

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2017 To: 08/31/2018	Run Date: 01/29/2019 Run Time: 14:33 Version: 2018.12 (01/15/2019)
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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 2. ☐ Manually submitted cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted the cost report 4. ☒ Medicare Utilization. Enter 'F' for full or 'L' for low.		Date: 01/29/2019 Time: 14:33
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ____ 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.	

PART II - CERTIFICATION

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by VIBRA HOSPITAL OF SPRINGFIELD (14-2014) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 09/01/2017 and ending 08/31/2018, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

☒ I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Signed) CLINT FEGAN
Chief Financial Officer or Administrator of Provider(s)

CFO
Title

01/29/2019 14:33
Date

PART III - SETTLEMENT SUMMARY

		TITLE XVIII					
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		280,890				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		280,890				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.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**WORKSHEET S-2
PART I**

Hospital and Hospital Health Care Complex Address:

1	Street: 701 NORTH WALNUT STREET	P.O. Box:		1
2	City: SPRINGFIELD	State: IL	ZIP Code: 62702	County: SANGAMON

Hospital and Hospital-Based Component Identification:

								Payment System (P, T, O, or N)		
Component		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	V	XVIII	XIX	
0		1	2	3	4	5	6	7	8	
3	Hospital	VIBRA HOSPITAL OF SPRINGFIELD	14-2014	44100	2	09 / 01 / 2011	N	P	P	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF									7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC									15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 09 / 01 / 2017	To: 08 / 31 / 2018		20
21	Type of control (see instructions)	4			21

Inpatient PPS Information

		1	2	3	
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR §412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	N	N		22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, 'Y' for yes or 'N' for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, 'Y' for yes or 'N' for no.	N	N	N	22.03
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.	2	N		23

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.							24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.							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 is in effect in the cost reporting period.			37
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with the FY 2016 OPSS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)	N		37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**WORKSHEET S-2
PART I**

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40
		V	XVIII	XIX
	Prospective Payment System (PPS)-Capital	1	2	3
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	N	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	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	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	48

		1	2	3	
56	Teaching Hospitals 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 Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
		NAHE 413.85 Y/N 1	Worksheet A Line # 2	Pass-Through Qualification Criteria Code 3	
60	Are you claiming nursing and allied health education (NAHE) costs for any program(s) that meet the criteria under 42 CFR 413.85? (see instructions)	N			60
		Y/N 1	IME 4	Direct GME 5	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.

	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1	2	3	4	

Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the IME FTE unweighted count. Enter in column 4 direct the GME FTE unweighted count.

ACA Provisions Affecting the Health Resources and Services Administration (HRSA)

62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital 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 Nonprovider Settings

63	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64 through 67. (see instructions)	N			63
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PART I**

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

Inpatient Psychiatric Facility PPS

		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	N			70
71	If line 70 is 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, indicate which program year began during this cost reporting period. (see instructions)				71

Inpatient Rehabilitation Facility PPS

		1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.	N			75
76	If line 75 is 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, indicate which program year began during this cost reporting period. (see instructions)				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
81	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no.	N		81

TEFRA Providers

85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no.	N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.			86
87	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter 'Y' for yes and 'N' for no.	N		87

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PART I**

		V	XIX	
Title V and XIX Services		1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92
93	Does this facility operate an ICF/IID 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
98	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.06

Rural Providers

		1	2	
105	Does this hospital qualify as a CAH?	N		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106
107	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. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.			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.	Physical	Occupational Speech	Respiratory
		N	N	109
110	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.		1	N
111	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for additional beds; and/or 'C' for tele-health services.	1	2	111

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 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 Pub. 15-L, chapter 22, section 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
		Premiums	Paid Losses	Self Insurance
118.01	List amounts of malpractice premiums and paid losses:			118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.	N	N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.	N		121
122	Does the cost report contain state health care related taxes as defined in §1983(w)(3) of the Act? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.	N		122

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 in column 2.			126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date in column 2.			127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date in column 2.			128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date in column 2.			129
130	If this is a Medicare certified pancreas transplant center enter the certification date in column 1 and termination date in column 2.			130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date in column 2.			131
132	If this is a Medicare certified islet transplant center enter the certification date in column 1 and termination date in column 2.			132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date in column 2.			133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.			134

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**WORKSHEET S-2
PART I**

All Providers

		1	2	
140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)	Y	399018	140

If this facility is part of a chain organization, enter the name of the home office, the home office contractor name, and home office contractor number on line 141. Enter the address of the home office on lines 142 and 143.

141	Name: VIBRA MANAGEMENT, LLC	Contractor's Name: CGS	Contractor's Number: 15101	141
142	Street: 4600 LENA DRIVE	P.O. Box:		142
143	City: MECHANICSBURG	State: PA	ZIP Code: 17055	143
144	Are provider based physicians' costs included in Worksheet A?	Y		144
145	If costs for renal services are claimed on Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.	Y	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, chapter 40, §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 V	Title XIX	
		Part A	Part B	3	4	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N	N	N	156
157	Subprovider - IRF	N	N	N	N	157
158	Subprovider - Other					158
159	SNF	N	N	N	N	159
160	HHA	N	N	N	N	160
161	CMHC		N	N	N	161
161.10	CORF					161.10

Multicampus

165	Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter 'Y' for yes or 'N' for no.	N				165
166	If line 165 is yes, for each campus, enter the name in column 0, county in column 1, state in column 2, ZIP in column 3, CBSA in column 4, FTE/campus in column 5. (see instructions)					166
	Name	County	State	ZIP Code	CBSA	FTE/Campus
	0	1	2	3	4	5

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

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	N			167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)				168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)				168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. (see instructions)				169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)				170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no in column 1. If column 1 is 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions)	N		0	171

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE**WORKSHEET S-2
PART II**

General Instruction: Enter Y for all YES responses. Enter N for all NO responses.
Enter all dates in the mm/dd/yyyy format.

COMPLETED BY ALL HOSPITALS

		Y/N	Date	
Provider Organization and Operation		1	2	
1	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1
		Y/N	Date	V/I
		1	2	3
2	Has the provider terminated participation in the Medicare program? If yes, enter in column 2 the date of termination and in column 3, 'V' for voluntary or 'I' for involuntary.	N		2
3	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3

		Y/N	Type	Date	
Financial Data and Reports		1	2	3	
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	N			4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N			5

		Y/N	Y/N	
Approved Educational Activities		1	2	
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N		6
7	Are costs claimed for allied health programs? If yes, see instructions.	N		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N		8
9	Are costs claimed for Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	N		9
10	Was an approved Intern and Resident GME 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	
Bad Debts		Y	
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12
13	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	Y	13
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14

		Y/N	
Bed Complement		N	
15	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	01/07/2019	N		16
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N		18
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19
20	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE**WORKSHEET S-2
PART II**

General Instruction: Enter Y for all YES responses. Enter N for all NO responses.
Enter all dates in the mm/dd/yyyy format.

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

Capital Related Cost		
22	Have assets been relifed for Medicare purposes? If yes, see instructions.	22
23	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	23
24	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.	24
25	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	25
26	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	26
27	Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.	27

Interest Expense		
28	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	28
29	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions.	29
30	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	30
31	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	31

Purchased Services		
32	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	32
33	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	33

Provider-Based Physicians		
34	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	34
35	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	35

		Y/N	Date	
Home Office Costs		1	2	
36	Are home office costs claimed on the cost report?			36
37	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37
38	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38
39	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39
40	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40

Cost Report Preparer Contact Information			
41	First name: KIMBERLY	Last name: ROSSEY	Title: DIRECTOR OF REIMBURSEMENT
42	Employer: VIBRA HEALTHCARE		
43	Phone number: 7175915794	E-mail Address: KROSSEY@VIBRAHEALTH.COM	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
**WORKSHEET S-3
PART I**

		Inpatient Days / Outpatient Visits / Trips								
	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	50	18,250			4,860	270	7,130	1
2	HMO and other (see instructions)						454	223		2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF									5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		50	18,250			4,860	270	7,130	7
8	Intensive Care Unit	31								8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	Other Special Care (specify)	35								12
13	Nursery	43								13
14	Total (see instructions)		50	18,250			4,860	270	7,130	14
15	CAH Visits									15
16	Subprovider - IPF	40								16
17	Subprovider - IRF	41								17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44								19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101								22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116								24
24.10	Hospice (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	Total (sum of lines 14-26)		50							27
28	Observation Bed Days									28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)									32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33
33.01	LTCH site neutral days and discharges						1,553			33.01

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA**WORKSHEET S-3
PART I**

	Component	Full Time Equivalents			DISCHARGES				
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					197	14	297	1
2	HMO and other (see instructions)					19	5		2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider								4
5	Hospital Adults & Peds. Swing Bed SNF								5
6	Hospital Adults & Peds. Swing Bed NF								6
7	Total Adults & Peds. (exclude observation beds) (see instructions)								7
8	Intensive Care Unit								8
9	Coronary Care Unit								9
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
12	Other Special Care (specify)								12
13	Nursery								13
14	Total (see instructions)		103.73			197	14	297	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency								22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	Total (sum of lines 14-26)		103.73						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32.01
33	LTCH non-covered days								33
33.01	LTCH site neutral days and discharges					69			33.01

