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VIBRA HOSP FORT WAYNE Provider CCN: 15-2027	In Lieu of Form **CMS-2552-10**	Period : From: 11/01/2013 To: 10/31/2014	Run Date: 03/10/2015 Run Time: 17:11 Version: 2014.10

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

WORKSHEET S
PARTS I, II & III

PART I - COST REPORT STATUS

PROVIDER USE ONLY	1. [X] ELECTRONICALLY FILED COST REPORT DATE: 03/10/2015 TIME: 17:11 2. [ ] MANUALLY SUBMITTED COST REPORT 3. [ ] IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THE COST REPORT 4. [ ] MEDICARE UTILIZATION. ENTER 'F' FOR FULL OR 'L' FOR LOW.	
CONTRACTOR USE ONLY	5. [ ] COST REPORT STATUS 1 -AS SUBMITTED 2 -SETTLED WITHOUT AUDIT 3 -SETTLED WITH AUDIT 4 -REOPENED 5 -AMENDED 6. DATE RECEIVED: _____ 7. CONTRACTOR NO: _____ 8. [ ] INITIAL REPORT FOR THIS PROVIDER CCN 9. [ ] FINAL REPORT FOR THIS PROVIDER CCN	10. NPR DATE: _____ 11. CONTRACTOR'S VENDOR CODE: ___ 12. [ ] IF LINE 5, COLUMN 1 IS 4: ENTER NUMBER OF TIMES REOPENED = 0-9.

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY VIBRA HOSP FORT WAYNE (15-2027) {(PROVIDER NAME(S) AND NUMBER(S)} FOR THE COST REPORTING PERIOD BEGINNING 11/01/2013 AND ENDING 10/31/2014, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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

_____
TITLE

_____
DATE

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		121,631				1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		121,631				200

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

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:

1	Street: 2200 RANDALLIA DRIVE	P.O. Box: 5TH FLOOR		1
2	City: FORT WAYNE	State: IN	ZIP Code: 46805-4638	County: ALLEN	2

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Prov-ider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	VIBRA HOSP FORT WAYNE	15-2027	23060	2	09/01/2008	N	P	P	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF									7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC									15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 11 / 01 / 2013	To: 10 / 31 / 2014	20
21	Type of control (see instructions)	6		21

	Inpatient PPS Information	1	2	
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR§412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	N	N	22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
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	23

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.							24
25	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.							25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	1		26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.			35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.			37
38	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XVIII	XIX	
Prospective Payment System (PPS)-Capital		1	2	3	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	N	N	45
46	Is this facility eligible for additional paymetn exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N	48
Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Worksheet E-4. If column 2 is 'N', complete Worksheet D, Part III & IV and D-2, Part II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services ad 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, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline 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 osteopathci FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06
	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	
	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.					
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 reseived 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

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WORKSHEET S-2
PART I

Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings-This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	RATIO (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in oolumn 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						64
	Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)						
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
65							65
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings-Effective for cost reporting periods beginning on or after July 1, 2010				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	RATIO (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						66
	Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)						
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
67							67
Inpatient Psychiatric Faciltiy PPS				1	2	3	
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 5th or subsequent academic years of the new teaching program in existence, enter 5.						71
Inpatient Rehabilitation Facility PPS				1	2	3	
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 5th or 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.						86

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WORKSHEET S-2
PART I

				V	XIX	
Title V and XIX Services				1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.			N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.			N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the appilcable 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				1	2	
105	Does this hospital qualify as a Critical Access Hospital (CAH)?			N		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106
107	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. If yes, the GME elinination would not be on Worksheet B, Part I, column 25 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
		Physical	Occupational	Speech	Respiratory	
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.					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'		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
			Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:					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 high cost 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 cetfified 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 cetfified 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

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WORKSHEET S-2
PART I

All Providers

		1	2	
140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)	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				
		Part A	Part B	Title V	Title XIX	
			1	2	3	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N			156
157	Subprovider - IRF	N	N			157
158	Subprovider - Other					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.		166

	Name	County	State	ZIP Code	CBSA	FTE/Campus	
	0	1	2	3	4	5	

Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	N		167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)			168
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. (see instructions)			169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170

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VIBRA HOSP FORT WAYNE Provider CCN: 15-2027	In Lieu of Form **CMS-2552-10**	Period : From: 11/01/2013 To: 10/31/2014	Run Date: 03/10/2015 Run Time: 17:11 Version: 2014.10

HOSPITAL AND HOSPITAL 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		
PROVIDER ORGANIZATION AND OPERATION		1	2		
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (see instructions)	N			1
		Y/N	DATE	V/I	
		1	2	3	
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	N			2
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (e.g., chain home offices, drug or medical supply companies) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (see instructions)	N			3
		Y/N	TYPE	DATE	
FINANCIAL DATA AND REPORTS		1	2	3	
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (see instructions). IF NO, SEE INSTRUCTIONS.	N			4
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N			5
			Y/N	Y/N	
APPROVED EDUCATIONAL ACTIVITIES			1	2	
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?		N		6
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.		N		7
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?		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
BAD DEBTS				Y/N	
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.			Y	12
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.			N	13
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			N	14
BED COMPLEMENT					
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N	15

		PART A		PART B		
		Y/N	DATE	Y/N	DATE	
PS&R REPORT DATA		1	2	3	4	
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (see instructions)	Y	02/10/2015	N		16
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (see instructions)	N		N		17
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N		18
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N		19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N		20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N		21

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

		Y/N	DATE	
HOME OFFICE COSTS		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.			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 REORT PREPARER 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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						INPATIENT DAYS/OUTPATIENT VISITS/TRIPS				
	COMPONENT	WKSTA LINE NO.	NO. OF BEDS	BED DAYS AVAILABLE	CAH HOURS	TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		1	2	3	4	5	6	7	8	
1	HOSPITAL ADULTS & PEDS. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	48	17,520			3,489	50	6,491	1
2	HMO AND OTHER (see instructions)						1,074			2
3	HMO IPF SUBPROVIDER									3
4	HMO IRF SUBPROVIDER									4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF									5
6	HOSPITAL ADULTS & PEDS. SWING BED NF									6
7	TOTAL ADULTS & PEDS. (exclude observation beds)(see instructions)		48	17,520			3,489	50	6,491	7
8	INTENSIVE CARE UNIT	31								8
9	CORONARY CARE UNIT	32								9
10	BURN INTENSIVE CARE UNIT	33								10
11	SURGICAL INTENSIVE CARE UNIT	34								11
12	OTHER SPECIAL CARE (SPECIFY)	35								12
13	NURSERY	43								13
14	TOTAL (see instructions)		48	17,520			3,489	50	6,491	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101								22
23	ASC (Distinct Part)	115								23
24	HOSPICE (Distinct Part)	116								24
24.10	HOSPICE (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	TOTAL (sum of lines 14-26)		48							27
28	OBSERVATION BED DAYS									28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (see instructions)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (see instructions)									32
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)									32.01
33	LTCH NON-COVERED DAYS									33

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		FULL TIME EQUIVALENTS			DISCHARGES				
	COMPONENT	TOTAL INTERNS & RESIDENTS	EMPLOYEES ON PAYROLL	NONPAID WORKERS	TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		9	10	11	12	13	14	15	
1	HOSPITAL ADULTS & PEDS. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					142	4	233	1
2	HMO AND OTHER (see instructions)					36			2
3	HMO IPF SUBPROVIDER								3
4	HMO IRF SUBPROVIDER								4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF								5
6	HOSPITAL ADULTS & PEDS. SWING BED NF								6
7	TOTAL ADULTS & PEDS. (exclude observation beds)(see instructions)								7
8	INTENSIVE CARE UNIT								8
9	CORONARY CARE UNIT								9
10	BURN INTENSIVE CARE UNIT								10
11	SURGICAL INTENSIVE CARE UNIT								11
12	OTHER SPECIAL CARE (SPECIFY)								12
13	NURSERY								13
14	TOTAL (see instructions)		66.21			142	4	233	14
15	CAH VISITS								15
16	SUBPROVIDER - IPF								16
17	SUBPROVIDER - IRF								17
18	SUBPROVIDER I								18
19	SKILLED NURSING FACILITY								19
20	NURSING FACILITY								20
21	OTHER LONG TERM CARE								21
22	HOME HEALTH AGENCY								22
23	ASC (Distinct Part)								23
24	HOSPICE (Distinct Part)								24
24.10	HOSPICE (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	TOTAL (sum of lines 14-26)		66.21						27
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)								32

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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

