Health Financi	al Systems	UNION HOSPITAL			u of Form CMS-2552-10
This report is payments made	s required by law (42 USC 1 since the beginning of the	395g; 42 CFR 413.20(b)). Fa- cost reporting period being	ilure to report can res g deemed overpayments	sult in all interim (42 USC 1395g).	FORM APPROVED OMB NO. 0938-0050 EXPIRES 05-31-2019
HOSPITAL AND F AND SETTLEMENT		X COST REPORT CERTIFICATION	Provider CCN: 15-1326	Period: From 01/01/2016 To 12/31/2016	Worksheet S Parts I-III Date/Time Prepared: 5/25/2017 4:23 pm
PART I - COST	REPORT STATUS				
Provider use only	 [X] Electronically fi [] Manually submitted [0] If this is an amer [F] Medicare Utilizat 	•	of times the provider L" for low.	Date: 5/25/20 resubmitted this co	·
Contractor use only PART II - CERT	(3) Settled with Audit(4) Reopened(5) Amended	6 Date Received: 7.Contractor No. Hit 8.[N]Initial Report f 9.[N]Final Report for	or this Provider CCN 12).NPR Date: L.Contractor's Vendc 2.[0]If line 5, co number of tim	or Code: 4 Jumn 1 is 4: Enter les reopened = 0-9.
MISREPRESENTAT ADMINISTRATIVE PROVIDED OR PR	TION OR FALSIFICATION OF AN E ACTION, FINE AND/OR IMPRI	Y INFORMATION CONTAINED IN T SONMENT UNDER FEDERAL LAW. DIRECTLY OR INDIRECTLY OF A ISONMENT MAY RESULT.	FURTHERMORE, IF SERVIC	CES IDENTIFIED IN TH	IIS REPORT WERE
	CERTIFICATION BY OFFICE	R OR ADMINISTRATOR OF PROVID	DER(S)		
electi Expens endino	ronically filed or manually ses prepared by UNION HOSPJ g 12/31/2016 and to the bes ete and prepared from the b	d the above certification s submitted cost report and TAL CLINTON (15-1326) for t of my knowledge and belie pooks and records of the prov	the Balance Sheet and the cost reporting pe f, this report and sta vider in accordance wi	Statement of Revenue riod beginning 01/01 tement are true, cou th applicable instru	e and 1/2016 and rrect, uctions,

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. Encryption Information ECR: Date: 5/25/2017 Time: 4:23 pm 8K6p1XAMptw6xJRwvNubkDdIpnTms0 MRrfU0gGAmPUKLdNUwwqDitFcMVGdr Isc70dydBtOUz:2s PI: Date: 5/25/2017 Time: 4:23 pm xcDzn4r: uspPRzijbaeH3o.1KtJF00 WvSxF0CrszOCNV1V1JveowfTrNPp2k grRC0yxsFKOP9RqD

		Title X	VIII			
	Title V	Part A	Part B	HIT	Title XIX	
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
Hospital	0	290,037	-24,723	0	712,176	1.00
Subprovider – IPF	0	0	0		0	2.00
Subprovider – IRF	0	0	0		0	3.00
Swing bed - SNF	0	20,017	0		0	5.00
Swing bed - NF	0				0	6.00
Total	0	310,054	-24,723	0	712,176	200.00
	Hospital Subprovider – IPF Subprovider – IRF Swing bed – SNF Swing bed – NF	1.00PART III - SETTLEMENT SUMMARYHospital0Subprovider - IPF0Subprovider - IRF0Swing bed - SNF0Swing bed - NF0	Title v Part A 1.00 2.00 PART III - SETTLEMENT SUMMARY 0 Hospital 0 290,037 Subprovider - IPF 0 0 Subprovider - IRF 0 0 Swing bed - SNF 0 20,017 Swing bed - NF 0 0	Title v Part A Part B 1.00 2.00 3.00 PART III - SETTLEMENT SUMMARY 0 290,037 -24,723 Hospital 0 0 0 0 Subprovider - IPF 0 0 0 0 Swing bed - SNF 0 20,017 0 0 Swing bed - NF 0 0 0 0	Title v Part A Part B HIT 1.00 2.00 3.00 4.00 PART III - SETTLEMENT SUMMARY 0 290,037 -24,723 0 Subprovider - IPF 0 0 0 0 Subprovider - IRF 0 0 0 0 Swing bed - SNF 0 20,017 0 0	I.00 2.00 3.00 4.00 5.00 PART III - SETTLEMENT SUMMARY

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.

	AL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DA	ΑΓΑ	Provi d	er CCN: 1	5-1326	Period: From 01/01/ To 12/31/		Workshe Part I Date/Ti 5/25/20		epare
	1.00	2	. 00		3.00			4.00	0/20/20		
	Hospital and Hospital Health Care Co	omplex Address:									
00	Street: 801 SOUTH MAIN STREET	PO Box:									1.
00	City: CLINTON	State:			e: 47842-		ty: VERMILLI				2.
		Component N		CCN	CBSA	Provi der			ent Syst		
				Number	Number	Туре	Certified		, 0, or		_
								V	XVIII		-
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Componer			45400/	154/0		00 /01 /0005	N	0	0	
00	Hospi tal	UNION HOSPITAL C	LINION	151326	45460	1	03/01/2005	N	0	0	3.
00	Subprovider - IPF										4.
)0)0	Subprovider - IRF										5.
0	Subprovider - (Other)	SWING BEDS		157004	45460		03/01/2005	N	0	0	6.
0	Swing Beds - SNF Swing Beds - NF	SWING BEDS		15Z326	43460		03/01/2005				8.
0	Hospital-Based SNF										9.
00	Hospi tal -Based NF										10.
00	Hospi tal -Based OLTC										11
00	Hospi tal -Based HHA										12.
00	Separately Certified ASC										13.
00	Hospi tal -Based Hospi ce										14
	Hospital-Based Health Clinic - RHC										14
00	Hospital-Based Health Clinic - FQHC										16
	Hospital -Based (CMHC) I										17
00	Renal Dialysis										18
	Other										19
	1-2		I			1	From:	· · · · · ·	То):	
							1.00		2. (00	
	Cost Reporting Period (mm/dd/yyyy)						01/01/2	016	12/31	/2016	20
00	Type of Control (see instructions)						2				21
~~	Inpatient PPS Information									1	-
00	Does this facility qualify and is it						N		N		22
	share hospital adjustment, in accord										
	for yes or "N" for no. Is this facil	ILV SUDIECT TO 4.									
	amandment based to low as home of an				2. 106(C)	(2) (PI CKI	e				
01	amendment hospital?) In column 2, er	nter "Y" for yes	or "N" for	r no.					N		22
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02 03 00 00	Did this hospital receive interim ur period? Enter in column 1, "Y" for y reporting period occurring prior to for no for the portion of the cost r (see instructions) Is this a newly merged hospital that determined at cost report settlement or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for or after October 1. Did this hospital receive a geograph of the OMB standards for delineating in column 1, "Y" for yes or "N" for prior to October 1. Enter in column cost reporting period occurring on c hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in colum Medicaid eligible unpaid days in colum 4, Medicaid HMO paid and eligible unpaid 4, Medicaid HMO paid and eligible unpaid 4, Medicaid days in column 3, Hedicaid paid days in column 4, medicaid paid days in the column 5, and other Medicaid days in the Medicaid paid days in column 4, medicaid paid days in column 5, and other Medicaid adays in ft his provider is an IRF, enter th Medicaid paid days in column 1, the	nter "Y" for yes a compensated care yes or "N" for no October 1. Enter reporting period of requires final c? (see instruction no for the port nic reclassificat g statistical are no for the port of the port 2, "Y" for yes or or after October of more than 499 H "Y" for yes or after October of after October of after October of after October of active days on H f census days, o nis cost reporting iod? In column a , enter the unn 1, in-state umn 2, column 3, d days in column to unpaid days in n column 6. he in-state in-state	or "N" for payments for the p in column occurring uncompensa ons) Enter period pr ion of the ion from L as adopted on of the inses 24 ar g period c2, enter " In-State Medicaic paid day	r no. for thi portion n 2, "Y" on or a ated car r in col rior to e cost r urban to d by CMS cost re no for no for no for no for no for differer 'Y" for e In-S d Medi s elig unp da 2, 0	s cost r of the cd for yes fter Octo e paymen umn 1, "" October eporting o rural as in FY20 porting the porti ons) Doe in accord below? scharge. below? scharge t <u>yes or "I</u> tate 0 caid 5 ible Me aid pai ys 0 0	eporting ost or "N" ober 1. ts to be Y" for ye 1. Enter period o s a resul 15? Enter period ion of th s this dance wit In column Is the he method <u>N" for no</u> ut-of State di cai d d days 0	N N N N N N N N N N N N N N N N N N N	ledi ca IMO da	N N ys O O	ther di cai d days	22 22 23 23
02 03 00 00	Did this hospital receive interim ur period? Enter in column 1, "Y" for y reporting period occurring prior to for no for the portion of the cost r (see instructions) Is this a newly merged hospital that determined at cost report settlement or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for or after October 1. Did this hospital receive a geograph of the OMB standards for delineating in column 1, "Y" for yes or "N" for prior to October 1. Enter in column cost reporting period occurring on chospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in to used in the prior cost reporting per out-of-state Medicaid paid days in col out-of-state Medicaid paid days in col column 5, and other Medicaid days in If this provider is an IRF, enter th Medicaid paid days in column 1, the Medicaid eligible unpaid days in col	nter "Y" for yes in compensated care yes or "N" for no October 1. Enter reporting period of requires final in the cost reporting no, for the port ic reclassificat g statistical are no for the port ic reclassificat g statistical are no for the port 2, "Y" for yes or or after October ot more than 499 I "Y" for yes or " edicaid days on I f census days, o nis cost reporting f census days, o nis cost reporting in 1, in-state umn 2, column 3, d days in column in -state umn 2,	or "N" for payments for the p in column occurring uncompensa ons) Enter period pr ion of the ion from u as adopted on of the inses 24 ar In-State Medicaic paid day	r no. for thi portion n 2, "Y" on or a ated car r in col rior to e cost r urban to d by CMS cost re no for no for no for no for no for differer 'Y" for e In-S d Medi s elig unp da 2, 0	s cost r of the cd for yes fter Octo e paymen umn 1, "" October eporting o rural as in FY20 porting the porti ons) Doe in accord below? scharge. below? scharge t <u>yes or "I</u> tate 0 caid 5 ible Me aid pai ys 0 0	eporting ost or "N" ober 1. ts to be Y" for ye 1. Enter period o s a resul 15? Enter period ion of th s this dance wit In column Is the he method <u>N" for no</u> ut-of State di cai d d days 0	N N N N N N N N N N N N N N N N N N N	ledi ca IMO da	N N ys O O	ther di cai d days	222 222 23 23 23 24
02 03 00 00	Did this hospital receive interim ur period? Enter in column 1, "Y" for y reporting period occurring prior to for no for the portion of the cost r (see instructions) Is this a newly merged hospital that determined at cost report settlement or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for or after October 1. Did this hospital receive a geograph of the OMB standards for delineating in column 1, "Y" for yes or "N" for prior to October 1. Enter in column cost reporting period occurring on c hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in colum Medicaid eligible unpaid days in colum 4, Medicaid HMO paid and eligible unpaid 4, Medicaid HMO paid and eligible unpaid 4, Medicaid days in column 3, Hedicaid paid days in column 4, medicaid paid days in the column 5, and other Medicaid days in the Medicaid paid days in column 4, medicaid paid days in column 5, and other Medicaid adays in ft his provider is an IRF, enter th Medicaid paid days in column 1, the	nter "Y" for yes in compensated care yes or "N" for no October 1. Enter reporting period of requires final in requires final in requires final in requires final in requires final in requires final in requires final in reconstruction is cost reporting no, for the port is creclassificat g statistical are no for the port 2, "Y" for yes or " after October of more than 499 in "Y" for yes or " adicaid days on i f census days, o is cost reporting riod? In column i d days in column it unpaid days in no column 6. he in-state in-state umm 2, n 3, out-of-state	or "N" for payments for the p in column occurring uncompensa ons) Enter period pr ion of the ion from u as adopted on of the inses 24 ar In-State Medicaic paid day	r no. for thi portion n 2, "Y" on or a ated car r in col rior to e cost r urban to d by CMS cost re no for no for no for no for no for differer 'Y" for e In-S d Medi s elig unp da 2, 0	s cost r of the cd for yes fter Octo e paymen umn 1, "" October eporting o rural as in FY20 porting the porti ons) Doe in accord below? scharge. below? scharge t <u>yes or "I</u> tate 0 caid 5 ible Me aid pai ys 0 0	eporting ost or "N" ober 1. ts to be Y" for ye 1. Enter period o s a resul 15? Enter period ion of th s this dance wit In column Is the he method <u>N" for no</u> ut-of State di cai d d days 0	N N N N N N N N N N N N N N N N N N N	ledi ca IMO da	N N ys O O	ther di cai d days	22 22 23 23

HOSPI T	Financial Systems UNION H AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		AL CLINTON Provider CC		Period: From 01/01/		u of For Workshe Part I		
					To 12/31/		Date/Ti 5/25/20		
					Urban/Rur		Date of	Geogr	
26.00	Enter your standard geographic classification (not wag			inning of the	1.00	2	2. (00	26.00
27.00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wag reporting period. Enter in column 1, "1" for urban or	je) sta "2" fo	atus at the end or rural. If ap			2			27.00
35.00	enter the effective date of the geographic reclassific If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			H status in		0			35.00
					Begi nni		Endi		-
36.00	Enter applicable beginning and ending dates of SCH sta		Subscript line	36 for number	1.00		2. (0	36.00
37.00	of periods in excess of one and enter subsequent dates If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.		umber of period	s MDH status		0			37.00
37. 01	Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for instructions)				N				37.01
38. 00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38.00
					Y/N 1.00		Y/ 2. (-
39.00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(ii) or "N" for no. Does the facility meet the mileage requ	? Ente iiremer	er in column 1 nts in accordan	"Y" for yes ce with 42			2. (39.00
40. 00	CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes o Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octobe no in column 2, for discharges on or after October 1.	adjust er 1. E	tment? Enter "Y Enter "Y" for y	" for yes or	N.		N		40.00
						V 1.00	XVIII) 2.00	XI X 3.00	-
45.00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payment with 42 CFR Section §412.320? (see instructions)	for a	di sproporti onat	e share in ac	cordance	N	N	N	45.00
46. 00	Is this facility eligible for additional payment excep pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. Pt. III.					N	N	N	46.00
47.00 48.00	Is this a new hospital under 42 CFR §412.300 PPS capit Is the facility electing full federal capital payment? Teaching Hospitals					N N	N N	N N	47.00 48.00
56.00	Is this a hospital involved in training residents in a	pprove	ed GME programs	? Enter "Y"	for yes	N			56.00
57.00	or "N" for no. If line 56 is yes, is this the first cost reporting pe GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first month for yes or "N" for no in column 2. If column 2 is "Y" "N", complete Wkst. D, Parts III & IV and D-2, Pt. II,	yes or of th , comp	r "N" for no in his cost report plete Worksheet	column 1. lf ing period?	column 1 Enter "Y"				57.00
	If line 56 is yes, did this facility elect cost reimbu defined in CMS Pub. 15–1, chapter 21, §2148? If yes, c	irsemer complet	nt for physicia te Wkst. D-5.		as	N			58.00
	Are costs claimed on line 100 of Worksheet A? If yes, Are you claiming nursing school and/or allied health c				9	N N			59.00 60.00
	provider-operated criteria under §413.85? Enter "Y" f	<u>for yes</u> Y/N	s or "N" for no IME	<u>(see instru</u> Direct GME	ICTIONS)		Di rect	t GME	
61 00	Did your boshital receive ETE clote under ACA	1.00	2.00	3.00	4.00		5. (61 00
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)					0.00		0.00	61.00
61. 01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0. (00				61.01
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		0. 00	0. (00				61.02
61. 03	ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see		0.00	0.0	bo				61.03
61. 04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0.00	0. (00				61.04
61. 05	current cost reporting period.(see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's		0.00	0.0	bo				61.05

	nancial Systems AND HOSPITAL HEALTH CARE COMPL	EX IDENTIFICATION DA	TA	Provider CC	F	veriod: rom 01/01/2016 o 12/31/2016	Worksheet S-2 Part I Date/Time Pre	
			Y/N	IME	Direct GME	I ME	5/25/2017 4:2 Direct GME	
			1.00	2.00	3.00	4.00	5.00	-
use	ter the amount of ACA §5503 awa ed for cap relief and/or FTEs re or general surgery. (see ins	that are nonprimary		0.00				61.
			Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
				1.00	2.00	3.00	4.00	
spe for col pro unv	the FTEs in line 61.05, specific ecialty, if any, and the number reach new program. (see instru- lumn 1, the program name, enter ogram code, enter in column 3, weighted count and enter in col E unweighted count.	of FTE residents actions) Enter in in column 2, the the IME FTE				0.00	0.00	61.
1.20 Of pro res i ns ent 3,	the FTEs in line 61.05, speci- ogram specialty, if any, and the sidents for each expanded progra- structions) Enter in column 1, ter in column 2, the program co the IME FTE unweighted count a direct GME FTE unweighted count	ne number of FTE ram. (see the program name, ode, enter in column and enter in column				0. 00	0. 00	61.
							1.00	
	A Provisions Affecting the Hea							
you 2.01 Ent	ter the number of FTE residents ur hospital received HRSA PCRE ter the number of FTE residents	funding (see instruc s that rotated from a	ctions) a Teachi	ng Health Cent	ter (THC) into			62. 62.
	ring in this cost reporting pen aching Hospitals that Claim Re				15)			
	s your facility trained residen " for yes or "N" for no in colu					period? Enter	N	63.
					Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
					Si te			
Sec	ction 5504 of the ACA Base Yea	r FTE Residents in No	onprovi	der Settings	1.00 This base year	2.00 is your cost r	3.00 Teporting	
4.00 Ent in res set res	riod that begins on or after Ju ter in column 1, if line 63 is the base year period, the num sident FTEs attributable to ro ttings. Enter in column 2 the sident FTEs that trained in you (column 1 divided by (column 2	uly 1, 2009 and befor yes, or your facilit per of unweighted nor tations occurring in number of unweightee ur hospital. Enter ir	<u>re June</u> ty trair a-primar all nor d non-pr n columr	30, 2010. ned residents ry care nprovider rimary care n 3 the ratio	0.00	-		64.
		Program Name	Pro	ogram Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00		2.00	3.00	4.00	5.00	
is tra yea ass FTE pro res the col unw res rot nor col unw res you	ter in column 1, if line 63 yes, or your facility ained residents in the base ar period, the program name sociated with primary care Es for each primary care ogram in which you trained sidents. Enter in column 2, e program code, enter in lumn 3, the number of weighted primary care FTE sidents attributable to tations occurring in all n-provider settings. Enter in lumn 4, the number of weighted primary care sident FTEs that trained in ur hospital. Enter in column the ratio of (column 3 vided by (column 3 + column				0.00	0.00	0. 000000	

Heal th	Financial Systems		HOSPITAL CLINTON			u of Form CMS-2	
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPI	LEX IDENTIFICATION DA	TA Provider C		eriod: rom 01/01/2016 o 12/31/2016	Date/Time Pre 5/25/2017 4:2	pared:
				Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	Section 5504 of the ACA Current	Year FTE Residents in	n Nonprovider Setting	1.00 gsEffective fo	2.00 pr cost reporti	3.00 ng periods	
66.00	beginning on or after July 1, 20 Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-primar ccurring in all nonpr unweighted non-primar al. Enter in column 3	rovider settings. ry care resident 3 the ratio of	0. OC	0. 00	0. 000000	66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0. 00	0. 00	0. 000000	67.00
					1.0	0 2.00 3.00	
	Inpatient Psychiatric Facility P Is this facility an Inpatient Ps Enter "Y" for yes or "N" for no If line 70 yes: Column 1: Did th recent cost report filed on or b	ychiatric Facility (I e facility have an ap efore November 15, 20	oproved GME teaching 204? Enter "Y" for y	, program in the yes or "N" for r	provider? N most no. (see	0	70. 00 71. 00
75 00	42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF Column 3: If column 2 is Y, indi (see instructions) Inpatient Rehabilitation Facilit	R 412.424 (d)(1)(iii) cate which program ye y PPS)(D)? Enter "Y" for y ear began during this	yes or "N" for r s cost reporting	no. 1 peri od.		75.00
	Is this facility an Inpatient Re subprovider? Enter "Y" for yes If line 75 yes: Column 1: Did th recent cost reporting period end no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente	and "N" for no. e facility have an ap ing on or before Nove train residents in a r "Y" for yes or "N"	pproved GME teaching ember 15, 2004? Enter new teaching progran for no. Column 3: If	program in the - "Y" for yes or n in accordance f column 2 is Y,	"N" for with 42	0	75.00 76.00
	indicate which program year bega	n during this cost re	eporting period. (see	e instructions)			
	Long Term Care Hospital PPS					1.00	
	Is this a long term care hospital Is this a LTCH co-located within "Y" for yes and "N" for no. TEFRA Providers				period? Enter	N N	80. 00 81. 00
	Is this a new hospital under 42 Did this facility establish a ne §413.40(f)(1)(ii)? Enter "Y" fo	w Other subprovider ((excluded unit) under			N	85. 00 86. 00
87.00	ls this hospital a "subclause (I for yes or "N" for no.	l)" LTCH classified u	under section 1886(d))(1)(B)(iv)(II)?	'Enter "Y"	N	87.00
					V	XI X	
	Title V and XIX Services				1.00	2.00	
90.00	Does this facility have title V yes or "N" for no in the applica		hospital services? E	Enter "Y" for	Y	N	90.00
91.00	Is this hospital reimbursed for full or in part? Enter "Y" for y	title V and/or XIX th			N	N	91.00
92.00	Are title XIX NF patients occupy	ing title XVIII SNF b	oeds (dual certificat			N	92.00
93.00	instructions) Enter "Y" for yes Does this facility operate an IC	F/IID facility for pu		nd XIX? Enter	N	N	93.00
94.00	"Y" for yes or "N" for no in the Does title V or XIX reduce capit applicable column.		or yes, and "N" for r	no in the	N	Ν	94.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	AL CLINTON Provider C		eriod: rom 01/01/	2016	Worksheet Part I Date/Time	CMS-2552-10 S-2 Prepared: 4:22 pm
			V		XI X	
			1.00		2.00	
95.00 If line 94 is "Y", enter the reduction percentage in the app 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.			0. 00 N		0. 00 N	95.00 96.00
97.00 If line 96 is "Y", enter the reduction percentage in the ap Rural Providers		n.	0.00		0.00	97.00
105.00 Does this hospital qualify as a critical access hospital (CA 106.00 If this facility qualifies as a CAH, has it elected the all for outpatient services? (see instructions)		hod of payment	Y N			105.00 106.00
107.00 If this facility qualifies as a CAH, is it eligible for cos training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col- reimbursed. If yes complete Wkst. D-2, Pt. II.	n 1. (see inst . 25 and the p	ructions) lf rogram is cost	N			107.00
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N Spoor	h	Pocni rat	108.00
	Physi cal 1.00	Occupational 2.00	Speec 3.00		Respirat 4.00	UT y
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N	N		N	109.00
110.00 Did this hospital participate in the Rural Community Hospit: the current cost reporting period? Enter "Y" for yes or "N"		on project (410	DA Demo)foi	-	1.00 N	110. 00
				1. 00	2.00 3	3.00
Miscellaneous Cost Reporting Information						
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes of is yes, enter the method used (A, B, or E only) in column 2 3 either "93" percent for short term hospital or "98" percen psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, chapter 22, §2208.1.	. If column 2 i nt for long te	is "E", enter i rm care (includ	n column des	N		0 115.00
116.00 Is this facility classified as a referral center? Enter "Y" 117.00 Is this facility legally-required to carry malpractice insu			'N" for	N Y		116. 00 117. 00
no. 118.00 Is the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	licy? Enter 1	if the policy i	S	1		
						118.00
		Premi ums	Losse	S	Insuran	
118.01 List amounts of malpractice premiums and paid losses:		Premi ums	2.00		I nsuran 3. 00	
118.01 List amounts of malpractice premiums and paid losses:		1.00	2.00	0	3.00	ce
		1. 00 144, 152	2.00	0		0 118. 01
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scher and amounts contained therein.		1.00 144,152 than the	2.00	0	3.00	ce
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scher and amounts contained therein. 119.00 D0 NOT USE THIS LINE 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 qualified Harmless provision in ACA §3121 and applicable amendment	dule listing c d Harmless pro n column 1, "Y ualifies for th	1.00 144,152 than the ost centers vision in ACA " for yes or he Outpatient	2.00	0	3.00	Ce 0 118. 01 118. 02 119. 00
 118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scherand amounts contained therein. 119.00 D0 NOT USE THIS LINE 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 qualified data and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualified data and applicable amendments? 121.00 Did this facility incur and report costs for high cost implicable. 	dule listing co d Harmless pro n column 1, "Y ualifies for t nts? (see inst	1.00 144,152 than the ost centers vision in ACA " for yes or he Outpatient ructions)	2.00 2 1.00 N	0	3.00	Ce 0118.01 118.02 119.00 120.00
 118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scherand amounts contained therein. 119.00 D0 NOT USE THIS LINE 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 qualifier in the difference of the specific amendment in the specific and the specific and the specific amendment in the specific amendment in the specific amendment in the specific amendment in the specific amendment is the specific amendment in the specific amendment is the specific amendment in the specific amendment is the specific amendment amendment is the specific amendment is the specific	dule listing co d Harmless prov n column 1, "Y ualifies for th nts? (see inst antable devices Enter "Y" for	1.00 144,152 than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N"	2.00 2 1.00 N N	0	3.00	Ce 0 118. 01 118. 02 119. 00 120. 00 121. 00
 118. 02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scherand amounts contained therein. 119. 00 D0 NOT USE THIS LINE 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 qualified Harmless provision in ACA §3121 and applicable amendmenter in column 2, "Y" for yes or "N" for no. 121. 00 Did this facility incur and report costs for high cost implicable applients? Enter "Y" for yes or "N" for no. 122. 00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 there these taxes are included. Transplant Center Information 	dule listing co d Harmless pro n column 1, "Y ualifies for ti nts? (see inst antable device: Enter "Y" for he Worksheet A	1.00 144,152 than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number	2.00 2 1.00 N N N N	0	3.00	Ce 0118.01 118.02 119.00 120.00 121.00
 118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scherand amounts contained therein. 119.00 D0 NOT USE THIS LINE 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 qualifier in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implicable apatients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included. Transplant Center Information 	dule listing co d Harmless pro n column 1, "Y ualifies for ti nts? (see inst antable device: Enter "Y" for he Worksheet A	1.00 144,152 than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number	2.00 2 1.00 N N N	0	3.00	Ce 0 118. 01 118. 02 119. 00 120. 00 121. 00 122. 00
 118. 02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scherand amounts contained therein. 119. 00 D0 NOT USE THIS LINE 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 qualifies for the Outpatient amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold for the formation of the formation of the term of term of term of the term of the term of the term of term of term of term of the term of term of the term of term of term of term of the term of term of term of term of the term of term of the term of term	dule listing co d Harmless prov n column 1, "Y ualifies for th nts? (see inst antable device: Enter "Y" for he Worksheet A for yes and "N" nter the certi 2.	1.00 144,152 than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number for no. If fication date	2.00 2 1.00 N N N N	0	3.00	Ce 0 118. 01 118. 02 119. 00 120. 00 121. 00 122. 00 125. 00 126. 00
 118.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scherand amounts contained therein. 119.00 D0 NOT USE THIS LINE 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 que Hold Harmless provision in ACA §3121 and applicable amendment costs for high cost implementer in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implementers? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state heal th or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 there these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 3 	dule listing of d Harmless provin n column 1, "Y ualifies for ti nts? (see insti- antable device: Enter "Y" for he Worksheet A cor yes and "N" nter the certifion 2. ter the certifion 2.	1.00 144,152 than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number for no. If fication date ication date	2.00 2 1.00 N N N N	0	3.00	Ce 0 118. 01 118. 02 119. 00 120. 00 121. 00 122. 00 125. 00 126. 00 127. 00
 118. 02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scherand amounts contained therein. 119. 00 D0 NOT USE THIS LINE 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 qualifies for the Outpatient Hold for the data and another in a cost in the data and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold for the data and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the data and the amendment in the data and the applicable amendment is "Y", enter in column 1. 121. 00 Does the cost report contain state heal th or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. Transplant Center Information 125. 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126. 00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 1 128. 00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 1 128. 00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 1 	dule listing of d Harmless pro n column 1, "Y ualifies for th nts? (see inst antable device: Enter "Y" for he Worksheet A or yes and "N" nter the certif 2. ter the certif 2. ter the certif 2.	1.00 144,152 than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number for no. If fication date ication date	2.00 2 1.00 N N N N	0	3.00	Ce 0 118. 01 118. 02 119. 00 120. 00 121. 00 122. 00 125. 00 126. 00 127. 00 128. 00
 118. 02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scherand amounts contained therein. 119. 00 D0 NOT USE THIS LINE 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 que Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in Enter in column 2, "Y" for yes or "N" for no. 121. 00 Did this facility incur and report costs for high cost implipatients? Enter "Y" for yes or "N" for no. 122. 00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included. Transplant Center Information 125. 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126. 00 If this is a Medicare certified heart transplant center, entin column 1 and termination date, if applicable, in column 1 127. 00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 1 128. 00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 1 129. 00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 1 129. 00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2 	dule listing of d Harmless provin n column 1, "Y ualifies for th nts? (see insti- antable devices Enter "Y" for he Worksheet A for yes and "N" nter the certification ter the certification ter the certification er the certification	1.00 144,152 than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number for no. If fication date ication date ication date in	2.00 2 1.00 N N N N	0	3.00	Ce 0 118. 01 118. 02 119. 00 120. 00 121. 00 122. 00 125. 00 126. 00 127. 00 128. 00 129. 00
 and amounts contained therein. 119.00 D0 NOT USE THIS LINE 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 qualifies for high cost implies the inter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implipatients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified heart transplant center, entin column 1 and termination date, if applicable, in column 1 127.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 1 128.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 1 129.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 1 	dule listing co d Harmless prov n column 1, "Y ualifies for th nts? (see inst antable devices Enter "Y" for he Worksheet A cor yes and "N" nter the certific ter the certific enter the certific enter the certific enter the certific nter the certific enter the certific enter the certific	1.00 144,152 than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number for no. If fication date ication date ication date in tification	2.00 2 1.00 N N N N	0	3.00	0 118. 01

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ID	<u>UNI ON HOSPI TA</u> ENTI FI CATI ON DATA	L CLINTON Provider CC	F	In Lie Period: From 01/01/2016 Fo 12/31/2016		pared:
		÷	· · ·			
133.00 If this is a Medicare certified other	trancol ant contor onto	or the cortifi	cation data	1.00	2.00	133.00
in column 1 and termination date, if a						133.00
134.00 If this is an organ procurement organi and termination date, if applicable, i		e OPO number i	n column 1			134.00
All Providers 140.00 Are there any related organization or chapter 10? Enter "Y" for yes or "N" f	or no in column 1. If	yes, and home	office costs	Y	15H043	140.00
are claimed, enter in column 2 the hom 1.00			Tons)	3.00		
If this facility is part of a chain or			igh 143 the na		of the	
home office and enter the home office				- N - 0010	14	1.4.4
141.00Name: UNION HOSPITAL, INC. 142.00Street: 1606 NORTH SEVENTH ST	Contractor's Name: WPS PO Box:		Contracto	r's Number: 0810)1	141.00 142.00
143. 00 Ci ty: TERRE HAUTE	State: IN		Zip Code:	4780)4	143.00
	under de la Mandrahan de Al				1.00	144.00
144.00 Are provider based physicians' costs i	nciuded in worksneet A	(Y	144.00
				1.00	2.00	1
145.00 If costs for renal services are claime				N	N	145.00
inpatient services only? Enter "Y" for no, does the dialysis facility include period? Enter "Y" for yes or "N" for 146.00 Has the cost allocation methodology ch	Medicare utilization no in column 2.	for this cost	reporting	N		146.00
Enter "Y" for yes or "N" for no in col yes, enter the approval date (mm/dd/yy		5-2, chapter 4	0, §4020) If			
					1.00	-
147.00 Was there a change in the statistical	basis? Enter "Y" for ye	es or "N" for	no.		N	147.00
148.00 Was there a change in the order of all		2			N	148.00
149.00 Was there a change to the simplified c	ost finding method? En				N Title XIX	149.00
	-	Part A 1.00	<u>Part B</u> 2.00	Title V 3.00	4.00	-
Does this facility contain a provider	that qualifies for an					
or charges? Enter "Y" for yes or "N" f	or no for each compone					
155.00Hospi tal 156.00Subprovi der – IPF		N N	N N	N	N N	155.00 156.00
156. 00 Subprovider – TPF 157. 00 Subprovider – TRF		N	N	N	N	156.00
158. OO SUBPROVI DER						158.00
159. 00 SNF		N	Ν	N	N	159.00
160.00 HOME HEALTH AGENCY		N	N	N	N	160.00
161.00 CMHC			N	N	N	161.00
					1.00	-
Multicampus					1	
165.00 Is this hospital part of a Multicampus Enter "Y" for yes or "N" for no.	hospital that has one	or more campu	ses in differ	ent CBSAs?	N	165.00
	Name	County	State Zip	Code CBSA	FTE/Campus	
	0	1.00	2.00 3	. 00 4. 00	5.00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in					0.00	166.00
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in						
column 5 (see instructions)						
					1.00	-
Health Information Technology (HIT) ir				Act	1	
167.00 Is this provider a meaningful user und					Y	167.00
168.00 If this provider is a CAH (line 105 is reasonable cost incurred for the HIT a			16/ IS "Y"),	enter the	(168.00
168.01 If this provider is a CAH and is not a			qualify for	a hardship	N	168.01
exception under §413.70(a)(6)(ii)? Ent	er "Y" for yes or "N" 1	for no. (see i	nstructions)			
169.00 If this provider is a meaningful user transition factor. (see instructions)	(line 167 is "Y") and i	is not a CAH (line 105 is "	N"), enter the	0.00	169. 00

Health Financial Systems	UNI ON HOSPI TAL	CLINTON	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFI	CATION DATA	Provider CCN: 15-1326	Period: From 01/01/2016	Worksheet S-2 Part I	2
			To 12/31/2016		
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning of period respectively (mm/dd/yyyy)	late and ending dat	te for the reporting	01/01/2016	12/31/2016	170.00
			1.00	2.00	
171.00 If line 167 is "Y", does this provider have	any days for indiv	viduals enrolled in	N	(0171.00
section 1876 Medicare cost plans reported on	n Wkst. S-3, Pt. I,	line 2, col. 6? Enter			
"Y" for yes and "N" for no in column 1. If c 1876 Medicare days in column 2. (see instruc		nter the number of sectio	n		

IOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-1326	Period: From 01/01/2016 To 12/31/2016	Worksheet S- Part II Date/Time Pr 5/25/2017 4:	epared:
		I		Y/N	Date	
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	for all NO re	esponses. Ente	er all dates in t	he	
	COMPLETED BY ALL HOSPITALS					-
	Provider Organization and Operation					
. 00	Has the provider changed ownership immediately prior to the			N		1.00
	reporting period? If yes, enter the date of the change in c	olumn 2. (see	Y/N) Date	V/I	
			1.00	2.00	3.00	
. 00	Has the provider terminated participation in the Medicare P yes, enter in column 2 the date of termination and in colum		N			2.0
8. 00	voluntary or "I" for involuntary. Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of of directors through ownership, control, or family and othe relationships? (see instructions)	ffices, drug er or its f the board	Y			3. 00
			Y/N	Туре	Date	
			1.00	2.00	3.00	_
. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" fo or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	or Compiled,	Y	A		4.00
. 00	Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		Y			5.0
				Y/N 1.00	Legal Oper. 2.00	
. 00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	lfyes, is th	ne provider i	s N		6.00
7.00 8.00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved		during the	N N		7.00 8.00
. 00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction:		al education	Ν		9.0
0. 00	Was an approved Intern and Resident GME program initiated o cost reporting period? If yes, see instructions.	r renewed in t		N		10.0
1. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N	Y/N	11.0
					1.00	
2 00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes	soo instruct	long		Y	12.00
	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			ost reporting	N	13.0
4.00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement				N	14.0
5.00	Did total beds available change from the prior cost reportion		rt A	Par Y/N		15.00
		1.00	Date 2.00	3.00	Date 4.00	
(00	PS&R Data Was the cost report prepared using the PS&R Report onLy?					1/ 0
6. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	04/12/2017	Y	04/12/2017	16.0
7.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Ν		N		17.0
8.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	Ν		N		18. 0
9.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	Ν		Ν		19. 0

	Financial Systems UNION HOSPIT. TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNALRE		CN: 15-1326	Peri od: From 01/01/2016	u of Form CM Worksheet S Part II	
				To 12/31/2016		
		Descr	iption	Y/N	Y/N	
			0	1.00	3.00	
0. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			Ν	Ν	20.0
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
1. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.0
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE Capital Related Cost	PT CHILDRENS I	IOSPI TALS)			
2.00 3.00	Have assets been relifed for Medicare purposes? If yes, see Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.		sals made dur	ing the cost	N N	22. (23. (
4. 00	Were new leases and/or amendments to existing leases entere If yes, see instructions	Ν	24.			
5. 00	Have there been new capitalized leases entered into during linstructions.	Ν	25. (
6. 00	Were assets subject to Sec. 2314 of DEFRA acquired during th instructions.	ne cost report	ng period? I	f yes, see	Ν	26.
7.00	Has the provider's capitalization policy changed during the copy.	e cost reporti	ng period? If	yes, submit	Ν	27.
3. 00	Interest Expense Were new Loans, mortgage agreements or letters of credit en period? If yes, see instructions.	ntered into du	ring the cost	reporting	N	28.
9.00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see instr		ebt Service R	eserve Fund)	Ν	29.
). 00	Has existing debt been replaced prior to its scheduled matu instructions.		debt? If yes	, see	Ν	30.
1.00	Has debt been recalled before scheduled maturity without is instructions.	ssuance of new	debt? If yes	s, see	Ν	31.
2. 00	Purchased Services Have changes or new agreements occurred in patient care ser		ed through co	ntractual	N	32.
3. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		ng to competi	tive bidding? If	Ν	33.
4. 00	Provider-Based Physicians Are services furnished at the provider facility under an ar	rangement wit	n provider-ba	ised physi ci ans?	Y	34.
5. 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended exi		nts with the	provi der-based	Ν	35.
	physicians during the cost reporting period? If yes, see in	istructi ons.		Y/N	Date	
	Home Office Costs			1.00	2.00	
5 00	Were home office costs claimed on the cost report?			Y		36.
. 00 . 00	If line 36 is yes, has a home office cost statement been pr If yes, see instructions.	repared by the	home office?			30.
8. 00	If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end			Ň		38.
9. 00	If line 36 is yes, did the provider render services to othe see instructions.			s, N		39.
0. 00		home office?	lf yes, see	N		40.
	1.00 2.					
I. 00	Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	CAROLYN		CHAPLIN		41.
2. 00		BLUE AND CO.,	LLC			42.
3 00	preparer. Enter the telephone number and email address of the cost	3177137919		CCHAPLI N@BLUEA	NDCO. COM	43.