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HOSPITAL WAGE INDEX INFORMATION**WORKSHEET S-3
PARTS II-III****Part II - Wage Data**

		Wkst A Line No.	Amount Reported	Reclassif- ication of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)	
		1	2	3	4	5	6	
	SALARIES							
1	Total salaries (see instructions)	200	7,479,650			230,744.00		1
2	Non-physician anesthetist Part A							2
3	Non-physician anesthetest Part B							3
4	Physician-Part A - Administrative							4
4.01	Physician-Part A - Teaching							4.01
5	Physician-Part B							5
6	Non-physician-Part B							6
7	Interns & residents (in an approved program)	21						7
7.01	Contracted interns & residents (in an approved program)							7.01
8	Home office and/or related organization personnel							8
9	SNF	44						9
10	Excluded area salaries (see instructions)							10
	OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)							11
12	Contract management and administrative services							12
13	Contract labor: Physician-Part A - Administrative							13
14	Home office salaries & wage-related costs							14
14.01	Home office salaries							14.01
14.02	Related organization salaries							14.02
15	Home office: Physician Part A - Administrative							15
16	Home office & Contract Physicians Part A - Teaching							16
	WAGE-RELATED COSTS							
17	Wage-related costs (core)(see instructions)							17
18	Wage-related costs (other)(see instructions)							18
19	Excluded areas							19
20	Non-physician anesthetist Part A							20
21	Non-physician anesthetist Part B							21
22	Physician Part A - Administrative							22
22.01	Physician Part A - Teaching							22.01
23	Physician Part B							23
24	Wage-related costs (RHC/FQHC)							24
25	Interns & residents (in an approved program)							25
25.50	Home office wage-related							25.50
25.51	Related organization wage-related							25.51
25.52	Home office: Physician Part A - Administrative - wage-related							25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related							25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26	Employee Benefits Department		73,318					26
27	Administrative & General		1,123,475					27
28	Administrative & General under contract (see instructions)							28
29	Maintenance & Repairs							29
30	Operation of Plant		247,547					30
31	Laundry & Linen Service							31
32	Housekeeping		88,429					32
33	Housekeeping under contract (see instructions)							33
34	Dietary		149,539					34
35	Dietary under contract (see instructions)							35
36	Cafeteria							36
37	Maintenance of Personnel							37
38	Nursing Administration		246,327					38
39	Central Services and Supply							39
40	Pharmacy		377,953					40
41	Medical Records & Medical Records Library		103,319					41
42	Social Service							42
43	Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		7,479,650		7,479,650	230,744.00	32.42	1
2	Excluded area salaries (see instructions)							2
3	Subtotal salaries (line 1 minus line 2)		7,479,650		7,479,650	230,744.00	32.42	3
4	Subtotal other wages & related costs (see instructions)							4
5	Subtotal wage-related costs (see instructions)							5
6	Total (sum of lines 3 through 5)		7,479,650		7,479,650	230,744.00	32.42	6
7	Total overhead cost (see instructions)		2,409,907		2,409,907			7

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HOSPITAL WAGE RELATED COSTS**WORKSHEET S-3****Part IV - Wage Related Cost****PART IV****Part A - Core List**

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions		1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Nonqualified Defined Benefit Plan Cost (see instructions)		3
4	Qualified Defined Benefit Plan Cost (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA Plan Administration Fees		5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees		7
	HEALTH AND INSURANCE COST		
8	Health Insurance (Purchased or Self Funded)		8
8.01	Health Insurance (Self Funded without a Third Party Administrator)		8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		8.02
8.03	Health Insurance (Purchased)		8.03
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan		10
11	Life Insurance (If employee is owner or beneficiary)		11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)		13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance		15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-Employers Portion Only		17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance		19
20	State or Federal Unemployment Taxes		20
	OTHER		
21	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	Day Care Costs and Allowances		22
23	Tuition Reimbursement		23
24	Total Wage Related cost (Sum of lines 1-23)		24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)		25
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HOSPITAL CONTRACT LABOR AND BENEFIT COST**WORKSHEET S-3****Part V - Contract Labor and Benefit Cost****PART V****Hospital and Hospital-Based Component Identification:**

	Component	Contract Labor	Benefit Cost	
	0	1	2	
1	Total facility contract labor and benefit cost			1
2	Hospital			2
3	Subprovider - IPF			3
4	Subprovider - IRF			4
5	Subprovider - (OTHER)			5
6	Swing Beds - SNF			6
7	Swing Beds - NF			7
8	Hospital-Based SNF			8
9	Hospital-Based NF			9
10	Hospital-Based OLTC			10
11	Hospital-Based HHA			11
12	Separately Certified ASC			12
13	Hospital-Based Hospice			13
14	Hospital-Based Health Clinic - RHC			14
15	Hospital-Based Health Clinic - FQHC			15
16	Hospital-Based - CMHC			16
17	Renal Dialysis			17
18	Other			18

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VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2017 To: 08/31/2018	Run Date: 01/29/2019 Run Time: 14:33 Version: 2018.12 (01/15/2019)
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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt		1,444,423	1,444,423		1,444,423		1,444,423	1
2	00200	Cap Rel Costs-Mvble Equip		183,691	183,691		183,691		183,691	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	73,318	1,393,550	1,466,868		1,466,868		1,466,868	4
5	00500	Administrative & General	1,123,475	826,690	1,950,165		1,950,165	808,611	2,758,776	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	247,547	539,017	786,564		786,564		786,564	7
8	00800	Laundry & Linen Service		98,915	98,915		98,915		98,915	8
9	00900	Housekeeping	88,429	35,607	124,036		124,036		124,036	9
10	01000	Dietary	149,539	218,190	367,729		367,729	-39,339	328,390	10
11	01100	Cafeteria								11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	246,327	17,322	263,649		263,649		263,649	13
14	01400	Central Services & Supply		370,728	370,728		370,728		370,728	14
15	01500	Pharmacy	377,953	42,020	419,973		419,973		419,973	15
16	01600	Medical Records & Library	103,319	15,906	119,225		119,225	-6,529	112,696	16
17	01700	Social Service								17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	4,144,722	1,511,069	5,655,791		5,655,791	-1,657,359	3,998,432	30
		ANCILLARY SERVICE COST CENTERS								
54	05400	Radiology-Diagnostic	104,595	42,204	146,799		146,799		146,799	54
60	06000	Laboratory	3,717	253,195	256,912		256,912		256,912	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	665,962	102,068	768,030		768,030		768,030	65
66	06600	Physical Therapy		127,321	127,321		127,321		127,321	66
67	06700	Occupational Therapy		155,439	155,439		155,439		155,439	67
68	06800	Speech Pathology		65,915	65,915		65,915		65,915	68
71	07100	Medical Supplies Charged to Patients		162,029	162,029		162,029		162,029	71
73	07300	Drugs Charged to Patients		631,277	631,277		631,277		631,277	73
74	07400	Renal Dialysis	150,747	1,902	152,649		152,649		152,649	74
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	7,479,650	8,238,478	15,718,128		15,718,128	-894,616	14,823,512	118
		NONREIMBURSABLE COST CENTERS								
194	07950	NONALLOWABLE CASE MANAGER								194
194.01	07951	IDLE SPACE								194.01
194.02	07952	REGIONAL OFFICE								194.02
194.03	07953	DISTRICT OFFICE								194.03
194.04	07954	NON MCR CERTIFIED UNIT								194.04
194.05	07955	REG NURSG OFFICE								194.05
194.06	07956	DATA CTR SUBLEASE (XODIAC)								194.06
194.07	07957	OTHER NONREIMBURSABLE - OPEN								194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN								194.08
194.09	07958	VISITOR MEALS								194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS								194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATIO								194.11
200		TOTAL (sum of lines 118-199)	7,479,650	8,238,478	15,718,128		15,718,128	-894,616	14,823,512	200

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RECLASSIFICATIONS

WORKSHEET A-6

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

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

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RECLASSIFICATIONS

WORKSHEET A-6

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

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

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RECONCILIATION OF CAPITAL COST CENTERS**WORKSHEET A-7
PARTS I, II & III****PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES**

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
			Purchases	Donation	Total				
		1	2	3	4	5	6	7	
1	Land								1
2	Land Improvements	3,180	21,536		21,536		24,716		2
3	Buildings and Fixtures								3
4	Building Improvements	1,278	3,994		3,994		5,272		4
5	Fixed Equipment								5
6	Movable Equipment	247,759	59,154		59,154		306,913		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	252,217	84,684		84,684		336,901		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	252,217	84,684		84,684		336,901		10

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

	Description	SUMMARY OF CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		9	10	11	12	13	14	15	
*									
1	Cap Rel Costs-Bldg & Fixt		1,216,423			228,000		1,444,423	1
2	Cap Rel Costs-Mvble Equip	61,610	122,081					183,691	2
3	Total (sum of lines 1-2)	61,610	1,338,504			228,000		1,628,114	3

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may have been included in Worksheet A, column 2, lines 1 and 2.

