HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 150177	PERIOD: FROM 01/01/2015 TO 12/31/2015	WORKSHEET S PARTS I, II & III

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED OMB NO. 0938-0050 EXPIRES 05-31-2019

PART I - COST REPORT STATUS

Provider use only	1. [X] Electronically filed cost report	Date:	Time:
	2. [ ] Manually submitted cost report		
	3. [ ] If this is an amended report enter the number of times the provider resubmitted this cost report		
	4 [F] Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. [1] Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: 06/01/2016	10. NPR Date:
		7. Contractor No.: 08001	11. Contractor's Vendor Code: 4
		8. [N] Initial Report for this Provider CCN	12. [ ] If line 5, column 1 is 4: Enter number of times reopened = 0-9.
		9. [N] Final Report for this Provider CCN	

PART II - CERTIFICATION

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 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by _________________________{Provider Name(s) and Number(s)}for the cost reporting period beginning ______________ and ending ______________ 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.

(Signed)	
	Name NOT AVAILIABLE ON ELECTRONIC FORM
	Officer or Administrator of Provider(s)
	Title NOT AVAILIABLE ON ELECTRONIC FORM
	Date

PART III - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII		HIT	TITLE XIX	
			PART A	PART B			
		1	2	3	4	5	
1	HOSPITAL		19,016		-103,390		1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SNF						7
8	NF, ICF/IID						8
9	HOME HEALTH AGENCY						9
10	HOSPITAL-BASED - RHC						10
11	HOSPITAL-BASED -FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER (Specify)						12
200	TOTAL		19,016		-103,390		200

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this 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.

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
Cost report status - As Submitted
[Record code 577478 - 2010]

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 150177	PERIOD: FROM 01/01/2015 TO 12/31/2015	WORKSHEET S-10	

Line	Description			Value	Line
	Uncompensated and indigent care cost computation				
1	Cost to charge ratio (Worksheet C, Part I, line 202 column 3, divided by line 202, column 8)			0.275241	1
	Medicaid (see instructions for each line)				
2	Net revenue from Medicaid			1,344,299	2
3	Did you receive DSH or supplemental payments from Medicaid?			N	3
4	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?			N	4
5	If line 4 is no, enter DSH or supplemental payments from Medicaid?				5
6	Medicaid charges			1,931,018	6
7	Medicaid cost (line 1 times line 6)			531,495	7
8	Difference between net revenue and costs for Medicaid program (line 7 minus lines 2 and 5). If line 7 is less than the sum of lines 2 and 5, then enter zero.				8
	Children's Health Insurance Program (CHIP) (see instructions for each line)				
9	Net revenue from stand-alone CHIP				9
10	Stand-alone CHIP charges				10
11	Stand-alone CHIP cost (line 1 times line 10)				11
12	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9). If line 11 is less than line 9, then enter zero.				12
	Other state or local government indigent care program (see instructions for each line)				
13	Net revenue from state or local indigent care program (not included on lines 2, 5 or 9)				13
14	Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)				14
15	State or local indigent care program cost (line 1 times line 14)				15
16	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13). If line 15 is less than line 13, then enter zero.				16
	Uncompensated care (see instructions for each line)				
17	Private grants, donations, or endowment income restricted to funding charity care				17
18	Government grants, appropriations or transfers for support of hospital operations				18
19	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)				19
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1	2	3	
20	Charity care charges for the entire facility (see instructions)	20,623	85,010	105,633	20
21	Cost of patients approved for charity care (line 1 times line 20)	5,676	23,398	29,074	21
22	Partial payment by patients approved for charity care				22
23	Cost of charity care (line 21 minus line 22)	5,676	23,398	29,074	23
24	Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24
25	If line 24 is yes, enter charges for patient days beyond an indigent care program's length of stay limit (see instructions)				25
26	Total bad debt expense for the entire hospital complex (see instructions)			730,467	26
27	Medicare bad debts for the entire hospital complex (see instructions)			19,404	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)			711,063	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			195,714	29
30	Cost of uncompensated care (line 23 column 3 plus line 29)			224,788	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			224,788	31

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
Cost report status - As Submitted
[Record code 577478 - 2010]

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 150177	PERIOD: FROM 01/01/2015 TO 12/31/2015		WORKSHEET S-2 PART I		
Hospital and Hospital Health Care Complex Address:									
1	Street: 4455 EDISON LAKES PKWY			P.O. Box:					1
2	City: MISHAWAKA	State: IN	Zip Code: 46545	County: ST. JOSEPH					2

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	UNITY MEDICAL AND SURGICAL HOSPITAL	150177	43780	1	10/31/2009	N	P	P	3
4	Subprovider- IPF									4
5	Subprovider- IRF									5
6	Subprovider- (Other)									6
7	Swing Beds-SNF									7
8	Swing Beds-NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic-RHC									15
16	Hospital-Based Health Clinic-FQHC									16
17	Hospital-Based (CMHC, CORF and OPT)									17
18	Renal Dialysis									18
19	Other									19
20	Cost Reporting Period (mm/dd/yyyy)	From: 01/01/2015	To: 12/31/2015							20
21	Type of control (see instructions)	6								21

Inpatient PPS Information					
			1	2	
22	Does this facility qualify and is it currently receiving payments for 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 §412.106 (c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.		N	N	22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to 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.	N	N	N	22.03
23	Which method is used to determine Medicaid days on lines 24 and/or 25 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.	3	N		23

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	26						24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of state Medicaid eligible unpaid days in column 4 Medicaid HMO paid and eligible but unpaid days in column 5.							25

Line	Description					Line
26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1				26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable enter the effective date of the geographic reclassification in column 2.	1				27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:		Ending:		36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					37
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)					37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:		Ending:		38

Line	Description	1	2	Line
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40

Line		V	XVIII	XIX	Line
	Prospective Payment System (PPS)-Capital	1	2	3	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320? (see instructions)	N	N	N	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47
48	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48

Line	Teaching Hospitals	1	2	3	Line
56	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56
57	If line 56 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 "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Part III & IV and D-2, Part II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60

Line		Y/N			IME	Direct GME	Line
		1	2	3	4	5	
61	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N					61

Line		Y/N	IME	Direct GME	Line
		1	2	3	
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

Line		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	Line
		1	2	3	4	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.					61.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150177	PERIOD: FROM 01/01/2015 TO 12/31/2015	WORKSHEET S-2 PART I

Line	Description						Line
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 directGME FTE unweighted count.						61.20
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)						62
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)						62.01
	Teaching Hospitals that Claim Residents in Non-Provider Settings						
63	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete lines 64-67. (see instructions)			N			63
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						64
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1	2	3	4	5	
65	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. 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)						65
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010			1	2	3	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						66
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1	2	3	4	5	
67	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)						67
	Inpatient Psychiatric Facility PPS			1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N			70
71	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N	N		71
	Inpatient Rehabilitation Facility PPS						
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes or "N" for no.			N			75
76	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N	N		76
	Long Term Care Hospital PPS						
80	Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.				N		80
81	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.				N		81
	TEFRA Providers						
85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter "Y" for yes or "N" for no.						86
87	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no				N		87
					V	XIX	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150177	PERIOD: FROM 01/01/2015 TO 12/31/2015	WORKSHEET S-2 PART I

Line	Description			1	2	Line
	Title V and XIX Inpatient Services			1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in applicable column.			N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92
93	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93
94	Does title V or title XIX reduce capital cost? Enter "Y" for yes or "N" for no in the applicable column.			N	N	94
95	If line 94 is "Y", enter the reduction percentage in the applicable column.					95
96	Does title V or title XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	N	96
97	If line 96 is "Y", enter the reduction percentage in the applicable column.					97
	Rural Providers			1	2	
105	Does this hospital qualify as a critical access hospital (CAH)?			N		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106
107	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is notmade on Worksheet B, Part I, column 25 and the program is cost reimbursed. If yes complete Worksheet D-2, Part II.					107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter "Y" for yes or "N" for no.			N		108
		Physical	Occupational	Speech	Respiratory	
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.				N	110
	Miscellaneous Cost Reporting Information					
115	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub 15-1, chapter 22, §2208.1.		N			115
116	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.			N		116
117	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.			Y		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			1		118
118.01	List amounts of malpractice premiums and paid losses		Premiums	Paid Losses	Self Insurance	118.01
			52,935			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.			N		118.02
119	What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.					119
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with <=100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.			N	N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.			Y		121
122	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.					122
	Transplant Center Information					
125	Does this facility operate a transplant center? Enter "Y" for yes or "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.			N		125
126	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126
127	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127
128	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128
129	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129
130	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130
131	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131
132	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132
133	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134
	All Providers					
				1	2	
140	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)			N		140

If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.

Line							Line
141	Name:		Contractor's Name:		Contractor's Number:		141
142	Street:		P.O. Box:				142
143	City:	State	Zip Code:				143

Line	Description	1	2	Line
144	Are provider based physicians' costs included in Worksheet A?	N		144
145	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N		145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40 §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146
147	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147
148	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		148
149	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149

Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)

Line	Component	Part A	Part B	Title V	Title XIX	Line
		1	2	3	4	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N	N	N	156
157	Subprovider - IRF	N	N	N	N	157
158	Subprovider - Other					158
159	SNF	N	N	N	N	159
160	HHA	N	N	N	N	160
161	CMHC		N	N	N	161
161.10			N	N	N	161.10

Multicampus

Line	Description	0	Line
165	Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165

166 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip in column 3, CBSA in column 4, FTE/Campus in column 5. 166

Name	County	State	Zip Code	CBSA	FTE/ Campus
0	1	2	3	4	5

Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act

Line	Description	1	2	Line
167	Is this provider a meaningful user under §1886 (n)? Enter "Y" for yes or "N" for no.	Y		167
168	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets. (see instructions)			168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			168.01
169	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.50		169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2014	09/30/2015	170
171	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N		171

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
Cost report status - As Submitted
[Record code 577478 - 2010]

08-11	FORM CMS-2552-10			4090 (Cont.)
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 150177	PERIOD: FROM 01/01/2015 TO 12/31/2015	WORKSHEET S-2 Part II	

General Instruction:	Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.

COMPLETED BY ALL HOSPITALS							
			Y/N	Date			
Provider Organization and Operation			1	2			
1	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N				1
			Y/N	Date	V/I		
			1	2	3		
2	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.		N				2
3	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)		Y				3
			Y/N	Type	Date		
Financial Data and Reports			1	2	3		
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.		Y	A	06/30/2016		4
5	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.		N				5
				Y/N	Y/N		
Approved Educational Activities				1	2		
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N			6
7	Are costs claimed for allied health programs? If yes, see instructions.			N			7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8
9	Are costs claimed for Interns and Residents in approved GME programs in the current cost report? If yes, see instructions.			N			9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10
11	Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11
Bad Debts					Y/N		
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.				Y		12
13	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.				N		13
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.				N		14
Bed Complement							
15	Did total beds available change from the prior cost reporting period? If yes, see instructions.				N		15
		Part A		Part B			
		Y/N	Date	Y/N	Date		
PS&R Report Data		1	2	3	4		
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	04/12/2016	Y	04/12/2016		16
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either coumn 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N			18
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19
20	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N			20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N			21
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)							
Capital Related Cost							
22	Have assets been relifed for Medicare purposes? If yes, see instructions.						22
23	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.						23
24	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.						24
25	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.						25
26	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.						26
27	Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.						27
Interest Expense							

Line	Description		Y/N	Date	Line
28	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28
29	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions.			N	29
30	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30
31	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31
	Purchased Services				
32	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32
33	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33
	Provider-Based Physicians				
34	Are services furnished at the provider facility under an arrangement with provider-based physicians? If "Y" see instructions.			N	34
35	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35
			Y/N	Date	
	Home Office Costs		1	2	
36	Are home office costs claimed on the cost report?		N		36
37	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N		37
38	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38
39	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39
40	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40

Cost Report Preparer Contact Information

Line	Field	Value	Field	Value	Field	Value	Line
41	First Name:	*	Last Name:	*	Title:	*	41
42	Employer:	*					42
43	Phone number:	*	Email Address:	*			43

* Cost Report Preparer Contact Information has been redacted by CMS

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA	Provider CCN: 150177	PERIOD: FROM 01/01/2015 TO 12/31/2015	WORKSHEET S-3 PART I

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH Hours	Inpatient Days / Outpatient Visits / Trips				Full Time Equivalents			Discharges				
						Title V	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col.2 for the portion of LDP room available beds)	30.00	29	10,585			239	26	1,099					82	9	325	1
2	HMO and other (see instructions)						147										2
3	HMO IPF Subprovider																3
4	HMO IRF Subprovider																4
5	Hospital Adults & Peds. Swing Bed SNF																5
6	Hospital Adults & Peds.Swing Bed NF																6
7	Total Adults and Peds. (exclude observation beds) (see instructions)		29	10,585			239	26	1,099								7
8	Intensive Care Unit																8
9	Coronary Care Unit																9
10	Burn Intensive Care Unit																10
11	Surgical Intensive Care Unit																11
12	Other Special Care																12
13	Nursery	43.00															13
14	Total (see instructions)		29	10,585			239	26	1,099		121.58			82	9	325	14
15	CAH visits																15
16	Subprovider - IPF	40.00															16
17	Subprovider - IRF	41.00															17
18	Subprovider - Other	42.00															18
19	Skilled Nursing Facility	44.00															19
20	Nursing Facility	45.00															20
21	Other Long Term Care	46.00															21
22	Home Health Agency	101.00															22
23	ASC (Distinct Part)	115.00															23
24	Hospice (Distinct Part)	116.00															24
24.10	Hospice (non-distinct part)																24.10
25	CMHC	99.00															25
26	RHC/FQHC (specify)	88.00															26
27	Total (sum of lines 14-26)		29								121.58						27
28	Observation Bed Days																28
29	Ambulance Trips																29
30	Employee discount days (see instructions)																30
31	Employee discount days -IRF																31

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA																	Provider CCN: 150177	PERIOD: FROM 01/01/2015 TO 12/31/2015	WORKSHEET S-3 PART I
Component		Worksheet A Line No.	No. of Beds	Bed Days Available	CAH Hours	Inpatient Days / Outpatient Visits / Trips				Full Time Equivalents			Discharges						
						Title V	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients			
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15			
32	Labor & delivery (see instructions)																32		
32.01	Total ancillary labor & delivery room outpatient days (see instructions)																32.01		
33	LTCH non-covered days																33		

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
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[Record code 577478 - 2010]

HOSPITAL WAGE INDEX INFORMATION		Provider CCN: 150177		PERIOD: FROM 01/01/2015 TO 12/31/2015		WORKSHEET S-3 PART II and III	

Part II - Wage Data

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in column 4	Average Hourly Wage (column 4 ÷ column 5)	
		1	2	3	4	5	6	
SALARIES								
1	Total salaries (see instructions)	200	8,732,837		8,732,837	252,896	34.53	1
2	Non-physician anesthetist Part A							2
3	Non-physician anesthetist Part B							3
4	Physician-Part A - Administrative							4
4.01	Physician-Part A - Teaching							4.01
5	Physician and Non Physician -Part B							5
6	Non-physician-Part B for hospital-based RHC and FQHC services							6
7	Interns & residents (in an approved program)	21						7
7.01	Contracted Interns & residents (in an approved program)							7.01
8	Home office and/or related organization personnel							8
9	SNF	44						9
10	Excluded area salaries (see instructions)		3,226,060		3,226,060	70,909	45.50	10
OTHER WAGES AND RELATED COSTS								
11	Contract labor: Direct Patient Care		404,704		404,704	4,337	93.31	11
12	Contract labor: Top level management and other management and administrative services		283,540		283,540	2,422	117.07	12
13	Contract labor: Physician-Part A							13
14	Home office and/or related orgainzation salaries and wage-related costs							14
14.01	Home office salaries							14.01
14.02	Related organization salaries							14.02
15	Home office: physician Part A							15
16	Home office & Contract Physicians Part A - Teaching							16
WAGE-RELATED COSTS								
17	Wage-related costs (core) (see instructions)		1,037,465		1,037,465			17
18	Wage-related costs (other) (see instructions)							18
19	Excluded areas		589,986		589,986			19
20	Non-physician anesthetist Part A							20
21	Non-physician anesthetist Part B							21
22	Physician Part A - Administrative							22
22.01	Physician Part A - Teaching							22.01
23	Physician Part B							23
24	Wage-related costs (RHC/FQHC)							24
25	Interns & residents (in an approved program)							25
25.50	Home office wage-related							25.50
25.51	Related orgainzation wage-related							25.51
25.52	Home office: Physician Part A - Administrative - wage-related							25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related							25.53
OVERHEAD COSTS - DIRECT SALARIES								
26	Employee Benefits Department	4	191,467		191,467	3,670	52.17	26
27	Administrative & General	5	1,541,952		1,541,952	31,844	48.42	27
28	Administrative & General under contract (see instructions)							28
29	Maintenance & Repairs	6						29
30	Operation of Plant	7	169,535		169,535	14,308	11.85	30
31	Laundry & Linen Service	8						31
32	Housekeeping	9						32
33	Housekeeping under contract (see instructions)							33
34	Dietary	10	171,753		171,753	11,264	15.25	34
35	Dietary under contract (see instructions)							35
36	Cafeteria	11						36

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 150177		PERIOD: FROM 01/01/2015 TO 12/31/2015		WORKSHEET S-3 PART II and III	
Part II - Wage Data								
		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in column 4	Average Hourly Wage (column 4 ÷ column 5)	
		1	2	3	4	5	6	
37	Maintenance of Personnel	12						37
38	Nursing Administration	13	577,339		577,339	12,799	45.11	38
39	Central Services and Supply	14						39
40	Pharmacy	15	359,478		359,478	11,893	30.23	40
41	Medical Records & Medical Records Library	16	125,401		125,401	6,166	20.34	41
42	Social Service	17						42
43	Other General Service	18						43
Part III - Hospital Wage Index Summary								
1	Net salaries (see instructions)		8,732,837		8,732,837	252,896	34.53	1
2	Excluded area salaries (see instructions)		3,226,060		3,226,060	70,909	45.50	2
3	Subtotal salaries (line 1 minus line 2)		5,506,777		5,506,777	181,987	30.26	3
4	Subtotal other wages and related costs (see instructions)		688,244		688,244	6,759	101.83	4
5	Subtotal wage-related costs (see instructions)		1,037,465		1,037,465			5
6	Total (sum of lines 3 through 5)		7,232,486		7,232,486	188,746	38.32	6
7	Total overhead cost (see instructions)		3,136,925		3,136,925	91,944	34.12	7

