

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN

Cost report status - Settled Without Audit

[Record code 591947 - 2010]

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 150177	PERIOD: FROM 01/01/2014 TO 12/31/2014	WORKSHEET S PARTS I, II & III
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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. <input checked="" type="checkbox"/> Electronically filed cost report	Date:	Time:
	2. <input type="checkbox"/> Manually submitted cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4 <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: 06/02/2015	10. NPR Date: 01/30/2017
		7. Contractor No.: 08001	11. Contractor's Vendor Code: 4
		8. <input type="checkbox"/> Initial Report for this Provider CCN	12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.
		9. <input type="checkbox"/> 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 AVAILABLE ON ELECTRONIC FORM
		Officer or Administrator of Provider(s)
		Title NOT AVAILABLE ON ELECTRONIC FORM
		Date

PART III - SETTLEMENT SUMMARY

	TITLE V	TITLE XVIII		HIT	TITLE XIX	
		PART A	PART B			
		1	2			3
1	HOSPITAL		-2,339,437	9,701	12,348	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		-2,339,437	9,701	12,348	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.

FORM CMS-2552-10 (11/2016) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-II, SECTIONS 4003.1-4003.3)

40-503 - 11-16	Rev. 10
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HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 150177	PERIOD: FROM 01/01/2014 TO 12/31/2014	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)		0.305438	1
Medicaid (see instructions for each line)				
2	Net revenue from Medicaid		1,604,811	2
3	Did you receive DSH or supplemental payments from Medicaid?		Y	3
4	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?		Y	4
5	If line 4 is no, enter DSH or supplemental payments from Medicaid?			5
6	Medicaid charges		1,604,811	6
7	Medicaid cost (line 1 times line 6)		490,170	7
8	Difference between net revenue and costs for Medicaid program (line 7 minus lines 2 and 5). If line 7 is less than the sum of lines 2 and 5, then enter zero.			8
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9	Net revenue from stand-alone CHIP			9
10	Stand-alone CHIP charges			10
11	Stand-alone CHIP cost (line 1 times line 10)			11
12	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9). If line 11 is less than line 9, then enter zero.			12
Other state or local government indigent care program (see instructions for each line)				
13	Net revenue from state or local indigent care program (not included on lines 2, 5 or 9)			13
14	Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)			14
15	State or local indigent care program cost (line 1 times line 14)			15
16	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13). If line 15 is less than line 13, then enter zero.			16
Uncompensated care (see instructions for each line)				
17	Private grants, donations, or endowment income restricted to funding charity care			17
18	Government grants, appropriations or transfers for support of hospital operations			18
19	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			19
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1	2	3
20	Charity care charges for the entire facility (see instructions)			20
21	Cost of patients approved for charity care (line 1 times line 20)			21
22	Partial payment by patients approved for charity care			22
23	Cost of charity care (line 21 minus line 22)			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?			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)			26
27	Medicare bad debts for the entire hospital complex (see instructions)			27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)			28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			29
30	Cost of uncompensated care (line 23 column 3 plus line 29)			30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			31
FORM CMS-2552-10 (11/2016) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4012)				
40-523 - 11-2016			Rev. 10	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA						Provider CCN: 150177	PERIOD: FROM 01/01/2014 TO 12/31/2014	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	N	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: 01/01/2014	To: 12/31/2014							20	
21	Type of control (see instructions)	6								21	
Inpatient PPS Information								1	2		
22	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR §412.106 (c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.							N	N	22	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						N	N		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N	N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105) ? Enter in column 3, "Y" for yes or "N" for no.						N	N	N	22.03	
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						3	N		23	
					In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out- of State Medicaid paid days	Out- of State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
					1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.									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 01/01/2014 TO 12/31/2014	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 OPSS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N				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

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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
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		Program Name	Program Code			
		1	2	3	4	5
65	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)					65
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010			1	2	3	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					66
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		Program Name	Program Code			
		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						
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 01/01/2014 TO 12/31/2014		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	Y		90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N		91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N		92
93	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N		93
94	Does title V or title XIX reduce capital cost? Enter "Y" for yes or "N" for no in the applicable column.			N	N		94
95	If line 94 is "Y", enter the reduction percentage in the applicable column.						95
96	Does title V or title XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	N		96
97	If line 96 is "Y", enter the reduction percentage in the applicable column.						97
Rural Providers					1	2	
105	Does this hospital qualify as a critical access hospital (CAH)?			N			105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)						106
107	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made 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
				207,712			
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 01/01/2014 TO 12/31/2014	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		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)			0.75		169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			04/01/2014	06/30/2014	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
FORM CMS-2552-10 (09-2015) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4004.1)						
40-508 - 09-15					Rev. 8	

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN

Cost report status - Settled Without Audit

[Record code 591947 - 2010]

08-11		FORM CMS-2552-10			4090 (Cont.)	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150177	PERIOD: FROM 01/01/2014 TO 12/31/2014	WORKSHEET S-2 Part II		
General Instruction:		Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS						
		Y/N	Date			
Provider Organization and Operation		1	2			
1	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N				1
		Y/N	Date	V/I		
		1	2	3		
2	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N				2
3	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y				3
		Y/N	Type	Date		
Financial Data and Reports		1	2	3		
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	05/05/2015		4
5	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N				5
			Y/N	Y/N		
Approved Educational Activities			1	2		
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N			6
7	Are costs claimed for allied health programs? If yes, see instructions.		N			7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N			8
9	Are costs claimed for Interns and Residents in approved GME programs in the current cost report? If yes, see instructions.		N			9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N			10
11	Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N			11
Bad Debts				Y/N		
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y		12
13	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N		13
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N		14
Bed Complement						
15	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N		15
		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	04/24/2015	Y	04/24/2015	16
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	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	
		1		2	
Home Office Costs					
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					

