

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY**WORKSHEET S
PARTS I, II & III****PART I - COST REPORT STATUS**

Provider use only		1. ☒ Electronically filed cost report Date: 08/14/2019 Time: 10:06 2. ☐ Manually submitted cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted the cost report 4. ☒ Medicare Utilization. Enter 'F' for full or 'L' for low.	
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ____ 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY 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 09/01/2018 and ending 03/14/2019, 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

08/14/2019 10:06
Date

PART III - SETTLEMENT SUMMARY

		TITLE XVIII					
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		113,964				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		113,964				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.

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

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 / 2018	To: 03 / 14 / 2019		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)				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

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

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
----	--	---	--	--	----

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

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

Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all 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

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

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

		V	XIX	
Title V and XIX Services		1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the 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	Y	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	Y	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	Y	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	Y	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	Y	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	109

		1	2	
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.		N	110
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

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

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				
		Part A	Part B	Title V	Title XIX	
		1	2	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

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

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.	Y	03/14/2019	V	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	06/21/2019	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

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

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 relined 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	41
42	Employer: VIBRA HEALTHCARE			42
43	Phone number: 7175915794	E-mail Address: KROSSEY@VIBRAHEALTH.COM		43

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

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	9,800			1,301	22	1,814	1
2	HMO and other (see instructions)							146		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	9,800			1,301	22	1,814	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	9,800			1,301	22	1,814	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						204			33.01

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

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)					51	2	79	1
2	HMO and other (see instructions)						9		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)		80.26			51	2	79	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)		80.26						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					10			33.01

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

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	2,314,502			125,849.66		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		33,770					26
27	Administrative & General		237,874					27
28	Administrative & General under contract (see instructions)							28
29	Maintenance & Repairs							29
30	Operation of Plant		81,276					30
31	Laundry & Linen Service							31
32	Housekeeping		37,754					32
33	Housekeeping under contract (see instructions)							33
34	Dietary							34
35	Dietary under contract (see instructions)							35
36	Cafeteria							36
37	Maintenance of Personnel							37
38	Nursing Administration		101,218					38
39	Central Services and Supply							39
40	Pharmacy		145,144					40
41	Medical Records & Medical Records Library		45,011					41
42	Social Service							42
43	Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		2,314,502		2,314,502	125,849.66	18.39	1
2	Excluded area salaries (see instructions)							2
3	Subtotal salaries (line 1 minus line 2)		2,314,502		2,314,502	125,849.66	18.39	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)		2,314,502		2,314,502	125,849.66	18.39	6
7	Total overhead cost (see instructions)		682,047		682,047			7

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

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

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions		1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Nonqualified Defined Benefit Plan Cost (see instructions)		3
4	Qualified Defined Benefit Plan Cost (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA Plan Administration Fees		5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees		7
	HEALTH AND INSURANCE COST		
8	Health Insurance (Purchased or Self Funded)		8
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
----	------------------------------------	--	----

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	--------------------------------	--	--

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

Part V - Contract Labor and Benefit Cost

Hospital and Hospital-Based Component Identification:

	Component	Contract 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

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

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		852,001	852,001		852,001		852,001	1
2	00200	Cap Rel Costs-Mvble Equip		110,567	110,567		110,567		110,567	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	33,770	541,275	575,045		575,045		575,045	4
5	00500	Administrative & General	237,874	1,717,772	1,955,646		1,955,646	67,385	2,023,031	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	81,276	271,517	352,793		352,793		352,793	7
8	00800	Laundry & Linen Service		36,442	36,442		36,442		36,442	8
9	00900	Housekeeping	37,754	6,429	44,183		44,183		44,183	9
10	01000	Dietary		124,441	124,441		124,441	-10,898	113,543	10
11	01100	Cafeteria								11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	101,218	6,875	108,093		108,093		108,093	13
14	01400	Central Services & Supply		117,368	117,368		117,368		117,368	14
15	01500	Pharmacy	145,144	28,865	174,009		174,009		174,009	15
16	01600	Medical Records & Library	45,011	3,442	48,453		48,453	-1,549	46,904	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	1,273,704	533,734	1,807,438		1,807,438	-705,206	1,102,232	30
		ANCILLARY SERVICE COST CENTERS								
54	05400	Radiology-Diagnostic	35,003	9,488	44,491		44,491		44,491	54
60	06000	Laboratory	3,023	81,374	84,397		84,397		84,397	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	251,707	34,444	286,151		286,151		286,151	65
66	06600	Physical Therapy		30,123	30,123		30,123		30,123	66
67	06700	Occupational Therapy		35,473	35,473		35,473		35,473	67
68	06800	Speech Pathology		22,680	22,680		22,680		22,680	68
71	07100	Medical Supplies Charged to Patients		42,360	42,360		42,360		42,360	71
73	07300	Drugs Charged to Patients		176,084	176,084		176,084		176,084	73
74	07400	Renal Dialysis	69,018	1,765	70,783		70,783		70,783	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
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM								93.99
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	2,314,502	4,784,519	7,099,021		7,099,021	-650,268	6,448,753	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)	2,314,502	4,784,519	7,099,021		7,099,021	-650,268	6,448,753	200

