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: 14-1342 Worksheet S Peri od: From 01/14/2023 Parts I-III AND SETTLEMENT SUMMARY 09/30/2023 Date/Time Prepared: 2/27/2024 3: 24 pm PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 2/27/2024 3: 24 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 COUNTY HOSPITAL DISTRICT (14-1342) for the cost reporting period beginning 01/14/2023 and ending 09/30/2023 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	2	SIGNATURE STATEMENT	
1	An	nber Lipe	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	Amber Lipe			2
3	Signatory Title	CF0			3
4	Date	(Dated when report is electronica			4

		Title	XVIII			
	Title V	Part A	Part B	HI T	Title XIX	
	1. 00	2.00	3. 00	4. 00	5. 00	
PART III - SETTLEMENT SUMMARY						
1. 00 HOSPI TAL	0	533, 205	-448, 785	0	-2, 689	1.00
2. 00 SUBPROVI DER - I PF	0	0	0		0	2.00
3. 00 SUBPROVI DER - I RF	0	0	0		0	3.00
5. 00 SWING BED - SNF	0	542, 344	0		0	5.00
6.00 SWING BED - NF	0				0	6.00
10.00 RURAL HEALTH CLINIC I	0		-25, 042		0	10.00
200. 00 TOTAL	0	1, 075, 549	-473, 827	0	-2, 689	200.00
The above amounts represent "due to" or "due from"	Albaniana I talah a			المتناسين والمتاس والما	Land that the second	

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.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-1342 Peri od: Worksheet S-2 From 01/14/2023 Part I 09/30/2023 Date/Time Prepared: 2/27/2024 3:24 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 517 NORTH MAIN STREET 1.00 PO Box: 1.00 2.00 City: ANNA State: IL Zi p Code: 62906 County: UNION 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 UNION COUNTY HOSPITAL 141342 99914 07/01/1966 Ν 0 3.00 DUSTRUCT Subprovi der - IPF 4.00 4.00 5.00 Subprovi der - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF UNION COUNTY HOSP DIST |08/05/1992 147342 99914 N N 0 7.00 7 00 SWING BEDS 8.00 Swing Beds - NF 8.00 9.00 Hospital -Based SNF 9.00 Hospital -Based NF 10.00 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospital -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14 00 14 00 15.00 Hospital-Based Health Clinic - RHC UNION COUNTY HOSP DIST 143975 99914 05/22/1991 N 0 N 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: 2 00 1 00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/14/2023 09/30/2023 20.00 21.00 Type of Control (see instructions) 21.00 1.00 2. 00 3. 00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for N 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. Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no Ν Ν 22.01 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 determined at cost report settlement? (see instructions) Enter in column 22.02 Ν Ν 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 N N 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 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 yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 23 00 3 N 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 reporting period? In column 2, enter "Y" for yes or "N" for no.

57.00

57.00 For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes,

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

Y" for yes; otherwise, enter "N" for no in column 2.

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	UNI ON COUN	NTY HOSPITAL DISTRICT	-	In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP			CN: 14-1342 Pe	eri od:	Worksheet S-2	
			To	om 01/14/2023 09/30/2023	Part I Date/Time Pre 2/27/2024 3:2	pared: 4 pm
			Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 +	
			Nonprovi der	Hospi tal	col. 2))	
			Si te	·	, ,	
Cootian FEOA of the ACA Dage Vo	on ETE Dooidonto in N	lanneavi dan Catti nga	1.00	2.00	3.00	
Section 5504 of the ACA Base Year period that begins on or after .			-inis base year	r is your cost	reporting	
64.00 Enter in column 1, if line 63 is in the base year period, the nur resident FTEs attributable to rosettings. Enter in column 2 the resident FTEs that trained in year.	mber of unweighted no otations occurring in e number of unweighte	n-primary care all nonprovider d non-primary care	0.00	0. 00	0. 000000	64. 00
of (column 1 divided by (column						
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col.	
			FTEs Nonprovi der	FTEs in Hospital	3/ (col. 3 + col. 4))	
			Si te	nospi tai	COI. 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)			Unwei ghted FTEs Nonprovi der Si te			65.00
Section 5504 of the ACA Current beginning on or after July 1, 2		n Nonprovider Settin	gsEffective f	or cost report	ing periods	
66.00 Enter in column 1 the number of		ry care resident	0.00	0.00	0. 000000	66.00
FTEs attributable to rotations of						
Enter in column 2 the number of FTEs that trained in your hospi						
(column 1 divided by (column 1 -	column 2)). (see in					
	Program Name	Program Code	Unwei ghted	Unweighted	Ratio (col.	
			FTEs Nonprovi der	FTEs in Hospital	3/ (col. 3 + col. 4))	
			Si te	·		
(7.00   5.1	1. 00	2. 00	3.00	4. 00	5. 00	(7.55
67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

0.00

0.00

97.00

97.00 If line 96 is "Y", enter the reduction percentage in the applicable column.

reimbursed 101% of inpatient services cost? Enter "Y" for y		nospital (CAH) no in column 1			98.03		
for title V, and in column 2 for title XIX.							
98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH			N	N	98. 04		
outpatient services cost? Enter "Y" for yes or "N" for no i in column 2 for title XIX.	n column i for	title v, and					
98.05 Does title V or XIX follow Medicare (title XVIII) and add b			Υ	Υ	98. 05		
Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in	column 1 for t	itle V, and in					
column 2 for title XIX.  98.06 Does title V or XIX follow Medicare (title XVIII) when cost	reimbursed fo	or Wkst. D.	Υ	Y	98. 06		
Pts. I through IV? Enter "Y" for yes or "N" for no in colum							
column 2 for title XIX. Rural Providers							
105.00 Does this hospital qualify as a CAH?			Y		105.00		
106.00 f this facility qualifies as a CAH, has it elected the all-inclusive method of payment N							
for outpatient services? (see instructions)		6 100	N.		107.00		
107.00 Column 1: If line 105 is Y, is this facility eligible for a training programs? Enter "Y" for yes or "N" for no in column 1: If line 105 is Y, is this facility eligible for a training programs?			N		107. 00		
Column 2: If column 1 is Y and line 70 or line 75 is Y, do							
approved medical education program in the CAH's excluded I		uni t(s)?					
Enter "Y" for yes or "N" for no in column 2. (see instruct 108.00 is this a rural hospital qualifying for an exception to the		edul e? See 42	Υ		108.00		
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.							
	Physi cal	Occupati onal	Speech	Respi ratory			
109.00  f this hospital qualifies as a CAH or a cost provider, are	1. 00 N	2. 00 N	3. 00 N	4. 00 N	109. 00		
therapy services provided by outside supplier? Enter "Y"					107.00		
for yes or "N" for no for each therapy.							
				1.00	-		
110.00 Did this hospital participate in the Rural Community Hospit	al Demonstrati	on project (§4	10A	N	110.00		
Demonstration) for the current cost reporting period? Enter							
complete Worksheet E, Part A, lines 200 through 218, and Wo	orksheet E-2, I	ines 200 throu	gh 215, as				
аррг г саы с.							
444 00 15 H1	The French of		1.00	2. 00	111 00		
111.00 If this facility qualifies as a CAH, did it participate in			1. 00 N	2.00	111.00		
111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c	cost reporting	peri od? Enter		2.00	111.00		
Health Integration Project (FCHIP) demonstration for this on "Y" for yes or "N" for no in column 1. If the response to contintegration prong of the FCHIP demo in which this CAH is particularly.	cost reporting column 1 is Y, articipating ir	period? Enter enter the column 2.		2.00	111.00		
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Health Integration Project (FCHIP) demonstration for this of "Y" for yes or "N" for no in column 1. If the response to dintegration prong of the FCHIP demo in which this CAH is particle.  Integration prong of the FCHIP demo in which this CAH is particle.  Integration prong of the FCHIP demo in which this CAH is particle.  Integration prong of the FCHIP demo in which this CAH is particle.  Integration and particle in the Pennsylvania Rural Head (PARHM) demonstration for any portion of the current cost of period? Enter "Y" for yes or "N" for no in column 1. If "Y", enter in column 2, the date the hospital began particle demonstration. In column 3, enter the date the hospital content of particle pation in the demonstration, if applicable.  Miscellaneous Cost Reporting Information  In column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either "for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provided the definition in CMS Pub. 15-1, chapter 22, §2208. 1.	cost reporting column 1 is Y, articipating in additional beds alth Model reporting column 1 is pating in the cased or "N" for no B, or E only) 193" percent (includes ers) based on	period? Enter enter the n column 2. s; and/or "C"  1.00  N	N	3.00	112.00		
Health Integration Project (FCHIP) demonstration for this of "Y" for yes or "N" for no in column 1. If the response to dintegration prong of the FCHIP demo in which this CAH is partner all that apply: "A" for Ambulance services; "B" for a for tele-health services.  112.00 Did this hospital participate in the Pennsylvania Rural Health (PARHM) demonstration for any portion of the current cost in period? Enter "Y" for yes or "N" for no in column 1. If of "Y", enter in column 2, the date the hospital began participation. In column 3, enter the date the hospital conjumited participation in the demonstration, if applicable.  Miscellaneous Cost Reporting Information  115.00 Is this an all-inclusive rate provider? Enter "Y" for yes of in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either "for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provided the definition in CMS Pub. 15-1, chapter 22, §2208.1.  116.00 Is this facility classified as a referral center? Enter "Y"	cost reporting column 1 is Y, articipating in additional beds alth Model reporting column 1 is pating in the cased or "N" for no B, or E only) 193" percent (includes ers) based on	period? Enter enter the n column 2. s; and/or "C"	N	3.00	112.00		
Health Integration Project (FCHIP) demonstration for this of "Y" for yes or "N" for no in column 1. If the response to dintegration prong of the FCHIP demo in which this CAH is particle and that apply: "A" for Ambulance services; "B" for a for tele-health services.  112.00 Did this hospital participate in the Pennsylvania Rural Heac (PARHM) demonstration for any portion of the current cost of period? Enter "Y" for yes or "N" for no in column 1. If of "Y", enter in column 2, the date the hospital began participation. In column 3, enter the date the hospital conjumitation. In column 3, enter the date the hospital conjumitation in the demonstration, if applicable.  Miscellaneous Cost Reporting Information  115.00 Is this an all-inclusive rate provider? Enter "Y" for yes of in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either "for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provided the definition in CMS Pub. 15-1, chapter 22, §2208.1.  116.00 Is this facility classified as a referral center? Enter "Y" "N" for no.	cost reporting column 1 is Y, articipating in additional beds all th Model reporting column 1 is pating in the eased or "N" for no B, or E only) 193" percent (includes ers) based on the for yes or	period? Enter enter the n column 2. s; and/or "C"  1.00  N	N	3.00	112.00		
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Health Integration Project (FCHIP) demonstration for this of "Y" for yes or "N" for no in column 1. If the response to dintegration prong of the FCHIP demo in which this CAH is particle and that apply: "A" for Ambulance services; "B" for a for tele-health services.  112.00 Did this hospital participate in the Pennsylvania Rural Health (PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If of "Y", enter in column 2, the date the hospital began participation in the demonstration, if applicable.  Miscellaneous Cost Reporting Information  115.00 Is this an all-inclusive rate provider? Enter "Y" for yes of in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either "for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provided the definition in CMS Pub. 15-1, chapter 22, §2208. 1.  116.00 Is this facility classified as a referral center? Enter "Y" "N" for no.  117.00 Is this facility legally-required to carry mal practice insumy" for yes or "N" for no.	cost reporting column 1 is Y, articipating in additional beds alth Model reporting column 1 is pating in the eased or "N" for no B, or E only) '93" percent (includes ers) based on for yes or urance? Enter Dicy? Enter 1	period? Enter enter the n column 2. s; and/or "C"  1.00  N	N	3.00	112.00		
Health Integration Project (FCHIP) demonstration for this of "Y" for yes or "N" for no in column 1. If the response to dintegration prong of the FCHIP demo in which this CAH is particle and that apply: "A" for Ambulance services; "B" for a for tele-health services.  112.00 Did this hospital participate in the Pennsylvania Rural Head (PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If of "Y", enter in column 2, the date the hospital began particity demonstration. In column 3, enter the date the hospital comparticipation in the demonstration, if applicable.  Miscellaneous Cost Reporting Information  115.00 Is this an all-inclusive rate provider? Enter "Y" for yes of in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either "for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provided the definition in CMS Pub. 15-1, chapter 22, §2208.1.  116.00 Is this facility classified as a referral center? Enter "Y" "N" for no.  117.00 Is this facility legally-required to carry mal practice insu" "Y" for yes or "N" for no.	cost reporting column 1 is Y, articipating in additional beds alth Model reporting column 1 is pating in the eased or "N" for no B, or E only) '93" percent (includes ers) based on for yes or urance? Enter Dicy? Enter 1	period? Enter enter the n column 2. s; and/or "C"  1.00  N	N	3.00	112. 00 115. 00 116. 00 117. 00		
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Health Integration Project (FCHIP) demonstration for this of "Y" for yes or "N" for no in column 1. If the response to dintegration prong of the FCHIP demo in which this CAH is particle and that apply: "A" for Ambulance services; "B" for a for tele-health services.  112.00 Did this hospital participate in the Pennsylvania Rural Health (PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If of "Y", enter in column 2, the date the hospital began participation in the demonstration, if applicable.  Miscellaneous Cost Reporting Information  115.00 Is this an all-inclusive rate provider? Enter "Y" for yes of in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either "for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provided the definition in CMS Pub. 15-1, chapter 22, §2208. 1.  116.00 Is this facility legally-required to carry mal practice insumy" for yes or "N" for no.  117.00 Is this facility legally-required to carry mal practice insumy" for yes or "N" for no.	cost reporting column 1 is Y, articipating in additional beds alth Model reporting column 1 is pating in the eased or "N" for no B, or E only) '93" percent (includes ers) based on for yes or urance? Enter Dicy? Enter 1	period? Enter enter the n column 2. s; and/or "C"  1.00  N	N	3.00	112. 00 115. 00 116. 00 117. 00		

146.00

Ν

no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.

Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If

146.00 Has the cost allocation methodology changed from the previously filed cost report?

yes, enter the approval date (mm/dd/yyyy) in column 2.

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Ą	Provi der CC	CN: 14-134			/14/2023 /30/2023	Worksheet S- Part I Date/Time Pr 2/27/2024 3:	epared:
								1.00	
147.00Was there a change in the statist	cal hasis? Enter "V"	for v	ves or "N" for	no				1. 00 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					for	no.		N	149.00
			Part A	Part	В	Ti	tle V	Title XIX	
			1. 00	2. 00			3. 00	4. 00	
Does this facility contain a prov or charges? Enter "Y" for yes or			ent for Part A	and Part			2 CFR §41	3. 13)	
155. 00 Hospi tal			Y	Y			N	N	155.00
156. 00 Subprovi der - IPF 157. 00 Subprovi der - IRF			N N	N N			N N	N N	156. 00 157. 00
158. OO SUBPROVI DER			IN	Į IN			IN	IN IN	158. 00
159. 00 SNF			N	l N			N	N	159. 00
160. OOHOME HEALTH AGENCY			N	l N			N	N N	160.00
161. 00 CMHC				N N			N	N	161.00
		<u>'</u>				1		1. 00	
Mul ti campus									
165.00 Is this hospital part of a Multic	BSAs?	N	165. 00						
Enter "Y" for yes or "N" for no.	Name		County	State	7i n	Code	CBSA	FTE/Campus	
	0		1. 00	2.00		00	4. 00	5. 00	+
166.00  f  line 165 is yes, for each	0		1.00	2.00	J.	00	4.00		00166.00
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)									
								1.00	-
Health Information Technology (HI	T) incentive in the A	mari c	an Pecovery an	d Pai nyas	tmant	t Act		1. 00	
167. 00 Is this provider a meaningful use	r under §1886(n)? Fn	ter "\	Y" for ves or	"N" for n	in	. ACI		Υ	167.00
168.00 If this provider is a CAH (line 1						enter	the	·	168. 00
reasonable cost incurred for the									
168.01 If this provider is a CAH and is	not a meaningful user	, does	s this provide	r qualify	for	a hard	lshi p		168. 0°
exception under §413.70(a)(6)(ii)									
169.00 If this provider is a meaningful		) and	is not a CAH	(line 105	is "	N"), ∈	enter the	1. (	00169.00
transition factor. (see instructi	ons)					D		For all to a	
							ji nni ng 1. 00	Endi ng 2. 00	+
170.00 Enter in columns 1 and 2 the EHR	pedinning date and en	di na 7	date for the r	enorti na			1.00	2.00	170.00
period respectively (mm/dd/yyyy)	Degitiffing date and en	urng (	uate for the f	epor tring					170.00
							1. 00	2.00	
171.00 If line 167 is "Y", does this pro	vider have any davs f	or in	di vi dual s enro	lled in			N	2.00	0171.00
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 umn 1. If column 1 is	, Pt.	I, line 2, co	I. 6? Ent					

Heal th	Financial Systems UNION COUNTY HOS	SPITAL DISTRICT		In lie	u of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 14-1342	Peri od:	Worksheet S-2	
				From 01/14/2023 To 09/30/2023	Date/Time Pre	
				Y/N	2/27/2024 3: 2	24 pm
				1.00	2. 00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSI					
	General Instruction: Enter Y for all YES responses. Enter I	N for all NO r	esponses. Ent	er 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			Y	01/14/2023	1.00
	reporting period? If yes, enter the date of the change in	column 2. (see	Y/N	Date	V/I	
			1.00	2. 00	3. 00	
2. 00	Has the provider terminated participation in the Medicare		N			2.00
	yes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.	mn 3, "V" for				
3. 00	Is the provider involved in business transactions, including	ng management	Y			3.00
	contracts, with individuals or entities (e.g., chain home					
	or medical supply companies) that are related to the provious officers, medical staff, management personnel, or members					
	of directors through ownership, control, or family and other					
	relationships? (see instructions)					
			1.00	7ype 2.00	3. 00	
	Financial Data and Reports		1.00	2.00	3.00	
4. 00	Column 1: Were the financial statements prepared by a Cer		Y	А		4.00
	Accountant? Column 2: If yes, enter "A" for Audited, "C"					
	or "R" for Reviewed. Submit complete copy or enter date avaculumn 3. (see instructions) If no, see instructions.	arrabre in				
5.00	Are the cost report total expenses and total revenues diffe	erent from	N			5.00
	those on the filed financial statements? If yes, submit re	conciliation.		\/ (N)	1 1 0	
				Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities			1.00	2.00	
6. 00	Column 1: Are costs claimed for a nursing program? Column	2: If yes, i	s the provide	r N		6. 00
7. 00	the legal operator of the program?  Are costs claimed for Allied Health Programs? If "Y" see in	nstructi ons		N		7.00
8. 00	Were nursing programs and/or allied health programs approve		wed during th			8.00
	cost reporting period? If yes, see instructions.					
9. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cal educatior	N		9.00
10. 00	Was an approved Intern and Resident GME program initiated		the current	N		10.00
	cost reporting period? If yes, see instructions.					
11. 00	Are GME cost directly assigned to cost centers other than Teaching Program on Worksheet A? If yes, see instructions.	I & R in an Ap	proved	N		11.00
	reaching frogram on worksheet A: IT yes, see mistractions.				Y/N	
					1.00	
12 00	Bad Debts	a asa i natsua	+i ono			12.00
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection			ost reporting	Y N	12.00
	peri od? If yes, submit copy.	por roy oriango	aarriig tiii o c	oot roper triig		10.00
14. 00	If line 12 is yes, were patient deductibles and/or coinsur	ance amounts w	aived? If yes	, see	N	14.00
	instructions.  Bed Complement					
15. 00	Did total beds available change from the prior cost report	ing period? If	yes, see ins	tructions.	N	15.00
			t A		t B	
		1. 00	2.00	Y/N 3.00	Date 4. 00	
	PS&R Data	1.00	2.00	0.00	1. 00	
16. 00	Was the cost report prepared using the PS&R Report only?	Y	02/01/2024	Y	02/01/2024	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)					
17. 00	Was the cost report prepared using the PS&R Report for	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)					
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18.00
	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.					
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19.00
	Report data for corrections of other PS&R Report					
	information? If yes, see instructions.	I	I		I	I

Heal th	Financial Systems UNION COUNTY HOS	SPITAL DISTRICT		In Lie	u of Form CM	S-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C		Peri od: From 01/14/2023 To 09/30/2023		Prepared:
			iption	Y/N	Y/N	
20. 00	If line 1/ on 17 is you were adjustments and to DCCD		)	1. 00	3. 00 N	20.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	IN IN	20.00
	report data for other: bescribe the other adjustments.	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
	COMPLETED BY COST DELMBURGED AND TEEDA HOSDITALS ONLY (EVO	EDT CILL DDENC	IOCDI TALC)		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC Capital Related Cost	EPT CHILDRENS	HUSPITALS)			
22. 00	Have assets been relifed for Medicare purposes? If yes, se	e instructions			N	22. 00
23. 00	Have changes occurred in the Medicare depreciation expense			ring the cost	l N	23. 00
20.00	reporting period? If yes, see instructions.	ado to appi ai	oaro maao aa	ring the edet		20.00
24.00	Were new leases and/or amendments to existing leases enter	eporting period?	N	24.00		
	If yes, see instructions					
25.00	Have there been new capitalized leases entered into during	the cost repo	rting period	? If yes, see	N	25. 00
	instructions.					
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during t	he cost report	ing period?	If yes, see	N	26. 00
27. 00	instructions. Has the provider's capitalization policy changed during th	a cost ranorti	na neriod2 L	F vac submit	l N	27. 00
27.00	copy.	e cost reporti	ing period: i	yes, subiii t	14	27.00
	Interest Expense					
28.00	Were new Loans, mortgage agreements or Letters of credit e	ntered into du	ring the cos	t reporting	N	28. 00
	period? If yes, see instructions.		Ü			
29.00	Did the provider have a funded depreciation account and/or		ebt Service	Reserve Fund)	N	29. 00
	treated as a funded depreciation account? If yes, see inst					
30.00	Has existing debt been replaced prior to its scheduled mat	urity with new	debt? If ye	s, see	N	30.00
31. 00	instructions. Has debt been recalled before scheduled maturity without i	ssuance of now	dobt2 Lf vo	2 200	N	31.00
31.00	instructions.	33dance of new	debt: 11 ye	3, 300	14	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care se	rvi ces furni sh	ed through c	ontractual	N	32. 00
	arrangements with suppliers of services? If yes, see instr	uctions.	J			
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 ap	plied pertaini	ng to compet	itive bidding? If	N	33. 00
	no, see instructions.					
24.00	Provi der-Based Physi ci ans		4 h			24.00
34. 00	Were services furnished at the provider facility under an	arrangement wi	th provider-	based physicians:	Y	34.00
35 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended ex	istina aareeme	nts with the	nrovi der_hased	N	35.00
00.00	physicians during the cost reporting period? If yes, see i		into wi tii tiio	provider basea	''	55.55
	<u>,, , , , , , , , , , , , , , , , , , ,</u>			Y/N	Date	
				1. 00	2. 00	
	Home Office Costs					
	Were home office costs claimed on the cost report?			Y		36.00
37. 00	If line 36 is yes, has a home office cost statement been p	repared by the	nome office	? Y		37. 00
20 00	If yes, see instructions.	fice different	from that a	e N		20 00
38. 00	If line 36 is yes , was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year en			f N		38.00
39. 00	If line 36 is yes, did the provider render services to oth			s. N		39.00
	see instructions.	po	yo			
40.00	If line 36 is yes, did the provider render services to the	home office?	If yes, see	N		40.00
	i nstructi ons.					
	Cook Deposit Designer Contact   Const.	] 1.	00	2.	00	
41 00	Cost Report Preparer Contact Information	ALICTIN		FLCUED		41 00
41. 00	Enter the first name, last name and the title/position	AUSTI N		FISHER		41.00
	held by the cost report preparer in columns 1, 2, and 3, respectively.					
42.00	Enter the employer/company name of the cost report BLUE & CO., LLC					42.00
	preparer.					
43.00	Enter the telephone number and email address of the cost	AFI SHER@BLUEAN	IDCO. COM	3172757438		43.00
	report preparer in columns 1 and 2, respectively.	1				

Heal th	Financial Systems UNION COUNTY	HOSF	PITAL DISTRICT		In Lieu	of Form CMS-	2552-10
HOSPI 1	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1342		eri od:	Worksheet S-2	
				To	com 01/14/2023 0 09/30/2023	Part II Date/Time Pre 2/27/2024 3:2	pared: 4 pm
		L					
			3. 00				
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position	Ç	SENI OR MANAGER				41.00
	held by the cost report preparer in columns 1, 2, and 3,						
	respecti vel y.						
42.00	Enter the employer/company name of the cost report						42.00
	preparer.	l					
43.00	Enter the telephone number and email address of the cos	t					43.00
	report preparer in columns 1 and 2, respectively.						

Health Financial Systems In Lieu of Form CMS-2552-10 UNION COUNTY HOSPITAL DISTRICT HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 14-1342 Peri od: Worksheet S-3 From 01/14/2023 Part I 09/30/2023 Date/Time Prepared: 2/27/2024 3:24 pm I/P Days / 0/P Visits / Tri ps CAH/REH Hours Component Worksheet A No. of Beds Bed Days Title V Li ne No. Avai I abl e 1.00 2.00 3.00 4.00 5.00 PART I - STATISTICAL DATA 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 30.00 25 6,500 22, 632, 00 1.00 0 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HMO and other (see instructions) 2.00 3.00 HMO IPF Subprovider HMO IRF Subprovider 3.00 4.00 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 0 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 0 6.00 Total Adults and Peds. (exclude observation 25 6,500 22, 632. 00 7.00 7.00 beds) (see instructions) 8.00 INTENSIVE CARE UNIT 8.00

Health Financial Systems UNION COUNTY HOSPITAL DISTRICT
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCI In Lieu of Form CMS-2552-10 Peri od: Worksheet S-3 From 01/14/2023 Part I To 09/30/2023 Date/Ti me Prepared: 2/27/2024 3:24 pm Provider CCN: 14-1342

						2/27/2024 3: 2	4 pm
	·	I/P Days	/ O/P Visits	/ Tri ps	Full Time I	Equi val ents	
		,		'		•	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	'			Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	480	4	943			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)	171	72				2.00
3.00	HMO I PF Subprovi der	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	639	0	639			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0				6.00
7. 00	Total Adults and Peds. (exclude observation	1, 119	4	2, 091			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 UNI T						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13.00
14. 00	Total (see instructions)	1, 119	4	2, 091	0. 00	55. 50	1
15. 00	CAH visits	0	0		0.00	33.30	15.00
15. 10	REH hours and visits	0	0				15. 10
16. 00	SUBPROVI DER - I PF		O	J			16.00
17. 00	SUBPROVI DER - I RF						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			685	0.00	5. 99	
22. 00	HOME HEALTH AGENCY			003	0.00	3. 77	22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24. 00	HOSPICE						24.00
24. 00	HOSPICE (non-distinct part)			0			24. 00
25. 00	CMHC - CMHC			0			25.00
26. 00	RURAL HEALTH CLINIC	530	0	4, 991	0.00	2. 82	
26. 25		0.0	0		0.00		
27. 00	FEDERALLY QUALIFIED HEALTH CENTER	U	U	0	0.00		
	Total (sum of lines 14-26)	+	53	202	0.00	04. 31	
28. 00 29. 00	Observation Bed Days	0	53	303			28. 00 29. 00
	Ambulance Trips	U		_			
30.00	Employee discount days (see instruction)			0			30.00
31. 00 32. 00	Employee discount days - IRF	0	0	0			31.00 32.00
	Labor & delivery days (see instructions)	U	U				
32. 01	Total ancillary labor & delivery room			0			32. 01
22.00	outpatient days (see instructions)						22.00
33.00	LTCH non-covered days						33.00
33. 01	LTCH site neutral days and discharges	0	0	_			33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0		l	34.00

| Peri od: | Worksheet S-3 | From 01/14/2023 | Part | To 09/30/2023 | Date/Time Prepared: Provi der CCN: 14-1342

				To	09/30/2023	Date/Time Pre 2/27/2024 3:2	
		Full Time		Di sch	arges	2/2//2024 3.2	y piii
		Equi val ents			3		
	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	129	1	275	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2 00	for the portion of LDP room available beds)			46	2.4		2.00
2. 00 3. 00	HMO and other (see instructions) HMO IPF Subprovider			40	24		3.00
4. 00	HMO IRF Subprovider				0		4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF				٩		5.00
6. 00	Hospital Adults & Peds. Swing Bed NF			•			6.00
7. 00	Total Adults and Peds. (exclude observation						7.00
7.00	beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9. 00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	129	1	275	14.00
15.00	CAH visits						15. 00
	REH hours and visits						15. 10
16.00	SUBPROVIDER - IPF						16. 00
17. 00							17. 00
18. 00	SUBPROVI DER						18. 00
	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY	0.00					20.00
21. 00	OTHER LONG TERM CARE	0.00				0	21.00
22. 00	HOME HEALTH AGENCY						22.00
23. 00 24. 00	AMBULATORY SURGICAL CENTER (D. P. )   HOSPICE						23. 00 24. 00
24. 00	HOSPICE (non-distinct part)						24. 00
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC	0.00		•			26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
	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 - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days			0			33.00
33. 01	LTCH site neutral days and discharges			0			33. 01
34. 00	Temporary Expansion COVID-19 PHE Acute Care						34.00

Health Financial Systems UN	IION COUNTY HOS	PITAL DISTRIC	Т	In Li	eu of Form Cl	MS-2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der (	CCN: 14-1342	Peri od:	Worksheet	S-8
		Component	CCN: 14-3975	From 01/14/202 To 09/30/202		
				RHC I	Cos	
				1	. 00	
Clinic Address and Identification  1.00 Street				517 NORTH MAI	N CTDEET	1 00
1.00   Street		C	i ty	State	ZIP Code	1.00
			. 00	2.00	3.00	
2.00 City, State, ZIP Code, County		ANNA		I	L 62906	2.00
2 00 HOSPITAL BASED FOHCE ONLY. Decimpation Ent	or "D" for run	al or "II" for	urban		1.00	0 3.00
3.00   HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er k for rura	al of U for		nt Award	Date	0 3.00
				1. 00	2.00	
Source of Federal Funds			•			
4.00 Community Health Center (Section 330(d), PHS						4. 00
5.00 Migrant Health Center (Section 329(d), PHS A						5.00
<ul><li>6.00 Health Services for the Homeless (Section 34</li><li>7.00 Appalachian Regional Commission</li></ul>	u(a), PHS Act)					6. 00 7. 00
8. 00 Look-Alikes						8.00
9. 00 OTHER (SPECIFY)						9.00
			<b>'</b>			
				1. 00	2.00	
10.00 Does this facility operate as other than a h yes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o hours.)	ate number of o	other operatio	ons in column			0 10.00
Tiour 3. )	Sun	dav	l N	londay	Tuesday	
	from	to	from	to	from	
	1. 00	2. 00	3. 00	4. 00	5. 00	
Facility hours of operations (1)			00.00	17.00	lon, 00	11 00
11. 00   CLI NI C			08: 00	17: 00	08: 00	11. 00
				1.00	2.00	
12.00 Have you received an approval for an excepti	on to the produ	uctivity stand	dard?	N		12.00
13.00 Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report.	umn 1. If yes,	enter in colu	umn 2 the	N		0 13.00
numbers below.						
			Prov	ider name	CCN	
14 00 DUC/FOUG TOTAL CON				1. 00	2. 00	14.00
14.00 RHC/FOHC name, CCN	Y/N	V	XVIII	XIX	Total Visi	14.00
	1, 00	2.00	3.00	4.00	5. 00	13
15.00 Have you provided all or substantially all						15.00
GME cost? Enter "Y" for yes or "N" for no in						
column 1. If yes, enter in columns 2, 3 and						
4 the number of program visits performed by Intern & Residents for titles V, XVIII, and						
XIX, as applicable. Enter in column 5 the						
number of total visits for this provider.						
(see instructions)						
			unty			
2.00 City, State, ZIP Code, County		UNI ON	. 00			2.00
2.00   orty, State, 21F code, county	Tuesday		nesday	Thu	ırsday	2.00
	to	from	to	from	to	
	6. 00	7. 00	8.00	9. 00	10.00	
Facility hours of operations (1)						
11. 00   CLI NI C	17: 00	08: 00	17: 00	08: 00	17: 00	11.00

Health Financial Systems U	NION COUNTY HOS	In Lieu	u of Form CMS-2	2552-10		
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-1342	Peri od:	Worksheet S-8	
		Component	CCN: 14-3975	From 01/14/2023 To 09/30/2023		
				RHC I	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13. 00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	17: 00	09: 00	16: 50		11.00

	Financial Systems UNION COUNTY HOSPITAL				u of Form CMS-2	
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	rovi der CC	CN: 14-1342	Peri od: From 01/14/2023 To 09/30/2023	Worksheet S-1 Parts I & II Date/Time Pre 2/27/2024 3:2	pared:
					2/2//2024 3.2	4 piii
					1. 00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA					4
1 00	Uncompensated and Indigent Care Cost-to-Charge Ratio				0.244505	1 00
1. 00	Cost to charge ratio (see instructions) Medicaid (see instructions for each line)				0. 266505	1.00
2 00	Net revenue from Medicaid				2.015.072	2 00
2.00	Did you receive DSH or supplemental payments from Medicaid?				2, 015, 963 Y	2.00
4. 00	If line 3 is yes, does line 2 include all DSH and/or supplementa	al naumant	to from Modic	ai dO	N N	4.00
5. 00	If line 4 is no, then enter DSH and/or supplemental payments fro	arur	1, 034, 667	5.00		
6. 00	Medicaid charges		19, 590, 725			
7. 00	Medicaid cost (line 1 times line 6)		5, 221, 026			
8. 00	Difference between net revenue and costs for Medicaid program (		2, 170, 396			
8.00	nildren's Health Insurance Program (CHIP) (see instructions for each line)					
9. 00	let revenue from stand-al one CHIP					
	Stand-al one CHIP charges		0			
	Stand-alone CHIP cost (line 1 times line 10)		0			
12. 00	Difference between net revenue and costs for stand-alone CHIP (see instructions)					
	Other state or local government indigent care program (see instr			2)		1 .2.00
13.00	Net revenue from state or local indigent care program (Not inclu				0	13.00
14. 00	Charges for patients covered under state or local indigent care				0	
	10)	1 3	•			
15.00	State or local indigent care program cost (line 1 times line 14)	)			0	15.00
16.00					0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIF	P and stat	e/Local indi	gent care progra	ams (see	
	instructions for each line)					
	Private grants, donations, or endowment income restricted to ful				0	1
	Government grants, appropriations or transfers for support of he				0	1
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and local	i ndi gent	care program	s (sum of lines	2, 170, 396	19.00
	8, 12 and 16)		Uni navena	Lanconna	T-+-1 (1 1	
			Uni nsured	Insured	Total (col. 1	
			patients 1.00	pati ents 2, 00	+ col . 2) 3.00	
	Uncompensated care cost (see instructions for each line)		1.00	2.00	3.00	
20 00	Charity care charges and uninsured discounts (see instructions)		697, 9	14 0	697, 944	20.00
21. 00	Cost of patients approved for charity care and uninsured discour		186, 0			
200	instructions)	(555	.00, 0	30	100,000	
22. 00	Payments received from patients for amounts previously written	off as		0 0	0	22.00
	charity care	-				
23.00	Cost of charity care (see instructions)		186, 0	06	186, 006	23.00
					1. 00	
24 00	I Book and the second of the s		مالجنديدا بدادي	A 1 !! A	I NI	24 00

24.00

0 25.00

25.01

26.00

27.00

27.01

28.00

29.00

30.00

96, 621

62, 804

96, 621

33, 817

219, 823

2, 390, 219 31.00

24.00 Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?

