter the amount from line 8, otherwind tiply line 8 times the result of line 5 divided by the amount for the control of the second		14. 9	0.00	14. 92	9.
0. 00	Weighted dental and podiatric resident FTE count for the curr			0. 00		10.
). 01 . 00	Unweighted dental and podiatric resident FTE count for the cu Total weighted FTE count	ırrent year	14.	0. 00 92 0. 00		10. 11.
2. 00	Total weighted resident FTE count for the prior cost reportir instructions)	ng year (see		1		12.
3. 00	Total weighted resident FTE count for the penultimate cost reyear (see instructions)	eporti ng	14. '	92 0.00		13.
1. 00	Rolling average FTE count (sum of lines 11 through 13 divided	d by 3).	14.9			14.
5. 00 5. 01	Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new programs	orograms	0.0			15. 15.
6. 00	Adjustment for residents displaced by program or hospital clo	sure	0.0	0.00		16.
5. 01	Unweighted adjustment for residents displaced by program or h	nospi tal	0.0	0.00		16.
7. 00	Adjusted rolling average FTE count		14. 9	1		17.
3. 00 9. 00	Per resident amount Approved amount for resident costs		121, 554. ! 1, 813, 5		1, 813, 594	18. 19.
			, , , , , ,		1. 00	
). 00	Additional unweighted allopathic and osteopathic direct GME F Sec. 413.79(c)(4)	TE resident	cap slots re	ecei ved under 42	5. 75	20.
1.00	Direct GME FTE unweighted resident count over cap (see instru				6. 08	•
2. 00 3. 00	Allowable additional direct GME FTE Resident Count (see instr Enter the locality adjustment national average per resident a		instructions)		5. 75 96, 605. 30	•
4. 00	Multiply line 22 time line 23	amount (3cc	instructions)		555, 480	
. 00	Total direct GME amount (sum of lines 19 and 24)			Managard ages	2, 369, 074	25.
			Inpatient Part A	Managed care		
	COMPUTATION OF PROGRAM PATIENT LOAD		1.00	2. 00	3. 00	
6. 00	Inpatient Days (see instructions)		32, 30	05 3, 423		26.
7.00	Total Inpatient Days (see instructions)		64, 62			27.
8. 00 9. 00	Ratio of inpatient days to total inpatient days Program direct GME amount		0. 4998 ⁻ 1, 184, 24			28. 29.
0.00	Reduction for direct GME payments for Medicare Advantage		1, 104, 2	17, 730		30.
	Net Program direct GME amount		I		1, 291, 993	31.

Health Financial Systems UNION HOSPITAL, INC. In Lieu of Form CMS-2552-1							
DI RECT				Worksheet E-4			
MEDI CA				Date/Time Prepared: 11/12/2018 4:13 pm			
Title XVIII Hospital							
				1. 00			
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITL EDUCATION COSTS)	•		I CAL			
32. 00	Renal dialysis direct medical education costs (from Wkst. B, and 94)	Pt. I, sum of col. 20 a	nd 23, lines 74	0	32.00		
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt.		74 and 94)	0	33.00		
34.00	Ratio of direct medical education costs to total charges (lir	ne 32 ÷ line 33)		0.000000	34.00		
35.00	Medicare outpatient ESRD charges (see instructions)			0	35. 00		
36.00	Medicare outpatient ESRD direct medical education costs (line			0	36.00		
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	ONLY					
	Part A Reasonable Cost						
	Reasonable cost (see instructions)			78, 365, 531			
38. 00				-	38. 00		
	0 Cost of physicians' services in a teaching hospital (see instructions)			0	07.00		
	00 Primary payer payments (see instructions)			65, 912			
41. 00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40) 78,29				41.00		
42.00	Part B Reasonable Cost			F1 11F 12O	40.00		
42.00	Reasonable cost (see instructions) Primary payer payments (see instructions)			51, 115, 130 5, 276			
	Total Part B reasonable cost (line 42 minus line 43)			5, 276 51, 109, 854			
	Total reasonable cost (sum of lines 41 and 44)			129, 409, 473			
	Ratio of Part A reasonable cost to total reasonable cost (lir	ne 41 ÷ line 45)		0. 605053			
	Ratio of Part B reasonable cost to total reasonable cost (III			0. 394947			
00	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PA			3. 071717			
48. 00	Total program GME payment (line 31)			1, 291, 993	48. 00		
	Part A Medicare GME payment (line 46 x 48) (title XVIII only)	(see instructions)		781, 724			
	Part B Medicare GME payment (line 47 x 48) (title XVIII only)			510, 269	50.00		

