

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

WORKSHEET S
 PARTS I, II & III

PART I - COST REPORT STATUS

PROVIDER USE ONLY 1. ELECTRONICALLY FILED COST REPORT DATE: 04-22-2013 TIME: 16:33
 2. MANUALLY SUBMITTED COST REPORT
 3. IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT
 4. MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY VIBRA HOSP FORT WAYNE (15-2027) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 11/01/2011 AND ENDING 10/31/2012, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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

 TITLE

 DATE

PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII		HIT 4	TITLE XIX 5
		PART A 2	PART B 3		
1 HOSPITAL		54,379			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		54,379			200

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

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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 2626 FAIRFIELD ROAD
 2 CITY: FORT WAYNE

STATE: IN

P.O.BOX:
 ZIP CODE: 46807-

COUNTY: ALLEN

1
 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT 0	COMPONENT NAME 1	CCN NUMBER 2	CBSA NUMBER 3	PROV TYPE 4	DATE CERTIFIED 5	PAYMENT SYSTEM (P, T, O, OR N)			
						V 6	XVIII 7	XIX 8	
3	HOSPITAL	15-2027	23060	2	09/01/2008	N	P	N	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: 11/01/2011			TO: 10/31/2012				20
21	TYPE OF CONTROL				6				21

INPATIENT PPS INFORMATION

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

		IN-STATE		OUT-OF-STATE		OTHER		
		MEDICAID PAID DAYS	MEDICAID ELIGIBLE UNPAID DAYS	MEDICAID PAID DAYS	MEDICAID ELIGIBLE UNPAID DAYS	MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS	MEDICAID OTHER	
		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 PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:		ENDING:		38

		V		XVIII		XIX		
		1	2	3	4	5	6	
45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	N	N	N	N	N	N	45
46	IS THIS FACILITY ELIGIBLE FOR ADDITIONAL PAYMENT EXCEPTION FOR EXTRAORDINARY CIRCUMSTANCES PURSUANT TO 42 CFR §412.348(f)? IF YES, COMPLETE WORKSHEET L, PART III AND L-1, PARTS I THROUGH III.	N	N	N	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	N	N	N	47
48	IS THE FACILITY ELECTING FULL FEDERAL CAPITAL PAYMENT? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	N	N	N	48

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

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	N	57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-5.	N		58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N		59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	N		60

	Y/N	IME AVERAGE	DIRECT GME AVERAGE	
61	DID YOUR FACILITY RECEIVE ADDITIONAL FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF 'Y', EFFECTIVE FOR PORTIONS OF COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2011 ENTER THE AVERAGE NUMBER OF PRIMARY CARE FTE RESIDENTS FOR IME IN COLUMN 2 AND DIRECT GME IN COLUMN 3 FROM THE HOSPITAL'S THREE MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (SEE INSTRUCTIONS)	N		61

ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)

62	ENTER THE NUMBER OF FTE RESIDENTS THAT YOUR HOSPITAL TRAINED IN THIS COST REPORTING PERIOD FOR WHICH YOUR HOSPITAL RECEIVED HRSA PCRE FUNDING (SEE INSTRUCTIONS)			62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (SEE INSTRUCTIONS)			62.01

TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS

63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (SEE INSTRUCTIONS)	N		63
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SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS

	UNWEIGHTED FTES NONPROVIDER SITE	UNWEIGHTED FTES IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	
64	ENTER IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTES ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTES THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)			64

ENTER IN LINES 65-65.49 IN COLUMN 1, IF LINE 63 IS YES, OR YOUR
 FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE PROGRAM NAME.
 ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF
 UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS
 OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER
 OF UNWEIGHTED PRIMARY CARE RESIDENT FTES THAT TRAINED IN YOUR HOSPITAL.
 ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 + COLUMN 4)).
 (SEE INSTRUCTIONS)

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

SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS

	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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

ENTER IN LINES 67-67.49, COLUMN 1 THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 ÷ COLUMN 4)). (SEE INSTRUCTIONS)

PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1 / (COL.3 + COL.4))	
1	2	3	4	5	
INPATIENT PSYCHIATRIC FACILITY PPS					
70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER?			N 70	
71	IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			71	
INPATIENT REHABILITATION FACILITY PPS					
75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER?			N 75	
76	IF LINE 75 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			76	
LONG TERM CARE HOSPITAL PPS					
80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.			Y 80	
TEFRA PROVIDERS					
85	IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA?. ENTER 'Y' FOR YES OR 'N' FOR NO.			N 85	
86	DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.			N 86	
TITLE V AND XIX INPATIENT SERVICES					
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.			N N 90	
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 91	
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N 92	
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 93	
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 94	
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			95	
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 96	
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			97	
RURAL PROVIDERS					
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?			1 2 N 105	
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.			106	
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&Rs IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.			107	
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.			N 108	
109	IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.	PHY- SICAL	OCCUP- ATIONAL	SPEECH THERAPY	RESPI- RATORY
		Y	Y	Y	Y

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

MISCELLANEOUS COST REPORTING INFORMATION

115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2. IF COLUMN 2 IS 'E', ENTER IN COLUMN 3 EITHER '93' PERCENT FOR SHORT TERM HOSPITAL OR '98' PERCENT FOR LONG TERM CARE (INCLUDES PSYCHIATRIC, REHABILITATION AND LONG TERM HOSPITALS PROVIDERS) BASED ON THE DEFINITION IN CMS 15-1§ 2208.1.	N		115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.			118
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: PAID LOSSES: SELF INSURANCE:			118.01
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTER OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	N		118.02
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 BEDS THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	N	N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		121

TRANSPLANT CENTER INFORMATION

125	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, ENTER CERTIFICATION DATE(S) (MM/DD/YYYY) BELOW.	N		125
126	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			126
127	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			127
128	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			128
129	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			129
130	IF THIS IS A MEDICARE CERTIFIED PANCREAS TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			130
131	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			131
132	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			132
133	IF THIS IS A MEDICARE CERTIFIED OTHER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			133
134	IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			134

ALL PROVIDERS

140	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.	1 Y	2	140
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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:	CONTRACTOR'S NAME:	CONTRACTOR'S NUMBER:	141
142	STREET:	P.O. BOX:		142
143	CITY:	STATE:	ZIP CODE:	143
144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	N		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.	N		145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (SEE CMS PUB. 15-2, SECTION 4020). IF YES, ENTER THE APPROVAL DATE (MM/DD/YYYY) IN COLUMN 2.	N		146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		149

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

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

PROVIDER CCN: 15-2027 VIBRA HOSP FORT WAYNE
PERIOD FROM 11/01/2011 TO 10/31/2012

KPMG LLP COMPU-MAX MICRO SYSTEM
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HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I (CONT)

MULTICAMPUS

165	IS THIS HOSPITAL PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSAs? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	165			
166	IF LINE 165 IS YES, FOR EACH CAMPUS, ENTER THE NAME IN COLUMN 0, COUNTY IN COLUMN 1, STATE IN COLUMN 2, ZIP IN COLUMN 3, CBSA IN COLUMN 4, FTE/CAMPUS IN COLUMN 5.					
	NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
	0	1	2	3	4	5

