

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF NORTHWEST INDIANA Provider CCN: 15-2028	In Lieu of Form CMS-2552-10	Period : From: 11/01/2015 To: 10/31/2016	Run Date: 03/20/2017 Run Time: 09:14 Version: 2017.01 (02/16/2017)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

**WORKSHEET S
PARTS I, II & III**

PART I - COST REPORT STATUS

Provider use only		1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted the cost report 4. <input type="checkbox"/> Medicare Utilization. Enter 'F' for full or 'L' for low.	Date: 03/20/2017 Time: 09:14
Contractor use only	5. <input type="checkbox"/> 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. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ____ 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above 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 NORTHWEST INDIANA (15-2028) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 11/01/2015 and ending 10/31/2016, 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.

(Signed) _____
Officer or Administrator of Provider(s)

Title

Date

PART III - SETTLEMENT SUMMARY

		TITLE XVIII					
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		266,422	-1			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		266,422	-1			200

The above amounts represent 'due to' or 'due from' the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

**WORKSHEET S-2
PART I**

Hospital and Hospital Health Care Complex Address:

1	Street: 9509 GEORGIA STREET	P.O. Box:		1
2	City: CROWN POINT	State: IN	ZIP Code: 46307-6518 County: LAKE	2

Hospital and Hospital-Based Component Identification:

Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
						V	XVIII	XIX	
0	1	2	3	4	5	6	7	8	
3	Hospital	VIBRA HOSPITAL OF NORTHWEST INDIANA	15-2028	23844	2	08/08/2008	N	P	P
4	Subprovider - IPF								
5	Subprovider - IRF								
6	Subprovider - (OTHER)								
7	Swing Beds - SNF								
8	Swing Beds - NF								
9	Hospital-Based SNF								
10	Hospital-Based NF								
11	Hospital-Based OLTC								
12	Hospital-Based HHA								
13	Separately Certified ASC								
14	Hospital-Based Hospice								
15	Hospital-Based Health Clinic - RHC								
16	Hospital-Based Health Clinic - FQHC								
17	Hospital-Based (CMHC)								
18	Renal Dialysis								
19	Other								

20	Cost Reporting Period (mm/dd/yyyy)	From: 11/01/2015	To: 10/31/2016	20
21	Type of control (see instructions)	6		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	
22.01	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
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter 'Y' for yes or 'N' for no.		N	23

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

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	1					
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1					
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:		Ending:			
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.						
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)	N					
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:			

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

**WORKSHEET S-2
PART I**

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

Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete 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
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	N			60
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or 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 and enter in column 4 direct GME FTE unweighted count.

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

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

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

62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital 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 64-67. (see instructions)	N			63
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**WORKSHEET S-2
PART I**

Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all 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 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 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 a 'subclause (II)' LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter 'Y' for yes and 'N' for no.	N		87

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**WORKSHEET S-2
PART I**

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

Rural Providers

		1	2		
105	Does this hospital qualify as a critical access hospital (CAH)?	N		105	
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106	
107	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	
		Physical	Occupational	Speech	Respiratory
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.				
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.			N	110

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. 15-1, 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 or similar taxes? 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, if applicable in column 2.				126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				129
130	If this is a Medicare certified pancreas transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				131
132	If this is a Medicare certified islet transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.				134

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**WORKSHEET S-2
PART I**

All Providers

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

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

141	Name: VIBRA MANAGEMENT LLC	Contractor's Name: CGS	Contractor's Number: 15101	141
142	Street: 4550 LENA DRIVE	P.O. Box:		142
143	City: MECHANICSBURG	State: PA	ZIP Code: 17055	143
144	Are provider based physicians' costs included in Worksheet A?	Y		144
145	If costs for renal services are claimed on 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			156
157	Subprovider - IRF	N	N			157
158	Subprovider - Other					158
159	SNF	N	N			159
160	HHH	N	N			160
161	CMHC		N			161
161.10	CORF					161.10

Multicampus

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

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

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

**WORKSHEET S-2
PART II**

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

COMPLETED BY ALL HOSPITALS

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

		Y/N	Type	Date	
Financial Data and Reports					
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				
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			
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12
13	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14

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

		Part A		Part B	
		Y/N	Date	Y/N	Date
PS&R Report Data					
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	02/03/2017	Y	02/03/2017
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N	
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	
20	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

**WORKSHEET S-2
PART II**

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

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

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

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

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

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

Home Office Costs		Y/N	Date	
		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: REIMBURSEMENT MANAGER
42	Employer: VIBRA		
43	Phone number: 717-591-5794	E-mail Address: KROSSEY@VIBRAHEALTH.COM	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

**WORKSHEET S-3
PART I**

	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Inpatient Days / Outpatient Visits / Trips			Total All Patients	
						Title V	Title XVIII	Title XIX		
		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	40	14,640			9,052		12,259	1
2	HMO and other (see instructions)						1,225	212		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)		40	14,640			9,052		12,259	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)		40	14,640			9,052		12,259	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)		40							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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

**WORKSHEET S-3
PART I**

	Component	Full Time Equivalents			DISCHARGES				
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					396		520	1
2	HMO and other (see instructions)					51	15		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)		113.08			396		520	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)		113.08						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

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HOSPITAL WAGE INDEX INFORMATION

**WORKSHEET S-3
PARTS II-III**

Part II - Wage Data

	Wkst A Line No.	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)	
	1	2	3	4	5	6	
SALARIES							
1	Total salaries (see instructions)	200	7,579,197				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		85,555				26
27	Administrative & General		1,160,005				27
28	Administrative & General under contract (see instructions)						28
29	Maintenance & Repairs						29
30	Operation of Plant		167,917				30
31	Laundry & Linen Service						31
32	Housekeeping		126,167				32
33	Housekeeping under contract (see instructions)						33
34	Dietary		281,432				34
35	Dietary under contract (see instructions)						35
36	Cafeteria						36
37	Maintenance of Personnel						37
38	Nursing Administration		264,778				38
39	Central Services and Supply						39
40	Pharmacy		425,314				40
41	Medical Records & Medical Records Library		82,876				41
42	Social Service						42
43	Other General Service						43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		7,579,197		7,579,197		1
2	Excluded area salaries (see instructions)						2
3	Subtotal salaries (line 1 minus line 2)		7,579,197		7,579,197		3
4	Subtotal other wages & related costs (see instructions)						4
5	Subtotal wage-related costs (see instructions)						5
6	Total (sum of lines 3 through 5)		7,579,197		7,579,197		6
7	Total overhead cost (see instructions)		2,594,044		2,594,044		7