PART II - WAGE DATA

		WKST A LINE NO.	AMOUNT REPORTED	RECLASSIF-ICATION OF SALARIES (from Worksheet A-6)	ADJUSTED SALARIES (column 2 ± column 3)	PAID HOURS RELATED TO SALARIES IN COLUMN 4	AVERAGE HOURLY WAGE (column 4 ± column 5)	
		1	2	3	4	5	6	
	SALARIES							
1	TOTAL SALARIES (see instructions)	200	3,894,846			137,711.00		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 program)							7.01
8	HOME OFFICE PERSONNEL							8
9	SNF	44						9
10	EXCLUDED AREA SALARIES (see instructions)							10
	OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (see instructions)							11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES							12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE							13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS							14
15	HOME OFFICE: PHYSICIAN PART A - ADMINISTRATIVE							15
16	HOME OFFICE & CONTRACT PHYSICIANS PART A - TEACHING							16
	WAGE-RELATED COSTS							
17	WAGE-RELATED COSTS (core)(see instructions)							17
18	WAGE-RELATED COSTS (other)(see instructions)							18
19	EXCLUDED AREAS							19
20	NON-PHYSICIAN ANESTHETIST PART A							20
21	NON-PHYSICIAN ANESTHETIST PART B							21
22	PHYSICIAN PART A - ADMINISTRATIVE							22
22.01	PHYSICIAN PART A - TEACHING							22.01
23	PHYSICIAN PART B							23
24	WAGE-RELATED COSTS (RHC/FQHC)							24
25	INTERNS & RESIDENTS (in an approved program)							25
	OVERHEAD COSTS - DIRECT SALARIES							
26	EMPLOYEE BENEFITS DEPARTMENT		57,761					26
27	ADMINISTRATIVE & GENERAL		828,070					27
28	ADMINISTRATIVE & GENERAL UNDER CONTRACT (see instructions)							28
29	MAINTENANCE & REPAIRS							29
30	OPERATION OF PLANT							30
31	LAUNDRY & LINEN SERVICE							31
32	HOUSEKEEPING		111,487					32
33	HOUSEKEEPING UNDER CONTRACT (see instructions)							33
34	DIETARY		43,162					34
35	DIETARY UNDER CONTRACT (see instructions)							35
36	CAFETERIA							36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION		172,070					38
39	CENTRAL SERVICES AND SUPPLY							39
40	PHARMACY		235,923					40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		64,067					41
42	SOCIAL SERVICE							42
43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (see instructions)		3,894,846		3,894,846	137,711.00	28.28	1
2	EXCLUDED AREA SALARIES (see instructions)							2
3	SUBTOTAL SALARIES (line 1 minus line 2)		3,894,846		3,894,846	137,711.00	28.28	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (see instructions)							4
5	SUBTOTAL WAGE-RELATED COSTS (see instructions)							5
6	TOTAL (sum of lines 3 through 5)		3,894,846		3,894,846	137,711.00	28.28	6
7	TOTAL OVERHEAD COST (see instructions)		1,512,540		1,512,540			7

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HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

PART IV - WAGE RELATED COST

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 employee 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 REL		25

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VIBRA HOSP FORT WAYNE Provider CCN: 15-2027	Supporting Exhibit for Form **CMS-2552-10**	Period : From: 11/01/2013 To: 10/31/2014	Run Date: 03/10/2015 Run Time: 17:11 Version: 2014.10

WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3, Part IV, Line 4) **EXHIBIT 3**

	STEP 2: DETERMINE THE 3-YEAR AVERAGING PERIOD			
1	WAGE INDEX FISCAL YEAR ENDING DATE			1
2	PROVIDER'S COST REPORTING PERIOD USED FOR WAGE INDEX YEAR ON LINE 1 (FYB in Col. 1, FYE in Col. 2)			2
3	MIDPOINT OF PROVIDER'S COST REPORTING PERIOD SHOWN ON LINE 2, ADJUSTED TO FIRST OF MONTH			3
4	DATE BEGINNING THE 3-YEAR AVERAGING PERIOD (subtract 18 months from midpoint shown on Line 3)			4
5	DATE ENDING THE 3-YEAR AVERAGING PERIOD (add 18 months to midpoint shown on Line 3)			5
	STEP 2 (OPTIONAL): ADJUST AVERAGING PERIOD FOR A NEW PLAN (see instructions)			
6	EFFECTIVE DATE OF PENSION PLAN			6
7	FIRST DAY OF THE PROVIDER COST REPORTING PERIOD CONTAINING THE PENSION PLAN EFFECTIVE DATE			7
8	STARTING DATE OF THE ADJUSTED AVERAGING PERIOD (date on Line 7, adjusted to first of month)			8

IF THIS DATE OCCURS AFTER THE PERIOD SHOWN ON LINE 2, STOP HERE AND SEE INSTRUCTIONS

	STEP 3: AVERAGE PENSION CONTRIBUTIONS DURING THE AVERAGING PERIOD			
9	BEGINNING DATE OF AVERAGING PERIOD FROM LINE 4 OR LINE 8, AS APPLICABLE			9
10	ENDING DATE OF AVERAGING PERIOD FROM LINE 5			10
11	ENTER PROVIDER CONTRIBUTIONS MADE DURING AVERAGING PERIOD ON LINES 9 & 10	**DEPOSIT DATE(S)**	**CONTRIB-UTION(S)**	11
12	TOTAL CALENDAR MONTHS INCLUDED IN AVERAGING PERIOD (36 unless Step 2 completed)			12
13	TOTAL CONTRIBUTIONS MADE DURING AVERAGING PERIOD			13
14	AVERAGE MONTHLY CONTRIBUTION (Line 13 divided by Line 12)			14
15	NUMBER OF MONTHS IN PROVIDER COST REPORTING PERIOD ON LINE 2			15
16	AVERAGE PENSION CONTRIBUTIONS (Line 14 times Line 15)			16
	STEP 4: TOTAL PENSION COST FOR WAGE INDEX			
17	ANNUAL PREFUNDING INSTALLMENT (see instructions)			17
18	REPORTABLE PREFUNDING INSTALLMENT ((Line 17 times Line 15) divided by 12)			18
19	TOTAL PENSION COST FOR WAGE INDEX (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)			19

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HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPIAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT	CONTRACT LABOR	BENEFIT COST	
	0	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 OLTC			10
11	HOSPITAL-BASED HHA			11
12	SEPARATELY CERTIFIED ASC			12
13	HOSPITAL-BASED HOSPICE			13
14	HOSPITAL-BASED HEALTH CLINIC - RHC			14
15	HOSPITAL-BASED HEALTH CLINIC - FQHC			15
16	HOSPITAL-BASED (CMHC)			16
17	RENAL DIALYSIS			17
18	OTHER			18

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VIBRA HOSP FORT WAYNE Provider CCN: 15-2027	In Lieu of Form **CMS-2552-10**	Period : From: 11/01/2013 To: 10/31/2014	Run Date: 03/10/2015 Run Time: 17:11 Version: 2014.10

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES **WORKSHEET A**

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	CAP REL COSTS-BLDG & FIXT		1,612,049	1,612,049		1,612,049	-921,604	690,445	1
2	00200	CAP REL COSTS-MVBLE EQUIP		247,830	247,830		247,830		247,830	2
3	00300	OTHER CAP REL COSTS							-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	57,761	884,329	942,090		942,090		942,090	4
5	00500	ADMINISTRATIVE & GENERAL	828,070	634,681	1,462,751		1,462,751	570,221	2,032,972	5
6	00600	MAINTENANCE & REPAIRS								6
7	00700	OPERATION OF PLANT		152,870	152,870		152,870	-82,949	69,921	7
8	00800	LAUNDRY & LINEN SERVICE		59,883	59,883		59,883		59,883	8
9	00900	HOUSEKEEPING	111,487	26,971	138,458		138,458		138,458	9
10	01000	DIETARY	43,162	113,639	156,801		156,801		156,801	10
11	01100	CAFETERIA								11
12	01200	MAINTENANCE OF PERSONNEL								12
13	01300	NURSING ADMINISTRATION	172,070	1,729	173,799		173,799		173,799	13
14	01400	CENTRAL SERVICES & SUPPLY		677,068	677,068		677,068		677,068	14
15	01500	PHARMACY	235,923	30,763	266,686		266,686		266,686	15
16	01600	MEDICAL RECORDS & LIBRARY	64,067	17,714	81,781		81,781		81,781	16
17	01700	SOCIAL SERVICE								17
19	01900	NONPHYSICIAN ANESTHETISTS								19
20	02000	NURSING SCHOOL								20
21	02100	I&R SERVICES-SALARY & FRINGES APPRVD								21
22	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD								22
23	02300	PARAMED ED PRGM-(SPECIFY)								23
		INPATIENT ROUTINE SERV COST CENTERS								
30	03000	ADULTS & PEDIATRICS	1,939,061	389,033	2,328,094		2,328,094	-152,603	2,175,491	30
		ANCILLARY SERVICE COST CENTERS								
54	05400	RADIOLOGY-DIAGNOSTIC		326,933	326,933		326,933		326,933	54
60	06000	LABORATORY		213,028	213,028		213,028		213,028	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	RESPIRATORY THERAPY	443,245	23,618	466,863		466,863		466,863	65
66	06600	PHYSICAL THERAPY		114,190	114,190		114,190		114,190	66
67	06700	OCCUPATIONAL THERAPY		129,373	129,373		129,373		129,373	67
68	06800	SPEECH PATHOLOGY		31,535	31,535		31,535		31,535	68
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		150,843	150,843		150,843		150,843	71
73	07300	DRUGS CHARGED TO PATIENTS		711,517	711,517		711,517		711,517	73
74	07400	RENAL DIALYSIS		171,025	171,025		171,025		171,025	74
76	03950	WOUND CARE								76
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)								92
		OTHER REIMBURSABLE COST CENTERS								
99.20	09920	OUTPATIENT PHYSICAL THERAPY								99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY								99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY								99.40
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	3,894,846	6,720,621	10,615,467		10,615,467	-586,935	10,028,532	118
		NONREIMBURSABLE COST CENTERS								
194	07950	PHYSICIAN MEALS								194
200		TOTAL (sum of lines 118-199)	3,894,846	6,720,621	10,615,467		10,615,467	-586,935	10,028,532	200