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

167	IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(n)? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	167
168	IF THIS PROVIDER IS A CAH (LINE 105 IS 'Y') AND A MEANINGFUL USER (LINE 167 IS 'Y'), ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS.		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.		169

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
 PART II

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

COMPLETED BY ALL HOSPITALS

		Y/N	DATE		
PROVIDER ORGANIZATION AND OPERATION					
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (SEE INSTRUCTIONS)	N		1	
		Y/N	DATE	V/I	
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	N		2	
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (E.G., CHAIN HOME OFFICES, DRUG OR MEDICAL SUPPLY COMPANIES) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (SEE INSTRUCTIONS)	N		3	
FINANCIAL DATA AND REPORTS					
		Y/N	TYPE	DATE	
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (SEE INSTRUCTIONS). IF NO, SEE INSTRUCTIONS.	N		4	
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N		5	
APPROVED EDUCATIONAL ACTIVITIES					
		Y/N		Y/N	
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	N		6	
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N		7	
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N		8	
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N		9	
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N		10	
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N		11	
				Y/N	
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.			N 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.			13	
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			14	
BED COMPLEMENT					
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N 15	
PS&R REPORT DATA					
		PART A		PART B	
		Y/N	DATE	Y/N	DATE
		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)	N		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

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

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

CAPITAL RELATED COST

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

INTEREST EXPENSE

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

PURCHASED SERVICES

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

PROVIDER-BASED PHYSICIANS

- 34 ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIANS? IF YES, SEE INSTRUCTIONS. 34
- 35 IF LINE 34 IS YES, WERE THERE NEW AGREEMENTS OR AMENDED EXISTING AGREEMENTS WITH THE PROVIDER-BASED PHYSICIANS DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. 35

HOME OFFICE COSTS

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

COST REPORT PREPARER CONTACT INFORMATION

- | | | | |
|-----------------------------|---|------------|----|
| 41 FIRST NAME: JAMES | LAST NAME: WALMSLEY | TITLE: SVP | 41 |
| 42 EMPLOYER: VIBRA | | | 42 |
| 43 PHONE NUMBER: 6108690532 | E-MAIL ADDRESS: AMSLEEY@VIBRAHEALET.COM | | 43 |

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
 PART II & III

PART II - WAGE DATA

	WKST A LINE NUMBER	AMOUNT REPORTED	RECLASS OF SALARIES (FROM WKST A-6)	ADJUSTED SALARIES (COL. 2 + COL. 3)	PAID HOURS RELATED TO SALARIES IN COL. 4	AVERAGE HOURLY WAGE (COL. 4 + COL. 5)	
	1	2	3	4	5	6	
SALARIES							
1	TOTAL SALARIES (SEE INSTRUCTIONS)	200	2,764,844		35,527.00		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 PGM)						7.01
8	HOME OFFICE PERSONNEL						8
9	SNF	44					9
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)						10
OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (SEE INSTRUCTIONS)		2,964		61.75		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)		582,403				17
18	WAGE-RELATED COSTS (OTHER)						18
19	EXCLUDED AREAS						19
20	NON-PHYSICIAN ANESTHETIST PART A						20
21	NON-PHYSICIAN ANESTHETIST PART B						21
22	PHYSICIAN PART A - ADMINISTRATIVE						22
22.01	PHYSICIAN PART A - TEACHING						22.01
23	PHYSICIAN PART B						23
24	WAGE-RELATED COSTS (RHC/FQHC)						24
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)						25
OVERHEAD COSTS - DIRECT SALARIES							
26	EMPLOYEE BENEFITS		49,466				26
27	ADMINISTRATIVE & GENERAL		692,165				27
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)						28
29	MAINTENANCE & REPAIRS						29
30	OPERATION OF PLANT		115,709				30
31	LAUNDRY & LINEN SERVICE						31
32	HOUSEKEEPING		93,180				32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)						33
34	DIETARY		148,541				34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)						35
36	CAFETERIA						36
37	MAINTENANCE OF PERSONNEL						37
38	NURSING ADMINISTRATION		179,316				38
39	CENTRAL SERVICES AND SUPPLY						39
40	PHARMACY		167,553				40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		57,789				41
42	SOCIAL SERVICE						42
43	OTHER GENERAL SERVICE						43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	2,764,844		2,764,844	35,527.00	77.82	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)						2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	2,764,844		2,764,844	35,527.00	77.82	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	2,964		2,964	61.75	48.00	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	582,403		582,403		21.06%	5
6	TOTAL (SUM OF LINES 3 THRU 5)	3,350,211		3,350,211	35,588.75	94.14	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	1,503,719		1,503,719			7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

PART A - CORE LIST

	AMOUNT REPORTED	
RETIREMENT COST		
1 401K EMPLOYER CONTRIBUTIONS	5,211	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)	317,950	8
9 PRESCRIPTION DRUG PLAN		9
10 DENTAL, HEARING AND VISION PLAN	821	10
11 LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	14,836	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	71,599	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	186,060	17
18 MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19 UNEMPLOYMENT INSURANCE		19
20 STATE OR FEDERAL UNEMPLOYMENT TAXES	39,340	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	2,985	23
24 TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	638,802	24
PART B - OTHER THAN CORE RELATED COST		
25 OTHER WAGE RELATED (OTHER WAGE RELATED COST)		25

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HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION

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

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES	OTHER	TOTAL (COL. 1 + COL. 2)	RECLASSIFI- CATIONS
		1	2	3	4
GENERAL SERVICE COST CENTERS					
1	00100 CAP REL COSTS-BLDG & FIXT		921,279	921,279	1
2	00200 CAP REL COSTS-MVBLE EQUIP		155,351	155,351	2
3	00300 OTHER CAPITAL RELATED COSTS				3
4	00400 EMPLOYEE BENEFITS	49,466	606,721	656,187	4
5	00500 ADMINISTRATIVE & GENERAL	692,165	695,555	1,387,720	5
6	00600 MAINTENANCE & REPAIRS				6
7	00700 OPERATION OF PLANT	115,709	220,583	336,292	7
8	00800 LAUNDRY & LINEN SERVICE		31,484	31,484	8
9	00900 HOUSEKEEPING	93,180	21,834	115,014	9
10	01000 DIETARY	148,541	51,816	200,357	10
11	01100 CAFETERIA				11
12	01200 MAINTENANCE OF PERSONNEL				12
13	01300 NURSING ADMINISTRATION	179,316	2,403	181,719	13
14	01400 CENTRAL SERVICES & SUPPLY				14
15	01500 PHARMACY	167,553	10,493	178,046	15
16	01600 MEDICAL RECORDS & LIBRARY	57,789	1,985	59,774	16
17	01700 SOCIAL SERVICE				17
19	01900 NONPHYSICIAN ANESTHETISTS				19
20	02000 NURSING SCHOOL				20
21	02100 I&R SRVCES-SALARY & FRINGES APPRVD				21
22	02200 I&R SRVCES-OTHER PRGM COSTS APPRVD				22
23	02300 PARAMED ED PRGM-(SPECIFY)				23
INPATIENT ROUTINE SERV COST CENTERS					
30	03000 ADULTS & PEDIATRICS	969,503	280,305	1,249,808	30
ANCILLARY SERVICE COST CENTERS					
54	05400 RADIOLOGY-DIAGNOSTIC		66,939	66,939	54
55	05500 RADIOLOGY-THERAPEUTIC		113,507	113,507	55
60	06000 LABORATORY				60
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	06500 RESPIRATORY THERAPY	291,622	52,099	343,721	65
66	06600 PHYSICAL THERAPY		55,603	55,603	66
67	06700 OCCUPATIONAL THERAPY		54,507	54,507	67
68	06800 SPEECH PATHOLOGY		28,835	28,835	68
69	06900 ELECTROCARDIOLOGY		47,087	47,087	69
69.10	03180 HEMO DIALYSIS				69.10
71	07100 MEDICAL SUPPLIES CHRGD TO PATIENTS		275,367	275,367	71
73	07300 DRUGS CHARGED TO PATIENTS		266,969	266,969	73
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				92
OTHER REIMBURSABLE COST CENTERS					
99.10	09910 CORF				99.10
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)	2,764,844	3,960,722	6,725,566	118
NONREIMBURSABLE COST CENTERS					
194	07950 PHYSICIAN MEALS				194
200	TOTAL (SUM OF LINES 118-199)	2,764,844	3,960,722	6,725,566	200