28.00 Non-Medicare bad debt amount (see instructions)
29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)

Charges for insured patients' liability (see instructions)

31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30)

Medicare reimbursable bad debts (see instructions)

30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)

Medicare allowable bad debts (see instructions)

Bad debt amount (see instructions)

If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of

25.00

25. 01

26.00

27.00

27. 01

stay limit

				1.00	
	PART II - HOSPITAL DATA				
	Uncompensated and Indigent Care Cost-to-Charge Ratio				
00	Cost to charge ratio (see instructions)				1
	Medicaid (see instructions for each line)				
00	Net revenue from Medicaid				2
00	Did you receive DSH or supplemental payments from Medicaid?				3
00	If line 3 is yes, does line 2 include all DSH and/or supplemental paymen	ts from Medicai	d?		4
0	If line 4 is no, then enter DSH and/or supplemental payments from Medical	i d			5
0	Medi cai d charges				6
0	Medicaid cost (line 1 times line 6)				7
0	Difference between net revenue and costs for Medicaid program (see instri				8
	Children's Health Insurance Program (CHIP) (see instructions for each li	ne)			
0	Net revenue from stand-alone CHIP				9
00	Stand-alone CHIP charges				10
00				11	
00	Difference between net revenue and costs for stand-alone CHIP (see instru			12	
	Other state or local government indigent care program (see instructions			ı	
	Net revenue from state or local indigent care program (Not included on I				13
00	Charges for patients covered under state or local indigent care program	(Not included i	n lines 6 or		14
^^					1,
00		(	!		15
UU	Difference between net revenue and costs for state or local indigent card				16
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and sta-	tezi ocai i ndi ge	ent care progra	ills (see	
$\cap$	instructions for each line) Private grants, donations, or endowment income restricted to funding chains	ri ty caro			1 17
	Government grants, appropriations or transfers for support of hospital of			18	
00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent				
			(cum of linge		1 10
00		care programs	(sum of lines		19
	8, 12 and 16)	Uni nsured	(sum of lines	Total (col. 1	
				Total (col. 1 + col. 2)	
		Uni nsured	Insured		
		Uni nsured pati ents	Insured patients	+ col . 2)	
	8, 12 and 16)	Uni nsured pati ents	Insured patients	+ col . 2)	
00	Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (see	Uni nsured pati ents	Insured patients	+ col . 2)	20
00	Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions)	Uni nsured pati ents	Insured patients	+ col . 2)	20 21
00	Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as	Uni nsured pati ents	Insured patients	+ col . 2)	20 21
00 00 00	Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care	Uni nsured pati ents	Insured patients	+ col . 2)	20 21 22
000000	Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as	Uni nsured pati ents	Insured patients	+ col . 2)	20 21 22
00	Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care	Uni nsured pati ents	Insured patients	+ col. 2) 3.00	20 21 22
000 000 000 000	Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (see instructions)	Uninsured patients 1.00	Insured patients 2.00	+ col . 2)	20 21 22 23
000000000000000000000000000000000000000	Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (see instructions)  Does the amount on line 20 col. 2, include charges for patient days beyon	Uninsured patients 1.00	Insured patients 2.00	+ col. 2) 3.00	20 21 22 23
000000000000000000000000000000000000000	Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (see instructions)  Does the amount on line 20 col. 2, include charges for patient days beyon imposed on patients covered by Medicaid or other indigent care program?	Uninsured patients 1.00	Insured patients 2.00	+ col. 2) 3.00	20 21 22 23
000000000000000000000000000000000000000	Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (see instructions)  Does the amount on line 20 col. 2, include charges for patient days beyon imposed on patients covered by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indigent	Uninsured patients 1.00	Insured patients 2.00	+ col. 2) 3.00	20 21 22 23
000000000000000000000000000000000000000	Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (see instructions)  Does the amount on line 20 col. 2, include charges for patient days beyon imposed on patients covered by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indigent stay limit	Uninsured patients 1.00	Insured patients 2.00	+ col. 2) 3.00	20 21 22 23 24 24
000000000000000000000000000000000000000	Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (see instructions)  Does the amount on line 20 col. 2, include charges for patient days beyon imposed on patients covered by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indigent stay limit Charges for insured patients' liability (see instructions)	Uninsured patients 1.00	Insured patients 2.00	+ col. 2) 3.00	20 211 222 23 24 25 25
00 00 00 00 00 00 00 00	Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (see instructions)  Does the amount on line 20 col. 2, include charges for patient days beyon imposed on patients covered by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indigent stay limit Charges for insured patients' liability (see instructions) Bad debt amount (see instructions)	Uninsured patients 1.00	Insured patients 2.00	+ col. 2) 3.00	20 211 222 23 24 25 26 26
000 000 000 000 000 000 000	Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (see instructions)  Does the amount on line 20 col. 2, include charges for patient days beyon imposed on patients covered by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indigen stay limit Charges for insured patients' liability (see instructions) Bad debt amount (see instructions) Medicare reimbursable bad debts (see instructions)	Uninsured patients 1.00	Insured patients 2.00	+ col. 2) 3.00	20 21 22 23 24 28 26 26 27
00 00 00 00 00 00 00 00 00 00	Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (see instructions)  Does the amount on line 20 col. 2, include charges for patient days beyon imposed on patients covered by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indigent stay limit Charges for insured patients' liability (see instructions) Bad debt amount (see instructions) Medicare reimbursable bad debts (see instructions) Medicare allowable bad debts (see instructions)	Uninsured patients 1.00	Insured patients 2.00	+ col. 2) 3.00	20 21 22 23 24 28 26 26 27 27
000 000 000 000 000 000 000 001 000	Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (see instructions)  Does the amount on line 20 col. 2, include charges for patient days beyon imposed on patients covered by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indigent stay limit Charges for insured patients' liability (see instructions) Bad debt amount (see instructions) Medicare reimbursable bad debts (see instructions) Medicare allowable bad debts (see instructions) Non-Medicare bad debt amount (see instructions)	Uninsured patients 1.00  nd a length of t care program'	Insured patients 2.00	+ col. 2) 3.00	20 21 22 23 24 25 26 27 27 27 28
00 00 00 00 00 00	Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (see instructions)  Does the amount on line 20 col. 2, include charges for patient days beyon imposed on patients covered by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indigents stay limit Charges for insured patients' liability (see instructions) Bad debt amount (see instructions) Medicare reimbursable bad debts (see instructions) Medicare allowable bad debts (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see	Uninsured patients 1.00  nd a length of t care program'	Insured patients 2.00	+ col. 2) 3.00	200 211 222 233 244 255 266 277 277 288 299 300

Health Financial Systems UN	ION COUNTY HOSPI	TAL DISTRICT		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der Co		Peri od:	Worksheet A	
				From 01/14/2023 To 09/30/2023	Date/Time Pre 2/27/2024 3:2	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cat	Reclassi fied	4 piii
'			+ col . 2)	i ons (See	Trial Balance	
				A-6)	(col. 3 +-	
	1 00		2.00	1.00	col . 4)	
GENERAL SERVICE COST CENTERS	1. 00	2. 00	3. 00	4. 00	5. 00	
1.00 O0100 CAP REL COSTS-BLDG & FLXT		0		241, 047	241, 047	1.00
2. 00   00200 CAP REL COSTS-MVBLE EQUIP		499, 017	499, 01		499, 017	2.00
4. 00   00400 EMPLOYEE BENEFITS DEPARTMENT	56, 075	18, 710				4.00
5. 01 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	252, 416			301, 873	5. 01
5. 02 00590 OTHER ADMINISTRATIVE AND GENERAL	213, 042	7, 238, 938				5. 02
7.00 00700 OPERATION OF PLANT	139, 219	1, 168, 877	1, 308, 096	0	1, 308, 096	7.00
8.00   00800   LAUNDRY & LINEN SERVICE	1, 636	151, 091	152, 727	0	152, 727	8. 00
9. 00   00900   HOUSEKEEPI NG	205, 500	60, 546			266, 046	9. 00
10. 00   01000   DI ETARY	0	470, 662			470, 662	10.00
11. 00   01100   CAFETERI A	0	0	(	-	0	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	558, 080	56, 066			416, 749	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	108, 242	189, 780				14.00
15. 00   01500   PHARMACY 16. 00   01600   MEDI CAL RECORDS & LI BRARY	251, 339 0	430, 880			354, 516 4, 138	15.00
INPATIENT ROUTINE SERVICE COST CENTERS	U	4, 138	4, 138	<u> </u>	4, 130	16. 00
30. 00 03000 ADULTS & PEDIATRICS	1, 078, 330	773, 539	1, 851, 869	198, 850	2, 050, 719	30.00
46. 00 04600 OTHER LONG TERM CARE	416, 715	104, 882				46. 00
ANCILLARY SERVICE COST CENTERS	· · · · · ·	·		•	·	
50.00 05000 OPERATING ROOM	250, 524	158, 113			399, 151	50.00
51.00   05100   RECOVERY ROOM	53, 997	7, 635			61, 632	51.00
53. 00   05300   ANESTHESI OLOGY	0	216, 469			216, 469	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	373, 371	253, 523			962, 749	54.00
54. 01   05401   ULTRASOUND	57, 498	11, 204			0	54.01
56. 00   05600   RADI OI SOTOPE 57. 00   05700   CT   SCAN	0 52 472	61, 539			0	56. 00 57. 00
58. 00   05700   CT   SCAIN	53, 673 49, 167	56, 126 46, 648		· ·	0	58.00
60. 00   06000   LABORATORY	323, 709	659, 599			983, 308	60.00
65. 00 06500 RESPIRATORY THERAPY	44, 546	40, 068				
66. 00 06600 PHYSI CAL THERAPY	183, 575	24, 007			207, 582	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	288, 573	21, 882			310, 455	
68.00 06800 SPEECH PATHOLOGY	68, 429	6, 091			74, 520	68. 00
69. 00 06900 ELECTROCARDI OLOGY	90, 152	51, 576	141, 728		141, 728	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(	,		71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	(	19, 478	19, 478	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	(	327, 703	327, 703	73.00
76. 00   03610   SLEEP LAB 76. 01   03550   PSYCHI ATRI C/PSYCHOLOGI CAL   SERVI CES	0	υ 319. 911	319, 91		0 319, 911	76. 00 76. 01
76. 03   03950   WOUND CARE	2, 004	3, 783			5, 787	76.01
OUTPATIENT SERVICE COST CENTERS	2,004	3, 703	3, 70	<u> </u>	3, 707	70.03
88. 00 08800 RURAL HEALTH CLINIC	333, 994	79, 091	413, 085	-49, 457	363, 628	88. 00
91. 00 09100 EMERGENCY	841, 720	1, 138, 557			1, 980, 277	
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS						
118. 00 SUBTOTALS (SUM OF LINES 1 through 117)	6, 043, 110	14, 575, 364	20, 618, 474	-32, 296	20, 586, 178	118.00
NONREI MBURSABLE COST CENTERS  190. 00 19000 GI FT FLOWER COFFEE SHOP & CANTEEN	٥	0	1 (	0	0	190. 00
192. 00 19200 PHYSI CI ANS PRI VATE OFFI CES	o	0				192.00
194. 00 07956 AREAS UNDER RENOVATION	Ö	0		o o		194.00
194. 01 07951 OTHER NONREI MBURSABLE - MARKETI NG	o	0		32, 296		194. 01
194. 02 07952 OTHER NONREIMBURSABLE - SENIOR CIRC	o	0		0		194. 02
194. 03 07953 FREESTANDING HHA COSTS	O	0		0		194. 03
194. 04 07954 LEASED TO SPECIALTY CLINICS	0	0	(	0		194. 04
194. 05 07955 VACANT SPACE	0	0	(	0		194. 05
200.00   TOTAL (SUM OF LINES 118 through 199)	6, 043, 110	14, 575, 364	20, 618, 474	1 0	20, 618, 474	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1342 Period:

Peri od: Worksheet A From 01/14/2023 To 09/30/2023 Date/Time Prepared:

2/27/2024 3: 24 pm Cost Center Description Adjustments Net Expenses (See A-8) For Allocation 6. 00 7 00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT -181, 298 59, 749 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 499, 017 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 619, 686 1,041,470 4 00 5.01 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 301, 873 5.01 00590 OTHER ADMINISTRATIVE AND GENERAL -2, 998, 106 3, 832, 079 5.02 5.02 7.00 00700 OPERATION OF PLANT 204, 245 1, 512, 341 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 89, 278 242,005 8 00 9.00 00900 HOUSEKEEPI NG 266, 046 9.00 10.00 01000 DI ETARY 51, 175 521, 837 10.00 01100 CAFETERI A -24, 180 -24. 180 11.00 11.00 01300 NURSING ADMINISTRATION 13.00 141, 422 558, 171 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 182, 993 14.00 15.00 01500 PHARMACY 142, 659 497, 175 15.00 01600 MEDICAL RECORDS & LIBRARY <u>2, 9</u>52 7, 090 16.00 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 30.00 03000 ADULTS & PEDIATRICS -2, 352 2,048,367 04600 OTHER LONG TERM CARE 46.00 521, 597 46,00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 399, 151 50.00 05100 RECOVERY ROOM 0 51.00 61, 632 51.00 0 05300 ANESTHESI OLOGY 53.00 216, 469 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 962, 749 54.00 54.01 05401 ULTRASOUND 000000000000000 0 54.01 56.00 05600 RADI OI SOTOPE 56.00 0 05700 CT SCAN 57 00 Λ 57.00 58.00 05800 MRI C 58.00 06000 LABORATORY 60.00 983, 308 60.00 65.00 06500 RESPIRATORY THERAPY 65.00 54.768 06600 PHYSI CAL THERAPY 207.582 66.00 66.00 67.00 06700 OCCUPATI ONAL THERAPY 310, 455 67.00 06800 SPEECH PATHOLOGY 68.00 74, 520 68.00 69 00 06900 ELECTROCARDI OLOGY 141 728 69 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 134,883 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 19, 478 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 327, 703 73.00 76 00 03610 SLEEP LAB 76 00 0 76.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 319, 911 76.01 03950 WOUND CARE 76.03 76.03 5, 787 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 206, 581 570, 209 88.00 91.00 09100 EMERGENCY 1, 980, 277 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) -1, 747, 938 18, 838, 240 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 190.00 0 192.00 19200 PHYSICIANS PRIVATE OFFICES 192.00 0 194.00 07956 AREAS UNDER RENOVATION 0 C 194.00 194. 01 07951 OTHER NONREI MBURSABLE - MARKETI NG 0 194. 01 32, 296 194. 02 07952 OTHER NONREI MBURSABLE - SENI OR CIRC 0 194. 02 0 194. 03 07953 FREESTANDI NG HHA COSTS 0 Ω 194 03 194.04 07954 LEASED TO SPECIALTY CLINICS 0 194.04 194. 05 07955 VACANT SPACE 194.05 200.00 TOTAL (SUM OF LINES 118 through 199) -1, 747, 938 18, 870, 536 200.00

Health Financial Systems	UNION COUNTY HOSPITAL DISTRICT	In Lieu of Form CMS-2552-10
RECLASSI FI CATI ONS	Provi der CCN: 14-1342	Peri od: Worksheet A-6

	Cost Center 2.00	Increases				
	2. 00	Li ne #	Sal ary	0ther		
		3. 00	4. 00	5. 00		
. 00	A - EMPLOYEE BENEFITS RECLASS					
Ì	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34 <u>6, 9</u> 99		
	0		0	346, 999		
	B - OXYGEN RECLASS					
. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	29, 846		
	PATI ENT					
		$+$		29, 846		
1	C - OTHER CAPITAL COSTS RECLAS	SS	-	,		
	CAP REL COSTS-BLDG & FLXT	1. 00	0	241, 047		
	<u> </u>	<del></del> +		241, 047		
1	D - MARKETING RECLASS		<u> </u>	211,017		
	OTHER NONREI MBURSABLE -	194, 01	0	32, 296		
	MARKETI NG	174.01	٥	32, 270		
-	NARRETTNO	+	— — <del> </del>	32, 296		
	E - MEDICAL SUPPLIES RECLASS		U_	32, 290		
	MEDICAL SUPPLIES RECLASS  MEDICAL SUPPLIES CHARGED TO	71. 00	O	105, 037		
		71.00	o <sub>l</sub>	105, 037		
	PATI ENT	70.00		40 470		
	IMPL. DEV. CHARGED TO	72. 00	0	19, 478		
	PATI ENTS	+				
	D DDUGG (L) ( COLUTIONS DEGLACE		0	124, 515		
	F - DRUGS/IV SOLUTIONS RECLASS					
.00	DRUGS CHARGED TO PATIENTS		•	327, 703		
	0		0	327, 703		
	G - RADI OLOGY RECLASS				1	
	RADI OLOGY-DI AGNOSTI C	54. 00	160, 338	175, 517		
00		0.00	0	0		
00		0.00	0	0		
00		0.00	0	0		
	$\frac{1}{0} = \frac{1}{0} = \frac{1}{0}$		160, 338	175, 517		
1	I - RHC ADMIN RECLASS					
00	CASHI ERI NG/ACCOUNTS	5. 01	49, 457	0		
	RECEI VABLE					
			49, 457			
1	J - INFECTION CONTROL RECLASS	<u> </u>				
	NURSI NG ADMI NI STRATI ON	13. 00	0	1, 453		
	0	— — <del></del> °+	— — <del>"</del>			
-	K - HOUSE SUPERVISOR RECLASS		O <sub>1</sub>	1, 433		
	ADULTS & PEDIATRICS	30.00	198, 850	0		
00	DOLIS & FLUI AIKI CS	— <del>30.00</del>	198, 850	$ \frac{0}{0}$		
00 00	Grand Total: Increases		408, 645	1, 279, 376		50

					Т	o 09/30/2023	Date/Time Prepared: 2/27/2024 3:24 pm
		Decreases					2/2//2024 3. 24 piii
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
	A - EMPLOYEE BENEFITS RECLASS						
1.00	OTHER ADMINISTRATIVE AND	5. 02	0	346, 999	0		1.00
	GENERAL						
	0		0	346, 999			
	B - OXYGEN RECLASS						
1.00	RESPI RATORY THERAPY	<u>65.</u> 00	0	2 <u>9, 8</u> 46			1.00
	0		0	29, 846			
	C - OTHER CAPITAL COSTS RECLA						
1.00	OTHER ADMINISTRATIVE AND	5. 02	0	241, 047	12		1.00
	GENERAL						
	0		0	241, 047			
	D - MARKETING RECLASS						
1.00	OTHER ADMINISTRATIVE AND	5. 02	0	32, 296	0		1.00
	GENERAL						
	0		0	32, 296			
	E - MEDICAL SUPPLIES RECLASS				,		
1.00	CENTRAL SERVICES & SUPPLY	14. 00	0	115, 029			1.00
2.00	OPERATI NG ROOM	<u>50.</u> 00	0	<u>9, 4</u> 86			2.00
	0		0	124, 515			
	F - DRUGS/IV SOLUTIONS RECLAS		. 1		1		
1.00	PHARMACY	<u>15.</u> 00		32 <u>7, 7</u> 03			1.00
	0		0	327, 703			
	G - RADIOLOGY RECLASS						
1.00	ULTRASOUND	54. 01	57, 498	11, 204			1.00
2.00	RADI OI SOTOPE	56. 00	0	61, 539			2.00
3.00	CT SCAN	57. 00	53, 673	56, 126			3.00
4.00	MRI	<u>58.</u> 00	4 <u>9, 1</u> 67	4 <u>6, 6</u> 48			4.00
	0		160, 338	175, 517			
	I - RHC ADMIN RECLASS						
1.00	RURAL HEALTH CLINIC		4 <u>9, 4</u> 57	<sup>0</sup>	<u> </u>		1.00
	0		49, 457	0			
	J - INFECTION CONTROL RECLASS						
1. 00	OTHER ADMINISTRATIVE AND	5. 02	0	1, 453	0		1.00
	GENERAL	+	- — — 🛨	- <del> </del>			
	U HOUSE CHREDATON PEGLANO		0	1, 453			
	K - HOUSE SUPERVI SOR RECLASS	40.5-	100 05-1				
1. 00	NURSING ADMINISTRATION	1300	198, 850	0	<u> </u>		1.00
	0		198, 850				
500.00	Grand Total: Decreases		408, 645	1, 279, 376			500.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS

Provi der CCN: 14-1342

Period: Worksheet A-7 From 01/14/2023 Part I To 09/30/2023 Date/Time Prepared:

				10	0 09/30/2023	2/27/2024 3: 2	
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1. 00	2. 00	3. 00	4. 00	5. 00	
F	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	T BALANCES					
1.00 I	Land	0	0	0	0	0	1.00
	Land Improvements	47, 473	0	0	0	47, 473	2.00
3. 00 E	Buildings and Fixtures	7, 978, 791	0	0	0	7, 978, 791	3.00
4. 00 E	Building Improvements	16, 076, 740	0	0	0	12, 405, 822	4.00
5.00 I	Fixed Equipment	1, 779, 634	0	0	0	1, 779, 634	5.00
	Movable Equipment	8, 120, 477	0	0	0	3, 880, 670	6.00
	HIT designated Assets	3, 186, 190	0	0	0	3, 186, 190	7.00
	Subtotal (sum of lines 1-7)	37, 189, 305	0	0	0	29, 278, 580	8. 00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	37, 189, 305	0	0	0	29, 278, 580	10.00
		Endi ng	Ful I y				
		Bal ance	Depreci ated				
			Assets				
		6. 00	7. 00				
_	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
	Land	0	0				1.00
4	Land Improvements	0	0				2.00
	Buildings and Fixtures	0	0				3.00
4	Building Improvements	3, 670, 918	0				4.00
4	Fixed Equipment	0	0				5.00
	Movable Equipment	4, 239, 807	0				6. 00
	HIT designated Assets	0	0				7.00
	Subtotal (sum of lines 1-7)	7, 910, 725	0				8. 00
	Reconciling Items	0	0				9. 00
10.00	Total (line 8 minus line 9)	7, 910, 725	0				10.00

Heal th	Financial Systems UN	NION COUNTY HOS	PITAL DISTRICT		In Lie	u of Form CMS-2	2552-10
	CILIATION OF CAPITAL COSTS CENTERS		Provider Co	CN: 14-1342	Period: From 01/14/2023	Worksheet A-7	pared:
		SUMMARY OF CAPITAL					
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9. 00	10. 00	11.00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	MN 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	499, 017	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	499, 017	0		0 0	0	3.00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	Other	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, COLUM	MN 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	499, 017				2.00
3 00	Total (sum of lines 1-2)	0	499 017				3 00

0 0 0

0 499, 017 499, 017

1.00 2.00

3.00 Total (sum of lines 1-2)

Heal th	n Financial Systems UM	NION COUNTY HOS	PITAL DISTRICT		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Period: From 01/14/2023 To 09/30/2023	Worksheet A-7 Part III Date/Time Pre 2/27/2024 3:24	pared:
		COM	PUTATION OF RAT	TI 0S	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 -			
				col . 2)			
	DART III DECONOLILIATION OF CARLTAL COCTO	1.00	2. 00	3. 00	4. 00	5. 00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS C			1	0.000000	0	1 00
1. 00 2. 00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	7, 910, 725	0	7 010 72	0. 000000 1. 00000		1. 00 2. 00
3. 00	Total (sum of lines 1-2)	7, 910, 725		7, 910, 72! 7, 910, 72!			3.00
3.00	Total (Suiii of Titles 1-2)		TION OF OTHER (			F CAPI TAL	3.00
		ALLUCA	IION OF OTHER (	CAPITAL	SUMMART	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Rel at		.,		
			ed Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	0		0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		99, 017		2.00
3.00	Total (sum of lines 1-2)	0	0	(	99, 017	0	3.00
			Sl	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)	
			(see	instructions)	Capi tal -Rel at	,	
			instructions)		ed Costs (see	9 through 14)	
					instructions)		
	DART III DECONOLILATION OF CARLTAL COCTO	11.00	12. 00	13. 00	14. 00	15. 00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS C		F0.740	1		FO 740	1 00
1. 00 2. 00	CAP REL COSTS-BLDG & FIXT	0	59, 749	]	0	59, 749 499, 017	1. 00 2. 00
2. 00 3. 00	Total (sum of lines 1-2)		59, 749	]	0 0	558, 766	
3.00	Tiotal (Suil Of TITIES 1-2)	1	J 39, 749	1	J <sub>1</sub> 0	J 330, 700	3.00

ADJUSTMENTS TO EXPENSES Provider CCN: 14-1342 Peri od: Worksheet A-8 From 01/14/2023 09/30/2023 Date/Time Prepared: 2/27/2024 3:24 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Line # Wkst. A-7 Cost Center Description Amount (2) Ref. 1.00 2.00 3.00 4.00 5. 00 1.00 Investment income - CAP REL -181, 298 CAP REL COSTS-BLDG & FIXT 1. 00 12 1.00 COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 2.00 COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other 0.00 3.00 (chapter 2) 4.00 Trade, quantity, and time 0.00 4.00 discounts (chapter 8) 5.00 Refunds and rebates of 5.00 0.00 expenses (chapter 8) Rental of provider space by 6.00 0.00 6.00 suppliers (chapter 8) Tel ephone servi ces (pay 7.00 0 00 7.00 stations excluded) (chapter 8.00 Television and radio service 0.00 8.00 (chapter 21) 9.00 Parking lot (chapter 21) 0.00 9.00 10.00 Provi der-based physici an -367, 762 10.00 A-8-2 adjustment 11.00 Sale of scrap, waste, etc. 0.00 11.00 (chapter 23) Related organization 12.00 12.00 A-8-1 7.422 transactions (chapter 10) 13.00 Laundry and linen service 0.00 13.00 Cafeteria-employees and guests -24, 180 CAFETERI A 11.00 14.00 В 14.00 15.00 Rental of quarters to employee 0.00 15.00 and others Sale of medical and surgical 16.00 16.00 0 0.00 supplies to other than pati ents 17.00 Sale of drugs to other than 0.00 17.00 pati ents Sale of medical records and -574 MEDICAL RECORDS & LIBRARY 18.00 R 16.00 18.00 abstracts 19.00 Nursing and allied health 0 0.00 19.00 education (tuition, fees, books, etc.) 20.00 Vending machines 0.00 20.00 21.00 Income from imposition of 0.00 21.00 interest, finance or penalty charges (chapter 21) Interest expense on Medicare 22.00 0 00 ol 22.00 overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory ORESPIRATORY THERAPY 65.00 23.00 A-8-3 therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical OPHYSICAL THERAPY 24.00 A-8-3 66.00 therapy costs in excess of limitation (chapter 14) Utilization review 0 \*\*\* Cost Center Deleted \*\*\* 25.00 25.00 114.00 physicians' compensation (chapter 21) OCAP REL COSTS-BLDG & FIXT 26.00 Depreciation - CAP REL 1.00 26.00 COSTS-BLDG & FLXT 27.00 Depreciation - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 27.00 COSTS-MVBLE EQUIP Non-physician Anesthetist Physicians' assistant 0 \*\*\* Cost Center Deleted \*\*\* 28.00 19.00 28.00 29 00 0.00 29 00 Adjustment for occupational O OCCUPATIONAL THERAPY 30.00 A-8-3 67.00 30.00 therapy costs in excess of limitation (chapter 14) Hospice (non-distinct) (see 30.99 OADULTS & PEDIATRICS 30.00 30.99

instructions)

						2/2//2024 3.2	T PIII
				Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
					,		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2)				Ref.	
		1. 00	2. 00	3. 00	4. 00	5. 00	
31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00
	pathology costs in excess of						
	limitation (chapter 14)						
32.00	CAH HIT Adjustment for		0		0.00	0	32.00
02.00	Depreciation and Interest				0.00	O	02.00
33.00	FITNESS REVENUE	В	4 500	OTHER ADMINISTRATIVE AND	5. 02	0	33.00
33.00	FITNESS REVENUE	D	-4, 360	GENERAL	3. 02	U	33.00
22 01	LL DDOVIDED TAY	ь	1 004 //7	· · - · · · -	г оо	0	22 01
33. 01	IL PROVIDER TAX	В	-1,034,667	OTHER ADMINISTRATIVE AND	5. 02	0	33. 01
				GENERAL		_	
33. 03	CHARI TABLE CONTRI BUTI ONS	Α	-4, 016	OTHER ADMINISTRATIVE AND	5. 02	0	33. 03
				GENERAL			
33.06	MARKETING EXPENSE - EXCLUDING	Α	-100	OTHER ADMINISTRATIVE AND	5. 02	0	33.06
	MARKET			GENERAL			
33.07	LOBBYING EXPENSE IN	А	-4, 893	OTHER ADMINISTRATIVE AND	5. 02	0	33. 07
	ASSOCIATION DUES		·	GENERAL			
33 08	MI SCELLANEOUS I NCOME	В	-133, 290	OTHER ADMINISTRATIVE AND	5. 02	0	33. 08
00.00	662227.112666 7.11661112		100,270	GENERAL	0.02	ŭ	00.00
50.00	TOTAL (sum of lines 1 thru 49)		-1, 747, 938	1 ·			50.00
50.00	(Transfer to Worksheet A,		1, 747, 730				30.00
	column 6, line 200.)						L
(1) De	scrintion - all chanter referen	ices in this co	dumn nertain t	n CMS Pub 15-1			

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

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

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

B. Amount Received - if cost cannot be determined.

<sup>(3)</sup> Additional adjustments may be made on lines 33 thru 49 and subscripts thereof. Note: See instructions for column 5 referencing to Worksheet A-7.

OFFICE COSTS

Provider CCN: 14-1342

Worksheet A-8-1

From 01/14/2023 | Date/Time Prepared:

				10 09/30/2023	2/27/2024 3: 2		
	Li ne No.	Cost Center	Expense Items	Amount of	Amount		
			·	Allowable Cost	Included in		
					Wks. A, column		
					5		
	1. 00	2. 00	3. 00	4. 00	5. 00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME						
	OFFICE COSTS:						
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	EMPLOYEE BENEFITS DEPARTMENT	619, 686	0	1.00	
2.00	5. 02	OTHER ADMINISTRATIVE AND GEN	ADMINISTRATIVE & GENERAL	1, 151, 680	2, 968, 240	2.00	
3.00	7. 00	OPERATION OF PLANT	MAI NTENANCE	204, 245	0	3.00	
3. 01	8.00	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	89, 278	0	3.01	
3.02	10.00	DI ETARY	DI ETARY	51, 175	0	3.02	
3.03	13.00	NURSING ADMINISTRATION	NURSING ADMIN	141, 422	0	3.03	
3.04	15. 00	PHARMACY	PHARMACY	142, 659	0	3.04	
4.00	16. 00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS & LIBRARY	3, 526	0	4.00	
4.01	50.00	OPERATING ROOM	SURGERY	365, 410	0	4.01	
4.02	88.00	RURAL HEALTH CLINIC	RHC	206, 581	0	4.02	
4.03	0.00			0	0	4.03	
5.00	TOTALS (sum of lines 1-4).			2, 975, 662	2, 968, 240	5.00	
	Transfer column 6, line 5 to						
	Worksheet A-8, column 2,						
	line 12.						

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

			Related Organization(s) and/	or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	
1. 00	2. 00	3. 00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HO	OME OFFICE:	<u> </u>		

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	В	0. 00 DEACONESS HOSPI 100. 0	6.00
7. 00		0.00	7.00
8. 00		0.00	8.00
9. 00		0.00	9.00
10.00		0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

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

\* 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.

4 01

4.02

4.03

5.00

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

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

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

	HOSPITAL MANAGE		6.00
7.00			7.00
7. 00 8. 00			8.00
9.00			9.00
9. 00 10. 00			10.00
100.00			100.00

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

365, 410

206, 581

7, 422

4.01

4.02

4.03

5.00

0

0

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Peri od: Worksheet A-8-2
From 01/14/2023
To 09/30/2023 Date/Time Prepar Provider CCN: 14-1342

							To 09/30/2023		epared: 24 pm
	Wkst. A Line #		Total	Professi		Provi der	RCE Amount	Physi ci an/Prov	
		l denti fi er	Remuneration	Compon	ient	Component		ider Component Hours	
	1. 00	2.00	3. 00	4. 00	0	5. 00	6. 00	7. 00	
1. 00	30.00	ADULTS & PEDIATRICS	569, 828		2, 352	567, 476	0	0	1. 00
2.00	50.00	OPERATING ROOM	365, 410	30	65, 410	C	0	0	2.00
3.00	91. 00	EMERGENCY	937, 080		0	937, 080	0	0	3.00
4.00	0.00		0		0	C	0	0	4.00
5.00	0.00		0		0	C	0	0	5.00
6.00	0.00		0		0	C	0	0	6.00
7.00	0.00		0		0	C	0	0	7.00
8.00	0.00		0		0	C	0	0	8.00
9.00	0.00		0		0	C	0	0	9.00
10.00	0.00		0		0	C	0	0	10.00
200.00			1, 872, 318	30	67, 762	1, 504, 556		0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percei	nt of	Cost of	Provi der	Physician Cost	
		I denti fi er	Li mi t	Unadj ust	ed RCE	Memberships &	Component	of Malpractice	
				Limi	t	Conti nui ng	Share of col.	Insurance	
						Educati on	12		
	1. 00	2. 00	8. 00	9. 00		12. 00	13. 00	14. 00	
1. 00		ADULTS & PEDIATRICS	0		0			0	1.00
2. 00		OPERATING ROOM	0		0	_ ·		0	2.00
3. 00		EMERGENCY	0		0	_ ·	1	0	3. 00
4. 00	0. 00		0		0	_	0	0	4.00
5. 00	0. 00		0		0	0	0	0	5.00
6. 00	0.00		0		0	C	0	0	6. 00
7. 00	0.00		0		0	C	0	0	7.00
8. 00	0.00		0		0	C	0	0	8. 00
9. 00	0. 00		0		0	C	0	0	9. 00
10.00	0. 00		0		0	C	0	0	10.00
200.00	WI+ A I : "	Cook Cooker (Dhire) of or	Draw data	A -1: + -	-1 DCE	RCE	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component	Adjusted Limi		Di sal I owance	Adjustment		
		rdentifier	Share of col.	LIIIII	ι	Disarrowance			
			14						
	1. 00	2.00	15. 00	16.0	00	17. 00	18. 00		
1. 00		ADULTS & PEDIATRICS	0	10.0	0				1. 00
2. 00		OPERATING ROOM	0		0	_ ·			2.00
3. 00		EMERGENCY	0		0	i c	1		3. 00
4. 00	0.00		0		0	_ ·	0		4. 00
5. 00	0.00		0		0	_	0		5. 00
6. 00	0.00		1 0		0	_			6. 00
7. 00	0.00		0	i	0	I -	0		7. 00
8. 00	0.00		1 0		0	_ ·			8.00
9. 00	0.00		0		0	_ ·	1		9. 00
10. 00	0.00	1	1 0		0	_ ·	-		10.00
200.00	0.00				0				200.00
_00.00	ı	I	1	1	٥	1	33.,702	1	

Period: Worksheet B
From 01/14/2023 Part I
To 09/30/2023 Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-1342

				To	09/30/2023		pared:
			CAPI TAL REI	LATED COSTS		2/27/2024 3: 2	4 pm
	Cook Cooker December 1	Not Formando	DIDC & FLVT	MANDLE FOLLID	EMDL OVEE	CACHI EDI NO (AC	
	Cost Center Description	Net Expenses for Cost	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS	CASHI ERI NG/AC COUNTS	
		Allocation			DEPARTMENT	RECEI VABLE	
		(from Wkst A col. 7)					
		0	1. 00	2.00	4. 00	5. 01	
4 00	GENERAL SERVI CE COST CENTERS	50 740	50.710	1			
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	59, 749 499, 017	59, 749	499, 017			1.00 2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 041, 470	481		1, 045, 968		4.00
5. 01	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	301, 873	789	6, 593	8, 640	317, 895	5. 01
5. 02	00590 OTHER ADMINISTRATIVE AND GENERAL	3, 832, 079	5, 138		37, 220	0	5.02
7. 00 8. 00	OO7OO   OPERATION OF PLANT   OO8OO   LAUNDRY & LINEN SERVICE	1, 512, 341 242, 005	18, 999 1, 057		24, 322 286	0	7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	266, 046	840		35, 902	0	9. 00
10.00	01000 DI ETARY	521, 837	3, 328		0	0	10.00
11. 00 13. 00	O1100   CAFETERI A   O1300   NURSI NG   ADMI NI STRATI ON	-24, 180 558, 171	0 532		0 62, 760	0	11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	182, 993	1, 272		18, 911	0	14.00
15.00	01500 PHARMACY	497, 175	780		43, 910	0	15.00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	7, 090	667	5, 574	0	0	16. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	2, 048, 367	4, 261	35, 585	223, 128	25, 257	30.00
46. 00	04600 OTHER LONG TERM CARE	521, 597	2, 130		72, 803	1, 431	46.00
	ANCILLARY SERVICE COST CENTERS						
50. 00 51. 00	O5000   OPERATI NG ROOM   O5100   RECOVERY ROOM	399, 151 61, 632	2, 482 0		43, 768 9, 434	15, 455 2, 845	1
53. 00	05300 ANESTHESI OLOGY	216, 469	0		9, 434	1, 470	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	962, 749	3, 517	29, 374	93, 242	108, 203	54.00
54. 01	05401 ULTRASOUND	0	0		0	0	54.01
56. 00 57. 00	05600 RADI OI SOTOPE 05700 CT SCAN	0	0	1	0	0	56.00 57.00
58. 00	05800 MRI	Ö	0	Ö	0	0	58.00
60.00	06000 LABORATORY	983, 308	1, 222		56, 554	45, 935	60.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	54, 768 207, 582	459 4, 223		7, 782 32, 072	2, 249 15, 462	1
67. 00	06700 OCCUPATI ONAL THERAPY	310, 455	324		50, 415	5, 879	
68. 00	06800 SPEECH PATHOLOGY	74, 520	155		11, 955	1, 535	1
69.00	06900 ELECTROCARDI OLOGY	141, 728	434 0		15, 750 0	6, 184	69.00
71. 00 72. 00	O7100   MEDICAL SUPPLIES CHARGED TO PATIENT   O7200   MPL. DEV. CHARGED TO PATIENTS	134, 883 19, 478	0	-	0	4, 179 315	
73. 00	07300 DRUGS CHARGED TO PATIENTS	327, 703	0	0	0	22, 588	1
76. 00	03610 SLEEP LAB	0	0	-	0	0	76.00
76. 01 76. 03	03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   03950   WOUND CARE	319, 911 5, 787	717 389		0 350	2, 739 94	76. 01 76. 03
70.03	OUTPATIENT SERVICE COST CENTERS	3, 707	307	5, 232	330	74	70.03
88. 00	08800 RURAL HEALTH CLINIC	570, 209	2, 037		49, 710	4, 580	
	O9100   EMERGENCY   O9200   OBSERVATION   BEDS   (NON-DISTINCT   PART	1, 980, 277	2, 951	24, 643	147, 054	51, 495	91.00 92.00
92.00	SPECIAL PURPOSE COST CENTERS						72.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	18, 838, 240	59, 184	494, 305	1, 045, 968	317, 895	118. 00
100.00	NONREI MBURSABLE COST CENTERS		222	2 (04	0	0	100.00
190.00	1900 GIFT FLOWER COFFEE SHOP & CANTEEN  1920 PHYSICIANS PRIVATE OFFICES	0	323 0		0		190. 00 192. 00
	07956 AREAS UNDER RENOVATION	Ö	0		0		194.00
	07951 OTHER NONREIMBURSABLE - MARKETING	32, 296	242		0		194. 01
	07952 OTHER NONREIMBURSABLE - SENIOR CIRC 07953 FREESTANDING HHA COSTS	0	0	0	0		194. 02 194. 03
	07954 LEASED TO SPECIALTY CLINICS		0	0	0		194. 03
194. 05	07955 VACANT SPACE	0	0	O	0		194. 05
200.00	1 1		^		0	_	200.00
201. 00 202. 00		18, 870, 536	59, 749	499, 017	0 1, 045, 968		201. 00 202. 00
50	, , , , , , , , , , , , , , , , , , ,		= // / //	, 517	., , , 50	2.7,070	,