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
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HOSPITAL WAGE RELATED COSTS		Provider CCN: 150177	PERIOD: FROM 01/01/2015 TO 12/31/2015	WORKSHEET S-3, PART IV
Part IV - Wage Related Cost				
Part A - Core List				
		Amount Reported		
RETIREMENT COST				
1	401k Employer Contributions	193,302	1	
2	Tax Sheltered Annuity (TSA) Employer Contribution		2	
3	Nonqualified Defined Benefit Plan Cost (see instructions)		3	
4	Qualified Defined Benefit Plan Cost (see instructions)		4	
PLAN ADMINISTRATIVE COSTS (Paid to External Organization):				
5	401k/TSA Plan Administration fees		5	
6	Legal/Accounting/Management Fees-Pension Plan		6	
7	Employee Managed Care Program Administration Fees		7	
HEALTH AND INSURANCE COST				
8	Health Insurance (Purchased or Self Funded)	807,402	8	
8.01	Health Insurance (Self Funded without a Third Party Administrator)		8.01	
8.02	Health Insurance (Self Funded with a Third Party Administrator)		8.02	
8.03	Health Insurance (Purchased)		8.03	
9	Prescription Drug Plan		9	
10	Dental, Hearing and Vision Plan		10	
11	Life Insurance (If employee is owner or beneficiary)		11	
12	Accident Insurance (If employee is owner or beneficiary)		12	
13	Disability Insurance (If employee is owner or beneficiary)		13	
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14	
15	Workers' Compensation Insurance	36,761	15	
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16	
TAXES				
17	FICA-Employers Portion Only	589,986	17	
18	Medicare Taxes - Employers Portion Only		18	
19	Unemployment Insurance		19	
20	State or Federal Unemployment Taxes		20	
OTHER				
21	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21	
22	Day Care Cost and Allowances		22	
23	Tuition Reimbursement		23	
24	Total Wage Related cost (Sum of lines 1 through 23)	1,627,451	24	
Part B - Other than Core Related Cost				
25	Other Wage Related Costs (specify)__		25	

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
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HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 150177	PERIOD: FROM 01/01/2015 TO 12/31/2015	WORKSHEET S-3, PART V

Part V - Contract Labor and Benefit Cost
Hospital and Hospital-Based Component Identification:

	Component	Contract Labor	Benefit Cost	
	0	1	2	
1	Total facility contract labor and benefit cost	404,704	1,627,451	1
2	Hospital	404,704	1,037,465	2
3	Subprovider- IPF			3
4	Subprovider- IRF			4
5	Subprovider- (Other)			5
6	Swing Beds-SNF			6
7	Swing Beds-NF			7
8	Hospital-Based SNF			8
9	Hospital-Based NF			9
10	Hospital-Based OLTC			10
11	Hospital-Based HHA			11
12	Separately Certified ASC			12
13	Hospital-Based Hospice			13
14	Hospital-Based Health Clinic RHC			14
15	Hospital-Based Health Clinic FQHC			15
16	Hospital-Based-CMHC			16
17	Renal Dialysis			17
18	Other		589,986	18

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES					Provider CCN: 150177		PERIOD: FROM 01/01/2015 TO 12/31/2015		WORKSHEET A	
COST CENTER DESCRIPTIONS (omit cents)			SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Capital Related Costs-Buildings and Fixtures		3,336,950	3,336,950	1,001,155	4,338,105		4,338,105	1
2	00200	Capital Related Costs-Movable Equipment		252,000	252,000	2,034,585	2,286,585		2,286,585	2
3	00300	Other Capital Related Costs							-0-	3
4	00400	Employee Benefits Department	191,467	716,281	907,748	36,761	944,509		944,509	4
5	00500	Administrative and General	1,541,952	12,127,681	13,669,633	698,961	14,368,594	-4,982,679	9,385,915	5
6	00600	Maintenance and Repairs								6
7	00700	Operation of Plant	169,535	580,036	749,571		749,571		749,571	7
8	00800	Laundry and Linen Service		88,088	88,088		88,088		88,088	8
9	00900	Housekeeping		41	41		41		41	9
10	01000	Dietary	171,753	83,040	254,793		254,793	-19,518	235,275	10
11	01100	Cafeteria								11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	577,339	216,323	793,662		793,662		793,662	13
14	01400	Central Services and Supply								14
15	01500	Pharmacy	359,478	347,616	707,094		707,094		707,094	15
16	01600	Medical Records & Medical Records Library	125,401	107,805	233,206		233,206	-6,138	227,068	16
17	01700	Social Service								17
18		Other General Service (specify)								18
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	Intern & Res. Service-Salary & Fringes (Approved)								21
22	02200	Intern & Res. Other Program Costs (Approved)								22
23	02300	Paramedical Ed. Program (specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults and Pediatrics (General Routine Care)	1,388,307	190,377	1,578,684		1,578,684		1,578,684	30
31	03100	Intensive Care Unit								31
32	03200	Coronary Care Unit								32
33	03300	Burn Intensive Care Unit								33
34	03400	Surgical Intensive Care Unit								34
35		Other Special Care (specify)								35
40	04000	Subprovider - IPF								40
41	04100	Subprovider - IRF								41
42	04200	Subprovider (specify)								42
43	04300	Nursery								43
44	04400	Skilled Nursing Facility								44
45	04500	Nursing Facility								45

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES					Provider CCN: 150177		PERIOD: FROM 01/01/2015 TO 12/31/2015		WORKSHEET A	
COST CENTER DESCRIPTIONS (omit cents)			SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
46	04600	Other Long Term Care								46
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	642,011	715,080	1,357,091		1,357,091		1,357,091	50
51	05100	Recovery Room								51
52	05200	Labor Room and Delivery Room								52
53	05300	Anesthesiology		322,433	322,433		322,433		322,433	53
54	05400	Radiology-Diagnostic	339,534	446,963	786,497		786,497		786,497	54
55	05500	Radiology-Therapeutic								55
56	05600	Radioisotope								56
57	05700	Computed Tomography (CT) Scan								57
58	05800	Magnetic Resonance Imaging (MRI)								58
59	05900	Cardiac Catheterization								59
60	06000	Laboratory		292,340	292,340		292,340		292,340	60
61	06100	PBP Clinical Laboratory Services-Program Only								61
62	06200	Whole Blood & Packed Red Blood Cells								62
63	06300	Blood Storing, Processing, & Trans.								63
64	06400	Intravenous Therapy								64
65	06500	Respiratory Therapy								65
66	06600	Physical Therapy		107,793	107,793		107,793		107,793	66
67	06700	Occupational Therapy		64,515	64,515		64,515		64,515	67
68	06800	Speech Pathology								68
69	06900	Electrocardiology								69
70	07000	Electroencephalography		8,491	8,491		8,491		8,491	70
71	07100	Medical Supplies Charged to Patients		1,074,130	1,074,130		1,074,130		1,074,130	71
72	07200	Implantable Devices Charged to Patients		10,608,410	10,608,410		10,608,410		10,608,410	72
73	07300	Drugs Charged to Patients		283,373	283,373		283,373		283,373	73
74	07400	Renal Dialysis								74
75	07500	ASC (Non-Distinct Part)								75
76		Other Ancillary (specify)								76
		OUTPATIENT SERVICE COST CENTERS								
88	08800	Rural Health Clinic (RHC)								88
89	08900	Federally Qualified Health Center (FQHC)								89
90	09000	Clinic								90
91	09100	Emergency								91
92	09200	Observation Beds (Non-Distinct Part)								92
92.01	09201	Observation Beds (Distinct Part)								92.01
93		Other Outpatient Service (specify)								93
		OTHER REIMBURSABLE COST CENTERS								
94	09400	Home Program Dialysis								94
95	09500	Ambulance Services								95

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES					Provider CCN: 150177		PERIOD: FROM 01/01/2015 TO 12/31/2015		WORKSHEET A	
COST CENTER DESCRIPTIONS (omit cents)			SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
96	09600	Durable Medical Equipment-Rented								96
97	09700	Durable Medical Equipment-Sold								97
98		Other Reimbursable (specify)								98
99		Outpatient Rehabilitation Provider (specify)								99
100	10000	Intern-Resident Service (not appvd. tchng. prgm.)								100
101	10100	Home Health Agency								101
		SPECIAL PURPOSE COST CENTERS								
105	10500	Kidney Acquisition								105
106	10600	Heart Acquisition								106
107	10700	Liver Acquisition								107
108	10800	Lung Acquisition								108
109	10900	Pancreas Acquisition								109
110	11000	Intestinal Acquisition								110
111	11100	Islet Acquisition								111
112		Other Organ Acquisition (specify)								112
113	11300	Interest Expense		3,771,462	3,771,462	-3,771,462			- 0 -	113
114	11400	Utilization Review-SNF							- 0 -	114
115	11500	Ambulatory Surgical Center (Distinct Part)								115
116	11600	Hospice								116
117		Other Special Purpose (specify)								117
118		SUBTOTALS (sum of lines 1-117)	5,506,777	35,741,228	41,248,005		41,248,005	-5,008,335	36,239,670	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop, & Canteen								190
191	19100	Research								191
192	19200	Physicians' Private Offices	3,165,248	1,325,733	4,490,981		4,490,981	90,119	4,581,100	192
193	19300	Nonpaid Workers	60,812	87,828	148,640		148,640		148,640	193
194		Other Nonreimbursable (specify)								194
200		TOTAL (sum of lines 118-199)	8,732,837	37,154,789	45,887,626	- 0 -	45,887,626	-4,918,216	40,969,410	200

FORM CMS-2552-10 (11/2016) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, § 4013)

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
Cost report status - As Submitted
[Record code 577478 - 2010]

RECLASSIFICATIONS	Provider CCN: 150177	PERIOD: FROM 01/01/2015 TO 12/31/2015	WORKSHEET A-6

A - RECLASSIFY MVBLE EQUIP DEP

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				DECREASES				Wkst. A-7 Ref.	
			COST CENTER	LINE #	SALARY	OTHER	COST CENTER	LINE #	SALARY	OTHER		
		1	2	3	4	5	6	7	8	9	10	
1	RECLASSIFY MVBLE EQUIP DEPRECIATION	A		2.00		1,952,032		1.00		1,952,032	9	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21												21
22												22
23												23
24												24
25												25
26												26
27												27
28												28
29												29
500	Total reclassifications (sum of columns 4 and 5 must equal sum of columns 8 and 9)					1,952,032				1,952,032		500

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.

Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
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RECLASSIFICATIONS	Provider CCN: 150177	PERIOD: FROM 01/01/2015 TO 12/31/2015	WORKSHEET A-6

B - RECLASSIFY INTEREST EXPENS

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				DECREASES				Wkst. A-7 Ref.	
			COST CENTER	LINE #	SALARY	OTHER	COST CENTER	LINE #	SALARY	OTHER		
		1	2	3	4	5	6	7	8	9	10	
1	RECLASSIFY INTEREST EXPENSE	B		1.00		2,925,004		113.00		2,925,004	11	1
2	RECLASSIFY INTEREST EXPENSE	B		2.00		82,553		113.00		82,553	11	2
3	RECLASSIFY INTEREST EXPENSE	B		5.00		763,905		113.00		763,905		3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21												21
22												22
23												23
24												24
25												25
26												26
27												27
28												28
29												29
500	Total reclassifications (sum of columns 4 and 5 must equal sum of columns 8 and 9)					3,771,462				3,771,462		500

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.

Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

RECLASSIFICATIONS	Provider CCN: 150177	PERIOD: FROM 01/01/2015 TO 12/31/2015	WORKSHEET A-6

C - RECLASSIFY INSURANCE EXPEN

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				DECREASES				Wkst. A-7 Ref.	
			COST CENTER	LINE #	SALARY	OTHER	COST CENTER	LINE #	SALARY	OTHER		
		1	2	3	4	5	6	7	8	9	10	
1	RECLASSIFY INSURANCE EXPENSE	C		1.00		28,183		5.00		28,183	12	1
2	RECLASSIFY INSURANCE EXPENSE	C		4.00		36,761		5.00		36,761		2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21												21
22												22
23												23
24												24
25												25
26												26
27												27
28												28
29												29
500	Total reclassifications (sum of columns 4 and 5 must equal sum of columns 8 and 9)					64,944				64,944		500

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.

Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

RECONCILIATION OF CAPITAL COSTS CENTERS	Provider CCN: 150177	PERIOD: FROM 01/01/2015 TO 12/31/2015	WORKSHEET A-7, PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
			Purchases	Donation	Total				
		1	2	3	4	5	6	7	
1	Land								1
2	Land Improvements								2
3	Buildings and Fixtures	14,379,799					14,379,799		3
4	Building Improvements	810,770					810,770		4
5	Fixed Equipment	534,064	1,751		1,751		535,815		5
6	Movable Equipment	13,454,396	616,175		616,175	18,369	14,052,202	2,032,492	6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	29,179,029	617,926		617,926	18,369	29,778,586	2,032,492	8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	29,179,029	617,926		617,926	18,369	29,778,586	2,032,492	10

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 AND 2

	Description	SUMMARY OF CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		9	10	11	12	13	14	15	
1	Capital Related Costs-Buildings and Fixtures	2,732,395	448,555			156,000		3,336,950	1
2	Capital Related Costs-Movable Equipment					252,000		252,000	2
3	Total (sum of lines 1-2)	2,732,395	448,555			408,000		3,588,950	3

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may have been included in Worksheet A, column 2, lines 1 and 2. All lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS

	Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
		1	2	3	4	5	6	7	8	
1	Capital Related Costs-Buildings and Fixtures	15,726,384	14,379,799	1,346,585						1
2	Capital Related Costs-Movable Equipment	14,052,202	3,463,427	10,588,775						2
3	Total (sum of lines 1-2)	29,778,586	17,843,226	11,935,360	1.000000					3

	Description	SUMMARY OF CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		9	10	11	12	13	14	15	
1	Capital Related Costs-Buildings and Fixtures	780,363	448,555	2,925,004	28,183	156,000		4,338,105	1
2	Capital Related Costs-Movable Equipment	1,952,032		82,553		252,000		2,286,585	2
3	Total (sum of lines 1-2)	2,732,395	448,555	3,007,557	28,183	408,000		6,624,690	3

(2) The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, lines 1 and 2. Columns 9 through 14 should include related Worksheet A-6 reclassifications, Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)

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ADJUSTMENTS TO EXPENSES		Provider CCN: 150177		PERIOD: FROM 01/01/2015 TO 12/31/2015		WORKSHEET A-8	
DESCRIPTION (1)		BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		Wkst. A-7 Ref.	
				COST CENTER	LINE #		
		1	2	3	4	5	
1	Investment income - buildings and fixtures (chapter 2)			Buildings and Fixtures	1		1
2	Investment income - movable equipment (chapter 2)			Movable Equipment	2		2
3	Investment income - other (chapter 2)	B	-773	ADMINISTRATIVE & GENERAL	5.00		3
4	Trade, quantity, and time discounts (chapter 8)	B	-2,542	ADMINISTRATIVE & GENERAL	5.00		4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excluded) (chapter 21)						7
8	Television and radio service (chapter 21)						8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Worksheet A-8-2					10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Worksheet A-8-1					12
13	Laundry and linen service						13
14	Cafeteria-employees and guests	B	-19,518	DIETARY	10.00		14
15	Rental of quarters to employee and others						15
16	Sale of medical and surgical supplies to other than patients						16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts	B	-6,138	MEDICAL RECORDS & LIBRARY	16.00		18
19	Nursing school (tuition, fees, books, etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments						22
23	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	Worksheet A-8-3		Respiratory Therapy	65		23
24	Adjustment for physical therapy costs in excess of limitation (chapter 14)	Worksheet A-8-3		Physical Therapy	66		24
25	Utilization review - physicians' compensation (chapter 21)			Utilization Review - SNF	114		25
26	Depreciation - buildings and fixtures			Buildings and Fixtures	1		26
27	Depreciation - movable equipment			Movable Equipment	2		27
28	Non-physician Anesthetist			Nonphysician Anesthetist	19		28
29	Physicians' assistant						29
30	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	Worksheet A-8-3		Occupational Therapy	67		30
30.99	Hospice (non-distinct) (see intructions)			Adults and Pediatrics	30		30.99
31	Adjustment for speech pathology costs in excess of limitation (chapter 14)	Worksheet A-8-3		Speech Pathology	68		31
32	CAH HIT Adjustment for Depreciation and Interest						32
33	Other adjustments (specify) (3)						33
33.01	G&A BAD DEBT EXPENSES	A	-4,220,060	ADMINISTRATIVE & GENERAL	5.00		33.01
33.02	PHYSICIAN OFFICES BAD DEBT EXPENSES	A	90,119	PHYSICIANS PRIVATE OFFICES	192.00		33.02
33.03	PENALTIES & SETTLEMENTS	A	-1,986	ADMINISTRATIVE & GENERAL	5.00		33.03
33.04	CHARITABLE CONTRIBUTIONS	A	-41,279	ADMINISTRATIVE & GENERAL	5.00		33.04
33.05	AMORTIZATION OF INTANGIBLES	A	-716,039	ADMINISTRATIVE & GENERAL	5.00		33.05
34							34
35							35
36							36
37							37

ADJUSTMENTS TO EXPENSES		Provider CCN: 150177		PERIOD: FROM 01/01/2015 TO 12/31/2015	WORKSHEET A-8		
38							38
39							39
40							40
41							41
42							42
43							43
44							44
45							45
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200)		-4,918,216				50

