### UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA , IN Cost report status - As Submitted

[Record code	e 598260	- 20101

2 SUBPROVIDER - IPF 3 SUBPROVIDER - IRF 4 SUBPROVIDER (OTHER) 5 SWING BED - SNF 6 SWING BED - NF 7 SNF 8 NF, ICF/IID 9 HOME HEALTH AGENCY 10 HOSPITAL-BASED - RHC 11 HOSPITAL-BASED -FQHC 12 OUTPATIENT REHABILITATION PROVIDER (Specify)	REPORT CERTIFICA	SPITAL HEALTH CARE COMPLEX COST ATION AND SETTLEMENT SUMMARY	Provider CCN: 1		PERIOD: FROM 01/01/20 TO 12/31/2016		WORKSHEET S PARTS I, II & II	
Provider use only   2.1   Manually submitted cost report   3.1   Hi his is an annealed report enter the number of times the provider resubmitted this cost report   41   F   Medicare Utilization. Enter "F" for full or "L" for low.   1.2   Medicare Utilization. Enter "F" for full or "L" for low.   1.3   Sealed with a unit   1.3   Sealed with a unit   1.3   Sealed with a unit   1.4   Responsed   1.3   A submitted   1.3   Sealed with a unit   1.4   Responsed   1.5   Sealed with a unit   1.4   Response   1.5   Sealed with a unit   1.4   Response   1.5   Sealed with a unit   1.5   Sealed with a	payments made since	the beginning of the cost reporting period being deer						
2.1   Montally sobmitted tool report								
S.     If this is an amended report enter the number of times the provider resulbanited this cost report	Provider use only	1. [ X ] Electronically filed cost report		_		Date:	Time:	
Contractor use onlay   S.   1   Core Report Status   (2) A Submitted   (2) Settled with audit   (3) Settled with audit   (4) Responde   (5) Amended   (5) Amended   (6) Amended   (6) Amended   (7)		2. [] Manually submitted cost report						
Contractor use only    S.   I.   Core Report Status   (1) As Submitted   (2) Settled without audit   (3) Settled without audit   (4) Reopened   (5) S. Amended   (5) S. Amended   (6) S. Amended   (		3. [] If this is an amended report enter the number	of times the provide	r resubmitted this c	ost report			
Contractor No. 9001   1. Contractor's Vendor Code. 4		4 [ F ] Medicare Utilization. Enter "F" for full or ".	L" for low.					
2) Settled without audit   (4) Reopened   (5) Amended   (4) Reopened   (5) Amended   (5) Amended   (4) Reopened   (5) Amended   (6) Amended	Contractor use only		6. Date Received	1: 06/01/2017		10. NPR Date:		
Settled with audit   4  Reopender   5    Settled with audit   4  Reopender   5    Settled with audit   4  Reopender   5    Settled with audit   5  Amended   5		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	7. Contractor No	o.: 08001	-	11. Contractor's V	Vendor Code: 4	
4   Reopened		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	8. [ N ] Initial Re	eport for this Provid	ler CCN	12. [] If line 5, co	olumn 1 is 4: Ente	r
S. J. Amended   S. I. S. Final Report for this Provider CCN						number of times	reopened = 0-9.	
MINERPRESENTATION OR FALSHICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL CIVIL. AND ADMINISTRATIVE ACTION, FINE AND DRIMPRISONNEST UNDER FEDERAL LAW, FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILEGAL, CRIMINAL CIVIL, AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.  LERRIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDERS(S)  LHEKEBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by [Provider Name(s) and Number(s)] for the cost reporting period beginning and ending and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.  PART III - SETTLEMENT SUMMARY  TITLE V   TITLE XVIII   MINERAL ADDITIONAL ADDITIONA		(5) Amended	9. [ N ] Final Re	port for this Provid	er CCN			
AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONNENT UNDER FEDERAL LAW, FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR NDRIBECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.  CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)  I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by permitted and the Balance Sheet and Statement of Revenue and Expenses prepared by gening and ending and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such and regulations and regu	PART II - CERTIFIC	ATION						
Signed   Name NOT AVAILIABLE ON ELECTRONIC FORM   Officer or Administrator of Provider(s)   Title NOT AVAILIABLE ON ELECTRONIC FORM   Date	CIVIL AND ADMIN CERTIFICATION BY I HEREBY CERTIFY and the Balance Sheet beginning the books and records	ISTRATIVE ACTION, FINES AND/OR IMPRISORY  Y OFFICER OR ADMINISTRATOR OF PROVIDE  That I have read the above certification statement at and Statement of Revenue and Expenses prepared by and ending and to the best of the provider in accordance with applicable instru-	NMENT MAY RESU (R(S)) and that I have examin by	ed the accompanying Provide Belief, this report and I further certify	ng electronically der Name(s) and and statement are that I am familiar	filed or manually st Number(s)}for the true, correct, comp with the laws and r	ibmitted cost repo cost reporting per lete and prepared	rt iod from
PART III - SETTLEMENT SUMMARY    TITLE V	the provision of health	a care services, and that the services identified in this		vided in compliand	e with such laws	and regulations.		
PART III - SETTLEMENT SUMMARY  TITLE V TITLE XVIII HIT TITLE XIX PART A PART B 1 2 3 4 5 1 1 2 3 3 4 5 2 SUBPROVIDER - IPF 3 SUBPROVIDER - IRF 4 SUBPROVIDER (OTHER) 5 SWING BED - SNF 6 SWING BED - SNF 7 SNF 8 NF, ICF/IID 9 HOME HEALTH AGENCY 10 HOSPITAL-BASED - FHC 11 HOSPITAL-BASED - FHC 11 HOSPITAL-BASED - FHC 12 OUTPATIENT REHABILITATION PROVIDER (Specify) 10 OUTPATIENT REHABILITATION PROVIDER (Specify) 10 MB control number for this information collection Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 938-0050. The time required to complete that no review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Atm: PRA Report Clearance Officer, Mall Stop C4-26-05, Baltimore, Maryland 2124+1850, Please do not send applications, calms, payments, medical records or any documents containing sensitive informatio to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number is please contact 1-800-MEDICARE.			(Signed)	Name NOT AVA	ILIABLE ON E	LECTRONIC FOR	M	
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8 NF, ICF/IID  9 HOME HEALTH AGENCY  10 HOSPITAL-BASED - RHC  11 HOSPITAL-BASED - FQHC  12 OUTPATIENT REHABILITATION PROVIDER (Specify)  13 36,380  15,868  20 Total  16 Total  17 According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information oblection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.	6 SWING BED - 1	NF						6
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12 OUTPATIENT REHABILITATION PROVIDER (Specify)  200 TOTAL  36,380  35,868  20  The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.  According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 9938-0050. The time required to complete this information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.								11
Total 36,380 35,868 20  The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.  According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 9938-0050. The time required to complete this information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.								12
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	According to the Pape valid OMB control nu including the time to r concerning the accura Mail Stop C4-26-05, I to the PRA Reports C number listed on this in MEDICARE.	rework Reduction Act of 1995, no persons are requirember for this information collection is 0938-0050. The review instructions, search existing resources, gather cy of the time estimate(s) or suggestions for improvibility and the suggestions for improvibility. All the suggestions for improvibility and the suggestions for improvibility and the suggestions for improvibility. Please do not send learance Office. Please note that any correspondence form will not be reviewed, forwarded, or retained. If	ed to respond to a col he time required to c the data needed, and ng this form, please d applications, claims not pertaining to the you have questions of	lection of informat omplete this inform complete and reviewrite to: CMS, 750 , payments, medical information collector concerns regarding	ion unless it disp nation collection where the informatic O Security Boule Il records or any tion burden approng where to subm	is estimated 673 hour collection. If you ward, Attn: PRA Redocuments containing oved under the associat your documents,	ars per response, have any comment port Clearance Of ng sensitive informated OMB contractions.	nts ficer, nation
40-503 - 11-16 Rev. 10		(11/2010) (INDIRECTIONS FOR THIS WORKS)	LLI MET ODLISI	LLD II CIVIS I UD	13-11, 5ECTION	15 1003.1-4003.3)	Pay 10	

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016	WORKSHEET S-10	
Uncompensated and indigent care cost computation			•	
1 Cost to charge ratio (Worksheet C, Part I, line 202 column 3, divi	ided by line 202, column 8)		0.302138	1
Medicaid (see instructions for each line)				
2 Net revenue from Medicaid				2
3 Did you receive DSH or supplemental payments from Medicaid?			N	3
4 If line 3 is yes, does line 2 include all DSH or supplemental payn			N	4
5 If line 4 is no, enter DSH or supplemental payments from Medica		_		5
6 Medicaid charges			608,152	6
7 Medicaid cost (line 1 times line 6)		_	183,746	7
8 Difference between net revenue and costs for Medicaid program If line 7 is less than the sum of lines 2 and 5, then enter zero.	(line 7 minus lines 2 and 5).	_	183,746	_
Children's Health Insurance Program (CHIP) (see instructions for each	line)	_	•	
9 Net revenue from stand-alone CHIP		_		9
10 Stand-alone CHIP charges		_		10
11 Stand-alone CHIP cost (line 1 times line 10)		_		11
12 Difference between net revenue and costs for stand-alone CHIP ( If line 11 is less than line 9, then enter zero.	line 11 minus line 9).			12
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)			13
14 Charges for patients covered under state or local indigent care pro		10)		14
15 State or local indigent care program cost (line 1 times line 14)				15
16 Difference between net revenue and costs for state or local indige If line 15 is less than line 13, then enter zero.	ent care program (line 15 minus	line 13).		16
Uncompensated care (see instructions for each line)				
17 Private grants, donations, or endowment income restricted to fund	ding charity care			17
18 Government grants, appropriations or transfers for support of hos		_		18
19 Total unreimbursed cost for Medicaid, CHIP and state and local i		ines 8, 12 and 16)	183,746	19
,	Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
	1	2	3	
20 Charity care charges for the entire facility (see instructions)	9,64			20
21 Cost of patients approved for charity care (line 1 times line 20)	2,91	· · · · · · · · · · · · · · · · · · ·	<u> </u>	
22 Partial payment by patients approved for charity care	2,>1.	15,000	10,775	22
23 Cost of charity care (line 21 minus line 22)	2,91	3 15,880	18,793	
24 Does the amount in line 20, column 2 include charges for patient by Medicaid or other indigent care program?	<u>'</u>		N N	24
25 If line 24 is yes, enter charges for patient days beyond an indigen	t care program's length of stay l	mit (see instructions)		25
26 Total bad debt expense for the entire hospital complex (see instru			-98,592	
27 Medicare bad debts for the entire hospital complex (see instruction			37,122	
28 Non-Medicare and non-reimbursable Medicare bad debt expense	· · · · · · · · · · · · · · · · · · ·	_	-135,714	
29 Cost of non-Medicare and non-reimbursable Medicare bad debt e		_	-41,004	
30 Cost of uncompensated care (line 23 column 3 plus line 29)	pense (inie i tilies inie 20)	_	-22,211	30
31 Total unreimbursed and uncompensated care cost (line 19 plus lin	20 30)	_	161,535	
31 Total unremoursed and uncompensated care cost (line 19 plus in	IC 30)		101,333	اد
FORM CMS-2552-10 (11/2016) (INSTRUCTIONS FOR THIS WOR	KSHEET ARE PUBLISHED IN	CMS PUB. 15-2, SECTION 401	2)	
40-523 - 11-2016	<del>-</del>		Rev. 10	

	TAL AND HOSPITAL HEALTH	CARE COMPLEX IDENTIFICATION D	ATA		Provider CCN: 150177	PERIOD: FROM 01/0 TO 12/31/20		WORKSHE	ET S-2 PAR	T I
Hospit	al and Hospital Health Care Comp	lex Address:		_	I	1		I		
1	Street: 4455 EDISON LAKES PK	WY			P.O. Box:					1
	City: MISHAWAKA		State: IN	Zip Code: 46545	County: ST	. JOSEPH				2
Hospit	al and Hospital-Based Component	·								
	Component	Component Name	CCN	CBSA	Provider	Date		System (P, T	, O, or N)	
			Number	Number	Туре	Certified	V	XVIII	XIX	]
	0	1	2	3	4	5	6	7	8	
3	Hospital	UNITY MEDICAL AND SURGICAL HOSPITAL	150177	43780	1	10/31/2009	N	P	P	3
	Subprovider- IPF									4
	Subprovider- IRF									5
	Subprovider- (Other)									6
	Swing Beds-SNF									7
	Swing Beds-NF									8
	Hospital-Based SNF									9
	Hospital-Based NF									10
	Hospital-Based OLTC									11
	Hospital-Based HHA									12
	Separately Certified ASC									13
	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic- RHC									15
16	Hospital-Based Health Clinic- FQHC									16
17	Hospital-Based (CMHC, CORF and OPT)									17
18	Renal Dialysis									18
	Other									19
20	Cost Reporting Period (mm/dd/	From: 01/01/2016	To:							20
	уууу)		12/31/2016							
21	Type of control (see instructions)		6							21
Inpatie	ent PPS Information							1	2	
22		currently receiving payments for dispropor for yes or "N" for no. Is this facility subject for no.						N	N	22
22.01	Did this hospital receive interim u "N" for no for the portion of the co	ncompensated care payments for this cost rost reporting period occurring prior to Octo	ber 1. Enter i	n column 2,			N	N		22.01
22.02		g period occurring on or after October 1. (s					.,,	.,		22.02
22.02	instructions) Enter in column 1, "	at requires final uncompensated care paymer's for yes or "N" for no, for the portion of the forth and the forth an	the cost repor	ting period p			N	N		22.02
22.02		no, for the portion of the cost reporting periobic reclassification from urban to rural as			arde for dali-		N	N	N	22.03
22.03	statistical areas adopted by CMS i period prior to October 1. Enter in on or after October 1. (see instruct	n FY2015? Enter in column 1, "Y" for yes column 2, "Y" for yes or "N" for no for the cions) Does this hospital contain at least 100	or "N" for no e portion of t 0 but not mor	for the portine cost report	on of the cost ting period oc	reporting ccurring	14	14	I	22.03
	Which method is used to determine	? Enter in column 3, "Y" for yes or "N" for see Medicaid days on lines 24 and/or 25 below.	w? In colum				3	N		23
		narge. Is the method of identifying the days rting period? In column 2, enter "Y" for ye			od different f	rom the				
			_		T . ~			3.5.11		
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out- of State Medicaid paid days	Out- of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
							days	-		-
	TCALL 11 1 YERG 1 1	Control of the state of the sta	.1 1	1	2	3	4	5	6	2 .
24	in-state Medicaid eligible unpaid column 3, out-of-state Medicaid e	l, enter the in-state Medicaid paid days in c days in column 2, out-of-state Medicaid pai ligible unpaid days in column 4, Medicaid lumn 5, and other Medicaid days in columr	id days in HMO paid							24
25	Medicaid eligible unpaid days in o	e in-state Medicaid paid days in column 1, column 2, out-of-state Medicaid paid days i aid days in column 4 Medicaid HMO paid	n column 3,							25
			_		1		1			

HOSPI	TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150177	PERIOD: FROM 01/0 TO 12/31/20		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.	eriod. Enter	1				26
	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 per	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:	36
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 rule? Enter "Y" for yes or "N" for no. (see instructions)						37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscriptor the number of periods in excess of one and enter subsequent dates.	ot this line	Beginning:		Enc	ling:	38
							1
	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 ac (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)				N N	2 N	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in coloctober 1. Enter "Y" for yes or "N" for no in coloctober 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instru		discharges pri	or to	N	N	40
				V	XVIII	XIX	
	ctive Payment System (PPS)-Capital	CED 9412.20	200 /	1	2	3	4.5
	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			N N	N N	N N	45
	complete Worksheet L, Part III and L-1, Parts I through III.	CFK 9412.3	46(1)? II yes,				
	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.			N	N	N	47
48	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.			N	N	N	48
	ng Hospitals  Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for			1 N	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 E-4. If colu	cost mn 2 is "N",	N			57
	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)	N N			59 60		
		Y/N			IME	Direct	
		1	2	3	4	GME 5	
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N					61
				Y/N	IME	Direct GME	
			_	1	2	3	
	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 lefter added under section 5503 of ACA). (see instructions)	FTEs, and pri	imary care				61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determined the 75% test. (see instructions)	mining comp	pliance 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 gen	eral surgery.				61.06
		Progra	m Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
C* 12			1	2	3	4	
	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	T I
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the numbe residents for each expanded program. (see instructions) Enter in column 1 the program name column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in directGME FTE unweighted count.	ne, 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 fo	r which you	r hospital rec	eived HRSA				62
PCRE funding (see instructions)	1						62.01
62.01 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	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 period yes, complete lines 64-67. (see instructions)	? Enter "Y"	for yes or "N	I" for no. If	N			63
Section 5504 of the ACA Base Year FTE Residents in Nonprovider settingsThis base year is you or after July 1, 2009 and before June 30, 2010.	ır cost report	ing period th	at begins on	Unweighted FTEs Nonprovider Site	FTEs in	Ratio (col. 1/ (col. 1 + col. 2))	
64 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period primary care resident FTEs attributable to rotations occurring in all non-provider settings. I unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 (column 1 + column 2)). (see instructions)	Enter in colu	mn 2 the nun	nber of			D.: (1	64
	Prograi	n Name	Program Code	FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1	2	3	4	5	
65 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)							65
			ı	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	reporting pe	riods beginni	ing on or	1	2	3	
66 Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to provider settings. Enter in column 2 the number of unweighted non-primary care resident F Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instruction	TEs that trai			IV. Calaca	YY	Paris (cal	66
	Prograi	n Name	Program Code	Unweighted FTEs Nonprovider Site	FTEs in	Ratio (col. 3/ (col. 3 + col. 4))	
		1	2	3	4	5	
67 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)							67
Inpatient Psychiatric Facility PPS			-	1	2	3	
70 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider?  71 If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost re 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a ne with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column began during this cost reporting period. (see instructions)	eport filed or ew teaching	n or before N program in a	ovember ccordance	N N	N		70
Inpatient Rehabilitation Facility PPS	1.05		UNIU C				
75 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovidure 16 If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the r		-	_	N N	N		75
ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did the teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or Y, indicate which program year began during this cost reporting period. (see instructions)	his facility tr	ain residents	in a new				
Long Term Care Hospital PPS  80 Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.					N		80
81 Is this a LTCH co-located within another hospital for part or all of the cost reporting period	? Enter "Y"	for yes and "	'N" for no.		N		81
margh b 11							
TEFRA Providers							
85 Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for		113.711.0	H240 0		N		
	f)(1)(ii)? Ent			no.	N N		85 86 87

HOSP:	TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			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	
	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for ye	es or "l	N" for no in	applicable c	olumn.		N	N	90
ļ	Is this hospital reimbursed for title V and/or XIX through the cost report either in full applicable column.			* *		n the	N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see in applicable column.	structi	ons) 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? Enter "Y	Y" for	yes or "N"	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 the ap	plicab	le column.				N	N	94
95	If line 94 is "Y", enter the reduction percentage in the applicable column.					-			95
96	Does title V or title XIX reduce operating cost? Enter "Y" for yes or "N" for no in the	applic	able colum	n.			N	N	96
97	If line 96 is "Y", enter the reduction percentage in the applicable column.								97
Rural l	Providers						1	2	
105	Does this hospital qualify as a critical access hospital (CAH)?						N		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for	or 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 I for no in column 1. (see instructions) If yes, the GME elimination is notmade on Work reimbursed. If yes complete Worksheet D-2, Part II.								107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 G	CFR §	412.113(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 provided by for yes or "N" for no for each therapy.	outsio	de supplier?	Enter "Y"					109
110	Did this hospital participate in the Rural Community Hospital Demonstration project (yes or "N" for no.	(410A	Demo) for	the current c	ost reporting	period? Ente	r "Y" for	N	110
Miscel	laneous Cost Reporting Information								,
115	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yo in column 2.	es, ent	er the meth	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 "98 psychiatric, rehabilitation and long term hospitals providers) based on the definition in								
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	N" for	no.				Y		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy	is cla	im-made. E	nter 2 if the	policy is occu	irrence.	1		118
118.01	List amounts of malpractice premiums and paid losses					Premiums 102,392	Paid Losses	Self Insurance	118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Adn	ministr	ative and G	eneral? If ye	s, submit sup		N		118.02
119	schedule listing cost centers and amounts contained therein.  What is the liability limit for the malpractice insurance policy? Enter in column 1 the	monet	ary limit pe	r lawsuit. En	ter in columr	2 the			119
120	monetary limit per policy year.  Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in A	VCA 83	3121 and an	nlicable ame	endments? (se		N	N	120
120	instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with Harmless provision in ACA §3121 and applicable amendments? (see instructions) Ent	<=100	beds that o	ualifies for t	he Outpatien			11	120
121	Did this facility incur and report costs for high cost implantable devices charged to pa	tients	Enter "Y"	for yes or "N	" for no.		Y		121
122	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for	no in	column 1. I	f column 1 is	s "Y", enter i	n column 2	N		122
m	the Worksheet A line number where these taxes are included.								
	lant Center Information			1	(11/ ) 1 1			I	125
	Does this facility operate a transplant center? Enter "Y" for yes or "N" for no. If yes, e						N		125
126	If this is a Medicare certified kidney transplant center, enter the certification date in co. 2.	olumn	1 and termi	nation date,	if applicable,	in column			126
127	If this is a Medicare certified heart transplant center, enter the certification date in colu	umn 1	and termina	ation date, if	applicable, ii	column 2.			127
	If this is a Medicare certified liver transplant center, enter the certification date in colu								128
_	If this is a Medicare certified lung transplant center, enter the certification date in colu					-			129
	If this is a Medicare certified pancreas transplant center, enter the certification date in 2.								130
131	If this is a Medicare certified intestinal transplant center, enter the certification date in column 2.	colun	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 colu	ımn 1 a	and termina	tion date, if a	applicable, in	column 2.			132
	If this is a Medicare certified other transplant center, enter the certification date in column transplant center, enter the certification date in column transplant center.								133
134	If this is an organ procurement organization (OPO), enter the OPO number in column	1 and	termination	date, if app	icable, in col	umn 2.			134
	viders						l		
							1	2	
140	Are there any related organization or home office costs as defined in CMS Pub. 15-1, 1. If yes, and home office costs are claimed, enter in column 2 the home office chain relationship.				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 add	dress o	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:	1	P.O. Box:			1 validet.			142
<u> </u>	City: State		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	TI
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	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	r "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	Subprovider - IRF			N	N	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	rampus							
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	column 4, FT	E/Campus in	column 5.	166			
	Name	Соц	inty	State Zip Coo		CBSA	FTE/ Campus	
	0		1	2	3	4	5	1
								1
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	68 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets. (see instructions)							168
168.01	.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6) (ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01
169	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter instructions)	the trans	ition factor.	(see	0.25			169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period res	pectively	(mm/dd/yyy	y)	J	10/01/2015	09/30/2016	170
171	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 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	I CMS-2552-10 (09-2015) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED I	N CMS P	UB. 15-II, S	SECTION 400	04.1)			
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08-11 FORM CMS-2552-10			_	4090 (Cont.)	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX Provider CCN:	PERIOD:		WORKSHEET S	-2 Part II	
REIMBURSEMENT QUESTIONNAIRE 150177	FROM 01/01/2016 TO 12/31/2016				
General Instruction: Enter Y for all YES responses. Enter N for all NO respo					
Enter all dates in the mm/dd/yyyy format.	ises.				
COMPLETED BY ALL HOSPITALS					
		Y/N	Date		
Provider Organization and Operation		1	2		
1 Has the provider changed ownership immediately prior to the beginning of the cost repo	orting period? If ves.	N			
enter the date of the change in column 2. (see instructions)					
		Y/N	Date	V/I	$\top$
		1	2	3	7
2 Has the provider terminated participation in the Medicare Program? If yes, enter in colu	mn 2 the date of	N			
termination and in column 3, "V" for voluntary or "I" for involuntary.					
3 Is the provider involved in business transactions, including management contracts, with (e.g., chain home offices, drug or medical supply companies) that are related to the promedical staff, management personnel, or members of the board of directors through ow family and other similar relationships? (see instructions)	rider or its officers,	Y			
		Y/N	Type	Date	
Financial Data and Reports		1	2	3	
4 Column 1: Were the financial statements prepared by a Certified Public Accountant? C "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or entecolumn 3. (see instructions) If no, see instructions.	er date available in	N			
5 Are the cost report total expenses and total revenues different from those on the filed fin	nancial 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	e legal operator of the pr	rogram?	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 instructions.	cost reporting period? I	f yes, see	N		
9 Are costs claimed for Interns and Residents in approved GME programs in the current	ost report? If yes, see in	structions.	N		
Was an approved Intern and Resident GME program initiated or renewed in the current instructions.	cost reporting period? I	f yes, see	N		1
11 Are GME costs directly assigned to cost centers other than I & R in an Approved Teach instructions.	ing Program on Worksh	neet A? If yes, see	N		1
Bad Debts				Y/N	1
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 rep	orting period? If ves. su	ıbmit copy.	_	N	1
14 If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instru				N	1
Bed Complement					
15 Did total beds available change from the prior cost reporting period? If yes, see instruct	ions.			N	1
To but tour bods a amount change from the prior cost reporting period. If yes, see institute	Part A		Part B		+-
	Y/N	Date	Y/N	Date	-
PS&R Report Data	1	2	3	4	-
16 Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	05/18/2017	Y	05/18/2017	1
17 Was the cost report prepared using the PS&R Report for totals and the provider's record for allocation? If either coumn 1 or 3 is yes, enter the paid-through date in columns 2 at 4. (see instructions)			N		1
18 If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional clain that have been billed but are not included on the PS&R Report used to file the cost report fyes, see instructions.			N		1
19 If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		1
20 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	e N		N		2
21 Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		2
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CI		LS)			
<u></u>		/			
Capital Related Cost					2
•		period? If yes sen	nstructions		2
22 Have assets been relifed for Medicare purposes? If yes, see instructions.	ring the cost reporting r		mon ucuona.		2
<ul> <li>Have assets been relifed for Medicare purposes? If yes, see instructions.</li> <li>Have changes occurred in the Medicare depreciation expense due to appraisals made du</li> </ul>					
<ul> <li>Have assets been relifed for Medicare purposes? If yes, see instructions.</li> <li>Have changes occurred in the Medicare depreciation expense due to appraisals made du</li> <li>Were new leases and/or amendments to existing leases entered into during this cost report</li> </ul>	orting period? If yes, see				
<ul> <li>Have changes occurred in the Medicare depreciation expense due to appraisals made dt</li> <li>Were new leases and/or amendments to existing leases entered into during this cost rep</li> <li>Have there been new capitalized leases entered into during the cost reporting period? If</li> </ul>	orting period? If yes, see yes, see instructions.				2.
Have assets been relifed for Medicare purposes? If yes, see instructions.  Have changes occurred in the Medicare depreciation expense due to appraisals made du Were new leases and/or amendments to existing leases entered into during this cost rep Have there been new capitalized leases entered into during the cost reporting period? If Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If	orting period? If yes, see yes, see instructions.  f yes, see instructions.				2
<ul> <li>Have assets been relifed for Medicare purposes? If yes, see instructions.</li> <li>Have changes occurred in the Medicare depreciation expense due to appraisals made du</li> <li>Were new leases and/or amendments to existing leases entered into during this cost rep</li> <li>Have there been new capitalized leases entered into during the cost reporting period? If</li> </ul>	orting period? If yes, see yes, see instructions.  f yes, see instructions.				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)		
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* Cost Report Preparer Contact Information has been redacted by CMS			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA	Provider CCN: 150177	PERIOD:	WORKSHEET S-3 PART I
		FROM 01/01/2016	

