UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
Cost report status - As Submitted
[Record code 598260 - 2010]

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016	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: 06/01/2017	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		36,380		35,868		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		36,380		35,868		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
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HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016	WORKSHEET S-10

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)	0.302138	1
Medicaid (see instructions for each line)			
2	Net revenue from Medicaid		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	608,152	6
7	Medicaid cost (line 1 times line 6)	183,746	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.	183,746	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)	183,746	19

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1	2	3	
20	Charity care charges for the entire facility (see instructions)	9,640	52,559	62,199	20
21	Cost of patients approved for charity care (line 1 times line 20)	2,913	15,880	18,793	21
22	Partial payment by patients approved for charity care				22
23	Cost of charity care (line 21 minus line 22)	2,913	15,880	18,793	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)	-98,592	26
27	Medicare bad debts for the entire hospital complex (see instructions)	37,122	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	-135,714	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	-41,004	29
30	Cost of uncompensated care (line 23 column 3 plus line 29)	-22,211	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	161,535	31

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016	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: 01/01/2016	To: 12/31/2016							20
21	Type of control (see instructions)	6								21

Inpatient PPS Information				
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.							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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016	WORKSHEET S-2 PART I		

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
			1	2	
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
			V	XVIII	XIX	
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
Teaching Hospitals			1	2	3	
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

		Y/N			IME	Direct GME	
		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

		Y/N	IME	Direct GME	
		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

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		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 01/01/2016 TO 12/31/2016	WORKSHEET S-2 PART I		

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

Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		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 01/01/2016 TO 12/31/2016	WORKSHEET S-2 PART I

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	N	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
			102,392			
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.			N		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.

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016	WORKSHEET S-2 PART I

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	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)	Part A	Part B	Title V	Title XIX	
		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

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

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)	0.25			169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		10/01/2015	09/30/2016	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 598260 - 2010]

08-11	FORM CMS-2552-10		4090 (Cont.)
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016	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.	N			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	05/18/2017	Y	05/18/2017	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			

08-11		FORM CMS-2552-10	4090 (Cont.)	
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							
41	First Name:	*	Last Name:	*	Title:	*	41
42	Employer:	*					42
43	Phone number:	*		Email Address:	*		43

FORM CMS-2552-10 (09-2015) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-II, SECTIONS 4004.2)

40-510 - 09-15 Rev. 8

* Cost Report Preparer Contact Information has been redacted by CMS

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
Cost report status - As Submitted
[Record code 598260 - 2010]

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA	Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016	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	10,614			354		1,140					107		326	1
2	HMO and other (see instructions)						130										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	10,614			354		1,140								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	10,614			354		1,140		126.12			107		326	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								126.12						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 01/01/2016 TO 12/31/2016	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

FORM CMS-2552-10 (09/2015) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4005.1)	
40-511 - 09-15	Rev. 8

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
Cost report status - As Submitted
[Record code 598260 - 2010]

HOSPITAL WAGE INDEX INFORMATION	Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016	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	9,646,999		9,646,999	263,348	36.63	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)		3,824,031		3,824,031	79,345	48.19	10
OTHER WAGES AND RELATED COSTS								
11	Contract labor: Direct Patient Care		728,573		728,573	9,207	79.13	11
12	Contract labor: Top level management and other management and administrative services		155,055		155,055	849	182.63	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)		1,236,239		1,236,239			17
18	Wage-related costs (other) (see instructions)							18
19	Excluded areas		620,778		620,778			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	123,474		123,474	3,864	31.95	26
27	Administrative & General	5	1,674,245		1,674,245	34,578	48.42	27
28	Administrative & General under contract (see instructions)							28
29	Maintenance & Repairs	6						29
30	Operation of Plant	7	198,434		198,434	11,643	17.04	30
31	Laundry & Linen Service	8						31
32	Housekeeping	9						32
33	Housekeeping under contract (see instructions)							33
34	Dietary	10	179,129		179,129	11,208	15.98	34
35	Dietary under contract (see instructions)							35
36	Cafeteria	11						36

HOSPITAL WAGE INDEX INFORMATION	Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016	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	564,735		564,735	14,915	37.86	38
39	Central Services and Supply	14						39
40	Pharmacy	15	375,534		375,534	7,937	47.31	40
41	Medical Records & Medical Records Library	16	176,471		176,471	5,984	29.49	41
42	Social Service	17						42
43	Other General Service	18						43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		9,646,999		9,646,999	263,348	36.63	1
2	Excluded area salaries (see instructions)		3,824,031		3,824,031	79,345	48.19	2
3	Subtotal salaries (line 1 minus line 2)		5,822,968		5,822,968	184,003	31.65	3
4	Subtotal other wages and related costs (see instructions)		883,628		883,628	10,056	87.87	4
5	Subtotal wage-related costs (see instructions)		1,236,239		1,236,239			5
6	Total (sum of lines 3 through 5)		7,942,835		7,942,835	194,059	40.93	6
7	Total overhead cost (see instructions)		3,292,022		3,292,022	90,129	36.53	7

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
Cost report status - As Submitted
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HOSPITAL WAGE RELATED COSTS	Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016	WORKSHEET S-3, PART IV

Part IV - Wage Related Cost

Part A - Core List

		Amount Reported	
RETIREMENT COST			
1	401k Employer Contributions	198,694	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)	1,012,960	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	24,585	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	620,778	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)	1,857,017	24

Part B - Other than Core Related Cost

25	Other Wage Related Costs (specify)__		25

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
Cost report status - As Submitted
[Record code 598260 - 2010]

HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016	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	728,573	1,857,017	1
2	Hospital	728,573	1,236,239	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		620,778	18

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
Cost report status - As Submitted
[Record code 598260 - 2010]