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		RECLASSIFIED TRIAL BALANCE (COL. 3 ± COL. 4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL. 5 ± COL. 6) 7	
GENERAL SERVICE COST CENTERS					
1	00100	921,279		921,279	1
2	00200	155,351		155,351	2
3	00300				3
4	00400	656,187		656,187	4
5	00500	1,387,720	220,912	1,608,632	5
6	00600				6
7	00700	336,292		336,292	7
8	00800	31,484		31,484	8
9	00900	115,014		115,014	9
10	01000	200,357		200,357	10
11	01100				11
12	01200				12
13	01300	181,719		181,719	13
14	01400				14
15	01500	178,046		178,046	15
16	01600	59,774		59,774	16
17	01700				17
19	01900				19
20	02000				20
21	02100				21
22	02200				22
23	02300				23
INPATIENT ROUTINE SERV COST CENTERS					
30	03000	1,249,808		1,249,808	30
ANCILLARY SERVICE COST CENTERS					
54	05400	66,939		66,939	54
55	05500	113,507		113,507	55
60	06000				60
62.30	06250				62.30
65	06500	343,721		343,721	65
66	06600	55,603		55,603	66
67	06700	54,507		54,507	67
68	06800	28,835		28,835	68
69	06900	47,087		47,087	69
69.10	03180				69.10
71	07100	275,367		275,367	71
73	07300	266,969		266,969	73
76	03950				76
76.97	07697				76.97
76.98	07698				76.98
76.99	07699				76.99
OUTPATIENT SERVICE COST CENTERS					
92	09200				92
OTHER REIMBURSABLE COST CENTERS					
99.10	09910				99.10
99.20	09920				99.20
99.30	09930				99.30
99.40	09940				99.40
118		6,725,566	220,912	6,946,478	118
NONREIMBURSABLE COST CENTERS					
194	07950				194
200		6,725,566	220,912	6,946,478	200
GRAND TOTAL (INCREASES)					
GRAND TOTAL (DECREASES)					

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
 PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	----- ACQUISITIONS -----			DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
		PURCHASE 2	DONATION 3	TOTAL 4			
1 LAND							1
2 LAND IMPROVEMENTS							2
3 BUILDINGS AND FIXTURES	20,566					20,566	3
4 BUILDING IMPROVEMENTS							4
5 FIXED EQUIPMENT							5
6 MOVABLE EQUIPMENT							6
7 HIT DESIGNATED ASSETS							7
8 SUBTOTAL (SUM OF LINES 1-7)	20,566					20,566	8
9 RECONCILING ITEMS							9
10 TOTAL (LINE 7 MINUS LINE 9)	20,566					20,566	10

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

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

DESCRIPTION	DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(1) (SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT		921,279					921,279 1
2 CAP REL COSTS-MVBLE EQUIP		155,351					155,351 2
3 TOTAL (SUM OF LINES 1-2)		1,076,630					1,076,630 3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

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

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

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

DESCRIPTION	DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(2) (SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT		921,279					921,279 1
2 CAP REL COSTS-MVBLE EQUIP		155,351					155,351 2
3 TOTAL		1,076,630					1,076,630 3

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF
			COST CENTER	LINE NO.	
	1	2	3	4	5
1 INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)			CAP REL COSTS-BLDG & FIXT	1	1
2 INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)			CAP REL COSTS-MVBLE EQUIP	2	2
3 INVESTMENT INCOME-OTHER (CHAPTER 2)	A	-159	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				10
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)					11
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1	335,023			12
13 LAUNDRY AND LINEN SERVICE					13
14 CAFETERIA - EMPLOYEES AND GUESTS					14
15 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15
16 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					16
17 SALE OF DRUGS TO OTHER THAN PATIENTS					17
18 SALE OF MEDICAL RECORDS AND ABSTRACTS					18
19 NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)					19
20 VENDING MACHINES					20
21 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)					21
22 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					22
23 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		RESPIRATORY THERAPY	65	23
24 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		PHYSICAL THERAPY	66	24
25 UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114	25
26 DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1	26
27 DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2	27
28 NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	28
29 PHYSICIANS' ASSISTANT					29
30 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67	30
31 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		SPEECH PATHOLOGY	68	31
32 CAH HIT ADJ FOR DEPRECIATION AND					32
33 OTHER	A	-3,705	ADMINISTRATIVE & GENERAL	5	33
34 BAD DEBT	A	-110,247	ADMINISTRATIVE & GENERAL	5	34
35					35
36					36
37					37
38					38
39					39
40					40
41					41
42					42
43					43
44					44
45					45
46					46
47					47
48					48
49					49
50 TOTAL (SUM OF LINES 1 THRU 49)		220,912			50
TRANSFER TO WKST A, COL. 6, LINE 200)					

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

WORKSHEET A-8-1

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL. 5)	NET ADJ- USTMENTS (COL. 4-5)	WKST A-7 REF
1	2	3	4	5	6	7
1	5	ADMINISTRATIVE & GENERAL				
2		CORPORATE EXPENSES	452,689	117,666	335,023	1
3						2
4						3
5		TOTALS (SUM OF LINES 1-4)	452,689	117,666	335,023	4
		TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.				5

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

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

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

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

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

PROVIDER CCN: 15-2027 VIBRA HOSP FORT WAYNE
PERIOD FROM 11/01/2011 TO 10/31/2012

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

VERSION: 2012.11
04/22/2013 16:33

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST	A	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	5 PERCENT OF UNAD- JUSTED RCE LIMIT
LINE NO.		2	3	4	5	6	7	8	9
200		TOTAL							200

PROVIDER CCN: 15-2027 VIBRA HOSP FORT WAYNE
PERIOD FROM 11/01/2011 TO 10/31/2012

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

VERSION: 2012.11
04/22/2013 16:33

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUST- MENT
LINE NO.		12	13	14	15	16	17	18
10	11							
200	TOTAL							200