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RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
	GRAND TOTAL (INCREASES)						

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

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RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
	GRAND TOTAL (DECREASES)							

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

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VIBRA HOSP FORT WAYNE Provider CCN: 15-2027	In Lieu of Form **CMS-2552-10**	Period : From: 11/01/2013 To: 10/31/2014	Run Date: 03/10/2015 Run Time: 17:11 Version: 2014.10

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

			ACQUISITIONS						
	DESCRIPTION	BEGINNING BALANCES	PURCHASES	DONATION	TOTAL	DISPOSALS AND RETIRE-MENTS	ENDING BALANCE	FULLY DEPREC-IATED ASSETS	
		1	2	3	4	5	6	7	
1	LAND								1
2	LAND IMPROVEMENTS	6,534					6,534		2
3	BUILDINGS AND FIXTURES	7,314	2,536		2,536		9,850		3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT								5
6	MOVABLE EQUIPMENT	13,809	82,984		82,984		96,793		6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (sum of lines 1-7)	27,657	85,520		85,520		113,177		8
9	RECONCILING ITEMS								9
10	TOTAL (line 7 minus line 9)	27,657	85,520		85,520		113,177		10

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

		SUMMARY OF CAPITAL							
	DESCRIPTION	DEPREC-IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)	TOTAL(1) (Sum of (cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	CAP REL COSTS-BLDG & FIXT		1,564,599	2,399		45,051		1,612,049	1
2	CAP REL COSTS-MVBLE EQUIP	16,813	231,017					247,830	2
3	TOTAL (sum of lines 1-2)	16,813	1,795,616	2,399		45,051		1,859,879	3

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	DESCRIPTION	GROSS ASSETS	CAPITAL-IZED LEASES	GROSS ASSETS FOR RATIO (col. 1 - col. 2)	RATIO (see instr.)	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL (sum of (cols. 5 through 7)	
*		9	10	11	12	13	14	15	16	
1	CAP REL COSTS-BLDG & FI	16,384		16,384	0.144764					1
2	CAP REL COSTS-MVBLE EQU	96,793		96,793	0.855236					2
3	TOTAL (sum of lines 1-2)	113,177		113,177	1.000000					3

		SUMMARY OF CAPITAL							
	DESCRIPTION	DEPREC-IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)	TOTAL(2) (sum of (cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	CAP REL COSTS-BLDG & FIXT		683,545	-1		6,901		690,445	1
2	CAP REL COSTS-MVBLE EQUIP	16,813	231,017					247,830	2
3	TOTAL (sum of lines 1-2)	16,813	914,562	-1		6,901		938,275	3

(2) The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, lines 1 and 2. Columns 9 through 14 should include related Worksheet A-6 reclassifications, Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)

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ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	WKST A-7 REF.	
		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	-2,555	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	-152,603				10
11	SALE OF SCRAP, WASTE, ETC. (chapter 23)						11
12	RELATED ORGANIZATION TRANSACTIONS (chapter 10)	WKST A-8-1	651,704				12
13	LAUNDRY AND LINEN SERVICE						13
14	CAFETERIA - EMPLOYEES AND GUESTS						14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS						16
17	SALE OF DRUGS TO OTHER THAN PATIENTS						17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS						18
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)						19
20	VENDING MACHINES						20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (chapter 21)						21
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENTS						22
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		RESPIRATORY THERAPY	65		23
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		PHYSICAL THERAPY	66		24
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (chapter 21)			UTILIZATION REVIEW-SNF	114		25
26	DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1		26
27	DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2		27
28	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19		28
29	PHYSICIANS' ASSISTANT						29
30	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67		30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		SPEECH PATHOLOGY	68		31
32	CAH HIT ADJ FOR DEPRECIATION AND						32
33	OTHER INCOME	B	-1,787	ADMINISTRATIVE & GENERAL	5		33
34	COST REPORT NON-ALLOWABLE	A	-90	ADMINISTRATIVE & GENERAL	5		34
35	NON-COMPETE AGREEMENT	A	-38,802	ADMINISTRATIVE & GENERAL	5		35
36	MARKETING - NON-ALLOWABLE	A	-30,157	ADMINISTRATIVE & GENERAL	5		36
37	OFF SITE BUILDING	A	-2,400	CAP REL COSTS-BLDG & FIXT	1	11	37
38	OFF SITE BUILDING	A	-8,092	ADMINISTRATIVE & GENERAL	5		38
39	OFF SITE BUILDING	A	-82,949	OPERATION OF PLANT	7		39
40	OFF SITE BUILDING	A	-38,150	CAP REL COSTS-BLDG & FIXT	1	13	40
41	OFF SITE BUILDING	A	-881,054	CAP REL COSTS-BLDG & FIXT	1	10	41
42							42
43							43
44							44
45							45
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-586,935				50

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1
(2) Basis for adjustment (see instructions)
A. Costs - if cost, including applicable overhead, can be determined
B. Amount Received - if cost cannot be determined
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

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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 CLAIMED HOME OFFICE COSTS:

	LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT INCLUDED IN WKST. A COLUMN 5	NET ADJUST-MENTS (col. 4 minus col. 5)*	WKST. A-7 REF.	
	1	2	3	4	5	6	7	
1	5	ADMINISTRATIVE & GENERAL	CORPORATE EXPENSES	867,014	215,310	651,704		1
2								2
3								3
4								4
5	TOTALS (SUM OF LINES 1-4) TRANSFER COLUMN 6, LINE 5 TO WORKSHEET A-8, COLUMN 2, LINE 12			867,014	215,310	651,704		5

* The amounts on lines 1 through 4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which have not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

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

The Secretary, by virtue of the 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.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors 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.

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

(1) Use the following symbols to indicate the interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.
G. Other (financial Or non-financial) specify:

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN-ERATION	PROFESS-IONAL COMPON-ENT	PROVIDER COMPON-ENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPON-ENT HOURS	UNADJ-USTED RCE LIMIT	5 PERCENT OF UNADJ-USTED RCE LIMIT	
	1	2	3	4	5	6	7	8	9	
1	30	ADULTS & PEDIATRICS PHYSICIAN DIREC	98,112	98,112		171,400				1
2	30	ADULTS & PEDIATRICS PHYSICIAN ADMIN	90,172		90,172	171,400	433	35,681	1,784	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	188,284	98,112	90,172		433	35,681	1,784	200

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBER-SHIPS & CONTIN-UING EDUCATION	PROVIDER COMPON-ENT SHARE OF COL. 12	PHYSICIAN COST OF MALPRACT-ICE INSURANCE	PROVIDER COMPON-ENT SHARE OF COL. 14	ADJUSTED RCE LIMIT	RCE DISALLOW-ANCE	ADJUST-MENT	
	10	11	12	13	14	15	16	17	18	
1	30	ADULTS & PEDIATRICS PHYSICIAN DIREC							98,112	1
2	30	ADULTS & PEDIATRICS PHYSICIAN ADMIN					35,681	54,491	54,491	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL					35,681	54,491	152,603	200

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS-TRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	690,445	690,445					1
2	CAP REL COSTS-MVBLE EQUIP	247,830		247,830				2
4	EMPLOYEE BENEFITS DEPARTMENT	942,090	5,218	1,873	949,181			4
5	ADMINISTRATIVE & GENERAL	2,032,972	124,120	44,552	204,840	2,406,484	2,406,484	5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	69,921	271,162	97,331		438,414	138,419	7
8	LAUNDRY & LINEN SERVICE	59,883	13,207	4,740		77,830	24,573	8
9	HOUSEKEEPING	138,458	3,452	1,239	27,579	170,728	53,903	9
10	DIETARY	156,801	2,409	865	10,677	170,752	53,911	10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	173,799			42,565	216,364	68,312	13
14	CENTRAL SERVICES & SUPPLY	677,068				677,068	213,769	14
15	PHARMACY	266,686	17,301	6,210	58,360	348,557	110,049	15
16	MEDICAL RECORDS & LIBRARY	81,781	14,451	5,187	15,848	117,267	37,024	16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	2,175,491	206,652	74,176	479,666	2,935,985	926,967	30
	ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC	326,933				326,933	103,222	54
60	LABORATORY	213,028				213,028	67,259	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	466,863	3,492	1,254	109,646	581,255	183,518	65
66	PHYSICAL THERAPY	114,190	9,152	3,285		126,627	39,980	66
67	OCCUPATIONAL THERAPY	129,373	8,028	2,882		140,283	44,291	67
68	SPEECH PATHOLOGY	31,535	1,806	648		33,989	10,731	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	150,843	9,995	3,588		164,426	51,914	71
73	DRUGS CHARGED TO PATIENTS	711,517				711,517	224,645	73
74	RENAL DIALYSIS	171,025				171,025	53,997	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							
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	10,028,532	690,445	247,830	949,181	10,028,532	2,406,484	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)	10,028,532	690,445	247,830	949,181	10,028,532	2,406,484	202