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA										Provider CCN: 150177		PERIOD: FROM 01/01/2014 TO 12/31/2014		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 - Settled Without Audit

[Record code 591947 - 2010]

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 150177	PERIOD: FROM 01/01/2014 TO 12/31/2014	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	7,757,336		7,757,336	243,729	31.83	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)		2,585,980		2,585,980	68,132	37.96	10
OTHER WAGES AND RELATED COSTS								
11	Contract labor: Direct Patient Care		307,712		307,712	6,386	48.19	11
12	Contract labor: Top level management and other management and administrative services		123,500		123,500	494	250.00	12
13	Contract labor: Physician-Part A							13
14	Home office and/or related organization 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)		980,678		980,678			17
18	Wage-related costs (other) (see instructions)							18
19	Excluded areas		510,955		510,955			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 organization 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	182,610		182,610	4,445	41.08	26
27	Administrative & General	5	1,371,357		1,371,357	26,789	51.19	27
28	Administrative & General under contract (see instructions)		142,492		142,492	4,786	29.77	28
29	Maintenance & Repairs	6						29
30	Operation of Plant	7	193,377		193,377	17,017	11.36	30
31	Laundry & Linen Service	8						31
32	Housekeeping	9						32
33	Housekeeping under contract (see instructions)		3,308		3,308	151	21.91	33
34	Dietary	10	154,001		154,001	10,347	14.88	34
35	Dietary under contract (see instructions)							35
36	Cafeteria	11						36

HOSPITAL WAGE INDEX INFORMATION	Provider CCN: 150177	PERIOD: FROM 01/01/2014 TO 12/31/2014	WORKSHEET S-3 PART II and III
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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	481,853		481,853	7,569	63.66	38
39 Central Services and Supply	14						39
40 Pharmacy	15	350,568		350,568	13,787	25.43	40
41 Medical Records & Medical Records Library	16	135,025		135,025	6,297	21.44	41
42 Social Service	17						42
43 Other General Service	18						43

Part III - Hospital Wage Index Summary

1 Net salaries (see instructions)		7,903,136		7,903,136	248,666	31.78	1
2 Excluded area salaries (see instructions)		2,585,980		2,585,980	68,132	37.96	2
3 Subtotal salaries (line 1 minus line 2)		5,317,156		5,317,156	180,534	29.45	3
4 Subtotal other wages and related costs (see instructions)		431,212		431,212	6,880	62.68	4
5 Subtotal wage-related costs (see instructions)		980,678		980,678			5
6 Total (sum of lines 3 through 5)		6,729,046		6,729,046	187,414	35.90	6
7 Total overhead cost (see instructions)		3,014,591		3,014,591	91,188	33.06	7

FORM CMS-2552-10 (11/2016) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4005.2 - 4005.3)

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN

Cost report status - Settled Without Audit

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HOSPITAL WAGE RELATED COSTS		Provider CCN: 150177	PERIOD: FROM 01/01/2014 TO 12/31/2014	WORKSHEET S-3, PART IV
Part IV - Wage Related Cost				
Part A - Core List				
				Amount Reported
RETIREMENT COST				
1	401k Employer Contributions		182,839	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)		797,839	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			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		545,677	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)		1,526,355	24
Part B - Other than Core Related Cost				
25	Other Wage Related Costs (specify)___			25
FORM CMS-2552-10 (11/2016) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4005.4)				
40-514 - 11-16			Rev. 10	

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES			Provider CCN: 150177		PERIOD: FROM 01/01/2014 TO 12/31/2014		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. tchnng. 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		3,923,834	3,923,834	-3,923,834			- 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)	5,171,356	29,200,689	34,372,045		34,372,045	-2,127,528	32,244,517	118
NONREIMBURSABLE COST CENTERS										
190	19000	Gift, Flower, Coffee Shop, & Canteen								190
191	19100	Research								191
192	19200	Physicians' Private Offices	2,535,678	1,556,041	4,091,719		4,091,719	-195,836	3,895,883	192
193	19300	Nonpaid Workers	50,302	34,887	85,189		85,189		85,189	193
194		Other Nonreimbursable (specify)								194
200		TOTAL (sum of lines 118-199)	7,757,336	30,791,617	38,548,953	- 0 -	38,548,953	-2,323,364	36,225,589	200
FORM CMS-2552-10 (11/2016) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, § 4013)										
40-524 - 11-16									Rev. 10	

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN

Cost report status - Settled Without Audit

[Record code 591947 - 2010]

RECLASSIFICATIONS	Provider CCN: 150177	PERIOD: FROM 01/01/2014 TO 12/31/2014	WORKSHEET A-6
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A - RECLASSIFY MVBLE EQUIP DEP

EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				DECREASES				Wkst. A-7 Ref. 10
		COST CENTER	LINE #	SALARY	OTHER	COST CENTER	LINE #	SALARY	OTHER	
1 RECLASSIFY MVBLE EQUIP DEPRECIATION	A		2.00		2,069,027		1.00		2,069,027	9
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										
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19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
500 Total reclassifications (sum of columns 4 and 5 must equal sum of columns 8 and 9)					2,069,027				2,069,027	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 - Settled Without Audit

[Record code 591947 - 2010]

RECLASSIFICATIONS	Provider CCN: 150177	PERIOD: FROM 01/01/2014 TO 12/31/2014	WORKSHEET A-6
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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		2,840,269		113.00		2,840,269		11	1
2 RECLASSIFY INTEREST EXPENSE	B		2.00		279,782		113.00		279,782		11	2
3 RECLASSIFY INTEREST EXPENSE	B		5.00		803,783		113.00		803,783			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)					3,923,834				3,923,834			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)