												FROM 01/0 TO 12/31/2				
Component	Worksheet	No. of Beds	Bed Days	CAH Hours	Inpati	ent Days / Out	patient Visits	s / Trips	Ful	l Time Equiva	lents		Disch	narges		
	A Line No.		Available		Title V	Title XVIII		Total All Patients	Total Interns & Residents	Employees	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	
1 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col.2 for the portion of LDP room available beds)	30.00	29	10,614			354		1,140					107		326	
2 HMO and other (see instructions)						130										
3 HMO IPF Subprovider																
4 HMO IRF Subprovider																
5 Hospital Adults & Peds. Swing Bed SNF																
6 Hospital Adults & Peds.Swing Bed NF																
7 Total Adults and Peds. (exclude observation beds) (see instructions)		29	10,614			354		1,140	)							
8 Intensive Care Unit																
9 Coronary Care Unit																
10 Burn Intensive Care Unit																1
11 Surgical Intensive Care Unit																
12 Other Special Care																
13 Nursery	43.00															1
14 Total (see instructions)		29	10,614			354		1,140	)	126.12			107		326	5 .
15 CAH visits																
16 Subprovider - IPF	40.00															
17 Subprovider - IRF	41.00															
18 Subprovider - Other	42.00															
19 Skilled Nursing Facility	44.00															
20 Nursing Facility	45.00															:
21 Other Long Term Care	46.00															1
22 Home Health Agency	101.00															1
23 ASC (Distinct Part)	115.00															2
24 Hospice (Distinct Part)	116.00															1
24.10 Hospice (non-distinct part)																24.
25 CMHC	99.00															2
26 RHC/FQHC (specify)	88.00															2
27 Total (sum of lines 14-26)		29								126.12						2
28 Observation Bed Days																:
29 Ambulance Trips																2
30 Employee discount days (see instructions)																3
31 Employee discount days -IRF																3

HOSP	HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA  Provider CCN: 150177 PERIOD: WORKSHEET S-3 PART I																
	FROM 01/01/2016 TO 12/31/2016																
Compo	Component Worksheet No. of Beds Bed Days CAH Hours Inpatient Days / Outpatient Visits / Trips Full Time Equivalents 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 & delivery (see instructions)																32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)																32.01
33	LTCH non-covered days																33
FORM	CMS-2552-10 (09/2015) (INSTRUCTIONS FOR	THIS WORK	KSHEET ARI	E PUBLISHE	ED IN CMS PU	JB. 15-II, SI	ECTION 4005	.1)						,			-
40-511	-511 - 09-15 Rev. 8																

	OSPITAL WAGE INDEX INFORMATION rt II - Wage Data		Provider CCN: 150	177	PERIOD: FROM 01/01/2016 TO 12/31/2016	WORKSHEET S-3 PAR II and III		
Part II	- Wage Data							
		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in column 4	Average Hourly Wage (column 4 ÷ column 5)	
SALA	RIFS	1	2	3	4	5	6	
	Total salaries (see instructions)	200	9,646,999		9,646,999	263,348	36.63	1
	Non-physician anesthetist Part A	200	7,010,777		2,010,222	203,310	30.03	
	Non-physician anesthetist Part B							3
	Physician-Part A - Administrative							
4.01	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							(
	Interns & residents (in an approved program)  Contracted Interns & residents (in an	21						7.01
8	approved program)  Home office and/or related organization							8
	personnel							
	SNF	44						è
	Excluded area salaries (see instructions)		3,824,031		3,824,031	79,345	48.19	10
	R WAGES AND RELATED COSTS							
	Contract labor: Direct Patient Care		728,573		728,573	9,207		
	Contract labor: Top level management and other management and administrative services		155,055		155,055	849	182.63	12
	Contract labor: Physician-Part A  Home office and/or related organization							13
14.01	salaries and wage-related costs  Home office salaries		-					14.01
	Related organization salaries							14.01
	Home office: physician Part A							15.02
	Home office & Contract Physicians Part A -							16
	Teaching E-RELATED COSTS							-
	Wage-related costs (core) (see instructions)		1,236,239		1,236,239			17
	Wage-related costs (cote) (see instructions)		1,230,237		1,230,237			18
	Excluded areas		620,778		620,778			19
	Non-physician anesthetist Part A				320,			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
	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							<u> </u>
	Employee Benefits Department	4	123,474		123,474	3,864		26
	Administrative & General	5	1,674,245		1,674,245	34,578	48.42	
	Administrative & General under contract (see instructions)							28
	Maintenance & Repairs	6						29
	Operation of Plant	7	198,434		198,434	11,643	17.04	30
	Laundry & Linen Service	8					1	31
	Housekeeping Housekeeping under contract (see	9					-	33
	instructions)	10	150.150		150.100	11.000	17.00	
	Dietary	10	179,129		179,129	11,208	15.98	
	Dietary under contract (see instructions)	1.1					-	35
36	Cafeteria	11						3

HOSPI	TAL WAGE INDEX INFORMATION		Provider CCN: 150	177	PERIOD: FROM 01/01/2016 TO 12/31/2016		WORKSHEET S-3 PAI II and III	
Part II	- Wage Data							
		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in column 4	Average Hourly Wage (column 4 ÷ column 5)	
		1	2	3	4	5	6	
37	Maintenance of Personnel	12						37
38	Nursing Administration	13	564,735		564,735	14,915	37.86	38
39	Central Services and Supply	14						39
40	Pharmacy	15	375,534		375,534	7,937	47.31	40
41	Medical Records & Medical Records Library	16	176,471		176,471	5,984	29.49	41
42	Social Service	17						42
43	Other General Service	18						43
Part III	- Hospital Wage Index Summary							
1	Net salaries (see instructions)		9,646,999		9,646,999	263,348	36.63	1
2	Excluded area salaries (see instructions)		3,824,031		3,824,031	79,345	48.19	2
3	Subtotal salaries (line 1 minus line 2)		5,822,968		5,822,968	184,003	31.65	3
	Subtotal other wages and related costs (see instructions)		883,628		883,628	10,056	87.87	4
5	Subtotal wage-related costs (see instructions)		1,236,239		1,236,239			5
6	Total (sum of lines 3 through 5)		7,942,835		7,942,835	194,059	40.93	6
7	Total overhead cost (see instructions)		3,292,022		3,292,022	90,129	36.53	7
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40-513	- 11-16						Rev. 10	

[Record code 598260 - 2010]				
HOSPITAL WAGE RELATED COSTS	Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016	WORKSHEET S-3, PART IV	
Part IV - Wage Related Cost	ı		1	-
Part A - Core List				
			Amount Reported	T
RETIREMENT COST				
1 401k Employer Contributions			198,694	4 1
2 Tax Sheltered Annuity (TSA) Employer Contribut	ion			2
3 Nonqualified Defined Benefit Plan Cost (see instru				3
4 Qualified Defined Benefit Plan Cost (see instruction	ons)			
PLAN ADMINISTRATIVE COSTS (Paid to External Costs)				
5 401k/TSA Plan Administration fees	, , , , , , , , , , , , , , , , , , ,			- 5
6 Legal/Accounting/Management Fees-Pension Plan	1			1
7 Employee Managed Care Program Administration				1 7
HEALTH AND INSURANCE COST				
8 Health Insurance (Purchased or Self Funded)			1,012,960	3 (
8.01 Health Insurance (Self Funded without a Third Pa	rty Administrator)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	8.01
8.02 Health Insurance (Self Funded with a Third Party	<u>*</u>			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 beneficiar	v)			1
12 Accident Insurance (If employee is owner or bene	•			12
13 Disability Insurance (If employee is owner or bene	•			13
14 Long-Term Care Insurance (If employee is owner	• *			14
15 Workers' Compensation Insurance	,/		24,585	
16 Retirement Health Care Cost (Only current year, r	ot the extraordinary accrual required by F	ASB 106. Non cumulative portion		10
TAXES		F		ــــــــــــــــــــــــــــــــــــــ
17 FICA-Employers Portion Only			620,778	3 17
18 Medicare Taxes - Employers Portion Only			020,770	18
19 Unemployment Insurance				19
20 State or Federal Unemployment Taxes				20
OTHER			I	
21 Executive Deferred Compensation (Other Than Ro	etirement Cost Reported on lines 1 through	4 above)(see instructions)		21
22 Day Care Cost and Allowances				22
23 Tuition Reimbursement				23
24 Total Wage Related cost (Sum of lines 1 through 2	23)		1,857,017	
Part B - Other than Core Related Cost				
25 Other Wage Related Costs (specify)				25
FORM CMS-2552-10 (11/2016) (INSTRUCTIONS FO	R THIS WORKSHEET ARE PUBLISHE	D IN CMS PUB. 15-II, SECTIO	N 4005.4)	
40-514 - 11-16			Rev. 10	

HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016	WORKSHEET S-3, PART V	-
Part V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
Component		Contract Labor	Benefit Cost	
0		1	2	
1 Total facility contract labor and benefit cost		728,573	1,857,017	1
2 Hospital		728,573	1,236,239	2
3 Subprovider- IPF				3
4 Subprovider- IRF				4
5 Subprovider- (Other)				- 5
6 Swing Beds-SNF				$\epsilon$
7 Swing Beds-NF				7
8 Hospital-Based SNF				8
9 Hospital-Based NF				ç
10 Hospital-Based OLTC				10
11 Hospital-Based HHA				11
12 Separately Certified ASC				12
13 Hospital-Based Hospice				13
14 Hospital-Based Health Clinic RHC				14
15 Hospital-Based Health Clinic FQHC				15
16 Hospital-Based-CMHC				16
17 Renal Dialysis				17
18 Other			620,778	18
FORM CMS-2552-10 (09/2015) (INSTRUCTIONS FOR THIS W	VORKSHEET ARE PUBLISHEI	O IN CMS PUB. 15-II, SECTION 400	)5.5)	
40-515 - 09-15			Rev. 8	

	RECLASSIFICATION AND ADJUSTMENT OF TRIAL	ES	Provider CCN: 150177	/2016	WORKSHEET A				
CC	OST 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 0010	0 Capital Related Costs-Buildings and Fixtures		3,586,124	3,586,124	515,453	4,101,577		4,101,577	1
2 0020	0 Capital Related Costs-Movable Equipment		188,880	188,880	1,767,456	1,956,336		1,956,336	2
3 0030	Other Capital Related Costs							-0-	3
4 0040	0 Employee Benefits Department	123,474	1,904,221	2,027,695	24,585	2,052,280		2,052,280	4
5 0050	0 Administrative and General	1,674,245	7,075,444	8,749,689	756,264	9,505,953	2,431	9,508,384	:
6 0060	0 Maintenance and Repairs								
7 0070	O Operation of Plant	198,434	579,746	778,180		778,180		778,180	
8 0080	0 Laundry and Linen Service		96,377	96,377		96,377		96,377	:
9 0090	0 Housekeeping		174	174		174		174	9
10 0100	0 Dietary	179,129	53,942	233,071		233,071	-19,155	213,916	10
11 0110	0 Cafeteria								1
12 0120	0 Maintenance of Personnel								1:
13 0130	0 Nursing Administration	564,735	45,236	609,971		609,971		609,971	1
14 0140	0 Central Services and Supply								1
15 0150	0 Pharmacy	375,534	245,722	621,256		621,256		621,256	1:
16 0160	0 Medical Records & Medical Records Library	176,471	82,562	259,033		259,033	-7,814	251,219	10
17 0170	0 Social Service								1
18	Other General Service (specify)								13
19 0190	0 Nonphysician Anesthetists								1
20 0200	0 Nursing School								2
21 0210	0 Intern & Res. Service-Salary & Fringes (Approved)								2
22 0220	0 Intern & Res. Other Program Costs (Approved)								2
23 0230	0 Paramedical Ed. Program (specify)								2
	INPATIENT ROUTINE SERVICE COST CENTERS								
30 0300	O Adults and Pediatrics (General Routine Care)	1,548,627	146,625	1,695,252		1,695,252		1,695,252	3
31 0310	0 Intensive Care Unit								3
32 0320	0 Coronary Care Unit								3
33 0330	0 Burn Intensive Care Unit								3
34 0340	0 Surgical Intensive Care Unit								3
35	Other Special Care (specify)								3
40 0400									4
41 0410									4
42 0420	_								4
43 0430	1 1 2/								4
44 0440	-								4
45 0450	5 ,								4:

	RI	ECLASSIFICATION AND ADJUSTMENT OF TRIAI	L BALANCE OF EXPENS	SES P	rovider CCN: 150177		PERIOD: FROM 01/01 TO 12/31/2016	/2016	WORKSHEET A	
	COST	CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
46	04600	Other Long Term Care								46
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	618,865	583,047	1,201,912		1,201,912		1,201,912	50
51	05100	Recovery Room								51
52	05200	Labor Room and Delivery Room								52
53	05300	Anesthesiology		433,083	433,083		433,083		433,083	53
54	05400	Radiology-Diagnostic	363,454	384,995	748,449		748,449		748,449	54
55	05500	Radiology-Therapeutic								55
56	05600	Radioisotope								56
57										57
58	05800	Magnetic Resonance Imaging (MRI)								58
59	05900	Cardiac Catheterization								59
60	06000	Laboratory		348,398	348,398		348,398		348,398	60
61	06100	PBP Clinical Laboratory Services-Program Only								61
62	06200	Whole Blood & Packed Red Blood Cells								62
63	06300	Blood Storing, Processing, & Trans.								63
64	06400	Intravenous Therapy								64
65	06500	Respiratory Therapy								65
66	06600	Physical Therapy		108,509	108,509		108,509		108,509	66
67	06700	Occupational Therapy		75,360	75,360		75,360		75,360	67
68	06800	Speech Pathology								68
69	06900	Electrocardiology								69
70	07000	Electroencephalography		226,022	226,022		226,022		226,022	70
71	07100	Medical Supplies Charged to Patients		1,004,590	1,004,590		1,004,590		1,004,590	71
72	07200	Implantable Devices Charged to Patients		9,520,811	9,520,811		9,520,811		9,520,811	72
73	07300	Drugs Charged to Patients		317,529	317,529		317,529		317,529	73
74	07400	Renal Dialysis								74
75	07500	ASC (Non-Distinct Part)								75
76		Other Ancillary (specify)								76
		OUTPATIENT SERVICE COST CENTERS								
88	08800	Rural Health Clinic (RHC)								88
89	08900	Federally Qualified Health Center (FQHC)								89
90	09000	Clinic								90
91	09100	Emergency								91
92	09200	Observation Beds (Non-Distinct Part)								92
92.01	09201	Observation Beds (Distinct Part)								92.01
93		Other Outpatient Service (specify)								93
,		OTHER REIMBURSABLE COST CENTERS								
94	09400	Home Program Dialysis								94
95	09500	Ambulance Services								95

113   11300   Interest Expense   3,063,758   3,063,758   -3,063,758   -3,063,758   -0 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1		RE	CLASSIFICATION AND ADJUSTMENT OF TRIAL	BALANCE OF EXPEN	ISES	Provider CCN: 150177		PERIOD: FROM 01/01 TO 12/31/2016	WORKSHEET A		
96   0960   Durable Medical Equipment-Rented		COST	CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER			TRIAL BALANCE	ADJUSTMENTS	FOR ALLOCATION	
97   09700   Durable Medical Equipment-Sold				1	2	3	4	5	6	7	
Other Reimbursable (specify)	96	09600	Durable Medical Equipment-Rented								96
99   0   Outpatient Rehabilitation Provider (specify)   0   1000   Intern-Resident Service (not approd. tching prgm.)   0   1000   10000   Intern-Resident Service (not approd. tching prgm.)   0   0   0   0   0   0   0   0   0	97	09700	Durable Medical Equipment-Sold								97
100   10000   Intern-Resident Service (not apprd. tehng. prgm.)	98										98
1010   10100   Home Health Agency	99		Outpatient Rehabilitation Provider (specify)								99
SPECIAL PURPOSE COST CENTERS	100	10000	Intern-Resident Service (not appvd. tchng. prgm.)								100
105	101	10100	Home Health Agency								101
1060   Heart Acquisition			SPECIAL PURPOSE COST CENTERS								
1070	105	10500	Kidney Acquisition								105
108   10800   Lung Acquisition	106	10600	Heart Acquisition								106
109   10900   Pancreas Acquisition	107	10700	Liver Acquisition								107
110	108	10800	Lung Acquisition								108
111   11100   Islet Acquisition	109	10900	Pancreas Acquisition								109
Other Organ Acquisition (specify)	110	11000	Intestinal Acquisition								110
113   11300   Interest Expense   3,063,758   3,063,758   -3,063,758   -3,063,758   -0 - 1   -1   -1   -1   -1   -1   -1	111	11100	Islet Acquisition								111
114   11400   Utilization Review-SNF	112		Other Organ Acquisition (specify)								112
115   11500   Ambulatory Surgical Center (Distinct Part)	113	11300	Interest Expense		3,063,758	3,063,758	-3,063,758			- 0 -	113
1160	114	11400	Utilization Review-SNF							- 0 -	114
117	115	11500	Ambulatory Surgical Center (Distinct Part)								115
SUBTOTALS (sum of lines 1-117)   5,822,968   30,071,155   35,894,123   35,894,123   -24,538   35,869,585	116	11600	Hospice								116
NONREIMBURSABLE COST CENTERS   Separate	117		Other Special Purpose (specify)								117
190   1900   Gift, Flower, Coffee Shop, & Canteen	118		SUBTOTALS (sum of lines 1-117)	5,822,968	30,071,155	35,894,123		35,894,123	-24,538	35,869,585	118
191         19100         Research			NONREIMBURSABLE COST CENTERS								
192         19200         Physicians' Private Offices         3,761,428         1,139,711         4,901,139         4,901,139         -58,262         4,842,877           193         19300         Nonpaid Workers         62,603         58,085         120,688         120,688         120,688           194         Other Nonreimbursable (specify)         TOTAL (sum of lines 118-199)         9,646,999         31,268,951         40,915,950         -0 -         40,915,950         -82,800         40,833,150	190	19000	Gift, Flower, Coffee Shop, & Canteen								190
193         19300         Nonpaid Workers         62,603         58,085         120,688         120,688         120,688           194         Other Nonreimbursable (specify)         TOTAL (sum of lines 118-199)         9,646,999         31,268,951         40,915,950         -0 -         40,915,950         -82,800         40,833,150	191	19100	Research								191
194         Other Nonreimbursable (specify)         5         6         7         6         4         9         15         9         6         6         9         3         1         2         6         1         9         6         6         9         3         1         2         8         9         6         4         9         1         9         6         4         9         1         9         6         4         9         1         9         6         4         9         1         9         6         4         9         1         9         6         4         9         1         9         6         4         9         1         0         -         -         4         0         9         3         1         0         -         -         -         -         -         -         -         -         -         -         -         -         -         -	192	19200	Physicians' Private Offices	3,761,428	1,139,711	4,901,139		4,901,139	-58,262	4,842,877	192
200 TOTAL (sum of lines 118-199) 9,646,999 31,268,951 40,915,950 -0 - 40,915,950 -82,800 40,833,150	193	19300	Nonpaid Workers	62,603	58,085	120,688		120,688		120,688	193
	194		Other Nonreimbursable (specify)								194
ORM CMS-2552-10 (11/2016) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II. 8 4013)	200		TOTAL (sum of lines 118-199)	9,646,999	31,268,951	40,915,950	- 0 -	40,915,950	-82,800	0 40,833,150	200
order of the 2002 To (1720 To) (1720	ORM C	MS-2552-	10 (11/2016) (INSTRUCTIONS FOR THIS WORKSH	EET ARE PUBLISHED	IN CMS PUB. 15-II,	§ 4013)				•	

Cost report status - As Submitted

[Record	code	598260	- 2010]

