	OSPITAL HEALTH CARE COMPLEX COST	Provider CCN: 1:	50177	PERIOD:	4	WORKSHEET S	
REPORT CERTIFICA	ATION AND SETTLEMENT SUMMARY			FROM 01/01/201 TO 12/31/2014	14	PARTS I, II & III	ı
					FORM APPROV 0938-0050 EXPIR		
PART I - COST REP	ORT STATUS						
Provider use only	1. [X] Electronically filed cost report				Date:	Time:	
	2. [] Manually submitted cost report		_				1
	3. [] If this is an amended report enter the number of	times the provider	resubmitted this co	ost report	1		
	4 [F] Medicare Utilization. Enter "F" for full or "L"	for low.					
Contractor use only	5. [2] Cost Report Status	6. Date Received	: 06/02/2015	-	10. NPR Date: 01	/30/2017	
	(1) As Submitted	7. Contractor No.	: 08001		11. Contractor's V	endor Code: 4	
	()	8. [N] Initial Re	port for this Providen	ler CCN	12. [] If line 5, co	olumn 1 is 4: Enter	r
	(4) Reopened				number of times r		
DADT II. CEDTIEIC		>.[1,]1 mar reep		-			
AND ADMINISTRA WERE PROVIDED (CIVIL AND ADMIN CERTIFICATION B	TIVE ACTION, FINE AND/OR IMPRISONMENT UP OR PROCURED THROUGH THE PAYMENT DIRECT ISTRATIVE ACTION, FINES AND/OR IMPRISONN OFFICER OR ADMINISTRATOR OF PROVIDER(NDER FEDERAL TILY OR INDIREMENT MAY RESU S)	LAW. FURTHER CTLY OF A KICK ILT.	MORE, IF SERVI KBACK OR WER	CES IDENTIFIED E OTHERWISE II	IN THIS REPOR LLEGAL, CRIMIN	RT NAL,
		hat I have examine					
	and Statement of Revenue and Expenses prepared by	. 1 1 . 1 1			Number(s)} for the		
						egulations regardin	115
		(Signed)			ECTRONIC FORM	Л	
			Officer or Admin	istrator of Provide	r(s)		
			Title NOT AVAI	LIABLE ON ELE	CTRONIC FORM		
			Date	-			
PART III - SETTLEN	MENT SUMMARY						
		TITLE V	TITLE	EXVIII	HIT	TITLE XIX	
				PART B	-		
		1		3	4	5	-
1 HOSPITAL		1			12,348		1
	R - IPF		2,337,137	2,701	12,310		2
							3
							4
	S (CALMER)						
	SNF						5
6 SWING BED -	SNF						5
2. [] Manually submitted cost report 3. [] If this is an amended report enter the number of times the provider resubmitted this 4 [F] Medicare Utilization. Enter "F" for full or "L" for low. Contractor use only 5. [2] Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled without audit (4) Reopened (5) Amended (6) Amended (7) Amended (8) PART II - CERTIFICATION MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST RE AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHER WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KIC 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 accompany and the Balance Sheet and Statement of Revenue and Expenses prepared by Provided and ending and ending and to the best of my knowledge and belief, this report he books and records of the provider in accordance with applicable instructions, except as noted. I further certify the provision of health care services, and that the services identified in this cost report were provided in compliant provided in accordance with applicable instructions, except as noted. I further certify the provision of health care services, and that the services identified in this cost report were provided in compliant provided in accordance with applicable instructions, except as noted. I further certify the provision of health care services, and that the services identified in this cost report were provided in compliant provided in accordance with applicable instructions, except as noted. I further certify the provision of health care services, and that the services identified in this cost report were provided in compliant provided in accordance with applicable instructions, except as noted. I further certify the provider in accordance with applicable instructions, except as noted. I further c						5 6 7	
6 SWING BED - 1 7 SNF 8 NF, ICF/IID	SNF NF						5 6 7 8
6 SWING BED - 1 7 SNF 8 NF, ICF/IID 9 HOME HEALT	NF H AGENCY						5 6 7 8 9
6 SWING BED - 1 7 SNF 8 NF, ICF/IID 9 HOME HEALT 10 HOSPITAL-BA	NF H AGENCY SED - RHC						5 6 7 8 9
6 SWING BED - 1 7 SNF 8 NF, ICF/IID 9 HOME HEALT 10 HOSPITAL-BA 11 HOSPITAL-BA	SNF NF H AGENCY SED - RHC SED -FQHC						5 6 7 8 9 10
6 SWING BED - 1 7 SNF 8 NF, ICF/IID 9 HOME HEALT 10 HOSPITAL-BA 11 HOSPITAL-BA	SNF NF H AGENCY SED - RHC SED -FQHC						5 6 7 8 9 10 11
6 SWING BED - 1 7 SNF 8 NF, ICF/IID 9 HOME HEALT 10 HOSPITAL-BA 11 HOSPITAL-BA 12 OUTPATIENT 200 TOTAL	SNF NF H AGENCY SED - RHC SED -FQHC REHABILITATION PROVIDER (Specify)		-2,339,437	9,701	12,348		5 6 7 8 9 10
6 SWING BED - 1 7 SNF 8 NF, ICF/IID 9 HOME HEALT 10 HOSPITAL-BA 11 HOSPITAL-BA 12 OUTPATIENT 200 TOTAL	SNF NF H AGENCY SED - RHC SED -FQHC REHABILITATION PROVIDER (Specify)	for the element of t		<u> </u>	12,348		5 6 7 8 9 10 11
6 SWING BED - 1 7 SNF 8 NF, ICF/IID 9 HOME HEALT 10 HOSPITAL-BA 11 HOSPITAL-BA 12 OUTPATIENT 200 TOTAL The above amounts re According to the Paper valid OMB control nu including the time to a concerning the accura Mail Stop C4-26-05, 1 to the PRA Reports C number listed on this	SNF NF NF H AGENCY SED - RHC SED - FQHC REHABILITATION PROVIDER (Specify) Peresent "due to" or "due from" the applicable program erwork Reduction Act of 1995, no persons are required umber for this information collection is 0938-0050. The review instructions, search existing resources, gather the cy of the time estimate(s) or suggestions for improving Baltimore, Maryland 21244-1850. Please do not send a learance Office. Please note that any correspondence no	to respond to a coll time required to co e data needed, and this form, please v oplications, claims, or pertaining to the	the above complex lection of information per this inform complete and reviewrite to: CMS, 7500 payments, medica information collection.	indicated. ion unless it displanation collection is we the information Security Bouleval records or any detion burden appro	lys a valid OMB co estimated 673 hou collection. If you ard, Attn: PRA Repocuments containing wed under the association	ars per response, have any commen port Clearance Off ag sensitive inform ciated OMB contro	5 6 7 8 9 10 11 12 200 et atts
6 SWING BED - 1 7 SNF 8 NF, ICF/IID 9 HOME HEALT 10 HOSPITAL-BA 11 HOSPITAL-BA 12 OUTPATIENT 200 TOTAL The above amounts re According to the Pape valid OMB control nu including the time to a concerning the accura Mail Stop C4-26-05, 1 to the PRA Reports C number listed on this MEDICARE.	SNF NF N	to respond to a coll time required to co e data needed, and this form, please w oplications, claims, of pertaining to the u have questions o	the above complex lection of information per this inform complete and review rite to: CMS, 7500 payments, medica information collectroncerns regarding	indicated. ion unless it displated in the collection is the information of Security Bouleval records or any detion burden approng where to submi	nys a valid OMB co estimated 673 hou collection. If you ard, Attn: PRA Repocuments containing wed under the associ t your documents,	ars per response, have any commen port Clearance Off ag sensitive inform ciated OMB contro	5 6 7 8 9 10 11 12 200 et atts

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, divi	ded by line 202, column 8)	0.305438	
Medicaid (see instructions for each line)			•	
2 Net revenue from Medicaid			1,604,811	
3 Did you receive DSH or supplemental payments from Medicaid?			Y	
4 If line 3 is yes, does line 2 include all DSH or supplemental payn	nents from Medicaid?		Y	
5 If line 4 is no, enter DSH or supplemental payments from Medica	nid?			
6 Medicaid charges			1,604,811	
7 Medicaid cost (line 1 times line 6)			490,170	
8 Difference between net revenue and costs for Medicaid program If line 7 is less than the sum of lines 2 and 5, then enter zero.	(line 7 minus lines 2 and 5).		
Children's Health Insurance Program (CHIP) (see instructions for each	line)		'	
9 Net revenue from stand-alone CHIP				
10 Stand-alone CHIP charges				
11 Stand-alone CHIP cost (line 1 times line 10)				
12 Difference between net revenue and costs for stand-alone CHIP (If line 11 is less than line 9, then enter zero.	line 11 minus line 9).			
Other state or local government indigent care program (see instructions	s for each line)			
13 Net revenue from state or local indigent care program (not includ	ed on lines 2, 5 or 9)			
14 Charges for patients covered under state or local indigent care pro	ogram (not included in line	s 6 or 10)		T
15 State or local indigent care program cost (line 1 times line 14)				T
16 Difference between net revenue and costs for state or local indige	ent care program (line 15 m	inus line 13).		T
If line 15 is less than line 13, then enter zero.				
Incompensated care (see instructions for each line)				
17 Private grants, donations, or endowment income restricted to fund	ding charity care			
18 Government grants, appropriations or transfers for support of hos				
19 Total unreimbursed cost for Medicaid, CHIP and state and local i	ndigent care programs (sur	m of lines 8, 12 and 16)		
	Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
	1	2	3	
20 Charity care charges for the entire facility (see instructions)				
21 Cost of patients approved for charity care (line 1 times line 20)				
22 Partial payment by patients approved for charity care				
23 Cost of charity care (line 21 minus line 22)				
24 Does the amount in line 20, column 2 include charges for patient by Medicaid or other indigent care program?	days beyond a length of st	ay limit imposed on patients covered		
25 If line 24 is yes, enter charges for patient days beyond an indigen	t care program's length of	stay limit (see instructions)		
26 Total bad debt expense for the entire hospital complex (see instru	ctions)			
27 Medicare bad debts for the entire hospital complex (see instruction	ons)			
28 Non-Medicare and non-reimbursable Medicare bad debt expense	(line 26 minus line 27)			
29 Cost of non-Medicare and non-reimbursable Medicare bad debt e	xpense (line 1 times line 2	8)		
30 Cost of uncompensated care (line 23 column 3 plus line 29)				
31 Total unreimbursed and uncompensated care cost (line 19 plus lin	ne 30)			
FORM CMS-2552-10 (11/2016) (INSTRUCTIONS FOR THIS WOR	KSHEET ARE PUBLISHI	ED IN CMS PUB. 15-2, SECTION 4		_
40-523 - 11-2016			Rev. 10	

HOSP	ITAL AND HOSPITAL HEALTH	I CARE COMPLEX IDENTIFICATION D	ATA		Provider CCN: 150177	PERIOD: FROM 01/0 TO 12/31/20		WORKSHE	ET S-2 PAR	TI
Hospit	al and Hospital Health Care Comp	olex Address:		_	'					-
	Street: 4455 EDISON LAKES PE City: MISHAWAKA	KWY	State: IN	Zip Code: 46545	P.O. Box: County: ST	. JOSEPH				2
Hospit	al and Hospital-Based Component	Identification:			-	,				
	Component	Component Name	CCN	CBSA	Provider	Date	Payment	System (P, T	, O, or N)	
	Î	•	Number	Number	Type	Certified	V	XVIII	XIX	1
	0	1	2	3	4	5	6	7	8	
3	Hospital	UNITY MEDICAL AND SURGICAL	150177	43780	1	10/31/2009	N	P	N	3
		HOSPITAL								
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
	Hospital-Based NF									10
11	Hospital-Based OLTC									11
	Hospital-Based HHA									12
	Separately Certified ASC									13
	Hospital-Based Hospice									14
	Hospital-Based Health Clinic-									15
10	RHC									10
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/	From: 01/01/2014	To:							20
	уууу)		12/31/2014							
21	Type of control (see instructions)		6							21
Inpatie	ent PPS Information							1	2	
22		currently receiving payments for dispropor						N	N	22
	column 2, enter "Y" for yes or "N	for yes or "N" for no. Is this facility subject for no.	t to 42 CFR	§412.106 (c)	(2) (Pickie ai	nenament nos	spitai)? in			
22.01		uncompensated care payments for this cost i	reporting peri	od? Enter in	column 1 "V	" for yes or	N	N		22.01
22.01		cost reporting period occurring prior to Octo					1	1		22.01
		ng period occurring on or after October 1. (s								
22.02	Is this a newly merged hospital th	at requires final uncompensated care payme	ents to be det	ermined at co	ost report sett	lement? (see	N	N		22.02
	· ·	Y" for yes or "N" for no, for the portion of t			rior to Octob	er 1. Enter in				
		no, for the portion of the cost reporting peri				_				
22.03		phic reclassification from urban to rural as					N	N	N	22.03
		in FY2015? Enter in column 1, "Y" for yes a column 2, "Y" for yes or "N" for no for the								
	ļ* *	tions) Does this hospital contain at least 10			U 1	_				
	accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for	or no.							
23		ne Medicaid days on lines 24 and/or 25 belo					3	N		23
		harge. Is the method of identifying the days			od different f	rom the				
	method used in the prior cost repo	orting period? In column 2, enter "Y" for ye	S OF IN TOFT	10.						
				T. Citata	T. Cut.	0.4	0.4	M. P 11	0:1	1
				In-State Medicaid	In-State Medicaid	Out- of State	Out- of State	Medicaid HMO days	Other Medicaid	
				paid days	eligible	Medicaid	Medicaid		days	
					unpaid	paid days	eligible			
					days		unpaid			
				1	2	3	days 4	5	6	-
24	If this provider is an IDDS basely	d anter the in stete Medicaid ==:id d=== 'e	olume 1	1	2	3	4	3	U	24
24	1 -	 al, enter the in-state Medicaid paid days in c days in column 2, out-of-state Medicaid paid 								24
		eligible unpaid days in column 4, Medicaid	-							
		lumn 5, and other Medicaid days in column								
25		e in-state Medicaid paid days in column 1,								25
		column 2, out-of-state Medicaid paid days i								
	but unpaid days in column 5.	paid days in column 4 Medicaid HMO paid	anu engible							
<u> </u>			_					1	L	<u></u>
L										

HOSPI	TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150177			WORKSHE	ET S-2 PAR	ΤΙ
26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting por "1" for urban or "2" for rural.	CCN:					
	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. I column 1, "1" for urban or "2" for rural. If applicable enter the effective date of the geographic reclassi 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 pe	riod.				35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in and enter subsequent dates.				Enc	ling:	
37.01	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with the			N			
38	rule? Enter "Y" for yes or "N" for no. (see instructions) If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscriptor the number of periods in excess of one and enter subsequent dates.	ot this line	Beginning:		Enc	ling:	38
	for the number of periods in excess of one and enter subsequent dates.						
	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in acc (ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in acc (iii)? In the column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in acc						39
40	(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)		discharges pri	or to	N	N	40
				V	XVIII	XIX	
_ ^	ctive Payment System (PPS)-Capital						
	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 instructions)		_				
	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 complete Worksheet L, Part III and L-1, Parts I through III.	CFR §412.3	48(f)? If yes,				
	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.						
48	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.			N	N	N	48
	ng Hospitals				2	3	
	If line 56 is yes, is this the first cost reporting period during which residents in approved GME program Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first n reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet complete Wkst. D, Part III & IV and D-2, Part II, if applicable.	nonth of this t E-4. If colum	cost nn 2 is "N",				
	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Posection 2148? If yes, complete Wkst. D-5.	ub. 15-1, cha	pter 21,	N			58
60	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I. Are you claiming nursing school and/or allied health costs for a program that meets the provider-operate \$413.85? Enter "Y" for yes or "N" for no. (see instructions)	ted criteria u	nder				
		Y/N			IME		
		1	2	3	4		
	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
1				Y/N	IME		
				1	2	3	
	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost repo before March 23, 2010. (see instructions)	rts ending an	d submitted				61.01
	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery bFTEs added under section 5503 of ACA). (see instructions)	FTEs, and pr	imary care				61.02
	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determine the 75% test. (see instructions)	rmining com	oliance with				61.03
	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the curr (see instructions).	ent cost repo	rting period.				61.04
	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's p general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)	rimary care a	nd/or				61.05
	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimar (see instructions)	y care or ger	eral surgery.				61.06
		Progra	m Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
C1 10	OCAL PTT: 11 (105 15 1		1	2	3	4	(1.10
	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.						61.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150177	PERIOD: FROM 01/0 TO 12/31/20		WORKSHE	ET S-2 PAR	ΤΙ
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the numb residents for each expanded program. (see instructions) Enter in column 1 the program nat column 2 the program code, enter in column 3 the IME FTE unweighted count and enter i directGME FTE unweighted count.	me, enter in						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 f	or which you	r hospital rec	eived HRSA				62
PCRE funding (see instructions)							
Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into reporting period of HRSA THC program. (see instructions)	your hospita	l during in th	is cost				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 perio yes, complete lines 64-67. (see instructions)	d? Enter "Y"	for yes or "N	" for no. If	N			63
Section 5504 of the ACA Base Year FTE Residents in Nonprovider settingsThis base year is yo or after July 1, 2009 and before June 30, 2010.	our cost report	ting period th		Unweighted FTEs Nonprovider Site	FTEs in	Ratio (col. 1/ (col. 1 + col. 2))	
Enter in column 1, if line 63 is yes, or your facility trained residents in the base year perior primary care resident FTEs attributable to rotations occurring in all non-provider settings. unweighted non-primary care resident FTEs that trained in your hospital. Enter in column (column 1 + column 2)). (see instructions)	Enter in colu	mn 2 the nun	nber of				64
	Progra	m Name	Program	Unweighted FTEs Nonprovider Site	FTEs in	Ratio (col. 3/ (col. 3 + col. 4))	
		1	2	3	4	5	
65 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	1						65
(<u> </u>	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 settingsEffective for cost after July 1, 2010	t reporting pe	riods beginni	ng on or	1	2	3	
Enter in column 1, the number of unweighted non-primary care resident FTEs attributable provider settings. Enter in column 2 the number of unweighted non-primary care resident Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instruction of the column 2) is column 2 to the column 3 the ratio of (column 1 divided by (column 1 + column 2)).	FTEs that tra						66
			-	Unweighted	Unweighted	Ratio (col	
		m Name	Program Code	Unweighted FTEs Nonprovider Site	FTEs in Hospital	3/ (col. 3 + col. 4))	
		m Name	Program	FTEs Nonprovider	FTEs in	3/ (col. 3	(7)
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)			Program Code	FTEs Nonprovider Site	FTEs in Hospital	3/ (col. 3 + col. 4))	67
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) Inpatient Psychiatric Facility PPS		1	Program Code	FTEs Nonprovider Site 3	FTEs in Hospital	3/ (col. 3 + col. 4))	
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	r? Enter "Y" if	1 for yes or "N" n or before N program in a	Program Code 2 for no. ovember ccordance	FTEs Nonprovider Site 3	FTEs in Hospital	3/ (col. 3 + col. 4))	70 71
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) Inpatient Psychiatric Facility PPS 70 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider 71 If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a 1 with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If colum began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS	r? Enter "Y" if report filed on new teaching nn 2 is Y, indi	for yes or "N" n or before N program in a icate which p	Program Code 2 for no. ovember ccordance rogram year	FTEs Nonprovider Site 3 1 N N	FTEs in Hospital	3/ (col. 3 + col. 4))	70 71
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) Inpatient Psychiatric Facility PPS 70 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a 1 with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If colum began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subproving the contain	r? Enter "Y" freport filed onew teaching in 2 is Y, individer? Enter "	for yes or "N" n or before N program in a icate which p	Program Code 2 ' for no. ovember ccordance rogram year "N" for no.	FTEs Nonprovider Site 3 1 N N	FTEs in Hospital 4 2 N	3/ (col. 3 + col. 4))	70
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HOSP	TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	A		Provider CCN: 150177	PERIOD: FROM 01/0 TO 12/31/20		WORKSHE	ET S-2 PAR	ΤΙ
Title V	and XIX Inpatient Services						1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for	or yes or "	N" for no in	applicable c	olumn.		N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in applicable column.	full or in	part? Enter "	Y" for yes o	r "N" for no	n the	N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (seapplicable column.	ee instruct	ions) Enter "	'Y" for yes o	r "N" for no	in the		N	92
93	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Ent	ter "Y" for	yes or "N" i	for no in the	applicable co	lumn.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter "Y" for yes or "N" for no in th	ne applicat	ole 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	n the appli	cable columi	n.			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 payme	ent for out	patient servi	ces? (see ins	tructions)				106
107	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for no in column 1. (see instructions) If yes, the GME elimination is notmade on verimbursed. 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	e 42 CFR §	3412.113(c).	Enter "Y" fo	or yes or "N"	for no.	N		108
					Physical	Occupationa	Speech	Respiratory	
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provide	ed by outsi	de supplier?	Enter "Y"					109
110	for yes or "N" for no for each therapy. Did this hospital participate in the Rural Community Hospital Demonstration projutes or "N" for no.	ject (410A	Demo) for	the current c	ost reporting	period? Ente	r "Y" for	N	110
Miscel	laneous Cost Reporting Information				-				
	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. in column 2.	. If yes, en	ter the metho	od used (A, l	B, or E only)	N			115
	If column 2 is "E", enter in column 3 either "93" percent for short term hospital or psychiatric, rehabilitation and long term hospitals providers) based on the definition								
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 po	olicy is cla	im-made. E	nter 2 if the p	policy is occu	irrence.	1		118
118.01	List amounts of malpractice premiums and paid losses					Premiums 207,712	Paid Losses	Self Insurance	118.01
118 02	Are malpractice premiums and paid losses reported in a cost center other than the	Administ	rative and G	eneral? If ve	s suhmit sur		N		118.02
	schedule listing cost centers and amounts contained therein.						- 1		
	What is the liability limit for the malpractice insurance policy? Enter in column 1 monetary limit per policy year.								119
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital v Harmless provision in ACA §3121 and applicable amendments? (see instructions)	with <=10	0 beds that q	ualifies for t	he Outpatien		N	N	120
121	Did this facility incur and report costs for high cost implantable devices charged t	to patients	? Enter "Y"	for yes or "N	" for no.		Y		121
	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N'					n column 2	N		122
	the Worksheet A line number where these taxes are included.								
Transp	lant Center Information								
125	Does this facility operate a transplant center? Enter "Y" for yes or "N" for no. If y	es, enter c	ertification of	date(s) (mm/	dd/yyyy) bel	ow.	N		125
126	If this is a Medicare certified kidney transplant center, enter the certification date	in column	1 and termi	nation date,	if applicable,	in column			126
	2.								
	If this is a Medicare certified heart transplant center, enter the certification date in								127
	If this is a Medicare certified liver transplant center, enter the certification date in					-			128
	If this is a Medicare certified lung transplant center, enter the certification date in If this is a Medicare certified pancreas transplant center, enter the certification dat 2								129 130
131	 If this is a Medicare certified intestinal transplant center, enter the certification da column 2. 	ate in colu	nn 1 and ter	mination dat	e, if applicab	le, in			131
132	If this is a Medicare certified islet transplant center, enter the certification date in	column 1	and terminat	tion date if s	nnlicable in	column 2			132
	If this is a Medicare certified other transplant center, enter the certification date in								133
	If this is an organ procurement organization (OPO), enter the OPO number in colu								134
-	viders		termination	dute, ir uppi	ileable, ili coi	umm 2.			131
711111	WILLIS	-					1	2	
140	Are there any related organization or home office costs as defined in CMS Pub. 1. If yes, and home office costs are claimed, enter in column 2 the home office ch				or "N" for no	in column	N		140
If this	facility is part of a chain organization, enter on lines 141 through 143 the name and	d address	of the home	office and en	nter the home	office contr	actor name ar	nd contractor	
	Name:		Contractor's	Name:		Contractor's			141
142	Street:		P.O. Box:						142
	City: Sta		Zip Code:						143
			_						