RECONCILIATION OF CAPITAL COSTS CENTERS	Provider CCN: 150177	PERIOD: FROM 01/01/2014 TO 12/31/2014	WORKSHEET A-7, PARTS I, II & III
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PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		Purchases	Donation	Total				
	1	2	3	4	5	6	7	
1 Land								1
2 Land Improvements								2
3 Buildings and Fixtures	14,379,799					14,379,799		3
4 Building Improvements	800,339	10,431		10,431		810,770		4
5 Fixed Equipment	512,549	21,515		21,515		534,064		5
6 Movable Equipment	13,122,947	369,751		369,751	38,302	13,454,396	1,040,706	6
7 HIT-designated Assets								7
8 Subtotal (sum of lines 1-7)	28,815,634	401,697		401,697	38,302	29,179,029	1,040,706	8
9 Reconciling Items								9
10 Total (line 7 minus line 9)	28,815,634	401,697		401,697	38,302	29,179,029	1,040,706	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	2,737,423				156,000		2,893,423	1	
2 Capital Related Costs-Movable Equipment					252,000		252,000	2	
3 Total (sum of lines 1-2)	2,737,423				408,000		3,145,423	3	

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

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS

Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
	1	2	3	4	5	6	7	8	
1 Capital Related Costs-Buildings and Fixtures	15,724,633	14,379,799	1,344,834						1
2 Capital Related Costs-Movable Equipment	13,454,396	3,115,151	10,339,245						2
3 Total (sum of lines 1-2)	29,179,029	17,494,950	11,684,079	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	668,396		2,840,269		156,000		3,664,665	1	
2 Capital Related Costs-Movable Equipment	2,069,027		279,782		252,000		2,600,809	2	
3 Total (sum of lines 1-2)	2,737,423		3,120,051		408,000		6,265,474	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 - Settled Without Audit

[Record code 591947 - 2010]

ADJUSTMENTS TO EXPENSES		Provider CCN: 150177		PERIOD: FROM 01/01/2014 TO 12/31/2014		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	-3,646	ADMINISTRATIVE & GENERAL	5.00		3
4	Trade, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excluded) (chapter 21)						7
8	Television and radio service (chapter 21)						8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Worksheet A-8-2					10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Worksheet A-8-1					12
13	Laundry and linen service						13
14	Cafeteria-employees and guests	B	-16,717	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	-7,843	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 instructions)			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
33.00	MISCELLANEOUS REVENUE	B	-250,983	ADMINISTRATIVE & GENERAL	5.00		33.00
33.01	G&A BAD DEBT EXPENSES	A	-1,055,289	ADMINISTRATIVE & GENERAL	5.00		33.01
33.02	PHYSICIAN OFFICES BAD DEBT EXPENSES	A	-195,836	PHYSICIANS PRIVATE OFFICES	192.00		33.02
33.03	PENALTIES & SETTLEMENTS	A	-43,874	ADMINISTRATIVE & GENERAL	5.00		33.03
33.04	CHARITABLE CONTRIBUTIONS	A	-33,137	ADMINISTRATIVE & GENERAL	5.00		33.04
33.05	AMORTIZATION OF INTANGIBLES	A	-716,039	ADMINISTRATIVE & GENERAL	5.00		33.05
34							34
35							35
36							36

ADJUSTMENTS TO EXPENSES		Provider CCN: 150177		PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET A-8	
37							37
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)		-2,323,364				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.							
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4016)							
40-529 - 09-13						Rev. 4	

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 150177			PERIOD: FROM 01/01/2014 TO 12/31/2014		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. tchnng. 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)	32,244,517	2,057,282	1,460,051	1,213,722	28,867,226	6,858,258	52,916	665,245	76,266	118
NONREIMBURSABLE COST CENTERS										
190 Gift, Flower, Coffee Shop, & Canteen										190
191 Research										191
192 Physicians' Private Offices	3,895,883	1,607,383	1,140,758	616,912	7,260,936	2,565,710	58,346	833,175		192
193 Nonpaid Workers	85,189			12,238	97,427	34,427				193
194 Other Nonreimbursable (specify)										194
200 Cross Foot Adjustments										200
201 Negative Cost Centers										201
202 TOTAL (sum lines 118-201)	36,225,589	3,664,665	2,600,809	1,842,872	36,225,589	9,458,395	111,262	1,498,420	76,266	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	

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 150177			PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET B, PART I		
COST CENTER DESCRIPTIONS	HOUSE-KEEPING	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	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. tchnng. 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)	66,402	347,708	313,382	26,373	960,229	105,393	1,109,460	419,042	25,293	118
NONREIMBURSABLE COST CENTERS										
190 Gift, Flower, Coffee Shop, & Canteen		82,246								190
191 Research										191
192 Physicians' Private Offices	86,615									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)	153,017	429,954	313,382	26,373	960,229	105,393	1,109,460	419,042	25,293	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	

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 150177			PERIOD: FROM 01/01/2014 TO 12/31/2014		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. tchnng. 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)							25,206,707		25,206,707	118
NONREIMBURSABLE COST CENTERS										
190 Gift, Flower, Coffee Shop, & Canteen							82,246		82,246	190
191 Research										191
192 Physicians' Private Offices							10,804,782		10,804,782	192
193 Nonpaid Workers							131,854		131,854	193
194 Other Nonreimbursable (specify)										194
200 Cross Foot Adjustments										200
201 Negative Cost Centers										201
202 TOTAL (sum lines 118-201)							36,225,589		36,225,589	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		