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HOSPITAL WAGE RELATED COSTS

**WORKSHEET S-3
PART IV**

Part IV - Wage Related Cost

Part A - Core List

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

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)	25
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HOSPITAL CONTRACT LABOR AND BENEFIT COST

**WORKSHEET S-3
PART V**

Part V - Contract Labor and Benefit Cost

Hospital and Hospital-Based Component Identification:

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

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt		1,631,353	1,631,353		1,631,353		1,631,353	1
2	00200	Cap Rel Costs-Mvble Equip		314,469	314,469		314,469		314,469	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	85,555	1,748,565	1,834,120		1,834,120		1,834,120	4
5	00500	Administrative & General	1,160,005	858,533	2,018,538		2,018,538	1,048,360	3,066,898	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	167,917	383,724	551,641		551,641		551,641	7
8	00800	Laundry & Linen Service		145,629	145,629		145,629		145,629	8
9	00900	Housekeeping	126,167	63,537	189,704		189,704		189,704	9
10	01000	Dietary	281,432	119,868	401,300		401,300		401,300	10
11	01100	Cafeteria								11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	264,778	2,564	267,342		267,342		267,342	13
14	01400	Central Services & Supply		563,438	563,438		563,438		563,438	14
15	01500	Pharmacy	425,314	15,291	440,605		440,605		440,605	15
16	01600	Medical Records & Library	82,876	57,219	140,095		140,095		140,095	16
17	01700	Social Service								17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	4,236,231	1,349,756	5,585,987		5,585,987	-353,775	5,232,212	30
		ANCILLARY SERVICE COST CENTERS								
54	05400	Radiology-Diagnostic		159,800	159,800		159,800		159,800	54
60	06000	Laboratory		359,528	359,528		359,528		359,528	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	748,922	56,786	805,708		805,708		805,708	65
66	06600	Physical Therapy		256,794	256,794		256,794		256,794	66
67	06700	Occupational Therapy		247,530	247,530		247,530		247,530	67
68	06800	Speech Pathology		84,988	84,988		84,988		84,988	68
71	07100	Medical Supplies Charged to Patients		199,096	199,096		199,096		199,096	71
73	07300	Drugs Charged to Patients		1,164,985	1,164,985		1,164,985		1,164,985	73
74	07400	Renal Dialysis		364,800	364,800		364,800		364,800	74
76	03950	WOUND CARE								76
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	7,579,197	10,148,253	17,727,450		17,727,450	694,585	18,422,035	118
		NONREIMBURSABLE COST CENTERS								
194	07950	PHYSICIAN MEALS								194
200		TOTAL (sum of lines 118-199)	7,579,197	10,148,253	17,727,450		17,727,450	694,585	18,422,035	200

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RECLASSIFICATIONS

WORKSHEET A-6

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

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

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RECLASSIFICATIONS

WORKSHEET A-6

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

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

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RECONCILIATION OF CAPITAL COST CENTERS

**WORKSHEET A-7
PARTS I, II & III**

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
			Purchases	Donation	Total				
		1	2	3	4	5	6	7	
1	Land								1
2	Land Improvements	2,509	82,093		82,093		84,602		2
3	Buildings and Fixtures								3
4	Building Improvements	15,183	5,150		5,150		20,333		4
5	Fixed Equipment	36,002	10,991		10,991		46,993		5
6	Movable Equipment	306,275	76,500		76,500		382,775		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	359,969	174,734		174,734		534,703		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	359,969	174,734		174,734		534,703		10

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

	Description	SUMMARY OF CAPITAL							Total (1) (sum of cols. 9 through 14)	
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt		1,471,021			158,371	1,961	1,631,353	1	
2	Cap Rel Costs-Mvble Equip	78,527	235,942					314,469	2	
3	Total (sum of lines 1-2)	78,527	1,706,963			158,371	1,961	1,945,822	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 line 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	151,927		151,927	0.329915					1
2	Cap Rel Costs-Mvble Equip	382,776	74,200	308,576	0.670085					2
3	Total (sum of lines 1-2)	534,703	74,200	460,503	1.000000					3

	Description	SUMMARY OF CAPITAL							Total (2) (sum of cols. 9 through 14)	
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt		1,471,021			158,371	1,961	1,631,353	1	
2	Cap Rel Costs-Mvble Equip	78,527	235,942					314,469	2	
3	Total (sum of lines 1-2)	78,527	1,706,963			158,371	1,961	1,945,822	3	

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

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		Wkst. A-7 Ref.
				COST CENTER	LINE#	
		1	2	3	4	5
1	Investment income-buildings & fixtures (chapter 2)			Cap Rel Costs-Bldg & Fixt	1	1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2	2
3	Investment income-other (chapter 2)	B	-298	Administrative & General	5	3
4	Trade, quantity, and time discounts (chapter 8)					4
5	Refunds and rebates of expenses (chapter 8)					5
6	Rental of provider space by suppliers (chapter 8)					6
7	Telephone services (pay stations excl) (chapter 21)					7
8	Television and radio service (chapter 21)					8
9	Parking lot (chapter 21)					9
10	Provider-based physician adjustment	Wkst A-8-2	-353,775			10
11	Sale of scrap, waste, etc. (chapter 23)					11
12	Related organization transactions (chapter 10)	Wkst A-8-1	1,109,837			12
13	Laundry and linen service					13
14	Cafeteria - employees and guests					14
15	Rental of quarters to employees & others					15
16	Sale of medical and surgical supplies to other than patients					16
17	Sale of drugs to other than patients					17
18	Sale of medical records and abstracts					18
19	Nursing school (tuition,fees,books,etc.)					19
20	Vending machines					20
21	Income from imposition of interest, finance or penalty charges (chapter 21)					21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments					22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65	23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66	24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114	25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1	26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2	27
28	Non-physician anesthetist			Nonphysician Anesthetists	19	28
29	Physicians' assistant					29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67	30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68	31
32	CAH HIT Adj for Depreciation					32
33	OTHER OPERATING INCOME	B	-20,641	Administrative & General	5	33
34	CHARITABLE CONTRIBUTIONS	A	-250	Administrative & General	5	34
35	COST REPORT NON-ALLOWABLE	A	-134	Administrative & General	5	35
36	BANK CHARGES & FEES	A	-311	Administrative & General	5	36
37	MARKETING - NON ALLOWABLE	A	-38,486	Administrative & General	5	37
38	BUSINESS GIFTS	A	-1,357	Administrative & General	5	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)		694,585			50

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

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

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

WORKSHEET A-8-1

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

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1	5	Administrative & General	CORPORATE EXPENSES	1,466,025	356,188	1,109,837		1
2								2
3								3
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12			1,466,025	356,188	1,109,837		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			
				Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
6	B	VIBRA MANAGEMENT LLC	100.00	VIBRA HEALTHCARE LLC	100.00	CORPORATE OFFICE	6
7							7
8							8
9							9
10							10