* All lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
		1	2	3	4	5	6	7	8	
*										
1	Cap Rel Costs-Bldg & Fi	29,988	29,988		0.000000					1
2	Cap Rel Costs-Mvble Equip	306,913	38,246	268,667	1.000000					2
3	Total (sum of lines 1-2)	336,901	68,234	268,667	1.000000					3

	Description	SUMMARY OF CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		9	10	11	12	13	14	15	
*									
1	Cap Rel Costs-Bldg & Fixt		1,216,423			228,000		1,444,423	1
2	Cap Rel Costs-Mvble Equip	61,610	122,081					183,691	2
3	Total (sum of lines 1-2)	61,610	1,338,504			228,000		1,628,114	3

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

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ADJUSTMENTS TO EXPENSES
WORKSHEET A-8

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		Wkst. A-7 Ref.	
				COST CENTER	LINE#		
		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)						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	-1,657,359				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1	1,014,416				12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-39,339	Dietary	10		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	B	-6,529	Medical Records & Library	16		18
19	Nursing and allied health education (tuition, fees, books, etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)	B	-69,249	Administrative & General	5		21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation						32
33	BANK CHARGES & FEES	A	-139	Administrative & General	5		33
34	BAD DEBT EXPENSE	A	-77,303	Administrative & General	5		34
35	MARKETING NON-ALLOW	A	-32,040	Administrative & General	5		35
36	OTHER OPERATING INCOME	B	-27,074	Administrative & General	5		36
37							37
38							38
39							39
40							40
41							41
42							42
43							43
44							44
45							45
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-894,616				50

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1

(2) Basis for adjustment (see instructions)

A. Costs - if cost, including applicable overhead, can be determined

B. Amount Received - if cost cannot be determined

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

KPMG LLP Compu-Max 2552-10

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

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1	5	Administrative & General	HOME OFFICE COSTS	1,250,816	236,400	1,014,416		1
2								2
3								3
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12			1,250,816	236,400	1,014,416		5

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

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

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office			
	1	2	3	Name	Percentage of Ownership	Type of Business	
6	B		100.00	ADMIN & GEN	100.00	HOME OFFICE COST	6
7							7
8							8
9							9
10							10

- (1) Use the following symbols to indicate the interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.

E. Individual is director, officer, administrator, or key person of provider and related organization.

F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

G. Other (financial Or non-financial) specify:

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun- eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	30	Adults & Pediatrics HOSPITALIST 779	1,625,313	1,625,313		206,300				1
2	30	Adults & Pediatrics PHYS ADMIN 779	79,852		79,852	206,300	482	47,806	2,390	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	1,705,165	1,625,313	79,852		482	47,806	2,390	200

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2017 To: 08/31/2018	Run Date: 01/29/2019 Run Time: 14:33 Version: 2018.12 (01/15/2019)
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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	30	Adults & Pediatrics HOSPITALIST 779							1,625,313	1
2	30	Adults & Pediatrics PHYS ADMIN 779					47,806	32,046	32,046	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL					47,806	32,046	1,657,359	200

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VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2017 To: 08/31/2018	Run Date: 01/29/2019 Run Time: 14:33 Version: 2018.12 (01/15/2019)
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COST ALLOCATION - GENERAL SERVICE COSTS
**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVEABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS- TRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	1,444,423	1,444,423					1
2	Cap Rel Costs-Mvble Equip	183,691		183,691				2
4	Employee Benefits Department	1,466,868	5,321	677	1,472,866			4
5	Administrative & General	2,758,776	127,437	16,206	223,421	3,125,840	3,125,840	5
6	Maintenance & Repairs							6
7	Operation of Plant	786,564	265,058	33,708	49,229	1,134,559	303,176	7
8	Laundry & Linen Service	98,915	32,157	4,090		135,162	36,118	8
9	Housekeeping	124,036	23,946	3,045	17,586	168,613	45,057	9
10	Dietary	328,390	143,906	18,301	29,738	520,335	139,043	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	263,649	21,239	2,701	48,986	336,575	89,939	13
14	Central Services & Supply	370,728	91,564	11,644		473,936	126,645	14
15	Pharmacy	419,973	45,186	5,746	75,162	546,067	145,919	15
16	Medical Records & Library	112,696	16,652	2,118	20,547	152,013	40,621	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	3,998,432	568,145	72,253	824,243	5,463,073	1,459,837	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	146,799	9,266	1,178	20,800	178,043	47,576	54
60	Laboratory	256,912	3,991	508	739	262,150	70,051	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	768,030	20,047	2,549	132,437	923,063	246,660	65
66	Physical Therapy	127,321	40,644	5,169		173,134	46,265	66
67	Occupational Therapy	155,439				155,439	41,536	67
68	Speech Pathology	65,915				65,915	17,614	68
71	Medical Supplies Charged to Patients	162,029				162,029	43,297	71
73	Drugs Charged to Patients	631,277				631,277	168,689	73
74	Renal Dialysis	152,649	29,864	3,798	29,978	216,289	57,797	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	14,823,512	1,444,423	183,691	1,472,866	14,823,512	3,125,840	118
	NONREIMBURSABLE COST CENTERS							
194	NONALLOWABLE CASE MANAGER							194
194.01	IDLE SPACE							194.01
194.02	REGIONAL OFFICE							194.02
194.03	DISTRICT OFFICE							194.03
194.04	NON MCR CERTIFIED UNIT							194.04
194.05	REG NURSG OFFICE							194.05
194.06	DATA CTR SUBLEASE (XODIAC)							194.06
194.07	OTHER NONREIMBURSABLE - OPEN							194.07
194.08	OTHER NONREIMBURSABLE - OPEN							194.08
194.09	VISITOR MEALS							194.09
194.10	OTHER NONREIMBURSABLE COST CENTERS							194.10
194.11	NONREIMB NEW BUSINESS IMPLEMENTATIO							194.11
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	14,823,512	1,444,423	183,691	1,472,866	14,823,512	3,125,840	202

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

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	
		7	8	9	10	13	14	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	1,437,735						7
8	Laundry & Linen Service	44,175	215,455					8
9	Housekeeping	32,895		246,565				9
10	Dietary	197,685		35,822	892,885			10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	29,177		5,287		460,978		13
14	Central Services & Supply	125,782		22,793			749,156	14
15	Pharmacy	62,072		11,248				15
16	Medical Records & Library	22,875		4,145				16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	780,468	215,455	141,429	892,885	460,978	473,670	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	12,729		2,307				54
60	Laboratory	5,482		993				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	27,538		4,990				65
66	Physical Therapy	55,833		10,117				66
67	Occupational Therapy							67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients						275,486	71
73	Drugs Charged to Patients							73
74	Renal Dialysis	41,024		7,434				74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,437,735	215,455	246,565	892,885	460,978	749,156	118
	NONREIMBURSABLE COST CENTERS							
194	NONALLOWABLE CASE MANAGER							194
194.01	IDLE SPACE							194.01
194.02	REGIONAL OFFICE							194.02
194.03	DISTRICT OFFICE							194.03
194.04	NON MCR CERTIFIED UNIT							194.04
194.05	REG NURSG OFFICE							194.05
194.06	DATA CTR SUBLEASE (XODIAC)							194.06
194.07	OTHER NONREIMBURSABLE - OPEN							194.07
194.08	OTHER NONREIMBURSABLE - OPEN							194.08
194.09	VISITOR MEALS							194.09
194.10	OTHER NONREIMBURSABLE COST CENTERS							194.10
194.11	NONREIMB NEW BUSINESS IMPLEMENTATIO							194.11
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,437,735	215,455	246,565	892,885	460,978	749,156	202

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VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2017 To: 08/31/2018	Run Date: 01/29/2019 Run Time: 14:33 Version: 2018.12 (01/15/2019)
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COST ALLOCATION - GENERAL SERVICE COSTS
**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL	
		15	16	24	25	26	
	GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5	Administrative & General						5
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy	765,306					15
16	Medical Records & Library		219,654				16
17	Social Service						17
19	Nonphysician Anesthetists						19
20	Nursing School						20
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
23	Paramed Ed Prgm-(specify)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	Adults & Pediatrics		120,256	10,008,051		10,008,051	30
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic		2,621	243,276		243,276	54
60	Laboratory		10,767	349,443		349,443	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy		20,499	1,222,750		1,222,750	65
66	Physical Therapy		3,602	288,951		288,951	66
67	Occupational Therapy		4,624	201,599		201,599	67
68	Speech Pathology		1,961	85,490		85,490	68
71	Medical Supplies Charged to Patients		4,685	485,497		485,497	71
73	Drugs Charged to Patients	765,306	46,855	1,612,127		1,612,127	73
74	Renal Dialysis		3,784	326,328		326,328	74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)	765,306	219,654	14,823,512		14,823,512	118
	NONREIMBURSABLE COST CENTERS						
194	NONALLOWABLE CASE MANAGER						194
194.01	IDLE SPACE						194.01
194.02	REGIONAL OFFICE						194.02
194.03	DISTRICT OFFICE						194.03
194.04	NON MCR CERTIFIED UNIT						194.04
194.05	REG NURSG OFFICE						194.05
194.06	DATA CTR SUBLEASE (XODIAC)						194.06
194.07	OTHER NONREIMBURSABLE - OPEN						194.07
194.08	OTHER NONREIMBURSABLE - OPEN						194.08
194.09	VISITOR MEALS						194.09
194.10	OTHER NONREIMBURSABLE COST CENTERS						194.10
194.11	NONREIMB NEW BUSINESS IMPLEMENTATIO						194.11
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	765,306	219,654	14,823,512		14,823,512	202