ALLOCATION OF CAPITAL-RELATED COSTS				Provider CCN: 150177		PERIOD: FROM 01/01/2014 TO 12/31/2014		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		342,610	243,150	585,760	6,074	64,443	9,494	40,428		50
51 Recovery Room										51
52 Labor Room and Delivery Room										52
53 Anesthesiology		1,503	1,066	2,569		11,368	42	177		53
54 Radiology-Diagnostic		228,407	162,100	390,507	2,891	38,664	6,329	26,952		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		9,557	6,783	16,340		10,715	265	1,128		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		5,410	3,839	9,249		3,346	150	638		66
67 Occupational Therapy		1,202	853	2,055		2,082	33	142		67
68 Speech Pathology		1,202	853	2,055		68	33	142		68
69 Electrocardiology										69
70 Electroencephalography										70
71 Medical Supplies Charged to Patients		1,503	1,066	2,569		30,731	42	177		71
72 Implantable Devices Charged to Patients						274,272				72
73 Drugs Charged to Patients		2,404	1,706	4,110		8,929	67	284		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 01/01/2014 TO 12/31/2014		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
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. tchg. 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)		2,057,282	1,460,051	3,517,333	45,687	642,484	40,394	151,443	1,865		118
NONREIMBURSABLE COST CENTERS											
190 Gift, Flower, Coffee Shop, & Canteen											190
191 Research											191
192 Physicians' Private Offices		1,607,383	1,140,758	2,748,141	23,218	240,352	44,539	189,671			192
193 Nonpaid Workers					461	3,225					193
194 Other Nonreimbursable (specify)											194
200 Cross Foot Adjustments											200
201 Negative Cost Centers											201
202 TOTAL (sum lines 118-201)		3,664,665	2,600,809	6,265,474	69,366	886,061	84,933	341,114	1,865		202
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4021)											
40-544 - 09-13									Rev. 4		

ALLOCATION OF CAPITAL-RELATED COSTS			Provider CCN: 150177			PERIOD: FROM 01/01/2014 TO 12/31/2014		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. tchn. 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)	42,460	69,343	111,677	9,398	48,023	70,198	133,236	65,443	16,847	118
NONREIMBURSABLE COST CENTERS										
190 Gift, Flower, Coffee Shop, & Canteen		16,402								190
191 Research										191
192 Physicians' Private Offices	55,385									192
193 Nonpaid Workers										193
194 Other Nonreimbursable (specify)										194
200 Cross Foot Adjustments										200
201 Negative Cost Centers										201
202 TOTAL (sum lines 118-201)	97,845	85,745	111,677	9,398	48,023	70,198	133,236	65,443	16,847	202
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4021)										
40-544 - 09-13									Rev. 4	

ALLOCATION OF CAPITAL-RELATED COSTS			Provider CCN: 150177			PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET B, PART II		
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. tchn. 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)							2,944,080		2,944,080	118
NONREIMBURSABLE COST CENTERS										
190 Gift, Flower, Coffee Shop, & Canteen							16,402		16,402	190
191 Research										191
192 Physicians' Private Offices							3,301,306		3,301,306	192
193 Nonpaid Workers							3,686		3,686	193
194 Other Nonreimbursable (specify)										194
200 Cross Foot Adjustments										200
201 Negative Cost Centers										201
202 TOTAL (sum lines 118-201)							6,265,474		6,265,474	202
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4021)										
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COST ALLOCATION - STATISTICAL BASIS			Provider CCN: 150177			PERIOD: FROM 01/01/2014 TO 12/31/2014		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
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. tchn. 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	4,988,746	19,408,831	24,252	21,352	94,486	20,502	118
NONREIMBURSABLE COST CENTERS											
190	Gift, Flower, Coffee Shop, & Canteen										190
191	Research										191
192	Physicians' Private Offices	26,742	26,742	2,535,678	7,260,936	26,742	26,742			26,742	192
193	Nonpaid Workers			50,302	97,427						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)	3,664,665	2,600,809	1,842,872	9,458,395	111,262	1,498,420	76,266	153,017		202
203	Unit cost multiplier (Worksheet B, Part I)	60.11	42.66	0.243292	0.353358	2.18	31.16	0.807167	3.24		203
204	Cost to be allocated (per Worksheet B, Part II)			69,366	886,061	84,933	341,114	1,865	97,845		204
205	Unit cost multiplier (Worksheet B, Part II)			0.009158	0.033102	1.67	7.09	0.019738	2.07		205

COST ALLOCATION - STATISTICAL BASIS			Provider CCN: 150177			PERIOD: FROM 01/01/2014 TO 12/31/2014		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)	9,081	9,720	840	85,119	100	100	840	840	118
NONREIMBURSABLE COST CENTERS										
190	Gift, Flower, Coffee Shop, & Canteen	2,148								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)	429,954	313,382	26,373	960,229	105,393	1,109,460	419,042	25,293	202
203	Unit cost multiplier (Worksheet B, Part I)	38.29	32.24	31.40	11.28	1,054	11,095	498.86	30.11	203
204	Cost to be allocated (per Worksheet B, Part II)	85,745	111,677	9,398	48,023	70,198	133,236	65,443	16,847	204
205	Unit cost multiplier (Worksheet B, Part II)	7.64	11.49	11.19	0.564187	701.98	1,332	77.91	20.06	205
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4020)										
40-553 - 09-13									Rev. 4	

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 150177			PERIOD: FROM 01/01/2014 TO 12/31/2014		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		
	19	20	SALARY AND FRINGES (ASSIGNED TIME)	PROGRAM COSTS (ASSIGNED TIME)						21
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. tchn. 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

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN

Cost report status - Settled Without Audit

[Record code 591947 - 2010]

COMPUTATION OF RATIO OF COSTS TO CHARGES							Provider CCN: 150177		PERIOD: FROM 01/01/2014 TO 12/31/2014		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)	5,431,884		5,431,884	5,431,884			1,987,835				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	2,843,219		2,843,219	2,843,219			37,722,040	0.075373	0.075373	0.075373	50
51	Recovery Room											51
52	Labor Room and Delivery Room											52
53	Anesthesiology	465,677		465,677	465,677			1,111,048	0.419133	0.419133	0.419133	53
54	Radiology-Diagnostic	1,741,234		1,741,234	1,741,234			2,519,158	0.691197	0.691197	0.691197	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	443,890		443,890	443,890			284,765	1.558794	1.558794	1.558794	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	140,094		140,094	140,094			225,177	0.622151	0.622151	0.622151	66