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

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

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun- eration	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								1
2	30	Adults & Pediatrics PHYSICIAN DIREC	199,150	181,150	18,000	206,300	72	7,141	357	2
3	30	Adults & Pediatrics PHYSICIAN CONSU	273,842	48,000	225,842	206,300	1,130	112,076	5,604	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	472,992	229,150	243,842		1,202	119,217	5,961	200

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VIBRA HOSPITAL OF NORTHWEST INDIANA Provider CCN: 15-2028	In Lieu of Form CMS-2552-10	Period : From: 11/01/2015 To: 10/31/2016	Run Date: 03/20/2017 Run Time: 09:14 Version: 2017.01 (02/16/2017)
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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	30	Adults & Pediatrics								1
2	30	Adults & Pediatrics PHYSICIAN DIREC					7,141	10,859	192,009	2
3	30	Adults & Pediatrics PHYSICIAN CONSU					112,076	113,766	161,766	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					119,217	124,625	353,775	200

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINISTRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	1,631,353	1,631,353					1
2	Cap Rel Costs-Mvble Equip	314,469		314,469				2
4	Employee Benefits Department	1,834,120			1,834,120			4
5	Administrative & General	3,066,898	96,415	18,586	283,919	3,465,818	3,465,818	5
6	Maintenance & Repairs							6
7	Operation of Plant	551,641	605,717	116,762	41,099	1,315,219	304,777	7
8	Laundry & Linen Service	145,629	21,319	4,110		171,058	39,639	8
9	Housekeeping	189,704	11,532	2,223	30,880	234,339	54,304	9
10	Dietary	401,300	80,215	15,463	68,882	565,860	131,127	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	267,342			64,806	332,148	76,969	13
14	Central Services & Supply	563,438				563,438	130,566	14
15	Pharmacy	440,605	26,551	5,118	104,099	576,373	133,563	15
16	Medical Records & Library	140,095	19,632	3,784	20,284	183,795	42,591	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	5,232,212	703,315	135,573	1,036,847	7,107,947	1,647,131	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	159,800	4,050	781		164,631	38,150	54
60	Laboratory	359,528	3,431	661		363,620	84,262	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	805,708	2,138	412	183,304	991,562	229,776	65
66	Physical Therapy	256,794	16,369	3,155		276,318	64,031	66
67	Occupational Therapy	247,530	19,519	3,763		270,812	62,756	67
68	Speech Pathology	84,988	5,850	1,128		91,966	21,311	68
71	Medical Supplies Charged to Patients	199,096	9,844	1,898		210,838	48,858	71
73	Drugs Charged to Patients	1,164,985				1,164,985	269,963	73
74	Renal Dialysis	364,800	5,456	1,052		371,308	86,044	74
76	WOUND CARE							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	18,422,035	1,631,353	314,469	1,834,120	18,422,035	3,465,818	118
	NONREIMBURSABLE COST CENTERS							
194	PHYSICIAN MEALS							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	18,422,035	1,631,353	314,469	1,834,120	18,422,035	3,465,818	202

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	
		7	8	9	10	13	14	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	1,619,996						7
8	Laundry & Linen Service	37,168	247,865					8
9	Housekeeping	20,104		308,747				9
10	Dietary	139,846		27,629	864,462			10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration					409,117		13
14	Central Services & Supply						694,004	14
15	Pharmacy	46,288		9,145				15
16	Medical Records & Library	34,226		6,762				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	1,226,152	247,865	242,252	864,462	409,117		30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	7,061		1,395				54
60	Laboratory	5,982		1,182				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	3,727		736				65
66	Physical Therapy	28,538		5,638				66
67	Occupational Therapy	34,030		6,723				67
68	Speech Pathology	10,199		2,015				68
71	Medical Supplies Charged to Patients	17,162		3,391			694,004	71
73	Drugs Charged to Patients							73
74	Renal Dialysis	9,513		1,879				74
76	WOUND CARE							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,619,996	247,865	308,747	864,462	409,117	694,004	118
	NONREIMBURSABLE COST CENTERS							
194	PHYSICIAN MEALS							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,619,996	247,865	308,747	864,462	409,117	694,004	202

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		15	16	24	25	26	
	GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5	Administrative & General						5
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy	765,369					15
16	Medical Records & Library		267,374				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		267,374	12,012,300		12,012,300	30
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic			211,237		211,237	54
60	Laboratory			455,046		455,046	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy			1,225,801		1,225,801	65
66	Physical Therapy			374,525		374,525	66
67	Occupational Therapy			374,321		374,321	67
68	Speech Pathology			125,491		125,491	68
71	Medical Supplies Charged to Patients			974,253		974,253	71
73	Drugs Charged to Patients	765,369		2,200,317		2,200,317	73
74	Renal Dialysis			468,744		468,744	74
76	WOUND CARE						76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)	765,369	267,374	18,422,035		18,422,035	118
	NONREIMBURSABLE COST CENTERS						
194	PHYSICIAN MEALS						194
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	765,369	267,374	18,422,035		18,422,035	202

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF NORTHWEST INDIANA Provider CCN: 15-2028	In Lieu of Form CMS-2552-10	Period : From: 11/01/2015 To: 10/31/2016	Run Date: 03/20/2017 Run Time: 09:14 Version: 2017.01 (02/16/2017)
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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	ADMINIS- TRATIVE & GENERAL	OPERATION OF PLANT	
		0	1	2	2A	5	7	
	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		96,415	18,586	115,001	115,001		5
6	Maintenance & Repairs							6
7	Operation of Plant		605,717	116,762	722,479	10,113	732,592	7
8	Laundry & Linen Service		21,319	4,110	25,429	1,315	16,808	8
9	Housekeeping		11,532	2,223	13,755	1,802	9,091	9
10	Dietary		80,215	15,463	95,678	4,351	63,241	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration					2,554		13
14	Central Services & Supply					4,332		14
15	Pharmacy		26,551	5,118	31,669	4,432	20,932	15
16	Medical Records & Library		19,632	3,784	23,416	1,413	15,478	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		703,315	135,573	838,888	54,655	554,490	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic		4,050	781	4,831	1,266	3,193	54
60	Laboratory		3,431	661	4,092	2,796	2,705	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		2,138	412	2,550	7,624	1,685	65
66	Physical Therapy		16,369	3,155	19,524	2,125	12,905	66
67	Occupational Therapy		19,519	3,763	23,282	2,082	15,389	67
68	Speech Pathology		5,850	1,128	6,978	707	4,612	68
71	Medical Supplies Charged to Patients		9,844	1,898	11,742	1,621	7,761	71
73	Drugs Charged to Patients					8,958		73
74	Renal Dialysis		5,456	1,052	6,508	2,855	4,302	74
76	WOUND CARE							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)		1,631,353	314,469	1,945,822	115,001	732,592	118
	NONREIMBURSABLE COST CENTERS							
194	PHYSICIAN MEALS							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		1,631,353	314,469	1,945,822	115,001	732,592	202