HOSP:	ITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150177	PERIOD: FROM 01/0 TO 12/31/20		WORKSHE	ET S-2 PAR	ΤΙ
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 of 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting column 2.					N		145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" Pub. 15-2, chapter 40 §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	for yes or	"N" for no	in column 1.	(See CMS	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
	This facility contain a provider that qualifies for an exemption from the application of the lower Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)	of costs o	r charges?	Part A	Part B	Title V	Title XIX	
				1	2	3	4	1
155	Hospital			N	N	N	N	155
156	Subprovider - IPF			N	N	N	N	156
157	157 Subprovider - IRF N N							157
158	Subprovider - Other							158
159	SNF			N	N	N	N	159
160	ННА			N	N	N	N	160
161	СМНС				N	N	N	161
161.10					N	N	N	161.10
Multic	ampus							,
165	Is this hospital part of a multicampus hospital that has one or more campuses in different CBS Enter "Y" for yes or "N" for no.	As?	N					165
166	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in co	lumn 2, z	ip in columr	3, CBSA in	column 4, F7	ΓE/Campus ir	n column 5.	166
	Name	Соц	inty	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 HIT assets. (see instructions)	reasonab	le cost incur	red for the				168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardshi (ii)? Enter "Y" for yes or "N" for no. (see instructions)	p exception	on under §41	3.70(a)(6)				168.01
169	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter instructions)	the trans	ition factor.	(see	0.75			169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period res]	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 M line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the numl (see instructions)					N		171
FORM	CMS-2552-10 (09-2015) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED I	N CMS P	UB. 15-II, S	SECTION 400	04.1)			

				4090 (Cont.)	
REIMBURSEMENT QUESTIONNAIRE 150177	PERIOD: FROM 01/01/2014		WORKSHEET S	-2 Part II	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses	ГО 12/31/2014				
Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					_
		Y/N	Date		
Provider Organization and Operation		1	2		
Has the provider changed ownership immediately prior to the beginning of the cost reporting	g period? If yes,	N			
enter the date of the change in column 2. (see instructions)		37.37	D .	X 7 /T	4
		Y/N	Date	V/I	4
	2.1.1.6	1	2	3	+
2 Has the provider terminated participation in the Medicare Program? If yes, enter in column termination and in column 3, "V" for voluntary or "I" for involuntary.	2 the date of	N			
3 Is the provider involved in business transactions, including management contracts, with indi	ividuals or entities	Y			
(e.g., chain home offices, drug or medical supply companies) that are related to the provider medical staff, management personnel, or members of the board of directors through owners family and other similar relationships? (see instructions)	or its officers,	-			
		Y/N	Type	Date	Т
Financial Data and Reports		1	2	3	1
4 Column 1: Were the financial statements prepared by a Certified Public Accountant? Colum "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter da column 3. (see instructions) If no, see instructions.		Y	A	05/05/2015	
5 Are the cost report total expenses and total revenues different from those on the filed finance	ial statements? If	N			
yes, submit reconciliation.					
			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 leg	al operator of the pr	ogram?	N		
7 Are costs claimed for allied health programs? If yes, see instructions.			N		
8 Were nursing school and/or allied health programs approved and/or renewed during the cost instructions.	t reporting period? Is	f yes, see	N		
9 Are costs claimed for Interns and Residents in approved GME programs in the current cost	report? If yes, see in	structions.	N		
10 Was an approved Intern and Resident GME program initiated or renewed in the current cost instructions.	reporting period? If	f yes, see	N		
11 Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching instructions.	Program on Worksh	eet A? If yes, see	N		1
Bad Debts				Y/N	
12 Is the provider seeking reimbursement for bad debts? If yes, see instructions.				Y	1
13 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting	ng period? If yes, su	bmit copy.		N	
14 If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instruction	ıs.		_	N	1
Bed Complement					
15 Did total beds available change from the prior cost reporting period? If yes, see instructions.			_	N	1
	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	Y	04/24/2015	Y	04/24/2015	1
instructions)			NT.		1
Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either coumn 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		\perp
Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either coumn 1 or 3 is yes, enter the paid-through date in columns 2 and	N N		N		1
 17 Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either coumn 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 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? 					
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17 Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either coumn 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 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. 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. 20 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe	N N		N N		1 2
Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either coumn 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 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. 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. 20 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments: 21 Was the cost report prepared only using the provider's records? If yes, see instructions. COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILI	N N N	S)	N N N		1 2
17 Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either coumn 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 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. 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. 20 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments: 21 Was the cost report prepared only using the provider's records? If yes, see instructions. COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILI Capital Related Cost	N N N	S)	N N N		1 2 2
Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either coumn 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 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. 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. 20 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments: 21 Was the cost report prepared only using the provider's records? If yes, see instructions. COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILE Capital Related Cost Have assets been relifed for Medicare purposes? If yes, see instructions.	N N N N ORENS HOSPITAL		N N N N		2
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Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either coumn 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 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. 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. 20 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments: 21 Was the cost report prepared only using the provider's records? If yes, see instructions. COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILI Capital Related Cost 22 Have assets been relifed for Medicare purposes? If yes, see instructions. 23 Have changes occurred in the Medicare depreciation expense due to appraisals made during 4 Were new leases and/or amendments to existing leases entered into during this cost reporting the cost	N N N ORENS HOSPITAL the cost reporting p g period? If yes, see	eriod? If yes, see i	N N N N		2 2 2 2 2 2
Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either coumn 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 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. 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. If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments: Was the cost report prepared only using the provider's records? If yes, see instructions. COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILI Capital Related Cost Have assets been relifed for Medicare purposes? If yes, see instructions. Were new leases and/or amendments to existing leases entered into during this cost reportin 25 Have there been new capitalized leases entered into during the cost reporting period? If yes,	N N N ORENS HOSPITAL the cost reporting p g period? If yes, see see instructions.	eriod? If yes, see i	N N N N		2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2
Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either coumn 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 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. 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. If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments: Was the cost report prepared only using the provider's records? If yes, see instructions. COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILI Capital Related Cost Have assets been relifed for Medicare purposes? If yes, see instructions. Were new leases and/or amendments to existing leases entered into during this cost reporting the	N N N ORENS HOSPITAL the cost reporting p g period? If yes, see see instructions. s, see instructions.	eriod? If yes, see i	N N N N		2 2 2 2 2

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 see instructions.	ntion account? If yes,	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 instructions.	services? If yes, see	N	32
33 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N	33
Provider-Based Physicians			
34 Are services furnished at the provider facility under an arrangement with provider-based physicians? If "Y" see instructions.		N	34
35 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N	35
	Y/N	Date	
Home Office Costs	1	2	7 i
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.	l 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 4	1004.2)		
40-510 - 09-15		Rev. 8	
* Cost Report Preparer Contact Information has been redacted by CMS			

Cost report status - Settled Without Audit

[Record code 591947 - 2010]

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 150177 | PERIOD: | WORKSF

CCN: 150177 PERIOD: WORKSHEET S-3 PART I FROM 01/01/2014 TO 12/31/2014

												TO 12/31/2				
Component		No. of Beds		CAH Hours	Inpati	ent Days / Out		/ Trips	Full	Time Equiva	lents		Disch			
	A Line No.		Available		Title V	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	1
1 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col.2 for the portion of LDP room available beds)	30.00	29	10,585			257	7	840					73	3	224	1
2 HMO and other (see instructions)						134							27			2
3 HMO IPF Subprovider																3
4 HMO IRF Subprovider																4
5 Hospital Adults & Peds. Swing Bed SNF																5
6 Hospital Adults & Peds.Swing Bed NF																e
7 Total Adults and Peds. (exclude observation beds) (see instructions)		29	10,585			257	7	840								7
8 Intensive Care Unit																8
9 Coronary Care Unit																ç
10 Burn Intensive Care Unit																10
11 Surgical Intensive Care Unit																11
12 Other Special Care																12
13 Nursery	43.00															13
14 Total (see instructions)		29	10,585			257	7	840		117.18			73	3	224	14
15 CAH visits																15
16 Subprovider - IPF	40.00															16
17 Subprovider - IRF	41.00															17
18 Subprovider - Other	42.00															18
19 Skilled Nursing Facility	44.00															19
20 Nursing Facility	45.00															20
21 Other Long Term Care	46.00															21
22 Home Health Agency	101.00															22
23 ASC (Distinct Part)	115.00															23
24 Hospice (Distinct Part)	116.00															24
24.10 Hospice (non-distinct part)																24.10
25 CMHC	99.00															25
26 RHC/FQHC (specify)	88.00															26
27 Total (sum of lines 14-26)		29								117.18						27
28 Observation Bed Days																28
29 Ambulance Trips																29
30 Employee discount days (see instructions)																30
31 Employee discount days -IRF																31

HOSPITAL AND HOS	SPITAL HEALTH CARE COMPL	EX STATIST	ΓICAL DATA	Λ							Provider CCI	N: 150177	PERIOD: FROM 01/0 TO 12/31/20	1/2014	WORKSHE	ET S-3 PART	ΓI
Component		Worksheet	No. of Beds	Bed Days	CAH Hours	Inpatie	ent Days / Out	patient Visits	/ Trips	Full	Time Equival	lents		Disch	Discharges		
		A Line No.		Available		Title V	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	1
32 Labor & delive	ery (see instructions)																32
32.01 Total ancillary days (see instru	labor & delivery room outpatient actions)																32.01
33 LTCH non-cov	rered days																33
FORM CMS-2552-10	(09/2015) (INSTRUCTIONS FOR	THIS WORK	KSHEET ARI	E PUBLISHE	D IN CMS PU	JB. 15-II, SI	ECTION 4005	.1)									*
40-511 - 09-15																Rev. 8	

HOSP	l code 591947 - 2010] TAL WAGE INDEX INFORMATION		Provider CCN: 150	177	PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET S-3 II and III	PART
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)	
CALA	DIEC	1	2	3	4	5	6	
SALA		200	7.757.226		7.757.226	242.720	21.02	1
	Total salaries (see instructions) Non-physician anesthetist Part A	200	7,757,336		7,757,336	243,729	31.83	2
	Non-physician anesthetist Part B							3
	Physician-Part A - Administrative							4
	Physician-Part A - Teaching							4.01
	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
	Contracted Interns & residents (in an approved program)							7.01
	Home office and/or related organization personnel	44						8
	SNF Evaluded area salaries (see instructions)	44	2 505 000		2 505 000	60 122	27.00	9
	Excluded area salaries (see instructions) R WAGES AND RELATED COSTS		2,585,980		2,585,980	68,132	37.96	10
	Contract labor: Direct Patient Care		307,712		307,712	6,386	48.19	11
	Contract labor: Direct Patient Care Contract labor: Top level management and other management and administrative services		123,500		123,500	-	250.00	-
13	Contract labor: Physician-Part A							13
14	Home office and/or related orgainzation salaries and wage-related costs							14
	Home office salaries							14.01
14.02	Related organization salaries							14.02
	Home office: physician Part A							15
16	Home office & Contract Physicians Part A -							16
WACI	Teaching E-RELATED COSTS							
	Wage-related costs (core) (see instructions)		980,678		980,678			17
	Wage-related costs (cofe) (see instructions)		980,078		980,078			18
	Excluded areas		510,955		510,955			19
	Non-physician anesthetist Part A		510,755		210,522			20
	Non-physician anesthetist Part B							21
	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
	Related orgainzation wage-related							25.51
	Home office: Physician Part A - Administrative - wage-related							25.52
	Home office & Contract Physicians Part A - Teaching - wage-related							25.53
	HEAD COSTS - DIRECT SALARIES	4	102 (10		102 (10	4 445	41.00	26
	Employee Benefits Department Administrative & General	5	182,610 1,371,357		182,610 1,371,357		41.08 51.19	
	Administrative & General under contract (see instructions)		142,492		142,492	-	29.77	-
29	Maintenance & Repairs	6						29
	Operation of Plant	7	193,377		193,377	17,017	11.36	30
31	Laundry & Linen Service	8						31
	Housekeeping	9						32
	Housekeeping under contract (see instructions)		3,308		3,308		21.91	
	Dietary	10	154,001		154,001	10,347	14.88	
	Dietary under contract (see instructions)							35
36	Cafeteria	11						36

HOSPI	TAL WAGE INDEX INFORMATION		Provider CCN: 150	177	PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET S-3 PA	
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							
	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
	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 FO	OR THIS WORKS	HEET ARE PUBLIS	HED IN CMS PUB	. 15-II, SECTION 4	005.2 - 4005.3)	-	
40-513	- 11-16					-	Rev. 10	

[Record code 591947 - 2010]				
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	1		1	
Part A - Core List				
			Amount Reported	
RETIREMENT COST				
1 401k Employer Contributions			182,839	9 1
2 Tax Sheltered Annuity (TSA) Employer Contribution	1			2
3 Nonqualified Defined Benefit Plan Cost (see instruct	ions)			1
4 Qualified Defined Benefit Plan Cost (see instructions)			4
PLAN ADMINISTRATIVE COSTS (Paid to External Org	ganization):			
5 401k/TSA Plan Administration fees				:
6 Legal/Accounting/Management Fees-Pension Plan				(
7 Employee Managed Care Program Administration Fe	ees			,
HEALTH AND INSURANCE COST			-	
8 Health Insurance (Purchased or Self Funded)			797,839	9 8
8.01 Health Insurance (Self Funded without a Third Party	Administrator)			8.0
8.02 Health Insurance (Self Funded with a Third Party Ad	ministrator)			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)				1
12 Accident Insurance (If employee is owner or benefici	ary)			12
13 Disability Insurance (If employee is owner or benefic	ciary)			1.
14 Long-Term Care Insurance (If employee is owner or				14
15 Workers' Compensation Insurance	* '			1:
16 Retirement Health Care Cost (Only current year, not	the extraordinary accrual required by FA	ASB 106. Non cumulative portion)	10
TAXES				
17 FICA-Employers Portion Only			545,677	7 1
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 Retir	ement Cost Reported on lines 1 through	4 above)(see instructions)		2
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	5 24
,			<u> </u>	
Part B - Other than Core Related Cost				
25 Other Wage Related Costs (specify)				25
· · · · · · · · · · · · · · · · · · ·			I	
FORM CMS-2552-10 (11/2016) (INSTRUCTIONS FOR	THIS WORKSHEET ARE PUBLISHE	D IN CMS PUB. 15-II, SECTION	4005.4)	
40-514 - 11-16		·	Rev. 10	

	RECLASSIFICATION AND ADJUSTMENT OF TRIAL	BALANCE OF EXPENS	ES	Provider CCN: 150177		PERIOD: FROM 01/01/ TO 12/31/2014	/2014	WORKSHEET A	
COS	ST CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6)	
		1	2	3	4	5	6	7	
	GENERAL SERVICE COST CENTERS								
1 00100	Capital Related Costs-Buildings and Fixtures		2,893,423	2,893,423	771,242	3,664,665		3,664,665	1
2 00200	Capital Related Costs-Movable Equipment		252,000	252,000	2,348,809	2,600,809		2,600,809	2
3 00300	Other Capital Related Costs							-0-	3
4 00400	Employee Benefits Department	182,610	1,590,896	1,773,506		1,773,506		1,773,506	4
5 00500	Administrative and General	1,371,357	8,179,081	9,550,438	803,783	10,354,221	-2,102,968	8,251,253	5
6 00600	Maintenance and Repairs								6
7 00700	Operation of Plant	193,377	564,070	757,447		757,447		757,447	7
8 00800	Laundry and Linen Service		56,353	56,353		56,353		56,353	8
9 00900	Housekeeping		4,776	4,776		4,776		4,776	9
10 01000) Dietary	154,001	57,930	211,931		211,931	-16,717	195,214	10
11 01100) Cafeteria								11
12 01200	Maintenance of Personnel								12
13 01300	Nursing Administration	481,853	83,071	564,924		564,924		564,924	13
14 01400	Central Services and Supply								14
15 01500) Pharmacy	350,568	257,807	608,375		608,375		608,375	15
16 01600	Medical Records & Medical Records Library	135,025	83,974	218,999		218,999	-7,843	211,156	16
17 01700	Social Service								17
18	Other General Service (specify)								18
19 01900	Nonphysician Anesthetists								19
20 02000	Nursing School								20
21 02100	Intern & Res. Service-Salary & Fringes (Approved)								21
22 02200	Intern & Res. Other Program Costs (Approved)								22
23 02300	Paramedical Ed. Program (specify)								23
	INPATIENT ROUTINE SERVICE COST CENTERS								
30 03000	Adults and Pediatrics (General Routine Care)	1,323,584	54,504	1,378,088		1,378,088		1,378,088	30
31 03100									31
32 03200	Coronary Care Unit								32
33 03300									33
34 03400	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40 04000									40
41 04100									41
42 04200	_								42
43 04300	1 2 2								43
44 04400	-								44
45 04500	£ ,								45

	RI	ECLASSIFICATION AND ADJUSTMENT OF TRIAI	L BALANCE OF EXPENS	SES P	rovider CCN: 150177		PERIOD: FROM 01/01/ 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	
46	04600	Other Long Term Care								46
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	663,271	536,409	1,199,680		1,199,680		1,199,680	50
51	05100	Recovery Room								51
52	05200	Labor Room and Delivery Room								52
53	05300	Anesthesiology		340,845	340,845		340,845		340,845	53
54	05400	Radiology-Diagnostic	315,710	385,008	700,718		700,718		700,718	54
55	05500	Radiology-Therapeutic								55
56	05600	Radioisotope								56
57	05700	Computed Tomography (CT) Scan								57
58	05800	Magnetic Resonance Imaging (MRI)								58
59	05900	Cardiac Catheterization								59
60	06000	Laboratory		307,354	307,354		307,354		307,354	60
61	06100	PBP Clinical Laboratory Services-Program Only								61
62	06200	Whole Blood & Packed Red Blood Cells								62
63	06300	Blood Storing, Processing, & Trans.								63
64	06400	Intravenous Therapy								64
65	06500	Respiratory Therapy								65
66	06600	Physical Therapy		91,835	91,835		91,835		91,835	66
67	06700	Occupational Therapy		60,827	60,827		60,827		60,827	67
68	06800	Speech Pathology								68
69	06900	Electrocardiology								69
70	07000	Electroencephalography								70
71	07100	Medical Supplies Charged to Patients		925,804	925,804		925,804		925,804	71
72	07200	Implantable Devices Charged to Patients		8,285,260	8,285,260		8,285,260		8,285,260	72
73	07300	Drugs Charged to Patients		265,628	265,628		265,628		265,628	73
74	07400	Renal Dialysis								74
75	07500	ASC (Non-Distinct Part)								75
76		Other Ancillary (specify)								76
		OUTPATIENT SERVICE COST CENTERS								
88	08800	Rural Health Clinic (RHC)								88
89	08900	Federally Qualified Health Center (FQHC)								89
90	09000	Clinic								90
91	09100	Emergency								91
92	09200	Observation Beds (Non-Distinct Part)								92
92.01	09201	Observation Beds (Distinct Part)								92.01
93		Other Outpatient Service (specify)								93
		OTHER REIMBURSABLE COST CENTERS								
94	09400	Home Program Dialysis								94
95	09500	Ambulance Services								95

96 096 97 097	COST CENTER DESCRIPTION		SALARIES					WORKSHEET A		
		ONS (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	
97 097	600 Durable Medical Equi	pment-Rented								96
71 071	700 Durable Medical Equi	pment-Sold								97
98	Other Reimbursable (s	pecify)								98
99	Outpatient Rehabilitat	ion Provider (specify)								99
100 100	000 Intern-Resident Service	e (not appvd. tchng. prgm.)								100
101 101	Home Health Agency									101
	SPECIAL PURPOSE	COST CENTERS								
105 105	500 Kidney Acquisition									105
106 106	600 Heart Acquisition									106
107 107	700 Liver Acquisition									107
108 108	800 Lung Acquisition									108
109 109	900 Pancreas Acquisition									109
110 110	000 Intestinal Acquisition									110
111 111	100 Islet Acquisition									111
112	Other Organ Acquisiti	on (specify)								112
113 113	300 Interest Expense			3,923,834	3,923,834	-3,923,834			- 0 -	113
114 114	400 Utilization Review-SN	IF .							- 0 -	114
115 115	500 Ambulatory Surgical (Center (Distinct Part)								115
116 116	600 Hospice									116
117	Other Special Purpose	(specify)								117
118	SUBTOTALS (sum of	flines 1-117)	5,171,356	29,200,689	34,372,045		34,372,045	-2,127,528	32,244,517	118
	NONREIMBURSABI	LE COST CENTERS								
190 190	000 Gift, Flower, Coffee S	hop, & Canteen								190
191 191	100 Research									191
192 192	200 Physicians' Private Of	fices	2,535,678	1,556,041	4,091,719		4,091,719	-195,836	3,895,883	192
193 193	300 Nonpaid Workers		50,302	34,887	85,189		85,189		85,189	193
194	Other Nonreimbursab	e (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
ORM CMS-2	2552-10 (11/2016) (INSTRU	CTIONS FOR THIS WORKSH	EET ARE PUBLISHED	IN CMS PUB. 15-II,	§ 4013)		1		1	1

RECLASSIFICATIONS						Provider CCN: 150177	PERIOD: FROM 01/01/2014 TO 12/31/2014	ı	WORKSHEET A-6		
A - RECLASSIFY MVBLE EQUIP DEP											
EXPLANATION OF RECLASSIFICATION(S)	CODE		INCRE				DECRE			Wkst.	'
	(1)	COST CENTER	LINE#	SALARY	OTHER	COST CENTER	LINE#	SALARY	OTHER	A-7 Ref.	
	1	2	3	4	5	6	7	8	9	10	
1 RECLASSIFY MVBLE EQUIP DEPRECIATION	A		2.00		2,069,027		1.00		2,069,027		9 1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
500 Total reclassifications (sum of columns 4 and 5 must equal					2,069,027				2,069,027		500
(1) A letter (A, B, etc.) must be entered on each line to identify each											
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, col											
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS W	ORKSHEET ARE P	UBLISHED IN CMS I	PUB. 15-II, SECT	(ON 4014)							
40-527 - 10-12		·							Re	ev. 3	
	•										

RECLASSIFICATIONS						Provider CCN:	PERIOD:		WORKSHEET A-6		
						150177	FROM 01/01/2014 TO 12/31/2014				
B - RECLASSIFY INTEREST EXPENS							10 12/31/2014		_		
EXPLANATION OF RECLASSIFICATION(S)	CODE		INCRE	ASES			DECRE	ASES		Wkst.	
ENVINOR OF REELISM RETURN(b)	(1)	COST CENTER	LINE #	SALARY	OTHER	COST CENTER		SALARY	OTHER	A-7 Ref.	
	1	2	3	4	5	6	7	8	9	10	
1 RECLASSIFY INTEREST EXPENSE	В		1.00		2,840,269		113.00		2,840,269	11	1
2 RECLASSIFY INTEREST EXPENSE	В		2.00		279,782		113.00		279,782	11	2
3 RECLASSIFY INTEREST EXPENSE	В		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 sur	m of columns 8 and	d 9)			3,923,834				3,923,834		500
(1) A letter (A, B, etc.) must be entered on each line to identify each re											
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column											
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WOR			PUB. 15-II, SECT	ION 4014)							
40-527 - 10-12									Re	v. 3	
<u> </u>				·					l l		

