This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0023 Worksheet S Peri od: From 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/21/2024 12:12 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/21/2024 Time: 12:12 pm] Manually prepared cost report use only If this is an amended report enter the number of times the provider resubmitted this cost report Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled with Audit 9. [N] Final Report for this Provider CCN (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

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

(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by UNION HOSPITAL, INC. (15-0023) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

			Title XVIII				
		Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
PART	III - SETTLEMENT SUMMARY						
1. 00 HOSPI	I TAL	0	302, 368	-247, 627	0	-4, 409, 574	1.00
2. 00 SUBPI	ROVIDER - IPF	0	0	0		0	2.00
3. 00 SUBPI	ROVIDER - IRF	0	-49, 667	-1		16, 124	3.00
5. 00 SWI NO	G BED - SNF	0	O	0		0	5.00
6.00 SWI NO	G BED - NF	0				0	6.00
200. 00 TOTAL	L	0	252, 701	-247, 628	0	-4, 393, 450	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

Health Financial Systems UNION HOSPITAL, INC. In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 15-0023 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/21/2024 12:12 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1606 NORTH SEVENTH ST 1.00 PO Box: 1.00 Ci ty: TERRE HAUTE State: IN 2.00 Zip Code: 47804-County: VIGO 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N) Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal UNION HOSPITAL, INC. 150023 45460 01/01/1966 Ν 0 3.00 1 Subprovi der - IPF 4.00 4.00 5.00 Subprovi der - IRF MEDICAL REHAB 15T023 45460 5 09/01/1989 N Ρ 0 5.00 Subprovi der - (Other) 6.00 6.00 7.00 Swing Beds - SNF 7.00 Swing Beds - NF 8.00 8.00 9.00 Hospital -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 11.00 Hospital -Based OLTC 11 00 12.00 Hospital -Based HHA 12.00 13.00 Separately Certified ASC 13.00 14.00 Hospi tal -Based Hospi ce 14.00 15.00 Hospital -Based Health Clinic - RHC 15 00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18 00 19.00 Other 19.00 From To: 1.00 2.00 01/01/2023 12/31/2023 20.00 Cost Reporting Period (mm/dd/yyyy) 20 00 21.00 Type of Control (see instructions) 21.00 2 1.00 2. 00 3. 00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Υ Ν 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. 22.01 Did this hospital receive interim UCPs, including supplemental UCPs, for Ν Ν 22.01 this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires a final UCP to be Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to Ν Ν Ν 22 03 rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22 04

reporting period? In column 2, enter "Y" for yes or "N" for no.

Ν

3

23.00

rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for

below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost

23.00 Which method is used to determine Medicaid days on lines 24 and/or 25

yes or "N" for no.

Health Financial Systems UNION HOSPITAL, INC. In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0023 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/21/2024 12:12 pm In-State In-State Out-of Out-of Medi cai d 0ther Medi cai d Medi cai d State State HMO days Medi cai d paid days eligible Medi cai d Medi cai d days unpai d pai d days el i gi bl e days unpai d 1.00 2. 00 3.00 4. 00 5. 00 6. 00 24.00 If this provider is an IPPS hospital, enter the 752 470 15.360 91 24.00 2.164 62 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 15 25 0 18 259 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5. Urban/Rural S Date of Geogr 1.00 2.00 26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. 26.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, 27.00 enter the effective date of the geographic reclassification in column 2. 35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in 0 35.00 effect in the cost reporting period. Begi nni ng: Endi ng: 1.00 2.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates. 36 00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 0 37.00 is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in 37.01 accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions) 38.00 | If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 38.00 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. Y/N Y/N 1.00 2.00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume 39.00 Ν hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or Ν N 40.00 "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions) XVIII XIX V 1. 00 2.00 3.00 Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance N N 45.00 with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exception for extraordinary circumstances 46.00 Ν Ν Ν 46.00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. N N N 47.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. 48.00 Ν N Ν 48.00 Teaching Hospitals Is this a hospital involved in training residents in approved GME programs? For cost reporting Υ 56.00 periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter Y" for yes; otherwise, enter "N" for no in column 2. 57.00 For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, Υ 57.00 is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.

Health Financial Systems UNION HOSPITAL, INC. In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0023 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/21/2024 12: 12 pm XVIII XIX 1. 00 2.00 3.00 58.00 | If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. Ν 58.00 Pt. I 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qual i fi cati on Cri teri on Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see 60 00 instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. If line 60 is yes, complete columns 2 and 3 for each program. (see 23.00 60 01 1 60 01 instructions) 60.02 If line 60 is yes, complete columns 2 and 3 for each program. (see 23.01 1 60.02 instructions) Y/N LME Direct GME IME Direct GME 1. 00 2.00 3.00 4.00 5.00 61.00 Did your hospital receive FTE slots under ACA 0.00 0.00 61.00 Ν section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61. 01 Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 61.04 Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). Enter the difference between the baseline primary 61.05 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Name Program Code Unwei ghted Unwei ghted IME FTE Count Direct GME FTE Count 1.00 2.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0. 00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Of the FTEs in line 61.05, specify each expanded 0 00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 1. 00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 62.01 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) 63.00

Health Financial Systems	LINI ON	N HOSPITAL, I	NC.		In lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COM					Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I	pared:
				Unwei ghted FTEs Nonprovi der	Unwei ghted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
				Si te	·		
Section 5504 of the ACA Base Ye	ar FTF Pasidonts in N	lonnrovi der S	atti nas	1.00	2.00	3. 00	
period that begins on or after 64.00 Enter in column 1, if line 63 i	July 1, 2009 and before s yes, or your facility	ore June 30, ty trained ro	2010. esi dents	0. (64.00
in the base year period, the nu resident FTEs attributable to r settings. Enter in column 2 th resident FTEs that trained in y of (column 1 divided by (column	otations occurring in e number of unweighte our hospital. Enter in	all nonprovi d non-primary n column 3 ti	ider y care he ratio				
or (cordillir r drvrded by (cordillir	Program Name	Program		Unwei ghted	Unwei ghted	Ratio (col.	
	ŭ	3		FTEs Nonprovi der Si te	FTEs in	3/ (col. 3 + col. 4))	
	1. 00	2.00)	3. 00	4. 00	5. 00	
65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	UH FAMILY MEDICINE RESIDENCY	1201711131		0.5			65. 00
				Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
				1. 00	2. 00	3. 00	-
Section 5504 of the ACA Current		n Nonprovi de	r Setting	sEffective	for cost report	ing periods	
beginning on or after July 1, 2 66.00 Enter in column 1 the number of FTEs attributable to rotations Enter in column 2 the number of FTEs that trained in your hospi (column 1 divided by (column 1	unweighted non-prima occurring in all nonp unweighted non-prima tal. Enter in column	rovider setti ry care resid 3 the ratio	i ngs. dent	0. (0.00	0. 000000	66. 00
	Program Name	Program		Unwei ghted FTEs Nonprovi der Si te	·	Ratio (col. 3/ (col. 3 + col. 4))	
67.00 Enter in column 1, the program	1.00 UH FAMILY MEDICINE	2. 00 1201711131	J	3. 00	4. 00	5. 00 0. 010572	67.00
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)	RESI DENCY					0.010072	

Health Financial Systems UNION HOSPITAL, INC. In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0023 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/21/2024 12:12 pm 1.00 Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022) 68.00 For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your 68.00 MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)? 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS 70.00 70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no. 71.00 | If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most 0 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for Υ 0 76.00 Ν 76.00 no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) 1.00 Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. N 80.00 81.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter Ν 81.00 "Y" for yes and "N" for no. TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. N 85.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 87.00 N 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. Approved for Number of Permanent Approved Adiustment Permanent (Y/N)Adjustments 1.00 2.00 88. 00 88.00 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target Ν amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments Effecti ve Wkst. A Line Approved Date Permanent No. Adjustment Amount Per Di scharge 3. 00 2.00 1.00 89.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number 0 00 0 89 00 on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per di scharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. XIX 1.00 2.00 Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for 90.00 Ν Υ yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column. 91.00 Υ 91.00 Ν Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. 92.00 Ν 92.00 93.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. Ν Ν 93.00 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the 94.00 Ν Ν applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 95.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the 96.00 Ν Ν 96.00 applicable column. 97.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 97.00 0.00 0.00

Health Financial Systems UNION HOSPITAL, INC.		In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CO		eriod: rom 01/01/2023	Worksheet S- Part I	-2
		0 12/31/2023	Date/Time Pi	
		V	5/21/2024 12 XI X	2: 12 pm
		1.00	2. 00	
98.00 Does title V or XIX follow Medicare (title XVIII) for the interns and res stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" column 1 for title V, and in column 2 for title XIX.		Y	Y	98.00
98.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of ch C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in		Y	Y	98. 01
title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no		Y	Y	98. 02
for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access h reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for for title V, and in column 2 for title XIX.		N	N	98. 03
98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 10 outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for		N	N	98. 04
in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE di Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for t		Y	Y	98. 05
column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed fo Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title column 2 for title XIX.		Y	Y	98. 06
Rural Providers				
105.00 Does this hospital qualify as a CAH? 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive met	hod of pavment	N N		105. 00 106. 00
for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursem	. ,	N		107. 00
training programs? Enter "Y" for yes or "N" for no in column 1. (see ins Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train L&R approved medical education program in the CAH's excluded LPF and/or LRF	structions) Rs in an	N N		107.00
Enter "Y" for yes or "N" for no in column 2. (see instructions) 107.01 If this facility is a REH (line 3, column 4, is "12"), is it eligible for	, ,			107. 01
reimbursement for I&R training programs? Enter "Y" for yes or "N" for no.				107.01
instructions) 108.00 Is this a rural hospital qualifying for an exception to the CRNA fee sche	edul e? See 42	N		108.00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.				
Physi cal Physi cal	Occupati onal	Speech	Respi ratory	/
Physical 1.00 109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y"	Occupati onal 2.00 N	Speech 3.00 N	Respiratory 4.00 N	109.00
Physical 1.00 109.00 If this hospital qualifies as a CAH or a cost provider, are	2. 00	3. 00	4. 00 N	
Physical 1.00 109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y"	2. 00 N	3. 00 N	4.00	
Physical 1.00 109.00 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.	2.00 N on project (§4	3.00 N	4. 00 N	109.00
Physical 1.00 109.00 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. 110.00 Did this hospital participate in the Rural Community Hospital Demonstration Demonstration) for the current cost reporting period? Enter "Y" for yes or complete Worksheet E, Part A, Lines 200 through 218, and Worksheet E-2, Lines 200 through 218, and Worksheet E-2	2.00 N on project (§4	3.00 N	4.00 N	109.00
Physical 1.00 109.00 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. 110.00 Did this hospital participate in the Rural Community Hospital Demonstrati Demonstration) for the current cost reporting period? Enter "Y" for yes or complete Worksheet E, Part A, Lines 200 through 218, and Worksheet E-2, L	2.00 N on project (§4 "N" for no. I ines 200 throu	3.00 N	4. 00 N	109.00
Physical 1.00 109.00 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. 110.00 Did this hospital participate in the Rural Community Hospital Demonstrati Demonstration) for the current cost reporting period? Enter "Y" for yes or complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, I applicable. 111.00 If this facility qualifies as a CAH, did it participate in the Frontier C Health Integration Project (FCHIP) demonstration for this cost reporting "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, integration prong of the FCHIP demo in which this CAH is participating in Enter all that apply: "A" for Ambulance services; "B" for additional beds	on project (§4 "N" for no. I ines 200 throu	3.00 N 10A f yes, igh 215, as	4.00 N	109.00
Physical 1.00 109.00 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. 110.00 Did this hospital participate in the Rural Community Hospital Demonstrati Demonstration) for the current cost reporting period? Enter "Y" for yes or complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, I applicable. 111.00 If this facility qualifies as a CAH, did it participate in the Frontier C Health Integration Project (FCHIP) demonstration for this cost reporting "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, integration prong of the FCHIP demo in which this CAH is participating in	2.00 N on project (§4 "N" for no. I ines 200 throu community period? Enter enter the column 2. ;; and/or "C"	3.00 N	4. 00 N	109.00
Physical 1.00 109.00 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. 110.00 Did this hospital participate in the Rural Community Hospital Demonstrati Demonstration) for the current cost reporting period? Enter "Y" for yes or complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lapplicable. 111.00 If this facility qualifies as a CAH, did it participate in the Frontier C Health Integration Project (FCHIP) demonstration for this cost reporting "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, integration prong of the FCHIP demo in which this CAH is participating in Enter all that apply: "A" for Ambulance services; "B" for additional beds for tele-health services.	on project (§4 "N" for no. I ines 200 throu	3.00 N 10A f yes, igh 215, as	4.00 N	109.00
Physical 1.00 109.00 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. 110.00 Did this hospital participate in the Rural Community Hospital Demonstrati Demonstration) for the current cost reporting period? Enter "Y" for yes or complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, I applicable. 111.00 If this facility qualifies as a CAH, did it participate in the Frontier C Health Integration Project (FCHIP) demonstration for this cost reporting "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, integration prong of the FCHIP demo in which this CAH is participating in Enter all that apply: "A" for Ambulance services; "B" for additional beds for tele-health services.	on project (§4 "N" for no. I ines 200 throu community period? Enter enter the column 2. ;; and/or "C"	3.00 N	4. 00 N	1109.00
Physical 1.00 109.00 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. 110.00 Did this hospital participate in the Rural Community Hospital Demonstrati Demonstration) for the current cost reporting period? Enter "Y" for yes or complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, I applicable. 111.00 If this facility qualifies as a CAH, did it participate in the Frontier C Health Integration Project (FCHIP) demonstration for this cost reporting "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, integration prong of the FCHIP demo in which this CAH is participating in Enter all that apply: "A" for Ambulance services; "B" for additional beds for tele-health services. 112.00 Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the	on project (§4 "N" for no. I ines 200 throu community period? Enter enter the column 2. ;; and/or "C"	3.00 N	4. 00 N	1109.00
Physical 1.00 109.00 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. 110.00 Did this hospital participate in the Rural Community Hospital Demonstrati Demonstration) for the current cost reporting period? Enter "Y" for yes or complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, I applicable. 111.00 If this facility qualifies as a CAH, did it participate in the Frontier C Health Integration Project (FCHIP) demonstration for this cost reporting "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, integration prong of the FCHIP demo in which this CAH is participating in Enter all that apply: "A" for Ambulance services; "B" for additional beds for tele-health services. 112.00 Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is	on project (§4 "N" for no. I ines 200 throu community period? Enter enter the column 2. ;; and/or "C"	3.00 N	4. 00 N	1109.00
Physical 1.00 109.00 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. 110.00 Did this hospital participate in the Rural Community Hospital Demonstrati Demonstration) for the current cost reporting period? Enter "Y" for yes or complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lapplicable. 111.00 If this facility qualifies as a CAH, did it participate in the Frontier CHealth Integration Project (FCHIP) demonstration for this cost reporting "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, integration prong of the FCHIP demo in which this CAH is participating in Enter all that apply: "A" for Ambulance services; "B" for additional beds for tele-health services. 112.00 Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information	2.00 N on project (§4 "N" for no. I ines 200 throu community period? Enter enter the column 2. ;; and/or "C"	3.00 N	4. 00 N	110.00
Physical 1.00 109.00 1	on project (§4 "N" for no. I ines 200 throu community period? Enter enter the column 2. ;; and/or "C"	3.00 N	4. 00 N	110.00
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. 110.00 Did this hospital participate in the Rural Community Hospital Demonstrati Demonstration) for the current cost reporting period? Enter "Y" for yes or complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lapplicable. 111.00 If this facility qualifies as a CAH, did it participate in the Frontier C Health Integration Project (FCHIP) demonstration for this cost reporting "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, integration prong of the FCHIP demo in which this CAH is participating in Enter all that apply: "A" for Ambulance services; "B" for additional beds for tele-health services. 112.00 Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. Mi scellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 1. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208.1.	2.00 N on project (§4 "N" for no. I ines 200 throu community period? Enter enter the column 2. ;; and/or "C"	3.00 N	4. 00 N	110.00
Physical 1.00	2.00 N on project (§4 "N" for no. I i nes 200 throu community period? Enter enter the n column 2. s; and/or "C" 1.00 N	3.00 N	4. 00 N	110.00
Physical 1.00 109.00 1	2.00 N on project (§4 "N" for no. I ines 200 throu community period? Enter enter the column 2. ;; and/or "C"	3.00 N	4. 00 N	1109. 00 1110. 00 1111. 00 1112. 00

Health Financial Systems UNION HOS	SPITAL, INC.		In Lie	u of Form CN	IS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CC		Peri od: From 01/01/2023	Worksheet : Part I	S-2
			To 12/31/2023	Date/Time	Prepared:
		Premi ums	Losses	5/21/2024 Insurance	
		1.00	2. 00	3.00	
118.01 List amounts of malpractice premiums and paid losses:		751, 39	91 C		0118.01
			1. 00	2.00	
118.02 Are malpractice premiums and paid losses reported in a confidence of Administrative and General? If yes, submit supporting so	ost center other	than the	N		118. 02
and amounts contained therein.	should trating of	ost centers			
119.00 DO NOT USE THIS LINE	lal d llarmi aca pro	vicion in ACA	N	N	119. 00 120. 00
120.00 s this a SCH or EACH that qualifies for the Outpatient F \$3121 and applicable amendments? (see instructions) Enter			N N	IN IN	120.00
"N" for no. Is this a rural hospital with < 100 beds that	t qualifies for t	he Outpatient			
Hold Harmless provision in ACA §3121 and applicable amend Enter in column 2, "Y" for yes or "N" for no.	dments? (see inst	ructions)			
121.00 Did this facility incur and report costs for high cost in	mplantable device	s charged to	Υ		121. 00
patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as	defined in \$1903	(w)(3) of the	y Y	5. 06	122. 00
Act?Enter "Y" for yes or "N" for no in column 1. If colum				5.00	122.00
the Worksheet A line number where these taxes are include		:1	N.		122.00
123.00 Did the facility and/or its subproviders (if applicable) services, e.g., legal, accounting, tax preparation, bookly			N		123. 00
management/consulting services, from an unrelated organiz					
for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.	e greater than	50% of total			
professional services expenses, for services purchased fi	rom unrelated orga	ani zati ons			
located in a CBSA outside of the main hospital CBSA? In a "N" for no.	column 2, enter "	Y" for yes or	•		
Certified Transplant Center Information					
125.00 Does this facility operate a Medicare-certified transplan		"Y" for yes	N		125. 00
and "N" for no. If yes, enter certification date(s) (mm/o 126.00 If this is a Medicare-certified kidney transplant program		ification dat	e		126. 00
in column 1 and termination date, if applicable, in colum	mn 2.				
127.00 f this is a Medicare-certified heart transplant program, in column 1 and termination date, if applicable, in colum	enter the certi mn 2	fication date	•		127. 00
128.00 If this is a Medicare-certified liver transplant program,	enter the certi	fication date			128. 00
in column 1 and termination date, if applicable, in colur 129.00 of this is a Medicare-certified lung transplant program,		ication date			129. 00
in column 1 and termination date, if applicable, in colum		reation date			127.00
130.00 olf this is a Medicare-certified pancreas transplant progradate in column 1 and termination date, if applicable, in		rti fi cati on			130. 00
131.00 f this is a Medicare-certified intestinal transplant pro		certi fi cati on	ı		131. 00
date in column 1 and termination date, if applicable, in		C'			100.00
132.00 f this is a Medicare-certified islet transplant program, in column 1 and termination date, if applicable, in colum		rication date	2		132. 00
133.00 Removed and reserved					133. 00
134.00 If this is a hospital-based organ procurement organization in column 1 and termination date, if applicable, in column		he OPO number	,		134. 00
All Providers					
140.00 Are there any related organization or home office costs a chapter 10? Enter "Y" for yes or "N" for no in column 1.			Υ .	15H043	140. 00
are claimed, enter in column 2 the home office chain number			•		
	2. 00		3.00	-C -L L	
If this facility is part of a chain organization, enter office and enter the home office contractor name and con		ougn 143 the r	name and address	or the nome	9
141.00 Name: UNION HOSPITAL, INC. Contractor's Name:	WI SCONSI N PHYSI C	I ANS Contracto	or's Number: 0810)1	141. 00
142.00 Street: 1606 NORTH SEVENTH ST PO Box:	SERVI CES				142. 00
143. 00 Ci ty: TERRE HAUTE State:	IN	Zi p Code:	4780)4	143. 00
				1 00	
144.00 Are provider based physicians' costs included in Workshee	et A?			1. 00 Y	144. 00
			1.00		
145.00 If costs for renal services are claimed on Wkst. A, line	74, are the costs	s for	1. 00	2.00	145. 00
inpatient services only? Enter "Y" for yes or "N" for no	in column 1. If	column 1 is			1. 15. 55
no, does the dialysis facility include Medicare utilizati period? Enter "Y" for yes or "N" for no in column 2.	on for this cost	reporti ng			
146.00 Has the cost allocation methodology changed from the prev	viously filed cos	t report?	N		146. 00
Enter "Y" for yes or "N" for no in column 1. (See CMS Pub	o. 15-2, chapter	40, §4020) If			
yes, enter the approval date (mm/dd/yyyy) in column 2.			I	I	I

Health Financial Systems	UNI ON HOSPI T	ΓAL, INC.			In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLI	EX IDENTIFICATION DATA	Provi der CO	CN: 15-0023		: 1/01/2023 2/31/2023		repared:
						1.00	_
147.00 Was there a change in the statist	ical basis? Enter "Y" for	yes or "N" for	no.			N	147. 00
148.00 Was there a change in the order o						N	148. 00
149.00 Was there a change to the simplif	ied cost finding method? E					N	149. 00
		Part A	Part B	T	itle V	Title XIX	
D		1.00	2.00		3. 00	4.00	
Does this facility contain a prov or charges? Enter "Y" for yes or							
155. 00 Hospi tal	N TOT HO TOT EACH COMPORT	N N	N A AIIU PAI L	D. (3ee 2	12 CFR 941 N	N N	155. 00
156. 00 Subprovi der - IPF		N	N N		N	N N	156.00
157. 00 Subprovi der - I RF		N	N		N	N	157. 00
158. 00 SUBPROVI DER							158.00
159. 00 SNF		N	N		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						1.00	
165.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	ampus hospital that has on	e or more camp	ouses in dit	fferent C	BSAs?	N	165. 00
Enter 1 for yes of 10 for no.	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1. 00	2.00	3. 00	4.00	5. 00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0. (00 166. 00
Usalith Information Tashaslam (III	T) :	D	D-:			1. 00	
Health Information Technology (HI 167.00 Is this provider a meaningful use						Y	167. 00
168.00 If this provider is a CAH (line 1 reasonable cost incurred for the	05 is "Y") and is a meaning	gful user (lin			er the		168. 00
168.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii)	not a meaningful user, doe:	s this provide			dshi p		168. 01
169.00 If this provider is a meaningful transition factor. (see instructi		is not a CAH	(line 105 i	is "N"),	enter the	9. 9	99169. 00
				Ве	gi nni ng	Endi ng	
470 00 5 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Land and the second	La La Caracte			1. 00	2. 00	470.55
170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	peginning date and ending i	date for the r	reporting				170. 00
					1. 00	2. 00	
171.00 If line 167 is "Y", does this pro section 1876 Medicare cost plans "Y" for yes and "N" for no in col 1876 Medicare days in column 2. (reported on Wkst. S-3, Pt. umn 1. If column 1 is yes,	I, line 2, co	ol. 6? Enter		N N	2.00	0171.00

Health Financial Systems UNION HOSPITAL, INC. In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-0023 Peri od: Worksheet S-2 From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/21/2024 12:12 pm Y/N Date 1.00 2.00 PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation 1.00 Has the provider changed ownership immediately prior to the beginning of the cost Ν 1.00 reporting period? If yes, enter the date of the change in column 2. (see instructions) Date V/I 1.00 2.00 3.00 2.00 Has the provider terminated participation in the Medicare Program? If N 2 00 yes, enter in column 2 the date of termination and in column $\hat{\textbf{3}},$ "V" for voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Date Type 1.00 2.00 3.00 Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, 4.00 Α 4.00 or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 5.00 Are the cost report total expenses and total revenues different from 5.00 Ν those on the filed financial statements? If yes, submit reconciliation Legal Oper. Y/N 1.00 2.00 Approved Educational Activities 6.00 Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider N 6.00 the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. 7 00 7 00 8.00 Were nursing programs and/or allied health programs approved and/or renewed during the Ν 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9.00 9.00 program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 N 10.00 cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in an Approved 11.00 Ν Teaching Program on Worksheet A? If yes, see instructions Y/N 1.00 Bad Debts Is the provider seeking reimbursement for bad debts? If yes, see instructions. 12.00 12.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Ν 13.00 13.00 period? If yes, submit copy. 14.00 If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see Ν 14.00 instructions. Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions N 15.00 Part A Part B Y/N Date Y/N Date 1.00 2.00 3.00 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R Report only? Υ 02/21/2024 Υ 02/21/2024 16.00 If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&R Report for 17.00 N N 17.00 totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R 18.00 18.00 N N Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R 19.00 Ν Ν Report data for corrections of other PS&R Report information? If yes, see instructions.

modi en	Financial Systems UNION HOSPI	TAL, INC.		In Lie	u of Form CMS-	2552-1	
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CCN: 15-0023	Peri od: From 01/01/2023 To 12/31/2023		epared:	
			i pti on	Y/N	Y/N	F	
	1011 11 12 12 13 13 13 13 13 13 13 13 13 13 13 13 13		0	1.00	3. 00		
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00	
	nopor t data for other. Bosorrbo the other day astments.	Y/N	Date	Y/N	Date		
		1.00	2.00	3. 00	4. 00		
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00	
					1. 00		
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS	HOSPI TALS)				
	Capital Related Cost						
22. 00	Have assets been relifed for Medicare purposes? If yes, see				N	22. 0	
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprai	sais made du	ring the cost	N	23. 0	
24. 00	Were new leases and/or amendments to existing leases entered if yes, see instructions	ed into during	this cost r	eporting period?	N	24. 0	
25. 00	Have there been new capitalized leases entered into during	the cost repo	rting period	? If yes, see	N	25.0	
24 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during the	ho cost =====	ing pari 10	If you are	N	26. 0	
26. 00	instructions.	ne cost report	ing period?	ir yes, see	N	26.0	
27. 00	Has the provider's capitalization policy changed during the	e cost reporti	ng period? I	f yes, submit	N	27. 0	
	copy.						
28. 00	Interest Expense Were new loans, mortgage agreements or letters of credit en	ntered into du	ring the cos	t reporting	N	28. 0	
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	N	29. 0				
30. 00	treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled matu	N	30.0				
31. 00							
	instructions. Purchased Services						
32. 00	Have changes or new agreements occurred in patient care ser	rvi ces furni sh	ed through c	ontractual	N	32.0	
33. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app		ng to compet	itive bidding? If	N	33.0	
	no, see instructions. Provider-Based Physicians					-	
34 00	Were services furnished at the provider facility under an a	arrangement wi	th provider-	based physicians?	' N	34.0	
	If yes, see instructions.	Ü	·	. ,		"	
35. 00	If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in	isting agreeme nstructions.	ents with the		N	35. 0	
				Y/N	Date		
	Home Office Costs			1. 00	2. 00		
36. 00	Were home office costs claimed on the cost report?			Y		36.0	
	If line 36 is yes, has a home office cost statement been pu	repared by the	home office			37.0	
20 00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home of	fico difforent	from that a	f N		38. 0	
.00	the provider? If yes, enter in column 2 the fiscal year end			IN IN		30.0	
39. 00				s, N		39. 0	
40. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see	N		40. 0	
	00						
	Cost Report Preparer Contact Information	nformati on					
41. 00	held by the cost report preparer in columns 1, 2, and 3,	MI KE		ALESSANDRI NI		41.0	
	respecti vel y.			42.0			
42. 00	Enter the employer/company name of the cost report BLUE & CO., LLC preparer.						

2
epared:
: 12 pm
41.00
42.00
43.00
'n

| In Lieu of Form CMS-2552-10 | Period: | Worksheet S-3 | From 01/01/2023 | Part | | To 12/31/2023 | Date/Time Prepared: Heal th Financial SystemsUNIONHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-0023

				Т	o 12/31/2023	Date/Time Pre 5/21/2024 12:	pared: 12 nm
			<u> </u>			I/P Days /	, <u>L</u>
						0/P Visits /	
						Tri ps	
	Component	Worksheet A	No. of Beds	Bed Days	CAH/REH Hours	Title V	
		Li ne No.		Avai I abl e			
	DADT I CTATICTICAL DATA	1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	PART I - STATISTICAL DATA	30. 00	221	80, 665	0.00	0	1.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and	30.00	221	80, 665	0.00	0	1.00
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6. 00
7.00	Total Adults and Peds. (exclude observation		221	80, 665	0.00	0	7. 00
	beds) (see instructions)						
8. 00	INTENSIVE CARE UNIT	31. 00	24	8, 760	0. 00	0	8. 00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00 12. 00	SURGICAL INTENSIVE CARE UNIT INTENSIVE NURSERY	35. 00	15	E 475	0.00	0	11. 00 12. 00
13. 00	NURSERY	43. 00	15	5, 475	0. 00	0	13.00
14. 00	Total (see instructions)	43.00	260	94, 900	0. 00	0	14.00
15. 00	CAH visits		200	74, 700	0.00	0	15.00
15. 10	REH hours and visits				0.00	0	15. 10
16. 00	SUBPROVI DER - I PF				0.00	· ·	16. 00
17. 00	SUBPROVIDER - IRF	41. 00	15	5, 475		0	17. 00
18.00	SUBPROVI DER						18. 00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23. 00	AMBULATORY SURGI CAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)	30. 00					24. 10
25. 00 26. 00	CMHC - CMHC						25. 00 26. 00
26. 00	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 00
27. 00	Total (sum of lines 14-26)	69.00	275			U	20. 23
28. 00	Observation Bed Days		273			0	
29. 00	Ambul ance Tri ps					O O	29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33. 00
33. 01	LTCH site neutral days and discharges		_			_	33. 01
34. 00	Temporary Expansion COVID-19 PHE Acute Care	30. 00	0	0	1	0	34.00

Health Financial SystemsUNIONHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-0023

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part I | To 12/31/2023 | Date/Time Prepared:

				''	0 12/31/2023	5/21/2024 12:	
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	12 0
		.,. baye	, ,, ,, ,, ,,	,ps		_qu. va. 00	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8.00	9. 00	10.00	
	PART I - STATISTICAL DATA	0.00	71.00	0.00	7. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	19, 811	1, 593	55, 965			1.00
	8 exclude Swing Bed, Observation Bed and	.,,	., 0,0	00,700			
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)	7, 356	16, 644				2.00
3.00	HMO IPF Subprovider	,, 555	10, 011				3.00
4. 00	HMO IRF Subprovider	190	302				4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF	1,70	0				5.00
6. 00	Hospital Adults & Peds. Swing Bed NF	٥	0				6.00
7. 00	Total Adults and Peds. (exclude observation	19, 811	1, 593				7.00
7.00	beds) (see instructions)	19,011	1, 373	33, 703			7.00
8. 00	INTENSIVE CARE UNIT	1, 910	84	6, 692			8.00
9. 00	CORONARY CARE UNIT	1, 710	04	0,072			9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	INTENSIVE NURSERY	0	364	4, 536			12.00
13.00	NURSERY	٩	123				13.00
14. 00	1	21, 721	2, 164		20. 59	1, 495. 01	14.00
15. 00	Total (see instructions) CAH visits	21, /21	2, 104		20. 39	1, 493. 01	15.00
15. 00	REH hours and visits		0				15. 00
16. 00	SUBPROVIDER - IPF	٩	U	0			16.00
17. 00	SUBPROVIDER - IPF	1, 648	15	3, 229	0. 00	16. 78	1
18.00	SUBPROVI DER	1, 040	13	3, 229	0.00	10.76	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						20.00
22.00	HOME HEALTH AGENCY						22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24. 00	HOSPI CE			10			24.00
24. 10	HOSPICE (non-distinct part)			18			24. 10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC		0		0.00	0.00	26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		0.00	1
27. 00	Total (sum of lines 14-26)		4 00/	40.457	20. 59	1, 511. 79	
28. 00	Observation Bed Days		1, 986	10, 457			28.00
29. 00	Ambul ance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF		0.4	0			31.00
32.00	Labor & delivery days (see instructions)	0	91	135			32.00
32. 01	Total ancillary labor & delivery room			0			32. 01
00.05	outpatient days (see instructions)	_					00.00
33.00	LTCH non-covered days	0					33.00
33. 01	LTCH site neutral days and discharges	0	_	_			33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

Health Financial SystemsUNIONHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part I | | To | 12/31/2023 | Date/Time Prepared: | From 01/01/2024 | Part 1 | Part

				10) 12/31/2023	Date/IIMe Pre 5/21/2024 12:	
		Full Time		Di sch	arges	0,21,2021 121	, <u>, , , , , , , , , , , , , , , , , , </u>
		Equi val ents			ŭ		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	4, 957	444	16, 537	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)			942	4, 483		2.00
3.00	HMO IPF Subprovider				0		3.00
4. 00	HMO IRF Subprovider				24		4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7.00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8. 00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGI CAL INTENSI VE CARE UNIT						11.00
12.00	I NTENSI VE NURSERY						12.00
13. 00	NURSERY		_				13.00
14.00	Total (see instructions)	0.00	0	4, 957	444	16, 537	14.00
15.00	CAH visits						15.00
15. 10	REH hours and visits						15. 10
16.00	SUBPROVIDER - I PF	0.00		404		040	16.00
17. 00	SUBPROVIDER - IRF	0.00	0	121	'	219	17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21. 00 22. 00	OTHER LONG TERM CARE						21. 00 22. 00
23. 00	HOME HEALTH AGENCY						23.00
24. 00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE						24.00
24. 00	HOSPICE (non-distinct part)						24. 00
25. 00	CMHC - CMHC						25.00
26. 00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0.00					27. 00
28. 00	Observation Bed Days	0.00					28.00
29. 00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days (see Histruction)						31.00
32.00	Labor & delivery days (see instructions)						32.00
32. 00	Total ancillary labor & delivery room						32.00
JZ. U1	outpatient days (see instructions)						JZ. U1
33. 00	LTCH non-covered days			o			33. 00
33. 01	LTCH site neutral days and discharges			0			33. 01
	Temporary Expansion COVID-19 PHE Acute Care						34.00

| Period: | Worksheet S-3 | From 01/01/2023 | Part II | To | 12/31/2023 | Date/Time | Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 15-0023

					Ť	0 12/31/2023	Date/Time Pre 5/21/2024 12:	
		Wkst. A Line	Amount	Recl assi fi cat	Adj usted	Paid Hours	Average	12 piii
		Number	Reported	i on of Sal ari es	Sal ari es (col. 2 ± col.	Related to Salaries in	Hourly Wage (col. 4 ÷	
				(from Wkst.	3)	col. 4	col . 5)	
		1 00		A-6)	,	5.00	, , , ,	
	PART II - WAGE DATA	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	SALARI ES							
1. 00	Total salaries (see instructions)	200. 00	120, 596, 951	0	120, 596, 951	3, 123, 230. 50	38. 61	1.00
2. 00	Non-physician anesthetist Part		0	0	0	0.00	0. 00	2. 00
3. 00	A Non-physician anesthetist Part		0	0	О	0. 00	0. 00	3.00
4 00	В		0			0.00	0.00	4 00
4. 00	Physician-Part A - Administrative		0	0	0	0. 00	0. 00	4. 00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		590, 375 3, 431, 958		590, 375 3, 431, 958		145. 56 352. 54	
5.00	Physician-Part B		3, 431, 930	U	3, 431, 930	9, 735.00	352. 54	3.00
6. 00	Non-physician-Part B for hospital-based RHC and FQHC		0	0	0	0. 00	0. 00	6. 00
	servi ces							
7. 00	Interns & residents (in an approved program)	21. 00	0	1, 451, 588	1, 451, 588	46, 654. 00	31. 11	7. 00
7. 01	Contracted interns and		0	0	0	0. 00	0. 00	7. 01
	residents (in an approved programs)							
8. 00	Home office and/or related organization personnel		0	0	0	0. 00	0. 00	8. 00
9. 00	SNF	44.00	0	0	0	0. 00	0. 00	
10. 00	Excluded area salaries (see instructions)		19, 579, 222	-2, 224, 867	17, 354, 355	265, 303. 00	65. 41	10.00
	OTHER WAGES & RELATED COSTS							
11. 00	Contract Labor: Direct Patient Care		25, 635, 403	0	25, 635, 403	272, 194. 00	94. 18	11.00
12.00	Contract Labor: Top Level		0	0	0	0. 00	0. 00	12.00
	management and other management and administrative							
13. 00	services Contract Labor: Physician-Part		185, 500	0	185, 500	1, 237. 00	1/0 06	13.00
	A - Administrative							
14. 00	Home office and/or related organization salaries and		0	0	0	0. 00	0. 00	14.00
	wage-related costs		0, 055 070		0, 055 070	5.47 (07 00	47.04	
14. 01 14. 02	Home office salaries Related organization salaries		26, 255, 078 6, 652, 078		26, 255, 078 6, 652, 078			14. 01 14. 02
15. 00	Home office: Physician Part A		0	0	0	0.00	0. 00	
16. 00	- Administrative Home office and Contract		0	0	0	0. 00	0. 00	16.00
17 01	Physicians Part A - Teaching Home office Physicians Part A		0	0	0	0. 00	0.00	16. 01
10.01	- Teaching		Ü	U	0	0.00	0.00	10.01
16. 02	Home office contract Physicians Part A - Teaching		0	0	0	0. 00	0. 00	16. 02
	WAGE-RELATED COSTS							
17. 00	Wage-related costs (core) (see instructions)		27, 842, 504	0	27, 842, 504			17. 00
18. 00	Wage-related costs (other)							18. 00
19. 00	(see instructions) Excluded areas		3, 091, 697	0	3, 091, 697			19.00
20. 00	Non-physician anesthetist Part		0	0	0			20.00
21. 00	Non-physician anesthetist Part		0	0	0			21.00
22. 00	B Physician Part A -		0	0	0			22. 00
	Admi ni strati ve		· ·					
22. 01 23. 00	Physician Part A - Teaching Physician Part B		69, 674 241, 611	0	69, 674 241, 611			22. 01 23. 00
24. 00	Wage-related costs (RHC/FQHC)		0	0	241,011			24.00
25. 00	Interns & residents (in an approved program)		394, 247	0	394, 247			25. 00
25. 50	Home office wage-related		5, 748, 205	0	5, 748, 205			25. 50
25. 51	(core) Related organization		1, 681, 712	0	1, 681, 712			25. 51
	wage-related (core)				, , , , , , , ,			
25. 52	Home office: Physician Part A - Administrative -		0		"			25. 52
	wage-related (core)							

Provi der CCN: 15-0023

					T	o 12/31/2023	Date/Time Pre 5/21/2024 12:	
		Wkst. A Line	Amount	Recl assi fi cat	Adj usted	Pai d Hours	Average	
		Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from Wkst.	3)	col. 4	col. 5)	
				A-6)				
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
25. 53	Home office: Physicians Part A		0	0	0			25.53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARI							
26. 00	Employee Benefits Department	4. 00	97, 396			·		26.00
27. 00	Administrative & General	5. 00	6, 208, 000			·		27. 00
28. 00	Administrative & General under		2, 676, 369	0	2, 676, 369	12, 367. 00	216. 41	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	0	0	0	0. 00		29. 00
30.00	Operation of Plant	7. 00	79, 216	-448		·	24. 49	
31.00	Laundry & Linen Service	8. 00	866, 140				19. 59	
32.00	Housekeepi ng	9. 00	2, 664, 460	-15, 075	2, 649, 385			32.00
33. 00	Housekeeping under contract (see instructions)		0	0	0	0. 00	0. 00	33. 00
34.00	Dietary	10.00	2, 116, 681	-1, 740, 580	376, 101	20, 105. 94	18. 71	34.00
35. 00	Dietary under contract (see instructions)		0	0	0	0. 00	0. 00	35. 00
36.00	Cafeteri a	11.00	0	1, 725, 858	1, 725, 858	95, 565. 00	18. 06	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	2, 034, 535	-11, 511	2, 023, 024	59, 400. 13	34. 06	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15. 00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical	16.00	0	0	0	0. 00	0.00	41.00
	Records Library							
42.00	Social Service	17. 00	0	0	0	0. 00	0. 00	42.00
43.00	Other General Service	18. 00	0	0	0	0. 00	0. 00	43.00

Health Financial Systems	UNION HOSPITAL, INC.	In Lieu of Form CMS-2552-10
HOSPITAL WAGE INDEX INFORMATION	Provider CCN: 15-0023	Period: Worksheet S-3

						To 12/31/2023		pared: 12 pm
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Pai d Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		119, 250, 987	-1, 451, 588	117, 799, 399	3, 075, 152. 50	38. 31	1.00
	instructions)							
2.00	Excluded area salaries (see		19, 579, 222	-2, 224, 867	17, 354, 355	265, 303. 00	65. 41	2.00
	instructions)							
3.00	Subtotal salaries (line 1		99, 671, 765	773, 279	100, 445, 044	2, 809, 849. 50	35. 75	3.00
	minus line 2)							
4.00	Subtotal other wages & related		58, 728, 059	0	58, 728, 059	1, 002, 059. 00	58. 61	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		35, 272, 421	0	35, 272, 42	0.00	35. 12	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		193, 672, 245	773, 279	194, 445, 524	3, 811, 908. 50	51. 01	6.00
7.00	Total overhead cost (see		16, 742, 797	1, 172, 225	17, 915, 022	625, 065. 93	28. 66	7.00
	instructions)							

Health Financial Systems	UNION HOSPITAL, INC.	In Lieu of Form CMS-2552-10	
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0023	Period: Worksheet S-3 From 01/01/2023 Part IV	
		To 12/31/2023 Date/Time Prepared:	

	To 12/31/2023	Date/Time Pre 5/21/2024 12:	
		Amount	12 piii
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	4, 113, 042	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	18, 684, 409	8. 02
8. 03	Health Insurance (Purchased)	0	8.03
9. 00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	-134, 834	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	56, 724	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13. 00	Disability Insurance (If employee is owner or beneficiary)	231, 270	13.00
14. 00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15. 00	'Workers' Compensation Insurance	83, 286	
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
	Noncumul ati ve porti on)		
47.00	TAXES	0.005.000	47.00
17. 00		8, 335, 202	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20. 00	State or Federal Unemployment Taxes OTHER	0	20.00
21 00		0	21 00
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))	0	21. 00
22. 00	Day Care Cost and Allowances	0	22. 00
23. 00	Tuition Reimbursement	269, 815	23.00
24. 00		31, 638, 914	24.00
24. UU	Part B - Other than Core Related Cost	31, 038, 914	∠4. 00
25 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00
25.00	Tomac made near to soon (or corresponding to the co		20.00

Health Financial Systems	UNION HOSPITAL, INC.	In Lie	u of Form CMS-2	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST		Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part V Date/Time Pre 5/21/2024 12:	pared:
Cost Center Description		Contract Labor	Benefit Cost	
		4 00	0 00	

Cost Center Description Contract Labor and Benefit Cost Labor Labor				5/21/2024 12:	12 pm_
PART V - Contract Labor and Benefit Cost Hospital and Hospital-Based Component Identification:		Cost Center Description	Contract	Benefit Cost	
PART V - Contract Labor and Benefit Cost Hospital and Hospital -Based Component Identification:			Labor		
Hospital and Hospital-Based Component Identification: 1.00			1. 00	2. 00	
1.00 Total facility's contract labor and benefit cost 2.00 Hospital 2.00 Hospital 3.00 SUBPROVIDER - IPF 4.00 SUBPROVIDER - IRF 5.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7.00 Swing Beds - NF 8.00 SKILLED NURSING FACILITY 9.00 NURSING FACILITY 10.00 OTHER LONG TERM CARE I 11.00 Hospital - Based Hospice 13.00 Hospital - Based Heal th Clinic RHC 15.00 Hospital - Based Heal th Clinic RHC 16.00 Hospital - Based - CMHC 17.00 RENAL DIALYSIS I		PART V - Contract Labor and Benefit Cost			
2.00 Hospital		Hospital and Hospital-Based Component Identification:			
3.00 SUBPROVIDER - I PF 4.00 SUBPROVIDER - I RF 5.00 Subprovider - (0ther) 6.00 Swi ng Beds - SNF 6.00 Swi ng Beds - NF 7.00 Swi ng Beds - NF 8.00 SKI LLED NURSI NG FACI LI TY 9.00 NURSI NG FACI LI TY 9.00 OTHER LONG TERM CARE I 11.00 Hospi tal -Based HHA 12.00 AMBULATORY SURGI CAL CENTER (D. P.) I 13.00 Hospi tal -Based Hospi ce 14.00 Hospi tal -Based Heal th Clinic RHC 15.00 Hospi tal -Based Heal th Clinic FOHC 16.00 Hospi tal -Based-CMHC 17.00 RENAL DI ALYSI S I	1.00	Total facility's contract labor and benefit cost	25, 627, 596	31, 619, 694	1.00
4.00 SUBPROVIDER - IRF 5.00 Subprovider - (Other) 6.00 Swing Beds - SNF 6.00 Swing Beds - NF 7.00 Swing Beds - NF 8.00 SKILLED NURSING FACILITY 9.00 NURSING FACILITY 9.00 OTHER LONG TERM CARE I 11.00 Hospi tal -Based HHA 12.00 AMBULATORY SURGI CAL CENTER (D. P.) I 13.00 Hospi tal -Based Heal th Clinic RHC 15.00 Hospi tal -Based Heal th Clinic FQHC 16.00 Hospi tal -Based-CMHC 17.00 RENAL DIALYSIS I	2.00	Hospi tal	25, 627, 596	31, 619, 694	2.00
5.00 Subprovider - (Other) 6.00 Swing Beds - SNF 0 0 0 6.00 7.00 Swing Beds - NF 0 0 0 7.00 8.00 SKILLED NURSING FACILITY 9.00 NURSING FACILITY 10.00 OTHER LONG TERM CARE I 11.00 Hospi tal -Based HHA 12.00 AMBULATORY SURGICAL CENTER (D.P.) I 13.00 Hospi tal -Based Heal th Clinic RHC 15.00 Hospi tal -Based Heal th Clinic RHC 16.00 Hospi tal -Based Heal th Clinic FOHC 16.00 Hospi tal -Based-CMHC 17.00 RENAL DIALYSIS I	3.00	SUBPROVI DER - I PF			3.00
6.00 Swing Beds - SNF 0 0 0 6.00 7.00 Swing Beds - NF 8.00 SKILLED NURSING FACILITY 9.00 NURSING FACILITY 9.00 OTHER LONG TERM CARE I 11.00 Hospi tal -Based HHA 12.00 AMBULATORY SURGI CAL CENTER (D. P.) I 13.00 Hospi tal -Based Heal th Clinic RHC 15.00 Hospi tal -Based Heal th Clinic FOHC 16.00 Hospi tal -Based Heal th Clinic FOHC 17.00 RENAL DIALYSIS I 10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4.00	SUBPROVI DER - I RF	0	0	4.00
7.00 Swing Beds - NF 8.00 SKILLED NURSING FACILITY 9.00 NURSING FACILITY 9.00 OTHER LONG TERM CARE I 10.00 Hospi tal - Based HHA 11.00 Hospi tal - Based Heal th Clinic RHC 15.00 Hospi tal - Based Heal th Clinic FOHC 16.00 Hospi tal - Based - CMHC 17.00 RENAL DIALYSIS I	5.00	Subprovi der - (0ther)	0	0	5.00
8.00 SKILLED NURSING FACILITY 9.00 10.00 NURSING FACILITY 9.00 11.00 OTHER LONG TERM CARE I 10.00 11.00 Hospi tal -Based HHA 11.00 12.00 AMBULATORY SURGICAL CENTER (D.P.) I 12.00 13.00 Hospi tal -Based Heal th Clinic RHC 13.00 14.00 Hospi tal -Based Heal th Clinic FQHC 15.00 16.00 Hospi tal -Based-CMHC 17.00 17.00 RENAL DIALYSIS I 17.00	6.00	Swing Beds - SNF	0	0	6.00
9.00 NURSING FACILITY 9.00 10.00 OTHER LONG TERM CARE I 10.00 11.00 Hospi tal -Based HHA 11.00 12.00 AMBULATORY SURGICAL CENTER (D.P.) I 12.00 13.00 Hospi tal -Based Hospi ce 13.00 14.00 Hospi tal -Based Heal th Clinic RHC 15.00 15.00 Hospi tal -Based Heal th Clinic FQHC 15.00 16.00 Hospi tal -Based-CMHC 16.00 17.00 RENAL DIALYSIS I 17.00	7.00	Swing Beds - NF	0	0	7. 00
10. 00 OTHER LONG TERM CARE I 11. 00 Hospi tal -Based HHA 12. 00 AMBULATORY SURGI CAL CENTER (D. P.) I 13. 00 Hospi tal -Based Hospi ce 14. 00 Hospi tal -Based Heal th Clinic RHC 15. 00 Hospi tal -Based Heal th Clinic FQHC 16. 00 Hospi tal -Based-CMHC 17. 00 RENAL DIALYSIS I 10. 00 11. 00 12. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	8.00	SKILLED NURSING FACILITY			8.00
11. 00 Hospi tal -Based HHA 12. 00 AMBULATORY SURGI CAL CENTER (D. P.) I 13. 00 Hospi tal -Based Hospi ce 14. 00 Hospi tal -Based Heal th Clinic RHC 15. 00 Hospi tal -Based Heal th Clinic FOHC 16. 00 Hospi tal -Based-CMHC 17. 00 RENAL DIALYSIS I 11. 00 12. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	9.00	NURSING FACILITY			9. 00
12.00 AMBULATORY SURGICAL CENTER (D. P.) I 12.00 13.00 Hospi tal -Based Hospi ce 13.00 14.00 Hospi tal -Based Heal th Clinic RHC 14.00 15.00 Hospi tal -Based Heal th Clinic FOHC 15.00 16.00 Hospi tal -Based-CMHC 16.00 17.00 RENAL DIALYSIS I 17.00	10.00	OTHER LONG TERM CARE I			10.00
13. 00 Hospi tal -Based Hospi ce 13. 00 14. 00 Hospi tal -Based Heal th Clinic RHC 14. 00 15. 00 Hospi tal -Based Heal th Clinic FOHC 15. 00 16. 00 Hospi tal -Based-CMHC 16. 00 17. 00 RENAL DIALYSIS I 17. 00	11.00	Hospi tal -Based HHA			11.00
14.00 Hospital - Based Health Clinic RHC 14.00 15.00 Hospital - Based Health Clinic FOHC 15.00 16.00 Hospital - Based - CMHC 16.00 17.00 RENAL DIALYSIS I 17.00	12.00	AMBULATORY SURGICAL CENTER (D. P.) I			12.00
15. 00 Hospital -Based Health Clinic FOHC 15. 00 16. 00 Hospital -Based-CMHC 16. 00 17. 00 RENAL DIALYSIS I 17. 00	13.00	Hospi tal -Based Hospi ce			13.00
16. 00 Hospi tal -Based-CMHC 16. 00 17. 00 RENAL DIALYSIS I 16. 00	14.00	Hospital-Based Health Clinic RHC			14.00
17. 00 RENAL DIALYSIS I 17. 00	15.00	Hospital -Based Health Clinic FQHC			15.00
	16.00	Hospi tal -Based-CMHC			16.00
18.00 Other 0 0 18.00	17.00	RENAL DIALYSIS I			17.00
	18. 00	Other	0	0	18. 00