RECLASSIFICATIONS						150177	PERIOD: FROM 01/01/2016 TO 12/31/2016	5	WORKSHEET A-6		
A - RECLASSIFY MVBLE EQUIP DEP		_									
EXPLANATION OF RECLASSIFICATION(S)	CODE		INCRE		1		DECRI			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
1 RECLASSIFY MVBLE EQUIP DEPRECIATION	A		2.00		1,750,27	79	1.00		1,750,279	9	9 1
2											3
3											
4											4
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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 su					1,750,27	9			1,750,279		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, columns 4, 5, 8, and 9 to Worksheet A, columns 4, 5, 8, and 9 to Worksheet A, columns 4, 5, 8, and 9 to Worksheet A, columns 4, 5, 8, and 9 to Worksheet A, columns 4, 5, 8, and 9 to Worksheet A, columns 4, 5, 8, and 9 to Worksheet A, columns 4, 5, 8, and 9 to Worksheet A, columns 4, 5, 8, and 9 to Worksheet A, columns 4, 5, 8, and 9 to Worksheet A, columns 4, 5, 8, and 9 to Worksheet A, columns 4, 5, 8, and 9 to Worksheet A, columns 4, 5, 8, and 9 to Worksheet A, columns 4, 5, 8, and 9 to Worksheet A, columns 4, 5, 8, and 9 to Worksheet A, columns 4, 5, 8, and 9 to Worksheet A, columns 4, 5, 8, and 9 to Worksheet A, columns 4, 5, 8, and 9 to Worksheet A, columns 4, 5, 8, 8, 8, 8, 8, 8, 8, 8, 8, 8, 8, 8, 8,											
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WO	RKSHEET ARE PU	JBLISHED IN CMS	PUB. 15-II, SECT	TON 4014)							
40-527 - 10-12									R	lev. 3	
					,		,				

RECLASSIFICATIONS						Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016		WORKSHEET A-6		
B - RECLASSIFY INTEREST EXPENS											
EXPLANATION OF RECLASSIFICATION(S)	CODE		INCRE				DECREA	ASES		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 INTEREST EXPENSE	В		1.00		2,234,057		113.00		2,234,057	11	1 1
2 RECLASSIFY INTEREST EXPENSE	В		2.00		17,177		113.00		17,177	11	1 2
3 RECLASSIFY INTEREST EXPENSE	В		5.00		812,524		113.00		812,524		3
4											4
5											5
6											6
7											7
8											8
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24											24
25											25
26											26
27											27
28											28
29											29
500 Total reclassifications (sum of columns 4 and 5 must equal					3,063,758				3,063,758		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, co											
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS W	ORKSHEET ARE P	JBLISHED IN CMS I	PUB. 15-II, SECT	ION 4014)							
40-527 - 10-12									Re	ev. 3	
									<del></del>		

[Record code 598260 - 2010] RECLASSIFICATIONS						150177	PERIOD: FROM 01/01/2016 TO 12/31/2016	i	WORKSHEET A-6		
C - RECLASSIFY INSURANCE EXPEN											
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 INSURANCE EXPENSE	C		1.00		31,675	5	5.00		31,675		12 1
2 RECLASSIFY INSURANCE EXPENSE	C		4.00		24,585	5	5.00		24,585		2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
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26											26
27											27
28											28
29											29
500 Total reclassifications (sum of columns 4 and 5 must equa					56,260	0			56,260		500
(1) A letter (A, B, etc.) must be entered on each line to identify ea											
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, c		_									
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS V	WORKSHEET ARE P	UBLISHED IN CMS I	PUB. 15-II, SECT	ION 4014)							
40-527 - 10-12									R	Rev. 3	

[Record code 598260 - 2010] RECONCILIATION OF CAPITAL COSTS CENTER.	S			Provider CCN	: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016		WORKSHEET A-7, PARTS I, & III	
PART I - ANALYSIS OF CHANGES IN CAPITAL A	SSET BALANCI	ES		,					
Description		Beginning Balances	Purchases	Acquisitions Donation	Total	Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		1	2	3	4	5	6	7	
1 Land			3,985		3,985		3,985		
2 Land Improvements									
3 Buildings and Fixtures		14,379,799				14,379,799			
4 Building Improvements		810,770	52,306		52,306	2,799	860,277		
5 Fixed Equipment		535,815	33,369		33,369		569,184	441,392	
6 Movable Equipment		14,052,202	374,071		374,071	274,054	14,152,219	7,912,049	
7 HIT-designated Assets									
8 Subtotal (sum of lines 1-7)		29,778,586	463,731		463,731	14,656,652	15,585,665	8,353,441	
9 Reconciling Items 10 Total (line 7 minus line 9)		29,778,586	463,731		463,731	14,656,652	15,585,665	8,353,441	1
PART II - RECONCILIATION OF AMOUNTS FROM	M WORKSHEET	A, COLUMN	2, LINES 1 AI	ND 2	Į.		J.		
Description				SUMN	MARY OF CA	PITAL			
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital- Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		9	10	11	12	13	14	15	
1 Capital Related Costs-Buildings and Fixtures		2,296,156	1,169,968			120,000		3,586,124	_
2 Capital Related Costs-Movable Equipment						188,880		188,880	
3 Total (sum of lines 1-2)		2,296,156	1,169,968			308,880		3,775,004	
(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. Description	et A, column 2, lin		l lines numbers	s are to be cons	istent with Wo		numbers for c	apital cost cente	rs.
	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital- Related Costs	Total (sum of cols. 5 through 7)	
	1	2	3	4	5	6	7	8	_
1 Capital Related Costs-Buildings and Fixtures	1,429,461		1,429,461						
2 Capital Related Costs-Movable Equipment	14,152,219	3,463,427	10,688,792						
3 Total (sum of lines 1-2)	15,581,680	3,463,427	12,118,253	1.000000					
Description				SUMN	MARY OF CA	PITAL			
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital- Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		9	10	11	12	13	14	15	
1 Capital Related Costs-Buildings and Fixtures		545,877	1,169,968	2,234,057	31,675	120,000		4,101,577	
2 Capital Related Costs-Movable Equipment		1,750,279		17,177		188,880		1,956,336	
3 Total (sum of lines 1-2)		2,296,156	1,169,968	2,251,234	31,675	308,880		6,057,913	
(2) The amounts on lines 1 and 2 must equal the corres							nclude related	Worksheet A-6	
									_
reclassifications, Worksheet A-8 adjustments, and Wor FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FO									_

[Record code 598260 - 2010]  ADJUSTMENTS TO EX	PENSES Provider CCN: 150	0177	PERIOD: FROM 01/01/2016 TO 12/31/2016	WORKSHEET A-8		
DESCRIPTION (1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATI WORKSHEET A TO/FROM THE AMOUNT IS TO BE AI	WHICH DJUSTED	Wkst. A-7 Ref.	
			COST CENTER	LINE #	_	-
1 Investment income - buildings and (chapter 2)	d fixtures	2	3 Buildings and Fixtures	4	5	1
2 Investment income - movable equ (chapter 2)	ipment		Movable Equipment	2		2
3 Investment income - other (chapte	er 2) B	-2,888	ADMINISTRATIVE & GENERAL	5.00		3
4 Trade, quantity, and time discount (chapter 8)		1,694	ADMINISTRATIVE & GENERAL	5.00		4
5 Refunds and rebates of expenses (8)	chapter A	-5,194	4 ADMINISTRATIVE & GENERAL	5.00		
6 Rental of provider space by supple (chapter 8) 7 Telephone services (pay stations e						1
(chapter 21)  8 Television and radio service (chapter 21)	oter 21)					1
9 Parking lot (chapter 21)						Ģ
10 Provider-based physician adjustm	ent Worksheet A-8-2					10
11 Sale of scrap, waste, etc. (chapter						11
12 Related organization transactions 10)	(chapter Worksheet A-8-1					12
13 Laundry and linen service						13
14 Cafeteria-employees and guests	В	-19,155	DIETARY	10.00		14
15 Rental of quarters to employee and	d others					15
16 Sale of medical and surgical supplet other than patients	lies to					10
17 Sale of drugs to other than patient	S					17
18 Sale of medical records and abstra	acts B	-7,814	MEDICAL RECORDS & LIBRARY	16.00		18
19 Nursing school (tuition, fees, bool	ks, etc.)					19
20 Vending machines						20
21 Income from imposition of interest finance or penalty charges (chapter	st, er 21)					21
22 Interest expense on Medicare overpayments and borrowings to a Medicare overpayments						22
Adjustment for respiratory therapy excess of limitation (chapter 14)	y costs in Worksheet A-8-3		Respiratory Therapy	65		23
Adjustment for physical therapy c excess of limitation (chapter 14)	osts in Worksheet A-8-3		Physical Therapy	66		24
25 Utilization review - physicians' compensation (chapter 21)			Utilization Review - SNF	114		25
26 Depreciation - buildings and fixtu			Buildings and Fixtures	1		20
27 Depreciation - movable equipmen	t		Movable Equipment	2		27
28 Non-physician Anesthetist			Nonphysician Anesthetist	19		28
29 Physicians' assistant 30 Adjustment for occupational thera			Occupational Therapy	67		30
in excess of limitation (chapter 14 30.99 Hospice (non-distinct) (see intruct			Adults and Pediatrics	20		20.00
31 Adjustment for speech pathology excess of limitation (chapter 14)			Speech Pathology	68		30.99
32 CAH HIT Adjustment for Deprecand Interest	iation					32
33 Other adjustments (specify) (3)						33
33.01 G&A BAD DEBT EXPENSES	A	98,592	ADMINISTRATIVE & GENERAL	5.00		33.0
33.02 PHYSICIAN OFFICES BAD DE EXPENSES	BT A	-58,262	PHYSICIANS PRIVATE OFFICES	192.00		33.02
33.03 PENALTIES & SETTLEMENTS	A	-6,276	ADMINISTRATIVE & GENERAL	5.00		33.03
33.04 CHARITABLE CONTRIBUTION	NS A	-34,125	ADMINISTRATIVE & GENERAL	5.00		33.04
33.05 AMORTIZATION OF INTANGI	BLES A	-49,372	ADMINISTRATIVE & GENERAL	5.00		33.05
34						34
35						3:
36						30
37						3′

	ADJUSTMENTS TO EXPENSES	Provider CCN: 15	0177	PERIOD: FROM 01/01/2016 TO 12/31/2016	WORKSHEET A-8	
38						38
39						39
40						40
41						41
42						42
43						43
44						44
45						45
46						46
47						47
48						48
49						49
	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200)		-82,800			50
(1) Des	scription - all chapter references in this colu	nn pertain to CMS	S Pub. 15-1		'	
A. Cos	is for adjustment (see instructions) ts - if cost, including applicable overhead, c ount Received - if cost cannot be determined					
(3) Ad	ditional adjustments may be made on lines 3	3 thru 49 and subs	scripts thereof.			
Note: S	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. 15-1	II, SECTION 4016)	

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COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 150177		]	PERIOD: FROM 01/01/2016 TO 12/31/2016			WORKSHEET B, PART I		
COST CENTER DESCRIPTIONS	NET EXPENSES FOR COST ALLOCATION (from Wkst. A col. 7)	CAPITAL 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	4,101,577	4,101,577								1	
2 Capital Related Costs-Movable Equipment	1,956,336		1,956,336							2	
4 Employee Benefits Department	2,052,280	44,755	21,347	2,118,382						4	
5 Administrative and General	9,508,384	563,576	268,810	372,414	10,713,184	10,713,184				5	
6 Maintenance and Repairs										6	
7 Operation of Plant	778,180	245,322	117,011	44,139	1,184,652	421,362		1,606,014		7	
8 Laundry and Linen Service	96,377				96,377	34,280			130,657	8	
9 Housekeeping	174	56,358	26,881		83,413	29,669		27,867		9	
10 Dietary	213,916	43,429	20,714	39,845	317,904	113,073		21,474		10	
11 Cafeteria		39,782	18,975		58,757	20,899		19,671		11	
12 Maintenance of Personnel										12	
13 Nursing Administration	609,971	9,548	4,554	125,618	749,691	266,653		4,721		13	
14 Central Services and Supply		39,782	18,975		58,757	20,899		19,671		14	
15 Pharmacy	621,256	56,358	26,881	83,533	788,028	280,289		27,867		15	
16 Medical Records & Medical Records Library	251,219	29,836	14,231	39,254	334,540	118,991		14,753		16	
17 Social Service		9,548	4,554		14,102	5,016		4,721		17	
18 Other General Service (specify)										18	
19 Nonphysician Anesthetists										19	
20 Nursing School										20	
21 Intern & Res. Service-Salary & Fringes (Approved)										21	
22 Intern & Res. Other Program Costs (Approved)										22	
23 Paramedical Education Program (specify)										23	
INPATIENT ROUTINE SERVICE COST CENTERS											
30 Adults and Pediatrics (General Routine Care)	1,695,252	401,863	191,677	344,472	2,633,264	936,610		198,711	130,657	30	
31 Intensive Care Unit				·		·			·	31	
32 Coronary Care Unit										32	
33 Burn Intensive Care Unit										33	
34 Surgical Intensive Care Unit										34	
35 Other Special Care Unit (specify)										35	
40 Subprovider IPF										40	
41 Subprovider IRF										41	
42 Subprovider (specify)										42	
43 Nursery										43	
44 Skilled Nursing Facility										44	

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 150	1177		PERIOD: WORKSHEET B, PART I FROM 01/01/2016 TO 12/31/2016				
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	1,201,912	377,928	180,261	137,658	1,897,759	675,003	3	186,875	5	50
51 Recovery Room										51
52 Labor Room and Delivery Room										52
53 Anesthesiology	433,083	1,658	791		435,532	154,912	2	820	)	53
54 Radiology-Diagnostic	748,449	251,952	120,174	80,846	1,201,421	427,326	5	124,584	1	54
55 Radiology-Therapeutic										55
56 Radioisotope										56
57 Computed Tomography (CT) Scan										57
58 Magnetic Resonance Imaging (MRI)										58
59 Cardiac Catheterization										59
60 Laboratory	348,398	10,542	5,028		363,968	129,458	3	5,213	3	60
61 PBP Clinical Laboratory Services-Program Only										61
62 Whole Blood & Packed Red Blood Cells										62
63 Blood Storing, Processing, & Trans.										63
64 Intravenous Therapy										64
65 Respiratory Therapy										65
66 Physical Therapy	108,509	5,967	2,846		117,322	2 41,730	)	2,951	1	66
67 Occupational Therapy	75,360	2,652	1,265		79,277	7 28,198	3	1,311	1	67
68 Speech Pathology										68
69 Electrocardiology										69
70 Electroencephalography	226,022	74,193	35,388		335,603	3 119,369		36,687	7	70
71 Medical Supplies Charged to Patients	1,004,590	1,658	791		1,007,039	358,188	3	820	)	71
72 Implantable Devices Charged to Patients	9,520,811	<u> </u>			9,520,811					72
73 Drugs Charged to Patients	317,529	2,652	1,265		321,446			1,311	1	73
74 Renal Dialysis	1		,		, -	,				74
75 ASC (Non-Distinct Part)										75
76 Other Ancillary (specify)										76
OUTPATIENT SERVICE COST CENTERS										
88 Rural Health Clinic (RHC)										88
89 Federally Qualified Health Center (FQHC)										89
90 Clinic										90
91 Emergency										91
92 Observation Beds (Non-Distinct Part)										92
92.01 Observation Beds (Distinct Part)										92.01

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 150	)177		PERIOD: FROM 01/01/2016 TO 12/31/2016			WORKSHEET B, PART I		
COST CENTER DESCRIPTIONS	NET EXPENSES	CAPITAL REI	ATED COSTS	EMPLOYEE	SUBTOTAL	ADMINISTRATIVE	MAINTENANCE	OPERATION	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)	35,869,585	2,269,359	1,082,419	1,267,779	32,312,847	7,682,648		700,028	130,657	118	
NONREIMBURSABLE COST CENTERS	20,000,000	_,,	3,002,103	3,201,111	0 = ,0 = = ,0	1,,,			200,007		
190 Gift, Flower, Coffee Shop, & Canteen										190	
191 Research										191	
192 Physicians' Private Offices	4,842,877	1,832,218	873,917	836,678	8,385,690	2,982,656		905,986		192	
193 Nonpaid Workers	120,688	,,,,,		13,925	134,613					193	
194 Other Nonreimbursable (specify)	===,000			,>20		17,000				194	
200 Cross Foot Adjustments										200	
201 Negative Cost Centers										201	
202 TOTAL (sum lines 118-201)	40,833,150	4,101,577	1,956,336	2,118,382	40,833,150	0 10,713,184		1,606,014	130,657	202	
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR T					10,033,130	10,713,104	1	1,000,014	150,057		
40-535 - 09-13			. 5.1.5 1 OB. 15-II	,					Rev. 4		

COST ALLOCATION - GENERAL SERVICE COSTS				0177		PERIOD: FROM 01/01/2016 TO 12/31/2016		WORKSHEET B, PART I		
COST CENTER DESCRIPTIONS	HOUSE- KEEPING	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
	9	10	11	12	13	14	15	16	17	
GENERAL SERVICE COST CENTERS										
1 Capital Related Costs-Buildings and Fixtures										1
2 Capital Related Costs-Movable Equipment										2
4 Employee Benefits Department										4
5 Administrative and General										5
6 Maintenance and Repairs										6
7 Operation of Plant										7
8 Laundry and Linen Service										8
9 Housekeeping	140,949									9
10 Dietary	1,918	454,369								10
11 Cafeteria	1,757	217,475	318,559							11
12 Maintenance of Personnel										12
13 Nursing Administration	422		38,713	3	1,060,200					13
14 Central Services and Supply	1,757					101,084				14
15 Pharmacy	2,489		20,625	1			1,119,298			15
16 Medical Records & Medical Records Library	1,318		15,550					485,152		16
17 Social Service	422								24,261	17
18 Other General Service (specify)										18
19 Nonphysician Anesthetists										19
20 Nursing School										20
21 Intern & Res. Service-Salary & Fringes (Approved)										21
22 Intern & Res. Other Program Costs (Approved)										22
23 Paramedical Education Program (specify)										23
INPATIENT ROUTINE SERVICE COST CENTERS										
30 Adults and Pediatrics (General Routine Care)	17,747	135,064	149,237	,	1,060,200	101,084		485,152	24,261	30
31 Intensive Care Unit										31
32 Coronary Care Unit										32
33 Burn Intensive Care Unit										33
34 Surgical Intensive Care Unit										34
35 Other Special Care Unit (specify)										35
40 Subprovider IPF										40
41 Subprovider IRF										41
42 Subprovider (specify)										42
43 Nursery										43
44 Skilled Nursing Facility										44
45 Nursing Facility										45
46 Other Long Term Care										46

COST ALLOCATION - GENERAL SERVICE COSTS			F T			PERIOD: FROM 01/01/2016 TO 12/31/2016	WORKSHEET B, PART I			
COST CENTER DESCRIPTIONS	HOUSE- KEEPING	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
	9	10	11	12	13	14	15	16	17	
ANCILLARY SERVICE COST CENTERS										
50 Operating Room	16,690		63,49	96						50
51 Recovery Room										51
52 Labor Room and Delivery Room										52
53 Anesthesiology	73									53
54 Radiology-Diagnostic	11,127		30,93	88						54
55 Radiology-Therapeutic										55
56 Radioisotope										56
57 Computed Tomography (CT) Scan										57
58 Magnetic Resonance Imaging (MRI)										58
59 Cardiac Catheterization										59
60 Laboratory	466									60
61 PBP Clinical Laboratory Services-Program Only										61
62 Whole Blood & Packed Red Blood Cells										62
63 Blood Storing, Processing, & Trans.										63
64 Intravenous Therapy										64
65 Respiratory Therapy										65
66 Physical Therapy	264									66
67 Occupational Therapy	117									67
68 Speech Pathology										68
69 Electrocardiology										69
70 Electroencephalography	3,277									70
71 Medical Supplies Charged to Patients	73									71
72 Implantable Devices Charged to Patients										72
73 Drugs Charged to Patients	117						1,119,298	3		73
74 Renal Dialysis										74
75 ASC (Non-Distinct Part)										75
76 Other Ancillary (specify)										76
OUTPATIENT SERVICE COST CENTERS										
88 Rural Health Clinic (RHC)										88
89 Federally Qualified Health Center (FQHC)										89
90 Clinic										90
91 Emergency										91
92 Observation Beds (Non-Distinct Part)										92
92.01 Observation Beds (Distinct Part)										92.01
93 Other Outpatient Service (specify)										93
OTHER REIMBURSABLE COST CENTERS										
94 Home Program Dialysis										94
95 Ambulance Services										95

OST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15	50177		PERIOD: FROM 01/01/2016 TO 12/31/2016		WORKSHEET B, PART I			
COST CENTER DESCRIPTIONS	HOUSE- KEEPING	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
	9	10	11	12	13	14	15	16	17	
96 Durable Medical Equipment-Rented										96
97 Durable Medical Equipment-Sold										97
98 Other Reimbursable (specify)										98
99 Outpatient Rehabilitation Provider (specify)										99
100 Intern-Resident Service (not appvd. tchng. prgm.)										100
101 Home Health Agency										101
SPECIAL PURPOSE COST CENTERS										
105 Kidney Acquisition										105
106 Heart Acquisition										106
107 Liver Acquisition										107
108 Lung Acquisition										108
109 Pancreas Acquisition										109
110 Intestinal Acquisition										110
111 Islet Acquisition										111
112 Other Organ Acquisition (specify)										112
115 Ambulatory Surgical Center (Distinct Part)										115
116 Hospice										116
117 Other Special Purpose (specify)										117
118 SUBTOTALS (sum of lines 1-117)	60,034	352,539	318,55	9	1,060,200	101,084	1,119,298	485,152	24,261	118
NONREIMBURSABLE COST CENTERS										
190 Gift, Flower, Coffee Shop, & Canteen		101,830								190
191 Research										191
192 Physicians' Private Offices	80,915									192
193 Nonpaid Workers										193
194 Other Nonreimbursable (specify)										194
200 Cross Foot Adjustments										200
201 Negative Cost Centers										201
202 TOTAL (sum lines 118-201)	140,949	454,369	318,55	9	1,060,200	101,084	1,119,298	485,152	24,261	202
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR TH	IIS WORKSHEET AI	RE PUBLISHED I	N CMS PUB. 15-I	I, SECTION 4020)		1	1			
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COST ALLOCATION - GENERAL SERVICE COSTS						PERIOD: FROM 01/01/2016 TO 12/31/2016		WORKSHEET B, PART I		
COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE	NON- PHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY AND FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARAMEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
	18	19	20	21	22	23	24	25	26	
GENERAL SERVICE COST CENTERS										
1 Capital Related Costs-Buildings and Fixtures										1
2 Capital Related Costs-Movable Equipment										2
4 Employee Benefits Department										4
5 Administrative and General										5
6 Maintenance and Repairs										6
7 Operation of Plant										7
8 Laundry and Linen Service										8
9 Housekeeping										9
10 Dietary										10
11 Cafeteria										11
12 Maintenance of Personnel										12
13 Nursing Administration										13
14 Central Services and Supply										14
15 Pharmacy										15
16 Medical Records & Medical Records Library										16
17 Social Service										17
18 Other General Service (specify)										18
19 Nonphysician Anesthetists										19
20 Nursing School										20
21 Intern & Res. Service-Salary & Fringes (Approved)										21
22 Intern & Res. Other Program Costs (Approved)										22
23 Paramedical Education Program (specify)										23
INPATIENT ROUTINE SERVICE COST CENTERS										
30 Adults and Pediatrics (General Routine Care)							5,871,987		5,871,987	30
31 Intensive Care Unit										31
32 Coronary Care Unit										32
33 Burn Intensive Care Unit										33
34 Surgical Intensive Care Unit										34
35 Other Special Care Unit (specify)										35
40 Subprovider IPF										40
41 Subprovider IRF										41
42 Subprovider (specify)										42
43 Nursery										43
44 Skilled Nursing Facility										44