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS 4	SUBTOTAL (COLS.0-4) 4A	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	921,279	921,279				1
2 CAP REL COSTS-MVBLE EQUIP	155,351		155,351			2
4 EMPLOYEE BENEFITS	656,187	2,473	417	659,077		4
5 ADMINISTRATIVE & GENERAL	1,608,632	39,980	6,742	168,002	1,823,356	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	336,292	294,865	49,722	28,085	708,964	7
8 LAUNDRY & LINEN SERVICE	31,484	8,463	1,427		41,374	8
9 HOUSEKEEPING	115,014	10,552	1,779	22,617	149,962	9
10 DIETARY	200,357	36,903	6,223	36,054	279,537	10
11 CAFETERIA		22,779	3,841		26,620	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	181,719			43,524	225,243	13
14 CENTRAL SERVICES & SUPPLY		22,120	3,730		25,850	14
15 PHARMACY	178,046	10,029	1,691	40,668	230,434	15
16 MEDICAL RECORDS & LIBRARY	59,774	7,749	1,307	14,027	82,857	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
30 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS	1,249,808	437,558	73,783	235,318	1,996,467	30
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC	66,939				66,939	54
55 RADIOLOGY-THERAPEUTIC	113,507				113,507	55
60 LABORATORY		9,233	1,557		10,790	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	343,721			70,782	414,503	65
66 PHYSICAL THERAPY	55,603	18,575	3,132		77,310	66
67 OCCUPATIONAL THERAPY	54,507				54,507	67
68 SPEECH PATHOLOGY	28,835				28,835	68
69 ELECTROCARDIOLOGY	47,087				47,087	69
69.10 HEMO DIALYSIS						69.10
71 MEDICAL SUPPLIES CHRGED TO PATIENTS	275,367				275,367	71
73 DRUGS CHARGED TO PATIENTS	266,969				266,969	73
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						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
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)	6,946,478	921,279	155,351	659,077	6,946,478	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)	6,946,478	921,279	155,351	659,077	6,946,478	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL 5	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	1,823,356					5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	252,325	961,289				7
8 LAUNDRY & LINEN SERVICE	14,725	14,497	70,596			8
9 HOUSEKEEPING	53,373	18,074		221,409		9
10 DIETARY	99,489	63,214		14,463	456,703	10
11 CAFETERIA	9,474			8,927	19,368	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	80,166					13
14 CENTRAL SERVICES & SUPPLY	9,200	37,890		8,669		14
15 PHARMACY	82,013	17,180		3,931		15
16 MEDICAL RECORDS & LIBRARY	29,489	13,273		3,037		16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
30 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS	710,558	749,527	70,596	171,484	426,737	30
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC	23,824					54
55 RADIOLOGY-THERAPEUTIC	40,398					55
60 LABORATORY	3,840	15,815		3,618		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	147,525					65
66 PHYSICAL THERAPY	27,515	31,819		7,280		66
67 OCCUPATIONAL THERAPY	19,399					67
68 SPEECH PATHOLOGY	10,263					68
69 ELECTROCARDIOLOGY	16,759					69
69.10 HEMO DIALYSIS						69.10
71 MEDICAL SUPPLIES CHRGED TO PATIENTS	98,005					71
73 DRUGS CHARGED TO PATIENTS	95,016					73
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						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	1,823,356	961,289	70,596	221,409	446,105	118
NONREIMBURSABLE COST CENTERS						
194 PHYSICIAN MEALS					10,598	194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	1,823,356	961,289	70,596	221,409	456,703	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	CAFETERIA 11	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						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	64,389					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	6,931	312,340				13
14 CENTRAL SERVICES & SUPPLY			81,609			14
15 PHARMACY	6,477			340,035		15
16 MEDICAL RECORDS & LIBRARY	2,234				130,890	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
30 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS	37,475	312,340	81,609	130	130,890	30
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC						54
55 RADIOLOGY-THERAPEUTIC						55
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	11,272					65
66 PHYSICAL THERAPY						66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
69.10 HEMO DIALYSIS						69.10
71 MEDICAL SUPPLIES CHRGED TO PATIENTS						71
73 DRUGS CHARGED TO PATIENTS				339,905		73
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						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
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)	64,389	312,340	81,609	340,035	130,890	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)	64,389	312,340	81,609	340,035	130,890	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS				
1 CAP REL COSTS-BLDG & FIXT				1
2 CAP REL COSTS-MVBLE EQUIP				2
4 EMPLOYEE BENEFITS				4
5 ADMINISTRATIVE & GENERAL				5
6 MAINTENANCE & REPAIRS				6
7 OPERATION OF PLANT				7
8 LAUNDRY & LINEN SERVICE				8
9 HOUSEKEEPING				9
10 DIETARY				10
11 CAFETERIA				11
12 MAINTENANCE OF PERSONNEL				12
13 NURSING ADMINISTRATION				13
14 CENTRAL SERVICES & SUPPLY				14
15 PHARMACY				15
16 MEDICAL RECORDS & LIBRARY				16
17 SOCIAL SERVICE				17
19 NONPHYSICIAN ANESTHETISTS				19
20 NURSING SCHOOL				20
21 I&R SRVCES-SALARY & FRINGES APPRVD				21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD				22
23 PARAMED ED PRGM-(SPECIFY)				23
INPATIENT ROUTINE SERV COST CENTERS				
30 ADULTS & PEDIATRICS	4,687,813		4,687,813	30
ANCILLARY SERVICE COST CENTERS				
54 RADIOLOGY-DIAGNOSTIC	90,763		90,763	54
55 RADIOLOGY-THERAPEUTIC	153,905		153,905	55
60 LABORATORY	34,063		34,063	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	573,300		573,300	65
66 PHYSICAL THERAPY	143,924		143,924	66
67 OCCUPATIONAL THERAPY	73,906		73,906	67
68 SPEECH PATHOLOGY	39,098		39,098	68
69 ELECTROCARDIOLOGY	63,846		63,846	69
69.10 HEMO DIALYSIS				69.10
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	373,372		373,372	71
73 DRUGS CHARGED TO PATIENTS	701,890		701,890	73
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				92
OTHER REIMBURSABLE COST CENTERS				
99.10 CORF				99.10
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)	6,935,880		6,935,880	118
NONREIMBURSABLE COST CENTERS				
194 PHYSICIAN MEALS	10,598		10,598	194
200 CROSS FOOT ADJUSTMENTS				200
201 NEGATIVE COST CENTER				201
202 TOTAL (SUM OF LINES 118-201)	6,946,478		6,946,478	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	SUBTOTAL 2A	EMPLOYEE BENEFITS 4	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS		2,473	417	2,890	2,890	4
5 ADMINISTRATIVE & GENERAL	39,980		6,742	46,722	736	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT		294,865	49,722	344,587	123	7
8 LAUNDRY & LINEN SERVICE		8,463	1,427	9,890		8
9 HOUSEKEEPING		10,552	1,779	12,331	99	9
10 DIETARY		36,903	6,223	43,126	158	10
11 CAFETERIA		22,779	3,841	26,620		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION					191	13
14 CENTRAL SERVICES & SUPPLY		22,120	3,730	25,850		14
15 PHARMACY		10,029	1,691	11,720	178	15
16 MEDICAL RECORDS & LIBRARY		7,749	1,307	9,056	61	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS		437,558	73,783	511,341	1,034	30
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC						54
55 RADIOLOGY-THERAPEUTIC						55
60 LABORATORY		9,233	1,557	10,790		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY					310	65
66 PHYSICAL THERAPY		18,575	3,132	21,707		66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
69.10 HEMO DIALYSIS						69.10
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
73 DRUGS CHARGED TO PATIENTS						73
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						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
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)		921,279	155,351	1,076,630	2,890	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)		921,279	155,351	1,076,630	2,890	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL 5	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	47,458					5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	6,567	351,277				7
8 LAUNDRY & LINEN SERVICE	383	5,298	15,571			8
9 HOUSEKEEPING	1,389	6,605		20,424		9
10 DIETARY	2,589	23,100		1,334	70,307	10
11 CAFETERIA	247			824	2,982	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	2,086					13
14 CENTRAL SERVICES & SUPPLY	239	13,846		800		14
15 PHARMACY	2,135	6,278		363		15
16 MEDICAL RECORDS & LIBRARY	768	4,850		280		16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	18,496	273,894	15,571	15,817	65,694	30
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC	620					54
55 RADIOLOGY-THERAPEUTIC	1,051					55
