

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT
CERTIFICATION AND SETTLEMENT SUMMARY

WORKSHEET S
PARTS I, II & III

PART I - COST REPORT STATUS

PROVIDER USE ONLY 1. ELECTRONICALLY FILED COST REPORT DATE: 03-21-2014 TIME: 15:12
2. MANUALLY SUBMITTED COST REPORT
3. IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT
4. MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.

CONTRACTOR USE ONLY 5. COST REPORT STATUS 6. DATE RECEIVED: _____ 10. NPR DATE: _____
1 - AS SUBMITTED 7. CONTRACTOR NO: _____ 11. CONTRACTOR'S VENDOR CODE: _____
2 - SETTLED WITHOUT AUDIT 8. INITIAL REPORT FOR THIS PROVIDER CCN 12. IF LINE 5, COLUMN 1 IS 4: ENTER
3 - SETTLED WITH AUDIT 9. FINAL REPORT FOR THIS PROVIDER CCN NUMBER OF TIMES REOPENED - 0-9.
4 - REOPENED
5 - AMENDED

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WHERE 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 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 VIBRA HOSP FORT WAYNE (15-2027) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 11/01/2012 AND ENDING 10/31/2013, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

(SIGNED) _____
OFFICER OR ADMINISTRATOR OF PROVIDER(S)

TITLE

DATE

PART III - SETTLEMENT SUMMARY

	TITLE V	TITLE XVIII	HIT	TITLE XIX	
	1	PART A 2	PART B 3	4	5
1	HOSPITAL				1
2	SUBPROVIDER - IPF	94,523			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	HOME HEALTH AGENCY				9
10	HEALTH CLINIC - RHC				10
11	HEALTH CLINIC - FQHC				11
12	OUTPATIENT REHABILITATION PROVIDER				12
200	TOTAL	94,523			200

THE ABOVE AMOUNTS REPRESENT 'DUE TO' OR 'DUE FROM' THE APPLICABLE PROGRAM FOR THE ELEMENT OF THE ABOVE COMPLEX INDICATED.

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A VALID OMB CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED 673 HOURS PER RESPONSE, INCLUDING THE TIME TO REVIEW INSTRUCTIONS, SEARCH EXISTING RESOURCES, GATHER THE DATA NEEDED, AND COMPLETE AND REVIEW THE INFORMATION COLLECTION. IF YOU HAVE ANY COMMENTS CONCERNING THE ACCURACY OF THE TIME ESTIMATE(S) OR SUGGESTIONS FOR IMPROVING THIS FORM, PLEASE WRITE TO: CMS, 7500 SECURITY BOULEVARD, ATTN: PRA REPORT CLEARANCE OFFICER, MAIL STOP C4-26-05, BALTIMORE, MARYLAND 21244-1850.

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 2200 RANDALLIA DRIVE
 2 CITY: FORT WAYNE STATE: IN

P.O.BOX: 5TH FLOOR
 ZIP CODE: 46805-4638 COUNTY: ALLEN

1
 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT 0	COMPONENT NAME 1	CCN NUMBER 2	CBSA NUMBER 3	PROV TYPE 4	DATE CERTIFIED 5	PAYMENT SYSTEM (P, T, O, OR N)				
						V 6	XVIII 7	XIX 8		
3	HOSPITAL	VIBRA HOSP FORT WAYNE	15-2027	23060	2	09/01/2008	N	P	P	3
4	SUBPROVIDER - IPF									4
5	SUBPROVIDER - IRF									5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF									7
8	SWING BEDS - NF									8
9	HOSPITAL-BASED SNF									9
10	HOSPITAL-BASED NF									10
11	HOSPITAL-BASED OLTC									11
12	HOSPITAL-BASED HHA									12
13	SEPARATELY CERTIFIED ASC									13
14	HOSPITAL-BASED HOSPICE									14
15	HOSPITAL-BASED HEALTH CLINIC - RHC									15
16	HOSPITAL-BASED HEALTH CLINIC - FQHC									16
17	HOSPITAL-BASED (CMHC)									17
18	RENAL DIALYSIS									18
19	OTHER									19
20	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 11/01/2012				TO: 10/31/2013				20
21	TYPE OF CONTROL									21

INPATIENT PPS INFORMATION

22	DOES THIS FACILITY QUALIFY FOR AND RECEIVE DISPROPORTIONATE SHARE HOSPITAL PAYMENT IN ACCORDANCE WITH 42 CFR §412.106 IN COLUMN 1, ENTER 'Y' FOR YES AND 'N' FOR NO. IS THIS FACILITY SUBJECT TO 42 CFR §412.06(c)(2)(PICKLE AMENDMENT HOSPITAL)? IN COLUMN 2, ENTER 'Y', FOR YES OR 'N' FOR NO.									1	2
23	WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS ON LINES 24 AND/OR 25 BELOW? IN COLUMN 1, ENTER 1 IF DATE OF ADMISSION, 2 IF CENSUS DAYS, OR 3 IF DATE OF DISCHARGE. IS THE METHOD OF IDENTIFYING THE DAYS IN THIS COST REPORTING PERIOD DIFFERENT FROM THE METHOD USED IN THE PRIOR COST REPORTING PERIOD? IN COLUMN 2, ENTER 'Y' FOR YES OR 'N' FOR NO.									N	N
											23

		IN-STATE		OUT-OF-STATE		OUT-OF-STATE		MEDICAID	OTHER				
		MEDICAID PAID	MEDICAID ELIGIBLE	MEDICAID PAID	MEDICAID ELIGIBLE	MEDICAID HMO	MEDICAID						
		DAYS	DAYS	DAYS	DAYS	DAYS	DAYS						
		1	2	3	4	5	6						
24	IF THIS PROVIDER IS AN IPHS HOSPITAL, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.									24			
25	IF THIS PROVIDER IS AN IRF, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.									25			
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.									1	26		
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER IN COLUMN 1, '1' FOR URBAN OR '2' FOR RURAL. IF APPLICABLE, ENTER THE EFFECTIVE DATE OF THE GEOGRAPHIC RECLASSIFICATION IN COLUMN 2.									1	27		
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.										35		
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.									BEGINNING:	ENDING:	36	
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.											37	
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.									BEGINNING:	ENDING:	38	
39	DOES THIS FACILITY QUALIFY FOR THE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW VOLUME HOSPITALS IN ACCORDANCE WITH 42 CFR §412.101(b)(2)(ii)? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. DOES THE FACILITY MEET THE MILEAGE REQUIREMENTS IN ACCORDANCE WITH 42 CFR 412.101(b)(2)(ii)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)											1	2
										N	N		39

PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL

		V	XVIII	XIX	
		1	2	3	
45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	N	N	N	45
46	IS THIS FACILITY ELIGIBLE FOR ADDITIONAL PAYMENT EXCEPTION FOR EXTRAORDINARY CIRCUMSTANCES PURSUANT TO 42 CFR §412.348(f)? IF YES, COMPLETE WORKSHEET L, PART III AND L-1, PARTS I THROUGH III.	N	N	N	46
47	IS THIS A NEW HOSPITAL UNDER 42 CFR §412.300 PPS CAPITAL? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	47
48	IS THE FACILITY ELECTING FULL FEDERAL CAPITAL PAYMENT? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	48

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

TEACHING HOSPITALS

56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	1 N	2	3	56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N		57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-5.	N			58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N			59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	N			60
61	DID YOUR HOSPITAL RECEIVE FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1.)(SEE INSTRUCTIONS)	Y/N N	IME	DIRECT GME	61
61.01	ENTER THE AVERAGE NUMBER OF UNWEIGHTED PRIMARY CARE FTEs FROM THE HOSPITAL'S 3 MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (SEE INSTRUCTIONS)				61.01
61.02	ENTER THE CURRENT YEAR TOTAL UNWEIGHTED PRIMARY CARE FTE COUNT (EXCLUDING OB/GYN AND GENERAL SURGERY FTEs, AND PRIMARY CARE FTEs ADDED UNDER SECTION 5503). (SEE INSTRUCTIONS)				61.02
61.03	ENTER THE BASE LINE FTE COUNT FOR PRIMARY CARE AND/OR GENERAL SURGERY RESIDENTS, WHICH IS USED FOR DETERMINING COMPLIANCE WITH THE 75% TEST. (SEE INSTRUCTIONS)				61.03
61.04	ENTER THE NUMBER OF UNWEIGHTED PRIMARY CARE/OR SURGERY ALLOPATHIC AND/OR OSTEOPATHIC FTEs IN THE CURRENT COST REPORTING PERIOD. (SEE INSTRUCTIONS)				61.04
61.05	ENTER THE DIFFERENCE BETWEEN THE BASELINE PRIMARY AND/OR GENERAL SURGERY FTE AND THE CURRENT YEAR'S PRIMARY CARE AND/OR GENERAL SURGERY FTE COUNTS (LINE 61.04 MINUS LINE 61.03). (SEE INSTRUCTIONS)				61.05
61.06	ENTER THE AMOUNT OF ACA §5503 AWARD THAT IS BEING USED FOR CAP RELIEF AND/OR FTEs THAT ARE NONPRIMARY CARE OR GENERAL SURGERY. (SEE INSTRUCTIONS)				61.06
	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.				
			UNWEIGHTED IME	UNWEIGHTED DIRECT GME	
	PROGRAM NAME	PROGRAM CODE	FTE COUNT	FTE COUNT	
	1	2	3	4	
					61.10
	OF THE FTEs IN LINE 61.05, SPECIFY EACH EXPANDED PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH EXPANDED PROGRAM (SEE INSTRUCTIONS) ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.				
					61.20
ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)					
62	ENTER THE NUMBER OF FTE RESIDENTS THAT YOUR HOSPITAL TRAINED IN THIS COST REPORTING PERIOD FOR WHICH YOUR HOSPITAL RECEIVED HRSA PCRE FUNDING (SEE INSTRUCTIONS)				62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (SEE INSTRUCTIONS)				62.01
TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS					
63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (SEE INSTRUCTIONS)	N			63

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER JULY 1, 2009 AND BEFORE JUNE 30, 2010.	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))
64 ENTER IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)			64

ENTER IN LINES 65-65.49 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)

PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.3+COL.4))
1	2	3	4	5

SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2010	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))
66 ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)			66

ENTER IN LINES 67-67.49, COLUMN 1 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)

PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.3+COL.4))
1	2	3	4	5

INPATIENT PSYCHIATRIC FACILITY PPS	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.3+COL.4))
70 IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 70
71 IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			71

INPATIENT REHABILITATION FACILITY PPS	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.3+COL.4))
75 IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 75
76 IF LINE 75 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			76

LONG TERM CARE HOSPITAL PPS	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.3+COL.4))
80 IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.			Y 80

TEFRA PROVIDERS	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.3+COL.4))
85 IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA?. ENTER 'Y' FOR YES OR 'N' FOR NO.			N 85
86 DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.			N 86

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

		V	XIX		
TITLE V AND XIX INPATIENT SERVICES					
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.	1	2		
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	Y	90	
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.		N	92	
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	93	
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	94	
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			95	
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	96	
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			97	
RURAL PROVIDERS					
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?	N		105	
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.			106	
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&RS IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.			107	
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.	N		108	
109	IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.		PHY- SICAL	OCUP- ATIONAL	RESPI- RATORY
MISCELLANEOUS COST REPORTING INFORMATION					
115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2. IF COLUMN 2 IS 'E', ENTER IN COLUMN 3 EITHER '93' PERCENT FOR SHORT TERM HOSPITAL OR '98' PERCENT FOR LONG TERM CARE (INCLUDES PSYCHIATRIC, REHABILITATION AND LONG TERM HOSPITALS PROVIDERS) BASED ON THE DEFINITION IN CMS 15-1§ 2208.1.		N	115	
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.		N	116	
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.		N	117	
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.			118	
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: _____ PAID LOSSES: _____ SELF INSURANCE:			118.01	
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTER OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.		N	118.02	
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 BEDS THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.		N	N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.		N	121	
TRANSPLANT CENTER INFORMATION					
125	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, ENTER CERTIFICATION DATE(S) (MM/DD/YYYY) BELOW.		N	125	
126	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			126	
127	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			127	
128	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			128	
129	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			129	
130	IF THIS IS A MEDICARE CERTIFIED PANCREAS TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			130	
131	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			131	
132	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			132	
133	IF THIS IS A MEDICARE CERTIFIED OTHER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			133	
134	IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			134	

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

ALL PROVIDERS

140 ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.