COST CENTER DESCRIPTIONS	COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 150177			PERIOD: FROM 01/01/2016 TO 12/31/2016	WORKSHEET B, PART I			
4.5   April	COST CENTER DESCRIPTIONS	GENERAL	PHYSICIAN	SCHOOL	RESIDENTS SALARY AND	RESIDENTS PROGRAM		SUBTOTAL	RESIDENT COST & POST STEPDOWN	TOTAL	
46 Ober Long Tem Care  \$50 Operating Brown \$51 Recovery Room \$52 Recovery Room \$52 Labor Room and Delivery Room \$53 Associated Playments \$54 Recovery Room \$55 Associated Playments \$55 Associated Playments \$55 Associated Playments \$55 Recovery Room \$55 Computed Temperative \$55 Recovery Room \$55 Room \$55 Recovery Room \$55 Recovery Room \$55 Recovery Room \$55 Room \$55 Recovery Room \$55 Room		18	19	20	21	22	23	24	25	26	
ANCILLARY SERVICE COST CENTERS  50 Operating Room 51 Recovery Room 52 Assemble Service Program 53 Assemble Service Program Service Program Only 54 Radiology-Theraportic 55 Radiology-Theraportic 56 Radiology-Theraportic 57 Compared Tomography (CT) Sun 58 Radiology-Theraportic 58 Radiology-Theraportic 59 Radiology-Theraportic 50 Radiology-Theraport 50 Radiology-Theraportic 50 Radiology-Theraport	45 Nursing Facility										
SO Operating Room   2,839,823   2,839,823   50	46 Other Long Term Care										46
S1   Recovery Room	ANCILLARY SERVICE COST CENTERS										
Section 2   Section 2   Section 3   Sect	50 Operating Room							2,839,823		2,839,823	50
53 Anesthesiology   591,337   591,	51 Recovery Room										
5.5   Radiology-Dagnostic   1,795,396   1,795,396   54	52 Labor Room and Delivery Room										52
55 RadioisotyPhenpatric	53 Anesthesiology							591,337		591,337	
56   Radioisotope	54 Radiology-Diagnostic							1,795,396		1,795,396	54
57   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
Sp   Cardiac Catheterization   Sp   Go   Laboratory   Sp   Go   Laboratory   Sp   Go   Laboratory   Sp   Go   Laboratory   Sp   Go   Catheterization   Sp   Go   Go   Go   Go   Go   Go   Go   G	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 [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 [Soc. District Party 76 [Other Ancillary (specify) 76 [Other Ancillary (specify) 77 [Seed and Content of Patients 77 [Seed and Content of Patients 78 [Seed Pathology 79 [Seed Patients 79 [Seed Patients 70 [Seed Patients 70 [Seed Patients 71 [Seed Patients 72 [Implantable Devices Charged to Patients 73 [Drugs Charged to Patients 74 [Renal Dialysis 75 [Seed Patients 76 [Seed Patients 77 [Seed Patients 77 [Seed Patients 77 [Seed Patients 78 [Seed Patients 79 [Seed Patients 79 [Seed Patients 70 [Seed Patients 70 [Seed Patients 70 [Seed Patients 71 [Seed Patients 72 [Seed Patients 73 [Seed Patients 74 [Seed Patients 75 [Seed Patients	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 Respiratory Therapy 66 Pspecial Therapy 67 Occupational Therapy 68 Speech Pathology 69 Cecupational 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 ASC (Non-Distinct Part) 76 Other Ancillary (specify) 77 Other Ancillary (specify) 78 Renal Pathol Center (FQHC) 79 Courage of Path Center (FQHC) 79 Courage of Path Center (FQHC) 79 Courage of Patient (FQHC) 70 Derevation Beds (Non-Distinct Part) 70 Description Beds (Non-Distinct Part) 71 Demography 72 Demography 73 Description Beds (Non-Distinct Part) 74 Renal Dialysis 75 Page Charged (Patient Part) 76 Dother Ancillary (specify) 77 Demography 78 Demography 79 Demography 70 Demography 70 Demography 71 Demography 71 Demography 72 Demography 73 Demography 74 Demography 75 Demography 76 Dother Ancillary (specify) 77 Demography 78 Demography 79 Demography 79 Demography 70 Demography 70 Description Beds (Non-Distinct Part) 70 Demography 71 Demography 72 Description Beds (Non-Distinct Part) 73 Demography 74 Demography 75 Demography 76 Description Beds (Non-Distinct Part) 76 Demography 77 Demography 78 Description Beds (Non-Distinct Part) 79 Demography 70 Description Beds (Non-Distinct Part) 70 Demography 71 Demography 72 Description Beds (Non-Distinct Part) 75 Demography 76 Description Beds (Non-Distinct Part) 77 Demography 78 Description Beds (Non-Distinct Part) 79 Demography 70 Description Beds (Non-Distinct Part) 70 Description Beds (Non-Distinct Part) 70 Description Beds (Non-Distinct Part) 71 Description Description Beds (Non-Distinct Part) 75 Description Beds (Non-Distinct Part) 75 Description Description Beds (Non-Distinct Part) 75 Description	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 Electrocneephalography 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) 76 OUTPATIENT SERVICE COST CENTERS 77 Red Pathy Control of the Pathy C	60 Laboratory							499,105		499,105	60
63 Blood Storing, Processing, & Trans.	61 PBP Clinical Laboratory Services-Program Only										61
64 Intravenous Therapy   64     65 Respiratory Therapy   66     66 Physical Therapy   67     66 Physical Therapy   68     67 Occupational Therapy   68     68 Speech Pathology   68     69 Electrocardiology   69     70 Electrocardiology   69     71 Medical Supplies Charged to Patients   1,366,120   1,366,120   71     72 Implantable Devices Charged to Patients   1,2907,201   12,907,201   72     73 Drugs Charged to Patients   1,556,505   1,556,505   73     74 Renal Dialysis   75     75 ASC (Non-Distinet Part)   75     76 Other Ancillary (specify)   76     77 Other Tierry Erevice CoST CENTER   78     88 Rural Health Clinic (RHC)   89     90 Clinic   90     90 Clinic   90     90 Clinic   90     90 Clinic   90     90 Closervation Beds (Non-Distinct Part)   90     90 Closervation Beds (Non-D	62 Whole Blood & Packed Red Blood Cells										62
65   Respiratory Therapy	63 Blood Storing, Processing, & Trans.										63
66   Physical Therapy   162,267   162,267   66	64 Intravenous Therapy										64
67   Occupational Therapy   108,903   108,903   67	65 Respiratory Therapy										65
68   Speech Pathology   68   69   69   69   69   69   69   69	66 Physical Therapy							162,267		162,267	66
69   Electroencephalography   69   69   70   Electroencephalography   69   494,936   494,936   70   71   Medical Supplies Charged to Patients   1,366,120   1,366,120   71   72   Implantable Devices Charged to Patients   12,907,201   12,907,201   72   73   Drugs Charged to Patients   1,556,505   73   74   Renal Dialysis   1,556,505   73   74   Renal Dialysis   74   Renal Dialysis   75   Other Ancillary (specify)   76   76   76   76   76   76   76   7	67 Occupational Therapy							108,903		108,903	67
To   Electroencephalography   494,936   494,936   70	68 Speech Pathology										68
71   Medical Supplies Charged to Patients   1,366,120   1,366,120   71     72   Implantable Devices Charged to Patients   12,907,201   12,907,201   72     73   Drugs Charged to Patients   1,556,505   1,556,505   73     74   Renal Dialysis   1,556,505   1,556,505   73     75   ASC (Non-Distinct Part)   75     76   Other Ancillary (specify)   76     77   OUTPATIENT SERVICE COST CENTERS   88   Rural Health Clinic (RHC)   88     89   Federally Qualified Health Center (FQHC)   90     90   Clinic   90     91   Emergency   91     92   Observation Beds (Non-Distinct Part)   92	69 Electrocardiology										69
71   Medical Supplies Charged to Patients   1,366,120   1,366,120   71     72   Implantable Devices Charged to Patients   12,907,201   12,907,201   72     73   Drugs Charged to Patients   1,556,505   1,556,505   73     74   Renal Dialysis   1,556,505   1,556,505   73     75   ASC (Non-Distinct Part)   75     76   Other Ancillary (specify)   76     77   OUTPATIENT SERVICE COST CENTERS   88   Rural Health Clinic (RHC)   88     89   Federally Qualified Health Center (FQHC)   90     90   Clinic   90     91   Emergency   91     92   Observation Beds (Non-Distinct Part)   92	70 Electroencephalography							494,936		494,936	70
72 Implantable Devices Charged to Patients       12,907,201       12,907,201       72         73 Drugs Charged to Patients       1,556,505       1,556,505       73         74 Renal Dialysis       74         75 ASC (Non-Distinct Part)       75         76 Other Ancillary (specify)       76         OUTPATIENT SERVICE COST CENTERS       88         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								1,366,120		1,366,120	
73 Drugs Charged to Patients       1,556,505       1,556,505       73         74 Renal Dialysis       74         75 ASC (Non-Distinct Part)       75         76 Other Ancillary (specify)       76         OUTPATIENT SERVICE COST CENTERS       88         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								12,907,201			
74 Renal Dialysis       5 ASC (Non-Distinct Part)       75         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       90         91 Emergency       91         92 Observation Beds (Non-Distinct Part)       92										1,556,505	
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       90         91       Emergency       91         92       Observation Beds (Non-Distinct Part)       92											
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         90           91 Emergency         91           92 Observation Beds (Non-Distinct Part)         92											
OUTPATIENT SERVICE COST CENTERS         88           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	76 Other Ancillary (specify)										
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											
89 Federally Qualified Health Center (FQHC)       89         90 Clinic       90         91 Emergency       91         92 Observation Beds (Non-Distinct Part)       92											88
90 Clinic         90           91 Emergency         91           92 Observation Beds (Non-Distinct Part)         92	` '	+									
91 Emergency         91           92 Observation Beds (Non-Distinct Part)         92		+									
92 Observation Beds (Non-Distinct Part) 92		1									
72.01   Obbertation Dead (Distinct Late)   72.01	92.01 Observation Beds (Distinct Part)										92.01

COST ALLOCATION - GENERAL SERVICE COSTS	Provider CCN: 150177					PERIOD: FROM 01/01/2016 TO 12/31/2016		WORKSHEET B, PART I		
COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE	NON- PHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY AND FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARAMEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
	18	19	20	21	22	23	24	25	26	
93 Other Outpatient Service (specify)										93
OTHER REIMBURSABLE COST CENTERS										
94 Home Program Dialysis										94
95 Ambulance Services										95
96 Durable Medical Equipment-Rented										96
97 Durable Medical Equipment-Sold										97
98 Other Reimbursable (specify)										98
99 Outpatient Rehabilitation Provider (specify)										99
100 Intern-Resident Service (not appvd. tchng. prgm.)										100
101 Home Health Agency										101
SPECIAL PURPOSE COST CENTERS										
105 Kidney Acquisition										105
106 Heart Acquisition										106
107 Liver Acquisition										107
108 Lung Acquisition										108
109 Pancreas Acquisition										109
110 Intestinal Acquisition										110
111 Islet Acquisition										111
112 Other Organ Acquisition (specify)										112
115 Ambulatory Surgical Center (Distinct Part)										115
116 Hospice										116
117 Other Special Purpose (specify)										117
118 SUBTOTALS (sum of lines 1-117)							28,193,580	)	28,193,580	118
NONREIMBURSABLE COST CENTERS									=0,570,000	
190 Gift, Flower, Coffee Shop, & Canteen							101,830		101,830	190
191 Research									222,000	191
192 Physicians' Private Offices							12,355,247	1	12,355,247	192
193 Nonpaid Workers							182,493		182,493	193
194 Other Nonreimbursable (specify)							102,170		102,.95	194
200 Cross Foot Adjustments										200
201 Negative Cost Centers										201
202 TOTAL (sum lines 118-201)							40,833,150		40,833,150	
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR TH	IS WORKSHEET	ARE PUBLISHED IN	CMS PUB. 15-II	SECTION 4020)	<u> </u>		.0,035,130		.0,055,150	
40-535 - 09-13				,				1	Rev. 4	
.0 000 07 10										

ALLOCATION OF CAPITAL-RELATED COSTS		Provider CCN: 150177			PERIOD: FROM 01/01/2016 TO 12/31/2016			WORKSHEET B, PART II		
COST CENTER DESCRIPTIONS	DIRECTLY	CAPITAL RELATED 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	
GENERAL SERVICE COST CENTERS										
1 Capital Related Costs-Buildings and Fixtures										1
2 Capital Related Costs-Movable Equipment										2
4 Employee Benefits Department		44,755	21,347	66,102	66,102					4
5 Administrative and General		563,576	268,810	832,386	11,621	844,00	7			5
6 Maintenance and Repairs										6
7 Operation of Plant		245,322	117,011	362,333	1,377	33,19	6	396,906		7
8 Laundry and Linen Service						2,70	1		2,701	8
9 Housekeeping		56,358	26,881	83,239		2,33	7	6,887		9
10 Dietary		43,429	20,714	64,143	1,243	8,90	8	5,307		10
11 Cafeteria		39,782	18,975	58,757		1,64	6	4,861		11
12 Maintenance of Personnel										12
13 Nursing Administration		9,548	4,554	14,102	3,920	21,00	8	1,167		13
14 Central Services and Supply		39,782	18,975	58,757		1,64	6	4,861		14
15 Pharmacy		56,358	26,881	83,239	2,607	22,08	2	6,887		15
16 Medical Records & Medical Records Library		29,836	14,231	44,067	1,225	9,37	4	3,646		16
17 Social Service		9,548	4,554	14,102		39:	5	1,167		17
18 Other General Service (specify)										18
19 Nonphysician Anesthetists										19
20 Nursing School										20
21 Intern & Res. Service-Salary & Fringes (Approved)										21
22 Intern & Res. Other Program Costs (Approved)										22
23 Paramedical Education Program (specify)										23
INPATIENT ROUTINE SERVICE COST CENTERS										
30 Adults and Pediatrics (General Routine Care)		401,863	191,677	593,540	10,749	73,789	9	49,109	2,701	30
31 Intensive Care Unit										31
32 Coronary Care Unit										32
33 Burn Intensive Care Unit										33
34 Surgical Intensive Care Unit							1			34
35 Other Special Care Unit (specify)										35
40 Subprovider IPF										40
41 Subprovider IRF										41
42 Subprovider (specify)										42
43 Nursery										43
44 Skilled Nursing Facility										44
45 Nursing Facility										45

ALLOCATION OF CAPITAL-RELATED COSTS			Provider CCN: 150177			PERIOD: FROM 01/01/2016 TO 12/31/2016	WORKSHEET B, PART II			
COST CENTER DESCRIPTIONS	DIRECTLY	CAPITAL REI	ATED COSTS	SUBTOTAL (sum of (cols. 0-2)	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY &	
	ASSIGNED NEW CAPITAL RELATED COSTS	BLDGS. & FIXTURES	MOVABLE EQUIPMENT						LINEN SERVICE	
	0							7		
46 Other Long Term Care										46
ANCILLARY SERVICE COST CENTERS										
50 Operating Room		377,928	180,261	558,189	4,296	53,179		46,184		50
51 Recovery Room										51
52 Labor Room and Delivery Room										52
53 Anesthesiology		1,658	791	2,449		12,204		203	3	53
54 Radiology-Diagnostic		251,952	120,174	372,126	2,523	33,666		30,789	)	54
55 Radiology-Therapeutic										55
56 Radioisotope										56
57 Computed Tomography (CT) Scan										57
58 Magnetic Resonance Imaging (MRI)										58
59 Cardiac Catheterization										59
60 Laboratory		10,542	5,028	15,570		10,199		1,288	3	60
61 PBP Clinical Laboratory Services-Program Only										61
62 Whole Blood & Packed Red Blood Cells										62
63 Blood Storing, Processing, & Trans.										63
64 Intravenous Therapy										64
65 Respiratory Therapy										65
66 Physical Therapy		5,967	2,846	8,813		3,288		729		66
67 Occupational Therapy		2,652	1,265	3,917		2,222		324	1	67
68 Speech Pathology										68
69 Electrocardiology										69
70 Electroencephalography		74,193	35,388	109,581		9,404		9,067	7	70
71 Medical Supplies Charged to Patients		1,658	791	2,449		28,219		203	3	71
72 Implantable Devices Charged to Patients						266,780				72
73 Drugs Charged to Patients		2,652	1,265	3,917		9,008		324	Į.	73
74 Renal Dialysis										74
75 ASC (Non-Distinct Part)										75
76 Other Ancillary (specify)										76
OUTPATIENT SERVICE COST CENTERS										
88 Rural Health Clinic (RHC)										88
89 Federally Qualified Health Center (FQHC)										89
90 Clinic										90
91 Emergency										91
92 Observation Beds (Non-Distinct Part)										92
92.01 Observation Beds (Distinct Part)										92.01
93 Other Outpatient Service (specify)										93
OTHER REIMBURSABLE COST CENTERS										

ALLOCATION OF CAPITAL-RELATED COSTS			Provider CCN: 150177			PERIOD: FROM 01/01/2016 TO 12/31/2016	WORKSHEET B, PART II				
COST CENTER DESCRIPTIONS		DIRECTLY	CAPITAL REI	LATED COSTS	SUBTOTAL	EMPLOYEE	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY &	
		ASSIGNED NEW CAPITAL RELATED COSTS	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	(sum of (cols. 0-2)	BENEFITS DEPARTMENT				LINEN SERVICE	
		0	1	2	2A	4	5	6	7	8	
94 Ho	ne Program Dialysis										94
95 Am	bulance Services										95
96 Du	rable Medical Equipment-Rented										96
97 Du	rable Medical Equipment-Sold										97
98 Oth	er Reimbursable (specify)										98
99 Out	patient Rehabilitation Provider (specify)										99
100 Inte	ern-Resident Service (not appvd. tchng. prgm.)										100
101 Ho	ne Health Agency										101
SPECIAL I	PURPOSE COST CENTERS										
105 Kid	ney Acquisition										105
	art Acquisition										106
	er Acquisition										107
	ng Acquisition										108
	creas Acquisition										109
	estinal Acquisition										110
	t Acquisition										111
	er Organ Acquisition (specify)										112
	bulatory Surgical Center (Distinct Part)										115
116 Hos											116
	er Special Purpose (specify)										117
	BTOTALS (sum of lines 1-117)		2,269,359	1,082,41	9 3,351,778	39,561	605,251		173,003	3 2,701	118
	BURSABLE COST CENTERS					,	,		,	,	
190 Gif	t, Flower, Coffee Shop, & Canteen										190
191 Res	**										191
	rsicians' Private Offices		1,832,218	873,91	7 2,706,135	26,106	5 234,984		223,903	3	192
	npaid Workers		, <b>,-</b>		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	435	<u>'</u>		,,,,,,		193
	er Nonreimbursable (specify)						3,772				194
	ss Foot Adjustments										200
	gative Cost Centers										201
	TAL (sum lines 118-201)		4,101,577	1,956,33	6 6,057,913	66,102	2 844,007	,	396,906	5 2,701	
	S-2552-10 (08/2011) (INSTRUCTIONS FOR TH			1 1	1 1	03,102	311,007		1 270,700	2,701	

ALLOCATION OF CAPITAL-RELATED COSTS			Provider CCN: 150	0177		PERIOD: FROM 01/01/2016 TO 12/31/2016		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	92,463									9
10 Dietary	1,258	80,859								10
11 Cafeteria	1,153	38,701	105,118							11
12 Maintenance of Personnel										12
13 Nursing Administration	277		12,775		53,249					13
14 Central Services and Supply	1,153					66,417				14
15 Pharmacy	1,633		6,806				123,254			15
16 Medical Records & Medical Records Library	864		5,131					64,307		16
17 Social Service	277								15,941	17
18 Other General Service (specify)										18
19 Nonphysician Anesthetists										19
20 Nursing School										20
21 Intern & Res. Service-Salary & Fringes (Approved)										21
22 Intern & Res. Other Program Costs (Approved)										22
23 Paramedical Education Program (specify)										23
INPATIENT ROUTINE SERVICE COST CENTERS										
30 Adults and Pediatrics (General Routine Care)	11,642	24,036	49,245		53,249	66,417		64,307	15,941	30
31 Intensive Care Unit										31
32 Coronary Care Unit										32
33 Burn Intensive Care Unit										33
34 Surgical Intensive Care Unit										34
35 Other Special Care Unit (specify)										35
40 Subprovider IPF										40
41 Subprovider IRF										41
42 Subprovider (specify)										42
43 Nursery										43
44 Skilled Nursing Facility										44
45 Nursing Facility										45
46 Other Long Term Care										46

ALLOCATION OF CAPITAL-RELATED COSTS			Provider CCN: 150	0177		PERIOD: FROM 01/01/2016 TO 12/31/2016		WORKSHEET B, PART II			
COST CENTER DESCRIPTIONS	HOUSE- KEEPING	DIETARY		MAINTENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE		
	9	10	11	12	13	14	15	16	17		
ANCILLARY SERVICE COST CENTERS											
50 Operating Room	10,949		20,952							50	
51 Recovery Room										51	
52 Labor Room and Delivery Room										52	
53 Anesthesiology	48									53	
54 Radiology-Diagnostic	7,299		10,209							54	
55 Radiology-Therapeutic										55	
56 Radioisotope										56	
57 Computed Tomography (CT) Scan										57	
58 Magnetic Resonance Imaging (MRI)										58	
59 Cardiac Catheterization										59	
60 Laboratory	305									60	
61 PBP Clinical Laboratory Services-Program Only										61	
62 Whole Blood & Packed Red Blood Cells										62	
63 Blood Storing, Processing, & Trans.										63	
64 Intravenous Therapy										64	
65 Respiratory Therapy										65	
66 Physical Therapy	173									66	
67 Occupational Therapy	77									67	
68 Speech Pathology										68	
69 Electrocardiology										69	
70 Electroencephalography	2,149									70	
71 Medical Supplies Charged to Patients	48									71	
72 Implantable Devices Charged to Patients	10									72	
73 Drugs Charged to Patients	77						123,254	1		73	
74 Renal Dialysis	77						123,23-			74	
75 ASC (Non-Distinct Part)										75	
76 Other Ancillary (specify)										76	
OUTPATIENT SERVICE COST CENTERS										70	
88 Rural Health Clinic (RHC)										88	
89 Federally Qualified Health Center (FQHC)										89	
90 Clinic										90	
91 Emergency										91	
92 Observation Beds (Non-Distinct Part)										92	
92.01 Observation Beds (Distinct Part)										92.01	
93 Other Outpatient Service (specify)										93	
OTHER REIMBURSABLE COST CENTERS											
94 Home Program Dialysis										94	
95 Ambulance Services										95	

ALLOCATION OF CAPITAL-RELATED COSTS		Provider CCN: 15	0177		PERIOD: FROM 01/01/2016 TO 12/31/2016	WORKSHEET B, PART II				
COST CENTER DESCRIPTIONS	HOUSE- KEEPING	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
	9	10	11	12	13	14	15	16	17	
96 Durable Medical Equipment-Rented										96
97 Durable Medical Equipment-Sold										97
98 Other Reimbursable (specify)										98
99 Outpatient Rehabilitation Provider (specify)										99
100 Intern-Resident Service (not appvd. tchng. prgm.)										100
101 Home Health Agency										101
SPECIAL PURPOSE COST CENTERS										
105 Kidney Acquisition										105
106 Heart Acquisition										106
107 Liver Acquisition										107
108 Lung Acquisition										108
109 Pancreas Acquisition										109
110 Intestinal Acquisition										110
111 Islet Acquisition										111
112 Other Organ Acquisition (specify)										112
115 Ambulatory Surgical Center (Distinct Part)										115
116 Hospice										116
117 Other Special Purpose (specify)										117
118 SUBTOTALS (sum of lines 1-117)	39,382	62,73	7 105,118	3	53,249	66,417	123,254	64,307	15,941	118
NONREIMBURSABLE COST CENTERS										
190 Gift, Flower, Coffee Shop, & Canteen		18,122	2							190
191 Research										191
192 Physicians' Private Offices	53,081									192
193 Nonpaid Workers										193
194 Other Nonreimbursable (specify)										194
200 Cross Foot Adjustments										200
201 Negative Cost Centers										201
202 TOTAL (sum lines 118-201)	92,463	80,859	9 105,113	3	53,249	66,417	123,254	64,307	15,941	202
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR TH	IS WORKSHEET ARE PU		,		, -	1	1	,	· · · · · · · · · · · · · · · · · · ·	-
40-544 - 09-13			,					I	Rev. 4	

