



HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 9509 GEORGIA STREET  
 2 CITY: CROWN POINT

STATE: IN

P.O.BOX:

ZIP CODE: 46307-6518 COUNTY: LAKE

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 HOSPITAL OF NORTHWEST IN	15-2028	23844	2	08/08/2008	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

		1	2
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.	N	N
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

		IN-STATE		OUT-OF-STATE		OTHER	
		MEDICAID PAID DAYS	MEDICAID ELIGIBLE UNPAID DAYS	MEDICAID PAID DAYS	MEDICAID ELIGIBLE UNPAID DAYS	MEDICAID HMO UNPAID DAYS	MEDICAID OTHER UNPAID 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.						
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.						
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		
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		
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.						
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:	
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.						
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:	
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)						

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
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
47	IS THIS A NEW HOSPITAL UNDER 42 CFR §412.300 PPS CAPITAL? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N
48	IS THE FACILITY ELECTING FULL FEDERAL CAPITAL PAYMENT? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N

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
		Y/N	IME	DIRECT GME	
61	DID YOUR HOSPITAL RECEIVE FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. )(SEE INSTRUCTIONS)	N			61
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.				
		PROGRAM NAME	PROGRAM CODE	UNWEIGHTED IME FTE COUNT	UNWEIGHTED DIRECT GME FTE COUNT
		1	2	3	4
					61.10
	OF THE FTEs IN LINE 61.05, SPECIFY EACH 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		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)

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

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

INPATIENT PSYCHIATRIC FACILITY PPS

70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		70
71	IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES 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

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

80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		80
----	--	---	--	----

TEFRA PROVIDERS

85	IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA?. ENTER 'Y' FOR YES OR 'N' FOR NO.	N		85
86	DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.	N		86

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I (CONT)

		V	XIX		
		1	2		
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.	N	N	90	
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	91	
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? 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 N	OCUP- ATIONAL SPEECH RESPI- RATORY	109
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. (mmddyyyy) (SEE INSTRUCTIONS)

	N	167
		168
		169
		170

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 ALL HOSPITALS

		Y/N	DATE	
<b>PROVIDER ORGANIZATION AND OPERATION</b>				
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)	1 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.	1 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
<b>FINANCIAL DATA AND REPORTS</b>				
		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.	1 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
<b>APPROVED EDUCATIONAL ACTIVITIES</b>				
		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?	1 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	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
<b>BED COMPLEMENT</b>				
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		N	15

		PART A		PART B	
		Y/N	DATE	Y/N	DATE
<b>PS&amp;R REPORT DATA</b>					
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	03/17/2014	Y	02/17/2014
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	
		1	2	
36	WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT?			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	7,164,587			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 WAGE-RELATED COSTS					16
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) OVERHEAD COSTS - DIRECT SALARIES					25
26	EMPLOYEE BENEFITS DEPARTMENT		41,455			26
27	ADMINISTRATIVE & GENERAL		1,127,253			27
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)					28
29	MAINTENANCE & REPAIRS					29
30	OPERATION OF PLANT		146,511			30
31	LAUNDRY & LINEN SERVICE					31
32	HOUSEKEEPING		107,663			32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)					33
34	DIETARY		261,106			34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)					35
36	CAFETERIA					36
37	MAINTENANCE OF PERSONNEL					37
38	NURSING ADMINISTRATION		244,037			38
39	CENTRAL SERVICES AND SUPPLY					39
40	PHARMACY		406,960			40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		82,537			41
42	SOCIAL SERVICE					42
43	OTHER GENERAL SERVICE					43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	7,164,587		7,164,587		1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)					2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	7,164,587		7,164,587		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)	7,164,587		7,164,587		6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)		2,417,522		2,417,522	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

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		1,507,703	1,507,703	2
3	00300		346,043	346,043	3
4	00400	41,455	1,447,304	1,488,759	4
5	00500	1,127,253	892,055	2,019,308	5
6	00600				6
7	00700	146,511	326,077	472,588	7
8	00800		133,702	133,702	8
9	00900	107,663	63,436	171,099	9
10	01000	261,106	128,541	389,647	10
11	01100				11
12	01200				12
13	01300	244,037	41,415	285,452	13
14	01400				14
15	01500	406,960	10,626	417,586	15
16	01600	82,537	20,001	102,538	16
17	01700				17
INPATIENT ROUTINE SERV COST CENTERS					
30	03000	4,071,919	1,618,461	5,690,380	30
ANCILLARY SERVICE COST CENTERS					
54	05400		272,764	272,764	54
60	06000		481,879	481,879	60
62.30	06250				62.30
65	06500	675,146	59,514	734,660	65
66	06600		282,737	282,737	66
67	06700		287,618	287,618	67
68	06800		58,814	58,814	68
71	07100		297,977	297,977	71
73	07300		1,156,514	1,156,514	73
74	07400		386,063	386,063	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
SPECIAL PURPOSE COST CENTERS					
118		7,164,587	9,819,244	16,983,831	118
SUBTOTALS (sum of lines 1-117)					
NONREIMBURSABLE COST CENTERS					
194	07950				194
200		7,164,587	9,819,244	16,983,831	200
TOTAL (sum of lines 118-199)					

