KPMG LLP COMPU-MAX

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

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

PART I - COST REPORT STATUS

PROVIDER USE ONLY	1. [X] ELECTRONICALLY FILED COST REPORT DATE: 05/19/2014 TIME: 09:30 2. [ ] MANUALLY SUBMITTED COST REPORT 3. [ ] IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THE COST REPORT 4. [F] MEDICARE UTILIZATION. ENTER 'F' FOR FULL OR 'L' FOR LOW.	
CONTRACTOR USE ONLY	5. [ ] COST REPORT STATUS 1 -AS SUBMITTED 2 -SETTLED WITHOUT AUDIT 3 -SETTLED WITH AUDIT 4 -REOPENED 5 -AMENDED	6. DATE RECEIVED: _____ 7. CONTRACTOR NO: _____ 8. [ ] INITIAL REPORT FOR THIS PROVIDER CCN 9. [ ] FINAL REPORT FOR THIS PROVIDER CCN
		10. NPR DATE: _____ 11. CONTRACTOR'S VENDOR CODE: ___ 12. [ ] IF LINE 5, COLUMN 1 IS 4: ENTER NUMBER OF TIMES REOPENED = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY VAN MATRE HEALTHSOUTH REHABILITATION (14-3028) {(PROVIDER NAME(S) AND NUMBER(S)} FOR THE COST REPORTING PERIOD BEGINNING 01/01/2013 AND ENDING 12/31/2013, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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

_____
TITLE

_____
DATE

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		92,293				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		92,293				200

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

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

KPMG LLP COMPU-MAX

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX ADDRESS:

1	STREET: 950 S MULFORD ROAD	P.O. BOX:			1
2	CITY: ROCKFORD	STATE: IL	ZIP CODE: 61108	COUNTY: WINNEBAGO	2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT	COMPONENT NAME	CCN NUMBER	CBSA NUMBER	PROV-IDER TYPE	DATE CERTIFIED	PAYMENT SYSTEM (P, T, O, OR N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	HOSPITAL	VAN MATRE HEALTHSOUTH REHABILITATION	14-3028	40420	5	04/12/2002	N	P	P	3
4	SUBPROVIDER - IPF									4
5	SUBPROVIDER - IRF									5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF									7
8	SWING BEDS - NF									8
9	HOSPITAL-BASED SNF									9
10	HOSPITAL-BASED NF									10
11	HOSPITAL-BASED OLTC									11
12	HOSPITAL-BASED HHA									12
13	SEPARATELY CERTIFIED ASC									13
14	HOSPITAL-BASED HOSPICE									14
15	HOSPITAL-BASED HEALTH CLINIC - RHC									15
16	HOSPITAL-BASED HEALTH CLINIC - FQHC									16
17	HOSPITAL-BASED (CMHC)									17
18	RENAL DIALYSIS									18
19	OTHER									19
20	COST REPORTING PERIOD (mm/dd/yyyy)	FROM: 01 / 01 / 2013	TO: 12 / 31 / 2013							20
21	TYPE OF CONTROL (see instructions)	5								21

INPATIENT PPS INFORMATION		1	2	
22	DOES THIS FACILITY QUALIFY FOR AND RECEIVE DISPROPORTIONATE SHARE HOSPITAL PAYMENT IN ACCORDANCE WITH 42 CFR §412.106 IN COLUMN 1, ENTER 'Y' FOR YES AND 'N' FOR NO. IS THIS FACILTY SUBJECT TO 42 CFR§412.06(c)(2)(Pickle amendment hospital)? IN COLUMN 2, ENTER 'Y', FOR YES OR 'N' FOR NO.	N	N	22
22.01	DID THIS HOSPITAL RECEIVE INTERIM UNCOMPENSATED CARE PAYMENTS FOR THIS COST REPORTING PERIOD? ENTER IN COLUMN 1, 'Y' FOR YES Or 'N' FOR NO FOR THE PORTION OF THE COST REPORTING PERIOD OCCURRING PRIOR TO OCTOBER 1. ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO FOR THE PORTION OF THE COST REPORTING PERIOD OCCURRING ON OR AFTER OCTOBER 1. (see instructions)	N	N	22.01
23	WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS ON LINES 24 AND/OR 25 BELOW? IN COLUMN 1, ENTER 1 IF DATE OF ADMISSION, 2 IF CENSUS DAYS, OR 3 IF DATE OF DISCHARGE. IS THE METHOD OF IDENTIFYING THE DAYS IN THIS COST REPORTING PERIOD DIFFERENT FROM THE METHOD USED IN THE PRIOR COST REPORTING PERIOD? IN COLUMN 2, ENTER 'Y' FOR YES OR 'N' FOR NO.	3	N	23