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

(2) Basis for adjustment (see instructions)
A. Costs - if cost, including applicable overhead, can be determined
B. Amount Received - if cost cannot be determined

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

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

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COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 150177			PERIOD: FROM 01/01/2015 TO 12/31/2015		WORKSHEET B, PART I			
COST CENTER DESCRIPTIONS	NET EXPENSES FOR COST ALLOCATION (from Wkst. A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols. 0-4)	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		BLDGS. & FIXTURES	MOVABLE EQUIPMENT							
	0	1	2	4	4A	5	6	7	8	
GENERAL SERVICE COST CENTERS										
1 Capital Related Costs-Buildings and Fixtures	4,338,105	4,338,105								1
2 Capital Related Costs-Movable Equipment	2,286,585		2,286,585							2
4 Employee Benefits Department	944,509	45,864	24,174	1,014,547						4
5 Administrative and General	9,385,915	577,544	304,420	174,325	10,442,204	10,442,204				5
6 Maintenance and Repairs		54,357	28,651		83,008	28,394	111,402			6
7 Operation of Plant	749,571	197,045	103,861	28,965	1,079,442	369,236	5,997	1,454,675		7
8 Laundry and Linen Service	88,088				88,088	30,132			118,220	8
9 Housekeeping	41	57,754	30,442		88,237	30,183	1,758	24,258		9
10 Dietary	235,275	44,505	23,458	20,401	323,639	110,705	1,355	18,693		10
11 Cafeteria		40,768	21,488		62,256	21,295	1,241	17,124		11
12 Maintenance of Personnel										12
13 Nursing Administration	793,662	9,784	5,157	68,576	877,179	300,050	298	4,110		13
14 Central Services and Supply		40,768	21,488		62,256	21,295	1,241	17,124		14
15 Pharmacy	707,094	57,754	30,442	42,699	837,989	286,644	1,758	24,258		15
16 Medical Records & Medical Records Library	227,068	30,576	16,116	14,895	288,655	98,738	931	12,843		16
17 Social Service		9,784	5,157		14,941	5,111	298	4,110		17
18 Other General Service (specify)										18
19 Nonphysician Anesthetists										19
20 Nursing School										20
21 Intern & Res. Service-Salary & Fringes (Approved)										21
22 Intern & Res. Other Program Costs (Approved)										22
23 Paramedical Education Program (specify)										23
INPATIENT ROUTINE SERVICE COST CENTERS										
30 Adults and Pediatrics (General Routine Care)	1,578,684	411,823	217,069	164,903	2,372,479	811,535	12,534	172,976	118,220	30
31 Intensive Care Unit										31
32 Coronary Care Unit										32
33 Burn Intensive Care Unit										33
34 Surgical Intensive Care Unit										34
35 Other Special Care Unit (specify)										35
40 Subprovider IPF										40
41 Subprovider IRF										41
42 Subprovider (specify)										42
43 Nursery										43
44 Skilled Nursing Facility										44

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 150177			PERIOD: FROM 01/01/2015 TO 12/31/2015		WORKSHEET B, PART I			
COST CENTER DESCRIPTIONS	NET EXPENSES FOR COST ALLOCATION (from Wkst. A col. 7)	CAPITAL RELATED COSTS BLDGS. & FIXTURES	CAPITAL RELATED COSTS MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols. 0-4)	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
	0	1	2	4	4A	5	6	7	8	
45 Nursing Facility										45
46 Other Long Term Care										46
ANCILLARY SERVICE COST CENTERS										
50 Operating Room	1,357,091	387,294	204,140	76,258	2,024,783	692,601	11,787	162,674		50
51 Recovery Room										51
52 Labor Room and Delivery Room										52
53 Anesthesiology	322,433	1,699	895		325,027	111,179	52	713		53
54 Radiology-Diagnostic	786,497	258,196	136,093	40,330	1,221,116	417,697	7,858	108,449		54
55 Radiology-Therapeutic										55
56 Radioisotope										56
57 Computed Tomography (CT) Scan										57
58 Magnetic Resonance Imaging (MRI)										58
59 Cardiac Catheterization										59
60 Laboratory	292,340	10,803	5,694		308,837	105,641	329	4,538		60
61 PBP Clinical Laboratory Services-Program Only										61
62 Whole Blood & Packed Red Blood Cells										62
63 Blood Storing, Processing, & Trans.										63
64 Intravenous Therapy										64
65 Respiratory Therapy										65
66 Physical Therapy	107,793	6,115	3,223		117,131	40,066	186	2,569		66
67 Occupational Therapy	64,515	1,359	716		66,590	22,778	41	571		67
68 Speech Pathology		1,359	716		2,075	710	41	571		68
69 Electrocardiology										69
70 Electroencephalography	8,491	76,032	40,076		124,599	42,621	2,314	31,935		70
71 Medical Supplies Charged to Patients	1,074,130	1,699	895		1,076,724	368,306	52	713		71
72 Implantable Devices Charged to Patients	10,608,410				10,608,410	3,628,741				72
73 Drugs Charged to Patients	283,373	2,718	1,433		287,524	98,351	83	1,142		73
74 Renal Dialysis										74
75 ASC (Non-Distinct Part)										75
76 Other Ancillary (specify)										76
OUTPATIENT SERVICE COST CENTERS										
88 Rural Health Clinic (RHC)										88
89 Federally Qualified Health Center (FQHC)										89
90 Clinic										90
91 Emergency										91
92 Observation Beds (Non-Distinct Part)										92
92.01 Observation Beds (Distinct Part)										92.01

COST ALLOCATION - GENERAL SERVICE COSTS				Provider CCN: 150177			PERIOD: FROM 01/01/2015 TO 12/31/2015		WORKSHEET B, PART I		
COST CENTER DESCRIPTIONS		NET EXPENSES FOR COST ALLOCATION (from Wkst. A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols. 0-4)	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			BLDGS. & FIXTURES	MOVABLE EQUIPMENT							
		0	1	2	4	4A	5	6	7	8	
93	Other Outpatient Service (specify)										93
OTHER REIMBURSABLE COST CENTERS											
94	Home Program Dialysis										94
95	Ambulance Services										95
96	Durable Medical Equipment-Rented										96
97	Durable Medical Equipment-Sold										97
98	Other Reimbursable (specify)										98
99	Outpatient Rehabilitation Provider (specify)										99
100	Intern-Resident Service (not appvd. tchng. prgm.)										100
101	Home Health Agency										101
SPECIAL PURPOSE COST CENTERS											
105	Kidney Acquisition										105
106	Heart Acquisition										106
107	Liver Acquisition										107
108	Lung Acquisition										108
109	Pancreas Acquisition										109
110	Intestinal Acquisition										110
111	Islet Acquisition										111
112	Other Organ Acquisition (specify)										112
115	Ambulatory Surgical Center (Distinct Part)										115
116	Hospice										116
117	Other Special Purpose (specify)										117
118	SUBTOTALS (sum of lines 1-117)	36,239,670	2,325,600	1,225,804	631,352	32,783,189	7,642,009	50,154	609,371	118,220	118
NONREIMBURSABLE COST CENTERS											
190	Gift, Flower, Coffee Shop, & Canteen										190
191	Research										191
192	Physicians' Private Offices	4,581,100	2,012,505	1,060,781	375,972	8,030,358	2,746,880	61,248	845,304		192
193	Nonpaid Workers	148,640			7,223	155,863	53,315				193
194	Other Nonreimbursable (specify)										194
200	Cross Foot Adjustments										200
201	Negative Cost Centers										201
202	TOTAL (sum lines 118-201)	40,969,410	4,338,105	2,286,585	1,014,547	40,969,410	10,442,204	111,402	1,454,675	118,220	202

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COST ALLOCATION - GENERAL SERVICE COSTS				Provider CCN: 150177			PERIOD: FROM 01/01/2015 TO 12/31/2015		WORKSHEET B, PART I		
COST CENTER DESCRIPTIONS		HOUSE-KEEPING	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		9	10	11	12	13	14	15	16	17	
GENERAL SERVICE COST CENTERS											
1	Capital Related Costs-Buildings and Fixtures										1
2	Capital Related Costs-Movable Equipment										2
4	Employee Benefits Department										4
5	Administrative and General										5
6	Maintenance and Repairs										6
7	Operation of Plant										7
8	Laundry and Linen Service										8
9	Housekeeping	144,436									9
10	Dietary	1,888	456,280								10
11	Cafeteria	1,729	205,865	309,510							11
12	Maintenance of Personnel										12
13	Nursing Administration	415		32,105		1,214,157					13
14	Central Services and Supply	1,729					103,645				14
15	Pharmacy	2,449		29,860				1,182,958			15
16	Medical Records & Medical Records Library	1,297		15,452					417,916		16
17	Social Service	415								24,875	17
18	Other General Service (specify)										18
19	Nonphysician Anesthetists										19
20	Nursing School										20
21	Intern & Res. Service-Salary & Fringes (Approved)										21
22	Intern & Res. Other Program Costs (Approved)										22
23	Paramedical Education Program (specify)										23
INPATIENT ROUTINE SERVICE COST CENTERS											
30	Adults and Pediatrics (General Routine Care)	17,466	139,793	133,168		1,214,157	103,645		417,916	24,875	30
31	Intensive Care Unit										31
32	Coronary Care Unit										32
33	Burn Intensive Care Unit										33
34	Surgical Intensive Care Unit										34
35	Other Special Care Unit (specify)										35
40	Subprovider IPF										40
41	Subprovider IRF										41
42	Subprovider (specify)										42
43	Nursery										43
44	Skilled Nursing Facility										44
45	Nursing Facility										45
46	Other Long Term Care										46

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 150177			PERIOD: FROM 01/01/2015 TO 12/31/2015			WORKSHEET B, PART I			
COST CENTER DESCRIPTIONS		HOUSE-KEEPING	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		9	10	11	12	13	14	15	16	17	
ANCILLARY SERVICE COST CENTERS											
50	Operating Room	16,426		62,487							50
51	Recovery Room										51
52	Labor Room and Delivery Room										52
53	Anesthesiology	72									53
54	Radiology-Diagnostic	10,951		36,438							54
55	Radiology-Therapeutic										55
56	Radioisotope										56
57	Computed Tomography (CT) Scan										57
58	Magnetic Resonance Imaging (MRI)										58
59	Cardiac Catheterization										59
60	Laboratory	458									60
61	PBP Clinical Laboratory Services-Program Only										61
62	Whole Blood & Packed Red Blood Cells										62
63	Blood Storing, Processing, & Trans.										63
64	Intravenous Therapy										64
65	Respiratory Therapy										65
66	Physical Therapy	259									66
67	Occupational Therapy	58									67
68	Speech Pathology	58									68
69	Electrocardiology										69
70	Electroencephalography	3,225									70
71	Medical Supplies Charged to Patients	72									71
72	Implantable Devices Charged to Patients										72
73	Drugs Charged to Patients	115						1,182,958			73
74	Renal Dialysis										74
75	ASC (Non-Distinct Part)										75
76	Other Ancillary (specify)										76
OUTPATIENT SERVICE COST CENTERS											
88	Rural Health Clinic (RHC)										88
89	Federally Qualified Health Center (FQHC)										89
90	Clinic										90
91	Emergency										91
92	Observation Beds (Non-Distinct Part)										92
92.01	Observation Beds (Distinct Part)										92.01
93	Other Outpatient Service (specify)										93
OTHER REIMBURSABLE COST CENTERS											
94	Home Program Dialysis										94
95	Ambulance Services										95

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 150177		PERIOD: FROM 01/01/2015 TO 12/31/2015		WORKSHEET B, PART I			
COST CENTER DESCRIPTIONS	HOUSE-KEEPING	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
	9	10	11	12	13	14	15	16	17	
96 Durable Medical Equipment-Rented										96
97 Durable Medical Equipment-Sold										97
98 Other Reimbursable (specify)										98
99 Outpatient Rehabilitation Provider (specify)										99
100 Intern-Resident Service (not appvd. tchng. prgm.)										100
101 Home Health Agency										101
SPECIAL PURPOSE COST CENTERS										
105 Kidney Acquisition										105
106 Heart Acquisition										106
107 Liver Acquisition										107
108 Lung Acquisition										108
109 Pancreas Acquisition										109
110 Intestinal Acquisition										110
111 Islet Acquisition										111
112 Other Organ Acquisition (specify)										112
115 Ambulatory Surgical Center (Distinct Part)										115
116 Hospice										116
117 Other Special Purpose (specify)										117
118 SUBTOTALS (sum of lines 1-117)	59,082	345,658	309,510		1,214,157	103,645	1,182,958	417,916	24,875	118
NONREIMBURSABLE COST CENTERS										
190 Gift, Flower, Coffee Shop, & Canteen		110,622								190
191 Research										191
192 Physicians' Private Offices	85,354									192
193 Nonpaid Workers										193
194 Other Nonreimbursable (specify)										194
200 Cross Foot Adjustments										200
201 Negative Cost Centers										201
202 TOTAL (sum lines 118-201)	144,436	456,280	309,510		1,214,157	103,645	1,182,958	417,916	24,875	202

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COST ALLOCATION - GENERAL SERVICE COSTS				Provider CCN: 150177			PERIOD: FROM 01/01/2015 TO 12/31/2015		WORKSHEET B, PART I		
COST CENTER DESCRIPTIONS		OTHER GENERAL SERVICE	NON-PHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY AND FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARAMEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
		18	19	20	21	22	23	24	25	26	
GENERAL SERVICE COST CENTERS											
1	Capital Related Costs-Buildings and Fixtures										1
2	Capital Related Costs-Movable Equipment										2
4	Employee Benefits Department										4
5	Administrative and General										5
6	Maintenance and Repairs										6
7	Operation of Plant										7
8	Laundry and Linen Service										8
9	Housekeeping										9
10	Dietary										10
11	Cafeteria										11
12	Maintenance of Personnel										12
13	Nursing Administration										13
14	Central Services and Supply										14
15	Pharmacy										15
16	Medical Records & Medical Records Library										16
17	Social Service										17
18	Other General Service (specify)										18
19	Nonphysician Anesthetists										19
20	Nursing School										20
21	Intern & Res. Service-Salary & Fringes (Approved)										21
22	Intern & Res. Other Program Costs (Approved)										22
23	Paramedical Education Program (specify)										23
INPATIENT ROUTINE SERVICE COST CENTERS											
30	Adults and Pediatrics (General Routine Care)							5,538,764		5,538,764	30
31	Intensive Care Unit										31
32	Coronary Care Unit										32
33	Burn Intensive Care Unit										33
34	Surgical Intensive Care Unit										34
35	Other Special Care Unit (specify)										35
40	Subprovider IPF										40
41	Subprovider IRF										41
42	Subprovider (specify)										42
43	Nursery										43
44	Skilled Nursing Facility										44

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 150177			PERIOD: FROM 01/01/2015 TO 12/31/2015		WORKSHEET B, PART I				
COST CENTER DESCRIPTIONS		OTHER GENERAL SERVICE	NON-PHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY AND FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARAMEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
		18	19	20	21	22	23	24	25	26	
45	Nursing Facility										45
46	Other Long Term Care										46
ANCILLARY SERVICE COST CENTERS											
50	Operating Room							2,970,758		2,970,758	50
51	Recovery Room										51
52	Labor Room and Delivery Room										52
53	Anesthesiology							437,043		437,043	53
54	Radiology-Diagnostic							1,802,509		1,802,509	54
55	Radiology-Therapeutic										55
56	Radioisotope										56
57	Computed Tomography (CT) Scan										57
58	Magnetic Resonance Imaging (MRI)										58
59	Cardiac Catheterization										59
60	Laboratory							419,803		419,803	60
61	PBP Clinical Laboratory Services-Program Only										61
62	Whole Blood & Packed Red Blood Cells										62
63	Blood Storing, Processing, & Trans.										63
64	Intravenous Therapy										64
65	Respiratory Therapy										65
66	Physical Therapy							160,211		160,211	66
67	Occupational Therapy							90,038		90,038	67
68	Speech Pathology							3,455		3,455	68
69	Electrocardiology										69
70	Electroencephalography							204,694		204,694	70
71	Medical Supplies Charged to Patients							1,445,867		1,445,867	71
72	Implantable Devices Charged to Patients							14,237,151		14,237,151	72
73	Drugs Charged to Patients							1,570,173		1,570,173	73
74	Renal Dialysis										74
75	ASC (Non-Distinct Part)										75
76	Other Ancillary (specify)										76
OUTPATIENT SERVICE COST CENTERS											
88	Rural Health Clinic (RHC)										88
89	Federally Qualified Health Center (FQHC)										89
90	Clinic										90
91	Emergency										91
92	Observation Beds (Non-Distinct Part)										92
92.01	Observation Beds (Distinct Part)										92.01

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150177 | PERIOD: FROM 01/01/2015 TO 12/31/2015 | WORKSHEET B, PART I

	COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE	NON-PHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY AND FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARAMEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
		18	19	20	21	22	23	24	25	26	
93	Other Outpatient Service (specify)										93
OTHER REIMBURSABLE COST CENTERS											
94	Home Program Dialysis										94
95	Ambulance Services										95
96	Durable Medical Equipment-Rented										96
97	Durable Medical Equipment-Sold										97
98	Other Reimbursable (specify)										98
99	Outpatient Rehabilitation Provider (specify)										99
100	Intern-Resident Service (not appvd. tchng. prgm.)										100
101	Home Health Agency										101
SPECIAL PURPOSE COST CENTERS											
105	Kidney Acquisition										105
106	Heart Acquisition										106
107	Liver Acquisition										107
108	Lung Acquisition										108
109	Pancreas Acquisition										109
110	Intestinal Acquisition										110
111	Islet Acquisition										111
112	Other Organ Acquisition (specify)										112
115	Ambulatory Surgical Center (Distinct Part)										115
116	Hospice										116
117	Other Special Purpose (specify)										117
118	SUBTOTALS (sum of lines 1-117)							28,880,466		28,880,466	118
NONREIMBURSABLE COST CENTERS											
190	Gift, Flower, Coffee Shop, & Canteen							110,622		110,622	190
191	Research										191
192	Physicians' Private Offices							11,769,144		11,769,144	192
193	Nonpaid Workers							209,178		209,178	193
194	Other Nonreimbursable (specify)										194
200	Cross Foot Adjustments										200
201	Negative Cost Centers										201
202	TOTAL (sum lines 118-201)							40,969,410		40,969,410	202