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	1,507,703		1,507,703	1
2	00200	346,043		346,043	2
3	00300				3
4	00400	1,488,759		1,488,759	4
5	00500	2,019,308	928,435	2,947,743	5
6	00600				6
7	00700	472,588		472,588	7
8	00800	133,702		133,702	8
9	00900	171,099		171,099	9
10	01000	389,647		389,647	10
11	01100				11
12	01200				12
13	01300	285,452		285,452	13
14	01400				14
15	01500	417,586		417,586	15
16	01600	102,538		102,538	16
17	01700				17
INPATIENT ROUTINE SERV COST CENTERS					
30	03000	5,690,380	-181,343	5,509,037	30
ANCILLARY SERVICE COST CENTERS					
54	05400	272,764		272,764	54
60	06000	481,879		481,879	60
62.30	06250				62.30
65	06500	734,660		734,660	65
66	06600	282,737		282,737	66
67	06700	287,618		287,618	67
68	06800	58,814		58,814	68
71	07100	297,977		297,977	71
73	07300	1,156,514		1,156,514	73
74	07400	386,063		386,063	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
SPECIAL PURPOSE COST CENTERS					
118		16,983,831	747,092	17,730,923	118
NONREIMBURSABLE COST CENTERS					
194	07950				194
200		16,983,831	747,092	17,730,923	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	2,509					2,509		2
3 BUILDINGS AND FIXTURES								3
4 BUILDING IMPROVEMENTS	12,565	14,889		14,889		27,454		4
5 FIXED EQUIPMENT	14,092	8,259		8,259		22,351		5
6 MOVABLE EQUIPMENT	48,672	8,886		8,886		57,558		6
7 HIT DESIGNATED ASSETS								7
8 SUBTOTAL (SUM OF LINES 1-7)	77,838	32,034		32,034		109,872		8
9 RECONCILING ITEMS								9
10 TOTAL (LINE 7 MINUS LINE 9)	77,838	32,034		32,034		109,872		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		1,296,252			211,451		1,507,703 1
2 CAP REL COSTS-MVBLE EQUIP	11,774	334,269					346,043 2
3 TOTAL (SUM OF LINES 1-2)	11,774	1,630,521			211,451		1,853,746 3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

COMPUTATION OF RATIOS

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	52,314		52,314	0.476136					1
2 CAP REL COSTS-MVBLE EQUIP	57,558		57,558	0.523864					2
3 TOTAL (SUM OF LINES 1-2)	109,872		109,872	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		1,296,252			211,451		1,507,703 1
2 CAP REL COSTS-MVBLE EQUIP	11,774	334,269					346,043 2
3 TOTAL	11,774	1,630,521			211,451		1,853,746 3

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF
			COST CENTER	LINE NO.	
	1	2	3	4	5
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	-462	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	-181,343			10
11 SALE OF SCRAP, WASTE, ETC. (chapter 23)					11
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1	990,308			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	B	-661	ADMINISTRATIVE & GENERAL	5	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 OPERATING INCOME	B	-2,358	ADMINISTRATIVE & GENERAL	5	33
34 NON-ALLOWABLE COST	A	-147	ADMINISTRATIVE & GENERAL	5	34
35 NON-ALLOWABLE AMORTIZATION	A	-32,335	ADMINISTRATIVE & GENERAL	5	35
36 MARKETING	A	-25,910	ADMINISTRATIVE & GENERAL	5	36
37					37
38					38
39					39
40					40
41					41
42					42
43					43
44					44
45					45
46					46
47					47
48					48
49					49
50 TOTAL (SUM OF LINES 1 THRU 49)		747,092			50
TRANSFER TO WKST A, COL. 6, LINE 200)					

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 ADJ- USTMENTS (COL. 4-5) 6	WKST A-7 REF 7
1	5	ADMINISTRATIVE & GENERAL				
2		PROGRESSIVE HEALTHCARE INC COR	1,383,520	393,212	990,308	1
3						2
4						3
5		TOTALS (SUM OF LINES 1-4)	1,383,520	393,212	990,308	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 -----			
		PERCENT OF OWNERSHIP 3	NAME 4	PERCENT OF OWNERSHIP 5	TYPE OF BUSINESS 6
6	B VIBRA MANAGEMENT LLC	100.00	VIBRA HEALTHCARE LLC	100.00	CORPORATE OFFICE
7					
8					
9					
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: 15-2028 VIBRA HOSPITAL OF NORTHWEST IN  
 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 15:48

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	LINE NO.	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	
	1	2	3	4	5	6	7	8	9	
	1	30 ADULTS & PEDIATRICS								
		MEDICAL STAFF D	226,550		226,550	171,400	943	77,707	3,885	1
	2	30 ADULTS & PEDIATRICS	32,500	32,500						2
		PHYSICIAN DIREC								
	200	TOTAL	259,050	32,500	226,550		943	77,707	3,885	200