RECONCILIATION OF CAPITAL COSTS CENTERS	S			Provider CCN	I: 150177	PERIOD: FROM 01/01/	2014	WORKSHEE A-7, PARTS	
						TO 12/31/201		& III	., 11
PART I - ANALYSIS OF CHANGES IN CAPITAL A	SSET BALANCI	ES							
Description		Beginning		Acquisitions		Disposals	Ending	Fully	
		Balances	Purchases	Donation	Total	and Retirements	Balance	Depreciated Assets	
		1	2	3	4	5	6	7	
1 Land									
2 Land Improvements									
3 Buildings and Fixtures		14,379,799					14,379,799		
4 Building Improvements		800,339	10,431		10,431		810,770		
5 Fixed Equipment		512,549	21,515		21,515		534,064		
6 Movable Equipment		13,122,947	369,751		369,751	38,302	13,454,396	1,040,706	
7 HIT-designated Assets			<u> </u>		,	· · ·		, ,	
8 Subtotal (sum of lines 1-7)		28,815,634	401,697		401,697	38,302	29,179,029	1,040,706	
9 Reconciling Items		-,,	. , , , , , , , , , , , , , , , , , , ,		. ,		-,,.	,, ,,,,,,	
10 Total (line 7 minus line 9)		28,815,634	401,697		401,697	38,302	29,179,029	1,040,706	-
PART II - RECONCILIATION OF AMOUNTS FROM	1 WORKSHEET			ND 2	101,057	50,502	27,177,027	1,010,700	
Description Description		ii, cozenii (MARY OF CA	PITAI.			\Box
		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	10	11	12	156,000	17	2,893,423	\vdash
Capital Related Costs-Buildings and Fixtures Capital Related Costs-Movable Equipment		2,737,423				252,000		252,000	
3 Total (sum of lines 1-2)		2,737,423				408,000		3,145,423	-
(1) The amount in columns 9 through 14 must equal the assigned cost that may have been included in Workshee PART III - RECONCILIATION OF CAPITAL COSTS	t A, column 2, lii								
Description		OMADLIT ATTIC							,
		OMPUTATIC	N OF RATIO	S	ALL	OCATION OF	OTHER CAP	ITAL	
	Gross Assets	Capitalized Leases	ON OF RATIO Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	ALL/ Insurance	OCATION OF Taxes	OTHER CAP Other Capital- Related Costs	Total (sum of cols. 5	
	Gross Assets	Capitalized	Gross Assets for Ratio (col. 1	Ratio (see			Other Capital-	Total (sum of cols. 5	
1 Capital Related Costs-Buildings and Fixtures		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)	
Capital Related Costs-Buildings and Fixtures Capital Related Costs-Movable Equipment	1	Capitalized Leases 2 14,379,799	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 15,724,633	Capitalized Leases 2 14,379,799 3,115,151	Gross Assets for Ratio (col. 1 - col. 2) 3 1,344,834 10,339,245	Ratio (see instructions)	Insurance 5	Taxes	Other Capital- Related Costs	Total (sum of cols. 5 through 7)	
2 Capital Related Costs-Movable Equipment 3 Total (sum of lines 1-2)	1 15,724,633 13,454,396	Capitalized Leases 2 14,379,799 3,115,151	Gross Assets for Ratio (col. 1 - col. 2) 3 1,344,834 10,339,245	Ratio (see instructions) 4 1.000000	Insurance 5	Taxes 6	Other Capital- Related Costs	Total (sum of cols. 5 through 7)	
2 Capital Related Costs-Movable Equipment 3 Total (sum of lines 1-2)	1 15,724,633 13,454,396	Capitalized Leases 2 14,379,799 3,115,151	Gross Assets for Ratio (col. 1 - col. 2) 3 1,344,834 10,339,245	Ratio (see instructions) 4 1.000000	Insurance 5	Taxes 6	Other Capital- Related Costs	Total (sum of cols. 5 through 7)	
2 Capital Related Costs-Movable Equipment 3 Total (sum of lines 1-2)	1 15,724,633 13,454,396	Capitalized Leases 2 14,379,799 3,115,151 17,494,950	Gross Assets for Ratio (col. 1 - col. 2) 3 1,344,834 10,339,245 11,684,079	Ratio (see instructions) 4 1.000000 SUMM	Insurance 5 MARY OF CA Insurance (see	Taxes 6 PITAL Taxes (see	Other Capital- Related Costs 7 Other Capital- Related Costs (see	Total (sum of cols. 5 through 7) 8 Total (2) (sum of cols.	
2 Capital Related Costs-Movable Equipment 3 Total (sum of lines 1-2)	1 15,724,633 13,454,396	Capitalized Leases 2 14,379,799 3,115,151 17,494,950 Depreciation	Gross Assets for Ratio (col. 1 - col. 2) 3 1,344,834 10,339,245 11,684,079 Lease	Ratio (see instructions) 4 1.000000 SUMN Interest	Insurance 5 MARY OF CAL Insurance (see instructions)	Taxes 6 PITAL Taxes (see instructions)	Other Capital- Related Costs 7 Other Capital- Related Costs (see instructions)	Total (sum of cols. 5 through 7) 8 Total (2) (sum of cols. 9 through 14)	
2 Capital Related Costs-Movable Equipment 3 Total (sum of lines 1-2) Description	1 15,724,633 13,454,396	Capitalized Leases 2 14,379,799 3,115,151 17,494,950 Depreciation	Gross Assets for Ratio (col. 1 - col. 2) 3 1,344,834 10,339,245 11,684,079 Lease	Ratio (see instructions) 4 1.000000 SUMN Interest	Insurance 5 MARY OF CAL Insurance (see instructions)	Taxes 6 PITAL Taxes (see instructions)	Other Capital- Related Costs 7 Other Capital- Related Costs (see instructions)	Total (sum of cols. 5 through 7) 8 Total (2) (sum of cols. 9 through 14)	-
2 Capital Related Costs-Movable Equipment 3 Total (sum of lines 1-2) Description 1 Capital Related Costs-Buildings and Fixtures	1 15,724,633 13,454,396	Capitalized Leases 2 14,379,799 3,115,151 17,494,950 Depreciation 9 668,396	Gross Assets for Ratio (col. 1 - col. 2) 3 1,344,834 10,339,245 11,684,079 Lease	Ratio (see instructions) 4 1.000000 SUMN Interest 11 2,840,269	Insurance 5 MARY OF CAL Insurance (see instructions)	Taxes 6 PITAL Taxes (see instructions) 13 156,000	Other Capital- Related Costs 7 Other Capital- Related Costs (see instructions)	Total (sum of cols. 5 through 7) 8 Total (2) (sum of cols. 9 through 14) 15 3,664,665	
2 Capital Related Costs-Movable Equipment 3 Total (sum of lines 1-2) Description 1 Capital Related Costs-Buildings and Fixtures 2 Capital Related Costs-Movable Equipment 3 Total (sum of lines 1-2) (2) The amounts on lines 1 and 2 must equal the correspreclassifications, Worksheet A-8 adjustments, and World	1 15,724,633 13,454,396 29,179,029 29,179,029	2 14,379,799 3,115,151 17,494,950 Depreciation 9 668,396 2,069,027 2,737,423 on Worksheet ted organizatio	Gross Assets for Ratio (col. 1 - col. 2) 3 1,344,834 10,339,245 11,684,079 Lease 10 A, column 7, lins and home o	Ratio (see instructions) 4 1.000000 SUMN Interest 11 2,840,269 279,782 3,120,051 ines 1 and 2. C ffice costs. (See	Insurance 5 MARY OF CA Insurance (see instructions) 12 olumns 9 througe instructions.)	Taxes 6 PITAL Taxes (see instructions) 13 156,000 252,000 408,000 agh 14 should i	Other Capital- Related Costs 7 Other Capital- Related Costs (see instructions) 14	Total (sum of cols. 5 through 7) 8 Total (2) (sum of cols. 9 through 14) 15 3,664,665 2,600,809 6,265,474	
2 Capital Related Costs-Movable Equipment 3 Total (sum of lines 1-2) Description 1 Capital Related Costs-Buildings and Fixtures 2 Capital Related Costs-Movable Equipment	1 15,724,633 13,454,396 29,179,029 29,179,029	2 14,379,799 3,115,151 17,494,950 Depreciation 9 668,396 2,069,027 2,737,423 on Worksheet ted organizatio	Gross Assets for Ratio (col. 1 - col. 2) 3 1,344,834 10,339,245 11,684,079 Lease 10 A, column 7, lins and home o	Ratio (see instructions) 4 1.000000 SUMN Interest 11 2,840,269 279,782 3,120,051 ines 1 and 2. C ffice costs. (See	Insurance 5 MARY OF CA Insurance (see instructions) 12 olumns 9 througe instructions.)	Taxes 6 PITAL Taxes (see instructions) 13 156,000 252,000 408,000 agh 14 should i	Other Capital- Related Costs 7 Other Capital- Related Costs (see instructions) 14	Total (sum of cols. 5 through 7) 8 Total (2) (sum of cols. 9 through 14) 15 3,664,665 2,600,809 6,265,474	

ADJUSTMENTS TO EXPENSI		Provider CCN: 150	0177	PERIOD: FROM 01/01/2014 TO 12/31/2014	WORKSHEET A-8			
DESC	RIPTION (1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATI WORKSHEET A TO/FROM THE AMOUNT IS TO BE AI COST CENTER	WHICH	Wkst. A-7 Ref.		
		1	2	3	4	5		
1	Investment income - buildings and fixtures	1		Buildings and Fixtures	4	3	1	
	(chapter 2)				1			
	Investment income - movable equipment (chapter 2)			Movable Equipment	2		2	
	Investment income - other (chapter 2)	В	-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	
	Parking lot (chapter 21)						9	
	Provider-based physician adjustment	Worksheet A-8-2					10	
	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	В	-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	В	-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 intructions)			Adults and Pediatrics	30		30.99	
31	Adjustment for speech pathology costs in excess of limitation (chapter 14)	Worksheet A-8-3		Speech Pathology	68		31	
32	CAH HIT Adjustment for Depreciation and Interest						32	
33	Other adjustments (specify) (3)						33	
33.00	MISCELLANEOUS REVENUE	В	-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: 15	50177	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 colu	mn pertain to CMS	S Pub. 15-1			
(2) Basis for adjustment (see instructions) A. Costs - if cost, including applicable overhead, c B. Amount Received - if cost cannot be determined					
(3) Additional adjustments may be made on lines 3	3 thru 49 and subs	scripts thereof.			
Note: See instructions for column 5 referencing to	Worksheet A-7.				
FORM CMS-2552-10 (08/2011) (INSTRUCTION	S FOR THIS WO	RKSHEET ARE F	PUBLISHED IN CMS PUB. 15-	II, SECTION 4016)	

Rev. 4

40-529 - 09-13

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 150	177	1	PERIOD: FROM 01/01/2014 ΓΟ 12/31/2014	WORKSHEET B, PART I			
COST CENTER DESCRIPTIONS	NET EXPENSES FOR COST ALLOCATION (from Wkst. A col. 7)	CAPITAL REL BLDGS. & FIXTURES	ATED COSTS MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols. 0-4)	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
	0	1	2	4	4A	5	6	7	8	
GENERAL SERVICE COST CENTERS										
1 Capital Related Costs-Buildings and Fixtures	3,664,665	3,664,665								1
2 Capital Related Costs-Movable Equipment	2,600,809		2,600,809							2
4 Employee Benefits Department	1,773,506	40,572	28,794	1,842,872						4
5 Administrative and General	8,251,253	510,910	362,592	333,640	9,458,395	9,458,395				5
6 Maintenance and Repairs		48,086	34,126		82,212	29,050	111,262			6
7 Operation of Plant	757,447	174,310	123,708	47,047	1,102,512	389,581	6,327	1,498,420		7
8 Laundry and Linen Service	56,353				56,353	19,913			76,266	8
9 Housekeeping	4,776	51,091	36,259		92,126	32,553	1,855	26,483		9
10 Dietary	195,214	39,370	27,941	37,467	299,992	106,005	1,429	20,407		10
11 Cafeteria		36,064	25,595		61,659	21,788	1,309	18,694		11
12 Maintenance of Personnel										12
13 Nursing Administration	564,924	8,655	6,143	117,231	696,953	246,274	314	4,486		13
14 Central Services and Supply		36,064	25,595		61,659	21,788	1,309	18,694		14
15 Pharmacy	608,375	51,091	36,259	85,290	781,015	275,978	1,855	26,483		15
16 Medical Records & Medical Records Library	211,156	27,048	19,196	32,851	290,251	102,563	982	14,020		16
17 Social Service		8,655	6,143		14,798	5,229	314	4,486		17
18 Other General Service (specify)										18
19 Nonphysician Anesthetists										19
20 Nursing School										20
21 Intern & Res. Service-Salary & Fringes (Approved)										21
22 Intern & Res. Other Program Costs (Approved)										22
23 Paramedical Education Program (specify)										23
INPATIENT ROUTINE SERVICE COST CENTERS										
30 Adults and Pediatrics (General Routine Care)	1,378,088	431,568	306,284	322,017	2,437,957	861,472	15,666	223,701	76,266	30
31 Intensive Care Unit										31
32 Coronary Care Unit										32
33 Burn Intensive Care Unit										33
34 Surgical Intensive Care Unit										34
35 Other Special Care Unit (specify)										35
40 Subprovider IPF										40
41 Subprovider IRF										41
42 Subprovider (specify)										42
43 Nursery										43
44 Skilled Nursing Facility										44

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 150	0177		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 REL BLDGS. & FIXTURES	ATED COSTS MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols. 0-4)	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE		
	0	1	2	4	4A	5	6	7	8		
45 Nursing Facility										45	
46 Other Long Term Care										46	
ANCILLARY SERVICE COST CENTERS											
50 Operating Room	1,199,680	342,610	243,150	161,369	1,946,809	687,921	12,437	177,590	0	50	
51 Recovery Room										51	
52 Labor Room and Delivery Room										52	
53 Anesthesiology	340,845	1,503	1,066		343,414	121,348	55	779	9	53	
54 Radiology-Diagnostic	700,718	228,407	162,100	76,810	1,168,035	412,735	8,291	118,393	3	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	307,354	9,557	6,783		323,694	114,380	347	4,954	4	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	91,835	5,410	3,839		101,084	35,719	196	2,804	4	66	
67 Occupational Therapy	60,827	1,202	853		62,882	<u> </u>) 44	623	3	67	
68 Speech Pathology		1,202	853		2,055		5 44	623		68	
69 Electrocardiology		,								69	
70 Electroencephalography										70	
71 Medical Supplies Charged to Patients	925,804	1,503	1,066		928,373	328,048	3 55	779	9	71	
72 Implantable Devices Charged to Patients	8,285,260	,	,,,,,		8,285,260					72	
73 Drugs Charged to Patients	265,628	2,404	1,706		269,738			1,246	5	73	
74 Renal Dialysis	11,71	, -	,,,,,,					,		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	
72.01 Observation beus (Distinct Part)										92.01	

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15	0177		PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET B	, PART I	
COST CENTER DESCRIPTIONS	NET EXPENSES	CAPITAL REI	LATED COSTS	EMPLOYEE	SUBTOTAL	ADMINISTRATIVE	MAINTENANCE		LAUNDRY &	
	FOR COST ALLOCATION (from Wkst. A col. 7)	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	BENEFITS DEPARTMENT	(cols. 0-4)	& GENERAL	& REPAIRS	OF PLANT	LINEN SERVICE	
	0	1	2	4	4A	5	6	7	8	
93 Other Outpatient Service (specify)										93
OTHER REIMBURSABLE COST CENTERS										
94 Home Program Dialysis										94
95 Ambulance Services										95
96 Durable Medical Equipment-Rented										96
97 Durable Medical Equipment-Sold										97
98 Other Reimbursable (specify)										98
99 Outpatient Rehabilitation Provider (specify)										99
100 Intern-Resident Service (not appvd. tchng. prgm.)										100
101 Home Health Agency										101
SPECIAL PURPOSE COST CENTERS										
105 Kidney Acquisition										105
106 Heart Acquisition										106
107 Liver Acquisition										107
108 Lung Acquisition										108
109 Pancreas Acquisition										109
110 Intestinal Acquisition										110
111 Islet Acquisition										111
112 Other Organ Acquisition (specify)										112
115 Ambulatory Surgical Center (Distinct Part)										115
116 Hospice										116
117 Other Special Purpose (specify)										117
118 SUBTOTALS (sum of lines 1-117)	32,244,517	2,057,282	1,460,051	1,213,722	28,867,22	6,858,25	8 52,916	665,24	5 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	7,260,93	6 2,565,71	0 58,346	833,17	75	192
193 Nonpaid Workers	85,189			12,238	97,42	7 34,42	7			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	36,225,58	9 9,458,39	5 111,262	1,498,42	0 76,266	202
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR TI	HIS WORKSHEET AF		1	I, SECTION 4020)	· · ·	<u> </u>	1	<u> </u>	<u> </u>	-
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CONTENDISCRIPTIONS	COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 150	0177		PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET B, F	PART I	
Capital Related Costs-Musching and Fixtures	COST CENTER DESCRIPTIONS		DIETARY	CAFETERIA		ADMINIS-		PHARMACY	RECORDS		
1 Capital Related Costs-Buildings and Fixmes		9	10	11	12	13	14	15	16	17	
Capital Related Corts Movable Equipment											
A Employee Rendric Department											1
5 Administrative and General											2
6 Maintenance and Repairs 7 Operation of Plant 8 Laundry and Linen Service 9 Housekeeping 153,017 10 Dictary 2,121 1429,954 11 Cafeterin 1,948 207,989 313,382 12 Maintenance of Personnel 12 Maintenance of Personnel 13 Norsing Administration 14 Central Services and Supply 14 Central Services and Supply 1,943 15 Pharmacy 17 Social Service 16 Medical Records & Medical Records Library 1,457 17 Social Service 18 Other General Service (specify) 19 Norphysician Anasthetists 19 Norphysician Anasthetists 22 Intern & Res. Other Program Costs (Approved) 21 Intern & Res. Service Salary & Pringes (Approved) 22 Intern & Res. Service Salary & Pringes (Approved) 31 On Adults and Pelatinis: General Routine Care) 23 Paramedical Education Program (Gests (Approved) 31 Intensive Care Unit 32 Coronary Care Unit 33 Suprise Care Unit 34 Surgical Intensive Care Unit 34 Surgical Intensive Care Unit 35 Other Special Care Unit (specify) 40 Subprovider IPF 41 Subprovider IPF 41 Subprovider IPF											4
7 Operation of Plant											5
S Laundry and Linen Service											6
9 Housekeeping 153,017											7
10 Dietary 2,12 429,954											8
11 Cafeteria 1,943 207,989 313,382		153,017									9
12 Maintenance of Personnel 26,373 26,373 960,229 1		2,121	429,954								10
13 Nursing Administration 466 11,736 960,229	11 Cafeteria	1,943	207,989	313,382	:						11
14 Central Services and Supply	12 Maintenance of Personnel			26,373	26,373						12
15 Pharmacy	13 Nursing Administration	466		11,736	,	960,229					13
16 Medical Records & Medical Records Library	14 Central Services and Supply	1,943					105,393				14
17 Social Service	15 Pharmacy	2,753		21,376				1,109,460			15
18 Other General Service (specify)	16 Medical Records & Medical Records Library	1,457		9,769					419,042		16
19 Nonphysician Anesthetists	17 Social Service	466								25,293	17
20 Nursing School	18 Other General Service (specify)										18
21 Intern & Res. Service-Salary & Fringes (Approved)	19 Nonphysician Anesthetists										19
22 Intern & Res. Other Program Costs (Approved) 23 Paramedical Education Program (specify) 24 INPATIENT ROUTINE SERVICE COST CENTERS 25 25 25 25 25 25 25 2	20 Nursing School										20
23 Paramedical Education Program (specify)	21 Intern & Res. Service-Salary & Fringes (Approved)										21
23 Paramedical Education Program (specify)	22 Intern & Res. Other Program Costs (Approved)										22
30 Adults and Pediatrics (General Routine Care) 23,255 139,719 117,518 26,373 960,229 105,393 419,042 25,293 31 Intensive Care Unit											23
31 Intensive Care Unit	INPATIENT ROUTINE SERVICE COST CENTERS										
32 Coronary Care Unit	30 Adults and Pediatrics (General Routine Care)	23,255	139,719	117,518	26,373	960,229	105,393		419,042	25,293	30
33 Burn Intensive Care Unit	31 Intensive Care Unit										31
34 Surgical Intensive Care Unit	32 Coronary Care Unit										32
35 Other Special Care Unit (specify) 40 Subprovider IPF 41 Subprovider IRF 42 Subprovider (specify) 43 Subprovider (specify)	33 Burn Intensive Care Unit										33
40 Subprovider IPF	34 Surgical Intensive Care Unit										34
40 Subprovider IPF											35
41 Subprovider IRF 42 Subprovider (specify)											40
42 Subprovider (specify)											41
											42
43 Nursery	43 Nursery										43
44 Skilled Nursing Facility											44
45 Nursing Facility											45
46 Other Long Term Care											46

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 13	50177		PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET B,	PART I	
COST CENTER DESCRIPTIONS	HOUSE- KEEPING	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
	9	10	11	12	13	14	15	16	17	
ANCILLARY SERVICE COST CENTERS										
50 Operating Room	18,462									50
51 Recovery Room										51
52 Labor Room and Delivery Room										52
53 Anesthesiology	81									53
54 Radiology-Diagnostic	12,308		21,47	2						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	515									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	291									66
67 Occupational Therapy	65									67
68 Speech Pathology	65		2,38	66						68
69 Electrocardiology										69
70 Electroencephalography										70
71 Medical Supplies Charged to Patients	81									71
72 Implantable Devices Charged to Patients										72
73 Drugs Charged to Patients	130						1,109,460)		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			102,75	2						90
91 Emergency										91
92 Observation Beds (Non-Distinct Part)										92
92.01 Observation Beds (Distinct Part)										92.01
93 Other Outpatient Service (specify)										93
OTHER REIMBURSABLE COST CENTERS										
94 Home Program Dialysis										94
95 Ambulance Services										95

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15			PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET B, F		
COST CENTER DESCRIPTIONS	HOUSE- KEEPING	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
	9	10	11	12	13	14	15	16	17	
96 Durable Medical Equipment-Rented										96
97 Durable Medical Equipment-Sold										97
98 Other Reimbursable (specify)										98
99 Outpatient Rehabilitation Provider (specify)										99
100 Intern-Resident Service (not appvd. tchng. prgm.)										100
101 Home Health Agency										101
SPECIAL PURPOSE COST CENTERS										
105 Kidney Acquisition										105
106 Heart Acquisition										106
107 Liver Acquisition										107
108 Lung Acquisition										108
109 Pancreas Acquisition										109
110 Intestinal Acquisition										110
111 Islet Acquisition										111
112 Other Organ Acquisition (specify)										112
115 Ambulatory Surgical Center (Distinct Part)										115
116 Hospice										116
117 Other Special Purpose (specify)										117
118 SUBTOTALS (sum of lines 1-117)	66,402	347,708	313,38	2 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	313,38	2 26,373	960,229	105,393	1,109,460	419,042	25,293	202
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR TH		RE PUBLISHED IN	N CMS PUB. 15-I	I, SECTION 4020)	·	· · ·	-	<u> </u>	J	
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COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15	0177		PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET B, P	ART I	
COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE	NON- PHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY AND FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARAMEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
	18	19	20	21	22	23	24	25	26	
GENERAL SERVICE COST CENTERS										
1 Capital Related Costs-Buildings and Fixtures										1
2 Capital Related Costs-Movable Equipment										2
4 Employee Benefits Department										4
5 Administrative and General										5
6 Maintenance and Repairs										6
7 Operation of Plant										7
8 Laundry and Linen Service										8
9 Housekeeping										9
10 Dietary										10
11 Cafeteria										11
12 Maintenance of Personnel										12
13 Nursing Administration										13
14 Central Services and Supply										14
15 Pharmacy										15
16 Medical Records & Medical Records Library										16
17 Social Service										17
18 Other General Service (specify)										18
19 Nonphysician Anesthetists										19
20 Nursing School										20
21 Intern & Res. Service-Salary & Fringes (Approved)										21
22 Intern & Res. Other Program Costs (Approved)										22
23 Paramedical Education Program (specify)										23
INPATIENT ROUTINE SERVICE COST CENTERS										
30 Adults and Pediatrics (General Routine Care)							5,431,884		5,431,884	30
31 Intensive Care Unit										31
32 Coronary Care Unit										32
33 Burn Intensive Care Unit										33
34 Surgical Intensive Care Unit										34
35 Other Special Care Unit (specify)										35
40 Subprovider IPF										40
41 Subprovider IRF										41
42 Subprovider (specify)										42
43 Nursery										43
44 Skilled Nursing Facility										44