COMPUTATION OF RATIO OF COSTS TO CHARGES						Provider CCN: 150177			PERIOD: FROM 01/01/2014 TO 12/31/2014		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				
Medicaid - Title XIX												
115	Ambulatory Surgical Center (Distinct Part)											115
116	Hospice											116
117	Other Special Purpose (specify)											117
200	Subtotal (see instructions)	25,206,707		25,206,707		25,206,707			82,526,456			200
201	Less Observation Beds											201
202	Total (see instructions)			25,206,707		25,206,707	54,138,495	28,387,961	82,526,456			202
FORM CMS-2552-10 (10/2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTIONS 4023)												
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UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN

Cost report status - Settled Without Audit

[Record code 591947 - 2010]

COMPUTATION OF RATIO OF COSTS TO CHARGES							Provider CCN: 150177		PERIOD: FROM 01/01/2014 TO 12/31/2014		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)	5,431,884		5,431,884	5,431,884	1,987,835		1,987,835				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	2,843,219		2,843,219	2,843,219	17,047,959	20,674,081	37,722,040	0.075373	0.075373	0.075373	50
51	Recovery Room											51
52	Labor Room and Delivery Room											52
53	Anesthesiology	465,677		465,677	465,677	658,648	452,400	1,111,048	0.419133	0.419133	0.419133	53
54	Radiology-Diagnostic	1,741,234		1,741,234	1,741,234	145,124	2,374,034	2,519,158	0.691197	0.691197	0.691197	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	443,890		443,890	443,890	103,502	181,263	284,765	1.558794	1.558794	1.558794	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	140,094		140,094	140,094	220,124	5,053	225,177	0.622151	0.622151	0.622151	66

COMPUTATION OF RATIO OF COSTS TO CHARGES						Provider CCN: 150177			PERIOD: FROM 01/01/2014 TO 12/31/2014		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)	25,206,707		25,206,707		25,206,707	54,138,495	28,387,961	82,526,456			200
201	Less Observation Beds											201
202	Total (see instructions)	25,206,707		25,206,707		25,206,707	54,138,495	28,387,961	82,526,456			202
FORM CMS-2552-10 (10/2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTIONS 4023)												
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UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN

Cost report status - Settled Without Audit

[Record code 591947 - 2010]

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS				Provider CCN: 150177	PERIOD: FROM 01/01/2014 TO 12/31/2014	WORKSHEET D, PART I			
Medicare -Title XVIII - Hospital									
(A)	Cost Center Description	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)	
	INPATIENT ROUTNE SERVICE COST CENTERS								
30	Adults & Pediatrics (General Routine Care)	1,189,946		1,189,946	840	1,416.60	257	364,066	
31	Intensive Care Unit								
32	Coronary Care Unit								
33	Burn Intensive Care Unit								
34	Surgical Intensive Care Unit								
35	Other Special Care Unit (specify)								
40	Subprovider IPF								
41	Subprovider IRF								
42	Subprovider (Other)								
43	Nursery								
44	Skilled Nursing Facility								
45	Nursing Facility								
200	Total (lines 30-199)	1,189,946		1,189,946	840		257	364,066	
(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 - Settled Without Audit

[Record code 591947 - 2010]

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150177		PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET D, PART II	
Medicare -Title XVIII - Hospital							
(A)	Cost Center Description	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)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	718,004	37,722,040	0.019034	4,827,320	91,883	50
51	Recovery Room						51
52	Labor Room and Delivery Room						52
53	Anesthesiology	14,208	1,111,048	0.012788	216,837	2,773	53
54	Radiology-Diagnostic	480,865	2,519,158	0.190883	43,066	8,221	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	28,777	284,765	0.101055	85,337	8,624	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	13,569	225,177	0.060259	70,175	4,229	66
67	Occupational Therapy	4,353	169,873	0.025625	51,309	1,315	67
68	Speech Pathology	3,189					68
69	Electrocardiology						69
70	Electroencephalography						70
71	Medical Supplies Charged to Patients	33,571	3,130,766	0.010723	521,460	5,592	71
72	Implantable Devices Charged to Patients	274,272	33,948,573	0.008079	7,596,905	61,375	72
73	Drugs Charged to Patients	146,709	1,427,221	0.102793	462,803	47,573	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	36,617					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)	1,754,134	80,538,621	0.021780	13,875,212	231,585	200
(A) Worksheet A line numbers							
FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4024.2)							
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UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN

Cost report status - Settled Without Audit

[Record code 591947 - 2010]

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150177	PERIOD: FROM 01/01/2014 TO 12/31/2014	WORKSHEET D, PART III
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Medicare -Title XVIII - Hospital

(A) Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
	1	2	3	4	5	6	7	8	9	
INPATIENT ROUTINE SERVICE COST CENTERS										
30 Adults & Pediatrics (General Routine Care)						840		257		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)						840		257		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)

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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS										Provider CCN: 150177		PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET D, PART IV	
Medicare -Title XVIII - Hospital															
(A)	Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass- Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass- Through Costs (col. 9 x col. 12)	
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)							80,538,621			13,875,212		9,885,383		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)															
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UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN

Cost report status - Settled Without Audit

[Record code 591947 - 2010]

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS	Provider CCN: 150177	PERIOD: FROM 01/01/2014 TO 12/31/2014	WORKSHEET D, PART V
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Medicare -Title XVIII - Hospital