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	--------------------------------	--	--

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.

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	--------------------------------	--	--

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.

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

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	24,716					24,716		2
3	Buildings and Fixtures								3
4	Building Improvements	5,272					5,272		4
5	Fixed Equipment								5
6	Movable Equipment	306,913	13,109		13,109		320,022		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	336,901	13,109		13,109		350,010		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	336,901	13,109		13,109		350,010		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		719,001			133,000		852,001	1
2	Cap Rel Costs-Mvble Equip	31,474	79,093					110,567	2
3	Total (sum of lines 1-2)	31,474	798,094			133,000		962,568	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	320,022	47,689	272,333	1.000000					2
3	Total (sum of lines 1-2)	350,010	77,677	272,333	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		719,001			133,000		852,001	1
2	Cap Rel Costs-Mvble Equip	31,474	79,093					110,567	2
3	Total (sum of lines 1-2)	31,474	798,094			133,000		962,568	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.)

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

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	-638,170				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1	158,735				12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-10,898	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	-1,549	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	-9,566	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	-84	Administrative & General	5		33
34	BAD DEBT EXPENSE	A	-64,825	Administrative & General	5		34
35	MARKETING NON-ALLOW	A	-5,931	Administrative & General	5		35
36	OTHER OPERATING INCOME	B	-10,944	Administrative & General	5		36
37	AMBULANCE	A	-67,036	Adults & Pediatrics	30		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)		-650,268				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

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	--------------------------------	--	--

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

WORKSHEET A-8-1

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

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1	5	Administrative & General	HOME OFFICE COSTS	257,235	98,500	158,735		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			257,235	98,500	158,735		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:

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	--------------------------------	--	--

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	589,740	589,740		206,300				1
2	30	Adults & Pediatrics PHYS ADMIN 779	76,300		76,300	206,300	281	27,870	1,394	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	666,040	589,740	76,300		281	27,870	1,394	200

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	--------------------------------	--	--

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							589,740	1
2	30	Adults & Pediatrics PHYS ADMIN 779					27,870	48,430	48,430	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					27,870	48,430	638,170	200

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

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	852,001	852,001					1
2	Cap Rel Costs-Mvble Equip	110,567		110,567				2
4	Employee Benefits Department	575,045	3,139	407	578,591			4
5	Administrative & General	2,023,031	75,169	9,755	60,346	2,168,301	2,168,301	5
6	Maintenance & Repairs							6
7	Operation of Plant	352,793	156,346	20,290	20,619	550,048	278,632	7
8	Laundry & Linen Service	36,442	18,968	2,462		57,872	29,316	8
9	Housekeeping	44,183	14,125	1,833	9,578	69,719	35,317	9
10	Dietary	113,543	84,884	11,016		209,443	106,095	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	108,093	12,528	1,626	25,678	147,925	74,933	13
14	Central Services & Supply	117,368	54,009	7,009		178,386	90,363	14
15	Pharmacy	174,009	26,653	3,459	36,821	240,942	122,051	15
16	Medical Records & Library	46,904	9,822	1,275	11,419	69,420	35,165	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	1,102,232	335,124	43,488	323,119	1,803,963	913,813	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	44,491	5,466	709	8,880	59,546	30,164	54
60	Laboratory	84,397	2,354	306	767	87,824	44,488	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	286,151	11,825	1,535	63,855	363,366	184,066	65
66	Physical Therapy	30,123	23,974	3,111		57,208	28,979	66
67	Occupational Therapy	35,473				35,473	17,969	67
68	Speech Pathology	22,680				22,680	11,489	68
71	Medical Supplies Charged to Patients	42,360				42,360	21,458	71
73	Drugs Charged to Patients	176,084				176,084	89,197	73
74	Renal Dialysis	70,783	17,615	2,286	17,509	108,193	54,806	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
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	6,448,753	852,001	110,567	578,591	6,448,753	2,168,301	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)	6,448,753	852,001	110,567	578,591	6,448,753	2,168,301	202