PROVIDER CCN: 15-2028 VIBRA HOSPITAL OF NORTHWEST IN  
 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 15:48

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		MEDICAL STAFF D			77,707	148,843	148,843	1
2 30	ADULTS & PEDIATRICS		PHYSICIAN DIREC					32,500	2
200	TOTAL					77,707	148,843	181,343	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	1,507,703	1,507,703				1
2 CAP REL COSTS-MVBLE EQUIP	346,043		346,043			2
4 EMPLOYEE BENEFITS DEPARTMENT	1,488,759			1,488,759		4
5 ADMINISTRATIVE & GENERAL 6 MAINTENANCE & REPAIRS	2,947,743	89,114	20,453	235,599	3,292,909	5
7 OPERATION OF PLANT	472,588	559,845	128,494	30,621	1,191,548	7
8 LAUNDRY & LINEN SERVICE	133,702	23,552	5,406		162,660	8
9 HOUSEKEEPING	171,099	10,658	2,446	22,502	206,705	9
10 DIETARY	389,647	74,140	17,016	54,572	535,375	10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	285,452			51,004	336,456	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY	417,586	24,540	5,632	85,056	532,814	15
16 MEDICAL RECORDS & LIBRARY	102,538	18,145	4,165	17,250	142,098	16
17 SOCIAL SERVICE						17
30 INPATIENT ROUTINE SERV COST CENTERS ADULTS & PEDIATRICS	5,509,037	646,099	148,292	851,047	7,154,475	30
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC	272,764	3,743	859		277,366	54
60 LABORATORY	481,879	3,171	728		485,778	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	734,660	1,976	453	141,108	878,197	65
66 PHYSICAL THERAPY	282,737	15,130	3,472		301,339	66
67 OCCUPATIONAL THERAPY	287,618	18,041	4,141		309,800	67
68 SPEECH PATHOLOGY	58,814	5,407	1,241		65,462	68
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	297,977	9,099	2,088		309,164	71
73 DRUGS CHARGED TO PATIENTS	1,156,514				1,156,514	73
74 RENAL DIALYSIS	386,063	5,043	1,157		392,263	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
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (sum of lines 1-117)	17,730,923	1,507,703	346,043	1,488,759	17,730,923	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)	17,730,923	1,507,703	346,043	1,488,759	17,730,923	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	3,292,909					5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	271,759	1,463,307				7
8 LAUNDRY & LINEN SERVICE	37,098	40,133	239,891			8
9 HOUSEKEEPING	47,144	18,162		272,011		9
10 DIETARY	122,104	126,335		24,459	808,273	10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	76,736					13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY	121,520	41,816		8,096		15
16 MEDICAL RECORDS & LIBRARY	32,409	30,919		5,986		16
17 SOCIAL SERVICE						17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	1,631,738	1,100,957	239,891	213,144	808,273	30
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC	63,259	6,379		1,235		54
60 LABORATORY	110,792	5,404		1,046		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	200,292	3,367		652		65
66 PHYSICAL THERAPY	68,727	25,781		4,991		66
67 OCCUPATIONAL THERAPY	70,657	30,742		5,952		67
68 SPEECH PATHOLOGY	14,930	9,214		1,784		68
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	70,512	15,504		3,002		71
73 DRUGS CHARGED TO PATIENTS	263,768					73
74 RENAL DIALYSIS	89,464	8,594		1,664		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
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (sum of lines 1-117)	3,292,909	1,463,307	239,891	272,011	808,273	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)	3,292,909	1,463,307	239,891	272,011	808,273	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION 13	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SUBTOTAL 24	I&R COST & 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	413,192				13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY		704,246			15
16 MEDICAL RECORDS & LIBRARY			211,412		16
17 SOCIAL SERVICE					17
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	413,192		211,412	11,773,082	30
ANCILLARY SERVICE COST CENTERS					
54 RADIOLOGY-DIAGNOSTIC				348,239	54
60 LABORATORY				603,020	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY				1,082,508	65
66 PHYSICAL THERAPY				400,838	66
67 OCCUPATIONAL THERAPY				417,151	67
68 SPEECH PATHOLOGY				91,390	68
71 MEDICAL SUPPLIES CHARGED TO PATIENTS				398,182	71
73 DRUGS CHARGED TO PATIENTS		704,246		2,124,528	73
74 RENAL DIALYSIS				491,985	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
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (sum of lines 1-117)	413,192	704,246	211,412	17,730,923	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)	413,192	704,246	211,412	17,730,923	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION		TOTAL	
		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	11,773,082	30
	ANCILLARY SERVICE COST CENTERS		
54	RADIOLOGY-DIAGNOSTIC	348,239	54
60	LABORATORY	603,020	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS		62.30
65	RESPIRATORY THERAPY	1,082,508	65
66	PHYSICAL THERAPY	400,838	66
67	OCCUPATIONAL THERAPY	417,151	67
68	SPEECH PATHOLOGY	91,390	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	398,182	71
73	DRUGS CHARGED TO PATIENTS	2,124,528	73
74	RENAL DIALYSIS	491,985	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
	SPECIAL PURPOSE COST CENTERS		
118	SUBTOTALS (sum of lines 1-117)	17,730,923	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)	17,730,923	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	ADMINIS- TRATIVE & GENERAL 5	
GENERAL SERVICE COST CENTERS						
1						1
2						2
4						4
5	85,363	89,114	20,453	194,930	194,930	5
6						6
7		559,845	128,494	688,339	16,087	7
8		23,552	5,406	28,958	2,196	8
9		10,658	2,446	13,104	2,791	9
10		74,140	17,016	91,156	7,228	10
11						11
12						12
13					4,542	13
14						14
15		24,540	5,632	30,172	7,194	15
16		18,145	4,165	22,310	1,918	16
17						17
INPATIENT ROUTINE SERV COST CENTERS						
30		646,099	148,292	794,391	96,595	30
ANCILLARY SERVICE COST CENTERS						
54		3,743	859	4,602	3,745	54
60		3,171	728	3,899	6,558	60
62.30						62.30
65		1,976	453	2,429	11,857	65
66		15,130	3,472	18,602	4,068	66
67		18,041	4,141	22,182	4,183	67
68		5,407	1,241	6,648	884	68
71		9,099	2,088	11,187	4,174	71
73					15,614	73
74		5,043	1,157	6,200	5,296	74
76						76
76.97						76.97
76.98						76.98
76.99						76.99
OUTPATIENT SERVICE COST CENTERS						
92						92
OBSERVATION BEDS (NON-DISTINCT PART)						
OTHER REIMBURSABLE COST CENTERS						
94						94
HOME PROGRAM DIALYSIS						
SPECIAL PURPOSE COST CENTERS						
118	85,363	1,507,703	346,043	1,939,109	194,930	118
NONREIMBURSABLE COST CENTERS						
194						194
200						200
201						201
202	85,363	1,507,703	346,043	1,939,109	194,930	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	NURSING ADMINIS- TRATION 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	704,426					7
8 LAUNDRY & LINEN SERVICE	19,320	50,474				8
9 HOUSEKEEPING	8,743		24,638			9
10 DIETARY	60,817		2,215	161,416		10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION					4,542	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY	20,130		733			15
16 MEDICAL RECORDS & LIBRARY	14,884		542			16
17 SOCIAL SERVICE						17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	529,993	50,474	19,306	161,416	4,542	30
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC	3,071		112			54
60 LABORATORY	2,602		95			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	1,621		59			65
66 PHYSICAL THERAPY	12,411		452			66