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES			Provider CCN: 150177				PERIOD: FROM 01/01/2016 TO 12/31/2016		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		3,586,124	3,586,124	515,453	4,101,577		4,101,577	1
2	00200	Capital Related Costs-Movable Equipment		188,880	188,880	1,767,456	1,956,336		1,956,336	2
3	00300	Other Capital Related Costs							-0-	3
4	00400	Employee Benefits Department	123,474	1,904,221	2,027,695	24,585	2,052,280		2,052,280	4
5	00500	Administrative and General	1,674,245	7,075,444	8,749,689	756,264	9,505,953	2,431	9,508,384	5
6	00600	Maintenance and Repairs								6
7	00700	Operation of Plant	198,434	579,746	778,180		778,180		778,180	7
8	00800	Laundry and Linen Service		96,377	96,377		96,377		96,377	8
9	00900	Housekeeping		174	174		174		174	9
10	01000	Dietary	179,129	53,942	233,071		233,071	-19,155	213,916	10
11	01100	Cafeteria								11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	564,735	45,236	609,971		609,971		609,971	13
14	01400	Central Services and Supply								14
15	01500	Pharmacy	375,534	245,722	621,256		621,256		621,256	15
16	01600	Medical Records & Medical Records Library	176,471	82,562	259,033		259,033	-7,814	251,219	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)	1,548,627	146,625	1,695,252		1,695,252		1,695,252	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 01/01/2016 TO 12/31/2016		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	618,865	583,047	1,201,912		1,201,912		1,201,912	50
51	05100	Recovery Room								51
52	05200	Labor Room and Delivery Room								52
53	05300	Anesthesiology		433,083	433,083		433,083		433,083	53
54	05400	Radiology-Diagnostic	363,454	384,995	748,449		748,449		748,449	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		348,398	348,398		348,398		348,398	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		108,509	108,509		108,509		108,509	66
67	06700	Occupational Therapy		75,360	75,360		75,360		75,360	67
68	06800	Speech Pathology								68
69	06900	Electrocardiology								69
70	07000	Electroencephalography		226,022	226,022		226,022		226,022	70
71	07100	Medical Supplies Charged to Patients		1,004,590	1,004,590		1,004,590		1,004,590	71
72	07200	Implantable Devices Charged to Patients		9,520,811	9,520,811		9,520,811		9,520,811	72
73	07300	Drugs Charged to Patients		317,529	317,529		317,529		317,529	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 01/01/2016 TO 12/31/2016		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		3,063,758	3,063,758	-3,063,758			- 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)	5,822,968	30,071,155	35,894,123		35,894,123	-24,538	35,869,585	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop, & Canteen								190
191	19100	Research								191
192	19200	Physicians' Private Offices	3,761,428	1,139,711	4,901,139		4,901,139	-58,262	4,842,877	192
193	19300	Nonpaid Workers	62,603	58,085	120,688		120,688		120,688	193
194		Other Nonreimbursable (specify)								194
200		TOTAL (sum of lines 118-199)	9,646,999	31,268,951	40,915,950	- 0 -	40,915,950	-82,800	40,833,150	200

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
Cost report status - As Submitted
[Record code 598260 - 2010]

RECLASSIFICATIONS	Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016	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		1,750,279		1.00		1,750,279	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)					1,750,279				1,750,279		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.

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4014)

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
Cost report status - As Submitted
[Record code 598260 - 2010]

RECLASSIFICATIONS	Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016	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		2,234,057		113.00		2,234,057	11	1
2	RECLASSIFY INTEREST EXPENSE	B		2.00		17,177		113.00		17,177	11	2
3	RECLASSIFY INTEREST EXPENSE	B		5.00		812,524		113.00		812,524		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)					3,063,758				3,063,758		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.

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4014)

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
Cost report status - As Submitted
[Record code 598260 - 2010]

RECLASSIFICATIONS	Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016	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		31,675		5.00		31,675	12	1
2	RECLASSIFY INSURANCE EXPENSE	C		4.00		24,585		5.00		24,585		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)					56,260				56,260		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
Cost report status - As Submitted
[Record code 598260 - 2010]

RECONCILIATION OF CAPITAL COSTS CENTERS	Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016	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		3,985		3,985		3,985		1
2	Land Improvements								2
3	Buildings and Fixtures	14,379,799				14,379,799			3
4	Building Improvements	810,770	52,306		52,306	2,799	860,277		4
5	Fixed Equipment	535,815	33,369		33,369		569,184	441,392	5
6	Movable Equipment	14,052,202	374,071		374,071	274,054	14,152,219	7,912,049	6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	29,778,586	463,731		463,731	14,656,652	15,585,665	8,353,441	8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	29,778,586	463,731		463,731	14,656,652	15,585,665	8,353,441	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	2,296,156	1,169,968			120,000		3,586,124	1
2	Capital Related Costs-Movable Equipment					188,880		188,880	2
3	Total (sum of lines 1-2)	2,296,156	1,169,968			308,880		3,775,004	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	1,429,461		1,429,461						1
2	Capital Related Costs-Movable Equipment	14,152,219	3,463,427	10,688,792						2
3	Total (sum of lines 1-2)	15,581,680	3,463,427	12,118,253	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	545,877	1,169,968	2,234,057	31,675	120,000		4,101,577	1
2	Capital Related Costs-Movable Equipment	1,750,279		17,177		188,880		1,956,336	2
3	Total (sum of lines 1-2)	2,296,156	1,169,968	2,251,234	31,675	308,880		6,057,913	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.)

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 4015)

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
Cost report status - As Submitted
[Record code 598260 - 2010]

ADJUSTMENTS TO EXPENSES		Provider CCN: 150177		PERIOD: FROM 01/01/2016 TO 12/31/2016		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	-2,888	ADMINISTRATIVE & GENERAL	5.00		3
4	Trade, quantity, and time discounts (chapter 8)	B	1,694	ADMINISTRATIVE & GENERAL	5.00		4
5	Refunds and rebates of expenses (chapter 8)	A	-5,194	ADMINISTRATIVE & GENERAL	5.00		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	-19,155	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	-7,814	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	98,592	ADMINISTRATIVE & GENERAL	5.00		33.01
33.02	PHYSICIAN OFFICES BAD DEBT EXPENSES	A	-58,262	PHYSICIANS PRIVATE OFFICES	192.00		33.02
33.03	PENALTIES & SETTLEMENTS	A	-6,276	ADMINISTRATIVE & GENERAL	5.00		33.03
33.04	CHARITABLE CONTRIBUTIONS	A	-34,125	ADMINISTRATIVE & GENERAL	5.00		33.04
33.05	AMORTIZATION OF INTANGIBLES	A	-49,372	ADMINISTRATIVE & GENERAL	5.00		33.05
34							34
35							35
36							36
37							37

ADJUSTMENTS TO EXPENSES		Provider CCN: 150177		PERIOD: FROM 01/01/2016 TO 12/31/2016	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)		-82,800				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.