	1	2	
	Y	399018	140

IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER ON LINES 141 THROUGH 143 THE NAME AND ADDRESS OF THE HOME OFFICE AND ENTER THE HOME OFFICE CONTRACTOR NAME AND CONTRACTOR NUMBER.

141	NAME: VIBRA MANAGEMENT LLC	CONTRACTOR'S NAME: CGS	CONTRACTOR'S NUMBER: 15101	141
142	STREET: 4550 LENA DRIVE	P.O. BOX:		142
143	CITY: MECHANICSBURG	STATE: PA	ZIP CODE: 17055	143
144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?		Y	144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, LINE 74 ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.		Y	145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (SEE CMS PUB. 15-2, SECTION 4020). IF YES, ENTER THE APPROVAL DATE (MM/DD/YYYY) IN COLUMN 2.		N	146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.		N	147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.		N	148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.		N	149

DOES THIS FACILITY CONTAIN A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES? ENTER 'Y' FOR YES OR 'N' FOR NO FOR EACH COMPONENT FOR PART A AND PART B. SEE 42 CFR §413.13)

	TITLE XVIII		TITLE	TITLE
	PART A	PART B	V	XIX
	1	2	3	4
155 HOSPITAL	N	N		N 155
156 SUBPROVIDER - IPF	N	N		156
157 SUBPROVIDER - IRF	N	N		157
158 SUBPROVIDER - (OTHER)	N	N		158
159 SNF	N	N		159
160 HHA	N	N		160
161 CMHC		N		161
161.10 CORF				161.10

MULTICAMPUS

165 IS THIS HOSPITAL PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSAs? ENTER 'Y' FOR YES OR 'N' FOR NO.

	N	165
--	---	-----

166 IF LINE 165 IS YES, FOR EACH CAMPUS, ENTER THE NAME IN COLUMN 0, COUNTY IN COLUMN 1, STATE IN COLUMN 2, ZIP IN COLUMN 3, CBSA IN COLUMN 4, FTE/CAMPUS IN COLUMN 5.

NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
0	1	2	3	4	5

HEALTH INFORMATION TECHNOLOGY (HIT) INCENTIVE IN THE AMERICAN RECOVERY AND REINVESTMENT ACT

167 IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(n)? ENTER 'Y' FOR YES OR 'N' FOR NO.

168 IF THIS PROVIDER IS A CAH (LINE 105 IS 'Y') AND A MEANINGFUL USER (LINE 167 IS 'Y'), ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS.

169 IF THIS PROVIDER IS A MEANINGFUL USER (LINE 167 IS 'Y') AND IS NOT A CAH (LINE 105 IS 'N'), ENTER THE TRANSITIONAL FACTOR.

170 IF LINE 167 IS 'Y', ENTER IN COLUMNS 1 AND 2 THE EHR BEGINNING DATE AND ENDING DATE FOR THE REPORTING PERIOD, RESPECTIVELY. (mmdyyy) (SEE INSTRUCTIONS)

	N	167
		168
		169
		170

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

GENERAL INSTRUCTION: ENTER Y FOR ALL YES RESPONSES. ENTER N FOR ALL NO RESPONSES.
 ENTER ALL DATES IN THE MM/DD/YYYY FORMAT.

COMPLETED BY ALL HOSPITALS

		Y/N	DATE		
PROVIDER ORGANIZATION AND OPERATION					
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (SEE INSTRUCTIONS)	N	2	1	
		Y/N	DATE	V/I	
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	N	2	3 2	
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (E.G., CHAIN HOME OFFICES, DRUG OR MEDICAL SUPPLY COMPANIES) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (SEE INSTRUCTIONS)	N		3	
FINANCIAL DATA AND REPORTS					
		Y/N	TYPE	DATE	
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (SEE INSTRUCTIONS). IF NO, SEE INSTRUCTIONS.	N	2	3 4	
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N		5	
APPROVED EDUCATIONAL ACTIVITIES					
		Y/N	Y/N		
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	N	2	6	
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N		7	
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N		8	
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N		9	
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N		10	
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N		11	
			Y/N		
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.		Y	12	
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.		N	13	
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.		N	14	
BED COMPLEMENT					
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		N	15	
PS&R REPORT DATA					
		PART A		PART B	
		Y/N	DATE	Y/N	DATE
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	03/07/2014	N	
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	N		N	
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N	
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	
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

GENERAL INSTRUCTION: ENTER Y FOR ALL YES RESPONSES. ENTER N FOR ALL NO RESPONSES.
ENTER ALL DATES IN THE MM/DD/YYYY FORMAT.

COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)

CAPITAL RELATED COST

- 22 HAVE ASSETS BEEN RELIEFED FOR MEDICARE PURPOSES? IF YES, SEE INSTRUCTIONS. 22
- 23 HAVE CHANGES OCCURRED IN THE MEDICARE DEPRECIATION EXPENSE DUE TO APPRAISALS MADE DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. 23
- 24 WERE NEW LEASES AND/OR AMENDMENTS TO EXISTING LEASES ENTERED INTO DURING THIS COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. 24
- 25 HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. 25
- 26 WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. 26
- 27 HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. 27

INTEREST EXPENSE

- 28 WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. 28
- 29 DID THE PROVIDER HAVE A FUNDED DEPRECIATION ACCOUNT AND/OR BOND FUNDS (DEBT SERVICE RESERVE FUND) TREATED AS A FUNDED DEPRECIATION ACCOUNT? IF YES, SEE INSTRUCTIONS. 29
- 30 HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS. 30
- 31 HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS. 31

PURCHASED SERVICES

- 32 HAVE CHANGES OR NEW AGREEMENTS OCCURRED IN PATIENT CARE SERVICES FURNISHED THROUGH CONTRACTUAL ARRANGEMENTS WITH SUPPLIERS OF SERVICES? IF YES, SEE INSTRUCTIONS. 32
- 33 IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS. 33

PROVIDER-BASED PHYSICIANS

- 34 ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIANS? IF YES, SEE INSTRUCTIONS. 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. 35

HOME OFFICE COSTS

- | | Y/N | DATE | |
|---|-----|------|----|
| 36 WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT? | 1 | 2 | 36 |
| 37 IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS. | | | 37 |
| 38 IF LINE 36 IS YES, WAS THE FISCAL YEAR END OF THE HOME OFFICE DIFFERENT FROM THAT OF THE PROVIDER? IF YES, ENTER IN COLUMN 2 THE FISCAL YEAR END OF THE HOME OFFICE. | N | | 38 |
| 39 IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO OTHER CHAIN COMPONENTS? IF YES, SEE INSTRUCTIONS. | | | 39 |
| 40 IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS. | | | 40 |

COST REPORT PREPARER CONTACT INFORMATION

- | | | | |
|-------------------------------|--|-------------------------|----|
| 41 FIRST NAME: KIMBERLY | LAST NAME: HOFFMAN | TITLE: SR REIMB ANALYST | 41 |
| 42 EMPLOYER: VIBRA | | | 42 |
| 43 PHONE NUMBER: 717-591-5794 | E-MAIL ADDRESS: KHOFFMAN@VIBRAHEALTH.COM | | 43 |

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
 PART II & III

PART II - WAGE DATA

	WKST A LINE NUMBER	AMOUNT REPORTED	RECLASS OF SALARIES (FROM WKST A-6)	ADJUSTED SALARIES (COL. 2 + COL. 3)	PAID HOURS RELATED TO SALARIES IN COL. 4	AVERAGE HOURLY WAGE (COL. 4 + COL. 5)
	1	2	3	4	5	6
SALARIES						
1	TOTAL SALARIES (SEE INSTRUCTIONS)	200	3,242,018			1
2	NON-PHYSICIAN ANESTHETIST PART A					2
3	NON-PHYSICIAN ANESTHETIST PART B					3
4	PHYSICIAN-PART A ADMINISTRATIVE					4
4.01	PHYSICIAN-PART A - TEACHING					4.01
5	PHYSICIAN-PART B					5
6	NON-PHYSICIAN-PART B					6
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21				7
7.01	CONTRACTED INTERNS & RESIDENTS (IN AN APPROVED PGM)					7.01
8	HOME OFFICE PERSONNEL					8
9	SNF	44				9
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)					10
OTHER WAGES & RELATED COSTS						
11	CONTRACT LABOR (SEE INSTRUCTIONS)					11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES					12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE					13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS					14
15	HOME OFFICE: PHYSICIAN-PART A - ADMINISTRATIVE					15
16	HOME OFFICE & CONTRACT PHYSICIANS-PART A - TEACHING					16
WAGE-RELATED COSTS						
17	WAGE-RELATED COSTS (CORE)					17
18	WAGE-RELATED COSTS (OTHER)					18
19	EXCLUDED AREAS					19
20	NON-PHYSICIAN ANESTHETIST PART A					20
21	NON-PHYSICIAN ANESTHETIST PART B					21
22	PHYSICIAN PART A - ADMINISTRATIVE					22
22.01	PHYSICIAN PART A - TEACHING					22.01
23	PHYSICIAN PART B					23
24	WAGE-RELATED COSTS (RHC/FQHC)					24
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)					25
OVERHEAD COSTS - DIRECT SALARIES						
26	EMPLOYEE BENEFITS DEPARTMENT		41,029			26
27	ADMINISTRATIVE & GENERAL		734,902			27
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)					28
29	MAINTENANCE & REPAIRS					29
30	OPERATION OF PLANT		21,688			30
31	LAUNDRY & LINEN SERVICE					31
32	HOUSEKEEPING		114,810			32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)					33
34	DIETARY		48,550			34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)					35
36	CAFETERIA					36
37	MAINTENANCE OF PERSONNEL					37
38	NURSING ADMINISTRATION		171,226			38
39	CENTRAL SERVICES AND SUPPLY					39
40	PHARMACY		211,956			40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		39,582			41
42	SOCIAL SERVICE					42
43	OTHER GENERAL SERVICE					43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)		3,242,018		3,242,018	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)					2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)		3,242,018		3,242,018	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)					4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)					5
6	TOTAL (SUM OF LINES 3 THRU 5)		3,242,018		3,242,018	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)		1,383,743		1,383,743	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

PART A - CORE LIST

	AMOUNT REPORTED
RETIREMENT COST	
1 401K EMPLOYER CONTRIBUTIONS	1
2 TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION	2
3 NONQUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)	3
4 QUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)	4
PLAN ADMINISTRATIVE COSTS (PAID TO EXTERNAL ORGANIZATION)	
5 401K/TSA PLAN ADMINISTRATION FEES	5
6 LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN	6
7 EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES	7
HEALTH AND INSURANCE COST	
8 HEALTH INSURANCE (PURCHASED OR SELF FUNDED)	8
9 PRESCRIPTION DRUG PLAN	9
10 DENTAL, HEARING AND VISION PLAN	10
11 LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	11
12 ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	12
13 DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	13
14 LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	14
15 WORKERS' COMPENSATION INSURANCE	15
16 RETIREMENT HEALTH CARE COST (ONLY CURRENT YEAR, NOT THE EXTRAORDINARY ACCRUAL REQUIRED BY FASB 106. NON CUMULATIVE PORTION)	16
TAXES	
17 FICA-EMPLOYERS PORTION ONLY	17
18 MEDICARE TAXES - EMPLOYERS PORTION ONLY	18
19 UNEMPLOYMENT INSURANCE	19
20 STATE OR FEDERAL UNEMPLOYMENT TAXES	20
OTHER	
21 EXECUTIVE DEFERRED COMPENSATION (OTHER THAN RETIREMENT COST REPORTED ON LINES 1 THROUGH 4 ABOVE) (SEE INSTRUCTIONS)	21
22 DAY CARE COSTS AND ALLOWANCES	22
23 TUITION REIMBURSEMENT	23
24 TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	24
PART B - OTHER THAN CORE RELATED COST	
25 OTHER WAGE RELATED (OTHER WAGE RELATED COST)	25