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

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	828,680						7
8	Laundry & Linen Service	25,462	112,650					8
9	Housekeeping	18,960		123,996				9
10	Dietary	113,941		18,015	447,494			10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	16,817		2,659		242,334		13
14	Central Services & Supply	72,498		11,462			352,709	14
15	Pharmacy	35,777		5,657				15
16	Medical Records & Library	13,185		2,085				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	449,844	112,650	71,122	447,494	242,334	209,974	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	7,337		1,160				54
60	Laboratory	3,160		500				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	15,873		2,510				65
66	Physical Therapy	32,181		5,088				66
67	Occupational Therapy							67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients						142,735	71
73	Drugs Charged to Patients							73
74	Renal Dialysis	23,645		3,738				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
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	828,680	112,650	123,996	447,494	242,334	352,709	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)	828,680	112,650	123,996	447,494	242,334	352,709	202

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

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	404,427					15
16	Medical Records & Library		119,855				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		67,491	4,318,685		4,318,685	30
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic		1,600	99,807		99,807	54
60	Laboratory		6,244	142,216		142,216	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy		16,630	582,445		582,445	65
66	Physical Therapy		1,946	125,402		125,402	66
67	Occupational Therapy		2,304	55,746		55,746	67
68	Speech Pathology		1,476	35,645		35,645	68
71	Medical Supplies Charged to Patients		2,896	209,449		209,449	71
73	Drugs Charged to Patients	404,427	15,842	685,550		685,550	73
74	Renal Dialysis		3,426	193,808		193,808	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
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)	404,427	119,855	6,448,753		6,448,753	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)	404,427	119,855	6,448,753		6,448,753	202

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

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		3,139	407	3,546	3,546		4
5	Administrative & General		75,169	9,755	84,924	370	85,294	5
6	Maintenance & Repairs							6
7	Operation of Plant		156,346	20,290	176,636	126	10,960	7
8	Laundry & Linen Service		18,968	2,462	21,430		1,153	8
9	Housekeeping		14,125	1,833	15,958	59	1,389	9
10	Dietary		84,884	11,016	95,900		4,173	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration		12,528	1,626	14,154	157	2,948	13
14	Central Services & Supply		54,009	7,009	61,018		3,555	14
15	Pharmacy		26,653	3,459	30,112	226	4,801	15
16	Medical Records & Library		9,822	1,275	11,097	70	1,383	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		335,124	43,488	378,612	1,981	35,947	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic		5,466	709	6,175	54	1,187	54
60	Laboratory		2,354	306	2,660	5	1,750	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		11,825	1,535	13,360	391	7,240	65
66	Physical Therapy		23,974	3,111	27,085		1,140	66
67	Occupational Therapy						707	67
68	Speech Pathology						452	68
71	Medical Supplies Charged to Patients						844	71
73	Drugs Charged to Patients						3,509	73
74	Renal Dialysis		17,615	2,286	19,901	107	2,156	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
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)		852,001	110,567	962,568	3,546	85,294	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)		852,001	110,567	962,568	3,546	85,294	202

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

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	187,722						7
8	Laundry & Linen Service	5,768	28,351					8
9	Housekeeping	4,295		21,701				9
10	Dietary	25,811		3,153	129,037			10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	3,810		465		21,534		13
14	Central Services & Supply	16,423		2,006			83,002	14
15	Pharmacy	8,105		990				15
16	Medical Records & Library	2,987		365				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	101,903	28,351	12,449	129,037	21,534	49,413	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	1,662		203				54
60	Laboratory	716		87				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	3,596		439				65
66	Physical Therapy	7,290		890				66
67	Occupational Therapy							67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients						33,589	71
73	Drugs Charged to Patients							73
74	Renal Dialysis	5,356		654				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
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	187,722	28,351	21,701	129,037	21,534	83,002	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)	187,722	28,351	21,701	129,037	21,534	83,002	202