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
Cost report status - As Submitted
[Record code 598260 - 2010]

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 150177				PERIOD: FROM 01/01/2016 TO 12/31/2016		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	4,101,577	4,101,577								1
2	Capital Related Costs-Movable Equipment	1,956,336		1,956,336							2
4	Employee Benefits Department	2,052,280	44,755	21,347	2,118,382						4
5	Administrative and General	9,508,384	563,576	268,810	372,414	10,713,184	10,713,184				5
6	Maintenance and Repairs										6
7	Operation of Plant	778,180	245,322	117,011	44,139	1,184,652	421,362		1,606,014		7
8	Laundry and Linen Service	96,377				96,377	34,280			130,657	8
9	Housekeeping	174	56,358	26,881		83,413	29,669		27,867		9
10	Dietary	213,916	43,429	20,714	39,845	317,904	113,073		21,474		10
11	Cafeteria		39,782	18,975		58,757	20,899		19,671		11
12	Maintenance of Personnel										12
13	Nursing Administration	609,971	9,548	4,554	125,618	749,691	266,653		4,721		13
14	Central Services and Supply		39,782	18,975		58,757	20,899		19,671		14
15	Pharmacy	621,256	56,358	26,881	83,533	788,028	280,289		27,867		15
16	Medical Records & Medical Records Library	251,219	29,836	14,231	39,254	334,540	118,991		14,753		16
17	Social Service		9,548	4,554		14,102	5,016		4,721		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)	1,695,252	401,863	191,677	344,472	2,633,264	936,610		198,711	130,657	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 01/01/2016 TO 12/31/2016		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	
45	Nursing Facility										45
46	Other Long Term Care										46
ANCILLARY SERVICE COST CENTERS											
50	Operating Room	1,201,912	377,928	180,261	137,658	1,897,759	675,003		186,875		50
51	Recovery Room										51
52	Labor Room and Delivery Room										52
53	Anesthesiology	433,083	1,658	791		435,532	154,912		820		53
54	Radiology-Diagnostic	748,449	251,952	120,174	80,846	1,201,421	427,326		124,584		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	348,398	10,542	5,028		363,968	129,458		5,213		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	108,509	5,967	2,846		117,322	41,730		2,951		66
67	Occupational Therapy	75,360	2,652	1,265		79,277	28,198		1,311		67
68	Speech Pathology										68
69	Electrocardiology										69
70	Electroencephalography	226,022	74,193	35,388		335,603	119,369		36,687		70
71	Medical Supplies Charged to Patients	1,004,590	1,658	791		1,007,039	358,188		820		71
72	Implantable Devices Charged to Patients	9,520,811				9,520,811	3,386,390				72
73	Drugs Charged to Patients	317,529	2,652	1,265		321,446	114,333		1,311		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 01/01/2016 TO 12/31/2016		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)	35,869,585	2,269,359	1,082,419	1,267,779	32,312,847	7,682,648		700,028	130,657	118
NONREIMBURSABLE COST CENTERS											
190	Gift, Flower, Coffee Shop, & Canteen										190
191	Research										191
192	Physicians' Private Offices	4,842,877	1,832,218	873,917	836,678	8,385,690	2,982,656		905,986		192
193	Nonpaid Workers	120,688			13,925	134,613	47,880				193
194	Other Nonreimbursable (specify)										194
200	Cross Foot Adjustments										200
201	Negative Cost Centers										201
202	TOTAL (sum lines 118-201)	40,833,150	4,101,577	1,956,336	2,118,382	40,833,150	10,713,184		1,606,014	130,657	202
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4020)											
40-535 - 09-13										Rev. 4	

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
Cost report status - As Submitted
[Record code 598260 - 2010]

COST ALLOCATION - GENERAL SERVICE COSTS				Provider CCN: 150177			PERIOD: FROM 01/01/2016 TO 12/31/2016		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	140,949									9
10	Dietary	1,918	454,369								10
11	Cafeteria	1,757	217,475	318,559							11
12	Maintenance of Personnel										12
13	Nursing Administration	422		38,713		1,060,200					13
14	Central Services and Supply	1,757					101,084				14
15	Pharmacy	2,489		20,625				1,119,298			15
16	Medical Records & Medical Records Library	1,318		15,550					485,152		16
17	Social Service	422								24,261	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)	17,747	135,064	149,237		1,060,200	101,084		485,152	24,261	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 01/01/2016 TO 12/31/2016		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	16,690		63,496							50
51 Recovery Room										51
52 Labor Room and Delivery Room										52
53 Anesthesiology	73									53
54 Radiology-Diagnostic	11,127		30,938							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	466									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	264									66
67 Occupational Therapy	117									67
68 Speech Pathology										68
69 Electrocardiology										69
70 Electroencephalography	3,277									70
71 Medical Supplies Charged to Patients	73									71
72 Implantable Devices Charged to Patients										72
73 Drugs Charged to Patients	117						1,119,298			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 01/01/2016 TO 12/31/2016		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)	60,034	352,539	318,559		1,060,200	101,084	1,119,298	485,152	24,261	118
NONREIMBURSABLE COST CENTERS											
190	Gift, Flower, Coffee Shop, & Canteen		101,830								190
191	Research										191
192	Physicians' Private Offices	80,915									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)	140,949	454,369	318,559		1,060,200	101,084	1,119,298	485,152	24,261	202

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
Cost report status - As Submitted
[Record code 598260 - 2010]