60 LABORATORY	100	5,779		334		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	3,840					65
66 PHYSICAL THERAPY	716	11,627		672		66
67 OCCUPATIONAL THERAPY	505					67
68 SPEECH PATHOLOGY	267					68
69 ELECTROCARDIOLOGY	436					69
69.10 HEMO DIALYSIS						69.10
71 MEDICAL SUPPLIES CHRGED TO PATIENTS	2,551					71
73 DRUGS CHARGED TO PATIENTS	2,473					73
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						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
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)	47,458	351,277	15,571	20,424	68,676	118
NONREIMBURSABLE COST CENTERS						
194 PHYSICIAN MEALS					1,631	194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	47,458	351,277	15,571	20,424	70,307	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	CAFETERIA	NURSING	CENTRAL	PHARMACY	MEDICAL	
	11	ADMINIS- TRATION 13	SERVICES & SUPPLY 14	15	RECORDS & LIBRARY 16	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						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	30,673					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	3,302	5,579				13
14 CENTRAL SERVICES & SUPPLY			40,735			14
15 PHARMACY	3,085			23,759		15
16 MEDICAL RECORDS & LIBRARY	1,064				16,079	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
30 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS	17,852	5,579	40,735	9	16,079	30
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC						54
55 RADIOLOGY-THERAPEUTIC						55
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	5,370					65
66 PHYSICAL THERAPY						66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
69.10 HEMO DIALYSIS						69.10
71 MEDICAL SUPPLIES CHRGED TO PATIENTS						71
73 DRUGS CHARGED TO PATIENTS				23,750		73
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						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
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)	30,673	5,579	40,735	23,759	16,079	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)	30,673	5,579	40,735	23,759	16,079	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS				
1 CAP REL COSTS-BLDG & FIXT				1
2 CAP REL COSTS-MVBLE EQUIP				2
4 EMPLOYEE BENEFITS				4
5 ADMINISTRATIVE & GENERAL				5
6 MAINTENANCE & REPAIRS				6
7 OPERATION OF PLANT				7
8 LAUNDRY & LINEN SERVICE				8
9 HOUSEKEEPING				9
10 DIETARY				10
11 CAFETERIA				11
12 MAINTENANCE OF PERSONNEL				12
13 NURSING ADMINISTRATION				13
14 CENTRAL SERVICES & SUPPLY				14
15 PHARMACY				15
16 MEDICAL RECORDS & LIBRARY				16
17 SOCIAL SERVICE				17
19 NONPHYSICIAN ANESTHETISTS				19
20 NURSING SCHOOL				20
21 I&R SRVCES-SALARY & FRINGES APPRVD				21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD				22
23 PARAMED ED PRGM-(SPECIFY)				23
INPATIENT ROUTINE SERV COST CENTERS				
30 ADULTS & PEDIATRICS	982,101		982,101	30
ANCILLARY SERVICE COST CENTERS				
54 RADIOLOGY-DIAGNOSTIC	620		620	54
55 RADIOLOGY-THERAPEUTIC	1,051		1,051	55
60 LABORATORY	17,003		17,003	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	9,520		9,520	65
66 PHYSICAL THERAPY	34,722		34,722	66
67 OCCUPATIONAL THERAPY	505		505	67
68 SPEECH PATHOLOGY	267		267	68
69 ELECTROCARDIOLOGY	436		436	69
69.10 HEMO DIALYSIS				69.10
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	2,551		2,551	71
73 DRUGS CHARGED TO PATIENTS	26,223		26,223	73
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				92
OTHER REIMBURSABLE COST CENTERS				
99.10 CORF				99.10
99.20 OUTPATIENT PHYSICAL THERAPY				99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40 OUTPATIENT SPEECH PATHOLOGY				99.40
SPECIAL PURPOSE COST CENTERS				
118 SUBTOTALS (SUM OF LINES 1-117)	1,074,999		1,074,999	118
NONREIMBURSABLE COST CENTERS				
194 PHYSICIAN MEALS	1,631		1,631	194
200 CROSS FOOT ADJUSTMENTS				200
201 NEGATIVE COST CENTER				201
202 TOTAL (SUM OF LINES 118-201)	1,076,630		1,076,630	202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	
	1	2	4	5A	5	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	33,528					1
2 CAP REL COSTS-MVBLE EQUIP		33,528				2
4 EMPLOYEE BENEFITS	90	90	2,715,378			4
5 ADMINISTRATIVE & GENERAL	1,455	1,455	692,165	-1,823,356	5,123,122	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	10,731	10,731	115,709		708,964	7
8 LAUNDRY & LINEN SERVICE	308	308			41,374	8
9 HOUSEKEEPING	384	384	93,180		149,962	9
10 DIETARY	1,343	1,343	148,541		279,537	10
11 CAFETERIA	829	829			26,620	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION			179,316		225,243	13
14 CENTRAL SERVICES & SUPPLY	805	805			25,850	14
15 PHARMACY	365	365	167,553		230,434	15
16 MEDICAL RECORDS & LIBRARY	282	282	57,789		82,857	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	15,924	15,924	969,503		1,996,467	30
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC					66,939	54
55 RADIOLOGY-THERAPEUTIC					113,507	55
60 LABORATORY	336	336			10,790	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY			291,622		414,503	65
66 PHYSICAL THERAPY	676	676			77,310	66
67 OCCUPATIONAL THERAPY					54,507	67
68 SPEECH PATHOLOGY					28,835	68
69 ELECTROCARDIOLOGY					47,087	69
69.10 HEMO DIALYSIS						69.10
71 MEDICAL SUPPLIES CHRGED TO PATIENTS					275,367	71
73 DRUGS CHARGED TO PATIENTS					266,969	73
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						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
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)	33,528	33,528	2,715,378	-1,823,356	5,123,122	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	921,279	155,351	659,077		1,823,356	202
203 UNIT COST MULT-WS B PT I	27.477899	4.633471	0.242720		0.355907	203
204 COST TO BE ALLOC PER B PT II			2,890		47,458	204
205 UNIT COST MULT-WS B PT II			0.001064		0.009263	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION	LAUNDRY	HOUSE-	DIETARY	CAFETERIA	
	OF PLANT	& LINEN	KEEPING			
	SQUARE	SERVICE	SQUARE	MEALS	GROSS	
	FEET	POUNDS OF	FEET	SERVED	SALARIES	
	7	LAUNDRY	9	10	11	
		8				
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	20,423					7
8 LAUNDRY & LINEN SERVICE	308	100				8
9 HOUSEKEEPING	384		20,560			9
10 DIETARY	1,343		1,343	13,747		10
11 CAFETERIA			829	583	1,665,783	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION					179,316	13
14 CENTRAL SERVICES & SUPPLY	805		805			14
15 PHARMACY	365		365		167,553	15
16 MEDICAL RECORDS & LIBRARY	282		282		57,789	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	15,924	100	15,924	12,845	969,503	30
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC						54
55 RADIOLOGY-THERAPEUTIC						55
60 LABORATORY	336		336			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY					291,622	65
66 PHYSICAL THERAPY	676		676			66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
69.10 HEMO DIALYSIS						69.10
71 MEDICAL SUPPLIES CHRGED TO PATIENTS						71
73 DRUGS CHARGED TO PATIENTS						73
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						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	20,423	100	20,560	13,428	1,665,783	118
NONREIMBURSABLE COST CENTERS						
194 PHYSICIAN MEALS				319		194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	961,289	70,596	221,409	456,703	64,389	202
203 UNIT COST MULT-WS B PT I	47.068942	705.960000	10.768920	33.222012	0.038654	203
204 COST TO BE ALLOC PER B PT II	351,277	15,571	20,424	70,307	30,673	204
205 UNIT COST MULT-WS B PT II	17.200069	155.710000	0.993385	5.114352	0.018414	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION PATIENT DAYS 13	CENTRAL SERVICES & SUPPLY COSTED REQUIS. 14	PHARMACY COSTED REQUIS. 15	MEDICAL RECORDS & LIBRARY PATIENT DAYS 16	
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					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	3,417				13
14 CENTRAL SERVICES & SUPPLY		100			14
15 PHARMACY			260,605		15
16 MEDICAL RECORDS & LIBRARY				3,417	16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES APPRVD					21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	3,417	100	100	3,417	30
ANCILLARY SERVICE COST CENTERS					
54 RADIOLOGY-DIAGNOSTIC					54
55 RADIOLOGY-THERAPEUTIC					55
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
69 ELECTROCARDIOLOGY					69
69.10 HEMO DIALYSIS					69.10
71 MEDICAL SUPPLIES CHRGED TO PATIENTS					71
73 DRUGS CHARGED TO PATIENTS			260,505		73
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					92
OTHER REIMBURSABLE COST CENTERS					
99.10 CORF					99.10
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)	3,417	100	260,605	3,417	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	312,340	81,609	340,035	130,890	202
203 UNIT COST MULT-WS B PT I	91.407668	816.090000	1.304791	38.305531	203
204 COST TO BE ALLOC PER B PT II	5,579	40,735	23,759	16,079	204
205 UNIT COST MULT-WS B PT II	1.632719	407.350000	0.091169	4.705590	205