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VIBRA HOSP FORT WAYNE Provider CCN: 15-2027	In Lieu of Form **CMS-2552-10**	Period : From: 11/01/2013 To: 10/31/2014	Run Date: 03/10/2015 Run Time: 17:11 Version: 2014.10

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	
		7	8	9	10	13	14	
	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	576,833						7
8	LAUNDRY & LINEN SERVICE	26,274	128,677					8
9	HOUSEKEEPING	6,868		231,499				9
10	DIETARY	4,792		2,040	231,495			10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION					284,676		13
14	CENTRAL SERVICES & SUPPLY						890,837	14
15	PHARMACY	34,420		14,656				15
16	MEDICAL RECORDS & LIBRARY	28,750		12,241				16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	411,122	128,677	175,053	231,495	284,676	890,837	30
	ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC							54
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	6,948		2,958				65
66	PHYSICAL THERAPY	18,208		7,753				66
67	OCCUPATIONAL THERAPY	15,972		6,801				67
68	SPEECH PATHOLOGY	3,594		1,530				68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,885		8,467				71
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76	WOUND CARE							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	576,833	128,677	231,499	231,495	284,676	890,837	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)	576,833	128,677	231,499	231,495	284,676	890,837	202

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VIBRA HOSP FORT WAYNE Provider CCN: 15-2027	In Lieu of Form **CMS-2552-10**	Period : From: 11/01/2013 To: 10/31/2014	Run Date: 03/10/2015 Run Time: 17:11 Version: 2014.10

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		15	16	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY	507,682						15
16	MEDICAL RECORDS & LIBRARY		195,282					16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		195,282	6,180,094		6,180,094		30
	ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC			430,155		430,155		54
60	LABORATORY			280,287		280,287		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY			774,679		774,679		65
66	PHYSICAL THERAPY			192,568		192,568		66
67	OCCUPATIONAL THERAPY			207,347		207,347		67
68	SPEECH PATHOLOGY			49,844		49,844		68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS			244,692		244,692		71
73	DRUGS CHARGED TO PATIENTS	507,682		1,443,844		1,443,844		73
74	RENAL DIALYSIS			225,022		225,022		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							
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	507,682	195,282	10,028,532		10,028,532		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)	507,682	195,282	10,028,532		10,028,532		202

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VIBRA HOSP FORT WAYNE Provider CCN: 15-2027	In Lieu of Form **CMS-2552-10**	Period : From: 11/01/2013 To: 10/31/2014	Run Date: 03/10/2015 Run Time: 17:11 Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS-TRATIVE & GENERAL	
		0	1	2	2A	4	5	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT		5,218	1,873	7,091	7,091		4
5	ADMINISTRATIVE & GENERAL		124,120	44,552	168,672	1,530	170,202	5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT		271,162	97,331	368,493		9,790	7
8	LAUNDRY & LINEN SERVICE		13,207	4,740	17,947		1,738	8
9	HOUSEKEEPING		3,452	1,239	4,691	206	3,812	9
10	DIETARY		2,409	865	3,274	80	3,813	10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION					318	4,831	13
14	CENTRAL SERVICES & SUPPLY						15,119	14
15	PHARMACY		17,301	6,210	23,511	436	7,783	15
16	MEDICAL RECORDS & LIBRARY		14,451	5,187	19,638	118	2,619	16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		206,652	74,176	280,828	3,584	65,562	30
	ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC						7,300	54
60	LABORATORY						4,757	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		3,492	1,254	4,746	819	12,979	65
66	PHYSICAL THERAPY		9,152	3,285	12,437		2,828	66
67	OCCUPATIONAL THERAPY		8,028	2,882	10,910		3,133	67
68	SPEECH PATHOLOGY		1,806	648	2,454		759	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		9,995	3,588	13,583		3,672	71
73	DRUGS CHARGED TO PATIENTS						15,888	73
74	RENAL DIALYSIS						3,819	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							
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)		690,445	247,830	938,275	7,091	170,202	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)		690,445	247,830	938,275	7,091	170,202	202

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VIBRA HOSP FORT WAYNE Provider CCN: 15-2027	In Lieu of Form **CMS-2552-10**	Period : From: 11/01/2013 To: 10/31/2014	Run Date: 03/10/2015 Run Time: 17:11 Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	
		7	8	9	10	13	14	
	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	378,283						7
8	LAUNDRY & LINEN SERVICE	17,230	36,915					8
9	HOUSEKEEPING	4,504		13,213				9
10	DIETARY	3,142		116	10,425			10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION					5,149		13
14	CENTRAL SERVICES & SUPPLY						15,119	14
15	PHARMACY	22,572		836				15
16	MEDICAL RECORDS & LIBRARY	18,854		699				16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	269,612	36,915	9,992	10,425	5,149	15,119	30
	ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC							54
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	4,556		169				65
66	PHYSICAL THERAPY	11,941		443				66
67	OCCUPATIONAL THERAPY	10,474		388				67
68	SPEECH PATHOLOGY	2,357		87				68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,041		483				71
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76	WOUND CARE							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	378,283	36,915	13,213	10,425	5,149	15,119	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)	378,283	36,915	13,213	10,425	5,149	15,119	202

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VIBRA HOSP FORT WAYNE Provider CCN: 15-2027	In Lieu of Form **CMS-2552-10**	Period : From: 11/01/2013 To: 10/31/2014	Run Date: 03/10/2015 Run Time: 17:11 Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		15	16	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY	55,138						15
16	MEDICAL RECORDS & LIBRARY		41,928					16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		41,928	739,114		739,114		30
	ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC			7,300		7,300		54
60	LABORATORY			4,757		4,757		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY			23,269		23,269		65
66	PHYSICAL THERAPY			27,649		27,649		66
67	OCCUPATIONAL THERAPY			24,905		24,905		67
68	SPEECH PATHOLOGY			5,657		5,657		68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS			30,779		30,779		71
73	DRUGS CHARGED TO PATIENTS	55,138		71,026		71,026		73
74	RENAL DIALYSIS			3,819		3,819		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							
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	55,138	41,928	938,275		938,275		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)	55,138	41,928	938,275		938,275		202

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VIBRA HOSP FORT WAYNE Provider CCN: 15-2027	In Lieu of Form **CMS-2552-10**	Period : From: 11/01/2013 To: 10/31/2014	Run Date: 03/10/2015 Run Time: 17:11 Version: 2014.10

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	MAIN-TENANCE & REPAIRS SQUARE FEET	
		1	2	4	5A	5	6	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	17,200						1
2	CAP REL COSTS-MVBLE EQUIP		17,200					2
4	EMPLOYEE BENEFITS DEPARTMENT	130	130	3,837,085				4
5	ADMINISTRATIVE & GENERAL	3,092	3,092	828,070	-2,406,484	7,622,048		5
6	MAINTENANCE & REPAIRS						13,978	6
7	OPERATION OF PLANT	6,755	6,755			438,414	6,755	7
8	LAUNDRY & LINEN SERVICE	329	329			77,830	329	8
9	HOUSEKEEPING	86	86	111,487		170,728	86	9
10	DIETARY	60	60	43,162		170,752	60	10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION			172,070		216,364		13
14	CENTRAL SERVICES & SUPPLY					677,068		14
15	PHARMACY	431	431	235,923		348,557	431	15
16	MEDICAL RECORDS & LIBRARY	360	360	64,067		117,267	360	16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	5,148	5,148	1,939,061		2,935,985	5,148	30
	ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC					326,933		54
60	LABORATORY					213,028		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	87	87	443,245		581,255	87	65
66	PHYSICAL THERAPY	228	228			126,627	228	66
67	OCCUPATIONAL THERAPY	200	200			140,283	200	67
68	SPEECH PATHOLOGY	45	45			33,989	45	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	249	249			164,426	249	71
73	DRUGS CHARGED TO PATIENTS					711,517		73
74	RENAL DIALYSIS					171,025		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							
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	17,200	17,200	3,837,085	-2,406,484	7,622,048	13,978	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	690,445	247,830	949,181		2,406,484		202
203	UNIT COST MULT-WS B PT I	40.142151	14.408721	0.247370		0.315727		203
204	COST TO BE ALLOC PER B PT II			7,091		170,202		204
205	UNIT COST MULT-WS B PT II			0.001848		0.022330		205