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF NORTHWEST INDIANA Provider CCN: 15-2028	In Lieu of Form CMS-2552-10	Period : From: 11/01/2015 To: 10/31/2016	Run Date: 03/20/2017 Run Time: 09:14 Version: 2017.01 (02/16/2017)
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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		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	43,552						8
9	Housekeeping		24,648					9
10	Dietary		2,206	165,476				10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration				2,554			13
14	Central Services & Supply					4,332		14
15	Pharmacy		730				57,763	15
16	Medical Records & Library		540					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	43,552	19,339	165,476	2,554			30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic		111					54
60	Laboratory		94					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		59					65
66	Physical Therapy		450					66
67	Occupational Therapy		537					67
68	Speech Pathology		161					68
71	Medical Supplies Charged to Patients		271			4,332		71
73	Drugs Charged to Patients						57,763	73
74	Renal Dialysis		150					74
76	WOUND CARE							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	43,552	24,648	165,476	2,554	4,332	57,763	118
	NONREIMBURSABLE COST CENTERS							
194	PHYSICIAN MEALS							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	43,552	24,648	165,476	2,554	4,332	57,763	202

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VIBRA HOSPITAL OF NORTHWEST INDIANA Provider CCN: 15-2028	In Lieu of Form CMS-2552-10	Period : From: 11/01/2015 To: 10/31/2016	Run Date: 03/20/2017 Run Time: 09:14 Version: 2017.01 (02/16/2017)
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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY 16	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26		
	GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5	Administrative & General						5
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library	40,847					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	40,847	1,719,801		1,719,801		30
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic		9,401		9,401		54
60	Laboratory		9,687		9,687		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy		11,918		11,918		65
66	Physical Therapy		35,004		35,004		66
67	Occupational Therapy		41,290		41,290		67
68	Speech Pathology		12,458		12,458		68
71	Medical Supplies Charged to Patients		25,727		25,727		71
73	Drugs Charged to Patients		66,721		66,721		73
74	Renal Dialysis		13,815		13,815		74
76	WOUND CARE						76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)	40,847	1,945,822		1,945,822		118
	NONREIMBURSABLE COST CENTERS						
194	PHYSICIAN MEALS						194
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	40,847	1,945,822		1,945,822		202

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECONCILIATION	ADMINISTRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	29,001						1
2	Cap Rel Costs-Mvble Equip		29,001					2
4	Employee Benefits Department			7,493,642				4
5	Administrative & General	1,714	1,714	1,160,005	-3,465,818	14,956,217		5
6	Maintenance & Repairs							6
7	Operation of Plant	10,768	10,768	167,917		1,315,219	16,519	7
8	Laundry & Linen Service	379	379			171,058	379	8
9	Housekeeping	205	205	126,167		234,339	205	9
10	Dietary	1,426	1,426	281,432		565,860	1,426	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration			264,778		332,148		13
14	Central Services & Supply					563,438		14
15	Pharmacy	472	472	425,314		576,373	472	15
16	Medical Records & Library	349	349	82,876		183,795	349	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	12,503	12,503	4,236,231		7,107,947	12,503	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	72	72			164,631	72	54
60	Laboratory	61	61			363,620	61	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	38	38	748,922		991,562	38	65
66	Physical Therapy	291	291			276,318	291	66
67	Occupational Therapy	347	347			270,812	347	67
68	Speech Pathology	104	104			91,966	104	68
71	Medical Supplies Charged to Patients	175	175			210,838	175	71
73	Drugs Charged to Patients					1,164,985		73
74	Renal Dialysis	97	97			371,308	97	74
76	WOUND CARE							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	29,001	29,001	7,493,642	-3,465,818	14,956,217	16,519	118
	NONREIMBURSABLE COST CENTERS							
194	PHYSICIAN MEALS							194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,631,353	314,469	1,834,120		3,465,818	1,619,996	202
203	Unit Cost Multiplier (Wkst. B, Part I)	56.251612	10.843385	0.244757		0.231731	98.068648	203
204	Cost to be allocated (Per Wkst. B, Part II)					115,001	732,592	204
205	Unit Cost Multiplier (Wkst. B, Part II)					0.007689	44.348447	205

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE PATIENT DAYS	HOUSE-KEEPING SQUARE FEET	DIETARY PATIENT DAYS	NURSING ADMINISTRATION PATIENT DAYS	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	12,259						8
9	Housekeeping		15,935					9
10	Dietary		1,426	12,259				10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration				12,259			13
14	Central Services & Supply					100		14
15	Pharmacy		472				100	15
16	Medical Records & Library		349					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	12,259	12,503	12,259	12,259			30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic		72					54
60	Laboratory		61					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		38					65
66	Physical Therapy		291					66
67	Occupational Therapy		347					67
68	Speech Pathology		104					68
71	Medical Supplies Charged to Patients		175			100		71
73	Drugs Charged to Patients						100	73
74	Renal Dialysis		97					74
76	WOUND CARE							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	12,259	15,935	12,259	12,259	100	100	118
	NONREIMBURSABLE COST CENTERS							
194	PHYSICIAN MEALS							194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	247,865	308,747	864,462	409,117	694,004	765,369	202
203	Unit Cost Multiplier (Wkst. B, Part I)	20.219023	19.375400	70.516518	33.372787	6,940.040000	7,653.690000	203
204	Cost to be allocated (Per Wkst. B, Part II)	43,552	24,648	165,476	2,554	4,332	57,763	204
205	Unit Cost Multiplier (Wkst. B, Part II)	3.552655	1.546784	13.498328	0.208337	43.320000	577.630000	205

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY PATIENT DAYS						
		16						

GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt					1
2	Cap Rel Costs-Mvble Equip					2
4	Employee Benefits 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	12,259				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	12,259				30
ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic					54
60	Laboratory					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy					65
66	Physical Therapy					66
67	Occupational Therapy					67
68	Speech Pathology					68
71	Medical Supplies Charged to Patients					71
73	Drugs Charged to Patients					73
74	Renal Dialysis					74
76	WOUND CARE					76
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct Part)					92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)	12,259				118
NONREIMBURSABLE COST CENTERS						
194	PHYSICIAN MEALS					194
200	Cross foot adjustments					200
201	Negative cost centers					201
202	Cost to be allocated (Per Wkst. B, Part I)	267,374				202
203	Unit Cost Multiplier (Wkst. B, Part I)	21.810425				203
204	Cost to be allocated (Per Wkst. B, Part II)	40,847				204
205	Unit Cost Multiplier (Wkst. B, Part II)	3.332001				205