PART V - APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

(A)	Cost Center Description	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)	
		1	2	3	4	5	6	7	
ANCILLARY SERVICE COST CENTERS									
50	Operating Room		5,888,765			443,854			50
51	Recovery Room								51
52	Labor & Delivery Room								52
53	Anesthesiology		362,738			152,035			53
54	Radiology-Diagnostic		685,496			473,813			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		59,743			93,127			60
61	PBP Clinic Laboratory Services-Prgm. Only								61
62	Whole Blood & Packed Red Blood Cells								62
63	Blood Storing, Processing, & Transfusing								63
64	Intravenous Therapy								64
65	Respiratory Therapy								65
66	Physical Therapy								66
67	Occupational Therapy								67
68	Speech Pathology								68
69	Electrocardiology								69
70	Electroencephalography								70
71	Medical Supplies Charged To Patients		931,550			374,117			71
72	Implantable Devices Charged to Patients		1,776,321	82,874		586,703	27,373		72
73	Drugs Charged to Patients		180,770		457	186,945		473	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)		9,885,383	82,874	457	2,310,594	27,373	473	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		9,885,383	82,874	457	2,310,594	27,373	473	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 - Settled Without Audit

[Record code 591947 - 2010]

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS	Provider CCN: 150177	PERIOD: FROM 01/01/2014 TO 12/31/2014	WORKSHEET D, PART V
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Medicaid - Title XIX - Hospital

PART V - APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

(A)	Cost Center Description	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)	
		1	2	3	4	5	6	7	
ANCILLARY SERVICE COST CENTERS									
50	Operating Room		1,446,696						50
51	Recovery Room								51
52	Labor & Delivery Room								52
53	Anesthesiology		31,784						53
54	Radiology-Diagnostic		68,497						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		9,275						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		4,105						66
67	Occupational Therapy		3,549						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		27,144						73
74	Renal Dialysis								74
75	ASC (Non-Distinct Part)								75
76	Other Ancillary (specify)								76
OUTPATIENT SERVICE COST CENTERS									
88	Rural Health Clinic (RHC)								88
89	Federally Qualified Health Center (FQHC)								89
90	Clinic								90
91	Emergency								91
92	Observation Bed (Non-Distinct Part)								92
92.01	Observation Bed (Distinct Part)								92.01
93	Other Outpatient Service (specify)								93
OTHER REIMBURSABLE COST CENTERS									
94	Home Program Dialysis								94
95	Ambulance								95
96	Durable Medical Equipment-Rented								96
97	Durable Medical Equipment-Sold								97
98	Other Reimbursable Cost Center								98
200	Subtotal (see instructions)		1,591,050						200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)					216,585			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 - Settled Without Audit

[Record code 591947 - 2010]

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150177	PERIOD: FROM 01/01/2014 TO 12/31/2014	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)	840	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	840	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)	840	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)	257	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)	5,431,884	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)	5,431,884	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)	5,431,884	37
FORM CMS-2552-10 (09/2015) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 4025.1)			
40-573 - 09-15			Rev. 8

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN

Cost report status - Settled Without Audit

[Record code 591947 - 2010]

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150177		PERIOD: FROM 01/01/2014 TO 12/31/2014		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)						6,466.53	38
39	Program general inpatient routine service cost (line 9 x line 38)						1,661,898	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)						1,661,898	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1	2	3	4	5		
42	Nursery (title V & XIX only) Intensive Care Type Inpatient Hospital Units							42
43	Intensive Care Unit							43
44	Coronary Care Unit							44
45	Burn Intensive Care Unit							45
46	Surgical Intensive Care Unit							46
47	Other Special Care Unit (specify)							47
						1		
48	Program inpatient ancillary service cost (Worksheet D-3, column 3, line 200)						3,884,332	48
49	Total Program inpatient costs (sum of lines 41 through 48) (see instructions)						5,546,230	49
PASS-THROUGH COST ADJUSTMENTS								
50	Pass through costs applicable to Program inpatient routine services (from Worksheet D, sum of Parts I and III)						364,066	50
51	Pass through costs applicable to Program inpatient ancillary services (from Worksheet D, sum of Parts II and IV)						231,585	51
52	Total Program excludable cost (sum of lines 50 and 51)						595,651	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist, and medical education costs (line 49 minus line 52)						4,950,579	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
FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4025.2)								
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UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN

Cost report status - Settled Without Audit

[Record code 591947 - 2010]

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150177	PERIOD: FROM 01/01/2014 TO 12/31/2014	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	1,189,946	5,431,884	0.219067	
91	Nursing School cost		5,431,884		
92	Allied Health cost		5,431,884		
93	All other Medical Education		5,431,884		
FORM CMS-2552-10 (09/2015) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTIONS 4025.3 - 4025.4)					
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UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN

Cost report status - Settled Without Audit

[Record code 591947 - 2010]

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150177	PERIOD: FROM 01/01/2014 TO 12/31/2014		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)		306,913		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	0.075373	4,827,320	363,850	50
51	Recovery Room				51
52	Labor Room and Delivery Room				52
53	Anesthesiology	0.419133	216,837	90,884	53
54	Radiology-Diagnostic	0.691197	43,066	29,767	54
55	Radiology-Therapeutic				55
56	Radioisotope				56
57	Computed Tomography (CT) Scan				57
58	Magnetic Resonance Imaging (MRI)				58
59	Cardiac Catheterization				59
60	Laboratory	1.558794	85,337	133,023	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	0.622151	70,175	43,659	66
67	Occupational Therapy	0.505283	51,309	25,926	67
68	Speech Pathology				68
69	Electrocardiology				69
70	Electroencephalography				70
71	Medical Supplies Charged to Patients	0.401607	521,460	209,422	71
72	Implantable Devices Charged to Patients	0.330291	7,596,905	2,509,189	72
73	Drugs Charged to Patients	1.034160	462,803	478,612	73
74	Renal Dialysis				74
75	ASC (Non-Distinct Part)				75
76	Other Ancillary (specify)				76
OUTPATIENT SERVICE COST CENTERS					
88	Rural Health Clinic (RHC)				88
89	Federally Qualified Health Center (FQHC)				89
90	Clinic				90
91	Emergency				91
92	Observation Beds (Non-Distinct Part)				92
92.01	Observation Beds (Distinct Part)				92.01
93	Other Outpatient Service (specify)				93
OTHER REIMBURSABLE COST CENTERS					
94	Home Program Dialysis				94
95	Ambulance Services				95
96	Durable Medical Equipment-Rented				96
97	Durable Medical Equipment-Sold				97
98	Other Reimbursable (specify)				98
200	Total (sum of lines 50-94 and 96-98)		13,875,212	3,884,332	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		13,875,212		202
(A) Worksheet A line numbers					