COST CENTER DISCRIPTIONS	COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15	0177		PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET B, P	ART I	
AS Number Facility	COST CENTER DESCRIPTIONS	GENERAL	PHYSICIAN	SCHOOL	RESIDENTS SALARY AND	RESIDENTS PROGRAM		SUBTOTAL	RESIDENT COST & POST STEPDOWN	TOTAL	
A6 Other Lung Fern Care		18	19	20	21	22	23	24	25	26	
ANCILLARY SERVICE COST CENTERS	45 Nursing Facility										
SO Operating Room 2,843,219 2,843,219 50	46 Other Long Term Care										46
SI Reversey Room	ANCILLARY SERVICE COST CENTERS										
52 Labor Room and Delivery Room	50 Operating Room							2,843,219		2,843,219	50
53 Aussthesinlegy	51 Recovery Room										
55 Radiology- Diagnosic	52 Labor Room and Delivery Room										52
55 Radiology-Therapoutic	53 Anesthesiology							465,677		465,677	
56 Radioisotope	54 Radiology-Diagnostic							1,741,234		1,741,234	54
ST Computed Tomography (CT) Scan	55 Radiology-Therapeutic										55
S8 Magnetic Resonance Imaging (MRI) S8 S9 Cardiac Catheterization S9 S9 S9 S9 S9 S9 S9 S	56 Radioisotope										56
So Cardiac Catheterization	57 Computed Tomography (CT) Scan										57
60 Laboratory 61 PBP Clinical Laboratory Services-Program Only 62 Whole Blood & Packed Red Blood Cells 63 Blood Storing, Processing, & Trans. 64 Intravenous Therapy 65 Respiratory Therapy 66 Respiratory Therapy 66 Physical Therapy 67 Occupational Therapy 68 Speech Pathology 69 Electrocardiology 70 Electrocardiology 71 Medical Supplies Charged to Patients 72 Implantable Devices Charged to Patients 73 Drugs Charged to Patients 74 Renal Dialysis 75 ASC (Non-Distinct Part) 76 Other Ancillary (specify) 77 Other Ancillary (specify) 78 Renal Health Clinic (RBC) 79 Federally Qualified Health Center (FQHC) 79 Clinical Laboratory Services-Program Only 79 Electrocardiology 70 Clinical Laboratory Services-Program Only 71 Medical Supplies Charged to Patients 74 Renal Dialysis 75 ASC (Non-Distinct Part) 76 Other Ancillary (specify) 77 Outprattery Service COST CENTERS 78 Regular Health Clinic (RBC) 79 Electrocardiology 89 Pederally Qualified Health Center (FQHC) 90 Clinic	58 Magnetic Resonance Imaging (MRI)										58
61 PBP Clinical Laboratory Services-Program Only 62 Whole Blood & Packed Red Blood Cells 63 Blood Storing, Processing, & Trans. 64 Intravenous Therapy 65 Hortweep Storing, Processing, & Trans. 66 Physical Therapy 67 Occupational Therapy 68 Speech Pathology 69 Cocupational Therapy 69 Electroencephalography 70 Electroencephalography 71 Medical Supplies Charged to Patients 72 Implantable Devices Charged to Patients 73 Drugs Charged to Patients 74 Renal Dialysis 75 A SC (Kon-Distinct Part) 76 Other Ancillary (specify) 70 Unific 76 Other Ancillary (specify) 70 Unific 77 SB Rural Health Clinic (RHC) 78 Rural Health Clinic (RHC) 79 Electroencephalography 70 Elegraphy 71 Emergency 72 Devices Charged to Patients 74 Renal Dialysis 75 A SC (Kon-Distinct Part) 76 Other Ancillary (specify) 77 Diagraphy 78 Rural Health Clinic (RHC) 78 Page Charged to Patient (RHC) 79 Electroencephalography 70 Elegraphy 71 Emergency 72 Devices Charged to Patients 73 Drugs Charged to Patients 74 Renal Dialysis 75 A SC (Kon-Distinct Part) 76 Outpractical Health Clinic (RHC) 76 Devices Charged to Patient (RHC) 77 Devices Charged to Patient (RHC) 78 Devices Charged to Patient (RHC) 79 Devices Charged (PHC) 70 Devices Charged (PHC) 70 Dev	59 Cardiac Catheterization										59
62 Whole Blood & Packed Red Blood Cells 63 Blood Storing, Processing, & Trans. 64 Intravenous Therapy 65 Respiratory Therapy 66 Physical Therapy 67 Occupational Therapy 68 Speech Pathology 69 Electrocardiology 69 Electrocardiology 69 Electrocardiology 70 Electroencephalography 71 Medical Supplies Charged to Patients 72 Implantable Devices Charged to Patients 73 Drugs Charged to Patients 74 Renal Dialysis 75 ASC (Non-Distinct Part) 76 OUTPATIENT SERVICE COST CENTERS 76 OUTPATIENT SERVICE COST CENTERS 77 Elergency 78 Emergency 79 Emergency 70 Clinic 71 Emergency 70 Dialog Charged to Control Center (PQHC) 70 Emergency 71 Emergency 72 Diagree Control Center (PQHC) 73 Emergency 74 Emergency 75 Emergency 76 Outpatients 76 Outpatients 77 Emergency 78 Emergency 79 Olinic 79 Diagree Control Center (PQHC) 79 Emergency 79 Diagree Control Center (PQHC) 79 Di	60 Laboratory							443,890		443,890	60
63 Blood Storing, Processing, & Trans. 63 64 Intravenous Therapy 64 65 65 Respiratory Therapy	61 PBP Clinical Laboratory Services-Program Only										61
64 Intravenous Therapy 64 65 65 66 67 66 67 66 67 67	62 Whole Blood & Packed Red Blood Cells										62
65 Respiratory Therapy	63 Blood Storing, Processing, & Trans.										63
66 Physical Therapy 140,094 140,094 66	64 Intravenous Therapy										64
67 Occupational Therapy 85,834 85,834 67 68 Speech Pathology 5,899 5,899 68 69 Electrocardiology 1,257,336 1,257,336 1,257,336 71 70 Till Medical Supplies Charged to Patients 1,257,336 1,257,336 1,257,336 71 71 Medical Supplies Charged to Patients 11,212,913 11,212,913 72 73 Drugs Charged to Patients 1,475,975 1,475,975 73 74 Renal Dialysis 1,475,975 73 75 ASC (Non-Distinct Part) 76 Other Ancillary (specify) 76 OUTPATIENT SERVICE COST CENTERS 88 Rural Health Clinic (RHC) 88 89 Federally Qualified Health Center (FQHC) 90 90 Clinic 90 102,752 90 91 Emergency 90 90 90 92 Observation Beds (Non-Distinct Part) 92	65 Respiratory Therapy										65
68 Speech Pathology 5,899 5,899 68 69 Electrocardiology 69 69 70 Electrocandiology 70 70 Medical Supplies Charged to Patients 70 71 Medical Supplies Charged to Patients 70 72 Implantable Devices Charged to Patients 71,257,336 71 73 Drugs Charged to Patients 71,212,913 71,212,913 72 74 Renal Dialysis 74 75 ASC (Non-Distinct Part) 75 76 Other Ancillary (specify) 76 77 OUTPATIENT SERVICE COST CENTERS 78 88 Rural Health Clinic (RHC) 88 89 Federally Qualified Health Center (FQHC) 89 90 Clinic 90 91 91 Emergency 90 92 Observation Beds (Non-Distinct Part) 92	66 Physical Therapy							140,094		140,094	66
Electrocardiology	67 Occupational Therapy							85,834		85,834	67
Electrocardiology	68 Speech Pathology							5,899		5,899	68
71 Medical Supplies Charged to Patients 1,257,336 1,257,336 71 72 Implantable Devices Charged to Patients 11,212,913 11,212,913 72 73 Drugs Charged to Patients 1,475,975 1,475,975 73 74 Renal Dialysis 1,475,975 73 75 ASC (Non-Distinct Part) 75 76 Other Ancillary (specify) 76 OUTPATIENT SERVICE COST CENTERS 76 88 Rural Health Clinic (RHC) 88 89 Federally Qualified Health Center (FQHC) 89 90 Clinic 102,752 102,752 90 91 Emergency 92 Observation Beds (Non-Distinct Part) 92 92 Observation Beds (Non-Distinct Part) 92											69
71 Medical Supplies Charged to Patients 1,257,336 1,257,336 71 72 Implantable Devices Charged to Patients 11,212,913 11,212,913 72 73 Drugs Charged to Patients 1,475,975 1,475,975 73 74 Renal Dialysis 1,475,975 73 75 ASC (Non-Distinct Part) 75 76 Other Ancillary (specify) 76 OUTPATIENT SERVICE COST CENTERS 76 88 Rural Health Clinic (RHC) 88 89 Federally Qualified Health Center (FQHC) 89 90 Clinic 102,752 102,752 90 91 Emergency 92 Observation Beds (Non-Distinct Part) 92 92 Observation Beds (Non-Distinct Part) 92 93 Observation Beds (Non-Distinct Part) 92 94 Observation Beds (Non-Distinct Part) 92 95 Observation Beds (Non-Distinct Part) 92 96 Observation Beds (Non-Distinct Part) 92 96 Observation Beds (Non-Distinct Part) 92 97 Observation Beds (Non-Distinct Part) 92 98 Observation Beds (Non-Distinct Part) 92 99 Observation Beds (Non-Distinct Part) 92 90 Observation Beds (Non-Distinct Part) 93 90 Observation Beds (Non-Distinct Part) 93 90 Observation Beds (Non-Distinct Part) 93 90 Observation Beds (Non-Distinct Part) 94 90 Observation Beds (Non-Distin	70 Electroencephalography										70
72 Implantable Devices Charged to Patients 11,212,913 72 73 Drugs Charged to Patients 11,475,975 73 74 Renal Dialysis 74 75 ASC (Non-Distinct Part) 75 76 Other Ancillary (specify) 76 OUTPATIENT SERVICE COST CENTERS 88 88 Rural Health Clinic (RHC) 88 89 Federally Qualified Health Center (FQHC) 89 90 Clinic 102,752 102,752 90 91 Emergency 91 92 Observation Beds (Non-Distinct Part) 92								1,257,336		1,257,336	
73 Drugs Charged to Patients 1,475,975 73 74 Renal Dialysis 74 Renal Dialysis 75 ASC (Non-Distinct Part) 75 ASC (Non-Distinct Part) 76 Other Ancillary (specify) 76 OUTPATIENT SERVICE COST CENTERS 76 Rural Health Clinic (RHC) 88 Rural Health Clinic (RHC) 89 Clinic 89 Clinic 102,752 102,752 90 91 Emergency 90 Observation Beds (Non-Distinct Part) 92 Observation Beds (Non-Distinct Part) 92 Observation Beds (Non-Distinct Part) 93 Page Pag								11,212,913			
74 Renal Dialysis 74 75 ASC (Non-Distinct Part) 75 76 Other Ancillary (specify) 76 OUTPATIENT SERVICE COST CENTERS 76 88 Rural Health Clinic (RHC) 88 89 Federally Qualified Health Center (FQHC) 88 90 Clinic 102,752 102,752 90 91 Emergency 91 Observation Beds (Non-Distinct Part) 92								1,475,975		1,475,975	
75 ASC (Non-Distinct Part) 75 76 Other Ancillary (specify) 6 OUTPATIENT SERVICE COST CENTERS 8 88 Rural Health Clinic (RHC) 8 89 Federally Qualified Health Center (FQHC) 8 90 Clinic 102,752 102,752 91 Emergency 91 Observation Beds (Non-Distinct Part) 92											
76 Other Ancillary (specify) 50 Other Ancillary (specify) 76 Other Ancillary (specify) 88 Other Ancillary (specify) 89 Other Ancillary (specify) 89 Other Ancillary (specify) 90 Other Ancillary (specify) 90 Other Ancillary (specify) 90 Other Ancillary (specify) 90 Other Ancillary (specify) <td< td=""><td>-</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>	-										
OUTPATIENT SERVICE COST CENTERS 68 88 Rural Health Clinic (RHC) 88 88 89 Federally Qualified Health Center (FQHC) 89 89 Federally Qualified Health Center (FQHC) 89 89 90 Clinic 102,752 90 91 91 91 91 92 91 92 92 92 92 92 92 92 92 93 94 94 94 94 94 94 94 94 94 95 96 96 96 96 96 96 96 97 96 97 96 97 96 97 96 96 96 97 96 97 96 97 96 97 96 97 96 97 96 97 96 97 97 96 97 97 96 97 96 97 96 97 97 96 97 96 97 96 97 96 97 96 97 <td>76 Other Ancillary (specify)</td> <td></td>	76 Other Ancillary (specify)										
88 Rural Health Clinic (RHC) 88 89 Federally Qualified Health Center (FQHC) 89 90 Clinic 102,752 90 91 Emergency 91 92 Observation Beds (Non-Distinct Part) 92											
89 Federally Qualified Health Center (FQHC) 89 90 Clinic 102,752 90 91 Emergency 51 92 Observation Beds (Non-Distinct Part) 92											88
90 Clinic 102,752 90 91 Emergency 91 91 92 Observation Beds (Non-Distinct Part) 92	` '										
91 Emergency 91 92 Observation Beds (Non-Distinct Part) 92								102,752		102,752	
92 Observation Beds (Non-Distinct Part) 92								- ,,,,		. ,,,,,,,,	I
	5 7										
92.01 Observation Beds (Distinct Part) 92.01	92.01 Observation Beds (Distinct Part)										92.01

COST ALLOCATION - GENERAL SERVICE COSTS		F	rovider CCN: 15	0177		PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET B, P	ART I	
COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE	NON- PHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY AND FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARAMEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
	18	19	20	21	22	23	24	25	26	
93 Other Outpatient Service (specify)										93
OTHER REIMBURSABLE COST CENTERS										
94 Home Program Dialysis										94
95 Ambulance Services										95
96 Durable Medical Equipment-Rented										96
97 Durable Medical Equipment-Sold										97
98 Other Reimbursable (specify)										98
99 Outpatient Rehabilitation Provider (specify)										99
100 Intern-Resident Service (not appvd. tchng. prgm.)										100
101 Home Health Agency										101
SPECIAL PURPOSE COST CENTERS										
105 Kidney Acquisition										105
106 Heart Acquisition										106
107 Liver Acquisition										107
108 Lung Acquisition										108
109 Pancreas Acquisition										109
110 Intestinal Acquisition										110
111 Islet Acquisition										111
112 Other Organ Acquisition (specify)										112
115 Ambulatory Surgical Center (Distinct Part)										115
116 Hospice										116
117 Other Special Purpose (specify)										117
118 SUBTOTALS (sum of lines 1-117)							25,206,707	,	25,206,707	118
NONREIMBURSABLE COST CENTERS									, , , , , ,	
190 Gift, Flower, Coffee Shop, & Canteen							82,246	5	82,246	190
191 Research							- , -		- , -	191
192 Physicians' Private Offices							10,804,782	2	10,804,782	192
193 Nonpaid Workers							131,854		131,854	193
194 Other Nonreimbursable (specify)									- ,00	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 TH	IS WORKSHEET	ARE PUBLISHED IN	CMS PUB. 15-II	SECTION 4020)	<u> </u>		20,220,300		20,222,307	
40-535 - 09-13				,				T ₁	Rev. 4	$\overline{}$
				-						

ALLOCATION OF CAPITAL-RELATED COSTS			Provider CCN: 150	177	1	PERIOD: FROM 01/01/2014 FO 12/31/2014		WORKSHEET B, I	PART II	
COST CENTER DESCRIPTIONS	DIRECTLY	CAPITAL REL	ATED COSTS	SUBTOTAL	EMPLOYEE	ADMINISTRATIVE	MAINTENANCE	OPERATION	LAUNDRY &	
	ASSIGNED NEW CAPITAL RELATED COSTS	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	(sum of (cols. 0-2)	BENEFITS DEPARTMENT	& GENERAL	& REPAIRS	OF PLANT	LINEN SERVICE	
	0	1	2	2A	4	5	6	7	8	
GENERAL SERVICE COST CENTERS										
1 Capital Related Costs-Buildings and Fixtures										1
2 Capital Related Costs-Movable Equipment										2
4 Employee Benefits Department		40,572	28,794	69,366	69,366					4
5 Administrative and General		510,910	362,592	873,502	12,559	886,061				5
6 Maintenance and Repairs		48,086	34,126	82,212		2,721	84,933			6
7 Operation of Plant		174,310	123,708	298,018	1,771	36,495	4,830	341,114		7
8 Laundry and Linen Service						1,865			1,865	8
9 Housekeeping		51,091	36,259	87,350		3,050	1,416	6,029		9
10 Dietary		39,370	27,941	67,311	1,410	9,930	1,091	4,646		10
11 Cafeteria		36,064	25,595	61,659		2,041	999	4,256		11
12 Maintenance of Personnel										12
13 Nursing Administration		8,655	6,143	14,798	4,413	23,071	240	1,021		13
14 Central Services and Supply		36,064	25,595	61,659		2,041	999	4,256		14
15 Pharmacy		51,091	36,259	87,350	3,211	25,853	1,416	6,029		15
16 Medical Records & Medical Records Library		27,048	19,196	46,244	1,237	9,608	749	3,192		16
17 Social Service		8,655	6,143	14,798		490	240	1,021		17
18 Other General Service (specify)										18
19 Nonphysician Anesthetists										19
20 Nursing School										20
21 Intern & Res. Service-Salary & Fringes (Approved)										21
22 Intern & Res. Other Program Costs (Approved)										22
23 Paramedical Education Program (specify)										23
INPATIENT ROUTINE SERVICE COST CENTERS										
30 Adults and Pediatrics (General Routine Care)		431,568	306,284	737,852	12,121	80,701	11,959	50,925	1,865	30
31 Intensive Care Unit										31
32 Coronary Care Unit										32
33 Burn Intensive Care Unit										33
34 Surgical Intensive Care Unit										34
35 Other Special Care Unit (specify)										35
40 Subprovider IPF										40
41 Subprovider IRF										41
42 Subprovider (specify)										42
43 Nursery										43
44 Skilled Nursing Facility										44
45 Nursing Facility										45

ALLOCATION OF CAPITAL-RELATED COSTS			Provider CCN: 150	177		PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET B,	PART II	
COST CENTER DESCRIPTIONS	DIRECTLY	CAPITAL REI	ATED COSTS	SUBTOTAL	EMPLOYEE	ADMINISTRATIVE	MAINTENANCE		LAUNDRY &	
	ASSIGNED NEW CAPITAL RELATED COSTS	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	(sum of (cols. 0-2)	BENEFITS DEPARTMENT	& GENERAL	& REPAIRS	OF PLANT	LINEN SERVICE	
	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				68		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										<u> </u>

Home Health Agency SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE CENTERS SPECIAL PUR	ALLOC	CATION OF CAPITAL-RELATED COSTS	-		Provider CCN: 15	0177		PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET B,	PART II	
NEW CAPITAL RELATED COSTS STATURES EQUIPMENT DEPARTMENT DEPARTMENT S	COST	CENTER DESCRIPTIONS					_					
94 Home Program Dialysis 95 Ambalance Services 96 Durabhe Medical Equipment-Rented 97 Durabhe Medical Equipment-Sold 97 Durabhe Medical Equipment-Sold 97 Outable Medical Equipment-Sold 99 Outable Medical Equipment-Sold 99 Outable Medical Equipment-Sold 99 Outable Medical Equipment-Sold 90 Outable Medical Equipm			NEW CAPITAL			(sum of (cols. 0-2)		& GENERAL	& REPAIRS	OF PLANT	LINEN SERVICE	
95 Ambulance Services			0	1	2	2A	4	5	6	7	8	
96 Durable Medical Equipment-Rented	94	Home Program Dialysis										94
97 Durable Medical Equipment-Sold												95
98 Other Reinbursable (specify) 90 Outpatient Rehabilitation Provider (specify) 100 Intern-Readent Service (not approd. tchag. prgm.) 101 IHome Health Agency SPECIAL PURDSE COST CENTERS 105 Kidney Acquisition 106 Heart Acquisition 107 Liver Acquisition 108 Heart Acquisition 109 Puncreas Acquisition 109 Puncreas Acquisition 110 Intestinal Acquisition 111 Islet Acquisition 112 Other Organ Acquisition (specify) 115 Ambulatory Surgical Center (Distinct Part) 116 Hospice 117 Other Special Purpose (specify) 118 SUBTOTALS (sum of lines 1-117) 119 Acquisition Islet Islet Acquisition Islet Acquisition Islet Acquisition Islet Islet Islet Acquisition Isle	96	Durable Medical Equipment-Rented										96
99 Outputient Rehabilitation Provider (specify) 100 Intern-Resident Service (not approd. tchng. prgm.) 101 Home Health Agency SPECIAL PURPOSE COST CENTERS 105 Kidney Acquisition 107 Liver Acquisition 107 Liver Acquisition 108 Lung Acquisition 109 Pancreas Acquisition 110 Ill Islet Aguisition 110 Ill Islet Aguisition 111 Ill Islet Aguisition 112 Other Organ Acquisition 113 Islet Aguisition 114 Other Organ Acquisition (specify) 115 Ambulatory Surgical Center (Distinct Part) 116 Hospice 117 Other Special Purpose (specify) 118 ISUBTOTALS (sum of lines 1-117) 119 Islet Aguisition (specify) 110 Other Organ Acquisition (specify) 110 Other Special Purpose (specify) 111 SUBTOTALS (sum of lines 1-117) 112 Other Special Purpose (specify) 115 Other Special Purpose (specify) 116 Hospice 117 Other Special Purpose (specify) 118 SUBTOTALS (sum of lines 1-117) 119 Noneminus Purpose (specify) 119 Research 120 Office Slop, & Canteen 131 Physicians' Private Offices 1 1,607,883 1,140,788 2,748,141 23,218 240,352 44,539 189,671 121 Other Organ Acquisition (specify) 122 Otross Foot Adjustments 123 Nonpard Workers 124 Other Noneminus Purpose (specify) 125 Noneminus Residual (specify) 126 Otross Foot Adjustments 127 Noneminus Illa (specify) 128 Noneminus Residual (specify) 129 Physicians' Private Offices 1,607,883 1,140,788 2,748,141 23,218 240,352 44,539 189,671 129 Noneminus Residual (specify) 120 Otross Foot Adjustments 120 Noganive Core Centrers 130 Noganive Core Centrers 140 Noganive Core Centrers 141 Noganive Core Centrers 141 Noganive Core Centrers 141 Noganive Core Centrers 141 Noganive Core Centrers 142 Noganive Core Centrers 143 Noganive Core Centrers 144 Noganive Core Centrers 145	97	Durable Medical Equipment-Sold										97
100 Intern-Resident Service (not approd. tching. prgm.) 101 Home Health Agency 103 Kidney Acquisition 106 Kidney Acquisition 106 Heart Acquisition 107 Liver Acquisition 108 Lang Acquisition 109 Pancreas Acquisition 109 Pancreas Acquisition 109 Pancreas Acquisition 109 Pancreas Acquisition 110 Intersition 109 Pancreas Acquisition 111 Intersition 112 Intersition 113 Intersition 114 Intersition 115 Ambulatory Surgical Center (Distinct Part) 116 Intersition 117 Intersition 118 Intersition 119 Intersition 110 Inte	98	Other Reimbursable (specify)										98
Home Health Agency SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE CAPTION SPECIAL	99	Outpatient Rehabilitation Provider (specify)										99
SPECIAL PURPOSE COST CENTERS	100	Intern-Resident Service (not appvd. tchng. prgm.)										100
105 Kidney Acquisition	101	Home Health Agency										101
Heart Acquisition	SPECIA	AL PURPOSE COST CENTERS										
107 Liver Acquisition	105	Kidney Acquisition										105
107 Liver Acquisition		· -										106
108 Lung Acquisition												107
109 Pancreas Acquisition		_										108
Intestinal Acquisition Intertwinian Inte												109
Ill Islet Acquisition												110
112 Other Organ Acquisition (specify)		_										111
115 Ambulatory Surgical Center (Distinct Part)												112
116 Hospice												115
117 Other Special Purpose (specify)												116
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 NONREIMBURSABLE COST CENTERS 190 Gift, Flower, Coffee Shop, & Canteen 191 Research 191 Physicians' Private Offices 192 Physicians' Private Offices 1,607,383 1,140,758 2,748,141 23,218 240,352 44,539 189,671 193 Nonpaid Workers 461 3,225 194 Other Nonreimbursable (specify) 192 Other Nonreimbursable (specify) 193 Negative Cost Centers 194 Other Nonreimbursable (specify) 195 Other Nonreimbursable (specify) 195 Other Nonreimbursable (specify) 195 Other Nonreimbursable (specify) 196 Other Nonreimbursable (specify) 197 Other Nonreimbursable (specify) 198 Other Nonr		_										117
NONREIMBURSABLE COST CENTERS NONREIMBURSABLE COST CENTERS 190 Gift, Flower, Coffee Shop, & Canteen 9 191 Research 9 192 Physicians' Private Offices 1,607,383 193 Nonpaid Workers 461 194 Other Nonreimbursable (specify) 3,225 200 Cross Foot Adjustments 201 Negative Cost Centers 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				2.057.282	1 460 05	1 3 517 333	45 687	7 642.484	40 394	151 443	1 865	
190 Gift, Flower, Coffee Shop, & Canteen		*		2,00.,202	1,.00,00	2,017,033	.2,007	3.2,101	.5,571	151,115	1,363	110
191 Research 192 Physicians' Private Offices 1,607,383 1,140,758 2,748,141 23,218 240,352 44,539 189,671 193 Nonpaid Workers 461 3,225 194 Other Nonreimbursable (specify) 200 Cross Foot Adjustments 201 Negative Cost Centers 201 TOTAL (sum lines 118-201) 3,664,665 2,600,809 6,265,474 69,366 886,061 84,933 341,114 1,865	ļ											190
192 Physicians' Private Offices 1,607,383 1,140,758 2,748,141 23,218 240,352 44,539 189,671 193 Nonpaid Workers 461 3,225 194 Other Nonreimbursable (specify) 200 Cross Foot Adjustments 201 Negative Cost Centers 201 TOTAL (sum lines 118-201) 3,664,665 2,600,809 6,265,474 69,366 886,061 84,933 341,114 1,865												191
193 Nonpaid Workers 461 3,225 ————————————————————————————————————				1 607 383	1 140 759	2 748 141	23 218	240 352	44 539	189 671		192
194 Other Nonreimbursable (specify) 200 Cross Foot Adjustments 200 Regative Cost Centers 201 Negative Cost Centers 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		-		1,007,303	1,140,730	2,770,141	· · · · · · · · · · · · · · · · · · ·			102,071		193
200 Cross Foot Adjustments 201 Negative Cost Centers 201 TOTAL (sum lines 118-201) 3,664,665 2,600,809 6,265,474 69,366 886,061 84,933 341,114 1,865							401	3,223				193
201 Negative Cost Centers Separative Cost Centers 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												200
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												200
		-		2 661 665	2 600 900	6 265 474	60.264	5 00¢ N¢1	84.022	2/1 11/	1 065	
		,	HC WODI/CHEET ARE D				09,300	000,001	04,933	341,114	1,803	