Heal th	Financial Systems UNION HOSPITAL,	LNC		In lie	u of Form CMS-2	2552_10
		Provi der CC	N: 15_0023	Peri od:	Worksheet S-1	
1103111	AE GROOMI ENGATED AND THOUGHT GARE DATA	ilovidei oo	N. 13 0023	From 01/01/2023		O
		Date/Time Pre				
	5/21/2024 12: 12					
	DART I HOCKLIAL AND HOCKLIAL COMPLEY DATA				1. 00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA					
1 00	Uncompensated and Indigent Care Cost-to-Charge Ratio				0.207005	1 00
1. 00	Cost to charge ratio (see instructions)				0. 207085	1.00
2 00	Medicaid (see instructions for each line) Net revenue from Medicaid				22 154 700	2.00
2. 00 3. 00	Did you receive DSH or supplemental payments from Medicaid?				33, 156, 790 Y	3.00
4. 00	If line 3 is yes, does line 2 include all DSH and/or supplemen	tal navmont	s from Modia	ai d2	Y	4.00
5. 00	If line 4 is no, then enter DSH and/or supplemental payments f			arur	' 0	
6. 00	Medi cai d charges	rom wearear	u		275, 027, 792	
7. 00	Medicaid cost (line 1 times line 6)				56, 954, 130	1
8. 00	Difference between net revenue and costs for Medicaid program	(see instru	ictions)		23, 797, 340	1
	Children's Health Insurance Program (CHIP) (see instructions for					
9.00	Net revenue from stand-alone CHIP				147, 757	9.00
10.00	Stand-alone CHIP charges				367, 951	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)				76, 197	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP	(see instru	icti ons)		0	12.00
	Other state or local government indigent care program (see ins	tructions f	or each line	•)		
13.00	Net revenue from state or local indigent care program (Not inc	luded on li	nes 2, 5 or	9)	0	13.00
14.00	Charges for patients covered under state or local indigent car	e program (Not included	in lines 6 or	0	14.00
	10)					
15. 00	State or local indigent care program cost (line 1 times line 1				0	
16. 00	Difference between net revenue and costs for state or local in				0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CH	IP and stat	e/local indi	gent care progra	ams (see	
17 00	instructions for each line)					17.00
17.00	Private grants, donations, or endowment income restricted to f Government grants, appropriations or transfers for support of				0	
18. 00 19. 00				s (sum of lines	23, 797, 340	
19.00	8, 12 and 16)	i indigent	care program	is (Suill Of Titles	23, 191, 340	19.00
			Uni nsured	Insured	Total (col. 1	
			patients	pati ents	+ col . 2)	
			1.00	2. 00	3.00	
	Uncompensated care cost (see instructions for each line)					
20.00	Charity care charges and uninsured discounts (see instructions)	10, 308, 4	64 0	10, 308, 464	20. 00
21.00	Cost of patients approved for charity care and uninsured disco	unts (see	2, 134, 7	28 0	2, 134, 728	21.00
	instructions)					
22. 00	Payments received from patients for amounts previously written	off as		0	0	22. 00
00.00	charity care		0.404.7	20	0 404 700	00.00
23. 00	Cost of charity care (see instructions)		2, 134, 7	28 0	2, 134, 728	23.00
					1. 00	
24. 00	Does the amount on line 20 col. 2, include charges for patient	days heyon	ud a Length o	f stay limit	1.00 N	24.00
24.00	imposed on patients covered by Medicaid or other indigent care		id a religitif c	a stay iimit	I V	24.00
25. 00	If line 24 is yes, enter the charges for patient days beyond t		care progra	m's Lenath of	0	25. 00
20.00	stay limit	a. go	oa. o p. og. c	o rongen or		20.00
25. 01	Charges for insured patients' liability (see instructions)				0	25. 01
26. 00					34, 588, 029	1
27. 00	` ,				326, 459	
27. 01					502, 244	
28.00					34, 085, 785	28. 00
	Cost of non-Medicare and non-reimbursable Medicare bad debt am	ounts (see	instructions	(a)	7, 234, 440	1
	Cost of uncompensated care (line 23, col. 3, plus line 29)				9, 369, 168	1
31.00	Total unreimbursed and uncompensated care cost (line 19 plus I	i ne 30)			33, 166, 508	31.00

Heal th	Financial Systems UNION HOSPITAL,	LNC		In lie	u of Form CMS-2	2552-10
	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der CC	N: 15-0023	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-1 Parts I & II	0 pared:
	PART II - HOSPITAL DATA				1. 00	
	Uncompensated and Indigent Care Cost-to-Charge Ratio					
1. 00	Cost to charge ratio (see instructions)				0. 205981	1.00
	Medicaid (see instructions for each line)				0.200.00	
2.00	Net revenue from Medicaid					2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?					3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemer			cai d?		4. 00
5. 00	If line 4 is no, then enter DSH and/or supplemental payments f	rom Medicai	d			5. 00
6.00	Medi cai d charges					6.00
7. 00 8. 00	Medicaid cost (line 1 times line 6) Difference between net revenue and costs for Medicaid program	(coo inctru	otions)			7. 00 8. 00
6.00	Children's Health Insurance Program (CHIP) (see instructions f					0.00
9. 00	Net revenue from stand-alone CHIP	or cach fill	<u> </u>			9.00
10.00	Stand-alone CHIP charges					10.00
11. 00	Stand-alone CHIP cost (line 1 times line 10)					11.00
12.00	Difference between net revenue and costs for stand-alone CHIP	(see instru	ctions)			12.00
	Other state or local government indigent care program (see ins					
13.00	Net revenue from state or local indigent care program (Not inc					13.00
14. 00	Charges for patients covered under state or local indigent car 10)	e program (Not included	lin lines 6 or		14.00
15.00	State or local indigent care program cost (line 1 times line 1	4)				15.00
16.00	Difference between net revenue and costs for state or local in					16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see					
17 00	<pre>instructions for each line) Private grants, donations, or endowment income restricted to f</pre>	inding shop	1+11 0000		I	l 17. 00
17. 00 18. 00	Government grants, appropriations or transfers for support of					18.00
	Total unreimbursed cost for Medicaid , CHIP and state and Loca			ns (sum of lines		19.00
17.00	8, 12 and 16)	a. goire	oa. o p. og. a.	(34 31 111133		17.00
			Uni nsured	Insured	Total (col. 1	
			pati ents	pati ents	+ col . 2)	
			1. 00	2. 00	3. 00	
20. 00	Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions	.\	10, 303, 2	30 0	10, 303, 230	20.00
21. 00	Cost of patients approved for charity care and uninsured disco	,	2, 122, 2			1
21.00	instructions)	dires (see	2, 122, 2	, 0	2, 122, 270	21.00
22.00	Payments received from patients for amounts previously writter	off as		0 0	0	22. 00
	charity care					
23. 00	Cost of charity care (see instructions)		2, 122, 2	70 0	2, 122, 270	23.00
					1.00	
24. 00	Does the amount on line 20 col. 2, include charges for patient	days bayan	d a Longth (of ctov limit	1. 00 N	24. 00
24.00	imposed on patients covered by Medicaid or other indigent care		u a rengtii t	or Stay IIIII t	IN IN	24.00
25. 00	If line 24 is yes, enter the charges for patient days beyond t		care progra	am's length of	0	25. 00
25. 01	stay limit Charges for insured patients' liability (see instructions)				0	25. 01
	Bad debt amount (see instructions)				34, 498, 178	
27. 00					326, 459	
27. 01						
28. 00	,				33, 995, 934	
	Cost of non-Medicare and non-reimbursable Medicare bad debt an	ounts (see	i nstructi ons	s)	7, 178, 301	
	Cost of uncompensated care (line 23, col. 3, plus line 29)				9, 300, 571	
31. 00	Total unreimbursed and uncompensated care cost (line 19 plus l	ine 30)			9, 300, 571	31.00

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	UNION HOSPIT	AL, INC. Provider CO	`N: 15_0023	<u> </u>	u of Form CMS-: Worksheet A	2552-10
KLULA	STITICATION AND ADJUSTMENTS OF TRIAL BALANCE O	I LAFLINGES	Flovider CC	1	From 01/01/2023		
					Го 12/31/2023	Date/Time Pre 5/21/2024 12:	pared: 12 pm
	Cost Center Description	Sal ari es	0ther		Reclassificat	Reclassified Trial Balance	
				+ col. 2)	ions (See A-6)	(col. 3 +-	
					, , , ,	col . 4)	
	GENERAL SERVICE COST CENTERS	1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	00100 NEW CAP REL COSTS-BLDG & FIXT		15, 435, 547	15, 435, 54	5, 407, 710	20, 843, 257	1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	07.004	8, 020, 972	8, 020, 972		10, 680, 072	2.00
4. 00 5. 01	OO400	97, 396 503, 562	9, 523 248, 834	106, 919 752, 396		5, 366, 354 749, 547	4. 00 5. 01
5. 02	00550 DATA PROCESSING	0	0	, 52, 5,	0	0	5. 02
5. 03	00560 PURCHASING RECEIVING AND STORES	0	0	1 470 070	0 7 0(0	0	5. 03
5. 04 5. 05	O0570 ADMI TTI NG O0580 CASHI ERI NG/ACCOUNTS RECEI VABLE	1, 284, 819 0	194, 259 0	1, 479, 078	3 -7, 269 0 0	1, 471, 809 0	5. 04 5. 05
5. 06	00590 OTHER ADMIN AND GENERAL	4, 419, 619	50, 789, 078	55, 208, 69	7 -7, 994, 029	47, 214, 668	
7.00	00700 OPERATION OF PLANT	79, 216	505, 060	584, 276		583, 828	7.00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	866, 140 2, 664, 460	471, 382 1, 576, 753	1, 337, 522 4, 241, 213		1, 332, 622 4, 226, 138	
10.00	01000 DI ETARY	2, 116, 681	3, 277, 396			961, 725	
11.00	01100 CAFETERI A	0	0		4, 417, 630	4, 417, 630	
13. 00 16. 00	O1300 NURSI NG ADMI NI STRATI ON O1600 MEDI CAL RECORDS & LI BRARY	2, 034, 535	284, 141 20, 838	2, 318, 676 20, 838		2, 307, 165 20, 838	
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	Ö	0		1, 604, 022	1, 604, 022	21.00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	(1, 384, 850	1, 384, 850	1
23. 00 23. 01	O2300 PARAMED ED PRGM O2341 OTHER MED ED	1, 349, 339	181, 091	1, 530, 430	90, 713 42, 592	90, 713 1, 573, 022	1
	02301 PARAMED ED PRGM	0	0		0	0	
	INPATIENT ROUTINE SERVICE COST CENTERS	00.050.040	00 070 474	45 000 01		40.047.704	
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	23, 050, 340 5, 565, 594	22, 279, 471 5, 482, 772	45, 329, 81° 11, 048, 366		43, 817, 701 11, 108, 179	1
35. 00	02040 I NTENSI VE NURSERY	2, 848, 744	1, 531, 992	4, 380, 736		4, 426, 546	1
41.00	04100 SUBPROVI DER – I RF	1, 781, 027	329, 609	2, 110, 63		2, 144, 670	
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0	(1, 187, 108	1, 187, 108	43.00
50.00	05000 OPERATING ROOM	3, 466, 520	28, 058, 923	31, 525, 443	-8, 883, 872	22, 641, 571	50.00
50. 01	05001 CARDI AC SURGERY	1, 824, 612	2, 984, 742	4, 809, 354		4, 741, 351	1
50. 02 51. 00	05002 WVSC 05100 RECOVERY ROOM	4, 227, 789 1, 900, 200	12, 347, 453 550, 555	16, 575, 242 2, 450, 755		13, 329, 777 2, 440, 017	
51. 02	05101 O/P TREATMENT ROOM	392, 111	124, 669	516, 780		514, 562	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	4, 376, 344	4, 269, 255	8, 645, 59		8, 626, 365	
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	5, 101, 857 387, 759	6, 032, 555 4, 561, 027	11, 134, 412 4, 948, 786		11, 165, 013 4, 946, 592	
56. 00	05600 RADI OI SOTOPE	275, 468	1, 713, 964			1, 987, 874	
57.00	05700 CT SCAN	1, 374, 098	1, 923, 286	3, 297, 384		3, 289, 636	
58. 00 59. 00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	1, 012, 438 3, 241, 924	679, 298 20, 817, 118			1, 686, 008 21, 455, 275	
60.00		5, 803, 401	11, 410, 712			17, 181, 280	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1, 654, 880				
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	3, 187, 656	1, 719, 718 5, 411, 708	4, 907, 374 5, 411, 708		4, 927, 032 5, 411, 708	1
66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	Ö	0, 111, 700	(o o	0, 111, 700	1
66. 02	06602 O/P PHYSI CAL THERAPY	0	2, 886, 244	2, 886, 24	1 0	2, 886, 244	
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	986, 916	986, 916		0 986, 916	
69. 00	06900 ELECTROCARDI OLOGY	2, 697, 051	1, 460, 540	4, 157, 59		4, 142, 332	1
69. 01	06901 CARDI AC REHAB	361, 635	65, 232	426, 86		424, 821	
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 402, 256	2, 116, 232 1, 079, 475	4, 518, 488 1, 079, 479		4, 504, 897 -1	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	Ō	0		15, 655, 108	15, 655, 108	1
73.00	07300 DRUGS CHARGED TO PATIENTS	5, 941, 326	83, 298, 852			84, 124, 330	
76. 00	03020 RENAL ACUTE OUTPATIENT SERVICE COST CENTERS	0	1, 737, 571	1, 737, 57	1 0	1, 737, 571	76.00
90.00	09000 CLINIC	224, 185	58, 572	282, 75	7 -1, 268	281, 489	90.00
90.05	09005 PATIENT NUTRITION	0	3, 562			3, 562	
90. 07 91. 00	O9007 WOUND CLINIC O9100 EMERGENCY	458, 418 6, 829, 575	1, 275, 733 7, 473, 991	1, 734, 15° 14, 303, 566		1, 685, 982 14, 272, 160	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0,027,373	7, 475, 771	14, 303, 300	31, 400	14, 272, 100	92.00
440.00	SPECIAL PURPOSE COST CENTERS	404 440 005	047 044 504	101 100 50		101 011 011	
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	104, 148, 095	317, 341, 501	421, 489, 590	2, 727, 220	424, 216, 816]118.00]
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(0	0	190. 00
	07950 RURAL HEALTH	2, 304, 501	4, 278, 990			6, 714, 188	
	07951 RENTAL PROPERTY 07954 FAMILY PRACTICE	0 5, 284, 394	32, 315 2, 083, 469	32, 315 7, 367, 863		32, 315 4, 349, 094	194. 01 194. 02
	07952 WELLNESS	0, 204, 374	2, 303, 409		297, 963	297, 963	
194. 04	07955 PHYSICIAN PRACTICES	8, 224, 820	31, 660, 685		-46, 533	39, 838, 972	194. 04
194.06	07953 SYCAMORE SPORTS MED	13, 800	1, 404, 269	1, 418, 069	9 -78	1, 417, 991	1194.06

Health Financial Systems	UNI ON HOSPI	TAL, INC.		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provi der CO		Peri od:	Worksheet A	
				From 01/01/2023 To 12/31/2023	Date/Time Pre	nared·
					5/21/2024 12:	
Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
			+ col. 2)	ions (See	Trial Balance	
				A-6)	(col. 3 +-	
					col. 4)	
	1.00	2.00	3. 00	4. 00	5. 00	
194. 07 07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	621, 341	90, 484	711, 825	-90, 500	621, 325	194. 07
200.00 TOTAL (SUM OF LINES 118 through 199)	120, 596, 951	356, 891, 713	477, 488, 664	0	477, 488, 664	200. 00

 Health Financial
 Systems
 UNION HO

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0023

| Period: | Worksheet A | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: 5/21/2024 12: 12 pm

				5/21/2024 12:	12 pm
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For		
		6. 00	Allocation 7.00	_	
	GENERAL SERVICE COST CENTERS	0.00	7.00		
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	-3, 347, 267	17, 495, 990		1.00
2. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP	-1, 462, 365	9, 217, 707	1	2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	19, 018, 596	24, 384, 950		4.00
5. 01 5. 02	00540 NONPATI ENT TELEPHONES 00550 DATA PROCESSI NG	-57, 586 18, 579, 072	691, 961 18, 579, 072	1	5. 01 5. 02
5. 02	00560 PURCHASING RECEIVING AND STORES	2, 043, 404	2, 043, 404		5.02
5. 04	00570 ADMITTING	2,010,101	1, 471, 809	l .	5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	25, 128, 683	25, 128, 683	l .	5. 05
5. 06	00590 OTHER ADMIN AND GENERAL	-14, 334, 675	32, 879, 993	3	5. 06
7. 00	00700 OPERATION OF PLANT	9, 838, 250	10, 422, 078	l .	7.00
8. 00	00800 LAUNDRY & LI NEN SERVI CE	-6, 180	1, 326, 442		8.00
9. 00 10. 00	O0900 HOUSEKEEPI NG O1000 DI ETARY	-61, 181 -295, 540	4, 164, 957 666, 185		9. 00 10. 00
11. 00	01100 CAFETERI A	-1, 851, 389	2, 566, 241		11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	1, 930, 085	4, 237, 250		13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-17, 177	3, 661		16.00
21.00	02100 &R SERVICES-SALARY & FRINGES APPRVD	0	1, 604, 022	2	21.00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	1, 384, 850	l .	22. 00
23. 00	02300 PARAMED ED PRGM	0	90, 713	l .	23.00
23. 01 23. 02	02341 OTHER MED ED	-1, 381, 047 0	191, 975 0	1	23. 01 23. 02
23. 02	02301 PARAMED ED PRGM INPATIENT ROUTINE SERVICE COST CENTERS	U	0	<i>y</i>	23.02
30. 00	03000 ADULTS & PEDIATRICS	-3, 911, 640	39, 906, 061		30.00
31. 00	03100 I NTENSI VE CARE UNI T	0	11, 108, 179	•	31.00
35.00	02040 I NTENSI VE NURSERY	-911, 563	3, 514, 983	3	35.00
41.00	04100 SUBPROVI DER - I RF	-411, 770	1, 732, 900		41.00
43. 00	04300 NURSERY	0	1, 187, 108	3	43.00
50. 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	-4, 383, 981	18, 257, 590		50.00
50. 00	05001 CARDI AC SURGERY	-4, 363, 961 -2, 508, 742	2, 232, 609	1	50.00
50. 01	05002 WVSC	-2, 840, 850	10, 488, 927	1	50.02
51. 00	05100 RECOVERY ROOM	0	2, 440, 017	l .	51.00
51. 02	05101 0/P TREATMENT ROOM	0	514, 562	2	51.02
52.00	05200 DELIVERY ROOM & LABOR ROOM	-3, 176, 478	5, 449, 887	l .	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	509, 559	11, 674, 572	l .	54.00
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	4, 946, 592		55. 00 56. 00
57. 00	05700 CT SCAN	0	1, 987, 874 3, 289, 636		57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	o	1, 686, 008		58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	21, 455, 275		59.00
60.00	06000 LABORATORY	0	17, 181, 280		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1, 654, 880		62.00
65.00	06500 RESPI RATORY THERAPY	0	4, 927, 032		65.00
66.00	06600 PHYSI CAL THERAPY	-1, 486, 469 0	3, 925, 239 0	l .	66.00
66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 06602 0/P PHYSI CAL THERAPY	-1, 019, 364	1, 866, 880	1	66. 01 66. 02
67. 00	06700 OCCUPATI ONAL THERAPY	2, 540, 447	2, 540, 447		67.00
68. 00	06800 SPEECH PATHOLOGY	231, 199	1, 218, 115		68.00
69. 00	06900 ELECTROCARDI OLOGY	32, 369	4, 174, 701		69.00
69. 01	06901 CARDI AC REHAB	0	424, 821		69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	-3, 139, 957	1, 364, 940		70.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	-45 0	-46 15, 655, 108		71. 00 72. 00
72. 00 73. 00	O7200 I MPL. DEV. CHARGED TO PATIENTS O7300 DRUGS CHARGED TO PATIENTS	1, 422, 874	85, 547, 204		73.00
76. 00	03020 RENAL ACUTE	1, 422, 074	1, 737, 571	1	76.00
	OUTPATIENT SERVICE COST CENTERS	-1	., ,		
90.00	09000 CLI NI C	-13, 576	267, 913	l .	90.00
90. 05	09005 PATIENT NUTRITION	0	3, 562		90.05
90. 07	09007 WOUND CLINIC	0	1, 685, 982	l .	90.07
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	-3, 571, 911	10, 700, 249	1	91. 00 92. 00
72.00	SPECIAL PURPOSE COST CENTERS				72.00
118. 00		31, 083, 785	455, 300, 601		118. 00
	NONREI MBURSABLE COST CENTERS				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1	190. 00
	07950 RURAL HEALTH	0	6, 714, 188		194.00
	07951 RENTAL PROPERTY	0	32, 315		194. 01 194. 02
	07954 FAMILY PRACTICE 07952 WELLNESS	0	4, 349, 094 297, 963	l .	194. 02
	07955 PHYSI CI AN PRACTI CES	-410, 000	39, 428, 972	l .	194.03
	07953 SYCAMORE SPORTS MED	-1, 382, 992	34, 999		194. 06
	07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	621, 325	•	194. 07

Health Financi	al Systems	UNION HOSPI	TAL, INC.			In Lieu	of Form CM	MS-2552-10
RECLASSI FI CATI	ON AND ADJUSTMENTS OF TRIAL BALANCE (OF EXPENSES	Provi der C	CN: 15-0023	Peri oc	l: 01/01/2023	Worksheet	A
						2/31/2023	Date/Time 5/21/2024	
Co	ost Center Description	Adjustments	Net Expenses				3/21/2024	12. 12 piii
	·	(See A-8)	For					
			Allocation					
		6. 00	7.00					
200. 00 TO	OTAL (SUM OF LINES 118 through 199)	29, 290, 793	506, 779, 457					200.00

| Peri od: | Worksheet A-6 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared:

Cost Center						To 12/31/2023 Date/Ti	me Prepared: 024 12:12 pm
Description Color Color			Increases			, , , , , , , , , , , , , , , , , , , ,	
A. PARAMER PET ASS							
1.00			3.00	4. 00	5. 00		
Temperature	1 00		23 00	74 539	16, 596		1 00
1.00	1.00	0					1.00
ALLINESS 194_08 226,721 02,581 0 0 0 0 0 0 0 0 0							
1.00 ROW MYDICAL REALTH RECLASS 1.00		•					•
1.00 RURAL HEALTH	2. 00	WELLNESS	194. 03				2.00
1.00		C - CLAV CLTV RURAL HEALTH REC	224 1	348, /35	92, 194		
0 - CORK MEDICAL RURAL HEALTH 194.00 0 77, 453 1.00 1	1. 00			0	49, 789		1.00
1.00		0		0	49, 789		
0							
E - BRAZIL MEDICAL CENTER RECLASS 100	1.00	RURAL HEALTH	194.00				1.00
1.00 RURAL HEALTH		F - BRAZII MEDICAL CENTER RECI	ASS	o _l	77,455		
F - HOUSE NURSE ASSISTANT RECLASS 1.00	1.00			0	16, 493		1.00
1.00		0		0	16, 493		
NTERSIVE NURSERY 35, 00 55, 117 7, 122 3, 00 0 175, 037 22, 095 0 0 175, 037 22, 095 0 0 175, 037 22, 095 0 0 0 0 0 0 0 0 0	1 00			01 2/1	10 500		1.00
3.00 SUBPROVIDER - IRF 41.00 39,259 5,073							
1.00 EMPLOYEE BENEFITS DEPARTMENT 4,00 76,304 11,112 1.00							1
1.00		0					
1.00							
1.00	1. 00	EMPLOYEE BENEFITS DEPARTMENT	<u> 4.00</u>				1.00
ADULTS & PEDIATRICS 30,00 2,762 0 1,00		H - TURE FEEDLING RECLASS		76, 304	11, 112		
1. FAMILY MEDICINE RECLASS	1. 00		30.00	2, 762	0		1.00
1.00		0					
FRI NCES APPRVD	4 00		04.00	4 450 047	450 404		4 00
2. 00 RES SERVICES-OTHER PROM 22. 00 986. 217 404. 213 2. 00 2. 446. 064 556. 647 3.	1.00		21.00	1, 459, 847	152, 434		1.00
COSTS APPRVD	2. 00	•	22. 00	986, 217	404, 213		2.00
1. LOBBY PHARMACY RECLASS			`				
1.00 EMPLOYEE BENEFITS DEPARTMENT		0		2, 446, 064	556, 647		
New Cap Rel Costs-Myble 2.00 0 15,655,108 1.00	1 00		4 00	727 741	4 200 421		1 00
New Cap Rel Costs - Mules New Cap Rel Costs - Mules New Cap Rel Costs - Mules	1.00	0					1.00
PATI ENTS		K - IMPLANTABLE DEVICES RECLAS	SS	, , , , , , , ,	1,2,0,121		
2.00 3.00 4.00 5.00 0.00 0.00 0.00 0.00 0.00 0	1. 00		72. 00	0	15, 655, 108		1.00
3.00	2.00	PATI ENTS	0.00		0		2.00
4.00			I .		0		•
5.00				-	o		1
1.00 NEW CAP REL COSTS-BLDG & 1.00 0 5,551,445 1.00	5.00		0.00	0_	0		5. 00
1. 00 NEW CAP REL COSTS-BLDG & 1. 00 0 5, 551, 445		0		0	15, 655, 108		
FIXT	1 00		1 00	ol	5 551 1/15		1 00
2.00 NEW CAP REL COSTS-MVBLE 2.00 0 2,659,100 0 0 0 0 0 0 0 0 0	1.00		1.00	J	5, 551, 445		1.00
COULD P	2.00	NEW CAP REL COSTS-MVBLE	2. 00	О	2, 659, 100		2.00
NURSERY RECLASS 43.00 984,511 208,167 208,167							
1. 00 NURSERY				O	8, 210, 545		
1.00 OTHER MED ED 23.01 45,725 4,760 0 0 0 45,725 4,760 0 0 0 0 0 0 0 0 0	1. 00		43.00	984, 511	208. 167		1.00
1. 00 OTHER MED ED 23.01 45,725 4,760 0 1. 00		0					
1.00 CAFE RECLASS 1.00 CAFETERIA 11.00 1,735,678 2,691,772 0 1.735,678 2,691,772 0 1.735,678 2,691,772 0 1.00 0 0 0 0 0 0 0 0 0							
1. 00	1. 00	OTHER MED ED	<u>23.</u> 01				1.00
1. 00 CAFETERIA		O - CAFE RECLASS		45, 725	4, 700		
P - CENTRAL SUPPLY RECLASS 1.00 OPERATI NG ROOM 50.00 O 232,818 1.00	1. 00		11. 00	1, 735, 678	2, 691, 772		1.00
1. 00 OPERATI NG ROOM 50. 00 0 232, 818 1. 00 2. 00 CARDI AC SURGERY 50. 01 0 6, 976 2. 00 3. 00 WVSC 50. 02 0 81, 149 3. 00 4. 00 RECOVERY ROOM 51. 00 0 13 4. 00 5. 00 DELI VERY ROOM & LABOR ROOM 52. 00 0 5, 526 5. 00 6. 00 RADI OLOGY, DI AGNOSTI C 54. 00 0 150, 196 6. 00 7. 00 CT SCAN 57. 00 0 26 7. 00 8. 00 CARDI AC CATHETERI ZATI ON 59. 00 0 557, 846 8. 00 9. 00 RESPI RATORY THERAPY 65. 00 0 37, 693 9. 00 10. 00 EMERGENCY 91. 00 0 7, 233 10. 00		0			2, 691, 772		
2. 00 CARDI AC SURGERY 50. 01 0 6, 976 2. 00 3. 00 WVSC 50. 02 0 81, 149 3. 00 4. 00 RECOVERY ROOM 51. 00 0 13 4. 00 5. 00 DELI VERY ROOM & LABOR ROOM 52. 00 0 5, 526 5. 00 6. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 150, 196 6. 00 7. 00 CT SCAN 57. 00 0 26 7. 00 8. 00 CARDI AC CATHETERI ZATI ON 59. 00 0 557, 846 8. 00 9. 00 RESPI RATORY THERAPY 65. 00 0 37, 693 9. 00 10. 00 EMERGENCY 91. 00 0 7, 233 10. 00	1 00		FO 00		222 040		1.00
3.00 WVSC 50.02 0 81,149 3.00 4.00 RECOVERY ROOM 51.00 0 13 4.00 5.00 DELI VERY ROOM & LABOR ROOM 52.00 0 5,526 5.00 6.00 RADI OLOGY-DI AGNOSTI C 54.00 0 150,196 6.00 7.00 CT SCAN 57.00 0 26 7.00 8.00 CARDI AC CATHETERI ZATI ON 59.00 0 557, 846 8.00 9.00 RESPI RATORY THERAPY 65.00 0 37,693 9.00 10.00 EMERGENCY 91.00 0 7,233 10.00							
4. 00 RECOVERY ROOM 51. 00 0 13 4. 00 5. 00 DELI VERY ROOM & LABOR ROOM 52. 00 0 5, 526 5. 00 6. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 150, 196 6. 00 7. 00 CT SCAN 57. 00 0 26 7. 00 8. 00 CARDI AC CATHETERI ZATI ON 59. 00 0 557, 846 8. 00 9. 00 RESPI RATORY THERAPY 65. 00 0 37, 693 9. 00 10. 00 EMERGENCY 91. 00 0 7, 233 10. 00							
6. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 150, 196 6. 00 7. 00 CT SCAN 57. 00 0 26 7. 00 8. 00 CARDI AC CATHETERI ZATI ON 59. 00 0 557, 846 8. 00 9. 00 RESPI RATORY THERAPY 65. 00 0 37, 693 9. 00 10. 00 EMERGENCY 91. 00 0 7, 233 10. 00				o	13		
7. 00 CT SCAN 57. 00 0 26 7. 00 8. 00 CARDI AC CATHETERI ZATI ON 59. 00 0 557, 846 8. 00 9. 00 RESPI RATORY THERAPY 65. 00 0 37, 693 9. 00 10. 00 EMERGENCY 91. 00 0 7, 233 10. 00			I	О			1
8. 00 CARDI AC CATHETERI ZATI ON 59. 00 0 557, 846 8. 00 9. 00 RESPI RATORY THERAPY 65. 00 0 37, 693 9. 00 10. 00 EMERGENCY 91. 00 0 7, 233 10. 00			I	0			
9. 00 RESPIRATORY THERAPY 65. 00 0 37, 693 9. 00 10. 00 EMERGENCY 0 7, 233 10. 00				O			
10.00 <u>EMERGENCY</u> <u>91.00</u> <u>91.00</u> <u>7,233</u>							
[0 0 1,079,476				o_	<u>7, 2</u> 33		•
		0		O	1, 079, 476		[

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

| Period: | Worksheet A-6 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: 5/21/2024 12: 12 pm

					l .	5/21/2024 12:12 pm
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2.00	3. 00	4. 00	5. 00		
	Q - BONUS RECLASS					
1.00	OTHER ADMIN AND GENERAL	5. 06	657, 445	0		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7. 00		0.00	0	0		7.00
8. 00		0.00	0	0		8.00
9. 00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11. 00		0.00	0	0		11.00
12. 00		0.00	0	0		12.00
13.00		0.00	0	0		13. 00
14. 00		0.00	0	0		14.00
15. 00		0.00	0	0		15. 00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17. 00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0			22.00
23. 00 24. 00		0. 00 0. 00	0	0		23.00
25.00		0.00	0	0		24. 00 25. 00
26. 00		0.00	o	0		26. 00
27.00		0.00	o	0		27. 00
28. 00		0.00	o	0		28.00
29. 00		0.00	o	0		29.00
30.00		0.00	0	0		30.00
31. 00		0.00	Ö	0		31.00
32. 00		0.00	o	0		32.00
33.00		0.00	o	0		33.00
34.00		0.00	o	0		34.00
35.00		0.00	o	0		35.00
36.00		0.00	ol	0		36.00
37.00		0.00	o	0		37.00
38.00		0.00	O	0		38.00
39.00		0.00	O	0		39.00
40.00		0.00	0	0		40.00
41.00		0.00	O	0		41.00
42.00		0.00	0	0		42.00
43.00		0.00	0	0		43.00
44.00		0.00	0	0		44.00
45.00		0.00	0	0		45.00
	0		657, 445			
500.00	Grand Total: Increases		7, 285, 161	32, 991, 228		500.00
		·	•			•

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

Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: Provider CCN: 15-0023

						5/21/2024	
	21.21	Decreases	6.1	011	W		
	Cost Center 6.00	Li ne #	Sal ary 8. 00	0ther 9.00	Wkst. A-7 Ref. 10.00		
	A - PARAMED RECLASS	7.00	0.00	7.00	10.00		
1.00	RADI OLOGY-DI AGNOSTI C	54. 00	74, 539	16, 596	0		1.00
	0		74, 539	16, 596			
	B - FITNESS ACTIVITY RECLASS						
1.00	OTHER ADMIN AND GENERAL	5. 06	348, 735	92, 194			1.00
2. 00			348, 735	<u></u> 92, 194	0		2.00
	C - CLAY CITY RURAL HEALTH REC	CLASS	340, 733	72, 174			
1.00	NEW CAP REL COSTS-BLDG &	1. 00	0	49, 789	9		1.00
	FLXT						
	0	DEGL AGO	0	49, 789			
1. 00	D - CORK MEDICAL RURAL HEALTH NEW CAP REL COSTS-BLDG &	1. 00	O	77, 453	9		1.00
1.00	FIXT	1.00	ď	77, 455	9		1.00
		+		77, 453			i
	E - BRAZIL MEDICAL CENTER RECL	_ASS	- 1				
1.00	NEW CAP REL COSTS-BLDG &	1. 00	0	16, 493	9		1. 00
	FI XT	+					
	F - HOUSE NURSE ASSISTANT RECL	224	0	16, 493			
1. 00	ADULTS & PEDIATRICS	30.00	175, 637	22, 695	0		1.00
2. 00	ABOLTO & TESTATION	0.00	0	0			2.00
3.00		0. 00	o	0	0		3.00
	0		175, 637	22, 695			
	G - EMPLOYEE ACCESS RECLASS	404.07	77, 004				
1. 00	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	194. 07	76, 304	11, 112	0		1.00
	0	 	76, 304	_{11, 112}			
	H - TUBE FEEDING RECLASS			,			
1.00	DI ETARY	10. 00	2, 762	0	0		1.00
	0		2, 762	0			
1. 00	I - FAMILY MEDICINE RECLASS FAMILY PRACTICE	194. 02	2, 446, 064	556, 647	0		1.00
2. 00	PAWILY PRACTICE	0.00	2, 440, 004	0 0 0 0 0 0			2.00
2.00			2, 446, 064	556, 647			2.00
	J - LOBBY PHARMACY RECLASS						
1.00	DRUGS CHARGED TO PATIENTS	73. 00	737, 761	4, 298, 421			1.00
	0		737, 761	4, 298, 421			
1. 00	K - IMPLANTABLE DEVICES RECLAS	50.00		9, 098, 911	0		1.00
2. 00	CARDI AC SURGERY	50. 00		64, 656			2.00
3.00	WVSC	50. 02		3, 302, 695			3.00
4.00	CARDIAC CATHETERIZATION	59. 00		3, 143, 271			4.00
5.00	WOUND CLINIC	<u>90.</u> 07		4 <u>5, 5</u> 75			5. 00
	0 LATERECT RECLASS		0	15, 655, 108			
1. 00	L - INTEREST RECLASS OTHER ADMIN AND GENERAL	5. 06	0	8, 210, 545	11		1.00
2. 00	OTTIER NOMEN AND GENERALE	0.00	o	0, 210, 010			2.00
				8, 210, 545			
	M - NURSERY RECLASS						
1. 00	ADULTS & PEDIATRICS	3000	984, 511	208, 167			1.00
	N - PHARMACY PARAMED RECLASS		984, 511	208, 167			
1. 00	DRUGS CHARGED TO PATIENTS	73. 00	45, 725	4, 760	0		1.00
1.00	0		45, 725	4, 760			1.00
	0 - CAFE RECLASS	,					
1.00	DI ETARY	1000	1, 735, 678	<u>2, 691, 7</u> 72			1.00
	O CENTRAL CURRILY REGUACE		1, 735, 678	2, 691, 772			
1. 00	P - CENTRAL SUPPLY RECLASS MEDICAL SUPPLIES CHARGED TO	71. 00	O	1, 079, 476	0		1.00
1.00	PATI ENTS	71.00	o o	1,079,470			1.00
2.00		0.00	O	0	0		2.00
3.00		0. 00	0	0			3. 00
4.00		0. 00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6. 00 7. 00		0. 00 0. 00	U	0	0		6. 00 7. 00
8. 00		0.00	0	0	0		8.00
9. 00		0. 00	ő	0			9. 00
10.00		0.00	0	0	0		10.00
	0		0	1, 079, 476			

| Peri od: | Worksheet A-6 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Provider CCN: 15-0023

					'	5/21/2024	
		Decreases		·			
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	Q - BONUS RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	5, 790	0	0		1.00
2.00	NONPATIENT TELEPHONES	5. 01	2, 849	0			2. 00
3.00	ADMI TTI NG	5. 04	7, 269	0	0		3.00
4.00	OPERATION OF PLANT	7. 00	448	0	0		4. 00
5.00	LAUNDRY & LINEN SERVICE	8. 00	4, 900	0	0		5. 00
6.00	HOUSEKEEPI NG	9. 00	15, 075	0	0		6. 00
7.00	DI ETARY	10.00	2, 140	0	0		7. 00
8.00	CAFETERI A	11. 00	9, 820	0	0		8. 00
9.00	NURSING ADMINISTRATION	13. 00	11, 511	0	0		9. 00
10.00	I&R SERVICES-SALARY &	21. 00	8, 259	0	0		10.00
	FRI NGES APPRVD						
11.00	I&R SERVICES-OTHER PRGM	22. 00	5, 580	0	0		11.00
	COSTS APPRVD						
12.00	PARAMED ED PRGM	23. 00	422	0	0		12.00
13.00	OTHER MED ED	23. 01	7, 893	0	0		13.00
14.00	ADULTS & PEDIATRICS	30.00	123, 862	0	0		14.00
15.00	INTENSIVE CARE UNIT	31.00	31, 948	0	0		15. 00
16.00	INTENSIVE NURSERY	35.00	16, 429	0	0		16.00
17.00	SUBPROVI DER - I RF	41.00	10, 298	0	0		17. 00
18.00	NURSERY	43.00	5, 570	0	0		18. 00
19.00	OPERATING ROOM	50.00	17, 779	0	0		19. 00
20.00	CARDI AC SURGERY	50. 01	10, 323	0	0		20.00
21.00	wvsc	50. 02	23, 919	0	0		21.00
22.00	RECOVERY ROOM	51.00	10, 751	0	0		22. 00
23.00	O/P TREATMENT ROOM	51. 02	2, 218	0	0		23.00
24.00	DELIVERY ROOM & LABOR ROOM	52.00	24, 760	0	0		24.00
25.00	RADI OLOGY-DI AGNOSTI C	54.00	28, 460	0	0		25. 00
26.00	RADI OLOGY-THERAPEUTI C	55. 00	2, 194	0	0		26.00
27.00	RADI OI SOTOPE	56.00	1, 558	0	0		27. 00
28.00	CT SCAN	57.00	7, 774	0	0		28. 00
29.00	MAGNETIC RESONANCE IMAGING	58. 00	5, 728	0	0		29. 00
	(MRI)						
30.00	CARDÍ AC CATHETERI ZATI ON	59. 00	18, 342	0	0		30.00
31.00	LABORATORY	60.00	32, 833	0	0		31.00
32.00	RESPIRATORY THERAPY	65.00	18, 035	0	0		32.00
33.00	ELECTROCARDI OLOGY	69.00	15, 259	0	0		33.00
34.00	CARDI AC REHAB	69. 01	2, 046	0	0		34.00
35.00	ELECTROENCEPHALOGRAPHY	70.00	13, 591	0	0		35.00
36.00	DRUGS CHARGED TO PATIENTS	73. 00	29, 181	0	0		36.00
37.00	CLINIC	90. 00	1, 268	0	0		37.00
38.00	WOUND CLINIC	90. 07	2, 594	0	0		38.00
39.00	EMERGENCY	91.00	38, 639	0	0		39.00
40.00	RURAL HEALTH	194. 00	13, 038	0	0		40.00
41.00	FAMILY PRACTICE	194. 02	16, 058	0	0		41.00
42.00	WELLNESS	194. 03	1, 339	0	0	1	42.00
43.00	PHYSICIAN PRACTICES	194. 04	46, 533	0	0		43.00
44. 00	SYCAMORE SPORTS MED	194. 06	78	0	0	l .	44.00
45. 00	PSYCHI ATRI C/PSYCHOLOGI CAL	194. 07	3, 084	0	0	l .	45. 00
	SERVI CES						
	0		657, 445				
500.00	Grand Total: Decreases		7, 285, 161	32, 991, 228			500.00

| Peri od: | Worksheet A-7 | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS UNION HOSPITAL, INC. Provider CCN: 15-0023

				Ic	12/31/2023	Date/lime Pre 5/21/2024 12:	
				Acqui si ti ons		372172024 12.	12 piii
		Beginning	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	T BALANCES					
1.00	Land	18, 871, 495	131, 087	0	131, 087	0	1.00
2.00	Land Improvements	21, 208, 798	184, 543		184, 543		2.00
3.00	Buildings and Fixtures	307, 982, 453	8, 310	0	8, 310		3.00
4.00	Building Improvements	107, 844, 802	1, 785, 852	0	1, 785, 852	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5. 00
6.00	Movable Equipment	205, 501, 253	13, 885, 598	0	13, 885, 598	0	6. 00
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	661, 408, 801	15, 995, 390	0	15, 995, 390	0	8. 00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	661, 408, 801	15, 995, 390	0	15, 995, 390	0	10.00
		Endi ng	Ful I y				
		Bal ance	Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1. 00	Land	19, 002, 582	0			ļ	1.00
2.00	Land Improvements	21, 393, 341	0			ļ	2. 00
3. 00	Buildings and Fixtures	307, 990, 763	0			l	3. 00
4.00	Building Improvements	109, 630, 654	0			l	4. 00
5.00	Fixed Equipment	0	0			l	5. 00
6.00	Movable Equipment	219, 386, 851	0			l	6. 00
7. 00	HIT designated Assets	0	0			l	7. 00
8. 00	Subtotal (sum of lines 1-7)	677, 404, 191	0			ļ	8. 00
9. 00	Reconciling Items	0	0			ļ	9. 00
10. 00	Total (line 8 minus line 9)	677, 404, 191	0			ļ	10.00

Heal th	Financial Systems	UNION HOSPI	TAL, INC.		In Lieu of Form CMS-2552-10			
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co	CN: 15-0023	Peri od: From 01/01/2023	Worksheet A-7		
						B Date/Time Pre	pared:	
						5/21/2024 12:	12 pm	
			SU	MMARY OF CAP	I TAL			
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see		
					(see	instructions)		
					instructions)			
		9. 00	10. 00	11. 00	12. 00	13. 00		
	PART II - RECONCILIATION OF AMOUNTS FROM WOR			and 2				
1.00	NEW CAP REL COSTS-BLDG & FLXT	15, 435, 547	0		0	0	1.00	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	8, 020, 972	0		0	0	2.00	
3.00	Total (sum of lines 1-2)	23, 456, 519	0		0 0	0	3.00	
		SUMMARY O	F CAPITAL					
	Cost Center Description	0ther	Total (1)					
		Capi tal -Rel at	(sum of cols.					
		ed Costs (see	9 through 14)					
		instructions)						
		14. 00	15. 00					
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	MN 2, LINES 1 a	and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	15, 435, 547				1.00	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	8, 020, 972				2.00	
3. 00	Total (sum of lines 1-2)	0	23, 456, 519				3. 00	

Health Financial Systems	UNI ON HOSPI	TAL, INC.		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C	CN: 15-0023	Peri od:	Worksheet A-7	
				From 01/01/2023 To 12/31/2023		nared·
					5/21/2024 12:	
	COME	PUTATION OF RA	TI 0S	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
cost center bescription	dioss Assets	Leases	for Ratio	instructions)	i i isui ance	
		Louses	(col. 1 -	Thistractrons)		
			col . 2)			
	1. 00	2. 00	3.00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00 NEW CAP REL COSTS-BLDG & FIXT	458, 017, 340		100,017,01			1. 00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	219, 386, 851		2.77000700			2.00
3.00 Total (sum of lines 1-2)	677, 404, 191		677, 404, 19			3. 00
	ALLOCA ⁻	TION OF OTHER (CAPI TAL	SUMMARY C	F CAPITAL	
Cost Center Description	Taxes	0ther	Total (sum o	f Depreciation	Lease	
		Capi tal -Rel at	cols. 5			
		ed Costs	through 7)			
	6. 00	7. 00	8. 00	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	1		0 13, 492, 109		1. 00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0		0 7, 299, 878	l e	2.00
3.00 Total (sum of lines 1-2)	0	0		0 20, 791, 987	0	3. 00
		St	JMMARY OF CAPI	IAL		
Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)	
		(see	i nstructi ons	Capi tal -Rel at	(sum of cols.	
		instructions)		ed Costs (see	9 through 14)	
				instructions)		
	11. 00	12. 00	13. 00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS C			1	.1		
1.00 NEW CAP REL COSTS-BLDG & FLXT	4, 003, 881			0		1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	1, 917, 829			0		2.00
3.00 Total (sum of lines 1-2)	5, 921, 710	0	1	0 0	26, 713, 697	3. 00

	MENTS TO EXPENSES			Provider CCN: 15-0023	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/21/2024 12:	pared:
			1	Expense Classification o To/From Which the Amount is			
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2) 1. 00	2. 00	3.00	4.00	Ref. 5.00	
1. 00	Investment income - NEW CAP	В		NEW CAP REL COSTS-BLDG &	1.00	11	1. 00
2. 00	REL COSTS-BLDG & FLXT (chapter 2) Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter	В	-741, 271 N	FEXT NEW CAP REL COSTS-MVBLE EQUIP	2. 00	11	2. 00
3. 00	2) Investment income - other		0		0. 00	0	3. 00
4. 00	(chapter 2) Trade, quantity, and time discounts (chapter 8)	В	-6, 3340	OTHER ADMIN AND GENERAL	5. 06	0	4. 00
5. 00	Refunds and rebates of	В		PURCHASING RECEIVING AND	5. 03	0	5.00
6. 00	expenses (chapter 8) Rental of provider space by		0	STORES	0.00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay stations excluded) (chapter	А	-28, 462	NONPATIENT TELEPHONES	5. 01	0	7. 00
8. 00	21) Tel evi si on and radi o servi ce		0		0. 00	0	8. 00
9. 00 10. 00	(chapter 21) Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -25, 836, 085		0.00	0	9. 00 10. 00
11. 00	adjustment Sale of scrap, waste, etc.	H-0-2	-23, 830, 063		0.00	0	
12. 00	(chapter 23) Related organization	A-8-1	103, 609, 485			0	
13. 00	transactions (chapter 10) Laundry and Linen service		0		0.00	0	13. 00
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee and others	В	-1, 807, 758 (0	CAFETERI A	11. 00 0. 00	0	14.00
16. 00	Sale of medical and surgical supplies to other than	А		MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	16. 00
17. 00	patients Sale of drugs to other than patients	А	-5, 247	DRUGS CHARGED TO PATIENTS	73. 00	0	17. 00
18. 00	Sale of medical records and abstracts	В	-937 N	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	Nursing and allied health education (tuition, fees,		0		0. 00	0	19. 00
20.00	books, etc.) Vendi ng machi nes	А	-11, 902	OPERATION OF PLANT	7. 00	0	20.00
21. 00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0. 00	0	21.00
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22.00
23. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	OF	RESPI RATORY THERAPY	65. 00		23. 00
24. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	OF	PHYSICAL THERAPY	66. 00		24.00
25. 00	limitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25.00
26. 00	(chapter 21) Depreciation - NEW CAP REL COSTS-BLDG & FIXT			NEW CAP REL COSTS-BLDG &	1.00	0	26. 00
27. 00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE	2. 00	0	27. 00
28. 00	Non-physician Anesthetist			*** Cost Center Deleted ***		_	28.00
29. 00 30. 00	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATIONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30. 00		30. 99

Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted						12/31/2023	5/21/2024 12:	
Cost Center Description					Expense Classification on	Worksheet A	0,21,2021 121	12
Cost Center Description Basis/Code Amount Cost Center Line # Wkst. A-7 Perf								
C2								
C2								
C2								
C2								
C2								
C2								
C2		Cost Center Description	Rasis/Code	Amount	Cost Center	line #	Wkst A_7	
1.00		cost center bescription		Alliourt	Cost center	LITIC #		
33 .00 Agjustment for speech A - 8 - 3 OSPECH PATHOLOGY 68 .00 31 .00 22 .00 23 .00 25 .00 25 .00 25 .00 25 .00 26 .00 27 .00 27 .00 28 .00				2 00	2 00	4 00		
pathol ogy costs in excess of	21 00	Adjustment for speech					5.00	21 00
1 inititation (chapter 14) 22.00 23.00	31.00	.,	A-0-3		DSFEECH FAIRIOLOGY	00.00		31.00
22.00 CAH HIT Adjustment for								
Depreciation and Interest TELEPHONE DEPRECIATION A -53 NEW CAP REL COSTS-MVBLE 2, 00 9 33, 00 9 33, 00 33, 01 VENDING HOUSEKEEPING A -117, 000 OPERATION OF PLANT 7, 00 0 33, 02 20 20 20 20 20 20 20	22.00			_		0.00	0	22 00
33.00 TELEPHONE DEPRECIATION A	32.00			_	/	0.00	0	32.00
San	00.00				NEW OAR REL COCTS AND E	0.00		00.00
VENDING HOUSEKEEPING A -13, 589 HOUSEKEEPING 9, 00 0 33, 01	33.00	TELEPHONE DEPRECIATION	A	-53		2.00	9	33.00
ABAIL LOD CENTER OPERATION OF PLANT	00.61	VENDING HOUSEKEEDING		40.500		0.00	_	00.01
PLANT AMIL TON CENTER NUTRITION A -255, 896 DI ETARY 10, 00 0 33, 03								
33. 03 HAMILTON CENTER NUTRITION A -255, 896 DIETARY 10. 00 0 33. 03 3. 04 17THSS ACTIVITY B B -557, 665 EMPLOYEE BEREFITS DEPARTMENT 4. 00 0 33. 04 33. 05 0 HF - HOUSEKEEPING A -1. 464 HOUSEKEEPING 9. 00 0 33. 05 33. 06 MI SCELLANEOUS B -349, 916 OTHER ADMIN AND GENERAL 5. 06 0 33. 06 33. 07 CATERING B -43, 63.1 CATERING 11. 00 0 0 33. 07 33. 08 MANAGEMENT SERVICES B -1.611, 625 OTHER ADMIN AND GENERAL 5. 06 0 33. 08 33. 09 PHYSICI AN EQUIPMENT REVENUE B -29, 222 OPERATION OF PLANT 7. 00 0 33. 07 33. 09 LOBBY IN COSTS A -29, 997 OTHER ADMIN AND GENERAL 5. 06 0 33. 10 33. 11 LOBBY IN COSTS A -29, 997 OTHER ADMIN AND GENERAL 5. 06 0 33. 11 33. 11 LOBBY IN COSTS A -29, 997 OTHER ADMIN AND GENERAL 5. 06 0 33. 11 33. 12 AP&S REVENUE B -120, 902 NEW CAP REL COSTS-BLDG & 1. 00 9 33. 12 FLXT 1. 00 9 33. 12 FLXT 1. 00 9 33. 14 COH REVENUE B -146, 828 DATA PROCESSING 5. 02 0 33. 13 33. 14 COH REVENUE B -146, 828 DATA PROCESSING 5. 02 0 33. 13 33. 14 COH REVENUE B -146, 828 DATA PROCESSING 5. 02 0 33. 13 33. 14 COH REVENUE B -146, 828 DATA PROCESSING 5. 02 0 33. 14 FLXT 1. 00 9 33. 16 FLXT 1. 00 9 33. 18 FLXT 1. 00 9 33. 16 FLXT 1. 00 9 33. 26 FLXT 1. 00 9 3	33. 02		A	-117, 000	OPERATION OF PLANT	7. 00	0	33. 02
33. 04 FITNESS ACTIVITY								
33.05 UHF - HOUSEKEEPING								ı
33.06 MSCELLANEOUS	33. 04	FITNESS ACTIVITY	В	-57, 665	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 04
33.07 CATERING B	33. 05	UHF - HOUSEKEEPING	Α			9. 00	0	33. 05
33.07 CATERING B	33.06	MI SCELLANEOUS	В	-349, 916	OTHER ADMIN AND GENERAL	5. 06	0	33.06
33. 09 PHYSI CI AN EQUI PMENT REVENUE B -29, 222 DPERATI ON OF PLANT 7, 00 0 33. 09	33.07	CATERING	В			11. 00	0	33. 07
33. 09 PHYSICIAN EQUIPMENT REVENUE B -29, 222 OPERATI ON OF PLANT 7. 00 0 33. 09	33. 08	MANAGEMENT SERVICES	В	-1, 611, 625	OTHER ADMIN AND GENERAL	5. 06	0	33. 08
33. 10 LOBBY PHARMACY B -280, 662 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 33. 10 33. 11 LOBBY ING COSTS A -29, 997 OTHER ADMIN AND GENERAL 5.06 0 33. 11 33. 12 AP&S REVENUE B -120, 992 NEW CAP REL COSTS-BLDG & 1.00 9 33. 12 33. 13 AP&S REVENUE B -146, 828 DATA PROCESSING 5.02 0 33. 13 33. 14 COH REVENUE B -18, 408 NEW CAP REL COSTS-BLDG & 1.00 9 33. 14 71 71 71 71 71 71 71	33. 09	PHYSICIAN EQUIPMENT REVENUE	В	-29, 222	OPERATION OF PLANT	7.00	0	33. 09
33. 11 LOBBYI NG COSTS							0	
33. 12 AP&S REVENUE B			Α				0	
STATE STAT		1				•	9	
33. 13 AP&S REVENUE B -146, 828 DATA PROCESSING 5. 02 0 33. 13 33. 14 COH REVENUE B -18, 408 NEW CAP REL COSTS-BLDG & 1. 00 9 33. 14 33. 15 COH REVENUE B -4, 650 NONPATIENT TELEPHONES 5. 01 0 33. 15 33. 16 PHYSI CI AN RENTAL A -288, 352 OPERATION OF PLANT 7. 00 9 33. 16 33. 17 PHYSI CI AN RENTAL A -288, 352 OPERATION OF PLANT 7. 00 9 33. 18 33. 19 CHILD BIRTH CLASS B -420 DELI VERY ROOM & LABOR ROOM 52. 00 9 33. 18 33. 20 CONTINUI NG EDUCATION B -1, 500 OTHER ADMIN AND GENERAL 5. 06 0 33. 20 33. 21 EDUCATION SERVI CES B -24, 603 OTHER ADMIN AND GENERAL 5. 06 0 33. 21 33. 22 TRANSCRIPTION B -17, 003 MEDI CAL RECORDS & LI BRARY 16. 00 0 33. 23 33. 24 LANDSBAUM B -100, 689 OPERATION OF PLANT 7. 00 0 33. 24 33. 25 MAPLE CENTER B -149, 252 OTHER ADMIN AND GENERAL 5. 06 0 33. 25 33. 26 AP&S A/P PD SPACE/EQUI P RENT R B -14, 9, 252 OTHER ADMIN AND GENERAL 5. 06 0 33. 25 33. 29 RECUITMENT EXPENSE A -37, 936, 816 OTHER ADMIN AND GENERAL 5. 06 0 33. 25 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, 50. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	002	THE WEST PROPERTY.		120,702			ŕ	00.12
33. 14 COH REVENUE B -18, 408 NEW CAP REL COSTS-BLDG & 1. 00 9 33. 14 FIXT 33. 15 COH REVENUE B -4, 650 NONPATIENT TELEPHONES 5. 01 0 33. 15 33. 16 PHYSI CI AN RENTAL A -435, 586 NEW CAP REL COSTS-BLDG & 1. 00 9 33. 16 33. 17 PHYSI CI AN RENTAL A -288, 352 OPERATI ON OF PLANT 7. 00 0 33. 17 33. 18 ACCELERATED DEPRECIATION A 13, 280 NEW CAP REL COSTS-BLDG & 1. 00 9 33. 18 33. 19 CHILD BIRTH CLASS B -420 DELIVERY ROOM & LABOR ROOM 52. 00 0 33. 20 33. 20 CONTI NUI NG EDUCATI ON B -1, 500 OTHER ADMIN AND GENERAL 5. 06 0 33. 21 33. 22 TRANSCRI PTI ON B -24, 603 OTHER ADMIN AND GENERAL 5. 06 0 33. 21 33. 22 TRANSCRI PTI ON B -6, 180 LAUNDRY & LI NEN SERVI CE 8. 00 0 33. 23 33. 24 LANDSBAUM B -100, 689 OPERATION OF PLANT 7. 00 0 33. 25 33. 26 AP&S A/P PD SPACE/EQUI P RENT R B -149, 252 OTHER ADMIN AND GENERAL 5. 06 0 33. 25 33. 27 HAF A -37, 936, 816 OTHER ADMIN AND GENERAL 5. 06 0 33. 27 33. 28 DI ETARY EXPENSES A -822, 650 DI ETARY 10. 00 0 33. 28 33. 29 RECUI TIMENT EXPENSE A -25, 574 NURSI NG ADMINI STRATI ON 13. 00 0 33. 29 10 TOTAL (sum of 1 ines 1 thru 49) (Transfer to Worksheet A, 50 C) CONTACH T TO TOW CITALS TO THE ADMINISTRATION 15. 00 0 18. 29 29, 290, 793	33 13	AP&S REVENUE	В	-146 828		5 02	0	33 13
33. 15 COH REVENUE B -4, 650 NONPATIENT TELEPHONES 5. 01 0 33. 15 33. 16 PHYSI CI AN RENTAL A -435, 586 NEW CAP REL COSTS-BLDG & 1. 00 9 33. 16 FI XT 7. 00 0 33. 15 FI XT 7. 00 0 33. 17 ACCELERATED DEPRECIATION A 13, 280 NEW CAP REL COSTS-BLDG & 1. 00 9 33. 18 FI XT 7. 00 0 33. 18 FI XT 7. 00 0 0 33. 18 FI XT 7. 00 0 0 33. 18 FI XT 7. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1				•		
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State		1				•		
33. 19 CHILD BIRTH CLASS	55. 10	ACCELIATED DELICEOTATION	_ ^	13, 200		1.00	7	33. 10
33. 20 CONTINUING EDUCATION B -1,500 OTHER ADMIN AND GENERAL 5.06 0 33. 20 33. 21 EDUCATION SERVICES B -24,603 OTHER ADMIN AND GENERAL 5.06 0 33. 21 33. 22 TRANSCRIPTION B -17,003 MEDICAL RECORDS & LIBRARY 16.00 0 33. 22 33. 23 LAUNDRY B -6,180 LAUNDRY & LINEN SERVICE 8.00 0 33. 23 33. 24 LANDSBAUM B -100,689 OPERATION OF PLANT 7.00 0 33. 24 33. 25 MAPLE CENTER B -149, 252 OTHER ADMIN AND GENERAL 5.06 0 33. 25 33. 26 AP&S A/P PD SPACE/EQUIP RENT R B -149, 252 OTHER ADMIN AND GENERAL 5.06 0 33. 25 33. 27 HAF A -37, 936, 816 OTHER ADMIN AND GENERAL 5.06 0 33. 27 33. 28 DIETARY EXPENSES A -822, 650 DIETARY 10.00 0 33. 29 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, 50.00	33 10	CHILD BIRTH CLASS	R	_420		52 00	^	33 10
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33. 27 33. 28 33. 29 33. 29 50. 00 A -37, 936, 816 OTHER ADMIN AND GENERAL 5. 06 0 33. 27 10. 00 0 33. 28 -822, 650 DI ETARY 10. 00 0 33. 28 -25, 574 NURSI NG ADMINISTRATION 13. 00 0 33. 29 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A,						•		
33. 27 33. 28 33. 29 50. 00 A A A A A A A A A A A A A A A A A A	33. 26	AP&S A/P PD SPACE/EQUIP RENT R	В	-1, 065, 245		1. 00	9	33. 26
33. 28 33. 29 RECUITMENT EXPENSE A -822, 650 DI ETARY 10. 00 0 33. 28 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, 29, 290, 793								
33. 29 RECUITMENT EXPENSE A -25,574 NURSING ADMINISTRATION 13. 00 0 33. 29 50. 00 (Transfer to Worksheet A,		1 2 2 2					-	
50.00 TOTAL (sum of lines 1 thru 49) 29,290,793 50.00 (Transfer to Worksheet A,						•	-	
(Transfer to Worksheet A,			A			13. 00	0	
	50.00			29, 290, 793	B			50.00
column 6, line 200.)								
		column 6, line 200.)						L