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 150177	PERIOD: FROM 01/01/2014 TO 12/31/2014	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
40-578 - 09-15			Rev. 8

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN

Cost report status - Settled Without Audit

[Record code 591947 - 2010]

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150177	PERIOD: FROM 01/01/2014 TO 12/31/2014	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)	979,829		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	432,922		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)	3,726,351		2
2.01	Outlier reconciliation amount	-1,885,338		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 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 01/01/2014 TO 12/31/2014	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)		9,046,380,143	7,647,644,885	35
35.01	Factor 3 (see instructions)		0.000005188	0.000004029	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 and 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)		3,253,764		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)		3,253,764		49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		749,963		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)		4,003,727		59
60	Primary payer payments				60
61	Total amount payable for program beneficiaries (line 59 minus line 60)		4,003,727		61
62	Deductibles billed to program beneficiaries		80,256		62
63	Coinsurance billed to program beneficiaries				63
64	Allowable bad debts (see instructions)				64
65	Adjusted reimbursable bad debts (see instructions)				65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)				66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)		3,923,471		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)		-501,842		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)		8,619		70.93
70.94	HRR adjustment amount (see instructions)		-6,494		70.94
70.95	Recovery of accelerated depreciation				70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150177	PERIOD: FROM 01/01/2014 TO 12/31/2014	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)	3,423,754			71
71.01	Sequestration adjustment (see instructions)	68,475			71.01
72	Interim payments	5,694,716			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)	-2,339,437			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)	3,726,351			90
91	Capital outlier from Wkst. L, Pt. I, line 2	637,701			91
92	Operating outlier reconciliation adjustment amount (see instructions)	-1,885,338			92
93	Capital outlier reconciliation adjustment amount (see instructions)	-376,826			93
94	The rate used to calculate the time value of money (see instructions)	5.52			94
95	Time value of money for operating expenses (see instructions)	-104,191			95
96	Time value of money for capital related expenses (see instructions)	-20,825			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

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Cost report status - Settled Without Audit

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CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150177	PERIOD: FROM 01/01/2014 TO 12/31/2014	WORKSHEET E, PART B
Medicare -Title XVIII - Hospital			
PART B - MEDICAL AND OTHER HEALTH SERVICES			
1 Medical and other services (see instructions)		27,846	1
2 Medical and other services reimbursed under OPPS (see instructions).		2,310,594	2
3 PPS payments		1,723,104	3
4 Outlier payment (see instructions)		226,296	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)		27,846	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)		83,331	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)		83,331	18
19 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		55,485	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)		27,846	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)		1,949,400	24
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
25 Deductibles and coinsurance (see instructions)		16,575	25
26 Deductibles and Coinsurance relating to amount on line 24 (see instructions)		373,628	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)		1,587,043	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)		1,587,043	30
31 Primary payer payments		1,314	31
32 Subtotal (line 30 minus line 31)		1,585,729	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)		1,585,729	37
38 MSP-LCC reconciliation amount from PS&R		17	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)		1,585,712	40
40.01 Sequestration adjustment (see instructions)		31,714	40.01
41 Interim payments		1,543,032	41
42 Tentative settlement (for contractors use only)		1,265	42
43 Balance due provider/program (see instructions)		9,701	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)		226,493	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 01/01/2014 TO 12/31/2014	WORKSHEET E, PART B
93	Time Value of Money (see instructions)			93
94	Total (sum of lines 91 and 93)			94
FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4030.2)				
40-587 - 03-14			Rev. 7	

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN

Cost report status - Settled Without Audit

[Record code 591947 - 2010]

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 150177	PERIOD: FROM 01/01/2014 TO 12/31/2014	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)		224	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1 and 8 through 12)		257	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)		134	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1 and 8 through 12)		840	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)		82,526,456	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)			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)		698,250	8
9	Sequestration adjustment amount (see instructions)		13,965	9
10	Calculation of the HIT incentive payment after sequestration (see instructions)		684,285	10
INPATIENT HOSPITAL SERVICES UNDER THE IPSS & CAH				
30	Initial/interim HIT payment(s).		671,937	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)		12,348	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	

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[Record code 591947 - 2010]