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ALLOCATION OF CAPITAL-RELATED COSTS				Provider CCN: 150177			PERIOD: FROM 01/01/2015 TO 12/31/2015		WORKSHEET B, PART II		
COST CENTER DESCRIPTIONS		DIRECTLY ASSIGNED NEW CAPITAL RELATED COSTS	CAPITAL RELATED COSTS		SUBTOTAL (sum of (cols. 0-2)	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			BLDGS. & FIXTURES	MOVABLE EQUIPMENT							
		0	1	2	2A	4	5	6	7	8	
GENERAL SERVICE COST CENTERS											
1	Capital Related Costs-Buildings and Fixtures										1
2	Capital Related Costs-Movable Equipment										2
4	Employee Benefits Department		45,864	24,174	70,038	70,038					4
5	Administrative and General		577,544	304,420	881,964	12,035	893,999				5
6	Maintenance and Repairs		54,357	28,651	83,008		2,431	85,439			6
7	Operation of Plant		197,045	103,861	300,906	2,000	31,611	4,599	339,116		7
8	Laundry and Linen Service						2,580			2,580	8
9	Housekeeping		57,754	30,442	88,196		2,584	1,348	5,655		9
10	Dietary		44,505	23,458	67,963	1,408	9,478	1,039	4,358		10
11	Cafeteria		40,768	21,488	62,256		1,823	952	3,992		11
12	Maintenance of Personnel										12
13	Nursing Administration		9,784	5,157	14,941	4,734	25,688	228	958		13
14	Central Services and Supply		40,768	21,488	62,256		1,823	952	3,992		14
15	Pharmacy		57,754	30,442	88,196	2,948	24,541	1,348	5,655		15
16	Medical Records & Medical Records Library		30,576	16,116	46,692	1,028	8,453	714	2,994		16
17	Social Service		9,784	5,157	14,941		438	228	958		17
18	Other General Service (specify)										18
19	Nonphysician Anesthetists										19
20	Nursing School										20
21	Intern & Res. Service-Salary & Fringes (Approved)										21
22	Intern & Res. Other Program Costs (Approved)										22
23	Paramedical Education Program (specify)										23
INPATIENT ROUTINE SERVICE COST CENTERS											
30	Adults and Pediatrics (General Routine Care)		411,823	217,069	628,892	11,384	69,478	9,613	40,325	2,580	30
31	Intensive Care Unit										31
32	Coronary Care Unit										32
33	Burn Intensive Care Unit										33
34	Surgical Intensive Care Unit										34
35	Other Special Care Unit (specify)										35
40	Subprovider IPF										40
41	Subprovider IRF										41
42	Subprovider (specify)										42
43	Nursery										43
44	Skilled Nursing Facility										44
45	Nursing Facility										45

ALLOCATION OF CAPITAL-RELATED COSTS	Provider CCN: 150177	PERIOD: FROM 01/01/2015 TO 12/31/2015	WORKSHEET B, PART II

	COST CENTER DESCRIPTIONS	DIRECTLY ASSIGNED NEW CAPITAL RELATED COSTS	CAPITAL RELATED COSTS BLDGS. & FIXTURES	CAPITAL RELATED COSTS MOVABLE EQUIPMENT	SUBTOTAL (sum of (cols. 0-2)	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		0	1	2	2A	4	5	6	7	8	
46	Other Long Term Care										46
ANCILLARY SERVICE COST CENTERS											
50	Operating Room		387,294	204,140	591,434	5,264	59,296	9,040	37,923		50
51	Recovery Room										51
52	Labor Room and Delivery Room										52
53	Anesthesiology		1,699	895	2,594		9,518	40	166		53
54	Radiology-Diagnostic		258,196	136,093	394,289	2,784	35,760	6,027	25,282		54
55	Radiology-Therapeutic										55
56	Radioisotope										56
57	Computed Tomography (CT) Scan										57
58	Magnetic Resonance Imaging (MRI)										58
59	Cardiac Catheterization										59
60	Laboratory		10,803	5,694	16,497		9,044	252	1,058		60
61	PBP Clinical Laboratory Services-Program Only										61
62	Whole Blood & Packed Red Blood Cells										62
63	Blood Storing, Processing, & Trans.										63
64	Intravenous Therapy										64
65	Respiratory Therapy										65
66	Physical Therapy		6,115	3,223	9,338		3,430	143	599		66
67	Occupational Therapy		1,359	716	2,075		1,950	32	133		67
68	Speech Pathology		1,359	716	2,075		61	32	133		68
69	Electrocardiology										69
70	Electroencephalography		76,032	40,076	116,108		3,649	1,775	7,445		70
71	Medical Supplies Charged to Patients		1,699	895	2,594		31,532	40	166		71
72	Implantable Devices Charged to Patients						310,678				72
73	Drugs Charged to Patients		2,718	1,433	4,151		8,420	63	266		73
74	Renal Dialysis										74
75	ASC (Non-Distinct Part)										75
76	Other Ancillary (specify)										76
OUTPATIENT SERVICE COST CENTERS											
88	Rural Health Clinic (RHC)										88
89	Federally Qualified Health Center (FQHC)										89
90	Clinic										90
91	Emergency										91
92	Observation Beds (Non-Distinct Part)										92
92.01	Observation Beds (Distinct Part)										92.01
93	Other Outpatient Service (specify)										93
OTHER REIMBURSABLE COST CENTERS											

ALLOCATION OF CAPITAL-RELATED COSTS				Provider CCN: 150177		PERIOD: FROM 01/01/2015 TO 12/31/2015		WORKSHEET B, PART II		
COST CENTER DESCRIPTIONS		DIRECTLY ASSIGNED NEW CAPITAL RELATED COSTS	CAPITAL RELATED COSTS		SUBTOTAL (sum of (cols. 0-2)	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			BLDGS. & FIXTURES	MOVABLE EQUIPMENT							
		0	1	2	2A	4	5	6	7	8	
94	Home Program Dialysis										94
95	Ambulance Services										95
96	Durable Medical Equipment-Rented										96
97	Durable Medical Equipment-Sold										97
98	Other Reimbursable (specify)										98
99	Outpatient Rehabilitation Provider (specify)										99
100	Intern-Resident Service (not appvd. tchng. prgm.)										100
101	Home Health Agency										101
SPECIAL PURPOSE COST CENTERS											
105	Kidney Acquisition										105
106	Heart Acquisition										106
107	Liver Acquisition										107
108	Lung Acquisition										108
109	Pancreas Acquisition										109
110	Intestinal Acquisition										110
111	Islet Acquisition										111
112	Other Organ Acquisition (specify)										112
115	Ambulatory Surgical Center (Distinct Part)										115
116	Hospice										116
117	Other Special Purpose (specify)										117
118	SUBTOTALS (sum of lines 1-117)		2,325,600	1,225,804	3,551,404	43,585	654,266	38,465	142,058	2,580	118
NONREIMBURSABLE COST CENTERS											
190	Gift, Flower, Coffee Shop, & Canteen										190
191	Research										191
192	Physicians' Private Offices		2,012,505	1,060,781	3,073,286	25,954	235,169	46,974	197,058		192
193	Nonpaid Workers					499	4,564				193
194	Other Nonreimbursable (specify)										194
200	Cross Foot Adjustments										200
201	Negative Cost Centers										201
202	TOTAL (sum lines 118-201)		4,338,105	2,286,585	6,624,690	70,038	893,999	85,439	339,116	2,580	202

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
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ALLOCATION OF CAPITAL-RELATED COSTS				Provider CCN: 150177			PERIOD: FROM 01/01/2015 TO 12/31/2015		WORKSHEET B, PART II		
COST CENTER DESCRIPTIONS		HOUSE- KEEPING	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		9	10	11	12	13	14	15	16	17	
GENERAL SERVICE COST CENTERS											
1	Capital Related Costs-Buildings and Fixtures										1
2	Capital Related Costs-Movable Equipment										2
4	Employee Benefits Department										4
5	Administrative and General										5
6	Maintenance and Repairs										6
7	Operation of Plant										7
8	Laundry and Linen Service										8
9	Housekeeping	97,783									9
10	Dietary	1,278	85,524								10
11	Cafeteria	1,171	38,587	108,781							11
12	Maintenance of Personnel										12
13	Nursing Administration	281		11,284		58,114					13
14	Central Services and Supply	1,171					70,194				14
15	Pharmacy	1,658		10,495				134,841			15
16	Medical Records & Medical Records Library	878		5,431					66,190		16
17	Social Service	281								16,846	17
18	Other General Service (specify)										18
19	Nonphysician Anesthetists										19
20	Nursing School										20
21	Intern & Res. Service-Salary & Fringes (Approved)										21
22	Intern & Res. Other Program Costs (Approved)										22
23	Paramedical Education Program (specify)										23
INPATIENT ROUTINE SERVICE COST CENTERS											
30	Adults and Pediatrics (General Routine Care)	11,825	26,202	46,803		58,114	70,194		66,190	16,846	30
31	Intensive Care Unit										31
32	Coronary Care Unit										32
33	Burn Intensive Care Unit										33
34	Surgical Intensive Care Unit										34
35	Other Special Care Unit (specify)										35
40	Subprovider IPF										40
41	Subprovider IRF										41
42	Subprovider (specify)										42
43	Nursery										43
44	Skilled Nursing Facility										44
45	Nursing Facility										45
46	Other Long Term Care										46

ALLOCATION OF CAPITAL-RELATED COSTS				Provider CCN: 150177			PERIOD: FROM 01/01/2015 TO 12/31/2015		WORKSHEET B, PART II		
COST CENTER DESCRIPTIONS		HOUSE- KEEPING	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		9	10	11	12	13	14	15	16	17	
ANCILLARY SERVICE COST CENTERS											
50	Operating Room	11,120		21,962							50
51	Recovery Room										51
52	Labor Room and Delivery Room										52
53	Anesthesiology	49									53
54	Radiology-Diagnostic	7,414		12,806							54
55	Radiology-Therapeutic										55
56	Radioisotope										56
57	Computed Tomography (CT) Scan										57
58	Magnetic Resonance Imaging (MRI)										58
59	Cardiac Catheterization										59
60	Laboratory	310									60
61	PBP Clinical Laboratory Services-Program Only										61
62	Whole Blood & Packed Red Blood Cells										62
63	Blood Storing, Processing, & Trans.										63
64	Intravenous Therapy										64
65	Respiratory Therapy										65
66	Physical Therapy	176									66
67	Occupational Therapy	39									67
68	Speech Pathology	39									68
69	Electrocardiology										69
70	Electroencephalography	2,183									70
71	Medical Supplies Charged to Patients	49									71
72	Implantable Devices Charged to Patients										72
73	Drugs Charged to Patients	78						134,841			73
74	Renal Dialysis										74
75	ASC (Non-Distinct Part)										75
76	Other Ancillary (specify)										76
OUTPATIENT SERVICE COST CENTERS											
88	Rural Health Clinic (RHC)										88
89	Federally Qualified Health Center (FQHC)										89
90	Clinic										90
91	Emergency										91
92	Observation Beds (Non-Distinct Part)										92
92.01	Observation Beds (Distinct Part)										92.01
93	Other Outpatient Service (specify)										93
OTHER REIMBURSABLE COST CENTERS											
94	Home Program Dialysis										94
95	Ambulance Services										95

ALLOCATION OF CAPITAL-RELATED COSTS	Provider CCN: 150177	PERIOD: FROM 01/01/2015 TO 12/31/2015	WORKSHEET B, PART II

	COST CENTER DESCRIPTIONS	HOUSE- KEEPING	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		9	10	11	12	13	14	15	16	17	
96	Durable Medical Equipment-Rented										96
97	Durable Medical Equipment-Sold										97
98	Other Reimbursable (specify)										98
99	Outpatient Rehabilitation Provider (specify)										99
100	Intern-Resident Service (not appvd. tchng. prgm.)										100
101	Home Health Agency										101
SPECIAL PURPOSE COST CENTERS											
105	Kidney Acquisition										105
106	Heart Acquisition										106
107	Liver Acquisition										107
108	Lung Acquisition										108
109	Pancreas Acquisition										109
110	Intestinal Acquisition										110
111	Islet Acquisition										111
112	Other Organ Acquisition (specify)										112
115	Ambulatory Surgical Center (Distinct Part)										115
116	Hospice										116
117	Other Special Purpose (specify)										117
118	SUBTOTALS (sum of lines 1-117)	40,000	64,789	108,781		58,114	70,194	134,841	66,190	16,846	118
NONREIMBURSABLE COST CENTERS											
190	Gift, Flower, Coffee Shop, & Canteen		20,735								190
191	Research										191
192	Physicians' Private Offices	57,783									192
193	Nonpaid Workers										193
194	Other Nonreimbursable (specify)										194
200	Cross Foot Adjustments										200
201	Negative Cost Centers										201
202	TOTAL (sum lines 118-201)	97,783	85,524	108,781		58,114	70,194	134,841	66,190	16,846	202

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ALLOCATION OF CAPITAL-RELATED COSTS				Provider CCN: 150177			PERIOD: FROM 01/01/2015 TO 12/31/2015		WORKSHEET B, PART II		
COST CENTER DESCRIPTIONS		OTHER GENERAL SERVICE	NON-PHYSICIAN ANES-THETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY AND FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARAMEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
		18	19	20	21	22	23	24	25	26	
GENERAL SERVICE COST CENTERS											
1	Capital Related Costs-Buildings and Fixtures										1
2	Capital Related Costs-Movable Equipment										2
4	Employee Benefits Department										4
5	Administrative and General										5
6	Maintenance and Repairs										6
7	Operation of Plant										7
8	Laundry and Linen Service										8
9	Housekeeping										9
10	Dietary										10
11	Cafeteria										11
12	Maintenance of Personnel										12
13	Nursing Administration										13
14	Central Services and Supply										14
15	Pharmacy										15
16	Medical Records & Medical Records Library										16
17	Social Service										17
18	Other General Service (specify)										18
19	Nonphysician Anesthetists										19
20	Nursing School										20
21	Intern & Res. Service-Salary & Fringes (Approved)										21
22	Intern & Res. Other Program Costs (Approved)										22
23	Paramedical Education Program (specify)										23
INPATIENT ROUTINE SERVICE COST CENTERS											
30	Adults and Pediatrics (General Routine Care)							1,058,446		1,058,446	30
31	Intensive Care Unit										31
32	Coronary Care Unit										32
33	Burn Intensive Care Unit										33
34	Surgical Intensive Care Unit										34
35	Other Special Care Unit (specify)										35
40	Subprovider IPF										40
41	Subprovider IRF										41
42	Subprovider (specify)										42
43	Nursery										43
44	Skilled Nursing Facility										44

ALLOCATION OF CAPITAL-RELATED COSTS				Provider CCN: 150177			PERIOD: FROM 01/01/2015 TO 12/31/2015		WORKSHEET B, PART II		
COST CENTER DESCRIPTIONS		OTHER GENERAL SERVICE	NON-PHYSICIAN ANES-THETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY AND FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARAMEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
		18	19	20	21	22	23	24	25	26	
45	Nursing Facility										45
46	Other Long Term Care										46
ANCILLARY SERVICE COST CENTERS											
50	Operating Room							736,039		736,039	50
51	Recovery Room										51
52	Labor Room and Delivery Room										52
53	Anesthesiology							12,367		12,367	53
54	Radiology-Diagnostic							484,362		484,362	54
55	Radiology-Therapeutic										55
56	Radioisotope										56
57	Computed Tomography (CT) Scan										57
58	Magnetic Resonance Imaging (MRI)										58
59	Cardiac Catheterization										59
60	Laboratory							27,161		27,161	60
61	PBP Clinical Laboratory Services-Program Only										61
62	Whole Blood & Packed Red Blood Cells										62
63	Blood Storing, Processing, & Trans.										63
64	Intravenous Therapy										64
65	Respiratory Therapy										65
66	Physical Therapy							13,686		13,686	66
67	Occupational Therapy							4,229		4,229	67
68	Speech Pathology							2,340		2,340	68
69	Electrocardiology										69
70	Electroencephalography							131,160		131,160	70
71	Medical Supplies Charged to Patients							34,381		34,381	71
72	Implantable Devices Charged to Patients							310,678		310,678	72
73	Drugs Charged to Patients							147,819		147,819	73
74	Renal Dialysis										74
75	ASC (Non-Distinct Part)										75
76.											76.
OUTPATIENT SERVICE COST CENTERS											
88	Rural Health Clinic (RHC)										88
89	Federally Qualified Health Center (FQHC)										89
90	Clinic										90
91	Emergency										91
92	Observation Beds (Non-Distinct Part)										92
92.01	Observation Beds (Distinct Part)										92.01

ALLOCATION OF CAPITAL-RELATED COSTS	Provider CCN: 150177	PERIOD: FROM 01/01/2015 TO 12/31/2015	WORKSHEET B, PART II

	COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE	NON-PHYSICIAN ANES-THETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY AND FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARAMEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
		18	19	20	21	22	23	24	25	26	
93	Other Outpatient Service (specify)										93
OTHER REIMBURSABLE COST CENTERS											
94	Home Program Dialysis										94
95	Ambulance Services										95
96	Durable Medical Equipment-Rented										96
97	Durable Medical Equipment-Sold										97
98	Other Reimbursable (specify)										98
99	Outpatient Rehabilitation Provider (specify)										99
100	Intern-Resident Service (not appvd. tchng. prgm.)										100
101	Home Health Agency										101
SPECIAL PURPOSE COST CENTERS											
105	Kidney Acquisition										105
106	Heart Acquisition										106
107	Liver Acquisition										107
108	Lung Acquisition										108
109	Pancreas Acquisition										109
110	Intestinal Acquisition										110
111	Islet Acquisition										111
112	Other Organ Acquisition (specify)										112
115	Ambulatory Surgical Center (Distinct Part)										115
116	Hospice										116
117	Other Special Purpose (specify)										117
118	SUBTOTALS (sum of lines 1-117)							2,962,668		2,962,668	118
NONREIMBURSABLE COST CENTERS											
190	Gift, Flower, Coffee Shop, & Canteen							20,735		20,735	190
191	Research										191
192	Physicians' Private Offices							3,636,224		3,636,224	192
193	Nonpaid Workers							5,063		5,063	193
194	Other Nonreimbursable (specify)										194
200	Cross Foot Adjustments										200
201	Negative Cost Centers										201
202	TOTAL (sum lines 118-201)							6,624,690		6,624,690	202