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COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	NURSING ADMINIS-TRATION PATIENT DAYS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	
		7	8	9	10	13	14	
	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	7,223						7
8	LAUNDRY & LINEN SERVICE	329	100					8
9	HOUSEKEEPING	86		6,808				9
10	DIETARY	60		60	19,473			10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION					6,491		13
14	CENTRAL SERVICES & SUPPLY						100	14
15	PHARMACY	431		431				15
16	MEDICAL RECORDS & LIBRARY	360		360				16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	5,148	100	5,148	19,473	6,491	100	30
	ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC							54
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	87		87				65
66	PHYSICAL THERAPY	228		228				66
67	OCCUPATIONAL THERAPY	200		200				67
68	SPEECH PATHOLOGY	45		45				68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	249		249				71
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76	WOUND CARE							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	7,223	100	6,808	19,473	6,491	100	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	576,833	128,677	231,499	231,495	284,676	890,837	202
203	UNIT COST MULT-WS B PT I	79.860584	1,286.770000	34.003966	11.887999	43.857033	8,908.370000	203
204	COST TO BE ALLOC PER B PT II	378,283	36,915	13,213	10,425	5,149	15,119	204
205	UNIT COST MULT-WS B PT II	52.372006	369.150000	1.940805	0.535357	0.793252	151.190000	205

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VIBRA HOSP FORT WAYNE Provider CCN: 15-2027	In Lieu of Form **CMS-2552-10**	Period : From: 11/01/2013 To: 10/31/2014	Run Date: 03/10/2015 Run Time: 17:11 Version: 2014.10

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUIS.	MEDICAL 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		6,491					16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		6,491					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							
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	100	6,491					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	507,682	195,282					202
203	UNIT COST MULT-WS B PT I	5,076.820000	30.085041					203
204	COST TO BE ALLOC PER B PT II	55,138	41,928					204
205	UNIT COST MULT-WS B PT II	551.380000	6.459405					205

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VIBRA HOSP FORT WAYNE Provider CCN: 15-2027	In Lieu of Form **CMS-2552-10**	Period : From: 11/01/2013 To: 10/31/2014	Run Date: 03/10/2015 Run Time: 17:11 Version: 2014.10

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

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VIBRA HOSP FORT WAYNE Provider CCN: 15-2027	In Lieu of Form **CMS-2552-10**	Period : From: 11/01/2013 To: 10/31/2014	Run Date: 03/10/2015 Run Time: 17:11 Version: 2014.10

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

				COSTS			
	COST CENTER DESCRIPTIONS	TOTAL COST (from Wkst. B, Part I, col. 26)	THERAPY LIMIT ADJ.	TOTAL COSTS	RCE DISALLOW-ANCE	TOTAL COSTS	
		1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	6,180,094		6,180,094	54,491	6,234,585	30
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC	430,155		430,155		430,155	54
60	LABORATORY	280,287		280,287		280,287	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	774,679		774,679		774,679	65
66	PHYSICAL THERAPY	192,568		192,568		192,568	66
67	OCCUPATIONAL THERAPY	207,347		207,347		207,347	67
68	SPEECH PATHOLOGY	49,844		49,844		49,844	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	244,692		244,692		244,692	71
73	DRUGS CHARGED TO PATIENTS	1,443,844		1,443,844		1,443,844	73
74	RENAL DIALYSIS	225,022		225,022		225,022	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						
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
200	SUBTOTAL (SEE INSTRUCTIONS)	10,028,532		10,028,532	54,491	10,083,023	200
201	LESS OBSERVATION BEDS						201
202	TOTAL (SEE INSTRUCTIONS)	10,028,532		10,028,532		10,083,023	202

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VIBRA HOSP FORT WAYNE Provider CCN: 15-2027	In Lieu of Form **CMS-2552-10**	Period : From: 11/01/2013 To: 10/31/2014	Run Date: 03/10/2015 Run Time: 17:11 Version: 2014.10

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

		CHARGES						
	COST CENTER DESCRIPTIONS	INPATIENT	OUTPATIENT	TOTAL (column 6 + column 7)	COST OR OTHER RATIO	TEFRA INPATIENT RATIO	PPS INPATIENT RATIO	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	6,796,340		6,796,340				30
	ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC	725,893		725,893	0.592587	0.592587	0.592587	54
60	LABORATORY	544,209		544,209	0.515036	0.515036	0.515036	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	4,962,690		4,962,690	0.156101	0.156101	0.156101	65
66	PHYSICAL THERAPY	316,626		316,626	0.608188	0.608188	0.608188	66
67	OCCUPATIONAL THERAPY	353,665		353,665	0.586281	0.586281	0.586281	67
68	SPEECH PATHOLOGY	88,829		88,829	0.561123	0.561123	0.561123	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	869,363		869,363	0.281461	0.281461	0.281461	71
73	DRUGS CHARGED TO PATIENTS	5,718,214		5,718,214	0.252499	0.252499	0.252499	73
74	RENAL DIALYSIS	463,493		463,493	0.485492	0.485492	0.485492	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							
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
200	SUBTOTAL (SEE INSTRUCTIONS)	20,839,322		20,839,322				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	20,839,322		20,839,322				202

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VIBRA HOSP FORT WAYNE Provider CCN: 15-2027	In Lieu of Form **CMS-2552-10**	Period : From: 11/01/2013 To: 10/31/2014	Run Date: 03/10/2015 Run Time: 17:11 Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] PPS [XX] TITLE XVIII, PART A [ ] TEFRA [ ] TITLE XIX

		CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26)	SWING BED ADJUST-MENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	739,114		739,114	6,491	113.87	3,489	397,292	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)	739,114		739,114	6,491		3,489	397,292	200

(A) Worksheet A line numbers

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COMPU-MAX

VIBRA HOSP FORT WAYNE Provider CCN: 15-2027	In Lieu of Form **CMS-2552-10**	Period : From: 11/01/2013 To: 10/31/2014	Run Date: 03/10/2015 Run Time: 17:11 Version: 2014.10

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 15-2027** **WORKSHEET D PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [XX] PPS [ ] TEFRA

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26) 1	TOTAL CHARGES (from Wkst. C, Part I, (col. 8) 2	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL COSTS (col. 3 x col. 4) 5	
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC	7,300	725,893	0.010057	420,896	4,233	54
60	LABORATORY	4,757	544,209	0.008741	276,054	2,413	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	23,269	4,962,690	0.004689	2,393,500	11,223	65
66	PHYSICAL THERAPY	27,649	316,626	0.087324	171,504	14,976	66
67	OCCUPATIONAL THERAPY	24,905	353,665	0.070420	191,108	13,458	67
68	SPEECH PATHOLOGY	5,657	88,829	0.063684	47,281	3,011	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	30,779	869,363	0.035404	391,906	13,875	71
73	DRUGS CHARGED TO PATIENTS	71,026	5,718,214	0.012421	3,042,673	37,793	73
74	RENAL DIALYSIS	3,819	463,493	0.008240	249,540	2,056	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						
200	TOTAL (sum of lines 50-199)	199,161	14,042,982		7,184,462	103,038	200

(A) Worksheet A line numbers

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VIBRA HOSP FORT WAYNE Provider CCN: 15-2027	In Lieu of Form **CMS-2552-10**	Period : From: 11/01/2013 To: 10/31/2014	Run Date: 03/10/2015 Run Time: 17:11 Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] PPS [XX] TITLE XVIII, PART A [ ] TEFRA [ ] TITLE XIX

		NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUST-MENT AMOUNT (see instruct-ions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS (General Routine Care)						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)						200

(A) Worksheet A line numbers

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VIBRA HOSP FORT WAYNE Provider CCN: 15-2027	In Lieu of Form **CMS-2552-10**	Period : From: 11/01/2013 To: 10/31/2014	Run Date: 03/10/2015 Run Time: 17:11 Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] PPS [XX] TITLE XVIII, PART A [ ] TEFRA [ ] TITLE XIX

		TOTAL PATIENT DAYS	PER DIEM (col. 5÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	6,491		3,489		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)	6,491		3,489		200

(A) Worksheet A line numbers

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COMPU-MAX

VIBRA HOSP FORT WAYNE Provider CCN: 15-2027	In Lieu of Form **CMS-2552-10**	Period : From: 11/01/2013 To: 10/31/2014	Run Date: 03/10/2015 Run Time: 17:11 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 15-2027** | **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] ICF/MR | [XX] PPS [ ] TEFRA

		NON PHYSICIAN ANESTH-ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
	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							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							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers

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VIBRA HOSP FORT WAYNE Provider CCN: 15-2027	In Lieu of Form **CMS-2552-10**	Period : From: 11/01/2013 To: 10/31/2014	Run Date: 03/10/2015 Run Time: 17:11 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 15-2027** | **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] ICF/MR | [XX] PPS [ ] TEFRA

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPATIENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPATIENT PROGRAM CHARGES	OUTPATIENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)	
		7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
54	RADIOLOGY-DIAGNOSTIC	725,893			420,896				54
60	LABORATORY	544,209			276,054				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	4,962,690			2,393,500				65
66	PHYSICAL THERAPY	316,626			171,504				66
67	OCCUPATIONAL THERAPY	353,665			191,108				67
68	SPEECH PATHOLOGY	88,829			47,281				68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	869,363			391,906				71
73	DRUGS CHARGED TO PATIENTS	5,718,214			3,042,673				73
74	RENAL DIALYSIS	463,493			249,540				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								
200	TOTAL (sum of lines 50-199)	14,042,982			7,184,462				200