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

⁽²⁾ Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Worksheet A-8-1

OFFICE	00313				To 12/31/2023	Date/Time Prep 5/21/2024 12:	
	Li ne No.	Cost Center		Expense Items		Amount Included in Wks. A, column 5	
	1.00	2. 00		3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUST OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF	TRAN	ISACTIONS WITH RELATED	ORGANI ZATI ONS OF	R CLAIMED HOME	
1.00	23. 01	OTHER MED ED	PARAM	MED	149, 383	1, 530, 430	1.00
2.00		NEW CAP REL COSTS-BLDG & FIX			1, 607, 941	1, 780, 783	2.00
3.00		NEW CAP REL COSTS-MVBLE EQUI			3, 429, 170	4, 150, 211	3.00
4.00	50.00	OPERATING ROOM	HOME	OFFI CE	282, 511	0	4.00
4. 01				OFFI CE	63, 606	0	4.01
4. 02				OFFI CE	540, 176	0	4.02
4. 03				OFFI CE	140, 109	0	4.03
4. 04	I			OFFI CE	138, 951	0	4.04
4. 05				OFFICE	115, 393	0	4. 05
4. 06				OFFI CE	373, 144	0	4. 06
4. 07				OFFI CE	1, 134, 761	0	4. 07
4. 08	•			OFFI CE	293, 360	0	4. 08
4. 09	•			OFFI CE	2, 238, 212	0	4. 09
4. 10	•			OFFI CE	8, 157, 564	0	4. 10
4. 11		DIETARY PURCHASING RECEIVING AND STO		OFFI CE	783, 006	0	4. 11
4. 12 4. 13	•	PURCHASING RECEIVING AND STO			797, 191	0	4. 12 4. 13
4. 13 4. 14	•	ł		OFFI CE	1, 637, 202 5, 405, 395	0	4. 13 4. 14
4. 14				OFFI CE	13, 320, 505	0	4. 14
4. 16	•			OFFI CE	12, 330, 732	0	4. 16
4. 17	•			OFFICE	13, 444, 636	0	4. 17
4. 18				OFFICE	1, 388, 600	o	4. 18
4. 19				OFFICE	567, 059	0	4. 19
4. 20		EMPLOYEE BENEFITS DEPARTMENT			1, 789, 836	0	4. 20
4. 21		EMPLOYEE BENEFITS DEPARTMENT			17, 567, 087	0	4. 21
4. 22				OFFI CE	763	o	4. 22
4. 23		CASHI ERI NG/ACCOUNTS RECEI VAB			25, 128, 683	0	4. 23
4. 24	5. 01	NONPATIENT TELEPHONES	HOME	OFFI CE	164, 748	189, 222	4.24
4. 25	9. 00	HOUSEKEEPI NG	HOME	OFFI CE	429, 124	475, 252	4. 25
4. 26	7. 00	OPERATION OF PLANT	HOME	OFFI CE	96, 385	106, 746	4. 26
4. 27	50.00	OPERATING ROOM	HOME	OFFI CE	204, 703	0	4. 27
4. 28	50.00	OPERATING ROOM	HOME	OFFICE	22, 516	0	4. 28
4. 36	66.00	PHYSI CAL THERAPY	UNI ON	I THERAPIES	3, 273, 085	5, 132, 698	4.36
4. 37	66. 02			I THERAPIES	1, 499, 522	2, 518, 886	4.37
4. 38				THERAPIES	2, 540, 447	0	4. 38
4. 39				THERAPIES	1, 111, 330	880, 131	4. 39
4.40				THERAPIES	0	410, 000	4.40
4. 41	1	SYCAMORE SPORTS MED	UNI ON	THERAPIES	0	1, 382, 992	4.41
5. 00	0		0		122, 166, 836	18, 557, 351	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.

Huo	110 6	to been posted to worksheet K, cordinas i and or 2, the amount arrowable should be indicated in cordinar i or this part.									
					Related Organization(s) and/	or Home Office					
		Symbol (1)	Name	Percentage of	Name	Percentage of					
		•		Ownershi p		Ownershi p					
		1. 00	2. 00	3.00	4. 00	5. 00					
	F	R INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:							

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

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

reimbursement under title xviii.						
6. 00	G		0.00	UNION HOSPITAL	100.00	6.00
7.00	G		0.00	UNI ON THERAPY	100.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or	OTHER				100.00
	non-financial) specify:				l	

STATEME OFFI CE	ENT OF COSTS OF SERVICES FROM COSTS	RELATED ORGANI ZATI ONS AND HO	ME Provider (CCN: 15-0023	Peri od: From 01/01/2023 To 12/31/2023	Worksheet A-8 Date/Time Pre 5/21/2024 12:	epared:
				Related Organ	nization(s) and/o	or Home Office	
	Symbol (1)	Name	Percentage of Ownership	N	lame	Percentage of Ownership	
	1. 00	2. 00	3. 00	4	. 00	5. 00	

UNION HOSPITAL, INC.

In Lieu of Form CMS-2552-10

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

Health Financial Systems

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.B. Corporation, partnership, or other organization has financial interest in provider.C. Provider has financial interest in corporation, partnership, or other organization.

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

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

reriiibui	imbursement under title XVIII.								
6. 00	HOME OFFICE	6.00							
7.00	THERAPI ES	7.00							
8.00		8.00							
9.00		9.00							
10.00		10.00							
100.00		100.00							

Health Financial Systems	UNI ON HOSPI TAI	_, INC.	In Lieu	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOME	Provi der CCN: 15-0023	Peri od: From 01/01/2023	Worksheet A-8-1
OFFICE COSTS			To 12/31/2023	Date/Time Prepared: 5/21/2024 12:12 pm
Related Organization(s) and/or Home Office				
Type of Business				
6.00				

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

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

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-0023

						12/31/2023	5/21/2024 12:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2.00	3. 00	4. 00	5. 00	6. 00	7. 00	
1. 00		ADULTS & PEDIATRICS	3, 911, 640	3, 911, 640		169, 700	0	1.00
2.00		I NTENSI VE NURSERY	911, 563			169, 700	0	2.00
3. 00	41, 00	SUBPROVI DER - I RF	411, 770			211, 500	0	3.00
4. 00		OPERATING ROOM	5, 024, 840			246, 400	570	4.00
5. 00	50, 01	CARDI AC SURGERY	2, 508, 742		· ·	246, 400	0	5.00
6.00	50. 02	WVSC	2, 840, 850	2, 840, 850	0	246, 400	0	6.00
7. 00	52. 00	DELIVERY ROOM & LABOR ROOM	3, 176, 058			237, 100	0	7.00
8.00	54.00	RADI OLOGY-DI AGNOSTI C	1, 328, 000	0	1, 328, 000	271, 900	8, 853	8. 00
9. 00		ELECTROCARDI OLOGY	221, 975	221, 975	0	271, 900	0	9. 00
10.00	70. 00	ELECTROENCEPHALOGRAPHY	3, 139, 957	3, 139, 957	0	179, 000	0	10.00
11.00	90.00	CLINIC	13, 576	13, 576	0	179, 000	0	11.00
12.00	91. 00	EMERGENCY	3, 629, 311	3, 529, 311	100, 000	179, 000	667	12.00
200.00			27, 118, 282	25, 604, 782	1, 513, 500		10, 090	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		l denti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Mal practice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13. 00	14. 00	
1. 00		ADULTS & PEDIATRICS	0	1	_	0	0	
2. 00		I NTENSI VE NURSERY	0	1		0	0	
3. 00		SUBPROVI DER - I RF	0	1		0	0	
4. 00		OPERATI NG ROOM	67, 523			0	0	
5.00		CARDI AC SURGERY	0	1	_	0	0	
6. 00	50. 02		0	0	0	0	0	
7. 00 8. 00		DELIVERY ROOM & LABOR ROOM	1 157 274	57, 864	0	0	0	,
9. 00		RADI OLOGY-DI AGNOSTI C	1, 157, 274	57,804	0	0	0	
9. 00 10. 00		ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	0	0	0	0	0	7.00
11. 00		CLINIC	0	0	0	0	0	
			F7 400	2 070	0	0	ľ	
12.00	91.00	EMERGENCY	57, 400 1, 282, 197			0	0	12. 00 200. 00
200.00	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	U	200.00
	WKSt. A LITTE #	I denti fi er	Component	Limit	Di sal I owance	Aujustillerit		
		r delitti i i ei	Share of col.		Di Sai i Owanice			
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1. 00	30. 00	ADULTS & PEDIATRICS	0	0	0	3, 911, 640		1.00
2.00	35. 00	INTENSIVE NURSERY	0	0	0	911, 563		2.00
3.00	41. 00	SUBPROVI DER - I RF	0	0	0	411, 770		3.00
4.00	50. 00	OPERATING ROOM	0	67, 523	17, 977	4, 957, 317		4.00
5.00		CARDI AC SURGERY	0	0	0	2, 508, 742		5.00
6.00	50. 02		0	0	0	2, 840, 850		6.00
7.00		DELIVERY ROOM & LABOR ROOM	0		0	3, 176, 058		7. 00
8.00		RADI OLOGY-DI AGNOSTI C	0	1, .0,, 2, .	170, 726	170, 726		8. 00
9.00		ELECTROCARDI OLOGY	0	0	0	221, 975		9. 00
10.00		ELECTROENCEPHALOGRAPHY	0	0	0	3, 139, 957		10.00
11. 00		CLINIC	0	0	0	13, 576		11.00
12.00	91. 00	EMERGENCY	0	,	· ·	· ·		12.00
200.00			0	1, 282, 197	231, 303	25, 836, 085		200.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS | Peri od: | Worksheet B | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Provider CCN: 15-0023

					To	12/31/2023	Date/Time Pre 5/21/2024 12:	
				CAPI TAL REI	LATED COSTS		3/21/2024 12.	12 piii
		Cost Center Description	Net Expenses	NEW BLDG &	NEW MVBLE	EMPLOYEE	NONPATI ENT	
			for Cost Allocation	FLXT	EQUI P	BENEFITS DEPARTMENT	TELEPHONES	
			(from Wkst A			DELYMENT		
			col. 7)					
			0	1. 00	2. 00	4. 00	5. 01	
1. 00		AL SERVICE COST CENTERS NEW CAP REL COSTS-BLDG & FIXT	17, 495, 990	17, 495, 990				1. 00
2. 00		NEW CAP REL COSTS-BLDG & FIXT	9, 217, 707	17, 495, 990	9, 217, 707			2.00
4. 00		EMPLOYEE BENEFITS DEPARTMENT	24, 384, 950	109, 861		24, 494, 811		4.00
5. 01		NONPATIENT TELEPHONES	691, 961	11, 708	2, 186	103, 623	809, 478	5. 01
5. 02	1	DATA PROCESSING	18, 579, 072	0		0	0	5. 02
5. 03		PURCHASING RECEIVING AND STORES ADMITTING	2, 043, 404	0	_	0	0	5. 03 5. 04
5. 04 5. 05	1	CASHI ERI NG/ACCOUNTS RECEI VABLE	1, 471, 809 25, 128, 683	54, 565 0		264, 390 0	29, 353 0	5. 04
5. 06		OTHER ADMIN AND GENERAL	32, 879, 993	310, 160	_	978, 532	75, 664	5. 06
7.00		OPERATION OF PLANT	10, 422, 078	5, 967, 542		16, 301	46, 312	7. 00
8.00		LAUNDRY & LINEN SERVICE	1, 326, 442	106, 707		178, 234	11, 741	8.00
9.00		HOUSEKEEPI NG	4, 164, 957	27, 586		548, 293	5, 218	9.00
10. 00 11. 00		DI ETARY CAFETERI A	666, 185 2, 566, 241	195, 594 139, 567		77, 834 357, 168	3, 261 16, 307	10. 00 11. 00
13. 00		NURSING ADMINISTRATION	4, 237, 250	42, 341		418, 667	5, 871	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3, 661	94, 144		0	19, 568	16.00
21. 00		I&R SERVICES-SALARY & FRINGES APPRVD	1, 604, 022	0		300, 408	0	21. 00
22. 00		I&R SERVICES-OTHER PRGM COSTS APPRVD	1, 384, 850	0		202, 944	0	22.00
23. 00 23. 01		PARAMED ED PRGM OTHER MED ED	90, 713 191, 975	0 12, 831	_	15, 339 34, 882	0	23. 00 23. 01
23. 01		PARAMED ED PRGM	191, 9/3	12, 631		34, 862	0	23. 01
20.02		TENT ROUTINE SERVICE COST CENTERS				<u> </u>		20.02
30.00	03000	ADULTS & PEDIATRICS	39, 906, 061	3, 428, 545		4, 505, 089	111, 541	
31.00		INTENSIVE CARE UNIT	11, 108, 179	409, 685		1, 162, 011	18, 916	
35. 00 41. 00		INTENSIVE NURSERY SUBPROVIDER - IRF	3, 514, 983 1, 732, 900	70, 069 274, 840		597, 557 374, 579	11, 741	35. 00 41. 00
41.00		NURSERY	1, 732, 900			202, 593	20, 221 2, 609	41.00
10.00		LARY SERVICE COST CENTERS	1, 107, 100	10,000	<u> </u>	202, 070	2,007	10.00
50.00	1	OPERATING ROOM	18, 257, 590			713, 720	53, 487	50.00
50. 01		CARDI AC SURGERY	2, 232, 609			375, 469	3, 914	
50. 02 51. 00	05002	RECOVERY ROOM	10, 488, 927	542, 748 25, 518		869, 995 391, 023	11 741	50. 02 51. 00
51.00		O/P TREATMENT ROOM	2, 440, 017 514, 562	426, 365		80, 689	11, 741 17, 612	
52. 00		DELIVERY ROOM & LABOR ROOM	5, 449, 887	422, 587		900, 565	15, 002	52.00
54.00	1	RADI OLOGY-DI AGNOSTI C	11, 674, 572	576, 928	1, 356, 085	1, 034, 519	70, 446	54.00
55.00		RADI OLOGY-THERAPEUTI C	4, 946, 592	470, 327		79, 793	26, 743	
56. 00 57. 00		RADI OI SOTOPE CT SCAN	1, 987, 874 3, 289, 636	156, 817		56, 686 282, 762	0	56. 00 57. 00
58.00		MAGNETIC RESONANCE IMAGING (MRI)	1, 686, 008	38, 705 46, 208		208, 340	4, 566 2, 609	
59. 00		CARDI AC CATHETERI ZATI ON	21, 455, 275	640, 528		667, 124	22, 177	
60.00		LABORATORY	17, 181, 280	0		1, 194, 225	5, 218	60.00
62.00		WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 654, 880			0		62.00
65.00		RESPI RATORY THERAPY	4, 927, 032	92, 255		655, 956	9, 132	
66. 00 66. 01	1	PHYSI CAL THERAPY PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	3, 925, 239 0	180, 875 0		0	15, 002 0	66. 00 66. 01
66. 02		0/P PHYSICAL THERAPY	1, 866, 880	0		ő	652	
67.00		OCCUPATI ONAL THERAPY	2, 540, 447	29, 546		О	3, 261	
68. 00		SPEECH PATHOLOGY	1, 218, 115	58, 593		0	652	
69.00		ELECTROCARDI OLOGY	4, 174, 701	56, 686		555, 000	2, 609	
69. 01 70. 00		CARDI AC REHAB ELECTROENCEPHALOGRAPHY	424, 821 1, 364, 940	116, 437 0		74, 417 494, 337	3, 914 11, 089	
71.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	-46	0		474, 337	11,007	71.00
72. 00	1	IMPL. DEV. CHARGED TO PATIENTS	15, 655, 108	0	Ō	ō	0	72.00
		DRUGS CHARGED TO PATIENTS	85, 547, 204	369, 145		1, 061, 381	32, 614	
76. 00		RENAL ACUTE	1, 737, 571	62, 816	0	0	2, 609	76. 00
00 00		TIENT SERVICE COST CENTERS	247 012	12 420		44 122	0	90. 00
90. 00 90. 05		PATIENT NUTRITION	267, 913 3, 562	12, 438 34, 393		46, 133 0	0	90.00
90. 07		WOUND CLINIC	1, 685, 982	159, 526		94, 333	8, 480	
91.00	1	EMERGENCY	10, 700, 249			1, 405, 391	41, 094	
92.00		OBSERVATION BEDS (NON-DISTINCT PART)						92.00
110 00		AL PURPOSE COST CENTERS	4EE 200 (01	16 000 014	0.014.050	21 500 200	740.044	110 00
118.00		SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	455, 300, 601	16, 998, 914	9, 014, 258	21, 580, 302	742, 946	118.UU
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
194.00	07950	RURAL HEALTH	6, 714, 188	0		474, 221	652	194. 00
		RENTAL PROPERTY	32, 315	0		0		194. 01
194. 02	2 07954	FAMILY PRACTICE	4, 349, 094	213, 842	62, 914	584, 072	46, 312	194. 02

Health Financial Systems	UNI ON H	HOSPITAL, INC.		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE C	OSTS .	Provi der		Peri od:	Worksheet B	·
				From 01/01/2023 Fo 12/31/2023		pared:
					5/21/2024 12:	12 pm
		CAPITAL R	ELATED COSTS			
Cost Center Description	Net Exper	nses NEW BLDG &	NEW MVBLE	EMPLOYEE	NONPATI ENT	
·	for Cos		EQUI P	BENEFI TS	TELEPHONES	
	Allocati	on		DEPARTMENT		
	(from Wks	st A				
	col . 7)				
	0	1.00	2. 00	4. 00	5. 01	
194. 03 07952 WELLNESS	297	, 963 232, 16	1 (48, 713	0	194. 03
194. 04 07955 PHYSI CLAN PRACTI CES	39, 428	3, 972	0 120, 477	1, 692, 505	14, 350	194. 04
194.06 07953 SYCAMORE SPORTS MED	34	., 999	0 (2, 840	0	194. 06
194. 07 07956 PSYCHI ATRI C/PSYCHOLOGI C	AL SERVICES 621	, 325 51, 07	3 268	112, 158	5, 218	194. 07
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers			0 (0	0	201.00
202.00 TOTAL (sum lines 118 th	rough 201) 506,779	17, 495, 99	9, 217, 707	7 24, 494, 811	809, 478	202.00

Provider CCN: 15-0023

Peri od: Worksheet B From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared:

				1	0 12/31/2023	Date/lime Pre 5/21/2024 12:	
Cost Center	Description	DATA	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/AC	Subtotal	12 piii
	·	PROCESSI NG	RECEIVING AND		COUNTS		
		5.00	STORES		RECEI VABLE		
GENERAL SERVICE CO	OST CENTEDS	5. 02	5. 03	5. 04	5. 05	5A. 05	
	COSTS-BLDG & FLXT	I					1.00
	COSTS-MVBLE EQUIP						2.00
4. 00 00400 EMPLOYEE BEN							4. 00
5. 01 00540 NONPATI ENT 1	TELEPHONES						5. 01
5. 02 00550 DATA PROCESS	SI NG	18, 579, 072					5. 02
	RECEIVING AND STORES	0	2, 043, 404				5. 03
5. 04 00570 ADMITTING	ACCOUNTE DECELVARIE	109, 536	6, 440	1, 936, 093			5.04
	ACCOUNTS RECEIVABLE	412.060	0	0	25, 128, 683	24 (74 7(2	5.05
5. 06 00590 OTHER ADMIN 7. 00 00700 OPERATION OF		412, 868	11 0	0	0	34, 674, 763 16, 453, 246	•
8. 00 00800 LAUNDRY & LI		42, 129	3, 380		0	1, 735, 265	1
9. 00 00900 HOUSEKEEPI NO		75, 833	126	0	Ö	4, 828, 414	1
10. 00 01000 DI ETARY		33, 704	790	0	0	1, 059, 959	1
11. 00 01100 CAFETERI A		151, 666	0	0	0	3, 232, 570	11.00
13.00 01300 NURSING ADMI		8, 426	0	0	0	4, 712, 555	13. 00
16. 00 01600 MEDI CAL RECO		547, 682	122	0	0	665, 946	1
1	S-SALARY & FRINGES APPRVD	0	0	0	0	1, 904, 430	1
	S-OTHER PRGM COSTS APPRVD	0	0	0	0	1, 587, 794	
23. 00 02300 PARAMED ED F 23. 01 02341 OTHER MED ED	-	0	0		0	106, 052 239, 688	
23. 02 02301 PARAMED ED F		0	0		-	239, 000	1
	SERVICE COST CENTERS				<u> </u>		25.02
30. 00 03000 ADULTS & PED		4, 979, 698	252, 096	422, 195	1, 885, 127	55, 997, 565	30.00
31.00 03100 INTENSIVE CA	ARE UNIT	8, 426	99, 352	88, 185		13, 685, 790	
35.00 02040 INTENSIVE NU	JRSERY	160, 092	16, 642	64, 937	266, 938	4, 886, 962	35.00
41. 00 04100 SUBPROVI DER	- IRF	0	7, 913	16, 677	68, 553	2, 506, 656	41.00
43. 00 04300 NURSERY		0	0	8, 721	35, 850	1, 450, 389	43.00
ANCILLARY SERVICE		0.7.0	0.17 .170	100 171		05 755 000	
50. 00 05000 OPERATING RO 50. 01 05001 CARDIAC SURG		867, 866 84, 259	817, 472 79, 516	182, 471 17, 855		25, 755, 998 3, 063, 444	1
50. 01 05001 CARDI AC SURG	JEKY	960, 551	318, 406	432		15, 503, 108	1
51. 00 05100 RECOVERY ROO	DM	370, 739	23, 110	10, 311		3, 547, 289	•
51. 02 05101 0/P TREATMEN		42, 129	9, 838			1, 137, 160	•
52. 00 05200 DELI VERY ROO		454, 998	43, 924	78, 107		7, 915, 897	
54. 00 05400 RADI OLOGY-DI		556, 108	17, 381	73, 322		16, 466, 425	•
55. 00 05500 RADI OLOGY-TH	HERAPEUTI C	539, 257	479	8, 122	732, 321	7, 590, 329	55.00
56. 00 05600 RADI 0I SOTOPE	=	67, 407	1, 509	3, 740		2, 704, 934	•
57. 00 05700 CT SCAN		0	36, 676	67, 137		4, 623, 011	1
	SONANCE IMAGING (MRI)	16, 852	2, 202	11, 658		2, 545, 876	
59. 00 05900 CARDI AC CATH	HE LERI ZATI ON	808, 885	7, 597	109, 206		25, 558, 385	1
60. 00 06000 LABORATORY 62. 00 06200 WHOLE BLOOD	& PACKED RED BLOOD CELLS	0	83, 784 0	213, 084 8, 132		21, 404, 672	1
65. 00 06500 RESPIRATORY		185, 369	41, 378	117, 982		1, 704, 661 6, 745, 903	1
66. 00 06600 PHYSI CAL THE		404, 442	687	25, 113		4, 731, 362	1
	PSYCHOLOGI CAL SERVI CES	0	0	0		0	1
66. 02 06602 0/P PHYSI CAL		75, 833	515	0	81, 510	2, 036, 732	66. 02
67. 00 06700 OCCUPATI ONAL	_ THERAPY	o	0	20, 464	138, 092	2, 731, 810	67.00
68.00 06800 SPEECH PATHO		0	0	4, 723		1, 342, 492	
69. 00 06900 ELECTROCARDI		412, 868	90			6, 882, 840	1
69. 01 06901 CARDI AC REHA		33, 704	234	331		702, 708	
70. 00 07000 ELECTROENCEF		294, 906	352			2, 262, 603	
	PLIES CHARGED TO PATIENTS	0	0	71 021	١	-46	1
72. 00 07200 I MPL. DEV. (73. 00 07300 DRUGS CHARGE	CHARGED TO PATIENTS	1, 643, 047	31, 607	71, 821 101, 560		16, 687, 610 94, 745, 596	1
76. 00 03020 RENAL ACUTE	D TO FATTENTS	1, 043, 047	13, 951	101, 300		1, 869, 682	1
OUTPATIENT SERVICE	F COST CENTERS	<u> </u>	13, 731	10,000	42, 730	1,007,002	70.00
90. 00 09000 CLI NI C	E GGGT GENTENG	25, 278	58	0	6, 308	358, 128	90.00
90. 05 09005 PATIENT NUTF	RITION	42, 129	0	Ō		84, 100	•
90.07 09007 WOUND CLINIC		143, 240	16, 805	58	115, 705	2, 236, 153	90.07
91.00 09100 EMERGENCY		1, 137, 494	103, 121	134, 868	1, 823, 448	16, 064, 638	91.00
	BEDS (NON-DISTINCT PART)					0	92.00
SPECIAL PURPOSE CO							
	SUM OF LINES 1 through 117)	15, 697, 421	2, 037, 564	1, 936, 093	25, 128, 683	448, 731, 544	J118. 00
NONREI MBURSABLE CO		ام		_	ام	^	100 00
190. 00 19000 GI FT, FLOWER		0 901, 569	0 2, 064	0		0 8, 112, 191	190.00
194. 00 07950 RURAL HEALTF		901, 309	2, ∪04		-		194.00
194.0107951 RENTAL PROPE		505, 553	21			5, 761, 808	
194. 03 07952 WELLNESS		000, 000 N	0			578, 837	
194. 04 07955 PHYSI CI AN PF	RACTICES	1, 432, 400	3, 732	0	o	42, 692, 436	
194.06 07953 SYCAMORE SPC		O	0	0	o		194. 06
194. 07 07956 PSYCHI ATRI C/		42, 129	23	0	О	832, 194	

Health Financial Systems	UNION HOSPITAL, INC.	In Lieu	of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		From 01/01/2023 To 12/31/2023	Worksheet B Part I Date/Time Prepared: 5/21/2024 12:12 pm

						5/21/2024 12	2: 12 pm
	Cost Center Description	DATA	PURCHASI NG	ADMITTI NG	CASHI ERI NG/AC	Subtotal	
		PROCESSI NG	RECEIVING AND		COUNTS		
			STORES		RECEI VABLE		
		5. 02	5. 03	5. 04	5. 05	5A. 05	
200.00	Cross Foot Adjustments						0 200. 00
201. 00	Negative Cost Centers	0	0	0	0		0 201. 00
202. 00	TOTAL (sum lines 118 through 201)	18, 579, 072	2, 043, 404	1, 936, 093	25, 128, 683	506, 779, 45	7 202. 00

Provider CCN: 15-0023

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part I
To 12/31/2023 Date/Time Prepared:
5/21/2024 12:12 pm

						5/21/2024 12:	
	Cost Center Description	OTHER ADMIN	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	•	AND GENERAL 5.06	PLANT 7. 00	LINEN SERVICE 8.00	9. 00	10.00	
GENER	RAL SERVICE COST CENTERS	5. 00	7.00	8.00	9.00	10.00	
	NEW CAP REL COSTS-BLDG & FIXT						1.00
	NEW CAP REL COSTS-MVBLE EQUIP						2. 00
	O EMPLOYEE BENEFITS DEPARTMENT						4.00
	O NONPATI ENT TELEPHONES						5. 01
	O DATA PROCESSING						5.02
	O PURCHASING RECEIVING AND STORES O ADMITTING						5. 03 5. 04
	O CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
	O OTHER ADMIN AND GENERAL	34, 674, 763					5. 06
7.00 00700	O OPERATION OF PLANT	1, 208, 442	17, 661, 688				7.00
8.00 00800	D LAUNDRY & LINEN SERVICE	127, 450	170, 676	2, 033, 391			8. 00
	O HOUSEKEEPI NG	354, 633	44, 123		l ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '		9. 00
	O DI ETARY	77, 851	312, 848		· · ·	1, 555, 366	10.00
	O CAFETERIA	237, 423	223, 235		68, 657	0	11.00
	O NURSING ADMINISTRATION O MEDICAL RECORDS & LIBRARY	346, 123 48, 912	67, 723 150, 581	0	20, 828 46, 312	0	13. 00 16. 00
l l	0 I&R SERVICES-SALARY & FRINGES APPRVD	139, 875	130, 301	0	40, 312	0	21.00
	O I &R SERVICES-OTHER PRGM COSTS APPRVD	116, 619	0	Ö	o	0	22. 00
	O PARAMED ED PRGM	7, 789	0	0	O	0	23. 00
	1 OTHER MED ED	17, 604	20, 522	0	6, 312	0	23. 01
	1 PARAMED ED PRGM	0	0	0	0	0	23. 02
	TIENT ROUTINE SERVICE COST CENTERS		F 100 001	V	4 (0) 500	1 005 000	
1	O ADULTS & PEDIATRICS	4, 112, 853	5, 483, 884			1, 235, 809	30.00
	O INTENSIVE CARE UNIT O INTENSIVE NURSERY	1, 005, 180 358, 933	655, 283 112, 074		· · ·	147, 372 0	31. 00 35. 00
	O SUBPROVI DER – I RF	184, 106	439, 601	18, 334	· .	71, 106	41.00
	O NURSERY	106, 527	21, 605		l ' '	71, 100	43.00
	LLARY SERVICE COST CENTERS		,				
50.00 05000	O OPERATING ROOM	1, 891, 701	1, 196, 184	117, 686	367, 891	0	50.00
	1 CARDI AC SURGERY	225, 001	52, 360		· · ·	0	50. 01
	2 WVSC	1, 138, 657	868, 115			0	50.02
l l	O RECOVERY ROOM	260, 538	40, 816		· .	04 445	51.00
l l	1 O/P TREATMENT ROOM O DELIVERY ROOM & LABOR ROOM	83, 521 581, 399	681, 962 675, 919		· .	94, 465 31	51. 02 52. 00
1	O RADI OLOGY-DI AGNOSTI C	1, 209, 410	922, 783			0	54.00
	O RADI OLOGY-THERAPEUTI C	557, 487	752, 279			0	55. 00
	O RADI OI SOTOPE	198, 669	250, 826		77, 143	0	56.00
	O CT SCAN	339, 546	61, 908	0	19, 040	0	57.00
	O MAGNETIC RESONANCE IMAGING (MRI)	186, 987	73, 908		22, 731	0	58. 00
	O CARDI AC CATHETERI ZATI ON	1, 877, 187	1, 024, 510		315, 092	6, 583	59.00
	O LABORATORY O WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 572, 109 125, 202	0	0	0	0	60. 00 62. 00
1	O RESPIRATORY THERAPY	495, 466	147, 560	_	45, 383	0	65.00
	O PHYSI CAL THERAPY	347, 504	289, 305			0	66.00
1	1 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0	0	66. 01
66. 02 06602	2 O/P PHYSICAL THERAPY	149, 592	0	16, 760	0	0	66. 02
	O OCCUPATI ONAL THERAPY	200, 643	47, 258			0	67.00
	O SPEECH PATHOLOGY	98, 602	93, 718		28, 823	0	68. 00
	0 ELECTROCARDI OLOGY	505, 524	90, 668		27, 885	0	69.00
	1 CARDI AC REHAB 0 ELECTROENCEPHALOGRAPHY	51, 612 166, 181	186, 238	722 7, 223	l	0	69. 01 70. 00
1	O MEDICAL SUPPLIES CHARGED TO PATIENTS	100, 101	0	7,223	0	0	70.00
	O IMPL. DEV. CHARGED TO PATIENTS	1, 225, 655	0	0	l ől	0	72.00
	O DRUGS CHARGED TO PATIENTS	6, 958, 864	590, 439	9, 789	181, 592	0	73.00
	O RENAL ACUTE	137, 323	100, 473	7, 808	30, 901	0	76. 00
	ATIENT SERVICE COST CENTERS						
	O CLINIC	26, 303	19, 895	0	6, 119	0	90.00
	5 PATIENT NUTRITION	6, 177	55, 011	15 7/0	16, 919	0	90.05
1	7 WOUND CLINIC D EMERGENCY	164, 239 1, 179, 899	255, 158 687, 178		· · ·	0	90. 07 91. 00
	O OBSERVATION BEDS (NON-DISTINCT PART)	1, 179, 099	007, 170	207, 474	211, 344	U	92.00
	TAL PURPOSE COST CENTERS						72.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	30, 411, 318	16, 866, 626	2, 021, 774	5, 121, 336	1, 555, 366	118. 00
NONRE	EIMBURSABLE COST CENTERS						
	O GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
	O RURAL HEALTH	595, 816	0	1, 110	0		194.00
	1 RENTAL PROPERTY	2, 395	0	0	0		194. 01
	4 FAMILY PRACTICE	423, 188	342, 036				194. 02
194.03 0795	Z WELLNESS 5 PHYSI CI AN PRACTI CES	42, 514 3, 135, 631	371, 337 0	8, 669	114, 206		194. 03 194. 04
	3 SYCAMORE SPORTS MED	3, 135, 031 2, 779	0	0,009			194. 04
194. 07 07956	6 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	61, 122	81, 689	_	25, 124		194. 07
200.00	Cross Foot Adjustments	,				, and a	200.00

Health Fin	ancial Systems	UNI ON HOSPI	TAL, INC.		In Lie	u of Form CMS-	2552-10
COST ALLOC	ATION - GENERAL SERVICE COSTS		Provider Co		Period: From 01/01/2023 To 12/31/2023		
	Cost Center Description	OTHER ADMIN	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		AND GENERAL	PLANT	LINEN SERVICE			
		5. 06	7. 00	8. 00	9. 00	10.00	
201.00	Negative Cost Centers	0	0		0 0	0	201.00
202. 00	TOTAL (sum lines 118 through 201)	34, 674, 763	17, 661, 688	2, 033, 39	1 5, 365, 860	1, 555, 366	202. 00

| Peri od: | Worksheet B | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared:

					1		Date/lime Pre 5/21/2024 12:	
						INTERNS &	RESI DENTS	
		Cost Center Description	CAFETERI A	NURSING ADMINISTRATIO	MEDI CAL RECORDS & LI BRARY	SERVI CES-SALA RY & FRI NGES	SERVICES-OTHE R PRGM COSTS	
			11. 00	N 13. 00	16. 00	21.00	22. 00	
1. 00		AL SERVICE COST CENTERS NEW CAP REL COSTS-BLDG & FIXT						1.00
2. 00		NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-MVBLE EQUIP						2.00
4. 00		EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01 5. 02		NONPATIENT TELEPHONES DATA PROCESSING						5. 01 5. 02
5. 03		PURCHASING RECEIVING AND STORES						5. 03
5. 04		ADMITTING						5.04
5. 05 5. 06		CASHI ERI NG/ACCOUNTS RECEI VABLE OTHER ADMIN AND GENERAL						5. 05 5. 06
7. 00	1	OPERATION OF PLANT						7. 00
8.00	1	LAUNDRY & LINEN SERVICE						8.00
9. 00 10. 00	1	HOUSEKEEPI NG DI ETARY						9. 00 10. 00
11. 00	01100	CAFETERI A	3, 761, 885					11. 00
13. 00 16. 00	1	NURSING ADMINISTRATION MEDICAL RECORDS & LIBRARY	88, 265 0	5, 235, 494 0	911, 751			13. 00 16. 00
21. 00	1	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	911, 751			21.00
22. 00	1	I&R SERVICES-OTHER PRGM COSTS APPRVD	9, 226	0			1, 713, 639	22. 00
23. 00 23. 01	1	PARAMED ED PRGM OTHER MED ED	2, 768 30, 754	0 70, 980	_			23. 00 23. 01
23. 02		PARAMED ED PRGM	0	70, 700	1			23. 02
20.00		I ENT ROUTINE SERVICE COST CENTERS	054 ((0	1 022 415	(0.44/	1 005 414	0/7.03/	20.00
30. 00 31. 00		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	854, 668 187, 910				867, 936 4, 914	30. 00 31. 00
35.00	02040	I NTENSI VE NURSERY	96, 569	222, 878	9, 692	25, 962	21, 763	35.00
41. 00 43. 00	1	SUBPROVI DER – I RF NURSERY	54, 128 40, 596	124, 925 93, 694		0	0	41.00 43.00
43.00		LARY SERVICE COST CENTERS	40, 590	93, 094	1, 302	0	0	43.00
50.00		OPERATING ROOM	143, 623	331, 477		101, 894	85, 413	50.00
50. 01 50. 02	05001	CARDI AC SURGERY	12, 302 183, 297	7, 098 0		0	0 0	50. 01 50. 02
51.00	1	RECOVERY ROOM	79, 346	183, 129		0	0	51.00
51. 02 52. 00	1	O/P TREATMENT ROOM	12, 917	29, 812			144 051	51. 02 52. 00
54.00		DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	154, 387 217, 434	333, 607 0			144, 851 14, 742	54.00
55.00		RADI OLOGY-THERAPEUTI C	17, 222	0	26, 589		12, 402	55. 00
56. 00 57. 00		RADI OI SOTOPE CT SCAN	8, 611 39, 673	0		0	0	56. 00 57. 00
58. 00	1	MAGNETIC RESONANCE IMAGING (MRI)	31, 370	0		_	ő	58.00
59. 00		CARDI AC CATHETERI ZATI ON	124, 248	0			0	59.00
60. 00 62. 00	1	LABORATORY WHOLE BLOOD & PACKED RED BLOOD CELLS	378, 280 0	0			0	60. 00 62. 00
65.00	06500	RESPI RATORY THERAPY	120, 865	259, 077	18, 992	5, 862	4, 914	
66.00	06600	PHYSI CAL THERAPY PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	-,		· ·	
66. 01 66. 02		0/P PHYSICAL THERAPY	0	0	0 2, 960		0 47, 738	
67. 00		OCCUPATI ONAL THERAPY	0	0	5, 014		0	67.00
68. 00 69. 00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	0 127, 323	0 293, 858			0 9, 828	68. 00 69. 00
69. 01		CARDI AC REHAB	14, 455				0	69. 01
70.00		ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS	26, 449	27, 682 0			1, 170 0	70.00
71. 00 72. 00		IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	
73. 00		DRUGS CHARGED TO PATIENTS	169, 457	303, 085	213, 409		234	
76. 00		RENAL ACUTE TIENT SERVICE COST CENTERS	O	0	1, 551	0	0	76. 00
90.00	09000	CLINIC	6, 458	14, 906			314, 272	
90. 05 90. 07		PATIENT NUTRITION WOUND CLINIC	0 19, 068	0 44, 008			0 7, 956	
91.00		EMERGENCY	257, 722				1	
92.00		OBSERVATION BEDS (NON-DISTINCT PART)						92.00
118. 00		AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	3, 509, 391	5, 235, 494	911, 751	1, 916, 449	1, 606, 463	118. 00
		IMBURSABLE COST CENTERS		-				
		GIFT, FLOWER, COFFEE SHOP & CANTEEN RURAL HEALTH	0 0) 0 0	0	0	l	190. 00 194. 00
194. 01	07951	RENTAL PROPERTY	0	o o	Ö	Ö	0	194. 01
		FAMILY PRACTICE WELLNESS	155, 002	0	0			194. 02 194. 03
	1	PHYSI CI AN PRACTI CES	77, 194			_		194. 03 194. 04
		· ·			•		•	·

Health Financial Systems	UNION HOSPITAL, INC.	In Lieu of	Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-0023	From 01/01/2023 Par	rksheet B rt I te/Time Prepared:

						5/21/2024 12:	12 pm
					INTERNS &	RESI DENTS	
	Cost Center Description	CAFETERI A	NURSI NG	MEDI CAL	SERVI CES-SALA	SERVI CES-OTHE	
			ADMI NI STRATI O	RECORDS &	RY & FRINGES	R PRGM COSTS	
			N	LI BRARY			
		11. 00	13. 00	16.00	21.00	22. 00	
194. 06 07953	SYCAMORE SPORTS MED	0	0	0	0	0	194.06
194. 07 07956	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	20, 298	0	C	0	0	194.07
200. 00	Cross Foot Adjustments				0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	3, 761, 885	5, 235, 494	911, 751	2, 044, 305	1, 713, 639	202.00

Provi der CCN: 15-0023

| Period: | Worksheet B | From 01/01/2023 | Part | To | 12/31/2023 | Date/Time Prepared:

					o 12/31/2023		pared:
	Cost Center Description	PARAMED ED PRGM	OTHER MED ED	PARAMED ED PRGM	Subtotal	5/21/2024 12: Intern & Residents Cost & Post Stepdown Adjustments	12 pm
		23. 00	23. 01	23. 02	24. 00	25. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 5. 06 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 16. 00 21. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00540 NONPATIENT TELEPHONES 00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE 00590 OTHER ADMIN AND GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01600 MEDICAL RECORDS & LIBRARY 02100 I &R SERVICES-SALARY & FRINGES APPRVD 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM	116, 609	385, 860	C			2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 5. 06 7. 00 8. 00 9. 00 11. 00 13. 00 16. 00 21. 00 22. 00 23. 01 23. 02
30. 00	O3000 ADULTS & PEDIATRICS	0	O		73, 832, 152	-1, 903, 350	30.00
	03100 INTENSIVE CARE UNIT 02040 INTENSIVE NURSERY 04100 SUBPROVIDER - IRF 04300 NURSERY	0 0 0 0	0 0 0	C C	16, 426, 807 5, 779, 746 3, 536, 546	-1, 703, 336 -10, 776 -47, 725 0	31. 00 35. 00 41. 00
E0 00	ANCILLARY SERVICE COST CENTERS	0			20 07/ /11	107 207	1 50 00
68. 00 69. 00 69. 01 70. 00 71. 00 72. 00 73. 00	OSO00 OPERATING ROOM OSO01 CARDI AC SURGERY OSO02 WVSC OS100 RECOVERY ROOM OS101 O/P TREATMENT ROOM OS101 O/P TREATMENT ROOM OS200 DELI VERY ROOM & LABOR ROOM OS200 DELI VERY ROOM & LABOR ROOM OS400 RADI OLOGY-DI AGNOSTI C OS500 RADI OLOGY-THERAPEUTI C OS600 RADI OLOGY-THERAPEUTI C OS600 RADI OLOGY-THERAPEUTI C OS600 RADI OLOGY-THERAPEUTI C OS600 MAGNETI C RESONANCE I MAGI NG (MRI) OS900 CARDI AC CATHETERI ZATI ON O6000 LABORATORY O6200 WHOLE BLOOD & PACKED RED BLOOD CELLS O6600 RESPI RATORY THERAPY O6600 PHYSI CAL THERAPY O6601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES O6602 O/P PHYSI CAL THERAPY O6600 OCCUPATI ONAL THERAPY O6800 SPEECH PATHOLOGY O6901 CARDI AC REHAB O7000 ELECTROCARDI OLOGY O6901 CARDI AC REHAB O7000 IMPL. DEV. CHARGED TO PATI ENTS O7300 DRUGS CHARGED TO PATI ENTS O7300 DRUGS CHARGED TO PATI ENTS O3000 RENAL ACUTE OUTPATI ENT SERVI CE COST CENTERS	0 0 0 0 0 0 0 116, 609 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 385, 860		3, 379, 031 18, 154, 465 4, 217, 019 2, 259, 688 10, 304, 871 19, 359, 050 9, 222, 593 3, 258, 791 5, 111, 102 2, 955, 155 29, 023, 938 23, 440, 979 1, 831, 375 7, 844, 022 5, 470, 807 0 2, 310, 731 2, 999, 259 1, 565, 828 8, 033, 986 1, 047, 405 2, 495, 007 46 17, 948, 146 103, 558, 604 2, 147, 738	-187, 307 0 0 0 0 -317, 652 -32, 329 -27, 198 0 0 0 0 -10, 776 0 0 -104, 687 0 -21, 553 0 -2, 566 0 0 -513	54. 00 55. 00 56. 00 57. 00 58. 00 60. 00 62. 00 65. 00 66. 01 66. 02 67. 00 68. 00 69. 01 70. 00 71. 00 72. 00 73. 00
90. 05 90. 07 91. 00	09005 PATIENT NUTRITION 09007 WOUND CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0 0	o	C	162, 352 2, 834, 510	-17, 448 -149, 845	90. 05 90. 07 91. 00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	116, 609	385, 860	C	442, 929, 370	-3, 522, 912	118. 00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C			190. 00
194. 00 194. 01 194. 02 194. 03	07950 RURAL HEALTH 07951 RENTAL PROPERTY 07954 FAMILY PRACTICE 07952 WELLNESS 07955 PHYSICIAN PRACTICES	0 0 0 0 0	0 0 0	C C C	8, 709, 117 35, 003 7, 024, 098 1, 106, 894	0 0 -235, 032 0	194. 00 194. 01

Health Financial Systems	UNI ON HOSPI	TAL, INC.		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CO		Peri od:	Worksheet B	
				From 01/01/2023		
				To 12/31/2023	Date/Time Pre 5/21/2024 12:	
Cost Center Description	PARAMED ED	OTHER MED ED	PARAMED ED	Subtotal	Intern &	
	PRGM		PRGM		Resi dents	
					Cost & Post	
					Stepdown	
					Adjustments	
	23. 00	23. 01	23. 02	24.00	25.00	
194.06 07953 SYCAMORE SPORTS MED	0	0		0 40, 618	0	194. 06
194. 07 07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 1, 020, 427	0	194. 07
200.00 Cross Foot Adjustments	0	0		0	0	200.00
201.00 Negative Cost Centers	0	0		0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	116, 609	385, 860		0 506, 779, 457	-3, 757, 944	202. 00

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

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part I
To 12/31/2023 Date/Time Prepared:
5/21/2024 12:12 pm Provider CCN: 15-0023

				5/21/2024 12:	
		Cost Center Description	Total		
	CENED	AL CEDITOR COCT CENTERS	26. 00		
1. 00		AL SERVICE COST CENTERS NEW CAP REL COSTS-BLDG & FIXT			1.00
2. 00		NEW CAP REL COSTS-BUBB & TTXT			2.00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT			4.00
5. 01	1	NONPATI ENT TELEPHONES			5. 01
5. 02	1	DATA PROCESSING			5. 02
5. 03 5. 04	1	PURCHASING RECEIVING AND STORES ADMITTING			5. 03 5. 04
5. 05	1	CASHI ERI NG/ACCOUNTS RECEI VABLE			5. 05
5. 06		OTHER ADMIN AND GENERAL			5.06
7.00	00700	OPERATION OF PLANT			7.00
8.00		LAUNDRY & LINEN SERVICE			8. 00
9.00	1	HOUSEKEEPI NG			9.00
10. 00 11. 00	1	DI ETARY CAFETERI A			10.00
13.00	1	NURSING ADMINISTRATION			13.00
16. 00	1	MEDICAL RECORDS & LIBRARY			16. 00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD			21.00
22. 00		I&R SERVICES-OTHER PRGM COSTS APPRVD			22. 00
23. 00	1	PARAMED ED PRGM			23.00
23. 01 23. 02	1	OTHER MED ED PARAMED ED PRGM			23. 01 23. 02
23. 02		IENT ROUTINE SERVICE COST CENTERS			23.02
30.00		ADULTS & PEDIATRICS	71, 928, 802		30.00
31.00		INTENSIVE CARE UNIT	16, 416, 031		31.00
35.00		I NTENSI VE NURSERY	5, 732, 021		35.00
41.00		SUBPROVI DER - I RF	3, 536, 546		41.00
43. 00		NURSERY LARY SERVICE COST CENTERS	1, 720, 758		43.00
50. 00		OPERATING ROOM	29, 889, 304		50.00
50. 01		CARDI AC SURGERY	3, 379, 031		50. 01
50.02	05002	WVSC	18, 154, 465		50. 02
51.00		RECOVERY ROOM	4, 217, 019		51.00
51. 02	1	O/P TREATMENT ROOM	2, 259, 688		51.02
52. 00 54. 00	1	DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	9, 987, 219 19, 326, 721		52.00 54.00
55.00	1	RADI OLOGY-THERAPEUTI C	9, 195, 395		55.00
56. 00	1	RADI OI SOTOPE	3, 258, 791		56.00
57.00	05700	CT SCAN	5, 111, 102		57.00
58. 00	1	MAGNETIC RESONANCE IMAGING (MRI)	2, 955, 155		58. 00
59.00		CARDI AC CATHETERI ZATI ON	29, 023, 938		59.00
60. 00 62. 00	1	LABORATORY WHOLE BLOOD & PACKED RED BLOOD CELLS	23, 440, 979 1, 831, 375		60. 00 62. 00
65. 00	1	RESPIRATORY THERAPY	7, 833, 246		65.00
66. 00	1	PHYSI CAL THERAPY	5, 470, 807		66.00
66. 01	06601	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0		66. 01
66. 02	1	O/P PHYSI CAL THERAPY	2, 206, 044		66. 02
		OCCUPATIONAL THERAPY	2, 999, 259		67.00
		SPEECH PATHOLOGY ELECTROCARDI OLOGY	1, 565, 828 8, 012, 433		68. 00 69. 00
69. 00		CARDI AC REHAB	1, 047, 405		69. 01
70.00		ELECTROENCEPHALOGRAPHY	2, 492, 441		70.00
71.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	-46		71.00
72.00	1	IMPL. DEV. CHARGED TO PATIENTS	17, 948, 146		72.00
73.00		DRUGS CHARGED TO PATIENTS	103, 558, 091		73.00
76. 00		RENAL ACUTE TIENT SERVICE COST CENTERS	2, 147, 738		76. 00
90.00		CLINIC	432, 038		90.00
90. 05		PATIENT NUTRITION	162, 352		90.05
90. 07		WOUND CLINIC	2, 817, 062		90. 07
91.00	1	EMERGENCY	19, 349, 274		91.00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)			92.00
118. 00		AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	439, 406, 458		118. 00
. 10. 00		IMBURSABLE COST CENTERS	107, 400, 400		1
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190. 00
		RURAL HEALTH	8, 709, 117		194. 00
		RENTAL PROPERTY	35, 003		194. 01
		FAMILY PRACTICE	6, 789, 066		194. 02
	1	WELLNESS PHYSICIAN PRACTICES	1, 106, 894 45, 913, 930		194. 03 194. 04
		SYCAMORE SPORTS MED	40, 618		194. 04
	1	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	1, 020, 427		194. 07
200.00		Cross Foot Adjustments	0		200.00
201.00)	Negative Cost Centers	0		201. 00