PROVIDER CCN: 15-2027 VIBRA HOSP FORT WAYNE
PERIOD FROM 11/01/2012 TO 10/31/2013

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2013.11
03/21/2014 15:12

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION

COMPONENT		CONTRACT	BENEFIT	
0		LABOR	COST	
		1	2	
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST			1
2	HOSPITAL			2
3	SUBPROVIDER - IPF			3
4	SUBPROVIDER - IRF			4
5	SUBPROVIDER - (OTHER)			5
6	SWING BEDS - SNF			6
7	SWING BEDS - NF			7
8	HOSPITAL-BASED SNF			8
9	HOSPITAL-BASED NF			9
10	HOSPITAL-BASED OLTG			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			18

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES	OTHER	TOTAL	RECLASSIFI-
		1	2	(COL. 1 + COL. 2)	CATIONS
				3	4
GENERAL SERVICE COST CENTERS					
1	00100				1
2	00200		1,441,679	1,441,679	2
3	00300		221,073	221,073	3
4	00400	41,029	766,850	807,879	4
5	00500	734,902	714,849	1,449,751	5
6	00600				6
7	00700	21,688	196,691	218,379	7
8	00800		57,570	57,570	8
9	00900	114,810	23,980	138,790	9
10	01000	48,550	120,001	168,551	10
11	01100				11
12	01200				12
13	01300	171,226	2,001	173,227	13
14	01400		634,118	634,118	14
15	01500	211,956	27,016	238,972	15
16	01600	39,582	5,745	45,327	16
17	01700				17
INPATIENT ROUTINE SERV COST CENTERS					
30	03000	1,488,778	575,741	2,064,519	30
ANCILLARY SERVICE COST CENTERS					
54	05400		151,023	151,023	54
60	06000		177,998	177,998	60
62.30	06250				62.30
65	06500	369,497	27,207	396,704	65
66	06600		100,951	100,951	66
67	06700		102,830	102,830	67
68	06800		27,129	27,129	68
71	07100		73,062	73,062	71
73	07300		479,337	479,337	73
74	07400		172,684	172,684	74
76	03950				76
76.97	07697				76.97
76.98	07698				76.98
76.99	07699				76.99
OUTPATIENT SERVICE COST CENTERS					
92	09200				92
OTHER REIMBURSABLE COST CENTERS					
94	09400				94
99.20	09920				99.20
99.30	09930				99.30
99.40	09940				99.40
SPECIAL PURPOSE COST CENTERS					
118		3,242,018	6,099,535	9,341,553	118
NONREIMBURSABLE COST CENTERS					
194	07950				194
200		3,242,018	6,099,535	9,341,553	200

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		RECLASSIFIED TRIAL BALANCE (COL. 3 ± COL. 4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL. 5 ± COL. 6) 7	
GENERAL SERVICE COST CENTERS					
1	00100	1,441,679		757,910	1
2	00200	221,073	-683,769	221,073	2
3	00300				3
4	00400	807,879		807,879	4
5	00500	1,449,751	409,418	1,859,169	5
6	00600				6
7	00700	218,379	-104,563	113,816	7
8	00800	57,570		57,570	8
9	00900	138,790		138,790	9
10	01000	168,551		168,551	10
11	01100				11
12	01200				12
13	01300	173,227		173,227	13
14	01400	634,118		634,118	14
15	01500	238,972		238,972	15
16	01600	45,327		45,327	16
17	01700				17
INPATIENT ROUTINE SERV COST CENTERS					
30	03000	2,064,519	-133,574	1,930,945	30
ANCILLARY SERVICE COST CENTERS					
54	05400	151,023		151,023	54
60	06000	177,998		177,998	60
62.30	06250				62.30
65	06500	396,704		396,704	65
66	06600	100,951		100,951	66
67	06700	102,830		102,830	67
68	06800	27,129		27,129	68
71	07100	73,062		73,062	71
73	07300	479,337		479,337	73
74	07400	172,684		172,684	74
76	03950				76
76.97	07697				76.97
76.98	07698				76.98
76.99	07699				76.99
OUTPATIENT SERVICE COST CENTERS					
92	09200				92
OTHER REIMBURSABLE COST CENTERS					
94	09400				94
99.20	09920				99.20
99.30	09930				99.30
99.40	09940				99.40
SPECIAL PURPOSE COST CENTERS					
118		9,341,553	-512,488	8,829,065	118
NONREIMBURSABLE COST CENTERS					
194	07950				194
200		9,341,553	-512,488	8,829,065	200
GRAND TOTAL (INCREASES)					
GRAND TOTAL (DECREASES)					

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
 PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	----- ACQUISITIONS -----			DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
		PURCHASE 2	DONATION 3	TOTAL 4				
1 LAND								1
2 LAND IMPROVEMENTS	6,534					6,534		2
3 BUILDINGS AND FIXTURES	7,314					7,314		3
4 BUILDING IMPROVEMENTS								4
5 FIXED EQUIPMENT								5
6 MOVABLE EQUIPMENT	12,664	1,145		1,145		13,809		6
7 HIT DESIGNATED ASSETS								7
8 SUBTOTAL (SUM OF LINES 1-7)	26,512	1,145		1,145		27,657		8
9 RECONCILING ITEMS								9
10 TOTAL (LINE 7 MINUS LINE 9)	26,512	1,145		1,145		27,657		10

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

----- SUMMARY OF CAPITAL -----

DESCRIPTION	DEPREC- IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(1)
							(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT		1,399,835	1,754		40,090		1,441,679 1
2 CAP REL COSTS-MVBLE EQUIP	4,216	216,857					221,073 2
3 TOTAL (SUM OF LINES 1-2)	4,216	1,616,692	1,754		40,090		1,662,752 3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

----- COMPUTATION OF RATIOS ----- ALLOCATION OF OTHER CAPITAL -----

DESCRIPTION	GROSS ASSETS 1	CAPITALIZED LEASES 2	GROSS ASSETS FOR RATIO (COL. 1 - COL. 2) 3		RATIO (SEE INSTR.) 4	INSURANCE 5	TAXES 6	OTHER CAPITAL- RELATED COSTS 7	TOTAL
			(SUM OF COLS. 5-7) 8						
1 CAP REL COSTS-BLDG & FIXT	13,848		13,848	0.500705					1
2 CAP REL COSTS-MVBLE EQUIP	13,809		13,809	0.499295					2
3 TOTAL (SUM OF LINES 1-2)	27,657		27,657	1.000000					3

----- SUMMARY OF CAPITAL -----

DESCRIPTION	DEPREC- IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(2)
							(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT		744,253			13,657		757,910 1
2 CAP REL COSTS-MVBLE EQUIP	4,216	216,857					221,073 2
3 TOTAL	4,216	961,110			13,657		978,983 3

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF 5
			COST CENTER 3	LINE NO. 4	
1 INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)			CAP REL COSTS-BLDG & FIXT	1	1
2 INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)			CAP REL COSTS-MVBLE EQUIP	2	2
3 INVESTMENT INCOME-OTHER (chapter 2)	B	-470	ADMINISTRATIVE & GENERAL	5	3
4 TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)					4
5 REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)					5
6 RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)					6
7 TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)					7
8 TELEVISION AND RADIO SERVICE (chapter 21)					8
9 PARKING LOT (chapter 21)					9
10 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-133,574			10
11 SALE OF SCRAP, WASTE, ETC. (chapter 23)					11
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1	475,914			12
13 LAUNDRY AND LINEN SERVICE					13
14 CAFETERIA - EMPLOYEES AND GUESTS					14
15 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15
16 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					16
17 SALE OF DRUGS TO OTHER THAN PATIENTS					17
18 SALE OF MEDICAL RECORDS AND ABSTRACTS					18
19 NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)					19
20 VENDING MACHINES					20
21 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)					21
22 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					22
23 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		RESPIRATORY THERAPY	65	23
24 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		PHYSICAL THERAPY	66	24
25 UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114	25
26 DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1	26
27 DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2	27
28 NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	28
29 PHYSICIANS' ASSISTANT					29
30 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67	30
31 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		SPEECH PATHOLOGY	68	31
32 CAH HIT ADJ FOR DEPRECIATION AND					32
33 OTHER INCOME	B	-1,020	ADMINISTRATIVE & GENERAL	5	33
34 NON-ALLOWABLE COST	A	-1,010	ADMINISTRATIVE & GENERAL	5	34
35 NON-ALLOWABLE AMORTIZATION	A	-38,802	ADMINISTRATIVE & GENERAL	5	35
36 MARKETING	A	-19,125	ADMINISTRATIVE & GENERAL	5	36
37 VACANT SPACE	A	-6,069	ADMINISTRATIVE & GENERAL	5	37
37.01 VACANT SPACE	A	-104,563	OPERATION OF PLANT	7	37.01
37.02 VACANT SPACE	A	-26,433	CAP REL COSTS-BLDG & FIXT	1	13 37.02
37.03 VACANT SPACE	A	-1,754	CAP REL COSTS-BLDG & FIXT	1	11 37.03
37.04 VACANT SPACE	A	-655,582	CAP REL COSTS-BLDG & FIXT	1	10 37.04
38					38
39					39
40					40
41					41
42					42
43					43
44					44
45					45
46					46
47					47
48					48
49					49
50 TOTAL (SUM OF LINES 1 THRU 49) TRANSFER TO WKST A, COL. 6, LINE 200)		-512,488			50

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

WORKSHEET A-8-1

A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR THE CLAIMING OF HOME OFFICE COSTS:

LINE NO. 1	COST CENTER 2	EXPENSE ITEMS 3	AMOUNT OF ALLOWABLE COST 4	AMOUNT (INCL IN WKST A, COL. 5) 5	NET ADJUSTMENTS (COL. 4-5) 6	WKST A-7 REF 7
1	5	ADMINISTRATIVE & GENERAL				
2		CORPORATE EXPENSES	653,093	177,179	475,914	1
3						2
4						3
5		TOTALS (SUM OF LINES 1-4)	653,093	177,179	475,914	4
		TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.				5

B. INTERRELATIONSHIP OF RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

THE SECRETARY, BY VIRTUE OF AUTHORITY GRANTED UNDER SECTION 1814(b)(1) OF THE SOCIAL SECURITY ACT, REQUIRES THAT YOU FURNISH THE INFORMATION REQUESTED UNDER PART B OF THIS WORKSHEET.

THE INFORMATION IS USED BY THE HEALTH CARE FINANCING ADMINISTRATION AND ITS INTERMEDIARIES IN DETERMINING THAT THE COSTS APPLICABLE TO SERVICES, FACILITIES, AND SUPPLIES FURNISHED BY ORGANIZATIONS RELATED TO YOU BY COMMON OWNERSHIP OR CONTROL REPRESENT REASONABLE COSTS AS DETERMINED UNDER SECTION 1861 OF THE SOCIAL SECURITY ACT. IF YOU DO NOT PROVIDE ALL OR ANY PART OF THE REQUESTED INFORMATION, THE COST REPORT IS CONSIDERED INCOMPLETE AND NOT ACCEPTABLE FOR PURPOSES OF CLAIMING REIMBURSEMENT UNDER TITLE XVIII.