Heal th	Financial Systems	UNI ON HOSPI TA	AL CLINTON		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provi der	CCN: 15-1326	Period:	Worksheet S-2	
					From 01/01/2016 To 12/31/2016		pared: 2 pm
				3.00			
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the t	itle/position S	SENI OR MANAG	iER			41.00
	held by the cost report preparer in colum	ns 1, 2, and 3,					
	respecti vel y.						
42.00	Enter the employer/company name of the cost	st report					42.00
	preparer.						
43.00	Enter the telephone number and email addre	ess of the cost					43.00
	report preparer in columns 1 and 2, respe-						

	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC						
			Provider CC	10 1020	Period: From 01/01/2016	Worksheet S-3 Part I	
					To 12/31/2016	Date/Time Pre 5/25/2017 4:2	pared:
						I/P Days / 0/P	
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number		Avai I abl e			
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	19	6, 9	54 37, 728. 00	0	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO I PF Subprovi der						3.00
4.00	HMO I RF Subprovi der						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation		19	6, 9	54 37, 728. 00	0	
	beds) (see instructions)			-, -		-	
8.00	INTENSIVE CARE UNIT	31.00	6	2, 1	96 12, 456. 00	0	8.00
9.00	CORONARY CARE UNI T						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9, 1	50 50, 184. 00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00 21.00	NURSING FACILITY OTHER LONG TERM CARE						20.00
21.00	HOME HEALTH AGENCY						21.00
22.00	AMBULATORY SURGICAL CENTER (D. P.)						22.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30, 00					24.10
25.00	CMHC - CMHC	00.00					25.00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambul ance Tri ps						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0		0		32.00
32. 01	Total ancillary labor & delivery room						32.01
	outpatient days (see instructions) LTCH non-covered days						33.00

HOSPI 1	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	UNI ON HOSPI TA AL DATA	Provider CO	CN: 15-1326	In Lie Period: From 01/01/2016 To 12/31/2016		
					To 12/31/2016	5/25/2017 4:2	
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Patients	& Residents	Payrol I	
	L	6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 019	205	1, 57	2		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)	96	0				2.00
3.00	HMO I PF Subprovi der	90 0	0				3.00
4.00	HMO I RF Subprovi der	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	112	0	11	8		5.00
6.00	Hospital Adults & Peds. Swing Bed SM Hospital Adults & Peds. Swing Bed NF	112	0		1		6.00
7.00	Total Adults and Peds. (exclude observation	1, 131	205	1, 70			7.00
7.00	beds) (see instructions)	1, 131	205	1,70			7.00
8.00	INTENSI VE CARE UNI T	256	130	51	9		8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1, 387	335	2, 22	0.00	130.08	
15.00	CAH visits	0	0		0		15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24.10	HOSPICE (non-distinct part)	0	0		0		24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00	0.00	26. 25
27.00	Total (sum of lines 14-26)				0.00	130.08	27.00
28.00	Observation Bed Days		0	84	0		28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)				0		30.00
31.00	Employee discount days - IRF				0		31.00
32.00	Labor & delivery days (see instructions)	0	0		0		32.00
32. 01	Total ancillary labor & delivery room				0		32.01
	outpatient days (see instructions)						
33.00	LTCH non-covered days	0				1	33.00

HUSPI I	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider C	CN: 15-1326	Period: From 01/01/2016		
					To 12/31/2016	Date/Time Pre 5/25/2017 4:2	
		Full Time		Di s	charges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers 11.00	12.00	12.00	14.00	Patients	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	11.00	12.00	13.00	14.00 33 116	15.00 655	1.00
1.00	8 exclude Swing Bed, Observation Bed and		0	40	110	000	1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)				26 0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation						7.00
	beds) (see instructions)						
B. 00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.0
10.00	BURN INTENSIVE CARE UNIT						10.0
11.00	SURGI CAL INTENSI VE CARE UNI T						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	48	33 116	655	
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.0
17.00 18.00	SUBPROVI DER – I RF SUBPROVI DER						17.0 18.0
19.00	SUBPROVIDER SKILLED NURSING FACILITY						19.0
20.00	NURSING FACILITY						20.00
20.00	OTHER LONG TERM CARE						20.0
22.00	HOME HEALTH AGENCY						22.0
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.0
24.00	HOSPICE						24.0
24.10	HOSPICE (non-distinct part)						24.1
25.00	CMHC - CMHC						25.0
26.00	RURAL HEALTH CLINIC						26.0
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.2
27.00	Total (sum of lines 14-26)	0.00					27.0
28.00	Observation Bed Days						28.0
29.00	Ambul ance Trips						29.0
30.00	Employee discount days (see instruction)						30.0
31.00	Employee discount days - IRF						31.0
32.00	Labor & delivery days (see instructions)						32.0
32.01	Total ancillary labor & delivery room						32.0
	outpatient days (see instructions)						1

Heal th	Financial Systems	UNION HOSPITAL C	LINTON		In Lie	eu of Form CMS-	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN	V: 15-1326	Peri od:	Worksheet S-	10
					From 01/01/2016 To 12/31/2016		norod.
					10 12/31/2016	Date/Time Pre 5/25/2017 4:2	
						1.00	
	Uncompensated and indigent care cost computa				2)	0.00/7/	
1.00	Cost to charge ratio (Worksheet C, Part I li	ne 202 column 3 div	ided by lin	e 202 column	18)	0. 286715	5 1.00
2 00	Medicaid (see instructions for each line)					17(02)	1 2 00
2.00 3.00	Net revenue from Medicaid Did you receive DSH or supplemental payments	from Modicaid2				176, 024	2.00
3.00 4.00	If line 3 is "yes", does line 2 include all		novmonte f	rom Madi cai c	2		4.00
4.00 5.00	If line 4 is "no", then enter DSH or supplem				1 !		1
5.00 6.00	Medicaid charges	ientai payilients rioli	i meui cai u			2, 975, 787	
7.00	Medicaid cost (line 1 times line 6)					853, 203	
8.00	Difference between net revenue and costs for	Modicaid program (lino 7 minu	s sum of lir	os 2 and 5: if	677, 179	
0.00	< zero then enter zero)			S SUII OF TH		077, 175	0.00
	Children's Health Insurance Program (CHIP) (see instructions fo	r each line)			
9.00	Net revenue from stand-al one CHIP			/		(9.00
10.00	Stand-al one CHIP charges					(
11.00	Stand-alone CHIP cost (line 1 times line 10)						
12.00	Difference between net revenue and costs for		line 11 min	us line 9 [.] i	f < zero then		
	enter zero)						
	Other state or local government indigent car	e program (see inst	ructions fo	r each line)			
13.00	Net revenue from state or local indigent car	e program (Not incl	uded on lin	es 2, 5 or 9))	(13.00
14.00	Charges for patients covered under state or	local indigent care	e program (N	ot included	in lines 6 or	0	14.00
	10)						
15.00	State or local indigent care program cost (I	ine 1 times line 14)			0	15.00
16.00	Difference between net revenue and costs for	state or local inc	ligent care	program (lir	ne 15 minus line	0	16.00
	13; if < zero then enter zero)						
	Uncompensated care (see instructions for eac						
	Private grants, donations, or endowment inco					0	
18.00	Government grants, appropriations or transfe					0	
19.00	Total unreimbursed cost for Medicaid , CHIP	and state and local	indigent c	are programs	s (sum of lines	677, 179	19.00
	8, 12 and 16)	_				T + + (+ 4	
				Uni nsured	Insured	Total (col. 1	
			-	patients 1.00	patients 2.00	+ col . 2) 3.00	
20.00	Charity care charges for the entire facility	(soo instructions)		2, 212, 30			20.00
20.00	Cost of patients approved for charity care (634, 30			
21.00	Partial payment by patients approved for charty care (034, 30			
22.00	Cost of charity care (line 21 minus line 22)			634, 30			
23.00	cost of charty care (The 21 minus The 22)			034, 30	0	034, 300	23.00
						1.00	
24.00	Does the amount in line 20 column 2 include	charges for patient	days beyon	d a length o	of stay limit		24.00
	imposed on patients covered by Medicaid or c	ther indigent care	program?	0	5		
25.00	If line 24 is "yes," charges for patient da	iys beyond an indige	ent care pro	gram's lengt	h of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospit					2, 500, 179	
27.00	Medicare bad debts for the entire hospital c	complex (see instruc	tions)			728, 838	3 27.00
28.00	Non-Medicare and non-reimbursable Medicare b					1, 771, 341	28.00
29.00	Cost of non-Medicare and non-reimbursable Me		ense (line	1 times line	28)	507, 870	
30.00	Cost of uncompensated care (line 23 column 3					1, 142, 170	
31.00	Total unreimbursed and uncompensated care co	ost (line 19 plus li	ne 30)			1, 819, 349	9 31.00

Health Financial Systems	UNI ON HOSPI TAL	CLINTON		In Lie	eu of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provider CO		Peri od:	Worksheet A	
				From 01/01/2016 To 12/31/2016		narod
				10 12/31/2010	5/25/2017 4:2	
Cost Center Description	Sal ari es	Other	Total (col.	Recl assi fi cati	Recl assi fi ed	
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
	1.00	2.00	3.00	4.00	col. 4) 5.00	
GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT		754, 255	754, 25	5 -63, 943	690, 312	1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP		258, 748	258, 74			2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	0		0 0		4.00
5.01 00540 NONPATI ENT TELEPHONES	0	44, 470	44, 47	0 0	44, 470	5. 01
5. 02 00550 DATA PROCESSI NG	0	856, 120	856, 12	0 0	856, 120	5.02
5.03 00560 PURCHASING RECEIVING AND STORES	0	72, 122	72, 12			5.03
5. 04 00570 ADMI TTI NG	449, 170	71, 747	520, 91		520, 917	5.04
5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	21, 407	345, 185	366, 59			5.05
5. 06 00591 ADMI NI STRATI VE AND GENERAL	639, 069	1, 124, 097	1, 763, 16			5.06
7.00 00700 OPERATION OF PLANT	379, 087	627, 782	1, 006, 86		.,	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	0	210	21		-	
9.00 00900 HOUSEKEEPING	223, 688	85,075	308, 76			9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	316, 389	232, 299	548, 68			10.00 11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	536, 347	0 100, 253	636, 60			13.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	210, 141	108, 801	318, 94			16.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	210, 141	100, 001	510, 74	2 0	510, 742	10.00
30. 00 03000 ADULTS & PEDI ATRI CS	1,089,173	716, 864	1, 806, 03	7 0	1, 806, 037	30.00
31.00 03100 INTENSIVE CARE UNIT	716, 446	95, 228	811, 67			31.00
ANCI LLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	294, 656	410, 756	705, 41	2 0	705, 412	50.00
51.00 05100 RECOVERY ROOM	56, 226	4, 141	60, 36			51.00
51.01 05101 0/P TREATMENT ROOM	161, 788	42, 010	203, 79			51.01
54. 00 05400 RADI OLOGY-DI AGNOSTI C	680, 012	742, 173	1, 422, 18			54.00
56. 00 05600 RADI 0I SOTOPE	0	105, 528	105, 52			56.00
60. 00 06000 LABORATORY	0	896, 075	896, 07			60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	58, 858	58, 85			62.00
65. 00 06500 RESPI RATORY THERAPY	417, 752	117, 365	535, 11			65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	0	1, 241, 716	1, 241, 71			66.00 67.00
68.00 06800 SPEECH PATHOLOGY	0	7, 466 28, 530	7,46		7, 466 28, 530	
69. 00 06900 ELECTROCARDI OLOGY	114, 003	28, 530 62, 149	28, 53 176, 15			69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	69, 201	69, 20			71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	07,201		0 0		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	396, 087	868, 052	1, 264, 13	· · · ·		
OUTPATIENT SERVICE COST CENTERS		,	.,,	-1 -	.,,	
90. 00 09000 CLI NI C	0	0		0 0	0	90.00
91.00 09100 EMERGENCY	1, 164, 177	287, 220	1, 451, 39	7 0	1, 451, 397	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS					1	
118.00 SUBTOTALS (SUM OF LINES 1-117)	7, 865, 618	10, 434, 496	18, 300, 11	4 -63, 943	18, 236, 171	118.00
NONREI MBURSABLE COST CENTERS	011 10-	0.05	510	4 05 5 15	544 015	101 22
194. 00 07950 PHYSI CLAN PRACTICES	214, 432	305, 212	519, 64			
194. 01 07951 MEDICAL OFFICE BUILDING	0	0		0 38, 625		
194.02 07952 VPCHC 200.00 TOTAL (SUM OF LINES 118-199)	8, 080, 050	0 10, 739, 708	18, 819, 75	0 0 8 0		194.02
200.00 10TAL (30W OF LINES 110-177)	0,000,000	10, 737, 700	10,017,70	U U	1 10,017,730	1200.00

RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CCN: 15-1326		orksheet A
				From 01/01/2016 To 12/31/2016 D	ate/Time Prepared /25/2017 4:22 pm
	Cost Center Description		Net Expenses		
		(See A-8) F 6.00	or Allocation 7.00		
	GENERAL SERVICE COST CENTERS	0.00	7.00		
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	600, 267	1, 290, 579		1.
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	0	258, 748		2.
1.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 714, 506	1, 714, 506		4.
5. 01	00540 NONPATIENT TELEPHONES	30, 183	74, 653		5.
5. 02	00550 DATA PROCESSI NG	1, 780, 706	2, 636, 826		5.
5.03	00560 PURCHASING RECEIVING AND STORES	102, 178	174, 300		5.
5.04	00570 ADMI TTI NG	0	520, 917		5.
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	362, 154	728, 746		5.
5.06	00591 ADMINI STRATI VE AND GENERAL	290, 773	2,053,939		5.
7.00	00700 OPERATION OF PLANT	144, 262	1, 151, 131		7.
B. 00	00800 LAUNDRY & LINEN SERVICE	0	210		8.
7.00	00900 HOUSEKEEPI NG	20, 152	328, 915		9.
10.00	01000 DI ETARY	4, 455	121, 461		10.
11.00	01100 CAFETERIA	-163, 554	268, 128		11.
13.00		80, 877	717, 477		13.
6.00		15, 297	334, 239		16.
0.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	10,277	001,207		10.
30. 00		-544, 499	1, 261, 538		30.
	03100 I NTENSI VE CARE UNI T	0	811, 674		31.
	ANCI LLARY SERVICE COST CENTERS	-1			
50.00		-34, 375	671,037		50.
51.00	05100 RECOVERY ROOM	86	60, 453		51.
51.01	05101 0/P TREATMENT ROOM	0	203, 798		51.
54.00		44, 501	1, 466, 686		54.
56.00	05600 RADI OI SOTOPE	0	105, 528		56.
50.00		0	896, 075		60.
52.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	58, 858		62.
5.00	06500 RESPI RATORY THERAPY	0	535, 117		65.
6.00		-697, 975	543, 741		66.
57.00		130, 937	138, 403		67.
8.00		-5, 984	22, 546		68.
9.00		2,636	178, 788		69.
71.00		0	69, 201		71.
72.00		0	0		72.
	07300 DRUGS CHARGED TO PATIENTS	21, 764	1, 285, 903		73.
	OUTPATIENT SERVICE COST CENTERS				
0. 00		0	0		90.
1.00		-5, 265	1, 446, 132		91.
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	-, _00	,		92.
	SPECIAL PURPOSE COST CENTERS	· · · · · ·			
118.00		3, 894, 082	22, 130, 253		118.
	NONREI MBURSABLE COST CENTERS				
94.00	DO7950 PHYSI CI AN PRACTI CES	0	544, 962		194.
	107951 MEDICAL OFFICE BUILDING	Ő	38, 625		194.
	207952 VPCHC	0	0		194.
200.00		3, 894, 082	22, 713, 840		200.

Heal th	Financial Systems		UNI ON HOSPI T	AL CLINTON		In Lieu	u of Form CMS-	-2552-10
RECLAS	SEFECATIONS			Provider C	CN: 15-1326	Period: From 01/01/2016	Worksheet A-	6
						To 12/31/2016	Date/Time Pr 5/25/2017 4::	epared: 22 pm
		Increases						
	Cost Center	Line #	Salary	0ther				
	2.00	3.00	4.00	5.00				
	A - CAFETERIA RECLASS							
1.00	CAFETERI A	11.00	248, 920	182, 762				1.00
	0 — — — — — — —		248, 920	182, 762				
	B - DEPRECIATION RECLASS							
1.00	PHYSICIAN PRACTICES	194.00	0	25, 318				1.00
2.00	MEDICAL OFFICE BUILDING	194.01	0	38, 625				2.00
	TOTALS		0	63, 943				
500.00	Grand Total: Increases		248, 920	246, 705				500.00

Heal th	Financial Systems		UNI ON HOSPI	TAL CLINTON		In Lie	u of Form CMS	-2552-10
RECLAS	SEFECATIONS			Provider (Period: From 01/01/2016	Worksheet A	-6
						To 12/31/2016	Date/Time Pr 5/25/2017 4:	repared: 22 pm
		Decreases						
	Cost Center	Line #	Sal ary	0ther	Wkst. A-7 Ref			
	6.00	7.00	8.00	9.00	10.00			
	A - CAFETERIA RECLASS							
1.00	DI ETARY	10.00	248, 920	182, 762		0		1.00
	0		248, 920	182, 762		7		
	B - DEPRECIATION RECLASS							
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	63, 943		9		1.00
	FLXT							
2.00		0.00	0	0		o		2.00
	TOTALS		o	63, 943		7		
500.00	Grand Total: Decreases		248, 920	246, 705				500.00

Heal th	Financial Systems	UNI ON HOSPI T	AL CLINTON		In Lie	eu of Form CMS-:	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider CC	CN: 15-1326	Period: From 01/01/2016 To 12/31/2016		pared:
				Acqui si ti on	S	10/20/2011 112	
		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	F BALANCES				_	
1.00	Land	339, 822	0		0 0	0	1.00
2.00	Land Improvements	269, 938	0		0 0	0	2.00
3.00	Buildings and Fixtures	11, 514, 480	31, 000		0 31,000	0	3.00
4.00	Building Improvements	1, 645, 471	0		0 0	0	4.00
5.00	Fixed Equipment	0	0		0 0	0	5.00
6.00	Movable Equipment	6, 037, 609	73, 785		0 73, 785	333, 526	6.00
7.00	HIT designated Assets	0	0		0 0	0	7.00
8.00	Subtotal (sum of lines 1-7)	19, 807, 320	104, 785		0 104, 785	333, 526	8.00
9.00	Reconciling Items	0	0		0 0	0	9.00
10.00	Total (line 8 minus line 9)	19, 807, 320	104, 785		0 104, 785	333, 526	10.00
		Ending Balance	Fully				
		Ŭ	Depreci ated				
			Assets				
		6.00	7.00			-	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	339, 822	0				1.00
2.00	Land Improvements	269, 938	0				2.00
3.00	Buildings and Fixtures	11, 545, 480	0				3.00
4.00	Building Improvements	1, 645, 471	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	5, 777, 868	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	19, 578, 579	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	19, 578, 579	0				10.00

Heal th	Financial Systems	UNI ON HOSPI T	AL CLINTON		In Lie	u of Form CMS-2	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-1326	Period:	Worksheet A-7	
					From 01/01/2016 To 12/31/2016		nared
					10 12/01/2010	5/25/2017 4:2	2 pm
			SL	JMMARY OF CAP	'I TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
	'					instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR			nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	754, 255	0		0 0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	258, 748	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	1, 013, 003	0		0 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate					
		d Costs (see					
		instructions)	5 <i>,</i>				
		14.00	15.00	1			
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	754, 255				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	258, 748				2.00
3.00	Total (sum of lines 1-2)	0	1, 013, 003				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-1326 Period: Period: Period: From 01/01/2016 To 12/31/2016 Worksheet A-7 Period: From 01/01/2016 To 12/31/2016 COMPUTATION OF RATIOS ALLOCATION OF OTHER CAPITAL COMPUTATION OF RATIOS ALLOCATION OF OTHER CAPITAL Cost Center Description Gross Assets Capitalized Gross Assets for Ratio (see instructions) Insurance instructions) Insurance 1.00 2.00 3.00 4.00 5.00 ART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 2.00 3.00 1.00 1.00 2.00 3.00 1.00 1.00 2.00 3.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 <th>Heal th Financial</th> <th>Systems</th> <th>UNI ON HOSPI T</th> <th>AL CLINTON</th> <th></th> <th>In Lie</th> <th>u of Form CMS-2</th> <th>2552-10</th>	Heal th Financial	Systems	UNI ON HOSPI T	AL CLINTON		In Lie	u of Form CMS-2	2552-10
Cost Center Description Gross Assets Capitalized Leases Gross Assets for Ratio (col. 1 - col. 2) Ratio (see instructions) Insurance 1.00 2.00 3.00 4.00 5.00 1.00 NEW CAP REL COSTS-BLOG & FIXT 13,800,711 0 13,800,711 0.704888 0 1.00 2.00 NEW CAP REL COSTS-BLOG & FIXT 13,800,711 0 13,800,711 0.704888 0 2.00 3.00 Total (sum of lines 1-2) 19,578,579 0 19,578,579 0 19,578,579 0 3.00 ALLOCATION OF CAPITAL COSTS CENTERS Cost Center Description Taxes Other Capital -Relate d Costs Total (sum of cols. 5 Depreciation through 7) Lease 1.00 NEW CAP REL COSTS-BLOG & FIXT 0 0 0 1.00 0 2.00 NEW CAP REL COSTS-BLOG & FIXT 0 0 1.00 1.00 Center Description Taxes Other d Costs Total (sum of through 7) 1.00 0 0 0 0 0 0 2.00 1.00 1.00	RECONCILIATION (OF CAPI TAL COSTS CENTERS		Provider CO		From 01/01/2016	Part III Date/Time Pre	
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS for Ratio instructions) 1.00 2.00 3.00 4.00 5.00 1.00 2.00 3.00 4.00 5.00 1.00 2.00 3.00 4.00 5.00 1.00 NEW CAP REL COSTS-BLDG & FIXT 13,800,711 0 13,800,711 0.704888 0 1.00 2.00 3.00 Total (sum of lines 1-2) 19,578,579 0 19,578,579 19,578,579 0 3.00 3.00 Cost Center Description Taxes Other Capital-Relate d Costs Total (sum of cols.5 Depreciation Lease 1.00 NEW CAP REL COSTS-BLDG & FIXT 0			COM	PUTATION OF RAT	10S	ALLOCATION OF	OTHER CAPITAL	
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 NEW CAP REL COSTS-BLDG & FIXT 13,800,711 0 13,800,711 0.704888 0 1.00 2.00 NEW CAP REL COSTS-MVBLE EQUIP 5,777,868 0 5,777,868 0.295112 0 2.00 3.00 Total (sum of lines 1-2) 19,578,579 0 19,578,579 1.000000 0 3.00 ALLOCATION OF OTHER CAPITAL Cost Center Description Taxes Other Capital -Relate d Costs Depreciation Lease 1.00 NEW CAP REL COSTS-BLDG & FIXT 0 0 9.00 10.00 Other Capital -Relate d Costs Total (sum of cols. 5 Depreciation Lease 1.00 NEW CAP REL COSTS-BLDG & FIXT 0 0 9.00 10.00 2.00 NEW CAP REL COSTS-BLDG & FIXT 0 0 0 1.00 2.00 3.00 TOTAL (Sum of Lines 1-2) 0 0 0 1.00 2.00 3.00 Total (sum of lines 1-2) 0<	Cos	t Center Description	Gross Assets		for Ratio (col. 1 - col	instructions)	Insurance	
1.00 NEW CAP REL COSTS-BLDG & FIXT 13,800,711 0 13,800,711 0.704888 0 1.00 2.00 NEW CAP REL COSTS-MVBLE EQUIP 5,777,868 0 5,777,868 0.295112 0 2.00 3.00 Total (sum of lines 1-2) 19,578,579 0 19,578,579 1.000000 0 3.00 Cost Center Description Total (sum of cost center Description 0 1.00 0 0 0 0 3.00 0 </td <td></td> <td></td> <td></td> <td>2.00</td> <td>3.00</td> <td>4.00</td> <td>5.00</td> <td></td>				2.00	3.00	4.00	5.00	
2.00 NEW CAP REL COSTS-MVBLE EQUIP 5,777,868 0 5,777,868 0.295112 0 2.00 3.00 Total (sum of lines 1-2) 19,578,579 0 19,578,579 1.000000 0 3.00 Cost Center Description Taxes 0 ther Capital -Relate d Costs Total (sum of Depreciation Lease PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 NEW CAP REL COSTS-BLDG & FIXT 0 0 0 1,291,426 0 1.00 2.00 NEW CAP REL COSTS-MVBLE EQUIP 0 0 0 0 1.00 2.00 SUMMARY OF CAPITAL				-				
3.00 Total (sum of lines 1-2) 19,578,579 0 19,578,579 1.00000 0 3.00 ALLOCATION OF OTHER CAPITAL Cost Center Description Taxes Other Cost Center Description Total (sum of capital -Relate d Costs Cost Center Description Total (sum of capital -Relate d Costs Cost Center Description Depreciation Lease Cost Center Description PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 NEW CAP REL COSTS-BLDG & FIXT 0 0 0 1,291,426 0 1.00 2.00 NEW CAP REL COSTS-MVBLE EQUIP 0 0 0 2.00 2.00 3.00 SUMMARY OF CAPITAL Cost Center Description								
ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL Cost Center Description Taxes Other Total (sum of costs								
Cost Center Description Taxes Other Capital -Relate Cols. 5 through 7) Depreciation Lease PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 0 0 7.00 8.00 9.00 10.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 0 0 0 1, 291, 426 0 1.00 NEW CAP REL COSTS-BLDG & FIXT 0 0 0 0 2.00 1, 291, 426 0 1.00 2.00 NEW CAP REL COSTS-MVBLE EQUIP 0 0 0 0 2.00 3.00 7.44 0 3.00 3.00 Total (sum of lines 1-2) 1 Interest Insurance (see Taxes (see Other Total (2) (sum	3.00 Total (su	um of lines 1-2)	1					3.00
Capital-Relate d Costs cols.5 through 7) d PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 6.00 7.00 8.00 9.00 10.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 0 0 1.291,426 0 1.00 1.00 NEW CAP REL COSTS-BLDG & FIXT 0 0 0 1.00 258,748 0 2.00 3.00 Total (sum of lines 1-2) 0 0 0 1,550,174 0 3.00 SUMMARY OF CAPITAL Cost Center Description			ALLOCA	IION OF OTHER (CAPITAL	SUMMARY C	F CAPITAL	
I.OO PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 NEW CAP REL COSTS-BLDG & FIXT 0 0 1,291,426 0 1.00 2.00 NEW CAP REL COSTS-MVBLE EQUIP 0 0 0 258,748 0 2.00 3.00 Total (sum of lines 1-2) 0 0 0 1,550,174 0 3.00	Cos	t Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
6.00 7.00 8.00 9.00 10.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 NEW CAP REL COSTS-BLDG & FIXT 0 0 1,291,426 0 1.00 2.00 NEW CAP REL COSTS-BLDG & FIXT 0 0 0 258,748 0 2.00 3.00 Total (sum of lines 1-2) 0 0 0 1,550,174 0 3.00 Cost Center Description				Capi tal -Rel ate	cols. 5			
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 NEW CAP REL COSTS-BLDG & FIXT 0 0 1,291,426 0 1.00 2.00 NEW CAP REL COSTS-BLDG & FIXT 0 0 0 258,748 0 2.00 3.00 Total (sum of lines 1-2) 0 0 0 1,550,174 0 3.00 Cost Center Description Interest Insurance (see Taxes (see Other Total (2) (sum					through 7)			
1.00 NEW CAP REL COSTS-BLDG & FIXT 0 0 0 1,291,426 0 1.00 2.00 NEW CAP REL COSTS-MVBLE EQUIP 0 0 0 258,748 0 2.00 3.00 Total (sum of lines 1-2) 0 0 0 1,550,174 0 3.00 SUMMARY OF CAPI TAL Cost Center Description				7.00	8.00	9.00	10.00	
2.00 NEW CAP REL COSTS-MVBLE EQUIP 0 0 0 258,748 0 2.00 3.00 Total (sum of lines 1-2) 0 0 0 1,550,174 0 3.00 SUMMARY OF CAPITAL			ENTERS			- i		
3.00 Total (sum of lines 1-2) 0 0 0 1,550,174 0 3.00 SUMMARY OF CAPITAL Cost Center Description Interest Insurance (see Taxes (see Other Total (2) (sum total))			0	0				
SUMMARY OF CAPITAL Cost Center Description Interest Insurance (see Taxes (see Other Total (2) (sum			0	0				
Cost Center Description Interest Insurance (see Taxes (see Other Total (2) (sum	3.00 Total (su	um of lines 1-2)	0	0			0	3.00
				SL	IMMARY OF CAPI	TAL		
instructions) instructions) Capital-Relate of cols. 9	Cos	t Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
				instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
d Costs (see through 14)							through 14)	
instructions)								
<u> </u>				12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS				I		-		
1.00 NEW CAP REL COSTS-BLDG & FIXT -847 0 0 1, 290, 579 1.00						-		
2.00 NEW CAP REL COSTS-MVBLE EQUI P 0 0 0 258, 748 2.00			-	-		-		
3.00 Total (sum of lines 1-2) -847 0 0 0 1,549,327 3.00	3.00 Total (su	um of lines 1-2)	-847	0		0 0	1, 549, 327	3.00

	Financial Systems MENTS TO EXPENSES		UNI ON HOSPIT	AL CLINTON Provider CCN: 15-1326	Period:	u of Form CMS-2 Worksheet A-8	2552-1
	WILINIS IU EAPENSES				From 01/01/2016 To 12/31/2016		pared: 2_pm
				Expense Classification c To/From Which the Amount is			
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
1.00	Investment income - NEW CAP	1.00	2.00	3.00 NEW CAP REL COSTS-BLDG &	4.00	5.00 0	1.00
	REL COSTS-BLDG & FIXT (chapter			FIXT			
2.00	2) Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter			NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	2) Investment income - other	В	-847	NEW CAP REL COSTS-BLDG &	1.00	11	3.00
1.00	(chapter 2) Trade, quantity, and time		0	FIXT	0.00	0	4.00
5.00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5.00
	expenses (chapter 8)		0				
5.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
. 00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
3. 00	Television and radio service		0		0.00	0	8.00
9.00	(chapter 21) Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provi der-based physi ci an	A-8-2	-619, 631			0	10.00
1.00	adjustment Sale of scrap, waste, etc.		0		0.00	0	11.00
2.00	(chapter 23) Related organization	A-8-1	5, 679, 659			0	12.00
	transactions (chapter 10)				0.00		
3.00 4.00	Laundry and linen service Cafeteria-employees and guests		0 0		0. 00 0. 00	0	13.0 14.0
5.00	Rental of quarters to employee and others		0		0.00	0	15.0
6. 00	Sale of medical and surgical supplies to other than		0		0.00	0	16.00
7.00	patients Sale of drugs to other than		0		0.00	0	17.00
8.00	patients Sale of medical records and		0		0.00	0	18.00
	abstracts		0				
9.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines Income from imposition of		0		0.00 0.00		
	interest, finance or penalty charges (chapter 21)						
2.00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22.00
23.00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
24.00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24.00
25.00	limitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted **'	114.00		25.00
26. 00	(chapter 21) Depreciation - NEW CAP REL COSTS-BLDG & FIXT			NEW CAP REL COSTS-BLDG & FIXT	1.00	о	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist			*** Cost Center Deleted ***			28.00
9.00 0.00	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	0 0	OCCUPATI ONAL THERAPY	0.00 67.00		29.00 30.00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
31.00	instructions) Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	limitation (chapter 14) CAH HIT Adjustment for Depreciation and Interest		0		0.00	о	32.00

Heal th	Financial Systems		UNI ON HOSPI T	AL CLINTON	In Lie	u of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES			Provider CCN: 15-1326	Peri od:	Worksheet A-8	
					From 01/01/2016 To 12/31/2016		narod
					10 12/31/2010	5/25/2017 4:22	
				Expense Classification o	n Worksheet A		
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)		Cost Center		Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	MI SCELLANEOUS REVENUE	В		ADMINISTRATIVE AND GENERAL	5.06		33.00
33.01	CAFETERIA REVENUE	В	-181, 379	CAFETERI A	11.00		33.01
33.02	REBATE	A	-16	ADMINISTRATIVE AND GENERAL	5.06	0	33.02
35.00	CAFETERIA REVENUE	В	-2, 542	CAFETERI A	11.00	0	35.00
36.00	ADVERTI SI NG	A	-907	ADMINISTRATIVE AND GENERAL	5.06	0	36.00
39.00	VPCHC	В	-7, 916	HOUSEKEEPI NG	9.00	0	39.00
42.00	RENTAL REVENUE	В	-146, 746	OPERATION OF PLANT	7.00	0	42.00
43.00	HAF	A	-783, 383	ADMINISTRATIVE AND GENERAL	5.06	0	43.00
44.00	EHR DEPRECIATION	A	-36, 488	NEW CAP REL COSTS-BLDG &	1.00	9	44.00
				FIXT			
50.00	TOTAL (sum of lines 1 thru 49)		3, 894, 082				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

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

(2) basis for adjustment (see first detroits).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Systems	UNI ON HOSPI	TAL CLINTON	In Lie	eu of Form CMS-2	2552-10
STATEME OFFICE		RELATED ORGANIZATIONS AND HO	ME Provider CCN: 15-1326	Period: From 01/01/2016 To 12/31/2016		bared:
	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	HOME OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF		RGANIZATIONS OR	CLAI MED	
1.00		NEW CAP REL COSTS-BLDG & FIX		637, 602		1.00
2.00			HOME OFFICE	1, 714, 506		2.00
3.00		NONPATIENT TELEPHONES	HOME OFFICE	30, 183		3.00
4.00		DATA PROCESSING	HOME OFFICE	1, 780, 706		4.00
4.01		PURCHASING RECEIVING AND STO		102, 178		4.01
4.02		CASHI ERI NG/ACCOUNTS RECEI VAB		362, 154	0	4.02
4.03		ADMINISTRATIVE AND GENERAL	HOME OFFICE	1, 080, 801	0	4.03
4.04		OPERATION OF PLANT	HOME OFFICE	291, 008		4.04
4.05		HOUSEKEEPING	HOME OFFICE	28, 068		4.05
4.06		DIETARY	HOME OFFICE	4, 455		4.06
4.07		CAFETERIA	HOME OFFICE	20, 367		4.07
4.08		NURSING ADMINISTRATION	HOME OFFICE	80, 877	0	4.08
4.09		MEDICAL RECORDS & LIBRARY	HOME OFFICE	15, 297		4.09
4.10		OPERATING ROOM	HOME OFFICE	2, 185		4.10
4.11		RECOVERY ROOM	HOME OFFICE	86		4.11
4.12		RADI OLOGY-DI AGNOSTI C	HOME OFFICE	75, 916		4.12
4.13		PHYSI CAL THERAPY	HOME OFFICE	3, 051		4.13
4.14		OCCUPATIONAL THERAPY	HOME OFFICE	903	0	4.14
4.15		SPEECH PATHOLOGY	HOME OFFICE	142	0	4.15
4.16		ELECTROCARDI OLOGY	HOME OFFICE	4, 528	0	4.16
4.17		DRUGS CHARGED TO PATIENTS	HOME OFFICE	21, 764	0	4.17
4.18	66.00	PHYSI CAL THERAPY	THERAPY	439, 623	1, 140, 649	4. 18
4.19		OCCUPATIONAL THERAPY	THERAPY	130, 034		4.19
4.20	68.00	SPEECH PATHOLOGY	THERAPY	20, 511		4.20
5.00	0		0	6, 846, 945	1, 167, 286	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	
				1	
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 RELAT	ED 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	51.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
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.