Provider CCN: 14-1342

| Peri od: | Worksheet B | From 01/14/2023 | Part | To 09/30/2023 | Date/Time Prepared:

				11	0 09/30/2023	2/27/2024 3: 2	
	Cost Center Description	Subtotal	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	, p
			ADMI NI STRATI V	PLANT	LINEN SERVICE		
			E AND GENERAL				
		5A. 01	5. 02	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS						
1. 00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 01
5. 02	00590 OTHER ADMINISTRATIVE AND GENERAL	3, 917, 350					5. 02
7. 00	00700 OPERATION OF PLANT	1, 714, 330					7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	252, 179			384, 727		8. 00
9. 00	00900 HOUSEKEEPI NG	309, 807			14, 177	457, 939	9. 00
10. 00	01000 DI ETARY	552, 962			2, 509	46, 976	1
11. 00	01100 CAFETERI A	-24, 180		0	0	0	11. 00
13.00	01300 NURSING ADMINISTRATION	625, 906			0	7, 508	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	213, 800			0	17, 954	14.00
15. 00	01500 PHARMACY	548, 380			0	11, 009	•
16. 00	01600 MEDICAL RECORDS & LIBRARY	13, 331	3, 487	42, 030	0	9, 420	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	2, 336, 598			117, 750	60, 140	30.00
46. 00	04600 OTHER LONG TERM CARE	615, 751	161, 050	134, 140	101, 598	30, 065	46. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	481, 585			20, 476	35, 031	50.00
51. 00	05100 RECOVERY ROOM	73, 911	19, 331	0	0	0	51.00
53. 00	05300 ANESTHESI OLOGY	217, 939			0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 197, 085	313, 099	221, 486	26, 287	49, 641	54.00
54. 01	05401 ULTRASOUND	0	0	0	0	0	54.01
56.00	05600 RADI OI SOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	4 007 007	0 001	7, 0,0	0	0	58.00
60.00	06000 LABORATORY	1, 097, 227		76, 968	0	17, 251	60.00
65.00	06500 RESPIRATORY THERAPY	69, 093		28, 918	0	6, 481	65.00
66.00	06600 PHYSI CAL THERAPY	294, 606			26, 287	59, 599	66.00
67.00	06700 OCCUPATI ONAL THERAPY	369, 782			0	4, 578	67.00
68.00	06800 SPEECH PATHOLOGY	89, 458			0	2, 185	1
69.00	06900 ELECTROCARDI OLOGY	167, 721	43, 868		U	6, 125	69.00
71. 00 72. 00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	139, 062			U	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	19, 793 350, 291			0	0	72. 00 73. 00
76.00	03610 SLEEP LAB	350, 291	91, 619		0	0	76.00
76. 00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	329, 357	86, 144	_	0	10, 124	76.00
76. 01	03950 WOUND CARE	9, 872		24, 523	0	5, 496	•
70.03	OUTPATIENT SERVICE COST CENTERS	7,072	2, 302	24, 323	<u> </u>	3, 470	70.03
88. 00	08800 RURAL HEALTH CLINIC	643, 547	168, 320	128, 268	4, 409	28, 748	88. 00
91.00	09100 EMERGENCY	2, 206, 420		185, 809	71, 234	41, 645	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 200, 420		103, 007	71, 234	41,043	92.00
72.00	SPECIAL PURPOSE COST CENTERS		l				72.00
118. 00		18, 832, 963	3, 907, 523	2, 127, 186	384, 727	449, 976	118 00
110.00	NONREI MBURSABLE COST CENTERS	10,032,703	3,707,323	2, 127, 100	304, 727	447, 770	1110.00
190 00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	3, 017	789	20, 313	0	4 553	190. 00
	19200 PHYSICIANS PRIVATE OFFICES	0,017	, , ,	0	0	.,	192.00
	07956 AREAS UNDER RENOVATION	0	l o	l o	0		194.00
	07951 OTHER NONREI MBURSABLE - MARKETI NG	34, 556	9, 038	15, 216	0		194. 01
	07952 OTHER NONREI MBURSABLE - SENI OR CIRC	0.7000	0	0	0	· ·	194. 02
	07953 FREESTANDING HHA COSTS	Ö	l 0	Ö	n		194. 03
	07954 LEASED TO SPECIALTY CLINICS	0	0	ا	o		194. 04
	07955 VACANT SPACE	l o	0	ا م	ol		194. 05
200.00		l				ū	200.00
201.00	1 1	Ö	0	0	o	0	201.00
202.00		18, 870, 536	3, 917, 350	2, 162, 715	384, 727	457, 939	
		•	•		. '		

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 14-1342

| Peri od: | Worksheet B | From 01/14/2023 | Part I | To 09/30/2023 | Date/Time Prepared:

				To	09/30/2023		
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O	CENTRAL SERVI CES &	2/27/2024 3: 2 PHARMACY	4 piii
		10.00	11 00	N 12.00	SUPPLY	15.00	
CENI	ERAL SERVICE COST CENTERS	10. 00	11. 00	13. 00	14. 00	15. 00	
	OO CAP REL COSTS-BLDG & FIXT						1.00
1	OO CAP REL COSTS-BEBG & TTXT			•			2.00
1	OO EMPLOYEE BENEFITS DEPARTMENT			•			4.00
1	80 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 01
	90 OTHER ADMINISTRATIVE AND GENERAL						5. 02
	OO OPERATION OF PLANT						7. 00
	00 LAUNDRY & LINEN SERVICE						8.00
	00 HOUSEKEEPI NG						9.00
	00 DI ETARY	956, 669					10.00
	OO CAFETERI A	318, 912	294, 732				11.00
	OO NURSING ADMINISTRATION	0	18, 320	1			13.00
	00 CENTRAL SERVICES & SUPPLY	0	8, 378		376, 159		14.00
	OO PHARMACY	0	9, 104		32, 054	793, 097	15. 00
	00 MEDICAL RECORDS & LIBRARY	0	0		561	0	16. 00
	ATIENT ROUTINE SERVICE COST CENTERS	J		<u> </u>	001		10.00
	00 ADULTS & PEDIATRICS	465, 112	61, 940	423, 846	48, 704	0	30.00
4	OO OTHER LONG TERM CARE	135, 518	33, 455		2, 565	0	46. 00
	ILLARY SERVICE COST CENTERS	,			_,		
	OO OPERATING ROOM	0	16, 756	101, 058	50, 685	0	50.00
4	00 RECOVERY ROOM	0	0	1	3, 297	0	51.00
4	00 ANESTHESI OLOGY	0	168	0	3, 642	0	53.00
	00 RADI OLOGY-DI AGNOSTI C	0	29, 546		11, 041	0	54.00
	01 ULTRASOUND	0	0	0	0	0	54. 01
56. 00 056	00 RADI 0I SOTOPE	0	0	0	0	0	56.00
57. 00 057	OO CT SCAN	0	0	0	o	0	57.00
58. 00 058	00 MRI	0	0	0	o	0	58.00
60.00 060	00 LABORATORY	0	22, 508	0	41, 135	0	60.00
65. 00 065	00 RESPI RATORY THERAPY	0	3, 239	14, 783	2, 051	0	65.00
66. 00 066	00 PHYSI CAL THERAPY	0	14, 131	0	421	0	66.00
67. 00 067	OO OCCUPATI ONAL THERAPY	0	12, 176	0	733	0	67.00
68. 00 068	00 SPEECH PATHOLOGY	0	2, 513	0	975	0	68.00
69. 00 069	00 ELECTROCARDI OLOGY	0	4, 636	29, 918	683	0	69. 00
	00 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	104, 163	0	71. 00
	00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	19, 316	0	72.00
	00 DRUGS CHARGED TO PATIENTS	0	0	0	0	793, 097	73.00
	10 SLEEP LAB	0	0	0	0	0	76. 00
	50 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0	59	0	76. 01
	50 WOUND CARE	0	335	0	2, 728	0	76. 03
	PATIENT SERVICE COST CENTERS						
	00 RURAL HEALTH CLINIC	0	15, 750		7, 408	0	88. 00
4	OO EMERGENCY	8, 045	41, 777	279, 333	43, 938	0	91.00
	00 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	CIAL PURPOSE COST CENTERS						
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	927, 587	294, 732	848, 938	376, 159	793, 097	1118.00
	REIMBURSABLE COST CENTERS				٥		
	00 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0		190.00
	00 PHYSICIANS PRIVATE OFFICES	0	0	0	0		192.00
	56 AREAS UNDER RENOVATION	0	0	0	0		194.00
	51 OTHER NONREIMBURSABLE - MARKETING	20, 002	0	0	U O		194. 01
1	52 OTHER NONREIMBURSABLE - SENIOR CIRC	29, 082	0		ol		194. 02
	53 FREESTANDING HHA COSTS 54 LEASED TO SPECIALTY CLINICS	0	0		ol		194. 03 194. 04
		0	0		o		1
	55 VACANT SPACE	0	0	ا ا	٥	0	194. 05
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers		^			0	200. 00 201. 00
201.00	TOTAL (sum lines 118 through 201)	956, 669	294, 732	848, 938	376, 159	793, 097	
202.00	TOTAL (Suil Titles 110 till bugit 201)	750,009	274, /32	040, 930	370, 139	173,091	1202.00

					2552-10
	Provi der CC	CN: 14-1342   F	Period: From 01/14/2023 To 09/30/2023	Worksheet B Part I Date/Time Pre	epared:
MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	272772021 0.2	
16. 00	24. 00	25. 00	26.00		_
					1 00
68, 829					1.00 2.00 4.00 5.01 5.02 7.00 8.00 9.00 11.00 11.00 13.00 14.00 15.00
					4
1					30.00
310	1, 214, 452		] 1, 214, 452		46. 00
68 4, 889 0 ES 593 20	991, 196 97, 155 279, 069 1, 871, 623 0 0 0 1, 552, 013 143, 123 741, 362 505, 683 128, 611 281, 620 280, 502 44, 354 1, 239, 896 0 471, 446 45, 556		991, 196 97, 155 279, 069 1, 871, 623 0 0 0 0 0 1, 552, 013 143, 123 741, 362 505, 683 128, 611 281, 620 280, 502 44, 354 1, 239, 896 0 0 471, 446 45, 556		50. 00 51. 00 53. 00 54. 00 54. 01 56. 00 57. 00 68. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 76. 01 76. 03
991	997, 441	(	997, 441		88. 00
11, 147	3, 466, 439				91.00
ARI			)		92.00
117) 40 020	10 750 542	,	19 750 542		118.00
1 117)   00,029	16, 750, 562		0 16, 750, 562		]110.00
0 0 0	28, 672 0 0 62, 220 29, 082 0 0 0 0		0 0 0 0 62, 220 29, 082 0 0 0		190. 00 192. 00 194. 00 194. 01 194. 02 194. 03 194. 04 194. 05 200. 00 201. 00 202. 00
	RECORDS & LI BRARY	RECORDS & LI BRARY	MEDI CAL RECORDS & LI BRARY Subtotal Residents Cost & Post Stepdown Adjustments  16.00 24.00 25.00  5, 467 4, 399, 021 25.00  1, 214, 452 6  3, 346 991, 196 6 616 97, 155 318 279, 069 6 23, 438 1, 871, 623 6 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	MEDICAL   RECORDS & LIBRARY   Subtotal   Intern & Resi dents   Cost & Post Stepdown   Adjustments   16.00   24.00   25.00   26.00	MEDICAL RECORDS & LIBRARY   Subtotal Residents   Cost & Post Stepdown Adj ustments   Total Residents   Cost & Post Stepdown Adj ustments   Total Residents   Total Residents

| Peri od: | Worksheet B | From 01/14/2023 | Part | I | To 09/30/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 14-1342

				To	09/30/2023	Date/Time Pre 2/27/2024 3:2	
			CAPITAL RELATED COSTS				
			57.11 THE THE	21125 00010			
	Cost Center Description	Di rectly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New				BENEFI TS	
		Capi tal				DEPARTMENT	
		Related Costs 0	1.00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	ZA	4.00	
1. 00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	481	4, 017	4, 498	4, 498	4.00
5. 01	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	789	6, 593	7, 382	37	5. 01
5. 02	00590 OTHER ADMINISTRATIVE AND GENERAL	0	5, 138		48, 051	160	5. 02
7. 00	00700 OPERATION OF PLANT	0	18, 999	1	177, 667	105	7.00
8.00	00800 LAUNDRY & LI NEN SERVI CE	0	1, 057	1	9, 888	1	8.00
9.00	00900 HOUSEKEEPI NG	0	840		7, 859	154	9.00
10. 00 11. 00	01000   DI ETARY   01100   CAFETERI A	0	3, 328	1	31, 125 0	0	10. 00 11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	532		4, 975	270	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	1, 272	1	11, 896	81	14.00
15. 00	01500 PHARMACY	0	780	1	7, 295	189	15. 00
	01600 MEDICAL RECORDS & LIBRARY	0	667	1	6, 241	0	16. 00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		007	5/5/1	0,211	<u> </u>	10.00
30.00	03000 ADULTS & PEDIATRICS	0	4, 261	35, 585	39, 846	960	30.00
46.00	04600 OTHER LONG TERM CARE	0	2, 130	17, 790	19, 920	313	46. 00
	ANCILLARY SERVICE COST CENTERS	_					
50. 00	05000 OPERATING ROOM	0	2, 482	1	23, 211	188	50.00
51.00	05100 RECOVERY ROOM	0	0		0	41	51.00
53.00	05300 ANESTHESI OLOGY	0	0	1	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	3, 517		32, 891	401	54.00
54. 01 56. 00	05401   ULTRASOUND   05600   RADI OI SOTOPE	0	0	_	0	0	54. 01 56. 00
57.00	05700 CT SCAN	0			0	0	57.00
58. 00	05800 MRI	0	0		0	0	58.00
60.00	06000 LABORATORY	0	1, 222	_	11, 430	243	60.00
65. 00	06500 RESPIRATORY THERAPY	0	459		4, 294	33	65.00
66. 00	06600 PHYSI CAL THERAPY	0	4, 223		39, 490	138	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	324		3, 033	217	67.00
68.00	06800 SPEECH PATHOLOGY	0	155	1, 293	1, 448	51	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	434	3, 625	4, 059	68	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	_	0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03610 SLEEP LAB	0	0		0	0	76.00
76. 01 76. 03	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	717		6, 707	0	76. 01
76.03	03950 WOUND CARE OUTPATIENT SERVICE COST CENTERS	0	389	3, 252	3, 641		76. 03
88. 00	08800 RURAL HEALTH CLINIC	0	2, 037	17, 011	19, 048	214	88. 00
91. 00	09100 EMERGENCY	0	,	1	27, 594	632	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		2,701	2.70.0	2,, 0,,	552	92.00
	SPECIAL PURPOSE COST CENTERS				-,		
118.00		0	59, 184	494, 305	553, 489	4, 498	118. 00
	NONREI MBURSABLE COST CENTERS	T					
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	020	1	3, 017		190. 00
	19200 PHYSI CI ANS PRI VATE OFFI CES	0	0		0		192.00
	07956 AREAS UNDER RENOVATION	0	0	T .	0		194. 00
	07951 OTHER NONREIMBURSABLE - MARKETING	0	242	1	2, 260		194. 01
	07952 OTHER NONREI MBURSABLE - SENI OR CIRC	0	0	0	0		194. 02 194. 03
	07953 FREESTANDING HHA COSTS 07954 LEASED TO SPECIALTY CLINICS				0		194. 03
	07955 VACANT SPACE				0		194. 04
200.00			١		٥		200.00
200.00	1 1		n	n	n		200.00
202.00	1 9	0	59, 749	499, 017	558, 766		202.00

| Peri od: | Worksheet B | From 01/14/2023 | Part II | To 09/30/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 14-1342

CASHLER MCARE   CASHLER MCAR					T <sub>1</sub>	09/30/2023		
ENERAL SERVICE COST CENTERS		Cost Center Description	CASHLERI NG/AC	OTHER	OPERATION OF	LAUNDRY &		4 pili
SENTRAL SERVICE COST CENTERS		3331 3311131 33331 1 211 311						
SMERIAL SERVICE COST CINITES			RECEI VABLE	E AND GENERAL				
1.00		T	5. 01	5. 02	7. 00	8. 00	9. 00	
0.0000   CAP PET, COSTS-MUBLE FOULP	1 00		I	T	I			4 00
4.00   00400   EMPLOYEE BENEFITS DEPARTMENT								
DOSEG CASHIER INC/ACCOUNTS RECEIVABLE   7,419   5.00   00500 OPTER ADMINISTRATIVE AND GENERAL   0   48,211   183,290   7.00   00500 OPTER ADMINISTRATIVE AND GENERAL   0   5,518   183,290   7.00   00500 OPTER ADMINISTRATIVE AND GENERAL   0   81,215   5,643   16,344   8.00   00500 OPTER ADMINISTRATIVE AND GENERAL   0   997   4,485   602   14,097   9.00   00900 OPTER ADMINISTRATION   0   17,763   107   1,446   10.00   11.00   00500 OPTER ADMINISTRATION   0   7,763   107   1,446   10.00   11.00   00500 OPTER ADMINISTRATION   0   2,015   2,839   0   231   13.00   130   01300 OPTER ADMINISTRATION   0   2,015   2,839   0   231   13.00   130   01300 OPTER ADMINISTRATION   0   1,765   3,563   0   333   15.00   130   01300 OPTER ADMINISTRATION   0   1,765   3,563   0   333   15.00   15.00 OPTER ADMINISTRATION   0   1,765   3,563   0   333   15.00   15.00 OPTER ADMINISTRATION   0   1,765   3,563   0   333   15.00   15.00 OPTER ADMINISTRATION   0   1,765   3,563   0   333   15.00   15.00 OPTER ADMINISTRATION   0   1,765   3,563   0   333   15.00   15.00 OPTER ADMINISTRATION   0   1,765   3,563   0   333   15.00   15.00 OPTER ADMINISTRATION   0   1,765   3,563   0   339   15.00   0   15.00 OPTER ADMINISTRATION   0   1,765   3,563   0   339   15.00   0   15.00 OPTER ADMINISTRATION   0   1,765   0   1,765   0   1,765   0   0   1,765   0   0   0   0   0   0   0   0   0		1						
5.02 00590 OTHER ADM IN STRATIVE AND GENERAL 0 48, 211 0 5.02			7 419					1
7.0 0         007000 DEPEATION OF PLANT         0         5,518         183,290         7.00         9.00         9.00         16,344         8.00         9.00         0.0000 LAURDRY & LINEW SERVICE         0         9.97         4,485         602         14,097         9.00         9.00         0.00         17,763         107         1,446         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         11.00			,,,	l .				1
0,000   009000   HOUSEKEEPINK   0   0   7,760   17,763   107   1,444   10,00   11.00   01000   DETARY   0   0   1,760   17,763   107   1,444   10,00   11.00   01100   CAFETERI A   0   0   0   0   0   0   0   0   11.00   1			0					1
10.00   01000   DETARY   0   1.780   17,763   107   1.446   10.00   13.00   0   0   0   0   0   11.00   13.00   1300   NRISIN 6 ADMINISTRATION   0   2.015   2.839   0   231   13.00   15.00   15.00   15.00   01500   PHARMACY   0   1.765   3.163   0   339   15.00   15.00   01500   PHARMACY   0   1.765   3.162   0   290   16.00   15.00   01500   PHARMACY   0   1.765   3.162   0   290   16.00   15.00   01500   PHARMACY   0   1.765   3.163   0   339   15.00   10.00   10.00   MEDI CAL RECORDS & LIBRARY   0   5.87   7.521   22.742   5.002   1.851   30.00   10.00   30.00	8.00		0					8. 00
11.00   01100   CAFETERI   0   0   0   0   0   0   0   11.00   13.00   13.00   01300   MRSI NA ADMINISTRATION   0   0   0   0   6.88   6.789   0   231   13.00   13.00   13.00   01300   MRSI NA ADMINISTRATION   0   0   0   6.88   6.789   0   55.31   14.00   16.00   16.00   MRSI NA ADMINISTRATION   0   0   0   0   4.3   3,562   0   290   16.00   MRSI NA ADMINISTRATION   0   0   4.3   3,562   0   290   16.00   MRSI NA ADMINISTRATION   0   0   4.3   3,562   0   290   16.00   MRSI NA ADMINISTRATION   0   0   4.3   3,562   0   290   16.00   MRSI NA ADMINISTRATION   0   0   0   0   0   0   0   0   0	9. 00	00900 HOUSEKEEPI NG	0	997	4, 485	602	14, 097	9. 00
13.00   01300 NNESIN C ADMIN ISTRATION   0   2.015   2.839   0   231   13.00   15.00   15.00   01500   PHARMACY   0   1.765   4.163   0   339   15.00   16.00   16.00   01600   MEDICAL RECORDS & LIBRARY   0   4.3   3.502   0   290   16.00   16.00   16.00   01600   MEDICAL RECORDS & LIBRARY   0   4.3   3.502   0   290   16.00   16.00   16.00   01600   MEDICAL RECORDS & LIBRARY   0   4.3   3.502   0   290   16.0	10.00		0	1, 780	17, 763	107	1, 446	10.00
14. 00   01400   CRITRAL SERVICES & SUPPLY   0   6.88   6.789   0   553   14. 00   16. 00   10600   HARMACY   0   1.7655   4.163   0   290   16. 00   10600   HARMACY   0   43   3.562   0   290   16. 00   10600   HARMACY   0   43   3.562   0   290   16. 00   10600   HARMACY   0   43   3.562   0   290   16. 00   10600   HARMACY   0   43   3.562   0   290   16. 00   10600   HARMACY   0   43   3.562   0   290   16. 00   10600   HARMACY   0   40   10600   HARMACY   0   40   40   40   40   40   40   40			0	_	-	-		1
15.00   01500   PHAMACY			0	· ·		-		1
16 00   01-060   MEDICAL RECORDS & LIBRARY   0   43   3,562   0   290   16 00			0					1
INPATI ENT ROUTINE SERVICE COST CENTERS   30.00   0.00			0			-		1
30.00   03000   03000   03000   03000   03000   03000   0300   03000   03000   0300   030000   030000   0300000   0300000000	16.00		0	43	3, 562	U	290	16.00
Accord   Oxford   Control   Contro	30 00		587	7 521	22 742	5 002	1 851	30 00
ANCILLARY SERVICE COST CENTERS   S		1					· ·	1
50.00   05000   05000   05000   05000   05000   0510	10.00			1, 702	11,000	1, 010	720	10.00
53.00   05300   AIRSTHESI OLOGY   34   702   0   0   0   53.00	50.00		359	1, 550	13, 246	870	1, 078	50.00
54.00   05400   RADI   OLGVY-DI ACROSTIC   2,546   3,853   18,771   1,117   1,528   54.00   56.00   054.01   ULTRASQUIND   0   0   0   0   0   0   0   0   0	51.00		66	238	0	0	0	51.00
54.01   05401   UITRASOUND	53.00				0	-	0	53.00
55. 00   05500   CT SCAN   0   0   0   0   0   0   0   57. 00		1	2, 546	3, 853	18, 771	1, 117		
57.00   05700   05700   05700   0500   0500   05700   0500   05700   0500   050000   050000   050000   050000   050000   050000   050000   050000   050000   050000   050000   050000   0500000   0500000   05000000   0500000000		1	0	_				
58.00   05800   MR    0 0 0 0 0 0 0 0 0 58.00		1	0	1	1	0		1
60.00   06000   LABORATORY   1,068   3,522   6,523   0   531   60.00   65.00   06500   RESPIRATORY THERAPY   52   222   2,451   0   200   65.00   66.00   06600   PHYSI CAL THERAPY   359   948   22,536   1,117   1,835   66.00   67.00   06700   0CCUPATI ONAL THERAPY   137   1,190   1,731   0   141   67.00   68.00   06600   PHYSI CAL THERAPY   137   1,190   1,731   0   141   67.00   69.00   06900   ELECTROCARDI OLOGY   36   288   826   0   67   68.00   69.00   06900   ELECTROCARDI OLOGY   144   540   2,316   0   189   69.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   7   64   0   0   0   71.00   72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   7   64   0   0   0   0   0   73.00   07300   DRIGS CHARGED TO PATIENTS   525   1,128   0   0   0   0   0   73.00   76.01   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   64   1,060   3,828   0   312   76.01   76.01   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   64   1,060   3,828   0   312   76.01   76.01   03550   PSYCHI ATRI EXPIVE COST CENTERS    88.00   08800   RURAL HEALTH CLINIC   106   2,072   10,871   187   885   88.00   79.00   09100   EMERGENCY   1,197   7,102   15,747   3,026   1,282   91.00   79.00   09100   EMERGENCY   1,197   7,419   48,090   180,278   16,344   13,852   79.00   07900   0950   CENTERS   79.00   07900   0950   CENTERS   79.00   07900   07950   AREAS UNDER RENOVATION   0   0   0   0   0   0   794.00   07952   OTHER NONREI MBURSABLE - MARKETING   0   111   1,290   0   0   0   794.00   07952   OTHER NONREI MBURSABLE - SENI OR CIRC   0   0   0   0   794.00   07955   VACANT SPACE   0   0   0   0   0   794.00   07955   VACANT SPACE   0   0   0   0   0   7900   0000   0000   0000   0000   0000   0   7900   00000   0000   0000   0000   0000   0   7900   00000   0000   0000   0000   0   7900   00000   00000   00000   0000   0000   0   7900   00000   00000   0000   0000   0000   0000   0000   7900   07950   VACANT SPACE   0   0   0   0   0   7900   00000   00000   00000   0000   0   7900   00000   00000   0000   0000   0000   0000   000			0	0		0		
65. 00   06500   RESPIRATORY THERAPY   359   948   22,536   1,117   1,835   66. 00   66.00   06600   PHYSI CAL THERAPY   359   948   22,536   1,117   1,835   66. 00   66.00   06000   CONTROLOGY   137   1,190   1,731   0   141   67.00   06000   CONTROLOGY   144   540   2,316   0   189   69.00   189   69.00   171.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT   97   448   0   0   0   0   0   0   0   0   0			1 060	2 522	_	-		1
66. 00 06600 PHYSICAL THERAPY 359 948 22,536 1,117 1,835 66.00 67.00 06700 0CCUPATI ONAL THERAPY 137 1,190 1,731 0 141 67.00 68.00 06800 SPEECH PATHOLOGY 36 288 826 0 67 68.00 69.00 06900 ELECTROCARDI OLOGY 144 540 2,316 0 189 69.00 171.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 97 448 0 0 0 0 0 72.00 172				1		-		1
67. 00   06700   OCCUPATI ONAL THERAPY   137   1, 190   1, 731   0   141   67. 00   68. 00   06800   SPEECH PATHOLOGY   36   288   826   0   67   68. 00   69. 00   06900   ELECTROCARDI OLOGY   144   540   2, 316   0   189   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   97   448   0   0   0   0   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   7   64   0   0   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   525   1, 128   0   0   0   0   0   76. 01   03500   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   64   1, 060   3, 828   0   312   76. 01   76. 03   03950   WOUND CARE   2   32   2, 078   0   169   76. 03   76. 03   03950   WOUND CARE   2   32   2, 078   0   169   76. 03   76. 03   09100   EMERGENCY   1, 197   7, 102   15, 747   3, 026   1, 282   79. 00   09200   DSSERVATI ON BEDS (NON-DI STI NCT PART   1, 197   7, 419   48, 090   180, 278   16, 344   13, 852   118. 00   79. 00   192. 00   19200   PHYSI CI ANS PRI VATE OFFICES   0   0   0   0   0   0   794. 00   07955   AREAS UNDER RENOVATI ON   0   0   0   0   0   794. 00   07955   VACANT SPACE   0   0   0   0   0   794. 00   07955   VACANT SPACE   0   0   0   0   0   794. 00   07955   VACANT SPACE   0   0   0   0   0   794. 00   07955   VACANT SPACE   0   0   0   0   0   794. 00   07955   VACANT SPACE   0   0   0   0   794. 00   07955   VACANT SPACE   0   0   0   0   795. 00   0   0   0   0   0   796. 00   0   0   0   0   797. 00   0   0   0   0   797. 00   0   0   0   797. 00   0   0   0   797. 00   0   0   0   797. 00   0   0   0   797. 00   0   0   0   797. 00   0   0   0   797. 00   0   0		1		l .		-		1
68.00		1	l .					1
71. 00	68. 00	06800 SPEECH PATHOLOGY	36			0	67	68. 00
72. 00   07200   IMPL   DEV. CHARGED TO PATIENTS   7   64   0   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   525   1, 128   0   0   0   0   76. 00   03610   SLEEP   LAB   0   0   0   0   0   76. 01   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   64   1, 060   3, 828   0   312   76. 01   76. 03   03950   WOUND   CARE   2   32   2, 078   0   169   76. 03    OUTPATIENT SERVI CE COST CENTERS  88. 00   08800   RURAL   HEALTH   CLI NI C   106   2, 072   10, 871   187   885   88. 00   91. 00   09100   EMERGENCY   1, 197   7, 102   15, 747   3, 026   1, 282   91. 00   92. 00   09200   DSSERVATI ON   BEDS   (NON-DI STI NCT   PART   SEPCI AL   PURPOSE COST CENTERS  118. 00   SUBTOTALS   SUM OF LI NES 1   through   117   7, 419   48, 090   180, 278   16, 344   13, 852   118. 00    100   NONREI   MBURSABLE   COST CENTERS   0   0   0   0   0   194. 00   07956   AREAS   UNDER   RENOVATI ON   0   0   0   0   194. 01   07951   OTHER   NONREI   MBURSABLE   SENI OR CI RC   0   0   0   0   194. 02   07952   OTHER   NONREI   MBURSABLE   SENI OR CI RC   0   0   0   0   194. 04   07954   LEASED   TO SPECI ALTY   CLI NI CS   0   0   0   0   194. 05   07955   VACANT   SPACE   0   0   0   0   0   201. 00   Negative   Cost   Centers   0   0   0   0   0   201. 00   Negative   Cost   Centers   0   0   0   0   201. 00   Negative   Cost   Centers   0   0   0   0   201. 00   Negative   Cost   Centers   0   0   0   0   201. 00   Negative   Cost   Centers   0   0   0   0   201. 00   Negative   Cost   Centers   0   0   0   0   201. 00   Negative   Cost   Centers   0   0   0   0   201. 00   Negative   Cost   Centers   0   0   0   0   201. 00   Negative   Cost   Centers   0   0   0   0   201. 00   Negative   Cost   Centers   0   0   0   0   201. 00   0   0   0   0   201. 00   0   0   0   0   0   201. 00   0   0   0   0   201. 00   0   0   0   0   201. 00   0   0   0   201. 00   0   0   0   201. 00   0   0   0   0   201. 00   0   0   0   201. 00   0   0   0   201. 00   0   0   201. 00   0   0   0   201. 00   0   0   0   201. 00	69.00	06900 ELECTROCARDI OLOGY	144	540	2, 316	0	189	69.00
73. 00   07300   DRUGS CHARGED TO PATIENTS   525   1, 128   0   0   0   73. 00   76. 01   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   64   1, 060   3, 828   0   312   76. 01   76. 03   03950   WOUND CARE   2   32   2, 078   0   169   76. 04   03950   WOUND CARE   2   32   2, 078   0   169   76. 05   004   004   004   004   76. 07   03950   WOUND CARE   2   32   2, 078   0   169   76. 08   004   004   004   004   76. 09   004   004   004   76. 00   005   004   004   76. 00   004   004   004   76. 00   004   004   004   76. 00   004   004   004   76. 00   004   004   004   76. 00   004   004   004   76. 00   004   76. 00   004   004   76. 00   004   004   76. 00   004   004   76. 00   004   004   76. 00   004   004   76. 00   004   004   76. 00   004   004   76. 00   004   004   76. 004   004   76. 004   004   76. 004   004   004   76. 004   004   004   76. 004   004   76. 004   004   004   76. 004   004   004   76. 004   004   76. 004   004   004   76. 004   004   004   76. 004   004   004   76. 004   004   004   76. 004   004   004   76. 004   004   004   76. 004   004   004   76. 004   004   004   76. 004   004   76. 004   004   004   76. 004   004   004   76. 004   004   004   76. 004   004   004   76. 004   004   004   76. 004   004   004   76. 004   004   004   76. 004   004   004   76. 004   004   004   76. 004   004   004   76. 004   004   004   76. 004   004   004   76. 004   004   004   76. 004   004   004   76. 004   004   004   76. 004   004   004   76. 004   004   004   76. 004	71. 00		97	448	0	0	0	71.00
76. 00 03610 SLEEP LAB 76. 01 03650 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 64 1, 060 3, 828 0 312 76. 01 76. 03 03950 WOUND CARE 2 32 2, 078 0 169 76. 03  0UTPATIENT SERVI CE COST CENTERS  88. 00 08800 RURAL HEALTH CLINIC 106 2, 072 10, 871 187 885 88. 00 91. 00 09100 EMERGENCY 1, 197 7, 102 15, 747 3, 026 1, 282 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS  118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 7, 419 48, 090 180, 278 16, 344 13, 852 118. 00 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 10 1, 722 0 140 190. 00 192. 00 19200 PHYSI CI ANS PRI VATE OFFI CES 0 0 0 0 0 0 0 192. 00 194. 00 07956 AREAS UNDER RENOVATION 0 0 0 0 0 194. 00 194. 01 07951 OTHER NONREI MBURSABLE - MARKETING 0 111 1, 290 0 105 194. 01 194. 02 07952 OTHER NONREI MBURSABLE - SENI OR CIRC 0 0 0 0 0 194. 02 194. 04 07954 LEASED TO SPECIALTY CLINICS 0 0 0 0 0 0 194. 03 194. 04 07954 LEASED TO SPECIALTY CLINICS 0 0 0 0 0 0 0 194. 03 194. 05 07955 VACANT SPACE 0 0 0 0 0 0 0 0 194. 03 200. 00 Negative Cost Centers 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			7			0	_	1
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES						-		1
76. 03					_	- 1		1
SUBTOTALS (SUM OF LINES 1 through 117)   7, 419   48, 090   180, 278   16, 344   13, 852   118. 00   19200   PHYSI CIANS PRIVATE OFFICES   0 0 0 19200   097950   AREAS UNDER RENOVATION ON O			04					1
88. 00	70.03			] 32	2,070	U	109	70.03
91. 00   09100   EMERGENCY   1, 197   7, 102   15, 747   3, 026   1, 282   91. 00   92. 00	88 00		106	2 072	10 871	187	885	88 00
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART   SPECIAL PURPOSE COST CENTERS   118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   7, 419   48, 090   180, 278   16, 344   13, 852   118. 00   NONREI MBURSABLE COST CENTERS   100   100   1, 722   00   140   190. 00   192. 00   194. 00   07956   AREAS UNDER RENOVATION   0   0   0   0   0   194. 00   194. 01   194. 02   194. 03   197. 05   194. 01   194. 02   194. 03   197. 05   194. 01   194. 02   194. 03   197. 05   194. 01   194. 02   194. 03   194. 04   194. 05   197. 07954   LEASED TO SPECIALTY CLINICS   0   0   0   0   0   194. 04   194. 05   07955   VACANT SPACE   0   0   0   0   0   194. 05   194.		1						1
118.00   SUBTOTALS (SUM OF LINES 1 through 117)   7,419   48,090   180,278   16,344   13,852   118.00   NONREI MBURSABLE COST CENTERS   10   10   1,722   0   140   190.00   192.00   194.00				,		, ,		1
NONRE   MBURSABLE   COST   CENTERS   190. 00   19000   GIFT   FLOWER   COFFEE   SHOP & CANTEEN   0   10   1,722   0   140   190. 00   192. 00   192. 00   19200   PHYSI CI ANS   PRI VATE   OFFI CES   0   0   0   0   0   0   192. 00   194. 00   194. 00   195. 00   195. 00   0   0   0   0   0   0   194. 00   194. 00   194. 01   195. 00		SPECIAL PURPOSE COST CENTERS						
190. 00   19000   GIFT FLOWER COFFEE SHOP & CANTEEN   0   10   1,722   0   140   190. 00   192. 00   192. 00   19200	118.00	SUBTOTALS (SUM OF LINES 1 through 117)	7, 419	48, 090	180, 278	16, 344	13, 852	118. 00
192. 00   19200   PHYSI CI ANS PRI VATE OFFI CES		NONREI MBURSABLE COST CENTERS						
194.00 07956 AREAS UNDER RENOVATION 0 0 0 0 194.00 194.00 194.01 07951 OTHER NONREIMBURSABLE - MARKETING 0 111 1,290 0 105 194.01 194.01 194.02 194.03 07952 OTHER NONREIMBURSABLE - SENIOR CIRC 0 0 0 0 0 0 194.02 194.03 07953 FREESTANDING HHA COSTS 0 0 0 0 0 194.03 194.04 07954 LEASED TO SPECIALTY CLINICS 0 0 0 0 0 194.05 07955 VACANT SPACE 0 0 0 0 0 0 194.05 200.00 Cross Foot Adjustments 0 0 0 0 0 0 0 0 0 0 0 0 0 0 194.06 201.00			0	ľ				
194. 01 07951 OTHER NONREIMBURSABLE - MARKETING 0 111 1, 290 0 105 194. 01 194. 01 194. 02 07952 OTHER NONREIMBURSABLE - SENI OR CIRC 0 0 0 0 0 194. 02 194. 03 07953 FREESTANDI NG HHA COSTS 0 0 0 0 0 194. 03 194. 04 07954 LEASED TO SPECIALTY CLINICS 0 0 0 0 0 194. 04 194. 05 07955 VACANT SPACE 0 0 0 0 0 0 194. 06 194. 05 07955 VACANT SPACE 200. 00 0 0 0 0 194. 06 194. 06 194. 06 194. 07			0			0		
194. 02 07952 OTHER NONREIMBURSABLE - SENIOR CIRC 0 0 0 0 0 194. 02 194. 03 07953 FREESTANDING HHA COSTS 0 0 0 0 0 194. 03 194. 04 07954 LEASED TO SPECIALTY CLINICS 0 0 0 0 0 194. 04 194. 05 07955 VACANT SPACE 0 0 0 0 0 194. 04 194. 05 07955 VACANT SPACE 0 0 0 0 0 194. 06 194. 06 194. 06 194. 07 07 07 07 07 07 07 07 07 07 07 07 07			0	_	_	0		
194. 03 07953 FREESTANDING HHA COSTS 0 0 0 0 194. 03 194. 04 07954 LEASED TO SPECIALTY CLINICS 0 0 0 0 194. 04 194. 05 07955 VACANT SPACE 0 0 0 0 0 194. 05 200. 00 Cross Foot Adjustments 0 0 0 0 0 0 0 0 0 0 201. 00						0		
194.04 07954 LEASED TO SPECIALTY CLINICS 0 0 0 0 194.04 194.05 07955 VACANT SPACE 0 0 0 0 194.05 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 0 0 0 0 0 0 0 0 201.00						0		
194. 05 07955 VACANT SPACE 0 0 0 0 194. 05 200. 00 Cross Foot Adjustments 201. 00 Negative Cost Centers 0 0 0 0 0 0 201. 00			1 0	0		n		
200.00   Cross Foot Adjustments   200.00   201.00   Negative Cost Centers   0   0   0   0   0   0   201.00		1	0	Ö		ő		
201.00   Negative Cost Centers   0   0   0   0   201.00								
202.00   TOTAL (sum lines 118 through 201)   7,419  48,211  183,290  16,344  14,097 202.00	201.00	Negative Cost Centers	0	0		o	0	201.00
	202.00	TOTAL (sum lines 118 through 201)	7, 419	48, 211	183, 290	16, 344	14, 097	202.00

| Peri od: | Worksheet B | From 01/14/2023 | Part II | To 09/30/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 14-1342