SYMBOL (1) 1	NAME 2	----- RELATED ORGANIZATION(S) AND/OR HOME OFFICE -----				TYPE OF BUSINESS 6
		PERCENT OF OWNERSHIP 3	NAME 4	PERCENT OF OWNERSHIP 5		
6	B VIBRA MANAGEMENT LLC	100.00	VIBRA HEALTHCARE LLC	100.00	CORPORATE OFFICE	6
7						7
8						8
9						9
10						10

- (1) USE THE FOLLOWING SYMBOLS TO INDICATE THE INTERRELATIONSHIP TO RELATED ORGANIZATIONS:
- A. INDIVIDUAL HAS FINANCIAL INTEREST (STOCKHOLDER, PARTNER, ETC.) IN BOTH RELATED ORGANIZATION AND IN PROVIDER.
 - B. CORPORATION, PARTNERSHIP, OR OTHER ORGANIZATION HAS FINANCIAL INTEREST IN PROVIDER.
 - C. PROVIDER HAS FINANCIAL INTEREST IN CORPORATION, PARTNERSHIP, OR OTHER ORGANIZATION.
 - D. DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF PROVIDER OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN RELATED ORGANIZATION.
 - E. INDIVIDUAL IS DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF PROVIDER AND RELATED ORGANIZATION.
 - F. DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF RELATED ORGANIZATION OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN PROVIDER.
 - G. OTHER (FINANCIAL OR NON-FINANCIAL) SPECIFY:

PROVIDER CCN: 15-2027 VIBRA HOSP FORT WAYNE
 PERIOD FROM 11/01/2012 TO 10/31/2013

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2013.11
 03/21/2014 15:12

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	5 PERCENT OF UNAD- JUSTED RCE LIMIT	
LINE NO.	2	3	4	5	6	7	8	9	
1 30	ADULTS & PEDIATRICS	97,464	97,464		171,400				1
2 30	ADULTS & PEDIATRICS	64,375		64,375	171,400	343	28,265	1,413	2
200	TOTAL	161,839	97,464	64,375		343	28,265	1,413	200

PROVIDER CCN: 15-2027 VIBRA HOSP FORT WAYNE
 PERIOD FROM 11/01/2012 TO 10/31/2013

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2013.11
 03/21/2014 15:12

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUST- MENT	
LINE NO.	11	12	13	14	15	16	17	18	
1 30	ADULTS & PEDIATRICS							97,464	1
2 30	ADULTS & PEDIATRICS					28,265	36,110	36,110	2
200	TOTAL					28,265	36,110	133,574	200

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION (FROM WKST A, COL. 7) 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS DEPARTMENT 4	SUBTOTAL (COLS. 0-4) 4A	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	757,910	757,910				1
2 CAP REL COSTS-MVBLE EQUIP	221,073		221,073			2
4 EMPLOYEE BENEFITS DEPARTMENT	807,879	4,528	1,321	813,728		4
5 ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	1,859,169	102,764	29,975	186,820	2,178,728	5
7 OPERATION OF PLANT	113,816	279,827	81,621	5,513	480,777	7
8 LAUNDRY & LINEN SERVICE	57,570	12,062	3,518		73,150	8
9 HOUSEKEEPING	138,790	5,381	1,570	29,186	174,927	9
10 DIETARY	168,551	17,666	5,153	12,342	203,712	10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	173,227			43,528	216,755	13
14 CENTRAL SERVICES & SUPPLY	634,118				634,118	14
15 PHARMACY	238,972	15,513	4,525	53,882	312,892	15
16 MEDICAL RECORDS & LIBRARY	45,327	12,804	3,735	10,062	71,928	16
17 SOCIAL SERVICE						17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	1,930,945	269,956	78,743	378,465	2,658,109	30
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC	151,023				151,023	54
60 LABORATORY	177,998	2,449	714		181,161	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	396,704	2,598	758	93,930	493,990	65
66 PHYSICAL THERAPY	100,951	11,728	3,421		116,100	66
67 OCCUPATIONAL THERAPY	102,830	5,975	1,743		110,548	67
68 SPEECH PATHOLOGY	27,129	1,336	390		28,855	68
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	73,062	13,323	3,886		90,271	71
73 DRUGS CHARGED TO PATIENTS	479,337				479,337	73
74 RENAL DIALYSIS	172,684				172,684	74
76 WOUND CARE						76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (sum of lines 1-117)	8,829,065	757,910	221,073	813,728	8,829,065	118
NONREIMBURSABLE COST CENTERS						
194 PHYSICIAN MEALS						194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	8,829,065	757,910	221,073	813,728	8,829,065	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL 5	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL	2,178,728					5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	157,508	638,285				7
8 LAUNDRY & LINEN SERVICE	23,965	20,763	117,878			8
9 HOUSEKEEPING	57,308	9,263		241,498		9
10 DIETARY	66,738	30,410		12,074	312,934	10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	71,012					13
14 CENTRAL SERVICES & SUPPLY	207,745					14
15 PHARMACY	102,507	26,704		10,602		15
16 MEDICAL RECORDS & LIBRARY	23,564	22,041		8,751		16
17 SOCIAL SERVICE						17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	870,826	464,707	117,878	184,503	312,934	30
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC	49,477					54
60 LABORATORY	59,351	4,216		1,674		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	161,837	4,472		1,776		65
66 PHYSICAL THERAPY	38,036	20,188		8,015		66
67 OCCUPATIONAL THERAPY	36,217	10,286		4,084		67
68 SPEECH PATHOLOGY	9,453	2,300		913		68
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	29,574	22,935		9,106		71
73 DRUGS CHARGED TO PATIENTS	157,037					73
74 RENAL DIALYSIS	56,573					74
76 WOUND CARE						76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (sum of lines 1-117)	2,178,728	638,285	117,878	241,498	312,934	118
NONREIMBURSABLE COST CENTERS						
194 PHYSICIAN MEALS						194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	2,178,728	638,285	117,878	241,498	312,934	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SUBTOTAL 24	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	287,767					13
14 CENTRAL SERVICES & SUPPLY		841,863				14
15 PHARMACY			452,705			15
16 MEDICAL RECORDS & LIBRARY				126,284		16
17 SOCIAL SERVICE						17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	287,767	841,863		126,284	5,864,871	30
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC					200,500	54
60 LABORATORY					246,402	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY					662,075	65
66 PHYSICAL THERAPY					182,339	66
67 OCCUPATIONAL THERAPY					161,135	67
68 SPEECH PATHOLOGY					41,521	68
71 MEDICAL SUPPLIES CHARGED TO PATIENTS					151,886	71
73 DRUGS CHARGED TO PATIENTS			452,705		1,089,079	73
74 RENAL DIALYSIS					229,257	74
76 WOUND CARE						76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (sum of lines 1-117)	287,767	841,863	452,705	126,284	8,829,065	118
NONREIMBURSABLE COST CENTERS						
194 PHYSICIAN MEALS						194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	287,767	841,863	452,705	126,284	8,829,065	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	I&R COST &	TOTAL	
	POST STEP- DOWN ADJS 25		
GENERAL SERVICE COST CENTERS			
1	CAP REL COSTS-BLDG & FIXT		1
2	CAP REL COSTS-MVBLE EQUIP		2
4	EMPLOYEE BENEFITS DEPARTMENT		4
5	ADMINISTRATIVE & GENERAL		5
6	MAINTENANCE & REPAIRS		6
7	OPERATION OF PLANT		7
8	LAUNDRY & LINEN SERVICE		8
9	HOUSEKEEPING		9
10	DIETARY		10
11	CAFETERIA		11
12	MAINTENANCE OF PERSONNEL		12
13	NURSING ADMINISTRATION		13
14	CENTRAL SERVICES & SUPPLY		14
15	PHARMACY		15
16	MEDICAL RECORDS & LIBRARY		16
17	SOCIAL SERVICE		17
INPATIENT ROUTINE SERV COST CENTERS			
30	ADULTS & PEDIATRICS	5,864,871	30
ANCILLARY SERVICE COST CENTERS			
54	RADIOLOGY-DIAGNOSTIC	200,500	54
60	LABORATORY	246,402	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS		62.30
65	RESPIRATORY THERAPY	662,075	65
66	PHYSICAL THERAPY	182,339	66
67	OCCUPATIONAL THERAPY	161,135	67
68	SPEECH PATHOLOGY	41,521	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	151,886	71
73	DRUGS CHARGED TO PATIENTS	1,089,079	73
74	RENAL DIALYSIS	229,257	74
76	WOUND CARE		76
76.97	CARDIAC REHABILITATION		76.97
76.98	HYPERBARIC OXYGEN THERAPY		76.98
76.99	LITHOTRIPSY		76.99
OUTPATIENT SERVICE COST CENTERS			
92	OBSERVATION BEDS (NON-DISTINCT PART)		92
OTHER REIMBURSABLE COST CENTERS			
94	HOME PROGRAM DIALYSIS		94
99.20	OUTPATIENT PHYSICAL THERAPY		99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY		99.30
99.40	OUTPATIENT SPEECH PATHOLOGY		99.40
SPECIAL PURPOSE COST CENTERS			
118	SUBTOTALS (sum of lines 1-117)	8,829,065	118
NONREIMBURSABLE COST CENTERS			
194	PHYSICIAN MEALS		194
200	CROSS FOOT ADJUSTMENTS		200
201	NEGATIVE COST CENTER		201
202	TOTAL (SUM OF LINES 118-201)	8,829,065	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	SUBTOTAL 2A	EMPLOYEE BENEFITS DEPARTMENT 4	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT		4,528	1,321	5,849	5,849	4
5 ADMINISTRATIVE & GENERAL	36,402	102,764	29,975	169,141	1,343	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT		279,827	81,621	361,448	40	7
8 LAUNDRY & LINEN SERVICE		12,062	3,518	15,580		8
9 HOUSEKEEPING		5,381	1,570	6,951	210	9
10 DIETARY		17,666	5,153	22,819	89	10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION					313	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY		15,513	4,525	20,038	387	15
16 MEDICAL RECORDS & LIBRARY		12,804	3,735	16,539	72	16
17 SOCIAL SERVICE						17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS		269,956	78,743	348,699	2,720	30
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC						54
60 LABORATORY		2,449	714	3,163		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY		2,598	758	3,356	675	65
66 PHYSICAL THERAPY		11,728	3,421	15,149		66
67 OCCUPATIONAL THERAPY		5,975	1,743	7,718		67
68 SPEECH PATHOLOGY		1,336	390	1,726		68
71 MEDICAL SUPPLIES CHARGED TO PATIENTS		13,323	3,886	17,209		71
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76 WOUND CARE						76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (sum of lines 1-117)	36,402	757,910	221,073	1,015,385	5,849	118
NONREIMBURSABLE COST CENTERS						
194 PHYSICIAN MEALS						194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	36,402	757,910	221,073	1,015,385	5,849	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL 5	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL	170,484					5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	12,325	373,813				7
8 LAUNDRY & LINEN SERVICE	1,875	12,160	29,615			8
9 HOUSEKEEPING	4,484	5,425		17,070		9
10 DIETARY	5,222	17,810		853	46,793	10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	5,557					13
14 CENTRAL SERVICES & SUPPLY	16,256					14
15 PHARMACY	8,021	15,639		749		15
16 MEDICAL RECORDS & LIBRARY	1,844	12,908		619		16
17 SOCIAL SERVICE						17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	68,143	272,157	29,615	13,040	46,793	30
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC	3,871					54
60 LABORATORY	4,644	2,469		118		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	12,663	2,619		126		65
66 PHYSICAL THERAPY	2,976	11,823		567		66
67 OCCUPATIONAL THERAPY	2,834	6,024		289		67
68 SPEECH PATHOLOGY	740	1,347		65		68
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,314	13,432		644		71
73 DRUGS CHARGED TO PATIENTS	12,288					73
74 RENAL DIALYSIS	4,427					74
76 WOUND CARE						76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (sum of lines 1-117)	170,484	373,813	29,615	17,070	46,793	118
NONREIMBURSABLE COST CENTERS						
194 PHYSICIAN MEALS						194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	170,484	373,813	29,615	17,070	46,793	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SUBTOTAL 24	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	5,870					13
14 CENTRAL SERVICES & SUPPLY		16,256				14
15 PHARMACY			44,834			15
16 MEDICAL RECORDS & LIBRARY				31,982		16
17 SOCIAL SERVICE						17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	5,870	16,256		31,982	835,275	30
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC					3,871	54
60 LABORATORY					10,394	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY					19,439	65
66 PHYSICAL THERAPY					30,515	66
67 OCCUPATIONAL THERAPY					16,865	67
68 SPEECH PATHOLOGY					3,878	68
71 MEDICAL SUPPLIES CHARGED TO PATIENTS					33,599	71
73 DRUGS CHARGED TO PATIENTS			44,834		57,122	73
74 RENAL DIALYSIS					4,427	74
76 WOUND CARE						76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (sum of lines 1-117)	5,870	16,256	44,834	31,982	1,015,385	118
NONREIMBURSABLE COST CENTERS						
194 PHYSICIAN MEALS						194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	5,870	16,256	44,834	31,982	1,015,385	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	I&R COST & POST STEP- DOWN ADJS	TOTAL	
	25	26	
GENERAL SERVICE COST CENTERS			
1 CAP REL COSTS-BLDG & FIXT			1
2 CAP REL COSTS-MVBLE EQUIP			2
4 EMPLOYEE BENEFITS DEPARTMENT			4
5 ADMINISTRATIVE & GENERAL			5
6 MAINTENANCE & REPAIRS			6
7 OPERATION OF PLANT			7
8 LAUNDRY & LINEN SERVICE			8
9 HOUSEKEEPING			9
10 DIETARY			10
11 CAFETERIA			11
12 MAINTENANCE OF PERSONNEL			12
13 NURSING ADMINISTRATION			13
14 CENTRAL SERVICES & SUPPLY			14
15 PHARMACY			15
16 MEDICAL RECORDS & LIBRARY			16
17 SOCIAL SERVICE			17
INPATIENT ROUTINE SERV COST CENTERS			
30 ADULTS & PEDIATRICS		835,275	30
ANCILLARY SERVICE COST CENTERS			
54 RADIOLOGY-DIAGNOSTIC		3,871	54
60 LABORATORY		10,394	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS			62.30
65 RESPIRATORY THERAPY		19,439	65
66 PHYSICAL THERAPY		30,515	66
67 OCCUPATIONAL THERAPY		16,865	67
68 SPEECH PATHOLOGY		3,878	68
71 MEDICAL SUPPLIES CHARGED TO PATIENTS		33,599	71
73 DRUGS CHARGED TO PATIENTS		57,122	73
74 RENAL DIALYSIS		4,427	74
76 WOUND CARE			76
76.97 CARDIAC REHABILITATION			76.97
76.98 HYPERBARIC OXYGEN THERAPY			76.98
76.99 LITHOTRIPSY			76.99
OUTPATIENT SERVICE COST CENTERS			
92 OBSERVATION BEDS (NON-DISTINCT PART)			92
OTHER REIMBURSABLE COST CENTERS			
94 HOME PROGRAM DIALYSIS			94
99.20 OUTPATIENT PHYSICAL THERAPY			99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY			99.30
99.40 OUTPATIENT SPEECH PATHOLOGY			99.40
SPECIAL PURPOSE COST CENTERS			
118 SUBTOTALS (sum of lines 1-117)		1,015,385	118
NONREIMBURSABLE COST CENTERS			
194 PHYSICIAN MEALS			194
200 CROSS FOOT ADJUSTMENTS			200
201 NEGATIVE COST CENTER			201
202 TOTAL (SUM OF LINES 118-201)		1,015,385	202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET 1	CAP MOVABLE EQUIPMENT SQUARE FEET 2	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES 4	RECON-CILIATION 5A	ADMINIS-TRATIVE & GENERAL ACCUM COST 5	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	20,422					1
2 CAP REL COSTS-MVBLE EQUIP		20,422				2
4 EMPLOYEE BENEFITS DEPARTMENT	122	122	3,200,989			4
5 ADMINISTRATIVE & GENERAL	2,769	2,769	734,902	-2,178,728	6,650,337	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	7,540	7,540	21,688		480,777	7
8 LAUNDRY & LINEN SERVICE	325	325			73,150	8
9 HOUSEKEEPING	145	145	114,810		174,927	9
10 DIETARY	476	476	48,550		203,712	10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION			171,226		216,755	13
14 CENTRAL SERVICES & SUPPLY					634,118	14
15 PHARMACY	418	418	211,956		312,892	15
16 MEDICAL RECORDS & LIBRARY	345	345	39,582		71,928	16
17 SOCIAL SERVICE						17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	7,274	7,274	1,488,778		2,658,109	30
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC					151,023	54
60 LABORATORY	66	66			181,161	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	70	70	369,497		493,990	65
66 PHYSICAL THERAPY	316	316			116,100	66
67 OCCUPATIONAL THERAPY	161	161			110,548	67
68 SPEECH PATHOLOGY	36	36			28,855	68
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	359	359			90,271	71
73 DRUGS CHARGED TO PATIENTS					479,337	73
74 RENAL DIALYSIS					172,684	74
76 WOUND CARE						76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (sum of lines 1-117)	20,422	20,422	3,200,989	-2,178,728	6,650,337	118
NONREIMBURSABLE COST CENTERS						
194 PHYSICIAN MEALS						194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	757,910	221,073	813,728		2,178,728	202
203 UNIT COST MULT-WS B PT I	37.112428	10.825237	0.254211		0.327612	203
204 COST TO BE ALLOC PER B PT II			5,849		170,484	204
205 UNIT COST MULT-WS B PT II			0.001827		0.025635	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	NURSING ADMINIS- TRATION	PATIENT DAYS
	SQUARE FEET	POUNDS OF LAUNDRY	SQUARE FEET	MEALS SERVED		
	7	8	9	10	13	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	9,991					7
8 LAUNDRY & LINEN SERVICE	325	100				8
9 HOUSEKEEPING	145		9,521			9
10 DIETARY	476		476	16,656		10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION					5,552	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY	418		418			15
16 MEDICAL RECORDS & LIBRARY	345		345			16
17 SOCIAL SERVICE						17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	7,274	100	7,274	16,656	5,552	30
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC						54
60 LABORATORY	66		66			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	70		70			65
66 PHYSICAL THERAPY	316		316			66
67 OCCUPATIONAL THERAPY	161		161			67
68 SPEECH PATHOLOGY	36		36			68
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	359		359			71
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76 WOUND CARE						76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (sum of lines 1-117)	9,991	100	9,521	16,656	5,552	118
NONREIMBURSABLE COST CENTERS						
194 PHYSICIAN MEALS						194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	638,285	117,878	241,498	312,934	287,767	202
203 UNIT COST MULT-WS B PT I	63.885997	1,178.780000	25.364773	18.788064	51.831232	203
204 COST TO BE ALLOC PER B PT II	373,813	29,615	17,070	46,793	5,870	204
205 UNIT COST MULT-WS B PT II	37.414973	296.150000	1.792879	2.809378	1.057277	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CENTRAL SERVICES & SUPPLY COSTED REQUIS. 14	PHARMACY COSTED REQUIS. 15	MEDICAL RECORDS & LIBRARY PATIENT DAYS 16	
GENERAL SERVICE COST CENTERS				
1 CAP REL COSTS-BLDG & FIXT				1
2 CAP REL COSTS-MVBLE EQUIP				2
4 EMPLOYEE BENEFITS DEPARTMENT				4
5 ADMINISTRATIVE & GENERAL				5
6 MAINTENANCE & REPAIRS				6
7 OPERATION OF PLANT				7
8 LAUNDRY & LINEN SERVICE				8
9 HOUSEKEEPING				9
10 DIETARY				10
11 CAFETERIA				11
12 MAINTENANCE OF PERSONNEL				12
13 NURSING ADMINISTRATION				13
14 CENTRAL SERVICES & SUPPLY	100			14
15 PHARMACY		100		15
16 MEDICAL RECORDS & LIBRARY			5,552	16
17 SOCIAL SERVICE				17
INPATIENT ROUTINE SERV COST CENTERS				
30 ADULTS & PEDIATRICS	100		5,552	30
ANCILLARY SERVICE COST CENTERS				
54 RADIOLOGY-DIAGNOSTIC				54
60 LABORATORY				60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY				65
66 PHYSICAL THERAPY				66
67 OCCUPATIONAL THERAPY				67
68 SPEECH PATHOLOGY				68
71 MEDICAL SUPPLIES CHARGED TO PATIENTS				71
73 DRUGS CHARGED TO PATIENTS		100		73
74 RENAL DIALYSIS				74
76 WOUND CARE				76
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
92 OBSERVATION BEDS (NON-DISTINCT PART)				92
OTHER REIMBURSABLE COST CENTERS				
94 HOME PROGRAM DIALYSIS				94
99.20 OUTPATIENT PHYSICAL THERAPY				99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40 OUTPATIENT SPEECH PATHOLOGY				99.40
SPECIAL PURPOSE COST CENTERS				
118 SUBTOTALS (sum of lines 1-117)	100	100	5,552	118
NONREIMBURSABLE COST CENTERS				
194 PHYSICIAN MEALS				194
200 CROSS FOOT ADJUSTMENTS				200
201 NEGATIVE COST CENTER				201
202 COST TO BE ALLOC PER B PT I	841,863	452,705	126,284	202
203 UNIT COST MULT-WS B PT I	8,418.630000	4,527.050000	22.745677	203
204 COST TO BE ALLOC PER B PT II	16,256	44,834	31,982	204
205 UNIT COST MULT-WS B PT II	162.560000	448.340000	5.760447	205