COST ALLOCATION - GENERAL SERVICE COSTS				Provider CCN: 150177			PERIOD: FROM 01/01/2016 TO 12/31/2016		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)							5,871,987		5,871,987	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 01/01/2016 TO 12/31/2016		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							2,839,823		2,839,823	50
51	Recovery Room										51
52	Labor Room and Delivery Room										52
53	Anesthesiology							591,337		591,337	53
54	Radiology-Diagnostic							1,795,396		1,795,396	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							499,105		499,105	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							162,267		162,267	66
67	Occupational Therapy							108,903		108,903	67
68	Speech Pathology										68
69	Electrocardiology										69
70	Electroencephalography							494,936		494,936	70
71	Medical Supplies Charged to Patients							1,366,120		1,366,120	71
72	Implantable Devices Charged to Patients							12,907,201		12,907,201	72
73	Drugs Charged to Patients							1,556,505		1,556,505	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 01/01/2016 TO 12/31/2016		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)							28,193,580		28,193,580	118
NONREIMBURSABLE COST CENTERS										
190 Gift, Flower, Coffee Shop, & Canteen							101,830		101,830	190
191 Research										191
192 Physicians' Private Offices							12,355,247		12,355,247	192
193 Nonpaid Workers							182,493		182,493	193
194 Other Nonreimbursable (specify)										194
200 Cross Foot Adjustments										200
201 Negative Cost Centers										201
202 TOTAL (sum lines 118-201)							40,833,150		40,833,150	202

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
Cost report status - As Submitted
[Record code 598260 - 2010]

ALLOCATION OF CAPITAL-RELATED COSTS		Provider CCN: 150177				PERIOD: FROM 01/01/2016 TO 12/31/2016		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		44,755	21,347	66,102	66,102					4
5 Administrative and General		563,576	268,810	832,386	11,621	844,007				5
6 Maintenance and Repairs										6
7 Operation of Plant		245,322	117,011	362,333	1,377	33,196		396,906		7
8 Laundry and Linen Service						2,701			2,701	8
9 Housekeeping		56,358	26,881	83,239		2,337		6,887		9
10 Dietary		43,429	20,714	64,143	1,243	8,908		5,307		10
11 Cafeteria		39,782	18,975	58,757		1,646		4,861		11
12 Maintenance of Personnel										12
13 Nursing Administration		9,548	4,554	14,102	3,920	21,008		1,167		13
14 Central Services and Supply		39,782	18,975	58,757		1,646		4,861		14
15 Pharmacy		56,358	26,881	83,239	2,607	22,082		6,887		15
16 Medical Records & Medical Records Library		29,836	14,231	44,067	1,225	9,374		3,646		16
17 Social Service		9,548	4,554	14,102		395		1,167		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)		401,863	191,677	593,540	10,749	73,789		49,109	2,701	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 01/01/2016 TO 12/31/2016		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	
46	Other Long Term Care										46
ANCILLARY SERVICE COST CENTERS											
50	Operating Room		377,928	180,261	558,189	4,296	53,179		46,184		50
51	Recovery Room										51
52	Labor Room and Delivery Room										52
53	Anesthesiology		1,658	791	2,449		12,204		203		53
54	Radiology-Diagnostic		251,952	120,174	372,126	2,523	33,666		30,789		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		10,542	5,028	15,570		10,199		1,288		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		5,967	2,846	8,813		3,288		729		66
67	Occupational Therapy		2,652	1,265	3,917		2,222		324		67
68	Speech Pathology										68
69	Electrocardiology										69
70	Electroencephalography		74,193	35,388	109,581		9,404		9,067		70
71	Medical Supplies Charged to Patients		1,658	791	2,449		28,219		203		71
72	Implantable Devices Charged to Patients						266,780				72
73	Drugs Charged to Patients		2,652	1,265	3,917		9,008		324		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 01/01/2016 TO 12/31/2016		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)		2,269,359	1,082,419	3,351,778	39,561	605,251		173,003	2,701	118
NONREIMBURSABLE COST CENTERS										
190 Gift, Flower, Coffee Shop, & Canteen										190
191 Research										191
192 Physicians' Private Offices		1,832,218	873,917	2,706,135	26,106	234,984		223,903		192
193 Nonpaid Workers					435	3,772				193
194 Other Nonreimbursable (specify)										194
200 Cross Foot Adjustments										200
201 Negative Cost Centers										201
202 TOTAL (sum lines 118-201)		4,101,577	1,956,336	6,057,913	66,102	844,007		396,906	2,701	202

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
Cost report status - As Submitted
[Record code 598260 - 2010]

ALLOCATION OF CAPITAL-RELATED COSTS				Provider CCN: 150177			PERIOD: FROM 01/01/2016 TO 12/31/2016		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	92,463									9
10 Dietary	1,258	80,859								10
11 Cafeteria	1,153	38,701	105,118							11
12 Maintenance of Personnel										12
13 Nursing Administration	277		12,775		53,249					13
14 Central Services and Supply	1,153					66,417				14
15 Pharmacy	1,633		6,806				123,254			15
16 Medical Records & Medical Records Library	864		5,131					64,307		16
17 Social Service	277								15,941	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)	11,642	24,036	49,245		53,249	66,417		64,307	15,941	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 01/01/2016 TO 12/31/2016		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	10,949		20,952							50
51 Recovery Room										51
52 Labor Room and Delivery Room										52
53 Anesthesiology	48									53
54 Radiology-Diagnostic	7,299		10,209							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	305									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	173									66
67 Occupational Therapy	77									67
68 Speech Pathology										68
69 Electrocardiology										69
70 Electroencephalography	2,149									70
71 Medical Supplies Charged to Patients	48									71
72 Implantable Devices Charged to Patients										72
73 Drugs Charged to Patients	77						123,254			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 01/01/2016 TO 12/31/2016		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)	39,382	62,737	105,118		53,249	66,417	123,254	64,307	15,941	118
NONREIMBURSABLE COST CENTERS											
190	Gift, Flower, Coffee Shop, & Canteen		18,122								190
191	Research										191
192	Physicians' Private Offices	53,081									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)	92,463	80,859	105,118		53,249	66,417	123,254	64,307	15,941	202

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
Cost report status - As Submitted
[Record code 598260 - 2010]