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

Health Financial Systems

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

Provi der CCN: 15-0023 | Peri od: | W | From 01/01/2016 | To 12/31/2016 | D: |

Peri od: Worksheet G From 01/01/2016 To 12/31/2016 Date/Time Prepared: 11/12/2018 4:13 pm

onl y)			10	12/31/2010	11/12/2018 4:	
		General Fund	Speci fi c	Endowment	Plant Fund	
		1.00	Purpose Fund 2.00	Fund 3. 00	4. 00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
1.00	Cash on hand in banks	65, 345, 825	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	1
4.00	Accounts receivable	49, 643, 813	1	0	0	1
5.00	Other receivable	0	0	O O	0	
6. 00 7. 00	Allowances for uncollectible notes and accounts receivable Inventory	4, 468, 365	1	0	0	6. 00 7. 00
8. 00	Prepai d expenses	-18, 595, 321		0	0	
9. 00	Other current assets	0	o	Ö	0	
10.00	Due from other funds	0	0	O	0	10.00
11. 00	Total current assets (sum of lines 1-10)	100, 862, 682	2 0	0	0	11. 00
10.00	FI XED ASSETS	27.2// 0/5		ما	0	10.00
12. 00 13. 00	Land Land improvements	37, 266, 965	0	0	0	12. 00 13. 00
14. 00	Accumulated depreciation			0	0	1
15. 00	Buildings	332, 148, 831	1	0	0	
16. 00	Accumulated depreciation	-264, 245, 226		Ö	0	1
17.00	Leasehold improvements	0	0	O	0	17. 00
18. 00	Accumulated depreciation	0	0	0	0	1
19. 00	Fi xed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21. 00 22. 00	Automobiles and trucks Accumulated depreciation			0	0	21. 00 22. 00
23. 00	Major movable equipment	145, 655, 146		0	0	1
24. 00	Accumulated depreciation	0		o	0	1
25. 00	Mi nor equi pment depreci abl e	0	0	O	0	1
26.00	Accumulated depreciation	0	0	0	0	26. 00
27. 00	HIT designated Assets	0	0	0	0	1
28. 00	Accumulated depreciation	0	0	0	0	28. 00
29. 00 30. 00	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	250, 825, 716	0	0	0	29. 00 30. 00
30.00	OTHER ASSETS	230, 623, 710	oj Oj	U _I		30.00
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on Leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	
34.00	Other assets	77, 099, 664		0	0	
35. 00 36. 00	Total other assets (sum of lines 31-34)	77, 099, 664 428, 788, 062		0	0	35. 00 36. 00
30.00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	420, 700, 002	.[0	U _I	0	30.00
37. 00	Accounts payable	34, 406, 282	! 0	0	0	37.00
38.00	Salaries, wages, and fees payable	21, 882, 194	0	O	0	38.00
39. 00	Payroll taxes payable	0	0	0	0	
40.00	Notes and Loans payable (short term)	0	0	0	0	
41.00	Deferred income	0		O	0	1
42. 00 43. 00	Accelerated payments Due to other funds		0	0	0	42. 00 43. 00
	Other current liabilities	14, 576, 253		0	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	70, 864, 729		Ö	0	
	LONG TERM LIABILITIES					
46. 00	Mortgage payable	0	0	0	0	
47.00	Notes payable	0	1	0	0	1
48. 00 49. 00	Unsecured Loans Other Long term Liabilities	266, 582, 443	0	0	0	
50.00	Total long term liabilities (sum of lines 46 thru 49)	266, 582, 443		0	0	1
51. 00	Total liabilities (sum of lines 45 and 50)	337, 447, 172		o	Ö	
	CAPI TAL ACCOUNTS					
52.00	General fund balance	91, 340, 890)		1	52.00
53.00	Specific purpose fund		0	_		53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55. 00 56. 00	Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance			0		55. 00 56. 00
57. 00	Plant fund balance - invested in plant			٩	0	1
58. 00	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion					
59. 00	Total fund balances (sum of lines 52 thru 58)	91, 340, 890		0	0	1
60. 00	Total liabilities and fund balances (sum of lines 51 and	428, 788, 062	0	0	0	60.00
	[59]	I	1	I		I

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

| Period: | Worksheet G-1 | From 01/01/2016 | To 12/31/2016 | Date/Time Prepared: Provi der CCN: 15-0023