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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		
		PART	LINE NO.	AMOUNT
	1	2	3	4

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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	COSTS					
		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	12,012,300		12,012,300	124,625	12,136,925	30
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	211,237		211,237		211,237	54
60	Laboratory	455,046		455,046		455,046	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	1,225,801		1,225,801		1,225,801	65
66	Physical Therapy	374,525		374,525		374,525	66
67	Occupational Therapy	374,321		374,321		374,321	67
68	Speech Pathology	125,491		125,491		125,491	68
71	Medical Supplies Charged to Patients	974,253		974,253		974,253	71
73	Drugs Charged to Patients	2,200,317		2,200,317		2,200,317	73
74	Renal Dialysis	468,744		468,744		468,744	74
76	WOUND CARE						76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
200	Subtotal (sum of lines 30 thru 199)	18,422,035		18,422,035	124,625	18,546,660	200
201	Less Observation Beds						201
202	Total (line 200 minus line 201)	18,422,035		18,422,035		18,546,660	202

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF NORTHWEST INDIANA Provider CCN: 15-2028	In Lieu of Form CMS-2552-10	Period : From: 11/01/2015 To: 10/31/2016	Run Date: 03/20/2017 Run Time: 09:14 Version: 2017.01 (02/16/2017)
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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	CHARGES			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		Inpatient	Outpatient	Total (column 6 + column 7)				
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	33,643,360		33,643,360				30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	823,973	367	824,340	0.256250	0.256250	0.256250	54
60	Laboratory	2,036,476		2,036,476	0.223448	0.223448	0.223448	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	9,337,654		9,337,654	0.131275	0.131275	0.131275	65
66	Physical Therapy	618,200		618,200	0.605831	0.605831	0.605831	66
67	Occupational Therapy	591,689		591,689	0.632631	0.632631	0.632631	67
68	Speech Pathology	206,132		206,132	0.608790	0.608790	0.608790	68
71	Medical Supplies Charged to Patients	1,058,991		1,058,991	0.919982	0.919982	0.919982	71
73	Drugs Charged to Patients	15,831,763		15,831,763	0.138981	0.138981	0.138981	73
74	Renal Dialysis	2,467,080		2,467,080	0.190000	0.190000	0.190000	74
76	WOUND CARE							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (sum of lines 30 thru 199)	66,615,318	367	66,615,685				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	66,615,318	367	66,615,685				202

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF NORTHWEST INDIANA Provider CCN: 15-2028	In Lieu of Form CMS-2552-10	Period : From: 11/01/2015 To: 10/31/2016	Run Date: 03/20/2017 Run Time: 09:14 Version: 2017.01 (02/16/2017)
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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)	1,719,801		1,719,801	12,259	140.29	9,052	1,269,905	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)	1,719,801		1,719,801	12,259		9,052	1,269,905	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF NORTHWEST INDIANA Provider CCN: 15-2028	In Lieu of Form CMS-2552-10	Period : From: 11/01/2015 To: 10/31/2016	Run Date: 03/20/2017 Run Time: 09:14 Version: 2017.01 (02/16/2017)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-2028

**WORKSHEET D
PART II**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	9,401	824,340	0.011404	596,723	6,805	54
60	Laboratory	9,687	2,036,476	0.004757	1,475,592	7,019	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	11,918	9,337,654	0.001276	6,329,229	8,076	65
66	Physical Therapy	35,004	618,200	0.056622	445,057	25,200	66
67	Occupational Therapy	41,290	591,689	0.069783	441,163	30,786	67
68	Speech Pathology	12,458	206,132	0.060437	125,534	7,587	68
71	Medical Supplies Charged to Pat	25,727	1,058,991	0.024294	739,633	17,969	71
73	Drugs Charged to Patients	66,721	15,831,763	0.004214	11,863,469	49,993	73
74	Renal Dialysis	13,815	2,467,080	0.005600	1,945,325	10,894	74
76	WOUND CARE						76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct)						92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	226,021	32,972,325		23,961,725	164,329	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF NORTHWEST INDIANA Provider CCN: 15-2028	In Lieu of Form CMS-2552-10	Period : From: 11/01/2015 To: 10/31/2016	Run Date: 03/20/2017 Run Time: 09:14 Version: 2017.01 (02/16/2017)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

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

		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjust- ment Amount (see instruct- ions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	Cost Center Description	1	2	3	4	5	
	INPATIENT ROUTINE 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 NORTHWEST INDIANA Provider CCN: 15-2028	In Lieu of Form CMS-2552-10	Period : From: 11/01/2015 To: 10/31/2016	Run Date: 03/20/2017 Run Time: 09:14 Version: 2017.01 (02/16/2017)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

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

(A)	Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	12,259		9,052		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)	12,259		9,052		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF NORTHWEST INDIANA Provider CCN: 15-2028	In Lieu of Form CMS-2552-10	Period : From: 11/01/2015 To: 10/31/2016	Run Date: 03/20/2017 Run Time: 09:14 Version: 2017.01 (02/16/2017)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 15-2028

**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

(A)	Cost Center Description	1 Non Physician Anesth- etist Cost	2 Nursing School	3 Allied Health	4 All Other Medical Education Cost	5 Total Cost (sum of col. 1 through col. 4)	6 Total Outpatient Cost (sum of col. 2, 3, and 4)	
	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	WOUND CARE							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF NORTHWEST INDIANA Provider CCN: 15-2028	In Lieu of Form CMS-2552-10	Period : From: 11/01/2015 To: 10/31/2016	Run Date: 03/20/2017 Run Time: 09:14 Version: 2017.01 (02/16/2017)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 15-2028

**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

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	824,340			596,723		367		54
60	Laboratory	2,036,476			1,475,592				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	9,337,654			6,329,229				65
66	Physical Therapy	618,200			445,057				66
67	Occupational Therapy	591,689			441,163				67
68	Speech Pathology	206,132			125,534				68
71	Medical Supplies Charged to Pat	1,058,991			739,633				71
73	Drugs Charged to Patients	15,831,763			11,863,469				73
74	Renal Dialysis	2,467,080			1,945,325				74
76	WOUND CARE								76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct)								92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	32,972,325			23,961,725		367		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF NORTHWEST INDIANA Provider CCN: 15-2028	In Lieu of Form CMS-2552-10	Period : From: 11/01/2015 To: 10/31/2016	Run Date: 03/20/2017 Run Time: 09:14 Version: 2017.01 (02/16/2017)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-2028