(A) Worksheet A line numbers

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VIBRA HOSP FORT WAYNE Provider CCN: 15-2027	In Lieu of Form **CMS-2552-10**	Period : From: 11/01/2013 To: 10/31/2014	Run Date: 03/10/2015 Run Time: 17:11 Version: 2014.10

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 15-2027** **WORKSHEET D PART V**

CHECK APPLICABLE BOXES: [ ] TITLE V - O/P [XX] TITLE XVIII, PART B [ ] TITLE XIX - O/P | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] SWING BED SNF [ ] SWING BED NF [ ] ICF/MR

			PROGRAM CHARGES			PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
54	RADIOLOGY-DIAGNOSTIC	0.592587							54
60	LABORATORY	0.515036							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.156101							65
66	PHYSICAL THERAPY	0.608188							66
67	OCCUPATIONAL THERAPY	0.586281							67
68	SPEECH PATHOLOGY	0.561123							68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.281461							71
73	DRUGS CHARGED TO PATIENTS	0.252499							73
74	RENAL DIALYSIS	0.485492							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								
200	SUBTOTAL (see instructions)								200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)								202

(A) Worksheet A line numbers

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VIBRA HOSP FORT WAYNE Provider CCN: 15-2027	In Lieu of Form **CMS-2552-10**	Period : From: 11/01/2013 To: 10/31/2014	Run Date: 03/10/2015 Run Time: 17:11 Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] PPS [ ] TITLE XVIII, PART A [ ] TEFRA [XX] TITLE XIX

		CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26)	SWING BED ADJUST-MENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	739,114		739,114	6,491	113.87	50	5,694	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)	739,114		739,114	6,491		50	5,694	200

(A) Worksheet A line numbers

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VIBRA HOSP FORT WAYNE Provider CCN: 15-2027	In Lieu of Form **CMS-2552-10**	Period : From: 11/01/2013 To: 10/31/2014	Run Date: 03/10/2015 Run Time: 17:11 Version: 2014.10

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 15-2027** **WORKSHEET D PART II**

CHECK APPLICABLE BOXES: **[ ] TITLE V** **[XX] TITLE XVIII, PART A** **[XX] TITLE XIX** **[XX] HOSPITAL** **[ ] IPF** **[ ] IRF** **[ ] SUB (OTHER)** **[XX] PPS** **[ ] TEFRA**

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26)	TOTAL CHARGES (from Wkst. C, Part I, (col. 8)	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC	7,300	725,893	0.010057	6,693	67	54
60	LABORATORY	4,757	544,209	0.008741	20,147	176	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	23,269	4,962,690	0.004689	119,595	561	65
66	PHYSICAL THERAPY	27,649	316,626	0.087324	11,662	1,018	66
67	OCCUPATIONAL THERAPY	24,905	353,665	0.070420	7,844	552	67
68	SPEECH PATHOLOGY	5,657	88,829	0.063684	2,219	141	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	30,779	869,363	0.035404	26,654	944	71
73	DRUGS CHARGED TO PATIENTS	71,026	5,718,214	0.012421	69,039	858	73
74	RENAL DIALYSIS	3,819	463,493	0.008240			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						
200	TOTAL (sum of lines 50-199)	199,161	14,042,982		263,853	4,317	200

(A) Worksheet A line numbers

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VIBRA HOSP FORT WAYNE Provider CCN: 15-2027	In Lieu of Form **CMS-2552-10**	Period : From: 11/01/2013 To: 10/31/2014	Run Date: 03/10/2015 Run Time: 17:11 Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK APPLICABLE BOXES: **[ ] TITLE V [XX] PPS [ ] TITLE XVIII, PART A [ ] TEFRA [XX] TITLE XIX**

		NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUST-MENT AMOUNT (see instruct-ions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS (General Routine Care)						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)						200

(A) Worksheet A line numbers

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VIBRA HOSP FORT WAYNE Provider CCN: 15-2027	In Lieu of Form **CMS-2552-10**	Period : From: 11/01/2013 To: 10/31/2014	Run Date: 03/10/2015 Run Time: 17:11 Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] PPS [ ] TITLE XVIII, PART A [ ] TEFRA [XX] TITLE XIX

		TOTAL PATIENT DAYS	PER DIEM (col. 5÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	6,491		50		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)	6,491		50		200

(A) Worksheet A line numbers

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VIBRA HOSP FORT WAYNE Provider CCN: 15-2027	In Lieu of Form **CMS-2552-10**	Period : From: 11/01/2013 To: 10/31/2014	Run Date: 03/10/2015 Run Time: 17:11 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 15-2027** | **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [XX] TITLE XIX [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] ICF/MR [XX] PPS [ ] TEFRA

		NON PHYSICIAN ANESTH-ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
	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							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							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP

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VIBRA HOSP FORT WAYNE Provider CCN: 15-2027	In Lieu of Form **CMS-2552-10**	Period : From: 11/01/2013 To: 10/31/2014	Run Date: 03/10/2015 Run Time: 17:11 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 15-2027** | **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [XX] TITLE XIX | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] ICF/MR | [XX] PPS [ ] TEFRA

		TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPATIENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPATIENT PROGRAM CHARGES	OUTPATIENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)	
(A)	COST CENTER DESCRIPTION	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
54	RADIOLOGY-DIAGNOSTIC	725,893			6,693				54
60	LABORATORY	544,209			20,147				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	4,962,690			119,595				65
66	PHYSICAL THERAPY	316,626			11,662				66
67	OCCUPATIONAL THERAPY	353,665			7,844				67
68	SPEECH PATHOLOGY	88,829			2,219				68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	869,363			26,654				71
73	DRUGS CHARGED TO PATIENTS	5,718,214			69,039				73
74	RENAL DIALYSIS	463,493							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								
200	TOTAL (sum of lines 50-199)	14,042,982			263,853				200

(A) Worksheet A line numbers

KPMG LLP

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VIBRA HOSP FORT WAYNE Provider CCN: 15-2027	In Lieu of Form **CMS-2552-10**	Period : From: 11/01/2013 To: 10/31/2014	Run Date: 03/10/2015 Run Time: 17:11 Version: 2014.10

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 15-2027** **WORKSHEET D PART V**

CHECK APPLICABLE BOXES: [ ] TITLE V - O/P [XX] TITLE XVIII, PART B [XX] TITLE XIX - O/P [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] SWING BED SNF [ ] SWING BED NF [ ] ICF/MR

			PROGRAM CHARGES			PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
54	RADIOLOGY-DIAGNOSTIC	0.592587							54
60	LABORATORY	0.515036							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.156101							65
66	PHYSICAL THERAPY	0.608188							66
67	OCCUPATIONAL THERAPY	0.586281							67
68	SPEECH PATHOLOGY	0.561123							68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.281461							71
73	DRUGS CHARGED TO PATIENTS	0.252499							73
74	RENAL DIALYSIS	0.485492							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								
200	SUBTOTAL (see instructions)								200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)								202

(A) Worksheet A line numbers

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VIBRA HOSP FORT WAYNE Provider CCN: 15-2027	In Lieu of Form **CMS-2552-10**	Period : From: 11/01/2013 To: 10/31/2014	Run Date: 03/10/2015 Run Time: 17:11 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 15-2027** **WORKSHEET D-1**
PART I

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XVIII, PART A [ ] TITLE XIX - I/P | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] ICF/MR | [XX] PPS [ ] TEFRA [ ] OTHER

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	6,491	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	6,491	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	6,491	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	3,489	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)	6,234,585	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	6,234,585	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	6,234,585	37

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VIBRA HOSP FORT WAYNE Provider CCN: 15-2027	In Lieu of Form **CMS-2552-10**	Period : From: 11/01/2013 To: 10/31/2014	Run Date: 03/10/2015 Run Time: 17:11 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 15-2027** **WORKSHEET D-1 PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XVIII, PART A [ ] TITLE XIX - I/P | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) | [XX] PPS [ ] TEFRA [ ] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

		1	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)	960.50	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	3,351,185	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)		40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)	3,351,185	41

		TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (col. 1 ÷ col. 2)	PROGRAM DAYS	PROGRAM COST (col. 3 x col. 4)	
		1	2	3	4	5	
42	NURSERY (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

		1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)	2,007,831	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	5,359,016	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	397,292	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	103,038	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	500,330	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)	4,858,686	53

TARGET AMOUNT AND LIMIT COMPUTATION

54	PROGRAM DISCHARGES		54
55	TARGET AMOUNT PER DISCHARGE		55
56	TARGET AMOUNT (line 54 x line 55)		56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)		57
58	BONUS PAYMENT (see instructions)		58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET		59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET		60
61	IF LINE 53 ÷ 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 (line 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

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VIBRA HOSP FORT WAYNE Provider CCN: 15-2027	In Lieu of Form **CMS-2552-10**	Period : From: 11/01/2013 To: 10/31/2014	Run Date: 03/10/2015 Run Time: 17:11 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 15-2027** **WORKSHEET D-1**
PARTS III & IV