		IN-STATE MEDICAID PAID DAYS	IN-STATE MEDICAID ELIGIBLE UNPAID DAYS	OUT-OF-STATE MEDICAID PAID DAYS	OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS	MEDICAID HMO DAYS	OTHER MEDICAID DAYS	
		1	2	3	4	5	6	
24	IF THIS PROVIDER IS AN IPPS HOSPITAL, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.							24
25	IF THIS PROVIDER IS AN IRF, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF STATE MEDICAID DAYS IN COL. 3, OUT-OF STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.	799	422	14		137		25

26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (not wage) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.	1		26
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (not wage) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER IN COLUMN 1, '1' FOR URBAN OR '2' FOR RURAL. IF APPLICABLE, ENTER THE EFFECTIVE DATE OF THE GEOGRAPHIC RECLASSIFICATION IN COLUMN 2.	1		27
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.			35
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.	BEGINNING:	ENDING:	36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.			37
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.	BEGINNING:	ENDING:	38

		1	2	
39	DOES THIS FACILITY QUALIFY FOR THE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW VOLUME HOSPITALS IN ACCORDANCE WITH 42 CFR §412.101(b)(2)(ii)? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. DOES THE FACILITY MEET THE MILEAGE REQUIREMENTS IN ACCORDANCE WITH 42 CFR 412.101(b)(2)(ii)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. (see instructions)	N	N	39

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XVIII	XIX	
PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL		1	2	3	
45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	N	N	N	45
46	IS THIS FACILITY ELIGIBLE FOR ADDITIONAL PAYMENT EXCEPTION FOR EXTRAORDINARY CIRCUMSTANCES PURSUANT TO 42 CFR §412.348(f)? IF YES, COMPLETE WORKSHEET L, PART III AND L-1, PARTS I THROUGH III.	N	N	N	46
47	IS THIS A NEW HOSPITAL UNDER 42 CFR §412.300 PPS CAPITAL? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	47
48	IS THE FACILITY ELECTING FULL FEDERAL CAPITAL PAYMENT? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	48
TEACHING HOSPITALS		1	2	3	
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N		57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-5.	N			58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N			59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (see instructions)	N			60
		Y/N	IME	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 BASE LINE 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 NON-PROVIDER SETTINGS						
63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (see instructions)	N				63

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

	SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS-THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER JULY 1, 2009 AND BEFORE JUNE 30, 2010.	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 1/ col. 1 + col. 2))	
64	ENTER IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN 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 NON-PROVIDER SETTINGS-EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2010	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 1/ col. 1 + col. 2))	
66	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (column 1 divided by (column 1 + column 2)). (see instructions)				66

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

		PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
67							67

	INPATIENT PSYCHIATRIC 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, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.				71

	INPATIENT REHABILITATION FACILITY PPS	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.	Y			75
76	IF LINE 75 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.	N			76

	LONG TERM CARE HOSPITAL PPS			
80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		80
	TEFRA PROVIDERS			
85	IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA?. ENTER 'Y' FOR YES OR 'N' FOR NO.	N		85
86	DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (excluded unit) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.			86

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WORKSHEET S-2
PART I

		V	XIX	
TITLE V AND XIX SERVICES		1	2	
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.	N	Y	90
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	91
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (dual certification)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.		N	92
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	93
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	94
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			95
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	96
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			97
RURAL PROVIDERS		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.			106
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&Rs IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.			107
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.	N		108

		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.	N				109

MISCELLANEOUS COST REPORTING INFORMATION					
115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, or E only) IN COLUMN 2. IF COLUMN 2 IS 'E', ENTER IN COLUMN 3 EITHER '93' PERCENT FOR SHORT TERM HOSPITAL OR '98'	N			115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.		N		116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.		Y		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.		1		118