67 OCCUPATIONAL THERAPY	14,799		539			67
68 SPEECH PATHOLOGY	4,435		162			68
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	7,463		272			71
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS	4,137		151			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
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (sum of lines 1-117)	704,426	50,474	24,638	161,416	4,542	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)	704,426	50,474	24,638	161,416	4,542	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 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	58,229					15
16 MEDICAL RECORDS & LIBRARY		39,654				16
17 SOCIAL SERVICE						17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS		39,654	1,696,371		1,696,371	30
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC			11,530		11,530	54
60 LABORATORY			13,154		13,154	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY			15,966		15,966	65
66 PHYSICAL THERAPY			35,533		35,533	66
67 OCCUPATIONAL THERAPY			41,703		41,703	67
68 SPEECH PATHOLOGY			12,129		12,129	68
71 MEDICAL SUPPLIES CHARGED TO PATIENTS			23,096		23,096	71
73 DRUGS CHARGED TO PATIENTS	58,229		73,843		73,843	73
74 RENAL DIALYSIS			15,784		15,784	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
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (sum of lines 1-117)	58,229	39,654	1,939,109		1,939,109	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)	58,229	39,654	1,939,109		1,939,109	202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	
	1	2	4	5A	5	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	28,999					1
2 CAP REL COSTS-MVBLE EQUIP		28,999				2
4 EMPLOYEE BENEFITS DEPARTMENT			7,123,132			4
5 ADMINISTRATIVE & GENERAL	1,714	1,714	1,127,253	-3,292,909	14,438,014	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	10,768	10,768	146,511		1,191,548	7
8 LAUNDRY & LINEN SERVICE	453	453			162,660	8
9 HOUSEKEEPING	205	205	107,663		206,705	9
10 DIETARY	1,426	1,426	261,106		535,375	10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION			244,037		336,456	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY	472	472	406,960		532,814	15
16 MEDICAL RECORDS & LIBRARY	349	349	82,537		142,098	16
17 SOCIAL SERVICE						17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	12,427	12,427	4,071,919		7,154,475	30
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC	72	72			277,366	54
60 LABORATORY	61	61			485,778	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	38	38	675,146		878,197	65
66 PHYSICAL THERAPY	291	291			301,339	66
67 OCCUPATIONAL THERAPY	347	347			309,800	67
68 SPEECH PATHOLOGY	104	104			65,462	68
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	175	175			309,164	71
73 DRUGS CHARGED TO PATIENTS					1,156,514	73
74 RENAL DIALYSIS	97	97			392,263	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
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (sum of lines 1-117)	28,999	28,999	7,123,132	-3,292,909	14,438,014	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	1,507,703	346,043	1,488,759		3,292,909	202
203 UNIT COST MULT-WS B PT I	51.991551	11.932929	0.209003		0.228072	203
204 COST TO BE ALLOC PER B PT II					194,930	204
205 UNIT COST MULT-WS B PT II					0.013501	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION	LAUNDRY	HOUSE-	DIETARY	NURSING	
	OF PLANT	& LINEN	KEEPING		ADMINIS-	
	SQUARE	SERVICE	SQUARE	MEALS	TRATION	
	FEET	PATIENT	FEET	SERVED	PATIENT	
	7	DAYS	9	10	DAYS	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	16,517					7
8 LAUNDRY & LINEN SERVICE	453	13,433				8
9 HOUSEKEEPING	205		15,859			9
10 DIETARY	1,426		1,426	40,299		10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION					13,433	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY	472		472			15
16 MEDICAL RECORDS & LIBRARY	349		349			16
17 SOCIAL SERVICE						17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	12,427	13,433	12,427	40,299	13,433	30
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC	72		72			54
60 LABORATORY	61		61			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	38		38			65
66 PHYSICAL THERAPY	291		291			66
67 OCCUPATIONAL THERAPY	347		347			67
68 SPEECH PATHOLOGY	104		104			68
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	175		175			71
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS	97		97			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
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (sum of lines 1-117)	16,517	13,433	15,859	40,299	13,433	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	1,463,307	239,891	272,011	808,273	413,192	202
203 UNIT COST MULT-WS B PT I	88.593994	17.858334	17.151838	20.056900	30.759473	203
204 COST TO BE ALLOC PER B PT II	704,426	50,474	24,638	161,416	4,542	204
205 UNIT COST MULT-WS B PT II	42.648544	3.757463	1.553566	4.005459	0.338123	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	PHARMACY	MEDICAL	
	COSTED REQUIS.	RECORDS & LIBRARY PATIENT DAYS	
	15	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			14
15 PHARMACY	100		15
16 MEDICAL RECORDS & LIBRARY		13,433	16
17 SOCIAL SERVICE			17
INPATIENT ROUTINE SERV COST CENTERS			
30 ADULTS & PEDIATRICS		13,433	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
SPECIAL PURPOSE COST CENTERS			
118 SUBTOTALS (sum of lines 1-117)	100	13,433	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	704,246	211,412	202
203 UNIT COST MULT-WS B PT I	7,042.460000	15.738257	203
204 COST TO BE ALLOC PER B PT II	58,229	39,654	204
205 UNIT COST MULT-WS B PT II	582.290000	2.951984	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	11,773,082		11,773,082	148,843	11,921,925	30
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC	348,239		348,239		348,239	54
60 LABORATORY	603,020		603,020		603,020	60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	1,082,508		1,082,508		1,082,508	65
66 PHYSICAL THERAPY	400,838		400,838		400,838	66
67 OCCUPATIONAL THERAPY	417,151		417,151		417,151	67
68 SPEECH PATHOLOGY	91,390		91,390		91,390	68
71 MEDICAL SUPPLIES CHARGED TO	398,182		398,182		398,182	71
73 DRUGS CHARGED TO PATIENTS	2,124,528		2,124,528		2,124,528	73
74 RENAL DIALYSIS	491,985		491,985		491,985	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
200 SUBTOTAL (SEE INSTRUCTIONS)	17,730,923		17,730,923	148,843	17,879,766	200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	17,730,923		17,730,923		17,879,766	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	21,195,520		21,195,520			30
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC	873,910	3,290	877,200	0.396989	0.396989	0.396989 54
60 LABORATORY	1,902,084	406	1,902,490	0.316964	0.316964	0.316964 60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	8,053,853		8,053,853	0.134409	0.134409	0.134409 65
66 PHYSICAL THERAPY	745,859		745,859	0.537418	0.537418	0.537418 66
67 OCCUPATIONAL THERAPY	762,992		762,992	0.546731	0.546731	0.546731 67
68 SPEECH PATHOLOGY	158,125		158,125	0.577960	0.577960	0.577960 68
71 MEDICAL SUPPLIES CHARGED TO	2,282,172		2,282,172	0.174475	0.174475	0.174475 71
73 DRUGS CHARGED TO PATIENTS	11,928,583		11,928,583	0.178104	0.178104	0.178104 73
74 RENAL DIALYSIS	2,293,683	37,215	2,330,898	0.211071	0.211071	0.211071 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
200 SUBTOTAL (SEE INSTRUCTIONS)	50,196,781	40,911	50,237,692			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	50,196,781	40,911	50,237,692			202