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

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	44,234						15
16	Medical Records & Library		15,902					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		8,953	768,180		768,180		30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic		212	9,493		9,493		54
60	Laboratory		829	6,047		6,047		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		2,207	27,233		27,233		65
66	Physical Therapy		258	36,663		36,663		66
67	Occupational Therapy		306	1,013		1,013		67
68	Speech Pathology		196	648		648		68
71	Medical Supplies Charged to Patients		384	34,817		34,817		71
73	Drugs Charged to Patients	44,234	2,102	49,845		49,845		73
74	Renal Dialysis		455	28,629		28,629		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
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	44,234	15,902	962,568		962,568		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)	44,234	15,902	962,568		962,568		202

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

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	2,280,732				4
5	Administrative & General	2,778	2,778	237,874	-2,168,301	4,280,452		5
6	Maintenance & Repairs							6
7	Operation of Plant	5,778	5,778	81,276		550,048	22,815	7
8	Laundry & Linen Service	701	701			57,872	701	8
9	Housekeeping	522	522	37,754		69,719	522	9
10	Dietary	3,137	3,137			209,443	3,137	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	463	463	101,218		147,925	463	13
14	Central Services & Supply	1,996	1,996			178,386	1,996	14
15	Pharmacy	985	985	145,144		240,942	985	15
16	Medical Records & Library	363	363	45,011		69,420	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	1,273,704		1,803,963	12,385	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	202	202	35,003		59,546	202	54
60	Laboratory	87	87	3,023		87,824	87	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	437	437	251,707		363,366	437	65
66	Physical Therapy	886	886			57,208	886	66
67	Occupational Therapy					35,473		67
68	Speech Pathology					22,680		68
71	Medical Supplies Charged to Patients					42,360		71
73	Drugs Charged to Patients					176,084		73
74	Renal Dialysis	651	651	69,018		108,193	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
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	31,487	31,487	2,280,732	-2,168,301	4,280,452	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)	852,001	110,567	578,591		2,168,301	828,680	202
203	Unit Cost Multiplier (Wkst. B, Part I)	27.058818	3.511513	0.253687		0.506559	36.321718	203
204	Cost to be allocated (Per Wkst. B, Part II)			3,546		85,294	187,722	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.001555		0.019926	8.228008	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: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

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	1,814						8
9	Housekeeping		21,592					9
10	Dietary		3,137	1,814				10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration		463		29			13
14	Central Services & Supply		1,996			104,675		14
15	Pharmacy		985				176,084	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	1,814	12,385	1,814	29	62,315		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					42,360		71
73	Drugs Charged to Patients						176,084	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
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,814	21,592	1,814	29	104,675	176,084	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)	112,650	123,996	447,494	242,334	352,709	404,427	202
203	Unit Cost Multiplier (Wkst. B, Part I)	62.100331	5.742682	246.689085	8,356.344828	3.369563	2.296784	203
204	Cost to be allocated (Per Wkst. B, Part II)	28,351	21,701	129,037	21,534	83,002	44,234	204
205	Unit Cost Multiplier (Wkst. B, Part II)	15.628997	1.005048	71.133958	742.551724	0.792950	0.251210	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: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

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	11,185,774						16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	6,298,855						30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	149,313						54
60	Laboratory	582,739						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,551,990						65
66	Physical Therapy	181,616						66
67	Occupational Therapy	215,050						67
68	Speech Pathology	137,757						68
71	Medical Supplies Charged to Patients	270,238						71
73	Drugs Charged to Patients	1,478,470						73
74	Renal Dialysis	319,746						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
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	11,185,774						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)	119,855						202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.010715						203
204	Cost to be allocated (Per Wkst. B, Part II)	15,902						204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.001422						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: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	--------------------------------	--	--

POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		AMOUNT	
		CODE	LINE NO.		
	1	2	3	4	