					То	12/31/2016	Date/Time Pre 11/12/2018 4:	
		General	Fund	Speci al	Purp	oose Fund	Endowment Fund	
		1. 00	2.00	3.00		4. 00	5. 00	
1. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)	1.00	102, 900, 227 -11, 559, 337			0	3.00	1.00
3. 00 4. 00	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	91, 340, 890		0	0	0	3. 00 4. 00
5. 00 6. 00	, , , , , , , , , , , , , , , , , , , ,	0			0		0	5. 00 6. 00
7. 00 8. 00		0			0		0	7. 00 8. 00
9. 00 10. 00	Total additions (sum of line 4-9)	0	0		0	0	0	9. 00 10. 00
11. 00 12. 00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	91, 340, 890		0	0	0	11. 00 12. 00
13. 00 14. 00		0			0		0	13. 00 14. 00
15. 00 16. 00 17. 00		0			0		0	15. 00 16. 00 17. 00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance		0 91, 340, 890		U	0	0	18. 00 19. 00
	sheet (line 11 minus line 18)	Endowment	PI ant	From al				
		Fund	Prant	runa				
		6. 00	7. 00	8. 00				
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)	0			0			1. 00 2. 00
3. 00 4. 00	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0		0			3. 00 4. 00
5. 00 6. 00 7. 00			0					5. 00 6. 00 7. 00
8. 00 9. 00			0					8. 00 9. 00
10. 00 11. 00	Total additions (sum of line 4–9) Subtotal (line 3 plus line 10)	0	U		0			10. 00 11. 00
12. 00 13. 00	Deductions (debit adjustments) (specify)		0					12. 00 13. 00
14. 00 15. 00			0 0					14. 00 15. 00
16. 00 17. 00			0 0					16. 00 17. 00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0			18. 00 19. 00

UNION HOSPITAL, INC.

| Peri od: | Worksheet G-2 | From 01/01/2016 | Parts | & II | To 12/31/2016 | Date/Time Prepared: Health Financial Systems
STATEMENT OF PATLENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0023

			To 12/31/2016	Date/Time Pre 11/12/2018 4:	
	Cost Center Description	I npati ent	Outpati ent	Total	ГО РІП
	3331 3311t31 23331 Pt 1311	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	95, 141, 7	71	95, 141, 771	1.00
2.00	SUBPROVI DER - I PF				2.00
3.00	SUBPROVI DER - I RF	3, 624, 4	14	3, 624, 414	3.00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF		0	0	5. 00
6.00	Swing bed - NF		0	0	6. 00
7.00	SKILLED NURSING FACILITY				7. 00
8.00	NURSING FACILITY				8. 00
9. 00	OTHER LONG TERM CARE				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	98, 766, 1	85	98, 766, 185	10.00
	Intensive Care Type Inpatient Hospital Services	05.040.0	. =1	1 05 040 045	
11.00	INTENSIVE CARE UNIT	25, 240, 3	15	25, 240, 315	
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14. 00 15. 00	SURGICAL INTENSIVE CARE UNIT	15 215 0	21	15 215 021	14. 00 15. 00
16.00	Total intensive care type inpatient hospital services (sum of lines	15, 215, 9, 40, 456, 2		15, 215, 931 40, 456, 246	
10.00	11-15)	40, 430, 2	40	40, 430, 240	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	139, 222, 4	31	139, 222, 431	17. 00
18. 00	Ancillary services	353, 311, 0		1, 005, 227, 506	
19. 00	Outpati ent servi ces	30, 697, 3			19.00
20.00	RURAL HEALTH CLINIC	00,077,0	· · · · ·	0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		-		21. 00
22. 00	HOME HEALTH AGENCY				22. 00
23.00	AMBULANCE SERVICES				23. 00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26.00	HOSPI CE				26.00
27.00	PRO FEES/LOBBY PHARMAACY		0 29, 840, 073	29, 840, 073	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wks	st. 523, 230, 8	42 800, 447, 382	1, 323, 678, 224	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES			.1	
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		314, 502, 686		29. 00
30.00	HOME OFFICE	68, 467, 7			30.00
31.00			0		31.00
32.00			0		32.00
33.00			0		33.00
34. 00 35. 00			0		34. 00 35. 00
36.00	Total additions (sum of lines 30-35)		68, 467, 74		36.00
37.00	DEDUCT (SPECIFY)		00, 407, 744	+	37.00
38.00	DEDUCT (SPECITI)		0		38.00
39. 00			0		39.00
40. 00			o		40.00
41. 00			0		41.00
42. 00	Total deductions (sum of lines 37-41)				42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(tran	nsfer	382, 970, 430		43. 00
	to Wkst. G-3, line 4)				
		•	•	•	•