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)	
	1	2	3		5		7	
INPAT ROUTINE SERV COST CTRS								
30 ADULTS & PEDIATRICS	1,696,371		1,696,371	13,433	126.28	10,568	1,334,527	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)	1,696,371		1,696,371	13,433		10,568	1,334,527	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D  
 PART II

CHECK [ ] TITLE V [XX] HOSPITAL (15-2028) [ ] 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	11,530	877,200	0.013144	523,613	6,882	54
60 LABORATORY	13,154	1,902,490	0.006914	1,472,950	10,184	60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY	15,966	8,053,853	0.001982	6,346,431	12,579	65
66 PHYSICAL THERAPY	35,533	745,859	0.047640	586,450	27,938	66
67 OCCUPATIONAL THERAPY	41,703	762,992	0.054657	612,502	33,478	67
68 SPEECH PATHOLOGY	12,129	158,125	0.076705	117,363	9,002	68
71 MEDICAL SUPPLIES CHARGED TO P	23,096	2,282,172	0.010120	1,725,912	17,466	71
73 DRUGS CHARGED TO PATIENTS	73,843	11,928,583	0.006190	9,257,176	57,302	73
74 RENAL DIALYSIS	15,784	2,330,898	0.006772	1,917,192	12,983	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)	242,738	29,042,172		22,559,589	187,814	200

PROVIDER CCN: 15-2028 VIBRA HOSPITAL OF NORTHWEST IN  
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 15:48

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
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: 15-2028 VIBRA HOSPITAL OF NORTHWEST IN  
 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 15:48