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I

COST CENTER DESCRIPTION	TOTAL COST	THERAPY	TOTAL COSTS	RCE DISALLOWANCE	TOTAL COSTS	
	(FROM WKST B, PART I, COL 26)	LIMIT ADJUSTMENT				
	1	2	3	4	5	
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	5,864,871		5,864,871	36,110	5,900,981	30
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC	200,500		200,500		200,500	54
60 LABORATORY	246,402		246,402		246,402	60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	662,075		662,075		662,075	65
66 PHYSICAL THERAPY	182,339		182,339		182,339	66
67 OCCUPATIONAL THERAPY	161,135		161,135		161,135	67
68 SPEECH PATHOLOGY	41,521		41,521		41,521	68
71 MEDICAL SUPPLIES CHARGED TO	151,886		151,886		151,886	71
73 DRUGS CHARGED TO PATIENTS	1,089,079		1,089,079		1,089,079	73
74 RENAL DIALYSIS	229,257		229,257		229,257	74
76 WOUND CARE						76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS (NON-DISTI						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THE						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
200 SUBTOTAL (SEE INSTRUCTIONS)	8,829,065		8,829,065	36,110	8,865,175	200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	8,829,065		8,829,065		8,865,175	202

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I (CONT)

COST CENTER DESCRIPTION	CHARGES			COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPATIENT 6	OUTPATIENT 7	TOTAL (COLS. 6 + 7) 8			
30 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS	7,241,897		7,241,897			30
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC	344,008		344,008	0.582835	0.582835	0.582835 54
60 LABORATORY	674,418		674,418	0.365355	0.365355	0.365355 60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	5,159,349		5,159,349	0.128325	0.128325	0.128325 65
66 PHYSICAL THERAPY	430,524		430,524	0.423528	0.423528	0.423528 66
67 OCCUPATIONAL THERAPY	419,737		419,737	0.383895	0.383895	0.383895 67
68 SPEECH PATHOLOGY	120,890		120,890	0.343461	0.343461	0.343461 68
71 MEDICAL SUPPLIES CHARGED TO	1,087,998		1,087,998	0.139601	0.139601	0.139601 71
73 DRUGS CHARGED TO PATIENTS	3,119,124		3,119,124	0.349162	0.349162	0.349162 73
74 RENAL DIALYSIS	654,209		654,209	0.350434	0.350434	0.350434 74
76 WOUND CARE						76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS (NON-DISTI						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THE						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
200 SUBTOTAL (SEE INSTRUCTIONS)	19,252,154		19,252,154			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	19,252,154		19,252,154			202

PROVIDER CCN: 15-2027 VIBRA HOSP FORT WAYNE
 PERIOD FROM 11/01/2012 TO 10/31/2013

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2013.11
 03/21/2014 15:12

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

CHECK [] TITLE V
 APPLICABLE [XX] TITLE XVIII-PT A
 BOXES [] TITLE XIX

COST CENTER DESCRIPTION	CAP-REL COST		REDUCED	TOTAL PATIENT DAYS	PER	INPAT PGM DAYS	INPAT PGM CAP COST		
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT	CAP-REL COST (COL.1 MINUS COL.2)		DIEM (COL.3 ÷ COL.4)		(COL.5 x COL.6)	30	31
	1	2	3		5		7		
INPAT ROUTINE SERV COST CTRS									
30 ADULTS & PEDIATRICS	835,275		835,275	5,552	150.45	3,034	456,465	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 I								42	
43 NURSERY								43	
44 SKILLED NURSING FACILITY								44	
45 NURSING FACILITY								45	
200 TOTAL (LINES 30-199)	835,275		835,275	5,552		3,034	456,465	200	