CHECK APPLICABLE BOXES:
[ ] TITLE V - I/P [XX] TITLE XVIII, PART A [ ] TITLE XIX - I/P
[XX] HOSPITAL [ ] IPF [ ] IRF
[ ] SUB (OTHER) [ ] SNF [ ] NF
[ ] ICF/MR
[XX] PPS [ ] TEFRA [ ] OTHER

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)					960.50	88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)						89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERV-ATION BED COST (from line89)	OBSERV-ATION BED PASS-THROUGH COST col. 3 x col. 4) (see instr-uctions	
		1	2	3	4	5	
90	CAPITAL-RELATED COST						90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

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VIBRA HOSP FORT WAYNE Provider CCN: 15-2027	In Lieu of Form **CMS-2552-10**	Period : From: 11/01/2013 To: 10/31/2014	Run Date: 03/10/2015 Run Time: 17:11 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 15-2027** **WORKSHEET D-1**
PART I

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XVIII, PART A [XX] TITLE XIX - I/P [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] ICF/MR [XX] PPS [ ] TEFRA [ ] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	6,491	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	6,491	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	6,491	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	50	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)	6,234,585	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	6,234,585	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	6,234,585	37

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VIBRA HOSP FORT WAYNE Provider CCN: 15-2027	In Lieu of Form **CMS-2552-10**	Period : From: 11/01/2013 To: 10/31/2014	Run Date: 03/10/2015 Run Time: 17:11 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 15-2027** **WORKSHEET D-1 PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XVIII, PART A [XX] TITLE XIX - I/P [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [XX] PPS [ ] TEFRA [ ] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

		1	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)	960.50	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	48,025	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)	48,025	41

		TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (col. 1 ÷ col. 2)	PROGRAM DAYS	PROGRAM COST (col. 3 x col. 4)	
		1	2	3	4	5	
42	NURSERY (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

		1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)	70,882	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	118,907	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	5,694	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	4,317	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	10,011	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)	108,896	53

TARGET AMOUNT AND LIMIT COMPUTATION

54	PROGRAM DISCHARGES		54
55	TARGET AMOUNT PER DISCHARGE		55
56	TARGET AMOUNT (line 54 x line 55)		56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)		57
58	BONUS PAYMENT (see instructions)		58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET		59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET		60
61	IF LINE 53 ÷ 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 (line 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

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COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 15-2027** **WORKSHEET D-1**
PARTS III & IV

CHECK APPLICABLE BOXES:
[ ] TITLE V - I/P [XX] TITLE XVIII, PART A [XX] TITLE XIX - I/P
[XX] HOSPITAL [ ] IPF [ ] IRF
[ ] SUB (OTHER) [ ] SNF [ ] NF
[ ] ICF/MR
[XX] PPS [ ] TEFRA [ ] OTHER

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	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERV-ATION BED COST (from line89)	OBSERV-ATION BED PASS-THROUGH COST col. 3 x col. 4) (see instr-uctions	
		1	2	3	4	5	
90	CAPITAL-RELATED COST						90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

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VIBRA HOSP FORT WAYNE Provider CCN: 15-2027	In Lieu of Form **CMS-2552-10**	Period : From: 11/01/2013 To: 10/31/2014	Run Date: 03/10/2015 Run Time: 17:11 Version: 2014.10

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 15-2027** **WORKSHEET D-3**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] SWING BED SNF [ ] SWING BED NF [ ] ICF/MR | [XX] PPS [ ] TEFRA [ ] OTHER

		RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		3,668,509		30
	ANCILLARY SERVICE COST CENTERS				
54	RADIOLOGY-DIAGNOSTIC	0.592587	420,896	249,417	54
60	LABORATORY	0.515036	276,054	142,178	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.156101	2,393,500	373,628	65
66	PHYSICAL THERAPY	0.608188	171,504	104,307	66
67	OCCUPATIONAL THERAPY	0.586281	191,108	112,043	67
68	SPEECH PATHOLOGY	0.561123	47,281	26,530	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.281461	391,906	110,306	71
73	DRUGS CHARGED TO PATIENTS	0.252499	3,042,673	768,272	73
74	RENAL DIALYSIS	0.485492	249,540	121,150	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				
200	TOTAL (sum of lines 50-94, and 96-98)		7,184,462	2,007,831	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		7,184,462		202

(A) Worksheet A line numbers

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 15-2027** **WORKSHEET D-3**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [XX] TITLE XIX [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] SWING BED SNF [ ] SWING BED NF [ ] ICF/MR [XX] PPS [ ] TEFRA [ ] OTHER

		RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		177,715		30
	ANCILLARY SERVICE COST CENTERS				
54	RADIOLOGY-DIAGNOSTIC	0.592587	6,693	3,966	54
60	LABORATORY	0.515036	20,147	10,376	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.156101	119,595	18,669	65
66	PHYSICAL THERAPY	0.608188	11,662	7,093	66
67	OCCUPATIONAL THERAPY	0.586281	7,844	4,599	67
68	SPEECH PATHOLOGY	0.561123	2,219	1,245	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.281461	26,654	7,502	71
73	DRUGS CHARGED TO PATIENTS	0.252499	69,039	17,432	73
74	RENAL DIALYSIS	0.485492			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				
200	TOTAL (sum of lines 50-94, and 96-98)		263,853	70,882	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		263,853		202

(A) Worksheet A line numbers

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CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 15-2027** **WORKSHEET E PART B**

CHECK APPLICABLE BOX: [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	MEDICAL AND OTHER SERVICES (see instructions)				1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (see instructions)				2
3	PPS PAYMENTS				3
4	OUTLIER PAYMENT (see instructions)				4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)				5
6	LINE 2 TIMES LINE 5				6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6				7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200				9
10	ORGAN ACQUISITION				10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES				12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)				13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)				16
17	RATIO OF LINE 15 TO LINE 16 (not to exceed 1.000000)	1.000000			17
18	TOTAL CUSTOMARY CHARGES (see instructions)				18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions)				19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 11 exceeds line 18 (see instructions)				20
21	LESSER OF COST OR CHARGES (line 11 minus line 20) (for CAH, see instructions)				21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)				25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)				26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)				27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Wkst E-4, line 50)				28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (from Wkst E-4, line 36)				29
30	SUBTOTAL (sum of lines 27 through 29)				30
31	PRIMARY PAYER PAYMENTS				31
32	SUBTOTAL (line 30 minus line 31)				32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	COMPOSITE RATE ESRD (from Wkst I-5, line 11)				33
34	ALLOWABLE BAD DEBTS (see instructions)				34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)				35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)				36
37	SUBTOTAL (see instructions)				37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)				40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)				40.01
41	INTERIM PAYMENTS				41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)				43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2				44

TO BE COMPLETED BY CONTRACTOR

90	ORIGINAL OUTLIER AMOUNT (see instructions)				90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (sse 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

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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 15-2027** **WORKSHEET E-1 PART I**

CHECK APPLICABLE BOXES: **[XX] HOSPITAL [ ] SUB (OTHER) [ ] IPF [ ] SNF [ ] IRF [ ] SWING BED SNF**

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				5,390,723			1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. If NONE, WRITE 'NONE' OR ENTER A ZERO							2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT		.01					3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM		.02					3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM	.03					3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO	.04					3.04
		PROVIDER	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		PROVIDER	.52					3.52
		TO	.53					3.53
		PROGRAM	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99					3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				5,390,723			4
	TO BE COMPLETED BY CONTRACTOR							
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT		.01					5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.		.02					5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM	.03					5.03
		TO	.04					5.04
		PROVIDER	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		PROVIDER	.52					5.52
		TO	.53					5.53
		PROGRAM	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due)		.01		234,128			6.01
	BASED ON THE COST REPORT (1)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				5,624,851			7
8	NAME OF CONTRACTOR			CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK APPLICABLE BOX: **[XX] HOSPITAL [ ] CAH**

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	6,491	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 ()		31
32	BALANCE DUE PROVIDER (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32

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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART IV

CHECK APPLICABLE BOX: **[XX] HOSPITAL**

PART IV - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER LTCH PPS

1	NET FEDERAL PPS PAYMENT (see instructions)	5,161,582	1
2	OUTLIER PAYMENTS	583,764	2
3	TOTAL PPS PAYMENTS (sum of lines 1 and 2)	5,745,346	3
4	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENTS (see instructions)		4
5	DO NOT USE THIS LINE		5
6	COST OF TEACHING PHYSICIANS		6
7	SUBTOTAL (see instructions)	5,745,346	7
8	PRIMARY PAYER PAYMENTS		8
9	SUBTOTAL (line 7 less line 8)	5,745,346	9
10	DEDUCTIBLES	10,912	10
11	SUBTOTAL (line 9 minus line 10)	5,734,434	11
12	COINSURANCE	233,688	12
13	SUBTOTAL (line 11 minus line 12)	5,500,746	13
14	ALLOWABLE BAD DEBTS (exclude bad debts for professional services) (see instructions)	190,931	14
15	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	124,105	15
16	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	121,598	16
17	SUBTOTAL (sum of lines 13 and 15)	5,624,851	17
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet 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)	5,624,851	22
22.01	SEQUESTRATION ADJUSTMENT (see instructions)	112,497	22.01
23	INTERIM PAYMENTS	5,390,723	23
24	TENTATIVE SETTLEMENT (for contractor use only)		24
25	BALANCE DUE PROVIDER/PROGRAM (line 22 minus lines 22.01, 23 and 24)	121,631	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