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 PATIENT DAYS 6	PER DIEM COL.5 ÷ COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM	30
				PASS THRU COSTS (COL.7 x COL.8) 9	
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS	13,433		10,568		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)	13,433		10,568		200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK [ ] TITLE V [XX] HOSPITAL (15-2028) [ ] 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 (15-2028)	[ ] SUB (OTHER)	[ ] ICF/MR	[XX] PPS		
APPLICABLE	[XX] TITLE XVIII-PT A	[ ] IPF	[ ] SNF		[ ] TEFRA		
BOXES	[ ] TITLE XIX	[ ] IRF	[ ] NF				
COST CENTER DESCRIPTION	TOTAL CHARGES	RATIO OF COST TO CHARGES	O/P RATIO OF COST TO CHARGES	INPAT PGM	INPAT PGM	O/P PGM	O/P PGM
	(FROM WKST C, PT. I, COL. 8)	(COL. 5 + COL. 7)	(COL. 6 + COL. 7)	PGM CHARGES	PASS-THRU COSTS (COL. 8 x COL. 10)	CHARGES	PASS-THRU COSTS (COL. 9 x COL. 12)
	7	8	9	10	11	12	13
ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC	877,200		523,613		3,290	54
60	LABORATORY	1,902,490		1,472,950		406	60
62.30	BLOOD CLOTTING FOR HEMOPHILI						62.30
65	RESPIRATORY THERAPY	8,053,853		6,346,431			65
66	PHYSICAL THERAPY	745,859		586,450			66
67	OCCUPATIONAL THERAPY	762,992		612,502			67
68	SPEECH PATHOLOGY	158,125		117,363			68
71	MEDICAL SUPPLIES CHARGED TO	2,282,172		1,725,912			71
73	DRUGS CHARGED TO PATIENTS	11,928,583		9,257,176			73
74	RENAL DIALYSIS	2,330,898		1,917,192		37,215	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)	29,042,172		22,559,589		40,911	200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D  
 PART V

CHECK [ ] TITLE V - O/P [XX] HOSPITAL (15-2028) [ ] 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	0.396989	3,290			1,306		54
60 LABORATORY	0.316964	406			129		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.134409						65
66 PHYSICAL THERAPY	0.537418						66
67 OCCUPATIONAL THERAPY	0.546731						67
68 SPEECH PATHOLOGY	0.577960						68
71 MEDICAL SUPPLIES CHARGED TO PAT	0.174475						71
73 DRUGS CHARGED TO PATIENTS	0.178104						73
74 RENAL DIALYSIS	0.211071	37,215			7,855		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)		40,911			9,290		200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)		40,911			9,290		202

PROVIDER CCN: 15-2028 VIBRA HOSPITAL OF NORTHWEST IN  
 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 15:48

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	1,696,371		1,696,371	13,433	126.28		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)	1,696,371		1,696,371	13,433			200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D  
 PART II

CHECK [ ] TITLE V [XX] HOSPITAL (15-2028) [ ] SUB (OTHER) [XX] PPS  
 APPLICABLE [ ] TITLE XVIII-PT A [ ] IPF [ ] TEFRA  
 BOXES [XX] TITLE XIX [ ] IRF [ ] OTHER

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	11,530	877,200	0.013144		54
60 LABORATORY	13,154	1,902,490	0.006914		60
62.30 BLOOD CLOTTING FOR HEMOPHILIA					62.30
65 RESPIRATORY THERAPY	15,966	8,053,853	0.001982		65
66 PHYSICAL THERAPY	35,533	745,859	0.047640		66
67 OCCUPATIONAL THERAPY	41,703	762,992	0.054657		67
68 SPEECH PATHOLOGY	12,129	158,125	0.076705		68
71 MEDICAL SUPPLIES CHARGED TO P	23,096	2,282,172	0.010120		71
73 DRUGS CHARGED TO PATIENTS	73,843	11,928,583	0.006190		73
74 RENAL DIALYSIS	15,784	2,330,898	0.006772		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)	242,738	29,042,172			200

PROVIDER CCN: 15-2028 VIBRA HOSPITAL OF NORTHWEST IN  
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 15:48

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: 15-2028 VIBRA HOSPITAL OF NORTHWEST IN  
 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 15:48

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 PATIENT DAYS 6	PER DIEM COL.5 ÷ COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM
				PASS THRU COSTS (COL.7 x COL.8) 9
INPAT ROUTINE SERV COST CTRS				
30 ADULTS & PEDIATRICS	13,433			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)	13,433			200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK [ ] TITLE V [XX] HOSPITAL (15-2028) [ ] 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 ANESTHETIST COST 1			MEDICAL EDUCATION COST 4	COST (SUM OF COLS.1-4) 5	COST (SUM OF COLS.2-4) 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 OTHER REIMBURSABLE COST CENTERS						92
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 (15-2028) [ ] 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 CHARGES	(COL. 8 x COL. 10)	CHARGES	(COL. 9 x COL. 12)
	7	8	9	10	11	12	13
ANCILLARY SERVICE COST CENTERS							
54 RADIOLOGY-DIAGNOSTIC	877,200						54
60 LABORATORY	1,902,490						60
62.30 BLOOD CLOTTING FOR HEMOPHILI							62.30
65 RESPIRATORY THERAPY	8,053,853						65
66 PHYSICAL THERAPY	745,859						66
67 OCCUPATIONAL THERAPY	762,992						67
68 SPEECH PATHOLOGY	158,125						68
71 MEDICAL SUPPLIES CHARGED TO	2,282,172						71
73 DRUGS CHARGED TO PATIENTS	11,928,583						73
74 RENAL DIALYSIS	2,330,898						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)	29,042,172						200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D  
 PART V