Health Financial Systems	UNION HOSPITA	L, INC.	In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0023	Peri od: From 01/01/2023	Worksheet B	
				Date/Time Pre 5/21/2024 12:	
Cost Center Description	Total	·			
	26. 00				
202.00 TOTAL (sum lines 118 through 201)	503, 021, 513				202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | From 12/31/2023 | From 12/31/2024 | Prepared: | From 12/31/2024 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0023

					Io	12/31/2023	Date/lime Pre 5/21/2024 12:	
				CAPI TAL REI	ATED COSTS		0/21/2021 12.	12 piii
		Cost Contor Description	Directly	NEW BLDG &	NEW MVBLE	Subtotal	EMDL OVEE	
		Cost Center Description	Directly Assigned New	FIXT	EQUI P	Subtotal	EMPLOYEE BENEFITS	
			Capi tal				DEPARTMENT	
			Related Costs	1.00	2.00	24	4.00	
	GENER	AL SERVICE COST CENTERS	0	1. 00	2.00	2A	4. 00	
1.00		NEW CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT	0	109, 861		109, 861	109, 861	4.00
5. 01 5. 02	1	NONPATIENT TELEPHONES DATA PROCESSING	0	11, 708 0		13, 894 0	465 0	5. 01 5. 02
5. 02		PURCHASING RECEIVING AND STORES		0		Ö	0	5. 02
5. 04	00570	ADMITTING	2, 157	54, 565	O	56, 722	1, 186	5. 04
5. 05		CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0	1	0	0	5.05
5. 06 7. 00	1	OTHER ADMIN AND GENERAL OPERATION OF PLANT	22, 026 26, 000	310, 160 5, 967, 542		349, 721 5, 994, 555	4, 388 73	5. 06 7. 00
8. 00		LAUNDRY & LINEN SERVICE	2, 854	106, 707		176, 193	799	8.00
9. 00		HOUSEKEEPI NG	0	27, 586		33, 987	2, 459	9. 00
10.00	1	DI ETARY	3, 539	195, 594		281, 724	349	10.00
11. 00 13. 00		CAFETERIA NURSI NG ADMI NI STRATI ON	0	139, 567 42, 341		141, 188 42, 341	1, 602 1, 877	11. 00 13. 00
16. 00	1	MEDICAL RECORDS & LIBRARY	8, 169	94, 144		103, 082	0	16.00
21. 00		I&R SERVICES-SALARY & FRINGES APPRVD	0	0		0	1, 347	
22. 00		I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0		0	910	
23. 00 23. 01		PARAMED ED PRGM OTHER MED ED	0	0 12, 831		0 12, 831	69 156	23. 00 23. 01
23. 01		PARAMED ED PRGM	0	12, 631		12, 631	0	23. 01
		IENT ROUTINE SERVICE COST CENTERS	,		· · · · · · · · · · · · · · · · · · ·	-		
30.00		ADULTS & PEDIATRICS	224, 274	3, 428, 545		4, 160, 032	20, 225	30.00
31. 00 35. 00		INTENSIVE CARE UNIT INTENSIVE NURSERY	184, 170 1, 613	409, 685 70, 069		1, 022, 385 255, 685	5, 211 2, 680	31.00 35.00
41. 00		SUBPROVI DER - I RF	5, 223	274, 840		291, 036	1, 680	
43.00		NURSERY	0	13, 508		13, 508	908	43.00
		LARY SERVICE COST CENTERS						
50. 00 50. 01	1	OPERATING ROOM CARDIAC SURGERY	629, 863 16, 248	747, 858 32, 736		3, 159, 255 212, 608	3, 200 1, 684	50. 00 50. 01
50. 01	05001	•	627, 756	542, 748		1, 829, 962	3, 901	50.01
51.00		RECOVERY ROOM	2, 651	25, 518		158, 836	1, 753	
51. 02		O/P TREATMENT ROOM	1, 309	426, 365		445, 696	362	51.02
52. 00 54. 00		DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	15, 994 103, 364	422, 587 576, 928		605, 464 2, 036, 377	4, 038 4, 639	
55. 00		RADI OLOGY-THERAPEUTI C	37, 092	470, 327		1, 294, 114	358	55.00
56.00	1	RADI OI SOTOPE	407	156, 817		379, 339	254	
57.00	1	CT SCAN	79, 314	38, 705		252, 482	1, 268	
58. 00 59. 00		MAGNETIC RESONANCE IMAGING (MRI) CARDIAC CATHETERIZATION	124 146, 256	46, 208 640, 528		415, 172 1, 257, 514	934 2, 991	
60.00		LABORATORY	135, 661	0		496, 408	5, 355	
62.00		WHOLE BLOOD & PACKED RED BLOOD CELLS	O	0		0	0	
		RESPIRATORY THERAPY	165, 838	92, 255		451, 815		65.00
66. 00 66. 01		PHYSI CAL THERAPY PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	1, 032	180, 875 0		183, 994	0	66. 00 66. 01
66. 02		0/P PHYSI CAL THERAPY	4, 925	0	· ·	16, 267	0	66. 02
67. 00		OCCUPATI ONAL THERAPY	0	29, 546		29, 546	0	67.00
68. 00 69. 00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	107.014	58, 593 56, 686		58, 593 704, 280	0 2, 489	68. 00 69. 00
69. 00		CARDI AC REHAB	187, 016 1, 027	116, 437		137, 915	334	
70.00		ELECTROENCEPHALOGRAPHY	20, 405	0		51, 762	2, 217	
71.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	744 450	240 145	42.000	0 1, 179, 593	0 4 750	72.00 73.00
73. 00 76. 00		RENAL ACUTE	746, 459 1, 116	369, 145 62, 816		63, 932	4, 759 0	
70.00		TIENT SERVICE COST CENTERS	.,	027010	,	007 702		70.00
90.00		CLINIC	0	12, 438		12, 438	207	90.00
90. 05 90. 07	1	PATIENT NUTRITION WOUND CLINIC	0 1, 852	34, 393 159, 526		34, 424	0 423	90. 05 90. 07
91.00		EMERGENCY	43, 939	429, 626		173, 402 762, 912	6, 302	
92.00		OBSERVATION BEDS (NON-DISTINCT PART)	10,101	,		0	5, 552	92.00
		AL PURPOSE COST CENTERS						
118. 00	_	SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	3, 449, 673	16, 998, 914	9, 014, 258	29, 462, 845	96, 793	118. 00
190. 00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	0	0	0	0	190. 00
194.00	07950	RURAL HEALTH	166, 953	0	19, 497	186, 450	2, 126	194. 00
		RENTAL PROPERTY	0	0		293		194. 01
		FAMILY PRACTICE WELLNESS	10, 463	213, 842 232, 161		287, 219 232, 161		194. 02 194. 03
	,	1	<u>, </u>	232, 101	<u>, </u>	202, 101	210	

Health Financial Systems	UNI ON HOSPI T	AL, INC.	In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CCN: 15-0023	Peri od: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Prepared: 5/21/2024 12:12 pm
		CAPITAL RELATED COSTS		

					5/21/2024 12:	12 piii
		CAPITAL REL	LATED COSTS			
Cost Center Description	Di rectly Assigned New Capital	NEW BLDG & FIXT	NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
	Related Costs					
	0	1. 00	2.00	2A	4. 00	
194. 04 07955 PHYSI CI AN PRACTI CES	1, 214, 800	0	120, 477	1, 335, 277	7, 589	194. 04
194.06 07953 SYCAMORE SPORTS MED	o	0	0	0	13	194.06
194. 07 07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	3, 654	51, 073	268	54, 995	503	194. 07
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	4, 845, 543	17, 495, 990	9, 217, 707	31, 559, 240	109, 861	202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 15-0023

Period: Worksheet B From 01/01/2023 Part II To 12/31/2023 Date/Time Prepared:

5/21/2024 12:12 pm Cost Center Description NONPATI ENT PURCHASI NG ADMI TTI NG CASHI ERI NG/AC TELEPHONES RECEIVING AND COUNTS PROCESSI NG **STORES** RECEI VABLE 5. 01 5. 02 5. 04 5 03 5 05 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 4 00 5.01 00540 NONPATIENT TELEPHONES 14, 359 5.01 00550 DATA PROCESSING 5.02 5.02 5.03 00560 PURCHASING RECEIVING AND STORES 0 0 5.03 00570 ADMITTING 58, 429 5.04 521 0 5.04 5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.05 5.06 00590 OTHER ADMIN AND GENERAL 1, 342 0 0 0 5.06 00700 OPERATION OF PLANT 0 7.00 0 0 822 7.00 0 00800 LAUNDRY & LINEN SERVICE 0 8.00 208 0 8.00 9.00 00900 HOUSEKEEPI NG 93 0 0 0 0 0 9.00 10.00 01000 DI ETARY 58 10.00 01100 CAFETERI A 0 289 0 11.00 11.00 13.00 01300 NURSING ADMINISTRATION 104 0 13.00 01600 MEDICAL RECORDS & LIBRARY 16 00 347 0 16.00 0 02100 | &R SERVICES-SALARY & FRINGES APPRVD 0 21.00 0 21.00 0 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 0 22 00 0 C 0 22 00 02300 PARAMED ED PRGM 0 0 0 23.00 23.00 02341 OTHER MED ED 0 23. 01 0 C 0 23.01 02301 PARAMED ED PRGM 23.02 0 0 23.02 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 1. 977 0 0 12, 712 0 30.00 03100 INTENSIVE CARE UNIT 31.00 0 0 0 31.00 336 2.663 02040 I NTENSI VE NURSERY 0 1, 961 35.00 208 0 0 35.00 0 41.00 04100 SUBPROVI DER - I RF 359 C 504 0 41.00 04300 NURSERY 43.00 46 0 263 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 949 0 0 5,510 0 50.01 05001 CARDI AC SURGERY 69 0 539 0 50.01 05002 WVSC 0 50.02 0 0 13 0 50.02 51 00 05100 RECOVERY ROOM 208 0 0 311 0 51 00 0 05101 0/P TREATMENT ROOM 51.02 312 0 0 51.02 05200 DELIVERY ROOM & LABOR ROOM 0 0 2, 359 0 52.00 266 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 250 0 2, 214 0 54.00 55 00 05500 RADI OLOGY-THERAPEUTI C 0 0 245 0 55 00 474 0 56.00 05600 RADI 0I S0T0PE 0 0 113 0 56.00 05700 CT SCAN 0 57.00 81 2,027 57.00 58 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 Ω 58 00 46 352 05900 CARDIAC CATHETERIZATION 0 59.00 393 0 3, 298 0 59.00 06000 LABORATORY 93 6, 435 0 60.00 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 62.00 246 06500 RESPIRATORY THERAPY 0 65.00 65 00 Ω 162 3.563 0 66.00 06600 PHYSI CAL THERAPY 266 0 758 0 66.00 66.01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 66.01 06602 0/P PHYSICAL THERAPY 66.02 12 0 66.02 0 06700 OCCUPATI ONAL THERAPY 0 67.00 67.00 58 0 618 0 68.00 06800 SPEECH PATHOLOGY 12 0 143 0 68.00 06900 ELECTROCARDI OLOGY 69.00 46 1.891 69.00 06901 CARDI AC REHAB 0 69.01 69 0 0 69.01 10 07000 ELECTROENCEPHALOGRAPHY 70 00 197 C 0 66 0 70 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 2, 169 0 72.00 0 07300 DRUGS CHARGED TO PATIENTS 579 73.00 0 3,067 0 73.00 76.00 03020 RENAL ACUTE 46 302 0 76.00 OUTPATIENT SERVICE COST CENTERS 09000 CLI NI C 90.00 0 0 0 90.00 0 90.05 09005 PATIENT NUTRITION 0 C 0 0 90.05 0 90.07 09007 WOUND CLINIC 150 C 0 90.07 91.00 09100 EMERGENCY 0 4,073 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 13, 177 0 0 58, 429 0 118.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190, 00 0 0 194.00 194.00 07950 RURAL HEALTH 0 12 C 0 194. 01 07951 RENTAL PROPERTY 0 0 0 0 194.01 0 194. 02 07954 FAMILY PRACTICE o 822 0 0 0 194.02 194. 03 07952 WELLNESS 0 0 0 194. 03 0 0 194. 04 07955 PHYSI CI AN PRACTI CES 0 0 0 194.04 255 194.06 07953 SYCAMORE SPORTS MED 0 0 0 194.06 194. 07 07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 93 0 0 194.07

Health Financial Systems	UNION HOSPITAL, INC.	In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-0023	Peri od: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Prepared: 5/21/2024 12:12 pm

						5/21/2024 12:	12 pm
	Cost Center Description	NONPATI ENT	DATA	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/AC	
	·	TELEPHONES	PROCESSI NG	RECEIVING AND		COUNTS	
				STORES		RECEI VABLE	
		5. 01	5. 02	5. 03	5. 04	5. 05	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202. 00	TOTAL (sum lines 118 through 201)	14, 359	0	0	58, 429	0	202. 00

Provider CCN: 15-0023

					5/21/2024 12:	12 pm
Cost Center Description	OTHER ADMIN	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	AND GENERAL	PLANT	LINEN SERVICE			
	5. 06	7.00	8. 00	9. 00	10.00	
GENERAL SERVICE COST CENTERS		•	•			
1.00 O0100 NEW CAP REL COSTS-BLDG & FLXT						1.00
2. 00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01 00540 NONPATI ENT TELEPHONES						5. 01
5. 02 00550 DATA PROCESSI NG						5. 02
5. 03 00560 PURCHASING RECEIVING AND STORES						5. 03
5. 04 00570 ADMITTING						5.04
5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.05
5. 06 00590 OTHER ADMIN AND GENERAL	355, 451					5.06
		/ 007 000				1
7.00 O0700 OPERATION OF PLANT	12, 389		1			7.00
8.00 00800 LAUNDRY & LINEN SERVICE	1, 307	58, 057	236, 564			8.00
9. 00 00900 HOUSEKEEPI NG	3, 636	15, 009	16, 135	71, 319		9.00
10. 00 01000 DI ETARY	798	106, 419	988	1, 279	391, 615	10.00
11. 00 01100 CAFETERI A	2, 434	1	1	l ' '	0	1
13. 00 01300 NURSI NG ADMI NI STRATI ON	3, 549		1	277	0	
1		1	1	l .		1
16.00 01600 MEDICAL RECORDS & LIBRARY	501	51, 222		616	0	
21.00 02100 1 &R SERVICES-SALARY & FRINGES APPR	/D 1, 434	0) 0	0	0	21.00
22.00 02200 1 &R SERVICES-OTHER PRGM COSTS APPR\	/D 1, 196	0) 0	0	0	22. 00
23. 00 02300 PARAMED ED PRGM	80	0	0	0	0	23.00
23. 01 02341 OTHER MED ED	180		0	84	0	1
23. 02 02301 PARAMED ED PRGM	0			١	0	1
		1 0	<u>'l</u>	U	0	23.02
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	42, 166			· .	311, 156	1
31.00 03100 INTENSIVE CARE UNIT	10, 305	222, 903	10, 018	2, 679	37, 106	31.00
35. 00 02040 I NTENSI VE NURSERY	3, 680	38, 123	1, 215	458	0	35.00
41. 00 04100 SUBPROVI DER - RF	1, 888			l .	17, 903	1
43. 00 04300 NURSERY	1, 092			l ' '	0	1
	1, 092	1, 349	10	00	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	19, 394	406, 897	13, 692	4, 890	0	
50. 01 05001 CARDI AC SURGERY	2, 307	17, 811	6	214	0	50. 01
50. 02 05002 WVSC	11, 674	295, 300	15, 581	3, 549	0	50. 02
51. 00 05100 RECOVERY ROOM	2, 671	13, 884		167	0	
51. 02 05100 REGOVERT ROOM	856	1		l .	23, 785	
· · · · · · · · · · · · · · · · · · ·	1					1
52. 00 05200 DELI VERY ROOM & LABOR ROOM	5, 961	229, 922			8	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	12, 399				0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	5, 716	255, 897	2, 341	3, 075	0	55.00
56. 00 05600 RADI 0I SOTOPE	2, 037	85, 322	1, 283	1, 025	0	56.00
57. 00 05700 CT SCAN	3, 481	21, 059		l ' '	0	57.00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 917	25, 141	1	l I	0	
				l .	_	
59. 00 05900 CARDI AC CATHETERI ZATI ON	19, 245	1	1	4, 188	1, 657	1
60. 00 06000 LABORATORY	16, 118	l .) 0	O	0	1
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	_S 1, 284	0) 0	0	0	62.00
65. 00 06500 RESPIRATORY THERAPY	5, 080	50, 194	. 0	603	0	65.00
66. 00 06600 PHYSI CAL THERAPY	3, 563	98, 411	837	1, 183	0	66.00
66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0		1	· · · · · · · · · · · · · · · · · · ·	0	
66. 02 06602 0/P PHYSI CAL THERAPY	1, 534	_	1, 950		0	
67. 00 06700 OCCUPATI ONAL THERAPY	2, 057				0	
68.00 06800 SPEECH PATHOLOGY	1, 011	31, 879	0 (383	0	
69. 00 06900 ELECTROCARDI OLOGY	5, 183	30, 842	4, 921	371	0	69.00
69. 01 06901 CARDI AC REHAB	529	63, 351	84	761	0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 704		840	l .	0	1
			0	0	0	1
		0	1	U		1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	12, 566	l .	0	0	0	
73.00 O7300 DRUGS CHARGED TO PATIENTS	71, 297	200, 845	1, 139	2, 414	0	73.00
76. 00 03020 RENAL ACUTE	1, 408	34, 177	908	411	0	76.00
OUTPATIENT SERVICE COST CENTERS			•			1
90. 00 09000 CLI NI C	270	6, 768		81	0	90.00
1	1	1		l .	0	
1 1	63		•	225		
90. 07 09007 WOUND CLINIC	1, 684	1	1		0	
91. 00 09100 EMERGENCY	12, 097	233, 752	33, 445	2, 809	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	T)					92.00
SPECIAL PURPOSE COST CENTERS		'				1
118.00 SUBTOTALS (SUM OF LINES 1 through 1	311, 741	5, 737, 388	235, 212	68, 069	391, 615	118. 00
NONREI MBURSABLE COST CENTERS						100
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		· 0	0	이		190.00
194.00 07950 RURAL HEALTH	6, 108	0	129	0		194. 00
194. 01 07951 RENTAL PROPERTY	25	0	0	ol	0	194. 01
194. 02 07954 FAMILY PRACTICE	4, 339	l .	214	1, 398	0	194. 02
194. 03 07952 WELLNESS	436			1, 518		194. 03
194. 04 07955 PHYSI CLAN PRACTICES	32, 147					194. 04
194. 06 07953 SYCAMORE SPORTS MED	28	l .	0			194.06
194. 07 07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	627	27, 788	0	334	0	194. 07
200.00 Cross Foot Adjustments						200.00

Heal th Fina	ncial Systems	UNI ON HOSPI	TAL, INC.		In Lie	u of Form CMS-2	2552-10
ALLOCATI ON	OF CAPITAL RELATED COSTS		Provi der C		Peri od:	Worksheet B	
					From 01/01/2023		
				[To 12/31/2023	Date/Time Pre	
						5/21/2024 12:	12 pm
	Cost Center Description	OTHER ADMIN	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		AND GENERAL	PLANT	LINEN SERVICE			
		5. 06	7. 00	8.00	9. 00	10.00	
201.00	Negative Cost Centers	0	0		0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	355, 451	6, 007, 839	236, 56	4 71, 319	391, 615	202.00

Provider CCN: 15-0023

						===:::	5/21/2024 12:	12 pm
						INTERNS &	RESI DENTS	
		Cost Center Description	CAFETERI A	NURSI NG	MEDICAL	SERVI CES_SALA	SERVI CES-OTHE	
		oust defice bescription	ONIETEKIA	ADMI NI STRATI O	RECORDS &	RY & FRINGES	R PRGM COSTS	
				N	LI BRARY			
			11. 00	13. 00	16. 00	21. 00	22. 00	
		AL SERVICE COST CENTERS		1		I		
1.00		NEW CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00		NEW CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
5. 01	1	NONPATIENT TELEPHONES						5. 01
5. 02		DATA PROCESSING						5.02
5. 03		PURCHASING RECEIVING AND STORES						5. 03
5.04	00570	ADMI TTI NG						5. 04
5.05		CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5. 06		OTHER ADMIN AND GENERAL						5.06
7.00	1	OPERATION OF PLANT						7.00
8. 00 9. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING						8. 00 9. 00
10.00	1	DI ETARY						10.00
11. 00		CAFETERI A	222, 362					11.00
13.00		NURSING ADMINISTRATION	5, 217	76, 402				13.00
16.00		MEDICAL RECORDS & LIBRARY	0	0	155, 768			16. 00
21.00		I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	2, 781		21.00
22. 00	1	I&R SERVICES-OTHER PRGM COSTS APPRVD	545	0	0		2, 651	
23. 00		PARAMED ED PRGM	164					23.00
23. 01 23. 02	1	OTHER MED ED PARAMED ED PRGM	1, 818 0	1				23. 01 23. 02
23. 02		TENT ROUTINE SERVICE COST CENTERS	0	0	0			23.02
30.00	03000	ADULTS & PEDIATRICS	50, 520	26, 756	11, 620			30.00
31.00		INTENSIVE CARE UNIT	11, 107	6, 329				31.00
35.00		INTENSIVE NURSERY	5, 708	3, 252	1, 645			35.00
41.00		SUBPROVI DER - I RF	3, 199					41.00
43.00		NURSERY	2, 400	1, 367	221			43.00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	0 400	4, 837	14 207	I	Γ]] EO OO
50. 00		CARDI AC SURGERY	8, 489 727	104				50. 00 50. 01
50. 02	05002		10, 835					50.02
51.00		RECOVERY ROOM	4, 690					51.00
51. 02	05101	O/P TREATMENT ROOM	764	435	172			51.02
52.00		DELIVERY ROOM & LABOR ROOM	9, 126					52.00
54.00		RADI OLOGY - DI AGNOSTI C	12, 852					54.00
55.00		RADI OLOGY-THERAPEUTI C RADI OI SOTOPE	1, 018					55. 00 56. 00
56. 00 57. 00	1	CT SCAN	509 2, 345					57.00
58. 00	1	MAGNETIC RESONANCE IMAGING (MRI)	1, 854					58.00
59. 00	1	CARDI AC CATHETERI ZATI ON	7, 344					59.00
60.00	06000	LABORATORY	22, 360					60.00
62.00		WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62.00
65.00		RESPI RATORY THERAPY	7, 144		3, 224			65.00
66.00	1	PHYSI CAL THERAPY	0	0	1			66.00
66. 01 66. 02		PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES O/P PHYSI CAL THERAPY	0	0	0 502			66. 01 66. 02
67. 00	1	OCCUPATIONAL THERAPY	0	0				67.00
68. 00		SPEECH PATHOLOGY	0	O	1			68.00
69.00		ELECTROCARDI OLOGY	7, 526	4, 288	7, 136			69. 00
69. 01	1	CARDI AC REHAB	854					69. 01
70.00		ELECTROENCEPHALOGRAPHY	1, 563					70.00
71. 00 72. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS	0	0				71. 00 72. 00
73.00	1	DRUGS CHARGED TO PATTENTS	10, 016	1	-, .==			73.00
76. 00	1	RENAL ACUTE	10, 010	0				76.00
		TIENT SERVICE COST CENTERS						
90.00		CLINIC	382	218				90.00
90.05	1	PATIENT NUTRITION	1 127	0				90.05
90. 07 91. 00		WOUND CLINIC EMERGENCY	1, 127 15, 234	642 8, 680				90. 07 91. 00
92.00	1	OBSERVATION BEDS (NON-DISTINCT PART)	15, 254	0,000	11, 240			92.00
72.00		AL PURPOSE COST CENTERS						, , , , , , , , , , , , , , , , , , , ,
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	207, 437	76, 402	155, 768	0	0	118. 00
		IMBURSABLE COST CENTERS						
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0					190.00
		RURAL HEALTH RENTAL PROPERTY	0	0				194. 00 194. 01
		FAMILY PRACTICE	9, 162	0				194. 01
		WELLNESS	0	Ö				194. 03
		PHYSICIAN PRACTICES	4, 563	0				194. 04

Health Financial Systems

UNION HOSPITAL, INC.

In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0023
From 01/01/2023
To 12/31/2023
Date/Time Prepared: 5/21/2024 12: 12 pm

						5/21/2024 12:	12 pm
					INTERNS &	RESI DENTS	
	Cost Center Description	CAFETERI A	NURSI NG	MEDI CAL	SERVI CES-SALA	SERVI CES-OTHE	
			ADMI NI STRATI O	RECORDS &	RY & FRINGES	R PRGM COSTS	
			N	LI BRARY			
		11. 00	13. 00	16.00	21.00	22. 00	
194. 06 07953	SYCAMORE SPORTS MED	0	0	0			194.06
194. 07 07956	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	1, 200	0	0			194.07
200. 00	Cross Foot Adjustments				2, 781	2, 651	200.00
201. 00	Negative Cost Centers	0	0	0	0	0	201.00
202. 00	TOTAL (sum lines 118 through 201)	222, 362	76, 402	155, 768	2, 781	2, 651	202.00

UNION HOSPITAL, INC.

| Period: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time | Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-0023

					To 12/31/2023		
	Cost Center Description	PARAMED ED PRGM	OTHER MED ED	PARAMED ED PRGM	Subtotal	5/21/2024 12: Intern & Residents Cost & Post Stepdown	12 piii
		23. 00	23. 01	23. 02	24. 00	Adjustments 25.00	
	GENERAL SERVICE COST CENTERS	23.00	23.01	23.02	24.00	25.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 01	00540 NONPATI ENT TELEPHONES						5. 01
5. 02	00550 DATA PROCESSING						5. 02
5. 03 5. 04	00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING						5. 03 5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5.06	00590 OTHER ADMIN AND GENERAL						5.06
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A						10.00
13. 00	01300 NURSI NG ADMI NI STRATI ON						11.00
16. 00	01600 MEDICAL RECORDS & LIBRARY						16.00
21. 00 22. 00	02100 1&R SERVICES-SALARY & FRINGES APPRVD 02200 1&R SERVICES-OTHER PRGM COSTS APPRVD						21. 00 22. 00
23. 00	02300 PARAMED ED PRGM	313					23.00
23. 01	02341 OTHER MED ED		23, 086	1			23. 01
23. 02	O2301 PARAMED ED PRGM INPATIENT ROUTINE SERVICE COST CENTERS				0		23. 02
30.00	03000 ADULTS & PEDIATRICS				6, 601, 256	0	30.00
31.00	03100 I NTENSI VE CARE UNI T				1, 333, 276	0	
35. 00 41. 00	02040 NTENSI VE NURSERY 04100 SUBPROVI DER - I RF				314, 615 472, 281	0	
43.00	04300 NURSERY				27, 242	0	43.00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM		T		3, 641, 500	0	50.00
50. 01	05001 CARDI AC SURGERY				236, 522	0	
50. 02 51. 00	05002 WVSC 05100 RECOVERY ROOM				2, 181, 063	0	
51.00	05100 RECOVERY ROOM 05101 0/P TREATMENT ROOM				196, 332 708, 209	0	1
52.00	05200 DELIVERY ROOM & LABOR ROOM				879, 260	0	
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C				2, 402, 373 1, 567, 752	0	
56. 00	05600 RADI OI SOTOPE				471, 169	0	
57. 00 58. 00	05700 CT SCAN				287, 737	0	
59.00	05800 MAGNETI C RESONANCE I MAGING (MRI) 05900 CARDI AC CATHETERI ZATI ON				457, 081 1, 661, 521	0	1
60.00	06000 LABORATORY				561, 355	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06500 RESPIRATORY THERAPY				1, 787 528, 507	0	
66. 00	06600 PHYSI CAL THERAPY				290, 109	0	1
66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES				0	0	•
66. 02 67. 00	06602 O/P PHYSICAL THERAPY 06700 OCCUPATIONAL THERAPY				20, 265 49, 398	0	
68. 00	06800 SPEECH PATHOLOGY				92, 393	0	68. 00
69.00	06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB				768, 973	0	
69. 01 70. 00					204, 569 59, 144	0	1
71. 00					0	0	
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS				20, 657 1, 515, 343	0	
	03020 RENAL ACUTE				101, 447	0	1
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	I	I		20, 403	0	90.00
90.00	09000 PATIENT NUTRITION				20, 403 53, 450	0	1
90. 07	09007 WOUND CLINIC				267, 814	0	1
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)				1, 091, 273	0	
72.00	SPECIAL PURPOSE COST CENTERS						72.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0	0		0 29, 086, 076	0	118. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN				0		190. 00
	07950 RURAL HEALTH				194, 825		194.00
	07951 RENTAL PROPERTY 07954 FAMILY PRACTICE				318 422, 121		194. 01 194. 02
194. 03	07952 WELLNESS				360, 648	0	194. 03
194.04	O7955 PHYSICIAN PRACTICES	1	<u> </u>	1	1, 380, 840	0	194. 04

Health Financial Systems	UNI ON HOSPI	TAL, INC.		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CO		Peri od: From 01/01/2023	Worksheet B Part II	
				To 12/31/2023	Date/Time Pre	epared:
					5/21/2024 12:	12 pm
Cost Center Description	PARAMED ED	OTHER MED ED	PARAMED ED	Subtotal	Intern &	
	PRGM		PRGM		Resi dents	
					Cost & Post	
					Stepdown	
					Adjustments	
	23. 00	23. 01	23. 02	24.00	25. 00	
194.06 07953 SYCAMORE SPORTS MED				41	0	194.06
194. 07 07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES				85, 540	0	194. 07
200.00 Cross Foot Adjustments	313	23, 086		0 28, 831	0	200.00
201.00 Negative Cost Centers	0	o		0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	313	23, 086		0 31, 559, 240	0	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS UNION HOSPITAL, INC.

Provider CCN: 15-0023

				5/21/2024 12:	
		Cost Center Description	Total		,
	OFNED	AL OFFICE OF THE PO	26. 00		
1 00		AL SERVICE COST CENTERS			1 00
1. 00 2. 00		NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-MVBLE EQUIP			1.00 2.00
4. 00	1	EMPLOYEE BENEFITS DEPARTMENT			4.00
5. 01		NONPATI ENT TELEPHONES			5. 01
5.02	00550	DATA PROCESSING			5. 02
5.03	00560	PURCHASING RECEIVING AND STORES			5. 03
5. 04	1	ADMITTI NG			5. 04
5. 05	1	CASHI ERI NG/ACCOUNTS RECEI VABLE			5. 05
5. 06 7. 00	1	OTHER ADMIN AND GENERAL OPERATION OF PLANT			5. 06 7. 00
8. 00	1	LAUNDRY & LINEN SERVICE			8.00
9. 00		HOUSEKEEPI NG			9.00
10.00	1	DI ETARY			10.00
11.00	01100	CAFETERI A			11.00
13.00	1	NURSING ADMINISTRATION			13.00
16.00	1	MEDICAL RECORDS & LIBRARY			16.00
	1	I&R SERVICES-SALARY & FRINGES APPRVD I&R SERVICES-OTHER PRGM COSTS APPRVD			21. 00 22. 00
23. 00	1	PARAMED ED PRGM			23.00
23. 01		OTHER MED ED			23. 01
23. 02	1	PARAMED ED PRGM			23. 02
	I NPAT	IENT ROUTINE SERVICE COST CENTERS			
30. 00		ADULTS & PEDIATRICS	6, 601, 256		30.00
31.00	1	INTENSIVE CARE UNIT	1, 333, 276		31.00
35.00	1	I NTENSI VE NURSERY	314, 615		35.00
41. 00 43. 00	1	SUBPROVI DER - I RF NURSERY	472, 281 27, 242		41. 00 43. 00
43.00		LARY SERVICE COST CENTERS	21, 242		43.00
50.00		OPERATING ROOM	3, 641, 500		50.00
50. 01	05001	CARDI AC SURGERY	236, 522		50. 01
50. 02	05002		2, 181, 063		50.02
51.00	1	RECOVERY ROOM	196, 332		51.00
51. 02 52. 00		O/P TREATMENT ROOM DELIVERY ROOM & LABOR ROOM	708, 209		51. 02 52. 00
54.00	1	RADI OLOGY-DI AGNOSTI C	879, 260 2, 402, 373		54.00
55. 00	1	RADI OLOGY-THERAPEUTI C	1, 567, 752		55.00
56. 00	1	RADI OI SOTOPE	471, 169		56.00
57.00	05700	CT SCAN	287, 737		57.00
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	457, 081		58. 00
59.00	1	CARDI AC CATHETERI ZATI ON	1, 661, 521		59.00
60. 00 62. 00	1	LABORATORY	561, 355 1, 787		60. 00 62. 00
65. 00		WHOLE BLOOD & PACKED RED BLOOD CELLS RESPIRATORY THERAPY	528, 507		65.00
66. 00	1	PHYSI CAL THERAPY	290, 109		66.00
66. 01	06601	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	o		66. 01
66. 02		O/P PHYSICAL THERAPY	20, 265		66. 02
67. 00		OCCUPATI ONAL THERAPY	49, 398		67.00
68. 00		SPEECH PATHOLOGY	92, 393		68.00
69. 00 69. 01	1	ELECTROCARDI OLOGY CARDI AC REHAB	768, 973 204, 569		69. 00 69. 01
70. 00		ELECTROENCEPHALOGRAPHY	59, 144		70.00
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0		71.00
72.00		IMPL. DEV. CHARGED TO PATIENTS	20, 657		72.00
73.00		DRUGS CHARGED TO PATIENTS	1, 515, 343		73.00
76. 00		RENAL ACUTE	101, 447		76. 00
90. 00		TIENT SERVICE COST CENTERS	20, 403		90.00
90.05		PATIENT NUTRITION	53, 450		90.05
90. 07	1	WOUND CLINIC	267, 814		90.07
91.00	09100	EMERGENCY	1, 091, 273		91.00
92.00		OBSERVATION BEDS (NON-DISTINCT PART)			92.00
110 00		AL PURPOSE COST CENTERS	20, 004, 074		110 00
118. 00		SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	29, 086, 076		118. 00
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190. 00
		RURAL HEALTH	194, 825		194. 00
		RENTAL PROPERTY	318		194. 01
		FAMILY PRACTICE	422, 121		194. 02
		WELLNESS DHYSI CLAN DRACTI CES	360, 648		194. 03
		PHYSICIAN PRACTICES SYCAMORE SPORTS MED	1, 380, 840 41		194. 04 194. 06
	1	PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES	85, 540		194. 00
200.00		Cross Foot Adjustments	28, 831		200.00
201.00	1	Negative Cost Centers	0		201.00

Heal th Financ	ial Systems	UNI ON HOSPITA	AL, INC.		In Lie	u of Form CMS-	2552-10
ALLOCATION OF	CAPITAL RELATED COSTS		Provi der	CCN: 15-0023	Peri od: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Pre 5/21/2024 12:	
C	Cost Center Description	Total					
		26. 00					
202. 00 T	OTAL (sum lines 118 through 201)	31, 559, 240					202.00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0023 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/21/2024 12:12 pm CAPITAL RELATED COSTS Cost Center Description NEW BLDG & NEW MVBLE **EMPLOYEE** NONPATI ENT DATA PROCESSI NG **FOULP** BENEFITS TELEPHONES FLXT (NEW TOTAL (NEW EQUIP DEPARTMENT (PHONES) (DEVICES) SQ FT) DEPRN) (GROSS SALARI ES) 1. 00 2.00 4.00 5. 01 5. 02 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 981, 809 1 00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 6, 943, 814 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 118, 360, 648 4.00 4.00 6.165 5.01 00540 NONPATIENT TELEPHONES 657 1,647 500, 713 1, 241 5.01 5.02 00550 DATA PROCESSING 0 C C 2, 205 5.02 5.03 00560 PURCHASING RECEIVING AND STORES 0 5.03 C 1, 277, 550 00570 ADMITTING 5 04 3 062 Ω 45 13 5 04 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.05 0 0 5.05 5.06 00590 OTHER ADMIN AND GENERAL 17, 405 13, 209 4, 728, 329 49 5.06 7.00 00700 OPERATION OF PLANT 334, 876 763 78, 768 71 0 7.00 00800 LAUNDRY & LINEN SERVICE 5, 988 50 195 8 00 861 240 18 8 00 5 9.00 00900 HOUSEKEEPI NG 1, 548 4,822 2, 649, 385 8 9 9.00 01000 DI ETARY 10, 976 62, 217 376, 101 5 10.00 10.00 01100 CAFETERI A 7,832 1, 725, 858 25 11.00 1. 221 18 11.00 01300 NURSING ADMINISTRATION 9 2, 376 13 00 2, 023, 024 13 00 16.00 01600 MEDICAL RECORDS & LIBRARY 5, 283 579 30 65 16.00 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 1, 451, 588 0 0 21.00 0 C 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 0 22 00 0 0 980, 637 0 22 00 0 23.00 02300 PARAMED ED PRGM 0 C 74, 117 0 23.00 02341 OTHER MED ED 720 0 0 23.01 168, 554 23.01 02301 PARAMED ED PRGM 23.02 0 0 0 23.02 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 192, 397 382, 090 21, 769, 091 171 591 30.00 22, 990 322, 817 03100 INTENSIVE CARE UNIT 31.00 5, 614, 907 29 31.00 02040 INTENSIVE NURSERY 3, 932 2, 887, 432 19 35.00 138, 612 18 35.00 04100 SUBPROVI DER - I RF 1, 809, 988 41.00 15.423 8, 266 31 0 41.00 43.00 04300 NURSERY 758 978, 941 0 43.00 4 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 41. 967 1, 342, 051 3, 448, 741 103 50.00 82 05001 CARDI AC SURGERY 50.01 1.837 123, 260 1, 814, 289 6 10 50.01 05002 WVSC 30, 457 496, 778 4, 203, 870 114 50.02 50.02 0 05100 RECOVERY ROOM 51.00 1, 432 98, 433 1, 889, 449 18 44 51.00 05101 0/P TREATMENT ROOM 389, 893 51.02 23, 926 13, 576 27 51.02 5 05200 DELIVERY ROOM & LABOR ROOM 52.00 23, 714 125, 715 4, 351, 584 23 54 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 32, 375 1,021,556 4, 998, 858 108 66 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 26, 393 592, 627 385, 565 55.00 41 64 05600 RADI OI SOTOPE 8,800 167, 322 273.910 8 56,00 0 56.00 57.00 05700 CT SCAN 2, 172 101, 293 1, 366, 324 7 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 2, 593 277, 852 1,006,710 2 58.00 05900 CARDIAC CATHETERIZATION 35, 944 3, 223, 582 96 59.00 354, 607 34 59.00 06000 LABORATORY 8 60.00 271, 755 5, 770, 568 0 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 62.00 06500 RESPIRATORY THERAPY 22 5, 177 145, 933 3, 169, 621 14 65.00 65.00 06600 PHYSI CAL THERAPY 23 48 66,00 10, 150 1, 572 C 66.00 66.01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 66.01 06602 0/P PHYSICAL THERAPY 66.02 0 8, 544 0 9 66.02 06700 OCCUPATIONAL THERAPY 5 67.00 1.658 0 0 67.00 06800 SPEECH PATHOLOGY 3, 288 68.00 \cap Ω 68.00 69.00 06900 ELECTROCARDI OLOGY 3, 181 346, 959 2, 681, 792 49 69.00 69.01 06901 CARDI AC REHAB 6,534 15, 406 359, 589 6 69.01 70 00 07000 ELECTROENCEPHALOGRAPHY 23, 622 2, 388, 665 35 70 00 0 17 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 C 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 20, 715 48, 204 5, 128, 659 50 195 73.00 03020 RENAL ACUTE 76.00 76.00 3.525 0 OUTPATIENT SERVICE COST CENTERS 90.00 698 0 90.00 09000 CLI NI C 222, 917 90.05 09005 PATIENT NUTRITION 1,930 23 ol 5 90.05 0 9,058 90 07 09007 WOUND CLINIC 8.952 455, 824 17 90 07 13 91.00 09100 EMERGENCY 24, 109 217, 969 6, 790, 936 63 135 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 SPECIAL PURPOSE COST CENTERS
SUBTOTALS (SUM OF LINES 1 through 117) 953, 915 118.00 6, 790, 553 104, 277, 569 1, 139 1, 863 118.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 194.00 07950 RURAL HEALTH 0 0 190, 00 107 194, 00 0 14, 687 2, 291, 463 1 194. 01 07951 RENTAL PROPERTY 221 0 0 194. 01 194. 02 07954 FAMILY PRACTICE 12,000 47, 394 2, 822, 272 71 60 194. 02

Health Financial Systems	UNION HOSPITAL, INC.	In Lieu	of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0023	Peri od:	Worksheet B-1
		From 01/01/2023	
		T- 10/01/0000	D-+- /T! D

				1	0 12/31/2023	Date/Time Pre 5/21/2024 12:	
		CAPI TAL REL	ATED COSTS			072172021 12.	IZ piii
	Cost Center Description	NEW BLDG &	NEW MVBLE	EMPLOYEE	NONPATI ENT	DATA	
		FI XT	EQUI P	BENEFITS	TELEPHONES	PROCESSI NG	
		(NEW TOTAL	(NEW EQUIP	DEPARTMENT	(PHONES)	(DEVICES)	
		SQ FT)	DEPRN)	(GROSS			
				SALARI ES)			
		1. 00	2. 00	4. 00	5. 01	5. 02	
194. 03 0795		13, 028	0	235, 382	0		194. 03
	5 PHYSI CI AN PRACTI CES	0	90, 757	8, 178, 287	22		194. 04
	3 SYCAMORE SPORTS MED	0	0	13, 722	0		194. 06
	6 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	2, 866	202	541, 953	8		194. 07
200. 00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	17, 495, 990	9, 217, 707	24, 494, 811	809, 478	18, 579, 072	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	17. 820156	1. 327470	0. 206951	652. 278807	8, 425. 882993	203. 00
204.00	Cost to be allocated (per Wkst. B,			109, 861	14, 359	0	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part			0. 000928	11. 570508	0.000000	205. 00
	11)						
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0023 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/21/2024 12:12 pm Cost Center Description PURCHASI NG ADMI TTI NG CASHIERING/AC Reconciliatio OTHER ADMIN COUNTS AND GENERAL RECEIVING AND (INPATIENT n STORES CHARGES) RECEI VABLE (ACCUM. (REQUISITIO) (GROSS COST) CHARGES) 5.03 5.04 5.05 5A. 06 5.06 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2 00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00540 NONPATIENT TELEPHONES 5.01 5.01 00550 DATA PROCESSING 5.02 5.02 00560 PURCHASING RECEIVING AND STORES 5.03 14, 859, 617 5.03 5.04 00570 ADMITTING 46,830 672, 063, 967 5.04 5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 2, 121, 860, 832 5.05 0 5.06 00590 OTHER ADMIN AND GENERAL 82 -34, 674, 763 472, 104, 740 5.06 C 7.00 00700 OPERATION OF PLANT 0 C 0 0 16, 453, 246 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 24, 582 1, 735, 265 8.00 00900 HOUSEKEEPI NG 918 0 0 0 4, 828, 414 9.00 9.00 1, 059, 959 01000 DI ETARY 0 0 10.00 5,747 C 10.00 11.00 01100 CAFETERI A 0 0 3, 232, 570 11.00 0 13.00 01300 NURSING ADMINISTRATION 0 0 0 0 0 4, 712, 555 13.00 01600 MEDICAL RECORDS & LIBRARY 0 0 665, 946 16,00 889 16,00 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 0 0 0 1, 904, 430 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 0 0 1, 587, 794 22.00 0 0 22.00 02300 PARAMED ED PRGM 0 0 0 106, 052 23.00 23.00 02341 OTHER MED ED o 23.01 0 C 0 239, 688 23.01 23.02 02301 PARAMED ED PRGM 0 23.02 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 1 833 237 146, 587, 752 159 176 508 0 55, 997, 565 30.00 03100 INTENSIVE CARE UNIT 0 31.00 722, 489 30, 609, 278 30, 609, 278 13, 685, 790 31.00 35.00 02040 INTENSIVE NURSERY 121, 023 22, 539, 741 22, 539, 741 0 4, 886, 962 35.00 04100 SUBPROVI DER - I RF ol 41.00 57, 541 5, 788, 465 5, 788, 465 2,506,656 41.00 04300 NURSERY 43.00 3, 027, 100 3, 027, 100 0 1, 450, 389 43 00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 5, 944, 654 63, 335, 860 197, 078, 460 0 25, 755, 998 50.00 6, 197, 505 50.01 05001 CARDI AC SURGERY 578, 237 6, 203, 005 0 3, 063, 444 50.01 50.02 150, 000 140, 385, 991 0 15, 503, 108 05002 WVSC 50 02 2, 315, 442 o 51.00 05100 RECOVERY ROOM 168, 056 3, 579, 082 12, 172, 804 3, 547, 289 51.00 05101 0/P TREATMENT ROOM 2, 353, 255 0 51.02 71, 540 25, 230 1, 137, 160 51.02 52.00 05200 DELIVERY ROOM & LABOR ROOM 319, 413 27, 111, 168 32, 419, 504 0 0 7, 915, 897 52.00 93, 478, 376 05400 RADI OLOGY-DI AGNOSTI C 126, 394 54.00 25, 450, 304 16, 466, 425 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 3, 483 2, 819, 074 61, 835, 759 7, 590, 329 55.00 56 00 05600 RADI OI SOTOPE 10, 972 1, 298, 094 17, 629, 483 0 0 2, 704, 934 56.00 05700 CT SCAN 266, 705 23, 303, 324 64. 938. 478 4, 623, 011 57.00 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 16, 010 4,046,346 17, 154, 339 2, 545, 876 58 00 59.00 05900 CARDI AC CATHETERI ZATI ON 55, 243 37, 905, 475 116, 259, 648 0 25, 558, 385 59.00 0 06000 LABORATORY 73, 961, 894 199, 808, 666 21, 404, 672 60.00 609, 279 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 2, 822, 613 1, 704, 661 62.00 0 3, 516, 803 62.00 65.00 06500 RESPIRATORY THERAPY 300, 899 40, 951, 790 44, 167, 631 0 0 0 6, 745, 903 65.00 66.00 06600 PHYSI CAL THERAPY 4, 993 8, 716, 730 15, 022, 945 4, 731, 362 66.00 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 66.01 C 0 66.01 0 06602 0/P PHYSICAL THERAPY 2, 036, 732 66.02 3.747 6.882.568 66.02 06700 OCCUPATIONAL THERAPY 7, 103, 144 11, 660, 251 0 2, 731, 810 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 0 1, 639, 281 5, 100, 829 0 0 1, 342, 492 68.00 21, 735, 586 6, 882, 840 06900 FLECTROCARDI OLOGY 97, 752, 918 69.00 657 69.00 69.01 06901 CARDI AC REHAB 1, 699 114, 745 2, 397, 947 702, 708 69.01 07000 ELECTROENCEPHALOGRAPHY 2,562 757, 695 5, 356, 656 0 2, 262, 603 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 46 71.00 71.00 O 07200 I MPL. DEV. CHARGED TO PATIENTS 16, 687, 610 24, 929, 337 0 72.00 81, 118, 042 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 229, 847 35, 251, 549 497, 809, 905 94, 745, 596 73.00 03020 RENAL ACUTE 1, 869, 682 76.00 101, 451 3, 472, 674 3, 608, 056 0 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLI NI C 425 125 532, 645 0 358, 128 09005 PATIENT NUTRITION 336, 479 90.05 0 84, 100 90.05 09007 WOUND CLINIC 90.07 122, 203 20,000 9, 769, 908 0 2, 236, 153 90.07 91 00 09100 EMERGENCY 749.892 46, 813, 006 153, 968, 389 16, 064, 638 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 SPECIAL PURPOSE COST CENTERS 672, 063, 967 2, 121, 860, 832 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 14, 817, 141 -34, 674, 717 414, 056, 827 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 194.00 07950 RURAL HEALTH 15,012 0 0 0 8, 112, 191 194. 00 194. 01 07951 RENTAL PROPERTY 0 0 o 32, 608 194. 01 0 0 194. 02 07954 FAMILY PRACTICE 156 0 0 5, 761, 808 194. 02 194. 03 07952 WELLNESS 0 578, 837 194. 03 194. 04 07955 PHYSI CI AN PRACTI CES 27, 138 0 0 42, 692, 436 194. 04

Health Financial Systems	UNION HOSPITAL, INC.	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0023	Period: Worksheet B-1 From 01/01/2023

				T	o 12/31/2023	Date/Time Pre 5/21/2024 12:	
	Cost Center Description	PURCHASI NG	ADMITTI NG	CASHI ERI NG/AC	Reconciliatio		
	·	RECEIVING AND	(I NPATI ENT	COUNTS	n	AND GENERAL	
		STORES	CHARGES)	RECEI VABLE		(ACCUM.	
		(REQUISITIO)		(GROSS		COST)	
				CHARGES)			
		5. 03	5. 04	5. 05	5A. 06	5. 06	
194. 06 07953	SYCAMORE SPORTS MED	0	0	0	0		194. 06
	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	170	0	0	0	832, 194	
200. 00	Cross Foot Adjustments]					200. 00
201. 00	Negative Cost Centers]					201.00
202. 00	Cost to be allocated (per Wkst. B,	2, 043, 404	1, 936, 093	25, 128, 683		34, 674, 763	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 137514	0. 002881			0. 073447	
204. 00	Cost to be allocated (per Wkst. B,	0	58, 429	0		355, 451	204. 00
205. 00	Part II)	0. 000000	0. 000087	0. 000000		0. 000753	205 00
205.00	Unit cost multiplier (Wkst. B, Part	0.000000	0.000087	0.000000		0.000753	205.00
206. 00	NAHE adjustment amount to be allocated						206.00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