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CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 15-2027** **WORKSHEET E-3 PART VII**

CHECK APPLICABLE BOXES:	**[ ] TITLE V**	**[XX] HOSPITAL**	**[ ] NF**	**[XX] PPS**
	[XX] TITLE XIX	**[ ] SUB (OTHER)**	**[ ] ICF/MR**	**[ ] TEFRA**
		[ ] SNF		**[ ] OTHER**

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

		INPATIENT TITLE V OR TITLE XIX	OUTPATIENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	INPATIENT HOSPITAL SNF/NF SERVICES			1
2	MEDICAL AND OTHER SERVICES			2
3	ORGAN ACQUISITION (certified transplant centers only)			3
4	SUBTOTAL (sum of lines 1, 2 and 3)			4
5	INPATIENT PRIMARY PAYER PAYMENTS			5
6	OUTPATIENT PRIMARY PAYER PAYMENTS			6
7	SUBTOTAL (line 4 less sum of lines 5 and 6)			7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	ROUTINE SERVICE CHARGES			8
9	ANCILLARY SERVICE CHARGES	263,853		9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE			10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION			11
12	TOTAL REASONABLE CHARGES (sum of lines 8-11)	263,853		12
	CUSTOMARY CHARGES			
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)			14
15	RATIO OF LINE 13 TO LINE 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	TOTAL CUSTOMARY CHARGES (see instructions)	263,853		16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 16 exceeds line 4) (see instructions)	263,853		17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 4 exceeds line 16) (see instructions)			18
19	INTERNS AND RESIDENTS (see instructions)			19
20	COST OF TEACHING PHYSICIANS (see instructions)			20
21	COST OF COVERED SERVICES (lesser of line 4 or line 16) (for CAH, see instructions)			21
	PROSPECTIVE PAYMENT AMOUNT			
22	OTHER THAN OUTLIER PAYMENTS			22
23	OUTLIER PAYMENTS			23
24	PROGRAM CAPITAL PAYMENTS			24
25	CAPITAL EXCEPTION PAYMENTS (see instructions)			25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS			26
27	SUBTOTAL (sum of lines 22 through 26)			27
28	CUSTOMARY CHARGES (Titles V or XIX PPS covered services only)			28
29	SUM OF LINES 27 AND 21			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	EXCESS OF REASONABLE COST (from line 18)			30
31	SUBTOTAL (sum of lines 19 and 20 plus 29 minus lines 5 and 6)			31
32	DEDUCTIBLES			32
33	COINSURANCE			33
34	ALLOWABLE BAD DEBTS (see instructions)			34
35	UTILIZATION REVIEW			35
36	SUBTOTAL (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	SUBTOTAL (line 36 ± line 37)			38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet 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

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BALANCE SHEET **WORKSHEET G**

(If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	-172,763				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	2,459,120				4
5	OTHER RECEIVABLES					5
6	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE	-523,418				6
7	INVENTORY	159,189				7
8	PREPAID EXPENSES	228,292				8
9	OTHER CURRENT ASSETS					9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	2,150,420				11
	FIXED ASSETS					
12	LAND					12
13	LAND IMPROVEMENTS	6,534				13
14	ACCUMULATED DEPRECIATION					14
15	BUILDINGS	9,850				15
16	ACCUMULATED DEPRECIATION					16
17	LEASEHOLD IMPROVEMENTS					17
18	ACCUMULATED AMORTIZATION					18
19	FIXED EQUIPMENT					19
20	ACCUMULATED DEPRECIATION					20
21	AUTOMOBILES AND TRUCKS					21
22	ACCUMULATED DEPRECIATION					22
23	MAJOR MOVABLE EQUIPMENT	96,793				23
24	ACCUMULATED DEPRECIATION	-28,622				24
25	MINOR EQUIPMENT DEPRECIABLE					25
26	ACCUMULATED DEPRECIATION					26
27	HIT DESIGNATED ASSETS					27
28	ACCUMULATED DEPRECIATION					28
29	MINOR EQUIPMENT-NONDEPRECIABLE					29
30	TOTAL FIXED ASSETS (sum of lines 12-29)	84,555				30
	OTHER ASSETS					
31	INVESTMENTS					31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	540,772				34
35	TOTAL OTHER ASSETS (sum of lines 31-34)	540,772				35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	2,775,747				36

	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	624,396				37
38	SALARIES, WAGES & FEES PAYABLE	301,378				38
39	PAYROLL TAXES PAYABLE	80,498				39
40	NOTES & LOANS PAYABLE (short term)					40
41	DEFERRED INCOME					41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS	513,350				43
44	OTHER CURRENT LIABILITIES	70,898				44
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	1,590,520				45
	LONG TERM LIABILITIES					
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE					47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES	252,912				49
50	TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49)	252,912				50
51	TOTAL LIABILITIES (sum of lines 45 and 50)	1,843,432				51
	CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	932,315				52
53	SPECIFIC PURPOSE FUND BALANCE					53
54	DONOR CREATED - ENDOWMENT FUND BALANCE - RESTRICTED					54
55	DONOR CREATED - ENDOWMENT FUND BALANCE - UNRESTRICTED					55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BALANCE					56
57	PLANT FUND BALANCE - INVESTED IN PLANT					57
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT, AND EXPANSION					58
59	TOTAL FUND BALANCES (sum of lines 52-58)	932,315				59
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)	2,775,747				60

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STATEMENT OF CHANGES IN FUND BALANCES **WORKSHEET G-1**

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	FUND BALANCES AT BEGINNING OF PERIOD		77,466			1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		-310,415			2
3	TOTAL (sun of line 1 and line 2)		-232,949			3
4	ADDITIONS (credit adjustments)					4
5	PRIOR PERIOD ADJUSTMENT	1,165,264				5
6	ROUNDING					6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)		1,165,264			10
11	SUBTOTAL (line 3 plus line 10)		932,315			11
12	DEDUCTIONS (debit adjustments)					12
13						13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)		932,315			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	FUND BALANCES AT BEGINNING OF PERIOD					1
2	NET INCOME (loss) (from Worksheet G-3, line 29)					2
3	TOTAL (sun of line 1 and line 2)					3
4	ADDITIONS (credit adjustments)					4
5	PRIOR PERIOD ADJUSTMENT					5
6	ROUNDING					6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)					11
12	DEDUCTIONS (debit adjustments)					12
13						13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)					19

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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	HOSPITAL	6,796,340		6,796,340	1
2	SUBPROVIDER IPF				2
3	SUBPROVIDER IRF				3
5	SWING BED - SNF				5
6	SWING BED - NF				6
7	SKILLED NURSING FACILITY				7
8	NURSING FACILITY				8
9	OTHER LONG TERM CARE				9
10	TOTAL GENERAL INPATIENT CARE SERVICES (sum of lines 1-9)	6,796,340		6,796,340	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT				11
12	CORONARY CARE UNIT				12
13	BURN INTENSIVE CARE UNIT				13
14	SURGICAL INTENSIVE CARE UNIT				14
15	OTHER SPECIAL CARE (SPECIFY)				15
16	TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (sum of lines 11-15)				16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (sum of lines 10 and 16)	6,796,340		6,796,340	17
18	ANCILLARY SERVICES	14,042,983		14,042,983	18
19	OUTPATIENT SERVICES				19
20	RHC				20
21	FQHC				21
22	HOME HEALTH AGENCY				22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	OTHER (SPECIFY)				27
28	TOTAL PATIENT REVENUES (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	20,839,323		20,839,323	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		10,615,467	29
30	ADD (SPECIFY)			30
31				31
32				32
33				33
34				34
35				35
36	TOTAL ADDITIONS (sum of lines 30-35)			36
37	DEDUCT (SPECIFY)			37
38				38
39				39
40				40
41				41
42	TOTAL DEDUCTIONS (sum of lines 37-41)			42
43	TOTAL OPERATING EXPENSES (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		10,615,467	43

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STATEMENT OF REVENUES AND EXPENSES **WORKSHEET G-3**

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (from Worksheet G-2, Part I, column 3, line 28)	20,839,323	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	10,241,117	2
3	NET PATIENT REVENUES (line 1 minus line 2)	10,598,206	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	10,615,467	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	-17,261	5

OTHER INCOME

6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	2,555	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 MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (fees, sale of textbooks, uniforms, etc.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (GRANT)	3,500	24
24.01	OTHER (OTHER)	1,787	24.01
24.02	OTHER (ROUNDING)	1	24.02
25	TOTAL OTHER INCOME (sum of lines 6-24)	7,843	25
26	TOTAL (line 5 plus line 25)	-9,418	26
27	OTHER EXPENSES (BAD DEBTS)	300,997	27
27.01	OTHER EXPENSES (ROUNDING)		27.01
28	TOTAL OTHER EXPENSES (sum of line 27 and subscripts)	300,997	28
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	-310,415	29