				u of Form CMS-2 Worksheet G-3	2552-10
STATE	From 01/01/2016				oared:
	To 12/31/2016 [
	I=			1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin			1, 323, 678, 224	1.00
2.00	Less contractual allowances and discounts on patients' accounts the second seco	nts		907, 343, 301	2.00
3.00	Net patient revenues (line 1 minus line 2)	40)		416, 334, 923	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		382, 970, 430	4.00
5. 00	Net income from service to patients (line 3 minus line 4) OTHER INCOME			33, 364, 493	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	n sarvi cas		0	8. 00
9. 00	Revenue from television and radio service	1 Sel VI Ces		0	9. 00
10.00	Purchase di scounts			0	10.00
11. 00	Rebates and refunds of expenses			0	11.00
12. 00				0	12.00
13. 00	Revenue from Laundry and Linen service			0	13.00
14. 00	Revenue from meals sold to employees and guests			0	14.00
15. 00	Revenue from rental of living quarters			0	15.00
16.00		than patients		0	16.00
17.00	Revenue from sale of drugs to other than patients	·		0	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 OPERATING			11, 966, 039	24.00
24. 01	NON OPERATING EXPENSES			4, 117, 319	24. 01
	Total other income (sum of lines 6-24)			16, 083, 358	25.00
	Total (line 5 plus line 25)			49, 447, 851	26.00
27. 00				61, 007, 188	
28. 00	Total other expenses (sum of line 27 and subscripts)			61, 007, 188	
29. 00	Net income (or loss) for the period (line 26 minus line 28)		l	-11, 559, 337	29. 00

Heal th	Financial Systems UNION HOSPITA	AL, INC.	In Lie	u of Form CMS-2	2552-10	
	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0023	Peri od:	Worksheet L		
			From 01/01/2016			
			To 12/31/2016	Date/Time Pre 11/12/2018 4:		
	Title XVIII Hospital					
				1. 00		
	PART I - FULLY PROSPECTIVE METHOD CAPITAL FEDERAL AMOUNT					
1. 00	Capital DRG other than outlier			4, 787, 082	1.00	
1. 00	Model 4 BPCI Capital DRG other than outlier		4, 707, 002	1.00		
2. 00	Capital DRG outlier payments			181, 119	1	
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 r	reporting period (see ins	tructions)	166. 62	3.00	
4.00	Number of interns & residents (see instructions)			20. 67	4.00	
5.00	Indirect medical education percentage (see instructions)			3. 56		
6.00	Indirect medical education adjustment (multiply line 5 by th	ne sum of lines 1 and 1.0	1, columns 1 and	170, 420	6. 00	
7 00	1.01) (see instructions)		F	4 50	7.00	
7. 00	Percentage of SSI recipient patient days to Medicare Part A 30) (see instructions)	patient days (worksheet	E, part A line	4. 52	7. 00	
8. 00	Percentage of Medicaid patient days to total days (see instr	ructions)		23. 20	8.00	
9. 00	Sum of lines 7 and 8	uctions)		27. 72		
10.00	Allowable disproportionate share percentage (see instruction	ns)		5. 77	1	
11. 00	Disproportionate share adjustment (see instructions)	,		276, 215		
12.00	Total prospective capital payments (see instructions)			5, 414, 836	12.00	
				1 00		
	PART II - PAYMENT UNDER REASONABLE COST			1. 00		
1.00	Program inpatient routine capital cost (see instructions)			0	1.00	
2.00	Program inpatient ancillary capital cost (see instructions)			0	2.00	
3.00	Total inpatient program capital cost (line 1 plus line 2)			0		
4. 00	Capital cost payment factor (see instructions)			0		
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	5.00	
				1. 00		
	PART III - COMPUTATION OF EXCEPTION PAYMENTS					
1.00	Program inpatient capital costs (see instructions)			0		
2.00	Program inpatient capital costs for extraordinary circumstar	nces (see instructions)		0		
3.00	Net program inpatient capital costs (line 1 minus line 2)			0	3.00	
4.00	Applicable exception percentage (see instructions)			0.00		
5. 00 6. 00	Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see i	netructione)		0 0. 00		
7. 00	Adjustment to capital minimum payment level for extraordinar	,	v line 6)	0.00	1	
8. 00	Capital minimum payment level (line 5 plus line 7)	y crredinstances (Trie 2	X TITIC 0)	0		
9. 00	Current year capital payments (from Part I, line 12, as appl	i cabl e)		Ö		
10.00	Current year comparison of capital minimum payment level to	,	less line 9)	0	10.00	
11.00	Carryover of accumulated capital minimum payment level over	capital payment (from pr	ior year	0	11.00	
	Worksheet L, Part III, line 14)					
12.00	Net comparison of capital minimum payment level to capital p			0	12.00	
13.00	Current year exception payment (if line 12 is positive, enter		0	13.00		
14. 00	Carryover of accumulated capital minimum payment level over (if line 12 is negative, enter the amount on this line)	capital payment for the	rorrowing period	0	14. 00	
15. 00						
16. 00	Current year operating and capital costs (see instructions)			0	15. 00 16. 00	
	Current year exception offset amount (see instructions)			Ö	1	