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VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2017 To: 08/31/2018	Run Date: 01/29/2019 Run Time: 14:33 Version: 2018.12 (01/15/2019)
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ALLOCATION OF CAPITAL-RELATED COSTS**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVEABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS- TRATIVE & GENERAL	
		0	1	2	2A	4	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department		5,321	677	5,998	5,998		4
5	Administrative & General		127,437	16,206	143,643	910	144,553	5
6	Maintenance & Repairs							6
7	Operation of Plant		265,058	33,708	298,766	201	14,020	7
8	Laundry & Linen Service		32,157	4,090	36,247		1,670	8
9	Housekeeping		23,946	3,045	26,991	72	2,084	9
10	Dietary		143,906	18,301	162,207	121	6,430	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration		21,239	2,701	23,940	200	4,159	13
14	Central Services & Supply		91,564	11,644	103,208		5,856	14
15	Pharmacy		45,186	5,746	50,932	306	6,748	15
16	Medical Records & Library		16,652	2,118	18,770	84	1,878	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		568,145	72,253	640,398	3,355	67,512	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic		9,266	1,178	10,444	85	2,200	54
60	Laboratory		3,991	508	4,499	3	3,239	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		20,047	2,549	22,596	539	11,406	65
66	Physical Therapy		40,644	5,169	45,813		2,139	66
67	Occupational Therapy						1,921	67
68	Speech Pathology						815	68
71	Medical Supplies Charged to Patients						2,002	71
73	Drugs Charged to Patients						7,801	73
74	Renal Dialysis		29,864	3,798	33,662	122	2,673	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)		1,444,423	183,691	1,628,114	5,998	144,553	118
	NONREIMBURSABLE COST CENTERS							
194	NONALLOWABLE CASE MANAGER							194
194.01	IDLE SPACE							194.01
194.02	REGIONAL OFFICE							194.02
194.03	DISTRICT OFFICE							194.03
194.04	NON MCR CERTIFIED UNIT							194.04
194.05	REG NURSG OFFICE							194.05
194.06	DATA CTR SUBLEASE (XODIAC)							194.06
194.07	OTHER NONREIMBURSABLE - OPEN							194.07
194.08	OTHER NONREIMBURSABLE - OPEN							194.08
194.09	VISITOR MEALS							194.09
194.10	OTHER NONREIMBURSABLE COST CENTERS							194.10
194.11	NONREIMB NEW BUSINESS IMPLEMENTATIO							194.11
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		1,444,423	183,691	1,628,114	5,998	144,553	202

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2017 To: 08/31/2018	Run Date: 01/29/2019 Run Time: 14:33 Version: 2018.12 (01/15/2019)
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ALLOCATION OF CAPITAL-RELATED COSTS**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	
		7	8	9	10	13	14	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	312,987						7
8	Laundry & Linen Service	9,617	47,534					8
9	Housekeeping	7,161		36,308				9
10	Dietary	43,035		5,275	217,068			10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	6,352		779		35,430		13
14	Central Services & Supply	27,382		3,356			139,802	14
15	Pharmacy	13,513		1,656				15
16	Medical Records & Library	4,980		610				16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	169,901	47,534	20,826	217,068	35,430	88,393	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	2,771		340				54
60	Laboratory	1,194		146				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	5,995		735				65
66	Physical Therapy	12,155		1,490				66
67	Occupational Therapy							67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients						51,409	71
73	Drugs Charged to Patients							73
74	Renal Dialysis	8,931		1,095				74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	312,987	47,534	36,308	217,068	35,430	139,802	118
	NONREIMBURSABLE COST CENTERS							
194	NONALLOWABLE CASE MANAGER							194
194.01	IDLE SPACE							194.01
194.02	REGIONAL OFFICE							194.02
194.03	DISTRICT OFFICE							194.03
194.04	NON MCR CERTIFIED UNIT							194.04
194.05	REG NURSG OFFICE							194.05
194.06	DATA CTR SUBLEASE (XODIAC)							194.06
194.07	OTHER NONREIMBURSABLE - OPEN							194.07
194.08	OTHER NONREIMBURSABLE - OPEN							194.08
194.09	VISITOR MEALS							194.09
194.10	OTHER NONREIMBURSABLE COST CENTERS							194.10
194.11	NONREIMB NEW BUSINESS IMPLEMENTATIO							194.11
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	312,987	47,534	36,308	217,068	35,430	139,802	202

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2017 To: 08/31/2018	Run Date: 01/29/2019 Run Time: 14:33 Version: 2018.12 (01/15/2019)
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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B PART II

	COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL		
		15	16	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy	73,155						15
16	Medical Records & Library		26,322					16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		14,412	1,304,829		1,304,829		30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic		314	16,154		16,154		54
60	Laboratory		1,290	10,371		10,371		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		2,456	43,727		43,727		65
66	Physical Therapy		432	62,029		62,029		66
67	Occupational Therapy		554	2,475		2,475		67
68	Speech Pathology		235	1,050		1,050		68
71	Medical Supplies Charged to Patients		561	53,972		53,972		71
73	Drugs Charged to Patients	73,155	5,615	86,571		86,571		73
74	Renal Dialysis		453	46,936		46,936		74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	73,155	26,322	1,628,114		1,628,114		118
	NONREIMBURSABLE COST CENTERS							
194	NONALLOWABLE CASE MANAGER							194
194.01	IDLE SPACE							194.01
194.02	REGIONAL OFFICE							194.02
194.03	DISTRICT OFFICE							194.03
194.04	NON MCR CERTIFIED UNIT							194.04
194.05	REG NURSG OFFICE							194.05
194.06	DATA CTR SUBLEASE (XODIAC)							194.06
194.07	OTHER NONREIMBURSABLE - OPEN							194.07
194.08	OTHER NONREIMBURSABLE - OPEN							194.08
194.09	VISITOR MEALS							194.09
194.10	OTHER NONREIMBURSABLE COST CENTERS							194.10
194.11	NONREIMB NEW BUSINESS IMPLEMENTATIO							194.11
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	73,155	26,322	1,628,114		1,628,114		202

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VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2017 To: 08/31/2018	Run Date: 01/29/2019 Run Time: 14:33 Version: 2018.12 (01/15/2019)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEE T #1	CAP MOVEABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	31,487						1
2	Cap Rel Costs-Mvble Equip		31,487					2
4	Employee Benefits Department	116	116	7,406,332				4
5	Administrative & General	2,778	2,778	1,123,475	-3,125,840	11,697,672		5
6	Maintenance & Repairs							6
7	Operation of Plant	5,778	5,778	247,547		1,134,559	22,815	7
8	Laundry & Linen Service	701	701			135,162	701	8
9	Housekeeping	522	522	88,429		168,613	522	9
10	Dietary	3,137	3,137	149,539		520,335	3,137	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	463	463	246,327		336,575	463	13
14	Central Services & Supply	1,996	1,996			473,936	1,996	14
15	Pharmacy	985	985	377,953		546,067	985	15
16	Medical Records & Library	363	363	103,319		152,013	363	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	12,385	12,385	4,144,722		5,463,073	12,385	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	202	202	104,595		178,043	202	54
60	Laboratory	87	87	3,717		262,150	87	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	437	437	665,962		923,063	437	65
66	Physical Therapy	886	886			173,134	886	66
67	Occupational Therapy					155,439		67
68	Speech Pathology					65,915		68
71	Medical Supplies Charged to Patients					162,029		71
73	Drugs Charged to Patients					631,277		73
74	Renal Dialysis	651	651	150,747		216,289	651	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	31,487	31,487	7,406,332	-3,125,840	11,697,672	22,815	118
	NONREIMBURSABLE COST CENTERS							
194	NONALLOWABLE CASE MANAGER							194
194.01	IDLE SPACE							194.01
194.02	REGIONAL OFFICE							194.02
194.03	DISTRICT OFFICE							194.03
194.04	NON MCR CERTIFIED UNIT							194.04
194.05	REG NURSG OFFICE							194.05
194.06	DATA CTR SUBLEASE (XODIAC)							194.06
194.07	OTHER NONREIMBURSABLE - OPEN							194.07
194.08	OTHER NONREIMBURSABLE - OPEN							194.08
194.09	VISITOR MEALS							194.09
194.10	OTHER NONREIMBURSABLE COST CENTERS							194.10
194.11	NONREIMB NEW BUSINESS IMPLEMENTATIO							194.11
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,444,423	183,691	1,472,866		3,125,840	1,437,735	202
203	Unit Cost Multiplier (Wkst. B, Part I)	45.873630	5.833868	0.198866		0.267219	63.017094	203
204	Cost to be allocated (Per Wkst. B, Part II)			5,998		144,553	312,987	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000810		0.012357	13.718475	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE PATIENT DAYS	HOUSE- KEEPING SQUARE FEET	DIETARY PATIENT DAYS	NURSING ADMINIS- TRATION NURSING FT ES	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUIS.	
		8	9	10	13	14	15	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	7,130						8
9	Housekeeping		21,592					9
10	Dietary		3,137	7,130				10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration		463		30			13
14	Central Services & Supply		1,996			440,621		14
15	Pharmacy		985				631,277	15
16	Medical Records & Library		363					16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	7,130	12,385	7,130	30	278,592		30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic		202					54
60	Laboratory		87					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		437					65
66	Physical Therapy		886					66
67	Occupational Therapy							67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients					162,029		71
73	Drugs Charged to Patients						631,277	73
74	Renal Dialysis		651					74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	7,130	21,592	7,130	30	440,621	631,277	118
	NONREIMBURSABLE COST CENTERS							
194	NONALLOWABLE CASE MANAGER							194
194.01	IDLE SPACE							194.01
194.02	REGIONAL OFFICE							194.02
194.03	DISTRICT OFFICE							194.03
194.04	NON MCR CERTIFIED UNIT							194.04
194.05	REG NURSG OFFICE							194.05
194.06	DATA CTR SUBLEASE (XODIAC)							194.06
194.07	OTHER NONREIMBURSABLE - OPEN							194.07
194.08	OTHER NONREIMBURSABLE - OPEN							194.08
194.09	VISITOR MEALS							194.09
194.10	OTHER NONREIMBURSABLE COST CENTERS							194.10
194.11	NONREIMB NEW BUSINESS IMPLEMENTATIO							194.11
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	215,455	246,565	892,885	460,978	749,156	765,306	202
203	Unit Cost Multiplier (Wkst. B, Part I)	30.218093	11.419276	125.229313	15,365.933333	1.700228	1.212314	203
204	Cost to be allocated (Per Wkst. B, Part II)	47,534	36,308	217,068	35,430	139,802	73,155	204
205	Unit Cost Multiplier (Wkst. B, Part II)	6.666760	1.681549	30.444320	1,181.000000	0.317284	0.115884	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY GROSS REVENUE						
		16						