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

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	4,318,685		4,318,685	48,430	4,367,115	30
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	99,807		99,807		99,807	54
60	Laboratory	142,216		142,216		142,216	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	582,445		582,445		582,445	65
66	Physical Therapy	125,402		125,402		125,402	66
67	Occupational Therapy	55,746		55,746		55,746	67
68	Speech Pathology	35,645		35,645		35,645	68
71	Medical Supplies Charged to Patients	209,449		209,449		209,449	71
73	Drugs Charged to Patients	685,550		685,550		685,550	73
74	Renal Dialysis	193,808		193,808		193,808	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
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Subtotal (sum of lines 30 thru 199)	6,448,753		6,448,753	48,430	6,497,183	200
201	Less Observation Beds						201
202	Total (line 200 minus line 201)	6,448,753		6,448,753		6,497,183	202

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

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	6,298,855		6,298,855				30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	149,313		149,313	0.668441	0.668441	0.668441	54
60	Laboratory	582,739		582,739	0.244048	0.244048	0.244048	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,551,990		1,551,990	0.375289	0.375289	0.375289	65
66	Physical Therapy	181,616		181,616	0.690479	0.690479	0.690479	66
67	Occupational Therapy	215,050		215,050	0.259223	0.259223	0.259223	67
68	Speech Pathology	137,757		137,757	0.258753	0.258753	0.258753	68
71	Medical Supplies Charged to Patients	270,238		270,238	0.775054	0.775054	0.775054	71
73	Drugs Charged to Patients	1,478,470		1,478,470	0.463689	0.463689	0.463689	73
74	Renal Dialysis	319,746		319,746	0.606131	0.606131	0.606131	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
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (sum of lines 30 thru 199)	11,185,774		11,185,774				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	11,185,774		11,185,774				202

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

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	4,318,685		4,318,685	48,430	4,367,115	30
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	99,807		99,807		99,807	54
60	Laboratory	142,216		142,216		142,216	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	582,445		582,445		582,445	65
66	Physical Therapy	125,402		125,402		125,402	66
67	Occupational Therapy	55,746		55,746		55,746	67
68	Speech Pathology	35,645		35,645		35,645	68
71	Medical Supplies Charged to Patients	209,449		209,449		209,449	71
73	Drugs Charged to Patients	685,550		685,550		685,550	73
74	Renal Dialysis	193,808		193,808		193,808	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
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Subtotal (sum of lines 30 thru 199)	6,448,753		6,448,753	48,430	6,497,183	200
201	Less Observation Beds						201
202	Total (line 200 minus line 201)	6,448,753		6,448,753	48,430	6,497,183	202

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

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	6,298,855		6,298,855				30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	149,313		149,313	0.668441	0.668441	0.668441	54
60	Laboratory	582,739		582,739	0.244048	0.244048	0.244048	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,551,990		1,551,990	0.375289	0.375289	0.375289	65
66	Physical Therapy	181,616		181,616	0.690479	0.690479	0.690479	66
67	Occupational Therapy	215,050		215,050	0.259223	0.259223	0.259223	67
68	Speech Pathology	137,757		137,757	0.258753	0.258753	0.258753	68
71	Medical Supplies Charged to Patients	270,238		270,238	0.775054	0.775054	0.775054	71
73	Drugs Charged to Patients	1,478,470		1,478,470	0.463689	0.463689	0.463689	73
74	Renal Dialysis	319,746		319,746	0.606131	0.606131	0.606131	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
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (sum of lines 30 thru 199)	11,185,774		11,185,774				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	11,185,774		11,185,774				202

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY
**WORKSHEET C
PART II**
☐ Title V

☒ 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	99,807	9,493	90,314		54
60	Laboratory	142,216	6,047	136,169		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy	582,445	27,233	555,212		65
66	Physical Therapy	125,402	36,663	88,739		66
67	Occupational Therapy	55,746	1,013	54,733		67
68	Speech Pathology	35,645	648	34,997		68
71	Medical Supplies Charged to Patients	209,449	34,817	174,632		71
73	Drugs Charged to Patients	685,550	49,845	635,705		73
74	Renal Dialysis	193,808	28,629	165,179		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
93.99	PARTIAL HOSPITALIZATION PROGRAM					93.99
	OTHER REIMBURSABLE COST CENTERS					
200	Subtotal	2,130,068	194,388	1,935,680		200
201	Less Observation Beds					201
202	Total	2,130,068	194,388	1,935,680		202