ALLOCATION OF CAPITAL-RELATED COSTS			Provider CCN: 150	0177		PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET B, P.	ART II	
COST CENTER DESCRIPTIONS	HOUSE- KEEPING	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
	9	10	11	12	13	14	15	16	17	
GENERAL SERVICE COST CENTERS										
1 Capital Related Costs-Buildings and Fixtures										1
2 Capital Related Costs-Movable Equipment										2
4 Employee Benefits Department										4
5 Administrative and General										5
6 Maintenance and Repairs										6
7 Operation of Plant										7
8 Laundry and Linen Service										8
9 Housekeeping	97,845									9
10 Dietary	1,357	85,745								10
11 Cafeteria	1,243	41,479	111,677							11
12 Maintenance of Personnel			9,398	9,398						12
13 Nursing Administration	298		4,182		48,023					13
14 Central Services and Supply	1,243					70,198				14
15 Pharmacy	1,760		7,617				133,236			15
16 Medical Records & Medical Records Library	932		3,481					65,443		16
17 Social Service	298								16,847	17
18 Other General Service (specify)										18
19 Nonphysician Anesthetists										19
20 Nursing School										20
21 Intern & Res. Service-Salary & Fringes (Approved)										21
22 Intern & Res. Other Program Costs (Approved)										22
23 Paramedical Education Program (specify)										23
INPATIENT ROUTINE SERVICE COST CENTERS										
30 Adults and Pediatrics (General Routine Care)	14,870	27,864	41,880	9,398	48,023	70,198		65,443	16,847	30
31 Intensive Care Unit										31
32 Coronary Care Unit										32
33 Burn Intensive Care Unit										33
34 Surgical Intensive Care Unit										34
35 Other Special Care Unit (specify)										35
40 Subprovider IPF										40
41 Subprovider IRF										41
42 Subprovider (specify)										42
43 Nursery										43
44 Skilled Nursing Facility										44
45 Nursing Facility										45
46 Other Long Term Care										46

ALLO	CATION OF CAPITAL-RELATED COSTS			Provider CCN: 15	0177		PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET B, P	ART II	
COST	CENTER DESCRIPTIONS	HOUSE- KEEPING	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	ı
ANCII	I ADV SEDVICE COST CENTEDS	9	10	11	12	13	14	15	16	17	
	LARY SERVICE COST CENTERS Operating Room	11,805									50
	Recovery Room	11,803									5:
	Labor Room and Delivery Room										5.
	Anesthesiology	52									5
	Radiology-Diagnostic	7,870		7,65							
		7,870		7,03.	2						5
	Radiology-Therapeutic										5
	Radioisotope Computed Tomography (CT) Scan										5
	Magnetic Resonance Imaging (MRI)										5
	Cardiac Catheterization	220									5
	Laboratory	329									6
	PBP Clinical Laboratory Services-Program Only										6
	Whole Blood & Packed Red Blood Cells										6
	Blood Storing, Processing, & Trans.										6
	Intravenous Therapy										6
	Respiratory Therapy	10.5									6
	Physical Therapy	186									6
	Occupational Therapy	41									6
	Speech Pathology	41		850	0						6
	Electrocardiology										6
	Electroencephalography										7
	Medical Supplies Charged to Patients	52									7
	Implantable Devices Charged to Patients										7
	Drugs Charged to Patients	83						133,236	5		7
	Renal Dialysis										7
	ASC (Non-Distinct Part)										7
76	Other Ancillary (specify)										7
	ATIENT SERVICE COST CENTERS										
	Rural Health Clinic (RHC)										8
	Federally Qualified Health Center (FQHC)										8
90	Clinic			36,61	7						9
	Emergency										9
	Observation Beds (Non-Distinct Part)										9
92.01	Observation Beds (Distinct Part)										92.0
93	Other Outpatient Service (specify)										9
OTHER	R REIMBURSABLE COST CENTERS										
94	Home Program Dialysis										9
95	Ambulance Services										9

ALLOCATION OF CAPITAL-RELATE	OCOSTS		Provider CCN: 15	0177		PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET B, P	ART II	
COST CENTER DESCRIPTIONS	HOUSE- KEEPIN	NG 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-Rent	ed									96
97 Durable Medical Equipment-Sold										97
98 Other Reimbursable (specify)										98
99 Outpatient Rehabilitation Provider	(specify)									99
100 Intern-Resident Service (not appv	d. 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 (Dist										115
116 Hospice										116
117 Other Special Purpose (specify)										117
118 SUBTOTALS (sum of lines 1-117	42.	460 69,34	3 111,67	7 9,398	48,023	70,198	133,236	65,443	16,847	
NONREIMBURSABLE COST CENTER		37,5		7,070	,	,		35,115		
190 Gift, Flower, Coffee Shop, & Can		16,40	2							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 85,74	5 111.67	7 9,398	48,023	70,198	133,236	65,443	16,847	
FORM CMS-2552-10 (08/2011) (INSTRU					10,023	70,170	133,230	05,445	10,047	
40-544 - 09-13	CITOTO FOR THIS WORKSHEET AF	CE I ODEISHED IN C	I OD. 13-11, SEC	7021)				l ₁	Rev. 4	

CONTENTED PESCRIPTIONS	ALLOCATION OF CAPITAL-RELATED COSTS			Provider CCN: 150	0177		PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET B, P	ART II	
CEAPERAL SERVICE COST CENTERS	COST CENTER DESCRIPTIONS		PHYSICIAN ANES-		RESIDENTS SALARY AND	RESIDENTS PROGRAM		SUBTOTAL	RESIDENT COST & POST STEPDOWN	TOTAL	
Capital Related Costs Morable Equipment		18	19	20	21	22	23	24	25	26	
2 Capital Related Costs-Morable Equipment											
4 Employee Benefits Department 5 Administrative and General 6 Maintenance and Repairs 7 Operation of Plant 8 Laundry and Linen Service 9 Housekeeping 10 Dietary 11 Cafeeria 12 Maintenance of Personnel 13 Nursung Administration 14 Central Services and Supply 15 Pharmacy 16 Medical Records & Medical Records Library 17 Social Services and Supply 18 Other General Service (specify) 19 Nonphysician Ansanticians 20 Nursing School 21 Intern & Res, Service-Salary & Fringes (Approved) 22 Intern & Res, Other Program (specify) 18 Paramedical Education Program (specify) 19 Nonphysician Ansanticians 10 Intern & Res, Service-Salary & Fringes (Approved) 22 Intern & Res, Other Program (specify) 18 Paramedical Education Program (specify) 19 Nonphysician Ansanticians 10 Intern & Res, Service-Salary & Fringes (Approved) 23 Paramedical Education Program (specify) 18 PATENT ROUTINE SERVICE COST CENTERS 10 Adults and Pediatrics (General Routine Cure) 33 Burn Intensive Cure Unit 34 Supplead Intensive Cure Unit 35 Other Special Cure Unit (specify) 40 Subprovider IPF											1
S Administrative and General											2
6 Maintenance and Repairs 7 Operation of Plant 8 Landry and Linen Service 9 Housekeeping 10 Dietary 11 Cafecteria 12 Maintenance of Personnel 13 Navising Administration 14 Central Services and Supply 15 Pharmacy 16 Medical Records & Medical Records Library 17 Social Service 19 Noner Social Service 19 Noner Social Service 20 Navising School 21 Intense Res. Service Salary & Fringes (Approved) 22 Intern & Res. Service Salary & Fringes (Approved) 23 Pharmacy 34 Intensive Care Unit 35 Coronary Care Unit 36 South Reserved Unit Special Care Unit 37 South Service (Specify) 38 South and Pediatrics (General Routine Care) 39 Intensive Care Unit 30 Linensive Care Unit 31 Intensive Care Unit 32 Southerster Core (Library 33 Southerster Care Unit 34 Supprovider IPF											4
7 Operation of Plant											5
8 Laundry and Linen Service 9 Housekeeping 10 Diseary 11 Cafeteria 12 Maintenance of Personnel 13 Norsing Administration 14 Central Services and Supply 15 Pharmacy 16 Medical Records & Medical Records Library 17 Social Service 18 Other General Service (specify) 19 Nonphysician Anesthetists 20 Nursing School 21 Inten & Res. Service-Salary & Fringes (Approved) 22 Inten & Res. Service-Salary & Fringes (Approved) 23 Paramedical Education Program (specify) 1NPATEENT ROUTINE SERVICE COST CENTERS 30 Adults and Pediatrics (General Routine Care) 31 Intensive Care Unit 33 Burn Intensive Care Unit 34 Surpical Intensive Care Unit 35 Other Special Care Unit (specify) 40 Subprovider IFF											6
9 Housekeeping 10 Dietary 11 Cafeteria 12 Maintenance of Personnel 12 Maintenance of Personnel 13 Nursing Administration 14 Central Services and Supply 15 Pharmacy 16 Medical Records & Medical Records Library 17 Social Service 18 Other General Service (specify) 19 Nonphysician Anesthetists 19 Nonphysician Anesthetists 19 Nonphysician Anesthetists 19 Nonphysician Anesthetists 10 Nonphysician Anes											7
10 Dietary	8 Laundry and Linen Service										8
11 Cafeteria	9 Housekeeping										9
12 Maintenance of Personnel	10 Dietary										10
13 Nursing Administration	11 Cafeteria										11
14 Central Services and Supply	12 Maintenance of Personnel										12
15 Pharmacy	13 Nursing Administration										13
Medical Records & Medical Records Library	14 Central Services and Supply										14
17 Social Service	15 Pharmacy										15
18 Other General Service (specify) 19 Nonphysician Anesthetists 20 Nursing School 21 Intern & Res. Service-Salary & Fringes (Approved) 22 Intern & Res. Other Program Costs (Approved) 23 Paramedical Education Program (specify) INPATIENT ROUTINE SERVICE COST CENTERS 30 Adults and Pediatrics (General Routine Care) 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	16 Medical Records & Medical Records Library										16
19 Nonphysician Anesthetists 20 Nursing School 21 Intern & Res. Service-Salary & Fringes (Approved) 22 Intern & Res. Other Program Costs (Approved) 23 Paramedical Education Program (specify) INPATIENT ROUTINE SERVICE COST CENTERS 30 Adults and Pediatrics (General Routine Care) 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	17 Social Service										17
20 Nursing School	18 Other General Service (specify)										18
21 Intern & Res. Service-Salary & Fringes (Approved) 22 Intern & Res. Other Program Costs (Approved) 23 Paramedical Education Program (specify) INPATIENT ROUTINE SERVICE COST CENTERS 30 Adults and Pediatrics (General Routine Care) 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	19 Nonphysician Anesthetists										19
22 Intern & Res. Other Program Costs (Approved) 23 Paramedical Education Program (specify)	20 Nursing School										20
23 Paramedical Education Program (specify) INPATIENT ROUTINE SERVICE COST CENTERS 30 Adults and Pediatrics (General Routine Care) 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	21 Intern & Res. Service-Salary & Fringes (Approved)										21
23 Paramedical Education Program (specify) INPATIENT ROUTINE SERVICE COST CENTERS 30 Adults and Pediatrics (General Routine Care) 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	22 Intern & Res. Other Program Costs (Approved)										22
INPATIENT ROUTINE SERVICE COST CENTERS											23
31 Intensive Care Unit	INPATIENT ROUTINE SERVICE COST CENTERS										
32 Coronary Care Unit	30 Adults and Pediatrics (General Routine Care)							1,189,946		1,189,946	30
33 Burn Intensive Care Unit 34 Surgical Intensive Care Unit 35 Other Special Care Unit (specify) 40 Subprovider IPF 41 Subprovider IRF	31 Intensive Care Unit										31
33 Burn Intensive Care Unit 34 Surgical Intensive Care Unit 35 Other Special Care Unit (specify) 40 Subprovider IPF 41 Subprovider IRF	32 Coronary Care Unit										32
34 Surgical Intensive Care Unit 35 Other Special Care Unit (specify) 40 Subprovider IPF 41 Subprovider IRF											33
35 Other Special Care Unit (specify)											34
40 Subprovider IPF 1 41 Subprovider IRF 1											35
41 Subprovider IRF											40
											41
42 Subprovider (specify)	_										42
43 Nursery											43
44 Skilled Nursing Facility											44

ALLOCATION OF CAPITAL-RELATED COSTS			Provider CCN: 15	0177		PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET B, PA	ART II	
COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE	NON- PHYSICIAN ANES- THETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY AND FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARAMEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
	18	19	20	21	22	23	24	25	26	
45 Nursing Facility										45
46 Other Long Term Care										46
ANCILLARY SERVICE COST CENTERS										
50 Operating Room							718,004		718,004	50
51 Recovery Room										51
52 Labor Room and Delivery Room										52
53 Anesthesiology							14,208	3	14,208	53
54 Radiology-Diagnostic							480,865		480,865	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							28,777	,	28,777	60
61 PBP Clinical Laboratory Services-Program Only										61
62 Whole Blood & Packed Red Blood Cells										62
63 Blood Storing, Processing, & Trans.										63
64 Intravenous Therapy										64
65 Respiratory Therapy										65
66 Physical Therapy							13,569		13,569	66
67 Occupational Therapy							4,353		4,353	67
68 Speech Pathology							3,189		3,189	68
69 Electrocardiology										69
70 Electroencephalography										70
71 Medical Supplies Charged to Patients							33,571		33,571	71
72 Implantable Devices Charged to Patients							274,272		274,272	72
73 Drugs Charged to Patients							146,709		146,709	73
74 Renal Dialysis										74
75 ASC (Non-Distinct Part)										75
76.										76.
OUTPATIENT SERVICE COST CENTERS										
88 Rural Health Clinic (RHC)										88
89 Federally Qualified Health Center (FQHC)										89
90 Clinic							36,617	,	36,617	90
91 Emergency										91
92 Observation Beds (Non-Distinct Part)										92
92.01 Observation Beds (Distinct Part)										92.01

ALLOCATION OF CAPITAL-RELATED COSTS			Provider CCN: 15	0177		PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET B, P	ART II	
COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE	NON- PHYSICIAN ANES- THETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY AND FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARAMEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
	18	19	20	21	22	23	24	25	26	
93 Other Outpatient Service (specify)										93
OTHER REIMBURSABLE COST CENTERS										
94 Home Program Dialysis										94
95 Ambulance Services										95
96 Durable Medical Equipment-Rented										96
97 Durable Medical Equipment-Sold										97
98 Other Reimbursable (specify)										98
99 Outpatient Rehabilitation Provider (specify)										99
100 Intern-Resident Service (not appvd. tchng. prgm.)										100
101 Home Health Agency										101
SPECIAL PURPOSE COST CENTERS										
105 Kidney Acquisition										105
106 Heart Acquisition										106
107 Liver Acquisition										107
108 Lung Acquisition										108
109 Pancreas Acquisition										109
110 Intestinal Acquisition										110
111 Islet Acquisition										111
112 Other Organ Acquisition (specify)										112
115 Ambulatory Surgical Center (Distinct Part)										115
116 Hospice										116
117 Other Special Purpose (specify)										117
118 SUBTOTALS (sum of lines 1-117)							2,944,080		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)							3,000		-,000	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 TH	 IS WORKSHEET ARE PI	UBLISHED IN C	MS PUB. 15-II. SEC	TION 4021)			0,200,171		2,200,.71	
40-544 - 09-13								1	Rev. 4	

COST ALLOCATION - STATISTICAL BASIS			Provider CCN: 150	0177		PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET B-1		
COST CENTER DESCRIPTIONS	CAPITAL REI BLDGS. & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSE- KEEPING (HOURS OF SERVICE)	
	1	2	4	5A	5	6	7	8	9	
GENERAL SERVICE COST CENTERS										
1 Capital Related Costs-Buildings and Fixtures	60,969									1
2 Capital Related Costs-Movable Equipment		60,969								2
4 Employee Benefits Department	675	675								4
5 Administrative and General	8,500	8,500			26,767,194					5
6 Maintenance and Repairs	800	800			82,212	50,994				6
7 Operation of Plant	2,900	2,900	193,377		1,102,512	2,900	48,094			7
8 Laundry and Linen Service					56,353			94,486		8
9 Housekeeping	850	850			92,126	850	850		47,244	9
10 Dietary	655	655	154,001		299,992	655	655		655	10
11 Cafeteria	600	600			61,659	600	600		600	11
12 Maintenance of Personnel										12
13 Nursing Administration	144	144	481,853		696,953	144	144		144	13
14 Central Services and Supply	600	600			61,659	600	600		600	14
15 Pharmacy	850	850	350,568		781,015	850	850		850	15
16 Medical Records & Medical Records Library	450	450	135,025		290,251	450	450		450	16
17 Social Service	144	144			14,798	144	144		144	17
18 Other General Service (specify)										18
19 Nonphysician Anesthetists										19
20 Nursing School										20
21 Intern & Res. Service-Salary & Fringes (Approved)										21
22 Intern & Res. Other Program Costs (Approved)										22
23 Paramedical Education Program (specify)										23
INPATIENT ROUTINE SERVICE COST CENTERS										
30 Adults and Pediatrics (General Routine Care)	7,180	7,180	1,323,584		2,437,957	7,180	7,180	94,486	7,180	30
31 Intensive Care Unit										31
32 Coronary Care Unit										32
33 Burn Intensive Care Unit										33
34 Surgical Intensive Care Unit						<u> </u>				34
35 Other Special Care Unit (specify)										35
40 Subprovider IPF										40
41 Subprovider IRF										41
42 Subprovider (specify)										42
43 Nursery										43

COST ALLOCATION - STATISTICAL BASIS			Provider CCN: 150	0177		PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET B-1		
COST CENTER DESCRIPTIONS	CAPITAL REL BLDGS. & FIXTURES (SQUARE FEET)	ATED COST MOVABLE EQUIPMENT (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUM. COST)	& REPAIRS	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSE- KEEPING (HOURS OF SERVICE)	
	1	2	4	5A	5	6	7	8	9	
44 Skilled Nursing Facility										44
45 Nursing Facility										45
46 Other Long Term Care										46
ANCILLARY SERVICE COST CENTERS										
50 Operating Room	5,700	5,700	663,271		1,946,809	5,700	5,700		5,700	50
51 Recovery Room										51
52 Labor Room and Delivery Room										52
53 Anesthesiology	25	25			343,414	25	25		25	53
54 Radiology-Diagnostic	3,800	3,800	315,710		1,168,035	3,800	3,800		3,800	54
55 Radiology-Therapeutic										55
56 Radioisotope										56
57 Computed Tomography (CT) Scan										57
58 Magnetic Resonance Imaging (MRI)										58
59 Cardiac Catheterization										59
60 Laboratory	159	159			323,694	159	159		159	60
61 PBP Clinical Laboratory Services-Program Only										61
62 Whole Blood & Packed Red Blood Cells										62
63 Blood Storing, Processing, & Trans.										63
64 Intravenous Therapy										64
65 Respiratory Therapy										65
66 Physical Therapy	90	90			101,084	90	90		90	66
67 Occupational Therapy	20	20			62,882	20	20		20	67
68 Speech Pathology	20	20			2,055	20	20		20	68
69 Electrocardiology										69
70 Electroencephalography										70
71 Medical Supplies Charged to Patients	25	25			928,373	25	25		25	71
72 Implantable Devices Charged to Patients					8,285,260					72
73 Drugs Charged to Patients	40	40			269,738	40	40		40	73
74 Renal Dialysis										74
75 ASC (Non-Distinct Part)										75
76 Other Ancillary (specify)										76
OUTPATIENT SERVICE COST CENTERS										
88 Rural Health Clinic (RHC)										88
89 Federally Qualified Health Center (FQHC)										89
90 Clinic										90
91 Emergency										91
92 Observation Beds (Non-Distinct Part)										92

COST ALLOCATION - STATISTICAL BASIS			Provider CCN: 150	0177		PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET B-1		
COST CENTER DESCRIPTIONS	CAPITAL REL BLDGS. & FIXTURES (SQUARE FEET)	ATED COST MOVABLE EQUIPMENT (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OF PLANT	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSE- KEEPING (HOURS OF SERVICE)	
	1	2	4	5A	5	6	7	8	9	
92.01 Observation Beds (Distinct Part)										92.01
93 Other Outpatient Service (specify)										93
OTHER REIMBURSABLE COST CENTERS										
94 Home Program Dialysis										94
95 Ambulance Services										95
96 Durable Medical Equipment-Rented										96
97 Durable Medical Equipment-Sold										97
98 Other Reimbursable (specify)										98
99 Outpatient Rehabilitation Provider (specify)										99
100 Intern-Resident Service (not appvd. tchng. prgm.)										100
101 Home Health Agency										101
SPECIAL PURPOSE COST CENTERS										
105 Kidney Acquisition										105
106 Heart Acquisition										106
107 Liver Acquisition										107
108 Lung Acquisition										108
109 Pancreas Acquisition										109
110 Intestinal Acquisition										110
111 Islet Acquisition										111
112 Other Organ Acquisition (specify)										112
115 Ambulatory Surgical Center (Distinct Part)										115
116 Hospice										116
117 Other Special Purpose (specify)										117
118 SUBTOTALS (sum of lines 1-117)	34,227	34,227	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			0.353358	-			3.24	
204 Cost to be allocated (per Worksheet B, Part II)			69,366		886,061	84,933			97,845	
205 Unit cost multiplier (Worksheet B, Part II)			0.009158		0.033102				2.07	
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR	THIS WORKSHEF	T ARE PUBLISH								-

COST ALLOCATION - STATISTICAL BASIS			Provider CCN: 150	0177	PERIOD: FROM 01/01/2014 TO 12/31/2014			WORKSHEET B-1		
COST CENTER DESCRIPTIONS	CAPITAL REI BLDGS. & FIXTURES (SQUARE FEET)	ATED COST MOVABLE EQUIPMENT (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OF PLANT	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSE- KEEPING (HOURS OF SERVICE)	
	1	2	4	5A	5	6	7	8	9	
40-553 - 09-13									Rev. 4	