	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	38,649,941						16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	21,159,366						30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	461,206						54
60	Laboratory	1,894,592						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	3,607,117						65
66	Physical Therapy	633,865						66
67	Occupational Therapy	813,683						67
68	Speech Pathology	345,086						68
71	Medical Supplies Charged to Patients	824,439						71
73	Drugs Charged to Patients	8,244,729						73
74	Renal Dialysis	665,858						74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	38,649,941						118
	NONREIMBURSABLE COST CENTERS							
194	NONALLOWABLE CASE MANAGER							194
194.01	IDLE SPACE							194.01
194.02	REGIONAL OFFICE							194.02
194.03	DISTRICT OFFICE							194.03
194.04	NON MCR CERTIFIED UNIT							194.04
194.05	REG NURSG OFFICE							194.05
194.06	DATA CTR SUBLEASE (XODIAC)							194.06
194.07	OTHER NONREIMBURSABLE - OPEN							194.07
194.08	OTHER NONREIMBURSABLE - OPEN							194.08
194.09	VISITOR MEALS							194.09
194.10	OTHER NONREIMBURSABLE COST CENTERS							194.10
194.11	NONREIMB NEW BUSINESS IMPLEMENTATIO							194.11
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	219,654						202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.005683						203
204	Cost to be allocated (Per Wkst. B, Part II)	26,322						204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.000681						205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2017 To: 08/31/2018	Run Date: 01/29/2019 Run Time: 14:33 Version: 2018.12 (01/15/2019)
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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

		WORKSHEET			
	DESCRIPTION	CODE	LINE NO.	AMOUNT	
	1	2	3	4	

KPMG LLP Compu-Max 2552-10

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COMPUTATION OF RATIO OF COST TO CHARGES
**WORKSHEET C
PART I**

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	10,008,051		10,008,051	32,046	10,040,097	30
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	243,276		243,276		243,276	54
60	Laboratory	349,443		349,443		349,443	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	1,222,750		1,222,750		1,222,750	65
66	Physical Therapy	288,951		288,951		288,951	66
67	Occupational Therapy	201,599		201,599		201,599	67
68	Speech Pathology	85,490		85,490		85,490	68
71	Medical Supplies Charged to Patients	485,497		485,497		485,497	71
73	Drugs Charged to Patients	1,612,127		1,612,127		1,612,127	73
74	Renal Dialysis	326,328		326,328		326,328	74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
200	Subtotal (sum of lines 30 thru 199)	14,823,512		14,823,512	32,046	14,855,558	200
201	Less Observation Beds						201
202	Total (line 200 minus line 201)	14,823,512		14,823,512		14,855,558	202

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2017 To: 08/31/2018	Run Date: 01/29/2019 Run Time: 14:33 Version: 2018.12 (01/15/2019)
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COMPUTATION OF RATIO OF COST TO CHARGES**WORKSHEET C
PART I**

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	21,159,366		21,159,366				30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	461,206		461,206	0.527478	0.527478	0.527478	54
60	Laboratory	1,894,592		1,894,592	0.184442	0.184442	0.184442	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	3,607,117		3,607,117	0.338983	0.338983	0.338983	65
66	Physical Therapy	633,865		633,865	0.455856	0.455856	0.455856	66
67	Occupational Therapy	813,683		813,683	0.247761	0.247761	0.247761	67
68	Speech Pathology	345,086		345,086	0.247735	0.247735	0.247735	68
71	Medical Supplies Charged to Patients	824,439		824,439	0.588882	0.588882	0.588882	71
73	Drugs Charged to Patients	8,244,729		8,244,729	0.195534	0.195534	0.195534	73
74	Renal Dialysis	665,858		665,858	0.490086	0.490086	0.490086	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (sum of lines 30 thru 199)	38,649,941		38,649,941				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	38,649,941		38,649,941				202

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2017 To: 08/31/2018	Run Date: 01/29/2019 Run Time: 14:33 Version: 2018.12 (01/15/2019)
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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)
**WORKSHEET C
PART I**

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (B Part I col 26 plus sum of cols 21 & 22)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	10,008,051		10,008,051		10,008,051	30
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	243,276		243,276		243,276	54
60	Laboratory	349,443		349,443		349,443	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	1,222,750		1,222,750		1,222,750	65
66	Physical Therapy	288,951		288,951		288,951	66
67	Occupational Therapy	201,599		201,599		201,599	67
68	Speech Pathology	85,490		85,490		85,490	68
71	Medical Supplies Charged to Patients	485,497		485,497		485,497	71
73	Drugs Charged to Patients	1,612,127		1,612,127		1,612,127	73
74	Renal Dialysis	326,328		326,328		326,328	74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
200	Subtotal (sum of lines 30 thru 199)	14,823,512		14,823,512		14,823,512	200
201	Less Observation Beds						201
202	Total (line 200 minus line 201)	14,823,512		14,823,512		14,823,512	202

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2017 To: 08/31/2018	Run Date: 01/29/2019 Run Time: 14:33 Version: 2018.12 (01/15/2019)
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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)**WORKSHEET C
PART I**

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic							54
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (sum of lines 30 thru 199)							200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)							202

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2017 To: 08/31/2018	Run Date: 01/29/2019 Run Time: 14:33 Version: 2018.12 (01/15/2019)
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CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY**WORKSHEET C
PART II****[] Title V****[XX] Title XIX**

	COST CENTER DESCRIPTIONS	Total Cost (Wkst B, Part I, col. 26)	Capital Cost (Wkst B, Part II, col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	
		1	2	3	4	
	ANCILLARY SERVICE COST CENTERS					
54	Radiology-Diagnostic	243,276	16,154	227,122		54
60	Laboratory	349,443	10,371	339,072		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy	1,222,750	43,727	1,179,023		65
66	Physical Therapy	288,951	62,029	226,922		66
67	Occupational Therapy	201,599	2,475	199,124		67
68	Speech Pathology	85,490	1,050	84,440		68
71	Medical Supplies Charged to Patients	485,497	53,972	431,525		71
73	Drugs Charged to Patients	1,612,127	86,571	1,525,556		73
74	Renal Dialysis	326,328	46,936	279,392		74
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
92	Observation Beds (Non-Distinct Part)					92
	OTHER REIMBURSABLE COST CENTERS					
200	Subtotal	4,815,461	323,285	4,492,176		200
201	Less Observation Beds					201
202	Total	4,815,461	323,285	4,492,176		202

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2017 To: 08/31/2018	Run Date: 01/29/2019 Run Time: 14:33 Version: 2018.12 (01/15/2019)
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CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY
**WORKSHEET C
PART II**
[] Title V
[XX] Title XIX