BALANCE SHEET		Provider CCN: 150177	PERIOD: FROM 01/01/2014 TO 12/31/2014	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	912,477			1
2 Temporary investments				2
3 Notes receivable				3
4 Accounts receivable	24,242,073			4
5 Other receivables	236,470			5
6 Allowances for uncollectible notes and accounts receivable	-11,097,333			6
7 Inventory	608,264			7
8 Prepaid expenses	128,536			8
9 Other current assets				9
10 Due from other funds				10
11 Total current assets (sum of lines 1-10)	15,030,487			11
FIXED ASSETS				
12 Land				12
13 Land improvements				13
14 Accumulated depreciation				14
15 Buildings	15,190,569			15
16 Accumulated depreciation	-3,665,261			16
17 Leasehold improvements				17
18 Accumulated depreciation				18
19 Fixed equipment	534,064			19
20 Accumulated depreciation	-292,276			20
21 Automobiles and trucks				21
22 Accumulated depreciation				22
23 Major movable equipment	13,454,396			23
24 Accumulated depreciation	-9,756,684			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)	15,464,808			30
OTHER ASSETS				
31 Investments				31
32 Deposits on leases	12,324			32
33 Due from owners/officers				33
34 Other assets	1,061,647			34
35 Total other assets (sum of lines 31-34)	1,073,971			35
36 Total assets (sum of lines 11, 30, and 35)	31,569,266			36
Liabilities and Fund Balances (Omit cents)				
CURRENT LIABILITIES				
37 Accounts payable	2,387,983			37
38 Salaries, wages, and fees payable				38
39 Payroll taxes payable				39
40 Notes and loans payable (short term)	4,000,000			40
41 Deferred income				41
42 Accelerated payments				42
43 Due to other funds	9,596,541			43
44 Other current liabilities				44
45 Total current liabilities (sum of lines 37 thru 44)	15,984,524			45
LONG TERM LIABILITIES				
46 Mortgage payable				46
47 Notes payable	14,738,967			47
48 Unsecured loans				48
49 Other long term liabilities	17,305,012			49
50 Total long term liabilities (sum of lines 46 thru 49)	32,043,979			50
51 Total liabilities (sum of lines 45 and 50)	48,028,503			51

BALANCE SHEET		Provider CCN: 150177	PERIOD: FROM 01/01/2014 TO 12/31/2014	WORKSHEET G	
(If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)					
Assets (Omit cents)		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund
		1	2	3	4
CAPITAL ACCOUNTS					
52	General fund balance	-16,459,237			52
53	Specific purpose fund				53
54	Donor created - endowment fund balance - restricted				54
55	Donor created - endowment fund balance - unrestricted				55
56	Governing body created - endowment fund balance				56
57	Plant fund balance - invested in plant				57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion				58
59	Total fund balances (sum of lines 52 thru 58)	-16,459,237			59
60	Total liabilities and fund balances (sum of lines 51 and 59)	31,569,266			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	

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[Record code 591947 - 2010]

STATEMENT OF CHANGES IN FUND BALANCES				Provider CCN: 150177	PERIOD: FROM 01/01/2014 TO 12/31/2014		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	-8,123,226							1
2	Net income (loss) (from Worksheet G-3, line 29)	-7,318,161							2
3	Total (sum of line 1 and line 2)	-15,441,387							3
4	Additions (credit adjustments) (specify)								4
5									5
6									6
7									7
8									8
9									9
10	Total additions (sum of lines 4-9)								10
11	Subtotal (line 3 plus line 10)	-15,441,387							11
12	Deductions (debit adjustments) (specify)DISTRIBUTIONS	3,887							12
13	DUE FROM PARENT (AFS NOTE 6)	754,137							13
14	PRIOR PERIOD ADJUSTMENT	259,826							14
15									15
16									16
17									17
18	Total deductions (sum of lines 12-17)	1,017,850							18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)	-16,459,237							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

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[Record code 591947 - 2010]

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES		Provider CCN: 150177	PERIOD: FROM 01/01/2014 TO 12/31/2014	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	1,987,835		1,987,835	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)	1,987,835		1,987,835	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)	1,987,835		1,987,835	17
18 Ancillary services	52,150,660	28,387,961	80,538,621	18
19 Outpatient services				19
20 Rural Health Clinic (RHC)				20
21 Federally Qualified Health Center (FQHC)				21
22 Home health agency				22
23 Ambulance				23
24 Outpatient rehabilitation providers				24
25 ASC				25
26 Hospice				26
27 Other (specify) PHYSICIAN PRIVATE OFFICES		3,295,886	3,295,886	27
28 Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	54,138,495	31,683,847	85,822,342	28
PART II - OPERATING EXPENSES				
		1	2	
29 Operating expenses (per Wkst. A, column 3, line 200)			38,548,953	29
30 Add (specify)				30
31				31
32				32
33				33
34				34
35				35
36 Total additions (sum of lines 30-35)				36
37 Deduct (specify)				37
38				38
39				39
40				40
41				41
42 Total deductions (sum of lines 37-41)				42
43 Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)			38,548,953	43
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4040)				
40-603 - 10-12			Rev. 3	

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN

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[Record code 591947 - 2010]

STATEMENT OF REVENUES AND EXPENSES		Provider CCN: 150177	PERIOD: FROM 01/01/2014 TO 12/31/2014	WORKSHEET G-3
Description				
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)		85,822,342	1
2	Less contractual allowances and discounts on patients' accounts		54,844,545	2
3	Net patient revenues (line 1 minus line 2)		30,977,797	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)		38,548,953	4
5	Net income from service to patients (line 3 minus line 4)		-7,571,156	5
OTHER INCOME				
6	Contributions, donations, bequests, etc			6
7	Income from investments		3,646	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		16,717	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		7,843	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		224,789	24.00
25	Total other income (sum of lines 6-24)		252,995	25
26	Total (line 5 plus line 25)		-7,318,161	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)		-7,318,161	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

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[Record code 591947 - 2010]

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150177	PERIOD: FROM 01/01/2014 TO 12/31/2014	WORKSHEET L
Medicare -Title XVIII - Hospital				
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
		1	1.01	
1	Capital DRG other than outlier	112,262		1
1.01	Model 4 BPCI Capital DRG other than outlier			1.01
2	Capital DRG outlier payments	637,701		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)	2.30		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)	749,963		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
FORM CMS-2552-10 (03-2014) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 4064.1 - 4064.3)				
40-646 - 09-15			Rev. 8	