SERVICE PHYSICIAN SCHOOL RESIDENTS RESIDENTS SALARY AND PROGRAM THETISTS FRINGES COSTS FRINGES COSTS RESIDENTS STEPDOWN ADJUSTMENTS	
Capital Related Costs-Buildings and Fixtures	ΓAL
Capital Related Costs-Buildings and Fixtures	26
2 Capital Related Costs-Movable 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 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 20 Nursing School 21 Intern & Res. Service-Salary & Fringes (Approved) 22 Intern & Res. Other Program Costs (Approved) 23 Paramedical Education Program (specify) 18 NPATIENT ROUTINE SERVICE COST CENTERS 30 Adults and Pediatrics (General Routine Care) 11 Intersive Care Unit	
4 Employee Benefits Department 5 Administrative and General 6 Maintenace and Repairs 7 Operation of Plant 8 Laundry and Linen Service 9 House-keeping 10 Dietary 11 Cafeteria 12 Maintenace 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 20 Nursing School 21 Intens Res. Service-Salary & Fringes (Approved) 22 Intens Res. Service-Salary & Fringes (Approved) 23 Paramedical Education Program (capecity) 18 NAPATIENT ROUTLINE SERVICE COST CENTERS 30 Adults and Pediatries (General Routine Care) 31 Intensive Care Unit 33 Bunn Intensive Care Unit	1
5 Administrative and General 6 Maintenance and Repairs 7 Operation of Plant 8 Laundry and Linen Service 9 Housekeeping 10 Dieterry 11 Cafeteria 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 20 Nursing School 21 Intern & Res. Service-Salary & Fringes (Approved) 22 Intern & Res. Service-Salary & Fringes (Approved) 23 Paramedical Education Program Gosts (Approved) 24 Intern & Res. Other Program Costs (Approved) 25 Paramedical Education Program (specify) 18 Other General Service (specify) 19 Nonphysician Anesthetists 10 Intern & Res. Other Program Costs (Approved) 25 Intern & Res. Other Program Costs (Approved) 26 Intern & Res. Other Program Costs (Approved) 27 Intern & Res. Other Program Costs (Approved) 28 Internise General Routine Care) 30 Adults and Pediatrics (General Routine Care) 31 Intensive Care Unit 32 Coronary Care Unit	2
6 Maintenance and Repairs 7 Operation of Plant 8 Laundy and Linen Service 9 Housekeeping 10 Dietary 11 Cafetria 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 20 Nursing School 21 Intern & Res. Service-Salary & Fringes (Approved) 22 Intern & Res. Service-Salary & Fringes (Approved) 23 Paramedical Education Program Costs (Approved) 24 Intern & Res. Service Social (Specify) 36 Adults and Pediatries (General Routine Care) 37 Internsive Care Unit 38 Other General Routine Care) 38 Intensive Care Unit 39 Goronary Care Unit 31 Intensive Care Unit	4
7 Operation of Plant   8   Laundry and Linen Service   9   Housekeeping   9   Housekeeping   9   Housekeeping   9   Housekeeping   9   10   Dietary   9   Housekeeping   9   11   Cafeteria   9   12   Maintenance of Personnel   12   Maintenance of Personnel   13   Nursing Administration   9   14   Central Services and Supply   14   Central Services and Supply   15   Pharmacy   16   Medical Records & Medic	5
8   Laundry and Linen Service	6
Housekeeping   Housekeeping	7
10   Dietary	8
11   Cafetria	9
Maintenance of Personnel   Maintenance of Pers	10
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  20 Nursing School  21 Intern & Res. Service-Salary & Fringes (Approved)  22 Intern & Res. Service-Salary & Fringes (Approved)  23 Paramedical Education Program (specify)  INPATIENT ROUTINE SERVICE COST CENTERS  30 Adults and Pediatrics (General Routine Care)  31 Intensive Care Unit  33 Burn Intensive Care Unit	11
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 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	12
115 Pharmacy 116 Medical Records & Medical Records Library 117 Social Service 118 Other General Service (specify) 119 Nonphysician Anesthetists 120 Nursing School 121 Intern & Res. Service-Salary & Fringes (Approved) 122 Intern & Res. Other Program Costs (Approved) 123 Paramedical Education Program (specify) 1NPATIENT ROUTINE SERVICE COST CENTERS 10 Adults and Pediatrics (General Routine Care) 11 Intensive Care Unit 12 Coronary Care Unit	13
16 Medical Records & Medical Records Library  17 Social Service  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 Parametical Education Program (specify)  INPATIENT ROUTINE SERVICE COST CENTERS  30 Adults and Pediatrics (General Routine Care)  31 Intensive Care Unit  32 Coronary Care Unit	14
17 Social Service 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	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	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	17
Nursing School	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	19
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	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	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	22
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	23
31 Intensive Care Unit 32 Coronary Care Unit 33 Burn Intensive Care Unit 31 Intensive Care Unit	
32 Coronary Care Unit 33 Burn Intensive Care Unit	1,014,725 30
33 Burn Intensive Care Unit	31
33 Burn Intensive Care Unit	32
	33
34 Surgical intensive Care Onit	34
35 Other Special Care Unit (specify)	35
40 Subprovider IPF	40
41 Subprovider IRF	41
42 Subprovider (specify)	42
43 Nursery	43
44 Skilled Nursing Facility	44

ALLOCATION OF CAPITAL-RELATED COSTS			Provider CCN: 15	0177		PERIOD: FROM 01/01/2016 TO 12/31/2016		WORKSHEET B, PART II		
COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE	NON- PHYSICIAN ANES- THETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY AND FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARAMEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
	18	19	20	21	22	23	24	25	26	
45 Nursing Facility										45
46 Other Long Term Care										46
ANCILLARY SERVICE COST CENTERS										
50 Operating Room							693,749		693,749	50
51 Recovery Room										51
52 Labor Room and Delivery Room										52
53 Anesthesiology							14,904		14,904	53
54 Radiology-Diagnostic							456,612		456,612	54
55 Radiology-Therapeutic										55
56 Radioisotope										56
57 Computed Tomography (CT) Scan										57
58 Magnetic Resonance Imaging (MRI)										58
59 Cardiac Catheterization										59
60 Laboratory							27,362		27,362	60
61 PBP Clinical Laboratory Services-Program Only										61
62 Whole Blood & Packed Red Blood Cells										62
63 Blood Storing, Processing, & Trans.										63
64 Intravenous Therapy										64
65 Respiratory Therapy										65
66 Physical Therapy							13,003		13,003	66
67 Occupational Therapy							6,540	1	6,540	67
68 Speech Pathology										68
69 Electrocardiology										69
70 Electroencephalography							130,201		130,201	70
71 Medical Supplies Charged to Patients							30,919		30,919	71
72 Implantable Devices Charged to Patients							266,780		266,780	72
73 Drugs Charged to Patients							136,580		136,580	73
74 Renal Dialysis										74
75 ASC (Non-Distinct Part)										75
76.										76.
OUTPATIENT SERVICE COST CENTERS										
88 Rural Health Clinic (RHC)										88
89 Federally Qualified Health Center (FQHC)										89
90 Clinic										90
91 Emergency								+		91
92 Observation Beds (Non-Distinct Part)										92
92.01 Observation Beds (Distinct Part)										92.01
72.01 Goset vation Bods (Distinct Latt)					L					72.01

ALLOCATION OF CAPITAL-RELATED COSTS			Provider CCN: 150	0177		PERIOD: FROM 01/01/2016 TO 12/31/2016		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)							2,791,375		2,791,375	118
NONREIMBURSABLE COST CENTERS										
190 Gift, Flower, Coffee Shop, & Canteen							18,122		18,122	190
191 Research										191
192 Physicians' Private Offices							3,244,209		3,244,209	192
193 Nonpaid Workers							4,207		4,207	193
194 Other Nonreimbursable (specify)							· · · · · · · · · · · · · · · · · · ·		•	194
200 Cross Foot Adjustments										200
201 Negative Cost Centers										201
202 TOTAL (sum lines 118-201)							6,057,913		6,057,913	202
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR TH	IS WORKSHEET ARE P	UBLISHED IN CN	AS PUB. 15-II, SEC	TION 4021)			· · · · · · · · · · · · · · · · · · ·			$\neg \neg$
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BI	CAPITAL REL BLDGS. & IXTURES UARE FEET)		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION		PERIOD: FROM 01/01/2016 TO 12/31/2016 MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	
BI FE (SQU	BLDGS. & IXTURES UARE FEET)	MOVABLE EQUIPMENT (DOLLAR VALUE)	BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	& GENERAL	& REPAIRS	OF PLANT			
		2	4				(SQUARE FEET)	(POUNDS OF LAUNDRY)	(HOURS OF SERVICE)	
	61,861			5A	5	6	7	8	9	
1 Capital Related Costs-Buildings and Fixtures	61,861									
										1
2 Capital Related Costs-Movable Equipment		61,861								2
4 Employee Benefits Department	675	675	9,523,525							4
5 Administrative and General	8,500	8,500	1,674,245		30,119,966					5
6 Maintenance and Repairs						52,686				6
7 Operation of Plant	3,700	3,700	198,434		1,184,652	3,700	48,986			7
8 Laundry and Linen Service					96,377			155,669		8
9 Housekeeping	850	850			83,413	850	850		48,136	9
10 Dietary	655	655	179,129		317,904	655	655		655	10
11 Cafeteria	600	600			58,757	600	600		600	11
12 Maintenance of Personnel										12
13 Nursing Administration	144	144	564,735		749,691	144	144		144	13
14 Central Services and Supply	600	600			58,757	600	600		600	14
15 Pharmacy	850	850	375,534		788,028	850	850		850	15
16 Medical Records & Medical Records Library	450	450	176,471		334,540	450	450		450	16
17 Social Service	144	144			14,102	144	144		144	17
18 Other General Service (specify)										18
19 Nonphysician Anesthetists										19
20 Nursing School										20
21 Intern & Res. Service-Salary & Fringes (Approved)										21
22 Intern & Res. Other Program Costs (Approved)										22
23 Paramedical Education Program (specify)										23
INPATIENT ROUTINE SERVICE COST CENTERS										
30 Adults and Pediatrics (General Routine Care)	6,061	6,061	1,548,627		2,633,264	6,061	6,061	155,669	6,061	30
31 Intensive Care Unit		· · · · · · · · · · · · · · · · · · ·					· · · · · · · · · · · · · · · · · · ·			31
32 Coronary Care Unit										32
33 Burn Intensive Care Unit										33
34 Surgical Intensive Care Unit										34
35 Other Special Care Unit (specify)										35
40 Subprovider IPF										40
41 Subprovider IRF										41
42 Subprovider (specify)										42
43 Nursery										43

COST ALLOCATION - STATISTICAL BASIS			Provider CCN: 150	0177		PERIOD: FROM 01/01/2016 TO 12/31/2016	;	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	618,865		1,897,759	5,700	5,700		5,700	50
51 Recovery Room										51
52 Labor Room and Delivery Room										52
53 Anesthesiology	25	25			435,532				25	53
54 Radiology-Diagnostic	3,800	3,800	363,454		1,201,421	3,800	3,800		3,800	54
55 Radiology-Therapeutic										55
56 Radioisotope										56
57 Computed Tomography (CT) Scan										57
58 Magnetic Resonance Imaging (MRI)										58
59 Cardiac Catheterization										59
60 Laboratory	159	159			363,968	159	159		159	60
61 PBP Clinical Laboratory Services-Program Only										61
62 Whole Blood & Packed Red Blood Cells										62
63 Blood Storing, Processing, & Trans.										63
64 Intravenous Therapy										64
65 Respiratory Therapy										65
66 Physical Therapy	90	90			117,322	90	90		90	66
67 Occupational Therapy	40	40			79,277	40	40		40	67
68 Speech Pathology										68
69 Electrocardiology										69
70 Electroencephalography	1,119	1,119			335,603	1,119	1,119		1,119	70
71 Medical Supplies Charged to Patients	25	25			1,007,039	25	25		25	71
72 Implantable Devices Charged to Patients					9,520,811					72
73 Drugs Charged to Patients	40	40			321,446	40	40		40	73
74 Renal Dialysis										74
75 ASC (Non-Distinct Part)										75
76 Other Ancillary (specify)										76
OUTPATIENT SERVICE COST CENTERS										
88 Rural Health Clinic (RHC)										88
89 Federally Qualified Health Center (FQHC)										89
90 Clinic										90
91 Emergency										91
92 Observation Beds (Non-Distinct Part)										92

COST ALLOCATION - STATISTICAL BASIS			Provider CCN: 150	0177		PERIOD: FROM 01/01/2016 TO 12/31/2016		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	5,699,494		21,599,663	25,052	21,352	155,669	20,502	118
NONREIMBURSABLE COST CENTERS										
190 Gift, Flower, Coffee Shop, & Canteen										190
191 Research										191
192 Physicians' Private Offices	27,634	27,634	3,761,428		8,385,690	27,634	27,634		27,634	192
193 Nonpaid Workers			62,603		134,613					193
194 Other Nonreimbursable (specify)										194
200 Cross foot adjustments										200
201 Negative cost centers										201
202 Cost to be allocated (per Worksheet B, Part I)	4,101,577	1,956,336	2,118,382		10,713,184		1,606,014	130,657	140,949	202
203 Unit cost multiplier (Worksheet B, Part I)	66.30	31.62			0.355684		32.79		2.93	
204 Cost to be allocated (per Worksheet B, Part II)			66,102		844,007		396,906		92,463	
205 Unit cost multiplier (Worksheet B, Part II)			0.006941		0.028022		8.10		1.92	
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR	THIS WORKSHEE	T ARE PUBLISH		5-II. SECTION 4020)	1	L			2	

COST ALLOCATION - STATISTICAL BASIS			Provider CCN: 150	0177		PERIOD: FROM 01/01/2016 TO 12/31/2016	i	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 (SQUARE FEET)	OF PLANT	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSE- KEEPING (HOURS OF SERVICE)	
	1	2	4	5A	5	6	7	8	9	
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COST ALLOCATION - STATISTICAL BASIS			Provider CCN: 150	0177		PERIOD: FROM 01/01/2016 TO 12/31/2016		WORKSHEET B-1		
COST CENTER DESCRIPTIONS	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	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										1
2 Capital Related Costs-Movable Equipment										2
4 Employee Benefits Department										4
5 Administrative and General										5
6 Maintenance and Repairs										6
7 Operation of Plant										7
8 Laundry and Linen Service										8
9 Housekeeping										9
10 Dietary	12,168									10
11 Cafeteria	5,824	5,900								11
12 Maintenance of Personnel										12
13 Nursing Administration		717		71,718						13
14 Central Services and Supply					100					14
15 Pharmacy		382				100				15
16 Medical Records & Medical Records Library		288					1,140			16
17 Social Service								1,140		17
18 Other General Service (specify)										18
19 Nonphysician Anesthetists										19
20 Nursing School										20
21 Intern & Res. Service-Salary & Fringes (Approved)										21
22 Intern & Res. Other Program Costs (Approved)										22
23 Paramedical Education Program (specify)										23
INPATIENT ROUTINE SERVICE COST CENTERS										
30 Adults and Pediatrics (General Routine Care)	3,617	2,764		71,718	100		1,140	1,140		30
31 Intensive Care Unit										31
32 Coronary Care Unit										32
33 Burn Intensive Care Unit										33
34 Surgical Intensive Care Unit										34
35 Other Special Care Unit (specify)										35
40 Subprovider IPF										40
41 Subprovider IRF										41
42 Subprovider (specify)										42
43 Nursery										43
44 Skilled Nursing Facility										44

COST ALLOCATION - STATISTICAL BASIS			Provider CCN: 150	0177		PERIOD: FROM 01/01/2016 TO 12/31/2016	;	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		1,176								50
51 Recovery Room										51
52 Labor Room and Delivery Room										52
53 Anesthesiology										53
54 Radiology-Diagnostic		573								54
55 Radiology-Therapeutic										55
56 Radioisotope										56
57 Computed Tomography (CT) Scan										57
58 Magnetic Resonance Imaging (MRI)										58
59 Cardiac Catheterization										59
60 Laboratory										60
61 PBP Clinical Laboratory Services-Program Only										61
62 Whole Blood & Packed Red Blood Cells										62
63 Blood Storing, Processing, & Trans.										63
64 Intravenous Therapy										64
65 Respiratory Therapy										65
66 Physical Therapy										66
67 Occupational Therapy										67
68 Speech Pathology										68
69 Electrocardiology										69
70 Electroencephalography										70
71 Medical Supplies Charged to Patients										71
72 Implantable Devices Charged to Patients										72
73 Drugs Charged to Patients						100				73
74 Renal Dialysis										74
75 ASC (Non-Distinct Part)										75
76 Other Ancillary (specify)										76
OUTPATIENT SERVICE COST CENTERS										
88 Rural Health Clinic (RHC)										88
89 Federally Qualified Health Center (FQHC)										89
90 Clinic										90
91 Emergency										91
92 Observation Beds (Non-Distinct Part)										92
92.01 Observation Beds (Distinct Part)										92.01
93 Other Outpatient Service (specify)										93

COST ALLOCATION - STATISTICAL BASIS			Provider CCN: 150	0177		PERIOD: FROM 01/01/2016 TO 12/31/2016	i	WORKSHEET B-1		
COST CENTER DESCRIPTIONS	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINIS- TRATION (DIRECT NURS. HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	(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	1									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	í									105
106 Heart Acquisition										106
107 Liver Acquisition										107
108 Lung Acquisition										108
109 Pancreas Acquisition										109
110 Intestinal Acquisition										110
111 Islet Acquisition										111
112 Other Organ Acquisition (specify)										112
115 Ambulatory Surgical Center (Distinct Part)										115
116 Hospice										116
117 Other Special Purpose (specify)										117
118 SUBTOTALS (sum of lines 1-117)	9,441	5,900		71,718	100	100	1,140	1,140		118
NONREIMBURSABLE COST CENTERS		- ,,		,,,,			, -	, -		
190 Gift, Flower, Coffee Shop, & Canteen	2,727									190
191 Research										191
192 Physicians' Private Offices										192
193 Nonpaid Workers										193
194 Other Nonreimbursable (specify)										194
200 Cross foot adjustments										200
201 Negative cost centers										201
202 Cost to be allocated (per Worksheet B, Part I)	454,369	318,559		1,060,200	101,084	1,119,298	485,152	24,261		202
203 Unit cost multiplier (Worksheet B, Part I)	37.34	53.99		14.78		11,193				202
204 Cost to be allocated (per Worksheet B, Part II)	80,859	105,118		53,249	· · · · · · · · · · · · · · · · · · ·	123,254	64,307			203
205 Unit cost multiplier (Worksheet B, Part II)	6.65	103,118		0.742477		1,233				204
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR					004.17	1,233	30.41	13.98		
40-553 - 09-13	I HIS WUKKSHEE	ARE PUBLISH	ED IN CMS PUB.	13-11, SECTION 4020)					Rev. 4	
40-333 - 07-13									NCV. 4	

Recor	l code 598260 - 2010]									
COST	ALLOCATION - STATISTICAL BASIS		Provider CCN: 15	0177		PERIOD: FROM 01/01/2016 TO 12/31/2016		WORKSHEET B-1		
COST	CENTER DESCRIPTIONS	NON- PHYSICIAN	NURSING SCHOOL	INTERNS SALARY AND	& RESIDENTS PROGRAM COSTS	PARAMEDICAL EDUCATION	SUBTOTAL	INTERN & RESIDENT	TOTAL	
		ANESTHETISTS (ASGND TIME)	(ASSIGNED TIME)	FRINGES (ASSIGNED TIME)	(ASSIGNED TIME)	(ASSIGNED TIME)		COST & POST STEPDOWN ADJUSTMENTS		
CENE	DAY GEDNIGE COOR GENEEDS	19	20	21	22	23	24	25	26	
	RAL SERVICE COST CENTERS									
	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
	Intern & Res. Other Program Costs (Approved)									22
	Paramedical Education Program (specify)									23
	IENT ROUTINE SERVICE COST CENTERS									
30	Adults and Pediatrics (General Routine Care)									30
	Intensive Care Unit									31
32	Coronary Care Unit									32
	Burn Intensive Care Unit									33
	Surgical Intensive Care Unit									34
35	Other Special Care Unit (specify)									35
	Subprovider IPF									40
	Subprovider IRF									41
42	Subprovider (specify)									42
43	Nursery									43

COST	ALLOCATION - STATISTICAL BASIS		Provider CCN: 15	0177		PERIOD: FROM 01/01/2016 TO 12/31/2016		WORKSHEET B-1		
COST	CENTER DESCRIPTIONS	NON- PHYSICIAN ANESTHETISTS (ASGND TIME)	NURSING SCHOOL (ASSIGNED TIME)	SALARY AND FRINGES (ASSIGNED TIME)	& RESIDENTS PROGRAM COSTS (ASSIGNED TIME)	PARAMEDICAL EDUCATION (ASSIGNED TIME)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
	I	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
	Federally Qualified Health Center (FQHC)									89
	Clinic									90
91	Emergency									91
	Observation Beds (Non-Distinct Part)									92