ALLOCATION OF CAPITAL-RELATED COSTS				Provider CCN: 150177			PERIOD: FROM 01/01/2016 TO 12/31/2016		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)							1,014,725		1,014,725	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 01/01/2016 TO 12/31/2016		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							693,749		693,749	50
51	Recovery Room										51
52	Labor Room and Delivery Room										52
53	Anesthesiology							14,904		14,904	53
54	Radiology-Diagnostic							456,612		456,612	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							27,362		27,362	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							13,003		13,003	66
67	Occupational Therapy							6,540		6,540	67
68	Speech Pathology										68
69	Electrocardiology										69
70	Electroencephalography							130,201		130,201	70
71	Medical Supplies Charged to Patients							30,919		30,919	71
72	Implantable Devices Charged to Patients							266,780		266,780	72
73	Drugs Charged to Patients							136,580		136,580	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 01/01/2016 TO 12/31/2016		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)							2,791,375		2,791,375	118
NONREIMBURSABLE COST CENTERS										
190 Gift, Flower, Coffee Shop, & Canteen							18,122		18,122	190
191 Research										191
192 Physicians' Private Offices							3,244,209		3,244,209	192
193 Nonpaid Workers							4,207		4,207	193
194 Other Nonreimbursable (specify)										194
200 Cross Foot Adjustments										200
201 Negative Cost Centers										201
202 TOTAL (sum lines 118-201)							6,057,913		6,057,913	202

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
Cost report status - As Submitted
[Record code 598260 - 2010]

COST ALLOCATION - STATISTICAL BASIS			Provider CCN: 150177			PERIOD: FROM 01/01/2016 TO 12/31/2016		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	61,861									1
2 Capital Related Costs-Movable Equipment		61,861								2
4 Employee Benefits Department	675	675	9,523,525							4
5 Administrative and General	8,500	8,500	1,674,245		30,119,966					5
6 Maintenance and Repairs						52,686				6
7 Operation of Plant	3,700	3,700	198,434		1,184,652	3,700	48,986			7
8 Laundry and Linen Service					96,377			155,669		8
9 Housekeeping	850	850			83,413	850	850		48,136	9
10 Dietary	655	655	179,129		317,904	655	655		655	10
11 Cafeteria	600	600			58,757	600	600		600	11
12 Maintenance of Personnel										12
13 Nursing Administration	144	144	564,735		749,691	144	144		144	13
14 Central Services and Supply	600	600			58,757	600	600		600	14
15 Pharmacy	850	850	375,534		788,028	850	850		850	15
16 Medical Records & Medical Records Library	450	450	176,471		334,540	450	450		450	16
17 Social Service	144	144			14,102	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	1,548,627		2,633,264	6,061	6,061	155,669	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 01/01/2016 TO 12/31/2016		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	618,865		1,897,759	5,700	5,700		5,700	50
51	Recovery Room										51
52	Labor Room and Delivery Room										52
53	Anesthesiology	25	25			435,532	25	25		25	53
54	Radiology-Diagnostic	3,800	3,800	363,454		1,201,421	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			363,968	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			117,322	90	90		90	66
67	Occupational Therapy	40	40			79,277	40	40		40	67
68	Speech Pathology										68
69	Electrocardiology										69
70	Electroencephalography	1,119	1,119			335,603	1,119	1,119		1,119	70
71	Medical Supplies Charged to Patients	25	25			1,007,039	25	25		25	71
72	Implantable Devices Charged to Patients					9,520,811					72
73	Drugs Charged to Patients	40	40			321,446	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 01/01/2016 TO 12/31/2016		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	5,699,494		21,599,663	25,052	21,352	155,669	20,502	118
NONREIMBURSABLE COST CENTERS											
190	Gift, Flower, Coffee Shop, & Canteen										190
191	Research										191
192	Physicians' Private Offices	27,634	27,634	3,761,428		8,385,690	27,634	27,634		27,634	192
193	Nonpaid Workers			62,603		134,613					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)	4,101,577	1,956,336	2,118,382		10,713,184		1,606,014	130,657	140,949	202
203	Unit cost multiplier (Worksheet B, Part I)	66.30	31.62	0.222437		0.355684		32.79	0.839326	2.93	203
204	Cost to be allocated (per Worksheet B, Part II)			66,102		844,007		396,906	2,701	92,463	204
205	Unit cost multiplier (Worksheet B, Part II)			0.006941		0.028022		8.10	0.017351	1.92	205

COST ALLOCATION - STATISTICAL BASIS			Provider CCN: 150177			PERIOD: FROM 01/01/2016 TO 12/31/2016		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
40-553 - 09-13									Rev. 4

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
Cost report status - As Submitted
[Record code 598260 - 2010]

COST ALLOCATION - STATISTICAL BASIS			Provider CCN: 150177			PERIOD: FROM 01/01/2016 TO 12/31/2016		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	12,168									10
11 Cafeteria	5,824	5,900								11
12 Maintenance of Personnel										12
13 Nursing Administration		717		71,718						13
14 Central Services and Supply					100					14
15 Pharmacy		382				100				15
16 Medical Records & Medical Records Library		288					1,140			16
17 Social Service								1,140		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)	3,617	2,764		71,718	100		1,140	1,140		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 01/01/2016 TO 12/31/2016		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		1,176								50
51	Recovery Room										51
52	Labor Room and Delivery Room										52
53	Anesthesiology										53
54	Radiology-Diagnostic		573								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 01/01/2016 TO 12/31/2016		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)	9,441	5,900		71,718	100	100	1,140	1,140		118
	NONREIMBURSABLE COST CENTERS										
190	Gift, Flower, Coffee Shop, & Canteen	2,727									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)	454,369	318,559		1,060,200	101,084	1,119,298	485,152	24,261		202
203	Unit cost multiplier (Worksheet B, Part I)	37.34	53.99		14.78	1,011	11,193	425.57	21.28		203
204	Cost to be allocated (per Worksheet B, Part II)	80,859	105,118		53,249	66,417	123,254	64,307	15,941		204
205	Unit cost multiplier (Worksheet B, Part II)	6.65	17.82		0.742477	664.17	1,233	56.41	13.98		205

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
Cost report status - As Submitted
[Record code 598260 - 2010]

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 150177			PERIOD: FROM 01/01/2016 TO 12/31/2016		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 01/01/2016 TO 12/31/2016		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 01/01/2016 TO 12/31/2016		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 01/01/2016 TO 12/31/2016		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
40-553 - 09-13								Rev. 4