WORKSHEET D
PART V

Check Title V - O/P Hospital SUB (Other) Swing Bed SNF
 Applicable Title XVIII, Part B IPF SNF Swing Bed NF
 Boxes: Title XIX - O/P IRF NF ICF/IID

(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost			
			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	0.256250	367			94			54
60	Laboratory	0.223448							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.131275							65
66	Physical Therapy	0.605831							66
67	Occupational Therapy	0.632631							67
68	Speech Pathology	0.608790							68
71	Medical Supplies Charged to Pat	0.919982							71
73	Drugs Charged to Patients	0.138981							73
74	Renal Dialysis	0.190000							74
76	WOUND CARE								76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct)								92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		367			94			200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		367			94			202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF NORTHWEST INDIANA Provider CCN: 15-2028	In Lieu of Form CMS-2552-10	Period : From: 11/01/2015 To: 10/31/2016	Run Date: 03/20/2017 Run Time: 09:14 Version: 2017.01 (02/16/2017)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

**WORKSHEET D
PART I**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, (col. 26))	Swing Bed Adjustment	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)	
		1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	1,719,801		1,719,801	12,259	140.29			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)	1,719,801		1,719,801	12,259				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF NORTHWEST INDIANA Provider CCN: 15-2028	In Lieu of Form CMS-2552-10	Period : From: 11/01/2015 To: 10/31/2016	Run Date: 03/20/2017 Run Time: 09:14 Version: 2017.01 (02/16/2017)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-2028

**WORKSHEET D
PART II**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	9,401	824,340	0.011404			54
60	Laboratory	9,687	2,036,476	0.004757			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	11,918	9,337,654	0.001276			65
66	Physical Therapy	35,004	618,200	0.056622			66
67	Occupational Therapy	41,290	591,689	0.069783			67
68	Speech Pathology	12,458	206,132	0.060437			68
71	Medical Supplies Charged to Pat	25,727	1,058,991	0.024294			71
73	Drugs Charged to Patients	66,721	15,831,763	0.004214			73
74	Renal Dialysis	13,815	2,467,080	0.005600			74
76	WOUND CARE						76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct)						92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	226,021	32,972,325				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF NORTHWEST INDIANA Provider CCN: 15-2028	In Lieu of Form CMS-2552-10	Period : From: 11/01/2015 To: 10/31/2016	Run Date: 03/20/2017 Run Time: 09:14 Version: 2017.01 (02/16/2017)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

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

(A)	Cost Center Description	1 Nursing School	2 Allied Health Cost	3 All Other Medical Education Cost	4 Swing-Bed Adjustment Amount (see instructions)	5 Total Costs (sum of cols. 1 through 3 minus col 4.)	
	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 NORTHWEST INDIANA Provider CCN: 15-2028	In Lieu of Form CMS-2552-10	Period : From: 11/01/2015 To: 10/31/2016	Run Date: 03/20/2017 Run Time: 09:14 Version: 2017.01 (02/16/2017)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

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

(A)	Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics (General Routine Care)	12,259			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)	12,259			200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF NORTHWEST INDIANA Provider CCN: 15-2028	In Lieu of Form CMS-2552-10	Period : From: 11/01/2015 To: 10/31/2016	Run Date: 03/20/2017 Run Time: 09:14 Version: 2017.01 (02/16/2017)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 15-2028

**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

(A)	Cost Center Description	Non Physician Anesthetist Cost	Nursing School	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)	
	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	WOUND CARE							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct)							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF NORTHWEST INDIANA Provider CCN: 15-2028	In Lieu of Form CMS-2552-10	Period : From: 11/01/2015 To: 10/31/2016	Run Date: 03/20/2017 Run Time: 09:14 Version: 2017.01 (02/16/2017)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 15-2028

**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

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	824,340							54
60	Laboratory	2,036,476							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	9,337,654							65
66	Physical Therapy	618,200							66
67	Occupational Therapy	591,689							67
68	Speech Pathology	206,132							68
71	Medical Supplies Charged to Pat	1,058,991							71
73	Drugs Charged to Patients	15,831,763							73
74	Renal Dialysis	2,467,080							74
76	WOUND CARE								76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct)								92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	32,972,325							200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF NORTHWEST INDIANA Provider CCN: 15-2028	In Lieu of Form CMS-2552-10	Period : From: 11/01/2015 To: 10/31/2016	Run Date: 03/20/2017 Run Time: 09:14 Version: 2017.01 (02/16/2017)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-2028

WORKSHEET D
PART V

Check Title V - O/P Hospital SUB (Other) Swing Bed SNF
 Applicable Title XVIII, Part B IPF SNF Swing Bed NF
 Boxes: Title XIX - O/P IRF 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	0.256250							54
60	Laboratory	0.223448							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.131275							65
66	Physical Therapy	0.605831							66
67	Occupational Therapy	0.632631							67
68	Speech Pathology	0.608790							68
71	Medical Supplies Charged to Pat	0.919982							71
73	Drugs Charged to Patients	0.138981							73
74	Renal Dialysis	0.190000							74
76	WOUND CARE								76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct)								92
	OTHER REIMBURSABLE COST CENTERS								
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 NORTHWEST INDIANA Provider CCN: 15-2028	In Lieu of Form CMS-2552-10	Period : From: 11/01/2015 To: 10/31/2016	Run Date: 03/20/2017 Run Time: 09:14 Version: 2017.01 (02/16/2017)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-2028

WORKSHEET D-1
PART I

Check [] Title V - I/P [XX] Hospital [] SUB (Other) [] ICF/IID [XX] PPS
 Applicable [XX] 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)	12,259	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	12,259	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)	12,259	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)	9,052	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)	12,136,925	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	12,136,925	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	12,136,925	37

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF NORTHWEST INDIANA Provider CCN: 15-2028	In Lieu of Form CMS-2552-10	Period : From: 11/01/2015 To: 10/31/2016	Run Date: 03/20/2017 Run Time: 09:14 Version: 2017.01 (02/16/2017)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-2028

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

38	Adjusted general inpatient routine service cost per diem (see instructions)					990.04	38
39	Program general inpatient routine service cost (line 9 x line 38)					8,961,842	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)					8,961,842	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

48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					4,637,502	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					13,599,344	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,269,905	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					164,329	51
52	Total Program excludable cost (sum of lines 50 and 51)					1,434,234	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					12,165,110	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 NORTHWEST INDIANA Provider CCN: 15-2028	In Lieu of Form CMS-2552-10	Period : From: 11/01/2015 To: 10/31/2016	Run Date: 03/20/2017 Run Time: 09:14 Version: 2017.01 (02/16/2017)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-2028