C. Provider has financial interest in corporation, partnership, or other organization.

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.

E. Individual is director, officer, administrator, or key person of provider and related organization.

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

Health Financial Systems	UNI ON HOSPI TAL	CLINTON	In Lieu	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM RELA OFFICE COSTS	ATED ORGANIZATIONS AND HOME	Provider CCN: 15-1326	Period: From 01/01/2016 To 12/31/2016	Worksheet A-8-1 Date/Time Prepared:

				5/25/2017 4:22 pm
		Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
			SULT OF TRANSACTIONS WITH RELATED ORG	ANIZATIONS OR CLAIMED
	HOME OFFICE CO			
1.00	637, 602			1.00
2.00	1, 714, 506			2.00
3.00	30, 183			3.00
4.00	1, 780, 706			4.00
4.01	102, 178			4.01
4.02	362, 154			4. 02
4.03	1, 080, 801			4.03
4.04	291,008	0		4.04
4.05	28, 068			4. 05
4.06	4, 455			4.06
4.07	20, 367			4.07
4.08	80, 877	0		4.08
4.09	15, 297	0		4.09
4.10	2, 185			4. 10
4.11	86	0		4. 11
4.12	75, 916	0		4. 12
4.13	3, 051	0		4. 13
4.14	903			4.14
4.15	142			4. 15
4.16	4, 528			4. 16
4.17	21, 764			4. 17
4.18	-701, 026			4. 18
4.19	130, 034			4. 19
4.20	-6, 126			4. 20
5.00	5, 679, 659			5.00

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

Related Organization(s) and/or Home Office		
 Type of Business		
6.00		
 B. INTERRELATIONSHIP TO RELAT	FED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6.00	HOME OFFICE	6.00
7.00	THERAPY	7.00
8.00		8.00
9.00		9.00
10.00		10.00
10. 00 100. 00		100.00

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.

E. Individual is director, officer, administrator, or key person of provider and related organization.

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

Heal th	Financial Syste	ems	UNI ON HOSPI	TAL C	LINTON		In Lie	eu of Form CMS-	2552-10
PROVI DE	R BASED PHYSIC	I AN ADJUSTMENT		1	Provider C	CN: 15-1326	Peri od:	Worksheet A-8	3-2
							From 01/01/2016		
							To 12/31/2016	Date/Time Pre 5/25/2017 4:2	
	Wkst. A Line #	Cost Center/Physician	Total	Prof	essi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identi fi er	Remuneration	Cor	mponent	Component		ider Component	
								Hours	
	1.00	2.00	3.00		4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	544, 499	•	544, 499		0 0	0	1.00
2.00	50.00	OPERATING ROOM	36, 560		36, 560		o l	0	2.00
3.00	54.00	RADI OLOGY-DI AGNOSTI C	31, 415		31, 415		o l	0	3.00
4.00		ELECTROCARDI OLOGY	1, 892		1, 892		0 0	0	4.00
5.00		EMERGENCY	5, 265		5, 265			0	5.00
6.00	0.00	Emerdenon	0,200		0,200			0	6.00
7.00	0.00		0		0			0	7.00
	0.00		0		0			0	7.00 8.00
8.00			0		0			0	
9.00	0.00		0		0		0 0	0	9.00
10.00	0.00		0		0		0 0	0	10.00
200.00			619, 631		619, 631		C	0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		rcent of	Cost of	Provi der	Physician Cost	
		I denti fi er	Limit			Memberships &		of Malpractice	
					_imit	Conti nui ng	Share of col.	Insurance	
						Educati on	12		
	1.00	2.00	8.00		9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0		0		0 0	0	1.00
2.00	50.00	OPERATING ROOM	0)	0		0 0	0	2.00
3.00	54.00	RADI OLOGY-DI AGNOSTI C	0		0		o l	0	3.00
4.00	69.00	ELECTROCARDI OLOGY	0		0		o l	0	4.00
5.00		EMERGENCY	0		0		o l	0	5.00
6.00	0.00		0		0			0	6.00
7.00	0.00		0		0			0	7.00
8.00	0.00				0			0	8.00
9.00	0.00		0		0			0	9.00
9.00 10.00	0.00		0		0			0	9.00 10.00
	0.00		0		0			-	
200.00			0		0	DOF	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der		sted RCE	RCE	Adjustment		
		Identi fi er	Component		_imit	Di sal I owance			
			Share of col.						
	1.00	0.00	14		1/ 00	47.00	10.00		
	1.00	2.00	15.00		16.00	17.00	18.00		
1.00		ADULTS & PEDIATRICS	0		0		544, 499		1.00
2.00		OPERATING ROOM	0		0		36, 560		2.00
3.00		RADI OLOGY-DI AGNOSTI C	0		0		0 31, 415		3.00
4.00	69.00	ELECTROCARDI OLOGY	0		0		0 1,892		4.00
5.00	91.00	EMERGENCY	0		0		5, 265		5.00
6.00	0.00		0		0		0 0		6.00
7.00	0.00		0		0		0 0		7.00
8.00	0.00		0		0		0 0		8.00
9.00	0.00		0		0				9.00
10.00	0.00				0				10.00
200.00					0		619,631		200.00
200.00	I	l	1 0	T	0		017,031		200.00

Heal th	Financial Systems	UNI ON HOSPI T	AL CLINTON		In Lie	u of Form CMS-:	2552-10
	ALLOCATION - GENERAL SERVICE COSTS		Provider CC	F	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part I Date/Time Pre	
			CAPI TAL REL	ATED COSTS		5/25/2017 4:2	2 pm
	Cost Center Description	Net Expenses for Cost	NEW BLDG & FIXT	NEW MVBLE EQUIP	EMPLOYEE BENEFI TS	NONPATI ENT TELEPHONES	
		Allocation (from Wkst A col. 7)			DEPARTMENT		
		0	1.00	2.00	4.00	5. 01	
	GENERAL SERVICE COST CENTERS	4 000 570	1 000 570				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	1, 290, 579	1, 290, 579				1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	258, 748		258, 748			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 714, 506	0			0/ 550	4.00
5.01	00540 NONPATI ENT TELEPHONES	74,653	1, 725			96, 552	5.01
5.02	00550 DATA PROCESSING	2, 636, 826	3, 368			1, 110	
5.03 5.04	00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING	174, 300 520, 917	13, 122 8, 361	12, 516 684		740 2, 220	
5.04	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	728, 746	4, 944			1, 480	5.04
5.05	00591 ADMI NI STRATI VE AND GENERAL	2,053,939			.,	5, 549	5.05
7.00	00700 OPERATION OF PLANT	1, 151, 131	356, 447	8, 251		7, 769	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	210	6, 868			0	8.00
9.00	00900 HOUSEKEEPING	328, 915	6, 503			370	
10.00	01000 DI ETARY	121, 461	15, 545			370	
11.00	01100 CAFETERI A	268, 128	58, 512			2, 220	
13.00	01300 NURSI NG ADMI NI STRATI ON	717, 477	22, 927			1, 480	
16.00	01600 MEDI CAL RECORDS & LI BRARY	334, 239	14, 516			3, 329	
101.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	001/207	11/010	2.0	11,070	0,02,	10100
30.00	03000 ADULTS & PEDIATRICS	1, 261, 538	232, 057	21, 576	231, 112	27,001	30.00
31.00	03100 I NTENSI VE CARE UNI T	811, 674		36, 271		2, 220	
	ANCILLARY SERVICE COST CENTERS	· · · · ·					
50.00	05000 OPERATI NG ROOM	671, 037	49, 520	29, 192	62, 523	2, 590	50.00
51.00	05100 RECOVERY ROOM	60, 453	4, 993	572	11, 931	740	51.00
51.01	05101 0/P TREATMENT ROOM	203, 798	26, 676	2, 367	34, 330	4, 069	51.01
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 466, 686	94, 644	64, 494	144, 292	5, 179	54.00
56.00	05600 RADI OI SOTOPE	105, 528	4, 363	(C	0 0	370	56.00
60.00	06000 LABORATORY	896, 075	28, 385	(C	0 0	1, 850	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	58, 858	0	0	0 0	0	62.00
65.00	06500 RESPI RATORY THERAPY	535, 117	16, 988			2, 590	65.00
66.00	06600 PHYSI CAL THERAPY	543, 741	56, 057	1, 706	0	4, 069	66.00
67.00	06700 OCCUPATI ONAL THERAPY	138, 403	47, 148	7	0	2, 959	67.00
68.00	06800 SPEECH PATHOLOGY	22, 546	6, 370		-	740	
69.00	06900 ELECTROCARDI OLOGY	178, 788	6, 951	4, 815		1, 850	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	69, 201	16, 855		-	370	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		0	
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 285, 903	16, 822	1, 143	8 84, 046	2, 220	73.00
00.00	OUTPATIENT SERVICE COST CENTERS		0			0	00.00
		0	0				90.00
	09100 EMERGENCY	1, 446, 132	138, 657	14, 717	247, 028	11, 098	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS						92.00
118.00		22, 130, 253	1, 290, 579	258, 748	1, 669, 006	96, 552	118.00
194 00	07950 PHYSICIAN PRACTICES	544, 962	0	(45, 500	0	194.00
	07951 MEDICAL OFFICE BUILDING	38, 625	0				194.01
	207952 VPCHC	0	0				194.02
200.00		Ĭ	0		0	j v	200.00
201.00			0	0	0	0	201.00
202.00	5	22, 713, 840	1, 290, 579	258, 748	1, 714, 506		202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	N: 15-1326	Peri od: From 01/01/2016 To 12/31/2016	Worksheet B Part I Date/Time Pre 5/25/2017 4:2	
Cost Center Description	DATA PROCESSI NG	PURCHASI NG RECEI VI NG AND STORES	ADMI TTI NG	CASHI ERI NG/ACC OUNTS RECEI VABLE	Subtotal	
	5.02	5.03	5.04	5.05	5A. 05	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG FIXT 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.01 00540 NONPATI ENT TELEPHONES 5.02 00550 DATA PROCESSI NG 5.03 00560 PURCHASI NG RECEI VI NG AND 5.04 00570 ADMI TTI NG S S 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE S 06 00571 ADMI NI STRATI VE AND GENERAL	2, 641, 560 0 120, 987 40, 329 262, 140	200, 678 343 0 129	748, 82	0 780, 041 0 0	2, 491, 961	1.00 2.00 4.00 5.01 5.02 5.03 5.04 5.05 5.06
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING 10.00 01000 DIETARY	524, 279 0 20, 165 60, 494	131 16, 168 12		0 0 0 0 0 0 0 0 0 0	2, 128, 342 7, 665 421, 781 214, 063	
11.00 01100 CAFETERIA 13.00 01300 NURSI NG ADMI NI STRATI ON 16.00 01600 MEDI CAL RECORDS & LI BRARY INPATI ENT ROUTI NE SERVI CE COST CENTERS	0 80, 658 161, 317	45 4 9		0 0 0 0 0 0	388, 738 936, 901 558, 240	13.00
30. 00 31. 00 31. 00 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT ANCI LLARY SERVICE COST CENTERS	221, 810 20, 165		182, 62 76, 73		2, 246, 685 1, 136, 846	30.00 31.00
50. 00 05000 OPERATI NG ROOM	80, 658	54, 155	55, 33		1, 052, 482	50. 00
51.00 05100 RECOVERY ROOM 51.01 05101 0/P TREATMENT ROOM	0 20, 165	0 12, 638	1, 79 94		82, 340 316, 173	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 56. 00 05600 RADI OL SOTOPE	20, 185 181, 481 0	12, 038 16, 697 169	67, 38 1, 90	206, 634	2, 247, 491 119, 492	54.00
60.00 06000 LABORATORY 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CE		0	88, 16 4, 67	79 1, 647	1, 132, 075 65, 184	62.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	40, 329 80, 658 0		23, 97 8, 39 2, 40	97 24, 404	737, 482 719, 481 198, 140	66.00
68.00 06800 SPEECH PATHOLOGY 69.00 06900 ELECTROCARDI OLOGY 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATHE		0 250 0	1, 26 34, 63 3, 08	58 1, 139 37 31, 561 39 802	32, 063 283, 042 90, 317	68.00 69.00 71.00
72.00 07200 I MPL. DEV. CHARGED TO PATI ENTS 73.00 07300 DRUGS CHARGED TO PATI ENTS 0UTPATI ENT SERVICE COST CENTERS	0 80, 658	0 1, 134	133, 18	0 0 37 73, 144	1, 678, 257	72.00 73.00
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT P/ SPECI AL PURPOSE COST CENTERS	0 302, 469 ART)	-	62, 28	0 0 39 198, 957	0 2, 471, 379 0	91.00
118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	2, 318, 927	199, 822	748, 82	21 775, 397	21, 756, 620	118. 00
194.00 07950 PHYSICIAN PRACTICES 194.01 07951 MEDICAL OFFICE BUILDING 194.02 07952 VPCHC 200.00 Cross Foot Adjustments	322, 633 0 0			0 4,644 0 0 0 0		
201.00Negative Cost Centers202.00TOTAL (sum lines 118-201)	0 2, 641, 560	0 200, 678	748, 82	0 0 21 780, 041		201.00

Heal th	n Financial Systems	UNI ON HOSPI T	AL CLINTON		In Lie	u of Form CMS-	2552-10
COST /	ALLOCATION - GENERAL SERVICE COSTS		Provider C	F	eriod: rom 01/01/2016	Worksheet B Part I	
					o 12/31/2016	Date/Time Pre 5/25/2017 4:2	epared:
	Cost Center Description	ADMI NI STRATI VE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
		5.06	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS		•				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540 NONPATI ENT TELEPHONES						5.01
5.02	00550 DATA PROCESSI NG						5.02
5.03	00560 PURCHASING RECEIVING AND STORES						5.03
5.04	00570 ADMI TTI NG						5.04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.05
5.06	00591 ADMI NI STRATI VE AND GENERAL	2, 491, 961					5.06
7.00	00700 OPERATION OF PLANT	262, 278	2, 390, 620)			7.00
8.00	00800 LAUNDRY & LINEN SERVICE	945	19, 558	28, 168			8.00
9.00	00900 HOUSEKEEPI NG	51, 976	18, 519				9.00
10.00	01000 DI ETARY	26, 379	44, 265			294, 104	
11.00	01100 CAFETERI A	47, 905	0	1		0	1
13.00	01300 NURSI NG ADMI NI STRATI ON	115, 455				0	
16.00		68, 792	41, 337			0	
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	00,172	11,007		0,071		10.00
30.00		276, 861	660, 815	8, 617	138, 978	206, 184	30.00
31.00		140,095				62, 899	
01.00	ANCI LLARY SERVICE COST CENTERS	110,070	17,007	2,070	1,071	02,077	01.00
50.00		129, 698	141, 017	1, 085	29, 658	0	50.00
51.00	05100 RECOVERY ROOM	10, 147	14, 220			0	
51.01	05101 0/P TREATMENT ROOM	38, 962	75, 965			25, 021	
54.00	05400 RADI OLOGY-DI AGNOSTI C	276, 961	269, 514			20,021	
56.00	05600 RADI OI SOTOPE	14, 725	12, 425			0	
60.00	06000 LABORATORY	139, 507	80, 831			0	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	8,033	00,001			0	
65.00	06500 RESPI RATORY THERAPY	90, 881	48, 376	-	-	0	
66.00	06600 PHYSI CAL THERAPY	88, 662	159, 630			0	
67.00	06700 OCCUPATI ONAL THERAPY	24, 417	134, 261	2, 437		0	
68.00	06800 SPEECH PATHOLOGY	3, 951	18, 141			0	
69.00	06900 ELECTROCARDI OLOGY	34, 880				0	
71.00		11, 130				0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	47,770	c c		0	
73.00		206, 813	47, 903			0	
73.00	OUTPATIENT SERVICE COST CENTERS	200, 813	47,903		10,075	0	73.00
90.00	09000 CLINIC	0	C	C	0	0	90.00
90.00		304, 549			-	0	
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	304, 349	374, 040	7,200	03, 042	0	92.00
92.00	SPECIAL PURPOSE COST CENTERS						92.00
118.00		2, 374, 002	2, 334, 072	28, 168	482, 883	294, 104	110 00
118.00		2, 374, 002	2, 334, 072	28, 108	482, 883	294, 104	
104 04	NONREIMBURSABLE COST CENTERS	110 100	0				104 00
		113, 199	-	-	-		194.00
	1 07951 MEDI CAL OFFI CE BUI LDI NG	4, 760	56, 548				194.01
	207952 VPCHC	0	0	C	0	0	194.02
200.00						0	200.00
201.00		0	2, 390, 620	28, 168	494, 776		201.00
202.00	0 TOTAL (sum lines 118-201)	2, 491, 961	2, 390, 620	'∣ ∠ŏ, 168	494, 776	294, 104	1202.00

COST ALLCOATION - GENERAL SERVICE COSTS Provider CCR: 15-1326 Provider CCR: 15	Health Financial Systems	UNI ON HOSPI T	AL CLINTON		In Lie	eu of Form CMS-2	2552-10
Cost Center Description CAFFTERIA ADMINISTRATION EXPENSION ADMINISTRATION ELIBRARY UESTING Subtotal ELIBRARY Deter Time Prepared: 32/5/2011 4/2 pm selection Stepdom EVERAL SERVICE COST CENTERS 11.00 13.00 16.00 24.00 25.00 100 00000 NFW CAP REL COSTS - NID. A FIXT 11.00 13.00 16.00 24.00 25.00 2.00 2.00 24.00 25.00 10.00 00000 NFW CAP REL COSTS - NID. A FIXT 10.00 10.00 00000 PRC CAP REL COSTS - NID. A FIXT 10.00 <td>COST ALLOCATION - GENERAL SERVICE COSTS</td> <td></td> <td>Provider CC</td> <td>CN: 15-1326</td> <td></td> <td></td> <td></td>	COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-1326			
Cost Center Description CAFETERIA ADMINISTRATION NURSI NC ADMINISTRATION NEEDICAL RECORDS 8 LIBORRS 8 Subtotal Subtotal Subtotal Subtotal Subtotal Subtotal Subtotal Subtotal Subtotal Subtotal Subtotal Subtotal Subtotal Subtotal							narod
Cost. Center. Description CAFETERIA AVMINISTRATION NULRISING AVMINISTRATION NULRISING RECORDS & LIBRARY Subtotal Sector Intern & Sector 1.00 13.00 16.00 24.00 30.00 4.00 30.00 0.00 00400 NEW CAP REL COSTS -MUBLC SELOU P 0.00 0.00 0.00 0.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 4.00 20.00 4.00 20.00 4.00 20.00 4.00 20.00 4.00 20.00 4.00					10 12/31/2010		
LIBRARY & Brost Stephown Adjustments 11.00 15.00 16.00 24.00 25.00 1.00 00100/NEW CAP REL COST -CENTERS 1.00 25.00 25.00 1.00 00100/NEW CAP REL COST -CENTERS 1.00 25.00 25.00 1.00 00000/NEW CAP REL COST -CENTERS 1.00 2.00 2.00 0.00000/NEW CAP REL COST -CENTERS 5.01 5.01 5.03 5.05 5.01 5.00 0550/DATA PROCESS IN 5.03 5.04 5.05 5.05 5.00 0500/DERATI (NO FEARTER) FEARTER 5.06 5.06 5.00 0500/DERATI (NO FEARTER) FEARTER 5.06 5.06 5.00 0500/DERATI (NO FEARTER) 7.00 7	Cost Center Description	CAFETERI A	NURSI NG	MEDI CAL	Subtotal		
Image: service cost centers 11 00 13 00 16.00 24.00 25.00 1.00 D0100 MPI CAP REL COST CENTERS 1.00 1.00 1.00 25.00 25.00 1.00 D0100 MPI CAP REL COST CENTERS 1.00 1.00 1.00 1.00 0.00 D0100 MPI CAP REL COST CENTERS 1.00 1.00 1.00 1.00 0.00 D0100 MPI CAP REL COST CENTERS 1.00 1.00 1.00 1.00 0.00 D0140 MONPAT IENT TELEPHONE 5.02			ADMI NI STRATI ON				
ENERGY SERVICE COST CENTERS 11.00 13.00 16.00 24.00 25.00 COMON NEY CAP REL COSTS-BLOG & FIXT 0 <td></td> <td></td> <td></td> <td>LI BRARY</td> <td></td> <td></td> <td></td>				LI BRARY			
Element SERVICE COST CENTERS 1.00 0100 NEW CAP REL COSTS-MUBLE GUIP 1.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
EXERCISE EXERCISE 1.00 OCTOON NEW CAP REL COSTS-BLDS & FIXT 1.00 2.00 OCZOON NEW CAP REL COSTS-WULE EQUIP 4.00 4.00 OVENUT CE TOSTS-BLDS & FIXT 2.00 5.01 ODS40 NON-RAT PREL COSTS-WULE EQUIP 4.00 5.02 OSS0 DATA PROCESSING 5.02 5.03 OOS60 PURCHASING RECEIVABLE 5.02 5.04 OSTO ADMITTING 5.02 5.05 OOS60 PURCHASING RECEIVABLE 5.06 5.06 OOS71 ADMINISTRATION OF PLANT 8.00 5.00 OOTOD OPENATION OF PLANT 8.00 5.00 OOTOD OPENATION OF PLANT 8.00 5.00 OOTOD OPENATION OF PLANT 4.36, 977 1.00 OITOD OWER & LIBRAY 23, 951 1.00 OITOD OWER & LIBRAY 23, 951 1.00 OOTOD OWER & LIBRAY 23, 951 1.00 OITOD OWER & LIBRAY 23, 951 1.00 OITOD OWER & LIBRAY 23, 951 1.00 OITOD OWER & LIBRAY 23, 951 1.00 OSTOD OWER &		11 00	13.00	16.00	24.00		
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71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 725 160, 265 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 25, 195 0 66, 128 2, 034, 371 0 73.00 00 09000 CLI NI C 0 0 0 0 90.00 90.00 09000 CLI NI C 0 0 0 90.00 90.00 91.00 09020 (DBSERVATI ON BEDS (NON-DI STI NCT PART) 84, 916 427, 032 179, 874 3, 952, 906 91.00 92.00 92.00 09200 (DBSERVATI ON BEDS (NON-DI STI NCT PART) 431, 684 1, 162, 895 701, 014 21, 564, 932 0 118.00 NONREL MBURSABLE COST CENTERS 194.00 07950 PHYSI CLAN PRACTI CES 5, 288 0 0 1, 037, 082 0 194.00 194.01 07951 MEDI CAL OFFICE BUI LDI NG 0 0 0 0 0 194.00		0	0	1, 02	29 58, 999	0	68.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 25,195 0 66,128 2,034,371 0 73.00 0UTPATIENT SERVICE COST CENTERS 0 0 0 0 0 0 90.00 90.00 09000 CLINIC 0 0 0 0 90.00 90.00 91.00 09200 DBSERVATION BEDS (NON-DISTINCT PART) 84,916 427,032 179,874 3,952,906 0 91.00 92.00 92.00 DBSERVATION BEDS (NON-DISTINCT PART) 431,684 1,162,895 701,014 21,564,932 0 118.00 NONREL MBURSABLE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) 431,684 1,162,895 701,014 21,564,932 0 194.00 194.01 07950 PHYSI CI AN PRACTICES 5,288 0 0 1,037,082 0 194.00 194.02 07951 MEDI CAL OFFICE BUI LDI NG 0 0 0 0 194.00 194.02<		7, 258	0	28, 53			
73. 00 DRUGS CHARGED TO PATIENTS 25, 195 0 66, 128 2, 034, 371 0 73. 00 0UTPATIENT SERVICE COST CENTERS 0				72			
OUTPATI ENT SERVICE COST CENTERS 0 0 0 0 0 0 0 0 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 91.00 92.0			-			-	
90. 00 09000 CLINIC 0 0 0 0 0 90. 00 91. 00 09100 EMERGENCY 84, 916 427, 032 179, 874 3, 952, 906 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0 20.00 92. 00 SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1-117) 431, 684 1, 162, 895 701, 014 21, 564, 932 0 118. 00 NONREI MBURSABLE COST CENTERS 194. 00 07950 PHYSI CI AN PRACTI CES 5, 288 0 0 1, 037, 082 0 194. 00 194. 01 07950 MEDI CAL OFFICE BUILDING 0 0 0 0 111, 826 0 194. 01 194. 02 07952 VPCHC 0 </td <td></td> <td>25, 195</td> <td>0</td> <td>66, 12</td> <td>28 2,034,371</td> <td>0</td> <td>73.00</td>		25, 195	0	66, 12	28 2,034,371	0	73.00
91.00 09100 EMERGENCY 84,916 427,032 179,874 3,952,906 91.00 92.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 92.00 92.00 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) 431,684 1,162,895 701,014 21,564,932 0 118.00 NONREI MBURSABLE COST CENTERS 194.00 07950 PHYSI CI AN PRACTI CES 5,288 0 0 1,037,082 0 194.00 194.01 07950 PHYSI CI AL OFFICE BUILDING 0 0 0 1111,826 0 194.00 194.02 07952 VPCHC 0 0 0 0 194.02 200.00 Cross Foot Adjustments 0 0 0 0 0 200.00 201.00 Negative Cost Centers 0 <		0			0 0	0	
92.00 OP200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) 431,684 1,162,895 701,014 21,564,932 0 118.00 NONREI MEURSABLE COST CENTERS 194.00 07950 PHYSI CI AN PRACTI CES 5,288 0 0 1,037,082 0 194.00 194.01 07951 MEDI CAL OFFICE BUI LDI NG 0 0 0 1111,826 0 194.01 194.02 07952 VPCHC 0 0 0 194.02 0 0 0 194.02 200.00 Cross Foot Adjustments 0 0 0 0 0 200.00 0 201.00 201.00 Negative Cost Centers 0 0 0 0 0 0 201.00				170 07			
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) 431,684 1,162,895 701,014 21,564,932 0 118.00 NONRELIMBURSABLE COST CENTERS 0 0 1,037,082 0 194.00 194.00 07950 PHYSI CI AN PRACTICES 5,288 0 0 1111,826 0 194.01 194.01 07951 MEDI CAL OFFICE BUI LDI NG 0 0 0 114.00 194.02 07952 VPCHC 0 0 0 194.02 200.00 Cross Foot Adjustments 0 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 201.00		04, 710	427,032	177,07	4 3, 932, 900		
I18.00 SUBTOTALS (SUM OF LINES 1-117) 431,684 1,162,895 701,014 21,564,932 0 118.00 NONREI MBURSABLE COST CENTERS 5,288 0 0 1,037,082 0 194.00 194.01 07950 PHYSI CI AN PRACTICES 5,288 0 0 111,826 0 194.00 194.02 07950 VPCHC 0 0 0 194.00 194.01 194.02 07952 VPCHC 0 0 0 194.02 0 194.02 0 194.02 0 0 0 194.02 0 194.02 0 0 0 194.02 0 194.02 0 194.02 0 0 0 194.02 0 0 0 194.02 0						0	72.00
NONREI MBURSABLE COST CENTERS 194.00 07950 PHYSI CI AN PRACTICES 5,288 0 0 1,037,082 0 194.00 194.01 07951 MEDI CAL OFFICE BUILDING 0 0 0 111,826 0 194.01 194.02 07952 VPCHC 0 0 0 194.02 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 201.00		431,684	1, 162, 895	701 01	4 21, 564 932	0	118.00
194.00 07950 PHYSI CI AN PRACTICES 5, 288 0 0 1, 037, 082 0 194.00 194.01 07951 MEDI CAL OFFICE BUILDING 0 0 0 111, 826 0 194.01 194.02 07952 VPCHC 0 0 0 0 194.02 200.00 Cross Foot Adjustments 0 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 201.00			., 102, 070				
194. 01 07951 MEDI CAL OFFICE BUILDING 0 0 111, 826 0 194. 01 194. 02 07952 VPCHC 0 0 0 0 194. 02 200. 00 Cross Foot Adjustments 0 0 0 0 0 200. 00 201. 00 Negative Cost Centers 0 0 0 0 0 0 201. 00		5, 288	0		0 1, 037, 082	0	194.00
200.00 Cross Foot Adjustments 0 0 200.00 201.00 Negative Cost Centers 0	194.0107951 MEDICAL OFFICE BUILDING	0	1 1		0 111, 826	0	194.01
201.00 Negative Cost Centers 0 </td <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td></td> <td></td>		0	0		0 0		
					0		
202.00 101AL (sum lines 118-201) 436,972 1,162,895 701,014 22,713,840 0 202.00		0	0		0 0		
	202.00 101AL (sum línes 118-201)	436, 972	1, 162, 895	701, 01	4 22, 713, 840	0	202.00

Health Financial Systems	UNI ON HOSPI TAL	CLINTON	In Lieu	of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-1326	Peri od:	Worksheet B
			From 01/01/2016	Part I
			To 12/31/2016	Date/Time Prepared: 5/25/2017 4:22 pm
Cost Center Description	Total			
	26.00			
GENERAL SERVICE COST CENTERS				
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01 00540 NONPATI ENT TELEPHONES				5. 01
5. 02 00550 DATA PROCESSI NG				5.02
5.03 00560 PURCHASING RECEIVING AND STORES				5.03
5. 04 00570 ADMI TTI NG				5.04
5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE				5.05
5. 06 00591 ADMI NI STRATI VE AND GENERAL				5.06
7.00 00700 OPERATION OF PLANT				7.00
8.00 00800 LAUNDRY & LINEN SERVICE				8.00
9.00 00900 HOUSEKEEPI NG				9.00
10. 00 01000 DI ETARY				10.00
11. 00 01100 CAFETERIA				11.00
13.00 01300 NURSING ADMINISTRATION				13.00
16.00 01600 MEDI CAL RECORDS & LI BRARY				16.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS	4, 101, 044			30.00
31. 00 03100 I NTENSI VE CARE UNI T	1, 665, 360			31.00
ANCI LLARY SERVI CE COST CENTERS				
50. 00 05000 OPERATING ROOM	1, 418, 217			50.00
51.00 O5100 RECOVERY ROOM	115, 054			51.00
51.01 05101 0/P TREATMENT ROOM	554, 775			51.01
54.00 05400 RADI OLOGY-DI AGNOSTI C	3, 096, 004			54.00
56. 00 05600 RADI 0I SOTOPE	155, 727			56.00
60. 00 06000 LABORATORY	1, 457, 503			60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	74, 706			62.00
65. 00 06500 RESPI RATORY THERAPY	924, 493			65.00
66. 00 06600 PHYSI CAL THERAPY	1, 025, 849			66.00
67.00 06700 OCCUPATIONAL THERAPY	391, 581			67.00
68.00 06800 SPEECH PATHOLOGY	58, 999			68.00
69. 00 06900 ELECTROCARDI OLOGY	378, 078			69.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	160, 265			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0			72.00
73.00 O7300 DRUGS CHARGED TO PATIENTS	2,034,371			73.00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLINIC	0			90.00
91.00 09100 EMERGENCY	3, 952, 906			91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)				92.00
SPECIAL PURPOSE COST CENTERS	01 E(4 000			110.00
118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	21, 564, 932			118.00
194. 00 07950 PHYSI CI AN PRACTI CES	1 027 002			104 00
194.00/07950 PHYSICIAN PRACTICES 194.01/07951 MEDICAL OFFICE BUILDING	1,037,082			194. 00 194. 01
194.02 07952 VPCHC	111, 826			194.01
	0			200.00
	0			200.00
201.00Negative Cost Centers202.00TOTAL (sum lines 118-201)	22, 713, 840			201.00
202.00 10TAL (SUII TITIES 110-201)	22,713,040			1202.00