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

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		99,807	149,313	0.668441	54
60	Laboratory		142,216	582,739	0.244048	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy		582,445	1,551,990	0.375289	65
66	Physical Therapy		125,402	181,616	0.690479	66
67	Occupational Therapy		55,746	215,050	0.259223	67
68	Speech Pathology		35,645	137,757	0.258753	68
71	Medical Supplies Charged to Patients		209,449	270,238	0.775054	71
73	Drugs Charged to Patients		685,550	1,478,470	0.463689	73
74	Renal Dialysis		193,808	319,746	0.606131	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
93.99	PARTIAL HOSPITALIZATION PROGRAM					93.99
	OTHER REIMBURSABLE COST CENTERS					
200	Subtotal		2,130,068	4,886,919		200
201	Less Observation Beds					201
202	Total		2,130,068	4,886,919		202

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	--------------------------------	--	--

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check [] Title V [XX] PPS
Applicable [XX] 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)	768,180		768,180	1,814	423.47	1,301	550,934	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)	768,180		768,180	1,814		1,301	550,934	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: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-2014

WORKSHEET D
PART II

Check
Applicable
Boxes:

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

☒ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)

☒ PPS
☐ 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	9,493	149,313	0.063578	139,992	8,900	54
60	Laboratory	6,047	582,739	0.010377	424,612	4,406	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	27,233	1,551,990	0.017547	958,593	16,820	65
66	Physical Therapy	36,663	181,616	0.201871	145,599	29,392	66
67	Occupational Therapy	1,013	215,050	0.004711	174,342	821	67
68	Speech Pathology	648	137,757	0.004704	89,758	422	68
71	Medical Supplies Charged to Pat	34,817	270,238	0.128838	270,070	34,795	71
73	Drugs Charged to Patients	49,845	1,478,470	0.033714	1,153,072	38,875	73
74	Renal Dialysis	28,629	319,746	0.089537	239,740	21,466	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
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	194,388	4,886,919		3,595,778	155,897	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: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

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: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	--------------------------------	--	--

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)	1,814		1,301		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)	1,814		1,301		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: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	--------------------------------	--	--

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
93.99	PARTIAL HOSPITALIZATION PROGRAM									93.99
	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: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

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	149,313			139,992				54
60	Laboratory	582,739			424,612				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	1,551,990			958,593				65
66	Physical Therapy	181,616			145,599				66
67	Occupational Therapy	215,050			174,342				67
68	Speech Pathology	137,757			89,758				68
71	Medical Supplies Charged to Pat	270,238			270,070				71
73	Drugs Charged to Patients	1,478,470			1,153,072				73
74	Renal Dialysis	319,746			239,740				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
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	4,886,919			3,595,778				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: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	0.668441							54
60	Laboratory	0.244048							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.375289							65
66	Physical Therapy	0.690479							66
67	Occupational Therapy	0.259223							67
68	Speech Pathology	0.258753							68
71	Medical Supplies Charged to Pat	0.775054							71
73	Drugs Charged to Patients	0.463689							73
74	Renal Dialysis	0.606131							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
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	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: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	--------------------------------	--	--

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)	768,180		768,180	1,814	423.47	22	9,316	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)	768,180		768,180	1,814		22	9,316	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: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-2014

WORKSHEET D
PART II

Check
Applicable
Boxes:

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

☒ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)

☒ PPS
☐ 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	9,493	149,313	0.063578	9,321	593	54
60	Laboratory	6,047	582,739	0.010377	1,968	20	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	27,233	1,551,990	0.017547			65
66	Physical Therapy	36,663	181,616	0.201871	306	62	66
67	Occupational Therapy	1,013	215,050	0.004711			67
68	Speech Pathology	648	137,757	0.004704			68
71	Medical Supplies Charged to Pat	34,817	270,238	0.128838	168	22	71
73	Drugs Charged to Patients	49,845	1,478,470	0.033714	6,106	206	73
74	Renal Dialysis	28,629	319,746	0.089537			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
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	194,388	4,886,919		17,869	903	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: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	--------------------------------	--	--