				To	09/30/2023	Date/Time Pre 2/27/2024 3:2	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	4 pili
	p			ADMI NI STRATI O	SERVICES &		
				N	SUPPLY		
		10. 00	11. 00	13. 00	14. 00	15. 00	
1 00	GENERAL SERVICE COST CENTERS				I		1 1 00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 01
5. 02	00590 OTHER ADMINISTRATIVE AND GENERAL						5. 02
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	52, 221					10.00
11. 00	01100 CAFETERI A	17, 408	16, 088				11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	1, 000				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	457		20, 464	45.000	14.00
15.00	01500 PHARMACY	0	497		1, 744	15, 992	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	U]	0	0	31	0	16.00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	25, 390	3, 381	5, 657	2, 650	0	30.00
46. 00	04600 OTHER LONG TERM CARE	7, 397	1, 826		140	0	46.00
40.00	ANCI LLARY SERVI CE COST CENTERS	7, 371	1,020	J	140		1 40.00
50.00	05000 OPERATING ROOM	0	915	1, 349	2, 757	0	50.00
51.00	05100 RECOVERY ROOM	0	0		179	0	51.00
53.00	05300 ANESTHESI OLOGY	0	9	0	198	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	1, 613	0	601	0	54.00
54. 01	05401 ULTRASOUND	0	0	0	0	0	54. 01
56. 00	05600 RADI 0I SOTOPE	0	0	0	0	0	56.00
57. 00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	1	0	0	58.00
60.00	06000 LABORATORY	0	1, 229		2, 238	0	60.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	177 771	197	112 23	0	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	665		40	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	137		53	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	Ö	253		37	0	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		5, 666	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1, 051	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	o	15, 992	73.00
76. 00	03610 SLEEP LAB	0	0	0	0	0	76. 00
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		3	0	76. 01
76. 03	03950 WOUND CARE	0	18	0	148	0	76. 03
00.00	OUTPATIENT SERVICE COST CENTERS		0.40		400		00.00
88. 00 91. 00	08800 RURAL HEALTH CLINIC 09100 EMERGENCY	0 439	860 2, 280		403 2, 390	0	88. 00 91. 00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	439	2, 200	3, 720	2, 390	U	91.00
72.00	SPECIAL PURPOSE COST CENTERS				l		72.00
118. 00		50, 634	16, 088	11, 330	20, 464	15, 992	118 00
110.00	NONREI MBURSABLE COST CENTERS	00,001	10,000	11,000	20, 101	10, 772	1110.00
190.00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
192.00	19200 PHYSICIANS PRIVATE OFFICES	0	0	0	o	0	192. 00
194.00	07956 AREAS UNDER RENOVATION	0	0	0	0		194. 00
	07951 OTHER NONREIMBURSABLE - MARKETING	0	0	0	0		194. 01
	07952 OTHER NONREIMBURSABLE - SENIOR CIRC	1, 587	0	0	0	0	194. 02
	07953 FREESTANDING HHA COSTS	0	0	-	0		194. 03
	07954 LEASED TO SPECIALTY CLINICS	0	0	-	0		194. 04
	07955 VACANT SPACE	O	0	0	0	0	194. 05
200. 00 201. 00			1, 320		0	0	200. 00 201. 00
201.00		52, 221	1, 320 17, 408		20, 464	15 002	201.00
202.00	TOTAL (Suil Titles TTO till ough 201)	JZ, ZZ I	17,400	11,330	20, 404	15, 772	1202.00

Health Financial Systems l	JNION COUNTY HOSF	TAL DISTRICT		In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CO	1	Period: From 01/14/2023 To 09/30/2023	Worksheet B Part II Date/Time Prepared: 2/27/2024 3:24 pm
Cost Center Description	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	16. 00	24. 00	25. 00	26. 00	
GENERAL SERVICE COST CENTERS			Т	1	
1. 00	10, 167				1. 00 2. 00 4. 00 5. 01 5. 02 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS	811	116, 398		116, 398	30.00
46. 00   04600  OTHER LONG TERM CARE	46	48, 266		48, 266	46. 00
ANCILLARY SERVICE COST CENTERS	40/	47.040		1/ 010	50.00
50.00   05000   0PERATING ROOM 51.00   05100   RECOVERY ROOM	496 91	46, 019 615		0 46, 019 0 615	50. 00 51. 00
53. 00   05300   ANESTHESI OLOGY	47	990		990	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	3, 438	66, 759		66, 759	54.00
54. 01   05401   ULTRASOUND	0, 100	00, 707	ı	0 00,707	54. 01
56. 00 05600 RADI 0I SOTOPE		0			56.00
57. 00   05700   CT   SCAN	l ol	0	•	ol ol	57.00
58. 00   05800 MRI	o	0		o	58.00
60. 00 06000 LABORATORY	1, 474	28, 268		28, 268	60.00
65. 00 06500 RESPIRATORY THERAPY	72	7, 810		7, 810	65.00
66. 00 06600 PHYSI CAL THERAPY	496	67, 713		67, 713	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	189	7, 343		7, 343	67.00
68. 00   06800   SPEECH PATHOLOGY	49	2, 955		2, 955	68.00
69. 00 06900 ELECTROCARDI OLOGY	198	8, 203	•	8, 203	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	134	6, 345		0 6, 345	71.00
72.00   07200   IMPL. DEV. CHARGED TO PATIENTS 73.00   07300   DRUGS CHARGED TO PATIENTS	10 725	1, 132 18, 370		1, 132 18, 370	72. 00 73. 00
76. 00   03610   SLEEP LAB	725	18, 370		0 18, 370	76.00
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	88	12, 062		12, 062	76. 01
76. 03   03950   WOUND   CARE	3	6, 093		6, 093	76. 03
OUTPATIENT SERVICE COST CENTERS	<u> </u>		•		
88. 00 08800 RURAL HEALTH CLINIC	147	34, 793	(	34, 793	88. 00
91. 00  09100   EMERGENCY	1, 653	67, 070		67, 070	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART				)	92.00
SPECIAL PURPOSE COST CENTERS	10 1/7	E 47, 204	,	547.204	110.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	10, 167	547, 204		547, 204	118. 00
NONREIMBURSABLE COST CENTERS  190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	4, 889	1 ,	4, 889	190.00
192. 00 19200 PHYSI CLANS PRI VATE OFFI CES		4, 009	1	0 4, 889	192.00
194. 00 07956 AREAS UNDER RENOVATION		0			194.00
194. 01 07951 OTHER NONREI MBURSABLE - MARKETI NG	o	3, 766		3, 766	194. 01
194.02 07952 OTHER NONREIMBURSABLE - SENIOR CIRC	o	1, 587		1, 587	194. 02
194. 03 07953 FREESTANDING HHA COSTS	0	0	(	0 0	194. 03
194.04 07954 LEASED TO SPECIALTY CLINICS	0	0		0 0	194. 04
194. 05 07955 VACANT_SPACE	0	0		0	194. 05
200.00 Cross Foot Adjustments		0		0 0	200.00
201.00 Negative Cost Centers	0	1, 320		1, 320	201.00
202.00 TOTAL (sum lines 118 through 201)	10, 167	558, 766	l (	558, 766	202. 00

(1)	LLOCATION - STATISTICAL BASIS	NION COUNTY HOS	Provider C	^N: 1/-13/12 [	Peri od:	Worksheet B-1	
CUST	ILLUCATION - STATISTICAL BASIS		Provider Co	F	From 01/14/2023 From 09/30/2023	Date/Time Pre	epared:
		CAPITAL REL	L LATED COSTS			2/27/2024 3: 2	24 pm
		07.11 7.712 11.21	271128 00010				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	CASHI ERI NG/AC	Reconciliatio	
		(SQUARE FEET)	(SQUARE FEET)	BENEFI TS	COUNTS	n	
				DEPARTMENT	RECEI VABLE		
				(GROSS	(GROSS		
		1.00	0.00	SALARI ES)	CHARGES)	54.00	
	OFFICE ALL OFFICE OF A CONTROL OF A CONTROL	1. 00	2. 00	4. 00	5. 01	5A. 02	
1 00	GENERAL SERVICE COST CENTERS    OO100   CAP REL COSTS-BLDG & FLXT	101.070		ı		ı	1
1.00		101, 878	101, 878				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P	000			_		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	820	l .				4.00
5. 01 5. 02		1, 346					5. 0° 5. 0°
7. 00	00590 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT	8, 761 32, 393		213, 042		-3, 917, 350	7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	1, 803				0	1
9. 00	00900 HOUSEKEEPI NG					0	1
10.00	01000 DI ETARY	1, 433				0	10.00
11. 00	01100 CAFETERI A	5, 675 0				24, 180	
13. 00	01300 NURSI NG ADMI NI STRATI ON	907	907	359, 230		24, 160	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	2, 169				0	1
15. 00	01500 PHARMACY	1, 330				0	15.00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	1, 138				0	1
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1, 130	1, 130		<u>)                                    </u>	0	10.00
30.00	03000 ADULTS & PEDIATRICS	7 245	7 245	1 277 100	E EOO 210	0	30.00
		7, 265					
46. 00	O4600 OTHER LONG TERM CARE   ANCILLARY SERVICE COST CENTERS	3, 632	3, 632	416, 715	316, 840	0	46.00
EO 00	05000 OPERATING ROOM	4 222	4 222	250 52	2 420 060	0	F0 00
50. 00 51. 00	05100 RECOVERY ROOM	4, 232					
		0	0	53, 997			1
53.00	05300 ANESTHESI OLOGY	F 007	U	[ [ [ [ ]			
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 997	5, 997	533, 709	23, 944, 741		54.00
54. 01	05401 ULTRASOUND	0	0			0	
56.00	05600 RADI OI SOTOPE	0	0			0	1 00.00
57.00	05700 CT SCAN	0	0			0	57.00
58.00	05800 MRI	2 004	2 004	222 700	10 1/7 004	0	58.00
60.00	06000 LABORATORY	2, 084					60.00
65.00	06500 RESPIRATORY THERAPY	783					65.00
66.00	06600 PHYSI CAL THERAPY	7, 200					66.00
67.00	06700 OCCUPATI ONAL THERAPY	553					67.00
68.00	06800 SPEECH PATHOLOGY	264	l .				68.00
69.00	06900 ELECTROCARDI OLOGY	740	ł	· .			1 07.0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(			1
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		69, 762		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	_		4, 999, 460	0	73.00
76.00	03610 SLEEP LAB 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0			0 404 150	0	76.00
76. 01		1, 223			606, 159		1
76. 03	03950 WOUND CARE	664	664	2, 004	1 20, 896	U	76.03
00 00	OUTPATIENT SERVICE COST CENTERS	2 472	2 472	201 E2	1 012 757	1 0	90 00
	08800  RURAL HEALTH CLINIC   09100  EMERGENCY	3, 473					91.00
		5, 031	5, 031	841, 720	11, 397, 655	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
110 0	SPECIAL PURPOSE COST CENTERS	100.014	100.016	E 007 021	70 257 200	2 002 170	110 0
118.00	SUBTOTALS (SUM OF LINES 1 through 117)   NONREIMBURSABLE COST CENTERS	100, 916	100, 916	5, 987, 035	70, 357, 390	-3, 893, 170	1118.00
100 00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	EEO	EEO	,			1100 0
		550	l .				190.00
	19200 PHYSICIANS PRIVATE OFFICES	0		(			192.00
	07956 AREAS UNDER RENOVATION	0		(			194.00
	07951 OTHER NONREIMBURSABLE - MARKETING	412	l .	(			194. 0
	07952 OTHER NONREIMBURSABLE - SENIOR CIRC	0	_	(	-		194. 02
	07953 FREESTANDING HHA COSTS 07954 LEASED TO SPECIALTY CLINICS	0	_	(	-		194.0
		0	_	(	0		194. 0
	07955 VACANT SPACE	0	0		٥	U	194. 0!
200.00							200.00
201.00		F0 740	400 017	1 045 07	217 005		201.00
202.00	,,,	59, 749	499, 017	1, 045, 968	317, 895		202. 00
203.00	Part I)  Unit cost multiplier (Wkst. B, Part I)	0. 586476	4. 898182	0. 174706	0. 004518		203. 00
		0. 366476	4. 090102				203.00
204.00	,,,			4, 498	7, 419		204.00
	Part II)   Unit cost multiplier (Wkst. B, Part			0. 00075	0. 000105		205 0
205 00				0.00075	0.000105		205. 0
205.00	1 1 -						206. 0
		i i	1	İ		I	1200. U
205. 00 206. 00							
206. 00	(per Wkst. B-2)						207 00
	(per Wkst. B-2)						207. 00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-1342 Peri od: Worksheet B-1 From 01/14/2023 09/30/2023 Date/Time Prepared: 2/27/2024 3:24 pm Cost Center Description OTHER OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY ADMI NI STRATI V LINEN SERVICE PLANT (SQUARE FEET) (MEALS E AND GENERAL (SQUARE FEET) (LBS OF LAU SERVED) (ACCUM. COST) NDRY) 7. 00 9. 00 10.00 5.02 8.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2 00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.01 5.01 5.02 00590 OTHER ADMINISTRATIVE AND GENERAL 14, 977, 366 5.02 00700 OPERATION OF PLANT 1, 714, 330 7 00 58.558 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 252, 179 1, 803 41, 711 8.00 9 00 00900 HOUSEKEEPI NG 309, 807 1, 433 1,537 55, 322 9 00 01000 DI ETARY 14, 507 10.00 552, 962 272 5, 675 10.00 5, 675 01100 CAFETERI A 11.00 0 4,836 11.00 13.00 01300 NURSING ADMINISTRATION 625, 906 907 0 907 0 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 213, 800 2, 169 0 2, 169 14.00 0 01500 PHARMACY 548, 380 1, 330 1, 330 15.00 0 15.00 0 01600 MEDICAL RECORDS & LIBRARY 16.00 13, 331 1, 138 0 1, 138 0 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 2, 336, 598 7, 265 7, 265 7, 053 30.00 12, 766 04600 OTHER LONG TERM CARE 615, 751 11, 015 2,055 46.00 3,632 3,632 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 481, 585 4, 232 2, 220 4, 232 0 50.00 05100 RECOVERY ROOM 73, 911 51.00 51.00 0 0 05300 ANESTHESI OLOGY 217, 939 53.00  $\cap$ 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 197, 085 5, 997 2,850 5, 997 0 54.00 54.01 05401 ULTRASOUND 0 54.01 C 56 00 05600 RADI OI SOTOPE 0 O 56 00 C 0 0 05700 CT SCAN 57.00 0 C 0 0 0 57.00 58.00 05800 MRI 0 0 58.00 60.00 06000 LABORATORY 1.097.227 2.084 0 2.084 0 60.00 06500 RESPIRATORY THERAPY 65.00 69,093 783  $\cap$ 783 0 65.00 66.00 06600 PHYSI CAL THERAPY 294,606 7, 200 2,850 7, 200 0 66.00 06700 OCCUPATI ONAL THERAPY 67.00 369, 782 553 0 553 0 67.00 68 00 06800 SPEECH PATHOLOGY 89 458 264 O 264 68 00 0 06900 ELECTROCARDI OLOGY 0 69.00 167, 721 740 740 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 139, 062 0 0 71.00 71.00 C 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 19, 793 0 0 ol 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73 00 350, 291 C 0 0 73 00 76.00 03610 SLEEP LAB C 0 0 0 76.00 1, 223 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 329, 357 0 0 76.01 1, 223 76.01 76.03 03950 WOUND CARE 9.872 0 0 76.03 664 664 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 643, 547 3, 473 478 3, 473 0 88.00 91.00 09100 EMERGENCY 2, 206, 420 5,031 7,723 5,031 122 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) 14, 939, 793 57, 596 41, 711 54, 360 14, 066 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 190. 00 3, 017 550 0 550 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 0 192.00 0 194.00 07956 AREAS UNDER RENOVATION 0 0 0 194.00 194. 01 07951 OTHER NONREI MBURSABLE - MARKETI NG 0 34, 556 412 0 194. 01 412 194. 02 07952 OTHER NONREI MBURSABLE - SENI OR CIRC 441 194.02 C 0 0 194. 03 07953 FREESTANDING HHA COSTS 0 C 0 0 0 194.03 194. 04 07954 LEASED TO SPECIALTY CLINICS 0 C 0 0 0 194.04 194. 05 07955 VACANT SPACE 0 194, 05 0 C 0 0 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 3, 917, 350 2, 162, 715 384, 727 457, 939 956, 669 202. 00 Part I) 65. 945337 203. 00 203.00 Unit cost multiplier (Wkst. B, Part I) 0.261551 36. 932870 9. 223634 8.277701 14, 097 204.00 Cost to be allocated (per Wkst. B, 48, 211 183, 290 16.344 52, 221 204. 00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.003219 3.130059 0. 391839 0.254817 3. 599710 205. 00 II)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)

	OCATION - STATISTICAL BASIS	11011 000111 1100	Provi der CO	CN: 14-1342 P	eri od:	Worksheet B-1	
				F	rom 01/14/2023 o 09/30/2023	Date/Time Pre	pared:
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	2/27/2024 3: 2 MEDI CAL	4 pm
	Cost Center Description	(FTES)	ADMI NI STRATI O	SERVICES &	(COSTED	RECORDS &	
			N N	SUPPLY	REQUIS.)	LI BRARY	
			(NURSING WA GES)	(COSTED REQUIS.)		(GROSS CHARGES)	
		11. 00	13. 00	14. 00	15. 00	16.00	
	NERAL SERVICE COST CENTERS 100 CAP REL COSTS-BLDG & FIXT						1.00
	200 CAP REL COSTS-MVBLE EQUIP						2.00
	400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	1580   CASHI ERI NG/ACCOUNTS RECEI VABLE   1590   OTHER ADMI NI STRATI VE AND GENERAL						5. 01 5. 02
	700 OPERATION OF PLANT						7.00
	800 LAUNDRY & LINEN SERVICE						8. 00
	900  HOUSEKEEPI NG 000  DI ETARY						9. 00 10. 00
	100 CAFETERI A	5, 277					11.00
13. 00 01	300 NURSING ADMINISTRATION	328	2, 558, 119				13.00
	400 CENTRAL SERVICES & SUPPLY 500 PHARMACY	150		379, 323			14. 00 15. 00
	600 MEDICAL RECORDS & LIBRARY	163	0	32, 324 566		70, 357, 390	
	PATIENT ROUTINE SERVICE COST CENTERS	-			-		
	000 ADULTS & PEDI ATRI CS	1, 109		49, 114			1
	600 OTHER LONG TERM CARE CILLARY SERVICE COST CENTERS	599	0	2, 587	0	316, 840	46.00
50.00 05	000 OPERATING ROOM	300	304, 521	51, 111	0	3, 420, 860	50.00
	100 RECOVERY ROOM	0	0	3, 325		629, 595	
	300 ANESTHESI OLOGY 400 RADI OLOGY-DI AGNOSTI C	3 529	0	3, 673 11, 134	0	325, 407 23, 944, 741	
	401 ULTRASOUND	0	0	0	0	23, 744, 741	1
	600 RADI OI SOTOPE	0	o	0	О	0	
	700 CT SCAN	0	0	0	0	0	
	800 MRI 000 LABORATORY	0 403	0	41, 481	0	10, 167, 004	
65. 00 06	500 RESPI RATORY THERAPY	58	44, 546	2, 068	0	497, 853	
	600 PHYSI CAL THERAPY	253		425	0	3, 422, 333	
	.700 OCCUPATIONAL THERAPY .800 SPEECH PATHOLOGY	218 45		739 983	0	1, 301, 279 339, 785	
	900 ELECTROCARDI OLOGY	83			0	1, 368, 703	
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	O	105, 037	0	924, 982	
	200 IMPL. DEV. CHARGED TO PATIENTS 300 DRUGS CHARGED TO PATIENTS	0	0	19, 478 0	0 100	69, 762 4, 999, 460	72.00
	610 SLEEP LAB	0	ő	o o	0	0	
	550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	60		606, 159	
	950 WOUND CARE TPATIENT SERVICE COST CENTERS	6	0	2, 751	0	20, 896	76. 03
	800 RURAL HEALTH CLINIC	282	0	7, 470	0	1, 013, 757	88. 00
	100 EMERGENCY	748					
	200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	5, 277	2, 558, 119	379, 323	100	70, 357, 390	118.00
	NREIMBURSABLE COST CENTERS						
	OOO GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0			190.00
	200 PHYSICIANS PRIVATE OFFICES 956 AREAS UNDER RENOVATION	0	1	0			192. 00 194. 00
	951 OTHER NONREIMBURSABLE - MARKETING	0		0			194. 01
	952 OTHER NONREIMBURSABLE - SENIOR CIRC	0	0	0	0		194. 02
	953 FREESTANDING HHA COSTS 954 LEASED TO SPECIALTY CLINICS	0	0	0	0		194. 03 194. 04
	955 VACANT SPACE	0	Ö	ő	0		194. 05
200.00	Cross Foot Adjustments						200.00
201. 00 202. 00	Negative Cost Centers Cost to be allocated (per Wkst. B,	294, 732	848, 938	376, 159	793, 097	60 020	201. 00 202. 00
202.00	Part I)	274, 732	040, 730	370, 139	793, 097	00, 029	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	55. 852189	1			0. 000978	
204.00	Cost to be allocated (per Wkst. B,	17, 408	11, 330	20, 464	15, 992	10, 167	204.00
205. 00	Part II)  Unit cost multiplier (Wkst. B, Part	3. 048702	0. 004429	0. 053949	159. 920000	0. 000145	205. 00
	11)						
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

Health Financial Systems	UNION COUNTY HOSPITAL DISTRICT	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 14-1342	From 01/14/2023	Worksheet C Part I Date/Time Prepared: 2/27/2024 3:24 pm

					To 09/30/2023	Date/Time Pre 2/27/2024 3:2	
			Title	XVIII	Hospi tal	Cost	
					Costs		
	Cost Center Description		Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst.	Adj .		Di sal I owance		
		B, Part I,					
		col . 26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
		4, 399, 021		4, 399, 02			30.00
46. 00	04600 OTHER LONG TERM CARE	1, 214, 452		1, 214, 45	2 0	0	46.00
	ANCILLARY SERVICE COST CENTERS				.	_	
	05000 OPERATING ROOM	991, 196		991, 19		0	
	05100 RECOVERY ROOM	97, 155		97, 15		0	51.00
		279, 069		279, 06		0	53.00
		1, 871, 623		1, 871, 62	3 0	0	54.00
54. 01	05401 ULTRASOUND	0		1	0	0	54. 01
		0		1	0	0	56.00
	05700 CT SCAN	0		1	0	0	57.00
	05800 MRI	0			0	0	58.00
	06000 LABORATORY	1, 552, 013		1, 552, 01		0	60.00
		143, 123	0	143, 12		0	65.00
		741, 362	0	741, 36		0	66.00
	06700 OCCUPATI ONAL THERAPY	505, 683	0	505, 68		0	67.00
	06800 SPEECH PATHOLOGY	128, 611	0	128, 61		0	68. 00
		281, 620		281, 62		0	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	280, 502		280, 50		0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	44, 354		44, 35		0	72.00
	07300 DRUGS CHARGED TO PATIENTS	1, 239, 896		1, 239, 89	6 0	0	73.00
	03610 SLEEP LAB	0			0	0	76.00
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	471, 446		471, 44		0	76. 01
76. 03	03950 WOUND CARE	45, 556		45, 55	6 0	0	76. 03
	OUTPATIENT SERVICE COST CENTERS						
		997, 441		997, 44		0	
	09100 EMERGENCY	3, 466, 439		3, 466, 43		0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	690, 037		690, 03		0	
200.00	,	19, 440, 599	0	1,7,1,0,0,			200. 00
201.00		690, 037		690, 03			201.00
202.00	Total (see instructions)	18, 750, 562	0	18, 750, 56	2 0	0	202. 00

Health Financial Systems	UNION COUNTY HOSPITAL DISTRICT	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 14-1342		Worksheet C
		From 01/14/2023	
		To 00/20/2022	Data/Tima Dranarada

Title XVIII					From 01/14/2023 o 09/30/2023	Part I Date/Time Pre	pared:
Charges			Title	XVIII	Hospi tal		4 piii
Inpati ent				XVIII	nespi tui	0031	
NPATI ENT ROUTI NE SERVI CE COST CENTERS	Cost Center Description	Inpati ent		Total (col. 6	Cost or Other	TEFRA	
INPATI ENT ROUTI NE SERVI CE COST CENTERS		,					
INPATIENT ROUTINE SERVICE COST CENTERS   30.00   03000   ADULTS & PEDIATRICS   5,128,955   5,128,955   316,840   46.00   46.00   04600   OTHER LONG TERM CARE   316,840   46.00   46.00   0716FR LONG TERM CARE   316,840   46.00							
30. 00   03000   ADULTS & PEDIATRICS   5, 128, 955   316, 840   316, 840   46. 00   Adv. 00		6. 00	7. 00	8.00	9. 00	10.00	
46. 00   04600   OTHER LONG TERM CARE   316, 840   316,	INPATIENT ROUTINE SERVICE COST CENTERS	'					
ANCILLARY SERVICE COST CENTERS	30. 00 03000 ADULTS & PEDIATRICS	5, 128, 955		5, 128, 955	5		30.00
50.00     05000     DERATTING ROMM   343,659   3,077,201   3,420,860   0.289751   0.000000   50.00   51.00   51.00   05100   RECOVERY ROMM   53,458   576,137   629,595   0.154313   0.000000   51.00   53.00   53.00   54.0	46.00 04600 OTHER LONG TERM CARE	316, 840		316, 840			46.00
51.00   05100   RECOVERY ROOM   53, 458   576, 137   629, 595   0. 154313   0. 000000   51.00   53.00   05300   ANESTHESI OLOGY   36, 036   289, 371   325, 407   0. 857600   0. 000000   54.00   54.00   05400   RADI OLOGY-DI AGNOSTI C   1, 128, 990   22, 815, 751   23, 944, 741   0. 078164   0. 000000   54.00   54.01   05401   ULTRASOUND   0   0   0   0. 000000   0. 000000   54.01   56.00   05600   RADI OLOGY-DI AGNOSTI C   0   0   0   0. 000000   0. 000000   54.01   57.00   05700   CT SCAN   0   0   0   0. 000000   0. 000000   57.00   58.00   05800   MRI   0   0   0   0. 000000   0. 000000   58.00   60.00   06000   LABORATORY   1, 560, 928   8, 606, 076   10, 167, 004   0. 152652   0. 000000   65.00   60.00   06000   LABORATORY   1875   79, 068   497, 853   0. 287480   0. 000000   65.00   66.00   06600   PHYSI CAL THERAPY   625, 613   2, 796, 720   3, 422, 333   0. 216625   0. 000000   66.00   67.00   06700   OCCUPATI ONAL THERAPY   503, 981   797, 298   1, 301, 279   0. 388605   0. 000000   67.00   68.00   06800   SPECH PATHOLOGY   240, 293   1, 128, 410   1, 368, 703   0. 205757   0. 000000   69.00   69.00   06900   ELECTROCARDI OLOGY   240, 293   1, 128, 410   1, 368, 703   0. 205757   0. 000000   69.00   67.00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENT   797, 604   127, 378   924, 982   0. 303251   0. 000000   72.00   73.00   07300   DRUGS CHARGED TO PATI ENTS   2, 128, 716   2, 870, 744   4, 999, 460   0. 248006   0. 000000   73.00   76.01   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   606, 159   606, 159   0. 777760   0. 000000   76.01   76.03   03950   WOUND CARE   0   1, 013, 757   1, 1013, 757   0. 000000   76.01   76.03   03950   WOUND CARE   0   292, 219   11, 105, 436   11, 397, 655   0. 304136   0. 000000   76.01   76.03   03950   WOUND CARE   0   1, 013, 757   1, 013, 757   0. 000000   76.01   76.00   09200   08SERVATI ON BEDS (NON-DISTINCT PART   29, 241   432, 123   461, 364   1. 495646   0. 000000   92.00   77.00   09200   08SERVATI ON BEDS (NON-DISTINCT PART   29, 241   432, 123	ANCILLARY SERVICE COST CENTERS						
53. 00         05300         ANESTHESI OLOGY         36, 036         289, 371         325, 407         0.857600         0.00000         53. 00           54. 00         05400         RADI OLOGY-DI AGNOSTI C         1, 128, 990         22, 815, 751         23, 944, 741         0.078164         0.00000         54. 00           54. 01         05401 ULTRASOUND         0         0         0         0.000000         54. 00           56. 00         05600 RADI OLOGY-DI AGNOSTI C         0         0         0         0.000000         54. 00           56. 00         05600 RADI OLOGY-DI AGNOSTI C         0         0         0         0.000000         56. 00           57. 00         05700 CT SCAN         0         0         0         0.000000         0.000000         56. 00           68. 00         05800 MRI         0         0         0         0.000000         57. 00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         66.00         66.00         66.00         8.606,076         10, 167, 004         0.152652         0.00000         65.00           65. 00         066000         RESPI RATIORY THERAPY         418, 785         79, 628	50.00 05000 OPERATING ROOM	343, 659	3, 077, 201	3, 420, 860	0. 289751	0. 000000	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 1, 128, 990 22, 815, 751 23, 944, 741 0. 078164 0. 000000 54. 00 54. 01 05401 ULTRASOUND 0 0 0. 000000 0. 000000 54. 01 056. 00 05600 RADI OLOGOMO 0. 000000 0. 000000 54. 01 056. 00 05600 RADI OLOGOMO 0. 000000 0. 000000 0. 000000 57. 00 0. 000000 0. 000000 0. 000000 0. 000000	51.00   05100   RECOVERY ROOM	53, 458	576, 137	629, 595	0. 154313	0.000000	51.00
54. 01 05401 ULTRASOUND 0 0 0 0 0.000000 54. 01 56. 00 5600 RADI OI SOTOPE 0 0 0 0 0 0.000000 56. 00 56. 00 57. 00 05700 CT SCAN 0 0 0 0 0 0.000000 0.000000 56. 00 56. 00 57. 00 05700 CT SCAN 0 0 0 0 0 0.000000 0.000000 57. 00 0.000000 0.000000 0.000000 0.000000	53. 00 05300 ANESTHESI OLOGY	36, 036	289, 371	325, 407	0. 857600	0.000000	53.00
56.00   05600   RADI OI SOTOPE   0   0   0   0   0   0   0   0   0	54. 00   05400   RADI OLOGY-DI AGNOSTI C	1, 128, 990	22, 815, 751	23, 944, 741	0. 078164	0.000000	54.00
57. 00         05700         CT SCAN         0         0         0         0         0.000000         57. 00           58. 00         05800         MRI         0         0         0         0.000000         0.000000         0.000000         58. 00           60. 00         06000         LABORATORY         1,560,928         8,606,076         10,167,004         0.152652         0.00000         60.00           65. 00         06500         RESPI RATORY THERAPY         418,785         79,068         497,853         0.287480         0.000000         65.00           66. 00         06600         PHYSI CAL THERAPY         625,613         2,796,720         3,422,333         0.216625         0.00000         66.00           67. 00         06700         OCCUPATI ONAL THERAPY         503,981         797,298         1,301,279         0.388605         0.000000         67.00           68. 00         06900         SPECH PATHOLOGY         199,828         139,957         339,785         0.378507         0.000000         67.00           71. 00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENT         797,604         127,378         924,982         0.303251         0.000000         71.00           72. 00         0	54. 01   05401   ULTRASOUND	0	0	(	0. 000000	0.000000	54. 01
58. 00	56. 00   05600   RADI 0I SOTOPE	0	0	(	0. 000000	0.000000	56.00
60. 00		0	0	(	0. 000000	0.000000	57.00
65. 00	58. 00   05800   MRI	0	0	(	0. 000000	0.000000	58. 00
66. 00   06600   PHYSI CAL THERAPY   625, 613   2, 796, 720   3, 422, 333   0. 216625   0. 000000   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   503, 981   797, 298   1, 301, 279   0. 388605   0. 000000   67. 00   68. 00   06800   SPEECH PATHOLOGY   199, 828   139, 957   339, 785   0. 378507   0. 000000   68. 00   06900   ELECTROCARDI OLOGY   240, 293   1, 128, 410   1, 368, 703   0. 205757   0. 000000   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   797, 604   127, 378   924, 982   0. 303251   0. 000000   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   43   69, 719   69, 762   0. 635790   0. 000000   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   2, 128, 716   2, 870, 744   4, 999, 460   0. 248006   0. 000000   73. 00   76. 00   0. 30550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   606, 159   606, 159   0. 777760   0. 000000   76. 01   76. 03   0. 3950   WOUND CARE   0   20, 896   20, 896   2. 180130   0. 000000   76. 03   0. 000000   76. 03   0. 000000   76. 03   0. 000000   76. 03   0. 000000   0. 000000   76. 03   0. 000000   0. 000000   0. 000000   76. 03   0. 000000   0. 000000   0. 000000   76. 03   0. 0000000   0. 000000   0. 000000   0. 0000000   0. 0000000   0. 0000000   0. 00000	60. 00   06000   LABORATORY	1, 560, 928	8, 606, 076	10, 167, 004	0. 152652	0.000000	60.00
67. 00   06700   OCCUPATI ONAL THERAPY   503, 981   797, 298   1, 301, 279   0. 388605   0. 000000   67. 00   68. 00   06800   SPEECH PATHOLOGY   199, 828   139, 957   339, 785   0. 378507   0. 000000   68. 00   69. 00   06900   ELECTROCARDI OLOGY   240, 293   1, 128, 410   1, 368, 703   0. 205757   0. 000000   69. 00   71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENT   797, 604   127, 378   924, 982   0. 303251   0. 000000   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   43   69, 719   69, 762   0. 635790   0. 000000   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   2, 128, 716   2, 870, 744   4, 999, 460   0. 248006   0. 000000   76. 00   76. 01   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   606, 159   606, 159   0. 777760   0. 000000   76. 01   76. 03   03950   WOUND CARE   0   20, 896   20, 896   2. 180130   0. 000000   76. 03   00100000   0. 0000000   76. 03   001000000   0. 0000000   0. 0000000   76. 03   0. 00000000	65. 00 06500 RESPIRATORY THERAPY	418, 785	79, 068	497, 853	0. 287480	0.000000	65.00
68. 00   06800   SPEECH PATHOLOGY   199, 828   139, 957   339, 785   0.378507   0.000000   68. 00   69. 00   06900   ELECTROCARDI OLOGY   240, 293   1, 128, 410   1, 368, 703   0.205757   0.000000   69. 00   71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENT   797, 604   127, 378   924, 982   0.303251   0.000000   71. 00   72. 00   72. 00   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   43   69, 719   69, 762   0.635790   0.000000   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   2, 128, 716   2, 870, 744   4, 999, 460   0.248006   0.000000   76. 00   76. 01   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   606, 159   606, 159   0.777760   0.000000   76. 01   76. 03   03950   WOUND CARE   0   20, 896   20, 896   2.180130   0.000000   76. 03   000000   76. 03   0000000   09100   EMERGENCY   292, 219   11, 105, 436   11, 397, 655   0.304136   0.000000   92. 00   200. 00   Subtotal (see instructions)   13, 805, 189   56, 552, 201   70, 357, 390   200. 00   201. 0	66. 00 06600 PHYSI CAL THERAPY	625, 613	2, 796, 720	3, 422, 333	0. 216625	0.000000	66.00
69. 00   06900   ELECTROCARDI OLOGY   240, 293   1, 128, 410   1, 366, 703   0. 205757   0. 000000   69. 00   71. 00   71. 00   71. 00   71. 00   71. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   74. 00   7	67. 00 06700 OCCUPATI ONAL THERAPY	503, 981	797, 298	1, 301, 279	0. 388605	0.000000	67.00
71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   797, 604   127, 378   924, 982   0.303251   0.000000   71. 00   72. 00   72. 00   72. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   74. 00	68.00 06800 SPEECH PATHOLOGY	199, 828	139, 957	339, 785	0. 378507	0.000000	68. 00
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   43   69,719   69,762   0.635790   0.000000   72.00   73.00   07300   DRUGS CHARGED TO PATIENTS   2,128,716   2,870,744   4,999,460   0.248006   0.000000   73.00   76.00   03610   SLEEP LAB   0   0   0   0.000000   0.000000   76.00   76.01   03550   PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES   0   606,159   606,159   0.777760   0.000000   76.01   76.03   03950   WOUND CARE   0   20,896   20,896   2.180130   0.000000   76.03   0000000   76.01   76.03   03950   WOUND CARE   0   0   1,013,757   1,013	69. 00 06900 ELECTROCARDI OLOGY	240, 293	1, 128, 410	1, 368, 703	0. 205757	0.000000	69.00
73. 00   07300   DRUGS CHARGED TO PATIENTS   2, 128, 716   2, 870, 744   4, 999, 460   0. 248006   0. 0000000   73. 00   76. 00   0. 0000000   0. 0000000   76. 00   0. 0000000   76. 00   76. 01   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   606, 159   606, 159   0. 777760   0. 000000   76. 01   76. 03   03950   WOUND CARE   0   20, 896   20, 896   2. 180130   0. 000000   76. 03   0. 0000000   76. 03   0. 0000000   76. 03   0. 0000000   76. 03   0. 0000000   76. 03   0. 0000000   76. 03   0. 0000000   76. 03   0. 0000000   76. 03   0. 0000000   76. 03   0. 0000000   76. 03   0. 0000000   76. 03   0. 00000000   76. 03   0. 00000000   76. 03   0. 000000000000   76. 03   0. 000000000000000000000000000000	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	797, 604	127, 378	924, 982	0. 303251	0.000000	71.00
76. 00   03610   SLEEP LAB   0   0   0   0   0   0   0   0   0	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	43	69, 719	69, 762	0. 635790	0.000000	72.00
76. 01   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   606, 159   606, 159   20, 896   20, 896   2. 180130   0. 0000000   76. 01   76. 03   0000000   76. 01   76. 03   000000000000000000000000000000000	73.00 07300 DRUGS CHARGED TO PATIENTS	2, 128, 716	2, 870, 744	4, 999, 460	0. 248006	0.000000	73.00
76. 03   03950   WOUND CARE   0   20,896   20,896   2.180130   0.000000   76.03	76. 00   03610   SLEEP LAB	0	0	(	0. 000000	0.000000	76.00
0UTPATIENT SERVICE COST CENTERS  88. 00 91. 00 91. 00 92. 00 92. 00 92. 00 92. 00 Subtotal (see instructions) Subservation Beds  00 1, 013, 757 1, 013, 757 11, 0		0	606, 159	606, 159			
88. 00   08800   RURAL HEALTH CLINIC   0   1,013,757   1,013,757   1,013,757   1,013,757   0.304136   0.000000   91.00   92.00   09200   0BSERVATION BEDS (NON-DISTINCT PART   29,241   432,123   461,364   1.495646   0.000000   92.00   201.00   Less Observation Beds   13,805,189   56,552,201   70,357,390   201.00   201		0	20, 896	20, 896	2. 180130	0.000000	76. 03
91. 00   09100   EMERGENCY   292, 219   11, 105, 436   11, 397, 655   0. 304136   0. 000000   91. 00   92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART   29, 241   432, 123   461, 364   1. 495646   0. 000000   92. 00   201. 00   Less Observation Beds   13, 805, 189   56, 552, 201   70, 357, 390   201. 00   201.							
92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART 29, 241 432, 123 461, 364 1. 495646 0. 000000 92. 00 201. 00   Less Observation Beds 13, 805, 189 56, 552, 201 70, 357, 390 201. 00		1 -1					
200.00   Subtotal (see instructions)   13,805,189   56,552,201   70,357,390   200.00   201.00   Less Observation Beds   201.00							
201.00 Less Observation Beds 201.00		· · ·	· ·				
		13, 805, 189	56, 552, 201	70, 357, 390	)		
202.00   Total (see instructions)   13,805,189  56,552,201  70,357,390      202.00							
	202.00   Total (see instructions)	13, 805, 189	56, 552, 201	70, 357, 390	)		202.00