NUMBRING   PROSECUTIONS   PROCESS	COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 150	0177		PERIOD: FROM 01/01/2016 TO 12/31/2016		WORKSHEET B-1		
9.20   Oservation Botk Offiniers Parti   9.20   9.20   9.20   9.30   9.30   9.00   9.20   9.3	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		
9.91 Other Outputient Services (openity)  9.14 Home Program Dulysis  9.24 Home Program Dulysis  9.35 Ambalance Services  9.4 Home Program Dulysis  9.5 Ambalance Services  9.5 Output Services  9.5 Ou		19	20	21	22	23	24	25	26	
OHER REMBURSABLE COST CENTERS  9   Home Program Dialysis  90   Darable Medica Equipment-Remot  91   Darable Medica Equipment-Remot  92   Darable Medica Equipment-Sold  93   Oursales Medica Equipment-Sold  94   Oursales Medica Equipment-Sold  95   Oursales Medica Equipment-Sold  96   Darable Medica Equipment-Sold  97   Oursales Medica Equipment-Sold  97   Oursales Medica Equipment-Sold  98   Olter Rembursable (specify)  99   Oursales Medica Equipment-Sold  99   Oursales Medica Equipment-Sold  90   Oursales Medical Equipment-Sold										
994 Home Program Dialysis 95 Autholiance Services 96 Durable Medical Equipment Rented 97 Durable Medical Equipment Sold 97 Durable Medical Equipment Sold 98 Other Rehmands (epecify) 99 Outpatient Rehabilitation Provider (epecify) 190 Intern. Resident Service (total good, tells, prign.) 191 Intern. Resident Service (total good, tells, prign.) 191 Intern. Resident Service (total good, tells, prign.) 192 Intern. Resident Service (total good, tells, prign.) 193 Intern. Resident Service (total good, tells, prign.) 194 Intern. Resident Service (total good, tells, prign.) 195 Intern. Resident Service (total good, tells, prign.) 195 Intern. Resident Service (total good, tells, prign.) 196 Intern. Resident Service (total good, tells, prign.) 197 Intern. Resident Service (total good, tells, prign.) 198 Intern. Resident Service (total good, tells, prign.) 199 Intern. Resident Service (total good, tells, prign.) 190 Intern. Resident Service (total good, tells, prign.) 191 Intern. Resident Service (total good, tells, prign.) 192 Intern. Resident Service (total good, tells, prign.) 193 Intern. Resident Service (total good, tells, prign.) 194 Intern. Resident Service (total good, tells, prign.) 195 Intern. Resident Service (total good, tells,										93
99 Autholiume Services 90 Durabibe Medical Equipment-Rented 91 Durabibe Medical Equipment-Rented 93 Durabibe Medical Equipment-Rented 94 Durabibe Medical Equipment-Rented 95 Outpatient Rehabilitation Provider (specify) 96 Outpatient Rehabilitation Provider (specify) 97 Outpatient Rehabilitation Provider (specify) 98 Durabite Medical Equipment Rented 99 Outpatient Rehabilitation Provider (specify) 99 Outpatient Rehabilitation Provider (specify) 90 Outpatient Rehabilitation Provider (specify) 91 Outpatient										
990   Durble Medical Equipment Sented   9   9   9   9   9   9   9   9   9										
Process   Proc										
98 Ober Reimbursahle (specify) 99 Outpatient Rehabilitation Provider (specify) 100 Interna-Readult Service (not appred, sching, prgm.) 101 Illome Health Agency 105 Kidney Acquisition 106 Heart Acquisition 107 Ilver Acquisition 108 Idean Acquisition 109 Pancreas Acquisition 109 Pancreas Acquisition 110 Illome Steal International Acquisition 111 Illome Acquisition 112 Other Organ Acquisition 113 Illome Steal International Acquisition 114 Illopice 115 Ambulatory Surgical Center (Distinct Part) 116 Illopice 117 Other Special Purpose (specify) 118 ONNEIMBURSABLE COST CENTERS 190 Gift, Flower, Coffee Shop, & Canteen 1919 Physicians Private Offices 1919 Research 1919 Research 1910 Cross foot adjustments 1910 Cross foot adjustments 1920 Cross foot adjustments 1930 Cross foot adjustments 1940 Cross foot adjustments 1950 Clutic vois multiplier (Worksheet B, Part II) 200 Cross to multiplier (Worksheet B, Part II) 2010 Clut on multiplier (Worksheet B, Part II) 2010 Clut on multiplier (Worksheet B, Part II) 2010 Clots to be allocated (per Worksheet B, Part II) 2010 Clots to be allocated (per Worksheet B, Part II) 2010 Clots to be allocated (per Worksheet B, Part II) 2010 Clots to be allocated (per Worksheet B, Part II) 2010 Clots to be allocated (per Worksheet B, Part II) 2010 Clots to be allocated (per Worksheet B, Part II)										
99 Outpaient Relabilitation Provider (specify) 100 Intern Resident Service (not appeal, tching, prgm) 101 Illone Thealth Agency 102 Illone Thealth Agency 103 Skithey Acquisition 105 Skithey Acquisition 106 Illenar Acquisition 107 Iller Acquisition 107 Iller Acquisition 108 Illenar Acquisition 109 Pancreas Acquisition 109 Pancreas Acquisition 110 Illonestinal Acquisition 110 Illonestinal Acquisition 110 Illonestinal Acquisition 111 Iller Acquisition 112 Other Organ Acquisition 113 Iller Acquisition 114 Other Organ Acquisition 115 Ambulatory Surgical Center (Distinct Part) 116 Illonestinal Acquisition (State Part) 117 Ambulatory Surgical Purpose (specify) 118 SURTOTALS (sum of lines 1-117) 119 Other Special Purpose (specify) 119 Research 119 Offit, Flower, Coffee Shop, & Canteen 119 Other Organ Acquisition 119 Organis Acquisition 110 Illonestinal Acquisition (State Part) 110 Illonestinal Acquisition (State Part) 111 State Acquisition (State Part) 112 Ambulatory Surgical Center (Distinct Part) 113 Ambulatory Surgical Purpose (specify) 114 Ambulatory Surgical Purpose (specify) 115 Ambulatory Surgical Purpose (specify) 116 Illones Special Purpose (specify) 117 Illones Special Purpose (specify) 118 SURTOTALS (sum of lines 1-117) 119 Ambulatory Surgical Purpose (specify) 110 Illones Special Purpose (specify) 110 Illones Special Purpose (specify) 111 Ambulatory Surgical Purpose (specify) 112 Ambulatory Surgical Purpose (specify) 113 Illones Special Purpose (specify) 114 Ambulatory Surgical Purpose (specify) 115 Ambulatory Surgical Purpose (specify) 116 Illones Special Purpose (specify) 117 Illones Special Purpose (specify) 118 Ambulatory Surgical Purpose (specify) 119 Ambulatory Surgical Purpose (specify) 110 Illones Special Purpose (specify) 110 Illones Special Purpose (specify) 111 Illones Special Purpose (specify) 110 Illones Special Purpose (specify) 111 Illones Special Purpose (specify) 112 Illones Special Purpose (specify) 113 Illones Special Purpose (specify) 114 Illones Special Purpose (specify) 115 Illones Spe										
100   Intern-Resident Service (not approd. sching. prgm.)										98
10   Home Health Agency										
SPECIAL PURPOSE COST CENTERS	100 Intern-Resident Service (not appvd. tchng. prgm.)									100
105   Kidney Acquisition	101 Home Health Agency									101
100   Heart Acquisition	SPECIAL PURPOSE COST CENTERS									
107   Liver Acquisition	105 Kidney Acquisition									105
108   Lung Acquisition	106 Heart Acquisition									106
100   Pancreas Acquisition	107 Liver Acquisition									107
Intestinal Acquisition   Intestinal Acquisit	108 Lung Acquisition									108
Ill   Islet Acquisition	109 Pancreas Acquisition									109
112   Other Organ Acquisition (specify)	110 Intestinal Acquisition									110
Ambulatory Surgical Center (Distinct Part)	111 Islet Acquisition									111
Hospice   Hosp	112 Other Organ Acquisition (specify)									112
117   Other Special Purpose (specify)	115 Ambulatory Surgical Center (Distinct Part)									115
SUBTOTALS (sum of lines 1-117)	116 Hospice									116
118   SUBTOTALS (sum of lines 1-117)	117 Other Special Purpose (specify)									117
190   Gift, Flower, Coffee Shop, & Canteen   190   190   191   Research   191   192   Physicians' Private Offices   192   193   Nonpaid Workers   193   194   195   19	118 SUBTOTALS (sum of lines 1-117)									118
191   Research   192   Physicians' Private Offices   193   194   195										
191   Research   192   Physicians' Private Offices   193   194   195	190 Gift, Flower, Coffee Shop, & Canteen									190
193 Nonpaid Workers       193         194 Other Nonreimbursable (specify)       194         200 Cross foot adjustments       194         201 Negative cost centers       195         202 Cost to be allocated (per Worksheet B, Part I)       196         203 Unit cost multiplier (Worksheet B, Part I)       196         204 Cost to be allocated (per Worksheet B, Part II)       197         205 Unit cost multiplier (Worksheet B, Part II)       197         206 Unit cost multiplier (Worksheet B, Part II)       198         207 Unit cost multiplier (Worksheet B, Part II)       198         208 Unit cost multiplier (Worksheet B, Part II)       198         209 Unit cost multiplier (Worksheet B, Part II)       199         200 Unit cost multiplier (Worksheet B, Part II)       201	191 Research									191
193 Nonpaid Workers       193         194 Other Nonreimbursable (specify)       194         200 Cross foot adjustments       194         201 Negative cost centers       195         202 Cost to be allocated (per Worksheet B, Part I)       196         203 Unit cost multiplier (Worksheet B, Part I)       196         204 Cost to be allocated (per Worksheet B, Part II)       197         205 Unit cost multiplier (Worksheet B, Part II)       197         206 Unit cost multiplier (Worksheet B, Part II)       198         207 Unit cost multiplier (Worksheet B, Part II)       198         208 Unit cost multiplier (Worksheet B, Part II)       198         209 Unit cost multiplier (Worksheet B, Part II)       199         200 Unit cost multiplier (Worksheet B, Part II)       201	192 Physicians' Private Offices									192
194 Other Nonreimbursable (specify)       194         200 Cross foot adjustments       200         201 Negative cost centers       201         202 Cost to be allocated (per Worksheet B, Part I)       202         203 Unit cost multiplier (Worksheet B, Part I)       203         204 Cost to be allocated (per Worksheet B, Part II)       204         205 Unit cost multiplier (Worksheet B, Part II)       204         205 Unit cost multiplier (Worksheet B, Part II)       205										193
200 Cross foot adjustments       200         201 Negative cost centers       201         202 Cost to be allocated (per Worksheet B, Part I)       202         203 Unit cost multiplier (Worksheet B, Part I)       203         204 Cost to be allocated (per Worksheet B, Part II)       204         205 Unit cost multiplier (Worksheet B, Part II)       205         205 Unit cost multiplier (Worksheet B, Part II)       205										
201 Negative cost centers       201         202 Cost to be allocated (per Worksheet B, Part I)       202         203 Unit cost multiplier (Worksheet B, Part I)       203         204 Cost to be allocated (per Worksheet B, Part II)       204         205 Unit cost multiplier (Worksheet B, Part II)       205										
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 Unit cost multiplier (Worksheet B, Part II) 206 Unit cost multiplier (Worksheet B, Part II) 207 Unit cost multiplier (Worksheet B, Part II) 208 Unit cost multiplier (Worksheet B, Part II) 209 Unit cost multiplier (Worksheet B, Part II) 200 Unit cost multiplier (Worksheet B, Part II) 201 Unit cost multiplier (Worksheet B, Part II) 202 Unit cost multiplier (Worksheet B, Part II)										
203 Unit cost multiplier (Worksheet B, Part I) 204 Cost to be allocated (per Worksheet B, Part II) 205 Unit cost multiplier (Worksheet B, Part II) 206 Unit cost multiplier (Worksheet B, Part II) 207 Unit cost multiplier (Worksheet B, Part II) 208 Unit cost multiplier (Worksheet B, Part II) 209 Unit cost multiplier (Worksheet B, Part II) 200 Unit cost multiplier (Worksheet B, Part II) 201 Unit cost multiplier (Worksheet B, Part II) 202 Unit cost multiplier (Worksheet B, Part II) 203 Unit cost multiplier (Worksheet B, Part II) 204 Unit cost multiplier (Worksheet B, Part II) 205 Unit cost multiplier (Worksheet B, Part II)										
204 Cost to be allocated (per Worksheet B, Part II) 205 Unit cost multiplier (Worksheet B, Part II) 206 Unit cost multiplier (Worksheet B, Part II) 207 Unit cost multiplier (Worksheet B, Part II)	_									
205 Unit cost multiplier (Worksheet B, Part II)	_									
		THIS WORKSHEI	L ET ARE PUBLISH	ED IN CMS PUB. 1	15-II, SECTION 4020)	l .				

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 150	0177		PERIOD: FROM 01/01/2016 TO 12/31/2016		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	
40-553 - 09-13								Rev. 4	

COMPUTATION OF RATIO OF COSTS TO CH.	ARGES				_		Provider CCN: 15	50177	PERIOD: FROM 01/01/201 TO 12/31/2016	6	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			1									
INPATIENT ROUTINE SERVICE COST CENTERS												
30 Adults and Pediatrics (General Routine Care)	5,871,987		5,871,987		5,871,987			3,378,347				30
31 Intensive Care Unit												31
32 Coronary Care Unit												32
33 Burn Intensive Care Unit												33
34 Surgical Intensive Care Unit												34
35 Other Special Care (specify)												35
40 Subprovider IPF												40
41 Subprovider IRF												41
42 Subprovider (Specify)												42
43 Nursery												43
44 Skilled Nursing Facility												44
45 Nursing Facility												45
46 Other Long Term Care												46
ANCILLARY SERVICE COST CENTERS												
50 Operating Room	2,839,823		2,839,823		2,839,823			36,926,438	0.076905	0.076905	0.076905	50
51 Recovery Room												51
52 Labor Room and Delivery Room												52
53 Anesthesiology	591,337		591,337		591,337			2,230,699	0.265090	0.265090	0.265090	53
54 Radiology-Diagnostic	1,795,396		1,795,396		1,795,396			2,333,917	0.769263	0.769263	0.769263	54
55 Radiology-Therapeutic												55
56 Radioisotope												56
57 Computed Tomography (CT) Scan												57
58 Magnetic Resonance Imaging (MRI)												58
59 Cardiac Catheterization												59
60 Laboratory	499,105		499,105		499,105			922,782	0.540870	0.540870	0.540870	60
61 PBP Clinical Laboratory Services-Prgm. Only												61
62 Whole Blood & Packed Red Blood Cells												62
63 Blood Storing, Processing, & Trans.												63
64 Intravenous Therapy												64
65 Respiratory Therapy												65
66 Physical Therapy	162,267		162,267		162,267			329,450	0.492539	0.492539	0.492539	66

COMPUTATION OF RATIO OF COSTS TO CHA	RGES						Provider CCN: 15		PERIOD: FROM 01/01/2010 TO 12/31/2016		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	108,903		108,903		108,903			204,739	0.531911	0.531911	0.531911	67
68 Speech Pathology												68
69 Electrocardiology												69
70 Electroencephalography	494,936		494,936		494,936			768,719	0.643845	0.643845	0.643845	70
71 Medical Supplies Charged to Patients	1,366,120		1,366,120		1,366,120			4,146,008	0.329502	0.329502	0.329502	71
72 Implantable Devices Charged to Patients	12,907,201		12,907,201		12,907,201			39,513,846	0.326650	0.326650	0.326650	
73 Drugs Charged to Patients	1,556,505		1,556,505		1,556,505			2,558,776	0.608301	0.608301	0.608301	73
74 Renal Dialysis												74
75 ASC (Non-Distinct Part)												75
76 Other Ancillary (specify)												76
OUTPATIENT SERVICE COST CENTERS												
88 Rural Health Clinic (RHC)												88
89 Federally Qualified Health Center (FQHC)												89
90 Clinic												90
91 Emergency												91
92 Observation Beds (Non-Distinct Part)												92
92.01 Observation Beds (Distinct Part)												92.01
93 Other Outpatient Service (specify)												93
OTHER REIMBURSABLE COST CENTERS												
94 Home Program Dialysis												94
95 Ambulance Services												95
96 Durable Medical Equipment-Rented												96
97 Durable Medical Equipment-Sold												97
98 Other Reimbursable (specify)												98
99 Outpatient Rehabilitation Provider (specify)												99
100 Intern-Resident Service (not appvd. tchng. prgm.)												100
101 Home Health Agency												101
SPECIAL PURPOSE COST CENTERS												
105 Kidney Acquisition												105
106 Heart Acquisition												106
107 Liver Acquisition												107
108 Lung Acquisition												108
109 Pancreas Acquisition												109
110 Intestinal Acquisition												110
111 Islet Acquisition												111
112 Other Organ Acquisition (specify)												112

COMPUTATION OF RATIO OF COSTS TO CHA	MPUTATION OF RATIO OF COSTS TO CHARGES									6	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)	28,193,580		28,193,580		28,193,580			93,313,721	l			200
201 Less Observation Beds												201
202 Total (see instructions)			28,193,580		28,193,580	68,187,119	25,126,602	93,313,721	l			202
FORM CMS-2552-10 (10/2012) (INSTRUCTIONS	FOR THIS WORKS	SHEET ARE PUI	BLISHED IN CMS	PUB. 15-2, SECT	TIONS 4023)							,
40-564 - 10-12											Rev. 3	

COMPUTATION OF RATIO OF COSTS TO CHA	ARGES						Provider CCN: 150	0177	PERIOD: FROM 01/01/201 TO 12/31/2016	6	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)	5,871,987		5,871,987		5,871,987	3,378,347		3,378,347	7			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	2,839,823		2,839,823		2,839,823	22,717,422	14,209,016	36,926,438	0.076905	0.076905	0.076905	50
51 Recovery Room												5
52 Labor Room and Delivery Room												52
53 Anesthesiology	591,337		591,337		591,337	1,133,157	1,097,542	2,230,699	0.265090	0.265090	0.265090	
54 Radiology-Diagnostic	1,795,396		1,795,396		1,795,396	158,367	2,175,550	2,333,917	0.769263	0.769263	0.769263	54
55 Radiology-Therapeutic												55
56 Radioisotope												50
57 Computed Tomography (CT) Scan												51
58 Magnetic Resonance Imaging (MRI)												58
59 Cardiac Catheterization												59
60 Laboratory	499,105		499,105		499,105	699,417	223,365	922,782	0.540870	0.540870	0.540870	60
61 PBP Clinical Laboratory Services-Prgm. Only												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	162,267		162,267		162,267	324,494	4,956	329,450	0.492539	0.492539	0.492539	60

COMPUTATION OF RATIO OF COSTS TO CHA	RGES						Provider CCN: 150		PERIOD: FROM 01/01/201 TO 12/31/2016		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	108,903		108,903		108,903	201,916	2,823	204,739	0.531911	0.531911	0.531911	67
68 Speech Pathology												68
69 Electrocardiology												69
70 Electroencephalography	494,936		494,936		494,936		768,719	768,719	0.643845	0.643845	0.643845	70
71 Medical Supplies Charged to Patients	1,366,120		1,366,120		1,366,120	2,059,250	2,086,758	4,146,008	0.329502	0.329502	0.329502	
72 Implantable Devices Charged to Patients	12,907,201		12,907,201		12,907,201	35,765,550	3,748,296	39,513,846	0.326650	0.326650	0.326650	72
73 Drugs Charged to Patients	1,556,505		1,556,505		1,556,505	1,749,199	809,577	2,558,776	0.608301	0.608301	0.608301	73
74 Renal Dialysis												74
75 ASC (Non-Distinct Part)												75
76 Other Ancillary (specify)												76
OUTPATIENT SERVICE COST CENTERS												
88 Rural Health Clinic (RHC)												88
89 Federally Qualified Health Center (FQHC)												89
90 Clinic												90
91 Emergency												91
92 Observation Beds (Non-Distinct Part)												92
92.01 Observation Beds (Distinct Part)												92.01
93 Other Outpatient Service (specify)												93
OTHER REIMBURSABLE COST CENTERS												
94 Home Program Dialysis												94
95 Ambulance Services												95
96 Durable Medical Equipment-Rented												96
97 Durable Medical Equipment-Sold												97
98 Other Reimbursable (specify)												98
99 Outpatient Rehabilitation Provider (specify)												99
100 Intern-Resident Service (not appvd. tchng. prgm.)												100
101 Home Health Agency												101
SPECIAL PURPOSE COST CENTERS												
105 Kidney Acquisition												105
106 Heart Acquisition												106
107 Liver Acquisition												107
108 Lung Acquisition												108
109 Pancreas Acquisition												109
110 Intestinal Acquisition												110
111 Islet Acquisition												111
112 Other Organ Acquisition (specify)												112

COMPUTATION OF RATIO OF COSTS TO CHA	MPUTATION OF RATIO OF COSTS TO CHARGES									6	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)	28,193,580		28,193,580		28,193,580	68,187,119	25,126,602	93,313,721	1			200
201 Less Observation Beds												201
202 Total (see instructions)	28,193,580		28,193,580		28,193,580	68,187,119	25,126,602	93,313,721	1			202
FORM CMS-2552-10 (10/2012) (INSTRUCTIONS	FOR THIS WORK	SHEET ARE PUI	BLISHED IN CMS	PUB. 15-2, SECT	TIONS 4023)							
40-564 - 10-12											Rev. 3	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE	CAPITAL COSTS		Provider CCN: 1501	77	PERIOD: FROM 01/01/2016 TO 12/31/2016		WORKSHEET D, P I	ART
Medicare -Title XVIII - Hospital								
	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A) Cost Center Description	1	2	3	4	5	6	7	
INPATIENT ROUTNE SERVICE COST CENTERS								
30 Adults & Pediatrics (General Routine Care)	1,014,725		1,014,725	1,140	890.11	354	315,099	30
31 Intensive Care Unit								3
32 Coronary Care Unit								32
33 Burn Intensive Care Unit								3.
34 Surgical Intensive Care Unit								34
35 Other Special Care Unit (specify)								3.
40 Subprovider IPF								40
41 Subprovider IRF								4
42 Subprovider (Other)								4
43 Nursery								4:
44 Skilled Nursing Facility								4
45 Nursing Facility								4:
200 Total (lines 30-199)	1,014,725		1,014,725	1,140		354	315,099	200
(A) Worksheet A line numbers								
FORM CMS-2552-10 (10/2012) (INSTRUCTIONS FOR THI	S WORKSHEET ARE	PUBLISHED IN C	CMS PUB. 15-2, SEC	TIONS 4024 - 4024.	1)			
40-567 - 10-12							Rev. 3	

### UNITY MEDICAL AND SURGICAL HOSPITAL - $\operatorname{MISHAWAKA}$ , $\operatorname{IN}$

	LARY SERVICE CAPITAL COSTS	Provider CCN: 150177		PERIOD: FROM 01/01/2016 TO 12/31/2016		WORKSHEET D, PART II	
Medica	re -Title XVIII - Hospital			<u> </u>		I.	-
	-	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	693,749	36,926,438	0.018787	6,921,874	130,041	50
51	Recovery Room						51
52	Labor Room and Delivery Room						52
	Anesthesiology	14,904	2,230,699	0.006681	337,865	2,257	53
	Radiology-Diagnostic	456,612	2,333,917	0.195642	51,420	10,060	
55	Radiology-Therapeutic						55
56	Radioisotope						56
57	Computed Tomography (CT) Scan						57
58	Magnetic Resonance Imaging (MRI)						58
59	Cardiac Catheterization						60
	Laboratory	27,362	922,782	0.029652	129,584	3,842	60
	PBP Clinical Laboratory Services- Prgm. Only						61
	Whole Blood & Packed Red Blood Cells						62
	Blood Storing, Processing, & Transfusing						63
64	Intravenous Therapy						64
65	Respiratory Therapy						65
66	Physical Therapy	13,003	329,450	0.039469	110,333	4,355	66
67	Occupational Therapy	6,540	204,739	0.031943	64,818	2,070	67
68	Speech Pathology						68
69	Electrocardiology						69
70	Electroencephalography	130,201	768,719	0.169374			70
71	Medical Supplies Charged to Patients	30,919	4,146,008	0.007458	783,923	5,846	71
	Implantable Devices Charged to Patients	266,780	39,513,846	0.006752	8,239,230	55,631	72
73	Drugs Charged to Patients	136,580	2,558,776	0.053377	714,270	38,126	73
74	Renal Dialysis						74
75	ASC (Non-Distinct Part)						75
76	Other Ancillary (specify)						76
	Rural Health Clinic (RHC)						88
	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
	Other Outpatient Service (specify) OTHER REIMBURSABLE COST CENTERS						93
	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)	1,776,650	89,935,374	0.019755	17,353,317	252,228	
(A) Wo	orksheet A line numbers						
	CMS-2552-10 (10-2012) (INSTRUCT	IONS FOR THIS WORKS	SHEET ARE PUBLISHE	D IN CMS PUB. 15-2, SEC	CTION 4024.2)		
40-560	- 10 - 12					Rev. 3	

APPORTIONMENT OF INPATIENT ROU	TINE SERV	ICE OTHER PA	ASS THROUC	GH COSTS	Provider CCN	: 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)						1,140		354		30
31 Intensive Care Unit										31
32 Coronary Care Unit										32
33 Burn Intensive Care Unit										33
34 Surgical Intensive Care Unit										34
35 Other Special Care Unit (specify)										35
40 Subprovider IPF										40
41 Subprovider IRF										41
42 Subprovider (Other)										42
43 Nursery										43
44 Skilled Nursing Facility										44
45 Nursing Facility										45
200 Total (sum of lines 30-199)						1,140		354		200
(A) Worksheet A line numbers										
FORM CMS-2552-10 (09-2014) (INSTRUC	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 - As Submitted

[Record code 598260 - 2010]

APPORTIONMENT OF	E INPATIENT/OUTPA	TIENT ANCILL ARY SERVICE	OTHER PASS THROUGH COSTS

Provider CCN: 150177 PERIOD:

FROM 01/01/2016 TO 12/31/2016

WORKSHEET D, PART IV

Medicare -Title XVIII - Hospital														
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total cost (sum of col 1 through col. 4)	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							36,926,438			6,921,874		5,749,114		50
51 Recovery Room														51
52 Labor room and Delivery Room														52
53 Anesthesiology							2,230,699			337,865		464,896		53
54 Radiology-Diagnostic							2,333,917			51,420		654,134		54
55 Radiology-Therapeutic														55
56 Radioisotope														56
57 Computed Tomography (CT) Scan														57
58 Magnetic Resonance Imaging (MRI)														58
59 Cardiac Catheterization														59
60 Laboratory							922,782			129,584		71,998		60
61 PBP Clinical Laboratory Services-Prgm. Only														61
62 Whole Blood & Packed Red Blood Cells														62
63 Blood Storing, Processing, & Transfusing														63
64 Intravenous Therapy														64
65 Respiratory Therapy														65
66 Physical Therapy							329,450			110,333		889		66
67 Occupational Therapy							204,739			64,818		600		67
68 Speech Pathology														68
69 Electrocardiology														69
70 Electroencephalography							768,719					270,655		70
71 Medical Supplies Charged To Patients							4,146,008			783,923		1,022,612		71
72 Implantable Devices Charged to Patients							39,513,846			8,239,230		1,689,241		72
73 Drugs Charged to Patients							2,558,776			714,270		379,725		73
74 Renal Dialysis														74
75 ASC (Non-Distinct Part)														75
76 Other Ancillary (specify)														76
OUTPATIENT SERVICE COST CENTERS														
88 Rural Health Clinic (RHC)														88
89 Federally Qualified Health Center (FQHC)														89
90 Clinic														90