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: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	--------------------------------	--	--

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)	1,814		22		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)	1,814		22		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: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-2014

WORKSHEET D PART IV

Check ☐ Title V ☒ Hospital ☐ SUB (Other) ☐ ICF/IID ☒ PPS
 Applicable ☐ Title XVIII, Part A ☐ IPF ☐ SNF ☐ TEFRA
 Boxes: ☒ Title XIX ☐ IRF ☐ NF ☐ 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
93.99	PARTIAL HOSPITALIZATION PROGRAM									93.99
	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: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

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	149,313			9,321				54
60	Laboratory	582,739			1,968				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	1,551,990							65
66	Physical Therapy	181,616			306				66
67	Occupational Therapy	215,050							67
68	Speech Pathology	137,757							68
71	Medical Supplies Charged to Pat	270,238			168				71
73	Drugs Charged to Patients	1,478,470			6,106				73
74	Renal Dialysis	319,746							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
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	4,886,919			17,869				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: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

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	0.668441							54
60	Laboratory	0.244048							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.375289							65
66	Physical Therapy	0.690479							66
67	Occupational Therapy	0.259223							67
68	Speech Pathology	0.258753							68
71	Medical Supplies Charged to Pat	0.775054							71
73	Drugs Charged to Patients	0.463689							73
74	Renal Dialysis	0.606131							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
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	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: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

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)	1,814	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,814	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)	1,814	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)	1,301	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)	4,367,115	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)	4,367,115	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)	4,367,115	37

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

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)						2,407.45 38
39	Program general inpatient routine service cost (line 9 x line 38)						3,132,092 39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)						3,132,092 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)						1,615,202 48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						4,747,294 49
PASS THROUGH COST ADJUSTMENTS							
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						550,934 50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						155,897 51
52	Total Program excludable cost (sum of lines 50 and 51)						706,831 52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						4,040,463 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

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	--------------------------------	--	--

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)					2,407.45	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: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

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)	1,814	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,814	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)	1,814	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)	22	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)	4,367,115	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)	4,367,115	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)	4,367,115	37

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

WORKSHEET D-1
PART II

PART II - HOSPITALS AND SUBPROVIDERS ONLY

Page : 56

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	--------------------------------	--	--

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)						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: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-2014

WORKSHEET D-3

Check [] Title V [XX] Hospital [] SUB (Other) [] Swing Bed SNF [XX] PPS
Applicable [XX] 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		4,471,232		30
	ANCILLARY SERVICE COST CENTERS				
54	Radiology-Diagnostic	0.668441	139,992	93,576	54
60	Laboratory	0.244048	424,612	103,626	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.375289	958,593	359,749	65
66	Physical Therapy	0.690479	145,599	100,533	66
67	Occupational Therapy	0.259223	174,342	45,193	67
68	Speech Pathology	0.258753	89,758	23,225	68
71	Medical Supplies Charged to Patients	0.775054	270,070	209,319	71
73	Drugs Charged to Patients	0.463689	1,153,072	534,667	73
74	Renal Dialysis	0.606131	239,740	145,314	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
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		3,595,778	1,615,202	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		3,595,778		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: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-2014

WORKSHEET D-3

Check [] Title V [XX] Hospital [] SUB (Other) [] Swing Bed SNF [XX] PPS
Applicable [] Title XVIII, Part A [] IPF [] SNF [] Swing Bed NF [] TEFRA
Boxes: [XX] 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		73,370		30
	ANCILLARY SERVICE COST CENTERS				
54	Radiology-Diagnostic	0.668441	9,321	6,231	54
60	Laboratory	0.244048	1,968	480	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.375289			65
66	Physical Therapy	0.690479	306	211	66
67	Occupational Therapy	0.259223			67
68	Speech Pathology	0.258753			68
71	Medical Supplies Charged to Patients	0.775054	168	130	71
73	Drugs Charged to Patients	0.463689	6,106	2,831	73
74	Renal Dialysis	0.606131			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
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		17,869	9,883	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		17,869		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: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

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: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

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			2,180,012		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)			2,180,012		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) based on the cost report (1)		.01	113,964		6.01
			.02			6.02
7	Total Medicare program liability (see instructions)			2,293,976		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.