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [] TITLE V [XX] HOSPITAL (15-2027) [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [] TITLE XIX [] IRF

COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5	
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC	3,871	344,008	0.011253	186,114	2,094	54
60 LABORATORY	10,394	674,418	0.015412	390,850	6,024	60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY	19,439	5,159,349	0.003768	2,357,384	8,883	65
66 PHYSICAL THERAPY	30,515	430,524	0.070879	227,879	16,152	66
67 OCCUPATIONAL THERAPY	16,865	419,737	0.040180	233,953	9,400	67
68 SPEECH PATHOLOGY	3,878	120,890	0.032079	64,397	2,066	68
71 MEDICAL SUPPLIES CHARGED TO P	33,599	1,087,998	0.030881	765,971	23,654	71
73 DRUGS CHARGED TO PATIENTS	57,122	3,119,124	0.018313	1,591,765	29,150	73
74 RENAL DIALYSIS	4,427	654,209	0.006767	357,510	2,419	74
76 WOUND CARE						76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS (NON-DISTINC OTHER REIMBURSABLE COST CENTERS						92
94 HOME PROGRAM DIALYSIS						94
200 TOTAL (SUM OF LINES 50-199)	180,110	12,010,257		6,175,823	99,842	200

PROVIDER CCN: 15-2027 VIBRA HOSP FORT WAYNE
 PERIOD FROM 11/01/2012 TO 10/31/2013

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2013.11
 03/21/2014 15:12

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

CHECK [] TITLE V
 APPLICABLE [XX] TITLE XVIII-PT A
 BOXES [] TITLE XIX

COST CENTER DESCRIPTION	NURSING SCHOOL 1	ALLIED HEALTH COST 2	ALL OTHER MEDICAL EDUCATION COST 3	SWING-BED ADJUSTMENT AMOUNT (SEE INSTR.) 4	TOTAL COSTS (SUM OF COLS. 1-3 MINUS COL. 4) 5
INPAT ROUTINE SERV COST CTRS					30
30 ADULTS & PEDIATRICS					31
31 INTENSIVE CARE UNIT					32
32 CORONARY CARE UNIT					33
33 BURN INTENSIVE CARE UNIT					34
34 SURGICAL INTENSIVE CARE UNIT					35
35 OTHER SPECIAL CARE (SPECIFY)					40
40 SUBPROVIDER - IPF					41
41 SUBPROVIDER - IRF					42
42 SUBPROVIDER I					43
43 NURSERY					44
44 SKILLED NURSING FACILITY					45
45 NURSING FACILITY					200
200 TOTAL (SUM OF LINES 30-199)					

PROVIDER CCN: 15-2027 VIBRA HOSP FORT WAYNE
 PERIOD FROM 11/01/2012 TO 10/31/2013

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2013.11
 03/21/2014 15:12

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

CHECK [] TITLE V
 APPLICABLE [XX] TITLE XVIII-PT A
 BOXES [] TITLE XIX

COST CENTER DESCRIPTION	TOTAL	PER DIEM	INPATIENT	INPAT PGM
	PATIENT	COL.5 ÷	PROGRAM	PASS THRU
	DAYS	COL.6)	DAYS	COSTS
	6	7	8	(COL.7 x
				COL.8)
				9
INPAT ROUTINE SERV COST CTRS				
30 ADULTS & PEDIATRICS	5,552		3,034	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 I				42
43 NURSERY				43
44 SKILLED NURSING FACILITY				44
45 NURSING FACILITY				45
200 TOTAL (SUM OF LINES 30-199)	5,552		3,034	200

PROVIDER CCN: 15-2027 VIBRA HOSP FORT WAYNE
 PERIOD FROM 11/01/2012 TO 10/31/2013

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2013.11
 03/21/2014 15:12

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (15-2027) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN			MEDICAL	COST	COST
	ANESTHETIST	SCHOOL	HEALTH	EDUCATION	(SUM OF	(SUM OF
	COST			COST	COLS. 1-4)	COLS. 2-4)
	1	2	3	4	5	6
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC						54
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
71 MEDICAL SUPPLIES CHARGED TO P						71
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76 WOUND CARE						76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS (NON-DISTINC						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[]	TITLE V	[XX]	HOSPITAL (15-2027)	[]	SUB (OTHER)	[]	ICF/MR	[XX]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[]	IPF	[]	SNF			[]	TEFRA
BOXES	[]	TITLE XIX	[]	IRF	[]	NF				

COST CENTER DESCRIPTION	TOTAL	RATIO OF	O/P RATIO	INPAT PGM	INPAT PGM	O/P PGM	O/P PGM
	CHARGES	COST TO	OF COST TO		PASS-THRU		PASS-THRU
	(FROM WKST	CHARGES	CHARGES	PGM	COSTS	CHARGES	COSTS
	C, PT. I,	(COL. 5 +	(COL. 6 +	CHARGES	(COL. 8 x	CHARGES	(COL. 9 x
	COL. 8)	COL. 7)	COL. 7)	10	COL. 10)	12	COL. 12)
	7	8	9	10	11	12	13
ANCILLARY SERVICE COST CENTERS							
54 RADIOLOGY-DIAGNOSTIC	344,008			186,114			54
60 LABORATORY	674,418			390,850			60
62.30 BLOOD CLOTTING FOR HEMOPHILI							62.30
65 RESPIRATORY THERAPY	5,159,349			2,357,384			65
66 PHYSICAL THERAPY	430,524			227,879			66
67 OCCUPATIONAL THERAPY	419,737			233,953			67
68 SPEECH PATHOLOGY	120,890			64,397			68
71 MEDICAL SUPPLIES CHARGED TO	1,087,998			765,971			71
73 DRUGS CHARGED TO PATIENTS	3,119,124			1,591,765			73
74 RENAL DIALYSIS	654,209			357,510			74
76 WOUND CARE							76
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
92 OBSERVATION BEDS (NON-DISTIN							92
OTHER REIMBURSABLE COST CENTERS							
94 HOME PROGRAM DIALYSIS							94
200 TOTAL (SUM OF LINES 50-199)	12,010,257			6,175,823			200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (15-2027) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO	PPS	COST REIMB. SERVICES	COST REIMB. SVCS NOT	COST SERVICES	COST SVCS NOT	
	FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	PPS SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
54 RADIOLOGY-DIAGNOSTIC	0.582835						54
60 LABORATORY	0.365355						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.128325						65
66 PHYSICAL THERAPY	0.423528						66
67 OCCUPATIONAL THERAPY	0.383895						67
68 SPEECH PATHOLOGY	0.343461						68
71 MEDICAL SUPPLIES CHARGED TO PAT	0.139601						71
73 DRUGS CHARGED TO PATIENTS	0.349162						73
74 RENAL DIALYSIS	0.350434						74
76 WOUND CARE							76
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
92 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS)							92
94 HOME PROGRAM DIALYSIS							94
200 SUBTOTAL (SEE INSTRUCTIONS)							200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)							202

PROVIDER CCN: 15-2027 VIBRA HOSP FORT WAYNE
 PERIOD FROM 11/01/2012 TO 10/31/2013

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2013.11
 03/21/2014 15:12

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

CHECK [] TITLE V
 APPLICABLE [] TITLE XVIII-PT A
 BOXES [XX] TITLE XIX

COST CENTER DESCRIPTION	CAP-REL COST		REDUCED CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM	INPAT PGM DAYS	INPAT PGM CAP COST	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT	(COL.1 MINUS COL.2)		(COL.3 ÷ COL.4)		(COL.5 x COL.6)	
	1	2	3	4	5	6	7	
INPAT ROUTINE SERV COST CTRS								
30 ADULTS & PEDIATRICS	835,275		835,275	5,552	150.45	131	19,709	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 I								42
43 NURSERY								43
44 SKILLED NURSING FACILITY								44
45 NURSING FACILITY								45
200 TOTAL (LINES 30-199)	835,275		835,275	5,552		131	19,709	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK APPLICABLE BOXES	[] TITLE V [] TITLE XVIII-PT A [XX] TITLE XIX	[XX] HOSPITAL (15-2027) [] IPF [] IRF	[] SUB (OTHER)	[XX] PPS [] TEFRA [] OTHER				
		CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5		
	ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC	3,871	344,008	0.011253	6,693	75		54
60	LABORATORY	10,394	674,418	0.015412	20,147	311		60
62.30	BLOOD CLOTTING FOR HEMOPHILIA							62.30
65	RESPIRATORY THERAPY	19,439	5,159,349	0.003768	119,595	451		65
66	PHYSICAL THERAPY	30,515	430,524	0.070879	11,662	827		66
67	OCCUPATIONAL THERAPY	16,865	419,737	0.040180	7,844	315		67
68	SPEECH PATHOLOGY	3,878	120,890	0.032079	2,219	71		68
71	MEDICAL SUPPLIES CHARGED TO P	33,599	1,087,998	0.030881	26,654	823		71
73	DRUGS CHARGED TO PATIENTS	57,122	3,119,124	0.018313	69,039	1,264		73
74	RENAL DIALYSIS	4,427	654,209	0.006767				74
76	WOUND CARE							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	OBSERVATION BEDS (NON-DISTINC OTHER REIMBURSABLE COST CENTERS							92
94	HOME PROGRAM DIALYSIS							94
200	TOTAL (SUM OF LINES 50-199)	180,110	12,010,257		263,853	4,137		200

PROVIDER CCN: 15-2027 VIBRA HOSP FORT WAYNE
PERIOD FROM 11/01/2012 TO 10/31/2013

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2013.11
03/21/2014 15:12

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK [] TITLE V
APPLICABLE [] TITLE XVIII-PT A
BOXES [XX] TITLE XIX

COST CENTER DESCRIPTION	NURSING SCHOOL 1	ALLIED HEALTH COST 2	ALL OTHER MEDICAL EDUCATION COST 3	SWING-BED ADJUSTMENT AMOUNT (SEE INSTR.) 4	TOTAL COSTS (SUM OF COLS. 1-3 MINUS COL. 4) 5
30 INPAT ROUTINE SERV COST CTRS					30
31 ADULTS & PEDIATRICS					31
32 INTENSIVE CARE UNIT					32
33 CORONARY CARE UNIT					33
34 BURN INTENSIVE CARE UNIT					34
35 SURGICAL INTENSIVE CARE UNIT					35
40 OTHER SPECIAL CARE (SPECIFY)					40
41 SUBPROVIDER - IPF					41
42 SUBPROVIDER - IRF					42
43 SUBPROVIDER I					43
44 NURSERY					44
45 SKILLED NURSING FACILITY					45
200 NURSING FACILITY					200
TOTAL (SUM OF LINES 30-199)					

PROVIDER CCN: 15-2027 VIBRA HOSP FORT WAYNE
 PERIOD FROM 11/01/2012 TO 10/31/2013

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2013.11
 03/21/2014 15:12

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

CHECK [] TITLE V
 APPLICABLE [] TITLE XVIII-PT A
 BOXES [XX] TITLE XIX

COST CENTER DESCRIPTION	TOTAL	PER DIEM	INPATIENT	INPAT PGM
	PATIENT	COL.5 ÷	PROGRAM	PASS THRU
	DAYS	COL.6)	DAYS	COSTS
	6	7	8	(COL.7 x
				COL.8)
				9
INPAT ROUTINE SERV COST CTRS				
30 ADULTS & PEDIATRICS	5,552		131	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 I				42
43 NURSERY				43
44 SKILLED NURSING FACILITY				44
45 NURSING FACILITY				45
200 TOTAL (SUM OF LINES 30-199)	5,552		131	200

PROVIDER CCN: 15-2027 VIBRA HOSP FORT WAYNE
 PERIOD FROM 11/01/2012 TO 10/31/2013

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2013.11
 03/21/2014 15:12

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (15-2027) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [] OTHER