[Record code 591947 - 2010]			D :1 CON 150	2177		DEDIOD		WORKSHEET D. 1		
COST ALLOCATION - STATISTICAL BASIS			Provider CCN: 150	J1//		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)		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE (SPECIFY)	
	10	11	12	13	14	15	16	17	18	
GENERAL SERVICE COST CENTERS										
1 Capital Related Costs-Buildings and Fixtures]
2 Capital Related Costs-Movable Equipment										2
4 Employee Benefits Department										4
5 Administrative and General										5
6 Maintenance and Repairs										(
7 Operation of Plant										7
8 Laundry and Linen Service										8
9 Housekeeping										9
10 Dietary	11,229									10
11 Cafeteria	5,432	9,720								11
12 Maintenance of Personnel		818	840							12
13 Nursing Administration		364		85,119						13
14 Central Services and Supply					100					14
15 Pharmacy		663				100				15
16 Medical Records & Medical Records Library		303					840			16
17 Social Service								840		17
18 Other General Service (specify)										18
19 Nonphysician Anesthetists										19
20 Nursing School										20
21 Intern & Res. Service-Salary & Fringes (Approved)										21
22 Intern & Res. Other Program Costs (Approved)										22
23 Paramedical Education Program (specify)										23
INPATIENT ROUTINE SERVICE COST CENTERS										
30 Adults and Pediatrics (General Routine Care)	3,649	3,645	840	85,119	100		840	840		30
31 Intensive Care Unit										3
32 Coronary Care Unit										32
33 Burn Intensive Care Unit										33
34 Surgical Intensive Care Unit										34
35 Other Special Care Unit (specify)										3:
40 Subprovider IPF										40
41 Subprovider IRF										4
42 Subprovider (specify)										42
43 Nursery										43
44 Skilled Nursing Facility										44

COST ALLOCATION - STATISTICAL BASIS			Provider CCN: 150	0177		PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET B-1		
COST CENTER DESCRIPTIONS	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	OF PERSONNEL (NUMBER HOUSED)	TRATION (DIRECT NURS. HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	(COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE (SPECIFY)	
	10	11	12	13	14	15	16	17	18	
45 Nursing Facility										45
46 Other Long Term Care										46
ANCILLARY SERVICE COST CENTERS										
50 Operating Room										50
51 Recovery Room										51
52 Labor Room and Delivery Room										52
53 Anesthesiology										53
54 Radiology-Diagnostic		666	i							54
55 Radiology-Therapeutic										55
56 Radioisotope										56
57 Computed Tomography (CT) Scan										57
58 Magnetic Resonance Imaging (MRI)										58
59 Cardiac Catheterization										59
60 Laboratory										60
61 PBP Clinical Laboratory Services-Program Only										61
62 Whole Blood & Packed Red Blood Cells										62
63 Blood Storing, Processing, & Trans.										63
64 Intravenous Therapy										64
65 Respiratory Therapy										65
66 Physical Therapy										66
67 Occupational Therapy										67
68 Speech Pathology		74								68
69 Electrocardiology										69
70 Electroencephalography										70
71 Medical Supplies Charged to Patients										71
72 Implantable Devices Charged to Patients										72
73 Drugs Charged to Patients						100				73
74 Renal Dialysis										74
75 ASC (Non-Distinct Part)										75
76 Other Ancillary (specify)										76
OUTPATIENT SERVICE COST CENTERS										
88 Rural Health Clinic (RHC)										88
89 Federally Qualified Health Center (FQHC)										89
90 Clinic		3,187	,							90
91 Emergency		1	1							91
92 Observation Beds (Non-Distinct Part)										92
92.01 Observation Beds (Distinct Part)										92.01
93 Other Outpatient Service (specify)										93

COST ALLOCATION - STATISTICAL BASIS			Provider CCN: 150	0177		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)		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	(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	2 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			· · · · · · · · · · · · · · · · · · ·	11,095				203
204 Cost to be allocated (per Worksheet B, Part II)	85,745	111,677			· · · · · · · · · · · · · · · · · · ·					203
205 Unit cost multiplier (Worksheet B, Part II)	7.64	111,07			· ·					204
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR					701.98	1,332	/7.91	20.00		
40-553 - 09-13	THIS WUKKSHEE	AND PUDLISH	ILD IN CIVIS FUB.	13-11, SECTION 4020)					Rev. 4	_
10 555 07-15									100 Y . T	

	ALLOCATION - STATISTICAL BASIS		Provider CCN: 15	0177		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 SALARY AND FRINGES (ASSIGNED	& RESIDENTS PROGRAM COSTS (ASSIGNED TIME)	PARAMEDICAL EDUCATION (ASSIGNED TIME)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN	TOTAL	
		10	20	TIME)	22	22	24	ADJUSTMENTS	26	-
GENE	RAL SERVICE COST CENTERS	19	20	21	22	23	24	25	26	
	Capital Related Costs-Buildings and Fixtures									1
	Capital Related Costs-Movable Equipment									2
	Employee Benefits Department									4
	Administrative and General									5
	Maintenance and Repairs									6
	Operation of Plant									7
	Laundry and Linen Service									8
	Housekeeping									9
	Dietary									10
	Cafeteria									11
	Maintenance of Personnel									12
	Nursing Administration									13
	Central Services and Supply									14
	Pharmacy									15
	Medical Records & Medical Records Library									16
	Social Service									17
	Other General Service (specify)									18
	Nonphysician Anesthetists									19
	Nursing School									20
	Intern & Res. Service-Salary & Fringes (Approved)									21
22	Intern & Res. Other Program Costs (Approved)									22
	Paramedical Education Program (specify)									23
INPAT	TENT ROUTINE SERVICE COST CENTERS									
30	Adults and Pediatrics (General Routine Care)									30
	Intensive Care Unit									31
32	Coronary Care Unit									32
33	Burn Intensive Care Unit									33
34	Surgical Intensive Care Unit									34
35	Other Special Care Unit (specify)									35
40	Subprovider IPF									40
41	Subprovider IRF									41
42	Subprovider (specify)									42
	Nursery									43

COST	ALLOCATION - STATISTICAL BASIS		Provider CCN: 15	0177		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 SALARY AND FRINGES (ASSIGNED TIME)	& RESIDENTS PROGRAM COSTS (ASSIGNED TIME)	PARAMEDICAL EDUCATION (ASSIGNED TIME)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
		19	20	21	22	23	24	25	26	
	Skilled Nursing Facility									44
	Nursing Facility									45
	Other Long Term Care									46
	LARY SERVICE COST CENTERS									
	Operating Room									50
	Recovery Room									51
	Labor Room and Delivery Room									52 53
	Anesthesiology									53
	Radiology-Diagnostic									54
	Radiology-Therapeutic									55
	Radioisotope									56
	Computed Tomography (CT) Scan									57
	Magnetic Resonance Imaging (MRI)									58
59	Cardiac Catheterization									59
	Laboratory									60
61	PBP Clinical Laboratory Services-Program Only									61
	Whole Blood & Packed Red Blood Cells									62
63	Blood Storing, Processing, & Trans.									63
64	Intravenous Therapy									64
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
69	Electrocardiology									69
70	Electroencephalography									70
71	Medical Supplies Charged to Patients									71
72	Implantable Devices Charged to Patients									72
73	Drugs Charged to Patients									73
	Renal Dialysis									74
75	ASC (Non-Distinct Part)									75
76	Other Ancillary (specify)									76
	ATIENT SERVICE COST CENTERS									
88	Rural Health Clinic (RHC)									88
89	Federally Qualified Health Center (FQHC)									89
	Clinic									90
91	Emergency									91
	Observation Beds (Non-Distinct Part)									92

No.	COST ALLOCATION - STATISTICAL BASIS	-	Provider CCN: 15	0177		PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET B-1		
20.20 Observation Bods (Distinct Part)	COST CENTER DESCRIPTIONS	PHYSICIAN ANESTHETISTS (ASGND TIME)	SCHOOL (ASSIGNED TIME)	SALARY AND FRINGES (ASSIGNED TIME)	PROGRAM COSTS (ASSIGNED TIME)	PARAMEDICAL EDUCATION (ASSIGNED TIME)		RESIDENT COST & POST STEPDOWN ADJUSTMENTS		
99 Ober Outputient Service (specify) OTHER REINBLE SABLE COST CENTRES 94 Home Program Dulysis 95 Anabulance Services 96 Durable Medical Equipment-Remed 97 Durable Medical Equipment-Remed 97 Durable Medical Equipment-Sold 98 Other Reinburshele (specify) 99 Outputient Reliabilitation Provider (specify) 100 Intern. Resident Service (specify) 101 Intern. Resident Service (specify) 101 Intern. Resident Service (specify) 102 Intern. Resident Service (specify) 103 Intern. Resident Service (specify) 104 Intern. Resident Service (specify) 105 Intern. Resident Service (specify) 106 Intern. Resident Service (specify) 107 Intern. Resident Service (specify) 108 Intern. Resident Service (specify) 109 Intern. Resident Service (specify) 109 Intern. Resident Service (specify) 100 Intern. Resident Service (specify) 100 Intern. Resident Service (specify) 101 Intern. Resident Service (specify) 102 Intern. Resident Service (specify) 103 Intern. Resident Service (specify) 104 Intern. Resident Service (specify) 105 Intern. Resident Service (specify) 106 Intern. Resident Service (specify) 107 Intern. Resident Service (specify) 108 Intern. Resident Service (specify) 109 Intern. Resident Service (specify) 110 Intern. Resident Service (specify) 111 Other Special Purpose (specify) 112 Intern. Resident Service (specify) 113 Antibulatory, Surgical Center (Ristine Part) 114 Other Special Purpose (specify) 115 Other Special Purpose (specify) 116 Intern. Resident Service (specify) 117 Other Special Purpose (specify) 118 Intern. Resident Service (specify) 119 Research 110 Intern. Resident Service (specify) 120 Other Special Purpose (spec		19	20	21	22	23	24	25	26	
OTHER REIMBURSABLE COST CENTERS										92.01
94 Home Program Dialysis 95 Ambulance Services 96 Durable Medical Equipment Sold 97 Durable Medical Equipment Sold 97 Durable Medical Equipment Sold 98 Char Reinbursable (specify) 99 Chargatem Rehabilitation Provider (specify) 90 Chargatem Rehabilitation Provider (specify) 90 Limited Rehabilitation Provider (specify) 91 Durable Medical Equipment Sold 98 Sold Relation Service (not apped tehing, prgm.) 10 Home Health Agency 99 Durable Medical Equipment Sold 99 Durable Medical Equipment Sold 90 Limited Medical Equipment Sold 90 Limited Medical Equipment Sold 90 Limited Medical Equipment Sold 91 Limited Acquisition Limited Medical Equipment Sold Equi										93
95 Ambulance Services 96 Durable Medical Equipment-Rented 97 Durable Medical Equipment-Rented 98 Obtained Medical Equipment-Sold 98 Obtained Rehabilitation Provider (specify) 99 Obtained Rehabilitation Provider (specify) 99 Obtained Rehabilitation Provider (specify) 90 Durable Medical Equipment Provider (specify) 90 Durable Rehabilitation Provider Rehabilitation Provider Rehabilitation Provider Rehabilitation Provider Rehabilitation Provider Rehabilitation Rehabilita										
96 Durable Medical Equipment-Soid 97 Durable Medical Equipment-Soid 98 Other Reinbursable (specify) 99 Outpatient Rehabilitation Provider (specify) 101 [Intern-Resident Service tool appeal, ching prgm.) 102 [Intern-Resident Service tool appeal, ching prgm.) 103 [Intern-Resident Service tool appeal, ching prgm.) 104 [Intern-Resident Service tool appeal, ching prgm.) 105 [Kidney Acquisition 106 [Intern Acquisition 107 [Liver Acquisition 107 [Liver Acquisition 108 [Ling Acquisition 109 Pancreas Acquisition 110 [Internal Acquisition 110 [Internal Acquisition 111 [Internal Acquisition 112 [Other Organ Acquisition 113 [Internal Acquisition 114 [Internal Acquisition 115 [Internal Acquisition [Internal										94
97 Durable Medical Equipment-Sold 98 Other Reimbursable (specify) 99 Outpatien Rehabilitation Provider (specify) 100 (Intern Resident Service (not appot, tchug, prgm.) 101 (Home Health Agency) 101 (Home Health Agency) 102 (Intern Resident Service (not appot, tchug, prgm.) 103 (Intern Resident Service (not appot, tchug, prgm.) 104 (Intern Acquisition 105 (Lear Acquisition 106 (Heart Acquisition 107 (Liver Acquisition 107 (Liver Acquisition 108 (Lung Acquisition 109 Paracreas Acquisition 110 (Interstinal Acquisition 111 (Interstinal Acquisition 111 (Interstinal Acquisition 112 (Other Organ Acquisition (specify) 113 (Adaptation 114 (Interstinal Acquisition (specify) 115 (Ambulatory Surgical Center (Distinct Part) 116 (Hospice 117 (Other Special Purpose (specify) 118 (SURTOTALS sum of lines 1-17) 119 (NORREIMBURSABLE COST CENTERS 190 (Git, Flower, Coffee Shop, & Canteen 1919 (Physician's Private Offices 1919 (Research 1919 (Physician's Private Offices 1919 (Nopad Workers 1919 (Other Norreimbursable (specify) 1919 (Nopad Workers 1919 (Other Norreimbursable (specify) 192 (Divin cost undiptier (Worksheet B, Part I) 202 (Cott to be allocated (fer Worksheet B, Part I) 204 (Cott to be allocated (fer Worksheet B, Part I) 205 (Cott to be allocated (fer Worksheet B, Part I) 204 (Cott to be allocated (fer Worksheet B, Part I) 205 (Cott to be allocated (fer Worksheet B, Part I) 205 (Cott to be allocated (fer Worksheet B, Part I) 206 (Cott to be allocated (fer Worksheet B, Part I) 207 (Cott to be allocated (fer Worksheet B, Part II) 208 (Cott to be allocated (fer Worksheet B, Part II)	95 Ambulance Services									95
98 Other Reimbursable (specify) 99 Outpatient Rehabilitation Provider (specify) 100 Intern. Resident Service (not apped, teling, prgm.) 101 Ipme Health Agency 105 Educy Acquisition 106 Heart Acquisition 107 Liver Acquisition 108 Ling Acquisition 109 Pactreas Acquisition 110 Interstinal Acquisition 111 Other Special Control of the Acquisition International Acquisition 112 Other Organ Acquisition International Acquisition 113 Other Organ Acquisition International Inter	96 Durable Medical Equipment-Rented									96
99 Outpuism Rehabilitation Provider (specify) 100 Intern-Resident Service (not apply, chap, prgm.) 101 Intern-Resident Service (not apply, chap, prgm.) 102 Intern-Resident Service (not apply, chap, prgm.) 103 Intern-Resident Service (not apply, chap, prgm.) 105 Intern-Resident Service (not apply, chap, prgm.) 105 Intern-Resident Service (not apply, chap, prgm.) 106 Intern-Resident Service (not apply, chap, prgm.) 107 International Acquisition 107 International Acquisition 108 International Acquisition 108 International Acquisition 109 Pancreas Acquisition 109 Pancreas Acquisition 101 Interstinal Acquisition 101 Interstinal Acquisition 101 Interstinal Acquisition (specify) 102 Interstinal Acquisition (specify) 103 Interstinal Acquisition (specify) 104 Interstinal Acquisition (specify) 105 Interstinal Acquisition (specify) 107 Interstinal Acquisition (specify) 108 Interstinal Acquisition (specify) 108 Interstinal Acquisition (specify) 109 Interstinal Acquisition (spec	97 Durable Medical Equipment-Sold									97
100 Ihome Health Agency	98 Other Reimbursable (specify)									98
101 Home Health Agency	99 Outpatient Rehabilitation Provider (specify)									99
SPECIAL PURPOSE COST CENTERS	100 Intern-Resident Service (not appvd. tchng. prgm.))								100
105 Kidney Acquisition	101 Home Health Agency									101
106 Heart Acquisition	SPECIAL PURPOSE COST CENTERS									
107 Liver Acquisition	105 Kidney Acquisition									105
108 Lung Acquisition 109 Pancreas Acquisition 101 Intestinal Acquisition (specify) 115 Ambulatory Surjical Center (Distinct Part) 101 Intestinal Center 101 Intestinal Center 101 Intertion Center 101 Intestinal Center 101 Intestinal Center 101 Intestinal Center 101 Intertion Center Intertion C	106 Heart Acquisition									106
109 Pancreas Acquisition	107 Liver Acquisition									107
Intestinal Acquisition	108 Lung Acquisition									108
111 Slet Acquisition	109 Pancreas Acquisition									109
111 Slet Acquisition	110 Intestinal Acquisition									110
112 Other Organ Acquisition (specify)	111 Islet Acquisition									111
115 Ambulatory Surgical Center (Distinct Part) 1 1 16 Hospice 1 1 17 Other Special Purpose (specify) 1 1 18 SUBTOTALS (sum of lines 1-117) 1 18 SUBTOTALS (sum of lines 1-107) 1 18 SUBTOTALS (sum of lines 1-107) 1 19 NonREIMBURSABLE COST CENTERS 190 Gift, Flower, Coffee Shop, & Canteen 191 Research 192 Physicians' Private Offices 191 Physicians' Private Offices 191 193 Nonpaid Workers 194 Other Nonreimbursable (specify) 194 Other Nonreimbursable (specify) 195 196 197	_									112
116 Hospice										115
117 Other Special Purpose (specify)										116
118 SUBTOTALS (sum of lines 1-117)	_									117
NONREIMBURSABLE COST CENTERS 190 Gift, Flower, Coffee Shop, & Canteen 1! 191 Research 192 Physicians' Private Offices 1! 193 Nonpaid Workers 194 Other Nonreimbursable (specify) 195 Other Nonreimbursable (specify) 200 Cross foot adjustments 201 Negative cost centers 202 Cost to be allocated (per Worksheet B, Part I) 203 Unit cost multiplier (Worksheet B, Part II) 204 Cost to be allocated (per Worksheet B, Part II) 205 Cost to be allocated (per Worksheet B, Part II) 206 Cost to be allocated (per Worksheet B, Part II) 207 Cost to be allocated (per Worksheet B, Part II) 207 Cost to be allocated (per Worksheet B, Part II) 207 Cost to be allocated (per Worksheet B, Part II) 207 Cost to be allocated (per Worksheet B, Part II) 207 Cost to be allocated (per Worksheet B, Part II) 207 Cost to be allocated (per Worksheet B, Part II) 207 Cost to be allocated (per Worksheet B, Part II) 207 Cost to be allocated (per Worksheet B, Part II) 207 Cost to be allocated (per Worksheet B, Part II) 207 Cost to be allocated (per Worksheet B, Part II) 208 Cost to be allocated (per Worksheet B, Part II) 208 Cost to be allocated (per Worksheet B, Part II) 209 Cost to be allocated (per Worksheet B, Part II) 209 Cost to be allocated (per Worksheet B, Part II) 209 Cost to be allocated (per Worksheet B, Part II) 209 Cost to be allocated (per Worksheet B, Part II) 209 Cost to be allocated (per Worksheet B, Part II)										118
190 Gift, Flower, Coffee Shop, & Canteen 191 Research 192 Physicians' Private Offices 193 Nonpaid Workers 194 Other Nonreimbursable (specify) 194 Other Nonreimbursable (specify) 195 196 197 198										
191 Research										190
192 Physicians' Private Offices 19 193 Nonpaid Workers 19 194 Other Nonreimbursable (specify) 19 200 Cross foot adjustments 20 201 Negative cost centers 20 202 Cost to be allocated (per Worksheet B, Part I) 20 203 Unit cost multiplier (Worksheet B, Part II) 20 204 Cost to be allocated (per Worksheet B, Part II) 20										191
193 Nonpaid Workers 194 194 Other Nonreimbursable (specify) 195 200 Cross foot adjustments 201 201 Negative cost centers 202 202 Cost to be allocated (per Worksheet B, Part I) 203 203 Unit cost multiplier (Worksheet B, Part I) 204 204 Cost to be allocated (per Worksheet B, Part II) 205										192
194 Other Nonreimbursable (specify) 200 Cross foot adjustments 201 Negative cost centers 202 Cost to be allocated (per Worksheet B, Part I) 203 Unit cost multiplier (Worksheet B, Part II) 204 Cost to be allocated (per Worksheet B, Part II) 205 Cost to be allocated (per Worksheet B, Part II) 206 Cost to be allocated (per Worksheet B, Part II) 207 Cost to be allocated (per Worksheet B, Part II) 208 Cost to be allocated (per Worksheet B, Part II) 209 Cost to be allocated (per Worksheet B, Part II)										193
200 Cross foot adjustments 201 Negative cost centers 202 Cost to be allocated (per Worksheet B, Part I) 203 Unit cost multiplier (Worksheet B, Part I) 204 Cost to be allocated (per Worksheet B, Part I) 205 Cost to be allocated (per Worksheet B, Part I) 206 Cost to be allocated (per Worksheet B, Part II) 207 Cost to be allocated (per Worksheet B, Part II) 208 Cost to be allocated (per Worksheet B, Part II) 209 Cost to be allocated (per Worksheet B, Part II)	_	+								194
201 Negative cost centers 202 Cost to be allocated (per Worksheet B, Part I) 203 Unit cost multiplier (Worksheet B, Part II) 204 Cost to be allocated (per Worksheet B, Part II) 205 Cost to be allocated (per Worksheet B, Part II) 206 Cost to be allocated (per Worksheet B, Part II) 207 Cost to be allocated (per Worksheet B, Part II) 208 Cost to be allocated (per Worksheet B, Part II) 209 Cost to be allocated (per Worksheet B, Part II)										200
202 Cost to be allocated (per Worksheet B, Part I) 203 Unit cost multiplier (Worksheet B, Part I) 204 Cost to be allocated (per Worksheet B, Part II) 205 Cost to be allocated (per Worksheet B, Part II) 206 Cost to be allocated (per Worksheet B, Part II) 207 Cost to be allocated (per Worksheet B, Part II) 208 Cost to be allocated (per Worksheet B, Part II) 209 Cost to be allocated (per Worksheet B, Part II) 200 Cost to be allocated (per Worksheet B, Part II) 201 Cost to be allocated (per Worksheet B, Part II) 202 Cost to be allocated (per Worksheet B, Part II)										201
203 Unit cost multiplier (Worksheet B, Part I) 204 Cost to be allocated (per Worksheet B, Part II) 205 Cost to be allocated (per Worksheet B, Part II) 206 Cost to be allocated (per Worksheet B, Part II)										202
204 Cost to be allocated (per Worksheet B, Part II)	_	+								203
	_	+								204
205 Unit cost multiplier (Worksheet B, Part II)	_									205
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4020)		THIS WORKSHE	 ET ARE PURI ISH	ED IN CMS PUR	 	1				203

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 150	0177		PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET B-1		
COST CENTER DESCRIPTIONS	NON- PHYSICIAN ANESTHETISTS (ASGND TIME)		INTERNS SALARY AND FRINGES (ASSIGNED TIME)	& RESIDENTS PROGRAM COSTS (ASSIGNED TIME)	PARAMEDICAL EDUCATION (ASSIGNED TIME)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
	19	20	21	22	23	24	25	26	
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COMPUTATION OF RATIO OF COSTS TO CH.	ARGES						Provider CCN: 15	50177	PERIOD: FROM 01/01/201 TO 12/31/2014	4	WORKSHEET C PART I	
COST CENTER DESCRIPTIONS	Total Cost	Therapy		Costs			Charges		Cost or	TEFRA	PPS Inpatient	
	(from Wkst. B, Part I, col. 26)	Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	Inpatient	Outpatient	Total (column 6 + column 7)	Other Ratio	Inpatient Ratio	Ratio	
	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	5			30
31 Intensive Care Unit												3
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												4:
42 Subprovider (Specify)												42
43 Nursery												43
44 Skilled Nursing Facility												44
45 Nursing Facility												45
46 Other Long Term Care												40
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												5
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												50
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												6
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	60