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
Cost report status - As Submitted
[Record code 598260 - 2010]

COMPUTATION OF RATIO OF COSTS TO CHARGES							Provider CCN: 150177		PERIOD: FROM 01/01/2016 TO 12/31/2016		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)	5,871,987		5,871,987		5,871,987			3,378,347				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	2,839,823		2,839,823		2,839,823			36,926,438	0.076905	0.076905	0.076905	50
51 Recovery Room												51
52 Labor Room and Delivery Room												52
53 Anesthesiology	591,337		591,337		591,337			2,230,699	0.265090	0.265090	0.265090	53
54 Radiology-Diagnostic	1,795,396		1,795,396		1,795,396			2,333,917	0.769263	0.769263	0.769263	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	499,105		499,105		499,105			922,782	0.540870	0.540870	0.540870	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	162,267		162,267		162,267			329,450	0.492539	0.492539	0.492539	66

COMPUTATION OF RATIO OF COSTS TO CHARGES							Provider CCN: 150177		PERIOD: FROM 01/01/2016 TO 12/31/2016		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	108,903		108,903		108,903			204,739	0.531911	0.531911	0.531911	67
68 Speech Pathology												68
69 Electrocardiology												69
70 Electroencephalography	494,936		494,936		494,936			768,719	0.643845	0.643845	0.643845	70
71 Medical Supplies Charged to Patients	1,366,120		1,366,120		1,366,120			4,146,008	0.329502	0.329502	0.329502	71
72 Implantable Devices Charged to Patients	12,907,201		12,907,201		12,907,201			39,513,846	0.326650	0.326650	0.326650	72
73 Drugs Charged to Patients	1,556,505		1,556,505		1,556,505			2,558,776	0.608301	0.608301	0.608301	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 01/01/2016 TO 12/31/2016		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)	28,193,580		28,193,580		28,193,580			93,313,721				200
201 Less Observation Beds												201
202 Total (see instructions)			28,193,580		28,193,580	68,187,119	25,126,602	93,313,721				202
FORM CMS-2552-10 (10/2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTIONS 4023)												
40-564 - 10-12											Rev. 3	

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
Cost report status - As Submitted
[Record code 598260 - 2010]

COMPUTATION OF RATIO OF COSTS TO CHARGES							Provider CCN: 150177		PERIOD: FROM 01/01/2016 TO 12/31/2016		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)	5,871,987		5,871,987		5,871,987	3,378,347		3,378,347				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	2,839,823		2,839,823		2,839,823	22,717,422	14,209,016	36,926,438	0.076905	0.076905	0.076905	50
51 Recovery Room												51
52 Labor Room and Delivery Room												52
53 Anesthesiology	591,337		591,337		591,337	1,133,157	1,097,542	2,230,699	0.265090	0.265090	0.265090	53
54 Radiology-Diagnostic	1,795,396		1,795,396		1,795,396	158,367	2,175,550	2,333,917	0.769263	0.769263	0.769263	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	499,105		499,105		499,105	699,417	223,365	922,782	0.540870	0.540870	0.540870	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	162,267		162,267		162,267	324,494	4,956	329,450	0.492539	0.492539	0.492539	66

COMPUTATION OF RATIO OF COSTS TO CHARGES							Provider CCN: 150177		PERIOD: FROM 01/01/2016 TO 12/31/2016		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	108,903		108,903		108,903	201,916	2,823	204,739	0.531911	0.531911	0.531911	67
68 Speech Pathology												68
69 Electrocardiology												69
70 Electroencephalography	494,936		494,936		494,936		768,719	768,719	0.643845	0.643845	0.643845	70
71 Medical Supplies Charged to Patients	1,366,120		1,366,120		1,366,120	2,059,250	2,086,758	4,146,008	0.329502	0.329502	0.329502	71
72 Implantable Devices Charged to Patients	12,907,201		12,907,201		12,907,201	35,765,550	3,748,296	39,513,846	0.326650	0.326650	0.326650	72
73 Drugs Charged to Patients	1,556,505		1,556,505		1,556,505	1,749,199	809,577	2,558,776	0.608301	0.608301	0.608301	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 01/01/2016 TO 12/31/2016		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)	28,193,580		28,193,580		28,193,580	68,187,119	25,126,602	93,313,721				200
201 Less Observation Beds												201
202 Total (see instructions)	28,193,580		28,193,580		28,193,580	68,187,119	25,126,602	93,313,721				202
FORM CMS-2552-10 (10/2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTIONS 4023)												
40-564 - 10-12											Rev. 3	

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
Cost report status - As Submitted
[Record code 598260 - 2010]

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016	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)	1,014,725		1,014,725	1,140	890.11	354	315,099	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 (Other)								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,014,725		1,014,725	1,140		354	315,099	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)

40-567 - 10-12 Rev. 3

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
Cost report status - As Submitted
[Record code 598260 - 2010]

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016	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	693,749	36,926,438	0.018787	6,921,874	130,041	50
51	Recovery Room						51
52	Labor Room and Delivery Room						52
53	Anesthesiology	14,904	2,230,699	0.006681	337,865	2,257	53
54	Radiology-Diagnostic	456,612	2,333,917	0.195642	51,420	10,060	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	27,362	922,782	0.029652	129,584	3,842	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	13,003	329,450	0.039469	110,333	4,355	66
67	Occupational Therapy	6,540	204,739	0.031943	64,818	2,070	67
68	Speech Pathology						68
69	Electrocardiology						69
70	Electroencephalography	130,201	768,719	0.169374			70
71	Medical Supplies Charged to Patients	30,919	4,146,008	0.007458	783,923	5,846	71
72	Implantable Devices Charged to Patients	266,780	39,513,846	0.006752	8,239,230	55,631	72
73	Drugs Charged to Patients	136,580	2,558,776	0.053377	714,270	38,126	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)	1,776,650	89,935,374	0.019755	17,353,317	252,228	200

(A) Worksheet A line numbers

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
Cost report status - As Submitted
[Record code 598260 - 2010]