		PREMIUMS	PAID LOSSES	SELF INSURANCE	
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:	29,350	428,197		118.01
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTER OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.		N		118.02
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (see instructions). ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 BEDS THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (see instructions). ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.		N	N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR HIGH COST IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.		N		121
TRANSPLANT CENTER INFORMATION					
125	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, ENTER CERTIFICATION DATE(S)(mm/dd/yyyy) BELOW.		N		125
126	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				126
127	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				127
128	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				128
129	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				129
130	IF THIS IS A MEDICARE 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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VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

ALL PROVIDERS

		1	2	
140	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.	Y	019005	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: HEALTHSOUTH CORPORATION	CONTRACTOR'S NAME: CAHABA GBA	CONTRACTOR'S NUMBER: 10101	141
142	STREET: 3660 GRANDVIEW PKWY, SUITE 200	P.O. BOX:		142
143	CITY: BIRMINGHAM	STATE: AL	ZIP CODE: 35243	143

144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y		144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, LINE 74 ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.	N		145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (see CMS Pub. 15-2, section 4020). IF YES, ENTER THE APPROVAL DATE (mm/dd/yyyy) IN COLUMN 2.	N		146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		149

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

		TITLE XVIII				
		PART A	PART B	TITLE V	TITLE XIX	
			1	2	3	
155	HOSPITAL	N	N		N	155
156	SUBPROVIDER - IPF	N	N			156
157	SUBPROVIDER - IRF	N	N			157
158	SUBPROVIDER - (OTHER)					158
159	SNF	N	N			159
160	HHA	N	N			160
161	CMHC		N			161
161.10	CORF					161.10

MULTICAMPUS

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

	NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS	
	0	1	2	3	4	5	

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

167	IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(n)? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		167
168	IF THIS PROVIDER IS A CAH (line 105 is 'Y') AND IS A MEANINGFUL USER (line 167 is 'Y'), ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS. (see instructions)			168
169	IF THIS PROVIDER IS A MEANINGFUL USER (line 167 is 'Y') AND IS NOT A CAH (line 105 is 'N'), ENTER THE TRANSITIONAL FACTOR. (see instructions)			169
170	ENTER IN COLUMNS 1 AND 2 THE EHR BEGINNING DATE AND ENDING DATE FOR THE REPORTING PERIOD RESPECTIVELY (mm/dd/yyyy)			170

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VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

COMPLETED BY ALL HOSPITALS

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

		PART A		PART B		
		Y/N	DATE	Y/N	DATE	
PS&R REPORT DATA		1	2	3	4	
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (see instructions)	N		Y	02/28/2014	16
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (see instructions)	Y	02/28/2014	N		17
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N		18
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N		19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:SPLIT FOR SUA SITUATION	Y		N		20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N		21

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VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

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

CAPITAL RELATED COSTS			
22	HAVE ASSETS BEEN RELIFED FOR MEDICARE PURPOSES? IF YES, SEE INSTRUCTIONS.		22
23	HAVE CHANGES OCCURRED IN THE MEDICARE DEPRECIATION EXPENSE DUE TO APPRAISALS MADE DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		23
24	WERE NEW LEASES AND/OR AMENDMENTS TO EXISTING LEASES ENTERED INTO DURING THIS COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		24
25	HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		25
26	WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		26
27	HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		27
INTEREST EXPENSE			
28	WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		28
29	DID THE PROVIDER HAVE A FUNDED DEPRECIATION ACCOUNT AND/OR BOND FUNDS (debt service reserve fund) TREATED AS A FUNDED DEPRECIATION ACCOUNT? IF YES, SEE INSTRUCTIONS.		29
30	HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS.		30
31	HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS.		31
PURCHASED SERVICES			
32	HAVE CHANGES OR NEW AGREEMENTS OCCURRED IN PATIENT CARE SERVICES FURNISHED THROUGH CONTRACTUAL ARRANGEMENTS WITH SUPPLIERS OF SERVICES? IF YES, SEE INSTRUCTIONS.		32
33	IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS.		33
PROVIDER-BASED PHYSICIANS			
34	ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIANS? IF YES, SEE INSTRUCTIONS.		34
35	IF LINE 34 IS YES, WERE THERE NEW AGREEMENTS OR AMENDED EXISTING AGREEMENTS WITH THE PROVIDER-BASED PHYSICIANS DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		35