In Lieu of Form CMS-2552-10 Health Financial Systems UNION HOSPITAL, INC. COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0023 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/21/2024 12:12 pm Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A LINEN SERVICE **PLANT** (NEW TOTAL (DI ETARY) (FTE) (NEW TOTAL (LINEN) SQ FT) SQ FT) 8.00 9.00 10.00 11.00 7.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 2 00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00540 NONPATIENT TELEPHONES 5.01 5.01 5.02 00550 DATA PROCESSING 5.02 00560 PURCHASING RECEIVING AND STORES 5.03 5.03 5.04 00570 ADMITTING 5.04 5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5 05 00590 OTHER ADMIN AND GENERAL 5.06 5.06 00700 OPERATION OF PLANT 619, 644 7 00 7 00 5, 988 8.00 00800 LAUNDRY & LINEN SERVICE 1, 258, 123 8.00 9.00 00900 HOUSEKEEPI NG 1,548 85, 812 612, 108 9.00 01000 DI ETARY 10, 976 10.976 10.00 5, 253 197, 761 10.00 12, 232 11.00 01100 CAFETERI A 7,832 C 7,832 0 11.00 13.00 01300 NURSING ADMINISTRATION 2, 376 2, 376 287 13.00 0 16.00 01600 MEDICAL RECORDS & LIBRARY 5, 283 0 5, 283 0 0 16.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 0 21 00 0 C 0 0 21.00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 0 C 0 0 30 22.00 02300 PARAMED ED PRGM o 9 23.00 0 0 0 23.00 o 02341 OTHER MED ED 100 23.01 720 0 720 23.01 02301 PARAMED ED PRGM 23.02 \cap 0 23.02 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 192, 397 405, 623 192, 397 157, 130 2, 779 30.00 03100 INTENSIVE CARE UNIT 31.00 22, 990 53. 279 22, 990 18, 738 611 31.00 02040 I NTENSI VE NURSERY 35.00 3, 932 6, 462 3, 932 314 35.00 15, 423 41.00 04100 SUBPROVI DER - I RF 11, 344 15, 423 9,041 176 41.00 43.00 04300 NURSERY 758 758 132 43.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 41, 967 72,816 41, 967 0 467 50.00 05001 CARDI AC SURGERY 50.01 1,837 34 1,837 0 40 50.01 05002 WVSC 50 02 30 457 82 867 30 457 0 596 50 02 05100 RECOVERY ROOM 51.00 1, 432 54, 519 1, 432 258 51.00 05101 0/P TREATMENT ROOM 23, 926 5, 630 23, 926 12, 011 42 51.02 51.02 52.00 05200 DELIVERY ROOM & LABOR ROOM 23, 714 64, 445 23, 714 502 52.00 05400 RADI OLOGY-DI AGNOSTI C 32, 375 43, 347 32, 375 0 707 54 00 54 00 05500 RADI OLOGY-THERAPEUTI C 55.00 26, 393 12, 451 26, 393 0 56 55.00 05600 RADI OI SOTOPE 8,800 8,800 0 56.00 6,823 28 56.00 57.00 05700 CT SCAN 2, 172 2, 172 0 129 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 2.593 53.772 0 102 58 00 2 593 58 00 42, 037 59.00 05900 CARDIAC CATHETERIZATION 35, 944 35, 944 837 404 59.00 60.00 06000 LABORATORY 0 0 0 1, 230 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 62.00 0 C 0 0 06500 RESPIRATORY THERAPY 65.00 5.177 5.177 0 393 65.00 66.00 06600 PHYSI CAL THERAPY 10, 150 4, 454 10, 150 0 0 66.00 66.01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 66.01 0 0 0 0 0 06602 0/P PHYSICAL THERAPY 66.02 0 10, 370 0 0 66.02 06700 OCCUPATI ONAL THERAPY 67.00 1.658 1,658 0 67.00 06800 SPEECH PATHOLOGY 3, 288 3, 288 68.00 68.00 0 06900 ELECTROCARDI OLOGY 69.00 3, 181 26, 173 3, 181 414 69.00 06901 CARDI AC REHAB 69.01 6,534 447 6,534 47 69.01 70.00 07000 ELECTROENCEPHALOGRAPHY 0 4, 469 0 86 70.00 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 C 0 0 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 6, 057 73.00 20.715 20.715 551 73.00 03020 RENAL ACUTE 76.00 3,525 4,831 3,525 0 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 698 698 0 21 90.00 09005 PATIENT NUTRITION 90.05 1, 930 r 1,930 0 0 90.05 90.07 09007 WOUND CLINIC 8, 952 9, 751 8, 952 0 62 90.07 91.00 09100 EMERGENCY 24, 109 24, 109 0 838 91.00 177, 869 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)
NONREIMBURSABLE COST CENTERS 11, 411 118. 00 118.00 591, 750 1, 250, 935 584, 214 197, 761 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190, 00 0 0 0 194.00 07950 RURAL HEALTH 0 687 0 0 0 194.00 194. 01 07951 RENTAL PROPERTY 0 0 0 0 194. 01 194. 02 07954 FAMILY PRACTICE 12,000 12,000 0 504 194. 02 1, 137 0 194. 03 07952 WELLNESS 13,028 13,028 0 194.03 194. 04 07955 PHYSICIAN PRACTICES 0 251 194.04 5, 364 0

0

0

0 194.06

194.06 07953 SYCAMORE SPORTS MED

Heal th Fina	ncial Systems	UNION HOSPITAL, INC.			In Lieu of Form CMS-2552-10			
COST ALLOCA	TION - STATISTICAL BASIS		Provi der CCN: 15-0023		Peri od:	Worksheet B-1		
					From 01/01/2023 To 12/31/2023			
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG		CAFETERI A		
		PLANT	LINEN SERVICE	(NEW TOTAL	(DI ETARY)	(FTE)		
		(NEW TOTAL	(LI NEN)	SQ FT)				
		SQ FT)						
		7. 00	8. 00	9. 00	10.00	11. 00		
	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	2, 866	0	2, 86	6 0	66	194. 07	
200. 00	Cross Foot Adjustments						200. 00	
201.00	Negative Cost Centers						201.00	
202. 00	Cost to be allocated (per Wkst. B, Part I)	17, 661, 688	2, 033, 391	5, 365, 86	0 1, 555, 366	3, 761, 885	202.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	28. 502960	1. 616210	8. 76619	8 7. 864877	307. 544555	203. 00	
204. 00	Cost to be allocated (per Wkst. B, Part II)	6, 007, 839	236, 564	71, 31	9 391, 615	222, 362	204. 00	
205. 00	Unit cost multiplier (Wkst. B, Part	9. 695630	0. 188029	0. 11651	1. 980244	18. 178712	205. 00	
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00	
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00	

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Period: Worksheet B-1
From 01/01/2023
To 12/31/2023 Date/Time Prepared: 5/21/2024 12:12 pm Provider CCN: 15-0023

				'	0 12/31/2023	5/21/2024 12:	
				INTERNS &	RESI DENTS		
	Cost Center Description	NURSI NG	MEDI CAL		SERVI CES-OTHE	PARAMED ED	
		ADMI NI STRATI O	RECORDS & LI BRARY	RY & FRINGES	R PRGM COSTS	PRGM	
		N (TIME	(GROSS	(INTERNS)	(INTERNS)	(PARAMED RADI OLOGY)	
		SPENT)	CHARGES)			RADI OLOGI)	
		13. 00	16. 00	21.00	22. 00	23. 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 5. 02	00540 NONPATI ENT TELEPHONES 00550 DATA PROCESSI NG						5. 01 5. 02
5. 02	00560 PURCHASING RECEIVING AND STORES			•			5. 02
5. 04	00570 ADMITTING						5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5.06	00590 OTHER ADMIN AND GENERAL						5.06
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A						10. 00 11. 00
13. 00	01300 NURSING ADMINISTRATION	7, 376					13.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	2, 121, 860, 832				16.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	7, 323			21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0		7, 323		22. 00
23.00	02300 PARAMED ED PRGM	0	0			100	23. 00
23. 01	02341 OTHER MED ED	100	0				23. 01
23. 02	02301 PARAMED ED PRGM	0	0				23. 02
30. 00	O3000 ADULTS & PEDIATRICS	2, 583	159, 176, 508	3, 709	3, 709	0	30.00
31. 00	03100 NTENSI VE CARE UNI T	611	30, 609, 278		21	0	31.00
35. 00	02040 I NTENSI VE NURSERY	314	22, 539, 741	1		0	35. 00
41.00	04100 SUBPROVI DER - I RF	176		1		0	41.00
43.00	04300 NURSERY	132	3, 027, 100	0	0	0	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	467	197, 078, 460	1		0	50.00
50. 01 50. 02	05001 CARDI AC SURGERY 05002 WVSC	10	6, 203, 005 140, 385, 991	1		0	50. 01 50. 02
51. 00	05100 RECOVERY ROOM	258			· ·	0	51.00
51. 02	05101 0/P TREATMENT ROOM	42	2, 353, 255	1	· · · · · · · · · · · · · · · · · · ·	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	470		1	l .	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	93, 478, 376	63	63	100	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	61, 835, 759	1		0	55.00
56. 00	05600 RADI OI SOTOPE	0	17, 629, 483	1		0	56. 00
57. 00	05700 CT SCAN	0	64, 938, 478	1	· ·	0	57.00
58. 00 59. 00	05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION	0	17, 154, 339 116, 259, 648	1	· ·	0	58. 00 59. 00
60. 00	06000 LABORATORY	0	199, 808, 666	1	· · · · · · · · · · · · · · · · · · ·	0	60.00
	1 1	O					62.00
	06500 RESPI RATORY THERAPY	365			21	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	15, 022, 945	0	0	0	66.00
66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	_	· ·	0	66. 01
66. 02	06602 0/P PHYSI CAL THERAPY	0	6, 882, 568		l .	0	66.02
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	11, 660, 251	1	· · · · · · · · · · · · · · · · · · ·	0	67. 00 68. 00
69.00	06900 ELECTROCARDI OLOGY	414	5, 100, 829 97, 752, 918		42	0	69.00
69. 01	06901 CARDI AC REHAB	47	2, 397, 947			0	69. 01
70. 00	07000 ELECTROENCEPHALOGRAPHY	39	5, 356, 656	1	· · · · · · · · · · · · · · · · · · ·	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	81, 118, 042		0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	427	497, 809, 905	1	1	0	73. 00
76. 00	03020 RENAL ACUTE	0	3, 608, 056	0	0	0	76. 00
00 00	OUTPATIENT SERVICE COST CENTERS	21	E22 (4E	1 242	1 242	0	90.00
90.00	09000 CLINIC 09005 PATIENT NUTRITION	21	532, 645 336, 479	1	l '	0	90.00
	09007 WOUND CLINIC	62		1	· · · · · · · · · · · · · · · · · · ·	0	90.03
91. 00	09100 EMERGENCY	838		1		0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			<u> </u>			92.00
	SPECIAL PURPOSE COST CENTERS						
118.00		7, 376	2, 121, 860, 832	6, 865	6, 865	100	118. 00
100.00	NONREI MBURSABLE COST CENTERS	1 51	_	1 -	51		100.00
) 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 07950 RURAL HEALTH		0				190. 00 194. 00
	07950 RUKAL HEALTH) 	0			194.00
	07954 FAMILY PRACTICE		0		· ·		194. 02
		1	•				

Heal th Financial Systems

UNION HOSPITAL, INC.

In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0023
From 01/01/2023
To 12/31/2023 Date/Time Prepared:

				1	0 12/31/2023	5/21/2024 12:	
				INTERNS & RESIDENTS			
	Cost Center Description	NURSI NG	MEDI CAL		SERVI CES-OTHE	PARAMED ED	
		ADMI NI STRATI O	RECORDS &	RY & FRINGES	R PRGM COSTS	PRGM	
		N	LI BRARY	(INTERNS)	(INTERNS)	(PARAMED	
		(TIME	(GROSS			RADI OLOGY)	
		SPENT)	CHARGES)				
		13. 00	16. 00	21. 00	22. 00	23. 00	
194. 03 07952		0	0	0	0		194. 03
	PHYSICIAN PRACTICES	0	0	0	0		194. 04
	SYCAMORE SPORTS MED	0	0	0	0		194. 06
194. 07 07956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0	0	0	0	0	194. 07
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	5, 235, 494	911, 751	2, 044, 305	1, 713, 639	116, 609	202.00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	709. 801247	0. 000430	279. 162229	234. 007784	1, 166. 090000	203. 00
204.00	Cost to be allocated (per Wkst. B,	76, 402	155, 768	2, 781	2, 651	313	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	10. 358189	0.000073	0. 379762	0. 362010	3. 130000	205.00
	[11]						
206.00	NAHE adjustment amount to be allocated					0	206.00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,					0.000000	207.00
	Parts III and IV)						

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

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/21/2024 12: 12 pm Provider CCN: 15-0023

				5/21/2024 12	2: 12 pm
	Cost Center Description	OTHER MED ED	PARAMED ED		
		(ASSI GNED	PRGM		
		TIME)	(PARAMED RADI OLOGY)		
		23. 01	23. 02		
	GENERAL SERVICE COST CENTERS	20.01	20.02		
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT				1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5. 01	00540 NONPATIENT TELEPHONES				5. 01
5.02	00550 DATA PROCESSING				5. 02
5.03	00560 PURCHASING RECEIVING AND STORES				5. 03
5.04	00570 ADMI TTI NG				5. 04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE				5. 05
5.06	00590 OTHER ADMIN AND GENERAL				5. 06
7. 00	00700 OPERATION OF PLANT				7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE				8. 00
9. 00	00900 HOUSEKEEPI NG				9.00
10.00	01000 DI ETARY				10.00
11.00	01100 CAFETERI A				11.00
13.00					13.00
16. 00 21. 00					16. 00 21. 00
	02100 L&R SERVICES-SALARY & FRINGES APPRVD 02200 L&R SERVICES-OTHER PRGM COSTS APPRVD				22.00
23. 00	02300 PARAMED ED PRGM				23. 00
23. 00	02341 OTHER MED ED	100			23. 00
	02301 PARAMED ED PRGM	100	100		23. 01
23. 02	INPATIENT ROUTINE SERVICE COST CENTERS		100		7 25.02
30. 00	03000 ADULTS & PEDIATRICS	0	0		30.00
	03100 I NTENSI VE CARE UNI T		ő		31.00
	02040 I NTENSI VE NURSERY	0	Ö		35. 00
41.00	04100 SUBPROVI DER - I RF	0	O		41.00
43.00		o	O		43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0		50.00
50. 01	05001 CARDI AC SURGERY	0	0		50. 01
50. 02	05002 WVSC	0	0		50. 02
51. 00	05100 RECOVERY ROOM	0	0		51.00
51. 02	05101 0/P TREATMENT ROOM	0	0		51.02
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	100		54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		55.00
56. 00	05600 RADI OI SOTOPE	0	0		56.00
57. 00	05700 CT SCAN	0	0		57.00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		59.00
60.00	06000 LABORATORY	0	0		60.00 62.00
62. 00 65. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0 0		
66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	0		65. 00 66. 00
66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		66. 01
66. 02	06602 0/P PHYSICAL THERAPY	0	0		66. 02
	06700 OCCUPATI ONAL THERAPY	0	ő		67.00
68. 00	06800 SPEECH PATHOLOGY	0	0		68.00
69. 00		0	0		69.00
69. 01		0	O		69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	O		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	O		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	O	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	100	0		73.00
76.00	03020 RENAL ACUTE	0	0		76. 00
	OUTPATIENT SERVICE COST CENTERS				
	09000 CLI NI C	0	0		90.00
	09005 PATIENT NUTRITION	0	0		90.05
	09007 WOUND CLINIC	0	0		90.07
	09100 EMERGENCY	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
110 0	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	100	100		110 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	100	100		118. 00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	ا	0		190. 00
	07950 RURAL HEALTH	ا	0		194.00
	107951 RENTAL PROPERTY		o o		194. 00
	207954 FAMILY PRACTICE		0		194. 01
	307952 WELLNESS		0		194. 02
	107955 PHYSICIAN PRACTICES	l ől	o		194. 04
	07953 SYCAMORE SPORTS MED		O		194.06
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Heal th Financial Systems

UNION HOSPITAL, INC.

In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0023 | Period: From 01/01/2023 | To 12/31/2023 | Date/Time Prepared:

					5/21/2024 12:	12 pm
	Cost Center Description	OTHER MED ED (ASSI GNED	PARAMED ED PRGM			
		TIME)	(PARAMED			
			RADI OLOGY)			
		23. 01	23. 02			
194. 07 07	956 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0			194. 07
200.00	Cross Foot Adjustments					200. 00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B,	385, 860	0			202.00
	Part I)					
203.00	Unit cost multiplier (Wkst. B, Part I)	3, 858. 600000	0. 000000			203. 00
204.00	Cost to be allocated (per Wkst. B,	23, 086	0			204.00
	Part II)					
205.00	Unit cost multiplier (Wkst. B, Part	230. 860000	0. 000000			205.00
	11)					
206.00	NAHE adjustment amount to be allocated	o	0			206.00
	(per Wkst. B-2)					
207. 00	NAHE unit cost multiplier (Wkst. D,	0. 000000	0. 000000			207.00
	Parts III and IV)					
	•	·		•		•

				o 12/31/2023	Date/Time Pre 5/21/2024 12:	pared:
		Title	XVIII	Hospi tal	PPS	12 piii
		11110	XVIII	Costs	113	
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
oost center bescription	(from Wkst.	Adj.	10101 00313	Di sal I owance	10141 00313	
	B, Part I,	7.00		Di dai i dilando		
	col . 26)					
	1. 00	2. 00	3, 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	71, 928, 802		71, 928, 802	0	71, 928, 802	30.00
31.00 03100 INTENSIVE CARE UNIT	16, 416, 031		16, 416, 031		16, 416, 031	31.00
35. 00 02040 I NTENSI VE NURSERY	5, 732, 021		5, 732, 021		5, 732, 021	35.00
41. 00 04100 SUBPROVI DER - RF	3, 536, 546		3, 536, 546	0	3, 536, 546	41.00
43. 00 04300 NURSERY	1, 720, 758		1, 720, 758	0	1, 720, 758	43.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	29, 889, 304		29, 889, 304	17, 977	29, 907, 281	50.00
50. 01 05001 CARDI AC SURGERY	3, 379, 031		3, 379, 031	0	3, 379, 031	50. 01
50. 02 05002 WVSC	18, 154, 465		18, 154, 465	0	18, 154, 465	50. 02
51.00 05100 RECOVERY ROOM	4, 217, 019		4, 217, 019	0	4, 217, 019	51.00
51.02 05101 0/P TREATMENT ROOM	2, 259, 688		2, 259, 688	0	2, 259, 688	51.02
52.00 05200 DELIVERY ROOM & LABOR ROOM	9, 987, 219		9, 987, 219	0	9, 987, 219	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	19, 326, 721		19, 326, 721	170, 726	19, 497, 447	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	9, 195, 395		9, 195, 395	0	9, 195, 395	55.00
56. 00 05600 RADI 0I SOTOPE	3, 258, 791		3, 258, 791	0	3, 258, 791	56.00
57. 00 05700 CT SCAN	5, 111, 102		5, 111, 102	0	5, 111, 102	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	2, 955, 155		2, 955, 155	0	2, 955, 155	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	29, 023, 938		29, 023, 938	0	29, 023, 938	59. 00
60. 00 06000 LABORATORY	23, 440, 979		23, 440, 979	0	23, 440, 979	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 831, 375		1, 831, 375		1, 831, 375	
65. 00 06500 RESPI RATORY THERAPY	7, 833, 246	0			7, 833, 246	
66. 00 06600 PHYSI CAL THERAPY	5, 470, 807	0	5, 470, 807		5, 470, 807	66. 00
66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	(0	66. 01
66. 02 06602 0/P PHYSI CAL THERAPY	2, 206, 044	0	2, 206, 044		2, 206, 044	66. 02
67. 00 06700 OCCUPATI ONAL THERAPY	2, 999, 259	0	2, 999, 259		2, 999, 259	67.00
68. 00 06800 SPEECH PATHOLOGY	1, 565, 828	0	1, 565, 828		1, 565, 828	
69. 00 06900 ELECTROCARDI OLOGY	8, 012, 433		8, 012, 433		8, 012, 433	
69. 01 06901 CARDI AC REHAB	1, 047, 405		1, 047, 405		1, 047, 405	1
70. 00 07000 ELECTROENCEPHALOGRAPHY	2, 492, 441		2, 492, 441		2, 492, 441	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	47.040.444		17.040.44		0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	17, 948, 146		17, 948, 146		17, 948, 146	
73.00 07300 DRUGS CHARGED TO PATIENTS 76.00 03020 RENAL ACUTE	103, 558, 091		103, 558, 091		103, 558, 091	73.00
	2, 147, 738		2, 147, 738	5 U	2, 147, 738	76.00
OUTPATIENT SERVICE COST CENTERS 90. 00 O9000 CLINIC	432, 038		432, 038		432, 038	00 00
90. 00 09000 CLI NI C 90. 05 09005 PATI ENT NUTRI TI ON	162, 352		162, 352		432, 038 162, 352	
90. 07 09007 WOUND CLINIC	2, 817, 062		2, 817, 062		2, 817, 062	
91. 00 09100 EMERGENCY	19, 349, 274		19, 349, 274			
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	11, 323, 990		11, 323, 990		11, 323, 990	
200.00 Subtotal (see instructions)	450, 730, 494	0			450, 961, 797	
201.00 Less Observation Beds	11, 323, 990	O	11, 323, 990	·	11, 323, 990	
202.00 Total (see instructions)	439, 406, 504	0				
202.00 10tal (300 1113t1 40t1 0113)	1 437, 400, 304	· ·	1 137, 100, 302	231, 303	137,037,007	1202.00

Date/Time Prepared: 12/31/2023 5/21/2024 12:12 pm Title XVIII Hospi tal PPS Charges Total (col. 6 Cost or Other Cost Center Description Inpati ent Outpati ent TEFRA + col. 7) Ratio Inpati ent Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 135 100 029 30.00 03000 ADULTS & PEDIATRICS 135, 100, 029 30.00 31.00 03100 INTENSIVE CARE UNIT 30, 609, 278 30, 609, 278 31.00 02040 INTENSIVE NURSERY 22, 539, 741 22, 539, 741 35.00 35.00 41.00 04100 SUBPROVI DER - I RF 5, 788, 465 5, 788, 465 41.00 04300 NURSERY 3, 027, 100 43.00 3, 027, 100 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 63, 335, 860 133, 742, 600 197, 078, 460 0.151662 0.000000 50.00 05001 CARDI AC SURGERY 6, 197, 505 6, 203, 005 0.544741 50.01 0.000000 5, 500 50.01 140, 235, 991 140, 385, 991 0. 129318 0.000000 50.02 05002 WVSC 150,000 50 02 51.00 05100 RECOVERY ROOM 3, 579, 082 8, 593, 722 12, 172, 804 0.346430 0.000000 51.00 51.02 05101 0/P TREATMENT ROOM 25, 230 2, 328, 025 2, 353, 255 0.960239 0.000000 51.02 05200 DELIVERY ROOM & LABOR ROOM 0. 308062 52 00 27, 111, 168 5, 308, 336 32, 419, 504 0.000000 52 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 25, 450, 304 68, 028, 072 93, 478, 376 0.206751 0.000000 54.00 05500 RADI OLOGY-THERAPEUTI C 55 00 2, 819, 074 59, 016, 685 61, 835, 759 0.148707 0.000000 55.00 1, 298, 094 05600 RADI OI SOTOPE 16, 331, 389 17, 629, 483 0.000000 56,00 0.184849 56,00 05700 CT SCAN 64, 938, 478 57 00 23, 303, 324 41, 635, 154 0.078707 0.000000 57 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 4, 046, 346 13, 107, 993 17, 154, 339 0. 172269 0.000000 58.00 58.00 05900 CARDI AC CATHETERI ZATI ON 59.00 37, 905, 475 78, 354, 173 116, 259, 648 0. 249648 0.000000 59.00 73, 961, 894 06000 LABORATORY 60.00 125, 846, 772 199, 808, 666 0.117317 0.000000 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 2, 822, 613 694, 190 3, 516, 803 0. 520750 0.000000 62.00 65.00 06500 RESPIRATORY THERAPY 40, 951, 790 3, 215, 841 44, 167, 631 0.177353 0.000000 65.00 06600 PHYSI CAL THERAPY 8, 716, 730 15, 022, 945 0.364163 0.000000 66.00 6, 306, 215 66.00 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 66.01 0 0 0.000000 0.000000 66.01 66.02 06602 0/P PHYSI CAL THERAPY O 6,882,568 6, 882, 568 0.320526 0.000000 66.02 06700 OCCUPATI ONAL THERAPY 7, 103, 144 4, 557, 107 0. 257221 67.00 11, 660, 251 0.000000 67.00 3, 461, 548 06800 SPEECH PATHOLOGY 1, 639, 281 5, 100, 829 0.306975 0.000000 68.00 68.00 06900 ELECTROCARDI OLOGY 21, 735, 586 97, 752, 918 69.00 76, 017, 332 0.081966 0.000000 69.00 69. 01 06901 CARDI AC REHAB 114, 745 2, 283, 202 2, 397, 947 0.436792 0.000000 69.01 70.00 07000 ELECTROENCEPHALOGRAPHY 757, 695 4, 598, 961 5, 356, 656 0.465298 0.000000 70.00 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 000000 0.000000 71 00 Γ 0 07200 IMPL. DEV. CHARGED TO PATIENTS 24, 929, 337 72.00 56, 188, 705 81, 118, 042 0. 221260 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 35, 251, 549 462, 558, 356 497, 809, 905 0.208027 0.000000 73.00 73.00 03020 RENAL ACUTE 76.00 3, 472, 674 135, 382 3, 608, 056 0.595262 0.000000 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 125 532, 520 532, 645 0.811118 0.000000 90.00 09005 PATIENT NUTRITION 0. 482503 90.05 336, 479 336, 479 0.000000 90.05 90 07 09007 WOUND CLINIC 20,000 9, 749, 908 9, 769, 908 0. 288341 0.000000 90.07 91.00 09100 EMERGENCY 46, 813, 006 107, 155, 383 153, 968, 389 0.125670 0.000000 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 11, 487, 723 12, 588, 756 24, 076, 479 0. 470334 0.000000 92.00 200.00 Subtotal (see instructions) 672, 063, 967 1, 449, 796, 865 2, 121, 860, 832 200.00 201 00 Less Observation Beds 201.00

672, 063, 967 1, 449, 796, 865 2, 121, 860, 832

202.00

202.00

Total (see instructions)

Health Financial Systems	UNI ON HOSPI TAL, INC.	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0023	Peri od: Worksheet C From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared: 5/21/2024 12:12 pm

				5/21/2024 12:12 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
35. 00 02040 I NTENSI VE NURSERY				35. 00
41. 00 04100 SUBPROVI DER - I RF				41.00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 151753			50.00
50. 01 05001 CARDI AC SURGERY	0. 544741			50. 01
50. 02 05002 WVSC	0. 129318			50.02
51. 00 05100 RECOVERY ROOM	0. 346430			51.00
51.02 05101 0/P TREATMENT ROOM	0. 960239			51.02
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 308062			52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 208577			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 148707			55.00
56. 00 05600 RADI OI SOTOPE	0. 184849			56.00
57. 00 05700 CT SCAN	0. 078707			57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 172269			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 249648			59.00
60. 00 06000 LABORATORY	0. 117317			60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 520750			62.00
65. 00 06500 RESPIRATORY THERAPY	0. 177353			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 364163			66.00
66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000			66. 01
66. 02 06602 0/P PHYSI CAL THERAPY	0. 320526			66. 02
67. 00 06700 OCCUPATI ONAL THERAPY	0. 257221			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 306975			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 081966			69.00
69. 01 06901 CARDI AC REHAB	0. 436792			69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 465298			70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 221260			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 208027			73.00
76. 00 03020 RENAL ACUTE	0. 595262			76.00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLINIC	0. 811118			90.00
90. 05 09005 PATI ENT NUTRI TI ON	0. 482503			90.05
90. 07 09007 WOUND CLINIC	0. 288341			90.07
91. 00 09100 EMERGENCY	0. 125947			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 470334			92.00
200.00 Subtotal (see instructions)	3. 170004			200.00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202.00
202. 00 10tal (000 1110ti doti 0110)	1			1202.00

				o 12/31/2023	Date/Time Pre 5/21/2024 12:	pared:
		Ti +I	e XIX	Hospi tal	Cost	12 piii
		11 (1	CAIA	Costs	0031	
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
oost center bescription	(from Wkst.	Adj .	10101 00313	Di sal I owance	10101 00313	
	B, Part I,	naj .		Di Sai i Gwarice		
	col . 26)					
	1, 00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	71, 928, 802		71, 928, 802	0	71, 928, 802	30.00
31. 00 03100 INTENSIVE CARE UNIT	16, 416, 031		16, 416, 031		16, 416, 031	31.00
35. 00 02040 NTENSI VE NURSERY	5, 732, 021		5, 732, 021		5, 732, 021	35.00
41. 00 04100 SUBPROVI DER - RF	3, 536, 546		3, 536, 546		3, 536, 546	41.00
43. 00 04300 NURSERY	1, 720, 758		1, 720, 758		1, 720, 758	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	29, 889, 304		29, 889, 304	17, 977	29, 907, 281	50.00
50. 01 05001 CARDI AC SURGERY	3, 379, 031		3, 379, 031	0	3, 379, 031	50. 01
50. 02 05002 WVSC	18, 154, 465		18, 154, 465	0	18, 154, 465	50. 02
51.00 05100 RECOVERY ROOM	4, 217, 019		4, 217, 019	0	4, 217, 019	51.00
51.02 05101 0/P TREATMENT ROOM	2, 259, 688		2, 259, 688	0	2, 259, 688	51.02
52.00 05200 DELIVERY ROOM & LABOR ROOM	9, 987, 219		9, 987, 219	0	9, 987, 219	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	19, 326, 721		19, 326, 721		19, 497, 447	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	9, 195, 395		9, 195, 395	0	9, 195, 395	55.00
56. 00 05600 RADI 0I SOTOPE	3, 258, 791		3, 258, 791	0	3, 258, 791	56.00
57. 00 05700 CT SCAN	5, 111, 102		5, 111, 102	0	5, 111, 102	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	2, 955, 155		2, 955, 155	0	2, 955, 155	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	29, 023, 938		29, 023, 938	0	29, 023, 938	59.00
60. 00 06000 LABORATORY	23, 440, 979		23, 440, 979	0	23, 440, 979	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 831, 375		1, 831, 375	0	1, 831, 375	62.00
65. 00 06500 RESPIRATORY THERAPY	7, 833, 246	0	7, 833, 246	0	7, 833, 246	65.00
66. 00 06600 PHYSI CAL THERAPY	5, 470, 807	0	5, 470, 807	0	5, 470, 807	66.00
66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	C	0	0	66. 01
66. 02 06602 0/P PHYSI CAL THERAPY	2, 206, 044	0	2, 206, 044	0	2, 206, 044	66. 02
67. 00 06700 OCCUPATI ONAL THERAPY	2, 999, 259	0	2, 999, 259	0	2, 999, 259	67.00
68.00 06800 SPEECH PATHOLOGY	1, 565, 828	0	1, 565, 828	0	1, 565, 828	68. 00
69. 00 06900 ELECTROCARDI OLOGY	8, 012, 433		8, 012, 433	0	8, 012, 433	69. 00
69. 01 06901 CARDI AC REHAB	1, 047, 405		1, 047, 405	0	1, 047, 405	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	2, 492, 441		2, 492, 441	0	2, 492, 441	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		(0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	17, 948, 146		17, 948, 146		17, 948, 146	
73.00 O7300 DRUGS CHARGED TO PATIENTS	103, 558, 091		103, 558, 091		103, 558, 091	73.00
76. 00 03020 RENAL ACUTE	2, 147, 738		2, 147, 738	0	2, 147, 738	76. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	432, 038		432, 038		432, 038	
90. 05 09005 PATI ENT NUTRI TI ON	162, 352		162, 352		162, 352	
90. 07 09007 WOUND CLINIC	2, 817, 062		2, 817, 062		2, 817, 062	
91. 00 09100 EMERGENCY	19, 349, 274		19, 349, 274		19, 391, 874	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	11, 323, 990	_	11, 323, 990		11, 323, 990	
200.00 Subtotal (see instructions)	450, 730, 494	0	,,	·	450, 961, 797	
201.00 Less Observation Beds	11, 323, 990	-	11, 323, 990		11, 323, 990	
202.00 Total (see instructions)	439, 406, 504	0	439, 406, 504	231, 303	439, 637, 807	J202. 00

Date/Time Prepared: 12/31/2023 5/21/2024 12:12 pm Title XIX Hospi tal Cost Charges Total (col. 6 Cost or Other Cost Center Description Inpati ent Outpati ent TEFRA + col. 7) Ratio Inpati ent Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 135 100 029 30.00 03000 ADULTS & PEDIATRICS 135, 100, 029 30.00 31.00 03100 INTENSIVE CARE UNIT 30, 609, 278 30, 609, 278 31.00 02040 INTENSIVE NURSERY 22, 539, 741 22, 539, 741 35.00 35.00 41.00 04100 SUBPROVI DER - I RF 5, 788, 465 5, 788, 465 41.00 04300 NURSERY 3, 027, 100 43.00 3, 027, 100 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 63, 335, 860 133, 742, 600 197, 078, 460 0.151662 0.000000 50.00 05001 CARDI AC SURGERY 6, 197, 505 6, 203, 005 0.544741 50.01 0.000000 5, 500 50.01 140, 235, 991 140, 385, 991 0. 129318 0.000000 50.02 05002 WVSC 150,000 50 02 51.00 05100 RECOVERY ROOM 3, 579, 082 8, 593, 722 12, 172, 804 0.346430 0.000000 51.00 51.02 05101 0/P TREATMENT ROOM 25, 230 2, 328, 025 2, 353, 255 0.960239 0.000000 51.02 05200 DELIVERY ROOM & LABOR ROOM 0. 308062 52 00 27, 111, 168 5, 308, 336 32, 419, 504 0.000000 52 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 25, 450, 304 68, 028, 072 93, 478, 376 0.206751 0.000000 54.00 05500 RADI OLOGY-THERAPEUTI C 59, 016, 685 55 00 2, 819, 074 61, 835, 759 0.148707 0.000000 55.00 1, 298, 094 05600 RADI OI SOTOPE 16, 331, 389 17, 629, 483 0.000000 56,00 0.184849 56,00 05700 CT SCAN 64, 938, 478 57 00 23, 303, 324 41, 635, 154 0.078707 0.000000 57 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 4, 046, 346 13, 107, 993 17, 154, 339 0. 172269 0.000000 58.00 58.00 05900 CARDI AC CATHETERI ZATI ON 59.00 37, 905, 475 78, 354, 173 116, 259, 648 0. 249648 0.000000 59.00 73, 961, 894 06000 LABORATORY 60.00 125, 846, 772 199, 808, 666 0.117317 0.000000 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 2, 822, 613 694, 190 3, 516, 803 0. 520750 0.000000 62.00 65.00 06500 RESPIRATORY THERAPY 40, 951, 790 3, 215, 841 44, 167, 631 0.177353 0.000000 65.00 06600 PHYSI CAL THERAPY 8, 716, 730 15, 022, 945 0.364163 0.000000 66.00 6, 306, 215 66.00 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 66.01 0 0 0.000000 0.000000 66.01 66.02 06602 0/P PHYSI CAL THERAPY O 6,882,568 6, 882, 568 0.320526 0.000000 66.02 06700 OCCUPATI ONAL THERAPY 7, 103, 144 4, 557, 107 0. 257221 67.00 11, 660, 251 0.000000 67.00 3, 461, 548 06800 SPEECH PATHOLOGY 1, 639, 281 5, 100, 829 0.306975 0.000000 68.00 68.00 06900 ELECTROCARDI OLOGY 21, 735, 586 97, 752, 918 69.00 76, 017, 332 0.081966 0.000000 69.00 69. 01 06901 CARDI AC REHAB 114, 745 2, 283, 202 2, 397, 947 0.436792 0.000000 69.01 70.00 07000 ELECTROENCEPHALOGRAPHY 757, 695 4, 598, 961 5, 356, 656 0.465298 0.000000 70.00 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 000000 0.000000 71 00 Γ 0 07200 IMPL. DEV. CHARGED TO PATIENTS 24, 929, 337 72.00 56, 188, 705 81, 118, 042 0. 221260 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 35, 251, 549 462, 558, 356 497, 809, 905 0.208027 0.000000 73.00 73.00 03020 RENAL ACUTE 76.00 3, 472, 674 135, 382 3, 608, 056 0.595262 0.000000 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 125 532, 520 532, 645 0.811118 0.000000 90.00 09005 PATIENT NUTRITION 0. 482503 90.05 336, 479 336, 479 0.000000 90.05 90 07 09007 WOUND CLINIC 20,000 9, 749, 908 9, 769, 908 0. 288341 0.000000 90.07 91.00 09100 EMERGENCY 46, 813, 006 107, 155, 383 153, 968, 389 0.125670 0.000000 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 11, 487, 723 12, 588, 756 24, 076, 479 0. 470334 0.000000 92.00 200.00 Subtotal (see instructions) 672, 063, 967 1, 449, 796, 865 2, 121, 860, 832 200.00 201 00 Less Observation Beds 201. 00

672, 063, 967 1, 449, 796, 865 2, 121, 860, 832

202.00

202.00

Total (see instructions)

Health Financial Systems	UNION HOSPITAL, INC.	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0023	Peri od: Worksheet C From 01/01/2023 Part I Date/Time Prepared: 5/21/2024 13:13 pm

			10 12/31/2023	5/21/2024 12:12 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
35. 00 02040 I NTENSI VE NURSERY				35.00
41. 00 04100 SUBPROVI DER - I RF				41.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 000000			50.00
50. 01 05001 CARDI AC SURGERY	0. 000000			50. 01
50. 02 05002 WVSC	0. 000000			50. 02
51.00 05100 RECOVERY ROOM	0. 000000			51.00
51.02 05101 0/P TREATMENT ROOM	0. 000000			51.02
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			55.00
56. 00 05600 RADI 0I SOTOPE	0. 000000			56.00
57. 00 05700 CT SCAN	0. 000000			57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.00
60. 00 06000 LABORATORY	0. 000000			60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			62.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.00
66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000			66. 01
66. 02 06602 0/P PHYSI CAL THERAPY	0. 000000			66. 02
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
69. 01 06901 CARDI AC REHAB	0. 000000			69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
76. 00 03020 RENAL ACUTE	0. 000000			76.00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 000000			90.00
90. 05 09005 PATI ENT NUTRI TI ON	0. 000000			90.05
90. 07 09007 WOUND CLINIC	0. 000000			90.07
91. 00 09100 EMERGENCY	0. 000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202.00
	·			•

Health Financial Systems	UNI ON HOSPI	TAL, INC.		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITA	AL COSTS	Provi der C		Period: From 01/01/2023 To 12/31/2023	Date/Time Pre 5/21/2024 12:	pared: 12 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst.	Swing Bed Adjustment	Reduced Capi tal Rel ated Cost	Total Patient Days	Per Diem (col. 3 / col. 4)	
	B, Part II, col. 26)		(col. 1 - col. 2)			
	1. 00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	6, 601, 256		6, 601, 25		99. 38	
31.00 INTENSIVE CARE UNIT	1, 333, 276		1, 333, 27			
35. 00 I NTENSI VE NURSERY	314, 615		314, 61			
41. 00 SUBPROVI DER - I RF	472, 281	0	472, 28			
43. 00 NURSERY	27, 242		27, 24			
200.00 Total (lines 30 through 199)	8, 748, 670		8, 748, 67	83, 667		200.00
Cost Center Description	Inpati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col. 6)				
	6, 00	7.00	-			
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	1	<u>. </u>		
30. 00 ADULTS & PEDIATRICS	19, 811	1, 968, 817				30.00
31. 00 INTENSIVE CARE UNIT	1, 910					31.00
35. 00 INTENSIVE NURSERY	0	000,027				35.00
41. 00 SUBPROVI DER - I RF	1, 648	241, 036				41.00
43. 00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	23, 369	2, 590, 382				200.00

ABBORTI OMENT OF ANDLE AND LEADY OF DAD T	00100 10311		011 45 0000		u 01 101111 CM3-2	2002 10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT.	AL COSTS	Provi der C	CN: 15-0023	Peri od:	Worksheet D	
				From 01/01/2023	Part II	
				To 12/31/2023	Date/Time Pre 5/21/2024 12:	parea:
			20111			12 pm
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS			•		•	
50. 00 05000 OPERATING ROOM	3, 641, 500	197, 078, 460	0. 01847	7 22, 600, 959	417, 598	50.00
50. 01 05001 CARDI AC SURGERY	236, 522					
50. 02 05002 WVSC	2, 181, 063					
51. 00 05100 RECOVERY ROOM	196, 332					
51. 02 05100 RECOVERT ROOM 51. 02 05101 0/P TREATMENT ROOM						
	708, 209					
52.00 05200 DELIVERY ROOM & LABOR ROOM	879, 260					1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 402, 373					
55. 00 05500 RADI OLOGY-THERAPEUTI C	1, 567, 752					
56. 00 05600 RADI 01 SOTOPE	471, 169	17, 629, 483	0. 02672	451, 249	12, 060	56.00
57. 00 05700 CT SCAN	287, 737	64, 938, 478	0.00443	8, 964, 480	39, 722	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	457, 081	17, 154, 339	0. 02664	1, 148, 030	30, 589	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 661, 521	116, 259, 648				
60. 00 06000 LABORATORY	561, 355					
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 787					
65. 00 06500 RESPIRATORY THERAPY						
	528, 507					
66. 00 06600 PHYSI CAL THERAPY	290, 109					
66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0				1	
66. 02 06602 0/P PHYSI CAL THERAPY	20, 265					
67. 00 06700 OCCUPATI ONAL THERAPY	49, 398				8, 248	67.00
68. 00 06800 SPEECH PATHOLOGY	92, 393	5, 100, 829	0. 01811	3 510, 755	9, 251	68.00
69. 00 06900 ELECTROCARDI OLOGY	768, 973	97, 752, 918	0. 00786	6 8, 112, 409	63, 812	69.00
69. 01 06901 CARDI AC REHAB	204, 569	2, 397, 947	0. 08531	0 45, 150	3, 852	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	59, 144					
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0					
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	20, 657	-	l .			
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 515, 343					
76. 00 03020 RENAL ACUTE	101, 447	3, 608, 056	0. 02811	7 1, 446, 801	40, 680	76.00
OUTPATIENT SERVICE COST CENTERS	T		1		Ι .	
90. 00 09000 CLI NI C	20, 403					
90. 05 09005 PATIENT NUTRITION	53, 450				1	
90. 07 09007 WOUND CLINIC	267, 814	9, 769, 908				90.07
91. 00 09100 EMERGENCY	1, 091, 273	153, 968, 389	0. 00708	15, 523, 899	110, 033	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 039, 259	24, 076, 479	0. 04316			92.00
200.00 Total (lines 50 through 199)		1, 924, 796, 219		156, 453, 978		
1.1.1. (, .= ., . , 5, 2, 7	1	1	1,, .20	,

Health Financial Systems	UNI ON HOSPI	TAL INC		In Lie	u of Form CMS-	2552 10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA		TS Provider C		Period: From 01/01/2023 To 12/31/2023	Worksheet D Part III Date/Time Pre 5/21/2024 12:	epared:
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Healtl	Allied Health	All Other	
	Program	Program	Post-Stepdow	Cost	Medi cal	
	Post-Stepdown		Adjustments		Educati on	
	Adjustments				Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0 0	0	
31.00 03100 INTENSIVE CARE UNIT	0	0		0 0	0	31.00
35.00 02040 INTENSIVE NURSERY	0	0		0 0	0	35.00
41. 00 04100 SUBPROVI DER - I RF	0	0		0 0	0	41.00
43. 00 04300 NURSERY	0	0		0 0	0	43.00
200.00 Total (lines 30 through 199)	0	0		0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patien	Per Diem	I npati ent	
	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col. 6)		
		minus col. 4)				
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						_
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	,			1
31.00 03100 INTENSIVE CARE UNIT		0	6, 69		1, 910	
35. 00 02040 I NTENSI VE NURSERY		0	4, 53		0	
41. 00 04100 SUBPROVI DER - I RF	0	0	3, 22		1, 648	
43. 00 04300 NURSERY		0				
200.00 Total (lines 30 through 199)		0	83, 66	7	23, 369	200.00
Cost Center Description	Inpatient					
	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31. 00 03100 I NTENSI VE CARE UNI T	0					31.00
35. 00 02040 I NTENSI VE NURSERY	0					35.00
41. 00 04100 SUBPROVI DER - I RF	0					41.00
43. 00 04300 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	0					200.00

Health Financial Systems	UNI ON HOSPI TAL	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCI LLARY SERVI CE OTHER PASS	Provi der CCN: 15-0023	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared:

					10 12/31/2023	5/21/2024 12:	
			Title	· XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1. 00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0		0	0	00.00
	05001 CARDI AC SURGERY	0	0)	0	0	
	05002 WVSC	0	0)	0	0	50. 02
	05100 RECOVERY ROOM	0	0)	0	0	51.00
	05101 0/P TREATMENT ROOM	0	0)	0	0	51.02
	05200 DELIVERY ROOM & LABOR ROOM	0	0)	0	0	52.00
	05400 RADI OLOGY-DI AGNOSTI C	0	0)	0	116, 609	
	05500 RADI OLOGY-THERAPEUTI C	0	0)	0	0	55.00
	05600 RADI OI SOTOPE	0	0)	0	0	56.00
	05700 CT SCAN	0	0)	0	0	57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0)	0	0	
	05900 CARDI AC CATHETERI ZATI ON	0	0)	0	0	59.00
	06000 LABORATORY	0	0)	0	0	60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0)	0	0	62.00
	06500 RESPI RATORY THERAPY	0	0)	0	0	65.00
	06600 PHYSI CAL THERAPY	0	0)	0	0	66.00
	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0)	0	0	66. 01
	06602 0/P PHYSICAL THERAPY	0	0)	0	0	66. 02
	06700 OCCUPATI ONAL THERAPY	0	0)	0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0)	0	0	68. 00
	06900 ELECTROCARDI OLOGY	0	0)	0	0	69.00
69. 01	06901 CARDI AC REHAB	0	0		0	0	69. 01
	07000 ELECTROENCEPHALOGRAPHY	0	0)	0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	385, 860	73.00
76.00	03020 RENAL ACUTE	0	0		0 0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0		0 0	0	90.00
	09005 PATIENT NUTRITION	0	0)	0	0	90. 05
90.07	09007 WOUND CLINIC	0	0		0 0	0	90. 07
91.00	09100 EMERGENCY	0	0		0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
200.00	Total (lines 50 through 199)	0	0)	0 0	502, 469	200.00

Health Financial Systems	UNION HOSPITAL, INC.	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT AN	ICILLARY SERVICE OTHER PASS Provider CCN: 15-0023	Peri od: Worksheet D		
THROUGH COSTS		From 01/01/2023 Part IV		

11111000	11 00313			Т	o 12/31/2023	Date/Time Pre 5/21/2024 12:	
			Title	XVIII	Hospi tal	PPS	. <u></u>
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
		Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
				and 4)		(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0				
	05001 CARDI AC SURGERY	0	0	· -	· · ·		
	05002 WVSC	0	0	(,		
	05100 RECOVERY ROOM	0	0	(
	05101 O/P TREATMENT ROOM	0	0	(2, 353, 255		
	05200 DELIVERY ROOM & LABOR ROOM	0	0	(32, 419, 504		
	05400 RADI OLOGY-DI AGNOSTI C	0	116, 609	116, 609	93, 478, 376	0. 001247	54.00
	05500 RADI OLOGY-THERAPEUTI C	0	0	(61, 835, 759		
56.00	05600 RADI 0I SOTOPE	0	0	C	17, 629, 483	0.000000	56.00
	05700 CT SCAN	0	0	C	64, 938, 478	0.000000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	C	17, 154, 339	0. 000000	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	C	116, 259, 648	0.000000	59.00
60.00	06000 LABORATORY	0	0	C	199, 808, 666	0.000000	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	C	3, 516, 803	0.000000	62.00
65.00	06500 RESPI RATORY THERAPY	0	0	C	44, 167, 631	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	0	0	C	15, 022, 945	0.000000	66.00
66.01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	C	0	0.000000	66. 01
66.02	06602 0/P PHYSICAL THERAPY	0	0	C	6, 882, 568	0.000000	66. 02
67.00	06700 OCCUPATI ONAL THERAPY	0	0	(11, 660, 251	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	(5, 100, 829	0.000000	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0	(97, 752, 918	0.000000	69.00
69. 01	06901 CARDI AC REHAB	0	0	(2, 397, 947	0.000000	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	(5, 356, 656	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(0	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(81, 118, 042	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	385, 860	385, 860	497, 809, 905	0. 000775	73.00
76.00	03020 RENAL ACUTE	0	0	(76.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	C	532, 645	0.000000	90.00
90.05	09005 PATIENT NUTRITION	0	0		336, 479	0.000000	90. 05
90. 07	09007 WOUND CLINIC	0	0		9, 769, 908	0.000000	90. 07
91.00	09100 EMERGENCY	0	0				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		24, 076, 479	0.000000	92.00
200.00	Total (lines 50 through 199)	0	502, 469	502, 469	1, 924, 796, 219		200. 00
		. '	•	•	•	'	•

Health Financial Systems	UNI ON HOSPI TAI	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-0023	From 01/01/2023	Worksheet D Part IV Date/Time Prepared:

				1	o 12/31/2023	Date/Time Pre 5/21/2024 12:	pared:
			Title	XVIII	Hospi tal	PPS	12 μιι
	Cost Center Description	Outpati ent	Inpatient	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col . 6 ÷	onal goo	Costs (col. 8		Costs (col. 9	
		col. 7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11.00	12.00	13.00	
ANC	LLARY SERVICE COST CENTERS	'			1		
50.00 050	OO OPERATING ROOM	0. 000000	22, 600, 959	(33, 347, 792	0	50.00
50. 01 050	01 CARDI AC SURGERY	0. 000000	2, 631, 966	(5, 049	0	50. 01
50. 02 050	02 WVSC	0. 000000	102, 784	(27, 178, 214	0	50.02
51.00 051	OO RECOVERY ROOM	0. 000000	1, 284, 498	(2, 217, 433	0	51.00
51.02 051	01 0/P TREATMENT ROOM	0. 000000	265		660, 605	0	51.02
52.00 052	OO DELIVERY ROOM & LABOR ROOM	0. 000000	109, 601		1, 091	0	52.00
54.00 054	00 RADI OLOGY-DI AGNOSTI C	0. 001247	10, 158, 010	12, 667	12, 852, 233	16, 027	54.00
55.00 055	00 RADI OLOGY-THERAPEUTI C	0. 000000	714, 800		19, 331, 212	0	55.00
56.00 056	00 RADI OI SOTOPE	0. 000000	451, 249		5, 255, 741	0	56.00
57.00 057	OO CT SCAN	0. 000000	8, 964, 480			0	57.00
58.00 058	OO MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	1, 148, 030		2, 512, 500	0	58. 00
	OO CARDI AC CATHETERI ZATI ON	0. 000000	15, 361, 948				59.00
60.00 060	00 LABORATORY	0. 000000	24, 306, 934		9, 969, 250		60.00
	00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	1, 039, 541				62.00
	00 RESPI RATORY THERAPY	0. 000000	12, 801, 592				65.00
	00 PHYSI CAL THERAPY	0. 000000	2, 772, 161		73, 835		66.00
	01 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	0	1	0	0	66. 01
	02 O/P PHYSICAL THERAPY	0. 000000	0		0	0	66. 02
	OO OCCUPATI ONAL THERAPY	0. 000000	1, 947, 025		15, 410	0	67.00
	OO SPEECH PATHOLOGY	0. 000000	510, 755				68.00
	OO ELECTROCARDI OLOGY	0. 000000	8, 112, 409				69.00
	01 CARDI AC REHAB	0. 000000	45, 150				69. 01
	OO ELECTROENCEPHALOGRAPHY	0. 000000	293, 753		1		70.00
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0			0	71.00
	00 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	9, 515, 982		17, 779, 097	0	72.00
	OO DRUGS CHARGED TO PATIENTS	0. 000775	12, 311, 995		· · ·	120, 042	73. 00
	20 RENAL ACUTE	0. 000000	1, 446, 801	.,		•	76. 00
	PATIENT SERVICE COST CENTERS		.,,				
	DO CLINIC	0. 000000	0		245, 621	0	90.00
90. 05 090	05 PATIENT NUTRITION	0. 000000	0	1 (160	0	90. 05
	07 WOUND CLINIC	0. 000000	0				90. 07
	OO EMERGENCY	0. 000000	15, 523, 899				91.00
	OO OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	2, 297, 391				92.00
200.00	Total (lines 50 through 199)		156, 453, 978				200.00

| Peri od: | Worksheet D | From 01/01/2023 | Part V | To | 12/31/2023 | Date/Time Prepared: Provider CCN: 15-0023

				Т	o 12/31/2023	Date/Time Pre 5/21/2024 12:	
			Title	XVIII	Hospi tal	PPS	12 piii
				Charges	noopi tai	Costs	
Cost Center Desc	cription	Cost to	PPS	Cost	Cost	PPS Services	
		Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Services (see		Services Not	(222 11.231)	
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.		Ded. & Coins.	Ded. & Coins.		
		9		(see inst.)	(see inst.)		
		1. 00	2.00	3.00	4.00	5. 00	
ANCILLARY SERVICE COST	T CENTERS	•		•			
50.00 05000 OPERATING ROOM		0. 151662	33, 347, 792	0	0	5, 057, 593	50.00
50. 01 05001 CARDI AC SURGERY		0. 544741	5, 049	0	0	2, 750	50. 01
50. 02 05002 WVSC		0. 129318	27, 178, 214	0	0	3, 514, 632	50. 02
51.00 05100 RECOVERY ROOM		0. 346430	2, 217, 433	0	0	768, 185	51.00
51.02 05101 0/P TREATMENT RO	OOM	0. 960239	660, 605	0	0	634, 339	51.02
52.00 05200 DELIVERY ROOM &	LABOR ROOM	0. 308062		0	0	336	52.00
54. 00 05400 RADI OLOGY-DI AGNO	OSTI C	0. 206751	12, 852, 233	0	0	2, 657, 212	54.00
55. 00 05500 RADI OLOGY-THERAF		0. 148707	19, 331, 212		O	2, 874, 687	55. 00
56. 00 05600 RADI 0I SOTOPE		0. 184849			O	971, 518	56.00
57.00 05700 CT SCAN		0. 078707	10, 570, 167		O	831, 946	57.00
58.00 05800 MAGNETIC RESONAN	ICE IMAGING (MRI)	0. 172269	2, 512, 500	l 0	O	432, 826	58. 00
59. 00 05900 CARDI AC CATHETER		0. 249648			0	7, 210, 644	
60. 00 06000 LABORATORY		0. 117317	9, 969, 250		0	1, 169, 563	
62.00 06200 WHOLE BLOOD & PA	ACKED RED BLOOD CELLS	0. 520750			0	139, 295	62.00
65. 00 06500 RESPIRATORY THER		0. 177353			0	89, 217	65.00
66.00 06600 PHYSI CAL THERAPY		0. 364163			0	26, 888	66.00
66. 01 06601 PSYCHI ATRI C/PSYC		0. 000000				0	66. 01
66. 02 06602 0/P PHYSI CAL THE		0. 320526	l e	0	0	0	66. 02
67. 00 06700 OCCUPATI ONAL THE		0. 257221	15, 410			3, 964	
68.00 06800 SPEECH PATHOLOGY		0. 306975				5, 650	68. 00
69. 00 06900 ELECTROCARDI OLOG		0. 081966				1, 885, 449	
69. 01 06901 CARDI AC REHAB		0. 436792				430, 472	69. 01
70. 00 07000 ELECTROENCEPHALO	GRAPHY	0. 465298				376, 667	70.00
71. 00 07100 MEDICAL SUPPLIES		0. 000000		ĺ	-	0	71.00
72. 00 07200 IMPL. DEV. CHARG		0. 221260				3, 933, 803	
73. 00 07300 DRUGS CHARGED TO		0. 208027	154, 892, 534			32, 221, 829	73. 00
76. 00 03020 RENAL ACUTE		0. 595262				20, 688	76.00
OUTPATIENT SERVICE COS	ST CENTERS	0.070202	01,701		<u> </u>	20, 000	70.00
90. 00 09000 CLINIC	or our end	0. 811118	245, 621	0	0	199, 228	90.00
90. 05 09005 PATIENT NUTRITIO	DN	0. 482503				77	90. 05
90. 07 09007 WOUND CLINIC		0. 288341	3, 355, 665			967, 576	90. 07
91. 00 09100 EMERGENCY		0. 125670				1, 700, 192	
92. 00 09200 OBSERVATION BEDS	(NON-DISTINCT PART)	0. 470334				714, 794	•
200.00 Subtotal (see in		3 300 1	369, 817, 198			68, 842, 020	
	Lab. Services-Program]	l	0, 7, 1	55, 5.2, 626	201.00
Only Charges	232. 301 V1 303 1 1 391 dill			Ĭ			
	ne 200 - line 201)	1	369, 817, 198	l o	8, 771	68, 842, 020	202.00
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		ı	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	'	-,	,	