	COST CENTER DESCRIPTIONS	Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Wkst C, Part I, col. 8)	Outpatient Cost to Charge Ratio(col. 6 ÷ col. 7)	
		5	6	7	8	
	ANCILLARY SERVICE COST CENTERS					
54	Radiology-Diagnostic		243,276			54
60	Laboratory		349,443			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy		1,222,750			65
66	Physical Therapy		288,951			66
67	Occupational Therapy		201,599			67
68	Speech Pathology		85,490			68
71	Medical Supplies Charged to Patients		485,497			71
73	Drugs Charged to Patients		1,612,127			73
74	Renal Dialysis		326,328			74
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
92	Observation Beds (Non-Distinct Part)					92
	OTHER REIMBURSABLE COST CENTERS					
200	Subtotal		4,815,461			200
201	Less Observation Beds					201
202	Total		4,815,461			202

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2017 To: 08/31/2018	Run Date: 01/29/2019 Run Time: 14:33 Version: 2018.12 (01/15/2019)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check ☐ Title V ☒ PPS
Applicable ☒ Title XVIII, Part A ☐ TEFRA
Boxes: ☐ Title XIX

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust- ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	1,304,829		1,304,829	7,130	183.01	4,860	889,429	30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,304,829		1,304,829	7,130		4,860	889,429	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2017 To: 08/31/2018	Run Date: 01/29/2019 Run Time: 14:33 Version: 2018.12 (01/15/2019)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-2014

WORKSHEET D PART II

Check ☐ Title V ☒ Hospital ☐ SUB (Other) ☒ PPS
Applicable ☒ Title XVIII, Part A ☐ IPF
Boxes: ☐ Title XIX ☐ IRF ☐ TEFRA

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	16,154	461,206	0.035026	451,257	15,806	54
60	Laboratory	10,371	1,894,592	0.005474	1,319,382	7,222	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	43,727	3,607,117	0.012122	1,686,764	20,447	65
66	Physical Therapy	62,029	633,865	0.097858	435,783	42,645	66
67	Occupational Therapy	2,475	813,683	0.003042	574,867	1,749	67
68	Speech Pathology	1,050	345,086	0.003043	221,035	673	68
71	Medical Supplies Charged to Pat	53,972	824,439	0.065465	807,808	52,883	71
73	Drugs Charged to Patients	86,571	8,244,729	0.010500	5,880,622	61,747	73
74	Renal Dialysis	46,936	665,858	0.070490	468,191	33,003	74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct						92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	323,285	17,490,575		11,845,709	236,175	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2017 To: 08/31/2018	Run Date: 01/29/2019 Run Time: 14:33 Version: 2018.12 (01/15/2019)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D PART III

Check ☐ Title V
Applicable ☒ Title XVIII, Part A
Boxes: ☐ Title XIX

☒ PPS
☐ TEFRA
☐ Other

		Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjust- ment Amount (see instruct- ions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	Cost Center Description	1A	1	2A	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)								30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	TOTAL (lines 30-199)								200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2017 To: 08/31/2018	Run Date: 01/29/2019 Run Time: 14:33 Version: 2018.12 (01/15/2019)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

☐ Title V
☒ Title XVIII, Part A
☐ Title XIX

☒ PPS
☐ TEFRA
☐ Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass- Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	7,130		4,860		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)	7,130		4,860		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2017 To: 08/31/2018	Run Date: 01/29/2019 Run Time: 14:33 Version: 2018.12 (01/15/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-2014

WORKSHEET D
PART IV

Check
Applicable
Boxes:

☐ Title V
☒ Title XVIII, Part A
☐ Title XIX

☒ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☒ PPS
☐ TEFRA
☐ Other

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
54	Radiology-Diagnostic									54
60	Laboratory									60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
71	Medical Supplies Charged to Pat									71
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
92	Observation Beds (Non-Distinct									92
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2017 To: 08/31/2018	Run Date: 01/29/2019 Run Time: 14:33 Version: 2018.12 (01/15/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-2014

WORKSHEET D
PART IV

Check
Applicable
Boxes:

☐ Title V
☒ Title XVIII, Part A
☐ Title XIX

☒ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☒ PPS
☐ TEFRA
☐ Other

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass- Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass- Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	461,206			451,257				54
60	Laboratory	1,894,592			1,319,382				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	3,607,117			1,686,764				65
66	Physical Therapy	633,865			435,783				66
67	Occupational Therapy	813,683			574,867				67
68	Speech Pathology	345,086			221,035				68
71	Medical Supplies Charged to Pat	824,439			807,808				71
73	Drugs Charged to Patients	8,244,729			5,880,622				73
74	Renal Dialysis	665,858			468,191				74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct								92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	17,490,575			11,845,709				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2017 To: 08/31/2018	Run Date: 01/29/2019 Run Time: 14:33 Version: 2018.12 (01/15/2019)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-2014

WORKSHEET D
PART V

Check
Applicable
Boxes:

☐ Title V - O/P

☒ Title XVIII, Part B

☐ Title XIX - O/P

☒ Hospital

☐ IPF

☐ IRF

☐ SUB (Other)

☐ SNF

☐ NF

☐ Swing Bed SNF

☐ Swing Bed NF

☐ ICF/IID

(A)	Cost Center Description	Program Charges				Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	0.527478							54
60	Laboratory	0.184442							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.338983							65
66	Physical Therapy	0.455856							66
67	Occupational Therapy	0.247761							67
68	Speech Pathology	0.247735							68
71	Medical Supplies Charged to Pat	0.588882							71
73	Drugs Charged to Patients	0.195534							73
74	Renal Dialysis	0.490086							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct								92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2017 To: 08/31/2018	Run Date: 01/29/2019 Run Time: 14:33 Version: 2018.12 (01/15/2019)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check [] Title V [XX] PPS
Applicable [] Title XVIII, Part A [] TEFRA
Boxes: [XX] Title XIX

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust- ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	1,304,829		1,304,829	7,130	183.01	270	49,413	30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,304,829		1,304,829	7,130		270	49,413	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2017 To: 08/31/2018	Run Date: 01/29/2019 Run Time: 14:33 Version: 2018.12 (01/15/2019)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS**COMPONENT CCN: 14-2014****WORKSHEET D
PART II**

Check ☐ Title V ☒ Hospital ☐ SUB (Other) ☒ PPS
 Applicable ☐ Title XVIII, Part A ☐ IPF
 Boxes: ☒ Title XIX ☐ IRF ☐ TEFRA

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	16,154	461,206	0.035026	9,949	348	54
60	Laboratory	10,371	1,894,592	0.005474	48,447	265	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	43,727	3,607,117	0.012122	7,332	89	65
66	Physical Therapy	62,029	633,865	0.097858	14,287	1,398	66
67	Occupational Therapy	2,475	813,683	0.003042	13,192	40	67
68	Speech Pathology	1,050	345,086	0.003043	5,219	16	68
71	Medical Supplies Charged to Pat	53,972	824,439	0.065465	16,631	1,089	71
73	Drugs Charged to Patients	86,571	8,244,729	0.010500	290,374	3,049	73
74	Renal Dialysis	46,936	665,858	0.070490			74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct						92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	323,285	17,490,575		405,431	6,294	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2017 To: 08/31/2018	Run Date: 01/29/2019 Run Time: 14:33 Version: 2018.12 (01/15/2019)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☒ PPS
☐ TEFRA
☐ Other

		Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjust- ment Amount (see instruct- ions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	Cost Center Description	1A	1	2A	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)								30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	TOTAL (lines 30-199)								200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2017 To: 08/31/2018	Run Date: 01/29/2019 Run Time: 14:33 Version: 2018.12 (01/15/2019)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☒ PPS
☐ TEFRA
☐ Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass- Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	7,130		270		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)	7,130		270		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2017 To: 08/31/2018	Run Date: 01/29/2019 Run Time: 14:33 Version: 2018.12 (01/15/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-2014

WORKSHEET D
PART IV

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☒ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☒ PPS
☐ TEFRA
☐ Other

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
54	Radiology-Diagnostic									54
60	Laboratory									60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
71	Medical Supplies Charged to Pat									71
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
92	Observation Beds (Non-Distinct									92
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2017 To: 08/31/2018	Run Date: 01/29/2019 Run Time: 14:33 Version: 2018.12 (01/15/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-2014

WORKSHEET D
PART IV

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☒ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☒ PPS
☐ TEFRA
☐ Other

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass- Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass- Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic				9,949				54
60	Laboratory				48,447				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy				7,332				65
66	Physical Therapy				14,287				66
67	Occupational Therapy				13,192				67
68	Speech Pathology				5,219				68
71	Medical Supplies Charged to Pat				16,631				71
73	Drugs Charged to Patients				290,374				73
74	Renal Dialysis								74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct								92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)				405,431				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2017 To: 08/31/2018	Run Date: 01/29/2019 Run Time: 14:33 Version: 2018.12 (01/15/2019)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-2014

WORKSHEET D
PART V

Check
Applicable
Boxes:

☐ Title V - O/P

☐ Title XVIII, Part B

☒ Title XIX - O/P

☒ Hospital

☐ IPF

☐ IRF

☐ SUB (Other)

☐ SNF

☐ NF

☐ Swing Bed SNF

☐ Swing Bed NF

☐ ICF/IID

(A)	Cost Center Description	Program Charges				Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic								54
60	Laboratory								60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy								65
66	Physical Therapy								66
67	Occupational Therapy								67
68	Speech Pathology								68
71	Medical Supplies Charged to Pat								71
73	Drugs Charged to Patients								73
74	Renal Dialysis								74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct								92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2017 To: 08/31/2018	Run Date: 01/29/2019 Run Time: 14:33 Version: 2018.12 (01/15/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-2014****WORKSHEET D-1
PART I**