CHECK [ ] TITLE V - O/P [XX] HOSPITAL (15-2028) [ ] 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	0.396989						54
60 LABORATORY	0.316964						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.134409						65
66 PHYSICAL THERAPY	0.537418						66
67 OCCUPATIONAL THERAPY	0.546731						67
68 SPEECH PATHOLOGY	0.577960						68
71 MEDICAL SUPPLIES CHARGED TO PAT	0.174475						71
73 DRUGS CHARGED TO PATIENTS	0.178104						73
74 RENAL DIALYSIS	0.211071						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 (15-2028) [ ] 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)	13,433	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	13,433	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	13,433	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)	10,568	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)	11,921,925	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	11,921,925	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)	11,921,925	37

WORKSHEET D-1  
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [ ] TITLE V-INPT [XX] HOSPITAL (15-2028) [ ] 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) 887.51 38  
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 9,379,206 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) 9,379,206 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)					4,600,164	48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					13,979,370	49

PASS-THROUGH COST ADJUSTMENTS  
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 1,334,527 50  
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 187,814 51  
 52 TOTAL PROGRAM EXCLUDABLE COST 1,522,341 52  
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 12,457,029 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) 887.51 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 (15-2028) [ ] 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)	13,433	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	13,433	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	13,433	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)		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)	11,921,925	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	11,921,925	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)	11,921,925	37

WORKSHEET D-1  
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [ ] TITLE V-INPT [XX] HOSPITAL (15-2028) [ ] 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) 887.51 38  
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 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) 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)						48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)						49
PASS-THROUGH COST ADJUSTMENTS						
50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)						50
51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)						51
52 TOTAL PROGRAM EXCLUDABLE COST						52
53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)						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

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [ ] TITLE V [XX] HOSPITAL (15-2028) [ ] 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	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
30 INPATIENT ROUTINE SERVICE COST CENTERS				
ADULTS & PEDIATRICS		16,802,579		30
ANCILLARY SERVICE COST CENTERS				
54 RADIOLOGY-DIAGNOSTIC	0.396989	523,613	207,869	54
60 LABORATORY	0.316964	1,472,950	466,872	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.134409	6,346,431	853,017	65
66 PHYSICAL THERAPY	0.537418	586,450	315,169	66
67 OCCUPATIONAL THERAPY	0.546731	612,502	334,874	67
68 SPEECH PATHOLOGY	0.577960	117,363	67,831	68
71 MEDICAL SUPPLIES CHARGED TO PAT	0.174475	1,725,912	301,128	71
73 DRUGS CHARGED TO PATIENTS	0.178104	9,257,176	1,648,740	73
74 RENAL DIALYSIS	0.211071	1,917,192	404,664	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				92
OTHER REIMBURSABLE COST CENTERS				
94 HOME PROGRAM DIALYSIS				94
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		22,559,589	4,600,164	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		22,559,589		202

PROVIDER CCN: 15-2028 VIBRA HOSPITAL OF NORTHWEST IN  
 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 15:48

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK	<input type="checkbox"/>	TITLE V	<input checked="" type="checkbox"/>	HOSPITAL (15-2028)	<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				30
ADULTS & PEDIATRICS				
ANCILLARY SERVICE COST CENTERS				
54 RADIOLOGY-DIAGNOSTIC	0.396989			54
60 LABORATORY	0.316964			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.134409			65
66 PHYSICAL THERAPY	0.537418			66
67 OCCUPATIONAL THERAPY	0.546731			67
68 SPEECH PATHOLOGY	0.577960			68
71 MEDICAL SUPPLIES CHARGED TO PAT	0.174475			71
73 DRUGS CHARGED TO PATIENTS	0.178104			73
74 RENAL DIALYSIS	0.211071			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				92
OTHER REIMBURSABLE COST CENTERS				
94 HOME PROGRAM DIALYSIS				94
200 TOTAL (SUM OF LINES 50-94 AND 96-98)				200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)				202

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
PART B

CHECK APPLICABLE BOX:             HOSPITAL (15-2028)                             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)	9,290	2
3	PPS PAYMENTS	8,613	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)	8,613	24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)		25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)	1,755	26
27	SUBTOTAL {(LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23} (SEE INSTRUCTIONS)	6,858	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)	6,858	30
31	PRIMARY PAYER PAYMENTS		31
32	SUBTOTAL (LINE 30 MINUS LINE 31)	6,858	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	6,858	37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R		38
39	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		39
40	SUBTOTAL (SEE INSTRUCTIONS)	6,858	40
40.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	80	40.01
41	INTERIM PAYMENTS	6,737	41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (SEE INSTRUCTIONS)	41	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



PROVIDER CCN: 15-2028 VIBRA HOSPITAL OF NORTHWEST IN  
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 15:48

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1  
PART II

CHECK  HOSPITAL (15-2028)  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	13,433 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 (15-2028)  
APPLICABLE BOX:

PART IV - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER LTCH PPS

1	NET FEDERAL PPS PAYMENT (SEE INSTRUCTIONS)	14,280,801	1
2	OUTLIER PAYMENTS	1,689,895	2
3	TOTAL PPS PAYMENTS (SUM OF LINES 1 AND 2)	15,970,696	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)	15,970,696	7
8	PRIMARY PAYER PAYMENTS	34,695	8
9	SUBTOTAL (LINE 7 LESS LINE 8)	15,936,001	9
10	DEDUCTIBLES	18,804	10
11	SUBTOTAL (LINE 9 MINUS LINE 10)	15,917,197	11
12	COINSURANCE	1,026,100	12
13	SUBTOTAL (LINE 11 MINUS LINE 12)	14,891,097	13
14	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	429,224	14
15	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	278,996	15
16	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	295,940	16
17	SUBTOTAL (SUM OF LINES 13 AND 15)	15,170,093	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)	15,170,093	22
22.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	177,490	22.01
23	INTERIM PAYMENTS	14,721,166	23
24	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		24
25	BALANCE DUE PROVIDER/PROGRAM (LINE 22 MINUS LINES 22.01, 23 AND 24)	271,437	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 [XX] HOSPITAL (15-2028) [ ] SNF [XX] PPS  
 APPLICABLE [XX] 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		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)		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)		16
17 EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 4 (SEE INSTRUCTIONS))		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	-289,377			1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	3,506,242			4
5	OTHER RECEIVABLES				5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-257,298			6
7	INVENTORY	141,555			7
8	PREPAID EXPENSES	222,305			8
9	OTHER CURRENT ASSETS				9
10	DUE FROM OTHER FUNDS				10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	3,323,427			11
FIXED ASSETS					
12	LAND				12
13	LAND IMPROVEMENTS	2,509			13
14	ACCUMULATED DEPRECIATION BUILDINGS				14
15	ACCUMULATED DEPRECIATION LEASEHOLD IMPROVEMENTS	27,454			15
16	ACCUMULATED DEPRECIATION FIXED EQUIPMENT	22,351			16
17	ACCUMULATED DEPRECIATION AUTOMOBILES AND TRUCKS				17
18	ACCUMULATED DEPRECIATION MAJOR MOVABLE EQUIPMENT	57,558			18
19	ACCUMULATED DEPRECIATION MINOR EQUIPMENT DEPRECIABLE	-27,127			19
20	ACCUMULATED DEPRECIATION HIT DESIGNATED ASSETS				20
21	ACCUMULATED DEPRECIATION MINOR EQUIPMENT-NONDEPRECIABLE				21
22	TOTAL FIXED ASSETS (SUM OF LINES 12-29)	82,745			22
23	OTHER ASSETS				23
24	INVESTMENTS				24
25	DEPOSITS ON LEASES				25
26	DUE FROM OWNERS/OFFICERS				26
27	OTHER ASSETS	8,600,511			27
28	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	8,600,511			28
29	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	12,006,683			29
30	LIABILITIES AND FUND BALANCES				30
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
31	ACCOUNTS PAYABLE	572,369			31
32	SALARIES, WAGES & FEES PAYABLE	594,230			32
33	PAYROLL TAXES PAYABLE	28,128			33
34	NOTES & LOANS PAYABLE (SHORT TERM)				34
35	DEFERRED INCOME				35
36	ACCELERATED PAYMENTS				36
37	DUE TO OTHER FUNDS	-1,379,930			37
38	OTHER CURRENT LIABILITIES	346,200			38
39	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	160,997			39
LONG-TERM LIABILITIES					
40	MORTGAGE PAYABLE				40
41	NOTES PAYABLE	217,170			41
42	UNSECURED LOANS				42
43	OTHER LONG TERM LIABILITIES				43
44	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	217,170			44
45	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	378,167			45
CAPITAL ACCOUNTS					
46	GENERAL FUND BALANCE	11,628,516			46
47	SPECIFIC PURPOSE FUND BALANCE				47
48	DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED				48
49	DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED				49
50	GOVERNING BODY CREATED - ENDOWMENT FUND BAL				50
51	PLANT FUND BALANCE - INVESTED IN PLANT				51
52	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				52
53	TOTAL FUND BALANCES (SUM OF LINES 52-58)	11,628,516			53
54	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	12,006,683			54

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		10,796,348							1
2 NET INCOME (LOSS) (FROM WKST G-3, LINE 29)		2,291,605							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		13,087,953							3
4 ADDITIONS (CREDIT ADJUSTMENTS)									4
5 ROUNDING		2							5
6									6
7									7
8									8
9									9
10 TOTAL ADDITIONS (SUM OF LINES 4-9)		2							10
11 SUBTOTAL (LINE 3 PLUS LINE 10)		13,087,955							11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)									12
13 EQUITY DISTRIBUTION		1,459,439							13
14									14
15									15
16									16
17									17
18 TOTAL DEDUCTIONS (SUM OF LINES 12-17)		1,459,439							18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)		11,628,516							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	21,195,520		21,195,520	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)	21,195,520		21,195,520	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)	21,195,520		21,195,520	18
19 ANCILLARY SERVICES	29,042,174		29,042,174	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)	50,237,694		50,237,694	

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		16,983,831	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)		16,983,831	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	50,237,694	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	30,677,980	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	19,559,714	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	16,983,831	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	2,575,883	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	462	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	661	21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (GRANTS)	13,000	24
24.01	OTHER (OTHER INCOME)	2,358	24.01
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	16,481	25
26	TOTAL (LINE 5 PLUS LINE 25)	2,592,364	26
27	OTHER EXPENSES (BAD DEBTS)	300,759	27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)	300,759	28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	2,291,605	29