Health Financial Systems	UNION COUNTY HOSPI	TAL DISTRICT	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 14-1342	From 01/14/2023	Worksheet C Part I Date/Time Pre 2/27/2024 3:2	
		Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				

			10 077 007 2020	2/27/2024 3: 24 pm
		Title XVIII	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
46. 00 04600 OTHER LONG TERM CARE				46. 00
ANCILLARY SERVICE COST CENTERS				
50. 00   05000 OPERATING ROOM	0. 000000			50.00
51. 00   05100   RECOVERY ROOM	0. 000000			51.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
54. 01   05401   ULTRASOUND	0. 000000			54. 01
56. 00   05600   RADI OI SOTOPE	0. 000000			56.00
57. 00  05700 CT SCAN	0. 000000			57. 00
58. 00   05800   MRI	0. 000000			58. 00
60. 00  06000  LABORATORY	0. 000000			60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	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   03610   SLEEP LAB	0. 000000			76. 00
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000			76. 01
76. 03 03950 WOUND CARE	0. 000000			76. 03
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 RURAL HEALTH CLINIC				88.00
91. 00   09100   EMERGENCY	0. 000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92.00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00   Total (see instructions)				202.00

Health Financial Systems	UNION COUNTY HOS	SPITAL DISTRICT		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der Co		Period: From 01/14/2023 To 09/30/2023	Worksheet C Part I Date/Time Pre 2/27/2024 3:2	
		Ti tl	e XIX	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	

					0 09/30/2023	2/27/2024 3: 2	parea: 4 nm
-			Ti tl	e XIX	Hospi tal	PPS	<u>, b</u>
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst.	Adj .		Di sal I owance		
		B, Part I,					
		col. 26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
	NPATIENT ROUTINE SERVICE COST CENTERS						
	3000 ADULTS & PEDIATRICS	4, 399, 021		4, 399, 021		4, 399, 021	30.00
	4600 OTHER LONG TERM CARE	1, 214, 452		1, 214, 452	2 0	1, 214, 452	46. 00
	NCILLARY SERVICE COST CENTERS						
	5000 OPERATING ROOM	991, 196		991, 196		991, 196	
	5100 RECOVERY ROOM	97, 155		97, 155		97, 155	
	5300 ANESTHESI OLOGY	279, 069		279, 069		279, 069	
	5400 RADI OLOGY-DI AGNOSTI C	1, 871, 623		1, 871, 623	0	1, 871, 623	
	5401 ULTRASOUND	0		(	0	0	54. 01
	5600 RADI OI SOTOPE	0		(	0	0	56.00
	5700 CT SCAN	0		(	0	0	
	5800 MRI	0		(	0	0	
	6000 LABORATORY	1, 552, 013		1, 552, 013		1, 552, 013	
	6500 RESPI RATORY THERAPY	143, 123	0			143, 123	
	6600 PHYSI CAL THERAPY	741, 362	0	741, 362		741, 362	
	6700 OCCUPATI ONAL THERAPY	505, 683	0	505, 683		505, 683	
	6800 SPEECH PATHOLOGY	128, 611	0	128, 611		128, 611	
	6900 ELECTROCARDI OLOGY	281, 620		281, 620		281, 620	
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	280, 502		280, 502		280, 502	
	7200 IMPL. DEV. CHARGED TO PATIENTS	44, 354		44, 354		44, 354	
	7300 DRUGS CHARGED TO PATIENTS	1, 239, 896		1, 239, 896	0	1, 239, 896	
	3610 SLEEP LAB	0		(	0	0	
	3550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	471, 446		471, 446		471, 446	
	3950 WOUND CARE	45, 556		45, 556	0	45, 556	76. 03
	UTPATIENT SERVICE COST CENTERS						
	8800 RURAL HEALTH CLINIC	997, 441		997, 441		997, 441	
	9100 EMERGENCY	3, 466, 439		3, 466, 439		3, 466, 439	
	9200 OBSERVATION BEDS (NON-DISTINCT PART	690, 037		690, 037		690, 037	
200. 00	Subtotal (see instructions)	19, 440, 599		,		19, 440, 599	
201. 00	Less Observation Beds	690, 037		690, 037		690, 037	
202. 00	Total (see instructions)	18, 750, 562	0	18, 750, 562	2 0	18, 750, 562	202.00

UNION COUNTY HOSPITAL DISTRICT	In Lie	u of Form CMS-2552-10
Provi der CCN: 14-1342		Worksheet C
		Part
		Provider CCN: 14-1342   Period: From 01/14/2023

Title XIX   Hospital   PPS
Cost Center Description  Inpatient Outpatient Total (col. 6 + col. 7)  Ratio Inpatient Ratio  6.00 7.00 8.00 9.00 10.00
Cost Center Description Inpatient Outpatient Total (col. 6 Cost or Other + col. 7) Ratio Inpatient Ratio  6.00 7.00 8.00 9.00 10.00
+ col. 7) Ratio Inpatient Ratio 6.00 7.00 8.00 9.00 10.00
Ratio
6.00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS
I NPATI ENT ROUTI NE SERVI CE COST CENTERS
30. 00   03000   ADULTS & PEDI ATRI CS   5, 128, 955   5, 128, 955   30.
46. 00 04600 OTHER LONG TERM CARE 316, 840 316, 840 46.
ANCILLARY SERVICE COST CENTERS
50. 00 05000 OPERATI NG ROOM 343, 659 3, 077, 201 3, 420, 860 0. 289751 0. 000000 50.
51. 00   05100   RECOVERY ROOM   53, 458   576, 137   629, 595   0. 154313   0. 000000   51.
53. 00   05300   ANESTHESI OLOGY   36, 036   289, 371   325, 407   0. 857600   0. 000000   53.
54. 00   05400   RADI OLOGY-DI AGNOSTI C   1, 128, 990   22, 815, 751   23, 944, 741   0. 078164   0. 000000   54.
54. 01   05401   ULTRASOUND   0   0   0. 000000   0. 000000   54.
56. 00   05600   RADI 01 SOTOPE   0   0   0   0. 000000   0. 000000   56.
57. 00   05700   CT SCAN   0   0   0   0.000000   0.000000   57.
58. 00   05800   MRI   0   0   0   0. 000000   0. 000000   58.
60. 00   06000   LABORATORY   1, 560, 928   8, 606, 076   10, 167, 004   0. 152652   0. 000000   60.
65. 00   06500   RESPI RATORY THERAPY 418, 785 79, 068 497, 853 0. 287480 0. 000000 65.
66. 00   06600   PHYSI CAL THERAPY   625, 613   2, 796, 720   3, 422, 333   0. 216625   0. 000000   66.
67. 00   06700   0CCUPATI ONAL THERAPY   503, 981   797, 298   1, 301, 279   0. 388605   0. 000000   67.
68. 00   06800   SPEECH PATHOLOGY   199, 828   139, 957   339, 785   0. 378507   0. 000000   68.
69. 00   06900   ELECTROCARDI OLOGY   240, 293   1, 128, 410   1, 368, 703   0. 205757   0. 000000   69.
71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT   797,604   127,378   924,982   0.303251   0.000000   71.
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 43 69,719 69,762 0.635790 0.000000 72.
73. 00   07300   DRUGS CHARGED TO PATIENTS   2, 128, 716   2, 870, 744   4, 999, 460   0. 248006   0. 000000   73.
76. 00   03610   SLEEP LAB   0   0   0   0.000000   0.000000   76.
76. 01   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   606, 159   606, 159   0. 777760   0. 000000   76.
76. 03 03950 WOUND CARE 0 20, 896 2. 180130 0. 000000 76.
OUTPATIENT SERVICE COST CENTERS
88. 00   08800   RURAL HEALTH CLINIC   0   1,013,757   1,013,757   0.983905   0.000000   88.
91. 00   09100   EMERGENCY   292, 219   11, 105, 436   11, 397, 655   0. 304136   0. 000000   91.
92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART   29, 241   432, 123   461, 364   1. 495646   0. 000000   92.
200. 00 Subtotal (see instructions) 13, 805, 189 56, 552, 201 70, 357, 390 200.
201.00 Less Observation Beds 201.
202. 00   Total (see instructions)   13, 805, 189   56, 552, 201   70, 357, 390   202.

Health Financial Systems	UNION COUNTY HOSP	NITAL DICTDICT	la li o	u of Form CMS-2	DEED 10
Health Financial Systems	UNI UN COUNTY HUSP				2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-1342	Peri od:	Worksheet C	
			From 01/14/2023		
				Date/Time Pre	
				2/27/2024 3: 2	4 pm
		Title XIX	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				

		II LI E XIX	HOSPI Lai	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS		·	·	30	0. 00
46.00 04600 OTHER LONG TERM CARE				46	. 00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 289751				0. 00
51.00   05100   RECOVERY ROOM	0. 154313			51	. 00
53. 00   05300   ANESTHESI OLOGY	0. 857600			53	3. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 078164			54	1.00
54. 01   05401   ULTRASOUND	0. 000000			54	1. 01
56. 00   05600   RADI 0I SOTOPE	0. 000000			56	6. 00
57. 00   05700 CT SCAN	0. 000000			57	7.00
58. 00   05800   MRI	0. 000000			58	3. 00
60. 00   06000   LABORATORY	0. 152652			60	0. 00
65. 00 06500 RESPIRATORY THERAPY	0. 287480			65	5. 00
66. 00   06600 PHYSI CAL THERAPY	0. 216625			66	o. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 388605			67	7.00
68. 00 06800 SPEECH PATHOLOGY	0. 378507			68	3. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 205757			69	9. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 303251			71	. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 635790			72	2. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 248006			73	3. 00
76. 00   03610   SLEEP LAB	0. 000000			76	o. 00
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 777760			76	o. 01
76. 03   03950   WOUND CARE	2. 180130			76	. 03
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC	0. 983905			88	3. 00
91. 00 09100 EMERGENCY	0. 304136			91	. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 495646			92	2. 00
200.00 Subtotal (see instructions)				200	0. 00
201.00 Less Observation Beds				201	. 00
202.00 Total (see instructions)				202	2. 00

Period: Worksheet C From 01/14/2023 Part II To 09/30/2023 Date/Time Prepared:

					0 09/30/2023	2/27/2024 3:2	
			Ti tl	e XIX	Hospi tal	PPS	. i p
	Cost Center Description	Total Cost	Capital Cost	Operati ng	Capi tal	Operati ng	
		(Wkst. B,	(Wkst. B,	Cost Net of	Reducti on	Cost	
		Part I, col.	Part II col.	Capital Cost		Reducti on	
		26)	26)	(col. 1 -		Amount	
				col. 2)			
		1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	, , ,		,	,		1
	05000 OPERATING ROOM	991, 196		•	1	0	
	05100 RECOVERY ROOM	97, 155	615	•		0	
	05300 ANESTHESI OLOGY	279, 069	990			0	
	05400 RADI OLOGY-DI AGNOSTI C	1, 871, 623	66, 759	1, 804, 864	0	0	0 00
	05401 ULTRASOUND	0	0	(	0	0	54. 01
	05600 RADI OI SOTOPE	0	0	(	0	0	56.00
	05700 CT SCAN	0	0	(	0	0	57.00
	05800 MRI	0	0	(	0	0	58. 00
	06000 LABORATORY	1, 552, 013	28, 268			0	60.00
	06500 RESPI RATORY THERAPY	143, 123	7, 810			0	65.00
	06600 PHYSI CAL THERAPY	741, 362	67, 713			0	66. 00
	06700 OCCUPATI ONAL THERAPY	505, 683				0	07100
	06800 SPEECH PATHOLOGY	128, 611	2, 955			0	
	06900 ELECTROCARDI OLOGY	281, 620				0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	280, 502	6, 345			0	
	07200 IMPL. DEV. CHARGED TO PATIENTS	44, 354	1, 132			0	
	07300 DRUGS CHARGED TO PATIENTS	1, 239, 896	18, 370	1, 221, 526	0	0	
	03610 SLEEP LAB	0	0	1	0	0	
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	471, 446	12, 062			0	
	03950 WOUND CARE	45, 556	6, 093	39, 463	0	0	76. 03
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	997, 441	34, 793	962, 648	0	0	
	09100 EMERGENCY	3, 466, 439	67, 070	3, 399, 369	0	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	690, 037	18, 258	671, 779	0	0	1 /2.00
200.00	Subtotal (sum of lines 50 thru 199)	13, 827, 126					200.00
201.00	Less Observation Beds	690, 037	18, 258	•			201.00
202.00	Total (line 200 minus line 201)	13, 137, 089	382, 540	12, 754, 549	0	0	202.00

09/30/2023 2/27/2024 3: 24 pm Title XIX Hospi tal PPS Cost Net of Total Charges Outpati ent Cost Center Description Capital and (Worksheet C, Cost to Charge Ratio Operating Part I Cost column 8) (col. 6 / Reduction col. 7) 7.00 8.00 6.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 991, 196 0. 289751 50 00 3, 420, 860 51. 00 | 05100 | RECOVERY ROOM 97, 155 629, 595 0.154313 51.00 05300 ANESTHESI OLOGY 279, 069 325, 407 0.857600 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 23, 944, 741 0.078164 54.00 54.00 1, 871, 623 05401 ULTRASOUND 0.000000 54.01 O r 54.01 56.00 05600 RADI OI SOTOPE 0 0 0.000000 56.00 57.00 05700 CT SCAN 0 0 0.000000 57.00 58.00 05800 MRI 0 0.000000 58.00 06000 LABORATORY 60.00 1, 552, 013 10, 167, 004 0.152652 60.00 65.00 06500 RESPIRATORY THERAPY 143, 123 497, 853 0. 287480 65.00 66.00 06600 PHYSI CAL THERAPY 741, 362 3, 422, 333 0.216625 66.00 06700 OCCUPATI ONAL THERAPY 1, 301, 279 505, 683 0.388605 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 128, 611 339, 785 0.378507 68.00 06900 ELECTROCARDI OLOGY 0. 205757 69.00 281, 620 1, 368, 703 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 280, 502 924. 982 0.303251 71.00 71 00 72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 44, 354 69, 762 0.635790 72.00 07300 DRUGS CHARGED TO PATIENTS 1, 239, 896 4, 999, 460 0. 248006 73.00 03610 SLEEP LAB 0.000000 76.00 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 471, 446 76.01 606, 159 0.777760 76.01 76.03 03950 WOUND CARE 45, 556 20, 896 2.180130 76.03 OUTPATIENT SERVICE COST CENTERS 1, 013, 757 88.00 08800 RURAL HEALTH CLINIC 997, 441 0. 983905 88.00 91.00 09100 EMERGENCY 3, 466, 439 11, 397, 655 0.304136 91.00

690, 037

690, 037

13, 827, 126

13, 137, 089

461, 364

64, 911, 595

64, 911, 595

1.495646

92.00

200.00

201 00

202.00

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Less Observation Beds

Subtotal (sum of lines 50 thru 199)

Total (line 200 minus line 201)

200.00

201 00

202.00

Health Financial Systems UNION COUNTY HOSPITAL DISTRICT In Lieu of Form CMS-25						
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			CN: 14-1342	Peri od:	Worksheet D	
			From 01/14/2023 To 09/30/2023		pared:	
2/27/2024 3						
			XVIII	Hospi tal	Cost	
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)	0.00	2.00	4.00	F 00	
ANOLLI ADV. CEDVILOE, COCT. CENTEDO	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	1/ 010	2 420 0/0	0.0104	0/ 102	1 204	F0 00
	46, 019					
51. 00 05100 RECOVERY ROOM	615 990					51.00
53. 00 05300 ANESTHESI OLOGY						53. 00 54. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	66, 759	23, 944, 741				54.00
54. 01   05401   ULTRASOUND 56. 00   05600   RADI OI SOTOPE	0	0	0.00000		0	
56. 00   05600   RADI 0I SOTOPE 57. 00   05700   CT   SCAN	0	0	0. 00000 0. 00000		0	56. 00 57. 00
58. 00   05800   MRI	0	0	0.00000		0	58.00
60. 00   06000   LABORATORY	20.240	10 147 004	1			60.00
65. 00   06500   RESPI RATORY THERAPY	28, 268		1			65.00
66. 00   06600 PHYSI CAL THERAPY	7, 810 67, 713		1			66.00
67. 00   06700   OCCUPATI ONAL THERAPY	7, 343					67.00
68. 00 06800 SPEECH PATHOLOGY	2, 955					68.00
69. 00   06900   ELECTROCARDI OLOGY	8, 203		1			69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	6, 345					
72. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 132					72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	18, 370					
76. 00   03610   SLEEP LAB	18, 370		1		2, 730	1
76. 00 03510 SELEF LAB  76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	12, 062	ı	1		0	76.00
76. 03   03950  WOUND CARE	6, 093				0	76.01
OUTPATIENT SERVICE COST CENTERS	0,093	20, 090	0. 27130	57  0	0	70.03
88. 00 08800 RURAL HEALTH CLINIC	34, 793	1, 013, 757	0. 03432	21 0	0	88.00
91. 00   09100   EMERGENCY	67, 070		1			
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	18, 258		1		l .	
200.00 Total (lines 50 through 199)	400, 798			2, 487, 479		
200.00   10tal (111103 00 till ough 177)	1 400,770	01,711,070	T	2,407,477	15,074	200.00

Health Financial Systems	UNI ON C	OUNTY HOSPIT	AL DISTRICT	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE	OTHER PASS	Provider CCN: 14-1342	Peri od: From 01/14/2023 To 09/30/2023	Worksheet D Part IV Date/Time Prepared:

Tilloudii 66515				1	Го 09/30/2023	Date/Time Pre 2/27/2024 3:2	
			Title	e XVIII	Hospi tal	Cost	
	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						
50.00	05000 OPERATING ROOM	0	0	)	0	0	50.00
51. 00	05100 RECOVERY ROOM	0	0	)	0	0	51.00
53.00	05300 ANESTHESI OLOGY	0	0	)	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	)	0	0	54.00
54. 01	05401 ULTRASOUND	0	0	)	0	0	54. 01
56. 00	05600 RADI OI SOTOPE	0	0	)	0	0	56.00
57. 00	05700 CT SCAN	0	0	)	0	0	57.00
58. 00	05800 MRI	0	0	)	0	0	58. 00
60.00	06000 LABORATORY	0	0	)	0	0	60.00
65. 00	06500 RESPI RATORY THERAPY	0	0	)	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0	)	0	0	66.00
67. 00	06700 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
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	)	0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	)	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0	)	0	0	73.00
	03610 SLEEP LAB	0	0	)	0	0	76. 00
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	)	0	0	76. 01
76. 03	03950 WOUND CARE	0	0	)	0	0	76. 03
	OUTPATIENT SERVICE COST CENTERS				_		
	08800 RURAL HEALTH CLINIC	0	0	)	0	0	00.00
91. 00	09100 EMERGENCY	0	0	)	0	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0				0	
200.00	Total (lines 50 through 199)	0	0	)  (	0 0	0	200.00

Health Financial Systems UNION COUNTY HOSPITAL DISTRICT

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 14-1342 Peri od: Worksheet D From 01/14/2023 Part IV To 09/30/2023 Date/Time Prepared: THROUGH COSTS

						2/27/2024 3: 2	4 pm
			Title	XVIII	Hospi tal	Cost	
	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	
	CILLARY SERVICE COST CENTERS						
	OOO OPERATING ROOM	0	0	(	3, 420, 860		
	100 RECOVERY ROOM	0	0	(	629, 595	0.000000	51.00
	300 ANESTHESI OLOGY	0	0	(	325, 407	0.000000	
54.00 05	400 RADI OLOGY-DI AGNOSTI C	0	0	(	23, 944, 741	0.000000	54.00
54. 01 05	401 ULTRASOUND	0	0	(	0	0.000000	54.01
56. 00 05	600 RADI OI SOTOPE	0	0	(	0	0.000000	56.00
57. 00 05	700 CT SCAN	0	0	(	0	0.000000	57.00
58. 00 05	800 MRI	0	0	(	0	0.000000	58.00
60.00 06	000 LABORATORY	0	0	(	10, 167, 004	0.000000	60.00
65. 00 06	500 RESPI RATORY THERAPY	0	0	(	497, 853	0.000000	65.00
66.00 06	600 PHYSI CAL THERAPY	0	0	(	3, 422, 333	0.000000	66. 00
67. 00 06	700 OCCUPATI ONAL THERAPY	0	0		1, 301, 279	0.000000	67.00
68. 00 06	800 SPEECH PATHOLOGY	0	0		339, 785		68. 00
69. 00 06	900 ELECTROCARDI OLOGY	0	0		1, 368, 703	0.000000	69.00
71. 00 07	100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		924, 982	0.000000	71.00
72. 00 07:	200 IMPL. DEV. CHARGED TO PATIENTS	0	0		69, 762	0.000000	72.00
73. 00 07	300 DRUGS CHARGED TO PATIENTS	0	0		4, 999, 460	0.000000	73.00
	610 SLEEP LAB	0	0		0	0. 000000	76.00
76, 01 03	550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		606, 159		
	950 WOUND CARE	0	0		20, 896		
	TPATIENT SERVICE COST CENTERS				, , , , , ,		
88. 00 08	800 RURAL HEALTH CLINIC	0	0		1, 013, 757	0.000000	88. 00
91.00 09	100 EMERGENCY	0	l o	1 (		0. 000000	91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART	1 0	l o	l	461, 364		
200.00	Total (lines 50 through 199)	0	l o		·		200. 00
	, , , , , , , , , , , , , , , , , , , ,		'	'		1	

Health Financial Systems	UNION COUNTY HOSPITAL	L DISTRICT	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS P	Provider CCN: 14-1342	Peri od:	Worksheet D

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Peri od: From 01/14/2023 To 09/30/2023	2/27/2024 3:2	pared: 4 pm		
					XVIII	Hospi tal	Cost	
	Cos	st 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-Throug		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	
		Y SERVICE COST CENTERS						
50.00		ERATING ROOM	0. 000000	96, 183		0	0	50.00
51.00		COVERY ROOM	0. 000000	10, 948		0	0	51.00
53.00	05300 ANE	ESTHESI OLOGY	0. 000000	6, 293		0 0	0	53.00
54.00	05400 RAI	DI OLOGY-DI AGNOSTI C	0. 000000	301, 991		0	0	54.00
54. 01	05401 UL	TRASOUND	0. 000000	0		0 0	0	54. 01
56.00	05600 RAI	DI OI SOTOPE	0. 000000	0		0 0	0	56.00
57.00	05700 CT	SCAN	0. 000000	0		0 0	0	57.00
58.00	05800 MRI	1	0. 000000	0		0 0	0	58.00
60.00	06000 LAE	BORATORY	0. 000000	479, 685		0 0	0	60.00
65.00	06500 RES	SPI RATORY THERAPY	0. 000000	162, 488		0 0	0	65.00
66.00	06600 PH	YSI CAL THERAPY	0. 000000	45, 158		0 0	0	66.00
67.00	06700 000	CUPATI ONAL THERAPY	0. 000000	35, 581		0 0	0	67.00
68.00	06800 SPE	EECH PATHOLOGY	0. 000000	36, 761		0 0	0	68. 00
69.00	06900 ELE	ECTROCARDI OLOGY	0. 000000	120, 536		0 0	0	69.00
71.00	07100 MEI	DICAL SUPPLIES CHARGED TO PATIENT	0. 000000	339, 688		0 0	0	71.00
72.00	07200 I MF	PL. DEV. CHARGED TO PATIENTS	0. 000000	43		0 0	0	72.00
73.00	07300 DRI	UGS CHARGED TO PATIENTS	0. 000000	797, 410		0 0	0	73.00
76.00	03610 SLE	EEP LAB	0. 000000	. 0		0 0	0	76.00
76. 01		YCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	0		0 0	0	76. 01
76. 03	03950 WOL		0. 000000	0		0 0	0	76. 03
		NT SERVICE COST CENTERS						
88. 00		RAL HEALTH CLINIC	0. 000000	0		0 0	0	88.00
91.00	09100 EME		0. 000000	50, 967		0 0	0	91.00
92.00	09200 OBS	SERVATION BEDS (NON-DISTINCT PART	0. 000000	3, 747		0 0	0	92.00
200.00		tal (lines 50 through 199)		2, 487, 479		0 0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provi der CCN: 14-1342 Peri od: Worksheet D From 01/14/2023 Part V 09/30/2023 Date/Time Prepared: 2/27/2024 3:24 pm Title XVIII Hospi tal Cost Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Ded. & Coins. Part I, col. Ded. & Coins. 9 (see inst.) (see inst.) 1.00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 539, 510 50.00 0. 289751 05100 RECOVERY ROOM 0 51.00 0.154313 90.859 51.00 0 0 53. 00 | 05300 | ANESTHESI OLOGY 0.857600 0 42, 502 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.078164 0 5, 305, 545 0 54.00 54.01 05401 ULTRASOUND 0.000000 0 54.01 0 05600 RADI OI SOTOPE 0 56.00 0.000000 0 0 56.00 57.00 05700 CT SCAN 0.000000 0 0 0 57.00 58.00 05800 MRI 0.000000 0 58.00 60.00 06000 LABORATORY 0. 152652 0 2, 182, 318 0 60.00 06500 RESPIRATORY THERAPY 0. 287480 77, 170 65.00 0 65.00 66.00 06600 PHYSI CAL THERAPY 0. 216625 767, 205 0 66.00 06700 OCCUPATI ONAL THERAPY 0. 388605 219, 679 0 67.00 67.00 06800 SPEECH PATHOLOGY 0.378507 68 00 51 148 0 68 00 69.00 06900 ELECTROCARDI OLOGY 0.205757 233, 735 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.303251 36, 643 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 33, 096 72.00 0.635790 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73 00 0 1, 100, 721 Ω 73 00 0.248006 03610 SLEEP LAB 76.00 0.000000 0 0 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0. 777760 586, 634 0 0 76.01 76.01 03950 WOUND CARE 76.03 2. 180130 0 5, 135 ol 0 76.03 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 09100 EMERGENCY 0. 304136 0 2, 654, 311 214 0 91.00 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1. 495646 179, 492 92.00 0 0 ol 0 200.00 200.00 Subtotal (see instructions) 14, 105, 703 0 214 201.00 Less PBP Clinic Lab. Services-Program 0 201.00 Only Charges

14, 105, 703

214

0 202.00

202.00

Net Charges (line 200 - line 201)

Health Financial Systems	UNI ON COUNTY HOSPI	TAL DISTRICT	In Lie	u of Form CMS-2552-10
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1342	Peri od: From 01/14/2023	

				From 01/14/2023 To 09/30/2023	Part V Date/Time Pro 2/27/2024 3:2	epared: 24 pm
		Title	XVIII	Hospi tal	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	156, 324	0	l .			50.00
51.00   05100   RECOVERY ROOM	14, 021	0				51.00
53. 00   05300   ANESTHESI OLOGY	36, 450	0				53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	414, 703	0				54.00
54. 01   05401   ULTRASOUND	0	0				54. 01
56. 00   05600 RADI 0I SOTOPE	0	0				56.00
57. 00   05700   CT   SCAN	0	0				57.00
58. 00   05800   MRI	0	0				58. 00
60. 00   06000   LABORATORY	333, 135	0				60.00
65. 00 06500 RESPIRATORY THERAPY	22, 185	0				65.00
66. 00 06600 PHYSI CAL THERAPY	166, 196	0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	85, 368	0				67.00
68. 00 06800 SPEECH PATHOLOGY	19, 360	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	48, 093	0				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	11, 112	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	21, 042	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	272, 985	0				73.00
76. 00   03610   SLEEP LAB	0	0				76.00
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	456, 260	0				76. 01
76. 03   03950   WOUND CARE	11, 195	0				76. 03
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC						88. 00
91. 00   09100   EMERGENCY	807, 272	65				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	268, 456	0				92.00
200.00 Subtotal (see instructions)	3, 144, 157	65				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	3, 144, 157	65				202.00
	•	•	•			

Health Financial Systems UN	NI ON COUNTY HOS	PITAL DISTRICT		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider Co		Period: From 01/14/2023 Fo 09/30/2023		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal Related Cost	Swing Bed Adjustment	Reduced Capi tal	Total Patient Days	Per Diem (col. 3 /	
	(from Wkst. B, Part II,		Related Cost (col. 1 -		col . 4)	
	col . 26)		col . 2)			
	1. 00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	116, 398	41, 316	75, 08:	1, 246	60. 26	30.00
200.00 Total (lines 30 through 199)	116, 398		75, 08:	1, 246		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col . 6)				
LANDATI ENT. DOUTLANE, OFFINA OF COOT, OFFITEDO	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS			I			
30. 00 ADULTS & PEDIATRICS	4	241				30.00
200.00 Total (lines 30 through 199)	4	241				200.00

Health Financial Systems U	NION COUNTY HOS	PITAL DISTRICT		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C	Provi der CCN: 14-1342		Worksheet D	
				From 01/14/2023 To 09/30/2023		pared.
					2/27/2024 3: 2	4 pm
			e XIX	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)	0.00	2.00	4.00	F 00	
ANGLEL ADV. CEDVICE COCT CENTERS	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	1/ 010	2 420 0/0	0.0104	24 201	220	F0 00
	46, 019					
51. 00 05100 RECOVERY ROOM	615 990					51.00
53. 00 05300 ANESTHESI OLOGY						53.00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	66, 759	23, 944, 741				54. 00 54. 01
54. 01   05401   ULTRASOUND 56. 00   05600   RADI OI SOTOPE	0	0	0. 00000 0. 00000		0	
56. 00   05600   RADI 0I SOTOPE 57. 00   05700   CT   SCAN	0	0	0.00000		0	56. 00 57. 00
58. 00   05800   MRI	0	0	0.00000		0	58.00
60. 00   06000   LABORATORY	20.240	10 147 004	l .			60.00
65. 00   06500   RESPI RATORY THERAPY	28, 268 7, 810		l .		10	65.00
66. 00   06600 PHYSI CAL THERAPY	67, 713		l .		0	66.00
67. 00   06700   OCCUPATI ONAL THERAPY	7, 343				0	67.00
68. 00 06800 SPEECH PATHOLOGY	2, 955				0	68.00
69. 00   06900   ELECTROCARDI OLOGY	8, 203				0	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	6, 345				0	1
72. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 132				0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	18, 370				_	73.00
76. 00   03610   SLEEP LAB	18, 370				0	1
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	12, 062	ı	l .		0	76.00
76. 03   03950   WOUND CARE	6, 093				0	76.01
OUTPATIENT SERVICE COST CENTERS	0,073	20,070	0. 27130	57  0	0	70.03
88. 00 08800 RURAL HEALTH CLINIC	34, 793	1, 013, 757	0. 03432	21 0	0	88. 00
91. 00   09100   EMERGENCY	67, 070		l .		0	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	18, 258		l .		0	92.00
200.00 Total (lines 50 through 199)	400, 798			47, 506	_	200.00
255. 55 <sub>1</sub>   15tal (11165 55 thi bugh 177)	100,770	1 01, 711, 070	ı	17,300	370	<sub>1</sub> =30.00

Health Financial Systems U	NION COUNTY HOS	PITAL DISTRICT	-	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P	ASS THROUGH COS	TS Provider C		Period: From 01/14/2023 To 09/30/2023		
			e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng Program Post-Stepdown	Nursi ng Program	Allied Health Post-Stepdowr Adjustments	Allied Health Cost	All Other Medical Education	
	Adjustments		Auj us tillerits		Cost	
	1A	1, 00	2A	2.00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	30.00
200.00 Total (lines 30 through 199)	0	0		0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem	I npati ent	
	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col . 6)		
	instructions)					
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00   03000   ADULTS & PEDI ATRI CS	0	0	1, 24			1 00.00
200.00   Total (lines 30 through 199)		0	1, 24	6	4	200.00
Cost Center Description	Inpatient					
	Program					
	Pass-Through Cost (col. 7					
	x col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	7.00					
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
200.00   Total (lines 30 through 199)	0					200.00