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COST ALLOCATION - STATISTICAL BASIS				Provider CCN: 150177			PERIOD: FROM 01/01/2015 TO 12/31/2015		WORKSHEET B-1		
COST CENTER DESCRIPTIONS		CAPITAL RELATED COST		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSE-KEEPING (HOURS OF SERVICE)	
		BLDGS. & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (DOLLAR VALUE)								
		1	2	4	5A	5	6	7	8	9	
GENERAL SERVICE COST CENTERS											
1	Capital Related Costs-Buildings and Fixtures	63,846									1
2	Capital Related Costs-Movable Equipment		63,846								2
4	Employee Benefits Department	675	675	8,541,370							4
5	Administrative and General	8,500	8,500	1,467,631		30,527,206					5
6	Maintenance and Repairs	800	800			83,008	53,871				6
7	Operation of Plant	2,900	2,900	243,856		1,079,442	2,900	50,971			7
8	Laundry and Linen Service					88,088			125,152		8
9	Housekeeping	850	850			88,237	850	850		50,121	9
10	Dietary	655	655	171,753		323,639	655	655		655	10
11	Cafeteria	600	600			62,256	600	600		600	11
12	Maintenance of Personnel										12
13	Nursing Administration	144	144	577,339		877,179	144	144		144	13
14	Central Services and Supply	600	600			62,256	600	600		600	14
15	Pharmacy	850	850	359,478		837,989	850	850		850	15
16	Medical Records & Medical Records Library	450	450	125,401		288,655	450	450		450	16
17	Social Service	144	144			14,941	144	144		144	17
18	Other General Service (specify)										18
19	Nonphysician Anesthetists										19
20	Nursing School										20
21	Intern & Res. Service-Salary & Fringes (Approved)										21
22	Intern & Res. Other Program Costs (Approved)										22
23	Paramedical Education Program (specify)										23
INPATIENT ROUTINE SERVICE COST CENTERS											
30	Adults and Pediatrics (General Routine Care)	6,061	6,061	1,388,307		2,372,479	6,061	6,061	125,152	6,061	30
31	Intensive Care Unit										31
32	Coronary Care Unit										32
33	Burn Intensive Care Unit										33
34	Surgical Intensive Care Unit										34
35	Other Special Care Unit (specify)										35
40	Subprovider IPF										40
41	Subprovider IRF										41
42	Subprovider (specify)										42
43	Nursery										43

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 150177			PERIOD: FROM 01/01/2015 TO 12/31/2015		WORKSHEET B-1		
COST CENTER DESCRIPTIONS	CAPITAL RELATED COST		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSE-KEEPING (HOURS OF SERVICE)	
	BLDGS. & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (DOLLAR VALUE)								
	1	2	4	5A	5	6	7	8	9	
44 Skilled Nursing Facility										44
45 Nursing Facility										45
46 Other Long Term Care										46
ANCILLARY SERVICE COST CENTERS										
50 Operating Room	5,700	5,700	642,011		2,024,783	5,700	5,700		5,700	50
51 Recovery Room										51
52 Labor Room and Delivery Room										52
53 Anesthesiology	25	25			325,027	25	25		25	53
54 Radiology-Diagnostic	3,800	3,800	339,534		1,221,116	3,800	3,800		3,800	54
55 Radiology-Therapeutic										55
56 Radioisotope										56
57 Computed Tomography (CT) Scan										57
58 Magnetic Resonance Imaging (MRI)										58
59 Cardiac Catheterization										59
60 Laboratory	159	159			308,837	159	159		159	60
61 PBP Clinical Laboratory Services-Program Only										61
62 Whole Blood & Packed Red Blood Cells										62
63 Blood Storing, Processing, & Trans.										63
64 Intravenous Therapy										64
65 Respiratory Therapy										65
66 Physical Therapy	90	90			117,131	90	90		90	66
67 Occupational Therapy	20	20			66,590	20	20		20	67
68 Speech Pathology	20	20			2,075	20	20		20	68
69 Electrocardiology										69
70 Electroencephalography	1,119	1,119			124,599	1,119	1,119		1,119	70
71 Medical Supplies Charged to Patients	25	25			1,076,724	25	25		25	71
72 Implantable Devices Charged to Patients					10,608,410					72
73 Drugs Charged to Patients	40	40			287,524	40	40		40	73
74 Renal Dialysis										74
75 ASC (Non-Distinct Part)										75
76 Other Ancillary (specify)										76
OUTPATIENT SERVICE COST CENTERS										
88 Rural Health Clinic (RHC)										88
89 Federally Qualified Health Center (FQHC)										89
90 Clinic										90
91 Emergency										91
92 Observation Beds (Non-Distinct Part)										92

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 150177			PERIOD: FROM 01/01/2015 TO 12/31/2015		WORKSHEET B-1				
COST CENTER DESCRIPTIONS		CAPITAL RELATED COST		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSE-KEEPING (HOURS OF SERVICE)	
		BLDGS. & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (DOLLAR VALUE)								
		1	2	4	5A	5	6	7	8	9	
92.01	Observation Beds (Distinct Part)										92.01
93	Other Outpatient Service (specify)										93
OTHER REIMBURSABLE COST CENTERS											
94	Home Program Dialysis										94
95	Ambulance Services										95
96	Durable Medical Equipment-Rented										96
97	Durable Medical Equipment-Sold										97
98	Other Reimbursable (specify)										98
99	Outpatient Rehabilitation Provider (specify)										99
100	Intern-Resident Service (not appvd. tchng. prgm.)										100
101	Home Health Agency										101
SPECIAL PURPOSE COST CENTERS											
105	Kidney Acquisition										105
106	Heart Acquisition										106
107	Liver Acquisition										107
108	Lung Acquisition										108
109	Pancreas Acquisition										109
110	Intestinal Acquisition										110
111	Islet Acquisition										111
112	Other Organ Acquisition (specify)										112
115	Ambulatory Surgical Center (Distinct Part)										115
116	Hospice										116
117	Other Special Purpose (specify)										117
118	SUBTOTALS (sum of lines 1-117)	34,227	34,227	5,315,310		22,340,985	24,252	21,352	125,152	20,502	118
NONREIMBURSABLE COST CENTERS											
190	Gift, Flower, Coffee Shop, & Canteen										190
191	Research										191
192	Physicians' Private Offices	29,619	29,619	3,165,248		8,030,358	29,619	29,619		29,619	192
193	Nonpaid Workers			60,812		155,863					193
194	Other Nonreimbursable (specify)										194
200	Cross foot adjustments										200
201	Negative cost centers										201
202	Cost to be allocated (per Worksheet B, Part I)	4,338,105	2,286,585	1,014,547		10,442,204	111,402	1,454,675	118,220	144,436	202
203	Unit cost multiplier (Worksheet B, Part I)	67.95	35.81	0.118780		0.342062	2.07	28.54	0.944611	2.88	203
204	Cost to be allocated (per Worksheet B, Part II)			70,038		893,999	85,439	339,116	2,580	97,783	204
205	Unit cost multiplier (Worksheet B, Part II)			0.008200		0.029285	1.59	6.65	0.020615	1.95	205

COST ALLOCATION - STATISTICAL BASIS			Provider CCN: 150177			PERIOD: FROM 01/01/2015 TO 12/31/2015		WORKSHEET B-1	
COST CENTER DESCRIPTIONS	CAPITAL RELATED COST		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSE-KEEPING (HOURS OF SERVICE)
	BLDGS. & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (DOLLAR VALUE)							
	1	2	4	5A	5	6	7	8	9

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COST ALLOCATION - STATISTICAL BASIS				Provider CCN: 150177			PERIOD: FROM 01/01/2015 TO 12/31/2015		WORKSHEET B-1		
COST CENTER DESCRIPTIONS		DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINIS-TRATION (DIRECT NURS. HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE (SPECIFY)	
		10	11	12	13	14	15	16	17	18	
GENERAL SERVICE COST CENTERS											
1	Capital Related Costs-Buildings and Fixtures										1
2	Capital Related Costs-Movable Equipment										2
4	Employee Benefits Department										4
5	Administrative and General										5
6	Maintenance and Repairs										6
7	Operation of Plant										7
8	Laundry and Linen Service										8
9	Housekeeping										9
10	Dietary	11,512									10
11	Cafeteria	5,194	5,929								11
12	Maintenance of Personnel										12
13	Nursing Administration		615		84,107						13
14	Central Services and Supply					100					14
15	Pharmacy		572				100				15
16	Medical Records & Medical Records Library		296					1,099			16
17	Social Service								1,099		17
18	Other General Service (specify)										18
19	Nonphysician Anesthetists										19
20	Nursing School										20
21	Intern & Res. Service-Salary & Fringes (Approved)										21
22	Intern & Res. Other Program Costs (Approved)										22
23	Paramedical Education Program (specify)										23
INPATIENT ROUTINE SERVICE COST CENTERS											
30	Adults and Pediatrics (General Routine Care)	3,527	2,551		84,107	100		1,099	1,099		30
31	Intensive Care Unit										31
32	Coronary Care Unit										32
33	Burn Intensive Care Unit										33
34	Surgical Intensive Care Unit										34
35	Other Special Care Unit (specify)										35
40	Subprovider IPF										40
41	Subprovider IRF										41
42	Subprovider (specify)										42
43	Nursery										43
44	Skilled Nursing Facility										44

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 150177	PERIOD: FROM 01/01/2015 TO 12/31/2015	WORKSHEET B-1

	COST CENTER DESCRIPTIONS	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINIS- TRATION (DIRECT NURS. HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE (SPECIFY)	
		10	11	12	13	14	15	16	17	18	
45	Nursing Facility										45
46	Other Long Term Care										46
ANCILLARY SERVICE COST CENTERS											
50	Operating Room		1,197								50
51	Recovery Room										51
52	Labor Room and Delivery Room										52
53	Anesthesiology										53
54	Radiology-Diagnostic		698								54
55	Radiology-Therapeutic										55
56	Radioisotope										56
57	Computed Tomography (CT) Scan										57
58	Magnetic Resonance Imaging (MRI)										58
59	Cardiac Catheterization										59
60	Laboratory										60
61	PBP Clinical Laboratory Services-Program Only										61
62	Whole Blood & Packed Red Blood Cells										62
63	Blood Storing, Processing, & Trans.										63
64	Intravenous Therapy										64
65	Respiratory Therapy										65
66	Physical Therapy										66
67	Occupational Therapy										67
68	Speech Pathology										68
69	Electrocardiology										69
70	Electroencephalography										70
71	Medical Supplies Charged to Patients										71
72	Implantable Devices Charged to Patients										72
73	Drugs Charged to Patients						100				73
74	Renal Dialysis										74
75	ASC (Non-Distinct Part)										75
76	Other Ancillary (specify)										76
OUTPATIENT SERVICE COST CENTERS											
88	Rural Health Clinic (RHC)										88
89	Federally Qualified Health Center (FQHC)										89
90	Clinic										90
91	Emergency										91
92	Observation Beds (Non-Distinct Part)										92
92.01	Observation Beds (Distinct Part)										92.01
93	Other Outpatient Service (specify)										93

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 150177			PERIOD: FROM 01/01/2015 TO 12/31/2015		WORKSHEET B-1			
COST CENTER DESCRIPTIONS		DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINIS-TRATION (DIRECT NURS. HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE (SPECIFY)	
		10	11	12	13	14	15	16	17	18	
OTHER REIMBURSABLE COST CENTERS											
94	Home Program Dialysis										94
95	Ambulance Services										95
96	Durable Medical Equipment-Rented										96
97	Durable Medical Equipment-Sold										97
98	Other Reimbursable (specify)										98
99	Outpatient Rehabilitation Provider (specify)										99
100	Intern-Resident Service (not appvd. tchng. prgm.)										100
101	Home Health Agency										101
SPECIAL PURPOSE COST CENTERS											
105	Kidney Acquisition										105
106	Heart Acquisition										106
107	Liver Acquisition										107
108	Lung Acquisition										108
109	Pancreas Acquisition										109
110	Intestinal Acquisition										110
111	Islet Acquisition										111
112	Other Organ Acquisition (specify)										112
115	Ambulatory Surgical Center (Distinct Part)										115
116	Hospice										116
117	Other Special Purpose (specify)										117
118	SUBTOTALS (sum of lines 1-117)	8,721	5,929		84,107	100	100	1,099	1,099		118
NONREIMBURSABLE COST CENTERS											
190	Gift, Flower, Coffee Shop, & Canteen	2,791									190
191	Research										191
192	Physicians' Private Offices										192
193	Nonpaid Workers										193
194	Other Nonreimbursable (specify)										194
200	Cross foot adjustments										200
201	Negative cost centers										201
202	Cost to be allocated (per Worksheet B, Part I)	456,280	309,510		1,214,157	103,645	1,182,958	417,916	24,875		202
203	Unit cost multiplier (Worksheet B, Part I)	39.64	52.20		14.44	1,036	11,830	380.27	22.63		203
204	Cost to be allocated (per Worksheet B, Part II)	85,524	108,781		58,114	70,194	134,841	66,190	16,846		204
205	Unit cost multiplier (Worksheet B, Part II)	7.43	18.35		0.690953	701.94	1,348	60.23	15.33		205

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COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 150177			PERIOD: FROM 01/01/2015 TO 12/31/2015		WORKSHEET B-1			
COST CENTER DESCRIPTIONS		NON-PHYSICIAN ANESTHETISTS (ASGND TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS		PARAMEDICAL EDUCATION (ASSIGNED TIME)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
				SALARY AND FRINGES (ASSIGNED TIME)	PROGRAM COSTS (ASSIGNED TIME)					
		19	20	21	22	23	24	25	26	
GENERAL SERVICE COST CENTERS										
1	Capital Related Costs-Buildings and Fixtures									1
2	Capital Related Costs-Movable Equipment									2
4	Employee Benefits Department									4
5	Administrative and General									5
6	Maintenance and Repairs									6
7	Operation of Plant									7
8	Laundry and Linen Service									8
9	Housekeeping									9
10	Dietary									10
11	Cafeteria									11
12	Maintenance of Personnel									12
13	Nursing Administration									13
14	Central Services and Supply									14
15	Pharmacy									15
16	Medical Records & Medical Records Library									16
17	Social Service									17
18	Other General Service (specify)									18
19	Nonphysician Anesthetists									19
20	Nursing School									20
21	Intern & Res. Service-Salary & Fringes (Approved)									21
22	Intern & Res. Other Program Costs (Approved)									22
23	Paramedical Education Program (specify)									23
INPATIENT ROUTINE SERVICE COST CENTERS										
30	Adults and Pediatrics (General Routine Care)									30
31	Intensive Care Unit									31
32	Coronary Care Unit									32
33	Burn Intensive Care Unit									33
34	Surgical Intensive Care Unit									34
35	Other Special Care Unit (specify)									35
40	Subprovider IPF									40
41	Subprovider IRF									41
42	Subprovider (specify)									42
43	Nursery									43

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 150177			PERIOD: FROM 01/01/2015 TO 12/31/2015		WORKSHEET B-1		
COST CENTER DESCRIPTIONS	NON-PHYSICIAN ANESTHETISTS (ASGND TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS		PARAMEDICAL EDUCATION (ASSIGNED TIME)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
			SALARY AND FRINGES (ASSIGNED TIME)	PROGRAM COSTS (ASSIGNED TIME)					
	19	20	21	22	23	24	25	26	
44 Skilled Nursing Facility									44
45 Nursing Facility									45
46 Other Long Term Care									46
ANCILLARY SERVICE COST CENTERS									
50 Operating Room									50
51 Recovery Room									51
52 Labor Room and Delivery Room									52
53 Anesthesiology									53
54 Radiology-Diagnostic									54
55 Radiology-Therapeutic									55
56 Radioisotope									56
57 Computed Tomography (CT) Scan									57
58 Magnetic Resonance Imaging (MRI)									58
59 Cardiac Catheterization									59
60 Laboratory									60
61 PBP Clinical Laboratory Services-Program Only									61
62 Whole Blood & Packed Red Blood Cells									62
63 Blood Storing, Processing, & Trans.									63
64 Intravenous Therapy									64
65 Respiratory Therapy									65
66 Physical Therapy									66
67 Occupational Therapy									67
68 Speech Pathology									68
69 Electrocardiology									69
70 Electroencephalography									70
71 Medical Supplies Charged to Patients									71
72 Implantable Devices Charged to Patients									72
73 Drugs Charged to Patients									73
74 Renal Dialysis									74
75 ASC (Non-Distinct Part)									75
76 Other Ancillary (specify)									76
OUTPATIENT SERVICE COST CENTERS									
88 Rural Health Clinic (RHC)									88
89 Federally Qualified Health Center (FQHC)									89
90 Clinic									90
91 Emergency									91
92 Observation Beds (Non-Distinct Part)									92