Health Financial Systems	UNI ON HOSPI TA	AL CLINTON		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-1326	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Pre 5/25/2017 4:2	pared:
		CAPI TAL REL	ATED COSTS		0,20,201, 112	
Cost Center Description	Directly Assigned New Capital Related Costs	NEW BLDG & FIXT	NEW MVBLE EQUI P	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
	0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.01 00540 NONPATI ENT TELEPHONES 5.02 00550 DATA PROCESSI NG	0 0 0	0 1, 725 3, 368	20, 1 2!		0 0 0	5.01
5. 03 00560 PURCHASING RECEIVING AND STORES	0	13, 122	12, 51		0	
5. 04 00570 ADMI TTI NG 5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	8, 361 4, 944	68	34 9, 045 0 4, 944	0	
5. 06 00591 ADMINI STRATI VE AND GENERAL	0	24, 453	10, 14		0	
7.00 00700 OPERATION OF PLANT	0	356, 447	8, 25		0	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	0	6, 868		56 7, 324	0	
9.00 00900 HOUSEKEEPING	0	6, 503	2, 10		0	
10. 00 01000 DI ETARY	0	15, 545	1, 80		0	
11. 00 01100 CAFETERIA 13. 00 01300 NURSING ADMINISTRATION	0	58, 512 22, 927	7,0	15 65, 527 18 23, 475	0	
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	14, 516		14, 756	0	
INPATIENT ROUTINE SERVICE COST CENTERS	0	14, 510	2	14,750	0	10.00
30. 00 03000 ADULTS & PEDI ATRI CS	0	232, 057	21, 5	76 253, 633	0	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	6, 802	36, 2	43, 073	0	31.00
ANCILLARY SERVICE COST CENTERS	1 1					
50. 00 05000 OPERATING ROOM	0	49, 520	29, 19		0	
51.00 05100 RECOVERY ROOM	0	4, 993	5		0	
51. 01 05101 0/P TREATMENT ROOM 54. 00 05400 RADI 0LOGY-DI AGNOSTI C	0	26, 676 94, 644	2, 30 64, 49		0	
56. 00 05600 RADIOLOGI - DI AGNOSTI C	0	4, 363	04, 4	0 4, 363	0	
60. 00 06000 LABORATORY	0	28, 385		0 28, 385	0	1
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	20,000		0 0	0	
65. 00 06500 RESPI RATORY THERAPY	0	16, 988	17, 54	40 34, 528	0	1
66. 00 06600 PHYSI CAL THERAPY	0	56, 057	1, 70	06 57, 763	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	47, 148		7 47, 155	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	6, 370		0 6, 370	0	
69. 00 06900 ELECTROCARDI OLOGY	0	6, 951	4, 8		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	16, 855		0 16,855	0	
73. 00 07200 DRUGS CHARGED TO PATIENTS	0	16, 822	1, 14	0	0	1
OUTPATIENT SERVICE COST CENTERS	0	10, 022	1, 1.	17, 705	0	1 / 3. 00
90. 00 09000 CLINIC	0	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0	138, 657	14, 7 ⁻	17 153, 374	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117)	0	1, 290, 579	258, 74	1, 549, 327	0	118.00
NONREI MBURSABLE COST CENTERS	0	1, 290, 379	230, 74	1, 549, 527	0	1118.00
194.0007950 PHYSI CLAN PRACTI CES	0	0		0 0		194.00
194. 01 07951 MEDICAL OFFICE BUILDING	0	0		0 0		194.01
194. 02 07952 VPCHC	0	0		0 0	0	194.02
200.00Cross Foot Adjustments201.00Negative Cost Centers		0		0	_	200. 00 201. 00
201.00 Negative cost centers 202.00 TOTAL (sum lines 118-201)	0	0 1, 290, 579	258, 74	48 1, 549, 327		201.00
	, si	. =	,	, ,		

Heal th	Financial Systems	UNI ON HOSPI T	AL CLINTON		In Lie	u of Form CMS-	2552-10
ALLOCA	ATION OF CAPITAL RELATED COSTS		Provider C	F	Period: From 01/01/2016 To 12/31/2016		
	Cost Center Description	NONPATI ENT TELEPHONES	DATA PROCESSI NG	PURCHASI NG RECEI VI NG AND STORES		CASHI ERI NG/ACC OUNTS RECEI VABLE	
		5.01	5.02	5.03	5.04	5.05	
	GENERAL SERVICE COST CENTERS	· · · · ·					
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540 NONPATI ENT TELEPHONES	21, 899					5.01
5.02	00550 DATA PROCESSI NG	252	3, 876	,			5.02
5.03	00560 PURCHASING RECEIVING AND STORES	168	C	25, 806	5		5.03
5.04	00570 ADMI TTI NG	503	178	44	4 9, 770		5.04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	336	59	(0 0	5, 339	5.05
5.06	00591 ADMI NI STRATI VE AND GENERAL	1, 259	385		7 0	0	
7.00	00700 OPERATION OF PLANT	1, 762	769			0	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0			0	
9.00	00900 HOUSEKEEPI NG	84	30		9 0	0	
10.00	01000 DI ETARY	84	89		2 0	0	
11.00	01100 CAFETERI A	503	0		-	0	1
13.00	01300 NURSI NG ADMI NI STRATI ON	336	118			0	
16.00	01600 MEDICAL RECORDS & LIBRARY	755	237	-	0	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	1		1			
30.00	03000 ADULTS & PEDIATRICS	6, 124	325			300	
31.00	03100 I NTENSI VE CARE UNI T	503	30	2, 139	9 1,001	99	31.00
50.00	ANCI LLARY SERVI CE COST CENTERS	587	118	6, 963	3 722	327	50.00
50.00	05100 RECOVERY ROOM	168				13	
51.00	05101 0/P TREATMENT ROOM	923	30			77	51.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	923 1, 175	266			1, 386	
56.00	05600 RADI OLOGI - DI AGNOSTI C	84	200		÷	49	
60.00	06000 LABORATORY	420	30			672	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	420	0			11	62.00
65.00	06500 RESPIRATORY THERAPY	587	59			48	
66.00	06600 PHYSI CAL THERAPY	923	118			168	1
67.00	06700 OCCUPATI ONAL THERAPY	671	0			50	1
68.00	06800 SPEECH PATHOLOGY	168	0			8	
69.00	06900 ELECTROCARDI OLOGY	420	0	32		218	
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	84	0	(6	1
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	(0	1
73.00	07300 DRUGS CHARGED TO PATIENTS	503	118	146	1,737	504	
	OUTPATIENT SERVICE COST CENTERS				· · · · ·		
90.00	09000 CLI NI C	0	0	(0 0	0	90.00
91.00	09100 EMERGENCY	2, 517	444	6, 434	1 813	1, 371	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
118.00		21, 899	3, 403	25, 696	9, 770	5, 307	118.00
	NONREI MBURSABLE COST CENTERS	1 1					
	07950 PHYSI CI AN PRACTI CES	0	473	1			194.00
	07951 MEDICAL OFFICE BUILDING	0	0		°		194.01
	207952 VPCHC	0	C	(0 0	0	194.02
200.00	5	_	-			-	200.00
201.00		0					201.00
202.00) TOTAL (sum lines 118-201)	21, 899	3, 876	25, 806	9, 770	5, 339	202.00

	Financial Systems	UNI ON HOSPI T				u of Form CMS-	2552-10
ALLOC	ATION OF CAPITAL RELATED COSTS		Provider C	F	eriod: rom 01/01/2016 o 12/31/2016	Worksheet B Part II Date/Time Pre 5/25/2017 4:2	pared:
	Cost Center Description	ADMI NI STRATI VE AND GENERAL	PLANT	LAUNDRY & LI NEN SERVI CE	HOUSEKEEPI NG	DI ETARY	
	GENERAL SERVICE COST CENTERS	5.06	7.00	8.00	9.00	10.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT			1			1.00
2.00	00200 NEW CAP REL COSTS-BEDG & TTXT						2.00
2.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
4.00 5.01	005400 NONPATIENT TELEPHONES						5.01
5.01	00550 DATA PROCESSING						5.02
5.02	00560 PURCHASING RECEIVING AND STORES						5.02
5.03	00570 ADMI TTI NG						5.03
5.04	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.04
5.05	00591 ADMI NI STRATI VE AND GENERAL	36, 261					5.05
5.08 7.00	00700 OPERATION OF PLANT	3, 816	371, 048				7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	14	3, 036 2, 874				8.00
							9.00
10.00	01000 DI ETARY	384	6, 870			25, 162	
11.00		697	, o	1		0	
13.00	01300 NURSI NG ADMI NI STRATI ON	1, 680				0	
16.00	01600 MEDI CAL RECORDS & LI BRARY	1,001	6, 416	C	271	0	16.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	4.020	100 5/7	0.170	4 220	17 (40	1 20 00
30.00	03000 ADULTS & PEDIATRICS	4, 028				17,640	
31.00	03100 I NTENSI VE CARE UNI T ANCI LLARY SERVI CE COST CENTERS	2,038	3,006	995	127	5, 381	31.00
50.00	05000 OPERATING ROOM	1, 887	21, 887	400	926	0	50.00
51.00	05100 RECOVERY ROOM	148				0	
51.00	05101 0/P TREATMENT ROOM	567	11, 790			2, 141	
54.00	05400 RADI OLOGY-DI AGNOSTI C	4,030				2,141	1
54.00	05600 RADI OLOGI - DI AGNOSTI C	214	1, 928			0	
60.00	06000 LABORATORY	2,030	12, 546			0	1
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	117	12, 340			0	
65.00	06500 RESPI RATORY THERAPY	1, 322	7, 508		-	0	
66.00	06600 PHYSI CAL THERAPY	1, 322				0	
67.00	06700 OCCUPATI ONAL THERAPY	355	20, 839			0	
68.00	06800 SPEECH PATHOLOGY	57	2,816			0	
69.00	06900 ELECTROCARDI OLOGY	507	3, 072			0	
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	162	7, 450			0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	,, 430	c c		0	
73.00	07300 DRUGS CHARGED TO PATIENTS	3,009	7,435			0	
/ 5. 00	OUTPATIENT SERVICE COST CENTERS	3,007	1,400		514	0	/ 5. 00
90.00	09000 CLINIC	0	C	C	0	0	90.00
91.00	09100 EMERGENCY	4,436			-	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,100	0.,20.	2,001	2,072	0	92.00
72.00	SPECIAL PURPOSE COST CENTERS				1		1 /2:00
118.00		34, 545	362, 271	10, 391	15, 073	25, 162	118.00
	NONREI MBURSABLE COST CENTERS						
194.00	07950 PHYSI CI AN PRACTI CES	1,647	C	C	0	0	194.00
	1 07951 MEDICAL OFFICE BUILDING	69	8, 777				194.01
	2 07952 VPCHC	0	C				194.02
200.00						-	200.00
201.00	5	0	c	C	0	0	201.00
202.00	5	36, 261	371, 048	10, 391	15, 444		202.00
						, 102	1 : 00

Heal th	Financial Systems	UNI ON HOSPI T	AL CLINTON		In Lie	eu of Form CMS-2	2552-10
	TION OF CAPITAL RELATED COSTS		Provider CC		Period: From 01/01/2016 To 12/31/2016		
	Cost Center Description		NURSI NG ADMI NI STRATI ON	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	GENERAL SERVICE COST CENTERS	11.00	13.00	16.00	24.00	25.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		1				1.00
2.00	00200 NEW CAP REL COSTS-BEBU & TTXT						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
4.00 5.01	00540 NONPATI ENT TELEPHONES						5.01
5.02	00550 DATA PROCESSI NG						5.02
5.02	00560 PURCHASING RECEIVING AND STORES						5.02
5.04	00570 ADMI TTI NG						5.04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.05
5.06	00591 ADMI NI STRATI VE AND GENERAL						5.06
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A	66, 854					11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	4, 822	40, 993				13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	3,664	0	27, 10	1		16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						1
30.00	03000 ADULTS & PEDIATRICS	13, 285	15, 396	1, 52	427, 994	0	30.00
31.00	03100 I NTENSI VE CARE UNI T	7,265	8, 423	50	0 74, 580	0	31.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	3, 268		1, 65			50.00
51.00	05100 RECOVERY ROOM	563			5 8, 845	0	51.00
51.01	05101 0/P TREATMENT ROOM	1, 896	2, 121	39	1 51, 115	0	51.01
54.00	05400 RADI OLOGY-DI AGNOSTI C	8, 566	1	7,22			54.00
56.00	05600 RADI OI SOTOPE	0	-	25			56.00
60.00	06000 LABORATORY	0	-	3,40			60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	-		8 247		62.00
65.00	06500 RESPI RATORY THERAPY	4, 759	1	24			65.00
66.00	06600 PHYSI CAL THERAPY	0	-	85			66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	25			67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0 9, 595		68.00
69.00	06900 ELECTROCARDI OLOGY	1, 110	1	1, 10			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			24, 940		71.00
72.00 73.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0 3, 855	-		0 0	-	72.00 73.00
73.00	OUTPATIENT SERVICE COST CENTERS	3, 600	<u> </u>	2, 55	6 38, 142	0	/3.00
90.00	09000 CLINIC	0	0		0 0	0	90.00
90.00 91.00	09100 EMERGENCY	12, 992		6, 95			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	12, 772	15,055	0, 75	270, 744	0	92.00
72.00	SPECIAL PURPOSE COST CENTERS					0	72.00
118.00		66, 045	40, 993	27, 10	1, 537, 039	0	118.00
110.00	NONREIMBURSABLE COST CENTERS	00,040	40, 773	27,10	1, 337, 037	0	1.10.00
194 00	07950 PHYSI CI AN PRACTI CES	809	0		0 3, 071	0	194.00
	07951 MEDICAL OFFICE BUILDING	007	1		0 9, 217		194.00
	07952 VPCHC		-		0 0		194.02
200.00		Ĭ			0		200.00
201.00		0	0		0 0		201.00
202.00		66, 854	40, 993	27, 10	1, 549, 327		202.00
				,			

Health Financial Systems	UNI ON HOSPI TA	L CLINTON	In Lieu of Form CMS	-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-1326	Period: Worksheet B From 01/01/2016 Part II	
			To 12/31/2016 Date/Time Pr	
Cost Center Description	Total		5/25/2017 4:	22 pm
cost center bescription	26.00			
GENERAL SERVICE COST CENTERS				
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5. 01 00540 NONPATI ENT TELEPHONES				5.01
5. 02 00550 DATA PROCESSI NG				5.02
5. 03 00560 PURCHASING RECEIVING AND STORES				5.03
				5.04
5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE				5.05
5. 06 00591 ADMINI STRATI VE AND GENERAL 7. 00 00700 OPERATI ON OF PLANT				5.06 7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG				8.00 9.00
10. 00 01000 DI ETARY				9.00
				11.00
				13.00 16.00
16. 00 01600 MEDICAL RECORDS & LIBRARY				10.00
	427, 994			20.00
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T	427, 994 74, 580			30.00 31.00
ANCI LLARY SERVICE COST CENTERS	74, 580			31.00
50. 00 05000 OPERATING ROOM	117, 456			50.00
51. 00 05100 RECOVERY ROOM	8, 845			51.00
51.01 05101 0/P TREATMENT ROOM	51, 115			51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	229, 356			54.00
56. 00 05600 RADI 0I SOTOPE	7, 017			56.00
60. 00 06000 LABORATORY	49, 169			60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS				62.00
65. 00 06500 RESPI RATORY THERAPY	50, 438			65.00
66. 00 06600 PHYSI CAL THERAPY	88,007			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	70, 234			67.00
68. 00 06800 SPEECH PATHOLOGY	9, 595			68.00
69. 00 06900 ELECTROCARDI OLOGY	18, 960			69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS				71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	38, 142			73.00
OUTPATIENT SERVICE COST CENTERS	00,112			/ 0.00
90. 00 09000 CLINIC	0			90.00
91. 00 09100 EMERGENCY	270, 944			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,0,,			92.00
SPECIAL PURPOSE COST CENTERS				
118.00 SUBTOTALS (SUM OF LINES 1-117)	1, 537, 039			118.00
NONREI MBURSABLE COST CENTERS	,,,			-
194. 00 07950 PHYSI CI AN PRACTI CES	3,071			194.00
194.01 07951 MEDICAL OFFICE BUILDING	9, 217			194.01
194. 02 07952 VPCHC	0			194.02
200.00 Cross Foot Adjustments	0			200.00
201.00 Negative Cost Centers	0			201.00
202.00 TOTAL (sum lines 118-201)	1, 549, 327			202.00
	, , ,			

GGS1 ALLCATION STATISTICAL BRANCE Provider CAL	Health Financial Systems	UNI ON HOSPI TA	AL CLINTON		In Lie	u of Form CMS-:	2552-10
Cost Center Description CAPITAL RELATE COSTS Having F Having F Having F Cost Center Description Nº BILOS & ISUN TO SUMMERS (SUM) Nº BILOS & SUMMERS (SUM) Having F BALA BALA Cost Center Description 1:00 2:00 4:00 5:01 5:02 1:00 0:000 (NPB CALES) 0:0100 (NPB CALES) 0:000 (NPB CALES) 5:01 5:02 1:00 0:000 (NPB CALES) 0:000 (NPB CALES) 0:000 (NPB CALES) 0:000 (NPB CALES) 1:00 0:000 (NPB CALES) 1:00 0:000 (NPB CALES) 1:00 0:000 (NPB CALES) 1:00 1:00 0:000 (NPB CALES) 0:000 (NPB CALES) 0:000 (NPB CALES) 1:00 1:00 0:000 (NPB CALES) 0:	COST ALLOCATION - STATISTICAL BASIS		Provider CC	CN: 15-1326		Worksheet B-1	
Cost Center Description Image: CAPTRL RELATED COSTS EMPLOYE EMPLOYE MONATI ENT ENT (S0 TT) OWNER (S0 TT) Image: CAPTRL (ELEVER) MONATI ENT (S0 TT) MONATI ENT (Date/Time Pre	pared:
FIXT (SD FT) EQUIP (SD FT) EQUIP (SD FT) EQUIP (SD FT) ELEMPTORES (PROUSS) PROCESS to (DEVICES) 0 1:00 2:00 54.05 5:01 5:01 0 0:0000 50.01 50.01 5:01 5:01 0 0:0000 0:0000 50.01 5:01 5:01 2:00 0:00000 0:0000 0:0000 0:0000 2:00 5:00 2:00 2:00 5:00 0:0000 2:00 5:00 0:0000 0:000 0:0000 0:0000 0:0000 0:0000 0:0000 0:0000 0:0000 0:0000 0:0000 0:0000 0:0000 0:0000 0:0000 0:0000 0:0000 0:0000 0:0000 0:0000		CAPI TAL REL	ATED COSTS			572572017 4.2	
CSD FT) FEDURAL SERVICE (OST CKNTERS 1.00 2.00 4.00 5.01 5.02 1.00 2.00 4.00 5.01 5.01 5.02 1.00 2.00 4.00 5.01 5.02 2.00 0.0000 INT CAP REL COSTS-MULE CONTS-MULE SOLP 77.744 2 2.00 2.00 0.0000 ONPATILIT TELEPIONES 1.00 2.00 2.00 0.0000 ONPATILIT TELEPIONES 1.00 4.00 5.01<	Cost Center Description	NEW BLDG &	NEW MVBLE	EMPLOYEE	NONPATI ENT	DATA	
Description Description Section Section Section 1.00 2.00 4.00 5.01 5.02 1.00 2.00 4.00 5.01 5.02 1.00 0.000,0180 CAP REL COSTS-BUCE A FIXT 77,794 255,312 0.000,056 4.00 0.000,001,001,0120,000,000 0.001,000,000 0.001,000,000 0.001,000,000 4.00 0.000,000,001,000,000,000,000,000,000,00							
I.OO SALARLESS I.OO S.O.D S.O.D DENERAL SERVICE COST CENTERS 1.00 2.00 4.00 5.01 5.02 DO DOTOO NEW CAP REL COSTS-MULE EQUIP 0 2.00 3.01 5.01		(SU FI)			(PHUNES)	(DEVICES)	
Denkeral SERVICE COST CENTERS 1.00 1.00 OCTOOR NEW CAP REL COSTS-BLOG & FIXT 77.74 25.312 0.00 2.00 0.00 2.01 2.00 0.00 2.01 2.00 2.00 2.01 2.00 0.00 <td></td> <td>1.00</td> <td>-</td> <td>SALARI ES)</td> <td>5.01</td> <td>5.00</td> <td></td>		1.00	-	SALARI ES)	5.01	5.00	
1.00 ORTON NEW CAP REL COSTS-HIDLE & FLYT 77,794 1.00 2.00 ORZON NEW CAP REL COSTS-HUDLE FORMULENT 0 0 8,080,050 4.00 0.10 ORSON DAVATELENT TELEMEMNES 100 17,900 253,30 0,3 131,500 0.00 ORSON DATA PROCESSING 203 253 0 3 131,500 0.00 ORSON DATA PROCESSING 200 253,00 3 131,500 0.00 ORSON DATA PROCESSING 200 253,00 3 131,500 0.00 ORSON DATA PROCENTING FERETIVABLE 296 670,072,073 21 26,700 0.00 ORSON DATA PROCENTING FERENCE 446,814 377,073 21 26,700 0.00 ORSON DITTARY 392 2,167 223,268 1 1,900 0.00 ORSON DITTARY 3,527 6,922 244,920 6 0 11,000 0.00 ORSON DITTARY 3,527 6,922 246,920 6 11,100 13,000 0.10.00	GENERAL SERVICE COST CENTERS	1.00	2.00	4.00	5.01	5.02	
4.00 00400 EMPLOYE BENEFITS DEPARTMENT 0 0 8.000,05 2.41 4.00 5.01 D0550 DATA PROCESS NG 2.03 2.53 0 3 1.31 5.02 5.02 D0550 DATA PROCESS NG 2.03 0.53 0.54 0.5.03 5.03 0.560 0.5.03 5.03 0.560 2.14.07 4 2.5.05 5.03 5.00 D0570 DANI TITING CASH ER NGACCOUNTS RECEIVABLE 2.98 0 2.14.07 4 2.5.05 5.00 D0570 DANI TITATIVE AND CENERAL 1.4.74 10.0.12 6.30,06 1.5 1.3 5.06 0.000000 DERATION OF PLANT ELANS S.5.77 1.2.35,06 1.1 9 0.0 0.0000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.00000000000000000000000000000000000	1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	77, 794					
5. 01 ODS40 NONPAT LENT TELEPHONES 104 19, 906 0 2ct 5. 00 5. 02 ODS50 DATA PROCESSING 203 2.5. 33 0 3 131 5. 02 5. 03 ODS50 PURCIASING RECEIVABLE 208 0 21, 407 4 25 5. 04 5. 04 ODS50 PURCIASING RECEIVABLE 208 0 21, 407 4 25 5. 04 5. 06 OOS90 LAMERY & LINE AND GENERAL 1, 474 10, 012 639, 069 15 13 5. 06 0.00 ODCOOL OPERATION OF PLANT 21, 466 8. 141 379, 087 21 26 7. 00 0.00 ODCOOL OPERATION OF PLANT 3. 527 6. 922 248, 920 6 0 11. 00 0.1000 OUT CATERY BUG 3. 557 6. 922 248, 920 6 0 11. 00 11.00 OTOSOL OFFICIAL TECOST CENTER 8. 13, 988 21, 284 720, 141 9 8 10. 00 10. 00 10. 00 10. 00 10. 00		0		9 090 OF	0		
5.02 00550 DATA PROCESSING 203 253 0 3 131 5.02 5.03 00550 DORTIASING RECEIVING AND STORES 791 12.330 0 2 0 5.04 5.04 00570 ADMINITING Control Control 5.04 6.75 449,170 6 6 5.04 5.06 00500 ADMINISTRATIVE AND GENERAL 1.474 10.012 6.39,069 15 13 5.06 0.00 000000 DIVENALING RECIVING AND INTRATIVE AND GENERAL 1.474 40.012 2.39,069 15 7.00 8.00 000000 0.00 <td></td> <td>-</td> <td>0</td> <td>8,080,05</td> <td></td> <td></td> <td></td>		-	0	8,080,05			
5. 04 00570 AUM IT IN INC 5. 04 6. 75 449, 170 6 6 5. 04 5. 05 0.05 0.0570 AUM IN STRATIVE AND CENERAL 1, 474 10, 012 639, 069 15 13 5 66 0.00 0.00000 DUBLED CALL 1, 474 10, 012 639, 069 15 13 5 66 0 <td></td> <td></td> <td></td> <td></td> <td>0 3</td> <td></td> <td></td>					0 3		
5. 65 00580 CASH LERN NCACCOUNTS RECEIVABLE 298 0 21,407 4 2 5. 65 5. 66 00570 OPERATION OF PLANT 21,426 639,089 15 13 5. 06 0.00 00000 OPERATION OF PLANT 21,426 639,089 1 1 9,00 0.00 00000 HOUSEKEPING 392 2,167 223,688 1 1 9,00 0.10 01000 CAFETERIA 3,527 6,922 246,920 6 0 11.00 13.00 0100 CAFETERIA 3,527 6,922 248,920 6 11.10 1 1 1 1 0 1 1 0 0 1 1 0 0 0 0 0 1 1 0 0 0 0 1 1 1 0 0 1 1 0 0 0 1 1 0 0 1 1 0 0 0 1 0 0 <t< td=""><td></td><td></td><td></td><td>110 17</td><td>0 2</td><td></td><td></td></t<>				110 17	0 2		
7. 00 00700 (PERATION OF PLANT 21,486 8,141 379,087 21 26 7.00 8. 00 00800 (ANDRY & LINEN SERVICE 414 450 0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
8. 00 000800 LANDRY & LINEN SERVICE 1414 1450 0							
9.00 00000 HOUSKEEPING 392 2.167 223.688 1 1 9.00 11.00 01100 (AFETRIA 3.527 6.922 248.920 6 0 11.00 13.00 01300 (NURSI NG ADMINI STRATION 1.382 541 536.347 4 4 13.00 13.00 01300 (NURSI NG ADMINI STRATION 1.382 5741 573.53.47 4 4 13.00 10.00 01400 NURSI NG ADMINI STRATION 1.382 5741 53.00 6.99.773 73 11 30.00 31.00 03000 OPERATI NG NOOM 2.985 28.804 294.656 7 4 50.00 51.00 05100 RECOVERY ROM 301 56.4 56.26 2 51.01 54.00 05400 RADI OLGY-DI AGNOSTIC 5,705 63.363 680.012 14 9 54.00 65.00 06600 LABORATORY 1,711 0 0 1 56.00 66.00 06600 LABORATORY 1,711 0 0 1<				379, 08			
11.00 01100 CAFETERIA 3, 527 6, 922 248, 920 6 0 11.00 13.00 01600 NURSING ADMINISTRATION 13, 322 5241 556, 347 4 4 13.00 16.00 01600 MEDICAL RECORDS & LIBRARY 875 237 210, 141 9 8 6.00 10.00 03000 AULTS & PEDIATRICS 13, 908 21, 289 1, 089, 173 73 11 31.00 31.00 03000 INTERSI VE CARE UNIT 410 35, 789 716, 446 6 1 31.00 50.00 DESCODO PERATING ROOM 2, 985 28, 804 294, 656 7 4 50.00 51.00 DSCODO RECOVERY ROOM 3.01 564 56, 226 2 0 51.00 51.00 DSCODO RADI CROTORY ROOM 1, 608 2, 338 601, 012, 079 144 9 54.00 56.00 DSCODO RESPI RATON ROOM 1, 608 2, 338 60, 012 11.00 0 56.00 50.00 DSCODO RESPI RATONE ROOM 1, 024 17, 171 0				223, 68	-	-	
13.00 01300 NURSI NG ADMINISTRATION 1,382 541 556,347 4 4 1 30.00 10.00 1600 01600 MEDICAL RECORDS & LIBRARY 875 237 210,141 9 8 16.00 0.00 03000 AURTS & FOLIATRI COST CENTERS 9 1.009,172 73 11 30.00 0.01 03000 AURCI LLARY SERVICE COST CENTERS 9 8 20,00 716,446 6 31.00 0.01 05100 OSCIOQ (PERATI NG ROOM 2,985 28,804 294,656 7 4 50.00 51.00 05100 RECOVERY ROOM 301 564 56,226 2 0 51.00 54.00 05400 RADI LOGY-DI AGNOSTIC 5,705 63,63 680.012 114 9 54.00 56.00 660.00 60.00 660.00 60.00 60.00 62.00 62.00 62.00 62.00 62.00 62.00 62.00 62.00 62.00 62.00 62.00 62.00 62.00 62.00 62.00 62.00 62.00 62.0						-	
16.00 Ord600 MEDICAL RECORDS & LIBRARY 875 237 210,141 9 8 16.00 10 03000 ADULTS & PEDIATRICS 13,968 21,289 1,089,173 73 11 30.00 30.00 03000 INTENSIVE CARE UNIT 410 35,789 716,446 6 1 31.00 30.00 05100 ICCOVERY ROOM 2,985 28,804 244,656 7 4 60.0 51.00 51.00 51.00 51.00 51.00 51.00 51.00 51.00 51.00 51.00 51.00 51.00 51.00 51.00 51.00 51.00 51.00 51.00 51.00 50.00 60.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
30.00 03000 ADULTS & PEDIATRICS 13, 968 21, 289 1, 089, 173 73 11 30, 00 31.00 031.00 030.00 INTERS VEC CARE UNIT 410 35, 789 716, 446 6 11 31, 00 ANCILLARY SERVICE COST CENTERS 28, 804 294, 656 7 4 50, 00 05000 RECOVERY ROM 301 564 56, 226 2 0 51, 00 51.00 DS100 RECOVERY ROM 1, 608 2, 336 161, 788 11 1 51, 00 54.00 GAGO RADILOGY-DI AGNOSTIC 5, 705 63, 638 680, 012 14 9 54, 00 56.00 05600 RESPIRATORY 1, 711 0 0 5 160, 00 62.00 6600 RESPIRATORY 1, 711 0 0 5 160, 00 62.00 66.00 62.00 66.00 6600 RESPIRATORY THERAPY 3, 379 1, 683 0 11 4 66.00 66.00 660.00 660.00 660.00 660.00 660.00 660.00 67.00 0 114 66.00 66.00 660.00 67.00<							
131.00 031.00 INTENSIVE CARE UNIT 410 35, 789 716, 446 6 1 31.00 ANCILARY SERVICE COST CENTERS		12,000	21 200	1 000 17	20 70	11	20.00
ANCLLARY SERVICE COST CENTERS							
51:00 OSIO0 RECOVERY ROM 301 564 56,226 2 0 51:00 51:01 OSIO0 RECOVERY ROM 1,608 2,336 161,788 11 1 51:00 54:00 OS400 RADIOLOGY-DIAGNOSTIC 5,705 63,638 680,012 14 9 54.00 05:00 RADIOLOGY-DIAGNOSTIC 5,705 63,638 680,012 14 9 54.00 06:00 OG000 LOGY-DIAGNOSTIC 7 2 65.00 62.00 62.00 62.00 62.00 62.00 62.00 62.00 62.00 62.00 63.00 RESPIRATORY 14.4 46.00 62.00 64:00 06400 RESPIRATORY THERAPY 3,379 1,683 0 11 46.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 69.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 <td>ANCILLARY SERVICE COST CENTERS</td> <td></td> <td></td> <td></td> <td></td> <td>· · · ·</td> <td></td>	ANCILLARY SERVICE COST CENTERS					· · · ·	
51.01 05101 0/P TREATMENT ROOM 1, 608 2, 336 161, 788 11 1 51.01 54.00 05400 RADIOLOGY-DIAGNOSTIC 5,705 63,638 680,012 14 9 54.00 60.00 06000 RADIOLOGY-DIAGNOSTIC 5,705 63,638 680,012 14 9 56.00 60.00 06000 LABORATORY 1,711 0 0 5 1 60.00 62.00 06000 LABORATORY 1,024 17,307 417,752 7 2 65.00 64.00 06600 PHSI CAL THERAPY 3,379 1,663 0 0 2 0 68.00 64.00 06600 SPECH PATHOLOGY 384 0 0 2 0 68.00 69.00 69.00 69.00 71.00 68.00 69.00 71.00 69.00 71.00 7100 68.00 0 0 0 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00							
54.00 05400 RADI OLGY-DI AGNOSTI C 5,705 63,638 680,012 14 9 54.00 56.00 05600 RADI OLSTOPE 263 0 0 1 0 56.00 60.00 06000 LABORATORY 1,711 0		1					
60.00 06000 LABORATORY 1,711 0 0 5 1 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 <t< td=""><td>54. 00 05400 RADI OLOGY-DI AGNOSTI C</td><td>5, 705</td><td></td><td></td><td></td><td>9</td><td></td></t<>	54. 00 05400 RADI OLOGY-DI AGNOSTI C	5, 705				9	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 62.00 65.00 06500 RESPIRATORY THERAPY 1,024 17,307 417,752 7 2 65.00 64.00 06600 PHYSICAL THERAPY 3,379 1,683 0 111 4 66.00 67.00 06700 0CCUPATI ONAL THERAPY 2,842 7 0 8 0 67.00 68.00 06900 ELECTROCARDI OLOGY 384 0 0 2 68.00 69.00 06900 ELECTROCARDI OLOGY 4119 4,751 114,003 5 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 1,014 1,128 396,087 6 4 73.00 00.00 90000 ELINIC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1	-		-		
65:00 06500 RESPIRATORY THERAPY 1,024 17,307 417,752 7 2 65:00 66:00 06600 PHYSICAL THERAPY 3,379 1,683 0 11 4 66:00 67:00 00 06700 00 0 0 8 0 67:00 68:00 06800 SPEECH PATHOLOGY 384 0 0 2 66:00 69:00 06900 ELECTROCARDIOLOGY 419 4,751 114.003 5 0 69:00 70:00 07200 IMPL. DEV. CHARGED TO PATIENTS 1,014 0 0 0 0 72:00 70:00 07200 IMPL. DEV. CHARGED TO PATIENTS 1,014 1,128 396,087 6 4 73:00 00 00700 CLINIC 0 0 0 0 0 90:00 90:00 141,417,730 15 18:00 00TPATIENT SERVICE COST CENTERS 0 0 0 0 0 90:00 90:00 91:00 90:00 91:00 91:00 92:00 92:00			0		0 0		
67.00 06700 OCCUPATIONAL THERAPY 2,842 7 0 8 0 67.00 68.00 06800 SPECH PATHOLOGY 384 0 0 2 0 68.00 69.00 06900 ELECTROCARDIOLOGY 384 0 0 2 0 68.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1,016 0 0 1 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 1,014 1,128 396,087 6 4 7 0.0 0 0 0 72.00 73.00 00 00 0 <t< td=""><td>65. 00 06500 RESPI RATORY THERAPY</td><td></td><td></td><td>417, 75</td><td></td><td>2</td><td>65.00</td></t<>	65. 00 06500 RESPI RATORY THERAPY			417, 75		2	65.00
68.00 06800 SPEECH PATHOLOGY 384 0 0 2 0 68.00 69.00 06900 ELECTROCARDIOLOGY 419 4,751 114,003 5 0 69.00 71.00 OTOO ICAL SUPPLIES CHARGED TO PATIENTS 1,016 0 0 0 0 72.00 73.00 O7300 DRUGS CHARGED TO PATIENTS 1,014 1,128 396,087 6 4 73.00 07300 DOPOD (CLINIC 0 0 0 0 0 90.00 09000 EMERGENCY 8,358 14,522 1,164,177 30 15 91.00 92.00 00 OSESERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS 92.00 0 0 0 0 0 0 15 91.00 92.00 0 15 91.00 92.00 0 0 0 0 0 15 91.00 92.00 0 15 91.00 92.00 0 15 91.00 92.00 15 91.00 92.00 15 91.00 92			1, 683		-	4	
69.00 06900 ELECTROCARDIOLOGY 419 4,751 114,003 5 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1,016 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 1,014 1,128 396,087 6 4 73.00 0010 0000 0100 0 0 0 0 0 72.00 00100 EMEGED TO PATIENTS 1,014 1,128 396,087 6 4 73.00 00100 EMEGENCY 8,358 14,522 1,164,177 30 15 90.00 92.00 OSERVATION BEDS (NON-DISTINCT PART) 8,358 14,522 1,164,177 30 15 92.00 SPECIAL PURPOSE COST CENTERS 118.00 0 0 0 0 0 100 92.00 194.00 O7950 PHYSI CI AN PRACTICES 0 0 0 0 16 194.02 194.01 O7951 MEDICAL OFFICE BULDING 0 0 0 0 194			0		0 2		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1,014 1,128 396,087 6 4 73.00 00.00 09000 CLINIC 0 0 0 0 0 90.00 90.00 09000 CLINIC 0 0 0 0 90.00 91.00 09100 EMERGENCY 8,358 14,522 1,164,177 30 15 91.00 92.00 92.00 OSERVATION BEDS (NON-DISTINCT PART) 8,358 14,522 1,164,177 30 15 91.00 92.00 18.00 SUBTOTALS (SUM OF LINES 1-117) 77,794 255,312 7,865,618 261 115 118.00 194.00 O7951 MEDICAL OFFICE BUI LDI NG 0 0 0 0 0 194.00 194.02 207.952 VPCHC 0 0 0 0 0 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00	69. 00 06900 ELECTROCARDI OLOGY	1	4, 751	114, 00	3 5		
73. 00 07300 DRUGS CHARGED TO PATIENTS 1,014 1,128 396,087 6 4 73. 00 90. 00 09000 CLINIC 0			0		0 1		
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 0 0 0 0 0 0 90. 00		0	0	396, 08	-		
91.00 09100 EMERGENCY 8,358 14,522 1,164,177 30 15 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 100 92.00 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) 77,794 255,312 7,865,618 261 115 118.00 NONREL MBURSABLE COST CENTERS 194.00 07950 PHYSI CI AN PRACTICES 0 0 0 0 194.00 194.01 07951 MEDI CAL OFFI CE BUI LDI NG 0 0 0 0 194.01 194.02 07952 VPCHC 0 0 0 0 194.02 200.00 Cross Foot Adjustments 0 0 0 0 200.00 202.00 Cost to be al located (per Wkst. B, Part I) 16.589698 1.013458 0.212190 369.931034 20,164.580153 203.00 203.00 Unit cost multiplier (Wkst. B, Part I) 16.589698 1.013458 0.212190 369.931034 20,164.580153 203.00 <	OUTPATIENT SERVICE COST CENTERS				_	-	
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) 77,794 255,312 7,865,618 261 115 118.00 NONREL MBURSABLE COST CENTERS 194.00 07950 PHYSI CI AN PRACTICES 0 0 214,432 0 16 194.01 194.00 07950 PHYSI CI AN ORACTICES 0 0 0 0 194.01 194.01 07951 WEDI CAL OFFICE BUILDING 0 0 0 194.02 0 194.02 200.00 Cross Foot Adjustments 0 0 0 0 194.02 200.00 200.00 201.00 200.00 201.00 200.00 201.00 201.00 201.00 202.00 20.641,560 202.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 20.164.580153 203.00 201.00 <t< td=""><td></td><td></td><td></td><td>1 164 17</td><td></td><td></td><td></td></t<>				1 164 17			
118.00 SUBTOTALS (SUM OF LINES 1-117) 77,794 255,312 7,865,618 261 115 118.00 NONREL MBURSABLE COST CENTERS NONREL MBURSABLE COST CENTERS 0 0 214,432 0 166 194.00 194.00 07950 PHYSI CLA N PRACTICES 0 0 0 0 0 194.01 194.01 07951 MEDICAL OFFICE BUILDING 0 0 0 0 194.01 194.02 07952 VPCHC 0 0 0 0 194.01 200.00 Cross Foot Adj ustments 0 0 0 0 200.00 201.00 Negative Cost Centers 200.00 201.00 201.00 201.00 202.00 Cost to be allocated (per Wkst. B, Part I) 16.589698 1.013458 0.212190 369.931034 20,164.580153 203.00 204.00 Cost to be allocated (per Wkst. B, Part I) 16.589698 1.013458 0.212190 369.931034 20,164.580153 203.00 205.00 Unit cost		0, 330	14, 322	1, 104, 17	, 30	15	
NONREI MBURSABLE COST CENTERS 194.00 07950 PHYSI CI AN PRACTICES 0 0 214, 432 0 16 194.00 194.01 07951 MEDI CAL OFFICE BUI LDI NG 0 0 0 0 0 194.01 194.02 07952 VPCHC 0 0 0 0 0 194.01 200.00 Cross Foot Adjustments 0 0 0 0 200.00 200.00 201.00 200.00 201.00 201.00 201.00 202.00 201.00 20.164.580153 203.00 20.1899 3.876 204.00 20.1899 3.876 204.00 21.899		77.704	055 010	7.0/5./1	0 0/1	115	110.00
194.00 07950 PHYSICIAN PRACTICES 0 0 214,432 0 16 194.00 194.01 07951 MEDICAL OFFICE BUILDING 0 0 0 0 0 194.01 194.02 07952 VPCHC 0 0 0 0 0 194.02 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 200.00 201.00 202.00 20.00 201.00 202.00		//, /94	255, 312	7,865,61	8 261	115	118.00
194.02 07952 VPCHC 0 0 0 194.02 200.00 Cross Foot Adjustments 200.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 201.00 202.00 20.00 201.00 202.00 20.00	194. 00 07950 PHYSI CLAN PRACTI CES	0	0	214, 43	2 0	16	194.00
200.00 Cross Foot Adjustments 200.00 200.00 201.00 201.00 Negative Cost Centers 200.00 201.00 201.00 202.00 Cost to be allocated (per Wkst. B, Part I) 1,290,579 258,748 1,714,506 96,552 2,641,560 202.00 203.00 Unit cost multiplier (Wkst. B, Part I) 16.589698 1.013458 0.212190 369.931034 20,164.580153 203.00 204.00 Cost to be allocated (per Wkst. B, Part I) 16.589698 1.013458 0.212190 369.931034 20,164.580153 203.00 205.00 Unit cost multiplier (Wkst. B, Part I) 16.589698 0.0000000 83.904215 29.587786 205.00		1	-		-		
201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, Part I) 1,290,579 258,748 1,714,506 96,552 2,641,560 202.00 203.00 Unit cost multiplier (Wkst. B, Part I) 16.589698 1.013458 0.212190 369.931034 20,164.580153 203.00 205.00 Unit cost multiplier (Wkst. B, Part I) 16.589698 0.000000 83.904215 29.587786 205.00		0	0		0 0	0	
203.00 Part I) 10.589698 1.013458 0.212190 369.931034 20,164.580153 203.00 204.00 Cost to be allocated (per Wkst. B, Part I) 16.589698 1.013458 0.212190 369.931034 20,164.580153 203.00 205.00 Unit cost multiplier (Wkst. B, Part II) 10.589698 1.013458 0.212190 369.931034 20,164.580153 203.00 205.00 Unit cost multiplier (Wkst. B, Part 0.000000 83.904215 29.587786 205.00							
203.00 Unit cost multiplier (Wkst. B, Part I) 16.589698 1.013458 0.212190 369.931034 20,164.580153 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 16.589698 1.013458 0.212190 369.931034 20,164.580153 203.00 205.00 Unit cost multiplier (Wkst. B, Part 0.000000 83.904215 29.587786 205.00		1, 290, 579	258, 748	1, 714, 50	96, 552	2, 641, 560	202.00
204.00 Cost to be allocated (per Wkst. B, Part II) 0 21,899 3,876 204.00 205.00 Unit cost multiplier (Wkst. B, Part 0.000000 83.904215 29.587786 205.00		16. 589698	1.013458	0. 21219	369. 931034	20, 164. 580153	203.00
205.00 Unit cost multiplier (Wkst. B, Part 0.000000 83.904215 29.587786 205.00	204.00 Cost to be allocated (per Wkst. B,						
				0 0000	0 83 00/215	20 507704	205 00
				0.00000	05.704215	27.307700	200.00