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN			MEDICAL	COST	COST
	ANESTHETIST	SCHOOL	HEALTH	EDUCATION	(SUM OF	(SUM OF
	COST			COST	COLS. 1-4)	COLS. 2-4)
	1	2	3	4	5	6
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC						54
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
71 MEDICAL SUPPLIES CHARGED TO P						71
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76 WOUND CARE						76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS (NON-DISTINC						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[] TITLE V	[XX] HOSPITAL (15-2027)	[] SUB (OTHER)	[] ICF/MR	[XX] PPS		
APPLICABLE	[] TITLE XVIII-PT A	[] IPF	[] SNF		[] TEFRA		
BOXES	[XX] TITLE XIX	[] IRF	[] NF		[] OTHER		
COST CENTER DESCRIPTION	TOTAL CHARGES	RATIO OF COST TO CHARGES	O/P RATIO OF COST TO CHARGES	INPAT PGM CHARGES	INPAT PGM PASS-THRU COSTS	O/P PGM CHARGES	O/P PGM PASS-THRU COSTS
	(FROM WKST C, PT. I, COL. 8)	(COL. 5 ÷ COL. 7)	(COL. 6 ÷ COL. 7)	PGM COL. 10	(COL. 8 x COL. 10)	PGM COL. 12	(COL. 9 x COL. 12)
	7	8	9	10	11	12	13
ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC	344,008		6,693			54
60	LABORATORY	674,418		20,147			60
62.30	BLOOD CLOTTING FOR HEMOPHILI						62.30
65	RESPIRATORY THERAPY	5,159,349		119,595			65
66	PHYSICAL THERAPY	430,524		11,662			66
67	OCCUPATIONAL THERAPY	419,737		7,844			67
68	SPEECH PATHOLOGY	120,890		2,219			68
71	MEDICAL SUPPLIES CHARGED TO	1,087,998		26,654			71
73	DRUGS CHARGED TO PATIENTS	3,119,124		69,039			73
74	RENAL DIALYSIS	654,209					74
76	WOUND CARE						76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
92	OBSERVATION BEDS (NON-DISTIN						92
OTHER REIMBURSABLE COST CENTERS							
94	HOME PROGRAM DIALYSIS						94
200	TOTAL (SUM OF LINES 50-199)	12,010,257		263,853			200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (15-2027) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [XX] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO	PPS	COST REIMB. SERVICES	COST REIMB. SVCS NOT	COST SERVICES	COST SVCS NOT	
	FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	PPS SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
54 RADIOLOGY-DIAGNOSTIC	0.582835						54
60 LABORATORY	0.365355						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.128325						65
66 PHYSICAL THERAPY	0.423528						66
67 OCCUPATIONAL THERAPY	0.383895						67
68 SPEECH PATHOLOGY	0.343461						68
71 MEDICAL SUPPLIES CHARGED TO PAT	0.139601						71
73 DRUGS CHARGED TO PATIENTS	0.349162						73
74 RENAL DIALYSIS	0.350434						74
76 WOUND CARE							76
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
92 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS)							92
94 HOME PROGRAM DIALYSIS							94
200 SUBTOTAL (SEE INSTRUCTIONS)							200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)							202

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (15-2027) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	5,552	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	5,552	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	5,552	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	3,034	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	5,900,981	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	5,900,981	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)		28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	5,900,981	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (15-2027) [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 1,062.86 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 3,224,717 39
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35) 40
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40) 3,224,717 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5	
42 NURSERY (TITLES V AND XIX ONLY)						42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
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 (SPECIFY)						47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					1,550,226	48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					4,774,943	49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 456,465 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 99,842 51
 52 TOTAL PROGRAM EXCLUDABLE COST 556,307 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 4,218,636 53

TARGET AMOUNT AND LIMIT COMPUTATION
 54 PROGRAM DISCHARGES 54
 55 TARGET AMOUNT PER DISCHARGE 55
 56 TARGET AMOUNT (LINE 54 x LINE 55) 56
 57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT 57
 58 BONUS PAYMENT (SEE INSTRUCTIONS) 58
 59 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET 59
 60 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET 60
 61 IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS) 61
 62 RELIEF PAYMENT (SEE INSTRUCTIONS) 62
 63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS) 63

PROGRAM INPATIENT ROUTINE SWING BED COST
 64 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 64
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 65
 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS) 66
 67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19) 67
 68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20) 68
 69 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68) 69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 1,062.86 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 89

	COST 1	ROUTINE COST (FROM LINE 27) 2	COL. 1 ÷ COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89) 4	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.) 5	
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST						
90 CAPITAL-RELATED COST						90
91 NURSING SCHOOL COST						91
92 ALLIED HEALTH COST						92
93 ALL OTHER MEDICAL EDUCATION						93

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (15-2027) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX-INPT [] IRF [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	5,552	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	5,552	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	5,552	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	131	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	5,900,981	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	5,900,981	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)		28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	5,900,981	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (15-2027) [] SUB (OTHER) [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [XX] TITLE XIX-INPT [] IRF [] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 1,062.86 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 139,235 39
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35) 40
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40) 139,235 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5	
42 NURSERY (TITLES V AND XIX ONLY)						42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
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 (SPECIFY)						47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					63,148	48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					202,383	49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 19,709 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 4,137 51
 52 TOTAL PROGRAM EXCLUDABLE COST 23,846 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 178,537 53

TARGET AMOUNT AND LIMIT COMPUTATION
 54 PROGRAM DISCHARGES 54
 55 TARGET AMOUNT PER DISCHARGE 55
 56 TARGET AMOUNT (LINE 54 x LINE 55) 56
 57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT 57
 58 BONUS PAYMENT (SEE INSTRUCTIONS) 58
 59 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET 59
 60 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET 60
 61 IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS) 61
 62 RELIEF PAYMENT (SEE INSTRUCTIONS) 62
 63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS) 63

PROGRAM INPATIENT ROUTINE SWING BED COST
 64 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 64
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 65
 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS) 66
 67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19) 67
 68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20) 68
 69 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68) 69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 89

	COST 1	ROUTINE COST (FROM LINE 27) 2	COL. 1 ÷ COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89) 4	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.) 5	
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST						
90 CAPITAL-RELATED COST						90
91 NURSING SCHOOL COST						91
92 ALLIED HEALTH COST						92
93 ALL OTHER MEDICAL EDUCATION						93

PROVIDER CCN: 15-2027 VIBRA HOSP FORT WAYNE
 PERIOD FROM 11/01/2012 TO 10/31/2013

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2013.11
 03/21/2014 15:12

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL (15-2027) [] SUB (OTHER) [] S/B SNF [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF [] ICF/MR [] OTHER

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2)		
			3	3	
30 INPATIENT ROUTINE SERVICE COST CENTERS					
ADULTS & PEDIATRICS		4,465,478			30
ANCILLARY SERVICE COST CENTERS					
54 RADIOLOGY-DIAGNOSTIC	0.582835	186,114	108,474		54
60 LABORATORY	0.365355	390,850	142,799		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	0.128325	2,357,384	302,511		65
66 PHYSICAL THERAPY	0.423528	227,879	96,513		66
67 OCCUPATIONAL THERAPY	0.383895	233,953	89,813		67
68 SPEECH PATHOLOGY	0.343461	64,397	22,118		68
71 MEDICAL SUPPLIES CHARGED TO PAT	0.139601	765,971	106,930		71
73 DRUGS CHARGED TO PATIENTS	0.349162	1,591,765	555,784		73
74 RENAL DIALYSIS	0.350434	357,510	125,284		74
76 WOUND CARE					76
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
92 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS)					92
94 HOME PROGRAM DIALYSIS					94
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		6,175,823	1,550,226		200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES					201
202 NET CHARGES (LINE 200 MINUS LINE 201)		6,175,823			202

PROVIDER CCN: 15-2027 VIBRA HOSP FORT WAYNE
 PERIOD FROM 11/01/2012 TO 10/31/2013

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2013.11
 03/21/2014 15:12

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK	<input type="checkbox"/>	TITLE V	<input checked="" type="checkbox"/>	HOSPITAL (15-2027)	<input type="checkbox"/>	SUB (OTHER)	<input type="checkbox"/>	S/B SNF	<input checked="" type="checkbox"/>	PPS
APPLICABLE	<input type="checkbox"/>	TITLE XVIII-PT A	<input type="checkbox"/>	IPF	<input type="checkbox"/>	SNF	<input type="checkbox"/>	S/B NF	<input type="checkbox"/>	TEFRA
BOXES	<input checked="" type="checkbox"/>	TITLE XIX	<input type="checkbox"/>	IRF	<input type="checkbox"/>	NF	<input type="checkbox"/>	ICF/MR	<input type="checkbox"/>	OTHER

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2)	
			3	
30 INPATIENT ROUTINE SERVICE COST CENTERS				
ADULTS & PEDIATRICS		177,715		30
ANCILLARY SERVICE COST CENTERS				
54 RADIOLOGY-DIAGNOSTIC	0.582835	6,693	3,901	54
60 LABORATORY	0.365355	20,147	7,361	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.128325	119,595	15,347	65
66 PHYSICAL THERAPY	0.423528	11,662	4,939	66
67 OCCUPATIONAL THERAPY	0.383895	7,844	3,011	67
68 SPEECH PATHOLOGY	0.343461	2,219	762	68
71 MEDICAL SUPPLIES CHARGED TO PAT	0.139601	26,654	3,721	71
73 DRUGS CHARGED TO PATIENTS	0.349162	69,039	24,106	73
74 RENAL DIALYSIS	0.350434			74
76 WOUND CARE				76
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
92 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS)				92
94 HOME PROGRAM DIALYSIS				94
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		263,853	63,148	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		263,853		202

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART B

CHECK APPLICABLE BOX: HOSPITAL (15-2027) IPF IRF
 SUB (OTHER) SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)		1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPTS (SEE INSTRUCTIONS)		2
3	PPS PAYMENTS		3
4	OUTLIER PAYMENT (SEE INSTRUCTIONS)		4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (SEE INSTRUCTIONS)		5
6	LINE 2 TIMES LINE 5		6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6		7
8	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)		8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200		9
10	ORGAN ACQUISITION		10
11	TOTAL COST (SUM OF LINES 1 AND 10) (SEE INSTRUCTIONS)		11
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
12	ANCILLARY SERVICE CHARGES		12
13	ORGAN ACQUISITION CHARGES (FROM WKST D-4, PART III, LINE 69, COL. 4)		13
14	TOTAL REASONABLE CHARGES (SUM OF LINES 12 AND 13)		14
	CUSTOMARY CHARGES		
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		16
17	RATIO OF LINE 15 TO LINE 16 (NOT TO EXCEED 1.000000)	1.000000	17
18	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 18 EXCEEDS LINE 11 (SEE INSTRUCTIONS))		19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 11 EXCEEDS LINE 18 (SEE INSTRUCTIONS))		20
21	LESSER OF COST OR CHARGES (LINE 11 MINUS LINE 20) (FOR CAH, SEE INSTRUCTIONS)		21
22	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		22
23	COST OF TEACHING PHYSICIANS (SEE INSTR., 42 CFR 415.160 AND CMS PUB. 15-1 §2148)		23
24	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 3, 4, 8 AND 9)		24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)		25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)		26
27	SUBTOTAL {(LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23} (SEE INSTRUCTIONS)		27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 50)		28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (FROM WKST E-4, LINE 36)		29
30	SUBTOTAL (SUM OF LINES 27 THROUGH 29)		30
31	PRIMARY PAYER PAYMENTS		31
32	SUBTOTAL (LINE 30 MINUS LINE 31)		32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33	COMPOSITE RATE ESRD (FROM WKST I-5, LINE 11)		33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		36
37	SUBTOTAL (SEE INSTRUCTIONS) ' T4 - 10/25/13 JF		37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R		38
39	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		39
40	SUBTOTAL (SEE INSTRUCTIONS)		40
40.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		40.01
41	INTERIM PAYMENTS		41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (SEE INSTRUCTIONS)		43
44	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		44
	TO BE COMPLETED BY CONTRACTOR		
90	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)		90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY		92
93	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		93
94	TOTAL (SUM OF LINES 91 AND 93)		94

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK [XX] HOSPITAL (15-2027) [] SUB (OTHER)
 APPLICABLE [] IPF [] SNF
 BOX: [] IRF [] SWING BED SNF