Health FinancialSystemsUNION HOSPITAL, INC.In Lieu of Form CMS-2552-10APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COSTProvider CCN: 15-0023Period: From 01/01/2023Worksheet D

12/31/2023 Date/Time Prepared: 5/21/2024 12:12 pm Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 7. 00 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 05001 CARDI AC SURGERY 50.01 50.01 0 05002 WVSC 0 50.02 50.02 51.00 05100 RECOVERY ROOM 0 51.00 51.02 05101 0/P TREATMENT ROOM 0 51.02 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 55.00 0 56.00 05600 RADI OI SOTOPE 56.00 05700 CT SCAN 0 57.00 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 05900 CARDI AC CATHETERI ZATI ON 0 59.00 59.00 06000 LABORATORY 0 60 00 60 00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 65.00 06500 RESPIRATORY THERAPY 0 65.00 06600 PHYSI CAL THERAPY 66.00 66.00 66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 66 01 06602 0/P PHYSI CAL THERAPY 0 66.02 66.02 67.00 06700 OCCUPATI ONAL THERAPY 67.00 68.00 06800 SPEECH PATHOLOGY 0 68.00 69 00 06900 ELECTROCARDI OLOGY 0 69 00 69.01 06901 CARDI AC REHAB 0 69.01 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 72.00 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1, 790 73.00 03020 RENAL ACUTE 76.00 0 0 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 90.00 09005 PATIENT NUTRITION 00000 90.05 90.05 0 90.07 09007 WOUND CLINIC 0 90.07 91.00 91. 00 09100 EMERGENCY 21 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 200.00 Subtotal (see instructions) 1,811 200.00 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges

0

1, 811

202.00

202.00

Net Charges (line 200 - line 201)

Health Financial Systems	UNI ON HOSPI	TAL LNC		In lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT.		Provi der C	CN: 15-0023	Peri od:	Worksheet D	1002 10
THE SECOND CONTRACT OF THE PROPERTY OF THE PRO	000.0			From 01/01/2023	Part II	
		· ·	CCN: 15-T023	To 12/31/2023	Date/Time Pre 5/21/2024 12:	pared: 12 pm
			e XVIII	Subprovi der - I RF	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col . 26)					
	1. 00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS		1				
50. 00 05000 OPERATI NG ROOM	3, 641, 500				259	50.00
50. 01 05001 CARDI AC SURGERY	236, 522				57	50. 01
50. 02 05002 WVSC	2, 181, 063		1		1	50. 02
51.00 05100 RECOVERY ROOM	196, 332				15	
51. 02 05101 0/P TREATMENT ROOM	708, 209				0	51.02
52. 00 05200 DELIVERY ROOM & LABOR ROOM	879, 260				1	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 402, 373		1		1, 238	1
55. 00 05500 RADI OLOGY-THERAPEUTI C	1, 567, 752		1		0	
56. 00 05600 RADI 0I SOTOPE	471, 169		1		29	56. 00
57. 00 05700 CT SCAN	287, 737		1		247	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	457, 081		1		254	
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 661, 521				80	
60. 00 06000 LABORATORY	561, 355		1		1, 003	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 787		1		3	62.00
65. 00 06500 RESPIRATORY THERAPY	528, 507				3, 430	1
66. 00 06600 PHYSI CAL THERAPY	290, 109			·	17, 727	66. 00
66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	_	0.0000		0	66. 01
66. 02 06602 0/P PHYSI CAL THERAPY	20, 265				0	
67. 00 06700 OCCUPATI ONAL THERAPY	49, 398		0. 00423		4, 058	1
68.00 06800 SPEECH PATHOLOGY	92, 393		1		4, 182	ı
69. 00 06900 ELECTROCARDI OLOGY	768, 973				95	
69. 01 06901 CARDI AC REHAB	204, 569				0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	59, 144				79	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	_	0.0000		0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	20, 657		1		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 515, 343				516	
76. 00 03020 RENAL ACUTE	101, 447	3, 608, 056	0. 02811	7 37, 274	1, 048	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	20, 403				0	
90. 05 09005 PATI ENT NUTRI TI ON	53, 450				0	
90. 07 09007 WOUND CLINIC	267, 814				0	
91. 00 09100 EMERGENCY	1, 091, 273		1		36	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	, ,			0	
200.00 Total (lines 50 through 199)	20, 337, 406	1, 924, 796, 219	1	3, 123, 447	34, 358	200. 00

Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PAS		CN: 15-0023 CCN: 15-T023	Peri od: From 01/01/2023 To 12/31/2023		pared:
		Title	× XVIII	Subprovi der - I RF	PPS	
Cost Center Description	Non Physician Anesthetist Cost	Nursi ng Program Post-Stepdown Adjustments	Nursi ng Program		Allied Health	
	1. 00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS		_				
50. 00 05000 0PERATING ROOM 50. 01 05001 CARDIAC SURGERY 50. 02 05002 WVSC 51. 00 05100 RECOVERY ROOM	0 0	0 0 0 0		0		50. 01 50. 02
51. 02 05101 0/P TREATMENT ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM 54. 00 05400 RADIOLOGY-DIAGNOSTIC	0 0 0	0 0 0		0 0	0 0 0 116, 609	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OI SOTOPE 57. 00 05700 CT SCAN 58. 00 05800 MAGNETI C RESONANCE MAGI NG (MRI)	0 0	0 0 0 0		0 0		56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0		59. 00 60. 00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY 66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0 0 0		0 0	0 0 0 0	66. 01
66. 02 06602 0/P PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0 0	0 0 0 0		0		67. 00 68. 00
70.00 069001 CARDI AC REHAB 70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0		0 0		70. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS 76.00 03020 RENAL ACUTE	0 0	0		0 0	0 0 385, 860 0 0	72. 00 73. 00
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC	0	0		0	ol o	90.00
90.05 O9005 PATIENT NUTRITION O9007 WOUND CLINIC	0	0	1	0 0		90. 05 90. 07
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 200.00 Total (lines 50 through 199)	0	0		0	0 0 502, 469	92.00

APPORT	Financial Systems TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF SH COSTS	UNION HOSPI RVICE OTHER PAS		CN: 15-0023	Period: From 01/01/2023	worksheet D Part IV	2552-10
THROUG	in COSTS		Component	CCN: 15-T023	To 12/31/2023		epared:
			Title	· XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
		Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
				and 4)		(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0			0 197, 078, 460		
50. 01	05001 CARDI AC SURGERY	0	0		0 6, 203, 005	0. 000000	
50. 02	05002 WVSC	0	0		0 140, 385, 991	0. 000000	
51. 00	05100 RECOVERY ROOM	0	0		0 12, 172, 804	0.000000	
51. 02	05101 0/P TREATMENT ROOM	0	0		0 2, 353, 255	0. 000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	•	0 32, 419, 504	0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	116, 609	116, 60		0. 001247	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 61, 835, 759	0.000000	
56.00	05600 RADI OI SOTOPE	0	0		0 17, 629, 483	0.000000	1
57.00	05700 CT SCAN	0			0 64, 938, 478		
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 17, 154, 339	0.000000	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 116, 259, 648	0.000000	
60.00	06000 LABORATORY	0	0		0 199, 808, 666	0.000000	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	1	0 3, 516, 803	0.000000	
65.00	06500 RESPI RATORY THERAPY	0	0	1	0 44, 167, 631	0.000000	
66.00	06600 PHYSI CAL THERAPY	0	0		0 15, 022, 945	0.000000	
66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 0	0.000000	1
66. 02 67. 00	O6602 O/P PHYSI CAL THERAPY O6700 OCCUPATI ONAL THERAPY	0	0		0 6, 882, 568 0 11, 660, 251	0. 000000 0. 000000	
68.00	06800 SPEECH PATHOLOGY	0	0		0 5, 100, 829	0.00000	
69.00	06900 ELECTROCARDI OLOGY				0 97, 752, 918	0.000000	1
69. 01	06901 CARDI AC REHAB	0			0 2, 397, 947	0.000000	1
70.00	07000 ELECTROENCEPHALOGRAPHY	0			0 5, 356, 656	0.000000	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 3, 330, 030	0.000000	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	1	l .	0 81, 118, 042	0. 000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1		- , - , - , - , - , - , - , - , - , - ,	0.000775	
76.00	03020 RENAL ACUTE	0			0 3, 608, 056		
70.00	OUTPATIENT SERVICE COST CENTERS				0, 000, 000	0.00000	70.00
90.00	09000 CLINIC	0	0		0 532, 645	0.000000	90.00
90.05	09005 PATIENT NUTRITION	0			0 336, 479	l .	
90. 07	09007 WOUND CLINIC	0	l .		0 9, 769, 908		
91.00	09100 EMERGENCY	0	1	•	0 153, 968, 389	l	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0 24, 076, 479	l	
						0.00000	

Health Financial Systems	UNI ON HOSPI TA		ON 45 0000		u of Form CMS-2552-10	
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provi der C	CN: 15-0023	Peri od: From 01/01/2023	Worksheet D Part IV	
THROUGH COSTS		Component	CCN: 15-T023	To 12/31/2023		pared: 12 pm
			xVIII	Subprovi der - I RF	PPS	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷		Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	14, 038		0	l e	
50. 01 05001 CARDI AC SURGERY	0. 000000	1, 505		0	0	
50. 02 05002 WVSC	0. 000000	61		0	0	50.02
51.00 05100 RECOVERY ROOM	0. 000000	901		0	0	51.00
51.02 05101 0/P TREATMENT ROOM	0. 000000	0	1	0	0	51.02
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	41		0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 001247	48, 163	$ $ ϵ	0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0	1	0	0	55.00
56. 00 05600 RADI 0I SOTOPE	0. 000000	1, 089		0	0	56.00
57. 00 05700 CT SCAN	0. 000000	55, 670		0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	9, 550		0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	5, 631		0	0	59.00
60. 00 06000 LABORATORY	0. 000000	356, 937		0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	5, 250	1	0	0	62.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	286, 642		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	917, 967		0 0	0	66.00
66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	0)	0 0	0	66. 01
66. 02 06602 0/P PHYSI CAL THERAPY	0. 000000	0		0 0	0	66. 02
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	957, 955		0 0	0	
68. 00 06800 SPEECH PATHOLOGY	0. 000000	230, 882		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	12, 052		0 0	0	69.00
69. 01 06901 CARDI AC REHAB	0. 000000	0	1	0 0	0	1
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	7, 159		0 0	0	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	. 0	1	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. 000775	169, 663	13		Ō	
76. 00 03020 RENAL ACUTE	0. 000000	37, 274		0 0	0	
OUTPATIENT SERVICE COST CENTERS	0.00000	0., 2	I	<u> </u>		70.00
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
90. 05 09005 PATI ENT NUTRI TI ON	0. 000000	0	1	0 0	Ö	
90. 07 09007 WOUND CLINIC	0. 000000	0	1	0 0	ĺ	1
91. 00 09100 EMERGENCY	0. 000000	5, 017	1	0 212	ĺ	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0,017		0 0	ĺ	
200.00 Total (lines 50 through 199)	0.000000	3, 123, 447	19	-		200.00
	1	5, .20, 147		., 212	,	

Health Financial Systems		In Lio	u of Form CMS-2	0552 10			
	PORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part V	
			·	e XVIII	Subprovi der -	5/21/2024 12: PPS	
Cost Center Descri	i pti on	Cost to	PPS	Charges Cost	Cost	Costs PPS Services	

					IRF		
				Charges		Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	·	Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Services (see	Servi ces	Services Not		
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.		Ded. & Coins.	Ded. & Coins.		
		9		(see inst.)	(see inst.)		
		1. 00	2. 00	3. 00	4. 00	5. 00	
	ILLARY SERVICE COST CENTERS						
	OO OPERATING ROOM	0. 151662	0	0	0	0	50.00
	01 CARDI AC SURGERY	0. 544741	0	0	0	0	50. 01
	02 WVSC	0. 129318	0	0	0	0	50. 02
	OO RECOVERY ROOM	0. 346430	0	0	0	0	51.00
51. 02 0510	01 0/P TREATMENT ROOM	0. 960239	0	0	0	0	51.02
52.00 0520	OO DELIVERY ROOM & LABOR ROOM	0. 308062	0	0	0	0	52.00
54.00 0540	OO RADI OLOGY-DI AGNOSTI C	0. 206751	0	0	0	0	54.00
55. 00 0550	OO RADI OLOGY-THERAPEUTI C	0. 148707	0	0	0	0	55.00
56. 00 0560	00 RADI 0I SOTOPE	0. 184849	0	0	0	0	56.00
57. 00 0570	OO CT SCAN	0. 078707	0	0	0	0	57.00
58. 00 0580	OO MAGNETIC RESONANCE IMAGING (MRI)	0. 172269	0	0	0	0	58. 00
59. 00 0590	OO CARDI AC CATHETERI ZATI ON	0. 249648	0	0	0	0	59.00
60.00 0600	00 LABORATORY	0. 117317	0	0	0	0	60.00
62. 00 0620	OO WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 520750	0	0	0	0	62.00
65. 00 0650	00 RESPI RATORY THERAPY	0. 177353	0	0	0	0	65.00
66. 00 0660	00 PHYSI CAL THERAPY	0. 364163	0	0	0	0	66. 00
66. 01 0660	01 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	0	0	0	0	66. 01
66. 02 0660	02 0/P PHYSICAL THERAPY	0. 320526	0	0	0	0	66. 02
67. 00 0670	OO OCCUPATI ONAL THERAPY	0. 257221	0	0	0	0	67. 00
68. 00 0680	00 SPEECH PATHOLOGY	0. 306975	0	0	0	0	68. 00
69. 00 0690	00 ELECTROCARDI OLOGY	0. 081966	0	0	0	0	69. 00
69. 01 0690	01 CARDI AC REHAB	0. 436792	0	0	0	0	69. 01
70.00 0700	OO ELECTROENCEPHALOGRAPHY	0. 465298	l 0	0	0	0	70.00
71. 00 0710	OO MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	l 0	0	0	0	71.00
	OO IMPL. DEV. CHARGED TO PATIENTS	0. 221260	0	0	0	0	72.00
	OO DRUGS CHARGED TO PATLENTS	0. 208027	l 0	0	342	0	73.00
76. 00 0302	20 RENAL ACUTE	0. 595262	0	0	0	0	76. 00
	PATIENT SERVICE COST CENTERS	•	•	•			
90.00 0900		0. 811118	0	0	0	0	90.00
90. 05 0900	05 PATIENT NUTRITION	0. 482503	l 0	0	0	0	90. 05
	07 WOUND CLINIC	0. 288341	l o	0	0	0	90. 07
	OO EMERGENCY	0. 125670	212	0	0	27	91.00
	OO OBSERVATION BEDS (NON-DISTINCT PART)	0. 470334	0	1	0	0	1
200.00	Subtotal (see instructions)		212	0	342	27	200.00
201.00	Less PBP Clinic Lab. Services-Program	1		1 0	0		201. 00
	Only Charges						
202. 00	Net Charges (line 200 - line 201)		212	0	342	27	202. 00

Health Financial Systems	UNION HOSPI	TAL, INC.		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES A	AND VACCINE COST	Provi der C	CN: 15-0023	Peri od:	Worksheet D	
		Component	CCN: 15-T023	From 01/01/2023 To 12/31/2023	Part V Date/Time Pre 5/21/2024 12:	epared: 12 pm
		Title	xVIII	Subprovi der - I RF	PPS	
	Co	sts		1		
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Servi ces Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
ANCILLARY SERVICE COST CENTERS	6. 00	7. 00				
50. 00 05000 OPERATING ROOM		0				50.00
50. 01 05001 CARDI AC SURGERY			•			50.00
50. 02 05002 WVSC						50.01
51. 00 05100 RECOVERY ROOM						51.00
51. 02 05101 0/P TREATMENT ROOM		0				51. 02
52.00 05200 DELIVERY ROOM & LABOR ROOM		Ö				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		o o				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	C	0				55.00
56. 00 05600 RADI OI SOTOPE	C	0				56.00
57. 00 05700 CT SCAN	C	0				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	C	0				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	C	0				59.00
60. 00 06000 LABORATORY	C	0				60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	1			62.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	C	0				66.00
66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	C	0	1			66. 01
66. 02 06602 0/P PHYSI CAL THERAPY	C	0				66. 02

67.00

68.00

69.00

69.01

67.00

69.01

06700 OCCUPATIONAL THERAPY

68.00 06800 SPEECH PATHOLOGY

69. 00 06900 ELECTROCARDI OLOGY

06901 CARDI AC REHAB

Heal th	Financial Systems UNION HOSPIT	AL. INC.	In Lie	u of Form CMS-:	2552-10
	ATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0023	Peri od:	Worksheet D-1	
			From 01/01/2023	D. I. (T' D	
			To 12/31/2023	Date/Time Pre 5/21/2024 12:	
-		Title XVIII	Hospi tal	PPS	12 piii
	Cost Center Description				
				1. 00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			66, 422	1.00
2.00	Inpatient days (including private room days, excluding swing			66, 422	
3.00	Private room days (excluding swing-bed and observation bed	days). If you have only p	rivate room days,	0	3.00
	do not complete this line.				
4.00	Semi-private room days (excluding swing-bed and observation			55, 965	
5. 00	Total swing-bed SNF type inpatient days (including private	room days) through Decemb	er 31 of the cost	0	5.00
4 00	reporting period	room daya) after December	21 of the cost	0	4 00
6. 00	Total swing-bed SNF type inpatient days (including private reporting period (if calendar year, enter 0 on this line)	room days) arter becember	31 of the cost	Ü	6. 00
7. 00	Total swing-bed NF type inpatient days (including private ro	nom days) through Docombo	r 21 of the cost	0	7.00
7.00	reporting period	bolli days) tili odgir becellibe	1 31 01 the cost	U	7.00
8. 00	Total swing-bed NF type inpatient days (including private ro	nom days) after December	31 of the cost	0	8.00
0.00	reporting period (if calendar year, enter 0 on this line)	dom days) arter becomber	31 01 1110 0031	O	0.00
9. 00	Total inpatient days including private room days applicable	to the Program (excluding	g swing-bed and	19, 811	9.00
	newborn days) (see instructions)	or one or ogram (one can	9	,	
10.00	Swing-bed SNF type inpatient days applicable to title XVIII	only (including private	room days)	0	10.00
	through December 31 of the cost reporting period (see instru	uctions)			
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII		room days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year,				
12. 00	Swing-bed NF type inpatient days applicable to titles V or 2	XIX only (including priva	te room days)	0	12.00
	through December 31 of the cost reporting period			_	
13. 00	Swing-bed NF type inpatient days applicable to titles V or X			0	13. 00
44.00	after December 31 of the cost reporting period (if calendar				14.00
14.00	Medically necessary private room days applicable to the Programme days (title V and VIV and VIV)	gram (excluding swing-bed	days)	0	
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
16.00	SWING BED ADJUSTMENT			U	16.00
17. 00	Medicare rate for swing-bed SNF services applicable to servi	icos through Docombor 21	of the cost	0.00	17. 00
17.00	reporting period	rces through becember 31	of the cost	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to servi	ices after December 31 of	the cost	0.00	18. 00
10.00	reporting period	rees arter becomber or or	the cost	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to servi	ces through December 31 d	f the cost	0.00	19. 00
	reporting period				
20.00	Medicaid rate for swing-bed NF services applicable to servi	ces after December 31 of	the cost	0.00	20.00
	reporting period				
21.00	Total general inpatient routine service cost (see instruction			71, 928, 802	
22.00	Swing-bed cost applicable to SNF type services through Dece	mber 31 of the cost repor	ting period (line	0	22. 00
	5 x line 17)				
23. 00	Swing-bed cost applicable to SNF type services after December	er 31 of the cost reporti	ng period (line 6	0	23. 00
	x line 18)		, , , , , , , ,	_	
24. 00	Swing-bed cost applicable to NF type services through December 100	ber 31 of the cost report	ing period (line	0	24.00
25 00	7 x line 19)	r 21 of the cost mana-ti-	a ported (line o	0	25 00
25. 00	Swing-bed cost applicable to NF type services after December x line 20)	i 3i oi the cost reportin	g perrou (Title 8	Ü	25. 00
27 00	Tatalanda landa da Araba da Ar			•	1 00 00

		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	I NPATI ENT DAYS		
00	Inpatient days (including private room days and swing-bed days, excluding newborn)	66, 422	
00	Inpatient days (including private room days, excluding swing-bed and newborn days)	66, 422	
00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0)
	do not complete this line.		
00	Semi-private room days (excluding swing-bed and observation bed days)	55, 965	
00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	
JU		U	'
	reporting period	_	
00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0)
	reporting period (if calendar year, enter 0 on this line)		
00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0)
	reporting period		
00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0)
	reporting period (if calendar year, enter 0 on this line)		
00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	19, 811	
,0	newborn days) (see instructions)	17,011	
00		0	
00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0) 1
	through December 31 of the cost reporting period (see instructions)		1
00		0) 1
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		1
00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0) 1
	through December 31 of the cost reporting period		
00		0	1 1
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	_	1
00		0	1
00		-	
	1	0	
00	3 3 1	0	1
	SWING BED ADJUSTMENT		
00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0. 00) 1
	reporting period		
00		0.00) l 1
	reporting period		
00		0. 00	1 1
00		0.00	Ί'
00	reporting period	0.00	ر ل
00	5	0. 00) 2
	reporting period		1
00	, ,	71, 928, 802	! 2
00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0) 2
	5 x line 17)		
00	,	0) 2
	x line 18)	_	-
00		0	2
00		U	′ ′
	7 x line 19)		. _
00		0) 2
	x line 20)		1
00		0	
00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	71, 928, 802	2
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT		
00		0	2
00		0	
	Semi - pri vate room charges (excluding swing-bed charges)	-	
		0	1
00		0. 000000	
00		0. 00	
00	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00) 3
00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00) 3
00		0. 00	
00	Private room cost differential adjustment (line 3 x line 35)	0.00	
	· · · · · · · · · · · · · · · · · · ·	-	
00		71, 928, 802	! 3
	27 minus line 36)		1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
00		1, 082. 91	٦ 3
		21, 453, 530	
00			1 4
. 00	, , , , , , , , , , , , , , , , , , , ,	21, 453, 530	

	Financial Systems TION OF INPATIENT OPERATING COST	UNI ON HOSPI	Provi der C		Peri od:	u of Form CMS-2 Worksheet D-1	
					From 01/01/2023 To 12/31/2023	Date/Time Pre	nare
						5/21/2024 12:	
	Cost Center Description	Total	litle Total	XVIII Average Per	Hospital Program Days	PPS Program Cost	
	COST CENTER DESCRIPTION	Inpatient	I npati ent	Diem (col. 1		(col. 3 x	
		Cost	Days	÷ col . 2)		col . 4)	
2. 00 N	NURSERY (title V & XIX only)	1. 00	2. 00	3.00	4.00	5. 00	42.
	ntensive Care Type Inpatient Hospital Units	υ _l	0	0.00	<u>J</u>	0	42.
	INTENSIVE CARE UNIT	16, 416, 031	6, 692	2, 453. 08	1, 910	4, 685, 383	43.
	CORONARY CARE UNIT						44.
	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45.
1	INTENSIVE NURSERY	5, 732, 021	4, 536	1, 263. 6	7 0	0	47
	Cost Center Description	27 : 22 / 22 : [.,	.,			
00 [Drogram i poeti ent ancil Larry corrilae acet (Wk	a+ D 2 and 2) Line 200)			1. 00	40
	Program inpatient ancillary service cost (Wk: Program inpatient cellular therapy acquisition			III line 10	column 1)	29, 118, 172 0	1
	Total Program inpatient costs (sum of lines				00. 4	55, 257, 085	
	PASS THROUGH COST ADJUSTMENTS			·			
	Pass through costs applicable to Program inp	atient routine	services (fro	n Wkst. D, sum	of Parts I and	2, 349, 346	50
	III) Pass through costs applicable to Program inp	atient ancillar	rv services (f	rom Wkst D s	sum of Parts II	1, 800, 337	51
	and IV)	att 611t 411611141	y 30. 1. 333 (o w.o b, c	0	1, 555, 557	"
	Total Program excludable cost (sum of lines					4, 149, 683	
	Total Program inpatient operating cost exclumedical education costs (line 49 minus line	9 1	elated, non-ph	ysician anesth	etist, and	51, 107, 402	53
	ARGET AMOUNT AND LIMIT COMPUTATION	32)					
	Program di scharges					0	54
	Target amount per discharge					0.00	
	Permanent adjustment amount per discharge	(برامه مما				0.00	
	Adjustment amount per discharge (contractor Target amount (line 54 x sum of lines 55, 55		1			0.00	1
	Difference between adjusted inpatient operat			ine 56 minus	line 53)	Ö	
	Bonus payment (see instructions)					0	
	Trended costs (lesser of line 53 ÷ line 54, updated and compounded by the market basket)	or line 55 from	n the cost rep	orting period	endi ng 1996,	0. 00	59
	Expected costs (lesser of line 53 ÷ line 54,	or line 55 fro	om prior vear	cost report. ı	updated by the	0. 00	60
	market basket)						"
5	Continuous improvement bonus payment (if line 55.01, or line 59, or line 60, enter the less 53) are less than expected costs (lines 54 x	ser of 50% of t	the amount by	which operatir	ng costs (İine	0	61
	enter zero. (see instructions) Relief payment (see instructions)					0	62
3. 00 <i>[</i>	Allowable Inpatient cost plus incentive paym	ent (see instru	ıcti ons)			0	63
	PROGRAM INPATIENT ROUTINE SWING BED COST						١
	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Dece	ember 31 of the	e cost reporti	ng period (See	0	64
	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	cost reporting	period (See	0	65
i	nstructions)(title XVIII only)						
	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	55)(title XVII	I only); for	0	66
	CAH, see instructions Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost re	porting period	0	67
	(line 12 x line 19)	g.			paramy paramy	1	-
	Title V or XIX swing-bed NF inpatient routing	e costs after D	December 31 of	the cost repo	orting period	0	68
	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient :	routine costs (line 67 + line	- 68)		0	69
	PART III - SKILLED NURSING FACILITY, OTHER NU					Ü	"
. 00 3	Skilled nursing facility/other nursing facil	ity/ICF/IID rou	ıtine service (cost (line 37)			70
- 1	Adjusted general inpatient routine service co Program routine service cost (line 9 y line)		ine 70 ÷ line	2)		 	71
	Program routine service cost (line 9 x line Medically necessary private room cost applic		n (line 14 x li	ne 35)		 	73
. 00 1	Total Program general inpatient routine serv	ice costs (line	e 72 + line 73)		 	74
	Capital-related cost allocated to inpatient	routine service	costs (from)	Worksheet B, F	art II, column	 	75
	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76
	Program capital-related costs (line 9 x line						77
00 1	Inpatient routine service cost (line 74 minus	s line 77)					78
1	Aggregate charges to beneficiaries for excess				11 70	 	79
1	Total Program routine service costs for comp Inpatient routine service cost per diem limi		cost iimitatio	ı (ııne /8 mir	us line /9)	 	80
1	Inpatient routine service cost per diem iimi Inpatient routine service cost limitation (l		1)			 	82
1	Reasonable inpatient routine service costs (•				83
1.	Program inpatient ancillary services (see in	structions)					84
. 00 F	Itilization roviou physician componention	coo inctructio	nc l				85
i. 00 F	Jtilization review - physician compensation				l	1	
i. 00 F i. 00 L i. 00 1	officer in Teview - physician compensation Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS	of lines 83 th					86

Health Financial Systems	UNI ON HOSPI	TAL, INC.		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		From 01/01/ To 12/31/				
		Title	XVIII	Hospi tal	PPS	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)			11, 323, 990	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		·		(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	6, 601, 256	71, 928, 802	0. 09177	75 11, 323, 990	1, 039, 259	90.00
91.00 Nursing Program cost	0	71, 928, 802	0. 00000	11, 323, 990	0	91.00
92.00 Allied health cost	0	71, 928, 802	0. 00000	11, 323, 990	0	92.00
93.00 All other Medical Education	0	71, 928, 802	0. 00000	0 11, 323, 990	0	93.00

Health Financial Systems	UNION HOSPITAL, INC.	In Lieu	of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0023		Worksheet D-1
		From 01/01/2023	
	Component CCN: 15-T023	To 12/31/2023	Date/Time Prepared:
	'		5/21/2024 12: 12 pm
	Title XVIII	Subprovi der -	PPS
		I RF	

		TI LIE AVIII	I RF	FF3	
	Cost Center Description			1.00	
Į.	PART I - ALL PROVIDER COMPONENTS			1. 00	
[NPATIENT DAYS				
	Inpatient days (including private room days and swing-bed day			3, 229	
	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		rivate room days	3, 229 0	2. 00 3. 00
	do not complete this line.	iyo). Ti you have only pi	rvate room days,	Ĭ	0.00
	Semi-private room days (excluding swing-bed and observation b			3, 229	4.00
5. 00	Total swing-bed SNF type inpatient days (including private ro reporting period	oom days) through Decembe	er 31 of the cost	0	5.00
6. 00	Tetal swing-bed SNF type inpatient days (including private ro	oom davs) after December	31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)				
	Total swing-bed NF type inpatient days (including private roo	om days) through December	r 31 of the cost	0	7.00
	reporting period Total swing-bed NF type inpatient days (including private roo	om days) after December :	31 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)	dayo, areor boodbor			0.00
	Total inpatient days including private room days applicable t	to the Program (excluding	g swing-bed and	1, 648	9.00
	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private o	room days)	o	10.00
10.00	through December 31 of the cost reporting period (see instruc		days)	ا	10.00
	Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private i	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		to room days)	0	12.00
12. 00	through December 31 of the cost reporting period	A only (Therading priva	te room days)	٥	12.00
	Swing-bed NF type inpatient days applicable to titles V or XI			0	13.00
44.00	after December 31 of the cost reporting period (if calendar y	year, enter 0 on this li	ne)		14.00
	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0	14. 00 15. 00
	Nursery days (title V or XIX only)			0	
Ç	SWING BED ADJUSTMENT		,		
17. 00	Medicare rate for swing-bed SNF services applicable to servic	ces through December 31 o	of the cost	0. 00	17.00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to servic	ces after December 31 of	the cost	0 00	18.00
	reporting period	oo artor boombor or or		0.00	
	Medicaid rate for swing-bed NF services applicable to service	es through December 31 o	f the cost	0. 00	19.00
	reporting period Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	0.00	20.00
	reporting period			0.00	20.00
	Total general inpatient routine service cost (see instruction			3, 536, 546	
	Swing-bed cost applicable to SNF type services through Decemb 5 x line 17)	per 31 of the cost repor	ting period (line	0	22.00
	Swing-bed cost applicable to SNF type services after December	31 of the cost reporti	ng period (line 6	0	23.00
	x line 18)	·			
	Swing-bed cost applicable to NF type services through Decembe 7 x line 19)	er 31 of the cost reporti	ing period (line	0	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)		9		
	Total swing-bed cost (see instructions)	(11 - 04 - 1 - 11 - 04)		0	
	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		3, 536, 546	27.00
	General inpatient routine service charges (excluding swing-be	ed and observation bed cl	narges)	0	28.00
29. 00	Private room charges (excluding swing-bed charges)			0	29.00
1	Semi-private room charges (excluding swing-bed charges)			0	
1	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0.000000	
1	Average private room per diem charge (line 29 ÷ line 3)			0.00	
4	Average semi-private room per diem charge (line 30 ÷ line 4)	nue Lino 22) (con i notico	ctions)	0.00	
	Average per diem private room charge differential (line 32 mi		Ctrons)	0. 00 0. 00	
	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35)	116 31)		0.00	35. 0 36. 0
	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line		
	27 minus line 36)] 5
H	PART II - HOSPITAL AND SUBPROVIDERS ONLY	UICTHENTO			-
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ Adjusted general inpatient routine service cost per diem (see		ı	1 005 24] 38. 00
20 00	BULLISTED DEDELAT TUDATIEDT FOULTDE SELVICE COST DEC DIEM (SEE	: 1115t1 uct1 0115)		1, 095. 24	
1		38)		1 804 956	1 30 0
39. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr	•		1, 804, 956 0	39. 00 40. 00

Health Financial Systems COMPUTATION OF INPATIENT OPERATING COST	UNI ON HOSPI		CN: 15-0023	In Lie	u of Form CMS-2 Worksheet D-1	
COMPUTATION OF INPATIENT OPERATING COST			CCN: 15-0023 CCN: 15-T023	From 01/01/2023 To 12/31/2023		
			e XVIII	Subprovi der -	5/21/2024 12: PPS	
				. I RF		
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. ÷ col. 2)		Program Cost (col. 3 x col. 4)	
42.00 NUDSERV (+; +Lo. V. 9. VLV. opl.)	1. 00	2.00	3.00	4.00	5. 00	42.00
42.00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Uni	0 ts	C	0.0	00 0	0	42.00
43.00 INTENSIVE CARE UNIT	0	С	0.0	00 0	0	
44.00 CORONARY CARE UNIT 45.00 BURN INTENSIVE CARE UNIT						44. 00 45. 00
46. 00 SURGI CAL I NTENSI VE CARE UNI T						46.00
47.00 INTENSIVE NURSERY Cost Center Description	0	C	0. 0	00 0	0	47.00
· ·					1. 00	
48.00 Program inpatient ancillary service cost (III line 10	column 1)	830, 413	1
48.01 Program inpatient cellular therapy acquisi 49.00 Total Program inpatient costs (sum of line				, column I)	0 2, 635, 369	
PASS THROUGH COST ADJUSTMENTS	V	, ,	,			1
50.00 Pass through costs applicable to Program i	npatient routine	services (fro	m Wkst. D, su	m of Parts I and	241, 036	50.00
51.00 Pass through costs applicable to Program i	npatient ancillar	ry services (f	rom Wkst. D,	sum of Parts II	34, 549	51.00
and IV) 52.00 Total Program excludable cost (sum of line	s 50 and 51)				275, 585	52.00
53.00 Total Program inpatient operating cost exc		elated, non-ph	ysician anest	hetist, and	2, 359, 784	
medical education costs (line 49 minus lin	e 52)	·	-			
TARGET AMOUNT AND LIMIT COMPUTATION 54.00 Program discharges					0] 54. 00
55.00 Target amount per discharge					0. 00	55.00
55.01 Permanent adjustment amount per discharge 55.02 Adjustment amount per discharge (contracto	ur use only)				0. 00 0. 00	
56.00 Target amount (line 54 x sum of lines 55,)			0.00	
57.00 Difference between adjusted inpatient oper	ating cost and ta	arget amount (line 56 minus	line 53)	0	
58.00 Bonus payment (see instructions) 59.00 Trended costs (lesser of line 53 ÷ line 54	or line 55 from	m the cost ren	ortina neriod	endina 1996	0 0. 00	
updated and compounded by the market baske	et)		0.			
60.00 Expected costs (lesser of line 53 ÷ line 5 market basket)	4, or line 55 fro	om prior year	cost report,	updated by the	0. 00	60.00
61.00 Continuous improvement bonus payment (if I 55.01, or line 59, or line 60, enter the I 53) are less than expected costs (lines 54 enter zero. (see instructions)	esser of 50% of t	the amount by	which operati	ng costs (line	0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable Inpatient cost plus incentive pa	yment (see instru	ucti ons)			0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST 64.00 Medicare swing-bed SNF inpatient routine of	osts through Dece	ember 31 of th	e cost report	ing period (See	0	64.00
instructions)(title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine of	osts after Decemb	oor 21 of the	cost roportin	a ported (See	0	65.00
instructions)(title XVIII only)			·			
66.00 Total Medicare swing-bed SNF inpatient rou CAH, see instructions	itine costs (line	64 plus line	65)(title XVI	II only); for	0	66.00
67.00 Title V or XIX swing-bed NF inpatient rout	ine costs through	December 31	of the cost r	eporting period	0	67.00
(line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient rout	ine costs after [December 31 of	the cost rep	orting period	0	68. 00
(line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatien	t routine costs ((line 67 + lin	e 68)		0	69.00
PART III - SKILLED NURSING FACILITY, OTHER				`		
70.00 Skilled nursing facility/other nursing fac 71.00 Adjusted general inpatient routine service	•)		70.00
72.00 Program routine service cost (line 9 x lin	e 71)		•			72.00
73.00 Medically necessary private room cost appl 74.00 Total Program general inpatient routine se	•	7				73.00 74.00
75.00 Capital-related cost allocated to inpatien	•		•	Part II, column		75. 00
26, line 45) 76.00 Per diem capital-related costs (line 75 ÷	line 2)					76.00
77.00 Program capital-related costs (line 9 x li	ne 76)					77.00
78.00 Inpatient routine service cost (line 74 mi 79.00 Aggregate charges to beneficiaries for exc		orovider recon	ds)			78.00 79.00
80.00 Total Program routine service costs for co				nus line 79)		80.00
81.00 Inpatient routine service cost per diem li		1)				81.00
82.00 Inpatient routine service cost limitation 83.00 Reasonable inpatient routine service costs						82. 00 83. 00
84.00 Program inpatient ancillary services (see	instructions)	ŕ				84.00
85.00 Utilization review - physician compensation 86.00 Total Program inpatient operating costs (s						85. 00 86. 00
PART IV - COMPUTATION OF OBSERVATION BED P	ASS THROUGH COST	549.1 55)				1
87.00 Total observation bed days (see instruction	ns)				0	87.00

Health Financial Systems	UNI ON HOSPI	TAL, INC.		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		·	CCN: 15-T023	From 01/01/2023 To 12/31/2023	Date/Time Prep 5/21/2024 12:	pared: 12 pm
		Title	XVIII	Subprovi der - I RF	PPS	
Cost Center Description						
					1. 00	
88.00 Adjusted general inpatient routine cost per	diem (line 27	÷ line 2)			0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)			0	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	472, 281	3, 536, 546	0. 13354	.3 0	0	90.00
91.00 Nursing Program cost	0	3, 536, 546	0. 00000	0 0	o	91.00
92.00 Allied health cost	0	3, 536, 546	0. 00000	0 0	o	92.00
93.00 All other Medical Education	0	3, 536, 546	0. 00000	0 0	0	93.00

Heal th	n Financial Systems UNION HOSPITA	AL, INC.	In Lie	u of Form CMS-2	2552-10
COMPU	TATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0023	Peri od:	Worksheet D-1	
			From 01/01/2023		
			To 12/31/2023		
		T: +L o VIV	Hooni tol	5/21/2024 12:	12 pm
	Cook Cooker Decoration	Title XIX	Hospi tal	Cost	
	Cost Center Description			1.00	
	DART I ALL PROVERED COMPONENTS			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1. 00	Inpatient days (including private room days and swing-bed da	<i>y</i> .		66, 422	1. 00
2. 00	00 Inpatient days (including private room days, excluding swing-bed and newborn days)			66, 422	2.00
3.00 Private room days (excluding swing-bed and observation bed days). If you have only private room days do not complete this line.			rivate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation	bed days)		55, 965	4.00
5.00	Total swing-bed SNF type inpatient days (including private r		er 31 of the cost		5.00
	reporting period				
6. 00	Total swing-bed SNF type inpatient days (including private r	oom days) after December	31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)			_	
7. 00	Total swing-bed NF type inpatient days (including private ro reporting period	oom days) through Decembe	r 31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private ro	nom days) after December	21 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	oni days, arter becenber	31 OF THE COST		6.00
9 00	Total inpatient days including private room days applicable	to the Program (excluding	g swing-bed and	1 593	9 00

	sout senter beast peron	1. 00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1. 00	Inpatient days (including private room days and swing-bed days, excluding newborn)	66, 422	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	66, 422	
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3.00
	do not complete this line.		
4. 00	Semi-private room days (excluding swing-bed and observation bed days)	55, 965	
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5.00
	reporting period		
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)	_	
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
	reporting period		
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	4 500	
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	1, 593	9. 00
10 00	newborn days) (see instructions)	0	10 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	U	10.00
11. 00	through December 31 of the cost reporting period (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11.00
11.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	o _l	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
12.00	through December 31 of the cost reporting period	U	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
13.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	O	13.00
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
	Total nursery days (title V or XIX only)	2, 788	
16.00	Nursery days (title V or XIX only)	123	
10.00	SWING BED ADJUSTMENT	120	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0. 00	17. 00
17.00	report in a peri od	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18. 00
10.00	report in a peri od	0.00	10.00
19.00	Medical d rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19.00
	reporting period		
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20.00
	reporting period		
21.00	Total general inpatient routine service cost (see instructions)	71, 928, 802	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22.00
	5 x line 17)		
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23.00
	x line 18)		
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24.00
	7 x line 19)		
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25.00
	x line 20)		
	Total swing-bed cost (see instructions)	0	
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	71, 928, 802	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	
	Private room charges (excluding swing-bed charges)	0	
	Semi-private room charges (excluding swing-bed charges)	0	
	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)	0. 00	
	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	1
	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00	
35. 00		0. 00	
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	71, 928, 802	37.00
	27 minus line 36)		1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		1
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1 000 01	1 20 22
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 082. 91	1
39.00	9 9 1	1, 725, 076	1
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	1 725 074	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1, 725, 076	41.00

	reporting period (if calendar year, enter 0 on this line)	_	
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
	reporting period		
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)		
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	1, 593	9. 00
	newborn days) (see instructions)		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
	through December 31 of the cost reporting period (see instructions)		
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
	through December 31 of the cost reporting period		
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15. 00	Total nursery days (title V or XIX only)	2, 788	
16. 00	Nursery days (title V or XIX only)	123	16. 00
	SWING BED ADJUSTMENT		
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0. 00	17. 00
40.00	reporting period	0.00	40.00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18. 00
10.00	reporting period	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19. 00
20.00	reporting period	0.00	20.00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions)	71, 928, 802	21 00
21.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line		22.00
22.00	5 x line 17)	. 0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
23.00	In line 18)	0	23.00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
21.00	7 x line 19)	· ·	200
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
	x line 20)		
26.00	Total swing-bed cost (see instructions)	0	26. 00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	71, 928, 802	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29.00	Private room charges (excluding swing-bed charges)	0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)	0	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)	0. 00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36. 00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	71, 928, 802	37.00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 082. 91	
39. 00	Program general inpatient routine service cost (line 9 x line 38)	1, 725, 076	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	1, 725, 076	41.00

MCRI F32 - 22. 2. 178. 1

OMPUT	Financial Systems ATION OF INPATIENT OPERATING COST	UNI ON HOSPI	Provi der CC		Period: From 01/01/2023	u of Form CMS-2 Worksheet D-1	
				1	o 12/31/2023	5/21/2024 12:	
	Cost Center Description	Total Inpati ent Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Hospital Program Days	Cost Program Cost (col. 3 x col. 4)	
2. 00	NURSERY (title V & XIX only)	1. 00 1, 720, 758	2. 00 2, 788	3. 00 617. 20	4. 00	5. 00 75, 916	42.
	Intensive Care Type Inpatient Hospital Units	1/ 41/ 021	((02	2 452 00	0.4	20/ 050	4.2
3. 00 4. 00 5. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	16, 416, 031	6, 692	2, 453. 08	84	206, 059	44. 45.
5. 00 7. 00	SURGICAL INTENSIVE CARE UNIT INTENSIVE NURSERY	5, 732, 021	4, 536	1, 263. 67	364	459, 976	46. 47.
	Cost Center Description					1. 00	
3. 00	Program inpatient ancillary service cost (Wk					1, 801, 242	1
3. 01 9. 00	Program inpatient cellular therapy acquisiti Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS				column 1)	0 4, 268, 269	
0. 00	Pass through costs applicable to Program inp	atient routine	services (from	Wkst. D, sum	of Parts I and	0	50.
. 00	III) Pass through costs applicable to Program inp	atient ancillar	ry services (fr	om Wkst. D, s	um of Parts II	0	51.
2. 00	and IV) Total Program excludable cost (sum of lines					0	1
3. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		erated, non-phy	sıcian anesth	etist, and	0	53.
. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.
. 00	Target amount per discharge					0.00	
. 01	Permanent adjustment amount per discharge					0.00	
. 02	Adjustment amount per discharge (contractor Target amount (line 54 x sum of lines 55, 55					0.00	1
00	Difference between adjusted inpatient operat			ine 56 minus	line 53)	0	
00	Bonus payment (see instructions)	ing cost and to	inger amount (i	THE GO III HGS	11110 00)	0	
00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost repo	rting period	endi ng 1996,	0. 00	
. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the						60
. 00	market basket) Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x	ser of 50% of t	he amount by w	hich operatin	g costs (line	0	61.
. 00	enter zero. (see instructions) Relief payment (see instructions)					0	1
	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST		·			0	63
00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dece	ember 31 of the	cost reporti	ng period (See	0	64
00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	er 31 of the c	ost reporting	period (See	0	65
.00	Total Medicare swing-bed SNF inpatient routi CAH, see instructions	ne costs (line	64 plus line 6	5)(title XVII	l only); for	0	66
00	Title V or XIX swing-bed NF inpatient routin (line 12×1 line 19)	e costs through	December 31 o	f the cost re	porting period	0	67
. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after [December 31 of	the cost repo	rting period	0	68
. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69
	Skilled nursing facility/other nursing facil	ity/ICF/IID rou	itine service c	ost (line 37)			70 71
.00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ine /u ÷ line	۷)			71
	Medically necessary private room cost applic		ı (line 14 x li	ne 35)			73
00	Total Program general inpatient routine serv						74
00	Capital-related cost allocated to inpatient 26, line 45)				art II, column		75
00	Per diem capital-related costs (line 75 ÷ li						76
00	Program capital -related costs (line 9 x line						77
	Inpatient routine service cost (line 74 minu		rouldor ross:	c)			78
00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp				us lina 70)		79 80
00	Inpatient routine service costs for comp		ost iiiii tati 011	(11116 /0 111111	us IIIIC /7)		81
00	Inpatient routine service cost per drem frim)				82
00	Reasonable inpatient routine service costs (•				83
. 00	Program inpatient ancillary services (see in		•				84
. 00	Utilization review - physician compensation		ons)				85
. 00	Total Program inpatient operating costs (sum		rough 85)				86
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST					1
. 00						10, 457	1 ~-

Health Financial Systems	lth Financial Systems UNION HOSPITAL, INC. In Lie			u of Form CMS-2	2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023		
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)			11, 323, 990	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		·		(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	6, 601, 256	71, 928, 802	0. 09177	75 11, 323, 990	1, 039, 259	90.00
91.00 Nursing Program cost	0	71, 928, 802	0. 00000	11, 323, 990	0	91.00
92.00 Allied health cost	0	71, 928, 802	0. 00000	0 11, 323, 990	0	92.00
93.00 All other Medical Education	0	71, 928, 802	0. 00000	0 11, 323, 990	0	93.00

Health Financial Systems	UNION HOSPITAL, INC.	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0023		Worksheet D-1	
		From 01/01/2023		
	Component CCN: 15-T023	Io		
			5/21/2024 12:	12 pm
	Ti tle XIX	Subprovi der -	Cost	
		I RF		

		IRF		
	Cost Center Description		1.00	
	PART I - ALL PROVIDER COMPONENTS		1. 00	
	I NPATI ENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days		3, 229	
2. 00 3. 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		3, 229 vs. 0	1
3.00	do not complete this line.	ys). If you have only private room da	ys, 0	3.00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)	3, 229	4.00
5.00	Total swing-bed SNF type inpatient days (including private ro		ost 0	5. 00
	reporting period	d) - 		/ 00
6. 00	Total swing-bed SNF type inpatient days (including private roll reporting period (if calendar year, enter 0 on this line)	om days) after becember 31 of the cos	t 0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room	m days) through December 31 of the co	st 0	7. 00
	reporting period	3 /		
8. 00	Total swing-bed NF type inpatient days (including private room	m days) after December 31 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	n the Program (eycluding swing-hed an	d 15	9. 00
7. 00	newborn days) (see instructions)	o the frogram (exertaining swring bed and	13	7.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o		0	10.00
44 00	through December 31 of the cost reporting period (see instruc			44.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, e		er 0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI		0	12.00
	through December 31 of the cost reporting period			
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI		0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progra		0	14. 00
15. 00	Total nursery days (title V or XIX only)	all (excluding swing-bed days)		15. 00
16. 00	Nursery days (title V or XIX only)		123	
	SWING BED ADJUSTMENT			
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of the cost	0.00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of the cost	0.00	18. 00
	reporting period			
19. 00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of the cost	0.00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s after December 31 of the cost	0.00	20.00
	reporting period			
21.00	Total general inpatient routine service cost (see instruction		3, 536, 546	
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 ine 17)	er 31 of the cost reporting period (i	ine 0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting period (line	e 6 0	23. 00
	x line 18)			
24. 00	Swing-bed cost applicable to NF type services through Decembe 7×1 ine 19)	r 31 of the cost reporting period (li	ne 0	24.00
25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting period (line	8 0	25. 00
20.00	x line 20)	or the book ropertring perrou (rine		20.00
	Total swing-bed cost (see instructions)		0	
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)	3, 536, 546	27.00
28. 00	General inpatient routine service charges (excluding swing-be	d and observation bed charges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)		0	
30.00	Semi-private room charges (excluding swing-bed charges)		0	
31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)	0.000000	
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	
34. 00	Average per diem private room charge differential (line 32 mi)	nus line 33)(see instructions)	0.00	ı
35.00	Average per diem private room cost differential (line 34 x li		0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)		0	
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost differential (I	i ne 3, 536, 546	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY			1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	JSTMENTS		1
38. 00	Adjusted general inpatient routine service cost per diem (see	instructions)	1, 095. 24	
39.00	Program general inpatient routine service cost (line 9 x line	· ·	16, 429	
40. 00 41. 00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39)	,	16 429	40. 00 41. 00
11.00	1. State		1 10, 427	1 11.00

	Financial Systems	UNION HOSPIT	AL, INC.		In Lie	u of Form CMS-2	2552-10
COMPUT	TATION OF INPATIENT OPERATING COST			CN: 15-0023 CCN: 15-T023	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Pre	
			·	e XIX	Subprovi der -	5/21/2024 12:	
					I RF	Cost	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. ÷ col. 2)	9	Program Cost (col. 3 x col. 4)	
42. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5. 00	42.00
42.00	Intensive Care Type Inpatient Hospital Units	U		η	0	U	42.00
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	(0.0	00 0	0	44.00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
47. 00	INTENSIVE NURSERY Cost Center Description	0	(0. (00 0	0	47.00
	·					1. 00	
48. 00 48. 01	Program inpatient ancillary service cost (Wk Program inpatient cellular therapy acquisiti			III line 10	column 1)	2, 697 0	1
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS				, corumii i)	19, 126	
50. 00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, su	m of Parts I and	0	50.00
51. 00	Pass through costs applicable to Program inpland IV)	atient ancillar	y services (f	rom Wkst. D,	sum of Parts II	0	51.00
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		lated non nh	veleian anost	hotist and	0	
55.00	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION		rateu, non-pn	ysi ci aii aliest	netrst, and	0	33.00
	Program di scharges					0	
55. 00 55. 01	Target amount per discharge Permanent adjustment amount per discharge					0. 00 0. 00	
55. 02	Adjustment amount per discharge (contractor	J.,				0.00	1
56. 00 57. 00	Target amount (line 54 x sum of lines 55, 55 Difference between adjusted inpatient operat		rget amount (line 56 minus	line 53)	0	
58.00	Bonus payment (see instructions)	on line EE from	+bo ooo+ ron	onting ported	anding 1004	0	58.00
59. 00 60. 00	Trended costs (lesser of line 53 ÷ line 54, updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54.	0. 00					
61. 00	market basket)						
01.00	55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise						
62.00	enter zero. (see instructions) Relief payment (see instructions)					0	
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	,	,			0	
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Dece	mber 31 of th	e cost report	ing period (See	0	64.00
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	er 31 of the	cost reportin	g period (See	0	65.00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH, see instructions	ne costs (line	64 plus line	65)(title XVI	II only); for	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	December 31	of the cost r	eporting period	0	67.00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after D	ecember 31 of	the cost rep	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N	JRSING FACILITY	, AND ICF/IID	ONLY		0	69. 00
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c)		70. 00 71. 00
72.00	Program routine service cost (line 9 x line	71)		•			72.00
73. 00 74. 00	Medically necessary private room cost applic Total Program general inpatient routine serv						73. 00 74. 00
75. 00	Capital -related cost allocated to inpatient 26, line 45)				Part II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00
78.00	Inpatient routine service cost (line 74 minu	s line 77)					78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp				nus line 79)		79. 00 80. 00
81. 00	Inpatient routine service costs for comp		ost rimitatio	(11116 /0 1111	1103 11116 <i>17)</i>		81.00
82. 00 83. 00	Inpatient routine service cost limitation (I						82. 00 83. 00
84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		3)				84.00
85.00	Utilization review - physician compensation	(see instructio					85.00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		i ougii 85)				86.00
87. 00	Total observation bed days (see instructions)				0	87.00