APPORTIONMENT OF INPATIENT/OUTPAT	TIENT ANCILLAR	RY SERVICE	OTHER PASS T	THROUGH CO	OSTS				Provider CCN:	150177	PERIOD: FROM 01/01/20 TO 12/31/2016		WORKSHEET PART IV	D,
Medicare -Title XVIII - Hospital														
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass- Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass- Through Costs (col. 9 x col. 12)	
(A) Cost Center Description	1	2	3	4	5	6	7	8	9	10	11	12	13	
91 Emergency														91
92 Observation Beds (Non-Distinct Part)														92
92.01 Observation Beds (Distinct Part)														92.01
93 Other Outpatient Service (specify)														93
OTHER REIMBURSABLE COST CENTERS														
94 Home Program Dialysis														94
95 Ambulance Services														95
96 Durable Medical Equipment-Rented														96
97 Durable Medical Equipment-Sold														97
98 Other Reimbursable (specify)														98
200 Total (sum of lines 50 through 199)							89,935,374			17,353,317	,	10,303,864		200
(A) Worksheet A line numbers					1	T.								
FORM CMS-2552-10 (09/2015) (INSTRUCTIO	NS FOR THIS W	ORKSHEET	ARE PUBLISHEI	D IN CMS PU	B. 15-2, SECTIO	ON 4024.4)								
40-571 - 09-15													Rev. 8	

### UNITY MEDICAL AND SURGICAL HOSPITAL - $\operatorname{MISHAWAKA}$ , $\operatorname{IN}$

	RTIONMENT OF MEDICAL AND OTHER HEA	LTH SERVICES (	COSTS	Provider CCN:	150177	PERIOD: FROM 01/01/20 TO 12/31/2016	016	WORKSHEET PART V	D,
	are -Title XVIII - Hospital	THED HEAT THE	EDVICES COST	20					
PAKI	V - APPORTIONMENT OF MEDICAL AND OT	Cost to Charge		S Program Charge	- -		Program Cost		
		Ratio from Worksheet C, Part I, col. 9	PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject to Ded. & Coins. (see instructions)	Cost Reimbursed Services Not	PPS Services (see instructions)	Cost Reimbursed Services Subject to Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject to Ded. & Coins. (see instructions)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
ANCI	LLARY SERVICE COST CENTERS								
50	Operating Room		5,749,114			442,136			
51	Recovery Room								1
52	Labor & Delivery Room								
53	Anesthesiology		464,896			123,239			:
	Radiology-Diagnostic	+	654,134			503,201			5
	Radiology-Therapeutic		, , ,			-, *-			
	Radioisotope								
	Computed Tomography (CT) Scan								1
	Magnetic Resonance Imaging (MRI)	+							
	Cardiac Catheterization	+							- :
	Laboratory		71,998			38,942			
	PBP Clinic Laboratory Services-Prgm. Only		71,550			30,712			,
	Whole Blood & Packed Red Blood Cells								
	Blood Storing, Processing, & Transfusing								
	Intravenous Therapy								
	Respiratory Therapy		990			420			
	Physical Therapy		889			438			(
	Occupational Therapy		600			319			
	Speech Pathology								
	Electrocardiology		270 655			171.260			
	Electroencephalography		270,655			174,260			
	Medical Supplies Charged To Patients		1,022,612			336,953			
	Implantable Devices Charged to Patients		1,689,241			551,791			
	Drugs Charged to Patients		379,725			230,987			
	Renal Dialysis								1
	ASC (Non-Distinct Part)								
	Other Ancillary (specify)								
	PATIENT SERVICE COST CENTERS								
	Rural Health Clinic (RHC)								:
	Federally Qualified Health Center (FQHC)								8
	Clinic								Š
	Emergency								!
	Observation Bed (Non-Distinct Part)								9
	Observation Bed (Distinct Part)								92.0
	Other Outpatient Service (specify)								ġ
	ER REIMBURSABLE COST CENTERS								
94	Home Program Dialysis								9
95	Ambulance								9
96	Durable Medical Equipment-Rented								9
97	Durable Medical Equipment-Sold								9
98	Other Reimbursable Cost Center								1
	Subtotal (see instructions)		10,303,864			2,402,266			20
201	Less PBP Clinic Lab. Services-Program Only								20
	Charges								
202	Net Charges (line 200 - line 201 )		10,303,864			2,402,266			20
ODA	1 CMS-2552-10 (09-2015) (INSTRUCTIONS FOR	THIS WODESHE	ET ADE DUDI	ISHED IN CMS	PLIR 15-2 SEC	TIONS 4024 5)			

_	a code 598260 - 2010] RTIONMENT OF MEDICAL AND OTHER HEAI	LTH SERVICES (	COSTS	Provider CCN:	150177	PERIOD: FROM 01/01/2 TO 12/31/2016		WORKSHEET PART V	D,
	aid - Title XIX - Hospital								
PART	V - APPORTIONMENT OF MEDICAL AND OTI						-		1
		Cost to Charge		Program Charge	1		Program Cost	1	
		Ratio from Worksheet C, Part I, col. 9	PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject to Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject to Ded. & Coins. (see instructions)	PPS Services (see instructions)	Cost Reimbursed Services Subject to Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject to Ded. & Coins. (see instructions)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
ANCI	LLARY SERVICE COST CENTERS								
	Operating Room		512,736						50
	Recovery Room								51
52	Labor & Delivery Room								52
	Anesthesiology		19,938						53
	Radiology-Diagnostic		33,401						54
	Radiology-Therapeutic								55
	Radioisotope								56
	Computed Tomography (CT) Scan								57
	Magnetic Resonance Imaging (MRI)								58
	Cardiac Catheterization								59
	Laboratory		7,188						60
61	PBP Clinic Laboratory Services-Prgm. Only								61
	Whole Blood & Packed Red Blood Cells								62
	Blood Storing, Processing, & Transfusing								63
64	Intravenous Therapy								64
	Respiratory Therapy								65
	Physical Therapy								66
	Occupational Therapy								67
	Speech Pathology								68
	Electrocardiology								69
II.	Electroencephalography		22,193						70
II.	Medical Supplies Charged To Patients								71
	Implantable Devices Charged to Patients								72
	Drugs Charged to Patients		12,696						73
	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)								92
	Observation Bed (Distinct Part)								92.01
	Other Outpatient Service (specify)								93
	R REIMBURSABLE COST CENTERS								0.1
<u> </u>	Home Program Dialysis								94
	Ambulance Durable Medical Equipment-Rented								95 96
	Durable Medical Equipment-Rented  Durable Medical Equipment-Sold								96
	Other Reimbursable Cost Center								98
	Subtotal (see instructions)		608,152						200
	Less PBP Clinic Lab. Services-Program Only		000,132						200
201	Charges								201
202	Net Charges (line 200 - line 201)					96,311			202
	I CMS-2552-10 (09-2015) (INSTRUCTIONS FOR	THIS WORKSHE	EET ARE PUBL	ISHED IN CMS	PUB. 15-2, SEC	CTIONS 4024.5)	1	I	1
40-572	2 - 09-15							Rev. 8	

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016	WORKSHEET D-1, PART I	
Medicare -Title XVIII - Hospital				
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1 Inpatient days (including private room days	and swing-bed days, excluding ne	wborn)	1,140	) 1
2 Inpatient days (including private room days,	excluding swing-bed and newborn	n days)	1,140	) 2
3 Private room days (excluding swing-bed and line.	d observation bed days). If you have	e only private room days, do not complete this		3
4 Semi-private room days (excluding swing-b	ed and observation bed days)		1,140	) 4
5 Total swing-bed SNF type inpatient days (in	cluding private room days) throug	h December 31 of the cost reporting period		1
6 Total swing-bed SNF type inpatient days (in calendar year, enter 0 on this line)	cluding private room days) after D	December 31 of the cost reporting period (if		(
7 Total swing-bed NF type inpatient days (inc	luding private room days) through	December 31 of the cost reporting period		7
year, enter 0 on this line)		cember 31 of the cost reporting period (if calenda	r	8
9 Total inpatient days including private room	days applicable to the Program (ex	cluding swing-bed and newborn days)	354	1 6
Swing-bed SNF type inpatient days applicate reporting period (see instructions).	ole to title XVIII only (including pr	rivate room days) through December 31 of the cos	it	10
11 Swing-bed SNF type inpatient days applicate reporting period (if calendar year, enter 0 on		rivate room days) after December 31 of the cost		11
12 Swing-bed NF type inpatient days applicable cost reporting period.	e to titles V or XIX only (including	g private room days) through December 31 of the		12
13 Swing-bed NF type inpatient days applicable reporting period (if calendar year, enter 0 on		g private room days) after December 31 of the cos	t	13
14 Medically necessary private room days appl	icable to the Program (excluding s	wing-bed days)		14
15 Total nursery days (title V or XIX only)				15
16 Nursery days (title V or XIX only)	_			16
SWING BED ADJUSTMENT				
17 Medicare rate for swing-bed SNF services a	pplicable to services through Dece	mber 31 of the cost reporting period		17
18 Medicare rate for swing-bed SNF services a	pplicable to services after Decemb	er 31 of the cost reporting period		18
19 Medicaid rate for swing-bed NF services ap	plicable to services through Decem	aber 31 of the cost reporting period		19
20 Medicaid rate for swing-bed NF services ap				20
21 Total general inpatient routine service cost (	<u>`</u>		5,871,987	+
22 Swing-bed cost applicable to SNF type servi		ost reporting period (line 5 x line 17)	2,072,20	22
23 Swing-bed cost applicable to SNF type serving				23
24 Swing-bed cost applicable to NF type service				24
25 Swing-bed cost applicable to NF type service				25
26 Total swing-bed cost (see instructions)	es arter December 31 of the cost re	period (line o x line 20)		26
27 General inpatient routine service cost net of	swing had cost (line 21 minus line	26)	5,871,987	
PRIVATE ROOM DIFFERENTIAL ADJUSTMI		: 20)	3,871,767	
		a had showers)		7 20
28 General inpatient routine service charges (ex		n bed charges)		28
29 Private room charges (excluding swing-bed				29
30 Semi-private room charges (excluding swing				30
31 General inpatient routine service cost/charge				31
32 Average private room per diem charge (line				32
33 Average semi-private room per diem charge		•		33
34 Average per diem private room charge diffe		instructions)		34
35 Average per diem private room cost differen				35
36 Private room cost differential adjustment (lin				36
37 General inpatient routine service cost net of			5,871,987	7 37
FORM CMS-2552-10 (09/2015) (INSTRUCTION	NS FOR THIS WORKSHEET AR	E PUBLISHED IN CMS PUB. 15-II, SECTIONS	4025.1)	
40-573 - 09-15			Rev. 8	

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016	WORKSHEET D-1, PART I
Medicaid - Title XIX - Hospital			
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1 Inpatient days (including private room days	and swing-bed days, excluding ne	ewborn)	1,140
2 Inpatient days (including private room days,	excluding swing-bed and newbor	n days)	1,140
		ve only private room days, do not complete this	3
line.	• • •		
4 Semi-private room days (excluding swing-be	ed and observation bed days)		1,140
5 Total swing-bed SNF type inpatient days (in	cluding private room days) throug	gh December 31 of the cost reporting period	5
6 Total swing-bed SNF type inpatient days (incalendar year, enter 0 on this line)	cluding private room days) after I	December 31 of the cost reporting period (if	(
7 Total swing-bed NF type inpatient days (incl	luding private room days) through	December 31 of the cost reporting period	7
8 Total swing-bed NF type inpatient days (include year, enter 0 on this line)	luding private room days) after D	ecember 31 of the cost reporting period (if calendar	
9 Total inpatient days including private room of	days applicable to the Program (ex	xcluding swing-bed and newborn days)	9
10 Swing-bed SNF type inpatient days applicab reporting period (see instructions).	le to title XVIII only (including p	rivate room days) through December 31 of the cost	10
11 Swing-bed SNF type inpatient days applicab reporting period (if calendar year, enter 0 on		rivate room days) after December 31 of the cost	11
12 Swing-bed NF type inpatient days applicable cost reporting period.	to titles V or XIX only (includin	g private room days) through December 31 of the	12
13 Swing-bed NF type inpatient days applicable reporting period (if calendar year, enter 0 on	•	g private room days) after December 31 of the cost	13
14 Medically necessary private room days appli	cable to the Program (excluding	swing-bed days)	14
15 Total nursery days (title V or XIX only)			15
16 Nursery days (title V or XIX only)			16
SWING BED ADJUSTMENT	_		
17 Medicare rate for swing-bed SNF services ap	oplicable to services through Dece	ember 31 of the cost reporting period	17
18 Medicare rate for swing-bed SNF services ap	oplicable to services after Decemb	per 31 of the cost reporting period	18
19 Medicaid rate for swing-bed NF services app	plicable to services through Decer	mber 31 of the cost reporting period	19
20 Medicaid rate for swing-bed NF services app	plicable to services after December	er 31 of the cost reporting period	20
21 Total general inpatient routine service cost (s	see instructions)		21
22 Swing-bed cost applicable to SNF type servi	ces through December 31 of the c	cost reporting period (line 5 x line 17)	22
23 Swing-bed cost applicable to SNF type servi	ces after December 31 of the cost	reporting period (line 6 x line 18)	23
24 Swing-bed cost applicable to NF type service	es through December 31 of the co	est reporting period (line 7 x line 19)	24
25 Swing-bed cost applicable to NF type service	es after December 31 of the cost r	reporting period (line 8 x line 20)	25
26 Total swing-bed cost (see instructions)			26
27 General inpatient routine service cost net of	swing-bed cost (line 21 minus lin	e 26)	27
PRIVATE ROOM DIFFERENTIAL ADJUSTME	ENT		
28 General inpatient routine service charges (ex	cluding swing-bed and observation	on bed charges)	28
29 Private room charges (excluding swing-bed	charges)		29
30 Semi-private room charges (excluding swing	g-bed charges)		30
31 General inpatient routine service cost/charge	ratio (line 27 ÷ line 28)		31
32 Average private room per diem charge (line	29 ÷ line 3)		32
33 Average semi-private room per diem charge	(line 30 ÷ line 4)		33
34 Average per diem private room charge differ	rential (line 32 minus line 33) (see	e instructions)	34
35 Average per diem private room cost differen	tial (line 34 x line 31)		35
36 Private room cost differential adjustment (lin	ne 3 x line 35)		36
37 General inpatient routine service cost net of	swing-bed cost and private room	cost differential (line 27 minus line 36)	37
FORM CMS-2552-10 (09/2015) (INSTRUCTION	S FOR THIS WORKSHEET AR	RE PUBLISHED IN CMS PUB. 15-II, SECTIONS	4025.1)
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[Record code 598260 - 2010]		·				
COMPUTATION OF INPATIENT OPERATING (	COST	Provider CCN: 150177		PERIOD: FROM 01/01/2016 TO 12/31/2016	WORKSHEET D-1, PA	4RT
Medicare -Title XVIII - Hospital	_			10 12/01/2010		
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				_	5,150.87	38
39 Program general inpatient routine service cost					1,823,408	
40 Medically necessary private room cost applica		14 x line 35)			1,020,100	40
41 Total Program general inpatient routine servic					1,823,408	
	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 (Work	sheet D-3, column 3, lir	ne 200)	I		4,204,495	48
49 Total Program inpatient costs (sum of lines 41					6,027,903	49
PASS-THROUGH COST ADJUSTMENTS						
50 Pass through costs applicable to Program inpa	eient routine services (fro	om Worksheet D, sum o	f Parts I and III)		315,099	50
51 Pass through costs applicable to Program inpa	ient ancillary services (1	from Worksheet D, sum	of Parts II and IV)		252,228	51
52 Total Program excludable cost (sum of lines 5	0 and 51)		<u> </u>		567,327	52
53 Total Program inpatient operating cost excludi 52)	ng capital related, nonpl	hysician anesthetist, and	medical education cos	sts (line 49 minus line	5,460,576	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 operating	g cost and target amoun	t (line 56 minus line 53)				57
58 Bonus payment (see instructions)				_		58
59 Lesser of line 53 ÷ line 54 or line 55 from the	cost reporting period end	ding 1996, updated and o	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				1	
64 Medicare swing-bed SNF inpatient routine cos	ts through December 31	of the cost reporting pe	riod (see instructions)	(title XVIII only)		64
65 Medicare swing-bed SNF inpatient routine cos	ts 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	costs after December 3	1 of the cost reporting po	eriod (line 13 x line 20	))		68
69 Total title V or XIX swing-bed NF inpatient ro	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 OPERATING	COST	Provider CCN: 150177		PERIOD: FROM 01/01/2016 TO 12/31/2016	WORKSHEET D-1, PAR III & IV	RTS
Medicare -Title XVIII - Hospital	<u> </u>					
PART III - SKILLED NURSING FACILITY, OT	HER NURSING FACII	LITY. AND ICF/IID ON	LY			
70 Skilled nursing facility/other nursing facility	/ICF/IID routine service	cost (line 37)		-		70
71 Adjusted general inpatient routine service co	•	ne 2)				71
72 Program routine service cost (line 9 x line 71	)					72
73 Medically necessary private room cost applie	cable to Program (line 1-	4 x line 35)		-		73
74 Total Program general inpatient routine servi	ce costs (line 72 + line '	73)				74
75 Capital-related cost allocated to inpatient rou	tine service costs (from	Worksheet B, Parts II, c	olumn 26, line 45)			75
76 Per diem capital-related costs (line 75 ÷ line	2)			-		76
77 Program capital-related costs (line 9 x line 7	5)					77
78 Inpatient routine service cost (line 74 minus	line 77)					78
79 Aggregate charges to beneficiaries for excess	costs (from provider re	ecords)		-		79
80 Total Program routine service costs for comp	parison to the cost limita	tion (line 78 minus line	79)			80
81 Inpatient routine service cost per diem limita	tion					81
82 Inpatient routine service cost limitation (line	9 x line 81)					82
83 Reasonable inpatient routine service costs (se	ee instructions)					83
84 Program inpatient ancillary services (see inst	ructions)					84
85 Utilization review - physician compensation	(see instructions)					85
86 Total Program inpatient operating costs (sum	of lines 83 through 85)	1				86
PART IV - COMPUTATION OF OBSERVATIO	N BED PASS-THROU	GH COST		_		
87 Total observation bed days (see instructions)						87
88 Adjusted general inpatient routine cost per d	em (line 27 ÷ line 2)					88
89 Observation bed cost (line 87 x line 88) (see	instructions)			-		89
COMPUTATION OF OBSERVATION BED PAS	SS THROUGH COST					
	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass- Through Cost (col. 3 x col. 4) (see instructions)	
	1	2	3	4	5	
90 Capital-related cost	1,014,725	5,871,987	0.172808			90
91 Nursing School cost		5,871,987				91
92 Allied Health cost		5,871,987				92
93 All other Medical Education		5,871,987				93
FORM CMS-2552-10 (09/2015) (INSTRUCTION	S EOR THIS WORKS	JEET ARE DURI ISHE	NICMS DID 15 2 SI	ECTIONS 4025 2 4025	1)	

	ovider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016		WORKSHEET D-3	
Medicare -Title XVIII - Hospital					,
(A) COST CENTER DESCRIPTION		Ratio of Cost to Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
NPATIENT ROUTINE SERVICE COST CENTERS					
30 Adults and Pediatrics (General Routine Care)			448,592		3
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) 40 Subprovider IPF					3
41 Subprovider IRF					-
42 Subprovider (Specify)					4
43 Nursery					
ANCILLARY SERVICE COST CENTERS					
50 Operating Room		0.076905	6,921,874	532,327	:
51 Recovery Room			, ,	*	5
52 Labor Room and Delivery Room					:
53 Anesthesiology		0.265090	337,865	89,565	-
54 Radiology-Diagnostic		0.769263	51,420	39,556	_
55 Radiology-Therapeutic					:
56 Radioisotope					:
57 Computed Tomography (CT) Scan					:
58 Magnetic Resonance Imaging (MRI)					
59 Cardiac Catheterization					
60 Laboratory		0.540870	129,584	70,088	
61 PBP Clinical Laboratory Services-Prgm. Only					
62 Whole Blood & Packed Red Blood Cells					
63 Blood Storing, Processing, & Trans.					
64 Intravenous Therapy					(
65 Respiratory Therapy					(
66 Physical Therapy		0.492539	110,333	54,343	
67 Occupational Therapy		0.531911	64,818	34,477	_
68 Speech Pathology					
69 Electrocardiology					
70 Electroencephalography		0.220502	702.022	259 204	
71 Medical Supplies Charged to Patients  72 Implantable Devices Charged to Patients		0.329502	783,923	258,304	
73 Drugs Charged to Patients		0.326650 0.608301	8,239,230 714,270	2,691,344	
74 Renal Dialysis		0.008301	714,270	434,491	
75 ASC (Non-Distinct Part)					
76 Other Ancillary (specify)					
DUTPATIENT SERVICE COST CENTERS					
88 Rural Health Clinic (RHC)					
89 Federally Qualified Health Center (FQHC)					
90 Clinic					
91 Emergency					9
92 Observation Beds (Non-Distinct Part)					9
92.01 Observation Beds (Distinct Part)					92.0
93 Other Outpatient Service (specify)					9
OTHER REIMBURSABLE COST CENTERS					
94 Home Program Dialysis					9
95 Ambulance Services					9
96 Durable Medical Equipment-Rented					9
97 Durable Medical Equipment-Sold					9
98 Other Reimbursable (specify)					
200 Total (sum of lines 50-94 and 96-98)			17,353,317	4,204,495	2
201 Less PBP Clinic Laboratory Services-Program only charges (line 61	)				20
202 Net Charges (line 200 minus line 201)			17,353,317		20
A) Worksheet A line numbers					

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016		WORKSHEET D-3
Medicare -Title XVIII - Hospital				
(A) COST CENTER DESCRIPTION		Ratio of Cost to Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1	2	3
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JI ILC	CULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016		WORKSHEET E	PART A
Лedic	care -Title XVIII - Hospital				1	
PART	A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
			1	1.01	1.02	
	DRG amounts other than outlier payments					
	DRG amounts other than outlier payments for discharges occurring p instructions)		1,753,397			1.
	DRG amounts other than outlier payments for discharges occurring o (see instructions)					1.
1.03	DRG for federal specific operating payment for Model 4 BPCI for disprior to October 1 (see instructions)	scharges occurring				1.
1.04	DRG for federal specific operating payment for Model 4 BPCI for disor after October 1 (see instructions)	scharges occurring on				1.
2	Outlier payments for discharges (see instructions)		1,732,085			
2.01	Outlier reconciliation amount					2.
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)					2.
3	Managed care simulated payments					
	Bed days available divided by number of days in the cost reporting pe Indirect Medical Education Adjustment Calculation for Hospitals	eriod (see instructions)	29.00			
	FTE count for allopathic and osteopathic programs for the most recently ending on or before 12/31/1996 (see instructions)					
	FTE count for allopathic and osteopathic programs which meet the cr the cap for new programs in in accordance with 42 CFR 413.79(e)	iteria for an add-on to				
	MMA Section 422 reduction amount to the IME cap as specified und (1)(iv)(B)(1)					
	ACA Section 5503 reduction amount to the IME cap as specified und (1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instruct	ions.				7
	Adjustment (increase or decrease) to the FTE count for allopathic and for affiliated programs in accordance with 42 CFR 413.75(b), 413.79 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	(c)(2)(iv), 64 FR				
	The amount of increase if the hospital was awarded FTE cap slots und ACA. If the cost report straddles July 1, 2011, see instructions.					8
	The amount of increase if the hospital was awarded FTE cap slots fro hospital under section 5506 of ACA. (see instructions)	m a closed teaching				8
	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus (see instructions)					
10	FTE count for allopathic and osteopathic programs in the current year	from your records				
	FTE count for residents in dental and podiatric programs					
	Current year allowable FTE (see instructions)					
13	Total allowable FTE count for the prior year					
	Total allowable FTE count for the penultimate year if that year ended 30, 1997, otherwise enter zero.	on or after September				
15	Sum of lines 12 through 14 divided by 3					
16	Adjustment for residents in initial years of the program					
17	Adjustment for residents displaced by program or hospital closure					
	Adjusted rolling average FTE count					
19	Current year resident to bed ratio (line 18 divided by line 4)					
20	Prior year resident to bed ratio (see instructions)					
21	Enter the lesser of lines 19 or 20 (see instructions)					
22	IME payment adjustment (see instructions)					
2.01	IME payment adjustment - Managed Care (see instructions)					22
ndire	ct Medical Education Adjustment for the Add-on for Section 422 of th	ne MMA			,	,
23	Number of additional allopathic and osteopathic IME FTE resident ca 412.105 (f)(1)(iv)(C).	ap slots under 42 Sec.				
24	IME FTE resident count over cap (see instructions)					
25	If the amount on line 24 is greater than -0-, then enter the lower of lin instructions)	e 23 or line 24 (see				
26	Resident to bed ratio (divide line 25 by line 4)					
27	IME payments adjustment factor (see instructions)					
28	IME add-on a djustment amount (see instructions)					
	IME add-on adjustment amount - Managed Care (see instructions)					28
	Total IME payment (sum of lines 22 and 28)					
	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		+			29
	oportionate Share Adjustment				I	123
_		ave (coo instructions)	<u> </u>			
30	Percentage of SSI recipient patient days to Medicare Part A patient day	ays (see instructions)				