Check ☐ Title V - I/P ☒ Hospital ☐ SUB (Other) ☐ ICF/IID ☒ PPS
 Applicable ☒ Title XVIII, Part A ☐ IPF ☐ SNF ☐ TEFRA
 Boxes: ☐ Title XIX - I/P ☐ IRF ☐ NF ☐ Other

PART I - ALL PROVIDER COMPONENTS**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,130	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,130	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	7,130	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	4,860	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 XIX only)		15
16	Nursery days (title V or 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)	10,040,097	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 (line 21 minus line 26)	10,040,097	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 31)		32
33	Average semi-private room per diem charge (line 30 ÷ line 31)		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 minus line 36)	10,040,097	37

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2017 To: 08/31/2018	Run Date: 01/29/2019 Run Time: 14:33 Version: 2018.12 (01/15/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-2014****WORKSHEET D-1
PART II**

Check ☐ Title V - I/P ☒ Hospital ☐ SUB (Other) ☒ PPS
Applicable ☒ Title XVIII, Part A ☐ IPF ☐ TEFRA
Boxes: ☐ Title XIX - I/P ☐ IRF ☐ Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS							1
38	Adjusted general inpatient routine service cost per diem (see instructions)						1,408.15 38
39	Program general inpatient routine service cost (line 9 x line 38)						6,843,609 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)						6,843,609 41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
							1
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						3,304,023 48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						10,147,632 49
PASS THROUGH COST ADJUSTMENTS							
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						889,429 50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						236,175 51
52	Total Program excludable cost (sum of lines 50 and 51)						1,125,604 52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						9,022,028 53
TARGET AMOUNT AND LIMIT COMPUTATION							
54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63
PROGRAM INPATIENT ROUTINE SWING BED COST							
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

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VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2017 To: 08/31/2018	Run Date: 01/29/2019 Run Time: 14:33 Version: 2018.12 (01/15/2019)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-2014

WORKSHEET D-1
PARTS III & IV

Check
Applicable
Boxes:

☐ Title V - I/P

☒ Title XVIII, Part A

☐ Title XIX - I/P

☒ Hospital

☐ IPF

☐ IRF

☐ SUB (Other)

☐ SNF

☐ NF

☐ ICF/IID

☒ PPS

☐ TEFRA

☐ Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)						87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,408.15	88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2017 To: 08/31/2018	Run Date: 01/29/2019 Run Time: 14:33 Version: 2018.12 (01/15/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-2014****WORKSHEET D-1
PART I**

Check ☐ Title V - I/P ☒ Hospital ☐ SUB (Other) ☐ ICF/IID ☒ PPS
 Applicable ☐ Title XVIII, Part A ☐ IPF ☐ SNF ☐ TEFRA
 Boxes: ☒ Title XIX - I/P ☐ IRF ☐ NF ☐ Other

PART I - ALL PROVIDER COMPONENTS**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,130	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,130	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	7,130	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	270	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 XIX only)		15
16	Nursery days (title V or 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)	10,008,051	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 (line 21 minus line 26)	10,008,051	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 31)		32
33	Average semi-private room per diem charge (line 30 ÷ line 31)		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 minus line 36)	10,008,051	37

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VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2017 To: 08/31/2018	Run Date: 01/29/2019 Run Time: 14:33 Version: 2018.12 (01/15/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-2014****WORKSHEET D-1
PART II**

Check ☐ Title V - I/P ☒ Hospital ☐ SUB (Other) ☒ PPS
Applicable ☐ Title XVIII, Part A ☐ IPF ☐ TEFRA
Boxes: ☒ Title XIX - I/P ☐ IRF ☐ Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS							1	
38	Adjusted general inpatient routine service cost per diem (see instructions)						1,403.65	38
39	Program general inpatient routine service cost (line 9 x line 38)						378,986	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)						378,986	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1	2	3	4	5		
42	Nursery (Titles V and XIX only)							42
	Intensive Care Type Inpatient Hospital Units							
43	Intensive Care Unit							43
44	Coronary Care Unit							44
45	Burn Intensive Care Unit							45
46	Surgical Intensive Care Unit							46
47	Other Special Care (specify)							47
							1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)							48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						378,986	49
PASS THROUGH COST ADJUSTMENTS								
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						49,413	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						6,294	51
52	Total Program excludable cost (sum of lines 50 and 51)						55,707	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						323,279	53
TARGET AMOUNT AND LIMIT COMPUTATION								
54	Program discharges							54
55	Target amount per discharge							55
56	Target amount (line 54 x line 55)							56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)							57
58	Bonus payment (see instructions)							58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.							59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.							60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)							61
62	Relief payment (see instructions)							62
63	Allowable Inpatient cost plus incentive payment (see instructions)							63
PROGRAM INPATIENT ROUTINE SWING BED COST								
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)							64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)							65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)							66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)							67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)							68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)							69

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VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2017 To: 08/31/2018	Run Date: 01/29/2019 Run Time: 14:33 Version: 2018.12 (01/15/2019)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-2014

WORKSHEET D-1
PARTS III & IV

Check
Applicable
Boxes:

☐ Title V - I/P

☐ Title XVIII, Part A

☒ Title XIX - I/P

☒ Hospital

☐ IPF

☐ IRF

☐ SUB (Other)

☐ SNF

☐ NF

☐ ICF/IID

☒ PPS

☐ TEFRA

☐ Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)						87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,403.65	88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2017 To: 08/31/2018	Run Date: 01/29/2019 Run Time: 14:33 Version: 2018.12 (01/15/2019)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-2014

WORKSHEET D-3

Check ☐ Title V ☒ Hospital ☐ SUB (Other) ☐ Swing Bed SNF ☒ PPS
 Applicable ☒ Title XVIII, Part A ☐ IPF ☐ SNF ☐ Swing Bed NF ☐ TEFRA
 Boxes: ☐ Title XIX ☐ IRF ☐ NF ☐ ICF/IID ☐ Other

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		14,552,235		30
	ANCILLARY SERVICE COST CENTERS				
54	Radiology-Diagnostic	0.527478	451,257	238,028	54
60	Laboratory	0.184442	1,319,382	243,349	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.338983	1,686,764	571,784	65
66	Physical Therapy	0.455856	435,783	198,654	66
67	Occupational Therapy	0.247761	574,867	142,430	67
68	Speech Pathology	0.247735	221,035	54,758	68
71	Medical Supplies Charged to Patients	0.588882	807,808	475,704	71
73	Drugs Charged to Patients	0.195534	5,880,622	1,149,862	73
74	Renal Dialysis	0.490086	468,191	229,454	74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
92	Observation Beds (Non-Distinct Part)				92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		11,845,709	3,304,023	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		11,845,709		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2017 To: 08/31/2018	Run Date: 01/29/2019 Run Time: 14:33 Version: 2018.12 (01/15/2019)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-2014

WORKSHEET D-3

Check ☐ Title V ☒ Hospital ☐ SUB (Other) ☐ Swing Bed SNF ☒ PPS
 Applicable ☐ Title XVIII, Part A ☐ IPF ☐ SNF ☐ Swing Bed NF ☐ TEFRA
 Boxes: ☒ Title XIX ☐ IRF ☐ NF ☐ ICF/IID ☐ Other

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		792,022		30
	ANCILLARY SERVICE COST CENTERS				
54	Radiology-Diagnostic		9,949		54
60	Laboratory		48,447		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy		7,332		65
66	Physical Therapy		14,287		66
67	Occupational Therapy		13,192		67
68	Speech Pathology		5,219		68
71	Medical Supplies Charged to Patients		16,631		71
73	Drugs Charged to Patients		290,374		73
74	Renal Dialysis				74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
92	Observation Beds (Non-Distinct Part)				92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		405,431		200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		405,431		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2017 To: 08/31/2018	Run Date: 01/29/2019 Run Time: 14:33 Version: 2018.12 (01/15/2019)
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CALCULATION OF REIMBURSEMENT SETTLEMENT**COMPONENT CCN: 14-2014****WORKSHEET E
PART B**Check applicable box: ☒ **Hospital** ☐ **IPF** ☐ **IRF** ☐ **SUB (Other)** ☐ **SNF****PART B - MEDICAL AND OTHER HEALTH SERVICES**

		1	1.01	1.02	
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	OPPS payments				3
4	Outlier payment (see instructions)				4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (see instructions)				21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)				26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)				27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)				30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)				32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)				34
35	Adjusted reimbursable bad debts (see instructions)				35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)				36
37	Subtotal (see instructions)				37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)				40
40.01	Sequestration adjustment (see instructions)				40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments				41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)				43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (see instructions)				91
92	The rate used to calculate the Time Value of Money				92
93	Time Value of Money (see instructions)				93
94	Total (sum of lines 91 and 93)				94