	Financial Systems	UNI ON HOSPI TA	L CLINTON			u of Form CMS-	2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provider C		Period: From 01/01/2016	Worksheet B-1	
					To 12/31/2016	Date/Time Pre	
	Cost Center Description	PURCHASI NG	ADMI TTI NG	CASHLERING/AC	CCReconciliation	5/25/2017 4:2	
	Cost Center Description	RECEIVING AND	(INPATIENT	OUNTS		AND GENERAL	
		STORES	REVENUE)	RECEI VABLE		(ACCUM.	
		(REQUISITIO)	,	(TOTAL		COST)	
				REVENUE)			
		5.03	5.04	5.05	5A. 06	5.06	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT	1		1			1.00
2.00	00200 NEW CAP REL COSTS-BEDG & FIXT						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	320, 796					5.03
5.04	00570 ADMI TTI NG	548	11, 049, 554				5.04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0	75, 727, 34	46		5.05
5.06	00591 ADMINISTRATIVE AND GENERAL	206	0		0 -2, 491, 961	20, 221, 879	5.06
7.00	00700 OPERATION OF PLANT	43	0		0 0	2, 128, 342	
8.00	00800 LAUNDRY & LINEN SERVICE	210	0		0 0	7,665	
9.00	00900 HOUSEKEEPI NG	25, 845	0		0 0	421, 781	
10.00	01000 DI ETARY	19	0		0 0	214,063	
11.00	01100 CAFETERIA	72	0		0 0	388, 738	
13.00	01300 NURSI NG ADMI NI STRATI ON	6	0		0 0	936, 901	
16.00	01600 MEDICAL RECORDS & LIBRARY	15	0		0 0	558, 240	16.00
30.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	40, 695	2, 694, 757	4, 223, 82	20 0	2, 246, 685	30.00
30.00	03100 INTENSIVE CARE UNIT	40, 895	1, 132, 366			1, 136, 846	
31.00	ANCI LLARY SERVICE COST CENTERS	20, 304	1, 132, 300	1, 390, 02	+5 0	1, 130, 040	31.00
50.00	05000 OPERATI NG ROOM	86, 573	816, 537	4, 608, 40	0 00	1, 052, 482	50.00
51.00	05100 RECOVERY ROOM	0	26, 553			82, 340	
51.01	05101 0/P TREATMENT ROOM	20, 202	13, 998			316, 173	
54.00	05400 RADI OLOGY-DI AGNOSTI C	26, 691	994, 326	20, 062, 18	39 0	2, 247, 491	54.00
56.00	05600 RADI OI SOTOPE	270	28, 091	694, 93	30 0	119, 492	56.00
60.00	06000 LABORATORY	0	1, 300, 963			1, 132, 075	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	69, 036			65, 184	
65.00	06500 RESPI RATORY THERAPY	8, 537	353, 704			737, 482	
66.00	06600 PHYSI CAL THERAPY	717	123, 906			719, 481	
67.00	06700 OCCUPATIONAL THERAPY	0	35, 481			198, 140	
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	18, 707 511, 106			32, 063 283, 042	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	45, 586			90, 317	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	43, 300		0 0	90, 317	
	07300 DRUGS CHARGED TO PATIENTS	1, 812	1, 965, 307			1, 678, 257	
	OUTPATIENT SERVICE COST CENTERS	.,	.,	.,,		.,	
90.00	09000 CLI NI C	0	0	I	0 0	0	90.00
91.00	09100 EMERGENCY	79, 979	919, 130	19, 314, 33	34 0	2, 471, 379	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
118.00		319, 428	11, 049, 554	75, 276, 52	26 -2, 491, 961	19, 264, 659	118.00
	NONREI MBURSABLE COST CENTERS	· · · ·					-
	07950 PHYSI CI AN PRACTI CES	1, 368	0			918, 595	
	07951 MEDICAL OFFICE BUILDING	0	0		0 0		194.01
	07952 VPCHC	0	0		0 0	0	194.02
200.00							200.00
201.00		200 (70	740 001	700.0	11	2 401 0/1	201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	200, 678	748, 821	780, 04	+ 1	2, 491, 961	202.00
203.00		0. 625563	0. 067769	0. 01030	01	0. 123231	203 00
		25, 806	9, 770				203.00
204 00		20,000	,,,,0	J 0, 00		JU, 201	1-01.00
204.00	Part II)						
204.00 205.00	Part II)	0. 080444	0. 000884	0.00007	71	0. 001793	205.00

ST A	Financial Systems ALLOCATION - STATISTICAL BASIS	UNI ON HOSPI TA	Provider C	CN: 15-1326	Period:	u of Form CMS- Worksheet B-1	
100	ALLOUATION - STATISTICAL DASIS		FIOVIDEI CO		From 01/01/2016	WULKSHEEL D-I	1
					To 12/31/2016	Date/Time Pre	epare
					DI CTADY	5/25/2017 4:2	22 pn
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPING		CAFETERI A	
			INEN SERVICE	(NUMBER	(DI ETARY)	(FTE)	
		(SQ_FT) 7.00	(LI NEN) 8.00	HOUSED) 9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS	7.00	0.00	9.00	10.00	11.00	-
00	00100 NEW CAP REL COSTS-BLDG & FIXT						1 1
00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2
00	00400 EMPLOYEE BENEFITS DEPARTMENT						4
01	00540 NONPATI ENT TELEPHONES						5
02	00550 DATA PROCESSI NG						5
03	00560 PURCHASING RECEIVING AND STORES						5
04	00570 ADMITTING						5
05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5
06	00591 ADMI NI STRATI VE AND GENERAL						5
00	00700 OPERATI ON OF PLANT	50, 604					7
00	00800 LAUNDRY & LINEN SERVICE	414	65, 828				8
00	00900 HOUSEKEEPING	392	5, 842		8		9
. 00	01000 DI ETARY	937	204				10
. 00	01100 CAFETERIA	0	769		0 0	8, 429	
. 00	01300 NURSI NG ADMI NI STRATI ON	1, 382	0			608	
. 00	01600 MEDI CAL RECORDS & LI BRARY	875	0			462	
. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0,0	0	07	0	102	
. 00	03000 ADULTS & PEDIATRICS	13, 988	20, 136	13, 98	8 4, 763	1, 675	30
. 00	03100 I NTENSI VE CARE UNI T	410	6, 301	41	-	916	
00	ANCI LLARY SERVICE COST CENTERS	110	0,001		1, 100	,10	1 .
. 00	05000 OPERATI NG ROOM	2, 985	2, 536	2, 98	5 0	412	2 50
. 00	05100 RECOVERY ROOM	301	_,			71	
01	05101 0/P TREATMENT ROOM	1,608	0			239	
. 00	05400 RADI OLOGY-DI AGNOSTI C	5, 705	5, 987	5, 70		1, 080	
. 00	05600 RADI OI SOTOPE	263	0			0	
. 00	06000 LABORATORY	1, 711	0			0	
. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	0	
. 00	06500 RESPI RATORY THERAPY	1,024	416	1, 02	4 0	600	
. 00	06600 PHYSI CAL THERAPY	3, 379	5, 701			0	
. 00	06700 OCCUPATI ONAL THERAPY	2,842	0,701			Ő	
. 00	06800 SPEECH PATHOLOGY	384	0			Ő	
. 00	06900 ELECTROCARDI OLOGY	419	951	41		140	
00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,016	0			0	
. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	Ő	
. 00	07300 DRUGS CHARGED TO PATIENTS	1,014	0			486	
	OUTPATIENT SERVICE COST CENTERS				- <u>-</u>		
. 00	09000 CLI NI C	0	0		0 0	C	0 90
00	09100 EMERGENCY	8, 358	16, 985	8, 35	8 0	1, 638	
00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92
	SPECIAL PURPOSE COST CENTERS			•			
8.00	SUBTOTALS (SUM OF LINES 1-117)	49, 407	65, 828	48, 60	1 6, 794	8, 327	118
	NONREI MBURSABLE COST CENTERS	· · ·		•			
1.00	07950 PHYSI CLAN PRACTI CES	0	0		0 0	102	2 194
4. Oʻ	07951 MEDICAL OFFICE BUILDING	1, 197	0	1, 19	7 0	C	194
	2 07952 VPCHC	0	0		0 0		194
0. 00							200
1.00							201
2.00		2, 390, 620	28, 168	494, 77	6 294, 104	436, 972	
	Part I)						
3.00		47. 241720	0. 427903	9. 93566	0 43. 288784	51.841500	203
4.00		371, 048	10, 391			66, 854	
	Part II)						
5.00		7. 332385	0. 157851	0. 31013	3 3. 703562	7.931427	205
5.00				1	1		1

Heal th	Financial Systems	UNI ON HOSPI TA		In Lieu of Form CMS	S-2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provider CCN: 15-13	26 Period: Worksheet B From 01/01/2016	-1
				To 12/31/2016 Date/Time P	
	Cost Center Description	NURSI NG	MEDI CAL	5/25/2017 4	:22 pm
	cost center bescription	ADMI NI STRATI ON	RECORDS &		
			LI BRARY		
		(TIME	(ASSI GNED		
		SPENT)	TI ME)		
	GENERAL SERVICE COST CENTERS	13.00	16.00		
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00540 NONPATI ENT TELEPHONES				5.01
5.02	00550 DATA PROCESSING				5.02
5.03 5.04	00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING				5.03 5.04
5.04	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE				5.04
5.06	00591 ADMI NI STRATI VE AND GENERAL				5.06
7.00	00700 OPERATION OF PLANT				7.00
8.00	00800 LAUNDRY & LINEN SERVICE				8.00
9.00	00900 HOUSEKEEPI NG				9.00
10.00	01000 DI ETARY				10.00
11.00	01100 CAFETERI A				11.00
	01300 NURSI NG ADMI NI STRATI ON	92, 774			13.00
16.00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	0	75, 276, 526		16.00
30, 00	03000 ADULTS & PEDIATRICS	34, 842	4, 223, 820		30.00
	03100 I NTENSI VE CARE UNI T	19,063	1, 390, 045		31.00
01100	ANCI LLARY SERVICE COST CENTERS	17,000	1,0,0,0,0,0		
50.00	05000 OPERATING ROOM	0	4, 608, 400		50.00
	05100 RECOVERY ROOM	0	179, 811		51.00
	05101 0/P TREATMENT ROOM	4, 801	1, 085, 392		51.01
	05400 RADI OLOGY-DI AGNOSTI C	0	20, 062, 189		54.00
56.00 60.00	05600 RADI OI SOTOPE 06000 LABORATORY	0	694, 930		56.00 60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	9, 458, 788 159, 862		62.00
	06500 RESPIRATORY THERAPY	0	676, 147		65.00
66.00	06600 PHYSI CAL THERAPY	0	2, 369, 116		66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	700, 752		67.00
68.00	06800 SPEECH PATHOLOGY	0	110, 532		68.00
	06900 ELECTROCARDI OLOGY	0	3, 063, 913		69.00
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	77, 844		71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	7 100 (51		72.00
73.00	OUTPATIENT SERVICE COST CENTERS	0	7, 100, 651		73.00
90.00	09000 CLINIC	0	0		90.00
	09100 EMERGENCY	34,068	19, 314, 334		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
	SPECIAL PURPOSE COST CENTERS				
118.00		92, 774	75, 276, 526		118. 00
	NONREI MBURSABLE COST CENTERS	-1	-1		
	07950 PHYSICIAN PRACTICES 07951 MEDICAL OFFICE BUILDING	0	0		194.00
	07951 MEDICAL OFFICE BUILDING 07952 VPCHC	0	0		194. 01 194. 02
200.00		0			200.00
200.00					201.00
202.00		1, 162, 895	701, 014		202.00
	Part I)				
203.00		12. 534708	0.009313		203.00
204.00		40, 993	27, 101		204.00
205.00	Part II) Unit cost multiplier (West B Part	0. 441859	0. 000360		205.00
200.00	Unit cost multiplier (Wkst. B, Part II)	0. 44 1039	0.000300		203.00
		1 1	I		I

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-1326 Period: From 01/01/2016 To 12/31/2016 Worksheet C Date/Time Prepared: 5/25/2017 4:22 pm 5/2017 4:20 pm 5/2017 4:2017 4:2017 4:2017 4:2017 4:2017 4:2017 4:	Health Financial Systems	UNI ON HOSPI T	AL CLINTON		In Lie	u of Form CMS-:	2552-10
Cost Center Description Total Cost (from Wkst: B, Part I, col. 26) Therapy Limit Adj. Therapy Limit Adj. Total Costs Disal Iowance Total Costs 30.00 0000 ADULTS & PEDIATRICS 4,101,044 0 0 30.00 31.00 03000 ADULTS & PEDIATRICS 4,101,044 4,101,044 0 0 30.00 ANCILLARY SERVICE COST CENTERS 1,665,360 1,665,360 0 0 31.00 50.00 05000 (DERATING ROOM 1,418,217 1,418,217 0 0 50.00 51.00 05101 (JCP TREATMENT ROOM 1,554,775 554,775 0 61.00 54.00 05400 (RADICLOR/F) ROOM 1557,727 155,727 0 56.00 60.00 06200 (MHOLE BLOOD & PACKED RED BLOOD CELLS 74,706 74,706 0 62.00 60.00 06200 (MHOLE BLOOD & PACKED RED BLOOD CELLS 74,706 1,457,503 0 66.00 60.00 06200 (MHOLE BLOOD & PACKED RED BLOOD CELLS 74,706 0 66.00 66.00 60.00 06200 (MHOLE BLOOD & PACKED TO PATIENTS	COMPUTATION OF RATIO OF COSTS TO CHARGES				From 01/01/2016 To 12/31/2016	Part I Date/Time Pre	
Cost Center Description Total Cost (from Wkst. B, 26) Therapy Lim it Adj. Total Costs Disal I owance Total Costs RCE Disal I owance Total Costs 0.00 3000 ADULTS & PEDIATRICS 1.00 2.00 3.00 4.00 5.00 0.01 03000 ADULTS & PEDIATRICS 4.101.044 4.101.044 0 0 30.00 31.00 03100 INTENSIVE CARE UNIT 1.665.360 1.665.360 0 0 31.00 ANCILLARY SERVICE COST CENTERS 115.054 0 0 51.00 55.00 51.00 55.00 51.00 55.00 51.00 55.00 51.01 55.00 51.01 55.00 51.01 51.01 55.4775 0 0 51.01 54.00 05400 RADIOLOGY - DIAGNOSTIC 3.096.004 3.096.004 0 0 54.00 60.00 06000 LABORATORY 1.457.503 1.457.503 0 66.00 66.00 60.00 06000 SPERTATORY THERAPY 1.025.849 0 924.493 0 64.00 67.00 66.00			Title	XVIII	Hospi tal	Cost	
Impart Entry of Construction Adj. Disal Lowance 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
Part I, col. 26 1 <th1< th=""> 1 1 <t< td=""><td>Cost Center Description</td><td></td><td></td><td>Total Costs</td><td></td><td>Total Costs</td><td></td></t<></th1<>	Cost Center Description			Total Costs		Total Costs	
26) 26) 4.00 5.00 1.00 2.00 3.00 4.00 5.00 30.00 03000 ADULTS & PEDIATRICS 4.101.044 4.101.044 0 0 31.00 30001 NITENS VE CARE UNIT 1.665.360 0 0 31.00 ANCI LLARY SERVICE COST CENTERS 1.418.217 1.418.217 0 0 50.00 50.00 05000 OPERATING ROOM 115.054 0 51.00 50.00 51.01 51.00 05101 (JP TREATMENT ROOM 154.60,04 3.096,004 0 51.01 54.00 05600 RADI 0LOGY-DI AGNOSTI C 3.096,004 3.096,004 0 56.00 60.00 06000 LABORATORY 1.457.503 1.457.503 0 66.00 61.00 64.00 56.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 <			Adj.		Di sal I owance		
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INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 03000 AUULTS & PEDIATRICS 4, 101, 044 0 0 30.00 31.00 03000 AUULTS & PEDIATRICS 4, 101, 044 0 0 0 31.00 31.00 03001 INTENSIVE CARE UNIT 1, 665, 360 0 0 0 0 31.00 ANCILLARY SERVICE COST CENTERS 1, 418, 217 1, 418, 217 0 0 50.00 0 51.00 51.00 51.00 51.00 51.00 51.00 51.00 51.00 51.00 51.01 54.00 54.00 54.00 56.00 0 51.01 54.00 05400 RADI 0LOGY-DI AGNOSTIC 3, 096, 004 3, 096, 004 0 54.00 56.00 60.00 66.00 62.00 66.00 62.00 62.00 66.00 66.00 66.00 62.00 62.00 62.00 62.00 62.00 62.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 6							
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31.00 O3100 INTENSI VE CARE UNIT 1, 665, 360 0 0 0 31.00 ANCILLARY SERVICE COST CENTERS		1	1		1		
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68.00 06800 SPEECH PATHOLOGY 58,999 0 58,999 0 68.00 69.00 06900 ELECTROCARDI OLOGY 378,078 378,078 0 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 160,265 160,265 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 2,034,371 2,034,371 0 0 73.00 00TPATIENT SERVICE COST CENTERS 0 0 0 0 0 90.00 990.00		1, 025, 849	0	1, 025, 8	49 0	0	
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73. 00 07300 DRUGS CHARGED TO PATIENTS 2,034,371 2,034,371 0 0 73. 00 OUTPATIENT SERVICE COST CENTERS 0 0 0 90. 00 9000 CLINIC 90. 00 90. 00 90. 00 90. 00 91. 00 91. 00 91. 00 92. 00 9200 0BSERVATION BEDS (NON-DISTINCT PART) 1, 360, 834 1, 360, 834 0 92. 00 92. 00 200. 00 Subtotal (see instructions) 22, 925, 766 0 22, 925, 766 0 200. 00 201. 00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	160, 265		160, 20	55 0	0	71.00
OUTPATI ENT_SERVICE_COST_CENTERS 90.00 09000 CLINIC 0 0 90.00 91.00 09100 EMERGENCY 3, 952, 906 3, 952, 906 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1, 360, 834 1, 360, 834 0 92.00 200.00 Subtotal (see instructions) 22, 925, 766 0 22, 925, 766 0 200.00 201.00 Less Observation Beds 1, 360, 834 1, 360, 834 0 201.00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0			0 0	0	72.00
90. 00 09000 CLINIC 0 0 0 90. 00 91. 00 09100 EMERGENCY 3, 952, 906 3, 952, 906 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 1, 360, 834 1, 360, 834 0 92. 00 200. 00 Subtotal (see instructions) 22, 925, 766 0 22, 925, 766 0 200. 00 201. 00 Less Observation Beds 1, 360, 834 1, 360, 834 0 201. 00	73.00 07300 DRUGS CHARGED TO PATIENTS	2,034,371		2, 034, 3	71 0	0	73.00
91.00 09100 EMERGENCY 3,952,906 3,952,906 0 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 1,360,834 1,360,834 0 92.00 200.00 Subtotal (see instructions) 22,925,766 0 22,925,766 0 200.00 201.00 Less Observation Beds 1,360,834 1,360,834 0 201.00	OUTPATIENT SERVICE COST CENTERS						
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200.00 Subtotal (see instructions) 22,925,766 0 22,925,766 0 0 200.00 201.00 Less Observation Beds 1,360,834 1,360,834 0 201.00	91.00 09100 EMERGENCY	3, 952, 906		3, 952, 90	0 0	0	91.00
201.00 Less Observation Beds 1, 360, 834 1, 360, 834 0 201.00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 360, 834		1, 360, 8	34	0	92.00
	200.00 Subtotal (see instructions)	22, 925, 766	0	22, 925, 70	66 0	0	200. 00
202.00 Total (see instructions) 21, 564, 932 0 21, 564, 932 0 0 0 202.00	201.00 Less Observation Beds	1, 360, 834		1, 360, 8	34	0	201.00
	202.00 Total (see instructions)	21, 564, 932	0	21, 564, 9	32 0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-1326 Period: From 01/01/2016 To 12/31/2016 Worksheet C Date/Time Prepared: 5/25/2017 4:22 pm (2/31/2016) Cost Center Description Inpati ent Inpati ent 00tpati ent (1 ppati ent 000tpati ent (1 ppati ent 00000 / 0000 / 0000 / 0000 / 0000 / 0000 / 0000 / 0000 / 0000 / 0000 / 0000 / 0000 / 0000 / 0000 / 0000 / 0000 / 0000 / 00000 / 00000 / 0000 / 000000	Health Financial Systems	UNI ON HOSPI TA	AL CLINTON		In Lie	u of Form CMS-	2552-10
Cost Center Description Charges TEFRA Inpati ent Outpati ent Total (col. 6) + col. 7) Cost or Other Ratio Inpati ent Ratio Inpati ent Ratio <tdinpati ent<br="">R</tdinpati>	COMPUTATION OF RATIO OF COSTS TO CHARGES				From 01/01/2016 To 12/31/2016	Part I Date/Time Pre	
Cost Center Description Inpatient Outpatient Total (col. 6 + col. 7) Cost or Other Ratio TEFRA Inpatient Ratio 30.00 03000 ADULTS & PEDIATRICS 2.726,842 2.726,842 30.00 31.00 03100 INTENSI VE CARE UNIT 1.390,045 1.900,045 30.00 ANCILLARY SERVICE COST CENTERS 1.390,045 1.900,045 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 (PERATING ROOM 26,553 153,258 179,811 0.639861 0.000000 51.00 51.00 05100 INCOVERY ROOM 26,553 153,258 1.029,383 0.538939 0.000000 51.00 54.00 05400 RADIOLGGY-DIAGNOSTIC 994,326 19,067,261 20,061,587 0.154325 0.000000 56.00 65.00 06500 RECOVERY ROOM 13,309,83 1.57,825 9,489,736 0.154325 0.000000 56.00 64.00 06600 RLDIOSTOPE 28,091 66,839 694,930 0.224909 0.000000 65.00 65.00 06500 RESPIRATORY THERAPY 133,096,43 8,157,825			Title	XVIII	Hospi tal	Cost	
INPATI ENT ROUTI NE SERVI CE COST CENTERS 6.00 7.00 8.00 9.00 10.00 30.00 03000 ADULTS & PEDI ATRI CS 2,726,842 2,726,842 30.00 31.00 03100 I NTENSI VE CARE UNI T 1,390,045 1,390,045 31.00 ANCILLARY SERVI CE COST CENTERS 50.00 5000 OPERATI NG ROOM 816,537 3,791,863 4,608,400 0.307746 0.000000 51.00 50.00 5000 OPERATI NG ROOM 26,553 153,258 179,811 0.639861 0.000000 51.00 51.01 51.01 51.01 51.01 51.01 51.01 51.02 51.01 51.01 51.01 51.02 51.01 51.02 51.01 51.01 51.02 51.01 51.02 51.01 51.01 51.02 51.01 51.02 51.01 51.01 51.02 51.01 51.02 51.01 51.02 51.01 51.02 51.01 51.02 51.01 51.02 51.01 51.01 51.01 51.01 51.02 51.01 50.02 51.01 50.02							
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INPATIENT ROUTINE SERVICE COST CENTERS 0.00 03000 ADULTS & PEDIATRICS 2, 726, 842 30.00 31.00 03100 INTENSIVE CARE UNIT 1, 390, 045 1, 390, 045 31.00 ANCILLARY SERVICE COST CENTERS 0.00 05000 PERATING ROOM 816, 537 3, 791, 863 4, 608, 400 0. 307746 0.0000000 50.00 DS000 PECOVERY ROOM 26, 553 153, 258 179, 811 0. 639861 0.000000 51.00 51.00 05400 RADI 0LOGY-DI AGNOSTIC 994, 326 19, 067, 261 20, 061, 587 0. 154325 0. 000000 51.01 54.00 05400 RADI 0LOGY-DI AGNOSTIC 994, 326 19, 067, 261 20, 061, 587 0. 154325 0. 000000 56.00 60.00 06200 WHOLE BLODD & PACKED RED BLODD CELLS 69, 036 90, 826 159, 862 0. 467316 0. 000000 66.00 61.00 06200 WHOLE BLODD & PACKED RED BLODD CELLS 69, 036 90, 826 159, 862 0. 467316 0. 000000 65.00 65.00 06500 RESPI RATORY THERAPY 123, 906 2, 245, 210 2, 369, 116				+ col. 7)	Ratio		
INPATI ENT ROUTINE SERVICE COST CENTERS 2,726,842 2,726,842 2,726,842 30.00 31.00 03000 ADULTS & PEDI ATRICS 2,726,842 2,726,842 31.00 31.00 ANCI LLARY SERVICE COST CENTERS 1,390,045 1,390,045 31.00 31.00 50.00 05000 (DPERATING ROOM 816,537 3,791,863 4,608,400 0.307746 0.000000 50.00 51.01 05100 (RCOVERY ROOM 26,553 153,258 179,811 0.6339461 0.000000 51.01 54.00 05400 RADI OLOGY-DI AGNOSTI C 994,326 19,067,261 20,061,587 0.154325 0.000000 56.00 65.00 06500 RADI OLOGY-DI AGNOSTI C 994,326 19,067,261 20,061,587 0.154090 0.000000 56.00 60.00 06000 LABORATORY 1,300,963 8,157,825 9,458,788 0.154090 0.000000 56.00 65.00 06500 RESPI RATORY HERAPY 123,906 2,243 67.417 1.367296 0.000000 65.00 65.00 06600 PHYSI CAL THERAPY 123,906							
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31. 00 03100 INTENSIVE CARE UNIT 1,390,045 31.00 ANCI LLARY SERVICE COST CENTERS							_
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71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 45,586 32,258 77,844 2.058797 0.000000 71.00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0.000000 72.00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 1,965,307 5,135,344 7,100,651 0.286505 0.000000 73.00 00 09000 CLI NI C 0 0 0 0.000000 0.000000 90.00 90. 00 09100 EMERGENCY 919,130 18,395,204 19,314,334 0.204662 0.000000 91.00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 47,724 1,480,962 1,528,686 0.890199 0.000000 92.00 200. 00 Subtotal (see instructions) 11,387,042 63,826,694 75,213,736 200.00 201.00	68.00 06800 SPEECH PATHOLOGY	18, 707	91, 825	110, 53	2 0. 533773	0.00000	68.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 0 0 0.00000 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1,965,307 5,135,344 7,100,651 0.286505 0.000000 73.00 0UTPATIENT SERVICE COST CENTERS 0 0 0 0.000000 0.000000 90.00 90.00 09100 EMERGENCY 919,130 18,395,204 19,314,334 0.204662 0.000000 91.00 92.00 09200 DBSERVATI ON BEDS (NON-DI STINCT PART) 47,724 1,480,962 1,528,686 0.890199 0.000000 92.00 200.00 Subtotal (see instructions) 11,387,042 63,826,694 75,213,736 200.00 201.00	69. 00 06900 ELECTROCARDI OLOGY	511, 106	2, 514, 920	3, 026, 02	6 0. 124942	0.00000	69.00
73.00 07300 DRUGS CHARGED TO PATIENTS 1,965,307 5,135,344 7,100,651 0.286505 0.000000 73.00 0UTPATI ENT SERVICE COST CENTERS 0 0 0 0.000000 0.000000 0.000000 90.00 90.00 90.00 09100 EMERGENCY 919,130 18,395,204 19,314,334 0.204662 0.000000 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 47,724 1,480,962 1,528,686 0.890199 0.000000 92.00 200.00 Subtotal (see instructions) 11,387,042 63,826,694 75,213,736 200.00 201.00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	45, 586	32, 258	77, 84	4 2.058797	0.00000	71.00
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 0 0.00000 0.000000 90.00 90.00 91.00 09100 EMERGENCY 919,130 18,395,204 19,314,334 0.204662 0.000000 91.00 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 47,724 1,480,962 1,528,686 0.890199 0.000000 92.00 200.00 Subtotal (see instructions) 11,387,042 63,826,694 75,213,736 200.00 201.00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0.000000	0.00000	72.00
90. 00 09000 CLINIC 0 0 0.00000 0.000000 90.00000 90.00000000 90.0000000000 90.00000000000000000000000000000000000	73.00 07300 DRUGS CHARGED TO PATIENTS	1, 965, 307	5, 135, 344	7, 100, 65	1 0. 286505	0.00000	73.00
91. 00 09100 EMERGENCY 919, 130 18, 395, 204 19, 314, 334 0. 204662 0. 000000 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 47, 724 1, 480, 962 1, 528, 686 0. 890199 0. 000000 92. 00 200. 00 Subtotal (see instructions) 11, 387, 042 63, 826, 694 75, 213, 736 200. 00 201. 00							
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 47, 724 1, 480, 962 1, 528, 686 0. 890199 0. 000000 92. 00 200. 00 Subtotal (see instructions) 11, 387, 042 63, 826, 694 75, 213, 736 0. 890199 0. 000000 200. 00 201. 00 Less Observation Beds 0.00000 201. 00		0	0		0 0.000000	0.00000	90.00
200.00 Subtotal (see instructions) 11, 387, 042 63, 826, 694 75, 213, 736 200.00 201.00 Less Observation Beds 11, 387, 042 63, 826, 694 75, 213, 736 200.00	91.00 09100 EMERGENCY	919, 130	18, 395, 204	19, 314, 33	4 0. 204662	0.00000	91.00
201.00 Less Observation Beds 201.00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	47, 724	1, 480, 962	1, 528, 68	6 0. 890199	0.00000	92.00
	200.00 Subtotal (see instructions)	11, 387, 042	63, 826, 694	75, 213, 73	6		200.00
202.00 Total (see instructions) 11, 387, 042 63, 826, 694 75, 213, 736 202.00	201.00 Less Observation Beds						201.00
	202.00 Total (see instructions)	11, 387, 042	63, 826, 694	75, 213, 73	6		202.00