CALC	ULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016		WORKSHEET E PAR	RT A
32	Sum of lines 30 and 31	1				32
33	Allowable disproportionate share percentage (see instructions)					33
34	Disproportionate share adjustment (see instructions)					34
	npensated Care Adjustment			Prior to October 1	On or after October 1	
	<u>, , , , , , , , , , , , , , , , , , , </u>			1	2	
35	Total uncompensated care amount (see instructions)			6,406,145,534	5,977,483,147	35
	Factor 3 (see instructions)			0.000001388	0.000002154	
				0.00001388	0.00002134	
	Hospital uncompensated care payment (If line 34 is zero, enter zero o		ions)			35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (s	ee instructions)	1			35.03
			1	1.01	2	
	Pro rata share of the hospital uncompensated care payment amount (M	MDH) (see				35.04
$\perp$	instructions)					
35.05	Pro rata share of the hospital uncompensated care payment amount (S	SCH) (see instructions)				35.05
				Prior to October 1	On or after October 1	
				1	2	
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)					36
Additi	onal payment for high percentage of ESRD beneficiary discharges (lin	nes 40 through 46)		I		
			1	1.01	1.02	
40	Total Medicare discharges, excluding discharges for MS-DRGs 652,	682, 683, 684 and 685	-			40
10	(see instructions)	002, 003, 007 and 003				40
41	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683	. 684 an 685 (see				41
	instructions)	, 50 i an 605 (see				71
	Total ESRD Medicare covered and paid discharges excluding MS-DF					41
	684, and 685 (see instructions)					11
	Divide line 41 by line 40 (if less than 10%, you do not qualify for adj					42
	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682,					43
	instructions)	085, 084 and 085 (see				43
	Ratio of average length of stay to one week (line 43 divided by line 4	1 01 divided by 7				44
44	days)	1.01 divided by 7				44
15	Average weekly cost for dialysis treatments (see instructions)					45
$\perp$						_
	Total additional payment (line 45 times line 44 times line 41.01)		2 405 402			46
	Subtotal (see instructions)		3,485,482			47
48	Hospital specific payments (to be completed by SCH and MDH, small	ll rural hospitals only				48
	(see instructions)					
	Total payment for inpatient operating costs (see instructions)		3,485,482			49
	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II,		382,720			50
51	Exception payment for inpatient program capital (Wkst. L, Pt. III) (se	e instructions)				51
52	Direct graduate medical education payment (from Wkst. E-4, line 49)	(see instructions).				52
53	Nursing and allied health managed care payment					53
	Special add-on payments for new technologies					54
	Islet isolation add-on payment					54.01
	* *					
	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
	Routine service other pass through costs (from Wkst. D, Pt. III, col. 9					57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col.	11, line 200)				58
59	Total (sum of amounts on lines 49 through 58)		3,868,202			59
60	Primary payer payments					60
61	Total amount payable for program beneficiaries (line 59 minus line 60	0)	3,868,202			61
	Deductibles billed to program beneficiaries	· · · · · · · · · · · · · · · · · · ·	124,908			62
	Coinsurance billed to program beneficiaries		12.,750	1		63
			57 110			64
	Allowable bad debts (see instructions)		57,110			
	Adjusted reimbursable bad debts (see instructions)		37,122			65
	Allowable bad debts for dual eligible beneficiaries (see instructions)					66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)		3,780,416			67
68	Credits received from manufacturers for replaced devices for application	ole MS-DRGs (see				68
	instructions)					
69	Outlier payments reconciliation (Sum of lines 93,95 and 96) (For SCI	H see instructions)				69
70	Other adjustments (specify) (see instructions)					70
70.88	SCH or MDH volume decrease adjustment					70.88
	Pioneer ACO demonstration payment adjustment amount (see instruc	tions)				70.89
	HSP bonus payment HVBP adjustment amount (see instructions)					70.90
	HSP bonus payment HRR adjustment amount (see instructions)					70.91
$\perp$	Bundled Model 1 discount amount (see instructions)					70.92
70.93	HVBP payment adjustment amount (see instructions)		19,957			70.93
	HRR adjustment amount (see instructions)					70.94
	Recovery of accelerated depreciation					70.95

CALC		Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016		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)		3,800,373			71
71.01	Sequestration adjustment (see instructions)		76,007			71.01
72	Interim payments		3,687,986			72
73	Tentative settlement (for contractor use only)					73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73	3)	36,380			74
75	Protested amounts (nonallowable cost report items) in accordance with Chapter 1, § 115.2	h CMS Pub. 15-2,				75
TO B	E COMPLETED BY CONTRACTOR (lines 90 through 96)				-	
90	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)	)	1,732,085			90
91	Capital outlier from Wkst. L, Pt. I, line 2		242,438			91
92	Operating outlier reconciliation adjustment amount (see instructions)					92
93	Capital outlier reconciliation adjustment amount (see instructions)					93
94	The rate used to calculate the time value of money (see instructions)					94
95	Time value of money for operating expenses (see instructions)					95
96	Time value of money for capital related expenses (see instructions)					96
				1	2	
	HSP Bonus Payment Amount			Prior to 10/1	On or After 10/1	
100	HSP Bonus Payment Amount (see instructions)					100
	HVBP Adjustment for HSP Bonus Payment			Prior to 10/1	On or After 10/1	
101	HVBP adjustment factor (see instructions)					101
102	HVBP adjustment amount for HSP bonus payment (see instructions)					102
	HRR Adjustment for HSP Bonus Payment			Prior to 10/1	On or After 10/1	
103	HRR adjustment factor (see instructions)					103
104	HRR adjustment amount for HSP bonus payment (see instructions)					104
	40-584 - 11-164 FORM CMS-2552-10 (11-2016) (INSTRUCT 15-2, § 4030.1)	IONS FOR THIS W	kst. ARE PUBLISHED	IN CMS PUB.		Rev. 10

Record code 598260 - 2010    CALCULATION OF REIMBURSEMENT   Provider CCN: 150177   PERIOD: FROM 01/01/2016   TO 12/31/2016	WORKSHEET E, PART B	
Medicare -Title XVIII - Hospital		
PART B - MEDICAL AND OTHER HEALTH SERVICES		
1 Medical and other services (see instructions)	2 402 255	
2 Medical and other services reimbursed under OPPS (see instructions).	2,402,266	
3 PPS payments	1,809,664	3
4 Outlier payment (see instructions)	29,915	4
5 Enter the hospital specific payment to cost ratio (see instructions)		
6 Line 2 times line 5		(
7 Sum of line 3 and line 4 divided by line 6		
8 Transitional corridor payment (see instructions)		8
9 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		Ģ
10 Organ acquisition		10
11 Total cost (sum of lines 1 and 10) (see instructions)		11
COMPUTATION OF LESSER OF COST OR CHARGES		
Reasonable charges		
12 Ancillary service charges		12
13 Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)		13
14 Total reasonable charges (sum of lines 12 and 13)		14
Customary charges		
15 Aggregate amount actually collected from patients liable for payment for services on a charge basis		15
Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		16
17 Ratio of line 15 to line 16 (not to exceed 1.000000)		17
18 Total customary charges (see instructions)		18
19 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see		19
instructions)		
20 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		20
21 Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)		2
22 Interns and residents (see instructions)		22
23 Cost of physicians' services in a teaching hospital (see instructions)		23
24 Total prospective payment (sum of lines 3, 4, 8, and 9)	1,839,579	24
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25 Deductibles and coinsurance (see instructions)		25
26 Deductibles and Coinsurance relating to amount on line 24 (see instructions)	329,799	26
27 Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see	1,509,780	27
instructions)	1,505,700	2.
28 Direct graduate medical education payments (from Wkst. E-4, line 50)		28
29 ESRD direct medical education costs (from Wkst. E-4, line 36)		29
30 Subtotal (sum of lines 27 through 29)	1,509,780	30
		31
31 Primary payer payments	1,047	
32 Subtotal (line 30 minus line 31)	1,508,733	32
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33 Composite rate ESRD (from Wkst. I-5, line 11)		33
34 Allowable bad debts (see instructions)		34
35 Adjusted reimbursable bad debts (see instructions)		35
36 Allowable bad debts for dual eligible beneficiaries (see instructions)		30
37 Subtotal (see instructions)	1,508,733	37
38 MSP-LCC reconciliation amount from PS&R		38
39 Other adjustments (specify) (see instructions)		39
39.50 Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.98 Partial or full credits received from manufacturers for replaced devices (see instructions)		39.98
39.99 Recovery of Accelerated depreciation		39.99
•	1.509.722	
40 Subtotal (see instructions)	1,508,733	40.01
40.01 Sequestration adjustment (see instructions)	30,175	
41 Interim payments	1,478,558	41
42 Tentative settlement (for contractors use only)		42
43 Balance due provider/program (see instructions)		43
Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,115.2		44
PART B - MEDICAL AND OTHER HEALTH SERVICES TO BE COMPLETED BY CONTRACTOR		
90 Original outlier amount (see instructions)	29,915	90
91 Outlier reconciliation adjustment amount (see instructions)		9

CALCULATION OF REIMBUR SETTLEMENT	RSEMENT	Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016	WORKSHEET E, PART I	3
			10 12/31/2016		
93 Time Value of Money (see	e instructions)				93
94 Total (sum of lines 91 and	193)				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 01/01/2016 TO 12/31/2016	WORKSHEET E-1, PART II	
Medicare -Title XVIII - Hospital				
To be completed by contractor for nonstandard cost reports Health Information Technology Data Collection and Calculation				
1 Total hospital discharges as defined in ARRA 4102 § (Wkst. S	-3, Pt. I, col. 15, line 14)		326	1
2 Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1 and 8 thr	rough 12)		354	2
3 Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)			130	3
4 Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1 and	8 through 12)		1,140	4
5 Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)			93,313,721	5
6 Total hospital charity care charges (Wkst. S-10, col. 3, line 20)			62,199	6
7 CAH only - The reasonable cost incurred for the purchase of co	ertified HIT technology (Wkst.	. S-2, Pt. I, line 168)		7
8 Calculation of the HIT incentive payment (see instructions)			212,400	8
9 Sequestration adjustment amount (see instructions)			4,248	9
10 Calculation of the HIT incentive payment after sequestration (s	see instructions)		208,152	10
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30 Initial/interim HIT payment(s).			172,284	30
31 Initial/interim HIT payment adjustments (see instructions)				31
32 Balance due provider (line 8 or line 10 minus line 30 and line 3	31) (see instructions)		35,868	32
FORM CMS-2552-10 (09/2015) (INSTRUCTIONS FOR THIS WO	RKSHEET ARE PUBLISHEI	D IN CMS PUB. 15-II, § 4031.2	2)	
* This worksheet is completed by the contractor for standard and not standard cost reporting period.	n-standard cost reporting perio	ds at cost report settlement. Pro	viders may complete this worksheet for a	a
40-589 - 09-15			Rev. 8	

$\overline{}$	ord code 598260 - 2010] LANCE SHEET		Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016	WORKSHEET G	
(If y	rou are nonproprietary and do not maintain fund-type accounting records	, complete the General Fund	column only)		'	
	Assets (Omit cents)	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
~~~		1	2	3	4	
	RRENT ASSETS	000 240	T		1	1
	Cash on hand and in banks Temporary investments	999,248				2
	Notes receivable					3
	Accounts receivable	31,158,776				4
5	Other receivables	1,068,515				5
6	Allowances for uncollectible notes and accounts receivable	-18,151,537				6
	/ Inventory	766,804				7
	Prepaid expenses	92,888				8
	Other current assets					9
	Due from other funds	15 024 604				10
	Total current assets (sum of lines 1-10) ED ASSETS	15,934,694				11
	Land	3,985				12
	B Land improvements	3,703				13
	Accumulated depreciation					14
	Buildings	860,277				15
16	Accumulated depreciation	-494,690				16
	Leasehold improvements					17
	Accumulated depreciation					18
	Fixed equipment	569,184				19
	Accumulated depreciation	-478,308				20
	Automobiles and trucks					21
	Accumulated depreciation  Major movable equipment	14,152,219				23
	Accumulated depreciation	-12,676,755				24
	Minor equipment depreciable	12,070,788				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)	1,935,912				30
	HER ASSETS					
	Investments	12.224				31
	Deposits on leases Due from owners/officers	12,324				32
	Other assets	296,235				34
	Total other assets (sum of lines 31-34)	308,559				35
	Total assets (sum of lines 11, 30, and 35)	18,179,165				36
	pilities and Fund Balances (Omit cents)					
CUI	RRENT LIABILITIES					
	Accounts payable	3,933,750				37
	Salaries, wages, and fees payable					38
	Payroll taxes payable					39
	Notes and loans payable (short term)	2,651,526				40
	Deferred income					41
	Accelerated payments Due to other funds	3,808,534				42
	Other current liabilities	3,000,334				44
	Total current liabilities (sum of lines 37 thru 44)	10,393,810				45
	NG TERM LIABILITIES		I	l	1	
	Mortgage payable					46
	Notes payable	15,222,272				47
	Unsecured loans					48
	Other long term liabilities	141,298				49
	Total long term liabilities (sum of lines 46 thru 49)	15,363,570				50
51	Total liabilities (sum of lines 45 and 50)	25,757,380				51

BALANCE SHEET		Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016	WORKSHEET G	
(If you are nonproprietary and do not maintain fund-type accounting records, con	mplete the General Fund	column only)			
Assets (Omit cents)	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1	2	3	4	
CAPITAL ACCOUNTS					
52 General fund balance	-7,578,215				52
53 Specific purpose fund					53
54 Donor created - endowment fund balance - restricted					54
55 Donor created - endowment fund balance - unrestricted					55
56 Governing body created - endowment fund balance					56
57 Plant fund balance - invested in plant					57
58 Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59 Total fund balances (sum of lines 52 thru 58)	-7,578,215				59
60 Total liabilities and fund balances (sum of lines 51 and 59)	18,179,165				60
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET	ARE PUBLISHED IN C	MS PUB. 15-II, SEC	CTION 4040)	'	
40-601 - 10-12		_		Rev. 3	

#### UNITY MEDICAL AND SURGICAL HOSPITAL - MISHAWAKA, IN

Cost report status - As Submitted [Record code 598260 - 2010]

STATI	EMENT OF CHANGES IN FUND BALANCES				Provider CCN: 150177	7	PERIOD: FROM 01/01/2016 TO 12/31/2016		WORKSHEET G-1	
		GENERA	L FUND	SPECIFIC PU	JRPOSE FUND	ENDOWN	MENT FUND	PLAN	T FUND	
		1	2	3	4	5	6	7	8	
	Fund balances at beginning of period		-16,318,812							1
2	Net income (loss) (from Worksheet G-3, line 29)		-169,406							2
3	Total (sum of line 1 and line 2)		-16,488,218							3
4	Additions (credit adjustments) (specify)PRIOR PERIOD ADJUSTMENT	8,910,003								4
5										5
6										6
7										7
8										8
9										9
	Total additions (sum of lines 4-9)		8,910,003							10
11	Subtotal (line 3 plus line 10)		-7,578,215							11
12	Deductions (debit adjustments) (specify)									12
13										13
14										14
15										15
16										16
17										17
	Total deductions (sum of lines 12-17)									18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		-7,578,215							19
FORM	CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS W	ORKSHEET ARE PUB	LISHED IN CMS PUB	. 15-II, SECTION 404	0)					
40-602	- 10-12								Rev. 3	

[Record code 598260 - 2010] STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016	WORKSHEET G-2, PARTS I	& II
PART I - PATIENT REVENUES				
REVENUE CENTER	INPATIENT	OUTPATIENT	TOTAL	
	1	2	3	
GENERAL INPATIENT ROUTINE CARE SERVICES				
1 Hospital	3,378,347		3,378,347	1
2 Subprovider IPF				2
3 Subprovider IRF				3
4 Subprovider (Other)				4
5 Swing bed - SNF				5
6 Swing bed - NF				6
7 Skilled nursing facility				7
8 Nursing facility				8
9 Other long term care				9
10 Total general inpatient care services (sum of lines 1-9)	3,378,347		3,378,347	10
INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES	1			
11 Intensive care unit				11
12 Coronary care unit				12
13 Burn intensive care unit				13
14 Surgical intensive care unit				14
15 Other special care (specify)				15
16 Total intensive care type inpatient hospital services (sum of of lines 11-15)				16
17 Total inpatient routine care services (sum of lines 10 and 16)	3,378,347		3,378,347	17
18 Ancillary services	64,808,772		64,808,772	18
19 Outpatient services	01,000,772	25,126,602		19
20 Rural Health Clinic (RHC)		25,120,002	23,120,002	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		4 474 420	4.474.420	26
27 Other (specify) PHYSICIAN PRIVATE OFFICES	60.107.110	4,474,430		27
Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	68,187,119	29,601,032	97,788,151	28
PART II - OPERATING EXPENSES		1	2	
29 Operating expenses (per Wkst. A, column 3, line 200)	_		40,915,950	29
30 Add (specify)				30
31				31
32				32
33				33
34				34
35				35
36 Total additions (sum of lines 30-35)				36
37 Deduct (specify) ROUNDING		8		37
38 38		0		38
				39
39	_			
40				40
41				41
42 Total deductions (sum of lines 37-41)			8	42
43 Total operating expenses (sum of lines 29 and 36 minus line 42) (tran FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEE		PUB. 15-II. SECTION 4040)	40,915,942	43
40-603 - 10-12		22.101, 0201101, 1070)	Rev. 3	

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016	WORKSHEET G-3	
Description				
1 Total patient revenues (from Worksh	neet G-2, Part I, column 3, line 28)		97,788,151	1 1
2 Less contractual allowances and disc	counts on patients' accounts		57,174,072	2 2
3 Net patient revenues (line 1 minus li	ne 2)		40,614,079	9 3
4 Less total operating expenses (from	Worksheet G-2, Part II, line 43)		40,915,942	2 4
5 Net income from service to patients	(line 3 minus line 4)		-301,863	3 :
OTHER INCOME				_
6 Contributions, donations, bequests, e	etc			(
7 Income from investments			2,888	3
8 Revenues from telephone and other	miscellaneous communication services			
9 Revenue from television and radio s	ervice			
10 Purchase discounts				10
11 Rebates and refunds of expenses				1
12 Parking lot receipts				1
13 Revenue from laundry and linen serv	vice			1
14 Revenue from meals sold to employ	ees and guests		19,155	5 1
15 Revenue from rental of living quarte	rs			1
16 Revenue from sale of medical and su	urgical supplies to other than patients			1
17 Revenue from sale of drugs to other	than patients			1
18 Revenue from sale of medical record	ls and abstracts		7,814	4 1
19 Tuition (fees, sale of textbooks, unif	orms, etc.)			1
20 Revenue from gifts, flowers, coffee	shops, and canteen			2
21 Rental of vending machines				2
22 Rental of hospital space				2
23 Governmental appropriations				2
24 Other (specify)				2
24.00 MISCELLANEOUS			102,600	24.0
25 Total other income (sum of lines 6-2	4)		132,457	7 2
26 Total (line 5 plus line 25)			-169,406	5 20
27 Other expenses (specify)				2
28 Total other expenses (sum of line 27	and subscripts)			2
29 Net income (or loss) for the period (	line 26 minus line 28)		-169,406	5 2
FORM CMS-2552-10 (08/2011) (INSTRUC	CTIONS FOR THIS WORKSHEET A	RE PUBLISHED IN CMS PUB. 15-II,	SECTION 4040)	
40-604 - 10-12			Rev. 3	

CAL	CULATION OF CAPITAL PAYMENT	Provider CCN: 150177	PERIOD: FROM 01/01/2016 TO 12/31/2016	W	VORKSHEET L	
Med	icare -Title XVIII - Hospital	-	,	1		
PAR	T I - FULLY PROSPECTIVE METHOD					
CAP	TTAL FEDERAL AMOUNT					
				1	1.01	
1	Capital DRG other than outlier			140,282		
1.01	Model 4 BPCI Capital DRG other than outlier					1.0
2	Capital DRG outlier payments			242,438		
2.01	Model 4 BPCI Capital DRG outlier payments					2.0
3	Total inpatient days divided by number of days i	n the cost reporting period (see instruction	ns)	3.11		
4	Number of interns & residents (see instructions)					
5	Indirect medical education percentage (see instru	ctions)				
6	Indirect medical education adjustment (see instru	actions))				
7	Percentage of SSI recipient patient days to Medi-	care Part A patient days (Worksheet E, Pa	art A line 30) (see instructions)			
8	Percentage of Medicaid patient days to total days	s (see instructions)				
9	Sum of lines 7 and 8					
10	Allowable disproportionate share percentage (see	e instructions)				1
11	Disproportionate share adjustment (see instruction	ons)				1
12	Total prospective capital payments (see instruction	ons)		382,720		1
PAR	T II - PAYMENT UNDER REASONABLE COS	T				
1	Program inpatient routine capital cost (see instru	ctions)				
2	Program inpatient ancillary capital cost (see instr	ructions)				
3	Total inpatient program capital cost (line 1 plus	ine 2)				
4	Capital cost payment factor (see instructions)					
5	Total inpatient program capital cost (line 3 x line	: 4)				
PAR	T III - COMPUTATION OF EXCEPTION PAY	MENTS				
1	Program inpatient capital costs (see instructions)					
2	Program inpatient capital costs for extraordinary	circumstances (see instructions)				
3	Net program inpatient capital costs (line 1 minus	line 2)				
4	Applicable exception percentage (see instruction	s)				
5	Capital cost for comparison to payments (line 3	( line 4)				
6	Percentage adjustment for extraordinary circums	tances (see instructions)				
7	Adjustment to capital minimum payment level for	or extraordinary circumstances (line 2 x li	ne 6)			
8	Capital minimum payment level (line 5 plus line	7)				
9	Current year capital payments (from Part I, line	2 as applicable)				
10	Current year comparison of capital minimum pa	ment level to capital payments (line 8 les	ss line 9)			1
11	Carryover of accumulated capital minimum payr line 14)	nent level over capital payment (from pri	or year Worksheet L, Part III,			1
12	Net comparison of capital minimum payment lev	rel to capital payments (line 10 plus line 1	1)			1
13	Current year exception payment (if line 12 is pos	itive, enter the amount on this line)				1
14	Carryover of accumulated capital minimum payr negative, enter the amount on this line)	nent level over capital payment for the fo	llowing period (if line 12 is			1
15	Current year allowable operating and capital pay	ment (see instructions)				1
16	Current year operating and capital costs (see inst	ructions)				1
17	Current year exception offset amount (see instruc	ctions)				1
FOR	M CMS-2552-10 (03-2014) (INSTRUCTIONS F	OR THIS WORKSHEET ARE PUBLISH	HED IN CMS PUB. 15-II, SECTION	ONS 4064.1 - 4064.3)		
	46 - 09-15				lev. 8	