COMPUTATION OF RATIO OF COSTS TO CHAI	RGES						Provider CCN: 15		PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET C PART I	
COST CENTER DESCRIPTIONS	Total Cost	Therapy		Costs			Charges		Cost or	TEFRA	PPS Inpatient	
	(from Wkst. B, Part I, col. 26)	Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	Inpatient	Outpatient	Total (column 6 + column 7)	Other Ratio	Inpatient Ratio	Ratio	
	1	2	3	4	5	6	7	8	9	10	11	
Medicaid - Title XIX	,						'					
67 Occupational Therapy	85,834		85,834		85,834			169,873	0.505283	0.505283	0.505283	67
68 Speech Pathology	5,899		5,899		5,899							68
69 Electrocardiology												69
70 Electroencephalography												70
71 Medical Supplies Charged to Patients	1,257,336		1,257,336		1,257,336			3,130,766	0.401607	0.401607	0.401607	71
72 Implantable Devices Charged to Patients	11,212,913		11,212,913		11,212,913			33,948,573	0.330291	0.330291	0.330291	72
73 Drugs Charged to Patients	1,475,975		1,475,975		1,475,975			1,427,221	1.034160	1.034160	1.034160	1
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	102,752		102,752		102,752							90
91 Emergency												91
92 Observation Beds (Non-Distinct Part)												92
92.01 Observation Beds (Distinct Part)												92.01
93 Other Outpatient Service (specify)												93
OTHER REIMBURSABLE COST CENTERS												
94 Home Program Dialysis												94
95 Ambulance Services												95
96 Durable Medical Equipment-Rented												96
97 Durable Medical Equipment-Sold												97
98 Other Reimbursable (specify)												98
99 Outpatient Rehabilitation Provider (specify)												99
100 Intern-Resident Service (not appvd. tchng. prgm.)												100
101 Home Health Agency												101
SPECIAL PURPOSE COST CENTERS												
105 Kidney Acquisition												105
106 Heart Acquisition												106
107 Liver Acquisition												107
108 Lung Acquisition												108
109 Pancreas Acquisition												109
110 Intestinal Acquisition												110
111 Islet Acquisition												111
112 Other Organ Acquisition (specify)			_									112

COMPUTATION OF RATIO OF COSTS TO CHA	RGES						Provider CCN: 150	0177	PERIOD: FROM 01/01/201 TO 12/31/2014	4	WORKSHEET C PART I	
COST CENTER DESCRIPTIONS	Total Cost	Therapy		Costs			Charges		Cost or	TEFRA	PPS Inpatient	
	(from Wkst. B, Part I, col. 26)	Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	Inpatient	Outpatient	Total (column 6 + column 7)	Other Ratio	Inpatient Ratio	Ratio	
	1	2	3	4	5	6	7	8	9	10	11	
Medicaid - Title XIX												
115 Ambulatory Surgical Center (Distinct Part)												115
116 Hospice												116
117 Other Special Purpose (specify)												117
200 Subtotal (see instructions)	25,206,707		25,206,707		25,206,707			82,526,456	5			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	5			202
FORM CMS-2552-10 (10/2012) (INSTRUCTIONS	FOR THIS WORKS	SHEET ARE PUI	BLISHED IN CMS	PUB. 15-2, SECT	TIONS 4023)					1		
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COMPUTATION OF RATIO OF COSTS TO CH.	ARGES						Provider CCN: 150	0177	PERIOD: FROM 01/01/201 TO 12/31/2014	4	WORKSHEET C PART I	
COST CENTER DESCRIPTIONS	Total Cost	Therapy		Costs			Charges		Cost or	TEFRA	PPS Inpatient	
	(from Wkst. B, Part I, col. 26)	Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	Inpatient	Outpatient	Total (column 6 + column 7)	Other Ratio	Inpatient Ratio	Ratio	
	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	5			30
31 Intensive Care Unit												3
32 Coronary Care Unit												3:
33 Burn Intensive Care Unit												3:
34 Surgical Intensive Care Unit												3-
35 Other Special Care (specify)												3:
40 Subprovider IPF												4
41 Subprovider IRF												4
42 Subprovider (Specify)												4:
43 Nursery												4
44 Skilled Nursing Facility												4
45 Nursing Facility												4:
46 Other Long Term Care												4
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	5
51 Recovery Room												5
52 Labor Room and Delivery Room												5:
53 Anesthesiology	465,677		465,677		465,677	658,648	452,400	1,111,048	0.419133	0.419133	0.419133	
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	5-
55 Radiology-Therapeutic												5:
56 Radioisotope												5
57 Computed Tomography (CT) Scan												5
58 Magnetic Resonance Imaging (MRI)												5
59 Cardiac Catheterization												5
60 Laboratory	443,890		443,890		443,890	103,502	181,263	284,765	1.558794	1.558794	1.558794	6
61 PBP Clinical Laboratory Services-Prgm. Only												6
62 Whole Blood & Packed Red Blood Cells												6
63 Blood Storing, Processing, & Trans.												6
64 Intravenous Therapy												6
65 Respiratory Therapy												6
66 Physical Therapy	140,094		140,094		140,094	220,124	5,053	225,177	0.622151	0.622151	0.622151	6

COMPUTATION OF RATIO OF COSTS TO CHA	RGES						Provider CCN: 150		PERIOD: FROM 01/01/201- TO 12/31/2014		WORKSHEET C PART I	
COST CENTER DESCRIPTIONS	Total Cost	Therapy		Costs			Charges		Cost or	TEFRA	PPS Inpatient	
	(from Wkst. B, Part I, col. 26)	Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	Inpatient	Outpatient	Total (column 6 + column 7)	Other Ratio	Inpatient Ratio	Ratio	
	1	2	3	4	5	6	7	8	9	10	11	
Consolidated												
67 Occupational Therapy	85,834		85,834		85,834	166,482	3,391	169,873	0.505283	0.505283	0.505283	67
68 Speech Pathology	5,899		5,899		5,899							68
69 Electrocardiology												69
70 Electroencephalography												70
71 Medical Supplies Charged to Patients	1,257,336		1,257,336		1,257,336	1,647,616	1,483,150	3,130,766	0.401607	0.401607	0.401607	71
72 Implantable Devices Charged to Patients	11,212,913		11,212,913		11,212,913	31,206,781	2,741,792	33,948,573	0.330291	0.330291	0.330291	72
73 Drugs Charged to Patients	1,475,975		1,475,975		1,475,975	954,424	472,797	1,427,221	1.034160	1.034160	1.034160	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	102,752		102,752		102,752							90
91 Emergency												91
92 Observation Beds (Non-Distinct Part)												92
92.01 Observation Beds (Distinct Part)												92.01
93 Other Outpatient Service (specify)												93
OTHER REIMBURSABLE COST CENTERS												
94 Home Program Dialysis												94
95 Ambulance Services												95
96 Durable Medical Equipment-Rented												96
97 Durable Medical Equipment-Sold												97
98 Other Reimbursable (specify)												98
99 Outpatient Rehabilitation Provider (specify)												99
100 Intern-Resident Service (not appvd. tchng. prgm.)												100
101 Home Health Agency												101
SPECIAL PURPOSE COST CENTERS												
105 Kidney Acquisition												105
106 Heart Acquisition												106
107 Liver Acquisition												107
108 Lung Acquisition												108
109 Pancreas Acquisition												109
110 Intestinal Acquisition												110
111 Islet Acquisition												111
112 Other Organ Acquisition (specify)												112

COMPUTATION OF RATIO OF COSTS TO CHA	RGES						Provider CCN: 150)177	PERIOD: FROM 01/01/2014 TO 12/31/2014	4	WORKSHEET C PART I	
COST CENTER DESCRIPTIONS	Total Cost	Therapy		Costs			Charges		Cost or	TEFRA	PPS Inpatient	
	(from Wkst. B, Part I, col. 26)	Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	Inpatient	Outpatient	Total (column 6 + column 7)	Other Ratio	Inpatient Ratio	Ratio	
	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	82,526,45	5			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	82,526,45	5			202
FORM CMS-2552-10 (10/2012) (INSTRUCTIONS	FOR THIS WORKS	SHEET ARE PU	BLISHED IN CMS	PUB. 15-2, SECT	TIONS 4023)							
40-564 - 10-12											Rev. 3	

APP	ORTIONMENT OF INPATIENT ROUTINE SERVICE C	CAPITAL COSTS		Provider CCN: 1501	77	PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET D, P	ART
Medi	icare -Title XVIII - Hospital								
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTNE SERVICE COST CENTERS								
30	Adults & Pediatrics (General Routine Care)	1,189,946		1,189,946	840	1,416.60	257	364,066	30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care Unit (specify)								35
40	Subprovider IPF								40
41	Subprovider IRF								41
42	Subprovider (Other)								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,189,946		1,189,946	840		257	364,066	200
(A) V	Worksheet A line numbers								
FOR	M CMS-2552-10 (10/2012) (INSTRUCTIONS FOR THIS	S WORKSHEET ARE	PUBLISHED IN C	MS PUB. 15-2, SEC	ΓΙΟΝS 4024 - 4024.	1)			
40-50	67 - 10-12							Rev. 3	

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN Cost report status - Settled Without Audit

[Record code 591947 - 2010]

ANCII	RTIONMENT OF INPATIENT LLARY SERVICE CAPITAL COSTS	Provider CCN: 150177		PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET D, PART II	
Medic	are -Title XVIII - Hospital						
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
(A)	Cost Center Description	1	2	3	4	5	1
	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
	Radioisotope						56
	Computed Tomography (CT) Scan						57
	Magnetic Resonance Imaging (MRI)						58
	Cardiac Catheterization						60
60	Laboratory	28,777	284,765	0.101055	85,337	8,624	_
	PBP Clinical Laboratory Services- Prgm. Only				32,627	4,12	61
62	Whole Blood & Packed Red Blood Cells						62
	Blood Storing, Processing, & Transfusing						63
	Intravenous Therapy						64
	Respiratory Therapy						65
	Physical Therapy	13,569	225,177	0.060259	70,175	4,229	
	Occupational Therapy	4,353	169,873	0.025625	51,309	1,315	
68	Speech Pathology	3,189					68
69	Electrocardiology						69
	Electroencephalography						70
	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
	Drugs Charged to Patients	146,709	1,427,221	0.102793	462,803	47,573	
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
	Emergency						91
	Observation Beds (Non-Distinct Part)						92
92.01	Observation Beds (Distinct Part)						92.01
93	Other Outpatient Service (specify) OTHER REIMBURSABLE COST						93
	CENTERS						<u> </u>
	Home Program Dialysis						94
	Ambulance Services						95
	Durable Medical Equipment-Rented						96
	Durable Medical Equipment-Sold						97
	Other Reimbursable (specify)						98
	Total (sum of lines 50 through 199)	1,754,134	80,538,621	0.021780	13,875,212	231,585	200
(A) W	orksheet A line numbers						
FORM	I CMS-2552-10 (10-2012) (INSTRUCT	IONS FOR THIS WORKS	SHEET ARE PUBLISHE	D IN CMS PUB. 15-2, SEC	CTION 4024.2)		
		1					

APPORTIONMENT OF INPATIENT ROL	JTINE SERV	ICE OTHER PA	ASS THROUG	SH COSTS	Provider CCN	I: 150177	PERIOD: FROM 01/01/ TO 12/31/201		WORKSHEE PART III	T D,
Medicare -Title XVIII - Hospital					,					
	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass- Through Cost (col. 7 x col. 8)	
(A) Cost Center Description	1	2	3	4	5	6	7	8	9	
INPATIENT ROUTINE SERVICE COST CENTERS										
30 Adults & Pediatrics (General Routine Care)						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) (INSTRU	CTIONS FOR	THIS WORKS	SHEET ARE F	UBLISHED II	N CMS PUB. 1	5-2, SECTIO	N 4024.3)			
40-569 - 09-15									Rev. 8	

Cost report status - Settled Without Audit

[Record code 591947 - 2010]

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Pro

Provider CCN: 150177 PERIOD: FROM 01/01/2014 TO 12/31/2014 WORKSHEET D, PART IV

Medicare -Title XVIII - Hospital									1		10 12/01/2011		I .	\dashv
	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)		Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass- Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass- Through Costs (col. 9 x col. 12)	
(A) Cost Center Description	1	2	3	4	5	6	7	8	9	10	11	12	13	
ANCILLARY SERVICE COST CENTERS														
50 Operating Room							37,722,040			4,827,320		5,888,765		50
51 Recovery Room														51
52 Labor room and Delivery Room														52
53 Anesthesiology							1,111,048			216,837		362,738		53
54 Radiology-Diagnostic							2,519,158			43,066		685,496		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							284,765			85,337		59,743		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							225,177			70,175				66
67 Occupational Therapy							169,873			51,309				67
68 Speech Pathology														68
69 Electrocardiology														69
70 Electroencephalography														70
71 Medical Supplies Charged To Patients							3,130,766			521,460		931,550		71
72 Implantable Devices Charged to Patients							33,948,573			7,596,905		1,776,321		72
73 Drugs Charged to Patients							1,427,221			462,803		180,770		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

APPOI	RTIONMENT OF INPATIENT/OUTPAT	TENT ANCILLAF	RY SERVICE	OTHER PASS T	HROUGH CC	OSTS				Provider CCN:	150177	PERIOD: FROM 01/01/20 TO 12/31/2014)14	WORKSHEET I PART IV	D,
Medica	are -Title XVIII - Hospital														
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)		Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass- Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass- Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	1	2	3	4	5	6	7	8	9	10	11	12	13	
91	Emergency														91
92	Observation Beds (Non-Distinct Part)														92
92.01	Observation Beds (Distinct Part)														92.01
93	Other Outpatient Service (specify)														93
OTHE	R 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) W	orksheet A line numbers			,		•	•								
FORM	CMS-2552-10 (09/2015) (INSTRUCTIO	NS FOR THIS WO	ORKSHEET A	ARE PUBLISHEI	O IN CMS PU	B. 15-2, SECTIO	ON 4024.4)								
40-571	- 09-15													Rev. 8	

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

	re -Title XVIII - Hospital V - APPORTIONMENT OF MEDICAL AND OT					TO 12/31/2014)14	PART V	
PART	V - APPORTIONMENT OF MEDICAL AND OT			I.				J.	
		HER HEALTH SE	ERVICES COST	S					
		Cost to Charge		Program Charges	S		Program Cost		
		Ratio from Worksheet C, Part I, col. 9	PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject to Ded. & Coins. (see instructions)	& Coins. (see instructions)	PPS Services (see instructions)	Cost Reimbursed Services Subject to Ded. & Coins. (see instructions)	& Coins. (see instructions)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	LARY SERVICE COST CENTERS								
	Operating Room		5,888,765			443,854			50
	Recovery Room								51
52	Labor & Delivery Room								52
	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
	Respiratory Therapy								65
	Physical Therapy								66
	Occupational Therapy								67
	Speech Pathology								68
	Electrocardiology								69
	Electroencephalography								70
	Medical Supplies Charged To Patients		931,550			374,117			71
	Implantable Devices Charged to Patients		1,776,321	82,874		586,703	27,373		72
	Drugs Charged to Patients		180,770	02,074	457	186,945	21,313	473	_
	Renal Dialysis		180,770		437	180,943		4/3	74
	ASC (Non-Distinct Part)								75
	Other Ancillary (specify)								76
	ATIENT SERVICE COST CENTERS								- 00
	Rural Health Clinic (RHC)								88
	Federally Qualified Health Center (FQHC)								89
	Clinic								90
	Emergency								91
	Observation Bed (Non-Distinct Part)								92
	Observation Bed (Distinct Part)								92.01
	Other Outpatient Service (specify)								93
	R REIMBURSABLE COST CENTERS								
	Home Program Dialysis								94
	Ambulance								95
	Durable Medical Equipment-Rented								96
	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
	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 WORKSHE	EET ARE PUBL	ISHED IN CMS	PUB. 15-2, SEC	TIONS 4024.5)			•
40-572	- 09-15							Rev. 8	-

UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA, IN Cost report status - Settled Without Audit [Record code 591947 - 2010] APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES

	uid - Title XIX - Hospital					FROM 01/01/2/ TO 12/31/2014		PART V	
						10 12/31/2014			
	V - APPORTIONMENT OF MEDICAL AND OT	HER HEALTH SE	ERVICES COST	S					
		Cost to Charge		Program Charges			Program Cost		
		Ratio from	PPS	Cost	Cost	PPS	Cost	Cost	1
		Worksheet C,	Reimbursed	Reimbursed	Reimbursed	Services (see	Reimbursed	Reimbursed	
		Part I, col. 9	Services (see	Services	Services Not	instructions)	Services	Services Not	
			instructions)	Subject to Ded.			Subject to Ded.		
				& Coins. (see	& Coins. (see		& Coins. (see	& Coins. (see	
				instructions)	instructions)	_	instructions)	instructions)	-
(A)	Cost Center Description	1	2	3	4	5	6	7	
	LARY SERVICE COST CENTERS		1 115 50 5						
	Operating Room		1,446,696						50
	Recovery Room								51
	Labor & Delivery Room								52
	Anesthesiology		31,784						53
54	Radiology-Diagnostic		68,497						54
55	Radiology-Therapeutic								55
56	Radioisotope								56
57	Computed Tomography (CT) Scan								57
	Magnetic Resonance Imaging (MRI)								58
	Cardiac Catheterization								59
	Laboratory	1	9,275						60
	PBP Clinic Laboratory Services-Prgm. Only		7,270						61
	Whole Blood & Packed Red Blood Cells								62
	Blood Storing, Processing, & Transfusing								63
									64
	Intravenous Therapy								1
	Respiratory Therapy		1105						65
	Physical Therapy		4,105						66
	Occupational Therapy		3,549						67
	Speech Pathology								68
69	Electrocardiology								69
70	Electroencephalography								70
	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
	ASC (Non-Distinct Part)								75
	Other Ancillary (specify)								76
	ATIENT SERVICE COST CENTERS								
	Rural Health Clinic (RHC)								88
	Federally Qualified Health Center (FQHC)					-	+	+	89
	Clinic							-	90
	Emergency							-	91
	Observation Bed (Non-Distinct Part)			<u> </u>		-		-	91
				<u> </u>		-		-	
	Observation Bed (Distinct Part)	-				-	-	-	92.01
	Other Outpatient Service (specify)								93
	R REIMBURSABLE COST CENTERS								<u> </u>
	Home Program Dialysis								94
	Ambulance								95
	Durable Medical Equipment-Rented								96
	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						İ		201
	Charges								
202	Net Charges (line 200 - line 201)					216,585			202
FORM	CMS-2552-10 (09-2015) (INSTRUCTIONS FOR	THIS WORKSHE	ET ARE PUBL	ISHED IN CMS	PUB. 15-2, SEC	CTIONS 4024.5)			-
10-572	- 09-15							Rev. 8	

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	<u> </u>			
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1 Inpatient days (including private room days a	nd swing-bed days, excluding no	ewborn)	840	
2 Inpatient days (including private room days,			840	-
		ve only private room days, do not complete this		
4 Semi-private room days (excluding swing-be	d and observation bed days)		840	\vdash
5 Total swing-bed SNF type inpatient days (inc		gh December 31 of the cost reporting period		\vdash
6 Total swing-bed SNF type inpatient days (incalendar year, enter 0 on this line)				
7 Total swing-bed NF type inpatient days (incl	uding private room days) through	h December 31 of the cost reporting period		
		december 31 of the cost reporting period (if calendar		
9 Total inpatient days including private room d	ays applicable to the Program (e	excluding swing-bed and newborn days)	257	
10 Swing-bed SNF type inpatient days applicable reporting period (see instructions).	e to title XVIII only (including p	private room days) through December 31 of the cost		1
11 Swing-bed SNF type inpatient days applicable reporting period (if calendar year, enter 0 on		private room days) after December 31 of the cost		1
12 Swing-bed NF type inpatient days applicable cost reporting period.	to titles V or XIX only (including	ng private room days) through December 31 of the		1
13 Swing-bed NF type inpatient days applicable reporting period (if calendar year, enter 0 on	• `	ng private room days) after December 31 of the cost		1
14 Medically necessary private room days applied	cable to the Program (excluding	swing-bed days)		1
15 Total nursery days (title V or XIX only)				1
16 Nursery days (title V or XIX only)		·		1
SWING BED ADJUSTMENT				
17 Medicare rate for swing-bed SNF services ap	plicable to services through Dec	ember 31 of the cost reporting period		1
18 Medicare rate for swing-bed SNF services ap	plicable to services after Decem	ber 31 of the cost reporting period		
19 Medicaid rate for swing-bed NF services app	licable to services through Dece	mber 31 of the cost reporting period		
20 Medicaid rate for swing-bed NF services app	licable to services after December	er 31 of the cost reporting period		- 2
21 Total general inpatient routine service cost (s	ee instructions)		5,431,884	1
22 Swing-bed cost applicable to SNF type service	ces through December 31 of the	cost reporting period (line 5 x line 17)		1
23 Swing-bed cost applicable to SNF type service				2
24 Swing-bed cost applicable to NF type service				
25 Swing-bed cost applicable to NF type service				1
26 Total swing-bed cost (see instructions)		,		1
27 General inpatient routine service cost net of s	wing-bed cost (line 21 minus lin	ne 26)	5,431,884	_
PRIVATE ROOM DIFFERENTIAL ADJUSTME				
28 General inpatient routine service charges (exc		on bed charges)		1
29 Private room charges (excluding swing-bed c		2		2
30 Semi-private room charges (excluding swing				3
31 General inpatient routine service cost/charge				3
32 Average private room per diem charge (line 2				3
33 Average semi-private room per diem charge	· · · · · · · · · · · · · · · · · · ·			3
34 Average per diem private room charge differ		e instructions)		3
35 Average per diem private room cost different		- manucuona)		1
36 Private room cost differential adjustment (lin				3
		cost differential (line 27 minus line 26)	5,431,884	-
37 General inpatient routine service cost net of s		RE PUBLISHED IN CMS PUB. 15-II, SECTIONS		3
	S FOR THIS WUKKSHEET AF	NE FUBLISHED IN CMS PUB. 13-II, SECTIONS	<u> </u>	
40-573 - 09-15			Rev. 8	