Health Financial Systems	UNION HOSPITAL, INC. In Lieu			u of Form CMS-2	2552-10	
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0			Peri od:	Worksheet D-1	
			CCN: 15-T023	From 01/01/2023 To 12/31/2023	Date/Time Prep 5/21/2024 12:	
		Ti tl	e XIX	Subprovi der - I RF	Cost	
Cost Center Description						
					1. 00	
88.00 Adjusted general inpatient routine cost per	diem (line 27	÷ line 2)			0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)			0	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	472, 281	3, 536, 546	0. 13354	.3 0	0	90.00
91.00 Nursing Program cost	0	3, 536, 546	0. 00000	0 0	ol	91.00
92.00 Allied health cost	0	3, 536, 546	0. 00000	0 0	ol	92.00
93.00 All other Medical Education	0	3, 536, 546	0. 00000	0 0	0	93.00

	Financial Systems	UNION HOSPITAL, INC.		In Lie	u of Form CMS-2	2552-10
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 15-0023	Peri od:	Worksheet D-3	
				From 01/01/2023 To 12/31/2023		pared: 12 pm
		Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col . 1 x	
			1.00	2.00	col. 2) 3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3.00	
30. 00	03000 ADULTS & PEDIATRICS			48, 716, 130		30.00
	03100 INTENSIVE CARE UNIT			9, 531, 300		31.00
	02040 I NTENSI VE NURSERY			7, 551, 500		35.00
	04100 SUBPROVI DER - I RF			0		41.00
43.00	04300 NURSERY			0		43.00
10.00	ANCI LLARY SERVI CE COST CENTERS					10.00
50.00	05000 OPERATING ROOM		0. 15175	22, 600, 959	3, 429, 763	50.00
	05001 CARDI AC SURGERY		0. 54474			
50.02	05002 WVSC		0. 12931	102, 784	13, 292	50.02
51.00	05100 RECOVERY ROOM		0. 34643	1, 284, 498	444, 989	51.00
51.02	05101 0/P TREATMENT ROOM		0. 96023	39 265	254	51.02
52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 30806	109, 601	33, 764	52.00
	05400 RADI OLOGY-DI AGNOSTI C		0. 20857		2, 118, 727	54.00
	05500 RADI OLOGY-THERAPEUTI C		0. 14870		106, 296	
56.00	05600 RADI 0I SOTOPE		0. 18484			56.00
57.00	05700 CT SCAN		0. 07870			
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 17226			
59.00	05900 CARDI AC CATHETERI ZATI ON		0. 24964			
60.00	06000 LABORATORY		0. 11731		2, 851, 617	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 52075		541, 341	62.00
65.00	06500 RESPI RATORY THERAPY		0. 17735		2, 270, 401	65.00
66.00	06600 PHYSI CAL THERAPY		0. 36416		1, 009, 518	
66. 01	06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0.00000		0	66. 01
66.02	06602 O/P PHYSICAL THERAPY		0. 32052		0	66.02
67.00	06700 OCCUPATIONAL THERAPY		0. 25722		500, 816	
68.00	06800 SPEECH PATHOLOGY		0. 30697	·	156, 789	
69.00	06900 ELECTROCARDI OLOGY		0. 08196			
	06901 CARDI AC REHAB 07000 ELECTROENCEPHALOGRAPHY		0. 43679 0. 46529			1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 46529		136, 683 0	•
	07200 IMDI DEV CHAPGED TO PATIENTS		0.00000		-	

9, 515, 982

1, 446, 801

15, 523, 899

2, 297, 391

156, 453, 978

156, 453, 978

0

ol

12, 311, 995

0. 221260

0. 208027

0. 595262

0.811118

0. 482503

0. 288341

0. 125947

0. 470334

2, 105, 506 72.00

0

0

0 90.07

29, 118, 172 200. 00

73.00

76.00

90.00

90.05

91.00

92.00

201.00

202.00

2, 561, 227

1, 955, 189

1, 080, 541

861, 226

72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS

OUTPATIENT SERVICE COST CENTERS

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

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

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

03020 RENAL ACUTE

90. 05 09005 PATIENT NUTRITION

09007 WOUND CLINIC

90. 00 09000 CLI NI C

91. 00 09100 EMERGENCY

76.00

90.07

200.00

201.00

202.00

Health Financial Systems UNION HOSPITAL,				u of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Period: From 01/01/2023	Worksheet D-3	3
	Component		To 12/31/2023	Date/Time Pre 5/21/2024 12:	
	Titl∈	e XVIII	Subprovi der - I RF	PPS	•
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x	
		1.00	2. 00	col. 2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 35. 00 02040 INTENSIVE NURSERY 41. 00 04100 SUBPROVIDER - IRF			2, 965, 935		30.00 31.00 35.00 41.00
43. 00 04300 NURSERY					43. 00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM 50. 01 05001 CARDIAC SURGERY		0. 15175 0. 54474	1 1, 505	2, 130 820	50. 01
50. 02 05002 WVSC 51. 00 05100 RECOVERY ROOM 51. 02 05101 0/P TREATMENT ROOM		0. 12931 0. 34643 0. 96023	901 9 0	8 312 0	51. 00 51. 02
52. 00 05200 DELI VERY ROOM & LABOR ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 30806 0. 20857 0. 14870	7 48, 163	13 10, 046 0	54.00
56. 00 05600 RADI 0I SOTOPE 57. 00 05700 CT SCAN 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI)		0. 18484 0. 07870 0. 17226	7 55, 670	201 4, 382 1, 645	57.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 24964 0. 11731 0. 52075	7 356, 937	1, 406 41, 875 2, 734	60.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY 66. 01 06601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 17735 0. 36416 0. 00000	3 286, 642 3 917, 967	50, 837 334, 290 0	65. 00 66. 00
66. 02		0. 32052 0. 25722 0. 30697	6 1 957, 955	0 246, 406 70, 875	66. 02 67. 00
69. 00 06900 ELECTROCARDI OLOGY 69. 01 06901 CARDI AC REHAB		0. 08196 0. 43679	6 12, 052 2 0	988 0 3, 331	69. 00 69. 01
71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS		0. 46529 0. 00000 0. 22126	0 0	0	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATI ENTS 76. 00 03020 RENAL ACUTE OUTPATI ENT SERVI CE COST CENTERS		0. 20802 0. 59526		35, 294 22, 188	76. 00
90. 00 09000 CLINIC 90. 05 09005 PATIENT NUTRITION 90. 07 09007 WOUND CLINIC		0. 81111 0. 48250 0. 28834	3 0	0 0 0	90.05
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 200.00 Total (sum of lines 50 through 94 and 96 through 98)		0. 12594 0. 47033		632 0 830, 413	92.00
201.00 Less PBP Clinic Laboratory Services-Program only charges 202.00 Net charges (line 200 minus line 201)	(line 61)		3, 123, 447	030, 413	201.00

Health Financial Systems	UNI ON HOSPI TAL	., INC.		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der Co		Peri od: From 01/01/2023	Worksheet D-3	
				To 12/31/2023	Date/Time Pre 5/21/2024 12:	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description			Ratio of Cos	t Inpatient	I npati ent	
			To Charges	Program	Program Costs	

				Fo 12/31/2023	Date/Time Pre 5/21/2024 12:	pared: 12 pm
		Ti tl	e XIX	Hospi tal	Cost	
	Cost Center Description		Ratio of Cost		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col . 1 x	
			1.00	2. 00	col . 2) 3.00	
	NPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	0.00	
30.00	3000 ADULTS & PEDIATRICS			3, 687, 028		30.00
31.00	3100 INTENSIVE CARE UNIT			1, 115, 180		31.00
35.00 0	2040 I NTENSI VE NURSERY			0		35.00
41.00	4100 SUBPROVI DER - I RF			68, 334		41.00
	14300 NURSERY			1, 990, 663		43.00
	NCILLARY SERVICE COST CENTERS					
	5000 OPERATING ROOM		0. 15166		242, 379	50.00
	5001 CARDI AC SURGERY		0. 54474		0	50. 01
	5002 WVSC		0. 129318		0	50.02
1	15100 RECOVERY ROOM		0. 346430		24, 595	
1	15101 O/P TREATMENT ROOM		0. 96023		0	51.02
1	15200 DELIVERY ROOM & LABOR ROOM		0. 308062		119, 635	1
1	15400 RADI OLOGY-DI AGNOSTI C		0. 20675		107, 369	54.00
1	15500 RADI OLOGY-THERAPEUTI C		0. 14870		0	55.00
	15600 RADI 01 SOTOPE 15700 CT SCAN		0. 18484 ^o		6, 456 49, 067	1
1	15800 MAGNETIC RESONANCE IMAGING (MRI)		0. 07870		15, 173	ł
1	15900 CARDI AC CATHETERI ZATI ON		0. 17220		81, 977	59.00
1	16000 LABORATORY		0. 11731		261, 830	ł
	16200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 520750		35, 749	62.00
	6500 RESPI RATORY THERAPY		0. 17735		253, 281	65.00
1	16600 PHYSI CAL THERAPY		0. 36416		55, 303	1
1	16601 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 000000		0	66. 01
1	06602 O/P PHYSICAL THERAPY		0. 32052		0	66. 02
	6700 OCCUPATI ONAL THERAPY		0. 25722		33, 319	67.00
68.00	6800 SPEECH PATHOLOGY		0. 30697!	33, 329	10, 231	68.00
69.00	6900 ELECTROCARDI OLOGY		0. 08196	557, 002	45, 655	69.00
69. 01	6901 CARDI AC REHAB		0. 436792	1, 462	639	69. 01
70.00	7000 ELECTROENCEPHALOGRAPHY		0. 465298	20, 129	9, 366	70.00
71.00	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.00000	0	0	71.00
	17200 IMPL. DEV. CHARGED TO PATIENTS		0. 221260	198, 989	44, 028	72.00
	17300 DRUGS CHARGED TO PATIENTS		0. 20802		220, 404	73.00
	3020 RENAL ACUTE		0. 59526	78, 552	46, 759	76. 00
	UTPATIENT SERVICE COST CENTERS					
	9000 CLI NI C		0. 811118		0	90.00
1	19005 PATIENT NUTRITION		0. 48250		0	90.05
	19007 WOUND CLINIC		0. 28834		120 027	90.07
	19100 EMERGENCY		0. 125670		138, 027	91.00
92. 00 C	9200 OBSERVATION BEDS (NON-DISTINCT PART) Total (sum of lines 50 through 94 and 96 through 98)		0. 47033		0 1, 801, 242	
200.00	Less PBP Clinic Laboratory Services-Program only charge:	s (lino 61)		10, 708, 867	1, 001, 242	200.00
201.00	Net charges (line 200 minus line 201)	3 (11110 01)		10, 708, 867		201.00
202.00	[1101 Shar ges (11110 200 IIII has 11110 201)		I	10, 700, 007	I	1202.00

	ncial Systems UNION HOSPITAL, NCILLARY SERVICE COST APPORTIONMENT		CN: 15-0023	In Lie Period:	Worksheet D-3	
		Component	CCN: 15-T023	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/21/2024 12:	pared:
		Ti tl	e XIX	Subprovi der -	Cost	12 piii
	Cost Center Description		Ratio of Cos To Charges		Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
	FIENT ROUTINE SERVICE COST CENTERS					
31. 00 03100 35. 00 02040 41. 00 04100 43. 00 04300	DADULTS & PEDIATRICS DINTENSIVE CARE UNIT DINTENSIVE NURSERY DSUBPROVIDER - IRF DNURSERY			102		30. 00 31. 00 35. 00 41. 00 43. 00
	LARY SERVICE COST CENTERS					4
50. 01 05001 50. 02 05002	OPERATING ROOM CARDIAC SURGERY WVSC RECOVERY ROOM		0. 1516 0. 5447 0. 1293 0. 3464	41 0 18 0		50. 01 50. 02
52.00 05200	O/P TREATMENT ROOM DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC		0. 9602 0. 3080 0. 2067	62 581	0 179 161	
56.00 05600	RADI OLOGY-THERAPEUTI C RADI OI SOTOPE CT SCAN		0. 1487 0. 1848 0. 0787	49 52	10	56.00
59. 00 05900 60. 00 06000	MAGNETIC RESONANCE IMAGING (MRI) CARDIAC CATHETERIZATION LABORATORY		0. 1722 0. 2496 0. 1173	48 491 17 3, 339		59. 00 60. 00
65. 00 06500 66. 00 06600) WHOLE BLOOD & PACKED RED BLOOD CELLS) RESPIRATORY THERAPY) PHYSICAL THERAPY		0. 5207 0. 1773 0. 3641	53 2, 137 63 227	379 83	65. 00 66. 00
66. 02 06602 67. 00 06700	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES O/P PHYSI CAL THERAPY OCCUPATI ONAL THERAPY		0. 00000 0. 3205 0. 2572	26 0 21 194	0 50	66. 02 67. 00
69. 00 06900 69. 01 06901	SPEECH PATHOLOGY DELECTROCARDI OLOGY CARDI AC REHAB		0. 3069 0. 0819 0. 4367	66 833 92 2	68 1	69. 00 69. 01
71. 00 07100 72. 00 07200	ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS DRIVES CHARGED TO PATIENTS		0. 4652 0. 0000 0. 2212	00 0 60 298	0 66	71. 00 72. 00
76. 00 03020 OUTPA	DRUGS CHARGED TO PATIENTS RENAL ACUTE THENT SERVICE COST CENTERS		0. 2080 0. 5952	62 118	70	76.00
90. 05 09005 90. 07 09007	D CLINIC 5 PATIENT NUTRITION 7 WOUND CLINIC		0. 8111 0. 4825 0. 2883	03 41 0	0	90. 05 90. 07
92. 00 09200 200. 00	DEMERGENCY DOBSERVATION BEDS (NON-DISTINCT PART) Total (sum of lines 50 through 94 and 96 through 98)		0. 1256 0. 4703	34 0 16, 022	0	92. 00 200. 00
201. 00 202. 00	Less PBP Clinic Laboratory Services-Program only charges Net charges (line 200 minus line 201)	(line 61)		0 16, 022		201. 00 202. 00

Health Financial Systems	UNION HOSPITAL, INC.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0023	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/21/2024 12:12 pm

	Title XVIII Hospital	5/21/2024 12: PPS	12 pm
		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS	1.00	
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	38, 523, 644	
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	12, 869, 888	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to Octo 1 (see instructions)		
1. 04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	
2.00	Outlier payments for discharges. (see instructions) Outlier reconciliation amount	0	
2. 02 2. 03 2. 04	Outlier payment for discharges for Model 4 BPCI (see instructions) Outlier payments for discharges occurring prior to October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see instructions)	144, 954 56, 574	2. 03
3. 00 4. 00	Managed Care Simulated Payments Bed days available divided by number of days in the cost reporting period (see instructions)	14, 243, 205 231. 30	3.00
5. 00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending		
5. 01	or before 12/31/1996. (see instructions) FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)	0.00	
6. 00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap new programs in accordance with 42 CFR 413.79(e)	for 0.00	6.00
6. 26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 the CAA 2021 (see instructions)		
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1) ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If 1 cost report straddles July 1, 2011 then see instructions.		
7. 02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(bland 87 FR 49075 (August 10, 2022) (see instructions)		7. 02
8. 00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8. 01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the creport straddles July 1, 2011, see instructions.		
8. 02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	
8. 21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)	0.00	
9. 00 10. 00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus of minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions) FTE count for allopathic and osteopathic programs in the current year from your records	or 12. 22 20. 59	
11. 00 12. 00	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)		11.00
13.00	Total allowable FTE count for the prior year.	12. 22	13.00
14. 00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 19 otherwise enter zero.		
	Adjustment for residents in initial years of the program (see instructions)	0.00	15.00
17. 00 18. 00	Adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count	0. 00 12. 22	17.00
19. 00	Current year resident to bed ratio (line 18 divided by line 4).	0. 052832	
20.00	Prior year resident to bed ratio (see instructions)	0. 054018	
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.052832	
22. 00 22. 01	IME payment adjustment (see instructions) IME payment adjustment - Managed Care (see instructions)	1, 461, 889 405, 148	
23. 00	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	8. 45	23. 00
24. 00 25. 00	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see	8. 37 8. 37	1
26. 00	instructions) Resident to bed ratio (divide line 25 by line 4)	0. 036187	
27. 00	IME payments adjustment factor. (see instructions)	0. 009571	
28. 00	IME add-on adjustment amount (see instructions)	491, 887	
28. 01	IME add-on adjustment amount - Managed Care (see instructions)	136, 322	
29. 00 29. 01	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	1, 953, 776 541, 470	
30. 00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	5. 09	30.00
31. 00	Percentage of Medicaid patient days (see instructions)	26. 95	1
32. 00	Sum of lines 30 and 31	32. 04	
33.00	Allowable disproportionate share percentage (see instructions)	i i	33.00

Heal th	Financial Systems UNION HOSP	PITAL, INC.	In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0023	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A	pared:
		Title XVIII	Hospi tal	PPS	12 piii
				1. 00	
34. 00	Disproportionate share adjustment (see instructions)			2, 010, 772	34.00
			Pri or to 10/1 1.00		
	Uncompensated Care Payment Adjustment		1.00	2. 00	
35.00	Total uncompensated care amount (see instructions)			5, 938, 006, 757	1
35. 01	Factor 3 (see instructions)	2)	0. 000471231	0. 000439805	
35. 02 35. 03	Hospital UCP, including supplemental UCP (see instruction Pro rata share of the hospital UCP, including supplementa		3, 239, 432 2, 422, 917	2, 611, 565 656, 459	
36. 00	Total UCP adjustment (sum of columns 1 and 2 on line 35.0	3)	3, 079, 376		36.00
40.00	Additional payment for high percentage of ESRD beneficiary	y discharges (lines 40 thro			10.00
40. 00 41. 00	Total Medicare discharges (see instructions) Total ESRD Medicare discharges (see instructions)		0		40. 00 41. 00
41. 01	Total ESRD Medicare covered and paid discharges (see inst	ructions)	o o		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not q		0. 00		42.00
43. 00 44. 00	Total Medicare ESRD inpatient days (see instructions)	ded by line 41 divided by	0. 000000		43. 00 44. 00
44.00	Ratio of average length of stay to one week (line 43 dividays)	ded by Title 41 divided by	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instruct		0.00		45. 00
46.00	Total additional payment (line 45 times line 44 times lin	e 41.01)	0		46.00
47. 00 48. 00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MD	H small rural hospitals	58, 638, 984 0		47. 00 48. 00
	only. (see instructions)	II, Smarr rarar nospi tars	ŭ		10.00
				Amount 1.00	
49. 00	Total payment for inpatient operating costs (see instruct	i ons)		59, 180, 454	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt.		e)	4, 316, 315	50.00
51.00	Exception payment for inpatient program capital (Wkst. L,			0	
52. 00 53. 00	Direct graduate medical education payment (from Wkst. E-4 Nursing and Allied Health Managed Care payment	, line 49 see instructions).	599, 355 9, 562	1
54.00	Special add-on payments for new technologies			15, 774	1
54. 01	Islet isolation add-on payment			0	54. 01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, li	ne 69)		0	55.00
55. 01 56. 00	Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see	intructions)		0	55. 01 56. 00
57.00	Routine service other pass through costs (from Wkst. D, P	*	through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D,		,	22, 209	58. 00
59.00	Total (sum of amounts on lines 49 through 58)			64, 143, 669	
60. 00 61. 00	Primary payer payments Total amount payable for program beneficiaries (line 59 m	inus line 60)		36, 497 64, 107, 172	
62.00	Deductibles billed to program beneficiaries			5, 332, 024	
63.00	Coinsurance billed to program beneficiaries			28, 712	
64. 00 65. 00	Allowable bad debts (see instructions)			198, 995 129, 347	1
66.00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see	instructions)		198, 995	
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	,		58, 875, 783	67.00
68.00	Credits received from manufacturers for replaced devices	• •	1 1	0	68.00
69. 00 70. 00	Outlier payments reconciliation (sum of lines 93, 95 and OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	96). (FOR SCH SEE INSTRUCTION	ons)	0	69. 00 70. 00
70. 50	Rural Community Hospital Demonstration Project (§410A Dem	onstration) adjustment (se	e instructions)	0	70.50
70. 75	N95 respirator payment adjustment amount (see instruction	s)	ŕ	0	70. 75
70.87	Demonstration payment adjustment amount before sequestrat			0	70.87
70. 88 70. 89	SCH or MDH volume decrease adjustment (contractor use onl Pioneer ACO demonstration payment adjustment amount (see			0	70. 88 70. 89
70. 90	HSP bonus payment HVBP adjustment amount (see instruction			0	1
70. 91	HSP bonus payment HRR adjustment amount (see instructions			0	70. 91
70. 92	Bundled Model 1 discount amount (see instructions)			40. 754	70. 92
70 00	HVBP payment adjustment amount (see instructions)			-49, 756	70. 93
70. 93 70. 94	HRR adjustment amount (see instructions)		I	-167, 129	70. 94

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der Co	CN: 15-0023	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Pre 5/21/2024 12:	pared: 12 pm
	Title	XVIII	Hospi tal	PPS	p
		FFY	(уууу)	Amount	
70 0/	0		0	1. 00	70.0
70.96 Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period prior to 10/1)	n corumn o		0	0	70.96
70.97 Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column 0		0	0	70. 9
the corresponding federal year for the period ending on or at			-		
O. 98 Low Volume Payment-3			0	0	70. 98
0.99 HAC adjustment amount (see instructions)	(0 0 70)			0	70.99
1.00 Amount due provider (line 67 minus lines 68 plus/minus lines 1.01 Sequestration adjustment (see instructions)	69 & 70)			58, 658, 898 1, 173, 178	
1.02 Demonstration adjustment (see Firstractions)				1, 173, 170	1
1.03 Sequestration adjustment-PARHM pass-throughs				_	71.0
2.00 Interim payments				57, 183, 352	72.00
2.01 Interim payments-PARHM					72.0
3.00 Tentative settlement (for contractor use only)				0	
3.01 Tentative settlement-PARHM (for contractor use only) 4.00 Balance due provider/program (line 71 minus lines 71.01, 71.0	12 72 and			302, 368	73. 0° 74. 00
73)	52, 72, and			302, 300	74.00
4.01 Balance due provider/program-PARHM (see instructions)					74. 0 ²
5.00 Protested amounts (nonallowable cost report items) in accorda	ance with			1, 177, 432	75.00
CMS Pub. 15-2, chapter 1, §115.2					ļ
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96) 0.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2 03			0	90.00
plus 2.04 (see instructions)	01 2.00				70.0
1.00 Capital outlier from Wkst. L, Pt. I, line 2				0	91.0
2.00 Operating outlier reconciliation adjustment amount (see instr				0	92.0
3.00 Capital outlier reconciliation adjustment amount (see instruc				0	93.00
4.00 The rate used to calculate the time value of money (see instr 5.00 Time value of money for operating expenses (see instructions)				0. 00 0	94. 00 95. 00
15.00 Time value of money for operating expenses (see instructions) 16.00 Time value of money for capital related expenses (see instruc				0	
order frime variate or morely for eaph tall for a tour expenses (edec frietrat	31. 01.0)		Prior to 10/1		70.00
				0 00	
			1. 00	2. 00	
HSP Bonus Payment Amount					100.0
00.00 HSP bonus amount (see instructions)			1.00		100. 0
00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment					
00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 01.00 HVBP adjustment factor (see instructions)	ns)		0	0. 0000000000	101. 00
DO. 00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment D1. 00 HVBP adjustment factor (see instructions) D2. 00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment	ns)		0. 0000000000	0. 0000000000	101. 0 102. 0
00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 01.00 HVBP adjustment factor (see instructions) 02.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 03.00 HRR adjustment factor (see instructions)			0. 0000000000	0. 0000000000 0 0. 00000	101. 00 102. 00 103. 00
00. 00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 01. 00 HVBP adjustment factor (see instructions) 02. 00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 03. 00 HRR adjustment factor (see instructions) 04. 00 HRR adjustment amount for HSP bonus payment (see instructions)	5)	uctmont.	0. 0000000000	0. 0000000000 0 0. 00000	101. 0 102. 0 103. 0
00. 00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 01. 00 HVBP adjustment factor (see instructions) 02. 00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 03. 00 HRR adjustment factor (see instructions) 04. 00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst	s) tration) Adju		0. 0000000000	0. 0000000000 0 0. 0000 0 0	101. 0 102. 0 103. 0 104. 0
00. 00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 01. 00 HVBP adjustment factor (see instructions) 02. 00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 03. 00 HRR adjustment factor (see instructions) 04. 00 HRR adjustment amount for HSP bonus payment (see instructions)	s) tration) Adju		0. 0000000000	0. 0000000000 0 0. 0000 0 0	101. 00 102. 00 103. 00 104. 00
00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 01.00 HVBP adjustment factor (see instructions) 02.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment factor (see instructions) 03.00 HRR adjustment factor (see instructions) 04.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration OO.00 Is this the first year of the current 5-year demonstration procentury Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement	s) tration) Adju eriod under		0. 0000000000	0. 0000000000 0 0. 0000 0	101. 00 102. 00 103. 00 104. 00 200. 00
00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 01.00 HVBP adjustment factor (see instructions) 02.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 03.00 HRR adjustment factor (see instructions) 04.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst 10 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 01.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir	s) tration) Adju eriod under		0. 0000000000	0. 0000000000 0 0. 0000 0 0	101. 00 102. 00 103. 00 104. 00 200. 00
00. 00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 01. 00 HVBP adjustment factor (see instructions) 02. 00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 03. 00 HRR adjustment factor (see instructions) 04. 00 HRR adjustment factor (see instructions) 04. 00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst 00. 00 Is this the first year of the current 5-year demonstration procentury Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 01. 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir 02. 00 Medicare discharges (see instructions)	s) tration) Adju eriod under		0. 0000000000	0. 0000000000 0 0. 0000 0 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00
00. 00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 01. 00 HVBP adjustment factor (see instructions) 02. 00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment factor (see instructions) 03. 00 HRR adjustment factor (see instructions) 04. 00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst of Section 1) Is this the first year of the current 5-year demonstration procentury Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 01. 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir occ.) 02. 00 Medicare discharges (see instructions) 03. 00 Case-mix adjustment factor (see instructions)	s) tration) Adju eriod under ne 49)	the 21st	0. 0000000000 0 0. 00000 0 0	0. 0000000000 0 0. 0000	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00
00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 01.00 HVBP adjustment factor (see instructions) 02.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 03.00 HRR adjustment factor (see instructions) 04.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration procentury Cures Act? Enter "Y" for yes or "N" for no.	s) tration) Adju eriod under ne 49)	the 21st	0. 0000000000 0 0. 00000 0 0	0. 0000000000 0 0. 0000	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00
00. 00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 01. 00 HVBP adjustment factor (see instructions) 02. 00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 03. 00 HRR adjustment factor (see instructions) 04. 00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration procentury Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 01. 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir Omedicare inpatient service costs (from Wkst. D-1, Pt. II, Iir Omedicare inpatient service costs (from Wkst. D-1, Pt. II, Iir Omedicare inpatient service instructions) Computation of Demonstration Target Amount Limitation (N/A ir period) 04. 00 Medicare target amount	s) tration) Adju eriod under ne 49)	the 21st	0. 0000000000 0 0. 00000 0 0	0. 0000000000 0. 0. 0000 0. 0000 0. trati on	102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
00. 00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 01. 00 HVBP adjustment factor (see instructions) 02. 00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 03. 00 HRR adjustment factor (see instructions) 04. 00 HRR adjustment factor (see instructions) 04. 00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration por Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 01. 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir 02. 00 Medicare discharges (see instructions) 03. 00 Case-mix adjustment factor (see instructions) 04. 00 Medicare target amount 05. 00 Case-mix adjusted target amount (line 203 times line 204)	s) tration) Adju eriod under ne 49) n first year	the 21st	0. 0000000000 0 0. 00000 0 0	0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00
HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment O1.00 HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP bonus Payment HRR Adjustment for HSP Bonus Payment O3.00 HRR adjustment factor (see instructions) O4.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst O5.00.00 Is this the first year of the current 5-year demonstration project Reimbursement O1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir O5.00 Medicare discharges (see instructions) O3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A ir period) O4.00 Medicare target amount O5.00 Case-mix adjusted target amount (line 203 times line 204) O6.00 Medicare inpatient routine cost cap (line 202 times line 205)	s) tration) Adju eriod under ne 49) n first year	the 21st	0. 0000000000 0 0. 00000 0 0	0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00
HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP bonus Payment HRR Adjustment for HSP Bonus Payment HRR Adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration project Reimbursement HRR adjustment service costs (from Wkst. D-1, Pt. II, Iir Demonstration Project (S410A Demonst Is this the first year of the current 5-year demonstration project Reimbursement HRR adjustment service costs (from Wkst. D-1, Pt. II, Iir Demonstration Demonstration Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir Demonstration of Demonstration Target Amount Limitation (N/A ir Demonstration Demonst	s) tration) Adju eriod under ne 49) n first year	the 21st	0. 0000000000 0 0. 00000 0 0	0. 0000000000 0 0. 0000 0 0 0000	101. 0 102. 0 103. 0 104. 0 200. 0 201. 0 202. 0 203. 0 204. 0 205. 0 206. 0
HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 01.00 HVBP adjustment factor (see instructions) 02.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment factor (see instructions) 03.00 HRR adjustment factor (see instructions) 04.00 HRR adjustment factor (see instructions) 04.00 HRR adjustment amount for HSP bonus payment (see instructions) 05.00 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. 07.00 Reimbursement 07.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir of the current of	ration) Adjuration) Adjuration and under the second under	the 21st	0. 0000000000 0 0. 00000 0 0	0. 0000000000 0 0. 0000 0 0 0 0 0 0 0 0	101. 0 102. 0 103. 0 104. 0 200. 0 201. 0 202. 0 203. 0 204. 0 205. 0 206. 0
00. 00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 01. 00 HVBP adjustment factor (see instructions) 02. 00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 03. 00 HRR adjustment factor (see instructions) 04. 00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration project Reimbursement 01. 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir 02. 00 Medicare discharges (see instructions) 03. 00 Case-mix adjustment factor (see instructions) 04. 00 Medicare target amount 05. 00 Case-mix adjusted target amount (line 203 times line 204) 06. 00 Medicare inpatient routine cost cap (line 202 times line 205)	ration) Adjuration) Adjuration and under the second under	the 21st	0. 0000000000 0 0. 00000 0 0	0. 0000000000 0 0. 0000 0 0. ooo	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00
HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 01.00 HVBP adjustment factor (see instructions) 02.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment amount for HSP bonus payment (see instruction HRR adjustment factor (see instructions) 04.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonstration Project (S410A Demonstration (N/A Insperiod) Program reimbursement under the S410A Demonstration (See instructions) Medicare Part A inpatient Reimbursement Project (S410A Demonstration (See instructions) Adjustment to Medicare IPPS payments (see instructions)	ration) Adjuration) Adjuration and under the second under	the 21st	0. 0000000000 0 0. 00000 0 0	0. 0000000000 0. 00000 0. 0000 0. otration	101. 0 102. 0 103. 0 104. 0 200. 0 201. 0 202. 0 203. 0 204. 0 205. 0 206. 0 207. 0 208. 0 209. 0
OO. OO HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment OO. OO HVBP adjustment factor (see instructions) OO. OO HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment OO. OO HRR adjustment factor (see instructions) OO. OO HRR adjustment amount for HSP bonus payment (see instructions) OO. OO HRR adjustment amount for HSP bonus payment (see instructions) OO. OO Is this the first year of the current 5-year demonstration por Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement OO. OO Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir OO. OO Medicare discharges (see instructions) OO. OO Case-mix adjustment factor (see instructions) OO. OO Case-mix adjustment factor (see instructions) OO. OO Medicare target amount OO. OO Medicare inpatient routine cost cap (line 202 times line 204) OO. OO Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement OO. OO Program reimbursement under the \$410A Demonstration (see inst OO. OO Adjustment to Medicare IPPS payments (see instructions) OO Reserved for future use OO. OO Total adjustment to Medicare IPPS payments (see instructions)	tration) Adjustration) Adjustration Adjustra	the 21st	0. 0000000000 0 0. 00000 0 0	0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 209. 00
HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 01. 00 HVBP adjustment factor (see instructions) 02. 00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 03. 00 HRR adjustment factor (see instructions) 04. 00 HRR adjustment amount for HSP bonus payment (see instructions) 04. 00 HRR adjustment amount for HSP bonus payment (see instructions) 06. 01 HRR adjustment amount for HSP bonus payment (see instructions) 07. 02 Is this the first year of the current 5-year demonstration por Century Cures Act? Enter "Y" for yes or "N" for no. 08. Cost Reimbursement 08. 00 Case-mix adjustment factor (see instructions) 09. 00 Case-mix adjustment factor (see instructions) 09. 00 Medicare discharges (see instructions) 09. 00 Medicare target amount 09. 00 Medicare target amount 09. 00 Medicare inpatient routine cost cap (line 202 times line 204) 09. 00 Medicare Part A Inpatient Reimbursement 09. 00 Medicare Part A inpatient Reimbursement 09. 00 Medicare Part A inpatient Reimbursement 09. 00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, 09. 00 Adjustment to Medicare IPPS payments (see instructions) 09. Comparision of PPS versus Cost Reimbursement	tration) Adjustration) Adjustration under the second unde	the 21st	0. 0000000000 0 0. 00000 0 0	0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00
HVBP Adjustment for HSP Bonus Payment O1. 00 HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction) HVBP adjustment amount for HSP bonus payment (see instruction) HRR Adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration Project Reimbursement) O1. 00 Is this the first year of the current 5-year demonstration project Reimbursement O1. 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir O2. 00 Medicare discharges (see instructions) O2. 00 Medicare discharges (see instructions) O3. 00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A ir period) O4. 00 Medicare target amount O5. 00 Case-mix adjusted target amount (line 203 times line 204) O6. 00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement O7. 00 Program reimbursement under the §410A Demonstration (see instructions) O8. 00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, O9. 00 Adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement O7. 01 Total adjustment to Medicare Part A IPPS payments (from line)	tration) Adjustration) Adjustration under the second unde	the 21st	0. 0000000000 0 0. 00000 0 0	0.0000000000 0.0000 0.0000 0	101. 0 102. 0 103. 0 104. 0 200. 0 201. 0 202. 0 203. 0 205. 0 206. 0 207. 0 208. 0 209. 0 211. 0
HVBP Adjustment for HSP Bonus Payment 10.00 HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonstration Project Reimbursement 100.00 Is this the first year of the current 5-year demonstration project Reimbursement 101.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir Demonstration of Demonstration Target Amount Limitation (N/A ir period) 103.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A ir period) 104.00 Medicare target amount 105.00 Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 107.00 Program reimbursement under the \$410A Demonstration (see instructions) 108.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, 199.00 Adjustment to Medicare IPPS payments (see instructions) 109.00 Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement 109.00 Low-volume adjustment (see instructions)	s) tration) Adjustration Adjust	of the curre	0. 0000000000 0 0. 00000 0 0	0. 0000000000 0. 00000 0. 0000 0. otration	101. 0 102. 0 103. 0 104. 0 200. 0 201. 0 202. 0 203. 0 204. 0 205. 0 206. 0 207. 0 208. 0 209. 0 211. 0
HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction) HRR Adjustment for HSP Bonus Payment HRR Adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Is this the first year of the current 5-year demonstration potentury Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement DI. 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir Medicare discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A ir period) DI. 00 Medicare target amount DI. 00 Medicare target amount DI. 00 Medicare inpatient routine cost cap (line 202 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement DI. 00 Medicare Part A inpatient Reimbursement DI. 00 Medicare Part A inpatient Reimbursement DI. 00 Medicare Part A inpatient Reimbursement DI. 01 Medicare Part A inpatient Reimbursement DI. 02 Medicare Part A inpatient Reimbursement DI. 03 Medicare Part A inpatient Reimbursement DI. 04 Medicare Part A inpatient Reimbursement DI. 05 Medicare Part A inpatient Reimbursement DI. 06 Medicare Part A inpatient Reimbursement DI. 07 Medicare Part A inpatient Reimbursement DI. 08 Medicare Part A inpatient Reimbursement DI. 09 Medicare Part A inpatient Reimbursement DI. 09 Medicare Part A inpatient Reimbursement DI. 09 Medicare Part A inpatient Reimbursement DI. 00 Medicare Part A inpatient Reimbursement DI. 01 Medicare Part A inpatient Reimbursement DI. 02 Medicare Part A inpatient Reimbursement DI. 03 Medicare Part A inpatient Reimbursement DI. 04 Medicare Part A inpatient Reimbursement DI. 05 Medicare Part A i	s) tration) Adjustration Adjust	of the curre	0. 0000000000 0 0. 00000 0 0	0. 0000000000 0. 00000 0. 0000 0. otration	101. 0 102. 0 103. 0 104. 0 200. 0 201. 0 202. 0 203. 0 204. 0 205. 0 206. 0 207. 0 208. 0 209. 0 210. 0

Peri od: Worksheet E From 01/01/2023 Part A Exhi bit 4 To 12/31/2023 Date/Time Prepared: Provider CCN: 15-0023

		W/S E, Part A	Amounts (from	Title Pre/Post	XVIII Period Prior	Hospi tal	PPS	
			lAmounts (from l	Dra/Dact I	Dariad Driar			
		I i ne	E, Part A)	Enti tl ement	to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
	DRG amounts other than outlier	1. 00	0	0	0	0	0	1. 00
1. 01	payments DRG amounts other than outlier payments for discharges	1. 01	38, 523, 644	0	38, 523, 644		38, 523, 644	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	12, 869, 888	0		12, 869, 888	12, 869, 888	1. 02
	1 DRG for Federal specific operating payment for Model 4 BPCI occurring prior to	1. 03	0	0	0		0	1. 03
1. 04	October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0		0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2. 00						2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	0	0	0	2. 01
2. 02	Outlier payments for discharges occurring prior to	2. 03	144, 954	0	144, 954		144, 954	2. 02
2. 03	October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see	2.04	56, 574	O		56, 574	56, 574	2. 03
3. 00	instructions) Operating outlier	2. 01	0	0	0	0	0	3. 00
4. 00	reconciliation Managed care simulated payments	3. 00	14, 243, 205	0	13, 259, 951	983, 254	14, 243, 205	4. 00
	Indirect Medical Education Adju							
	Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 052832	0. 052832	0. 052832	0. 052832		5. 00
6. 00	IME payment adjustment (see instructions)	22. 00	1, 461, 889	0	1, 095, 805	366, 084	1, 461, 889	6. 00
6. 01	IME payment adjustment for managed care (see	22. 01	405, 148	O	377, 179	27, 969	405, 148	6. 01
	instructions) Indirect Medical Education Adju	istment for the	Add-on for Se	ection 422 of t	he MMA			
	IME payment adjustment factor (see instructions)	27. 00	0. 009571	0. 009571	0. 009571	0. 009571		7. 00
	IME adjustment (see instructions)	28. 00	491, 887	0	368, 709	123, 178	491, 887	8. 00
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	136, 322	O	126, 911	9, 411	136, 322	8. 01
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	1, 953, 776	0	1, 464, 514	489, 262	1, 953, 776	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	541, 470	0	504, 090	37, 380	541, 470	9. 01
Ī	Disproportionate Share Adjustme							
	Allowable disproportionate share percentage (see instructions)	33. 00	0. 1565	0. 1565	0. 1565	0. 1565		10.00
11. 00	Disproportionate share adjustment (see instructions)	34. 00	2, 010, 772	0	1, 507, 238	503, 534	2, 010, 772	11. 00
11. 01	Uncompensated care payments Additional payment for high per	36.00	3, 079, 376 RD beneficiary	di scharges	2, 422, 917	656, 459	3, 079, 376	11. 01
	Total ESRD additional payment (see instructions)	46. 00	0	0	0	0	0	12. 00
14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47. 00 48. 00	58, 638, 984 0	0	44, 063, 267 0	14, 575, 717 0	58, 638, 984 0	
15. 00	(see instructions) Total payment for inpatient operating costs (see instructions)	49. 00	59, 180, 454	0	44, 567, 357	14, 613, 097	59, 180, 454	15. 00

						From 01/01/2023 To 12/31/2023		pared:
					XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Peri od On/After 10/01	Total (Col 2 through 4)	
	T	0	1. 00	2. 00	3. 00	4. 00	5. 00	
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	4, 316, 315	0	3, 218, 07	0 1, 098, 245	4, 316, 315	16. 00
17. 00 17. 01	Special add-on payments for new technologies Net organ aquisition cost	54. 00	15, 774	0	15, 77	4 0	15, 774	17. 00 17. 01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	0		0 0	0	
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	0		0 0	0	18.00
19. 00	SUBTOTAL			0	47, 801, 20	1 15, 711, 342	63, 512, 543	19.00
		W/S L, line	(Amounts from L)					
	I	0	1. 00	2. 00	3.00	4. 00	5. 00	
20. 00 20. 01	Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier	1. 00 1. 01	3, 902, 573 0	0	2, 909, 19	5 993, 378 0 0	3, 902, 573 0	20. 00
21. 00 21. 01	Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments	2. 00 2. 01	26, 997 0	0	20, 57	6, 423 0 0	26, 997 0	21. 00 21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0320	0. 0320	0. 032	0. 0320		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	124, 882	0	93, 09	4 31, 788	124, 882	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0671	0. 0671	0. 067	0. 0671		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	261, 863	0	195, 20	7 66, 656	261, 863	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	4, 316, 315	0	3, 218, 07	0 1, 098, 245	4, 316, 315	26. 00
		W/S E, Part A line	(Amounts to E, Part A)					
	I	0	1. 00	2. 00	3.00	4. 00	5. 00	
27. 00 28. 00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96			0. 00000	0. 000000	0	27. 00 28. 00
29. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				0	0	29. 00
100.00	Transfer Iow volume adjustments to Wkst. E, Pt. A.		Y					100.00

Health Financial SystemsUNION HOSPITALHOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 Peri od: Worksheet E From 01/01/2023 Part A Exhi bit 5 To 12/31/2023 Date/Time Prepared: 5/21/2024 12:12 pm Provider CCN: 15-0023

					0 12/31/2023	5/21/2024 12:	
				XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2. 00	3. 00	4. 00	
1. 00 1. 01	DRG amounts other than outlier payments DRG amounts other than outlier payments for discharges occurring prior to October 1	1. 00 1. 01	38, 523, 644	38, 523, 644		38, 523, 644	1. 00 1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	12, 869, 888		12, 869, 888	12, 869, 888	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1. 03	0	0		0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0		0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2. 00					2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	0	0	2. 01
2. 02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2. 03	144, 954	144, 954		144, 954	2. 02
2. 03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2. 04	56, 574		56, 574	56, 574	2.03
3. 00 4. 00	Operating outlier reconciliation Managed care simulated payments Indirect Medical Education Adjustment	2. 01 3. 00	14, 243, 205	13, 259, 951	983, 254	0 14, 243, 205	3. 00 4. 00
5. 00	Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 052832	0. 052832	0. 052832		5. 00
6.00	IME payment adjustment (see instructions)	22. 00	1, 461, 889	1, 095, 805	366, 084	1, 461, 889	6. 00
6. 01	IME payment adjustment for managed care (see instructions)		405, 148	·	27, 969	405, 148	6. 01
7. 00	Indirect Medical Education Adjustment for the IME payment adjustment factor (see	27. 00	0. 009571	0. 009571	0. 009571		7. 00
7.00	instructions)	27.00	0.007371	0.007371	0.007371		7.00
8. 00 8. 01	IME adjustment (see instructions) IME payment adjustment add on for managed	28. 00 28. 01	491, 887 136, 322	368, 709 126, 911	123, 178 9, 411	491, 887 136, 322	8. 00 8. 01
0.00	care (see instructions)	20.00	1 052 774	1 141 511	490 242	1 052 774	0.00
9. 00 9. 01	Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 00 29. 01	1, 953, 776 541, 470			1, 953, 776 541, 470	9. 00 9. 01
10.00	Di sproporti onate Share Adjustment	22.00	0.45/5	0.45/5	0.45/5		10.00
10. 00	Allowable disproportionate share percentage (see instructions)	33. 00	0. 1565	0. 1565	0. 1565		10. 00
11. 00	Disproportionate share adjustment (see instructions)	34. 00	2, 010, 772	1, 507, 238	503, 534	2, 010, 772	11. 00
11. 01	Uncompensated care payments	36. 00	3, 079, 376	2, 422, 917	656, 459	3, 079, 376	11. 01
10.00	Additional payment for high percentage of ES				51		10.00
12.00	Total ESRD additional payment (see instructions)	46. 00	0	0 44, 063, 267	14 575 717	0	12.00
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	47. 00 48. 00	58, 638, 984 0	44, 063, 267	14, 575, 717 0	58, 638, 984 0	13. 00 14. 00
15. 00	Total payment for inpatient operating costs (see instructions)	49. 00	59, 180, 454	44, 567, 357	14, 613, 097	59, 180, 454	15. 00
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	4, 316, 315	3, 218, 070	1, 098, 245	4, 316, 315	16. 00
17. 00 17. 01	Special add-on payments for new technologies Net organ acquisition cost	54. 00	15, 774	15, 774	0	15, 774	17. 01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	0	0	0	17. 02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0			0	18.00
19. 00	SUBTOTAL	l	I	47, 801, 201	15, 711, 342	63, 512, 543	19.00

	Financial Systems	UNI ON HOSPI				u of Form CMS-2	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ATION EXHIBIT 5	Provider Co		Peri od: From 01/01/2023 To 12/31/2023		pared:
			Title	XVIII	Hospi tal	PPS	•
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1. 00	2.00	3. 00	4. 00	
20. 00 20. 01	Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier	1. 00 1. 01	3, 902, 573 0		95 993, 378 0 0		20. 00 20. 01
21.00	Capital DRG outlier payments	2. 00	26, 997	20, 57	6, 423	26, 997	21.00
21. 01 22. 00	Model 4 BPCI Capital DRG outlier payments Indirect medical education percentage (see instructions)	2. 01 5. 00	0. 0320	0. 032	0. 0320	0	21. 01 22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	124, 882	93, 09	31, 788	124, 882	23. 00
24. 00		10. 00	0. 0671	0.067	0. 0671		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	261, 863	195, 20	07 66, 656	261, 863	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	4, 316, 315	3, 218, 07	70 1, 098, 245	4, 316, 315	26. 00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1. 00	2.00	3. 00	4. 00	
27. 00 28. 00 29. 00	Low volume adjustment prior to October 1 Low volume adjustment on or after October 1	70. 96 70. 97	0		0	0	27. 00 28. 00 29. 00
30. 00 30. 01	HVBP payment adjustment (see instructions) HVBP payment adjustment for HSP bonus	70. 93 70. 90	-49, 756 0		0 -49, 756 0 0	-49, 756 0	30. 00 30. 01
31. 00	payment (see instructions) HRR adjustment (see instructions)	70. 94	-167, 129	-100, 20	-66, 923	-167, 129	31.00
31. 01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 0	0	31. 01
						(Amt. to Wkst. E, Pt.	
		0	1, 00	2. 00	3. 00	A) 4. 00	
32. 00	HAC Reduction Program adjustment (see	70. 99			0 0		32.00

100.00

instructions)

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

Health Financial Systems	UNION HOSPITAL, INC.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0023	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/21/2024 12:12 pm

		Title XVIII	Hospi tal	5/21/2024 12: PPS	12 pm
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
1.00	Medical and other services (see instructions)	ana)		1, 811	1.00
2. 00 3. 00	Medical and other services reimbursed under OPPS (see instruction OPPS or REH payments	ons)		68, 705, 951 67, 804, 516	2. 00 3. 00
4. 00	Outlier payment (see instructions)			8, 301	4.00
4. 01	Outlier reconciliation amount (see instructions)			0	4. 01
5. 00 6. 00	Enter the hospital specific payment to cost ratio (see instruct Line 2 times line 5	i ons)		0.000	5. 00 6. 00
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7.00
8.00	Transitional corridor payment (see instructions)			0	8. 00
9. 00	Ancillary service other pass through costs including REH direct	graduate medical educ	ation costs from	136, 069	9. 00
10. 00	Wkst. D, Pt. IV, col. 13, line 200 Organ acquisitions			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			1, 811	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
12. 00	Reasonable charges Ancillary service charges			8 771	12.00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin	e 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			8, 771	14.00
15. 00	Customary charges Aggregate amount actually collected from patients liable for pa	vment for services on	a charge hasis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for			0	16.00
	had such payment been made in accordance with 42 CFR §413.13(e)				
17. 00 18. 00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0. 000000 8, 771	17. 00 18. 00
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds li	ne 11) (see	6, 960	
	instructions)			_	
20. 00	Excess of reasonable cost over customary charges (complete only instructions)	If line 11 exceeds li	ne 18) (see	0	20.00
21. 00	Lesser of cost or charges (see instructions)			1, 811	21.00
22. 00	Interns and residents (see instructions)			0	22.00
23. 00 24. 00	Cost of physicians' services in a teaching hospital (see instru Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	ctions)		0 67, 948, 886	23. 00 24. 00
24.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			07, 740, 000	24.00
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)			0	25. 00
26. 00 27. 00	Deductibles and Coinsurance amounts relating to amount on line Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl			11, 262, 897 56, 687, 800	26. 00 27. 00
27.00	instructions)	us the sum of filles 22	and 23] (See	30, 087, 800	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, lin	e 50)		713, 098	
28. 50 29. 00	REH facility payment amount (see instructions) ESRD direct medical education costs (from Wkst. E-4, line 36)			0	28. 50 29. 00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)			57, 400, 898	
31.00	Primary payer payments			8, 278	
32. 00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE:	c)		57, 392, 620	32.00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)	3)		0	33.00
34.00	Allowable bad debts (see instructions)			303, 249	34.00
	Adjusted reimbursable bad debts (see instructions)	-+!>		197, 112	
36. 00 37. 00	Allowable bad debts for dual eligible beneficiaries (see instru Subtotal (see instructions)	Ctions)		303, 249 57, 589, 732	
38. 00	MSP-LCC reconciliation amount from PS&R			-76	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39. 50 39. 75	Pioneer ACO demonstration payment adjustment (see instructions) N95 respirator payment adjustment amount (see instructions)			0	39. 50 39. 75
39. 73	Demonstration payment adjustment amount before sequestration			0	39. 73
39. 98	Partial or full credits received from manufacturers for replace	d devices (see instruc	tions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0 E7 E00 000	39. 99
40. 00 40. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)			57, 589, 808 1, 151, 796	40. 00 40. 01
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
40. 03	Sequestration adjustment-PARHM pass-throughs			5/ /05 /00	40.03
41. 00 41. 01	Interim payments Interim payments-PARHM			56, 685, 639	41. 00 41. 01
42. 00	Tentative settlement (for contractors use only)			0	42.00
42. 01	Tentative settlement-PARHM (for contractor use only)				42. 01
43.00	Balance due provider/program (see instructions)			-247, 627	43.00
43. 01 44. 00	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2	chapter 1.	0	43. 01 44. 00
50	§115. 2				
00 00	TO BE COMPLETED BY CONTRACTOR			^	00 00
90. 00 91. 00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	90. 00 91. 00
92.00	The rate used to calculate the Time Value of Money			0. 00	92.00
93. 00	Time Value of Money (see instructions)			0	93.00

Health Financial Systems	UNI ON HOSPI TAL	., INC.	In Lieu	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-0023	Peri od:	Worksheet E	
			From 01/01/2023		
			To 12/31/2023	Date/Time Pre	pared:
				5/21/2024 12:	12 pm
		Title XVIII	Hospi tal	PPS	
				1. 00	
94.00 Total (sum of lines 91 and 93)				0	94.00
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				0	200. 00

Health Financial Systems	UNION HOSPITAL, INC.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Peri od: From 01/01/2023	Worksheet E
	Component CCN: 15-T023		Date/Time Prepared:
			5/21/2024 12:12 pm
	Title XVIII	Subprovi der -	PPS
		I RF	

	IRF		
		1. 00	+
	PART B - MEDICAL AND OTHER HEALTH SERVICES	1.00	t
00	Medical and other services (see instructions)	71	1
00	Medical and other services reimbursed under OPPS (see instructions)	27	1
00	OPPS or REH payments	156	
00	Outlier payment (see instructions)	0	
)1	Outlier reconciliation amount (see instructions)	0	
00	Enter the hospital specific payment to cost ratio (see instructions)	0. 000	
)O)O	Line 2 times line 5	0.00	
00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)	0.00	
00	Ancillary service other pass through costs including REH direct graduate medical education costs from	-	
,0	Wkst. D, Pt. IV, col. 13, Line 200		
00	Organ acqui si ti ons	0) 1
00	Total cost (sum of lines 1 and 10) (see instructions)	71	1
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
00	Ancillary service charges	342	
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	
00	Total reasonable charges (sum of lines 12 and 13)	342	2 1
00	Customary charges	0	٠ ا
	Aggregate amount actually collected from patients liable for payment for services on a charge basis Amounts that would have been realized from patients liable for payment for services on a chargebasis	0	
00	had such payment been made in accordance with 42 CFR §413.13(e)	U	Ί.
00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0. 000000) 1
	Total customary charges (see instructions)	342	
	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	271	
	instructions)		
00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	0) 2
	instructions)		١.
	Lesser of cost or charges (see instructions)	71	
	Interns and residents (see instructions)	0	
	Cost of physicians' services in a teaching hospital (see instructions)	0 156	
00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT	100	4 4
00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	1 2
00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	0	
	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	227	
	instructions)		
00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0) 2
	REH facility payment amount (see instructions)		2
	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	
00	Subtotal (sum of lines 27, 28, 28.50 and 29)	227	
	Primary payer payments	0	
00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	227] 3
00	Composite rate ESRD (from Wkst. I-5, line 11)	0	3
	Allowable bad debts (see instructions)	0	
	Adjusted reimbursable bad debts (see instructions)	0	
	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	
	Subtotal (see instructions)	227	
	MSP-LCC reconciliation amount from PS&R	0	
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	
	Pioneer ACO demonstration payment adjustment (see instructions)		3
	N95 respirator payment adjustment amount (see instructions)	0	
	Demonstration payment adjustment amount before sequestration	0	
98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	
	RECOVERY OF ACCELERATED DEPRECIATION	0	
	Subtotal (see instructions)	227	
	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration	5	
	Sequestration payment adjustment amount after sequestration	U	7 2
	Interim payments	223	
	Interim payments	223	' Z
	Tentative settlement (for contractors use only)	0	
01	Tentative settlement-PARHM (for contractor use only)	-	4
	Balance due provider/program (see instructions)	-1	
01	Balance due provider/program-PARHM (see instructions)		4
00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0) 4
	§115. 2]
	TO BE COMPLETED BY CONTRACTOR		4
	Original outlier amount (see instructions)	0	
()()	Outlier reconciliation adjustment amount (see instructions)	0.00	
	The rate used to calculate the Time Value of Money		

Health Financial Systems	UNION HOSPITAL	, INC.	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0023	Peri od: From 01/01/2023	Worksheet E	
		Component CCN: 15-T023	To 12/31/2023		pared: 12 pm
		Title XVIII	Subprovi der -	PPS	
			IRF		
				1. 00	
93.00 Time Value of Money (see instructions)				0	93.00
94.00 Total (sum of lines 91 and 93)				0	94.00
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days					200. 00

Health Financial Systems UNANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED In Lieu of Form CMS-2552-10 UNION HOSPITAL, INC. Provider CCN: 15-0023

Peri od: Worksheet E-1 From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared: 5/21/2024 12:12 pm

				10 12/01/2020	5/21/2024 12:	12 pm
		Title	XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	⁻t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1. 00	Total interim payments paid to provider		56, 160, 50	6	55, 412, 356	1. 00
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,			0	0	2. 00
3. 00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
0.04	Program to Provider	40 (04 (0000	4 000 04	40 (04 (0000	4 070 000	0.04
3. 01	ADJUSTMENTS TO PROVIDER	12/31/2023	1, 022, 84		1, 273, 283	3. 01
3. 02				0	0	3. 02
3. 03				0	0	3. 03
3. 04				0	0	3. 04
3. 05	Drawit dans to Drawnson			0	0	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM			ol	0	3. 50
3. 51	ADJUSTIMENTS TO FROUNAM			0		3. 51
3. 52				Ö	l ől	3. 52
3. 53				Ö	l ől	3. 53
3. 54				Ö		3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		1, 022, 84		1, 273, 283	3. 99
4. 00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)				56, 685, 639	4. 00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		57, 183, 35	2	50, 005, 039	4.00
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5. 00
5.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provi der			_	_	
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5. 02				0	0	5. 02
5. 03	Dravi dan ta Dragnam			0	0	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM			o	0	5. 50
5. 51	TENTATIVE TO PROGRAW			0		5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		302, 36		0	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	247, 627	6. 02
7. 00	Total Medicare program liability (see instructions)		57, 485, 72		56, 438, 012	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
	· · · · · · · · · · · · · · · · · · ·					
8. 00	Name of Contractor	()	1.00	2. 00	8. 00

Heal th Financial Systems

UNION HOSPITAL, INC.