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2017 To: 08/31/2018	Run Date: 01/29/2019 Run Time: 14:33 Version: 2018.12 (01/15/2019)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED
COMPONENT CCN: 14-2014
**WORKSHEET E-1
PART I**

Check ☒ Hospital ☐ SUB (Other)
 Applicable ☐ IPF ☐ SNF
 Boxes: ☐ IRF ☐ Swing Bed SNF

			INPATIENT PART A		PART B	
	DESCRIPTION		mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4
1	Total interim payments paid to provider			7,063,544		1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero					2
3	List separately each retroactive lump sum adjustment		.01			3.01
	amount based on subsequent revision of the interim		.02			3.02
	rate for the cost reporting period. Also show date of	Program	.03			3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04			3.04
		Provider	.05			3.05
			.06			3.06
			.07			3.07
			.08			3.08
			.09			3.09
			.10			3.10
			.50			3.50
			.51			3.51
		Provider	.52			3.52
		to	.53			3.53
		Program	.54			3.54
			.55			3.55
			.56			3.56
			.57			3.57
			.58			3.58
			.59			3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)			7,063,544		4
	TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment		.01			5.01
	after desk review. Also show date of each payment.		.02			5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03			5.03
		to	.04			5.04
		Provider	.05			5.05
			.06			5.06
			.07			5.07
			.08			5.08
			.09			5.09
			.10			5.10
			.50			5.50
			.51			5.51
		Provider	.52			5.52
		to	.53			5.53
		Program	.54			5.54
			.55			5.55
			.56			5.56
			.57			5.57
			.58			5.58
			.59			5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99			5.99
6	Determined net settlement amount (balance due)		.01	280,890		6.01
	based on the cost report (1)		.02			6.02
7	Total Medicare program liability (see instructions)			7,344,434		7
8	Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)	

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

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CALCULATION OF REIMBURSEMENT SETTLEMENT

**WORKSHEET E-3
PART IV**

Check [XX] Hospital
applicable box:

PART IV - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER LTCH PPS

1	Net Federal PPS payment (see instructions)	6,875,897	1
1.01	Full standard payment amount	4,792,769	1.01
1.02	Short stay outlier standard payment amount	1,810,239	1.02
1.03	Site neutral payment amount - Cost	4,537	1.03
1.04	Site neutral payment amount - IPPS comparable	268,352	1.04
2	Outlier payments	930,864	2
3	Total PPS payments (sum of lines 1 and 2)	7,806,761	3
4	Nursing and allied health managed care payments (see instructions)		4
5	Organ acquisition DO NOT USE THIS LINE		5
6	Cost of physicians' services in a teaching hospital (see instructions)		6
7	Subtotal (see instructions)	7,806,761	7
8	Primary payer payments		8
9	Subtotal (line 7 less line 8)	7,806,761	9
10	Deductibles	15,912	10
11	Subtotal (line 9 minus line 10)	7,790,849	11
12	Coinsurance	583,150	12
13	Subtotal (line 11 minus line 12)	7,207,699	13
14	Allowable bad debts (exclude bad debts for professional services) (see instructions)	440,956	14
15	Adjusted reimbursable bad debts (see instructions)	286,621	15
16	Allowable bad debts for dual eligible beneficiaries (see instructions)	341,507	16
17	Subtotal (sum of lines 13 and 15)	7,494,320	17
18	Direct graduate medical education payments (from Wkst. E-4, line 49)		18
19	Other pass through costs (see instructions)		19
20	Outlier payments reconciliation		20
21	Other adjustments (specify) (see instructions)		21
21.50	Pioneer ACO demonstration payment adjustment (see instructions)		21.50
22	Total amount payable to the provider (see instructions)	7,494,320	22
22.01	Sequestration adjustment (see instructions)	149,886	22.01
22.02	Demonstration payment adjustment amount after sequestration		22.02
23	Interim payments	7,063,544	23
24	Tentative settlement (for contractor use only)		24
25	Balance due provider/program (line 22 minus lines 22.01, 22.02, 23 and 24)	280,890	25
26	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		26

TO BE COMPLETED BY CONTRACTOR

50	Original outlier amount from Wkst. E-3 Part IV, line 2 (see instructions)		50
51	Outlier reconciliation adjustment amount (see instructions)		51
52	The rate used to calculate the Time Value of Money (see instructions)		52
53	Time Value of Money (see instructions)		53

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-2014

WORKSHEET E-3
PART VII

Check ☐ Title V ☒ Hospital ☐ NF ☒ PPS
Applicable ☒ Title XIX ☐ SUB (Other) ☐ ICF/IID ☐ TEFRA
Boxes: ☐ SNF ☐ Other

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services			1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)			4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)			7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges	792,022		8
9	Ancillary service charges	405,431		9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)	1,197,453		12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahрге basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)	1,197,453		16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,197,453		17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)			21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)			30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	OTHER ADJUSTMENTS (OTHER ADJUSTMENTS)			37
37.01	OTHER ADJUSTMENTS			37.01
38	Subtotal (line 36 ± line 37)			38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)			40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

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BALANCE SHEET**WORKSHEET G**

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

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	Assets (Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	-8,427				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	2,460,250				4
5	Other receivables	28,790				5
6	Allowances for uncollectible notes and accounts receivable					6
7	Inventory	177,246				7
8	Prepaid expenses	-8,716				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	2,649,143				11
	FIXED ASSETS					
12	Land					12
13	Land improvements	24,716				13
14	Accumulated depreciation					14
15	Buildings					15
16	Accumulated depreciation					16
17	Leasehold improvements	5,272				17
18	Accumulated depreciation	-7,610				18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	306,912				23
24	Accumulated depreciation	-145,584				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)	183,706				30
	OTHER ASSETS					
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers	32				33
34	Other assets	810,964				34
35	Total other assets (sum of lines 31-34)	810,996				35
36	Total assets (sum of lines 11, 30 and 35)	3,643,845				36
	Liabilities and Fund Balances (Omit Cents)					
	CURRENT LIABILITIES					
37	Accounts payable	1,083,239				37
38	Salaries, wages and fees payable	468,587				38
39	Payroll taxes payable	-112,366				39
40	Notes and loans payable (short term)					40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds	8,905,644				43
44	Other current liabilities	244,316				44
45	Total current liabilities (sum of lines 37 thru 44)	10,589,420				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	425,579				49
50	Total long term liabilities (sum of lines 46 thru 49)	425,579				50
51	Total liabilities (sum of lines 45 and 50)	11,014,999				51
	CAPITAL ACCOUNTS					
52	General fund balance	-7,371,154				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	-7,371,154				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	3,643,845				60

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

		GENERAL FUND		SPECIFIC PURPOSE FUND	
		1	2	3	4
1	Fund balances at beginning of period		-4,238,741		1
2	Net income (loss) (from Worksheet G-3, line 29)		-3,132,413		2
3	Total (sum of line 1 and line 2)		-7,371,154		3
4	Additions (credit adjustments) (specify)				4
5	ROUNDING				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)		-7,371,154		11
12	Deductions (debit adjustments) (specify)				12
13	ROUNDING				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)		-7,371,154		19

		ENDOWMENT FUND		PLANT FUND	
		5	6	7	8
1	Fund balances at beginning of period				1
2	Net income (loss) (from Worksheet G-3, line 29)				2
3	Total (sum of line 1 and line 2)				3
4	Additions (credit adjustments) (specify)				4
5	ROUNDING				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)				11
12	Deductions (debit adjustments) (specify)				12
13	ROUNDING				13
14					14
15					15
16					16
17					17
18	Total deductions (sum of lines 12-17)				18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)				19

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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES**WORKSHEET G-2
PARTS I & II****PART I - PATIENT REVENUES**

	REVENUE CENTER	INPATIENT	OUTPATIENT	TOTAL	
		1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	21,591,047		21,591,047	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility				7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	21,591,047		21,591,047	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit				11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)				16
17	Total inpatient routine care services (sum of lines 10 and 16)	21,591,047		21,591,047	17
18	Ancillary services	17,058,897		17,058,897	18
19	Outpatient services				19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	Other (specify)				27
27.01	PHYSICIAN SERVICES	494,604		494,604	27.01
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	39,144,548		39,144,548	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		15,718,128	29
30	Add (specify)			30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)			37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		15,718,128	43

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	39,144,548	1
2	Less contractual allowances and discounts on patients' accounts	26,654,146	2
3	Net patient revenues (line 1 minus line 2)	12,490,402	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	15,718,128	4
5	Net income from service to patients (line 3 minus line 4)	-3,227,726	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments	69,249	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts		10
11	Rebates and refunds of expenses		11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests	39,339	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts		18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hosptial space		22
23	Governmental appropriations		23
24	Other (OTHER OPERATING INCOME)	33,604	24
24.01	Other (ROUNDING)		24.01
25	Total other income (sum of lines 6-24)	142,192	25
26	Total (line 5 plus line 25)	-3,085,534	26
27	Other expenses (BAD DEBT EXPENSE)	46,878	27
27.01	Other expenses (ROUNDING)	1	27.01
28	Total other expenses (sum of line 27 and subscripsts)	46,879	28
29	Net income (or loss) for the period (line 26 minus line 28)	-3,132,413	29