INPATIENT
 PART A PART B

DESCRIPTION	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4		
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		4,648,542				1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		NONE		2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01	NONE		NONE		3.01
	.02					3.02
	PROGRAM .03					3.03
	TO .04					3.04
	PROVIDER .05					3.05
	.06					3.06
	.07					3.07
	.08					3.08
	.09					3.09
	.50	NONE		NONE		3.50
	.51					3.51
	PROVIDER .52					3.52
	TO .53					3.53
	PROGRAM .54					3.54
	.55					3.55
	.56					3.56
	.57					3.57
	.58					3.58
	.59					3.59
	.99					3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)						
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		4,648,542				4

TO BE COMPLETED BY CONTRACTOR

5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01	NONE		NONE		5.01
	TO .02					5.02
	PROVIDER .03					5.03
	.04					5.04
	.05					5.05
	.06					5.06
	.07					5.07
	.08					5.08
	.09					5.09
	PROVIDER .50	NONE		NONE		5.50
	TO .51					5.51
	PROGRAM .52					5.52
	.53					5.53
	.54					5.54
	.55					5.55
	.56					5.56
	.57					5.57
	.58					5.58
	.59					5.59
	.99					5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)						
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM .01	150,674				6.01
	TO .02					6.02
	PROVIDER .03					6.03
	TO .04					6.04
	PROGRAM .05					6.05
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		4,799,216				7
8 NAME OF CONTRACTOR: _____		CONTRACTOR NUMBER: _____		NPR DATE: _____		8

PROVIDER CCN: 15-2027 VIBRA HOSP FORT WAYNE
PERIOD FROM 11/01/2012 TO 10/31/2013

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2013.11
03/21/2014 15:12

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK HOSPITAL (15-2027) CAH
APPLICABLE BOX

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	5,552 4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168	7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)	9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (SEE INSTRUCTIONS)	10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)	30
31	OTHER ADJUSTMENTS (SPECIFY)	31
32	BALANCE DUE PROVIDER (LINE 8 (OR LINE 10) MINUS LINE 30 AND LINE 31) (SEE INSTRUCTIONS)	32

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART IV

CHECK [XX] HOSPITAL (15-2027)
APPLICABLE BOX:

PART IV - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER LTCH PPS

1	NET FEDERAL PPS PAYMENT (SEE INSTRUCTIONS)	4,255,607	1
2	OUTLIER PAYMENTS	765,888	2
3	TOTAL PPS PAYMENTS (SUM OF LINES 1 AND 2)	5,021,495	3
4	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENTS (SEE INSTRUCTIONS)		4
5	ORGAN ACQUISITION		5
6	COST OF TEACHING PHYSICIANS		6
7	SUBTOTAL (SEE INSTRUCTIONS)	5,021,495	7
8	PRIMARY PAYER PAYMENTS		8
9	SUBTOTAL (LINE 7 LESS LINE 8)	5,021,495	9
10	DEDUCTIBLES	3,496	10
11	SUBTOTAL (LINE 9 MINUS LINE 10)	5,017,999	11
12	COINSURANCE	306,012	12
13	SUBTOTAL (LINE 11 MINUS LINE 12)	4,711,987	13
14	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	134,199	14
15	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	87,229	15
16	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	97,036	16
17	SUBTOTAL (SUM OF LINES 13 AND 15)	4,799,216	17
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 49) (FOR FREESTANDING LTCH ONLY)		18
19	OTHER PASS THROUGH COSTS (SEE INSTRUCTIONS)		19
20	OUTLIER PAYMENTS RECONCILIATION		20
21	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		21
22	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SEE INSTRUCTIONS)	4,799,216	22
22.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	56,151	22.01
23	INTERIM PAYMENTS	4,648,542	23
24	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		24
25	BALANCE DUE PROVIDER/PROGRAM (LINE 22 MINUS LINES 22.01, 23 AND 24)	94,523	25
26	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		26

TO BE COMPLETED BY CONTRACTOR

50	ORIGINAL PPS PAYMENT AND OUTLIER AMOUNT FROM WORKSHEET E-3, PART IV, LINE 3 (SEE INSTRUCTIONS)		50
51	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		51
52	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (SEE INSTRUCTIONS)		52
53	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		53

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART VII

CHECK TITLE V HOSPITAL (15-2027) SNF PPS
 APPLICABLE TITLE XIX IPF NF TEFRA
 BOXES: IRF ICF/MR OTHER
 SUB (OTHER)

PART VII - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR TITLE XIX SERVICES

	INPATIENT	OUTPATIENT
	TITLE V OR	TITLE V OR
	TITLE XIX	TITLE XIX
COMPUTATION OF NET COST OF COVERED SERVICES		
1 INPATIENT HOSPITAL SNF/NF SERVICES		1
2 MEDICAL AND OTHER SERVICES		2
3 ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)		3
4 SUBTOTAL (SUM OF LINES 1, 2 AND 3)		4
5 INPATIENT PRIMARY PAYER PAYMENTS		5
6 OUTPATIENT PRIMARY PAYER PAYMENTS		6
7 SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)		7
COMPUTATION OF LESSER OF COST OR CHARGES		
REASONABLE CHARGES		
8 ROUTINE SERVICE CHARGES		8
9 ANCILLARY SERVICE CHARGES	263,853	9
10 ORGAN ACQUISITION CHARGES, NET OF REVENUE		10
11 INCENTIVE FROM TARGET AMOUNT COMPUTATION		11
12 TOTAL REASONABLE CHARGES (SUM OF LINES 8-11)	263,853	12
CUSTOMARY CHARGES		
13 AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		13
14 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)		14
15 RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.000000)	1.000000	1.000000 15
16 TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	263,853	16
17 EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 4 (SEE INSTRUCTIONS))	263,853	17
18 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 4 EXCEEDS LINE 16 (SEE INSTRUCTIONS))		18
19 INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		19
20 COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)		20
21 COST OF COVERED SERVICES (LESSER OF LINE 4 OR LINE 16) (FOR CAH, SEE INSTRUCTIONS)		21
PROSPECTIVE PAYMENT AMOUNT		
22 OTHER THAN OUTLIER PAYMENTS		22
23 OUTLIER PAYMENTS		23
24 PROGRAM CAPITAL PAYMENTS		24
25 CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)		25
26 ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS		26
27 SUBTOTAL (SUM OF LINES 22 THROUGH 26)		27
28 CUSTOMARY CHARGES (TITLES V OR XIX PPS COVERED SERVICES ONLY)		28
29 SUM OF LINES 27 AND 21		29
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
30 EXCESS OF REASONABLE COST (FROM LINE 18)		30
31 SUBTOTAL (SUM OF LINES 19 AND 20 PLUS 29 MINUS LINES 5 AND 6)		31
32 DEDUCTIBLES		32
33 COINSURANCE		33
34 ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		34
35 UTILIZATION REVIEW		35
36 SUBTOTAL (SUM OF LINES 31, 34 AND 35 MINUS THE SUM OF LINES 32 AND 33)		36
37 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		37
38 SUBTOTAL (LINE 36 ± LINE 37)		38
39 DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4)		39
40 TOTAL AMOUNT PAYABLE TO THE PROVIDER (SUM OF LINES 38 AND 39)		40
41 INTERIM PAYMENTS		41
42 BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)		42
43 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		43

BALANCE SHEET

WORKSHEET G

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	-115,404			1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	2,665,487			4
5	OTHER RECEIVABLES				5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-420,016			6
7	INVENTORY	159,376			7
8	PREPAID EXPENSES	174,802			8
9	OTHER CURRENT ASSETS				9
10	DUE FROM OTHER FUNDS				10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	2,464,245			11
FIXED ASSETS					
12	LAND				12
13	LAND IMPROVEMENTS	6,534			13
14	ACCUMULATED DEPRECIATION				14
15	BUILDINGS	7,314			15
16	ACCUMULATED DEPRECIATION				16
17	LEASEHOLD IMPROVEMENTS				17
18	ACCUMULATED AMORTIZATION				18
19	FIXED EQUIPMENT				19
20	ACCUMULATED DEPRECIATION				20
21	AUTOMOBILES AND TRUCKS				21
22	ACCUMULATED DEPRECIATION				22
23	MAJOR MOVABLE EQUIPMENT	13,809			23
24	ACCUMULATED DEPRECIATION	-11,810			24
25	MINOR EQUIPMENT DEPRECIABLE				25
26	ACCUMULATED DEPRECIATION				26
27	HIT DESIGNATED ASSETS				27
28	ACCUMULATED DEPRECIATION				28
29	MINOR EQUIPMENT-NONDEPRECIABLE				29
30	TOTAL FIXED ASSETS (SUM OF LINES 12-29)	15,847			30
OTHER ASSETS					
31	INVESTMENTS				31
32	DEPOSITS ON LEASES				32
33	DUE FROM OWNERS/OFFICERS				33
34	OTHER ASSETS	588,926			34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	588,926			35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	3,069,018			36
LIABILITIES AND FUND BALANCES					
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	608,121			37
38	SALARIES, WAGES & FEES PAYABLE	240,777			38
39	PAYROLL TAXES PAYABLE	135,906			39
40	NOTES & LOANS PAYABLE (SHORT TERM)				40
41	DEFERRED INCOME				41
42	ACCELERATED PAYMENTS				42
43	DUE TO OTHER FUNDS	1,769,516			43
44	OTHER CURRENT LIABILITIES				44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	2,754,320			45
LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE				46
47	NOTES PAYABLE				47
48	UNSECURED LOANS				48
49	OTHER LONG TERM LIABILITIES	237,232			49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	237,232			50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	2,991,552			51
CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	77,466			52
53	SPECIFIC PURPOSE FUND BALANCE				53
54	DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED				54
55	DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED				55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BAL				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 52-58)	77,466			59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	3,069,018			60

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND 1	2	SPECIFIC PURPOSE FUND 3	4	ENDOWMENT FUND 5	6	PLANT FUND 7	8	
1 FUND BALANCES AT BEGINNING OF PERIOD		-809,664							1
2 NET INCOME (LOSS) (FROM WKST G-3, LINE 29)		-627,007							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		-1,436,671							3
4 ADDITIONS (CREDIT ADJUSTMENTS)									4
5 EQUITY CONTRIBUTION		1,514,134							5
6 ROUNDING		3							6
7									7
8									8
9									9
10 TOTAL ADDITIONS (SUM OF LINES 4-9)		1,514,137							10
11 SUBTOTAL (LINE 3 PLUS LINE 10)		77,466							11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)									12
13									13
14									14
15									15
16									16
17									17
18 TOTAL DEDUCTIONS (SUM OF LINES 12-17)									18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)		77,466							19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
 PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
1 GENERAL INPATIENT ROUTINE CARE SERVICES				1
2 HOSPITAL	7,241,897		7,241,897	2
3 SUBPROVIDER IPF				3
5 SUBPROVIDER IRF				5
6 SWING BED - SNF				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)	7,241,897		7,241,897	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT				12
13 CORONARY CARE UNIT				13
14 BURN INTENSIVE CARE UNIT				14
15 SURGICAL INTENSIVE CARE UNIT				15
16 OTHER SPECIAL CARE (SPECIFY)				16
17 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)				17
18 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	7,241,897		7,241,897	18
19 ANCILLARY SERVICES	12,010,257		12,010,257	19
20 OUTPATIENT SERVICES				20
21 RHC				21
22 FQHC				22
23 HOME HEALTH AGENCY				23
25 AMBULANCE				25
26 ASC				26
27 HOSPICE				27
28 OTHER (SPECIFY)				28
TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	19,252,154		19,252,154	

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		9,341,553	29
30 ADD (SPECIFY)			30
31			31
32			32
33			33
34			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)			36
37 DEDUCT (SPECIFY)			37
38			38
39			39
40			40
41			41
42 TOTAL DEDUCTIONS (SUM OF LINES 37-41)			42
43 TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		9,341,553	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	19,252,154	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	10,428,550	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	8,823,604	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	9,341,553	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	-517,949	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	470	7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS		14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (GRANT)	3,400	24
24.01	OTHER (OTHER)	1,020	24.01
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	4,890	25
26	TOTAL (LINE 5 PLUS LINE 25)	-513,059	26
27	OTHER EXPENSES (BAD DEBTS)	113,948	27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)	113,948	28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	-627,007	29