Health Financial Systems	UNI ON C	OUNTY HOSPIT	AL DISTRICT	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE	OTHER PASS	Provider CCN: 14-1342	Peri od: From 01/14/2023 To 09/30/2023	Worksheet D Part IV Date/Time Prepared:

THROOG	31 00313			1	o 09/30/2023	Date/Time Pre 2/27/2024 3:2	
			Ti tl	e XIX	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				
	T	1. 00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	(	0	0	50.00
51. 00	05100 RECOVERY ROOM	0	0	(	0	0	51.00
53.00	05300 ANESTHESI OLOGY	0	0	(	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	(	0	0	54.00
54. 01	05401 ULTRASOUND	0	0	(	0	0	54. 01
56.00	05600 RADI 0I SOTOPE	0	0	(	0	0	56.00
57. 00	05700 CT SCAN	0	0	(	0	0	57.00
58. 00	05800  MRI	0	0	(	0	0	58. 00
60.00	06000 LABORATORY	0	0	(	0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0	0	(	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0	(	0	0	66.00
67. 00	06700 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
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	(	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0	(	0	0	73.00
	03610 SLEEP LAB	0	0	(	0	0	76. 00
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	(	0	0	76. 01
76. 03	03950 WOUND CARE	0	0	(	0	0	76. 03
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0	(	0	0	00.00
91.00	09100 EMERGENCY	0	0	(	0	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			)	0	
200.00	Total (lines 50 through 199)	0	0	(	0	0	200.00

In Lieu of Form CMS-2552-10

Period:	Worksheet D	
From 01/14/2023	Part IV	
To 09/30/2023	Date/Time Prepared:	2/27/2024 3: 24 pm
 Heal th Financial
 Systems
 UNION COUNTY HOSPITAL DISTRICT

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE OTHER PASS Provider CCN: 14-1342
 THROUGH COSTS

					2/27/2024 3: 2	4 pm
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	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		3, 420, 860		1
51.00   05100   RECOVERY ROOM	0	0		629, 595		51.00
53. 00   05300   ANESTHESI OLOGY	0	0	(	325, 407	0.000000	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	(	23, 944, 741	0.000000	
54. 01   05401   ULTRASOUND	0	0	(	0	0.000000	54.01
56. 00   05600   RADI 0I SOTOPE	0	0	(	0	0.000000	56.00
57.00  05700 CT SCAN	0	0	(	0	0. 000000	57.00
58. 00   05800 MRI	0	0	(	0	0.000000	58. 00
60. 00   06000   LABORATORY	0	0	(	10, 167, 004	0.000000	60.00
65. 00 06500 RESPIRATORY THERAPY	0	0	(	497, 853	0.000000	65.00
66. 00   06600 PHYSI CAL THERAPY	0	0	(	3, 422, 333	0.000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	(	1, 301, 279	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	(	339, 785	0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	(	1, 368, 703	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(	924, 982	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(	69, 762	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	(	4, 999, 460	0.000000	73.00
76. 00 03610 SLEEP LAB	0	0		o	0.000000	76. 00
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		606, 159	0.000000	76. 01
76. 03 03950 WOUND CARE	0	0		20, 896	0.000000	76. 03
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	0	(	1, 013, 757	0.000000	88. 00
91. 00 09100 EMERGENCY	0	0		11, 397, 655		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		461, 364		92.00
200.00 Total (lines 50 through 199)	0	0		64, 911, 595		200.00
, , , , , , , , , , , , , , , , , , , ,	1	'	'		1	

Health Financial Systems UNION COUNTY HOSPITA			AL DISTRICT	In Lieu	of Form CMS-2552-10	
	APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCI LLARY SERV	VICE OTHER PASS	Provider CCN: 14-1342	Peri od: From 01/14/2023 To 09/30/2023	Worksheet D Part IV Date/Time Prepared

THROUGH COSTS				rom 01/14/2023 To 09/30/2023	Part IV   Date/Time Pre	
					2/27/2024 3: 2	4 pm
			e XIX	Hospi tal	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	Charges	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	24, 381	(	0	0	50.00
51.00   05100   RECOVERY ROOM	0. 000000	3, 726	(	0	0	51.00
53. 00   05300   ANESTHESI OLOGY	0. 000000	2, 188	(	0	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000	672	(	0	0	54.00
54. 01   05401   ULTRASOUND	0. 000000	0	(	0	0	54. 01
56. 00   05600   RADI 0I SOTOPE	0. 000000	0	(	0	0	56.00
57. 00   05700   CT   SCAN	0. 000000	0	(	0	0	57.00
58. 00   05800   MRI	0. 000000	0	(	0	0	58.00
60. 00   06000   LABORATORY	0. 000000	3, 650	(	0	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	0	(	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	0	(	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	0	(	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	0	(	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0	(	o	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	0	(	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0	(	o	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	12, 889	(	0	0	73.00
76. 00 03610 SLEEP LAB	0. 000000	0	(	0	0	76.00
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	0	(	0	0	76. 01
76. 03 03950 WOUND CARE	0. 000000	0	(	0	0	76. 03
OUTPATIENT SERVICE COST CENTERS	<u>'</u>					
88. 00 08800 RURAL HEALTH CLINIC	0. 000000	0	(	0	0	88. 00
91. 00 09100 EMERGENCY	0. 000000	0		o	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		o	0	92.00
200.00   Total (lines 50 through 199)		47, 506	(	0	0	200. 00

Health Financial Systems	UNION COUNTY HOSPI	TAL DISTRICT	In Lie	u of Form CMS-:	neen 10
	UNION COUNTY HUSPI		In Lie	u or Form CMS	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1342	Peri od: From 01/14/2023	Worksheet D-1	
			To 09/30/2023	Date/Time Pre 2/27/2024 3:2	
		Title XVIII	Hospi tal	Cost	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					
I NPATI ENT DAYS					
1 00 Inpatient days (including private roo	m days and swing-hed day	s excluding newborn)		2 394	1 1 00

		Title XVIII	Hospi tal	Cost	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day	ys, excluding newborn)		2, 394	1.00
2.00	Inpatient days (including private room days, excluding swing-	-bed and newborn days)		1, 246	2.00
3.00	Private room days (excluding swing-bed and observation bed days	ays). If you have only pr	rivate room days,	0	3.00
4 00	do not complete this line.			0.42	4 00
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation between Total swing-bed SNF type inpatient days (including private ro		or 31 of the cost	943 639	4. 00 5. 00
3. 00	reporting period	Join days) thi dagn becembe		037	3.00
6.00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)				
7. 00	Total swing-bed NF type inpatient days (including private roof reporting period	om days) through December	31 of the cost	509	7. 00
8. 00	Total swing-bed NF type inpatient days (including private roo	om davs) after December 3	11 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	s days, a. es. becombe. e		· ·	0.00
9. 00	Total inpatient days including private room days applicable t	to the Program (excluding	swing-bed and	480	9. 00
10.00	newborn days) (see instructions)	anly (including private r	and days)	420	10.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruc		oom days)	639	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII of		oom days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, e				
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	te room days)	0	12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	Y only (including privat	e room days)	0	13.00
13.00	after December 31 of the cost reporting period (if calendar y			O	13.00
14.00	Medically necessary private room days applicable to the Progr	•	,	0	14.00
15.00	Total nursery days (title V or XIX only)			0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17. 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to service	ces through December 31 c	of the cost		17. 00
17.00	reporting period	ces through becomber 51 c	in the cost		17.00
18.00	Medicare rate for swing-bed SNF services applicable to service	ces after December 31 of	the cost		18. 00
10.00	reporting period			200 70	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es through December 31 of	the cost	208. 70	19.00
20. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of t	he cost	0. 00	20.00
	reporting period				
21.00	Total general inpatient routine service cost (see instruction			4, 399, 021	
22. 00	Swing-bed cost applicable to SNF type services through Decemble $5 \times 1$ ine 17)	per 31 of the cost report	ing period (line	0	22. 00
23. 00		31 of the cost reportin	na period (line 6	0	23. 00
	x line 18)		.9	_	
24.00	3 11 31	er 31 of the cost reporti	ng period (line	106, 228	24. 00
25 00	7 x line 19)	21 of the cost reporting	noried (line O	0	25. 00
25. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	perrod (Trie 8	U	25.00
26.00	1			1, 561, 448	
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		2, 837, 573	27. 00
00.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT			-	00.00
	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	ed and observation bed cr	narges)	0	28. 00 29. 00
30.00	Semi - pri vate room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0.000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0. 00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	20) (		0. 00	33.00
34.00	Average per diem private room charge differential (line 32 mi		ctions)	0.00	34.00
35. 00 36. 00	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35)	110 31)		0.00	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	2, 837, 573	
	27 minus line 36)	·	·		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	HICTMENTS			
38 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJACQUE Adjusted general inpatient routine service cost per diem (see		Г	2, 277. 34	38 00
39.00	Program general inpatient routine service cost per drem (see			1, 093, 123	
	Medically necessary private room cost applicable to the Progr	•		0	40.00
41. 00				1, 093, 123	41.00

	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	480	9. 00
	newborn days) (see instructions)		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	639	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
10.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	Ŭ	10.00
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15. 00	Total nursery days (title V or XIX only)	0	15.00
16. 00	Nursery days (title V or XIX only)	0	16. 00
10.00	SWING BED ADJUSTMENT	U	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost		17. 00
17.00			17.00
10 00	reporting period		10 00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost		18. 00
40.00	reporting period	000 70	40.00
19. 00	Medicald rate for swing-bed NF services applicable to services through December 31 of the cost	208. 70	19. 00
	reporting period		
20. 00	Medicald 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)	4, 399, 021	
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	106, 228	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)		
26.00	Total swing-bed cost (see instructions)	1, 561, 448	
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2, 837, 573	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 -pri vate room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
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	35.00
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		37. 00
07.00	27 minus line 36)	2,007,070	07.00
	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)	2, 277. 34	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	1, 093, 123	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	1, 043, 123	40.00
	Total Program general inpatient routine service cost (line 39 + line 40)	1, 093, 123	
41.00	Tiotai irogiam generar impatrent routine service cost (fine 37 + fine 40)	1, 073, 123	41.00

Intensive Care Type Input on Hospital Units  14.00   COROMARY CARE UNIT    46.00   SUM INTERSIVE CARE (SPECIFY)    47.00   OTHER SPECIAL CARE (SPECIFY)    48.01   Program Input ent ancillary service cost (Mkst. D-3, col. 3, line 200)    48.00   Program Input ent ancillary service cost (Mkst. D-3, col. 3, line 200)    48.01   Program Input ent ancillary service cost (Mkst. D-3, col. 3, line 200)    48.01   Program Input ent cellular therapy acquisition cost (Morksheet D-6, Part III. line 10, column 1)    48.02   Program Input ent cellular therapy acquisition cost (Morksheet D-6, Part III. line 10, column 1)    48.03   Program Input ent cellular therapy acquisition cost (Morksheet D-6, Part III. line 10, column 1)    48.04   Program Input ent cellular therapy acquisition cost (Morksheet D-6, Part III. line 10, column 1)    48.05   Pass through costs applicable to Program Input ent routine services (from Wkst. D. sum of Parts II on III)    48.06   Pass through costs applicable to Program Input ent routine services (from Wkst. D. sum of Parts II on III)    48.07   Pass through costs applicable to Program Input ent routine services (from Wkst. D. sum of Parts II on III)    48.08   Pass through costs applicable to Program Input ent outline services (from Wkst. D. sum of Parts II on III)    48.09   Pass through costs applicable cost (sum of Ilnes SD and SD)    48.00   Program excludable costs (sum of Ilnes SD and SD)    48.01   Program acquisition of St. (free Pass Innes III)    48.02   Pass through costs (sum of Ilnes SD and SD)    48.02   Pass through costs (sum of Ilnes SD and SD)    48.00   Program acquisition of St. (free Pass Ilnes SD)    48.00   Program acquisition of Schoppe (contractor use only)    49.00   Program acquisition of Schoppe (contractor use only)			NION COUNTY HOSP	PITAL DISTRICT	г	In Lie	u of Form CMS-2	2552-10
TITLE NUTL   RESPECTATION   COST CONTROL PROGRAM   COST COST COST COST COST COST COST COST	COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C		From 01/14/2023		
Cost Center Description				T: 11			2/27/2024 3: 2	
1.00   2.00   3.00   4.00   5.00		Cost Center Description	I npati ent	Total Inpati ent	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x	
Intensive Care Type Inpatient Hispital Units 4. cm   ORDMANY CARE UNIT						4. 00		
Minterstructure CARE UNIT	42.00							42.00
44.00 CORONARY CARE UNIT 46.00 SURRICACL TUTINSIVE CARE UNIT 47.00 OTHER SPECIAL CARE CORE UNIT 48.01 CORE THE SPECIAL CARE CORE UNIT 48.02 Program inpatient and Inlary service cost (Wist. D-3, col. 3, Time 200) 48.02 Program inpatient cellulary service cost (Wist. D-3, col. 3, Time 200) 48.03 Program inpatient cellulary service cost (Wist. D-3, col. 3, Time 200) 48.00 Program inpatient cellulary thereps acquisition cost (Rorkshoet D-6, Part III, Time 10, column 1) 58.07, 48.01 58.07 Program inpatient costs (sun of Times 4) Through 48.01) (see instructions) 58.07 Program inpatient costs (sun of Times 4) 58.07 Program inpatient costs (sun of Times 4) 58.07 Program inpatient costs (sun of Times 5) 58.08 Program of the service of Times 50 and 51) 58.09 Program of the service of Times 50 and 51) 58.00 Intal Program of the service of Times 50 and 51) 58.00 Intal Program of the service of Times 50 and 51) 58.00 Intal Program of the service of Times 50 and 51) 58.00 Program of the service of Times 50 and 51) 58.00 Program of the service of Times 50 and 51) 58.00 Program of the service of Times 50 and 51) 58.00 Program of scharges 58.00 Program of scha	43. 00							43.00
4.0 00 SIRROCAL INTERSIVE CARE UNIT 4.0 00 THER SPICIAL CARE (SPICITY)  Cost Center Description  1.00		CORONARY CARE UNIT						44.00
OTHER SPECIAL CARE (SPECIFY)  Cost Center Description  48. 00   Program inpatient ancillary service cost (West. D-3, col. 3, Tine 200)   562, 726   48. 01   Program inpatient ancillary service cost (West. D-3, col. 3, Tine 200)   562, 726   48. 01   Program inpatient collular therapy acquisition cost (Worksheet D-6, Part III, Tine 10, column 1)   562, 726   48. 01   Program inpatient collular therapy acquisition cost (Worksheet D-6, Part III, Tine 10, column 1)   562, 726   56. 02   Pass through costs applicable to Program inpatient ancillary services (from West. D, sum of Parts I and III)   51. 00   51. 02   Pass through costs applicable to Program inpatient ancillary services (from West. D, sum of Parts II and III)   51. 00   51. 02   Pass through costs applicable to Program inpatient ancillary services (from West. D, sum of Parts II and III)   51. 00   51. 02   Pass through costs applicable to Program inpatient ancillary services (from West. D, sum of Parts II and III)   51. 00   51. 02   Pass through costs applicable to Program inpatient ancillary services (from West. D, sum of Parts II and III)   51. 00   51. 02   Pass through costs applicable to Program inpatient ancillary services (from West. D, sum of Parts II and III)   51. 00   51. 02   Pass through costs (sum of III)   52. 00								45.00
Cost Center Description  1.00  48.00   Program inpatient ancillary service cost (Wisst. D-3, col. 3, Tine 200)   1.00  48.01   Program inpatient collular therupy acquisition cost (Worksheet D-6, Part III, Tine 10, column 1)   562, 726  49.00   Total Program inpatient cost (sun of Tines 41 through 48, 01)(see Instructions)   1.655, 849  49.00   Pass through costs applicable to Program inpatient routine services (from Wisst. D, sun of Parts I and and IV)  50.00   Pass through costs applicable to Program inpatient ancillary services (from Wisst. D, sun of Parts II and IV)  50.00   Total Program excludable cost (sun of Tines 50 and 51)   0.00  50.00   Total Program excludable cost (sun of Tines 50 and 51)   0.00  50.00   Total Program excludable cost (sun of Tines 50 and 51)   0.00  50.00   Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and   0.00  50.00   Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and   0.00  50.00   Total Program discharge   0.00  50.01   Total Program discharge   0.00  50.02   Adjustment amount per discharge   0.00  50.03   Total Program inpatient amount per discharge   0.00  50.04   Total Program discharge   0.00  50.06   Total Program inpatient amount per discharge   0.00  50.07   Total Program inpatient per discharge   0.00  50.00   Total Program inpatient amount per discharge   0.00  50.01   Total Program inpatient amount per discharge   0.00  50.01   Total Program inpatient amount per discharge   0.00  50.02   Total Program inpatient amount per discharge   0.00  50.03   Total Program inpatient amount per dischar								46. 00 47. 00
49.00 Program Inpattent accillary service cost (Wist. D-3, col. 3, line 200) 49.01 Program Inpattent cellular threapy acquisistion cost (Wist. D-6, col. 3) 49.01 Cital Program Inpattent costs (sum of lines 41 through 48.01) (see instructions) 50.02 Pass through costs applicable to Program inpattent reutine services (from West. D, sum of Parts 1 and and IV) 50.01 Total Program applicable to Program inpattent ancillary services (from West. D, sum of Parts 11 and and IV) 50.02 Total Program excludable cost (sum of lines 50 and 51) 51.00 Pass through costs applicable to Program inpattent ancillary services (from West. D, sum of Parts 11 and and IV) 52.00 Total Program excludable cost (sum of lines 50 and 51) 53.00 Total Program excludable cost (sum of lines 50 and 51) 54.01 Total Program inpattent operating cost excluding capital related, non-physician anesthetist, and modified education costs (file 49 mins line 52) 54.01 Total Program excludable cost (sum of lines 50 and 51) 55.01 Target amount per discharge (contractor use only) 56.00 Target amount (line 54 x sum of lines 55, 55.01, and 55.02) 57.00 Difference between adjusted inpattent operating cost and target amount (line 56 minus line 53) 58.00 Bonus payment (see instructions) 59.00 Tirendeco costs (lesses of line 53 × line 54, or line 55 from the cost reporting period ending 1996, compared to the service of lines 51 line 54, or line 55 from the cost reporting period ending 1996, compared to the service of lines 55 huse 50 continuous improvement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 huse 50 continuous limprovement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 huse 50 continuous limprovement bonus payment (if line 54 x sum of lines 54 x 60), or 18 of the target amount (lines 66), otherwise 50 and 10 continuous limprovement bonus payment (see instructions) 60.00 Relicer payment (see instructions) 60.00 Relicer payment (see instructions) 60.00 Relicer payment (see) instructions 60 continuous limprovemen					'			
48.01 program inpati ent cell ular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)   40.0 Total Program inpati ent costs (cum of lines 41 through 48.01)(see instructions)   50.0 Pass through costs applicable to Program inpatient routine services (from West. D, sum of Parts I and D-85 through costs applicable to Program inpatient routine services (from West. D, sum of Parts II and D-85 through costs applicable to Program inpatient ancillary services (from West. D, sum of Parts II and D-86 through costs applicable to Program inpatient ancillary services (from West. D, sum of Parts II and D-86 through costs applicable to Program inpatient ancillary services (from West. D, sum of Parts II and D-86 through costs applicable to Program inpatient ancillary services (from West. D, sum of Parts II and D-86 through services (from West. D, sum of Parts II and D-86 through services (from West. D, sum of Parts II and D-86 through services (from West. D, sum of Parts II and D-86 through services (from West. D, sum of Parts II and D-86 through services (from West. D, sum of Parts II and D-86 through services (from West. D, sum of Parts II and D-86 through services (from West. D, sum of Parts II and D-86 through services (from West. D, sum of Parts II and D-86 through services (from West. D, sum of Parts II and D-86 through services (from West. D, sum of Parts II and D-86 through services (from West. D, sum of Parts II and D-86 through services (from West. D, sum of Parts II and D-86 through services (from West. D, sum of Parts II and D-86 through services (from West. D, sum of Parts II and D-86 through services (from West. D, sum of Parts II and D-86 through services (from West. D, sum of Parts II and D-86 through services (from West. D, sum of Parts II and D-86 through service (see Instructions) (from S) (from West.	48 00	Program innations ancillary service cost (Wk	st D-3 col 3	line 200)				48. 00
PASS. THROUGH COST ADJUSTMENTS  111)  51.00  50.00  Fass through costs applicable to Program inpatient routine services (from Wkst. D. sum of Parts II and 111)  51.00  Fass through costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts II 0)  52.00  Total Program excludable cost (sum of lines 50 and 51)  Total Program excludable cost (sum of lines 50 and 51)  Total Program inpatient operating cost sextual type stal related, non-physician anesthetist, and 00 medical education costs (line 49 minus IIne 52)  TARSET AUROUNT MO IIINT COMPUTATION  Program discharges  TARSET AUROUNT MO IINT COMPUTATION  Program discharges  0.00  TARSET AUROUNT MO IINT COMPUTATION  Permanent adjustment amount per discharge  0.00  Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)  Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)  Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)  Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)  Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)  Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)  Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)  Difference between adjusted inpatient operating cost and target amount (line 56 minus line 50)  Difference between adjusted inpatient operating cost and target amount (line 56 minus line 50)  Difference between adjusted inpatient operating cost and target amount (line 56 minus line 50)  Difference between adjusted inpatient line 53 - line 54 or line 55 from the cost reporting period ending minus line 50 - line 55 minus line 50 - line					III, line 10,	column 1)		1
50.00   Pass through costs applicable to Program inpatient routine services (from Wkst. D. sum of Parts I and III)   15.00   Pass through costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts II and IV)   15.00   Pass through costs applicable to program inpatient ancillary services (from Wkst. D. sum of Parts II and IV)   15.00   Pass through costs (June 40 inpatient operating cost excluding capital related, non-physician anesthetist, and   0   Pass through control of the Program inpatient operating cost excluding capital related, non-physician anesthetist, and   0   Pass through control of the Pass through East Inc. St. Oct. Oct. Oct. Oct. Oct. Oct. Oct. Oc	49. 00		41 through 48.0	1)(see instru	ctions)		1, 655, 849	49. 00
111   112   113   113   114   115	EO 00		ationt routing	convices (fra	m Wks+ D sur	m of Dorte L and	0	50.00
and IV)  152.00 Total Program excludable cost (sum of lines 50 and 51) 153.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and operating cost excluding capital related, non-physician anesthetist, and operating costs (costs (costs)	30.00		attent routine	services (iid	ill WKSt. D, Sui	ii Oi Faits i aiic		30.00
Total Program excludable cost (sum of Ilnes 50 and 51)	51.00		atient ancillar	y services (f	rom Wkst. D, s	sum of Parts II	0	51.00
Total Program Inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)  TARGET MOUNT AND LINIT COMPUTATION  54.00 Program discharge 0.00  55.01 Perment adjustment amount per discharge 0.00  55.01 Perment adjustment amount per discharge 0.00  55.01 Perment adjustment amount per discharge (contractor use only) 0.00  55.01 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0.00  57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0.00  58.00 Danup payment (see instructions) 0.00  59.01 Trended costs (lesser of line 53 - line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket) 0.00  60.01 Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the 0.00  60.01 Continuous improvement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus 0.00  60.01 Continuous improvement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus 0.00  60.01 Continuous improvement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus 0.00  60.01 Continuous improvement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus 0.00  60.01 Continuous improvement bonus payment (if line 54 is less than the lowest of lines 55 plus 0.00  60.01 Continuous improvement bonus payment (if line 54 is less than the lowest of lines 55 plus 0.00  60.01 Continuous improvement bonus payment (if line 54 is less than the lowest of lines 55 plus 0.00  60.01 Continuous improvement bonus payment (if line 54 is less than the lowest of lines 55 plus 0.00  60.02 Relief payment (see instructions) 0.00  60.03 Relief payment (see instructions) 0.00  60.04 Relief payment (see instructions) 0.00  60.05 Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title 2NIII only) in 1, 455, 220  60.05 Instructions) (tit	52.00		50 and 51)				n	52.00
TARGET MOUNT AND LIMIT COMPUTATION  TARGET MOUNT AND LIMIT COMPUTATION  55.00 To a forget amount per discharge  0.00  55.01 Persenant adjustment amount per discharge  0.00  55.01 Persenant adjustment amount per discharge  0.00  55.01 Persenant adjustment amount per discharge  0.00  55.00 Target amount (line 54 x sum of lines 55, 55.01, and 55.02)  0.07  57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)  0.07  58.00 Bonus payment (see instructions)  59.00 Trended costs (lesser of line 53 + line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)  60.00 Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket)  61.00 Continuous improvement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus 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 enter zero. (see instructions)  62.00 Relief payment (see instructions)  63.00 Allowable Inpatient cost plus incentive payment (see instructions)  64.00 Medicare swing-bed SNF Inpatient routine costs through December 31 of the cost reporting period (See Instructions) (title XVIII only)  65.00 Medicare swing-bed SNF inpatient routine costs sfree December 31 of the cost reporting period (See Instructions) (title XVIII only)  66.01 Total full control of the SNF inpatient routine costs sfree December 31 of the cost reporting period (Columbia) (line 3 x line 20)  67.00 Total title V or XIX swing-bed NF inpatient routine costs (line 64 plus line 65) (title XVIII only)  68.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  90 Persentine SNR inpatient routine service cost (line 7 + line 2)  90 Program routine service cost (line 9 x line 2)  91 Total title V or XIX swing-bed NF inpatient routine costs (line 7 + line 73)  91 Tota				lated, non-ph	ysician anesth	netist, and		
54.00   Program discharges			52)					
55.01 Perment adjustment amount per discharge 5.01 Perment adjustment amount per discharge 5.02 Adjustment amount per discharge (contractor use only) 5.02 Adjustment amount per discharge (contractor use only) 5.03 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 5.04 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 5.05 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 5.06 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 5.07 Trended costs (lesser of line 53 + line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket) 6.08 Difference between adjusted inpatient line 53 + line 54, or line 55 from prior year cost report, updated by the market basket) 6.09 Difference besket basket) 6.10 Continuous improvement bonus payment (if line 54, or line 55 from prior year cost report, updated by the market basket) 6.10 Continuous improvement bonus payment (if line 54, or line 55 from prior year cost report, updated by the market basket) 6.10 Continuous improvement bonus payment (if line 54, or line 55 from prior year cost report, updated by the market basket) 6.10 Continuous improvement bonus payment (if line 54, or line 55 from prior year cost reporting costs (line 53) are less than expected costs (lines 54 v. 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)  6.20 On Relief payment (see instructions)  6.20 On Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for linstructions (lille XVIII only)  6.20 On Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for line 12 x line 19)  6.20 On Total Medicare swing-bed SNF inpatient routine costs (line 67 + l	54.00						0	54. 00
3, adjustment amount per discharge (contractor use only)   0.00							-	55.00
56.00 Target amount (line 54 x sum of lines 55, 55.01, and 55.02)  57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)  58.00 Bonus payment (see instructions)  59.00 Trended costs (lesser of line 53 + line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)  60.00 Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket)  61.00 Continuous improvement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus 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 enter zero. (see instructions)  62.00 Relief payment (see instructions)  63.00 Allowable Inpatient cost plus incentive payment (see Instructions)  64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (see Instructions) (tilt XVIII only)  65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (see Instructions) (tilt XVIII only)  66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only): for CAH, see instructions  67.00 Title V or XIX swing-bed NF inpatient routine costs (line 64 plus line 65) (title XVIII only): for CHI is X line 20)  68.00 Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Pergram routine service cost (line 9 x line 71)  79.00 Aggregate charges to beneficiaries for excess costs (line 72 + line 73)  79.00 Captient provides period (line 14 x line 35)  79.00 Program routine service cost (line 75 + line 2)  79.00 Program againal related costs (line 75 + line 2)  79.00 Program againal related costs (line 75 + line 2)  79.00 Program againal related costs (line 75 + line 2)  79.00 Pro		, ,						55. 01
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62.00   Relief payment (see instructions)   0	01.00	55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 $\times$	ser of 50% of t	he amount by	which operatir	ng costs (line	0	01.00
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(line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) Per diem capital-related costs (line 75 ÷ line 2) Program capital-related costs (line 9 x line 76) Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 0.00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79) 0.101 Inpatient routine service cost per diem limitation 0.102 Inpatient routine service cost limitation (line 9 x line 81) 0.103 Reasonable inpatient routine service costs (see instructions) 0.104 Program inpatient ancillary services (see instructions) 0.105 Utilization review - physician compensation (see instructions) 0.106 Total Program inpatient operating costs (sum of lines 83 through 85)	07.00		e costs through	December 31	or the cost re	sporting period	Ü	07.00
69. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71. 00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)  Program routine service cost (line 9 x line 71)  73. 00 Medically necessary private room cost applicable to Program (line 14 x line 35)  74. 00 Total Program general inpatient routine service costs (line 72 + line 73)  Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  Program capital -related costs (line 75 ÷ line 2)  Program capital -related costs (line 9 x line 76)  Inpatient routine service cost (line 74 minus line 77)  Aggregate charges to beneficiaries for excess costs (from provider records)  Total Program routine service cost per diem limitation  1 Inpatient routine service cost per diem limitation  1 Inpatient routine service cost per diem limitation  2 Inpatient routine service cost per diem limitation  2 Inpatient routine service cost (see instructions)  Program inpatient ancillary services (see instructions)  Total Program inpatient acompensation (see instructions)  Total Program inpatient operating costs (sum of lines 83 through 85)	68. 00	l . · · · · · · · · · · · · · · · · · ·	e costs after D	ecember 31 of	the cost repo	orting period	0	68. 00
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 74 minus line 77) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 70.01 Program routine service cost per diem limitation 82.00 Inpatient routine service cost per diem limitation 83.00 Reasonable inpatient routine service cost (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 70.00 Total Program inpatient operating costs (sum of lines 83 through 85)	69. 00		routine costs (	line 67 + lin	e 68)		0	69. 00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital -related costs (line 75 ÷ line 2) 77.00 Program capital -related costs (line 9 x line 76) 18.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine services (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 75.00 Total Program inpatient operating costs (sum of lines 83 through 85)		PART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILITY	, AND ICF/IID	ONLY			70.00
72.00 Program routine service cost (line 9 x line 71)  73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  74.00 Total Program general inpatient routine service costs (line 72 + line 73)  75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00 Per diem capital-related costs (line 75 ÷ line 2)  77.00 Program capital-related costs (line 9 x line 76)  1 Inpatient routine service cost (line 74 minus line 77)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79)  81.00 Inpatient routine service cost per diem limitation  1 Inpatient routine service cost limitation (line 9 x line 81)  82.00 Reasonable inpatient routine service costs (see instructions)  97.00 Program inpatient ancillary services (see instructions)  81.00 Utilization review - physician compensation (see instructions)  82.00 Total Program inpatient operating costs (sum of lines 83 through 85)						)		70.00 71.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 11 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85)	72. 00	Program routine service cost (line 9 x line	71)		•			72. 00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00 Per diem capital-related costs (line 75 ÷ line 2)  77.00 Program capital-related costs (line 9 x line 76)  1 Inpatient routine service cost (line 74 minus line 77)  Aggregate charges to beneficiaries for excess costs (from provider records)  Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)  1 Inpatient routine service cost per diem limitation  1 Inpatient routine service cost limitation (line 9 x line 81)  8 2.00 Reasonable inpatient routine service costs (see instructions)  Program inpatient ancillary services (see instructions)  1 Utilization review - physician compensation (see instructions)  Total Program inpatient operating costs (sum of lines 83 through 85)			9	•	,			73.00
26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine services (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 76.00 Total Program inpatient operating costs (sum of lines 83 through 85)						Part II, column		74. 00 75. 00
77.00 Program capital-related costs (line 9 x line 76)  78.00 Inpatient routine service cost (line 74 minus line 77)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)  81.00 Inpatient routine service cost per diem limitation  82.00 Inpatient routine service cost limitation (line 9 x line 81)  83.00 Reasonable inpatient routine service costs (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  Total Program inpatient operating costs (sum of lines 83 through 85)		26, line 45)		<b>,</b> , , , , , , , , , , , , , , , , , ,				
78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85)		•	,					76.00 77.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85)								78.00
81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85)	79. 00	Aggregate charges to beneficiaries for exces	s costs (from p					79.00
82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85)		,		ost limitatio	n (IIne 78 mir	nus line 79)		80. 00 81. 00
84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85)				)				82.00
85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85)				s)				83.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)				ns)				84. 00 85. 00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST								86.00
	07 00						202	07 00
87.00   Total observation bed days (see instructions) 303   88.00   Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 2,277.35				line 2)				87. 00 88. 00

Health Financial Systems	JNI ON COUNTY HOS	PITAL DISTRICT		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der Co		Peri od:	Worksheet D-1	
				From 01/14/2023 To 09/30/2023		pared: 4 pm
		Title	XVIII	Hospi tal	Cost	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (s	ee instructions	)			690, 037	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	116, 398	4, 399, 021	0. 02646	690, 037	18, 258	90.00
91.00 Nursing Program cost	0	4, 399, 021	0. 00000	690, 037	0	91.00
92.00 Allied health cost	0	4, 399, 021	0. 00000	690, 037	0	92.00
93.00 All other Medical Education	0	4, 399, 021	0. 00000	690, 037	0	93.00

Health Financial Systems	UNION COUNTY HOSPITAL DISTRICT	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1342	Peri od: From 01/14/2023	Worksheet D-1	
		To 09/30/2023	Date/Time Pre 2/27/2024 3:2	pared: 4 pm
	Ti tle XIX	Hospi tal	PPS	
Cost Center Description				
			1. 00	
PART I - ALL PROVIDER COMPONENTS				
I NPATI ENT DAYS				
1.00 Inpatient days (including private room	2, 394	1.00		
2 00 Innetient days (including private room	davia avalvadi as avvias bad and assubasas davia		1 24/	2 00

	Cook Contan Description	PPS	
	Cost Center Description	1. 00	
	PART I - ALL PROVIDER COMPONENTS	1.00	
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2, 394	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1, 246	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.	0	3.00
4. 00	Semi-private room days (excluding swing-bed and observation bed days)	943	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	639	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
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	509	7.00
7.00	reporting period	309	7.00
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	4	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
10.00	through December 31 of the cost reporting period (see instructions)	O	10.00
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
13. 00	through December 31 of the cost reporting period  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
15.00	Total nursery days (title V or XIX only)	0	15.00
16. 00	Nursery days (title V or XIX only)	0	16.00
17 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost		17. 00
17. 00	reporting period		17.00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost		18.00
	reporting period		
19. 00	Medical drate for swing-bed NF services applicable to services through December 31 of the cost	208. 70	19.00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20.00
20.00	reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4, 399, 021	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22.00
00.00	5 x line 17)		00.00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6   x line 18)	0	23.00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line)	106, 228	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
0/ 00	x line 20)	4 5/4 440	0, 00
26. 00 27. 00	Total swing-bed cost (see instructions)  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1, 561, 448 2, 837, 573	
27.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	2,037,373	27.00
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	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00 0. 00	32. 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	2, 837, 573	37.00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY		-
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		1
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	2, 277. 35	38.00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	9, 109	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	9, 109	41.00

5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	639	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
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	509	7. 00
7.00	reporting period	509	7.00
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)	o l	0.00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	4	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
12 00	through December 31 of the cost reporting period	0	12 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
15. 00	Total nursery days (title V or XIX only)	0	15. 00
16. 00	Nursery days (title V or XIX only)	0	16.00
10.00	SWI NG BED ADJUSTMENT	5	
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost		17. 00
	reporting period		
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost		18.00
	reporting period		
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	208. 70	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
21 00	reporting period	4 200 021	21. 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	4, 399, 021 0	21.00
22.00	5 x line 17)	U	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
20.00	x line 18)		20.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	106, 228	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)		
26.00	Total swing-bed cost (see instructions)	1, 561, 448	
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2, 837, 573	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	Pri vate room charges (excluding swing-bed charges)	0	29.00
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	30. 00 31. 00
31.00	Average private room per diem charge (line 29 ÷ line 3)	0.000000	
32.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	
34. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line		
	27 minus line 36)	, ,	
	PART II - HOSPITÁL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
	Adjusted general inpatient routine service cost per diem (see instructions)	2, 277. 35	
39. 00	Program general inpatient routine service cost (line 9 x line 38)	9, 109	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	9, 109	41.00