WORKSHEET D-1
PARTS III & IV

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 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)						990.04	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 NORTHWEST INDIANA Provider CCN: 15-2028	In Lieu of Form CMS-2552-10	Period : From: 11/01/2015 To: 10/31/2016	Run Date: 03/20/2017 Run Time: 09:14 Version: 2017.01 (02/16/2017)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-2028

WORKSHEET D-1
PART I

Check [] Title V - I/P [XX] Hospital [] SUB (Other) [] ICF/IID [XX] PPS
 Applicable [] Title XVIII, Part A [] IPF [] SNF [] TEFRA
 Boxes: [XX] 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)	12,259	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	12,259	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)	12,259	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)		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)	12,136,925	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	12,136,925	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	12,136,925	37

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF NORTHWEST INDIANA Provider CCN: 15-2028	In Lieu of Form CMS-2552-10	Period : From: 11/01/2015 To: 10/31/2016	Run Date: 03/20/2017 Run Time: 09:14 Version: 2017.01 (02/16/2017)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-2028

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

38	Adjusted general inpatient routine service cost per diem (see instructions)					990.04	38
39	Program general inpatient routine service cost (line 9 x line 38)						39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)						41
		Total Inpatient Cost	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

48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51
52	Total Program excludable cost (sum of lines 50 and 51)						52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (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 NORTHWEST INDIANA Provider CCN: 15-2028	In Lieu of Form CMS-2552-10	Period : From: 11/01/2015 To: 10/31/2016	Run Date: 03/20/2017 Run Time: 09:14 Version: 2017.01 (02/16/2017)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-2028

WORKSHEET D-1
PARTS III & IV

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 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 NORTHWEST INDIANA Provider CCN: 15-2028	In Lieu of Form CMS-2552-10	Period : From: 11/01/2015 To: 10/31/2016	Run Date: 03/20/2017 Run Time: 09:14 Version: 2017.01 (02/16/2017)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-2028

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		25,570,409		30
	ANCILLARY SERVICE COST CENTERS				
54	Radiology-Diagnostic	0.256250	596,723	152,910	54
60	Laboratory	0.223448	1,475,592	329,718	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.131275	6,329,229	830,870	65
66	Physical Therapy	0.605831	445,057	269,629	66
67	Occupational Therapy	0.632631	441,163	279,093	67
68	Speech Pathology	0.608790	125,534	76,424	68
71	Medical Supplies Charged to Patients	0.919982	739,633	680,449	71
73	Drugs Charged to Patients	0.138981	11,863,469	1,648,797	73
74	Renal Dialysis	0.190000	1,945,325	369,612	74
76	WOUND CARE				76
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
92	Observation Beds (Non-Distinct Part)				92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		23,961,725	4,637,502	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		23,961,725		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF NORTHWEST INDIANA Provider CCN: 15-2028	In Lieu of Form CMS-2552-10	Period : From: 11/01/2015 To: 10/31/2016	Run Date: 03/20/2017 Run Time: 09:14 Version: 2017.01 (02/16/2017)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-2028

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
	ANCILLARY SERVICE COST CENTERS				
54	Radiology-Diagnostic	0.256250			54
60	Laboratory	0.223448			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.131275			65
66	Physical Therapy	0.605831			66
67	Occupational Therapy	0.632631			67
68	Speech Pathology	0.608790			68
71	Medical Supplies Charged to Patients	0.919982			71
73	Drugs Charged to Patients	0.138981			73
74	Renal Dialysis	0.190000			74
76	WOUND CARE				76
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
92	Observation Beds (Non-Distinct Part)				92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF NORTHWEST INDIANA Provider CCN: 15-2028	In Lieu of Form CMS-2552-10	Period : From: 11/01/2015 To: 10/31/2016	Run Date: 03/20/2017 Run Time: 09:14 Version: 2017.01 (02/16/2017)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-2028

**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)	94			2
3	PPS payments	59			3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 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 (line 11 minus line 20) (for CAH, 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, 8 and 9)	59			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	12			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)	47			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)	47			30
31	Primary payer payments	1			31
32	Subtotal (line 30 minus line 31)	46			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)	46			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)	46			40
40.01	Sequestration adjustment (see instructions)	1			40.01
41	Interim payments	46			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-1			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter I, §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 NORTHWEST INDIANA Provider CCN: 15-2028	In Lieu of Form CMS-2552-10	Period : From: 11/01/2015 To: 10/31/2016	Run Date: 03/20/2017 Run Time: 09:14 Version: 2017.01 (02/16/2017)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 15-2028

**WORKSHEET E-1
PART I**

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

	DESCRIPTION	INPATIENT PART A		PART B	
		mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT
		1	2	3	4
1	Total interim payments paid to provider		11,612,921		46
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 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)	.01			3.01
		.02			3.02
	Program	.03			3.03
	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)		11,612,921		46
TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)	.01			5.01
		.02			5.02
	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	266,422		6.01
		.02			-1
7	Total Medicare program liability (see instructions)		11,879,343		45
8	Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)
					8

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

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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

**WORKSHEET E-1
PART II**

Check applicable box: Hospital CAH

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	Total hospital discharges as defined in AARA §4102 (Wkst. S-3, Pt. I, col. 15, line 14)		1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)		2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)		3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	12,259	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)		5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)		6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)		7
8	Calculation of the HIT incentive payment (see instructions)		8
9	Sequestration adjustment amount (see instructions)		9
10	Calculation of the HIT incentive payment after sequestration (see instructions)		10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

30	Initial/interim HIT payment(s)		30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)		32

(*) This worksheet is completed by the contractor for standard and non-standard cost reporting periods at cost report settlement. Providers may complete this worksheet for a standard cost reporting period.