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016	WORKSHEET D, PART III

Medicare -Title XVIII - Hospital

		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)	
(A)	Cost Center Description	1	2	3	4	5	6	7	8	9	
INPATIENT ROUTINE SERVICE COST CENTERS											
30	Adults & Pediatrics (General Routine Care)						1,140		354		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)						1,140		354		200

(A) Worksheet A line numbers

FORM CMS-2552-10 (09-2014) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4024.3)

40-569 - 09-15 Rev. 8

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
Cost report status - As Submitted
[Record code 598260 - 2010]

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS										Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016		WORKSHEET D, PART IV	
Medicare -Title XVIII - Hospital														
		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)	
(A)	Cost Center Description	1	2	3	4	5	6	7	8	9	10	11	12	13	
ANCILLARY SERVICE COST CENTERS															
50	Operating Room							36,926,438			6,921,874		5,749,114		50
51	Recovery Room														51
52	Labor room and Delivery Room														52
53	Anesthesiology							2,230,699			337,865		464,896		53
54	Radiology-Diagnostic							2,333,917			51,420		654,134		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							922,782			129,584		71,998		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							329,450			110,333		889		66
67	Occupational Therapy							204,739			64,818		600		67
68	Speech Pathology														68
69	Electrocardiology														69
70	Electroencephalography							768,719					270,655		70
71	Medical Supplies Charged To Patients							4,146,008			783,923		1,022,612		71
72	Implantable Devices Charged to Patients							39,513,846			8,239,230		1,689,241		72
73	Drugs Charged to Patients							2,558,776			714,270		379,725		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 01/01/2016 TO 12/31/2016		WORKSHEET D, PART IV	
Medicare -Title XVIII - Hospital															
		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)	
(A)	Cost Center Description	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)							89,935,374			17,353,317		10,303,864		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)															
40-571 - 09-15														Rev. 8	

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
Cost report status - As Submitted
[Record code 598260 - 2010]

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS	Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016	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		5,749,114			442,136			50
51	Recovery Room								51
52	Labor & Delivery Room								52
53	Anesthesiology		464,896			123,239			53
54	Radiology-Diagnostic		654,134			503,201			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		71,998			38,942			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		889			438			66
67	Occupational Therapy		600			319			67
68	Speech Pathology								68
69	Electrocardiology								69
70	Electroencephalography		270,655			174,260			70
71	Medical Supplies Charged To Patients		1,022,612			336,953			71
72	Implantable Devices Charged to Patients		1,689,241			551,791			72
73	Drugs Charged to Patients		379,725			230,987			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)		10,303,864			2,402,266			200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		10,303,864			2,402,266			202

FORM CMS-2552-10 (09-2015) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTIONS 4024.5)

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
Cost report status - As Submitted
[Record code 598260 - 2010]

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS	Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016	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		512,736						50
51	Recovery Room								51
52	Labor & Delivery Room								52
53	Anesthesiology		19,938						53
54	Radiology-Diagnostic		33,401						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		7,188						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		22,193						70
71	Medical Supplies Charged To Patients								71
72	Implantable Devices Charged to Patients								72
73	Drugs Charged to Patients		12,696						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)		608,152						200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)					96,311			202

FORM CMS-2552-10 (09-2015) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTIONS 4024.5)

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
Cost report status - As Submitted
[Record code 598260 - 2010]

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016	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)	1,140	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,140	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)	1,140	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)	354	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)	5,871,987	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)	5,871,987	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)	5,871,987	37

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
Cost report status - As Submitted
[Record code 598260 - 2010]

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016	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)	1,140	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,140	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)	1,140	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)		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

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
Cost report status - As Submitted
[Record code 598260 - 2010]

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016	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)					5,150.87	38
39	Program general inpatient routine service cost (line 9 x line 38)					1,823,408	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)					1,823,408	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)					4,204,495	48
49	Total Program inpatient costs (sum of lines 41 through 48) (see instructions)					6,027,903	49
PASS-THROUGH COST ADJUSTMENTS							
50	Pass through costs applicable to Program inpatient routine services (from Worksheet D, sum of Parts I and III)					315,099	50
51	Pass through costs applicable to Program inpatient ancillary services (from Worksheet D, sum of Parts II and IV)					252,228	51
52	Total Program excludable cost (sum of lines 50 and 51)					567,327	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist, and medical education costs (line 49 minus line 52)					5,460,576	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 01/01/2016 TO 12/31/2016	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	1,014,725	5,871,987	0.172808			90
91	Nursing School cost		5,871,987				91
92	Allied Health cost		5,871,987				92
93	All other Medical Education		5,871,987				93

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
Cost report status - As Submitted
[Record code 598260 - 2010]

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016	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)		448,592		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	0.076905	6,921,874	532,327	50
51	Recovery Room				51
52	Labor Room and Delivery Room				52
53	Anesthesiology	0.265090	337,865	89,565	53
54	Radiology-Diagnostic	0.769263	51,420	39,556	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	0.540870	129,584	70,088	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	0.492539	110,333	54,343	66
67	Occupational Therapy	0.531911	64,818	34,477	67
68	Speech Pathology				68
69	Electrocardiology				69
70	Electroencephalography				70
71	Medical Supplies Charged to Patients	0.329502	783,923	258,304	71
72	Implantable Devices Charged to Patients	0.326650	8,239,230	2,691,344	72
73	Drugs Charged to Patients	0.608301	714,270	434,491	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)		17,353,317	4,204,495	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		17,353,317		202

(A) Worksheet A line numbers

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016	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

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
Cost report status - As Submitted
[Record code 598260 - 2010]

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016	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)	1,753,397			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)				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)	1,732,085			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)				31

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016		WORKSHEET E PART A	
32	Sum of lines 30 and 31				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)		6,406,145,534	5,977,483,147	35
35.01	Factor 3 (see instructions)		0.000001388	0.000002154	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)	3,485,482			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)	3,485,482			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	382,720			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)	3,868,202			59
60	Primary payer payments				60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	3,868,202			61
62	Deductibles billed to program beneficiaries	124,908			62
63	Coinsurance billed to program beneficiaries				63
64	Allowable bad debts (see instructions)	57,110			64
65	Adjusted reimbursable bad debts (see instructions)	37,122			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)				66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	3,780,416			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)	19,957			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 01/01/2016 TO 12/31/2016		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)		3,800,373			71
71.01	Sequestration adjustment (see instructions)		76,007			71.01
72	Interim payments		3,687,986			72
73	Tentative settlement (for contractor use only)					73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		36,380			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)		1,732,085			90
91	Capital outlier from Wkst. L, Pt. I, line 2		242,438			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
40-584 - 11-164	FORM CMS-2552-10 (11-2016) (INSTRUCTIONS FOR THIS Wkst. ARE PUBLISHED IN CMS PUB. 15-2, § 4030.1)					Rev. 10