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

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)	2,079,187	1
1.01	Full standard payment amount	1,461,506	1.01
1.02	Short stay outlier standard payment amount	576,242	1.02
1.03	Site neutral payment amount - Cost		1.03
1.04	Site neutral payment amount - IPPS comparable	41,439	1.04
2	Outlier payments	302,777	2
3	Total PPS payments (sum of lines 1 and 2)	2,381,964	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)	2,381,964	7
8	Primary payer payments		8
9	Subtotal (line 7 less line 8)	2,381,964	9
10	Deductibles	4,020	10
11	Subtotal (line 9 minus line 10)	2,377,944	11
12	Coinsurance	153,442	12
13	Subtotal (line 11 minus line 12)	2,224,502	13
14	Allowable bad debts (exclude bad debts for professional services) (see instructions)	178,908	14
15	Adjusted reimbursable bad debts (see instructions)	116,290	15
16	Allowable bad debts for dual eligible beneficiaries (see instructions)	145,363	16
17	Subtotal (sum of lines 13 and 15)	2,340,792	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)	2,340,792	22
22.01	Sequestration adjustment (see instructions)	46,816	22.01
22.02	Demonstration payment adjustment amount after sequestration		22.02
23	Interim payments	2,180,012	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)	113,964	25
26	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	895,633	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

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

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	17,869		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)	809,891		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)	809,891		16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	809,891		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

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

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	17,331				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	-26,864				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable					6
7	Inventory	70,568				7
8	Prepaid expenses	-47,095				8
9	Other current assets	101,315				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	115,255				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	-10,344				18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	320,020				23
24	Accumulated depreciation	-174,324				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)	165,340				30
	OTHER ASSETS					
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers	32				33
34	Other assets	-50,165				34
35	Total other assets (sum of lines 31-34)	-50,133				35
36	Total assets (sum of lines 11, 30 and 35)	230,462				36
	Liabilities and Fund Balances (Omit Cents)					
	CURRENT LIABILITIES					
37	Accounts payable	707,902				37
38	Salaries, wages and fees payable	33,066				38
39	Payroll taxes payable	-184,799				39
40	Notes and loans payable (short term)					40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds	9,973,425				43
44	Other current liabilities	401,571				44
45	Total current liabilities (sum of lines 37 thru 44)	10,931,165				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	421,709				49
50	Total long term liabilities (sum of lines 46 thru 49)	421,709				50
51	Total liabilities (sum of lines 45 and 50)	11,352,874				51
	CAPITAL ACCOUNTS					
52	General fund balance	-11,122,412				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)	-11,122,412				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	230,462				60

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

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		-7,371,154		1
2	Net income (loss) (from Worksheet G-3, line 29)		-3,751,258		2
3	Total (sum of line 1 and line 2)		-11,122,412		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)		-11,122,412		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)		-11,122,412		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

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

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	6,308,344		6,308,344	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility				7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	6,308,344		6,308,344	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit				11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)				16
17	Total inpatient routine care services (sum of lines 10 and 16)	6,308,344		6,308,344	17
18	Ancillary services	4,877,429		4,877,429	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	143,494		143,494	27.01
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	11,329,267		11,329,267	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		7,099,021	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)		7,099,021	43

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF SPRINGFIELD Provider CCN: 14-2014	In Lieu of Form CMS-2552-10	Period : From: 09/01/2018 To: 03/14/2019	Run Date: 08/14/2019 Run Time: 10:06 Version: 2018.12 (01/15/2019)
--	---------------------------------------	--	--

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	11,329,267	1
2	Less contractual allowances and discounts on patients' accounts	7,245,661	2
3	Net patient revenues (line 1 minus line 2)	4,083,606	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	7,099,021	4
5	Net income from service to patients (line 3 minus line 4)	-3,015,415	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments	9,566	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	10,898	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)	12,493	24
25	Total other income (sum of lines 6-24)	32,957	25
26	Total (line 5 plus line 25)	-2,982,458	26
27	Other expenses (PHARMACY PRIOR YEAR ADJUSTMENT)	768,800	27
28	Total other expenses (sum of line 27 and subscripts)	768,800	28
29	Net income (or loss) for the period (line 26 minus line 28)	-3,751,258	29