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 150177				PERIOD: FROM 01/01/2015 TO 12/31/2015		WORKSHEET B-1		
COST CENTER DESCRIPTIONS		NON-PHYSICIAN ANESTHETISTS (ASGND TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS		PARAMEDICAL EDUCATION (ASSIGNED TIME)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
				SALARY AND FRINGES (ASSIGNED TIME)	PROGRAM COSTS (ASSIGNED TIME)					
		19	20	21	22	23	24	25	26	
92.01	Observation Beds (Distinct Part)									92.01
93	Other Outpatient Service (specify)									93
OTHER REIMBURSABLE COST CENTERS										
94	Home Program Dialysis									94
95	Ambulance Services									95
96	Durable Medical Equipment-Rented									96
97	Durable Medical Equipment-Sold									97
98	Other Reimbursable (specify)									98
99	Outpatient Rehabilitation Provider (specify)									99
100	Intern-Resident Service (not appvd. tchng. prgm.)									100
101	Home Health Agency									101
SPECIAL PURPOSE COST CENTERS										
105	Kidney Acquisition									105
106	Heart Acquisition									106
107	Liver Acquisition									107
108	Lung Acquisition									108
109	Pancreas Acquisition									109
110	Intestinal Acquisition									110
111	Islet Acquisition									111
112	Other Organ Acquisition (specify)									112
115	Ambulatory Surgical Center (Distinct Part)									115
116	Hospice									116
117	Other Special Purpose (specify)									117
118	SUBTOTALS (sum of lines 1-117)									118
NONREIMBURSABLE COST CENTERS										
190	Gift, Flower, Coffee Shop, & Canteen									190
191	Research									191
192	Physicians' Private Offices									192
193	Nonpaid Workers									193
194	Other Nonreimbursable (specify)									194
200	Cross foot adjustments									200
201	Negative cost centers									201
202	Cost to be allocated (per Worksheet B, Part I)									202
203	Unit cost multiplier (Worksheet B, Part I)									203
204	Cost to be allocated (per Worksheet B, Part II)									204
205	Unit cost multiplier (Worksheet B, Part II)									205

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 150177			PERIOD: FROM 01/01/2015 TO 12/31/2015		WORKSHEET B-1	
COST CENTER DESCRIPTIONS	NON-PHYSICIAN ANESTHETISTS (ASGND TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS		PARAMEDICAL EDUCATION (ASSIGNED TIME)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL
			SALARY AND FRINGES (ASSIGNED TIME)	PROGRAM COSTS (ASSIGNED TIME)				
	19	20	21	22	23	24	25	26

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COMPUTATION OF RATIO OF COSTS TO CHARGES								Provider CCN: 150177		PERIOD: FROM 01/01/2015 TO 12/31/2015		WORKSHEET C PART I	
COST CENTER DESCRIPTIONS		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
				Total Costs	RCE Dis- allowance	Total Costs	Inpatient	Outpatient	Total (column 6 + column 7)				
		1	2	3	4	5	6	7	8	9	10	11	
Medicaid - Title XIX													
INPATIENT ROUTINE SERVICE COST CENTERS													
30	Adults and Pediatrics (General Routine Care)	5,538,764		5,538,764		5,538,764			2,458,759				30
31	Intensive Care Unit												31
32	Coronary Care Unit												32
33	Burn Intensive Care Unit												33
34	Surgical Intensive Care Unit												34
35	Other Special Care (specify)												35
40	Subprovider IPF												40
41	Subprovider IRF												41
42	Subprovider (Specify)												42
43	Nursery												43
44	Skilled Nursing Facility												44
45	Nursing Facility												45
46	Other Long Term Care												46
ANCILLARY SERVICE COST CENTERS													
50	Operating Room	2,970,758		2,970,758		2,970,758			43,221,948	0.068733	0.068733	0.068733	50
51	Recovery Room												51
52	Labor Room and Delivery Room												52
53	Anesthesiology	437,043		437,043		437,043			2,492,719	0.175328	0.175328	0.175328	53
54	Radiology-Diagnostic	1,802,509		1,802,509		1,802,509			2,479,173	0.727061	0.727061	0.727061	54
55	Radiology-Therapeutic												55
56	Radioisotope												56
57	Computed Tomography (CT) Scan												57
58	Magnetic Resonance Imaging (MRI)												58
59	Cardiac Catheterization												59
60	Laboratory	419,803		419,803		419,803			1,079,916	0.388737	0.388737	0.388737	60
61	PBP Clinical Laboratory Services-Prgm. Only												61
62	Whole Blood & Packed Red Blood Cells												62
63	Blood Storing, Processing, & Trans.												63
64	Intravenous Therapy												64
65	Respiratory Therapy												65
66	Physical Therapy	160,211		160,211		160,211			317,397	0.504765	0.504765	0.504765	66

COMPUTATION OF RATIO OF COSTS TO CHARGES									Provider CCN: 150177		PERIOD: FROM 01/01/2015 TO 12/31/2015		WORKSHEET C PART I
COST CENTER DESCRIPTIONS		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
				Total Costs	RCE Dis-allowance	Total Costs	Inpatient	Outpatient	Total (column 6 + column 7)				
		1	2	3	4	5	6	7	8	9	10	11	
Medicaid - Title XIX													
67	Occupational Therapy	90,038		90,038		90,038			186,892	0.481765	0.481765	0.481765	67
68	Speech Pathology	3,455		3,455		3,455							68
69	Electrocardiology												69
70	Electroencephalography	204,694		204,694		204,694			78,064	2.622131	2.622131	2.622131	70
71	Medical Supplies Charged to Patients	1,445,867		1,445,867		1,445,867			4,929,079	0.293334	0.293334	0.293334	71
72	Implantable Devices Charged to Patients	14,237,151		14,237,151		14,237,151			45,192,789	0.315031	0.315031	0.315031	72
73	Drugs Charged to Patients	1,570,173		1,570,173		1,570,173			2,491,369	0.630245	0.630245	0.630245	73
74	Renal Dialysis												74
75	ASC (Non-Distinct Part)												75
76	Other Ancillary (specify)												76
OUTPATIENT SERVICE COST CENTERS													
88	Rural Health Clinic (RHC)												88
89	Federally Qualified Health Center (FQHC)												89
90	Clinic												90
91	Emergency												91
92	Observation Beds (Non-Distinct Part)												92
92.01	Observation Beds (Distinct Part)												92.01
93	Other Outpatient Service (specify)												93
OTHER REIMBURSABLE COST CENTERS													
94	Home Program Dialysis												94
95	Ambulance Services												95
96	Durable Medical Equipment-Rented												96
97	Durable Medical Equipment-Sold												97
98	Other Reimbursable (specify)												98
99	Outpatient Rehabilitation Provider (specify)												99
100	Intern-Resident Service (not appvd. tchng. prgm.)												100
101	Home Health Agency												101
SPECIAL PURPOSE COST CENTERS													
105	Kidney Acquisition												105
106	Heart Acquisition												106
107	Liver Acquisition												107
108	Lung Acquisition												108
109	Pancreas Acquisition												109
110	Intestinal Acquisition												110
111	Islet Acquisition												111
112	Other Organ Acquisition (specify)												112

COMPUTATION OF RATIO OF COSTS TO CHARGES									Provider CCN: 150177		PERIOD: FROM 01/01/2015 TO 12/31/2015		WORKSHEET C PART I
COST CENTER DESCRIPTIONS		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
				Total Costs	RCE Dis-allowance	Total Costs	Inpatient	Outpatient	Total (column 6 + column 7)				
		1	2	3	4	5	6	7	8	9	10	11	
Medicaid - Title XIX													
115	Ambulatory Surgical Center (Distinct Part)												115
116	Hospice												116
117	Other Special Purpose (specify)												117
200	Subtotal (see instructions)	28,880,466		28,880,466		28,880,466			104,928,105				200
201	Less Observation Beds												201
202	Total (see instructions)			28,880,466		28,880,466	72,314,681	32,613,424	104,928,105				202

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COMPUTATION OF RATIO OF COSTS TO CHARGES									Provider CCN: 150177			PERIOD: FROM 01/01/2015 TO 12/31/2015		WORKSHEET C PART I	
COST CENTER DESCRIPTIONS		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio			
				Total Costs	RCE Dis-allowance	Total Costs	Inpatient	Outpatient	Total (column 6 + column 7)						
		1	2	3	4	5	6	7	8	9	10	11			
Consolidated															
INPATIENT ROUTINE SERVICE COST CENTERS															
30	Adults and Pediatrics (General Routine Care)	5,538,764		5,538,764		5,538,764	2,458,759		2,458,759				30		
31	Intensive Care Unit												31		
32	Coronary Care Unit												32		
33	Burn Intensive Care Unit												33		
34	Surgical Intensive Care Unit												34		
35	Other Special Care (specify)												35		
40	Subprovider IPF												40		
41	Subprovider IRF												41		
42	Subprovider (Specify)												42		
43	Nursery												43		
44	Skilled Nursing Facility												44		
45	Nursing Facility												45		
46	Other Long Term Care												46		
ANCILLARY SERVICE COST CENTERS															
50	Operating Room	2,970,758		2,970,758		2,970,758	23,508,070	19,713,878	43,221,948	0.068733	0.068733	0.068733	50		
51	Recovery Room												51		
52	Labor Room and Delivery Room												52		
53	Anesthesiology	437,043		437,043		437,043	1,154,437	1,338,282	2,492,719	0.175328	0.175328	0.175328	53		
54	Radiology-Diagnostic	1,802,509		1,802,509		1,802,509	194,596	2,284,577	2,479,173	0.727061	0.727061	0.727061	54		
55	Radiology-Therapeutic												55		
56	Radioisotope												56		
57	Computed Tomography (CT) Scan												57		
58	Magnetic Resonance Imaging (MRI)												58		
59	Cardiac Catheterization												59		
60	Laboratory	419,803		419,803		419,803	900,532	179,384	1,079,916	0.388737	0.388737	0.388737	60		
61	PBP Clinical Laboratory Services-Prgm. Only												61		
62	Whole Blood & Packed Red Blood Cells												62		
63	Blood Storing, Processing, & Trans.												63		
64	Intravenous Therapy												64		
65	Respiratory Therapy												65		
66	Physical Therapy	160,211		160,211		160,211	308,671	8,726	317,397	0.504765	0.504765	0.504765	66		

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 150177	PERIOD: FROM 01/01/2015 TO 12/31/2015	WORKSHEET C PART I

	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
				Total Costs	RCE Dis-allowance	Total Costs	Inpatient	Outpatient	Total (column 6 + column 7)				
		1	2	3	4	5	6	7	8	9	10	11	
Consolidated													
67	Occupational Therapy	90,038		90,038		90,038	182,345	4,547	186,892	0.481765	0.481765	0.481765	67
68	Speech Pathology	3,455		3,455		3,455							68
69	Electrocardiology												69
70	Electroencephalography	204,694		204,694		204,694		78,064	78,064	2.622131	2.622131	2.622131	70
71	Medical Supplies Charged to Patients	1,445,867		1,445,867		1,445,867	2,202,538	2,726,541	4,929,079	0.293334	0.293334	0.293334	71
72	Implantable Devices Charged to Patients	14,237,151		14,237,151		14,237,151	39,743,063	5,449,726	45,192,789	0.315031	0.315031	0.315031	72
73	Drugs Charged to Patients	1,570,173		1,570,173		1,570,173	1,661,670	829,699	2,491,369	0.630245	0.630245	0.630245	73
74	Renal Dialysis												74
75	ASC (Non-Distinct Part)												75
76	Other Ancillary (specify)												76
OUTPATIENT SERVICE COST CENTERS													
88	Rural Health Clinic (RHC)												88
89	Federally Qualified Health Center (FQHC)												89
90	Clinic												90
91	Emergency												91
92	Observation Beds (Non-Distinct Part)												92
92.01	Observation Beds (Distinct Part)												92.01
93	Other Outpatient Service (specify)												93
OTHER REIMBURSABLE COST CENTERS													
94	Home Program Dialysis												94
95	Ambulance Services												95
96	Durable Medical Equipment-Rented												96
97	Durable Medical Equipment-Sold												97
98	Other Reimbursable (specify)												98
99	Outpatient Rehabilitation Provider (specify)												99
100	Intern-Resident Service (not appvd. tchng. prgm.)												100
101	Home Health Agency												101
SPECIAL PURPOSE COST CENTERS													
105	Kidney Acquisition												105
106	Heart Acquisition												106
107	Liver Acquisition												107
108	Lung Acquisition												108
109	Pancreas Acquisition												109
110	Intestinal Acquisition												110
111	Islet Acquisition												111
112	Other Organ Acquisition (specify)												112

COMPUTATION OF RATIO OF COSTS TO CHARGES									Provider CCN: 150177		PERIOD: FROM 01/01/2015 TO 12/31/2015	WORKSHEET C PART I	
COST CENTER DESCRIPTIONS		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
				Total Costs	RCE Dis-allowance	Total Costs	Inpatient	Outpatient	Total (column 6 + column 7)				
		1	2	3	4	5	6	7	8	9	10	11	
Consolidated													
115	Ambulatory Surgical Center (Distinct Part)												115
116	Hospice												116
117	Other Special Purpose (specify)												117
200	Subtotal (see instructions)	28,880,466		28,880,466		28,880,466	72,314,681	32,613,424	104,928,105				200
201	Less Observation Beds												201
202	Total (see instructions)	28,880,466		28,880,466		28,880,466	72,314,681	32,613,424	104,928,105				202

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
Cost report status - As Submitted
[Record code 577478 - 2010]

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150177		PERIOD: FROM 01/01/2015 TO 12/31/2015		WORKSHEET D, PART I		
Medicare -Title XVIII - Hospital								
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTNE SERVICE COST CENTERS								
30	Adults & Pediatrics (General Routine Care)	1,058,446		1,058,446	1,099	963.10	239	230,181	30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care Unit (specify)								35
40	Subprovider IPF								40
41	Subprovider IRF								41
42	Subprovider (Other)								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,058,446		1,058,446	1,099		239	230,181	200

(A) Worksheet A line numbers

FORM CMS-2552-10 (10/2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTIONS 4024 - 4024.1)

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150177		PERIOD: FROM 01/01/2015 TO 12/31/2015		WORKSHEET D, PART II	
Medicare -Title XVIII - Hospital							
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	736,039	43,221,948	0.017029	5,217,457	88,848	50
51	Recovery Room						51
52	Labor Room and Delivery Room						52
53	Anesthesiology	12,367	2,492,719	0.004961	252,560	1,253	53
54	Radiology-Diagnostic	484,362	2,479,173	0.195372	29,541	5,771	54
55	Radiology-Therapeutic						55
56	Radioisotope						56
57	Computed Tomography (CT) Scan						57
58	Magnetic Resonance Imaging (MRI)						58
59	Cardiac Catheterization						60
60	Laboratory	27,161	1,079,916	0.025151	65,888	1,657	60
61	PBP Clinical Laboratory Services-Prgm. Only						61
62	Whole Blood & Packed Red Blood Cells						62
63	Blood Storing, Processing, & Transfusing						63
64	Intravenous Therapy						64
65	Respiratory Therapy						65
66	Physical Therapy	13,686	317,397	0.043120	78,098	3,368	66
67	Occupational Therapy	4,229	186,892	0.022628	46,770	1,058	67
68	Speech Pathology	2,340					68
69	Electrocardiology						69
70	Electroencephalography	131,160	78,064	1.680160			70
71	Medical Supplies Charged to Patients	34,381	4,929,079	0.006975	612,308	4,271	71
72	Implantable Devices Charged to Patients	310,678	45,192,789	0.006875	6,411,221	44,077	72
73	Drugs Charged to Patients	147,819	2,491,369	0.059332	484,578	28,751	73
74	Renal Dialysis						74
75	ASC (Non-Distinct Part)						75
76	Other Ancillary (specify)						76
88	Rural Health Clinic (RHC)						88
89	Federally Qualified Health Center (FQHC)						89
90	Clinic						90
91	Emergency						91
92	Observation Beds (Non-Distinct Part)						92
92.01	Observation Beds (Distinct Part)						92.01
93	Other Outpatient Service (specify)						93
	OTHER REIMBURSABLE COST CENTERS						
94	Home Program Dialysis						94
95	Ambulance Services						95
96	Durable Medical Equipment-Rented						96
97	Durable Medical Equipment-Sold						97
98	Other Reimbursable (specify)						98
200	Total (sum of lines 50 through 199)	1,904,222	102,469,346	0.018583	13,198,421	179,054	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150177	PERIOD: FROM 01/01/2015 TO 12/31/2015	WORKSHEET D, PART III

Medicare -Title XVIII - Hospital

(A)	Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
		1	2	3	4	5	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS										
30	Adults & Pediatrics (General Routine Care)						1,099		239		30
31	Intensive Care Unit										31
32	Coronary Care Unit										32
33	Burn Intensive Care Unit										33
34	Surgical Intensive Care Unit										34
35	Other Special Care Unit (specify)										35
40	Subprovider IPF										40
41	Subprovider IRF										41
42	Subprovider (Other)										42
43	Nursery										43
44	Skilled Nursing Facility										44
45	Nursing Facility										45
200	Total (sum of lines 30-199)						1,099		239		200

(A) Worksheet A line numbers

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
Cost report status - As Submitted
[Record code 577478 - 2010]

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150177	PERIOD: FROM 01/01/2015 TO 12/31/2015	WORKSHEET D, PART IV

Medicare -Title XVIII - Hospital

(A)	Cost Center Description	Non Physician Anesthetist Cost 1	Nursing School 2	Allied Health 3	All Other Medical Education Cost 4	Total cost (sum of col 1 through col. 4) 5	Total Outpatient Cost (sum of col. 2, 3 and 4) 6	Total Charges (from Wkst. C, Part I, col. 8) 7	Ratio of Cost to Charges (col. 5 ÷ col. 7) 8	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7) 9	Inpatient Program Charges 10	Inpatient Program Pass- Through Costs (col. 8 x col. 10) 11	Outpatient Program Charges 12	Outpatient Program Pass- Through Costs (col. 9 x col. 12) 13	
ANCILLARY SERVICE COST CENTERS															
50	Operating Room							43,221,948			5,217,457		6,998,021		50
51	Recovery Room														51
52	Labor room and Delivery Room														52
53	Anesthesiology							2,492,719			252,560		522,132		53
54	Radiology-Diagnostic							2,479,173			29,541		676,151		54
55	Radiology-Therapeutic														55
56	Radioisotope														56
57	Computed Tomography (CT) Scan														57
58	Magnetic Resonance Imaging (MRI)														58
59	Cardiac Catheterization														59
60	Laboratory							1,079,916			65,888		54,015		60
61	PBP Clinical Laboratory Services-Prgm. Only														61
62	Whole Blood & Packed Red Blood Cells														62
63	Blood Storing, Processing, & Transfusing														63
64	Intravenous Therapy														64
65	Respiratory Therapy												229		65
66	Physical Therapy							317,397			78,098		410		66
67	Occupational Therapy							186,892			46,770		300		67
68	Speech Pathology														68
69	Electrocardiology														69
70	Electroencephalography							78,064					10,800		70
71	Medical Supplies Charged To Patients							4,929,079			612,308		1,165,418		71
72	Implantable Devices Charged to Patients							45,192,789			6,411,221		1,932,557		72
73	Drugs Charged to Patients							2,491,369			484,578		312,364		73
74	Renal Dialysis														74
75	ASC (Non-Distinct Part)														75
76	Other Ancillary (specify)														76
OUTPATIENT SERVICE COST CENTERS															
88	Rural Health Clinic (RHC)														88
89	Federally Qualified Health Center (FQHC)														89
90	Clinic														90