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VIBRA HOSPITAL OF NORTHWEST INDIANA Provider CCN: 15-2028	In Lieu of Form CMS-2552-10	Period : From: 11/01/2015 To: 10/31/2016	Run Date: 03/20/2017 Run Time: 09:14 Version: 2017.01 (02/16/2017)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

**WORKSHEET E-3
PART IV**

Check applicable box: Hospital

PART IV - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER LTCH PPS

1	Net Federal PPS payment (see instructions)	12,885,991	1
1.01	Full standard payment amount	8,053,055	1.01
1.02	Short stay outlier standard payment amount	1,892,200	1.02
1.03	Site neutral payment amount - Cost	16,009	1.03
1.04	Site neutral payment amount - IPPS comparable	741,694	1.04
2	Outlier payments	-1,671	2
3	Total PPS payments (sum of lines 1 and 2)	12,884,320	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)	12,884,320	7
8	Primary payer payments	10,125	8
9	Subtotal (line 7 less line 8)	12,874,195	9
10	Deductibles	15,800	10
11	Subtotal (line 9 minus line 10)	12,858,395	11
12	Coinsurance	1,008,476	12
13	Subtotal (line 11 minus line 12)	11,849,919	13
14	Allowable bad debts (exclude bad debts for professional services) (see instructions)	418,246	14
15	Adjusted reimbursable bad debts (see instructions)	271,860	15
16	Allowable bad debts for dual eligible beneficiaries (see instructions)	278,879	16
17	Subtotal (sum of lines 13 and 15)	12,121,779	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)	12,121,779	22
22.01	Sequestration adjustment (see instructions)	242,436	22.01
23	Interim payments	11,612,921	23
24	Tentative settlement (for contractor use only)		24
25	Balance due provider/program (line 22 minus lines 22.01, 23 and 24)	266,422	25
26	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		26

TO BE COMPLETED BY CONTRACTOR

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

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VIBRA HOSPITAL OF NORTHWEST INDIANA Provider CCN: 15-2028	In Lieu of Form CMS-2552-10	Period : From: 11/01/2015 To: 10/31/2016	Run Date: 03/20/2017 Run Time: 09:14 Version: 2017.01 (02/16/2017)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-2028

WORKSHEET E-3
PART VII

Check [] Title V [XX] Hospital [] NF [XX] PPS
 Applicable [XX] 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			1
2			2
3			3
4			4
5			5
6			6
7			7
COMPUTATION OF LESSER OF COST OR CHARGES			
REASONABLE CHARGES			
8			8
9			9
10			10
11			11
12			12
CUSTOMARY CHARGES			
13			13
14			14
15	1.000000	1.000000	15
16			16
17			17
18			18
19			19
20			20
21			21
PROSPECTIVE PAYMENT AMOUNT			
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF NORTHWEST INDIANA Provider CCN: 15-2028	In Lieu of Form CMS-2552-10	Period : From: 11/01/2015 To: 10/31/2016	Run Date: 03/20/2017 Run Time: 09:14 Version: 2017.01 (02/16/2017)
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BALANCE SHEET

WORKSHEET G

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

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
Assets (Omit Cents)		1	2	3	4	
CURRENT ASSETS						
1	Cash on hand and in banks	-75,718				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	3,301,613				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-150,722				6
7	Inventory	179,103				7
8	Prepaid expenses	759,265				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	4,013,541				11
FIXED ASSETS						
12	Land					12
13	Land improvements	84,601				13
14	Accumulated depreciation					14
15	Buildings					15
16	Accumulated depreciation					16
17	Leasehold improvements	15,183				17
18	Accumulated depreciation	-8,181				18
19	Fixed equipment	1,408				19
20	Accumulated depreciation					20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment					23
24	Accumulated depreciation					24
25	Minor equipment depreciable	433,510				25
26	Accumulated depreciation	-187,819				26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	338,702				30
OTHER ASSETS						
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	8,557,118				34
35	Total other assets (sum of lines 31-34)	8,557,118				35
36	Total assets (sum of lines 11, 30 and 35)	12,909,361				36
Liabilities and Fund Balances (Omit Cents)						
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1	2	3	4	
CURRENT LIABILITIES						
37	Accounts payable	850,354				37
38	Salaries, wages and fees payable	542,096				38
39	Payroll taxes payable	-99,816				39
40	Notes and loans payable (short term)					40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds	90,369				43
44	Other current liabilities	290,448				44
45	Total current liabilities (sum of lines 37 thru 44)	1,673,451				45
LONG TERM LIABILITIES						
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	1,112,965				49
50	Total long term liabilities (sum of lines 46 thru 49)	1,112,965				50
51	Total liabilities (sum of lines 45 and 50)	2,786,416				51
CAPITAL ACCOUNTS						
52	General fund balance	10,122,945				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)	10,122,945				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	12,909,361				60

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF NORTHWEST INDIANA Provider CCN: 15-2028	In Lieu of Form CMS-2552-10	Period : From: 11/01/2015 To: 10/31/2016	Run Date: 03/20/2017 Run Time: 09:14 Version: 2017.01 (02/16/2017)
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STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	Fund balances at beginning of period		12,391,884			1
2	Net income (loss) (from Worksheet G-3, line 29)		-154,768			2
3	Total (sum of line 1 and line 2)		12,237,116			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)		12,237,116			11
12	Deductions (debit adjustments) (specify)					12
13	PRIOR PERIOD ADJSUSTMENT	2,114,171				13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)		2,114,171			18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		10,122,945			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	PRIOR PERIOD ADJSUSTMENT					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 NORTHWEST INDIANA Provider CCN: 15-2028	In Lieu of Form CMS-2552-10	Period : From: 11/01/2015 To: 10/31/2016	Run Date: 03/20/2017 Run Time: 09:14 Version: 2017.01 (02/16/2017)
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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

**WORKSHEET G-2
PARTS I & II**

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	33,643,360		33,643,360	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)	33,643,360		33,643,360	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)	33,643,360		33,643,360	17
18	Ancillary services	32,972,326		32,972,326	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 PATIENT REVENUES	292,901		292,901	27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	66,908,587		66,908,587	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		17,727,450	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)		17,727,450	43

KPMG LLP Compu-Max 2552-10

VIBRA HOSPITAL OF NORTHWEST INDIANA Provider CCN: 15-2028	In Lieu of Form CMS-2552-10	Period : From: 11/01/2015 To: 10/31/2016	Run Date: 03/20/2017 Run Time: 09:14 Version: 2017.01 (02/16/2017)
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STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	66,908,587	1
2	Less contractual allowances and discounts on patients' accounts	49,119,753	2
3	Net patient revenues (line 1 minus line 2)	17,788,834	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	17,727,450	4
5	Net income from service to patients (line 3 minus line 4)	61,384	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments	298	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts		10
11	Rebates and refunds of expenses		11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests		14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to 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 hospial space		22
23	Governmental appropriations		23
24	Other (GRANTS)		24
24.01	Other (OTHER INCOME)	20,641	24.01
25	Total other income (sum of lines 6-24)	20,939	25
26	Total (line 5 plus line 25)	82,323	26
27	Other expenses (BAD DEBTS)	237,090	27
27.01	Other expenses (ROUNDING)	1	27.01
28	Total other expenses (sum of line 27 and subscripts)	237,091	28
29	Net income (or loss) for the period (line 26 minus line 28)	-154,768	29