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I

COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 26) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
30 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS	4,687,813		4,687,813		4,687,813	30
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC	90,763		90,763		90,763	54
55 RADIOLOGY-THERAPEUTIC	153,905		153,905		153,905	55
60 LABORATORY	34,063		34,063		34,063	60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	573,300		573,300		573,300	65
66 PHYSICAL THERAPY	143,924		143,924		143,924	66
67 OCCUPATIONAL THERAPY	73,906		73,906		73,906	67
68 SPEECH PATHOLOGY	39,098		39,098		39,098	68
69 ELECTROCARDIOLOGY	63,846		63,846		63,846	69
69.10 HEMO DIALYSIS						69.10
71 MEDICAL SUPPLIES CHRGED TO	373,372		373,372		373,372	71
73 DRUGS CHARGED TO PATIENTS	701,890		701,890		701,890	73
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						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THE						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
200 SUBTOTAL (SEE INSTRUCTIONS)	6,935,880		6,935,880		6,935,880	200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	6,935,880		6,935,880		6,935,880	202

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I (CONT)

COST CENTER DESCRIPTION	----- CHARGES -----			COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPATIENT 6	OUTPATIENT 7	TOTAL (COLS. 6 + 7) 8			
30 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS	4,556,708		4,556,708			30
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC	247,664		247,664	0.366476	0.366476	54
55 RADIOLOGY-THERAPEUTIC						55
60 LABORATORY	327,769		327,769	0.103924	0.103924	60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	3,256,087		3,256,087	0.176070	0.176070	65
66 PHYSICAL THERAPY	235,016		235,016	0.612401	0.612401	66
67 OCCUPATIONAL THERAPY	231,353		231,353	0.319451	0.319451	67
68 SPEECH PATHOLOGY	127,599		127,599	0.306413	0.306413	68
69 ELECTROCARDIOLOGY						69
69.10 HEMO DIALYSIS	167,215		167,215			69.10
71 MEDICAL SUPPLIES CHRGED TO	361,369		361,369	1.033215	1.033215	71
73 DRUGS CHARGED TO PATIENTS	2,157,686		2,157,686	0.325298	0.325298	73
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						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THE						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
200 SUBTOTAL (SEE INSTRUCTIONS)	11,668,466		11,668,466			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	11,668,466		11,668,466			202

PROVIDER CCN: 15-2027 VIBRA HOSP FORT WAYNE
 PERIOD FROM 11/01/2011 TO 10/31/2012

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

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

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

COST CENTER DESCRIPTION	CAP-REL COST		REDUCED CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM (COL. 3 + COL. 4)	INPAT PGM DAYS	INPAT PGM CAP COST	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT	(COL. 1 MINUS COL. 2)				(COL. 5 x COL. 6)	
	1	2	3	4	5	6	7	
INPAT ROUTINE SERV COST CTRS								
30 ADULTS & PEDIATRICS	982,101		982,101	3,417	287.42	2,346	674,287	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)	982,101		982,101	3,417		2,346	674,287	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

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

COST CENTER DESCRIPTION	CAP-REL	TOTAL	RATIO OF	INPATIENT	CAPITAL	
	COST	CHARGES	COST TO			
	(FROM WKST	(FROM WKST	CHARGES	PROGRAM	(COL. 3 x	
	B, PT. II,	C, PT. I,	(COL.1 +	CHARGES	COL.4)	
	COL. 26)	COL. 8)	COL.2)			
	1	2	3	4	5	
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC	620	247,664	0.002503	200,862	503	54
55 RADIOLOGY-THERAPEUTIC	1,051					55
60 LABORATORY	17,003	327,769	0.051875	287,132	14,895	60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY	9,520	3,256,087	0.002924	2,178,077	6,369	65
66 PHYSICAL THERAPY	34,722	235,016	0.147743	150,727	22,269	66
67 OCCUPATIONAL THERAPY	505	231,353	0.002183	152,041	332	67
68 SPEECH PATHOLOGY	267	127,599	0.002092	89,269	187	68
69 ELECTROCARDIOLOGY	436					69
69.10 HEMO DIALYSIS						69.10
71 MEDICAL SUPPLIES CHRGED TO PA	2,551	361,369	0.007059	225,632	1,593	71
73 DRUGS CHARGED TO PATIENTS	26,223	2,157,686	0.012153	1,477,716	17,959	73
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						92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)	92,898	6,944,543		4,761,456	64,107	200