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150177	PERIOD: FROM 01/01/2015 TO 12/31/2015	WORKSHEET D, PART IV

Medicare -Title XVIII - Hospital

(A)	Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass- Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass- Through Costs (col. 9 x col. 12)	
		1	2	3	4	5	6	7	8	9	10	11	12	13	
91	Emergency														91
92	Observation Beds (Non-Distinct Part)														92
92.01	Observation Beds (Distinct Part)														92.01
93	Other Outpatient Service (specify)														93
OTHER REIMBURSABLE COST CENTERS															
94	Home Program Dialysis														94
95	Ambulance Services														95
96	Durable Medical Equipment-Rented														96
97	Durable Medical Equipment-Sold														97
98	Other Reimbursable (specify)														98
200	Total (sum of lines 50 through 199)							102,469,346			13,198,421		11,672,397		200

(A) Worksheet A line numbers

FORM CMS-2552-10 (09/2015) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4024.4)

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
Cost report status - As Submitted
[Record code 577478 - 2010]

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS	Provider CCN: 150177	PERIOD: FROM 01/01/2015 TO 12/31/2015	WORKSHEET D, PART V

Medicare -Title XVIII - Hospital

PART V - APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

		Cost to Charge Ratio from Worksheet C, Part I, col. 9	Program Charges			Program Cost			
			PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject to Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject to Ded. & Coins. (see instructions)	PPS Services (see instructions)	Cost Reimbursed Services Subject to Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject to Ded. & Coins. (see instructions)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
ANCILLARY SERVICE COST CENTERS									
50	Operating Room		6,998,021			480,995			50
51	Recovery Room								51
52	Labor & Delivery Room								52
53	Anesthesiology		522,132			91,544			53
54	Radiology-Diagnostic		676,151			491,603			54
55	Radiology-Therapeutic								55
56	Radioisotope								56
57	Computed Tomography (CT) Scan								57
58	Magnetic Resonance Imaging (MRI)								58
59	Cardiac Catheterization								59
60	Laboratory		54,015			20,998			60
61	PBP Clinic Laboratory Services-Prgm. Only								61
62	Whole Blood & Packed Red Blood Cells								62
63	Blood Storing, Processing, & Transfusing								63
64	Intravenous Therapy								64
65	Respiratory Therapy		229						65
66	Physical Therapy		410			207			66
67	Occupational Therapy		300			145			67
68	Speech Pathology								68
69	Electrocardiology								69
70	Electroencephalography		10,800			28,319			70
71	Medical Supplies Charged To Patients		1,165,418			341,857			71
72	Implantable Devices Charged to Patients		1,932,557			608,815			72
73	Drugs Charged to Patients		312,364			196,866			73
74	Renal Dialysis								74
75	ASC (Non-Distinct Part)								75
76	Other Ancillary (specify)								76
OUTPATIENT SERVICE COST CENTERS									
88	Rural Health Clinic (RHC)								88
89	Federally Qualified Health Center (FQHC)								89
90	Clinic								90
91	Emergency								91
92	Observation Bed (Non-Distinct Part)								92
92.01	Observation Bed (Distinct Part)								92.01
93	Other Outpatient Service (specify)								93
OTHER REIMBURSABLE COST CENTERS									
94	Home Program Dialysis								94
95	Ambulance								95
96	Durable Medical Equipment-Rented								96
97	Durable Medical Equipment-Sold								97
98	Other Reimbursable Cost Center								98
200	Subtotal (see instructions)		11,672,397			2,261,349			200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		11,672,397			2,261,349			202

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS	Provider CCN: 150177	PERIOD: FROM 01/01/2015 TO 12/31/2015	WORKSHEET D, PART V

Medicaid - Title XIX - Hospital

PART V - APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

		Cost to Charge Ratio from Worksheet C, Part I, col. 9	Program Charges			Program Cost			
			PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject to Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject to Ded. & Coins. (see instructions)	PPS Services (see instructions)	Cost Reimbursed Services Subject to Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject to Ded. & Coins. (see instructions)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
ANCILLARY SERVICE COST CENTERS									
50	Operating Room		1,080,547						50
51	Recovery Room								51
52	Labor & Delivery Room								52
53	Anesthesiology		23,664						53
54	Radiology-Diagnostic		38,159						54
55	Radiology-Therapeutic								55
56	Radioisotope								56
57	Computed Tomography (CT) Scan								57
58	Magnetic Resonance Imaging (MRI)								58
59	Cardiac Catheterization								59
60	Laboratory		3,858						60
61	PBP Clinic Laboratory Services-Prgm. Only								61
62	Whole Blood & Packed Red Blood Cells								62
63	Blood Storing, Processing, & Transfusing								63
64	Intravenous Therapy								64
65	Respiratory Therapy								65
66	Physical Therapy								66
67	Occupational Therapy								67
68	Speech Pathology								68
69	Electrocardiology								69
70	Electroencephalography								70
71	Medical Supplies Charged To Patients								71
72	Implantable Devices Charged to Patients								72
73	Drugs Charged to Patients		17,912						73
74	Renal Dialysis								74
75	ASC (Non-Distinct Part)								75
76	Other Ancillary (specify)								76
OUTPATIENT SERVICE COST CENTERS									
88	Rural Health Clinic (RHC)								88
89	Federally Qualified Health Center (FQHC)								89
90	Clinic								90
91	Emergency								91
92	Observation Bed (Non-Distinct Part)								92
92.01	Observation Bed (Distinct Part)								92.01
93	Other Outpatient Service (specify)								93
OTHER REIMBURSABLE COST CENTERS									
94	Home Program Dialysis								94
95	Ambulance								95
96	Durable Medical Equipment-Rented								96
97	Durable Medical Equipment-Sold								97
98	Other Reimbursable Cost Center								98
200	Subtotal (see instructions)		1,164,140						200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)					118,951			202

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
Cost report status - As Submitted
[Record code 577478 - 2010]

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150177	PERIOD: FROM 01/01/2015 TO 12/31/2015	WORKSHEET D-1, PART I

Medicare -Title XVIII - Hospital

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,099	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,099	2
3	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed and observation bed days)	1,099	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	239	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions).		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period.		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the Program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	5,538,764	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,538,764	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,538,764	37

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150177	PERIOD: FROM 01/01/2015 TO 12/31/2015	WORKSHEET D-1, PART I

Medicaid - Title XIX - Hospital

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,099	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,099	2
3	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed and observation bed days)	1,099	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	26	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions).		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period.		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the Program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)		21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		37

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150177		PERIOD: FROM 01/01/2015 TO 12/31/2015	WORKSHEET D-1, PART II	
Medicare -Title XVIII - Hospital						
PART II - HOSPITAL AND SUBPROVIDERS ONLY						
PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS					1	
38	Adjusted general inpatient routine service cost per diem (see instructions)				5,039.82	38
39	Program general inpatient routine service cost (line 9 x line 38)				1,204,517	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)					40
41	Total Program general inpatient routine service cost (line 39 + line 40)				1,204,517	41

		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care Unit (specify)						47

		1	
48	Program inpatient ancillary service cost (Worksheet D-3, column 3, line 200)	3,016,683	48
49	Total Program inpatient costs (sum of lines 41 through 48) (see instructions)	4,221,200	49
PASS-THROUGH COST ADJUSTMENTS			
50	Pass through costs applicable to Program inpatient routine services (from Worksheet D, sum of Parts I and III)	230,181	50
51	Pass through costs applicable to Program inpatient ancillary services (from Worksheet D, sum of Parts II and IV)	179,054	51
52	Total Program excludable cost (sum of lines 50 and 51)	409,235	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist, and medical education costs (line 49 minus line 52)	3,811,965	53
TARGET AMOUNT AND LIMIT COMPUTATION			
54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket		60
61	If line 53 ÷ line 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63
PROGRAM INPATIENT ROUTINE SWING BED COST			
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (see instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (see instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (Title XVIII only. For CAH, see instructions.)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150177	PERIOD: FROM 01/01/2015 TO 12/31/2015	WORKSHEET D-1, PART II

Medicaid - Title XIX - Hospital

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS	1	
38	Adjusted general inpatient routine service cost per diem (see instructions)		38
39	Program general inpatient routine service cost (line 9 x line 38)		39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40
41	Total Program general inpatient routine service cost (line 39 + line 40)		41

		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care Unit (specify)						47

		1	
48	Program inpatient ancillary service cost (Worksheet D-3, column 3, line 200)		48
49	Total Program inpatient costs (sum of lines 41 through 48) (see instructions)	200,975	49
	PASS-THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Worksheet D, sum of Parts I and III)		50
51	Pass through costs applicable to Program inpatient ancillary services (from Worksheet D, sum of Parts II and IV)		51
52	Total Program excludable cost (sum of lines 50 and 51)		52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist, and medical education costs (line 49 minus line 52)		53
	TARGET AMOUNT AND LIMIT COMPUTATION		
54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket		60
61	If line 53 ÷ line 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (see instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (see instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (Title XVIII only. For CAH, see instructions.)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150177	PERIOD: FROM 01/01/2015 TO 12/31/2015	WORKSHEET D-1, PARTS III & IV

Medicare -Title XVIII - Hospital

	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY. AND ICF/IID ONLY		
70	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70
71	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71
72	Program routine service cost (line 9 x line 71)		72
73	Medically necessary private room cost applicable to Program (line 14 x line 35)		73
74	Total Program general inpatient routine service costs (line 72 + line 73)		74
75	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Parts II, column 26, line 45)		75
76	Per diem capital-related costs (line 75 ÷ line 2)		76
77	Program capital-related costs (line 9 x line 76)		77
78	Inpatient routine service cost (line 74 minus line 77)		78
79	Aggregate charges to beneficiaries for excess costs (from provider records)		79
80	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80
81	Inpatient routine service cost per diem limitation		81
82	Inpatient routine service cost limitation (line 9 x line 81)		82
83	Reasonable inpatient routine service costs (see instructions)		83
84	Program inpatient ancillary services (see instructions)		84
85	Utilization review - physician compensation (see instructions)		85
86	Total Program inpatient operating costs (sum of lines 83 through 85)		86
	PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST		
87	Total observation bed days (see instructions)		87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)		88
89	Observation bed cost (line 87 x line 88) (see instructions)		89

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

		Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass-Through Cost (col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	1,058,446	5,538,764	0.191098			90
91	Nursing School cost		5,538,764				91
92	Allied Health cost		5,538,764				92
93	All other Medical Education		5,538,764				93

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150177	PERIOD: FROM 01/01/2015 TO 12/31/2015		WORKSHEET D-3	
Medicare -Title XVIII - Hospital						
(A) COST CENTER DESCRIPTION			Ratio of Cost to Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1	2	3	
INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults and Pediatrics (General Routine Care)			303,362		30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider IPF					40
41	Subprovider IRF					41
42	Subprovider (Specify)					42
43	Nursery					43
ANCILLARY SERVICE COST CENTERS						
50	Operating Room		0.068733	5,217,457	358,611	50
51	Recovery Room					51
52	Labor Room and Delivery Room					52
53	Anesthesiology		0.175328	252,560	44,281	53
54	Radiology-Diagnostic		0.727061	29,541	21,478	54
55	Radiology-Therapeutic					55
56	Radioisotope					56
57	Computed Tomography (CT) Scan					57
58	Magnetic Resonance Imaging (MRI)					58
59	Cardiac Catheterization					59
60	Laboratory		0.388737	65,888	25,613	60
61	PBP Clinical Laboratory Services-Prgm. Only					61
62	Whole Blood & Packed Red Blood Cells					62
63	Blood Storing, Processing, & Trans.					63
64	Intravenous Therapy					64
65	Respiratory Therapy					65
66	Physical Therapy		0.504765	78,098	39,421	66
67	Occupational Therapy		0.481765	46,770	22,532	67
68	Speech Pathology					68
69	Electrocardiology					69
70	Electroencephalography					70
71	Medical Supplies Charged to Patients		0.293334	612,308	179,611	71
72	Implantable Devices Charged to Patients		0.315031	6,411,221	2,019,733	72
73	Drugs Charged to Patients		0.630245	484,578	305,403	73
74	Renal Dialysis					74
75	ASC (Non-Distinct Part)					75
76	Other Ancillary (specify)					76
OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic (RHC)					88
89	Federally Qualified Health Center (FQHC)					89
90	Clinic					90
91	Emergency					91
92	Observation Beds (Non-Distinct Part)					92
92.01	Observation Beds (Distinct Part)					92.01
93	Other Outpatient Service (specify)					93
OTHER REIMBURSABLE COST CENTERS						
94	Home Program Dialysis					94
95	Ambulance Services					95
96	Durable Medical Equipment-Rented					96
97	Durable Medical Equipment-Sold					97
98	Other Reimbursable (specify)					98
200	Total (sum of lines 50-94 and 96-98)			13,198,421	3,016,683	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)					201
202	Net Charges (line 200 minus line 201)			13,198,421		202
(A) Worksheet A line numbers						
FORM CMS-2552-10 (09-2015) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4027)						

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 150177	PERIOD: FROM 01/01/2015 TO 12/31/2015		WORKSHEET D-3
Medicare -Title XVIII - Hospital				
(A) COST CENTER DESCRIPTION		Ratio of Cost to Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1	2	3

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150177	PERIOD: FROM 01/01/2015 TO 12/31/2015		WORKSHEET D-3	
Medicaid - Title XIX - Hospital						
(A) COST CENTER DESCRIPTION			Ratio of Cost to Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1	2	3	
INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults and Pediatrics (General Routine Care)			38,568		30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider IPF					40
41	Subprovider IRF					41
42	Subprovider (Specify)					42
43	Nursery					43
ANCILLARY SERVICE COST CENTERS						
50	Operating Room		0.068733	677,605		50
51	Recovery Room					51
52	Labor Room and Delivery Room					52
53	Anesthesiology		0.175328	13,920		53
54	Radiology-Diagnostic		0.727061	1,715		54
55	Radiology-Therapeutic					55
56	Radioisotope					56
57	Computed Tomography (CT) Scan					57
58	Magnetic Resonance Imaging (MRI)					58
59	Cardiac Catheterization					59
60	Laboratory		0.388737	2,013		60
61	PBP Clinical Laboratory Services-Prgm. Only					61
62	Whole Blood & Packed Red Blood Cells					62
63	Blood Storing, Processing, & Trans.					63
64	Intravenous Therapy					64
65	Respiratory Therapy					65
66	Physical Therapy		0.504765	9,063		66
67	Occupational Therapy		0.481765	5,405		67
68	Speech Pathology					68
69	Electrocardiology					69
70	Electroencephalography					70
71	Medical Supplies Charged to Patients					71
72	Implantable Devices Charged to Patients					72
73	Drugs Charged to Patients		0.630245	18,590		73
74	Renal Dialysis					74
75	ASC (Non-Distinct Part)					75
76	Other Ancillary (specify)					76
OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic (RHC)					88
89	Federally Qualified Health Center (FQHC)					89
90	Clinic					90
91	Emergency					91
92	Observation Beds (Non-Distinct Part)					92
92.01	Observation Beds (Distinct Part)					92.01
93	Other Outpatient Service (specify)					93
OTHER REIMBURSABLE COST CENTERS						
94	Home Program Dialysis					94
95	Ambulance Services					95
96	Durable Medical Equipment-Rented					96
97	Durable Medical Equipment-Sold					97
98	Other Reimbursable (specify)					98
200	Total (sum of lines 50-94 and 96-98)			728,311	69,940	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)					201
202	Net Charges (line 200 minus line 201)					202
(A) Worksheet A line numbers						

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 150177	PERIOD: FROM 01/01/2015 TO 12/31/2015		WORKSHEET D-3
Medicaid - Title XIX - Hospital				
(A) COST CENTER DESCRIPTION		Ratio of Cost to Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1	2	3

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
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CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150177	PERIOD: FROM 01/01/2015 TO 12/31/2015	WORKSHEET E PART A	
Medicare -Title XVIII - Hospital					
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
		1	1.01	1.02	
1	DRG amounts other than outlier payments				1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1(see instructions)	993,771			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	278,894			1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)				1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)				1.04
2	Outlier payments for discharges (see instructions)	1,234,471			2
2.01	Outlier reconciliation amount				2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)				2.02
3	Managed care simulated payments				3
4	Bed days available divided by number of days in the cost reporting period (see instructions) Indirect Medical Education Adjustment Calculation for Hospitals	29.00			4
5	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions)				5
6	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in in accordance with 42 CFR 413.79(e)				6
7	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)				7
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.				7.01
8	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).				8
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.				8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)				8.02
9	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions)				9
10	FTE count for allopathic and osteopathic programs in the current year from your records				10
11	FTE count for residents in dental and podiatric programs				11
12	Current year allowable FTE (see instructions)				12
13	Total allowable FTE count for the prior year				13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.				14
15	Sum of lines 12 through 14 divided by 3				15
16	Adjustment for residents in initial years of the program				16
17	Adjustment for residents displaced by program or hospital closure				17
18	Adjusted rolling average FTE count				18
19	Current year resident to bed ratio (line 18 divided by line 4)				19
20	Prior year resident to bed ratio (see instructions)				20
21	Enter the lesser of lines 19 or 20 (see instructions)				21
22	IME payment adjustment (see instructions)				22
22.01	IME payment adjustment - Managed Care (see instructions)				22.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA					
23	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).				23
24	IME FTE resident count over cap (see instructions)				24
25	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)				25
26	Resident to bed ratio (divide line 25 by line 4)				26
27	IME payments adjustment factor (see instructions)				27
28	IME add-on a djustment amount (see instructions)				28
28.01	IME add-on adjustment amount - Managed Care (see instructions)				28.01
29	Total IME payment (sum of lines 22 and 28)				29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)				29.01
Disproportionate Share Adjustment					
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)				30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.023700			31