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
Cost report status - As Submitted
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CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016	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).		2,402,266	2
3	PPS payments		1,809,664	3
4	Outlier payment (see instructions)		29,915	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)		1,839,579	24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
25	Deductibles and coinsurance (see instructions)			25
26	Deductibles and Coinsurance relating to amount on line 24 (see instructions)		329,799	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)		1,509,780	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)		1,509,780	30
31	Primary payer payments		1,047	31
32	Subtotal (line 30 minus line 31)		1,508,733	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)		1,508,733	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)		1,508,733	40
40.01	Sequestration adjustment (see instructions)		30,175	40.01
41	Interim payments		1,478,558	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)		29,915	90
91	Outlier reconciliation adjustment amount (see instructions)			91
92	The rate used to calculate the Time Value of Money			92

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016	WORKSHEET E, PART B

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

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
Cost report status - As Submitted
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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016	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)	326	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1 and 8 through 12)	354	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	130	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1 and 8 through 12)	1,140	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	93,313,721	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	62,199	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)	212,400	8
9	Sequestration adjustment amount (see instructions)	4,248	9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	208,152	10
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH			
30	Initial/interim HIT payment(s).	172,284	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)	35,868	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.

40-589 - 09-15		Rev. 8

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
Cost report status - As Submitted
[Record code 598260 - 2010]

BALANCE SHEET		Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016	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	999,248				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	31,158,776				4
5	Other receivables	1,068,515				5
6	Allowances for uncollectible notes and accounts receivable	-18,151,537				6
7	Inventory	766,804				7
8	Prepaid expenses	92,888				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	15,934,694				11
FIXED ASSETS						
12	Land	3,985				12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings	860,277				15
16	Accumulated depreciation	-494,690				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment	569,184				19
20	Accumulated depreciation	-478,308				20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	14,152,219				23
24	Accumulated depreciation	-12,676,755				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)	1,935,912				30
OTHER ASSETS						
31	Investments					31
32	Deposits on leases	12,324				32
33	Due from owners/officers					33
34	Other assets	296,235				34
35	Total other assets (sum of lines 31-34)	308,559				35
36	Total assets (sum of lines 11, 30, and 35)	18,179,165				36
Liabilities and Fund Balances (Omit cents)						
CURRENT LIABILITIES						
37	Accounts payable	3,933,750				37
38	Salaries, wages, and fees payable					38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	2,651,526				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds	3,808,534				43
44	Other current liabilities					44
45	Total current liabilities (sum of lines 37 thru 44)	10,393,810				45
LONG TERM LIABILITIES						
46	Mortgage payable					46
47	Notes payable	15,222,272				47
48	Unsecured loans					48
49	Other long term liabilities	141,298				49
50	Total long term liabilities (sum of lines 46 thru 49)	15,363,570				50
51	Total liabilities (sum of lines 45 and 50)	25,757,380				51

BALANCE SHEET		Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016	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	-7,578,215				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)	-7,578,215				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	18,179,165				60
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4040)						
40-601 - 10-12					Rev. 3	

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
Cost report status - As Submitted
[Record code 598260 - 2010]

STATEMENT OF CHANGES IN FUND BALANCES		Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016	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		-16,318,812							1
2	Net income (loss) (from Worksheet G-3, line 29)		-169,406							2
3	Total (sum of line 1 and line 2)		-16,488,218							3
4	Additions (credit adjustments) (specify)PRIOR PERIOD ADJUSTMENT	8,910,003								4
5										5
6										6
7										7
8										8
9										9
10	Total additions (sum of lines 4-9)		8,910,003							10
11	Subtotal (line 3 plus line 10)		-7,578,215							11
12	Deductions (debit adjustments) (specify)									12
13										13
14										14
15										15
16										16
17										17
18	Total deductions (sum of lines 12-17)									18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		-7,578,215							19

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4040)		
40-602 - 10-12		Rev. 3

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
Cost report status - As Submitted
[Record code 598260 - 2010]

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016	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	3,378,347		3,378,347	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)	3,378,347		3,378,347	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)	3,378,347		3,378,347	17
18	Ancillary services	64,808,772		64,808,772	18
19	Outpatient services		25,126,602	25,126,602	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		4,474,430	4,474,430	27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	68,187,119	29,601,032	97,788,151	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Wkst. A, column 3, line 200)		40,915,950	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) ROUNDING	8		37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)		8	42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		40,915,942	43

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
Cost report status - As Submitted
[Record code 598260 - 2010]

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016	WORKSHEET G-3	
Description				
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)		97,788,151	1
2	Less contractual allowances and discounts on patients' accounts		57,174,072	2
3	Net patient revenues (line 1 minus line 2)		40,614,079	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)		40,915,942	4
5	Net income from service to patients (line 3 minus line 4)		-301,863	5
OTHER INCOME				
6	Contributions, donations, bequests, etc			6
7	Income from investments		2,888	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		19,155	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		7,814	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		102,600	24.00
25	Total other income (sum of lines 6-24)		132,457	25
26	Total (line 5 plus line 25)		-169,406	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)		-169,406	29
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4040)				
40-604 - 10-12			Rev. 3	

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN
Cost report status - As Submitted
[Record code 598260 - 2010]

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016	WORKSHEET L

Medicare -Title XVIII - Hospital

PART I - FULLY PROSPECTIVE METHOD

CAPITAL FEDERAL AMOUNT

		1	1.01	
1	Capital DRG other than outlier	140,282		1
1.01	Model 4 BPCI Capital DRG other than outlier			1.01
2	Capital DRG outlier payments	242,438		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)	3.11		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)	382,720		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