PROVIDER CCN: 15-2027 VIBRA HOSP FORT WAYNE
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

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

PROVIDER CCN: 15-2027 VIBRA HOSP FORT WAYNE
PERIOD FROM 11/01/2011 TO 10/31/2012

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IN LIEU OF FORM CMS-2552-10 (08/2011)

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL.5 ÷ COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS	3,417		2,346		30
31 INTENSIVE CARE UNIT					31
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY					43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	3,417		2,346		200

PROVIDER CCN: 15-2027 VIBRA HOSP FORT WAYNE
 PERIOD FROM 11/01/2011 TO 10/31/2012

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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

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

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1			MEDICAL EDUCATION COST 4	COST (SUM OF COLS. 1-4) 5	COST (SUM OF COLS. 2-4) 6
ANCILLARY SERVICE COST CENTERS						
54 RADIOLOGY-DIAGNOSTIC						54
55 RADIOLOGY-THERAPEUTIC						55
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
69.10 HEMO DIALYSIS						69.10
71 MEDICAL SUPPLIES CHRGD TO PA						71
73 DRUGS CHARGED TO PATIENTS						73
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						92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[] TITLE V	[XX] HOSPITAL (15-2027)	[] SUB (OTHER)	[] ICF/MR	[XX] PPS		
APPLICABLE	[XX] TITLE XVIII-PT A	[] IPF	[] SNF		[] TEFRA		
BOXES	[] TITLE XIX	[] IRF	[] NF				
COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13
ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC	247,664		200,862			54
55	RADIOLOGY-THERAPEUTIC						55
60	LABORATORY	327,769		287,132			60
62.30	BLOOD CLOTTING FOR HEMOPHILI						62.30
65	RESPIRATORY THERAPY	3,256,087		2,178,077			65
66	PHYSICAL THERAPY	235,016		150,727			66
67	OCCUPATIONAL THERAPY	231,353		152,041			67
68	SPEECH PATHOLOGY	127,599		89,269			68
69	ELECTROCARDIOLOGY						69
69.10	HEMO DIALYSIS						69.10
71	MEDICAL SUPPLIES CHRGED TO P	361,369		225,632			71
73	DRUGS CHARGED TO PATIENTS	2,157,686		1,477,716			73
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						92
OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)	6,944,543		4,761,456			200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

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

COST CENTER DESCRIPTION	----- PROGRAM CHARGES -----				----- PROGRAM COSTS -----		
	COST TO	PPS	COST REIMB.	COST REIMB.	COST	COST	
	CHARGE RATIO	REIMBURSED	SUBJECT TO	SVCES NOT	SUBJECT TO	SVCES NOT	
	FROM WKST C,	SERVICES	DED & COINS	DED & COINS	PPS	SUBJECT TO	SUBJECT TO
	PT I, COL. 9	2	3	4	5	6	7
	1						
ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC	0.366476					54
55	RADIOLOGY-THERAPEUTIC						55
60	LABORATORY	0.103924					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	0.176070					65
66	PHYSICAL THERAPY	0.612401					66
67	OCCUPATIONAL THERAPY	0.319451					67
68	SPEECH PATHOLOGY	0.306413					68
69	ELECTROCARDIOLOGY						69
69.10	HEMO DIALYSIS						69.10
71	MEDICAL SUPPLIES CHRGD TO PATI	1.033215					71
73	DRUGS CHARGED TO PATIENTS	0.325298					73
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						92
OTHER REIMBURSABLE COST CENTERS							
200	SUBTOTAL (SEE INSTRUCTIONS)						200
201	LESS PBP CLINIC LAB SERVICES						201
202	NET CHARGES (LINE 200 - LINE 201)						202

WORKSHEET D-1
 PART I

COMPUTATION OF INPATIENT OPERATING COST

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	3,417	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,417	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,417	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	2,346	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)	4,687,813	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	4,687,813	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)		28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	4,687,813	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

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

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 1,371.91 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 3,218,501 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) 3,218,501 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5
42 NURSERY (TITLES V AND XIX ONLY)					42

INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS
 43 INTENSIVE CARE UNIT 43
 44 CORONARY CARE UNIT 44
 45 BURN INTENSIVE CARE UNIT 45
 46 SURGICAL INTENSIVE CARE UNIT 46
 47 OTHER SPECIAL CARE (SPECIFY) 47
 48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200) 1,368,997 48
 49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS) 4,587,498 49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 674,287 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 64,107 51
 52 TOTAL PROGRAM EXCLUDABLE COST 738,394 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 3,849,104 53

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

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 + LINE 2) 1,371.91 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 89

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

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

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

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS		3,193,929		30
ANCILLARY SERVICE COST CENTERS				
54 RADIOLOGY-DIAGNOSTIC	0.366476	200,862	73,611	54
55 RADIOLOGY-THERAPEUTIC				55
60 LABORATORY	0.103924	287,132	29,840	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.176070	2,178,077	383,494	65
66 PHYSICAL THERAPY	0.612401	150,727	92,305	66
67 OCCUPATIONAL THERAPY	0.319451	152,041	48,570	67
68 SPEECH PATHOLOGY	0.306413	89,269	27,353	68
69 ELECTROCARDIOLOGY				69
69.10 HEMO DIALYSIS		126,325		69.10
71 MEDICAL SUPPLIES CHRGD TO PATI	1.033215	225,632	233,126	71
73 DRUGS CHARGED TO PATIENTS	0.325298	1,477,716	480,698	73
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				92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		4,887,781	1,368,997	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		4,887,781		202

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

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

INPATIENT
 PART A PART B

DESCRIPTION	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
	1	2	3	4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		3,607,106		1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 .02 .03 .04 .05 .06 .07 .08 .09 .50 .51 PROVIDER .52 TO .53 PROGRAM .54 .55 .56 .57 .58 .59 .99	NONE		3.01 3.02 3.03 3.04 3.05 3.06 3.07 3.08 3.09 3.50 3.51 3.52 3.53 3.54 3.55 3.56 3.57 3.58 3.59 3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)				
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		3,607,106		4

TO BE COMPLETED BY CONTRACTOR

5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01 TO .02 PROVIDER .03 .04 .05 .06 .07 .08 .09 PROVIDER .50 TO .51 PROGRAM .52 .53 .54 .55 .56 .57 .58 .59 .99	NONE		5.01 5.02 5.03 5.04 5.05 5.06 5.07 5.08 5.09 5.50 5.51 5.52 5.53 5.54 5.55 5.56 5.57 5.58 5.59 5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)				
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM TO .01 PROVIDER PROVIDER TO .02 PROGRAM	54,379		6.01 6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		3,661,485		7
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:	NPR DATE:	8