Health Financial Systems	UNI ON HOSPI TAL	CLINTON	In Lie	u of Form CMS-25	52-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1326	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepa 5/25/2017 4:22	
		Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS	r				
30. 00 03000 ADULTS & PEDI ATRI CS				-	30.00
31.00 03100 INTENSIVE CARE UNIT				3	31.00
ANCI LLARY SERVI CE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 000000			5	50.00
51.00 05100 RECOVERY ROOM	0. 000000			5	51.00
51.01 05101 0/P TREATMENT ROOM	0. 000000			5	51.01
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			5	54.00
56. 00 05600 RADI OI SOTOPE	0. 000000			5	56.00
60. 00 06000 LABORATORY	0. 000000			6	50.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			6	52.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000			6	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			6	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000			6	57.00
68.00 06800 SPEECH PATHOLOGY	0. 000000			6	58.00
69.00 06900 ELECTROCARDI OLOGY	0. 000000			6	59.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			7	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			7	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			7	73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	0.000000			ç	90.00
91. 00 09100 EMERGENCY	0. 000000			Ģ	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			9	92.00
200.00 Subtotal (see instructions)				20	00.00
201.00 Less Observation Beds				20	01.00
202.00 Total (see instructions)				20	02.00
				•	

Health Financial Systems	UNI ON HOSPI T	AL CLINTON		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2016 To 12/31/2016		
		Titl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.					
	26)	0.00	0.00	1.00	F 00	
	1.00	2.00	3.00	4.00	5.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 O3000 ADULTS & PEDI ATRI CS	4, 101, 044		4, 101, 04		4, 101, 044	30,00
31. 00 03100 NTENSI VE CARE UNI T	1, 665, 360		1, 665, 36		1, 665, 360	•
ANCI LLARY SERVICE COST CENTERS	1,000,300		1,000,30	0 0	1,000,300	31.00
50. 00 05000 OPERATING ROOM	1, 418, 217		1, 418, 21	7 0	1, 418, 217	50.00
51. 00 05100 RECOVERY ROOM	115,054		115, 05		115, 054	
51. 01 05101 0/P TREATMENT ROOM	554, 775		554, 77		554, 775	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 096, 004		3, 096, 00		3, 096, 004	•
56. 00 05600 RADI 0I SOTOPE	155, 727		155, 72		155, 727	•
60. 00 06000 LABORATORY	1, 457, 503		1, 457, 50		1, 457, 503	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	74, 706		74, 70		74, 706	•
65. 00 06500 RESPI RATORY THERAPY	924, 493		924, 49		924, 493	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 025, 849	0	1, 025, 84	9 0	1, 025, 849	66.00
67.00 06700 OCCUPATI ONAL THERAPY	391, 581	0	391, 58	0	391, 581	67.00
68.00 06800 SPEECH PATHOLOGY	58, 999	0	58, 99	9 0	58, 999	68.00
69. 00 06900 ELECTROCARDI OLOGY	378, 078		378, 07	8 0	378, 078	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	160, 265		160, 26	5 0	160, 265	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0			0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2,034,371		2, 034, 37	'1 0	2, 034, 371	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0			0 0	-	
91.00 09100 EMERGENCY	3, 952, 906		3, 952, 90		3, 952, 906	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 360, 834		1, 360, 83		1, 360, 834	
200.00 Subtotal (see instructions)	22, 925, 766				22/ /20/ /00	
201.00 Less Observation Beds	1, 360, 834		1, 360, 83		1, 360, 834	
202.00 Total (see instructions)	21, 564, 932	0	21, 564, 93	0	21, 564, 932	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-1326 Period: Period: Trom 01/01/2016 To 01/2017 4:22 pm 5/25/2017 4:22 pm 1001 pt 1001 pt 1001 pt 1001 pt 1001 pt 1001 pt 1000 pt 1000000 pt 1000 pt	Health Financial Systems	UNI ON HOSPI TA	AL CLINTON		In Lie	u of Form CMS-	2552-10
Cost Center Description Charges Tetra Inpati ent Outpati ent Total (col. 6) + col. 7) Cost or Other Ratio Inpati ent Ratio Inpati ent	COMPUTATION OF RATIO OF COSTS TO CHARGES				From 01/01/2016 To 12/31/2016	Part I Date/Time Pre	
Cost Center Description Inpatient Outpatient Total (col. 6 + col. 7) Cost or Other Ratio TEFRA Inpatient Ratio 30.00 30000 ADULTS & PEDIATRICS 2.726,842 2.726,842 30.00 31.00 031000 INTENSI VE CARE UNIT 1.390,045 1.900,045 30.00 ANCILLARY SERVICE COST CENTERS 1.390,045 1.900,045 0.0000 50.00 50.00 05100 RECOVERY ROOM 26,553 153,258 179,811 0.639861 0.000000 51.00 51.01 05101 O/P TREATMENT ROOM 13,998 1,015,385 1,029,383 0.538939 0.000000 51.00 54.00 05400 RADIOLGY- DIAGNOSTIC 994,326 19,067,261 20,061,587 0.154325 0.000000 56.00 65.00 06500 RADIOLGY TREATMENT ROOM 13,309,963 8,157,825 9,48,788 0.154390 0.000000 56.00 66.00 06500 RECOVERATIONER THERAPY 133,908 1.1300,963 8,157,825 9,489,738 0.433009 0.000000 65.00 67.00 06500 RESPERATORY THERAPY 133,908 </td <td></td> <td></td> <td></td> <td>e XIX</td> <td>Hospi tal</td> <td>Cost</td> <td></td>				e XIX	Hospi tal	Cost	
INPATI ENT_ROUTI NE_SERVICE_COST_CENTERS 6.00 7.00 8.00 9.00 10.00 30.00 03000 ADULTS & PEDIATRICS 2,726,842 2,726,842 30.00 30.00 31.00 03000 INTENSIVE_CARE_UNIT 1,390,045 1,390,045 31.00 ANCILLARY_SERVICE_COST_CENTERS 30.00 51.01 51.00 05100 Recovery ROOM 26,553 153,258 179,811 0.639861 0.000000 51.00 51.01 51.01 05101 07 PTREATMENT ROOM 26,553 153,258 179,811 0.639861 0.000000 51.00 54.00 54.00 54.00 54.00 54.00 54.00 54.00 54.00 54.00 54.00 54.00 54.00 54.00 54.00 56.00							
INPATI ENT ROUTI NE SERVI CE COST CENTERS 6.00 7.00 8.00 9.00 10.00 30.00 03000 ADULTS & PEDI ATRI CS 2.726,842 2.726,842 30.00 30.00 31.00 03000 ADULTS WE CARE UNIT 1,390,045 1,390,045 30.00 31.00 ANCI LLARY SERVI CE COST CENTERS 50.00 05000 (PERATI NG ROOM 26,553 153,258 179,811 0.639861 0.000000 51.00 51.00 05100 RCOVERY ROOM 26,553 153,258 1.029,383 0.539839 0.000000 51.01 54.00 05400 RADI 0LOGY-DI AGNOSTI C 994,326 19.067,261 20.061,587 0.154325 0.000000 56.00 65.00 05600 RADI 0LOGY-DI AGNOSTI C 994,326 19.067,261 20.061,587 0.154325 0.000000 56.00 64.00 06500 RADI 0LOGY-DI AGNOSTI C 994,326 19.067,261 20.061,587 0.000000 56.00 06500 RESPI RATORY 1.300,963 9.8157,825 9.458,788 0.154090 0.000000 62.00 60.00 06000 PHYSI CAL THERAPY <td>Cost Center Description</td> <td>I npati ent</td> <td>Outpati ent</td> <td></td> <td></td> <td></td> <td></td>	Cost Center Description	I npati ent	Outpati ent				
INPATI ENT ROUTI NE SERVICE COST CENTERS 30.00 33000 ADULTS & PEDIATRI CS 2, 726, 842 2, 726, 842 30.00 31.00 03000 ADULTS & PEDIATRI CS 1, 390, 045 1, 390, 045 31.00 ANCI LLARY SERVICE COST CENTERS 0.00 0.00 00 (0.000 (0.000) 0.00000 (0.000) 0.000000 0.000000 50.00 05000 (0.000 (0.000) 0.00000 0.000000 51.00 0.000000 51.00 0.000000 51.00 0.000000 51.00 0.538939 0.000000 51.00 51.00 0.5400 (0.000000000000000000000000000000000				+ col. 7)	Ratio		
INPATI ENT ROUTI NE SERVI CE COST CENTERS 2,726,842 2,726,842 30.00 30.00 03000 ADULTS & PEDI ATRI CS 2,726,842 2,726,842 30.00 31.00 03100 INTENSI VE CARE UNIT 1,390,045 31.00 ANCI LLARY SERVI CE COST CENTERS 1,390,045 31.00 50.00 05000 (DPERATI NG ROOM 26,553 153,258 179,811 0.307746 0.000000 51.00 51.00 05100 RECOVERY ROOM 26,553 153,258 179,811 0.633961 0.000000 51.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 994,326 19,067,261 20,061,587 0.154325 0.000000 54.00 56.00 06500 RADI OLOGY-DI AGNOSTI C 994,326 19,067,261 20,061,587 0.154090 0.000000 56.00 0.00000 LABORATORY 1,300,963 8,157,825 9,458,788 0.154090 0.000000 56.00 65.00 06500 RADI NATORY HERAPY 353,704 322,443 676,147 1.367296 0.000000 65.00 65.00 06600 PHYSI CAL THERAPY							
30. 00 03000 ADULTS & PEDIATRICS 2, 726, 842 2, 726, 842 30. 00 31. 00 03100 INTENSIVE CARE UNIT 1, 390, 045 1, 390, 045 31. 00 ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM 816, 537 3, 791, 863 4, 608, 400 0. 307746 0. 000000 50. 00 51. 00 05100 RECOVERY ROOM 26, 553 153, 258 179, 811 0. 639861 0. 000000 51. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 994, 326 19, 067, 261 20, 061, 587 0. 154325 0. 000000 56. 00 56. 00 05600 RADI OLOGY-DI AGNOSTI C 994, 326 19, 067, 261 20, 061, 587 0. 154325 0. 000000 56. 00 60. 00 0600 LABORATORY 1, 300, 963 8, 157, 825 9, 458, 788 0. 154326 0. 000000 66. 00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 69, 036 90, 826 159, 862 0. 467316 0. 000000 66. 00 60.00 0600 DESPI RATORY THERAPY 123, 906 2. 242, 10 2. 369, 116 0. 433009 0.000000 66. 00 61.00 06600 PHYSI CAL		6.00	7.00	8.00	9.00	10.00	
31.00 03100 INTENSIVE CARE UNIT 1,390,045 1,390,045 31.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 0PERATING ROOM 816,537 3,791,863 4,608,400 0.307746 0.000000 50.00 51.00 0.639861 0.000000 51.00 51.00 0.5101 0.5101 0.7746 0.000000 51.00 51.01 0.5101 0.7746 0.000000 51.01 0.538939 0.000000 51.01 0.538939 0.000000 51.01 0.54.00 0.5400 RADI OLGY-DI AGNOSTI C 994,326 19,067,261 20,061,587 0.154325 0.000000 56.00 0.6000 LABORATORY 1,300,963 8,157,825 9,458,788 0.154090 0.000000 62.00 66.00<		,					-
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM 816, 537 3, 791, 863 4, 608, 400 0. 307746 0. 000000 51. 00 51. 00 05100 RECOVERY ROOM 26, 553 153, 258 179, 811 0. 639861 0. 000000 51. 00 51. 01 05101 0/P TREATMENT ROOM 13, 998 1, 015, 385 1, 029, 383 0. 538939 0. 000000 51. 01 54. 00 05400 RADI LOGY-DI AGNOSTI C 994, 326 19, 067, 261 20, 061, 587 0. 154325 0. 000000 56. 00 60. 00 O6000 RABORATORY 1, 300, 963 8, 157, 825 9, 458, 788 0. 154090 0. 000000 62. 00 66. 00 06500 RESPI RATORY THERAPY 123, 906 2, 245, 210 2, 369, 116 0. 433009 0. 000000 65. 00 67. 00 06700 OCCUPATI ONAL THERAPY 35, 481 665, 271 700, 752 0. 558801 0. 000000 67. 00 68. 00 06800 SPECH PATHOLOGY 511, 106 2, 514, 920							
50.00 05000 OPERATING ROOM 816, 537 3, 791, 863 4, 608, 400 0. 307746 0. 000000 50.00 51.00 05100 RECOVERY ROM 26, 553 153, 258 179, 811 0. 639861 0. 000000 51.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 994, 326 19, 067, 261 20, 061, 587 0. 154325 0.000000 54.00 56.00 05600 RADI OLOGY-DI AGNOSTI C 994, 326 19, 067, 261 20, 061, 587 0. 154325 0.000000 54.00 60.00 LABORATORY 1, 300, 963 8, 157, 825 9, 458, 788 0. 154090 0.000000 62.00 65.00 06500 RESPI RATORY THERAPY 353, 704 322, 443 676, 147 1. 367296 0.000000 62.00 66.00 06500 RESPI RATORY THERAPY 123, 906 2, 245, 210 2, 369, 116 0. 433009 0.000000 65.00 67.00 06700 CUPATI IONAL THERAPY 18, 707 91, 825 110, 532 0. 533773 0.000000 67.00		1, 390, 045		1, 390, 04	5		31.00
51.00 05100 RECOVERY ROOM 26,553 153,258 179,811 0.639861 0.000000 51.00 51.01 05101 0/P TREATMENT ROOM 13,998 1,015,385 1,029,383 0.538939 0.000000 51.01 54.00 05400 RADI OLOGY-DI AGNOSTI C 994,326 19,067,261 20,061,587 0.154325 0.000000 56.00 65.00 05600 RADI OLOGY-DI AGNOSTI C 28,091 666,839 694,930 0.224090 0.000000 56.00 60.00 06000 LABORATORY 1,300,963 8,157,825 9,458,788 0.154090 0.000000 62.00 65.00 06500 RESPI RATORY THERAPY 353,704 322,443 676,147 1.367296 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 123,906 2,245,210 2,369,116 0.433009 0.000000 66.00 67.00 06600 SPEECH PATHOLOGY 18,707 91,825 110,532 0.533773 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 511,106 2,514,920 3		· · · · · · ·					-
51.01 05101 0/P TREATMENT ROOM 13,998 1,015,385 1,029,383 0.538939 0.000000 51.01 54.00 05400 RADI OLOGY-DI AGNOSTI C 994,326 19,067,261 20,061,587 0.154325 0.000000 54.00 56.00 05600 RADI OLOGY-DI AGNOSTI C 28,091 666,839 694,930 0.224090 0.000000 66.00 60.00 LABORATORY 1,300,963 8,157,825 9,458,788 0.154090 0.000000 62.00 65.00 06500 RESPI RATORY THERAPY 353,704 322,443 676,147 1.367296 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 123,906 2,245,210 2,369,116 0.433009 0.000000 66.00 67.00 0C6700 0CUPATI ONAL THERAPY 35,481 665,271 700,752 0.558801 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 11,965,307 5,14,920 3,026,026 0.124942 0.000000 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0							
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60.00 06000 LABORATORY 1, 300, 963 8, 157, 825 9, 458, 788 0. 154090 0.000000 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 69, 036 90, 826 159, 862 0. 467316 0.000000 62.00 65.00 06500 RESPI RATORY THERAPY 353, 704 322, 443 676, 147 1. 367296 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 353, 704 322, 443 676, 147 1. 367296 0.000000 65.00 67.00 06700 OCCUPATI ONAL THERAPY 35, 481 665, 271 700, 752 0.58881 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 18, 707 91, 825 110, 532 0.533773 0.000000 69.00 69.00 06900 ELECTROCARDI OLOGY 511, 106 2, 514, 920 3, 026, 026 0. 124942 0.000000 69.00 73.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 45, 586 32, 258 77, 844 2.058797 0.000000 71.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 1, 965,							
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 69,036 90,826 159,862 0.467316 0.000000 62.00 65.00 06500 RESPI RATORY THERAPY 353,704 322,443 676,147 1.367296 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 123,906 2,245,210 2,369,116 0.433009 0.000000 66.00 67.00 06700 0CCUPATI ONAL THERAPY 35,481 666,271 700,752 0.558801 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 18,707 91,825 110,532 0.533773 0.000000 68.00 69.00 06900 ELCTROCARDI OLOGY 511,106 2,514,920 3,026,026 0.124942 0.000000 71.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 45,586 32,258 77,844 2.05877 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1,965,307 5,135,344 7,100,651 0.286505 0.000000 73.00 90.00 09000 CLINIC 0 0 0 </td <td></td> <td>28, 091</td> <td>666, 839</td> <td>694, 93</td> <td>0 0. 224090</td> <td>0.00000</td> <td>56.00</td>		28, 091	666, 839	694, 93	0 0. 224090	0.00000	56.00
65.00 06500 RESPI RATORY THERAPY 353, 704 322, 443 676, 147 1.367296 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 123, 906 2, 245, 210 2, 369, 116 0.433009 0.000000 66.00 67.00 06700 OCCUPATI ONAL THERAPY 35, 481 665, 271 700, 752 0.558801 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 18, 707 91, 825 110, 532 0.533773 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 511, 106 2, 514, 920 3, 026, 026 0.124942 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 45, 586 32, 258 77, 844 2.058797 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 1, 965, 307 5, 135, 344 7, 100, 651 0.286505 0.000000 73.00 90.00 09000 CLI NI C 0 0 0 0.000000 0.000000 91.00 91.00 09100 EMERGENCY 919, 130 18, 395, 204 1		1, 300, 963	8, 157, 825	9, 458, 78			
66.00 06600 PHYSI CAL THERAPY 123,906 2,245,210 2,369,116 0.433009 0.000000 66.00 67.00 06700 OCCUPATI ONAL THERAPY 35,481 665,271 700,752 0.558801 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 18,707 91,825 110,532 0.533773 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 11,106 2,514,920 3,026,026 0.124942 0.000000 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 45,586 32,258 77,844 2.058797 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1,965,307 5,135,344 7,100,651 0.286505 0.000000 73.00 90.00 09000 CLINIC 0 0 0.000000 0.000000 90.00 91.00 09100 EMERGENCY 919,130 18,395,204 19,314,334 0.204662 0.000000 92.00		69, 036	90, 826	159, 86			
67.00 06700 OCCUPATI ONAL THERAPY 35, 481 665, 271 700, 752 0.558801 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 18, 707 91, 825 110, 532 0.533773 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 511, 106 2, 514, 920 3, 026, 026 0.124942 0.000000 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 45, 586 32, 258 77, 844 2.058797 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 1, 965, 307 5, 135, 344 7, 100, 651 0.286505 0.000000 73.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 1, 965, 307 5, 135, 344 7, 100, 651 0.286505 0.000000 73.00 90.00 09100 EMERGENCY 919, 130 18, 395, 204 19, 314, 334 0.204662 0.000000 92.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 47, 724 1, 480, 962 1, 528, 686 0.890199 0.000000 92.00 92.00 Ubtotal (see instruct		353, 704					
68.00 06800 SPEECH PATHOLOGY 18,707 91,825 110,532 0.533773 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 511,106 2,514,920 3,026,026 0.124942 0.000000 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 45,586 32,258 77,844 2.058797 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1,965,307 5,135,344 7,100,651 0.286505 0.000000 73.00 0UTPATIENT SERVICE COST CENTERS 919,130 18,395,204 19,314,334 0.204662 0.000000 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 47,724 1,480,962 1,528,686 0.890199 0.000000 92.00 200.00 Subtotal (see instructions) 11,387,042 63,826,694 75,213,736 200.00 201.00							
69.00 06900 ELECTROCARDI OLOGY 511, 106 2, 514, 920 3, 026, 026 0. 124942 0. 000000 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 45, 586 32, 258 77, 844 2. 058797 0. 000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1, 965, 307 5, 135, 344 7, 100, 651 0. 286505 0. 000000 73.00 0UTPATIENT SERVICE COST CENTERS 0 0 0 0.000000 0. 000000 90.00 90.00 90.00 09000 CLINIC 0 0 0.000000 0.000000 91.00 91.00 09100 EMERGENCY 919, 130 18, 395, 204 19, 314, 334 0. 204662 0. 000000 92.00 92.00 09200 DSERVATI ON BEDS (NON-DI STINCT PART) 47, 724 1, 480, 962 1, 528, 686 0. 890199 0. 000000 92.00 200.00 Less Observation Beds 11, 387, 042 63, 826, 694 75, 213, 736 200.00 <td>67.00 06700 OCCUPATI ONAL THERAPY</td> <td>35, 481</td> <td>665, 271</td> <td>700, 75</td> <td>2 0. 558801</td> <td>0.00000</td> <td>67.00</td>	67.00 06700 OCCUPATI ONAL THERAPY	35, 481	665, 271	700, 75	2 0. 558801	0.00000	67.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 45,586 32,258 77,844 2.058797 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 1,965,307 5,135,344 7,100,651 0.286505 0.000000 73.00 00 09000 CLI NI C 0 0 0.000000 0.000000 90.00 91.00 09100 EMERGENCY 919,130 18,395,204 19,314,334 0.204662 0.000000 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 47,724 1,480,962 1,528,686 0.890199 0.000000 92.00 200.00 Subtotal (see instructions) 11,387,042 63,826,694 75,213,736 200.00 201.00	68.00 06800 SPEECH PATHOLOGY	18, 707	91, 825	110, 53	2 0. 533773	0.00000	68.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0.000000 72.00 73.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1,965,307 5,135,344 7,100,651 0.286505 0.000000 73.00 0UTPATIENT SERVICE COST CENTERS 0 0 0 0.000000 0.000000 90.00 90.00 09100 EMERGENCY 919,130 18,395,204 19,314,334 0.204662 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 47,724 1,480,962 1,528,686 0.890199 0.000000 92.00 200.00 Subtotal (see instructions) 11,387,042 63,826,694 75,213,736 200.00 201.00	69. 00 06900 ELECTROCARDI OLOGY	511, 106	2, 514, 920	3, 026, 02	6 0. 124942	0.00000	69.00
73.00 07300 DRUGS CHARGED TO PATIENTS 1,965,307 5,135,344 7,100,651 0.286505 0.000000 73.00 0UTPATIENT SERVICE COST CENTERS 0 0 0 0 0.000000 0.000000 0.000000 90.00 90.00 90.00 09100 EMERGENCY 919,130 18,395,204 19,314,334 0.204662 0.000000 91.00 92.00 9200 0BSERVATION BEDS (NON-DISTINCT PART) 47,724 1,480,962 1,528,686 0.890199 0.000000 92.00 92.00 92.00 11,387,042 63,826,694 75,213,736 200.00 201.00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	45, 586	32, 258	77, 84	4 2.058797	0.00000	71.00
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 0 0.000000 0.000000 90.00 90.00 919,130 18,395,204 19,314,334 0.204662 0.000000 91.00 91.00 91.00 92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 47,724 1,480,962 1,528,686 0.890199 0.000000 92.00 92.00 200.00 201.00 Less Observation Beds 11,387,042 63,826,694 75,213,736 200.00 201.00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0.000000	0.00000	72.00
90. 00 09000 CLINIC 0 0 0 0.00000 0.000000 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 91. 00 91. 30 18, 395, 204 19, 314, 334 0. 204662 0. 000000 91. 00 91. 00 92. 00 92. 00 0. 890199 0. 000000 92. 00	73.00 07300 DRUGS CHARGED TO PATIENTS	1, 965, 307	5, 135, 344	7, 100, 65	1 0. 286505	0.00000	73.00
91. 00 09100 EMERGENCY 919, 130 18, 395, 204 19, 314, 334 0. 204662 0. 000000 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 47, 724 1, 480, 962 1, 528, 686 0. 890199 0. 000000 92. 00 200. 00 Subtotal (see instructions) 11, 387, 042 63, 826, 694 75, 213, 736 0. 201. 00 201. 00							
92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 47, 724 1, 480, 962 1, 528, 686 0. 890199 0. 000000 92. 00 200. 00 Subtotal (see instructions) 11, 387, 042 63, 826, 694 75, 213, 736 0. 890199 0. 000000 92. 00 201. 00 Less Observation Beds 0. 00000 201. 00 201. 00 201. 00 201. 00 201. 00		0	0		0 0.000000	0.00000	90.00
200.00 Subtotal (see instructions) 11, 387, 042 63, 826, 694 75, 213, 736 200.00 201.00 Less Observation Beds 11, 387, 042 63, 826, 694 75, 213, 736 200.00	91.00 09100 EMERGENCY	919, 130	18, 395, 204	19, 314, 33	4 0. 204662	0.00000	91.00
201.00 Less Observation Beds 201.00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	47, 724	1, 480, 962	1, 528, 68	6 0. 890199	0.00000	92.00
	200.00 Subtotal (see instructions)	11, 387, 042	63, 826, 694	75, 213, 73	6		200.00
202.00 Total (see instructions) 11, 387, 042 63, 826, 694 75, 213, 736 202.00	201.00 Less Observation Beds						201.00
	202.00 Total (see instructions)	11, 387, 042	63, 826, 694	75, 213, 73	6		202.00

Health Financial Systems	UNI ON HOSPI TAL	CLINTON	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1326	Peri od: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Pre 5/25/2017 4:2	pared: 2 pm
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
ANCI LLARY SERVI CE COST CENTERS					
50.00 05000 OPERATI NG ROOM	0. 000000				50.00
51.00 05100 RECOVERY ROOM	0. 000000				51.00
51.01 05101 0/P TREATMENT ROOM	0. 000000				51.01
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
56. 00 05600 RADI OI SOTOPE	0. 000000				56.00
60. 00 06000 LABORATORY	0.000000				60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000				62.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000				68.00
69.00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	0.000000				90.00
91.00 09100 EMERGENCY	0. 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00
					•

Health Financial Systems	UNI ON HOSPI T	AL CLINTON		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider CO		Period: From 01/01/2016 To 12/31/2016		
			XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1					
50.00 05000 OPERATING ROOM	117, 456					
51.00 05100 RECOVERY ROOM	8, 845	179, 811	0. 04919	14, 274	702	51.00
51.01 05101 0/P TREATMENT ROOM	51, 115	1, 029, 383	0. 04965	6 3, 540	176	51.01
54. 00 05400 RADI OLOGY-DI AGNOSTI C	229, 356	20, 061, 587	0. 01143	3 385, 823	4, 411	54.00
56. 00 05600 RADI OI SOTOPE	7,017	694, 930	0. 01009	7 10, 743	108	56.00
60. 00 06000 LABORATORY	49, 169	9, 458, 788	0.00519	8 585, 694	3, 044	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	247	159, 862	0. 00154	5 51, 964	80	62.00
65. 00 06500 RESPI RATORY THERAPY	50, 438	676, 147	0. 07459	6 202, 854	15, 132	65.00
66. 00 06600 PHYSI CAL THERAPY	88, 007	2, 369, 116	0. 03714	8 73, 724	2, 739	66.00
67.00 06700 OCCUPATI ONAL THERAPY	70, 234	700, 752	0. 10022	7 17, 538	1, 758	67.00
68.00 06800 SPEECH PATHOLOGY	9, 595	110, 532	0. 08680	14, 260	1, 238	68.00
69. 00 06900 ELECTROCARDI OLOGY	18, 960	3, 026, 026	0. 00626	6 334, 951	2, 099	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	24, 940	77, 844	0. 32038	4 25, 034	8, 020	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0.00000	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	38, 142	7, 100, 651	0. 00537	2 1, 019, 830	5, 479	73.00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	0	0	0.00000	0 0	0	90.00
91. 00 09100 EMERGENCY	270, 944	19, 314, 334	0. 01402	.8 2, 820	40	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	142,019	1, 528, 686	0. 09290	3 1, 979	184	92.00
200.00 Total (lines 50-199)	1, 176, 484	71, 096, 849		3, 177, 872	56, 242	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCIELLARY SERVICE OTHER PASS THROUGH COSTS Provider CCN: 15-1326 Period: From 01/01/2016 To 12/31/2016 Porksheet D Part IV Date/Time Prepared: 5/25/2017 4:22 pm Title XVIII Hospital Cost Cost Center Description Non Physicial Anesthetist Cost All Other Amesthetist Cost All Other All Other Total Cost (sum of col 1 Education Cost 4) 50.00 05000 OPERATING ROOM 0 0 0 0 50.00 51.00 05100 (DS100 RECOVERY ROOM 0 0 0 0 51.00 56.00 05100 (DS100 RECOVERY ROOM 0 0 0 0 51.00 56.00 05100 IO/PT REATMENT ROOM 0 0 0 0 0 54.00 66.00 06000 REDSTORE 0 0 0 0 0 0 66.00 60.00 06000 REDSTORE 0 0 0 0 0 0 0 0 0	Health Financial Systems	UNI ON HOSPI TA	L CLINTON		In Lie	u of Form CMS-2	2552-10
Interview To 12/31/2016 Date/Time Prepared methods Cost Center Description Non Physician Nursing School Allied Health Allied Health Cost Total Cost Anesthetist Cost Cost Cost Cost Total Cost Total Cost Total Cost ANCILLARY SERVICE COST CENTERS 0 <		RVICE OTHER PASS	Provider C	CN: 15-1326			
Cost Center Description Non Physician Nursing School Allied Health Alliother Medical Education Cost Total Cost (sum of col 1 through col. 4) ANCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05000 OPERATING ROOM 0 0 0 0 50.00 51.00 05100 RECOVERY ROOM 0 0 0 0 50.00 51.00 05100 RECOVERY ROOM 0 0 0 0 50.00 54.00 05100 RECOVERY ROOM 0 0 0 0 51.00 54.00 05400 RADI OLGY-DI AGNOSTI C 0 0 0 0 56.00 56.00 06500 REDI DISOTOPE 0 0 0 0 0 56.00 66.00 06500 RADI DLOGY-DI AGNOSTI C 0 <	THROUGH COSTS						narod:
Cost Center Description Non Physician Nursing School Allied Health All Other Medical Education Cost Total Cost (sum of col 1 through col. 4) ANCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 ANCILLARY SERVICE COST CENTERS 0 0 0 0 50.00 50.00 05000 PERATING ROOM 0 0 0 0 50.00 51.00 05101 O/P TREATMENT ROOM 0 0 0 0 51.00 51.00 05000 PERATING ROOM 0 0 0 0 0 50.00 51.01 05101 O/P TREATMENT ROOM 0 </td <td></td> <td></td> <td></td> <td></td> <td>10 12/31/2010</td> <td>5/25/2017 4:2</td> <td>2 pm</td>					10 12/31/2010	5/25/2017 4:2	2 pm
Anesthetist Cost Medical Education Cost (sum of col 1 through col. 4) 1.00 2.00 3.00 4.00 5.00 50.00 05000 OPERATING ROM 0 0 0 0 50.00 51.00 05100 RECOVERY ROM 0 0 0 0 0 50.00 51.01 05101 O/P TREATMENT ROM 0 0 0 0 51.01 54.00 05400 RADI OLOCY-DI AGNOSTI C 0 0 0 0 54.00 60.00 LABORATORY 0 0 0 0 0 56.00 60.00 LABORATORY 0 0 0 0 0 62.00 0 0 0 0 62.00 65.00 65.00 65.00 66.00 65.00 66.00 65.00 66.00 66.00 66.00 67.00 0 0 0 0 0 0 0 66.00 67.00 0 0 0 <			Title	XVIII	Hospi tal		
Cost Education Cost through col. 4) 1.00 2.00 3.00 4.00 50.00 50.00 05000 0PERATINE ROOM 0 0 0 0 50.00 51.00 05100 RECOVERY ROOM 0 0 0 0 51.00 51.01 05101 0/P TREATMENT ROOM 0 0 0 0 51.01 54.00 05400 RADI LLGY-DI AGNOSTI C 0 0 0 0 54.00 56.00 06500 RADI OLOGY-DI AGNOSTI C 0 0 0 0 54.00 56.00 06500 RESPI RATORY 0 0 0 0 60.00 60.00 6400 HYSI CAL THERAPY 0 0 0 66.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 66.00 65.00 06500 PESPI RATORY THERAPY 0 0 0 67.00 65.00 06500 <td>Cost Center Description</td> <td>Non Physician N</td> <td>lursi ng School</td> <td>Allied Healt</td> <td>h All Other</td> <td></td> <td></td>	Cost Center Description	Non Physician N	lursi ng School	Allied Healt	h All Other		
ANCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05000 OPERATI NG ROOM 0 0 0 0 0 50.00 51.00 05100 RECOVERY ROOM 0 0 0 0 51.00 51.01 05101 0/P TREATMENT ROOM 0 0 0 0 51.01 54.00 05400 RADI 0LOGY-DI AGNOSTI C 0 0 0 0 54.00 54.00 05600 RADI 0LOGY-DI AGNOSTI C 0 0 0 0 56.00 60.00 06000 LABORATORY 0 0 0 0 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 66.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 67.00 67.00 67.00 67.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
1.00 2.00 3.00 4.00 5.00 ANCI LLARY SERVICE COST CENTERS 0<		Cost			Education Cost		
ANCI LLARY SERVICE COST CENTERS 50:00 05000 OPERATING ROOM 0 0 0 0 50:00 51:00 05100 RECOVERY ROOM 0 0 0 0 0 51:00 51:01 05101 0/P TREATMENT ROOM 0 0 0 0 51:01 54:00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 54:00 56:00 05600 RADI OLOGY-DI AGNOSTI C 0 0 0 54:00 56:00 05600 RADI OLOGY-DI AGNOSTI C 0 0 0 0 56:00 60:00 06000 LABORATORY 0 0 0 0 66:00 67:00 68:00 0 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
50.00 05000 0PERATING ROOM 0 0 0 0 0 0 0 0 0 50.00 51.00 05100 RECOVERY ROOM 0 0 0 0 0 0 0 0 0 0 0 0 0 51.00 51.01 05101 0/P TREATMENT ROOM 0 <td< td=""><td></td><td>1.00</td><td>2.00</td><td>3.00</td><td>4.00</td><td>5.00</td><td></td></td<>		1.00	2.00	3.00	4.00	5.00	
51.00 05100 RECOVERY ROOM 0 0 0 0 0 51.00 51.01 05100 PTREATMENT ROOM 0 0 0 0 51.01 54.00 05400 RADI OLOGY- DI AGNOSTI C 0 0 0 0 54.00 56.00 05600 RADI OLOGY-DI AGNOSTI C 0 0 0 0 56.00 56.00 05600 RADI OLOGY-DI AGNOSTI C 0 0 0 0 56.00 56.00 05600 RADI OLSOTOPE 0 0 0 0 60.00 62.00 06200 HADRATORY 0 0 0 0 62.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 66.00 67.00 0C200 CLOPATI ONAL THERAPY 0 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 67.00 <td></td> <td></td> <td></td> <td></td> <td>0</td> <td>0</td> <td>50.00</td>					0	0	50.00
51.01 0/P TREATMENT ROOM 0 0 0 0 51.01 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 54.00 56.00 05600 RADI OLOGY-DI AGNOSTI C 0 0 0 0 56.00 60.00 05600 RADI OLOGY-DI AGNOSTI C 0 0 0 0 56.00 60.00 06000 LABORATORY 0 0 0 0 66.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 62.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 67.00 69.00 06800 SPECH PATHOLOGY 0 0 0 0 67.00 69.00 06900 ELCTROCARDI OLOGY 0 0 0 0 71.00 <t< td=""><td></td><td>0</td><td>0</td><td></td><td>0 0</td><td>Ű</td><td></td></t<>		0	0		0 0	Ű	
54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 54.00 56.00 05600 RADI OI SOTOPE 0 0 0 0 56.00 60.00 06000 LABORATORY 0 0 0 0 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 62.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 67.00 69.00 0FORO 0 0 0 0 0 0 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 72.00 <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>u u u u u u u u u u u u u u u u u u u</td> <td></td>		0	0		0 0	u u u u u u u u u u u u u u u u u u u	
56.00 05600 RADI 0I SOTOPE 0 <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>-</td> <td></td>		0	0		0 0	-	
60.00 06000 LABORATORY 0		0	0		0 0	Ű	
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CCN: 15-1326 Period: Period: To 10/10/2016 Worksheet D Part IV Date/TIme Prepared: 5/25/2017 Impact Cost Center Description Total Outpatient Cost (sum of col. 2, 3 and 4) Total Charges (col. 5 + col. 8) Ratio of Cost (col. 5 + col. 7) Inpatient Program (col. 5 + col. 7) 50.00 05000 OPERATING ROOM 51.00 0 1.00 Inpatient Program (col. 5 + col. 7) 50.00 05000 REATINE NOM 0 1.029, 833 0.000000 0.000000 1.00 <td< th=""><th>Heal th</th><th>Financial Systems</th><th>UNI ON HOSPI T</th><th>AL CLINTON</th><th></th><th>In Lie</th><th>u of Form CMS-2</th><th>2552-10</th></td<>	Heal th	Financial Systems	UNI ON HOSPI T	AL CLINTON		In Lie	u of Form CMS-2	2552-10
Interview To 12/31/2016 Date/Time Prepared: 5/25/2017 4:22 pm Cost Center Description Total Cost (sum of col 2, 3 and 4) Total Charges (col. 5 + col. 9) Ratio of Cost (sum of col 2, 3 and 4) Uppatient (from Wkst. C, Part I, col. 8) Outpatient (col. 5 + col. 7) Date/Time Prepared: 5/25/2017 4:22 pm 50.00 05000 (DPERATING ROOM 51.00 0.00000 7.00 8.00 9.00 10.00 50.00 05100 (RECOVERY ROOM 51.01 0.1000 4.00 0.000000 0.000000 4.2844 50.00 51.00 05100 (RECOVERY ROOM 51.01 0.1027, 383 0.000000 0.000000 4.608, 400 0.000000 4.2844 50.00 54.00 05100 (RECOVERY ROOM 51.01 0.1027, 383 0.000000 0.000000 1.79, 811 0.000000 0.000000 1.7456.00 56.00 05100 (RECOVERY ROOM 56.00 0.1,029, 383 0.000000 0.000000 1.7456.00 1.7456.00 56.00 05000 (DEV TRATINENT TROM 0.1,229, 383 0.000000 0.000000 1.7456.00 60.00 06000 (LABORATORY 0 7,9481			VICE OTHER PASS	S Provider C				
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OUTPATI ENT_SERVICE_COST_CENTERS 90.00 09000 CLINIC 0 0.000000 0.000000 0 90.00 91.00 09100 EMERGENCY 0 19, 314, 334 0.000000 2, 820 91.00 92.00 09200 OBSERVATI ON_BEDS (NON-DI STINCT PART) 0 1, 528, 686 0.000000 0.000000 1, 979 92.00	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	C	0.00000	0. 000000	0	72.00
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200.00 Total (lines 50-199) 0 71,096,849 3,177,872 200.00			0			0.00000		
	200.00	Total (lines 50-199)	0	71, 096, 849			3, 177, 872	200. 00