In Lieu of Form CMS-2552-10

Provider CCN: 15-0023 | Period: From 01/01/2023 | Period: From 01/01/2

		Ti tl e	XVIII	Subprovi der - I RF	PPS	<u> </u>
		I npati er	nt Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		2, 902, 65	3	223	1.00
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for			0	0	2. 00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
3. 01	Program to Provider ADJUSTMENTS TO PROVIDER		I	ol	0	3. 01
3. 01	ADJUSTMENTS TO PROVIDER			0		3. 01
3. 02				0		3. 02
3. 04				0	0	3. 04
3. 05				0	0	3. 05
	Provider to Program		•			
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 51				0	0	3. 51
3. 52				0	0	3. 52
3. 53				0	0	3.53
3. 54 3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines				0	3. 54 3. 99
3. 99	3. 50-3. 98)			O O	0	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 902, 65	3	223	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as		_,,			
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1) Program to Provider					
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5. 02	TERMITYE TO TROVIDER			Ö	0	5. 02
5.03				0	0	5. 03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM		1	0	0	5. 50
5. 51				0	0	5. 51
5. 52 5. 99	Subtatal (sum of lines E O1 E 40 minus sum of lines			0	0	5. 52 5. 99
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			U	0	5. 99
6. 00	Determined net settlement amount (balance due) based on					6. 00
5. 55	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER			0	0	6. 01
6. 02	SETTLEMENT TO PROGRAM		49, 66		1	6. 02
7. 00	Total Medicare program liability (see instructions)		2, 852, 98		222	7. 00
				Contractor	NPR Date	
			0	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor		9	1.00	2.00	8. 00
5. 00	3. 30111 40101	1		1		0.00

Heal th	Financial Systems UNION HOSPITA	AL, INC.	In Lie	u of Form CMS-	2552-10
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0023 Period: From 01/01/2023				
			To 12/31/2023		
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				-
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATIO				
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst	. S-3, Pt. I col. 15 lin	e 14		1.00
2. 00	Medicare days (see instructions)				2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4.00	Total inpatient days (see instructions)				4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3	line 20			6. 00
7.00	CAH only - The reasonable cost incurred for the purchase of	certified HIT technology	Wkst. S-2, Pt. I		7. 00
	line 168				
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	Sequestration adjustment amount (see instructions)				9. 00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instructio	ns)		32.00
			·		•

	Financial Systems UNION HOSPITAL			u of Form CMS-2	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0023	Peri od:	Worksheet E-3	
		Component CCN: 15-T023	From 01/01/2023 To 12/31/2023	Part III Date/Time Pre 5/21/2024 12:	
		Title XVIII	Subprovi der -	PPS	
			I RF		
				1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			2, 809, 447	1.00
2. 00	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0354	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			114, 064	3.00
4.00	Outlier Payments			5, 108	4.00
5.00	Unweighted intern and resident FTE count in the most recent of	cost reporting period e	nding on or prior	20. 59	5.00
	to November 15, 2004 (see instructions)				
5. 01	Cap increases for the unweighted intern and resident FTE cour			0. 00	5. 01
	program or hospital closure, that would not be counted withou	ıt a temporary cap adjus	tment under 42		
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)				
6. 00	New Teaching program adjustment. (see instructions)			0. 00	6.00
7. 00	Current year's unweighted FTE count of I&R excluding FTEs in	the new program growth	period of a "new	0. 00	7.00
	teaching program" (see instructions)				
8.00	Current year's unweighted I&R FTE count for residents within	the new program growth	period of a "new	0. 00	8. 00
	teaching program" (see instructions)				
9. 00	Intern and resident count for IRF PPS medical education adjus	stment (see instructions)	0. 00	
10. 00	Average Daily Census (see instructions)			8. 846575	
	Teaching Adjustment Factor (see instructions)			0.000000	1
12. 00	Teaching Adjustment (see instructions)			0	
	Total PPS Payment (see instructions)			2, 928, 619	
14. 00	Nursing and Allied Health Managed Care payments (see instruct	i on)		0	
	Organ acquisition (DO NOT USE THIS LINE)				15. 00
	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	
	Subtotal (see instructions)			2, 928, 619	
	Primary payer payments			0	
	Subtotal (line 17 less line 18).			2, 928, 619	•
	Deducti bl es			12, 800	l
	Subtotal (line 19 minus line 20)			2, 915, 819	•
	Coi nsurance			4, 800	•
23.00	Subtotal (line 21 minus line 22)			2, 911, 019	23.00
24.00	Allowable bad debts (exclude bad debts for professional servi	ces) (see instructions)		0	24.00
	Adjusted reimbursable bad debts (see instructions)			0	25. 00
26.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	=0.00
	Subtotal (sum of lines 23 and 25)			2, 911, 019	
28. 00	Direct graduate medical education payments (from Wkst. E-4, I	ine 49)		0	28. 00
29. 00	Other pass through costs (see instructions)			191	29. 00
30.00	Outlier payments reconciliation			0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	31.00
31. 50	Pioneer ACO demonstration payment adjustment (see instruction	ns)		0	
31. 98	Recovery of accelerated depreciation.			0	31. 98

1.00	Net Federal PPS Payment (see Instructions)	2, 809, 447	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0. 0354	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	114, 064	3.00
4.00	Outlier Payments	5, 108	4.00
5. 00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	20. 59	5. 00
5. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42	0. 00	5. 01
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		
6. 00	New Teaching program adjustment. (see instructions)	0. 00	6.00
7. 00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7. 00
8. 00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8. 00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0. 00	9. 00
10.00	Average Daily Census (see instructions)	8. 846575	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00		0	12.00
13.00	Total PPS Payment (see instructions)	2, 928, 619	13.00
14.00		0	14. 00
15. 00			15.00
16. 00		0	16. 00
17. 00		2, 928, 619	
18. 00	,	2, 720, 017	18. 00
19. 00			
	Deductibles		
		12, 800	
21.00	, ,	2, 915, 819	
22. 00		4, 800	
23. 00		2, 911, 019	
24. 00		0	24.00
25.00	, , , , , , , , , , , , , , , , , , , ,	0	25. 00
	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26. 00
27.00	Subtotal (sum of lines 23 and 25)	2, 911, 019	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	191	29. 00
30.00	Outlier payments reconciliation	ol	30.00
31.00		ol	31.00
	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31. 98		ol	31. 98
31. 99		ő	31. 99
32. 00	1	2, 911, 210	
32. 01	Sequestration adjustment (see instructions)	58, 224	
32. 02		0	32.01
	Interim payments	2, 902, 653	
34.00	3/	0	34.00
35. 00		-49, 667	35.00
36. 00	§115. 2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
	Original outlier amount from Wkst. E-3, Pt. III, line 4	5, 108	
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (TH COVID-19 PHE)	E END OF THE	
99. 00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0. 000000	99.00
	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0. 000000	
	1		

Health Financial Systems	UNION HOSPITAL, INC.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0023	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part VII Date/Time Prepared: 5/21/2024 12:12 pm

			12/31/2023	5/21/2024 12:	12 pm
		Title XIX	Hospi tal	Cost	
			I npati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SE	RVICES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		4, 268, 269		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant programs only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		4, 268, 269	0	4.00
5.00	Inpatient primary payer payments		o		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		4, 268, 269	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				1
	Reasonable Charges]
8.00	Routine service charges		6, 861, 206		8.00
9.00	Ancillary service charges		10, 708, 867	0	9.00
10.00	Organ acquisition charges, net of revenue		O		10.00
11.00	Incentive from target amount computation		o		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		17, 570, 073	0	12.00
	CUSTOMARY CHARGES				1
13.00	Amount actually collected from patients liable for payment fo	r services on a charge	0	0	13.00
	basis	_			
14.00	Amounts that would have been realized from patients liable fo	r payment for services or	0	0	14.00
	a charge basis had such payment been made in accordance with	42 CFR §413.13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		17, 570, 073	0	16. 00
17.00	Excess of customary charges over reasonable cost (complete on	ly if line 16 exceeds	13, 301, 804	0	17.00
	line 4) (see instructions)				
18.00	Excess of reasonable cost over customary charges (complete on	ly if line 4 exceeds line	0	0	18. 00
	16) (see instructions)				
19.00	Interns and Residents (see instructions)		0	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see inst	ructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line		4, 268, 269	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provid	ers.		
	Other than outlier payments		0	0	
	Outlier payments		0	0	
	Program capital payments		0		24.00
	Capital exception payments (see instructions)		0		25. 00
	Routine and Ancillary service other pass through costs		0	0	
27.00	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)		4, 268, 269	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6	o)	4, 268, 269	0	31.00
32.00	Deducti bl es		0	0	32.00
33.00	Coi nsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 an	d 33)	4, 268, 269	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
	Subtotal (line 36 ± line 37)		4, 268, 269	0	38. 00
	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
	Total amount payable to the provider (sum of lines 38 and 39)		4, 268, 269	0	
41.00	Interim payments		8, 677, 843	0	
42.00	Balance due provider/program (line 40 minus line 41)		-4, 409, 574	0	
43.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2				

Health Financial Systems	UNI ON HOSPI TAL, INC.	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Peri od: From 01/01/2023	Worksheet E-3 Part VII
	Component CCN: 15-T023	To 12/31/2023	Date/Time Prepared: 5/21/2024 12:12 pm
	Title XIX	Subprovi der -	Cost
		I RF	

		II tie xix	I RF	COST	
			I npati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES	S FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES]
1.00	Inpatient hospital/SNF/NF services		19, 126		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant programs only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		19, 126	0	
5. 00	Inpatient primary payer payments		0		5. 00
6. 00	Outpatient primary payer payments			0	
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		19, 126	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8.00	Routi ne servi ce charges		102		8.00
9.00	Ancillary service charges		16, 022	0	
10.00	Organ acquisition charges, net of revenue		0		10.00
11. 00	Incentive from target amount computation		0	0	11.00
12. 00	Total reasonable charges (sum of lines 8 through 11) CUSTOMARY CHARGES		16, 124	0	12.00
13. 00	Amount actually collected from patients liable for payment for serv	dicas on a charge	0	0	13.00
13.00	basis	vices on a charge	١	U	13.00
14. 00	Amounts that would have been realized from patients liable for payr	ment for services on	o	0	14.00
14.00	a charge basis had such payment been made in accordance with 42 CFF			O	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	1 3110. 10(0)	0. 000000	0. 000000	15.00
16. 00	Total customary charges (see instructions)		16, 124	0.000000	16.00
17. 00	Excess of customary charges over reasonable cost (complete only if	Line 16 exceeds	0	0	
17.00	line 4) (see instructions)	Time to exceeds		Ü	17.00
18.00	Excess of reasonable cost over customary charges (complete only if	line 4 exceeds line	3, 002	0	18.00
	16) (see instructions)		3, 332	_	
19.00	Interns and Residents (see instructions)		o	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instruction	ons)	o	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		16, 124	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be compl	eted for PPS provid	ers.]
22.00	Other than outlier payments		0	0	22. 00
	Outlier payments		0	0	
	Program capital payments		0		24.00
	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	
27. 00			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)		16, 124	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	,		3, 002	0	
31.00			16, 124	0	
32.00	Deducti bl es		0	0	
33. 00			0	0	
34.00	, , , , , , , , , , , , , , , , , , , ,		0	0	
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		16, 124	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
	Subtotal (line 36 ± line 37)		16, 124	0	
	Direct graduate medical education payments (from Wkst. E-4)		1/ 104	^	39.00
	Total amount payable to the provider (sum of lines 38 and 39)		16, 124	0	
	Interim payments		1/ 104	0	
42.00	Balance due provider/program (line 40 minus line 41)	i +h CMC Dub 15 2	16, 124	0	
43. 00	, , , , , , , , , , , , , , , , , , , ,	I III UNS PUD 15-2,	0	Ü	43.00
	chapter 1, §115.2		I I		I

DI RECT	Financial Systems UNION HOSPITAL, IN GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT Pro	vider CCN: 15-0023	Peri od:	u of Form CMS-2 Worksheet E-4	
MEDI CA	AL EDUCATION COSTS		From 01/01/2023 To 12/31/2023	Date/Time Prep 5/21/2024 12:	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1. 00	Unweighted resident FTE count for allopathic and osteopathic progending on or before December 31, 1996.	rams for cost repor	ting periods	14. 92	1.00
1. 01	FTE cap adjustment under §131 of the CAA 2021 (see instructions)	2 70(-)(1) (!	t	0.00	1.01
2. 00 2. 26	Unweighted FTE resident cap add-on for new programs per 42 CFR 41 Rural track program FTE cap limitation adjustment after the cap-b			0. 00 0. 00	2. 00 2. 26
3. 00	the CAA 2021 (see instructions) Amount of reduction to Direct GME cap under section 422 of MMA			0. 00	3.00
3. 01	Direct GME cap reduction amount under ACA §5503 in accordance wit instructions for cost reporting periods straddling 7/1/2011)	h 42 CFR §413.79 (m). (see	0. 00	3. 0
3. 02	Adjustment (increase or decrease) to the hospital's rural track F programs with a rural track Medicare GME affiliation agreement in			0.00	3. 02
1. 00	49075 (August 10, 2022) (see instructions) Adjustment (plus or minus) to the FTE cap for allopathic and oste GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))	opathic programs du	e to a Medicare	0. 00	4.00
1. 01	ACA Section 5503 increase to the Direct GME FTE Cap (see instruct straddling 7/1/2011)	ions for cost repor	ting periods	0. 00	4. 01
1. 02	ACA Section 5506 number of additional direct GME FTE cap slots (periods straddling 7/1/2011)	see instructions fo	r cost reporting	0. 00	4. 02
1. 21	The amount of increase if the hospital was awarded FTE cap slots instructions)	under §126 of the C	AA 2021 (see	0. 00	4. 21
5. 00	FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus lines 2 3.01, plus or minus line 3.02, plus or minus line 4, plus lines 4		inus lines 3 and	14. 92	5.00
5. 00	Unweighted resident FTE count for allopathic and osteopathic progrecords (see instructions)	20. 59	6.00		
7. 00	Enter the lesser of line 5 or line 6			14. 92	7.00
		Primary Cau 1.00	<u>0ther</u> 2.00	<u>Total</u> 3. 00	
3. 00	Weighted FTE count for physicians in an allopathic and osteopathi		59 0.00	20. 59	8.00
9. 00	program for the current year. If line 6 is less than 5 enter the amount from line 8, otherwise	14.	92 0.00	14. 92	9. 00
	multiply line 8 times the result of line 5 divided by the amount 6. For cost reporting periods beginning on or after October 1, 20 if Worksheet S-2, Part I, line 68, is "Y", see instructions.	on line			
0. 00	Weighted dental and podiatric resident FTE count for the current	year	0.00		10.00
10. 01	Unweighted dental and podiatric resident FTE count for the currer	,	0.00		10. 01
1.00	Total weighted FTE count	14.			11.00
2. 00	Total weighted resident FTE count for the prior cost reporting ye instructions)	ar (see 14.	92 0.00		12.00
13. 00	Total weighted resident FTE count for the penultimate cost report year (see instructions)	i ng 14.	92 0.00		13.00
4.00	Rolling average FTE count (sum of lines 11 through 13 divided by	· .			14.00
	, ,		0.00		15.00
	Unweighted adjustment for residents in initial years of new progr		0.00		15. 01
15. 01			0.00		16. 00 16. 01
15. 01 16. 00	Adjustment for residents displaced by program or hospital closure Unweighted adjustment for residents displaced by program or hospi		00 0.00		10.0
15. 01 16. 00 16. 01	Adjustment for residents displaced by program or hospital closure	tal 0.			
15. 01 16. 00 16. 01	Adjustment for residents displaced by program or hospital closure Unweighted adjustment for residents displaced by program or hospiclosure Adjusted rolling average FTE count	tal 0.	00 0. 00 92 0. 00		17.00
15. 01 16. 00 16. 01 17. 00 18. 00 18. 01	Adjustment for residents displaced by program or hospital closure Unweighted adjustment for residents displaced by program or hospiclosure Adjusted rolling average FTE count Per resident amount Per resident amount under §131 of the CAA 2021	tal 0. 14. 155, 434. 155, 434.	00 0.00 92 0.00 28 155, 434. 28 28 155, 434. 28		17. 00 18. 00 18. 01
15. 01 16. 00 16. 01 17. 00 18. 00 18. 01	Adjustment for residents displaced by program or hospital closure Unweighted adjustment for residents displaced by program or hospiclosure Adjusted rolling average FTE count Per resident amount	tal 0.	00 0.00 92 0.00 28 155, 434. 28 28 155, 434. 28	2, 319, 079	17. 00 18. 00 18. 01
15. 01 16. 00 16. 01 17. 00 18. 00 18. 01 19. 00	Adjustment for residents displaced by program or hospital closure Unweighted adjustment for residents displaced by program or hospi closure Adjusted rolling average FTE count Per resident amount Per resident amount under §131 of the CAA 2021 Approved amount for resident costs	tal 0. 144. 155, 434. 155, 434. 2, 319, (00 0.00 92 0.00 28 155, 434. 28 28 155, 434. 28 079 0	1.00	17. 00 18. 00 18. 01 19. 00
15. 01 16. 00 16. 01 17. 00 18. 00 18. 01 19. 00	Adjustment for residents displaced by program or hospital closure Unweighted adjustment for residents displaced by program or hospiclosure Adjusted rolling average FTE count Per resident amount Per resident amount under §131 of the CAA 2021 Approved amount for resident costs Additional unweighted allopathic and osteopathic direct GME FTE resec. 413.79(c)(4)	tal 0. 14. 155, 434. 155, 434. 2, 319, 0. esident cap slots r	00 0.00 92 0.00 28 155, 434. 28 28 155, 434. 28 079 0	1. 00	17. 00 18. 00 18. 01 19. 00
16. 01 17. 00 18. 00 18. 01 19. 00 20. 00	Adjustment for residents displaced by program or hospital closure Unweighted adjustment for residents displaced by program or hospiclosure Adjusted rolling average FTE count Per resident amount Per resident amount under §131 of the CAA 2021 Approved amount for resident costs Additional unweighted allopathic and osteopathic direct GME FTE r Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instruction	tal 0. 14. 155, 434. 155, 434. 2, 319, 0 esident cap slots r	00 0.00 92 0.00 28 155, 434. 28 28 155, 434. 28 079 0	1. 00 5. 75 5. 67	17. 00 18. 00 18. 01 19. 00 20. 00
15. 01 16. 00 16. 01 17. 00 18. 00 18. 01 19. 00 20. 00 21. 00 22. 00	Adjustment for residents displaced by program or hospital closure Unweighted adjustment for residents displaced by program or hospiclosure Adjusted rolling average FTE count Per resident amount Per resident amount under §131 of the CAA 2021 Approved amount for resident costs Additional unweighted allopathic and osteopathic direct GME FTE r Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instructional direct GME FTE Resident Count (see instructional	tal 0. 14. 155, 434. 155, 434. 2, 319, 0 esi dent cap slots r ns) ons)	00 0.00 92 0.00 28 155, 434. 28 28 155, 434. 28 079 0 ecci ved under 42	1. 00 5. 75 5. 67 5. 67	17. 00 18. 00 18. 01 19. 00 20. 00 21. 00 22. 00
15. 01 16. 00 16. 01 17. 00 18. 00 18. 01 19. 00 20. 00 21. 00 22. 00 23. 00	Adjustment for residents displaced by program or hospital closure Unweighted adjustment for residents displaced by program or hospiclosure Adjusted rolling average FTE count Per resident amount Per resident amount under §131 of the CAA 2021 Approved amount for resident costs Additional unweighted allopathic and osteopathic direct GME FTE r Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instruction	tal 0. 14. 155, 434. 155, 434. 2, 319, 0 esi dent cap slots r ns) ons)	00 0.00 92 0.00 28 155, 434. 28 28 155, 434. 28 079 0 ecci ved under 42	1. 00 5. 75 5. 67	17. 00 18. 00 18. 01 19. 00 20. 00 21. 00 22. 00 23. 00

	Financial Systems UNION HOSPITAL				u of Form CMS-2	2552-10
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provi der C	CN: 15-0023	Peri od:	Worksheet E-4	
MEDI CA	LL EDUCATION COSTS			From 01/01/2023 To 12/31/2023	Date/Time Pre 5/21/2024 12:	
		Title	XVIII	Hospi tal	PPS	
			Inpatient Part A	Managed Care	Total	
			1.00	2. 00	3. 00	
	COMPUTATION OF PROGRAM PATIENT LOAD					
26. 00	Inpatient Days (see instructions) (Title XIX - see S-2 Part I 3.02, column 2)	X, line	23, 3	69 7, 546		26. 00
27. 00	Total Inpatient Days (see instructions)		70, 5	·	l	27. 00
28. 00	Ratio of inpatient days to total inpatient days		0. 3312			28. 00
29. 00	Program di rect GME amount		1, 000, 0			
29. 01				3. 27	1	29. 01
30.00	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			10, 560		
31.00	Net Program direct GME amount				1, 312, 453	31.00
	1. DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING PROGRAM AND PARAMEDICAL					
	EDUCATION COSTS)					
32. 00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)					32.00
33.00						33.00
34.00						34.00
35.00	Medicare outpatient ESRD charges (see instructions)	0	35.00			
36.00	Medicare outpatient ESRD direct medical education costs (line		35)		0	36. 00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	ONLY				
	Part A Reasonable Cost					
37. 00	Reasonable cost (see instructions)				57, 892, 454	
38. 00 39. 00	Organ acquisition and HSCT acquisition costs (see instruction Cost of physicians' services in a teaching hospital (see inst				0	38. 00 39. 00
40.00	Primary payer payments (see instructions)	ructions)			36, 497	
41. 00	Total Part A reasonable cost (sum of lines 37 through 39 minu	s line 40)			57, 855, 957	
41.00	Part B Reasonable Cost	13 11110 40)			37,033,737	71.00
42.00					68, 843, 929	42.00
43.00	Primary payer payments (see instructions)				8, 278	
44.00	Total Part B reasonable cost (line 42 minus line 43)				68, 835, 651	
45.00	Total reasonable cost (sum of lines 41 and 44)				126, 691, 608	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (lin				0. 456668	
47. 00	Ratio of Part B reasonable cost to total reasonable cost (lin		45)		0. 543332	47. 00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PA	RT B				
	Total program GME payment (line 31)		>		1, 312, 453	
49. 00	Part A Medicare GME payment (line 46 x 48) (title XVIII only)				599, 355	
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only)	(see instr	uctions)		713, 098	50.00

Health Financial Systems UNION HOSPITAL, INC. In Lieu				u of Form CMS-2	552-10
OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT Provider CCN: 15-0023 Period:					
			From 01/01/2023 To 12/31/2023	Date/Time Prep 5/21/2024 12:	pared: 12 pm
Title XVIII					
	1. 00				
TO BE COMPLETED BY CONTRACTOR					
1.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)					1.00
2.00 Capital outlier from Wkst. L, Pt. I, line 2					2.00
3.00 Operating outlier reconciliation adjustment amount (see instructions)					3.00
4.00	Capital outlier reconciliation adjustment amount (see instruc	ctions)		0	4.00
5.00 The rate used to calculate the time value of money (see instructions)				0.00	5.00
6.00	Time value of money for operating expenses (see instructions)			0	6.00
7. 00	Time value of money for capital related expenses (see instruc	ctions)		0	7.00

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

Health Financial Systems

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

Provider CCN: 15-0023 Peri

Peri od: Worksheet G From 01/01/2023 To 12/31/2023 Date/Time Prepared:

onl y)			10	12/31/2023	5/21/2024 12:	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1. 00	2.00	3. 00	4. 00	
4 00	CURRENT ASSETS	(/ 005 070		ما		1 00
1. 00 2. 00	Cash on hand in banks	66, 385, 273	0	0	0	1.00 2.00
3.00	Temporary investments Notes receivable	0		0	0	3.00
4. 00	Accounts receivable	68, 481, 893		0	0	4.00
5. 00	Other receivable	0	l o	Ö	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	10, 546, 951	O	0	0	7.00
8.00	Prepai d expenses	-29, 915, 820	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9. 00
10.00	Due from other funds	0	0	0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	115, 498, 297	0	0	0	11.00
40.00	FI XED ASSETS	40,000,500		ما		10.00
12.00	Land	19, 002, 582	1	0	0	12.00
13. 00 14. 00	Land improvements Accumulated depreciation	21, 393, 341	0	0	0	13. 00 14. 00
15. 00	Buildings	307, 990, 763	-	0	0	15.00
16. 00	Accumulated depreciation	-412, 161, 856		0	0	16.00
17. 00	Leasehold improvements	109, 630, 654		0	0	17. 00
18. 00	Accumulated depreciation	0	l o	Ö	0	18.00
19. 00	Fi xed equi pment	0	Ö	Ö	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22. 00
23.00	Major movable equipment	219, 386, 851	0	0	0	23.00
24. 00	Accumulated depreciation	0	0	0	0	24. 00
25. 00	Mi nor equi pment depreci abl e	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27. 00	HIT designated Assets	0	0	0	0	27.00
28. 00 29. 00	Accumulated depreciation Minor equipment-nondepreciable	0	0	0	0	28. 00 29. 00
30.00	Total fixed assets (sum of lines 12-29)	265, 242, 335		0	0	30.00
30.00	OTHER ASSETS	203, 242, 333	<u> </u>	<u> </u>	0	30.00
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on Leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	O	0	0	33.00
34.00	Other assets	292, 934, 778	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	292, 934, 778		0	0	35.00
36. 00	Total assets (sum of lines 11, 30, and 35)	673, 675, 410	0	0	0	36.00
07.00	CURRENT LIABILITIES	E0 404 0//		ما		07.00
37.00	Accounts payable	59, 131, 966		0	0	37.00
38.00	Salaries, wages, and fees payable Payroll taxes payable	23, 817, 767	0	0	0	38. 00 39. 00
39. 00 40. 00	Notes and Loans payable (short term)	0	0	0	0	40.00
41. 00	Deferred income	0	0	0	0	41.00
42.00	Accel erated payments	0		Ŭ	O	42. 00
43. 00	Due to other funds	0	o	0	0	43.00
44. 00	Other current liabilities	4, 258, 038	Ö	Ö	0	
45.00	Total current liabilities (sum of lines 37 thru 44)	87, 207, 771		0	0	
	LONG TERM LIABILITIES					
46.00	Mortgage payable	50, 034, 739	0	0	0	46. 00
47. 00	Notes payable	0	0	0	0	47. 00
48. 00	Unsecured Loans	0	0	0	0	48. 00
49.00	Other long term liabilities	219, 104, 824		0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	269, 139, 563		0	0	50.00
51. 00	Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS	356, 347, 334	0	0	0	51.00
52. 00	General fund balance	317, 328, 076				52.00
53.00	Specific purpose fund	317, 320, 070	0			53.00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			o		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement,				0	58.00
	replacement, and expansion					
59.00	Total fund balances (sum of lines 52 thru 58)	317, 328, 076		0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and	673, 675, 410	0	0	0	60.00
	[59]		I I	l		l

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES UNION HOSPITAL, INC. In Lieu of Form CMS-2552-10 Provider CCN: 15-0023

| Period: | Worksheet G-1 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared:

Comparigney						To	o 12/31/2023	Date/Time Pre 5/21/2024 12:	
1.00 2.00 3.00 4.00 5.00 1.00 Fund balances at beginning of period 211,724,713 0 1.00 2.00 3.00 3.00 4.00 5.00 1.00 2.00 3.0			Genera	Fund	Speci al	Pu	rpose Fund	Endowment	
1.00 Fund balances at beginning of period 211,724,713 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 105,603,363 0 2.00 3.00 Total (sum of line 1 and line 2) 317,328,076 0 3.00 4.00 Additions (credit adjustments) (specify) 0 0 0 0 0 5.00 0 0 0 0 0 0 0 6.00 0 0 0 0 0 0 0 7.00 0 0 0 0 0 0 0 8.00 0 0 0 0 0 0 0 9.00 0 0 0 0 0 0 0								i unu	
2.00 Net income (loss) (from Wkst. G-3, line 29) 3.00 Total (sum of line 1 and line 2) 4.00 Additions (credit adjustments) (specify) 5.00 6.00 7.00 8.00 9.00 9.00			1. 00				4. 00	5. 00	
3.00 Total (sum of line 1 and line 2) 317,328,076 0 3.00 4.00 5.00 6.00 7.00 8.00 9.00 0 0 0 0 0 0 9.00 0 0 0 0 0 0 0 0 0							0		1
4.00 Additions (credit adjustments) (specify) 0 0 0 0 0 5.00 6.00 7.00 8.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					1				1
5.00 0 0 5.00 6.00 0 0 0 6.00 7.00 0 0 0 7.00 8.00 0 0 0 8.00 9.00 0 0 0 9.00				317, 328, 076		0	ŭ,	0	1
6. 00 7. 00 8. 00 9. 00 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		Additions (credit adjustments) (specify)	0			-			1
7. 00 8. 00 9. 00 0 0 0 0 0 0 0 0 9. 00			Ö			-			
9.00			o			0		0	ł
			o			0		_	
10.00 Total additions (sum of line 4.0)			0			0		0	
	10.00	Total additions (sum of line 4-9)		0			0		10.00
11.00 Subtotal (line 3 plus line 10) 317,328,076 0 11.00 12.00 Deductions (debit adjustments) (specify) 0 0 12.00				317, 328, 076		0	O	0	
13. 00 beductions (debit adjustments) (specify) 0 0 13. 00		beductions (debit adjustillents) (specify)	0			-			
14.00			l ől			-			
15.00	15.00		o			0		0	15.00
16.00			o			0		_	
17. 00			0	_		0	_	0	
18.00 Total deductions (sum of lines 12-17) 0 18.00				0			-		
19.00 Fund balance at end of period per balance 317, 328, 076 0 19.00 sheet (line 11 minus line 18)	19.00			317, 328, 076			U		19.00
Endowment Plant Fund		Sheet (Title II illinus IIIIe 10)	Endowment	PI ant	Fund				
Fund			Fund						
					0.00				
6.00 7.00 8.00 1.00 Fund balances at beginning of period 0 0	1 00	Fund halances at heginning of period		7.00	8.00				1 00
2.00 Net income (loss) (from Wkst. G-3, line 29)			٩			U			
3.00 Total (sum of line 1 and line 2) 0 0 3.00			О			0			1
4.00 Additions (credit adjustments) (specify) 0 4.00		Additions (credit adjustments) (specify)		0					4.00
5.00				0					1
6.00				0					1
7. 00 8. 00				0					
9.00				0					l
10.00 Total additions (sum of line 4-9) 0 10.00		Total additions (sum of line 4-9)	o	O		0			
11.00 Subtotal (line 3 plus line 10) 0 0 11.00			o			0			1
12.00 Deductions (debit adjustments) (specify) 0 12.00		Deductions (debit adjustments) (specify)		0					
13.00				0					
14.00				0					
15. 00 16. 00				0					
17. 00				0					ł
18.00 Total deductions (sum of lines 12-17) 0 18.00		Total deductions (sum of lines 12-17)	o	O		0			
19.00 Fund balance at end of period per balance 0 0 19.00	19. 00	Fund balance at end of period per balance	o			0			19.00
sheet (line 11 minus line 18)		sheet (line 11 minus line 18)			l				

UNION HOSPITAL, INC.

| Peri od: | Worksheet G-2 | From 01/01/2023 | Parts | & II | To | 12/31/2023 | Date/Time | Prepared: Health Financial Systems
STATEMENT OF PATLENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0023

PART 1 - PATLENT REVENUES 1.00 2.00 3.00			Т	o 12/31/2023	Date/Time Pre 5/21/2024 12:	
PART I - PATIENT REVENUES Seneral Inspirit not Routine Services		Cost Center Description	Inpati ent	Outpati ent		12
SIRPROVIDER IPF 146, 811, 831 1.46, 811, 831 2.00 2.00 2		F				
1.00		PART I - PATIENT REVENUES				
1.00		General Inpatient Routine Services				
SUBPROVIDER 18F 6,256,695 6,256,695 3,00 5,00	1.00	Hospi tal	146, 811, 831		146, 811, 831	1.00
A. 0.0 SUPPROVIDER	2.00	SUBPROVI DER - I PF				2.00
5.00 Swing bed - SNF	3.00		6, 256, 695		6, 256, 695	3.00
Swing Ded - NF						
3.00 SKILLED NURSING FACILITY			0			1
8. 00 NURSING FACILITY 153,068,526 153,068,526 10,00			0		0	1
9.00 OTHER LONG TERM CARE 9,00 153,068,526 153,068,526 153,068,526 170,000						1
10.00						
Intensive Care Type Inpatient Hospital Services			450 0/0 50/		450 0/0 50/	1
11.00 INTENSIVE CARE UNIT	10.00		153, 068, 526		153, 068, 526	10.00
12.00 CORONARY CARE UNIT 12.00 13.00 13.00 14.00 15.00	44 00		1 04 007 540		24 207 540	14 00
13.00 BURN INTENSIVE CARE UNIT 14.00 10.10 1			31, 096, 549		31, 096, 549	1
14.00 SURSICAL INTENSIVE CARE UNIT 15.00 TOTAL INTENSIVE NURSERY 15.00 TOTAL INTENSIVE NURSERY 15.00 TOTAL INTENSIVE NURSERY 15.00 17.15) 17.00 TOTAL Intensive care type inpatient hospital services (sum of lines 53,763,090 16.00 17.15) 17.00 TOTAL Inpatient routine care services (sum of lines 10 and 16) 206, 831, 616 17.00 206, 831, 616 17.00 206, 831, 616 17.00 207, 831, 616 17.00 207, 831, 616 17.00 207, 831, 616 17.00 207, 831, 616 17.00 207, 831, 616 17.00 207, 831, 616 17.00 207, 831, 616 17.00 207, 831, 616 17.00 207, 831, 616 17.00 207, 831, 631 207, 831, 831, 831, 831, 831, 831, 831, 831						•
15. 00 INTENSIVE NURSERY						
16. 00 Total intensive care type inpatient hospital services (sum of lines 10 and 16) 11.15) 17. 00 17. 15. 17. 00 17. 15. 17. 00 17. 15. 17. 00 18. 38. 559 19. 00 18. 38. 55			22 666 541		22 666 541	•
11-15 17-16 1						
17.00	10.00	, , , , , , , , , , , , , , , , , , , ,	33, 703, 070		33, 703, 040	10.00
18. 00 Ancillary services 416, 641, 752 1, 330, 048, 905 1, 746, 690, 657 18. 09 00 00 00 00 00 00 00	17 00		206 831 616		206 831 616	17 00
19. 00 Outpatient services 48, 340, 522 119, 998, 037 168, 338, 559 19, 00 00 00 00 00 00 00 00			1			1
20. 00 RURAL HEALTH CLINIC 0 0 0 20. 00 0 20. 00 0 20. 00 0 20. 00 0 20. 00 0 20. 00 0 20. 00 0 20. 00 20						•
21. 00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 21. 00 22. 00 HOME HEALTH AGENCY 22. 00 23. 00 AMBULANCE SERVICES 23. 00 AMBULANCE SERVICES 24. 00 25. 00 CMHC 24. 00 25. 00 26. 00 40. 00 27. 00 27. 00 28. 00 29						•
22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 23.00 CMHC 24.00 CMHC 25.00 AMBULATORY SURGICAL CENTER (D.P.) 25.00 AMBULATORY SURGICAL CENTER (D.P.) 25.00 CMHC 25.00			0	0		
23. 00 AMBULANCE SERVICES 24. 00 CMHC 24. 00 CMHC 25. 00 AMBULATORY SURGICAL CENTER (D.P.) 26. 00 CM CM 27. 00 CM CM 28. 00 CM CM 28. 00 CM CM CM CM CM CM CM					_	
24. 00 CMHC 25. 00 AMBULATORY SURGICAL CENTER (D.P.) 26. 00 HOSPI CE 27. 00 RURAL HEALTH 0 7, 901, 986 7, 901, 986 27. 00 0 0 0 0 0 0 0 0 0						•
26. 00 HOSPICE						
27. 00 RURAL HEALTH 0 7, 901, 986 7, 901, 986 27. 00 7, 901, 986 27. 00 7, 901, 986 27. 00 7, 901, 986 27. 00 7, 901, 986 27. 00 27. 01 7, 901, 986 27. 00 27. 01 7, 901, 986 27. 00 27. 01 7, 901, 986 27. 00 27. 01 27. 02 27. 03 27. 04 27. 05 27. 05 27. 05 27. 05 27. 05 27. 05 27. 05 27. 05 27. 05 27. 05 27. 06 27. 07	25.00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
27. 01 RENTAL PROPERTY 27. 02 FAMILY PRACTICE 27. 03 WELLNESS 27. 04 WELLNESS 37. 04 PHYSICIAN PRACTICES 37. 05 SYCAMORE SPORTS MED 37. 06 PSYCHIATRI (CPSYCHOLOGICAL SERVICES) 38. 07 OF SYCHIATRI (CPSYCHOLOGICAL SERVICES) 47. 07 PROFEES 47. 08 PRO FEES 4	26.00	HOSPI CE				26.00
27. 02 FAMILY PRACTICE 27. 03 WELLNESS WELLNESS WELLNESS 1, 571, 156 30, 472, 066 32, 043, 222 27. 04 27. 05 SYCAMORE SPORTS MED 27. 06 PSYCHIATRI C/PSYCHOLOGICAL SERVICES PROFEES 1, 571, 156 30, 472, 066 32, 043, 222 27. 04 27. 05 27. 06 PSYCHIATRI C/PSYCHOLOGICAL SERVICES 248, 151 2, 619, 605 2, 624, 042 2, 624, 042 2, 649, 605 2, 624, 042 2, 649, 605 2, 624, 042 2, 168, 759, 113 28. 00 30. 00 30. 00 30. 00 30. 00 30. 00 31. 00 32. 00 33. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 40. 00 41. 00 41. 00 42. 00 Total additions (sum of lines 37-41) Total operating expenses (sum of lines 37-41) Total operating expenses (sum of lines 39-and 36 minus line 42) (transfer 595, 507, 870 1, 577, 156 30, 472, 066 32, 043, 222 27. 04 32, 043, 222 27. 04 32, 043, 222 37. 04 32, 05 32, 05 32, 07 32, 07 32, 07 34, 08 34, 09 35, 00 36, 00 37, 00 38, 00 39, 00 40, 00 41, 00 41, 00 42, 00 Total operating expenses (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer 595, 520, 870 1, 577, 156 30, 472, 066 32, 043, 222 37. 04 32, 043, 222 37. 04 32, 043, 223 32, 07 34, 07 477, 488, 664 382, 315 27. 06 7676, 252, 802 77. 06	27.00	RURAL HEALTH	0	7, 901, 986	7, 901, 986	27. 00
27. 03 WELLNESS	27. 01	RENTAL PROPERTY	0	0	0	27. 01
27. 04 PHYSICIAN PRACTICES 27. 05 SYCAMORE SPORTS MED 27. 06 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 27. 07 PRO FEES 28. 00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. (a.3, line 1) PART II - OPERATING EXPENSES 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 38. 00 39. 00 30. 00	27. 02	FAMILY PRACTICE	0	1, 327, 111	1, 327, 111	27. 02
27. 05 SYCAMORE SPORTS MED			0	0		
27. 06 PSYCHIATRIC/PSYCHOLOGICAL SERVICES PRO FEES 248, 151 2, 619, 605 2, 624, 042 5, 243, 647 27. 07 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 676, 252, 802 1, 492, 506, 311 2, 168, 759, 113 28. 00			1, 571, 156	30, 472, 066	32, 043, 222	
27. 07 28. 00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst.			0	0	_	•
28.00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 676, 252, 802 1, 492, 506, 311 2, 168, 759, 113 28.00			1			1
G-3, line 1) PART II - OPERATING EXPENSES Operating expenses (per Wkst. A, column 3, line 200) HOME OFFICE 118, 032, 206 33.00 32.00 33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY) Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer) 29.00 477, 488, 664 30.00 31.00 31.00 32.00 33.00 31.00 32.00 33.00 34.00 35.00 36.00 0 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer) 595, 520, 870 43.00						
PART II - OPERATING EXPENSES 29.00	28. 00		676, 252, 802	1, 492, 506, 311	2, 168, 759, 113	28.00
29. 00 30. 00 30. 00 31. 00 31. 00 32. 00 33. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 Total deductions (sum of lines 37-41) Total operating expenses (per Wkst. A, column 3, line 200) 477, 488, 664 30. 00 31. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer) 477, 488, 664 30. 00 31. 00 31. 00 32. 00 33. 00 34. 00 35. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 595, 520, 870						
30. 00	20.00			477 400 444		20.00
31.00 32.00 33.00 33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY) 0 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer) 0 31.00 32.00 33.00 33.00 33.00 34.00 35.00 0 36.00 0 37.00 0 38.00 0 0 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer) 595, 520, 870			110 022 204			1
32.00 33.00 33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY) 0 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 0 32.00 33.00 33.00 34.00 35.00 36.00 37.00 38.00 0 0 0 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 595,520,870		HOWE OFFICE				
33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) 37.00 BEDUCT (SPECIFY) 0 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 33.00 34.00 35.00 36.00 37.00 38.00 0 0 0 0 40.00 41.00 42.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 595,520,870 33.00 34.00 35.00 36.00 37.00 38.00 39.00 40.00 41.00 42.00 43.00						
34.00 35.00 36.00 Total additions (sum of lines 30-35) 37.00 BEDUCT (SPECIFY) 0 318,002 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 34.00 0 35.00 36.00 37.00 0 38.00 0 0 0 40.00 41.00 42.00 595,520,870 34.00						
35.00 36.00 Total additions (sum of lines 30-35) 37.00 DEDUCT (SPECIFY) 0 118,032,206 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 0 35.00 118,032,206 36.00 37.00 38.00 0 0 49.00 41.00 42.00 595,520,870 43.00						
36.00 Total additions (sum of lines 30-35) 37.00 DEDUCT (SPECIFY) 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 36.00 37.00 37.00 0 38.00 0 0 39.00 0 0 40.00 0 0 40.00 0 0 41.00 0 0 41.00 0 0 42.00 595,520,870 43.00						•
37. 00 38. 00 37. 00 38. 00 38. 00 39. 00 40. 00 41. 00 42. 00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 595, 520, 870 43. 00		Total additions (sum of lines 30-35)				
38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 595, 520, 870 38.00			0			
39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 595, 520, 870 39.00 41.00 42.00 595, 520, 870 43.00			1			
40.00			1			
41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 595, 520, 870 43.00			0			
42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 595, 520, 870 43.00			0			1
43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 595, 520, 870 43.00		Total deductions (sum of lines 37-41)		0		
		, ,		595, 520, 870		•
		to Wkst. G-3, line 4)				

Heal th	n Financial Systems UNION	N HOSPITAL, INC.	In Lie	u of Form CMS-2	2552-10
STATE	MENT OF REVENUES AND EXPENSES	Provi der CCN: 15-0023	Peri od:	Worksheet G-3	
	From 01/01/2023 To 12/31/2023				
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, colu			2, 168, 759, 113	•
2.00	Less contractual allowances and discounts on patient	s' accounts		1, 537, 300, 730	
3.00	Net patient revenues (line 1 minus line 2)			631, 458, 383	
4.00	Less total operating expenses (from Wkst. G-2, Part			595, 520, 870	
5. 00	Net income from service to patients (line 3 minus li	ne 4)		35, 937, 513	5.00
	OTHER I NCOME				, ,,
6.00	Contributions, donations, bequests, etc			0	
7.00	Income from investments			0	
8.00	Revenues from telephone and other miscellaneous comm	iuni cati on servi ces		0	
9.00	Revenue from television and radio service Purchase discounts			0	
10.00	Rebates and refunds of expenses			0	•
12. 00				0	
13. 00				0	13.00
	Revenue from meals sold to employees and quests			0	
	Revenue from rental of living quarters			0	1
16. 00	ğ ,	o other than nationts		0	16.00
	Revenue from sale of drugs to other than patients	o other than patrents		0	•
18. 00				0	•
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20. 00		en		0	•
	Rental of vending machines			0	
22. 00	g and a second s			0	22.00
23. 00				0	
	OTHER OPERATING INCOME			32, 338, 792	1
24. 01				2, 206, 107	1
24. 02				34, 250, 831	1
24. 03	TRANSFER FOR PROPERTY AND EQUIPENT			0	24. 03
24. 04	UNREALIZED GAIN/LOSS ON INVESTMENTS			0	24. 04
24. 05	OTHER INCOME AND EXPENSE			-341	24. 05
24.06	OTHER INCOME AND EXPENSE			870, 461	24.06
24. 50	COVI D-19 PHE Fundi ng			0	
25.00	Total other income (sum of lines 6-24)			69, 665, 850	25. 00
	Total (line 5 plus line 25)			105, 603, 363	26. 00
	OTHER EXPENSES (SPECIFY)			0	
28. 00	Total other expenses (sum of line 27 and subscripts)			0	28. 00

105, 603, 363 29. 00

50 25.00 63 26.00 0 27.00 0 28.00

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

Heal th	Financial Systems UNION HOSPITA	AL. INC.	In Lie	u of Form CMS-2	2552-10	
	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0023	Peri od: From 01/01/2023 To 12/31/2023	Worksheet L Parts I-III Date/Time Pre	pared:	
		Title XVIII	Hospi tal	5/21/2024 12: PPS	12 pm	
		I the Aviii	поѕрі таі	PPS		
				1. 00		
	PART I - FULLY PROSPECTIVE METHOD					
	CAPITAL FEDERAL AMOUNT					
1.00	Capital DRG other than outlier			3, 902, 573	1.00	
1. 01	Model 4 BPCI Capital DRG other than outlier	0	1. 01			
2. 00	Capital DRG outlier payments	26, 997	2.00			
2. 01	Model 4 BPCI Capital DRG outlier payments		0	2. 01		
3. 00 4. 00	Total inpatient days divided by number of days in the cost r	184. 46 20. 59	3. 00 4. 00			
4. 00 5. 00	Number of interns & residents (see instructions) Indirect medical education percentage (see instructions)			3. 20	4. 00 5. 00	
6. 00	Indirect medical education percentage (see instructions)	ne sum of lines 1 and 1.0	1 columns 1 and	124, 882	6.00	
0.00	1.01) (see instructions)	ic sum of fiftes f and f. o	i, cordiiiis r and	124, 002	0.00	
7. 00	Percentage of SSI recipient patient days to Medicare Part A	patient days (Worksheet	E, part A line	5. 09	7. 00	
	30) (see instructions)					
8.00	Percentage of Medicaid patient days to total days (see instr	ructions)		26. 95	8.00	
9.00	Sum of lines 7 and 8	32. 04	9. 00			
10.00	Allowable disproportionate share percentage (see instruction	6. 71 261, 863	10.00			
11. 00					11. 00 12. 00	
12. 00	12.00 Total prospective capital payments (see instructions)					
	PART II - PAYMENT UNDER REASONABLE COST			1. 00		
1.00	Program inpatient routine capital cost (see instructions)			0	1.00	
2.00	Program inpatient ancillary capital cost (see instructions)			0	2.00	
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	3.00	
4. 00	Capital cost payment factor (see instructions)			0	4.00	
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00	
				1. 00		
	PART III - COMPUTATION OF EXCEPTION PAYMENTS					
1.00	Program inpatient capital costs (see instructions)			0	1.00	
2.00	Program inpatient capital costs for extraordinary circumstar	nces (see instructions)		0	2.00	
3. 00	Net program inpatient capital costs (line 1 minus line 2)			0	3. 00	
4.00	Applicable exception percentage (see instructions)			0.00	4.00	
5.00	Capital cost for comparison to payments (line 3 x line 4)	+		0	5.00	
6. 00 7. 00	Percentage adjustment for extraordinary circumstances (see i Adjustment to capital minimum payment level for extraordinar		v lino ()	0. 00 0	6. 00 7. 00	
8. 00	Capital minimum payment level (line 5 plus line 7)	y circuiistances (irrie 2	x iiile o)	0	8.00	
9. 00	Current year capital payments (from Part I, line 12, as appl	i cable)		0	9. 00	
10.00	Current year comparison of capital minimum payment level to		less line 9)	Ö	10.00	
11. 00	Carryover of accumulated capital minimum payment level over			Ö	11. 00	
	Worksheet L, Part III, line 14)		,			
12.00	Net comparison of capital minimum payment level to capital p			0	12.00	
13.00	Current year exception payment (if line 12 is positive, enter			0	13.00	
14. 00	Carryover of accumulated capital minimum payment level over	capital payment for the	following period	0	14. 00	
15 00	(if line 12 is negative, enter the amount on this line) Current year allowable operating and capital payment (see in	netructions)		0	15. 00	
	Current year operating and capital costs (see instructions)	isti ucti olisj		0		
	Current year exception offset amount (see instructions)			0		
20	1					