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Health Financial Systems	JNI ON COUNTY HOS	SPITAL DISTRIC	Т	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der (	CCN: 14-1342	Peri od: From 01/14/2023 To 09/30/2023	Worksheet D-1 Date/Time Pre 2/27/2024 3:2	pared:
Cost Center Description	Total I npati ent	Ti t Total I npati ent	Average Per Diem (col.		PPS Program Cost (col. 3 x	4 piii
	1.00	Days 2.00	÷ col. 2)	4.00	col . 4) 5.00	
42.00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Unit	c					42.00
43. 00 INTENSIVE CARE UNIT  44. 00 CORONARY CARE UNIT  45. 00 BURN INTENSIVE CARE UNIT  46. 00 SURGICAL INTENSIVE CARE UNIT  47. 00 OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						43.00 44.00 45.00 46.00 47.00
					1. 00	
48.00 Program inpatient ancillary service cost (W 48.01 Program inpatient cellular therapy acquisit 49.00 PASS THROUGH COST ADJUSTMENTS	ion cost (Works	heet D-6, Part		, column 1)	13, 322 0 22, 431	48. 01
50.00 Pass through costs applicable to Program in	patient routine	services (fro	om Wkst. D, su	m of Parts I and	241	50.00
51.00 Pass through costs applicable to Program in and IV)	patient ancilla	ry services (f	rom Wkst. D,	sum of Parts II	398	51.00
52.00 Total Program excludable cost (sum of lines 53.00 Total Program inpatient operating cost excl medical education costs (line 49 minus line	uding capital r	elated, non-ph	nysician anest	hetist, and	639 21, 792	
TARGET AMOUNT AND LIMIT COMPUTATION  54.00 Program discharges  55.00 Target amount per discharge Permanent adjustment amount per discharge  55.02 Adjustment amount per discharge (contractor Target amount (line 54 x sum of lines 55, 5  57.00 Difference between adjusted inpatient opera  58.00 Bonus payment (see instructions)	5. 01, and 55. 02		(line 56 minus	line 53)	0 0.00 0.00 0.00 0	55. 00 55. 01 55. 02 56. 00 57. 00
59.00 Trended costs (lesser of line 53 ÷ line 54, updated and compounded by the market basket	)		0 .	o .	0. 00	
60.00 Expected costs (lesser of line 53 ÷ line 54 market basket)		. ,			0. 00	60.00
61.00 Continuous improvement bonus payment (if li 55.01, or line 59, or line 60, enter the le 53) are less than expected costs (lines 54 enter zero. (see instructions)	sser of 50% of	the amount by	which operati	ng costs (line	0	61.00
62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive pay	ment (see instr	uctions)			0	
PROGRAM INPATIENT ROUTINE SWING BED COST  64.00 Medicare swing-bed SNF inpatient routine co	sts through Dec	ember 31 of th	ne cost report	ing period (See	0	64.00
instructions)(title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine co	sts after Decem	ber 31 of the	cost reportir	g period (See	0	65. 00
instructions)(title XVIII only)  66.00 Total Medicare swing-bed SNF inpatient rout CAH, see instructions	ine costs (line	64 plus line	65)(title XVI	II only); for	0	66. 00
67.00 Title V or XIX swing-bed NF inpatient routi (line 12 x line 19)	ne costs throug	h December 31	of the cost r	eporting period	0	67. 00
68.00 Title V or XIX swing-bed NF inpatient routi (line 13 x line 20)	ne costs after	December 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					0	69. 00
70.00 Skilled nursing facility/other nursing faci 71.00 Adjusted general inpatient routine service 72.00 Program routine service cost (line 9 x line 73.00 Medically necessary private room cost appli 74.00 Total Program general inpatient routine ser 75.00 Capital-related cost allocated to inpatient	cost per diem ( 71) cable to Progra vice costs (lin	line 70 ÷ line m (line 14 x l e 72 + line 73	ine 35)			70.00 71.00 72.00 73.00 74.00 75.00
26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ I 77.00 Program capital-related costs (line 9 x lin 78.00 Inpatient routine service cost (line 74 min 79.00 Aggregate charges to beneficiaries for exce 80.00 Total Program routine service costs for com 81.00 Inpatient routine service cost per diem lim 82.00 Inpatient routine service cost limitation ( 83.00 Reasonable inpatient routine service costs 84.00 Program inpatient ancillary services (see i 85.00 Utilization review - physician compensation 86.00 Total Program inpatient operating costs (su PART IV - COMPUTATION OF OBSERVATION BED PA	e 76) us line 77) ss costs (from parison to the itation line 9 x line 8 (see instructio nstructions) (see instructi m of lines 83 t	cost limitation  1)  ns)  ons)  hrough 85)		nus line 79)		76. 00 77. 00 78. 00 79. 00 80. 00 81. 00 82. 00 83. 00 84. 00 85. 00 86. 00
87.00 Total observation bed days (see instruction 88.00 Adjusted general inpatient routine cost per	s)				303 2, 277. 35	87. 00 88. 00

Health Financial Systems	UNI ON COUNTY HOS	PITAL DISTRICT		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der Co		Peri od:	Worksheet D-1	
				From 01/14/2023 To 09/30/2023		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 8	8) (see instructions)	)			690, 037	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 THE	ROUGH COST					
90.00 Capital -related cost	116, 398	4, 399, 021	0. 02646	690, 037	18, 258	90.00
91.00 Nursing Program cost	o	4, 399, 021	0. 00000	690, 037	0	91.00
92.00 Allied health cost	o	4, 399, 021	0. 00000	690, 037	0	92.00
93.00 All other Medical Education	l ol	4, 399, 021	0. 00000	690, 037	0	93.00

NPATTENT AN	CILLARY SERVICE COST APPORTIONMENT	Provider C	CCN: 14-1342	Peri od: From 01/14/2023 To 09/30/2023	Worksheet D-3 Date/Time Pre	
					2/27/2024 3: 2	24 pm
		litle	XVIII	Hospi tal	Cost	_
,	Cost Center Description		Ratio of Cos To Charges		Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
	ENT ROUTINE SERVICE COST CENTERS					
	ADULTS & PEDIATRICS			1, 101, 202		30.
	ARY SERVICE COST CENTERS					4
	OPERATING ROOM		0. 2897			
	RECOVERY ROOM		0. 1543	-	1, 689	
	ANESTHESI OLOGY		0. 8576		5, 397	
	RADI OLOGY-DI AGNOSTI C		0. 0781		23, 605	
	ULTRASOUND		0.0000		0	
	RADI OI SOTOPE		0.0000		0	
	CT_SCAN		0.0000		0	
8. 00   05800			0.0000		0	
	LABORATORY		0. 1526	· ·	· ·	
	RESPI RATORY THERAPY		0. 2874		46, 712	
	PHYSI CAL THERAPY		0. 2166		9, 782	
	OCCUPATI ONAL THERAPY		0. 3886		13, 827	
	SPEECH PATHOLOGY		0. 3785			
	ELECTROCARDI OLOGY		0. 2057			
	MEDICAL SUPPLIES CHARGED TO PATIENT		0. 3032		103, 011	
	IMPL. DEV. CHARGED TO PATIENTS		0. 6357		27	
	DRUGS CHARGED TO PATIENTS		0. 2480			
	SLEEP LAB		0.0000		0	1
	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 7777		0	
6. 03 03950 I	WOUND CARE TENT SERVICE COST CENTERS		2. 1801	30 0	0	76.
	RURAL HEALTH CLINIC		0.0000	00	0	88.
	EMERGENCY		0. 3041		15, 501	
	OBSERVATION BEDS (NON-DISTINCT PART		1. 4956	·		
	Total (sum of lines 50 through 94 and 96 through 98)		1. 4950	2, 487, 479	· ·	
		(lino 41)		2, 487, 479		200.
J I . UUI	Less PBP Clinic Laboratory Services-Program only charges	s (TITHE OI)	1	1 0		∠U I .

Health Financial Systems UNION COUNTY HOSPITAL DISTRIC	Т	In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Provider	CCN: 14-1342	Peri od:	Worksheet D-3	3
Component	CCN: 14-Z342	From 01/14/2023 To 09/30/2023		
	e XVIII	Swing Beds - SNF		
Cost Center Description	Ratio of Cos To Charges	Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
	1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			ı	
30. 00 03000 ADULTS & PEDI ATRI CS ANCI LLARY SERVI CE COST CENTERS				30.00
50. 00 05000 OPERATING ROOM	0. 2897	51 1, 897	550	50.00
51. 00   05100   RECOVERY   ROOM	0. 1543			1
53. 00   05300   ANESTHESI OLOGY	0. 8576		l o	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 0781		4, 375	
54. 01   05401   ULTRASOUND	0.0000	00	0	54. 01
56. 00   05600   RADI 01 SOTOPE	0.0000	00 0	0	56.00
57.00  05700 CT SCAN	0.0000		0	57.00
58. 00   05800  MRI	0.0000		0	
60. 00   06000  LABORATORY	0. 1526			
65. 00 06500 RESPI RATORY THERAPY	0. 2874	·		
66. 00 O6600 PHYSI CAL THERAPY	0. 2166	·		
67. 00 06700 OCCUPATI ONAL THERAPY	0. 3886			
68. 00 06800 SPEECH PATHOLOGY	0. 3785			
69. 00 06900 ELECTROCARDI OLOGY	0. 2057	·		
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 3032		80, 068	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 6357		1	
73. 00   07300   DRUGS CHARGED TO PATI ENTS	0. 2480		90, 215	
76. 00 03610 SLEEP LAB	0.0000		-	
76. 01   03550   PSYCHI ATRI C/PSYCHOLOGI CAL   SERVI CES	0. 7777			76. 01
76. 03 O3950 WOUND CARE OUTPATIENT SERVICE COST CENTERS	2. 1801	30 0	0	76. 03
88. 00   08800   RURAL HEALTH CLINIC	0.0000	00	0	88.00
91. 00   09100   EMERGENCY	0. 3041		_	
92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART	1. 4956		0	1
200.00 Total (sum of lines 50 through 94 and 96 through 98)	,,,,,	1, 715, 677	_	
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)		1, 715, 677		202.00

Heal th Fina	ncial Systems UNION COUNTY HOSPITA	L DISTRICT		In Lie	u of Form CMS-2	2552-10
INPATIENT A	NCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 14-1342	Peri od:	Worksheet D-3	1
				From 01/14/2023 To 09/30/2023	Date/Time Pre 2/27/2024 3:2	
		Ti tl	e XIX	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	
INDAT	TIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
	ADULTS & PEDIATRICS			9, 592		30.00
	LLARY SERVICE COST CENTERS			7, 372		30.00
50.00 05000	OPERATING ROOM		0. 2897!	51 24, 381	7, 064	50.00
	RECOVERY ROOM		0. 1543		575	
	ANESTHESI OLOGY		0. 85760	2, 188		
	RADI OLOGY-DI AGNOSTI C		0. 0781		53	
	1 ULTRASOUND		0. 00000		0	
	RADI OI SOTOPE		0. 00000		0	
	CT SCAN		0. 00000		0	57.00
58. 00 05800			0. 00000		0	
	LABORATORY		0. 1526!		557	
	RESPIRATORY THERAPY		0. 28748		0	
	PHYSI CAL THERAPY		0. 2166		0	66.00
	OCCUPATIONAL THERAPY SPEECH PATHOLOGY		0. 38860		0	
	D ELECTROCARDI OLOGY		0. 37850 0. 2057		0	
	MEDICAL SUPPLIES CHARGED TO PATIENT		0. 2057		0	71.00
	IMPL. DEV. CHARGED TO PATIENTS		0. 6357		0	
	DRUGS CHARGED TO PATIENTS		0. 2480		3, 197	
	SLEEP LAB		0. 00000		0,177	
	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 7777		o o	76.01
	WOUND CARE		2. 1801:		Ō	76. 03
	ATLENT SERVICE COST CENTERS					
88. 00 08800	RURAL HEALTH CLINIC		0. 98390	05 0	0	88. 00
91.00 09100	EMERGENCY		0. 3041	36 0	0	91.00
	OBSERVATION BEDS (NON-DISTINCT PART		1. 4956	46 0	0	
200. 00	Total (sum of lines 50 through 94 and 96 through 98)			47, 506		
201. 00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201. 00
202. 00	Net charges (line 200 minus line 201)			47, 506		202.00

Health Financial Systems	UNION COUNTY HOSPITAL DISTRICT	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-1342		Worksheet E Part B Date/Time Prepared: 2/27/2024 3:24 pm

-	Title XVIII Hospita	al	2/2//2024 3: 2/ Cost	4 pm
	PART B - MEDICAL AND OTHER HEALTH SERVICES		1. 00	
1. 00	Medical and other services (see instructions)		3, 144, 222	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS or REH payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
4. 01 5. 00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instructions)		0. 000	4. 01 5. 00
6. 00	Line 2 times line 5		0.000	6. 00
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8. 00	Transitional corridor payment (see instructions)		0	8.00
9. 00 10. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 Organ acquisitions		0	9. 00 10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)		3, 144, 222	
	COMPUTATION OF LESSER OF COST OR CHARGES		97	
	Reasonabl e charges			
12.00	Ancillary service charges		0	12. 00 13. 00
13. 00 14. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) Total reasonable charges (sum of lines 12 and 13)		0	14.00
11.00	Customary charges			11.00
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge be	asi s	0	15.00
16. 00	Amounts that would have been realized from patients liable for payment for services on a chargel	basi s	0	16.00
17. 00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)		0. 000000	17. 00
18. 00	Total customary charges (see instructions)		0.000000	18.00
19. 00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	е	Ö	19. 00
	instructions)			
20. 00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	е	0	20. 00
21. 00	instructions) Lesser of cost or charges (see instructions)		3, 175, 664	21. 00
22. 00	Interns and residents (see instructions)		0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		0	24.00
25 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		15 145	25. 00
25. 00 26. 00	Deductibles and coinsurance amounts (for CAH, see instructions)  Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		15, 145 2, 343, 459	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (s	see	817, 060	
	instructions)			
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28. 00
28. 50 29. 00	REH facility payment amount ESRD direct medical education costs (from Wkst. E-4, line 36)		o	28. 50 29. 00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)		817, 060	
31.00	Primary payer payments		0	31.00
32. 00	Subtotal (line 30 minus line 31)		817, 060	32. 00
33. 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)  Composite rate ESRD (from Wkst. I-5, line 11)		0	33. 00
34. 00	Allowable bad debts (see instructions)		93, 421	
35.00			60, 724	35.00
	Allowable bad debts for dual eligible beneficiaries (see instructions)		93, 421	
	Subtotal (see instructions)   MSP-LCC reconciliation amount from PS&R		877, 784 0	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			39.00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)		_	39. 50
39. 75	N95 respirator payment adjustment amount (see instructions)		0	39. 75
39. 97	Demonstration payment adjustment amount before sequestration		0	39. 97
39. 98 39. 99	Partial or full credits received from manufacturers for replaced devices (see instructions) RECOVERY OF ACCELERATED DEPRECIATION		0	39. 98 39. 99
40. 00	Subtotal (see instructions)		877, 784	40. 00
40. 01	Sequestration adjustment (see instructions)		17, 556	
40. 02	Demonstration payment adjustment amount after sequestration		0	40. 02
40. 03	Sequestration adjustment-PARHM pass-throughs		1 200 012	40. 03
41. 00 41. 01	Interim payments  Interim payments-PARHM		1, 309, 013	41. 00 41. 01
42. 00	Tentative settlement (for contractors use only)		o	42. 00
42.01	Tentative settlement-PARHM (for contractor use only)			42.01
43.00	Balance due provider/program (see instructions)		-448, 785	
43. 01	Balance due provider/program-PARHM (see instructions)			43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44. 00
	TO BE COMPLETED BY CONTRACTOR			
	Original outlier amount (see instructions)		0	
91.00	Outlier reconciliation adjustment amount (see instructions)		0 00	91.00
92. 00 93. 00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)		0.00	92. 00 93. 00
	Total (sum of lines 91 and 93)			94.00

Health Financial Systems	UNION COUNTY HOSPITAL DISTRICT In Lieu				-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1342   Period:   From 01/14/2023   Period:   Peri		Worksheet E		
			To 09/30/2023	Date/Time Pr	epared:
				2/27/2024 3:	24 pm
		Title XVIII	Hospi tal	Cost	
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days					0 200. 00

In Lieu of Form CMS-2552-10

| Period: | Worksheet E-1 |
| From 01/14/2023 | Part |
| To 09/30/2023 | Date/Time Prepared: | 2/27/2024 | 3: 24 pm Health Financial Systems UNION CANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 14-1342

					2/27/2024 3: 24	4 pm
		Title	XVIII	Hospi tal	Cost	
		Inpatien	it Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4.00	
1. 00	Total interim payments paid to provider		979, 21	6	1, 309, 013	1.00
2.00	Interim payments payable on individual bills, either			0	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3. 00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3. 02	ADJUSTIMENTS TO TROVIDER			0		3. 02
3. 03			l .	0	o o	3. 03
3. 04				0	0	3. 04
3. 05				0	0	3. 05
0.00	Provider to Program			<u> </u>		0.00
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				0	0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		979, 21	6	1, 309, 013	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after		I			5. 00
5.00	desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5. 02				0	0	5. 02
5.03				0	0	5.03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				0	0	5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on					6. 00
<i>(</i> 01	the cost report. (1)		F22 20	NE		/ O1
6. 01 6. 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		533, 20	0	0 448, 785	6. 01 6. 02
7. 00	Total Medicare program liability (see instructions)		1, 512, 42	-	860, 228	7.00
7.00	Total medicale program frability (see Histructions)		1,512,42	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		(	)	1. 00	2.00	
8. 00	Name of Contractor					8. 00
				•		

ANALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der Co		Period: From 01/14/2023	Worksheet E-1 Part I	
		Component			Date/Time Pre 2/27/2024 3:2	pared:
		Title	XVIII	wing Beds - SNF		
		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		1, 315, 77	3	0	
2.00	Interim payments payable on individual bills, either			D	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero					
3. 00	List separately each retroactive lump sum adjustment					3.00
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER			D	0	
3. 02				O	0	3. 02
3. 03				O O	0	
3. 04				O O	0	3.04
3. 05	Provider to Program			0	0	3.05
3. 50	ADJUSTMENTS TO PROGRAM				0	3.50
3. 51	THE STATE OF THE S			o l	ő	
3. 52					0	3. 52
3.53				o l	0	3. 53
3.54				D	0	
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		(		0	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 315, 77	3	0	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5.00
3.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			D	0	
5. 02				D	0	
5. 03				0	0	5.03
F F0	Provi der to Program		,		0	
5. 50 5. 51	TENTATI VE TO PROGRAM				0 0	
5. 52					0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines				0	
0. 77	5. 50-5. 98)		,			0. 77
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVI DER		542, 34	4	0	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	0	6. 02
7. 00	Total Medicare program liability (see instructions)		1, 858, 11	Contractor	NDD Dato	7.00

Contractor

Number

1.00

NPR Date

(Mo/Day/Yr)

2.00

8. 00

8.00 Name of Contractor

Health Financial Systems UNION COUNTY HOSPITAL DISTRICT In Lieu of					
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-1342	Peri od:	Worksheet E-	1
			From 01/14/2023		onorod.
			To 09/30/2023	Date/Time Pr 2/27/2024 3:	
		Title XVIII	Hospi tal	Cost	<u> </u>
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst	. 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				6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of	certified HIT technology	Wkst. S-2, Pt. I		7. 00
0.00	line 168				0.00
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
20.00	I NPATI ENT HOSPI TAL SERVI CES UNDER THE I PPS & CAH		T		30.00
	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)	line 21) (coe instructio	no)		31.00
3∠. 00	Balance due provider (line 8 (or line 10) minus line 30 and	Time 31) (See Instruction	115)		32.00

Health Financial Systems	UNION COUNTY HOSPIT	In Lieu	of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT - S	SWING BEDS	Provider CCN: 14-1342		Worksheet E-2
			From 01/14/2023	
		Component CCN: 14-Z342	To 09/30/2023	Date/Time Prepared:
		•		2/27/2024 3: 24 pm
		Title XVIII	Swing Beds - SNF	Cost

		Component CCN: 14-Z342	o 09/30/2023	Date/Time Pre 2/27/2024 3:2	
		Title XVIII S	wing Beds - SNF		, p
			Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		1, 469, 772	0	
2.00	Inpatient routine services - swing bed-NF (see instructions)	+ A D	440.000	0	2.00
3. 00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Par		449, 822	0	3. 00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swill instructions)				
3. 01	Nursing and allied health payment-PARHM (see instructions)				3. 01
4. 00	Per diem cost for interns and residents not in approved teach	ing program (see		0.00	4.00
	instructions)	g pg (			
5.00	Program days		639	0	5.00
6.00	Interns and residents not in approved teaching program (see i			0	6.00
7.00	Utilization review - physician compensation - SNF optional me	thod only	0		7.00
8. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		1, 919, 594	0	
9.00	Primary payer payments (see instructions)		0	0	
10.00	Subtotal (line 8 minus line 9)		1, 919, 594	0	
11. 00	Deductibles billed to program patients (exclude amounts applied	cable to physician	0	0	11.00
12. 00	professional services) Subtotal (line 10 minus line 11)		1, 919, 594	0	12.00
13. 00	Coinsurance billed to program patients (from provider records	) (evelude coinsurance	23, 556	0	
13.00	for physician professional services)	(excrude corristrance	23, 330	O	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		1, 896, 038	0	
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)			16. 50
16. 55	Rural community hospital demonstration project (§410A Demonst	ration) payment	0		16. 55
	adjustment (see instructions)				
16. 99	Demonstration payment adjustment amount before sequestration		0	0	
17.00	Allowable bad debts (see instructions)		0	0	
17. 01	Adjusted reimbursable bad debts (see instructions)		0	0	
18.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)	1 004 020	0	
19. 00 19. 01	Total (see instructions)		1, 896, 038	0	
19.01	Sequestration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration)		37, 921	0	
19. 02	Sequestration adjustment-PARHM pass-throughs			O	19.02
19. 25	Sequestration for non-claims based amounts (see instructions)		0	0	
20.00	Interim payments		1, 315, 773	0	20.00
20. 01	Interim payments-PARHM				20. 01
21.00	Tentative settlement (for contractor use only)		0	0	21.00
21. 01	Tentative settlement-PARHM (for contractor use only)				21.01
22. 00	Balance due provider/program (line 19 minus lines 19.01, 19.0.	2, 19.25, 20, and 21)	542, 344	0	22.00
22. 01	Balance due provider/program-PARHM (see instructions)				22. 01
23. 00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	0	0	23.00
	chapter 1, §115.2				
200 00	Rural Community Hospital Demonstration Project (§410A Demonstr				200 00
200. UC	Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no.	riod under the 21st			200. 00
	Cost Reimbursement				1
201 00	Medicare swing-bed SNF inpatient routine service costs (from	Wkst. D-1, Pt. II, line			201. 00
201.00	66 (title XVIII hospital))				2011.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (fro	m Wkst. D-3, col. 3, line			202.00
	200 (title XVIII swing-bed SNF))				
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
	Computation of Demonstration Target Amount Limitation (N/A in	first year of the curren	t 5-year demons	tration	
	peri od)				
	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 t				206. 00
207.00	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburg				207 00
	17.00 Program reimbursement under the §410A Demonstration (see instructions) 18.00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1				207. 00
200.00	and 3)	z, cor. r, sum or rines r			208. 00
209 00	Adjustment to Medicare swing-bed SNF PPS payments (see instru	ctions)			209. 00
	Reserved for future use	011 0113)			210. 00
	Comparision of PPS versus Cost Reimbursement				1
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line	209 plus line 210) (see			215. 00
	instructions)				

Health Financial Systems	UNION COUNTY HOSPITAL DISTRICT	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-1342	From 01/14/2023	Worksheet E-3 Part V Date/Time Prepared:
		10 04/30/2023	2/27/2024 3: 24 pm
	Title XVIII	Hosni tal	Cost

PART YCALCILLATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT   1.00   Impattient services deal th Managed Care payment (see instructions)					2/27/2024 3: 2	4 pm
PART V . CALCULATION OF RETIBURSENINT SCRIPTLEMENT FOR MEDICARE PART A SERVICES - COST RETIBURSENENT			Title XVIII	Hospi tal	Cost	
PART V . CALCULATION OF RETIBURSENINT SCRIPTLEMENT FOR MEDICARE PART A SERVICES - COST RETIBURSENENT						
Inpatient services   1,655,849   1,00   2,00   2,00   Aurising and Allied Health Managed Care payment (see instructions)   0   3,00   3,00   0rgan acquisition cost (see instructions)   0   3,00   3,00   3,00   Cell ular therapy acquisition cost (see instructions)   1,655,849   4,00   5,00   Primary payer payments   1,655,849   4,00   6,00   Total cost (line 4 less line 5). For CAH (see instructions)   1,672,407   6,00   CoMPUTATION OF LESSER OF COST OR CHARGES   7,00   6,00   Computation of LESSER OF COST OR CHARGES   7,00   6,00   7,00   6,00   7,00   6,00   7					1. 00	
2.00   Nursing and Allied Health Managed Care payment (see instructions)   0 2.00   0.30		PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	PART A SERVICES - COST	REIMBURSEMENT		
3.00   Cellular therapy acquisition cost (see instructions)   0.3.01	1.00	Inpati ent servi ces			1, 655, 849	1.00
3.01   Celf ular therapy acquisition cost (see instructions)	2.00	Nursing and Allied Health Managed Care payment (see instruction	ons)		0	2.00
4.00   Subtotal (sum of lines 1 through 3.01)   1,655,849   4.00   5.00   6.00   Total cost (line 4 less line 5). For CAH (see instructions)   1,672,407   6.00   COMPUTATION OF LESSER OF COST OR CHARGES   Reasonable charges   0   7.00   Reasonable charges   0   0   0   0   0   0   0   0   0	3.00	Organ acqui si ti on			0	3.00
Primary payer payments	3. 01	Cellular therapy acquisition cost (see instructions)			0	3. 01
Primary payer payments	4.00	Subtotal (sum of lines 1 through 3.01)			1, 655, 849	4.00
Total Cost (line 4 less line 5). For CAH (see instructions)	5.00				0	5.00
COMPUTATION OF LESSER OF COST OR CHARGES	6. 00				1, 672, 407	6.00
Reasonable charges						
Routline service charges						
8.00   Ancillary service charges   0   8.00   0.00   Total reasonable charges   0   9.00   0.00   Total reasonable charges   0   0.00   0.00   Total reasonable charges   0   0.00   0	7.00	9			0	7.00
9.00   Organ acquisition charges, net of revenue   0   9.00   0.00   10.00   Total reasonable charges   0.10.00   10	8.00				0	8.00
10. 00   Total reasonable charges	9.00	Organ acquisition charges, net of revenue			0	9.00
Customary charges   0   11.00	10.00				0	10.00
11.00   Aggregate amount actually collected from patients liable for payment for services on a charge basis   0   11.00						
12.00   Amounts that would have been realized from patients   liable for payment for services on a charge basis had such payment been made in accordance with 44 CFR 413.13(e)   13.00   Ratio of line 11 to line 12 (not to exceed 1.000000)   13.00   14.00   1611   1611   17 to line 12 (not to exceed 1.000000)   17.00   17.00   17.00   18.00	11. 00		payment for services on	a charge basis	0	11.00
had such payment been made in accordance with 42 CFR 413.13(e)					. 0	
13.00		· ·	1 3	3		
14.00	13.00	, ,	•		0.000000	13.00
15.00   Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see Instructions)   16.00   Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see Instructions)   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   18.00   19.0	14.00	,			0	14.00
Instructions   Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see   0   16.00   17.00	15.00		y if line 14 exceeds li	ne 6) (see	0	15.00
Instructions   Cost of physicians' services in a teaching hospital (see instructions)   17.00   Cost of physicians' services in a teaching hospital (see instructions)   17.00   Cost of covered services (sum of lines 6, 17 and 18)   18.00   Cost of covered services (sum of lines 6, 17 and 18)   18.00   Cost of covered services (sum of lines 6, 17 and 18)   18.00   Cost of covered services (sum of lines 6, 17 and 18)   18.00   Cost of covered services (sum of lines 6, 17 and 18)   18.00   Cost of covered services (sum of lines 6, 17 and 18)   18.00   Cost of covered services (sum of lines 2, 17 and 18)   18.00   Cost of covered services (sum of lines 2, 18 and 18)   18.00   Cost of covered services (sum of lines 2, 18 and 18)   18.00   Cost of covered services (sum of lines 2, 18 and 18)   18.00   Cost of covered services (sum of lines 2, 18 and 18)   18.00   Cost of covered services (sum of lines 2, 18 and 18)   18.00   Cost of covered services (sum of lines 2, 18 and 18)   18.00   Cost of covered services (sum of lines 2, 18 and 25, or line 26)   18.00   Cost of covered services (sum of lines 2, 18 and 25, or line 26)   18.00   Cost of covered services (sum of lines 2, 18 and 25, or line 26)   18.00   Cost of covered services (sum of lines 2, 18 and 25, or line 26)   18.00   Cost of covered services (sum of lines 2, 18 and 25, or line 26)   18.00   Cost of covered services (sum of lines 2, 18 and 25, or line 26)   18.00   Cost of covered services (sum of lines 2, 18 and 26, sum of covered services (sum of covered servi		, ,		, ,		
17. 00	16.00	Excess of reasonable cost over customary charges (complete on	y if line 6 exceeds lir	ne 14) (see	0	16. 00
COMPUTATION OF REIMBURSEMENT SETTLEMENT   0   18. 00   18. 00   19. 00		instructions)				
18. 00	17.00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	17.00
19. 00       Cost of covered services (sum of lines 6, 17 and 18)       1, 672, 407       19. 00         20. 00       Deductibles (excl ude professi onal component)       126, 400       20. 00         21. 00       Excess reasonable cost (from line 16)       0       21. 00         22. 00       Subtotal (line 19 minus line 20 and 21)       1, 546, 007       22. 00         23. 00       Coin surance       1, 541, 207       24. 00         24. 00       Subtotal (line 22 minus line 23)       1, 541, 207       24. 00         25. 00       All owable bad debts (exclude bad debts (see instructions)       2, 080       25. 00         26. 00       Adj usted reimbursable bad debts (see instructions)       2, 080       26. 00         27. 00       All lowable bad debts for dual eligible beneficiaries (see instructions)       2, 080       26. 00         28. 00       Subtotal (sum of lines 24 and 25, or line 26)       1, 543, 287       28. 00         29. 00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0 29. 00         29. 99       Pioneer ACO demonstration payment adjustment (see instructions)       0 29. 50         29. 99       Pomonstration payment adjustment amount before sequestration       0 29. 99         30. 01       Sequestration adjustment amount after sequestration       0 30. 03		COMPUTATION OF REIMBURSEMENT SETTLEMENT				
20. 00       Deductibles (exclude professional component)       126, 400       20. 00         21. 00       Excess reasonable cost (from line 16)       0 21. 00         22. 00       Subtotal (line 19 minus line 20 and 21)       1,546, 007       22. 00         23. 00       Coinsurance       4,800       23. 00         24. 00       Subtotal (line 22 minus line 23)       1,541, 207       24. 00         25. 00       Allowable bad debts (exclude bad debts for professional services) (see instructions)       3, 200       25. 00         26. 00       Adjusted reimbursable bad debts (see instructions)       2, 080       26. 00         27. 00       Allowable bad debts for dual eligible beneficiaries (see instructions)       3, 200       27. 00         28. 00       Subtotal (sum of lines 24 and 25, or line 26)       1,543, 287       28. 00         29. 00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0, 29. 50         29. 99       Poneer ACO demonstration payment adjustment (see instructions)       0, 29. 90         29. 99       Recovery of accelerated depreciation.       0, 29. 98         29. 99       Demonstration payment adjustment amount before sequestration       0, 29. 99         30. 01       Sequestration adjustment emount after sequestration       30. 08         30. 02       Sequestration pa	18.00	Direct graduate medical education payments (from Worksheet E-	4, line 49)		0	18. 00
21.00   Excess reasonable cost (from line 16)   0   21.00   22.00   Subtotal (line 19 minus line 20 and 21)   1.546,007   22.00   23.00   20.00   24.00   Subtotal (line 22 minus line 23)   1.541,207   24.00   25.00   All owable bad debts (exclude bad debts for professional services) (see instructions)   3.200   25.00   27.00   All owable bad debts (see instructions)   2.080   26.00   27.00   All owable bad debts for dual eligible beneficiaries (see instructions)   3.200   27.00   28.00   Subtotal (sum of lines 24 and 25, or line 26)   29.50   29.50   29.50   29.90   29.50   29.90   29.50   29.90   29.50   29.90	19. 00	Cost of covered services (sum of lines 6, 17 and 18)			1, 672, 407	19.00
22.00       Subtotal (line 19 minus line 20 and 21)       1,546,007       22.00         23.00       Coinsurance       4,800       23.00         24.00       Subtotal (line 22 minus line 23)       1,541,207       24.00         25.00       Allowable bad debts (exclude bad debts for professional services) (see instructions)       3,200       25.00         26.00       Adjusted reimbursable bad debts (see instructions)       2,080       26.00         27.00       Allowable bad debts for dual eligible beneficiaries (see instructions)       3,200       27.00         28.00       Subtotal (sum of lines 24 and 25, or line 26)       1,543,287       28.00         29.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       29.00         29.98       Recovery of accelerated depreciation.       0       29.98         29.99       Recovery of accelerated depreciation.       0       29.99         30.00       Sequestration payment adjustment amount before sequestration       0       29.99         30.01       Sequestration adjustment (see instructions)       30.02       30.02       20.00         30.02       Demonstration payment adjustment amount after sequestration       0       29.99         30.02       Demonstration payment       30.02       30.02       30.02	20.00	Deductibles (exclude professional component)			126, 400	20.00
23. 00 Coinsurance 24. 00 Subtotal (line 22 minus line 23) 25. 00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 26. 00 Adjusted reimbursable bad debts (see instructions) 27. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 28. 00 Subtotal (sum of lines 24 and 25, or line 26) 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29. 50 Pioneer ACO demonstration payment adjustment (see instructions) 29. 99 Recovery of accelerated depreciation. 29. 99 Demonstration payment adjustment amount before sequestration 30. 01 Sequestration adjustment (see instructions) 30. 02 Sequestration adjustment (see instructions) 31. 00 Interim payments 31. 01 Interim payments 32. 00 Sequestration (for contractor use only) 33. 00 Balance due provider/program (line 30 minus lines 30. 01, 30. 02, chapter 1, 0 34. 00 34. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	21.00	Excess reasonable cost (from line 16)			0	21.00
24. 00       Subtotal (line 22 minus line 23)       1,541,207       24. 00         25. 00       Allowable bad debts (exclude bad debts for professional services) (see instructions)       3,200       25. 00         26. 00       Adjusted reimbursable bad debts (see instructions)       2,080       25. 00         27. 00       Allowable bad debts for dual eligible beneficiaries (see instructions)       3,200       27. 00         28. 00       Subtotal (sum of lines 24 and 25, or line 26)       1,543,287       28. 00         29. 00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       29. 00         29. 50       Pioneer ACO demonstration payment adjustment (see instructions)       0       29. 50         29. 99       Recovery of accelerated depreciation.       0       29. 99         29. 99       Subtotal (see instructions)       0       29. 99         30. 01       Sequestration adjustment (see instructions)       30. 00         30. 02       Demonstration payment adjustment amount after sequestration       0       29. 99         30. 03       Sequestration adjustment-PARHM       30. 02         31. 01       Interim payments       979, 216       31. 00         31. 01       Interim payments       979, 216       31. 00         32. 01       Tentative settlement-PA	22.00	Subtotal (line 19 minus line 20 and 21)			1, 546, 007	22.00
25. 00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 26. 00 Adjusted reimbursable bad debts (see instructions) 27. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 28. 00 Subtotal (sum of lines 24 and 25, or line 26) 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29. 50 Pi oneer ACO demonstration payment adjustment (see instructions) 29. 98 Recovery of accelerated depreciation. 29. 99 Demonstration payment adjustment amount before sequestration 30. 00 Subtotal (see instructions) 30. 01 Sequestration adjustment (see instructions) 30. 02 Sequestration adjustment (see instructions) 30. 03 Sequestration payment adjustment amount after sequestration 30. 02 Sequestration adjustment (see instructions) 30. 03 Interim payments 31. 00 Interim payments 32. 00 Tentative settlement (for contractor use only) 33. 00 Bal ance due provider/program (line 30 minus lines 30. 01, 30. 02, 31, and 32) 33. 01 Bal ance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30. 03, 31. 01, and 32. 01) 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34. 00	23.00	Coi nsurance			4, 800	23.00
26. 00 Adjusted reimbursable bad debts (see instructions) 27. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 28. 00 Subtotal (sum of lines 24 and 25, or line 26) 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29. 50 Pi oneer ACO demonstration payment adjustment (see instructions) 29. 98 Recovery of accelerated depreciation. 29. 99 Demonstration payment adjustment amount before sequestration 30. 00 Subtotal (see instructions) 30. 01 Sequestration adjustment (see instructions) 30. 02 Demonstration payment adjustment amount after sequestration 30. 02 Demonstration payment adjustment amount after sequestration 30. 03 Sequestration adjustment-PARHM 31. 00 Interim payments 31. 01 Interim payments 32. 00 Tentative settlement (for contractor use only) 33. 00 Balance due provider/program (line 30 minus lines 30. 01, 30. 02, 31, and 32) 33. 01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30. 03, 31. 01, and 32. 01) 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	24.00	Subtotal (line 22 minus line 23)			1, 541, 207	24.00
27. 00       Allowable bad debts for dual eligible beneficiaries (see instructions)       3, 200       27. 00         28. 00       Subtotal (sum of lines 24 and 25, or line 26)       1, 543, 287       28. 00         29. 00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0 29. 00         29. 50       Pi oneer ACO demonstration payment adjustment (see instructions)       0 29. 90         29. 98       Recovery of accelerated depreciation.       0 29. 99         30. 00       Subtotal (see instructions)       0 29. 99         30. 01       Sequestration adjustment (see instructions)       30. 08         30. 02       Demonstration payment adjustment amount after sequestration       0 30. 08         30. 03       Sequestration adjustment (see instructions)       30. 08         31. 00       Interim payments       979, 216         31. 01       Interim payments-PARHM       979, 216         31. 01       Interim payments-PARHM (for contractor use only)       31. 01         32. 01       Tentative settlement (for contractor use only)       32. 01         33. 01       Balance due provider/program (line 30 minus lines 30. 01, 30. 02, 31, and 32)       533, 205         33. 01       Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30. 03, 31. 01, and 32. 01)         34. 00       Protested amounts (nona	25.00	Allowable bad debts (exclude bad debts for professional servi-	ces) (see instructions)		3, 200	25.00
28. 00 Subtotal (sum of lines 24 and 25, or line 26) 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29. 50 Pi oneer ACO demonstration payment adjustment (see instructions) 29. 98 Recovery of accelerated depreciation. 29. 99 Demonstration payment adjustment amount before sequestration 30. 00 Subtotal (see instructions) 30. 01 Sequestration adjustment (see instructions) 30. 02 Demonstration payment adjustment amount after sequestration 30. 03 Sequestration adjustment (see instructions) 31. 00 Interim payments 31. 01 Interim payments 31. 01 Interim payments 32. 00 Tentative settlement (for contractor use only) 32. 01 Tentative settlement-PARHM (for contractor use only) 33. 00 Bal ance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	26.00	Adjusted reimbursable bad debts (see instructions)			2, 080	26.00
29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29. 50 Pi oneer ACO demonstration payment adj ustment (see instructions) 29. 98 Recovery of accelerated depreciation. 29. 99 Demonstration payment adj ustment amount before sequestration 30. 00 Subtotal (see instructions) 30. 01 Sequestration adj ustment (see instructions) 30. 02 Demonstration payment adj ustment amount after sequestration 30. 03 Sequestration adj ustment amount after sequestration 31. 00 Interim payments 31. 01 Interim payments 31. 01 Interim payments-PARHM 32. 00 Tentative settlement (for contractor use only) 32. 01 Tentative settlement-PARHM (for contractor use only) 33. 01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	27.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		3, 200	27.00
Pi oneer ACO demonstration payment adjustment (see instructions)  29. 98 Recovery of accelerated depreciation.  29. 99 Recovery of accelerated depreciation.  29. 99 30. 00 Subtotal (see instructions)  30. 01 Sequestration adjustment (see instructions)  30. 02 Demonstration payment adjustment amount before sequestration  30. 01 Demonstration payment adjustment (see instructions)  30. 02 Demonstration payment adjustment amount after sequestration  30. 03 Sequestration adjustment-PARHM  31. 00 Interim payments  Interim payments-PARHM  Tentative settlement (for contractor use only)  32. 00 Tentative settlement (for contractor use only)  33. 01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)  34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  0 29. 98 0 29. 98 0 29. 99 1, 543, 287 0 29. 99 1, 543, 287 0 30. 00 0 30. 02 0 30. 03 0 30. 03 0 30. 03 0 30. 03 0 30. 04 0 30. 05 0	28.00	Subtotal (sum of lines 24 and 25, or line 26)			1, 543, 287	28. 00
29. 98 Recovery of accelerated depreciation.  29. 98 Demonstration payment adjustment amount before sequestration  30. 00 Subtotal (see instructions)  30. 01 Sequestration adjustment (see instructions)  30. 02 Demonstration payment adjustment amount after sequestration  30. 03 Sequestration adjustment-PARHM  31. 00 Interim payments  Interim payments  Interim payments-PARHM  32. 00 Tentative settlement (for contractor use only)  32. 01 Tentative settlement-PARHM (for contractor use only)  33. 01 Bal ance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)  34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  0 29. 98  0 29. 98  0 29. 99  1, 543, 287  30. 00  30, 02  30, 03  30, 01  30, 02  31, 04  30, 02  31, 04  32, 05  33, 05  33, 05  33, 07  34, 00	29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29. 00
29. 99 30. 00 30. 01 Subtotal (see instructions) 30. 02 Demonstration payment adjustment (see instructions) 30. 02 Demonstration payment adjustment amount after sequestration 30. 02 30. 03 Sequestration adjustment amount after sequestration 30. 03 Sequestration adjustment-PARHM 30. 03 31. 00 Interim payments 31. 01 Interim payments-PARHM 32. 00 Tentative settlement (for contractor use only) 32. 00 Tentative settlement-PARHM (for contractor use only) 33. 00 Balance due provider/program (line 30 minus lines 30. 01, 30. 02, 31, and 32) 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 29. 99 1, 543, 287 30. 00 30, 02 30, 03 30, 03 30, 03 30, 03 30, 03 30, 03 30, 03 30, 03 30, 03 30, 03 30, 03 30, 03 30, 03 31. 01 32. 00 33. 01 34. 00	29. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)		0	29. 50
30.00 Subtotal (see instructions) 30.01 Sequestration adjustment (see instructions) 30.02 Demonstration payment adjustment amount after sequestration 30.03 Sequestration adjustment-PARHM 31.00 Interim payments 31.01 Interim payments-PARHM 32.00 Tentative settlement (for contractor use only) 32.00 Tentative settlement-PARHM (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 30.00 30.01 30.02 30.02 30.03 30.01 30.02 31.01 30.02 31.01 30.02 31.01 30.03 31.01 30.03 31.01 30.03 31.01 30.03 31.01 31.00 31.0	29. 98	Recovery of accelerated depreciation.			0	29. 98
30.01 Sequestration adjustment (see instructions) 30.02 Demonstration payment adjustment amount after sequestration 30.03 Sequestration adjustment-PARHM 31.00 Interim payments 31.01 Interim payments-PARHM 32.00 Tentative settlement (for contractor use only) 32.01 Tentative settlement-PARHM (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00	29. 99	Demonstration payment adjustment amount before sequestration			0	29. 99
30.02 Demonstration payment adjustment amount after sequestration 30.03 Sequestration adjustment-PARHM 31.00 Interim payments 31.01 Interim payments-PARHM 32.00 Tentative settlement (for contractor use only) 32.01 Tentative settlement-PARHM (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00	30.00	Subtotal (see instructions)			1, 543, 287	30.00
30.03 Sequestration adjustment-PARHM 30.03 31.00 Interim payments 979, 216 31.00 31.01 Interim payments-PARHM 31.01 Tentative settlement (for contractor use only) 0 32.00 Tentative settlement-PARHM (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 33.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00	30. 01	Sequestration adjustment (see instructions)			30, 866	30. 01
31.00 Interim payments  31.01 Interim payments-PARHM  32.00 Tentative settlement (for contractor use only)  32.01 Tentative settlement-PARHM (for contractor use only)  33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)  34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00	30. 02	Demonstration payment adjustment amount after sequestration			0	30. 02
31.01 Interim payments-PARHM 32.00 Tentative settlement (for contractor use only) 32.01 Tentative settlement-PARHM (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00	30. 03	Sequestration adjustment-PARHM				30. 03
32.00 Tentative settlement (for contractor use only) 32.01 Tentative settlement-PARHM (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00	31.00	Interim payments			979, 216	31.00
32.01 Tentative settlement-PARHM (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00	31.01	Interim payments-PARHM				31.01
33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00	32.00	Tentative settlement (for contractor use only)			0	32.00
33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00	32.01	Tentative settlement-PARHM (for contractor use only)				32. 01
34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00	33.00	Balance due provider/program (line 30 minus lines 30.01, 30.0	2, 31, and 32)		533, 205	33.00
	33. 01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, m	nus lines 30.03, 31.01,	and 32.01)		33. 01
§115. 2	34.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	chapter 1,	0	34.00
		§115. 2				