PROVIDER CCN: 15-2027 VIBRA HOSP FORT WAYNE
PERIOD FROM 11/01/2011 TO 10/31/2012

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

VERSION: 2012.11
04/22/2013 16:33

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

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

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	3,417
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	4
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	5
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168	6
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)	7

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)	30
31	OTHER ADJUSTMENTS (SPECIFY)	31
32	BALANCE DUE PROVIDER (LINE 8 MINUS LINE 30 ± LINE 31)	32

PROVIDER CCN: 15-2027 VIBRA HOSP FORT WAYNE
PERIOD FROM 11/01/2011 TO 10/31/2012

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

VERSION: 2012.11
04/22/2013 16:33

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART IV

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

PART IV - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER LTCH PPS

1	NET FEDERAL PPS PAYMENT (SEE INSTRUCTIONS)	3,278,855	1
2	OUTLIER PAYMENTS	569,598	2
3	TOTAL PPS PAYMENTS (SUM OF LINES 1 AND 2)	3,848,453	3
4	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENTS (SEE INSTRUCTIONS)		4
5	ORGAN ACQUISITION		5
6	COST OF TEACHING PHYSICIANS		6
7	SUBTOTAL (SEE INSTRUCTIONS)	3,848,453	7
8	PRIMARY PAYER PAYMENTS		8
9	SUBTOTAL (LINE 7 LESS LINE 8)	3,848,453	9
10	DEDUCTIBLES	4,600	10
11	SUBTOTAL (LINE 9 MINUS LINE 10)	3,843,853	11
12	COINSURANCE	236,748	12
13	SUBTOTAL (LINE 11 MINUS LINE 12)	3,607,105	13
14	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	77,685	14
15	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	54,380	15
16	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		16
17	SUBTOTAL (SUM OF LINES 13 AND 15)	3,661,485	17
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 49) (FOR FREESTANDING LTCH ONLY)		18
19	OTHER PASS THROUGH COSTS (SEE INSTRUCTIONS)		19
20	OUTLIER PAYMENTS RECONCILIATION		20
21	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		21
22	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SEE INSTRUCTIONS)	3,661,485	22
23	INTERIM PAYMENTS	3,607,106	23
24	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		24
25	BALANCE DUE PROVIDER/PROGRAM (LINE 22 MINUS THE SUM OF LINES 23 AND 24)	54,379	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

BALANCE SHEET

WORKSHEET G

ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	1	2	3	4	
CURRENT ASSETS					
1 CASH ON HAND AND IN BANKS					1
2 TEMPORARY INVESTMENTS					2
3 NOTES RECEIVABLE					3
4 ACCOUNTS RECEIVABLE					4
5 OTHER RECEIVABLES					5
6 ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE					6
7 INVENTORY					7
8 PREPAID EXPENSES					8
9 OTHER CURRENT ASSETS					9
10 DUE FROM OTHER FUNDS					10
11 TOTAL CURRENT ASSETS (SUM OF LINES 1-10)					11
FIXED ASSETS					
12 LAND					12
13 LAND IMPROVEMENTS					13
14 ACCUMULATED DEPRECIATION					14
15 BUILDINGS					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					23
24 ACCUMULATED DEPRECIATION					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)					30
OTHER ASSETS					
31 INVESTMENTS					31
32 DEPOSITS ON LEASES					32
33 DUE FROM OWNERS/OFFICERS					33
34 OTHER ASSETS					34
35 TOTAL OTHER ASSETS (SUM OF LINES 31-34)					35
36 TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)					36
LIABILITIES AND FUND BALANCES					
	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	1	2	3	4	
CURRENT LIABILITIES					
37 ACCOUNTS PAYABLE					37
38 SALARIES, WAGES & FEES PAYABLE					38
39 PAYROLL TAXES PAYABLE					39
40 NOTES & LOANS PAYABLE (SHORT TERM)					40
41 DEFERRED INCOME					41
42 ACCELERATED PAYMENTS					42
43 DUE TO OTHER FUNDS					43
44 OTHER CURRENT LIABILITIES					44
45 TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)					45
LONG-TERM LIABILITIES					
46 MORTGAGE PAYABLE					46
47 NOTES PAYABLE					47
48 UNSECURED LOANS					48
49 OTHER LONG TERM LIABILITIES					49
50 TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)					50
51 TOTAL LIABILITIES (SUM OF LINES 45 AND 50)					51
CAPITAL ACCOUNTS					
52 GENERAL FUND BALANCE					52
53 SPECIFIC PURPOSE FUND BALANCE					53
54 DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED					54
55 DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED					55
56 GOVERNING BODY CREATED - ENDOWMENT FUND BAL					56
57 PLANT FUND BALANCE - INVESTED IN PLANT					57
58 PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION					58
59 TOTAL FUND BALANCES (SUM OF LINES 52-58)					59
60 TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)					60

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	1	3	5	7	
	2	4	6	8	
1 FUND BALANCES AT BEGINNING OF PERIOD	-688,509				1
2 NET INCOME (LOSS) (FROM WKST G-3, LINE 29)	1,074,381				2
3 TOTAL (SUM OF LINE 1 AND LINE 2)	385,872				3
4 ADDITIONS (CREDIT ADJUSTMENTS)					4
5					5
6					6
7					7
8					8
9					9
10 TOTAL ADDITIONS (SUM OF LINES 4-9)					10
11 SUBTOTAL (LINE 3 PLUS LINE 10)	385,872				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)	385,872				19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
 PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
1 GENERAL INPATIENT ROUTINE CARE SERVICES				1
2 HOSPITAL	5,598,921		5,598,921	2
3 SUBPROVIDER IPF				3
5 SUBPROVIDER IRF				5
6 SWING BED - SNF				6
7 SWING BED - NF				7
8 SKILLED NURSING FACILITY				8
9 NURSING FACILITY				9
10 OTHER LONG TERM CARE				10
TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	5,598,921		5,598,921	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT				12
13 CORONARY CARE UNIT				13
14 BURN INTENSIVE CARE UNIT				14
15 SURGICAL INTENSIVE CARE UNIT				15
16 OTHER SPECIAL CARE (SPECIFY)				16
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)	5,598,921		5,598,921	17
18 ANCILLARY SERVICES	8,063,805		8,063,805	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 COL. 3 TO WKST G-3, LINE 1)	13,662,726		13,662,726	28

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		6,725,566	29
30 ADD (SPECIFY)			30
31			31
32			32
33			33
34 DEDUCT (SPECIFY)			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)			36
37 DEDUCT (SPECIFY)			37
38			38
39			39
40			40
41			41
42 TOTAL DEDUCTIONS (SUM OF LINES 37-41)			42
43 TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		6,725,566	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	13,662,726	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	5,873,453	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	7,789,273	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	6,725,566	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	1,063,707	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	1,826	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS		14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	604	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	111	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (GRANT)	5,400	24
24.01	OTHER (OTHER)	2,733	24.01
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	10,674	25
26	TOTAL (LINE 5 PLUS LINE 25)	1,074,381	26
27			27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)		28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	1,074,381	29