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150177	PERIOD: FROM 01/01/2015 TO 12/31/2015		WORKSHEET E PART A	
32	Sum of lines 30 and 31		0.023700			32
33	Allowable disproportionate share percentage (see instructions)					33
34	Disproportionate share adjustment (see instructions)					34
Uncompensated Care Adjustment				Prior to October 1	On or after October 1	
				1	2	
35	Total uncompensated care amount (see instructions)			7,647,644,885	6,406,145,534	35
35.01	Factor 3 (see instructions)			0.000004029	0.000001388	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)					35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)					35.03
			1	1.01	2	
35.04	Pro rata share of the hospital uncompensated care payment amount (MDH) (see instructions)					35.04
35.05	Pro rata share of the hospital uncompensated care payment amount (SCH) (see instructions)					35.05
				Prior to October 1	On or after October 1	
				1	2	
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)					36
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)						
			1	1.01	1.02	
40	Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)					40
41	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685 (see instructions)					41
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684, and 685 (see instructions)					41
42	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)					42
43	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)					43
44	Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days)					44
45	Average weekly cost for dialysis treatments (see instructions)					45
46	Total additional payment (line 45 times line 44 times line 41.01)					46
47	Subtotal (see instructions)		2,507,136			47
48	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see instructions)					48
49	Total payment for inpatient operating costs (see instructions)		2,507,136			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		282,605			50
51	Exception payment for inpatient program capital (Wkst. L, Pt. III) (see instructions)					51
52	Direct graduate medical education payment (from Wkst. E-4, line 49) (see instructions).					52
53	Nursing and allied health managed care payment					53
54	Special add-on payments for new technologies					54
54.01	Islet isolation add-on payment					54.01
55	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)					55
56	Cost of physicians' services in a teaching hospital (see instructions)					56
57	Routine service other pass through costs (from Wkst. D, Pt. III, col. 9, lines 30 through 35).					57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)					58
59	Total (sum of amounts on lines 49 through 58)		2,789,741			59
60	Primary payer payments					60
61	Total amount payable for program beneficiaries (line 59 minus line 60)		2,789,741			61
62	Deductibles billed to program beneficiaries		95,716			62
63	Coinsurance billed to program beneficiaries					63
64	Allowable bad debts (see instructions)		29,853			64
65	Adjusted reimbursable bad debts (see instructions)		19,404			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)					66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)		2,713,429			67
68	Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions)					68
69	Outlier payments reconciliation (Sum of lines 93,95 and 96) (For SCH see instructions)					69
70	Other adjustments (specify) (see instructions)					70
70.88	SCH or MDH volume decrease adjustment					70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)					70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)					70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)					70.91
70.92	Bundled Model 1 discount amount (see instructions)					70.92
70.93	HVBP payment adjustment amount (see instructions)		5,665			70.93
70.94	HRR adjustment amount (see instructions)					70.94
70.95	Recovery of accelerated depreciation					70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150177	PERIOD: FROM 01/01/2015 TO 12/31/2015		WORKSHEET E PART A	
70.96	Low volume adjustment for federal fiscal year (yyyy)					70.96
70.97	Low volume adjustment for federal fiscal year (yyyy)					70.97
70.98	See instructions					70.98
70.99	HAC adjustment amount (see instructions)					70.99
71	Amount due provider (see instructions)		2,719,094			71
71.01	Sequestration adjustment (see instructions)		54,382			71.01
72	Interim payments		2,645,696			72
73	Tentative settlement (for contractor use only)					73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		19,016			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, Chapter 1, § 115.2					75
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)						
90	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		1,234,471			90
91	Capital outlier from Wkst. L, Pt. I, line 2		181,502			91
92	Operating outlier reconciliation adjustment amount (see instructions)					92
93	Capital outlier reconciliation adjustment amount (see instructions)					93
94	The rate used to calculate the time value of money (see instructions)					94
95	Time value of money for operating expenses (see instructions)					95
96	Time value of money for capital related expenses (see instructions)					96
				1	2	
	HSP Bonus Payment Amount			Prior to 10/1	On or After 10/1	
100	HSP Bonus Payment Amount (see instructions)					100
	HVBP Adjustment for HSP Bonus Payment			Prior to 10/1	On or After 10/1	
101	HVBP adjustment factor (see instructions)					101
102	HVBP adjustment amount for HSP bonus payment (see instructions)					102
	HRR Adjustment for HSP Bonus Payment			Prior to 10/1	On or After 10/1	
103	HRR adjustment factor (see instructions)					103
104	HRR adjustment amount for HSP bonus payment (see instructions)					104

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CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150177	PERIOD: FROM 01/01/2015 TO 12/31/2015	WORKSHEET E, PART B

	Medicare -Title XVIII - Hospital		
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1	Medical and other services (see instructions)		1
2	Medical and other services reimbursed under OPPS (see instructions).	2,261,349	2
3	PPS payments	2,067,017	3
4	Outlier payment (see instructions)	84,985	4
5	Enter the hospital specific payment to cost ratio (see instructions)		5
6	Line 2 times line 5		6
7	Sum of line 3 and line 4 divided by line 6		7
8	Transitional corridor payment (see instructions)		8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		9
10	Organ acquisition		10
11	Total cost (sum of lines 1 and 10) (see instructions)		11
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12	Ancillary service charges		12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)		13
14	Total reasonable charges (sum of lines 12 and 13)		14
	Customary charges		
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis		15
16	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 42 CFR 413.13(e)		16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)		17
18	Total customary charges (see instructions)		18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)		21
22	Interns and residents (see instructions)		22
23	Cost of physicians' services in a teaching hospital (see instructions)		23
24	Total prospective payment (sum of lines 3, 4, 8, and 9)	2,152,002	24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25	Deductibles and coinsurance (see instructions)		25
26	Deductibles and Coinsurance relating to amount on line 24 (see instructions)	383,871	26
27	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	1,768,131	27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)		28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)		29
30	Subtotal (sum of lines 27 through 29)	1,768,131	30
31	Primary payer payments	9,102	31
32	Subtotal (line 30 minus line 31)	1,759,029	32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33	Composite rate ESRD (from Wkst. I-5, line 11)		33
34	Allowable bad debts (see instructions)		34
35	Adjusted reimbursable bad debts (see instructions)		35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)		36
37	Subtotal (see instructions)	1,759,029	37
38	MSP-LCC reconciliation amount from PS&R		38
39	Other adjustments (specify) (see instructions)		39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		39.98
39.99	Recovery of Accelerated depreciation		39.99
40	Subtotal (see instructions)	1,759,029	40
40.01	Sequestration adjustment (see instructions)	35,181	40.01
41	Interim payments	1,723,848	41
42	Tentative settlement (for contractors use only)		42
43	Balance due provider/program (see instructions)		43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,115.2		44
	PART B - MEDICAL AND OTHER HEALTH SERVICES TO BE COMPLETED BY CONTRACTOR		
90	Original outlier amount (see instructions)	84,985	90
91	Outlier reconciliation adjustment amount (see instructions)		91
92	The rate used to calculate the Time Value of Money		92

93	Time Value of Money (see instructions)		93
94	Total (sum of lines 91 and 93)		94

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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 150177	PERIOD: FROM 01/01/2015 TO 12/31/2015	WORKSHEET E-1, PART II

Medicare -Title XVIII - Hospital

To be completed by contractor for nonstandard cost reports
Health Information Technology Data Collection and Calculation

1	Total hospital discharges as defined in ARRA 4102 § (Wkst. S-3, Pt. I, col. 15, line 14)	325	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1 and 8 through 12)	239	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	147	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1 and 8 through 12)	1,099	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	104,928,105	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	105,633	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)		7
8	Calculation of the HIT incentive payment (see instructions)	351,600	8
9	Sequestration adjustment amount (see instructions)	7,032	9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	344,568	10
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30	Initial/interim HIT payment(s).	447,958	30
31	Initial/interim HIT payment adjustments (see instructions)		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)	-103,390	32

FORM CMS-2552-10 (09/2015) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, § 4031.2)

* This worksheet is completed by the contractor for standard and non-standard cost reporting periods at cost report settlement. Providers may complete this worksheet for a standard cost reporting period.

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BALANCE SHEET		Provider CCN: 150177	PERIOD: FROM 01/01/2015 TO 12/31/2015	WORKSHEET G	
(If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)					
Assets (Omit cents)	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1	2	3	4	
CURRENT ASSETS					
1 Cash on hand and in banks	318,481				1
2 Temporary investments					2
3 Notes receivable					3
4 Accounts receivable	34,974,204				4
5 Other receivables	201,374				5
6 Allowances for uncollectible notes and accounts receivable	-20,600,266				6
7 Inventory	693,489				7
8 Prepaid expenses	468,994				8
9 Other current assets					9
10 Due from other funds					10
11 Total current assets (sum of lines 1-10)	16,056,276				11
FIXED ASSETS					
12 Land					12
13 Land improvements					13
14 Accumulated depreciation					14
15 Buildings	15,190,569				15
16 Accumulated depreciation	-4,953,991				16
17 Leasehold improvements					17
18 Accumulated depreciation					18
19 Fixed equipment	535,815				19
20 Accumulated depreciation	-430,596				20
21 Automobiles and trucks					21
22 Accumulated depreciation					22
23 Major movable equipment	14,052,201				23
24 Accumulated depreciation	-11,061,579				24
25 Minor equipment depreciable					25
26 Accumulated depreciation					26
27 HIT designated Assets					27
28 Accumulated depreciation					28
29 Minor equipment-nondepreciable					29
30 Total fixed assets (sum of lines 12-29)	13,332,419				30
OTHER ASSETS					
31 Investments					31
32 Deposits on leases	12,324				32
33 Due from owners/officers					33
34 Other assets	345,607				34
35 Total other assets (sum of lines 31-34)	357,931				35
36 Total assets (sum of lines 11, 30, and 35)	29,746,626				36
Liabilities and Fund Balances (Omit cents)					
CURRENT LIABILITIES					
37 Accounts payable	1,708,480				37
38 Salaries, wages, and fees payable					38
39 Payroll taxes payable					39
40 Notes and loans payable (short term)	4,000,000				40
41 Deferred income					41
42 Accelerated payments					42
43 Due to other funds	10,169,039				43
44 Other current liabilities					44
45 Total current liabilities (sum of lines 37 thru 44)	15,877,519				45
LONG TERM LIABILITIES					
46 Mortgage payable					46
47 Notes payable	12,993,604				47
48 Unsecured loans					48
49 Other long term liabilities	17,194,315				49
50 Total long term liabilities (sum of lines 46 thru 49)	30,187,919				50
51 Total liabilities (sum of lines 45 and 50)	46,065,438				51

BALANCE SHEET		Provider CCN: 150177	PERIOD: FROM 01/01/2015 TO 12/31/2015	WORKSHEET G	
(If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)					
Assets (Omit cents)	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1	2	3	4	
CAPITAL ACCOUNTS					
52 General fund balance	-16,318,812				52
53 Specific purpose fund					53
54 Donor created - endowment fund balance - restricted					54
55 Donor created - endowment fund balance - unrestricted					55
56 Governing body created - endowment fund balance					56
57 Plant fund balance - invested in plant					57
58 Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59 Total fund balances (sum of lines 52 thru 58)	-16,318,812				59
60 Total liabilities and fund balances (sum of lines 51 and 59)	29,746,626				60

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
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STATEMENT OF CHANGES IN FUND BALANCES	Provider CCN: 150177	PERIOD: FROM 01/01/2015 TO 12/31/2015	WORKSHEET G-1

		GENERAL FUND		SPECIFIC PURPOSE FUND		ENDOWMENT FUND		PLANT FUND		
		1	2	3	4	5	6	7	8	
1	Fund balances at beginning of period		-16,459,237							1
2	Net income (loss) (from Worksheet G-3, line 29)		821,703							2
3	Total (sum of line 1 and line 2)		-15,637,534							3
4	Additions (credit adjustments) (specify)									4
5										5
6										6
7										7
8										8
9										9
10	Total additions (sum of lines 4-9)									10
11	Subtotal (line 3 plus line 10)		-15,637,534							11
12	Deductions (debit adjustments) (specify)DISTRIBUTIONS	35,773								12
13	DUE FROM PARENT (AFS NOTE 6)	645,505								13
14										14
15										15
16										16
17										17
18	Total deductions (sum of lines 12-17)		681,278							18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		-16,318,812							19

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES		Provider CCN: 150177	PERIOD: FROM 01/01/2015 TO 12/31/2015	WORKSHEET G-2, PARTS I & II	
PART I - PATIENT REVENUES					
REVENUE CENTER		INPATIENT	OUTPATIENT	TOTAL	
		1	2	3	
GENERAL INPATIENT ROUTINE CARE SERVICES					
1	Hospital	2,458,759		2,458,759	1
2	Subprovider IPF				2
3	Subprovider IRF				3
4	Subprovider (Other)				4
5	Swing bed - SNF				5
6	Swing bed - NF				6
7	Skilled nursing facility				7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	2,458,759		2,458,759	10
INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES					
11	Intensive care unit				11
12	Coronary care unit				12
13	Burn intensive care unit				13
14	Surgical intensive care unit				14
15	Other special care (specify)				15
16	Total intensive care type inpatient hospital services (sum of of lines 11-15)				16
17	Total inpatient routine care services (sum of lines 10 and 16)	2,458,759		2,458,759	17
18	Ancillary services	69,855,922	32,613,424	102,469,346	18
19	Outpatient services				19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
24	Outpatient rehabilitation providers				24
25	ASC				25
26	Hospice				26
27	Other (specify) PHYSICIAN PRIVATE OFFICES		3,934,832	3,934,832	27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	72,314,681	36,548,256	108,862,937	28

PART II - OPERATING EXPENSES				
		1	2	
29	Operating expenses (per Wkst. A, column 3, line 200)		45,887,626	29
30	Add (specify)			30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)			37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		45,887,626	43

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STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 150177	PERIOD: FROM 01/01/2015 TO 12/31/2015	WORKSHEET G-3

	Description		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	108,862,937	1
2	Less contractual allowances and discounts on patients' accounts	62,813,372	2
3	Net patient revenues (line 1 minus line 2)	46,049,565	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	45,887,626	4
5	Net income from service to patients (line 3 minus line 4)	161,939	5
	OTHER INCOME		
6	Contributions, donations, bequests, etc		6
7	Income from investments	773	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts		10
11	Rebates and refunds of expenses		11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests	19,518	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to other than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts	6,138	18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops, and canteen		20
21	Rental of vending machines		21
22	Rental of hospital space		22
23	Governmental appropriations		23
24	Other (specify)		24
24.00	MISCELLANEOUS	633,335	24.00
25	Total other income (sum of lines 6-24)	659,764	25
26	Total (line 5 plus line 25)	821,703	26
27	Other expenses (specify)		27
28	Total other expenses (sum of line 27 and subscripts)		28
29	Net income (or loss) for the period (line 26 minus line 28)	821,703	29

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CALCULATION OF CAPITAL PAYMENT	Provider CCN: 150177	PERIOD: FROM 01/01/2015 TO 12/31/2015	WORKSHEET L

Medicare -Title XVIII - Hospital

PART I - FULLY PROSPECTIVE METHOD

CAPITAL FEDERAL AMOUNT

		1	1.01	
1	Capital DRG other than outlier	101,103		1
1.01	Model 4 BPCI Capital DRG other than outlier			1.01
2	Capital DRG outlier payments	181,502		2
2.01	Model 4 BPCI Capital DRG outlier payments			2.01
3	Total inpatient days divided by number of days in the cost reporting period (see instructions)	3.01		3
4	Number of interns & residents (see instructions)			4
5	Indirect medical education percentage (see instructions)			5
6	Indirect medical education adjustment (see instructions))			6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)			7
8	Percentage of Medicaid patient days to total days (see instructions)			8
9	Sum of lines 7 and 8			9
10	Allowable disproportionate share percentage (see instructions)			10
11	Disproportionate share adjustment (see instructions)			11
12	Total prospective capital payments (see instructions)	282,605		12

PART II - PAYMENT UNDER REASONABLE COST

1	Program inpatient routine capital cost (see instructions)			1
2	Program inpatient ancillary capital cost (see instructions)			2
3	Total inpatient program capital cost (line 1 plus line 2)			3
4	Capital cost payment factor (see instructions)			4
5	Total inpatient program capital cost (line 3 x line 4)			5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	Program inpatient capital costs (see instructions)			1
2	Program inpatient capital costs for extraordinary circumstances (see instructions)			2
3	Net program inpatient capital costs (line 1 minus line 2)			3
4	Applicable exception percentage (see instructions)			4
5	Capital cost for comparison to payments (line 3 x line 4)			5
6	Percentage adjustment for extraordinary circumstances (see instructions)			6
7	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)			7
8	Capital minimum payment level (line 5 plus line 7)			8
9	Current year capital payments (from Part I, line 12 as applicable)			9
10	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)			10
11	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)			11
12	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)			12
13	Current year exception payment (if line 12 is positive, enter the amount on this line)			13
14	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)			14
15	Current year allowable operating and capital payment (see instructions)			15
16	Current year operating and capital costs (see instructions)			16
17	Current year exception offset amount (see instructions)			17