APPORTI ONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CCN: 15-1326 Period: From 01/01/2016 To 12/31/2016 Worksheet 0 Part IV Date/Time Prepared: 5/25/2017 Cost Center Description Inpatient Program Pass-Through Costs (col. 9 x col. 10) Title XVIII Hospital Cost ANCILLARY SERVICE COST CENTERS 0utpatient Program Pass-Through Costs (col. 9 x col. 10) 0utpatient Program Pass-Through Costs (col. 9 x col. 12) 0 50.00 ANCILLARY SERVICE COST CENTERS 0 0 0 0 51.00 50.00 05000 0PERATING ROOM 0 0 0 51.00 51.00 05100 0/P TREATMENT ROOM 0 0 51.00 54.00 50.00 05600 RADIO SOTOPE 0 0 0 56.00 56.00 60.00 0 0 0 0 0 0 62.00 61.00 0 6000 LABORATORY 0 0 0 0 62.00 62.00 62.00 0 6000 CLODA & ACKED RED BLOOD CELLS 0 0 0 64.00 64.00 0 0 <t< th=""><th>Heal th</th><th>Financial Systems</th><th>UNI ON HOSPI TA</th><th>AL CLINTON</th><th></th><th>In Lie</th><th>u of Form CMS-</th><th>2552-10</th></t<>	Heal th	Financial Systems	UNI ON HOSPI TA	AL CLINTON		In Lie	u of Form CMS-	2552-10
ANCILLARY SERVICE COST CENTERS Outpatient Program (Cost Conter Description) Inpatient Program (Cost Cost Conter Description) Outpatient Program (Cost Cost Conter Description) Science Cost Cost (Cost Cost Conter Description) Science Cost (Cost Cost Cost Cost (Cost Cost Cost Cost Cost Cost Cost (Cost Cost Cost Cost Cost Cost Cost Cost (Cost Cost Cost Cost Cost Cost (Cost Cost Cost Cost Cost Cost (Cost Cost Cost Cost Cost (Cost Cost Cost Cost Cost (Cost Cost (Cost (Cost Cost (Cos			VICE OTHER PASS	Provider C	CN: 15-1326	From 01/01/2016	Part IV	nared.
Cost Center Description Inpatient Program Pass-Through Costs (col. 8 x col. 10) Outpatient Program Charges Outpatient Program Charges Program Pass-Through Costs (col. 9 x col. 12) ANCI LLARY SERVICE COST CENTERS 0 0 10.00 12.00 13.00 50.00 05000 OPERATI NG ROOM 0 0 0 0 50.00 51.00 05100 RECOVERY ROOM 0 0 0 0 51.00 51.00 05100 RECOVERY ROOM 0 0 0 0 51.00 51.00 05000 RADIOLOGY-DIAGNOSTIC 0 0 0 0 54.00 56.00 06000 LABORATORY 0 0 0 0 0 60.00 62.00 06500 RESPI RATORY THERAPY 0 0 0 0 65.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 67.00 67.00 67.00 67.00 67.00						10 12/31/2010		
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92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 92. 00			0	0		0		
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200.00 Total (lines 50-199) 0 0 0 200.00			0	0		0		
	200.00	Total (lines 50-199)	0	0		0		200.00

Health Financial Systems	UNI ON HOSPI T	AL CLINTON		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCI NE COST	Provider C		Period:	Worksheet D	
				From 01/01/2016 To 12/31/2016		narod
				10 12/31/2010	5/25/2017 4:2	
		Title	XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 307746	0	.,		0	
51.00 05100 RECOVERY ROOM	0. 639861	0	51, 19		0	•
51.01 05101 0/P TREATMENT ROOM	0. 538939		458, 79		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 154325		5, 905, 70	7 131	0	54.00
56. 00 05600 RADI 0I SOTOPE	0. 224090	0	248, 97	2 0	0	56.00
60. 00 06000 LABORATORY	0. 154090	0	2, 935, 37	1 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 467316	0	65, 21	0 0	0	62.00
65. 00 06500 RESPI RATORY THERAPY	1. 367296	0	104, 48	9 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 433009	0	907, 48	1 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 558801	0	157, 32	9 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 533773	0	15, 06	5 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 124942	0	1, 038, 87	5 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2. 058797	0	16, 81	5 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 286505	0	2, 586, 99	5 3, 207	0	73.00
OUTPATIENT SERVICE COST CENTERS		•				1
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
91.00 09100 EMERGENCY	0. 204662	0	4, 721, 61	7 742	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 890199	0	682, 41	7 0	0	92.00
200.00 Subtotal (see instructions)		0	21, 186, 96	5 4, 080	0	200. 00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)		0	21, 186, 96	5 4, 080	0	202.00

Heal th	Financial Systems	UNI ON HOSPI T	AL CLINTON		In Lie	u of Form CMS-	2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CC		Peri od: From 01/01/2016 To 12/31/2016	5/25/2017 4:2	
			Title	XVIII	Hospi tal	Cost	_
			sts				
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00				
50.00	ANCI LLARY SERVICE COST CENTERS	007.407					
	05000 OPERATING ROOM	397, 187					50.00
	05100 RECOVERY ROOM	32, 760					51.00
	05101 0/P TREATMENT ROOM	247, 260					51.01
	05400 RADI OLOGY-DI AGNOSTI C	911, 398					54.00
	05600 RADI OI SOTOPE	55, 792					56.00
	06000 LABORATORY	452, 311					60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	30, 474					62.00
	06500 RESPI RATORY THERAPY	142, 867					65.00
	06600 PHYSI CAL THERAPY	392, 947					66.00
	06700 OCCUPATIONAL THERAPY	87, 916	0				67.00
	06800 SPEECH PATHOLOGY	8, 041	0				68.00
	06900 ELECTROCARDI OLOGY	129, 799					69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	34, 619					71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	741, 187	919				73.00
	OUTPATIENT SERVICE COST CENTERS	-	-				
	09000 CLI NI C	0	-				90.00
	09100 EMERGENCY	966, 336					91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	607, 487					92.00
200.00		5, 238, 381	1, 091				200.00
201.00		0					201.00
	Only Charges						
202.00	Net Charges (line 200 +/- line 201)	5, 238, 381	1, 091				202.00

Health Financial Systems	UNI ON HOSPI T	AL CLINTON		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Peri od:	Worksheet D	
		Component		From 01/01/2016		norod.
		Component	CCN: 15-Z326	To 12/31/2016	Date/Time Pre 5/25/2017 4:2	
		Title	2 XVIII	Swing Beds - SNF	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS			-			
50.00 05000 OPERATING ROOM	0. 307746	0		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0. 639861	0		0 0	0	51.00
51.01 05101 0/P TREATMENT ROOM	0. 538939	0		0 0	0	51.01
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 154325	0		0 0	0	54.00
56. 00 05600 RADI OI SOTOPE	0. 224090	0		0 0	0	56.00
60. 00 06000 LABORATORY	0. 154090	0		0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 467316	0		0 0	0	62.00
65. 00 06500 RESPI RATORY THERAPY	1. 367296	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 433009	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 558801	0)	0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 533773	0)	0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 124942	0)	0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2. 058797	0)	0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0)	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 286505	0)	0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0. 204662	0)	0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.890199			0 0	0	
200.00 Subtotal (see instructions)		0		0 0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)		0		0 0	0	202.00
				,	•	

Health Financial Systems	UNI ON HOSPI T	AL CLINTON		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C Component	CN: 15-1326 CCN: 15-Z326	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Pro	
			• XVIII	Swing Pode SNE	5/25/2017 4:: Cost	22 pm
	Co	sts		Swing Beds - SNF	COST	
Cost Center Description	Cost	Cost	-			
cost center bescription	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS	0.00	1.00	1			
50. 00 05000 OPERATING ROOM	0	0				50.00
51.00 05100 RECOVERY ROOM	0	0				51.00
51.01 05101 0/P TREATMENT ROOM	0	0				51.01
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
56. 00 05600 RADI OI SOTOPE	0	0				56.00
60. 00 06000 LABORATORY	0	0				60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62.00
65. 00 06500 RESPIRATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0					66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0					67.00
68. 00 06800 SPEECH PATHOLOGY	0	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
OUTPATIENT SERVICE COST CENTERS		<u> </u>				
90.00 09000 CLINIC	0	0				90.00
91.00 09100 EMERGENCY	0	0				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
200.00 Subtotal (see instructions)		n n				200.00
201.00 Less PBP Clinic Lab. Services-Program						201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	0	0				202.00

	Financial Systems UN ATION OF INPATIENT OPERATING COST	I ON HOSPITAL CL	rovider CCN: 15-1326	Period: From 01/01/2016	u of Form CMS-2 Worksheet D-1	
				To 12/31/2016	Date/Time Prep 5/25/2017 4:22	
	Cost Center Description		Title XVIII	Hospi tal	Cost	
					1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS					-
00	Inpatient days (including private room days and s	wing-bed days,	excluding newborn)		2, 541	1
00	Inpatient days (including private room days, excl				2, 412	2
00	Private room days (excluding swing-bed and observ do not complete this line.	ation bed days)	. If you have only pr	rivate room days,	0	3
00	Semi-private room days (excluding swing-bed and o	bservation bed	days)		1, 572	4
00	Total swing-bed SNF type inpatient days (includin	g private room	days) through Decembe	er 31 of the cost	118	5
00	reporting period Total swing-bed SNF type inpatient days (includin	a private room	davs) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on th	is line)				
00	Total swing-bed NF type inpatient days (including	private room c	lays) through December	- 31 of the cost	17	7
00	reporting period Total swing-bed NF type inpatient days (including	private room o	davs) after December 3	31 of the cost	0	8
	reporting period (if calendar year, enter 0 on th	is line)	-			
00	Total inpatient days including private room days newborn days)	applicable to t	the Program (excluding	g swing-bed and	1, 019	9
. 00	Swing-bed SNF type inpatient days applicable to t	itle XVIII only	/(including private r	room days)	112	10
	through December 31 of the cost reporting period	(see instructio	ons)	5 1		
. 00	Swing-bed SNF type inpatient days applicable to t December 31 of the cost reporting period (if cale			room days) after	0	11
. 00	Swing-bed NF type inpatient days applicable to ti			te room days)	0	12
	through December 31 of the cost reporting period		3 . 0 .	<u> </u>		
. 00	Swing-bed NF type inpatient days applicable to ti after December 31 of the cost reporting period (i				0	13
. 00	Medically necessary private room days applicable				0	14
. 00	Total nursery days (title V or XIX only)	0		5	0	
. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT				0	16
. 00	Medicare rate for swing-bed SNF services applicab	le to services	through December 31 d	of the cost		17
00	reporting period					1.0
. 00	Medicare rate for swing-bed SNF services applicab reporting period	le to services	arter December 31 of	the cost		18
. 00	Medicaid rate for swing-bed NF services applicabl reporting period	e to services t	through December 31 of	f the cost	137.32	19
. 00	Medicaid rate for swing-bed NF services applicabl	e to services a	after December 31 of 1	the cost	0.00	20
~~	reporting period	·			4 101 044	1 21
. 00	Total general inpatient routine service cost (see Swing-bed cost applicable to SNF type services th		31 of the cost report	ting period (line	4, 101, 044 0	21
. 00	5 x line 17)	bugit becchiber		ing period (inic	0	24
. 00	Swing-bed cost applicable to SNF type services af x line 18)	ter December 31	l of the cost reportin	ng period (line 6	0	23
. 00	Swing-bed cost applicable to NF type services thr	ough December 3	31 of the cost reporti	ng period (line	2, 334	24
. 00	7 x line 19) Swing-bed cost applicable to NF type services aft	er December 31	of the cost reporting	n period (line 8	0	25
	x line 20)	51 200000000 01			, i i i i i i i i i i i i i i i i i i i	
. 00	Total swing-bed cost (see instructions)				193, 499	
. 00	General inpatient routine service cost net of swi PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ng-bed cost (II	ne 21 minus line 26)		3, 907, 545	21
. 00	General inpatient routine service charges (exclud	ing swing-bed a	and observation bed ch	narges)	0	28
	Private room charges (excluding swing-bed charges				0	
. 00	Semi-private room charges (excluding swing-bed ch	0,	ine 28)		0 0. 000000	
00 00			1110 20)			
00 00 00	General inpatient routine service cost/charge rat Average private room per diem charge (line 29 + 1				0.00	
00 00 00 00 00 00	General inpatient routine service cost/charge rat Average private room per diem charge (line 29 ÷ 1 Average semi-private room per diem charge (line 3	ine 3) 0 ÷ line 4)			0.00	
. 00 . 00 . 00 . 00 . 00 . 00	General inpatient routine service cost/charge rat Average private room per diem charge (line 29 ÷ 1 Average semi-private room per diem charge (line 3 Average per diem private room charge differential	ine ³) 0 ÷ line 4) (line 32 minus		ctions)	0.00 0.00	34
. 00 . 00 . 00 . 00 . 00 . 00 . 00	General inpatient routine service cost/charge rat Average private room per diem charge (line 29 ÷ 1 Average semi-private room per diem charge (line 3 Average per diem private room charge differential Average per diem private room cost differential (ine 3) O ÷ line 4) (line 32 minus line 34 x line		ctions)	0.00 0.00 0.00	34 35
. 00	General inpatient routine service cost/charge rat Average private room per diem charge (line 29 ÷ 1 Average semi-private room per diem charge (line 3 Average per diem private room charge differential	ine ³) O÷line4) (line32minus line34xline xline35)	31)		0.00 0.00	34 35 36
. 00 . 00 . 00 . 00 . 00 . 00 . 00	General inpatient routine service cost/charge rat Average private room per diem charge (line 29 ÷ 1 Average semi-private room per diem charge (line 3 Average per diem private room charge differential Average per diem private room cost differential (Private room cost differential adjustment (line 3 General inpatient routine service cost net of swi 27 minus line 36)	ine ³) O÷line4) (line32minus line34xline xline35)	31)		0.00 0.00 0.00 0	34 35 36
. 00 . 00 . 00 . 00 . 00 . 00 . 00	General inpatient routine service cost/charge rat Average private room per diem charge (line 29 ÷ 1 Average semi-private room per diem charge (line 3 Average per diem private room charge differential Average per diem private room cost differential (Private room cost differential adjustment (line 3 General inpatient routine service cost net of swi 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY	ine 3) 0 ÷ line 4) (line 32 minus line 34 x line x line 35) ng-bed cost and	31) d private room cost di		0.00 0.00 0.00 0	34 35 36
00 00 00 00 00 00 00 00 00	General inpatient routine service cost/charge rat Average private room per diem charge (line 29 ÷ 1 Average semi-private room per diem charge (line 3 Average per diem private room charge differential Average per diem private room cost differential (Private room cost differential adjustment (line 3 General inpatient routine service cost net of swi 27 minus line 36)	ine 3) 0 ÷ line 4) (line 32 minus line 34 x line x line 35) ng-bed cost and JGH COST ADJUST	31) d private room cost di MENTS		0.00 0.00 0.00 0	34 35 36 37
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	General inpatient routine service cost/charge rat Average private room per diem charge (line 29 ÷ 1 Average semi-private room per diem charge (line 3 Average per diem private room charge differential Average per diem private room cost differential (Private room cost differential adjustment (line 3 General inpatient routine service cost net of swi 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THRO	ine 3) 0 + line 4) (line 32 minus line 34 x line x line 35) ng-bed cost and UGH COST ADJUST er diem (see ir ine 9 x line 38	31) d private room cost di MENTS Instructions) 3)		0.00 0.00 0.00 3,907,545	34 35 36 37 38 38

MPUT	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-1326	Period: From 01/01/2016	Worksheet D-1	1
					To 12/31/2016		
				XVIII	Hospi tal	Cost	- - p
	Cost Center Description	Total Inpatient Costl	Total Inpatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
. 00	NURSERY (title V & XIX only)			L		i	42.
00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	1,665,360	519	3, 208.	79 256	821, 450	43
00	CORONARY CARE UNI T	1,003,300	517	5,200.	230	021,430	44
00	BURN INTENSIVE CARE UNIT						45
	SURGI CAL INTENSI VE CARE UNI T					Í	46
00	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description					1.00	-
00	Program inpatient ancillary service cost (Wk		Lino 200)			1.00 1,035,340) 48
	Total Program inpatient costs (sum of lines			ins)		3, 507, 611	
00	PASS THROUGH COST ADJUSTMENTS			110)		0,00,7011	
00	Pass through costs applicable to Program inpa	atient routine :	services (from	Wkst. D, sur	n of Parts I and	0	50
~ ~							
00	Pass through costs applicable to Program inpa	atient ancillar	y services (fr	om Wkst. D, s	sum of Parts II	0	51
00	and IV) Total Program excludable cost (sum of lines !	50 and 51)				0	52
. 00	Total Program inpatient operating cost exclude		lated, non-phy	sician anestl	netist, and	0	
	medical education costs (line 49 minus line !	52)				<u> </u>	
~~	TARGET AMOUNT AND LIMIT COMPUTATION						
. 00	Program discharges Target amount per discharge					0.00	
00	Target amount per discharge Target amount (line 54 x line 55)					0.00	
00	Difference between adjusted inpatient operati	ng cost and ta	rget amount (l	ine 56 minus	line 53)	0	
. 00	Bonus payment (see instructions)	ng ooot and ta	got anount (i		11110 00)	0	
. 00	Lesser of lines 53/54 or 55 from the cost re	porting period (ending 1996, u	pdated and co	ompounded by the	0.00	
	market basket						
. 00 . 00	Lesser of lines 53/54 or 55 from prior year of lines 53/54 is less than the lower of lines					0.00	
. 00	which operating costs (line 53) are less than					l U	
	amount (line 56), otherwise enter zero (see i				the target		
. 00	Relief payment (see instructions)					0	
. 00	Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)			0	63
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	ts through Dece	mber 31 of the	cost report	ing period (See	181, 444	64
. 00	instructions) (title XVIII only)	through beech					
. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the c	ost reporting	g period (See	0	65
00	instructions)(title XVIII only)	a acata (lina	(1 plup line (E) (+; + o V)//		101 444	
. 00	Total Medicare swing-bed SNF inpatient routin CAH (see instructions)	ne costs (Tine)	64 prus rine d	5)(title XVII	T ONLY). FOR	181, 444	
. 00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 c	of the cost re	eporting period	0	67
	(line 12 x line 19)	Ū.					
. 00	Title V or XIX swing-bed NF inpatient routine	e costs after De	ecember 31 of	the cost repo	orting period	0	68
00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient n	coutine costs (line 67 ± line	68)		0	69
. 00	PART III - SKILLED NURSING FACILITY, OTHER NU					0	1 07
. 00	Skilled nursing facility/other nursing facili)		70
. 00	Adjusted general inpatient routine service co		ine 70 ÷ line	2)			71
. 00	Program routine service cost (line 9 x line			25			72
. 00	Medically necessary private room cost applica						73
. 00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient i	•			Part II column		74
	26, line 45)	Satine service	50313 (1100 M	STREEL D, 1	art i, corunni		'
. 00	Per diem capital-related costs (line 75 ÷ lin	ne 2)					76
00	Program capital-related costs (line 9 x line						77
	Inpatient routine service cost (line 74 minus		and all the second s	1-2			78
00	Aggregate charges to beneficiaries for excess				nuc line 70)	1	79
00 00	Total Program routine service costs for compa Inpatient routine service cost per diem limit		UST IT MITATION	(IINE /8 MI	ius IIIle /9)	1	80
00	Inpatient routine service cost per drem finm Inpatient routine service cost limitation (li)			1	82
00	Reasonable inpatient routine service cost frim tatron (in		•			1	83
. 00	Program inpatient ancillary services (see ins					1	84
	Utilization review - physician compensation		ns)				85
. 00	Total Program inpatient operating costs (sum		rough 85)			L	86
	PART IV - COMPUTATION OF OBSERVATION BED PASS					840	1
00							
7.00 8.00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per o		line 2)		I	1, 620. 04	

Health Financial Systems	UNI ON HOSPI T	AL CLINTON		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 01/01/2016 To 12/31/2016		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	427, 994	4, 101, 044	0. 10436	2 1, 360, 834	142, 019	90.00
91.00 Nursing School cost	0	4, 101, 044	0.00000	0 1, 360, 834	0	91.00
92.00 Allied health cost	0	4, 101, 044	0.00000	0 1, 360, 834	0	92.00
93.00 All other Medical Education	0	4, 101, 044	0.00000	0 1, 360, 834	0	93.00

	Financial Systems UNION HOSPITAL ATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1326	Peri od:	u of Form CMS-2 Worksheet D-1	
			From 01/01/2016 To 12/31/2016		
		Title XIX	Hospi tal	5/25/2017 4:22 Cost	2 pr
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1.00	
~~	I NPATI ENT DAYS			0.511	
00 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			2, 541 2, 412	
00	Private room days (excluding swing-bed and observation bed da		rivate room days,	0	
00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	ned days)		1, 572	4
00	Total swing-bed SNF type inpatient days (including private ro	5 /	er 31 of the cost	118	
00	reporting period Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)				
00	Total swing-bed NF type inpatient days (including private roc reporting period	om days) through December	31 of the cost	17	7
00	Total swing-bed NF type inpatient days (including private roc	om days) after December 3	1 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable t	to the Drogram (avaluding	, cwing bod and	205	9
00	newborn days)	to the Program (excruding	j swing-bed and	205	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruct		room days)	0	10
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of		room days) after	0	11
. 00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI			0	12
. 00	through December 31 of the cost reporting period	x only (including privat	e room days)	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13
. 00	Medically necessary private room days applicable to the Progr			0	14
. 00	Total nursery days (title V or XIX only)		-	0	
. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16
. 00	Medicare rate for swing-bed SNF services applicable to servic	ces through December 31 c	of the cost] 17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to servic reporting period	ces after December 31 of	the cost		18
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es through December 31 of	the cost	137.32	19
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es after December 31 of t	he cost	0.00	20
. 00 . 00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ing pariod (line)	4, 101, 044	21
	5 x line 17)		01	0	
. 00	Swing-bed cost applicable to SNF type services after December x line 18)	r 31 of the cost reportir	ng period (line 6	0	23
. 00	Swing-bed cost applicable to NF type services through December 7 x line 19)	er 31 of the cost reporti	ng period (line	2, 334	24
. 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) Total swing-bed cost (see instructions)			193, 499	26
. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		3, 907, 545	27
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	ed and observation bed ch	arges)	0	28
. 00	Private room charges (excluding swing-bed charges)		5,	0	
	Semi-private room charges (excluding swing-bed charges)	Line 20		0	
00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	÷ TINE 28)		0. 000000 0. 00	
00	Average semi-private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	tions)	0.00	
00	Average per diem private room cost differential (line 34 x li	, ,	,	0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)	- /		0.00	
. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	3, 907, 545	
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ			4 (00 5)	
~~		a instructions)		1, 620. 04	38
. 00	Adjusted general inpatient routine service cost per diem (see				
. 00 . 00 . 00	Program general inpatient routine service cost per drem (see Medically necessary private room cost applicable to the Progr	e 38)		332, 108	39

OMPUT	Financial Systems ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-1326	Period: From 01/01/2016	Worksheet D-1	1
					To 12/31/2016		
			Ti tl	e XIX	Hospi tal	5/25/2017 4:2 Cost	22 piii
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
. 00	NURSERY (title V & XIX only)						42.
. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	1, 665, 360	519	3, 208.	79 130	417, 143	3 43
. 00	CORONARY CARE UNIT	1,000,000	017	0,200.			44.
6.00	BURN INTENSIVE CARE UNIT						45.
	SURGICAL INTENSIVE CARE UNIT						46.
. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.
	cost center bescription					1.00	-
. 00	Program inpatient ancillary service cost (Wks					274, 617	/ 48
. 00	Total Program inpatient costs (sum of lines 4	41 through 48)(see instructio	ns)		1, 023, 868	3 49
. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	ationt routing	sorvicos (from	Wkst D su	m of Parts 1 and	C	50
. 00	(111)		services (IIOI	WKST. D, SU	II OF FAILS F ANU		50
. 00	Pass through costs applicable to Program inpa	atient ancillar	y services (fr	om Wkst. D,	sum of Parts II	C	51.
	and IV)						
2.00 3.00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclud		lated non ne	cician anact	natist and		
5.00	medical education costs (line 49 minus line 5		rated, non-phy		letist, allu		53
	TARGET AMOUNT AND LIMIT COMPUTATION						
	Program discharges					C	
. 00	Target amount per discharge					0.00	
0. 00 . 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operati	na cost and ta	raet amount (l	ine 56 minus	line 53)		
. 00	Bonus payment (see instructions)	ng cost and ta	rget anount (i	The 50 million	TTHE 55)		
9.00	Lesser of lines 53/54 or 55 from the cost rep	porting period	endi ng 1996, ι	pdated and c	ompounded by the	0.00	
	market basket						
). 00 . 00	Lesser of lines 53/54 or 55 from prior year of lines 53/54 is less than the lower of lines				the amount by	0.00	
1.00	which operating costs (line 53) are less than						
	amount (line 56), otherwise enter zero (see i		- (
2.00	Relief payment (see instructions)					C	
3. 00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ctions)			C) 63
I. 00	Medicare swing-bed SNF inpatient routine cost	ts through Dece	mber 31 of the	cost report	na period (See	C	64.
	instructions)(title XVIII only)	5			5 1 2 2		
5.00	Medicare swing-bed SNF inpatient routine cost	ts after Decemb	er 31 of the c	ost reporting	g period (See	C	65
5.00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routin	no costs (lino	64 plus lipo 6	5) (+i +l o XV/	L oply) For	c c	66
5.00	CAH (see instructions)		04 prus rine c	5)(title xvi	i ony). Toi		
7.00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 c	f the cost r	eporting period	c	67.
	(line 12 x line 19)						
3.00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after D	ecember 31 of	the cost rep	orting period	C	68
9.00	Total title V or XIX swing-bed NF inpatient i	routine costs (line 67 + line	68)		C	69.
	PART III - SKILLED NURSING FACILITY, OTHER NU						
0. 00	Skilled nursing facility/other nursing facili	5)		70
. 00	Adjusted general inpatient routine service co		ine 70 ÷ line	2)			71
. 00	Program routine service cost (line 9 x line 7 Medically necessary private room cost applica		(line 14 x li	ne 35)			73
. 00	Total Program general inpatient routine servi						74
5.00	Capital-related cost allocated to inpatient i	routine service	costs (from W	orksheet B, I	Part II, column		75
00	26, line 45)	20.2)					-,
. 00 . 00	Per diem capital-related costs (line 75 ÷ lin Program capital-related costs (line 9 x line						76
	Inpatient routine service cost (line 74 minus						78
. 00	Aggregate charges to beneficiaries for excess	,	rovi der record	s)			79
. 00	Total Program routine service costs for compa		ost limitatior	(line 78 mi	nus line 79)		80
	Inpatient routine service cost per diem limit		`				81
. 00 . 00	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (s		•				82
. 00	Program inpatient ancillary services (see ins		.,				84
	Utilization review - physician compensation		ns)				85
6.00	Total Program inpatient operating costs (sum	of lines 83 th					86
1 00	PART IV - COMPUTATION OF OBSERVATION BED PASS					0.12	1 07
	Total observation bed days (see instructions)					840	
7.00 3.00	Adjusted general inpatient routine cost per o	diem (line 27 ∸	line 2)			1, 620. 04	1 88.