[Record code 591947 - 2010]		1	,			
COMPUTATION OF INPATIENT OPERATING (COST	Provider CCN: 150177		PERIOD: FROM 01/01/2014 TO 12/31/2014	WORKSHEET D-1, PA	4RT
Medicare -Title XVIII - Hospital	_			10 12/01/2011		
PART II - HOSPITAL AND SUBPROVIDERS ON	ILY	,				
PROGRAM INPATIENT OPERATING COST BE	FORE PASS-THROUG	H COST ADJUSTMEN	TS		1	
38 Adjusted general inpatient routine service cost				_	6,466.53	38
39 Program general inpatient routine service cost					1,661,898	
40 Medically necessary private room cost applica		14 x line 35)		_	2,002,070	40
41 Total Program general inpatient routine servic				_	1,661,898	
	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	İ
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 (World	sheet D-3, column 3, lir	ne 200)	I		3,884,332	48
49 Total Program inpatient costs (sum of lines 41				_	5,546,230	49
PASS-THROUGH COST ADJUSTMENTS						
50 Pass through costs applicable to Program inpa	tient routine services (fro	om Worksheet D, sum o	f Parts I and III)		364,066	50
51 Pass through costs applicable to Program inpa	tient ancillary services (1	from Worksheet D, sum	of Parts II and IV)		231,585	51
52 Total Program excludable cost (sum of lines 5	0 and 51)		<u> </u>	_	595,651	52
53 Total Program inpatient operating cost excludi 52)	ng capital related, nonpl	nysician anesthetist, and	medical education cos	ts (line 49 minus line	4,950,579	53
TARGET AMOUNT AND LIMIT COMPUTATION	N	,				
54 Program discharges						54
55 Target amount per discharge						55
56 Target amount (line 54 x line 55)						56
57 Difference between adjusted inpatient operatir	g cost and target amoun	t (line 56 minus line 53)	1			57
58 Bonus payment (see instructions)				_		58
59 Lesser of line 53 ÷ line 54 or line 55 from the	cost reporting period end	ding 1996, updated and	compounded by the ma	arket basket		59
60 Lesser of line 53 ÷ line 54 or line 55 from prior	r year cost report, updat	ed by the market basket				60
61 If line 53 ÷ line 54 is less than the lower of lin than expected costs (lines 54 x 60), or 1 % of the state of the stat				ng costs (line 53) are less		61
62 Relief payment (see instructions)						62
63 Allowable Inpatient cost plus incentive payme	nt (see instructions)					63
PROGRAM INPATIENT ROUTINE SWING BED	COST					
64 Medicare swing-bed SNF inpatient routine cos	sts through December 31	of the cost reporting pe	riod (see instructions)	(title XVIII only)		64
65 Medicare swing-bed SNF inpatient routine cos	sts after December 31 of	the cost reporting period	d (see instructions) (tit	le XVIII only)		65
66 Total Medicare swing-bed SNF inpatient routi	ne costs (line 64 plus lin	e 65) (Title XVIII only.	For CAH, see instruct	ions.)		66
67 Title V or XIX swing-bed NF inpatient routine	costs through December	er 31 of the cost reportin	g period (line 12 x line	: 19)		67
68 Title V or XIX swing-bed NF inpatient routine	e costs after December 3	1 of the cost reporting pe	eriod (line 13 x line 20))		68
69 Total title V or XIX swing-bed NF inpatient re	outine costs (line 67 + lin	ne 68)				69
FORM CMS-2552-10 (10-2012) (INSTRUCTIONS	FOR THIS WORKSHI	EET ARE PUBLISHED	IN CMS PUB. 15-2, S	SECTION 4025.2)		
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COMPUTATION OF INPATIENT OPERAT	NG COST	Provider CCN: 150177		PERIOD: FROM 01/01/2014 TO 12/31/2014	WORKSHEET D-1, PAR III & IV	RTS
Medicare -Title XVIII - Hospital						
PART III - SKILLED NURSING FACILITY,			LY			
70 Skilled nursing facility/other nursing faci	lity/ICF/IID routine service	e cost (line 37)				70
71 Adjusted general inpatient routine service	e cost per diem (line 70 ÷ li	ine 2)				71
72 Program routine service cost (line 9 x lin	e 71)					72
73 Medically necessary private room cost ap						73
74 Total Program general inpatient routine s	,					74
75 Capital-related cost allocated to inpatient	routine service costs (from	Worksheet B, Parts II, c	olumn 26, line 45)			75
76 Per diem capital-related costs (line 75 ÷ 1	ine 2)					76
77 Program capital-related costs (line 9 x lin	e 76)					77
78 Inpatient routine service cost (line 74 min	nus line 77)					78
79 Aggregate charges to beneficiaries for ex	cess costs (from provider re	ecords)				79
80 Total Program routine service costs for c	omparison to the cost limita	ation (line 78 minus line	79)	_		80
81 Inpatient routine service cost per diem lin	mitation					81
82 Inpatient routine service cost limitation (line 9 x line 81)					82
83 Reasonable inpatient routine service cost	s (see instructions)			-		83
84 Program inpatient ancillary services (see	instructions)					84
85 Utilization review - physician compensat	ion (see instructions)					85
86 Total Program inpatient operating costs (sum of lines 83 through 85)				86
PART IV - COMPUTATION OF OBSERVA	ΓΙΟΝ BED PASS-THROU	GH COST				
87 Total observation bed days (see instruction	ons)					87
88 Adjusted general inpatient routine cost pe	er 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			90
91 Nursing School cost		5,431,884				91
92 Allied Health cost		5,431,884				92
93 All other Medical Education		5,431,884				93
FORM CMS-2552-10 (09/2015) (INSTRUCT	IONS FOR THIS WORKS	HEET ARE PUBLISHE	O IN CMS PUB. 15-2, SI	ECTIONS 4025.3 - 4025.4	4)	
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_	FIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 150177	PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET D-3	
Medic	are -Title XVIII - Hospital		1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2			
	OST CENTER DESCRIPTION		Ratio of Cost to Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		_	1	2	3	
INPA	TIENT 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
ANCII	LLARY SERVICE COST CENTERS					
50	Operating Room		0.075373	4,827,320	363,850	50
	Recovery Room	_			· · · · · · · · · · · · · · · · · · ·	51
	Labor Room and Delivery Room					52
	Anesthesiology		0.419133	216,837	90,884	53
	Radiology-Diagnostic		0.691197	43,066	29,767	54
	Radiology-Therapeutic		0.051157	15,000	2,,,,,,	55
	Radioisotope					56
	Computed Tomography (CT) Scan	_				57
	Magnetic Resonance Imaging (MRI)					58
	Cardiac Catheterization					
		_	1.550704	05 227	122.022	59
	Laboratory	_	1.558794	85,337	133,023	60
	PBP Clinical Laboratory Services-Prgm. Only					61
	Whole Blood & Packed Red Blood Cells					62
	Blood Storing, Processing, & Trans.	_				63
	Intravenous Therapy					64
	Respiratory Therapy					65
	Physical Therapy		0.622151	70,175	43,659	66
	Occupational Therapy		0.505283	51,309	25,926	67
68	Speech Pathology					68
	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
	Other Ancillary (specify)	_				76
	ATIENT SERVICE COST CENTERS					
	Rural Health Clinic (RHC)					88
	Federally Qualified Health Center (FQHC)					89
	Clinic					90
	Emergency					90
	Observation Beds (Non-Distinct Part)					91
	Observation Beds (Non-Distinct Part) Observation Beds (Distinct Part)					92.01
	,					
	Other Outpatient Service (specify)	_				93
	R REIMBURSABLE COST CENTERS					
	Home Program Dialysis					94
	Ambulance Services					95
	Durable Medical Equipment-Rented					96
	Durable Medical Equipment-Sold					97
	Other Reimbursable (specify)					98
	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 (lin	ne 61)				201
202	Net Charges (line 200 minus line 201)			13,875,212		202
(A) W	orksheet A line numbers					
FORM	CMS-2552-10 (09-2015) (INSTRUCTIONS FOR THIS WOR	KSHEET ARE PUBLISHE	ED IN CMS PUB. 15-2, SE	CTION 4027)		

INPATIENT ANCILLARY SERVICE COST APPORTIONM	ENT 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	

CALC	CULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150177	PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET E I	PART A
Medic	care -Title XVIII - Hospital		10 12/31/2014			
	A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
			1	1.01	1.02	
1	DRG amounts other than outlier payments					1
	DRG amounts other than outlier payments for discharges occurrin instructions)	g prior to October 1(see	979,829			1.0
1.02	DRG amounts other than outlier payments for discharges occurrin (see instructions)	g on or after October 1	432,922			1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for prior to October 1 (see instructions)	discharges occurring				1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for or after October 1 (see instructions)	discharges occurring on				1.0
2	Outlier payments for discharges (see instructions)		3,726,351			
2.01	Outlier reconciliation amount		-1,885,338			2.0
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions	s)				2.02
3	Managed care simulated payments					1
	Bed days available divided by number of days in the cost reporting Indirect Medical Education Adjustment Calculation for Hospitals	g period (see instructions)	29.00			4
	FTE count for allopathic and osteopathic programs for the most re ending on or before 12/31/1996 (see instructions) FTE count for allopathic and osteopathic programs which meet the					
	the cap for new programs in in accordance with 42 CFR 413.79(e) MMA Section 422 reduction amount to the IME cap as specified u)				,
	(1)(iv)(B)(1)					7.0
	ACA Section 5503 reduction amount to the IME cap as specified (1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instr	uctions.				
	Adjustment (increase or decrease) to the FTE count for allopathic for affiliated programs in accordance with 42 CFR 413.75(b), 413 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).					;
	The amount of increase if the hospital was awarded FTE cap slots ACA. If the cost report straddles July 1, 2011, see instructions.	under section 5503 of the				8.0
	The amount of increase if the hospital was awarded FTE cap slots hospital under section 5506 of ACA. (see instructions)	from a closed teaching				8.02
9	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 pl (see instructions)	lus lines (8.01 and 8.02)				9
10	FTE count for allopathic and osteopathic programs in the current y	year from your records				10
11	FTE count for residents in dental and podiatric programs					1
12	Current year allowable FTE (see instructions)					1
13	Total allowable FTE count for the prior year					1
14	Total allowable FTE count for the penultimate year if that year end 30, 1997, otherwise enter zero.	ded on or after September				1
15	Sum of lines 12 through 14 divided by 3					1.
16	Adjustment for residents in initial years of the program					1
17	Adjustment for residents displaced by program or hospital closure					1
	Adjusted rolling average FTE count					1
	Current year resident to bed ratio (line 18 divided by line 4)					1
	Prior year resident to bed ratio (see instructions)					2
	Enter the lesser of lines 19 or 20 (see instructions)					2
	IME payment adjustment (see instructions)					2:
	IME payment adjustment - Managed Care (see instructions)					22.0
	ct Medical Education Adjustment for the Add-on for Section 422 of					
	Number of additional allopathic and osteopathic IME FTE residen 412.105 (f)(1)(iv)(C).	at cap slots under 42 Sec.				2
	IME FTE resident count over cap (see instructions)					2
25	If the amount on line 24 is greater than -0-, then enter the lower of	Fline 23 or line 24 (see				2.
26	instructions) Resident to bed ratio (divide line 25 by line 4)					1
	IME payments adjustment factor (see instructions)					2
	IME add-on a djustment amount (see instructions)					2
	IME add-on adjustment amount (see instructions) IME add-on adjustment amount - Managed Care (see instructions)	<u> </u>				28.0
		,				
	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.0)	1)				29.0
	oportionate Share Adjustment	-/	1			27.0
	Percentage of SSI recipient patient days to Medicare Part A patien	nt days (see instructions)				3
	Percentage of Medicaid patient days to total patient days (see instr					3

CALC	CULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150177	PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET E PAR	RT A
32	Sum of lines 30 and 31					32
33	Allowable disproportionate share percentage (see instructions)					33
34	Disproportionate share adjustment (see instructions)					34
	npensated Care Adjustment		I	Prior to October 1	On or after October 1	
	1			1	2	
35	Total uncompensated care amount (see instructions)			9,046,380,143	_	35
	Factor 3 (see instructions)			0.000005188		
			·····	0.000003188	0.000004029	
	Hospital uncompensated care payment (If line 34 is zero, enter zero o		tions)			35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (so	ee instructions)	1			35.03
			1	1.01	2	
35.04	Pro rata share of the hospital uncompensated care payment amount (N	MDH) (see				35.04
	instructions)					
35.05	Pro rata share of the hospital uncompensated care payment amount (S	CH) (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
Additi	onal payment for high percentage of ESRD beneficiary discharges (lir	nes 40 through 46)				
			1	1.01	1.02	
40	Total Medicare discharges, excluding discharges for MS-DRGs 652,	682, 683, 684 and 685				40
	(see instructions)	, , ,				
41	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683	, 684 an 685 (see				41
	instructions)					
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DR	RGs 652, 682, 683,				41
	684, and 685 (see instructions)	. ,,				
42	Divide line 41 by line 40 (if less than 10%, you do not qualify for adju	ustment)				42
	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682,					43
	instructions)	, (
44	Ratio of average length of stay to one week (line 43 divided by line 4	1.01 divided by 7				44
	days)	•				
45	Average weekly cost for dialysis treatments (see instructions)					45
	Total additional payment (line 45 times line 44 times line 41.01)					46
	Subtotal (see instructions)		3,253,764			47
	Hospital specific payments (to be completed by SCH and MDH, small	I mural boanitals only	3,233,704			48
48	(see instructions)	ii rurai nospitais oniy				48
40	Total payment for inpatient operating costs (see instructions)		3,253,764			49
	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II,	1:b1-)				50
			749,963			
	Exception payment for inpatient program capital (Wkst. L, Pt. III) (se					51
	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
	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
	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col.					58
		11, line 200)	4,003,727			59
	Total (sum of amounts on lines 49 through 58)		4,003,727	<u> </u>		-
	Primary payer payments	0)	4000 ===			60
	Total amount payable for program beneficiaries (line 59 minus line 60	U)	4,003,727			61
	Deductibles billed to program beneficiaries		80,256			62
$\overline{}$	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
_	Credits received from manufacturers for replaced devices for applicab	ole MS-DRGs (see				68
	instructions)	(
69	Outlier payments reconciliation (Sum of lines 93,95 and 96) (For SCI	H see instructions)	-501,842			69
	Other adjustments (specify) (see instructions)	· · · · · · · · · · · · · · · · · · ·	·			70
	SCH or MDH volume decrease adjustment					70.88
	Pioneer ACO demonstration payment adjustment amount (see instruction)	tions)				70.89
		uons)				
	HSP bonus payment HVBP adjustment amount (see instructions)					70.90
	HSP bonus payment HRR adjustment amount (see instructions)					70.91
170.02	Bundled Model 1 discount amount (see instructions)					70.92
			9.610	I		70.93
	HVBP payment adjustment amount (see instructions)		8,619			70.75
70.93	HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions)		-6,494			70.94

CALC		Provider CCN: 150177	PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET E PA	RT 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 Chapter 1, § 115.2	CMS Pub. 15-2,				75
TO BI	E 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) (INSTRUCTI 15-2, § 4030.1)	ONS FOR THIS W	kst. ARE PUBLISHED	IN CMS PUB.		Rev. 10

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	
2 Medical and other services reimbursed under OPPS (see instructions).	2,310,594	
3 PPS payments	1,723,104	
4 Outlier payment (see instructions)	226,296	
5 Enter the hospital specific payment to cost ratio (see instructions)		
6 Line 2 times line 5		
7 Sum of line 3 and line 4 divided by line 6		
8 Transitional corridor payment (see instructions)		
9 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		
10 Organ acquisition		1
11 Total cost (sum of lines 1 and 10) (see instructions)	27,846	1
COMPUTATION OF LESSER OF COST OR CHARGES	27,840	1
Reasonable charges		
12 Ancillary service charges		1
13 Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)		1
14 Total reasonable charges (sum of lines 12 and 13)	83,331	1
Customary charges		
15 Aggregate amount actually collected from patients liable for payment for services on a charge basis		1
Amounts that would have been realized from patients liable for payment for services on a charge basis		1
had such payment been made in accordance with 42 CFR 413.13(e)		
17 Ratio of line 15 to line 16 (not to exceed 1.000000)		1
18 Total customary charges (see instructions)	83,331	1
19 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	55,485	1
instructions)		
20 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		2
21 Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)	27,846	2
22 Interns and residents (see instructions)		2
23 Cost of physicians' services in a teaching hospital (see instructions)		2
24 Total prospective payment (sum of lines 3, 4, 8, and 9)	1,949,400	2.
COMPUTATION OF REIMBURSEMENT SETTLEMENT	, , , , ,	
25 Deductibles and coinsurance (see instructions)	16,575	2
26 Deductibles and Coinsurance relating to amount on line 24 (see instructions)	373,628	2
		2
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	2
28 Direct graduate medical education payments (from Wkst. E-4, line 50)		2
29 ESRD direct medical education costs (from Wkst. E-4, line 36)		
	1 597 042	2
30 Subtotal (sum of lines 27 through 29)	1,587,043	3
31 Primary payer payments	1,314	3
32 Subtotal (line 30 minus line 31)	1,585,729	3:
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33 Composite rate ESRD (from Wkst. I-5, line 11)		3
34 Allowable bad debts (see instructions)		3
35 Adjusted reimbursable bad debts (see instructions)		3
36 Allowable bad debts for dual eligible beneficiaries (see instructions)		3
37 Subtotal (see instructions)	1,585,729	3
38 MSP-LCC reconciliation amount from PS&R	17	3
39 Other adjustments (specify) (see instructions)		3
39.50 Pioneer ACO demonstration payment adjustment (see instructions)		39.5
39.98 Partial or full credits received from manufacturers for replaced devices (see instructions)		39.9
39.99 Recovery of Accelerated depreciation		39.9
40 Subtotal (see instructions)	1,585,712	39.9
40.01 Sequestration adjustment (see instructions)	31,714	40.0
41 Interim payments	1,543,032	4
42 Tentative settlement (for contractors use only)	1,265	4
43 Balance due provider/program (see instructions)	9,701	4
44 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,115.2		4
PART B - MEDICAL AND OTHER HEALTH SERVICES TO BE COMPLETED BY CONTRACTOR		
90 Original outlier amount (see instructions)	226,493	91
91 Outlier reconciliation adjustment amount (see instructions)		9
-		

CALCULATION OF REIMBUR	SEMENT	Provider CCN: 150177	PERIOD:	WORKSHEET E, PART E	3
SETTLEMENT			FROM 01/01/2014		
			TO 12/31/2014		
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 T	THIS WORKSHEET ARE	PUBLISHED IN CMS PU	B. 15-2, SECTION 4030.2)
40-587 - 03-14				Rev. 7	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 150177	PERIOD: FROM 01/01/2014	WORKSHEET E-1, PART II	
HII		TO 12/31/2014		
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 th	rough 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	1 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 co	ertified 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 (s	see instructions)		684,285	10
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & 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 3	31) (see instructions)		12,348	32
FORM CMS-2552-10 (09/2015) (INSTRUCTIONS FOR THIS WO	RKSHEET ARE PUBLISHEI	O IN CMS PUB. 15-II, § 4031.2	2)	
* This worksheet is completed by the contractor for standard and no standard cost reporting period.	n-standard cost reporting perio	ds at cost report settlement. Pro	oviders may complete this worksheet for	a
40-589 - 09-15			Rev. 8	

_	ord code 591947 - 2010] LANCE SHEET		Provider CCN: 150177	PERIOD: FROM 01/01/2014 TO 12/31/2014	WORKSHEET G	
(If y	ou are nonproprietary and do not maintain fund-type accounting records	, complete the General Fund	column only)		1	
	Assets (Omit cents)	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1	2	3	4	
	RRENT ASSETS	012.477	Г		1	1
	Cash on hand and in banks Temporary investments	912,477				2
	Notes receivable					3
	Accounts receivable	24,242,073				4
5	Other receivables	236,470				5
ϵ	Allowances for uncollectible notes and accounts receivable	-11,097,333				6
	Inventory	608,264				7
	Prepaid expenses	128,536				8
	Other current assets					9
	Due from other funds	15 020 407				10
	Total current assets (sum of lines 1-10) ED ASSETS	15,030,487				11
	Land					12
	Land improvements					13
	Accumulated depreciation					14
	Buildings	15,190,569				15
16	Accumulated depreciation	-3,665,261				16
	Leasehold improvements					17
	Accumulated depreciation					18
	Fixed equipment	534,064				19
	Accumulated depreciation	-292,276				20
	Automobiles and trucks					21
	Accumulated depreciation Major movable equipment	13,454,396				23
	Accumulated depreciation	-9,756,684				24
	Minor equipment depreciable	7,750,001				25
	Accumulated depreciation					26
	HIT designated Assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable					29
	Total fixed assets (sum of lines 12-29)	15,464,808				30
	HER ASSETS		<u> </u>			
	Investments	12.224				31
	Deposits on leases Due from owners/officers	12,324				32
	Other assets	1,061,647				34
	Total other assets (sum of lines 31-34)	1,073,971				35
	Total assets (sum of lines 11, 30, and 35)	31,569,266				36
	ilities and Fund Balances (Omit cents)					
CUF	RRENT LIABILITIES					
	Accounts payable	2,387,983				37
	Salaries, wages, and fees payable					38
	Payroll taxes payable					39
	Notes and loans payable (short term)	4,000,000				40
	Deferred income					41
	Accelerated payments Due to other funds	9,596,541				42
	Other current liabilities	7,370,341				44
	Total current liabilities (sum of lines 37 thru 44)	15,984,524				45
	NG TERM LIABILITIES		I.		1	
	Mortgage payable					46
	Notes payable	14,738,967				47
	Unsecured loans					48
	Other long term liabilities	17,305,012				49
	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, con	nplete the General Fund	column only)			
Assets (Omit cents)	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
GLANTIAL ACCOUNTS	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
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 C	MS PUB. 15-II, SEC	CTION 4040)	•	
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STATEMENT OF CHANGES IN FUND BALANCES				Provider CCN: 15017	7	PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET G-1	
	GENERAL	FUND	SPECIFIC I	PURPOSE FUND	ENDOW	MENT FUND	PLAN	IT 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 WO	ORKSHEET ARE PUBL	LISHED IN CMS PUB	. 15-II, SECTION 40)40)					
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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		1		
REVENUE CENTER	INPATIENT	OUTPATIENT	TOTAL	
CENTED AT THE ATTIENT DOLUTINE CADE GEDVICES	1	2	3	
GENERAL INPATIENT ROUTINE CARE SERVICES	1			
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
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	1 1	85,822,342	28
PART II - OPERATING EXPENSES				
20 Operating aurences (non-What A polymer 2 line 200)	_	1	38,548,953	20
29 Operating expenses (per Wkst. A, column 3, line 200)	_		38,348,933	29 30
30 Add (specify)				
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) (tran			38,548,953	43
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEE 40-603 - 10-12		PUB. 15-II, SECTION 4040)	Rev. 3	

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 Works	heet G-2, Part I, column 3, line 28)		85,822,342	1
2 Less contractual allowances and dis	counts on patients' accounts		54,844,545	2
3 Net patient revenues (line 1 minus l	ine 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 s	ervice			9
10 Purchase discounts				10
11 Rebates and refunds of expenses				11
12 Parking lot receipts				12
13 Revenue from laundry and linen ser	vice			13
14 Revenue from meals sold to employ	ees and guests		16,717	14
15 Revenue from rental of living quarte	ers			15
16 Revenue from sale of medical and s	urgical supplies to other than patients			16
17 Revenue from sale of drugs to other	than patients			17
18 Revenue from sale of medical record	ds and abstracts		7,843	18
19 Tuition (fees, sale of textbooks, unit	Forms, 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 6-2	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) (INSTRU	CTIONS FOR THIS WORKSHEET AR	E PUBLISHED IN CMS PUB. 15-II,	SECTION 4040)	
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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		
1.01 Model 4 BPCI Capital DRG other than outlier					1.0
2 Capital DRG outlier payments			637,701		
2.01 Model 4 BPCI Capital DRG outlier payments					2.0
3 Total inpatient days divided by number of days in	the cost reporting period (see instruction	ns)	2.30		
4 Number of interns & residents (see instructions)					
5 Indirect medical education percentage (see instruc	tions)				
6 Indirect medical education adjustment (see instruc	etions))				
7 Percentage of SSI recipient patient days to Medic	are Part A patient days (Worksheet E, Pa	rt A line 30) (see instructions)			
8 Percentage of Medicaid patient days to total days					
9 Sum of lines 7 and 8					
10 Allowable disproportionate share percentage (see	instructions)				1
11 Disproportionate share adjustment (see instruction					1
12 Total prospective capital payments (see instructio	ns)		749,963		1:
PART II - PAYMENT UNDER REASONABLE COS'					
1 Program inpatient routine capital cost (see instruc	tions)				
2 Program inpatient ancillary capital cost (see instru					
3 Total inpatient program capital cost (line 1 plus li	· · · · · · · · · · · · · · · · · · ·				
4 Capital cost payment factor (see instructions)	·				
5 Total inpatient program capital cost (line 3 x line	4)				
PART III - COMPUTATION OF EXCEPTION PAYM					
1 Program inpatient capital costs (see instructions)					
2 Program inpatient capital costs for extraordinary of	ircumstances (see instructions)				
3 Net program inpatient capital costs (line 1 minus					
4 Applicable exception percentage (see instructions					
5 Capital cost for comparison to payments (line 3 x					
6 Percentage adjustment for extraordinary circumst					
7 Adjustment to capital minimum payment level for		ne 6)			
8 Capital minimum payment level (line 5 plus line	<u>.</u>				
9 Current year capital payments (from Part I, line 1)					
10 Current year comparison of capital minimum pay		s line 9)			1
11 Carryover of accumulated capital minimum paymline 14)					1
12 Net comparison of capital minimum payment leve	el to capital payments (line 10 plus line 1	1)			1
13 Current year exception payment (if line 12 is posi		,			1
14 Carryover of accumulated capital minimum paymengative, enter the amount on this line)		llowing period (if line 12 is			1
15 Current year allowable operating and capital payr	nent (see instructions)				1
16 Current year operating and capital costs (see instr					1
17 Current year exception offset amount (see instruc					1
FORM CMS-2552-10 (03-2014) (INSTRUCTIONS FO		HED IN CMS PUB. 15-II, SECTION	ONS 4064.1 - 4064.	.3)	
10-646 - 09-15		,		Rev. 8	