Health Financial Systems	UNION COUNTY HOSPITAL DISTRICT	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-1342	Peri od: From 01/14/2023 To 09/30/2023	Worksheet E-3 Part VII Date/Time Prepared: 2/27/2024 3:24 pm

		1	o 09/30/2023	Date/Time Pre 2/27/2024 3:2	
		Title XIX	Hospi tal	PPS	т рііі
		THE WAY	Inpatient	Outpati ent	
			1, 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	VICES FOR TITLES V OR XI			
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		0		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)		0	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6. 00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8. 00	Routine service charges		9, 592		8. 00
9. 00	Ancillary service charges		47, 506	0	9. 00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0	_	11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)		57, 098	0	12.00
12 00	CUSTOMARY CHARGES				12 00
13. 00	Amount actually collected from patients liable for payment for basis	services on a charge	0	0	13. 00
14. 00	Amounts that would have been realized from patients liable for	nayment for services on	o	0	14. 00
14.00	a charge basis had such payment been made in accordance with 42	1 3	0	U	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	2 CIR 9413. 13(e)	0. 000000	0. 000000	15. 00
	Total customary charges (see instructions)		57, 098	0.000000	16.00
17. 00	Excess of customary charges over reasonable cost (complete only	vifline 16 exceeds	57, 098	0	17. 00
	line 4) (see instructions)	,	.,,,,,,,	_	
18.00	Excess of reasonable cost over customary charges (complete only	y 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 instru	uctions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 1		0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be o	completed for PPS provid			
22. 00	Other than outlier payments		0	0	22. 00
23. 00	Outlier payments		0	0	23. 00
24. 00	Program capital payments		0		24.00
	Capital exception payments (see instructions)		0	0	25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27. 00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28. 00 29. 00	Customary charges (title V or XIX PPS covered services only) Titles V or XIX (sum of lines 21 and 27)		0	0	28. 00 29. 00
29.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		l o	0	29.00
30. 00	Excess of reasonable cost (from line 18)		0	0	30.00
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		o	0	31.00
	Deductibles		ő	0	32.00
33. 00	Coinsurance		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 and	33)	0	0	36.00
37.00	· · · · · · · · · · · · · · · · · · ·		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38. 00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00			2, 689	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		-2, 689	0	
43.00	, , , , , , , , , , , , , , , , , , , ,	ce with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2				l

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: 14-1342 Period: From 01/14

| Peri od: | From 01/14/2023 | To 09/30/2023 | Date/Time Prepared: | 2/27/2024 3: 24 pm

oni y)					2/27/2024 3: 2	4 pm
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3. 00	4.00	
4 00	CURRENT ASSETS	T = 450 047			1	
1. 00 2. 00	Cash on hand in banks Temporary investments	5, 150, 047	0	0	0	1. 00 2. 00
3. 00	Notes receivable		Ö	0	0	3.00
4. 00	Accounts receivable	34, 606, 243	Ö	0	0	4.00
5.00	Other recei vabl e	0	0	0	0	
6. 00	Allowances for uncollectible notes and accounts receivable		1	0	0	
7. 00 8. 00	Inventory Prepai d expenses	513, 154	1	0	0	7. 00 8. 00
9. 00	Other current assets	1, 137, 612 -30, 914	1	0	0	9.00
10.00	Due from other funds	00,711	Ö	0	ő	10.00
11.00	Total current assets (sum of lines 1-10)	14, 891, 898	0	0	0	11.00
40.00	FI XED ASSETS	1			1	10.00
12. 00 13. 00	Land Land improvements	0	0	0	_	
14. 00	Accumulated depreciation	0		0		14.00
15. 00	Bui I di ngs	0	Ö	0	ő	15. 00
16.00	Accumulated depreciation	0	0	0	0	16. 00
17. 00	Leasehold improvements	3, 670, 918	1	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19. 00 20. 00	Fixed equipment Accumulated depreciation	0	0	0	0	19.00
21. 00	Automobiles and trucks			0	0	21.00
22. 00	Accumul ated depreciation	0	O	0	0	22. 00
23. 00	Major movable equipment	4, 239, 807	1	0	0	23. 00
24. 00	Accumulated depreciation	-499, 017		0	0	24.00
25. 00 26. 00	Minor equipment depreciable Accumulated depreciation	33, 119	0	0	0	25. 00 26. 00
27. 00	HIT designated Assets			0	0	27.00
28. 00	Accumulated depreciation	0	Ö	0	ő	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	0	0	0	
30. 00	Total fixed assets (sum of lines 12-29)	7, 444, 827	0	0	0	30.00
31. 00	OTHER ASSETS Investments	1	ol	0	0	31.00
32. 00	Deposits on Leases		Ö	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	663, 114	1	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	663, 114	1	0		35.00
36. 00	Total assets (sum of lines 11, 30, and 35)  CURRENT LIABILITIES	22, 999, 839	0	0	0	36.00
37. 00	Accounts payable	5, 784, 199	0	0	0	37.00
38. 00	Salaries, wages, and fees payable	-1, 048, 200	0	0		38. 00
39. 00	Payroll taxes payable	0	0	0	0	39.00
40. 00 41. 00	Notes and Loans payable (short term) Deferred income	0	0	0	0	40.00
42.00	Accel erated payments		٥	Ü	0	42.00
43. 00	Due to other funds	0	О	0	0	
44.00	Other current liabilities	296, 932	0	0	0	44.00
45. 00	Total current liabilities (sum of lines 37 thru 44)	5, 032, 931	0	0	0	45. 00
44 00	LONG TERM LIABILITIES	1 0	ol	0	0	44 00
46. 00 47. 00	Mortgage payable Notes payable		0	0		
48. 00	Unsecured Loans	0	Ö	0	l	48. 00
49.00	Other long term liabilities	10, 258, 804	0	0	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	10, 258, 804	1	0		50.00
51. 00	Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS	15, 291, 735	0	0	0	51.00
52. 00	General fund balance	7, 708, 104				52.00
53.00	Specific purpose fund		0			53.00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55. 00 56. 00
56. 00 57. 00	Governing body created - endowment fund balance Plant fund balance - invested in plant			Ü	0	
58. 00	Plant fund balance - reserve for plant improvement,					58.00
. ==	repl acement, and expansi on					
59. 00	Total fund balances (sum of lines 52 thru 58)	7, 708, 104		0	0	
60. 00	Total liabilities and fund balances (sum of lines 51 and 59)	22, 999, 839	0	0	0	60.00
	∨ ′ /	I	ı		I	I

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Peri od: Worksheet G-1 From 01/14/2023 Provider CCN: 14-1342

					To 09/30/2023	Date/Time Pre 2/27/2024 3:2	pared: 4 pm
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
	I=	1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) NI DOUBLE COUNTED	415, 287	7, 708, 104 -415, 287 7, 292, 817		0	0	1. 00 2. 00 3. 00 4. 00
5. 00 6. 00 7. 00 8. 00 9. 00		0 0 0			0 0 0 0	0 0 0	5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	415, 287 7, 708, 104		0 0	0	10. 00 11. 00
14. 00 15. 00 16. 00 17. 00		0 0			0 0 0	0 0	14. 00 15. 00 16. 00
17. 00 18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0	0 7, 708, 104		0 0		17. 00 18. 00 19. 00
		Endowment Fund	PI ant	Fund	_		
		6. 00	7. 00	8. 00			
1. 00 2. 00 3. 00 4. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) NI DOUBLE COUNTED	0	0	0.00	0		1. 00 2. 00 3. 00 4. 00
5. 00 6. 00 7. 00 8. 00 9. 00			0 0 0 0				5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	0 0 0 0		0		10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00
17. 00 18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0	O		0		17. 00 18. 00 19. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet G-2 | From 01/14/2023 | Parts | & | | | To 09/30/2023 | Date/Time Prepared: Health Financial Systems UNIO STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 14-1342

			T	09/30/2023	Date/Time Pre 2/27/2024 3: 2	pared: 4 pm
	Cost Center Description		I npati ent	Outpati ent	Total	, p
			1.00	2.00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal		2, 354, 844		2, 354, 844	1.00
2.00	SUBPROVI DER - I PF					2.00
3.00	SUBPROVI DER - I RF					3.00
4.00	SUBPROVI DER					4. 00
5. 00	Swing bed - SNF		1, 449, 315		1, 449, 315	5. 00
6. 00	Swing bed - NF		1, 259, 249		1, 259, 249	6. 00
7.00	SKILLED NURSING FACILITY					7.00
8.00	NURSING FACILITY		24/ 242		04/ 040	8. 00
9.00	OTHER LONG TERM CARE		316, 840		316, 840	9.00
10. 00	Total general inpatient care services (sum of lines 1-9) Intensive Care Type Inpatient Hospital Services		5, 380, 248		5, 380, 248	10. 00
11. 00	INTENSIVE CARE UNIT	I				11. 00
12. 00	CORONARY CARE UNIT					12.00
13. 00	BURN INTENSIVE CARE UNIT					13. 00
14. 00	SURGICAL INTENSIVE CARE UNIT					14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)					15. 00
16. 00	Total intensive care type inpatient hospital services (sum of	Lines	0		0	16. 00
	11-15)		_		_	
17.00	Total inpatient routine care services (sum of lines 10 and 16)	)	5, 380, 248		5, 380, 248	17. 00
18.00	Ancillary services		8, 067, 175	44, 498, 555	52, 565, 730	18.00
19.00	Outpati ent servi ces		292, 219	11, 105, 436	11, 397, 655	19.00
20.00	RURAL HEALTH CLINIC		0	1, 013, 757	1, 013, 757	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21.00
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULANCE SERVICES					23.00
24.00	CMHC					24.00
25.00	AMBULATORY SURGI CAL CENTER (D. P. )					25.00
26.00	HOSPI CE					26.00
27. 00	PRO FEES		60, 619		662, 088	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	13, 800, 261	57, 219, 217	71, 019, 478	28. 00
	G-3, line 1)					
00.00	PART II - OPERATING EXPENSES			00 (40 474		00.00
29.00	Operating expenses (per Wkst. A, column 3, line 200)		0	20, 618, 474		29. 00
30.00	ADD (SPECIFY)		0			30.00
31. 00 32. 00			0			31. 00 32. 00
33. 00			0			33. 00
34.00			0			34.00
35. 00			0			35. 00
36. 00	Total additions (sum of lines 30-35)		O	o		36.00
37. 00	DEDUCT (SPECIFY)		0	Ğ		37. 00
38. 00	DEBOOT (SECONTY)		0			38. 00
39. 00			0			39. 00
40.00			0			40. 00
41. 00			0			41.00
42.00	Total deductions (sum of lines 37-41)			o		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42	2)(transfer		20, 618, 474		43.00
	to Wkst. G-3, line 4)					

Health Financial Systems UNION COUNTY HOSPITAL	DI STRI CT	la li o	u of Form CMS-2	DEE2 10
	ovi der CCN: 14-1342	Peri od:	Worksheet G-3	.552-10
		From 01/14/2023 To 09/30/2023	Date/Time Prep 2/27/2024 3:24	
			1. 00	
1.00 Total patient revenues (from Wkst. G-2, Part I, column 3, line 2	28)		71, 019, 478	1.00
2.00 Less contractual allowances and discounts on patients' accounts			52, 119, 702	2.00
3.00 Net patient revenues (line 1 minus line 2)			18, 899, 776	3.00
4.00 Less total operating expenses (from Wkst. G-2, Part II, line 43)	1		20, 618, 474	4.00
5.00 Net income from service to patients (line 3 minus line 4)			-1, 718, 698	5.00
OTHER I NCOME			_	
6.00 Contributions, donations, bequests, etc			0	6.00
7.00 Income from investments			950, 001	7.00
8.00 Revenues from telephone and other miscellaneous communication se	ervi ces		0	8. 00
9.00 Revenue from television and radio service			0	9. 00
10.00 Purchase discounts			0	10.00
11.00 Rebates and refunds of expenses			0	11.00
12.00 Parking lot receipts			0	12.00
13.00 Revenue from Laundry and Linen service			0	13.00
14.00 Revenue from meals sold to employees and guests			24, 180	
15.00 Revenue from rental of living quarters				15.00
16.00 Revenue from sale of medical and surgical supplies to other than	n patients		0	
17.00 Revenue from sale of drugs to other than patients			0	17.00
18.00 Revenue from sale of medical records and abstracts				18.00
19.00 Tuition (fees, sale of textbooks, uniforms, etc.)				19.00
20.00 Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21.00 Rental of vending machines			0	21.00
22.00 Rental of hospital space			0	22.00
23.00  Governmental appropriations			0	23.00
24. 00 OTHER OPERATING INCOME			328, 656	24.00
24. 50 COVI D-19 PHE Fundi ng			0	24.50
25.00 Total other income (sum of lines 6-24)			1, 303, 411	25.00
26.00 Total (line 5 plus line 25)			-415, 287	26.00
27. 00 OTHER EXPENSES (SPECIFY)			0	27.00
28.00 Total other expenses (sum of line 27 and subscripts)			0	28.00
29.00 Net income (or loss) for the period (line 26 minus line 28)			-415, 287	29.00

		NION COUNTY HOS			In Lie	eu of Form CMS-2	
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CN: 14-1342	Peri od:	Worksheet M-1	
			Component	CCN: 14-3975	From 01/14/2023 To 09/30/2023		nared:
			Component	CCN. 14-3975	10 09/30/2023	2/27/2024 3: 2	
					RHC I	Cost	
		Compensation	Other Costs	Total (col.	1 Reclassi fi cat	Recl assi fi ed	
				+ col . 2)	i ons	Trial Balance	
						(col. 3 +	
						col. 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS	_			_		
1.00	Physi ci an	0			0 0		
2. 00	Physician Assistant	0	0		0 0	1	
3. 00	Nurse Practitioner	0	0		0 0	1	
4.00	Visiting Nurse	0	0		0	0	
5.00	Other Nurse	0	0		0	0	5.00
6.00	Clinical Psychologist	0	0		0 0	_	
7.00	Clinical Social Worker	0	0		0	0	1
8.00	Laboratory Technician	0	07,00	0/4/	0	0	8.00
9.00	Other Facility Health Care Staff Costs	333, 994					1
10.00	Subtotal (sum of lines 1 through 9)	333, 994	27, 639	361, 63	33 0		1
11.00	Physician Services Under Agreement	0	10 221	10.2	٥	1	
12. 00 13. 00	Physician Supervision Under Agreement Other Costs Under Agreement	0	19, 321 0	19, 3:	0 0	19, 321	12. 00 13. 00
14. 00	Subtotal (sum of lines 11 through 13)	0	19, 321	19, 3:	0	0 19, 321	
15. 00	Medical Supplies	0	8, 796			•	
16. 00	Transportation (Health Care Staff)	0	0, 790	0, /	0 0	0, 790	1
17. 00	Depreciation-Medical Equipment	0	0		0		
18. 00	Professional Liability Insurance	0	0				
19. 00	Other Health Care Costs	0	0				
20.00	Allowable GME Costs						20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	8, 796	8, 79	96 0	8, 796	
22. 00	Total Cost of Health Care Services (sum of	333, 994				1	
22.00	lines 10, 14, and 21)	000, 771	00,700	007,71	50		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES	,			<b>'</b>		
23.00	Pharmacy	0	0		0 0	0	23. 00
24.00	Dental	0	0		0 0	0	24. 00
25.00	Optometry	0	0		0 0	0	25. 00
25. 01	Tel eheal th	0	0		0 0	0	25. 01
25. 02	Chronic Care Management	0	0		0 0	0	25. 02
26.00	All other nonreimbursable costs	0	0		0 0	0	26.00
27.00	Nonallowable GME costs					1	27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		0	0	28. 00
	through 27)			I		I	I

0

333, 994

804

-49, 457

-49, 457

-49, 457

22, 531

23, 335

413, 085

804

22, 531

23, 335

79, 091

804

-26, 926

-26, 122

363, 628

29.00

30.00

31.00

32.00

31.00

through 27) FACILITY OVERHEAD
29.00 Facility Costs

30.00 Administrative Costs

Total Facility Overhead (sum of lines 29 and

32.00 Total facility costs (sum of lines 22, 28 and 31)

Health Financial Systems	UNION COUNTY HOSPITAL DISTRICT	In Lieu o	of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 14-1342	Peri od: W From 01/14/2023	orksheet M-1
	Component CCN: 14-3975	To 09/30/2023 D	ate/Time Prepared:

			Component	JCIN. 14-3773	10 09/3	0/2023	2/27/2024 3: 2	
					RHC	I	Cost	
		Adjustments	Net Expenses					
		.,	for					
			Allocation					
			(col. 5 +					
			col. 6)					
		6. 00	7.00					
	FACILITY HEALTH CARE STAFF COSTS							
1.00	Physi ci an	83, 653	83, 653					1.00
2. 00	Physician Assistant	85, 864	85, 864					2.00
3.00	Nurse Practitioner	37, 064	37, 064					3.00
4. 00	Visiting Nurse	0.,00.	0					4.00
5. 00	Other Nurse	0	0					5.00
6. 00	Clinical Psychologist	0	0					6.00
7. 00	Clinical Social Worker	0	0					7.00
8. 00	Laboratory Techni ci an	0	0					8.00
9. 00	Other Facility Health Care Staff Costs	0	361, 633					9.00
	Subtotal (sum of lines 1 through 9)	206, 581	568, 214					10.00
10. 00 11. 00	Physician Services Under Agreement	200, 361	000, 214					11.00
		0	-					12.00
12.00	Physician Supervision Under Agreement	U	19, 321					
13.00	Other Costs Under Agreement	U	0					13.00
14.00	Subtotal (sum of lines 11 through 13)	0	19, 321					14.00
15.00	Medical Supplies	0	8, 796					15.00
16. 00	' ' '	0	0					16.00
17. 00	1 ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	0	0					17. 00
18. 00	1	0	0					18. 00
	Other Health Care Costs	0	0					19. 00
20.00	Allowable GME Costs							20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	8, 796					21.00
22. 00	Total Cost of Health Care Services (sum of	206, 581	596, 331					22. 00
	lines 10, 14, and 21)							
	COSTS OTHER THAN RHC/FQHC SERVICES	-1	.1					
23. 00	1	0	0					23.00
24.00	Dental	0	0					24. 00
25.00	Optometry	0	0					25.00
25. 01	Tel eheal th	0	0					25. 01
25. 02		0	0					25. 02
26.00	All other nonreimbursable costs	0	0					26.00
27. 00	Nonallowable GME costs							27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0					28. 00
	through 27)							
	FACILITY OVERHEAD							
29. 00	Facility Costs	0	804					29. 00
30.00	Administrative Costs	0	-26, 926					30.00
31.00	Total Facility Overhead (sum of lines 29 and	0	-26, 122					31.00
	30)							
32.00	Total facility costs (sum of lines 22, 28	206, 581	570, 209					32.00
	and 31)							

Heal th	Financial Systems U	NION COUNTY HOS	SPITAL DISTRICT	-	In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC :	SERVI CES	Provi der C		Peri od:	Worksheet M-2	!
			Component		From 01/14/2023 To 09/30/2023	Date/Time Pre	narad.
			Component	CCN: 14-39/5	To 09/30/2023	2/27/2024 3: 2	
					RHC I	Cost	p
		Number of FTE	Total Visits	Producti vi ty	Mi ni mum	Greater of	
		Personnel		Standard (1)	Visits (col.	col. 2 or	
					1 x col. 3)	col. 4	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						1
	Posi ti ons		1	1			
1. 00	Physi ci an	0. 28					1.00
2. 00	Physician Assistant	0. 65					2. 00
3.00	Nurse Practitioner	0. 25					3.00
4.00	Subtotal (sum of lines 1 through 3)	1. 18		1	3, 066	•	4.00
5.00	Visiting Nurse	0.00		1		0	
6.00	Clinical Psychologist	0.00				0	
7.00	Clinical Social Worker	0.00	l .			0	
7. 01 7. 02	Medical Nutrition Therapist (FQHC only) Diabetes Self Management Training (FQHC	0. 00 0. 00		1		0	1
7.02	only)	0.00				0	7.02
8. 00	Total FTEs and Visits (sum of lines 4	1. 18	4, 991			4, 991	8.00
0.00	through 7)	1.10	7, 771			7, 771	0.00
9. 00	Physician Services Under Agreements		0			0	9.00
	,		-				
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPI TAL-BAS	ED RHC/FQHC SEI	RVI CES			
10.00	Total costs of health care services (from Wk	st. M-1, col.	7, line 22)			596, 331	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line	28)			0	11.00
12.00	Cost of all services (excluding overhead) (s					596, 331	12.00
13.00	Ratio of hospital-based RHC/FQHC services (I					1. 000000	
14.00	Total hospital-based RHC/FQHC overhead - (fr			ine 31)		-26, 122	
15.00	Parent provider overhead allocated to facili	ty (see instru	ctions)			427, 232	
16.00	Total overhead (sum of lines 14 and 15)					401, 110	
	Allowable GME overhead (see instructions)					0	
	Enter the amount from line 16	NIO	40	40)		401, 110	
	Overhead applicable to hospital-based RHC/FC					401, 110	
∠∪. ∪∪	Total allowable cost of hospital-based RHC/F	runc services (	Sum of Lines I	o and 19)		997, 441	J 20.00

CALCULATION C	ial Systems UNION COUNTY HOSPIT F REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FOHC		Peri od:	u of Form CMS-2 Worksheet M-3	
SERVI CES		Component CCN, 14, 2075	From 01/14/2023	Doto/Time Dro	nonod.
		Component CCN: 14-3975	To 09/30/2023	Date/Time Pre 2/27/2024 3:2	
		Title XVIII	RHC I	Cost	
				1. 00	
DETERMI	NATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
	Allowable Cost of hospital-based RHC/FQHC Services (fro	om Wkst. M-2, line 20)		997, 441	1.0
2.00   Cost o	f injections/infusions and their administration (from W	/kst. M-4, line 15)		331	2.0
	allowable cost excluding injections/infusions (line 1 m	ninus line 2)		997, 110	1
	Visits (from Wkst. M-2, column 5, line 8)	11		4, 991	4.0
1 7	ans visits under agreement (from Wkst. M-2, column 5,	line 9)		4 001	5.0
	adjusted visits (line 4 plus line 5) ed cost per visit (line 3 divided by line 6)			4, 991 199. 78	6. 0 7. 0
7.00   Auj ust	su cost per visit (iffie 5 divided by iffie 0)		Cal cul ati on		7.0
				Rate Period 1	
			N/A	(01/14/2023	
				through 09/30/2023)	
			1.00	2. 00	
8.00 Per vi	sit payment limit (from CMS Pub. 100-04, chapter 9, §20	0.6 or your contractor)	0.00	260. 83	8.00
	or Program covered visits (see instructions)		0.00	199. 78	9.0
	ATION OF SETTLEMENT			500	100
	m covered visits excluding mental health services (from m cost excluding costs for mental health services (line		0	530 105, 883	1
, ,	n covered visits for mental health services (from contr	•	0	105, 665	1
	m covered cost from mental health services (line 9 x li	•	0	0	ı
, ,	adjustment for mental health services (see instructions	•	0	0	ı
15. 00   Gradua	te Medical Education Pass Through Cost (see instruction	is)			15.00
	Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	105, 883	
4	program charges (see instructions)(from contractor's re	•		100, 650	
4	orogram preventive charges (see instructions)(from prov orogram preventive costs ((line 16.02/line 16.01) times	•		0	16. 0: 16. 0:
	Program non-preventive costs ((Time 16.02/Time 16.01) times	*		80, 891	ı
	s V and XIX see instructions.)	o una re) trines : ee)		00,071	10.0
	orogram cost (see instructions)		0	80, 891	16.0
	y payer amounts			0	17.00
	Beneficiary deductible for RHC only (see instructions)	(from contractor		4, 769	18.00
record 19.00 Benefi	s) ciary coinsurance for RHC/FQHC services (see instructio	one) (from contractor		19, 176	19.00
record	· ·	ons) (IT on Contractor		17, 170	19.00
	dicare cost excluding vaccines (see instructions)			80, 891	20.00
21.00 Progra	m cost of vaccines and their administration (from Wkst.	M-4, line 16)		331	21.0
1	reimbursable Program cost (line 20 plus line 21)			81, 222	
	ole bad debts (see instructions)			0	ı
1 -	ed reimbursable bad debts (see instructions)			0	1
	ble bad debts for dual eligible beneficiaries (see inst ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ructions)		0	
	r ACO demonstration payment adjustment (see instruction	us)		0	
	tration payment adjustment amount before sequestration			-	25. 9
1	mbursable amount (see instructions)			81, 222	
	tration adjustment (see instructions)			1, 624	26. 0°
	tration payment adjustment amount after sequestration			0	
27.00   Interi				104, 640	
	ive settlement (for contractor use only)	02 27 and 20)		25.042	28.00
1	e due component/program (line 26 minus lines 26.01, 26. ted amounts (nonallowable cost report items) in accorda	•		-25, 042 0	
	r I, §115.2	WELL OND LOD. 19-11	'	U	ا 55. 0

		SPITAL DISTRICT			u of Form CMS-2	
COMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provider CO	JN: 14-1342	Period: From 01/14/2023	Worksheet M-4	
		Component (	CCN: 14-3975	To 09/30/2023	Date/Time Pre 2/27/2024 3:2	
			XVIII	RHC I	Cost	
		PNEUMOCOCCAL	INFLUENZA	COVI D-19	MONOCLONAL	
		VACCI NES	VACCI NES	VACCI NES	ANTI BODY	
		1.00	2.00	2. 01	PRODUCTS 2. 02	
1. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	568, 214			568, 214	1.00
2. 00	Ratio of injection/infusion staff time to total health	0. 000068		· ·	· ·	
2.00	care staff time	0.00000	0.0000	0.00000	0.000000	2.00
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	39		39 0	0	3.00
4. 00	'njections/infusions and related medical supplies costs (from your records)	100		20 0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	139		59 0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from	596, 331	596, 3	31 596, 331	596, 331	6.00
	Worksheet M-1, col. 7, line 22)					
7.00	Total overhead (from Wkst. M-2, line 19)	401, 110		· ·	· ·	
8. 00	Ratio of injection/infusion direct cost to total direct	0. 000233	0. 0000	99 0. 000000	0. 000000	8. 00
0.00	cost (line 5 divided by line 6)	0.0		40		0.00
9. 00 10. 00	Overhead cost - injection/infusion (line 7 x line 8) Total injection/infusion costs and their administration	93		40 0 99 0	0	
10.00	costs (sum of lines 5 and 9)	232		77	U	10.00
11. 00	Total number of injections/infusions (from your records)	1		1 0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	232. 00	99.	0. 00	0.00	12.00
13.00	Number of injection/infusion administered to Program	1		1 0	0	13.00
	benefi ci ari es					
13. 01	Number of COVID-19 vaccine injections/infusions			0	0	13. 01
44.00	administered to MA enrollees	000		00		44.00
14. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13	232	'	99 0	U	14.00
	and 13.01, as applicable)					
	and 10. 01, as approach e)				COST OF	
					INJECTIONS /	
					INFUSIONS AND	
					ADMI NI STRATI O	
				1.00	N	
15 00	Total cost of injections/infusions and their administration	n costs (sum of	f columns 1	1.00	2. 00	15.00
13.00	2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		COLUMNIS I,		331	13.00
16. 00	Total Program cost of injections/infusions and their admin		s (sum of		331	16.00
	columns 1, 2, 2.01, and 2.02, line 14) (transfer this amou				l	

Health Financial Systems	UNION COUNTY HOSPIT	AL DISTRICT	In Lieu	ı of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIAR			From 01/14/2023	Date/Time Prepared:
				2/27/2024 3:24 pm

				2/27/2024 3: 24	4 pm
			RHC I	Cost	
				t B	
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			104, 640	1. (
2. 00	Interim payments payable on individual bills, either submit			0	2. (
	the contractor for services rendered in the cost reporting	period. If none, write			
	"NONE" or enter a zero				
3. 00	List separately each retroactive lump sum adjustment amount				3.
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
. 01				0	3.
3. 02				0	3.
. 03				0	3.
3. 04				0	3.
. 05				0	3.
	Provider to Program				
. 50				0	3.
. 51				0	3.
. 52				l ol	3.
. 53				l ol	3.
. 54				l ol	3.
. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		l ol	3.
1. 00	Total interim payments (sum of lines 1, 2, and 3.99) (trans			104, 640	4.
	27)				
	TO BE COMPLETED BY CONTRACTOR		*		
5. 00	List separately each tentative settlement payment after des	k review. Also show date of			5.
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
. 01				0	5.
. 02				0	5.
				0	5.
	Provider to Program			0	5.
. 03	Provider to Program			0	
. 03	Provider to Program			_	5.
. 03 . 50 . 51	Provider to Program			0	5. 5.
. 03 . 50 . 51 . 52	Provider to Program  Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	98)		0 0	5. 5. 5.
. 03 . 50 . 51 . 52 . 99				0 0	5. 5. 5.
. 03 . 50 . 51 . 52 . 99 . 00	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.			0 0	5. 5. 5. 5. 6.
. 03 . 50 . 51 . 52 . 99 . 00	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5. Determined net settlement amount (balance due) based on the			0 0 0	5. 5. 5. 6.
5. 03 5. 50 5. 51 5. 52 5. 99 5. 00 6. 01	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5. Determined net settlement amount (balance due) based on the SETTLEMENT TO PROGRAM			0 0 0 0	5. 5. 5. 6. 6.
5. 03 5. 50 5. 51 5. 52 5. 99 5. 00 6. 01	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5. Determined net settlement amount (balance due) based on the SETTLEMENT TO PROVIDER		Contractor	0 0 0 0 0 0 25,042	5. 5. 5. 6. 6.
5. 03 5. 50 5. 51 5. 52 5. 99 5. 00 5. 01 5. 02	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5. Determined net settlement amount (balance due) based on the SETTLEMENT TO PROGRAM		Contractor Number	0 0 0 0 0 0 25, 042 79, 598	5. 5. 5. 6. 6.
5. 03 5. 50 5. 51 5. 52 5. 99 6. 00 6. 01 6. 02 7. 00	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5. Determined net settlement amount (balance due) based on the SETTLEMENT TO PROGRAM			0 0 0 0 0 0 25,042 79,598 NPR Date	5. 5. 5. 6. 6. 7.