Health Financial Systems	UNI ON HOSPI T	AL CLINTON		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 01/01/2016 To 12/31/2016		
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	427, 994	4, 101, 044	0. 10436	2 1, 360, 834	142, 019	90.00
91.00 Nursing School cost	0	4, 101, 044	0.00000	0 1, 360, 834	0	91.00
92.00 Allied health cost	0	4, 101, 044	0.00000	0 1, 360, 834	0	92.00
93.00 All other Medical Education	0	4, 101, 044	0.00000			93.00

Health Financial Systems	UNION HOSPITAL CLINTON		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi de	r CCN: 15-1326	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Pre 5/25/2017 4:2	pared:
	T	tle XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
			_	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			1, 698, 145		30.00
31.00 03100 INTENSIVE CARE UNIT			555, 825		31.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM		0. 3077	46 432, 844	133, 206	50.00
51.00 05100 RECOVERY ROOM		0. 6398	61 14, 274	9, 133	51.00
51.01 05101 0/P TREATMENT ROOM		0. 5389	39 3, 540	1, 908	51.01
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1543	25 385, 823	59, 542	54.00
56. 00 05600 RADI 0I SOTOPE		0. 2240	90 10, 743	2, 407	56.00
60. 00 06000 LABORATORY		0. 1540	90 585, 694	90, 250	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 4673	16 51, 964	24, 284	62.00
65. 00 06500 RESPI RATORY THERAPY		1.3672	96 202, 854	277, 361	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 4330	09 73, 724	31, 923	66.00
67.00 06700 OCCUPATI ONAL THERAPY		0. 5588	01 17, 538	9, 800	67.00
68.00 06800 SPEECH PATHOLOGY		0. 5337	73 14, 260	7,612	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 1249	42 334, 951	41, 849	69.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS		2.0587	97 25, 034	51, 540	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.0000	00 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2865	05 1, 019, 830	292, 186	73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C		0.0000	00 0	0	90.00
91.00 09100 EMERGENCY		0. 2046	62 2, 820	577	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 8901			92.00
200.00 Total (sum of lines 50-94 and 96-98)			3, 177, 872		200. 00
201.00 Less PBP Clinic Laboratory Services-Proc	ram only charges (line 6	1)	0		201.00
202.00 Net Charges (line 200 minus line 201)		í	3, 177, 872		202.00
		•		•	•

Health Financial Systems UNION HOSPIT	AL CLINTON		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C		Peri od:	Worksheet D-3	
	Component		From 01/01/2016 To 12/31/2016	Date/Time Pre	narad
	component	CCN: 15-2320	10 12/31/2016	5/25/2017 4:2	
	Title		Swing Beds - SNF		
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1	-		
30. 00 03000 ADULTS & PEDI ATRI CS			0		30.00
31.00 03100 INTENSIVE CARE UNIT			0		31.00
ANCI LLARY SERVI CE COST CENTERS		0.0077			
50. 00 05000 OPERATI NG ROOM		0. 30774		142	
51.00 05100 RECOVERY ROOM		0. 63986		0	51.00
51.01 05101 0/P TREATMENT ROOM		0. 53893		0	51.01
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 15432			54.00
56. 00 05600 RADI 0I SOTOPE		0. 22409		0	56.00
60. 00 06000 LABORATORY		0. 15409			
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 46731		0	62.00
65. 00 06500 RESPI RATORY THERAPY		1. 36729			65.00
66. 00 06600 PHYSI CAL THERAPY		0. 43300			66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 55880			
68.00 06800 SPEECH PATHOLOGY		0. 53377		152	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 12494		0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		2. 05879		1, 785	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.00000		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 28650	5 61, 361	17, 580	73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C		0.00000		0	
91. 00 09100 EMERGENCY		0. 20466		0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 89019		0	92.00
200.00 Total (sum of lines 50-94 and 96-98)			128, 518	54, 761	
201.00 Less PBP Clinic Laboratory Services-Program only charge	ges (line 61)		0		201.00
202.00 Net Charges (line 200 minus line 201)			128, 518		202.00

Health Financial Systems UNION HOSPIT	AL CLINTON		In Lie	u of Form CMS-2	2552-10
I NPATI ENT ANCI LLARY SERVI CE COST APPORTI ONMENT	Provider C	CN: 15-1326	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Pre 5/25/2017 4:2	pared:
	Titl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
		To Charges	Program	Program Costs	
		-	Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			247, 934		30.00
31. 00 03100 I NTENSI VE CARE UNI T			224, 229		31.00
ANCI LLARY SERVI CE COST CENTERS					
50.00 OPERATING ROOM		0. 30774	46 131, 233	40, 386	50.00
51.00 05100 RECOVERY ROOM		0. 63986	51 5, 565	3, 561	51.00
51.01 05101 0/P TREATMENT ROOM		0. 53893	39 0	0	51.01
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 15432	25 243, 580	37, 590	54.00
56. 00 05600 RADI 0I SOTOPE		0. 2240	90 11, 740	2, 631	56.00
60. 00 06000 LABORATORY		0. 15409	260, 575	40, 152	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 4673	16 11, 528	5, 387	62.00
65. 00 06500 RESPI RATORY THERAPY		1. 36729	49, 090	67, 121	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 43300)9 4, 998	2, 164	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 55880	01 0	0	67.00
68.00 06800 SPEECH PATHOLOGY		0. 5337	73 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 12494	42 45, 574	5, 694	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		2.05879	3, 939	8, 110	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.0000	0 00	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 28650	05 0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C		0.0000	0 00	0	90.00
91. 00 09100 EMERGENCY		0. 20466	302, 066	61, 821	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 89019	99 0	0	92.00
200.00 Total (sum of lines 50-94 and 96-98)			1, 069, 888	274, 617	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charge	ges (line 61)		0		201.00
202.00 Net Charges (line 200 minus line 201)	/		1, 069, 888		202.00

Health Financial Systems	UNION HOSPITAL CLINTON		In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C		Peri od:	Worksheet D-3	
	Component		From 01/01/2016		norod.
	Component	CCN: 15-Z326	To 12/31/2016	Date/Time Pre 5/25/2017 4:2	
	Titl	e XIX	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
		-	Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1	-		
30. 00 03000 ADULTS & PEDIATRICS			0		30.00
31. 00 03100 I NTENSI VE CARE UNI T			0		31.00
ANCI LLARY SERVI CE COST CENTERS		0.0077			50.00
50. 00 05000 OPERATING ROOM		0. 30774			50.00
51.00 05100 RECOVERY ROOM		0. 63986		-	51.00
51.01 05101 0/P TREATMENT ROOM		0. 53893		0	51.01
54. 00 05400 RADI OLOGY-DI AGNOSTI C 56. 00 05600 RADI OI SOTOPE		0. 15432		0	54.00 56.00
56. 00 05600 RADI OI SOTOPE 60. 00 06000 LABORATORY		0. 22409		0	60,00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 15409		0	62.00
65. 00 06500 RESPIRATORY THERAPY		1. 36729		0	65.00
66. 00 06600 PHYSICAL THERAPY		0. 43300		0	66,00
67. 00 06700 0CCUPATI ONAL THERAPY		0. 43300		0	67.00
68. 00 06800 SPEECH PATHOLOGY		0. 53377		0	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 12494		0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		2. 05879		0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 00000		-	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 28650			73.00
OUTPATIENT SERVICE COST CENTERS			-	-	
90. 00 09000 CLI NI C		0.00000	0 0	0	90.00
91.00 09100 EMERGENCY		0. 20466	2 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 89019	9 0	0	92.00
200.00 Total (sum of lines 50-94 and 96-98)			0	0	200.00
201.00 Less PBP Clinic Laboratory Services-Prog	ram only charges (line 61)		0		201.00
202.00 Net Charges (line 200 minus line 201)			0		202.00

CALCUL	Financial Systems UNION HOSPITAL ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1326	Peri od:	Worksheet E	2552-10
			From 01/01/2016 To 12/31/2016	Date/Time Pre	
		Title XVIII	Hospi tal	5/25/2017 4:22 Cost	2 pm
			nospi tui		
	PART B - MEDI CAL AND OTHER HEALTH SERVI CES			1.00	
1.00	Medical and other services (see instructions)			5, 239, 472	1.00
2.00	Medical and other services reimbursed under OPPS (see instruc	ctions)		0	2.00
3.00	PPS payments			0	3.00
4.00 5.00	Outlier payment (see instructions) Enter the hospital specific payment to cost ratio (see instru	uctions)		0.000	4.00 5.00
6.00	Line 2 times line 5			0.000	6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00	
8.00 9.00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt.	N/ col 12 Lino 200		0	8.00 9.00
9.00 10.00	Organ acquisitions	TV, COL. 13, THE 200		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			5, 239, 472	
	COMPUTATION OF LESSER OF COST OR CHARGES				
12.00	Reasonable charges Ancillary service charges			0	12.00
12.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0	
	Customary charges			_	
15.00 16.00	Aggregate amount actually collected from patients liable for Amounts that would have been realized from patients liable for	1 5	U U	0	15.00 16.00
10.00	had such payment been made in accordance with 42 CFR §413.13		r a chargebasi s	0	10.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	<->		0.000000	
18.00	Total customary charges (see instructions)			0	18.00
19.00	Excess of customary charges over reasonable cost (complete or instructions)	nly if line 18 exceeds lii	ne 11) (see	0	19.00
20.00	Excess of reasonable cost over customary charges (complete or	nlyifline 11 exceeds lin	ne 18) (see	0	20.00
	instructions)	-	<i>,</i> , ,		
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH se	ee instructions)		5, 291, 867	21.00
22.00	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see inst	tructions)		0	22.00 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00 26.00	Deductibles and coinsurance (for CAH, see instructions) Deductibles and Coinsurance relating to amount on line 24 (for	or CAH soo instructions)		57, 054 3, 638, 851	25.00 26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)		and 231 (see	1, 595, 962	
	instructions)		- 、		
28.00	Direct graduate medical education payments (from Wkst. E-4, I			0	28.00
29.00 30.00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29))		0 1, 595, 962	29.00 30.00
31.00	Primary payer payments			457	31.00
32.00	Subtotal (line 30 minus line 31)			1, 595, 505	32.00
22.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI Composite rate ESRD (from Wkst. I-5, line 11)	CES)		0	
	Allowable bad debts (see instructions)			0 1, 020, 174	
35.00	Adjusted reimbursable bad debts (see instructions)			663, 113	
36.00	Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		750, 044	36.00
37.00 38.00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			2, 258, 618 0	37.00 38.00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instruction	ns)		0	39.50
39. 98	Partial or full credits received from manufacturers for repla	aced devices (see instruc [.]	tions)	0	39. 98
39.99 40.00	RECOVERY OF ACCELERATED DEPRECIATION			0 2, 258, 618	39.99 40.00
40.00	Subtotal (see instructions) Sequestration adjustment (see instructions)			45, 172	
41.00	Interim payments			2, 238, 169	
	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	ance with CMS Dub 15.2	chanter 1	-24, 723 0	43.00 44.00
4 4. UU	§115. 2	ance with Gwis Mub. 19-2, (snapter I,	0	44. UU
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	
	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 00	91.00 92.00
	Time Value of Money (see instructions)			0.00	
	Total (sum of lines 91 and 93)			0	94.0

VALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	N: 15-1326	Period: From 01/01/2016 To 12/31/2016		
		Title		Hospi tal	Cost	
		I npati en	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider		2, 823, 5	76	2, 238, 169	1. C
00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	0	2.0
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)					3.0
0.4	Program to Provider			0		
01 02	ADJUSTMENTS TO PROVIDER			0	0	3. C 3. C
02				0	0	3.0
04				0	0	3.
05				0	0	3.
	Provider to Program			1		
50	ADJUSTMENTS TO PROGRAM			0	0	3.
51 52				0	0	3. 3.
52 53				0	0	3.
54				0	0	3.
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0	0	3.
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)		2, 823, 5	76	2, 238, 169	4.
	TO BE COMPLETED BY CONTRACTOR					_
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5.
01	TENTATI VE TO PROVI DER			0	0	5.
02				0	0	5.
03				0	0	5.
- 0	Provider to Program			0		-
50 51	TENTATI VE TO PROGRAM			0	0	5. 5.
51 52				0	0	5. 5.
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	5.
00	Determined net settlement amount (balance due) based on the cost report. (1)					6.
01	SETTLEMENT TO PROVIDER		290, 0	37	0	6.
02	SETTLEMENT TO PROGRAM			0	24, 723	6.
00	Total Medicare program liability (see instructions)		3, 113, 6		2, 213, 446	7.
		0		Contractor Number 1.00	NPR Date (Mo/Day/Yr) 2.00	
00	Name of Contractor	0		1.00	2.00	8.

IALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider Component (CN: 15-1326 CCN: 15-Z326	Period: From 01/01/2016 To 12/31/2016		
		component	36N. 13 2320	10 12/31/2010	5/25/2017 4:2	
				Swing Beds - SN		
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	<u> </u>
00	Total interim payments paid to provider		213, 40	53	0	1.
00	Interim payments payable on individual bills, either			0	0	2.
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero					
00	List separately each retroactive lump sum adjustment					3.
	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)					-
01	Program to Provider ADJUSTMENTS TO PROVIDER			0	0	3.
)2				0	0	
03				0	0	
04				0	0	3
05				0	0	3
- 0	Provider to Program				0	
50 51	ADJUSTMENTS TO PROGRAM			0	0	
52				0	0	-
53				0	0	
54				0	0	
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3
00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		213, 40	4.2	0	4
00	(transfer to Wkst. E or Wkst. E-3, line and column as		213,40	55	0	4
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR				1	
00	List separately each tentative settlement payment after					5
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
01	TENTATI VE TO PROVIDER			0	0	5
02				0	0	
03	Dravidar to Dragram			0	0	5
50	Provider to Program TENTATIVE TO PROGRAM			0	0	5
51				0	0	
52				0	0	5
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	5
	5. 50-5. 98)					
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
01	SETTLEMENT TO PROVIDER		20, 0 ⁻	17	0	6
02	SETTLEMENT TO PROGRAM			0	0	
00	Total Medicare program liability (see instructions)		233, 48		0	7
				Contractor	NPR Date	
)	<u>Number</u> 1.00	(Mo/Day/Yr) 2.00	
00	Name of Contractor			1.00	2.00	8

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-1326 Period: From 01/01/2016 Worksheet E-1 Part II Date/Time Prepare 5/25/2017 4: 22 pm Title XVIII Hospital Cost 1.00 1.00	
To 12/31/2016 Date/Time Prepare 5/25/2017 4:22 pm Title XVIII Hospital Cost	
Title XVIII Hospital Cost	_pm
1.00	
1.00	
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS	
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	4 00
3	1.00
	2.00
	3.00
	4.00
	5.00
	6.00
7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 0 7.	7.00
	8.00
	9.00
	10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	
30.00 Initial/interim HIT payment adjustment (see instructions) 0 30.	30.00
	31.00
	32.00

	Financial Systems UNION HOSPITA ATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1326	Peri od:	u of Form CMS-2 Worksheet E-2	
JALCOL	ATTON OF RELIMBORGEMENT SETTLEMENT SWING BEDS		From 01/01/2016	WORKSHEET E Z	
		Component CCN: 15-Z326	To 12/31/2016	Date/Time Prep 5/25/2017 4:22	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions		183, 258	0	
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.0
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Pa		55, 309	0	3.0
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see i				
4.00	Per diem cost for interns and residents not in approved tead	ching program (see		0.00	4.0
	instructions)				
5.00	Program days		112	0	
5.00	Interns and residents not in approved teaching program (see			0	
. 00	Utilization review - physician compensation - SNF optional n	nethod only	0		7.0
. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		238, 567	0	
9.00	Primary payer payments (see instructions)		0	0	
10.00	Subtotal (line 8 minus line 9)		238, 567	0	
11.00	Deductibles billed to program patients (exclude amounts appl professional services)	icable to physician	0	0	11. C
2.00	Subtotal (line 10 minus line 11)		238, 567	0	12.0
3. 00	Coinsurance billed to program patients (from provider record for physician professional services)	ds) (excl ude coi nsurance	322	0	13.0
4.00	80% of Part B costs (line 12 x 80%)			0	14.0
5.00	Subtotal (enter the lesser of line 12 minus line 13, or line	e 14)	238, 245	0	15.0
6.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.1
6. 50	Pioneer ACO demonstration payment adjustment (see instruction	ons)	0	0	
6. 55	410A RURAL DEMONSTRATION PROJECT		0		16.
7.00	Allowable bad debts (see instructions)		0	0	17.
7.01	Adjusted reimbursable bad debts (see instructions)		0	0	
8.00	Allowable bad debts for dual eligible beneficiaries (see ins	structions)	0	0	18.0
9.00	Total (see instructions)		238, 245	0	19.
9. 01	Sequestration adjustment (see instructions)		4, 765	0	19.1
0. 00	Interim payments		213, 463	0	20.
1.00	Tentative settlement (for contractor use only)		0	0	21.
2.00	Balance due provider/program (line 19 minus lines 19.01, 20,		20, 017	0	22.
23.00	Protested amounts (nonallowable cost report items) in accord	ance with CMS Pub. 15-2,	0	0	23. (
	chapter 1, §115.2				

Heal th	Financial Systems	UNI ON HOSPI TAL	CLINTON	In Lie	u of Form CMS	-2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT - SWING B	EDS	Provider CCN: 15-1326 Component CCN: 15-Z326	Period: From 01/01/2016 To 12/31/2016	Worksheet E- Date/Time Pr	
				10 12/31/2010	5/25/2017 4:	
			Title XIX	Swing Beds - SNF		
				Part A	Part B	
				1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF			0		1.00
2.00	Inpatient routine services - swing bed-NF (s	,		0		2.00
3.00	Ancillary services (from Wkst. D-3, col. 3,			0		3.00
	Part V, cols. 6 and 7, line 202, for Part B)					
4.00	Per diem cost for interns and residents not	in approved teach	ing program (see	0.00		4.00
	instructions)					5 00
5.00	Program days	<i>.</i> .		0		5.00
6.00	Interns and residents not in approved teachi			0		6.00
7.00	Utilization review - physician compensation		thod only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus line	es 6 and 7)		0		8.00
9.00	Primary payer payments (see instructions)			0		9.00
10.00	Subtotal (line 8 minus line 9)			0		10.00
11.00	Deductibles billed to program patients (excl professional services)	ude amounts appli	cable to physician	0		11.00
12.00	Subtotal (line 10 minus line 11)			0		12.00
13.00	Coinsurance billed to program patients (from for physician professional services)	n provider records) (excl ude coi nsurance	0		13.00
14.00	80% of Part B costs (line 12 x 80%)			0		14.00
15.00	Subtotal (enter the lesser of line 12 minus		14)	0		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIF	FY)		0		16.00
16.50	Pioneer ACO demonstration payment adjustment	t (see instruction	s)	0		16.50
16.55	410A RURAL DEMONSTRATION PROJECT			0		16.55
17.00	Allowable bad debts (see instructions)			0		17.00
17.01	Adjusted reimbursable bad debts (see instruc			0		17.01
18.00	Allowable bad debts for dual eligible benefi	ciaries (see inst	ructions)	0		18.00
19.00	Total (see instructions)			0		19.00
19.01	Sequestration adjustment (see instructions)			0		19.01
20.00	Interim payments			0		20.00
21.00	Tentative settlement (for contractor use onl			0		21.00
22.00	Balance due provider/program (line 19 minus	lines 19.01, 20,	and 21)	0		22.00
23.00	Protested amounts (nonallowable cost report	items) in accorda	nce with CMS Pub. 15-2,	0		23.00
	chapter 1, §115.2					

	5	TAL CLINTON		u of Form CMS-2	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1326	Period: From 01/01/2016	Worksheet E-3 Part V	
			To 12/31/2016	Date/Time Pre	pared.
			10 12/01/2010	5/25/2017 4:2	
		Title XVIII	Hospi tal	Cost	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICA			1.00	
1.00	Inpatient services	ARE PART A SERVICES - COST	RETWOURSEWENT	3, 507, 611	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruc	ctions)		3, 507, 011	2.00
3.00	Organ acquisition			0	3.00
4.00	Subtotal (sum of lines 1 through 3)			3, 507, 611	4.00
5.00	Primary payer payments			0,000,001	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions))		3, 542, 687	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES	/			
	Reasonabl e charges				
7.00	Routine service charges			0	7.00
8.00	Ancillary service charges			0	8.00
9.00	Organ acquisition charges, net of revenue			0	
10. 00	Total reasonable charges			0	10.00
	Customary charges				
11.00	Aggregate amount actually collected from patients liable for			0	
12.00	Amounts that would have been realized from patients liable had such payment been made in accordance with 42 CFR 413.1		n a charge basis	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	3(e)		0.000000	13.00
14.00	Total customary charges (see instructions)			0.000000	1
15.00	Excess of customary charges over reasonable cost (complete	only if line 14 exceeds li	ne 6) (see	0	
10.00	instructions)		110 0) (300	0	
16.00	Excess of reasonable cost over customary charges (complete	only if line 6 exceeds lin	ie 14) (see	0	16.00
	instructions)	5	, ,		
17.00	Cost of physicians' services in a teaching hospital (see in	nstructions)		0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet	E-4, line 49)		0	
19.00	Cost of covered services (sum of lines 6, 17 and 18)			3, 542, 687	•
20.00	Deductibles (exclude professional component)			431, 256	
21.00 22.00	Excess reasonable cost (from line 16) Subtotal (line 19 minus line 20 and 21)			0	
22.00	Coi nsurance			3, 111, 431 0	
24.00	Subtotal (line 22 minus line 23)			3, 111, 431	
25.00	Allowable bad debts (exclude bad debts for professional set	rvices) (see instructions)		101, 115	
26.00	Adjusted reimbursable bad debts (see instructions)			65, 725	
27.00	Allowable bad debts for dual eligible beneficiaries (see in	nstructions)		52, 432	
28.00	Subtotal (sum of lines 24 and 25, or line 26)	· · · · · · · ·		3, 177, 156	
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
29.50	Pioneer ACO demonstration payment adjustment (see instruct	i ons)		0	29.50
29. 99	Recovery of Accel erated Depreciation			0	29.99
30.00	Subtotal (see instructions)			3, 177, 156	30.00
30. 01	Sequestration adjustment (see instructions)			63, 543	30.01
31.00	Interim payments			2, 823, 576	
32.00	Tentative settlement (for contractor use only)			0	
33.00	Balance due provider/program (line 30 minus lines 30.01, 3			290, 037	33.00
34.00	Protested amounts (nonallowable cost report items) in accord	rdance with CMS Pub. 15-2.	chapter 1.	0	34.00

Heal th	Financial Systems UNION HOSPITAL	CLINTON	In Lie	u of Form CMS-:	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1326	Period: From 01/01/2016 To 12/31/2016		pared:
		Hospi tal	Cost		
			Inpati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR X	IX SERVICES		-
1.00	COMPUTATION OF NET COST OF COVERED SERVICES		1, 023, 868		1.00
2.00	Medical and other services		1, 023, 000	0	2.00
3.00	Organ acquisition (certified transplant centers only)		0	Ŭ	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		1, 023, 868	0	
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		1, 023, 868	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				-
8.00	Reasonable Charges Routine service charges		472 142		8.00
9.00	Ancillary service charges		472, 163 1, 069, 888	0	
10.00	Organ acquisition charges, net of revenue		1, 009, 000	0	10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		1, 542, 051	0	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13.00
14.00	basis Amounts that would have been realized from patients liable for	n 0	0	14.00	
14.00	a charge basis had such payment been made in accordance with 4		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		1, 542, 051	0	16.00
17.00	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	518, 183	0	17.00
40.00	line 4) (see instructions)				10.00
18.00	Excess of reasonable cost over customary charges (complete onl 16) (see instructions)	y if line 4 exceeds lin	e O	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instr	ructions)	0	0	
21.00	Cost of covered services (enter the lesser of line 4 or line 1		1, 023, 868	0	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be				1
22.00	Other than outlier payments		0	0	
23.00	Outlier payments		0	0	
24.00	Program capital payments		0		24.00
25.00 26.00	Capital exception payments (see instructions)		0	0	25.00 26.00
28.00	Routine and Ancillary service other pass through costs Subtotal (sum of lines 22 through 26)	0	0		
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	
29.00	Titles V or XIX (sum of lines 21 and 27)		1, 023, 868	0	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				1
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		1, 023, 868	0	
32.00	Deducti bl es		0	0	
	Coinsurance		0	0	
34.00 35.00	Allowable bad debts (see instructions) Utilization review		0	0	34.00 35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)			0	
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
38.00	Subtotal (line 36 ± line 37)			0	
39.00	Direct graduate medical education payments (from Wkst. E-4)				39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)			0	40.00
41.00	Interim payments			0	
42.00				0	
43.00	Protested amounts (nonallowable cost report items) in accordan	0	0	43.00	
	chapter 1, §115.2		1	I	I

LANCI	Financial Systems UNION HOSPIT E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C		eriod: rom 01/01/2016	u of Form CMS-: Worksheet G	
l y)			Te		Date/Time Pre 5/25/2017 4:2	parec 2 nm
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
00	CURRENT ASSETS Cash on hand in banks	1, 344	0	0	0	1.
00	Temporary investments	1, 344	0	0	0	
00	Notes receivable		0	0	0	
	Accounts receivable	2, 713, 587	0	0	0	
00	Other receivable	0	0	0	0	5.
	Allowances for uncollectible notes and accounts receivable	0	0	0	0	
	Inventory	297, 455		0	0	
	Prepaid expenses	28, 262, 340	0	0	0	
	Other current assets Due from other funds		0	0	0	9. 10.
	Total current assets (sum of lines 1-10)	31, 274, 726		0	0	
	FIXED ASSETS	31, 274, 720	ij U	U	0	
	Land	609, 760	0	0	0	12.
	Land improvements	007,700	0	0	0	
	Accumulated depreciation	C	0	0	0	
. 00	Bui I di ngs	13, 190, 951	0	0	0	15
	Accumulated depreciation	-11, 891, 132	0	0	0	16
	Leasehold improvements	0	0	0	0	17
	Accumulated depreciation	0	0	0	0	18
	Fixed equipment	0	0	0	0	19
	Accumulated depreciation	0	0	0	0	
	Automobiles and trucks	0	0	0	0	
	Accumulated depreciation	E 777 040	0	0	0	22
	Major movable equipment Accumulated depreciation	5, 777, 868	0	0	0	23
	Mi nor equi pment depreci abl e		0	0	0	24
	Accumulated depreciation		0	0	0	26
	HIT designated Assets		0	0	0	27
	Accumulated depreciation	0	0	0	0	
	Minor equipment-nondepreciable	C	0	0	0	
. 00	Total fixed assets (sum of lines 12-29)	7, 687, 447	0	0	0	30
	OTHER ASSETS	-				
	Investments	0	0	0	0	
	Deposits on Leases	0	0	0	0	32
	Due from owners/officers	C	0	0	0	33
	Other assets	0	0	0	0	34
	Total other assets (sum of lines 31-34)	0	0	0	0	
	Total assets (sum of lines 11, 30, and 35)	38, 962, 173	0	0	0	36
	CURRENT LI ABI LI TI ES	422.041	0	0	0	37
	Accounts payable Salaries, wages, and fees payable	422, 061 500, 784	0	0	0	
	Payroll taxes payable	300,704	0	0	0	
	Notes and Loans payable (short term)		0	0	0	
	Deferred income		0	0	0	
	Accelerated payments	C				42
. 00	Due to other funds	0	0	0	0	43
. 00	Other current liabilities	384, 656	0	0	0	44
. 00	Total current liabilities (sum of lines 37 thru 44)	1, 307, 501	0	0	0	45
	LONG TERM LIABILITIES	1				
	Mortgage payable	0	0	0	0	
	Notes payable		0	0	0	
	Unsecured Loans		0	0	0	
	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49)	2, 269, 469 2, 269, 469		0	0	
	Total liabilities (sum of lines 45 and 50)	3, 576, 970		0	0	
	CAPITAL ACCOUNTS	5, 570, 770	0	U U	0	
	General fund balance	35, 385, 203				52
	Specific purpose fund		0			53
	Donor created - endowment fund balance - restricted			0		54
	Donor created - endowment fund balance - unrestricted			0		55
00	Governing body created - endowment fund balance			0		56
	Plant fund balance - invested in plant				0	57
. 00	Plant fund balance - reserve for plant improvement,				0	58
	replacement, and expansion					
	Total fund balances (sum of lines 52 thru 58)	35, 385, 203		0	0	
	Total liabilities and fund balances (sum of lines 51 and	38, 962, 173	0	0	0	60

Heal th	Financial Systems	UNI ON HOSPI TA	AL CLINTON			In Lie	u of Form CMS	-2552-10	0
STATEMENT OF CHANGES IN FUND BALANCES			Provider CCN: 15-1326		Peri od: Worksheet From 01/01/2016 To To 12/31/2016 Date/Time		Worksheet G-	G-1 Prepared:	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fun	d	
1 00	Fund halanage at haginning of pariod	1.00	2.00	3.00		4.00	5.00	1.00	_
$\begin{array}{c} 1.00\\ 2.00\\ 3.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 14.00\\ 15.00\\ 16.00\\ 17.00\\ 18.00 \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17)		32, 196, 445 3, 188, 758 35, 385, 203 0 35, 385, 203 0 35, 385, 203 0			0 0 0 0 0		1.00 2.00 3.00 4.000 5.000 6.000 7.000 8.000 9.000 10.000 11.000 12.000 13.000 14.000 15.000 16.000 17.0000 18.000	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		35, 385, 203			0		19.00	<u>с</u>
		Endowment Fund	Pl ant	Fund					
		6.00	7.00	8.00					
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0 0 0		0			1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	0 0 0 0 0 0
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0	0 0 0 0 0 0		0 0 0 0			10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	0 0 0 0 0 0 0 0 0

STATE	Financial Systems UNION HOSPITAL ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CC	N. 15_1206	Peri od:	u of Form CMS-2 Worksheet G-2	
STATE	ENT OF PATTENT REVENUES AND OPERATING EXPENSES	Provider cc	N. 15-1520	From 01/01/2016 To 12/31/2016	Parts I & II	pared:
	Cost Center Description		Inpati ent	Outpati ent	Total	
	·		1.00	2.00	3.00	
	PART I – PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal		2, 726, 8	42	2, 726, 842	1.00
2.00	SUBPROVIDER - IPF					2.00
3.00	SUBPROVIDER - IRF					3.00
4.00	SUBPROVIDER					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)		2, 726, 8	42	2, 726, 842	10.00
	Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT		1, 390, 0	45	1, 390, 045	11.00
12.00	CORONARY CARE UNI T					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGICAL INTENSIVE CARE UNIT					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum of	lines	1, 390, 0	45	1, 390, 045	16.00
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4, 116, 8	87	4, 116, 887	17.00
18.00	Ancillary services		6, 303, 3	01 43, 950, 528	50, 253, 829	18.00
19.00	Outpatient services	1	966, 8	54 19, 876, 166	20, 843, 020	19.00
20.00	RURAL HEALTH CLINIC	1		0 0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	21.00
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULANCE SERVI CES					23.00
24.00	СМНС					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPI CE					26.00
27.00	PHYSICIAN PRACTICES			0 513, 612	513, 612	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	11, 387, 0	42 64, 340, 306	75, 727, 348	28.00
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)			18, 819, 758		29.00
30.00	ADD (SPECIFY)	1		0		30.00
31.00		1		0		31.00
32.00				0		32.00
33.00				0		33.00
34.00				0		34.00
35.00				0		35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37.00	DEDUCT (SPECI FY)			0		37.00
38.00				0		38.00
39.00				0		39.00
40.00				0		40.00
41.00				0		41.00
42.00	Total deductions (sum of lines 37-41)			0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 4	2)(transfer		18, 819, 758		43.00
	to Wkst. G-3, line 4)					

STATEMENT OF REVENUES AND EXPENSESProvider CCN: 15-1326Period: Trom 01/01/2016 Tom 01/01/2016 Tom 01/01/2016 Tom 01/01/2016 Date/Time Prepared: 5/25/2017 4:22 pm1.00Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)1.0015,02/2017 4:22 pm1.00Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)75,727,348 1.003.00Net patient revenues (line 1 minus line 2)23,874,434 3.000.0Less total operating expenses (from Wkst. G-2, Part II, line 43)18,819,758 4.005.00Net income from service to patients (line 3 minus line 4)5,054,676 5.000Income from investments06.000.00Revenues from telephone and other miscellaneous communication services08.009.00Revenues from service010.0011.00Rebates and refunds of expenses011.0012.00Revenue from neals sold to employees and guests012.0013.00Revenue from sale of medical and surgical supplies to other than patients012.0014.00Revenue from sale of medical cal and surgical supplies to other than patients015.0015.00Revenue from sale of medical express, and canteen019.0010.00Revenue from sale of medical express, and canteen019.0010.00Revenue from sale of medical express, and canteen019.0010.00Revenue from sale of files \$,02022.0010.00Revenue from sale of files \$,21019.0010.00	Heal th	Health Financial Systems UNION HOSPITAL CLINTON		In Lie	u of Form CMS-2	2552-10		
To 12/31/2016 Date/Time Prepared: 5/25/2017 4:22 pm 1.00 To 12/31/2016 Date/Time Prepared: 5/25/2017 4:22 pm 1.00 Less contractual allowances and discounts on patients' accounts 57,5727,348 1.00 2.00 Less contractual allowances and discounts on patients' accounts 51,852,914 2.00 3.00 Net patient revenues (line 1 minus line 2) 23,874,434 3.00 4.00 Less total operating expenses (from Wkst. 6-2, Part II, line 43) 18,819,758 4.00 0.01 Income from service to patients (line 3 minus line 4) 5.054,676 6.00 0.01 Income from investments 0 6.00 0.00 Revenues from television and radio service 0 7.00 0.00 Purchase discounts 0 10.00 0.01 Parking lot receipts 0 11.00 0.00 Revenue from asl of drugs to other than patients 0 12.00 0.01 Revenue from service drugs of expenses 0 12.00 0.00 Revenue from service drugs of expenses 0 12.00	STATEMENT OF REVENUES AND EXPENSES		Provider CCN: 15-1326		Worksheet G-3			
5/25/2017 4:22 pm 1.00 Total patient revenues (from Wkst. 6-2, Part I, column 3, line 28) 75, 727, 348 1.00 2.00 Less contractual allowances and discounts on patients' accounts 51, 852, 914 2.00 3.00 Net patient revenues (line 1 minus line 2) 23, 874, 434 3.00 4.00 Less total operating expenses (from Wkst. 6-2, Part II, line 43) 18, 819, 758 4.00 5.00 Net income from service to patients (line 3 minus line 4) 5.054, 676 5.00 0THER INCOME 0 6.00 7.00 8.00 Revenue from investments 0 7.00 8.00 Revenue from telephone and other miscel laneous communication services 0 9.00 9.00 Revenue from telephone and other miscel laneous communication services 0 9.00 10.00 Rebates and refunds of expenses 0 11.00 11.00 Rebates and refunds of expenses 0 11.00 12.00 Revenue from ale of medical and surgical supplies to other than patients 0 13.00 13.00 Revenue from sale of medical necords and abstracts 0 <t< td=""><td></td><td colspan="6"></td></t<>								
Image: 1.00 Total patient revenues (from Wkst. G-2, Part I, column 3, line 28) 75, 727, 348 1.00 2.00 Less contractual al lowances and discounts on patients' accounts 51, 852, 914 2.00 3.00 Net patient revenues (from Wkst. G-2, Part II, line 43) 18, 819, 758 4.00 4.00 Less total operating expenses (from Wkst. G-2, Part II, line 43) 18, 819, 758 4.00 5.00 Met income from service to patients (line 3 minus line 4) 0 6.00 7.00 0.01 Income from investments 0 6.00 7.00 0.00 Revenue from television and radio service 0 9.00 0.00 Purchase discounts 0 10.00 11.00 Rebates and refunds of expenses 0 11.00 12.00 Parking lot receipts 0 12.00 13.00 Revenue from rental of living quarters 0 13.00 14.00 Revenue from sale of medical and surgical supplies to other than patients 0 15.00 10.00 Revenue from sale of freqical and surgical supplies to other than patients 0 12.00								
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4.00 Less total operating expenses (from Wkst. G-2, Part II, line 43) 18,819,758 4.00 5.00 Net income from service to patients (line 3 minus line 4) 5,054,676 5.00 6.00 Contributions, donations, bequests, etc 0 6.00 7.00 Income from investments 0 7.00 8.00 Revenue from telephone and other miscellaneous communication services 0 9.00 9.00 Revenue from telephone and radio service 0 10.00 0.00 Purchase discounts 0 10.00 11.00 Rebates and refunds of expenses 0 11.00 12.00 Parking lot recelpts 0 13.00 13.00 Revenue from sels of medical and surgical supplies to other than patients 0 16.00 15.00 Revenue from sale of medical records and abstracts 0 17.00 18.00 Revenue from gifts, flowers, coffee shops, and canteen 0 2.00 10.00 Revenue from sale of textbooks, uniforms, etc.) 0 19.00 10.00 Revenue from sale of textbooks, uniforms, etc.) 0 19.00 10.00 Revenue from gifts, flowers, coffee shops,	2.00	Less contractual allowances and discounts on patients' accour	nts		51, 852, 914	2.00		
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OTHER INCOME6.00Contributions, donations, bequests, etc07.00Income from investments08.00Revenues from telephone and other miscellaneous communication services09.00Revenue from television and radio service00.00Purchase discounts011.00Rebates and refunds of expenses012.00Parking lot receipts013.00Revenue from laundry and linen service014.00Revenue from sale of medical and surgical supplies to other than patients015.00Revenue from sale of medical and surgical supplies to other than patients017.00Revenue from sale of medical records and abstracts019.00Rental of vending machines020.00Rental of vending machines021.00Rental of vending machines022.00Retal of ther income (sum of lines 6-24)023.00Total other income (sum of line 27 and subscripts)2,257,33420.00Total other expenses (sum of line 27 and subscripts)2,257,334	4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		18, 819, 758	4.00		
6.00Contributions, donations, bequests, etc06.007.00Income from investments07.008.00Revenues from telephone and other miscellaneous communication services08.009.00Revenue from television and radio service09.0010.00Purchase discounts010.0011.00Rebates and refunds of expenses011.0012.00Parking lot receipts012.0013.00Revenue from meals sold to employees and guests013.0014.00Revenue from sale of medical and surgical supplies to other than patients015.0015.00Revenue from sale of medical records and abstracts017.0019.00Revenue from sile of textbooks, uniforms, etc.)018.0010.00Revenue from gifts, flowers, coffee shops, and canteen022.0023.00Governmental appropriations023.0024.00OTHER REVENUE386.31224.0025.00Total other income (sum of lines 6-24)391.41625.0026.00Total (line 5 plus line 25)2, 257.33427.0028.00Total other expenses (sum of line 27 and subscripts)2, 257.33427.00	5.00				5, 054, 676	5.00		
7.00Income from investments07.008.00Revenues from telephone and other miscellaneous communication services08.009.00Revenue from television and radio service09.0010.00Purchase discounts010.0011.00Rebates and refunds of expenses011.0012.00Parking lot receipts012.0013.00Revenue from laundry and linen service013.0014.00Revenue from meals sold to employees and guests014.0015.00Revenue from sale of medical and surgical supplies to other than patients016.0017.00Revenue from sale of medical necords and abstracts017.0018.00Revenue from gifts, flowers, coffee shops, and canteen019.0020.00Rental of vending machines019.0021.00Rental of hospital space021.0022.00Rental of hospital space021.0023.00Governmental appropriations05.10424.0124.01Other kEVENUE386,31224.0024.00Total other income (sum of lines 6-24)5.446.0925.446.09225.00Total (line 5 plus line 25)2.257,33427.0028.00Total other expenses (sum of line 27 and subscripts)2.257,33428.00								
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