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

COST REORT PREPARER INFORMATION				
41	FIRST NAME: JIM	LAST NAME: WYATT	TITLE: SR REIMBURSEMENT SPECIALIS	41
42	EMPLOYER: HEALTHSOUTH CORPORATION			42
43	PHONE NUMBER: 205-969-8265	E-MAIL ADDRESS: JAMES.WYATT@HEALTHSOUTH.COM		43

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VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						INPATIENT DAYS/OUTPATIENT VISITS/TRIPS				
	COMPONENT	WKSTA LINE NO.	NO. OF BEDS	BED DAYS AVAILABLE	CAH HOURS	TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		1	2	3	4	5	6	7	8	
1	HOSPITAL ADULTS & PEDS. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	55	20,075			11,880	1,032	17,698	1
2	HMO AND OTHER (see instructions)						1,500	340		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)		55	20,075			11,880	1,032	17,698	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)		55	20,075			11,880	1,032	17,698	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)		55							27
28	OBSERVATION BED DAYS									28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (see instructions)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (see instructions)									32
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)									32.01
33	LTCH NON-COVERED DAYS									33

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VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		FULL TIME EQUIVALENTS			DISCHARGES				
	COMPONENT	TOTAL INTERNS & RESIDENTS	EMPLOYEES ON PAYROLL	NONPAID WORKERS	TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		9	10	11	12	13	14	15	
1	HOSPITAL ADULTS & PEDS. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					944	70	1,375	1
2	HMO AND OTHER (see instructions)					102			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)		173.90			944	70	1,375	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)		173.90						27
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)								32

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VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

PART II - WAGE DATA

		WKST A LINE NO.	AMOUNT REPORTED	RECLASSIF-ICATION OF SALARIES (from Worksheet A-6)	ADJUSTED SALARIES (column 2 ± column 3)	PAID HOURS RELATED TO SALARIES IN COLUMN 4	AVERAGE HOURLY WAGE (column 4 ± column 5)	
		1	2	3	4	5	6	
	SALARIES							
1	TOTAL SALARIES (see instructions)	200	9,941,094			361,712.00		1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN-PART A - ADMINISTRATIVE							4
4.01	PHYSICIAN-PART A - TEACHING							4.01
5	PHYSICIAN-PART B							5
6	NON-PHYSICIAN-PART B							6
7	INTERNS & RESIDENTS (in an approved program)	21						7
7.01	CONTRACTED INTERNS & RESIDENTS (in an approved program)							7.01
8	HOME OFFICE PERSONNEL							8
9	SNF	44						9
10	EXCLUDED AREA SALARIES (see instructions)			12,959		325.37		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		176,229			1,269.00		13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS		876,945			10,613.00		14
15	HOME OFFICE: PHYSICIAN PART A - ADMINISTRATIVE							15
16	HOME OFFICE & CONTRACT PHYSICIANS PART A - TEACHING							16
	WAGE-RELATED COSTS							
17	WAGE-RELATED COSTS (core)(see instructions)		1,838,366					17
18	WAGE-RELATED COSTS (other)(see instructions)							18
19	EXCLUDED AREAS		158,600					19
20	NON-PHYSICIAN ANESTHETIST PART A							20
21	NON-PHYSICIAN ANESTHETIST PART B							21
22	PHYSICIAN PART A - ADMINISTRATIVE							22
22.01	PHYSICIAN PART A - TEACHING							22.01
23	PHYSICIAN PART B							23
24	WAGE-RELATED COSTS (RHC/FQHC)							24
25	INTERNS & RESIDENTS (in an approved program)							25
	OVERHEAD COSTS - DIRECT SALARIES							
26	EMPLOYEE BENEFITS DEPARTMENT							26
27	ADMINISTRATIVE & GENERAL		1,574,921	-12,959		47,652.80		27
28	ADMINISTRATIVE & GENERAL UNDER CONTRACT (see instructions)		8,694			36.30		28
29	MAINTENANCE & REPAIRS							29
30	OPERATION OF PLANT		140,079	-19,609		5,865.60		30
31	LAUNDRY & LINEN SERVICE							31
32	HOUSEKEEPING		170,752			15,412.80		32
33	HOUSEKEEPING UNDER CONTRACT (see instructions)							33
34	DIETARY		301,097			19,510.40		34
35	DIETARY UNDER CONTRACT (see instructions)							35
36	CAFETERIA							36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION		536,944			13,520.00		38
39	CENTRAL SERVICES AND SUPPLY							39
40	PHARMACY							40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		150,446			7,633.60		41
42	SOCIAL SERVICE		422,920			12,188.80		42
43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (see instructions)		9,949,788		9,949,788	361,748.30	27.50	1
2	EXCLUDED AREA SALARIES (see instructions)			12,959	12,959	325.37	39.83	2
3	SUBTOTAL SALARIES (line 1 minus line 2)		9,949,788	-12,959	9,936,829	361,422.93	27.49	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (see instructions)		1,053,174		1,053,174	11,882.00	88.64	4
5	SUBTOTAL WAGE-RELATED COSTS (see instructions)		1,838,366		1,838,366		18.50%	5
6	TOTAL (sum of lines 3 through 5)		12,841,328	-12,959	12,828,369	373,304.93	34.36	6
7	TOTAL OVERHEAD COST (see instructions)		3,305,853	-32,568	3,273,285	121,820.30	26.87	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	173,543	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)	1,105,834	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN		10
11	LIFE INSURANCE (If employee is owner or beneficiary)	18,374	11
12	ACCIDENTAL INSURANCE (If employee is owner or beneficiary)		12
13	DISABILITY INSURANCE (If employee is owner or beneficiary)		13
14	LONG-TERM CARE INSURANCE (If employee is owner or beneficiary)		14
15	WORKERS' COMPENSATION INSURANCE	176,220	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	737,146	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE		19
20	STATE OR FEDERAL UNEMPLOYMENT TAXES	35,760	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	-249,911	22
23	TUITION REIMBURSEMENT		23
24	TOTAL WAGE RELATED COST (Sum of lines 1-23)	1,996,966	24

PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE REL		25

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

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

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

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

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HOSPITAL CONTRACT LABOR AND BENEFIT COST **WORKSHEET S-3 PART V**

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPIAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT	CONTRACT LABOR	BENEFIT COST	
	0	1	2	
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST	8,694	1,996,966	1
2	HOSPITAL	8,694	1,838,366	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		158,600	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		711,140	711,140	184,438	895,578	253,681	1,149,259	1
2	00200	CAP REL COSTS-MVBLE EQUIP		201,286	201,286	35,323	236,609	-1,226	235,383	2
3	00300	OTHER CAP REL COSTS		202,073	202,073	-202,073			-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT		2,077,256	2,077,256		2,077,256	-318,016	1,759,240	4
5	00500	ADMINISTRATIVE & GENERAL	1,574,921	2,907,946	4,482,867	-56,330	4,426,537	45,202	4,471,739	5
6	00600	MAINTENANCE & REPAIRS								6
7	00700	OPERATION OF PLANT	140,079	462,276	602,355	-47,958	554,397	-26,138	528,259	7
8	00800	LAUNDRY & LINEN SERVICE		131,559	131,559		131,559		131,559	8
9	00900	HOUSEKEEPING	170,752	66,508	237,260		237,260	-12	237,248	9
10	01000	DIETARY	301,097	291,118	592,215	-17	592,198	-51,265	540,933	10
11	01100	CAFETERIA								11
12	01200	MAINTENANCE OF PERSONNEL								12
13	01300	NURSING ADMINISTRATION	536,944	1,034	537,978		537,978		537,978	13
14	01400	CENTRAL SERVICES & SUPPLY								14
15	01500	PHARMACY								15
16	01600	MEDICAL RECORDS & LIBRARY	150,446	63,268	213,714		213,714	-250	213,464	16
17	01700	SOCIAL SERVICE	422,920	3,645	426,565		426,565		426,565	17
19	01900	NONPHYSICIAN ANESTHETISTS								19
20	02000	NURSING SCHOOL								20
21	02100	I&R SERVICES-SALARY & FRINGES APPRVD								21
22	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD								22
23	02300	PARAMED ED PRGM-(SPECIFY)								23
		INPATIENT ROUTINE SERV COST CENTERS								
30	03000	ADULTS & PEDIATRICS	3,542,892	63,954	3,606,846	28,420	3,635,266	-11,253	3,624,013	30
		ANCILLARY SERVICE COST CENTERS								
54	05400	RADIOLOGY-DIAGNOSTIC	47,737	151,347	199,084	86,847	285,931	-36,647	249,284	54
60	06000	LABORATORY		324,507	324,507	-120,257	204,250	-10,354	193,896	60
60.01	06001	LAB - SUA				131,141	131,141	-7,854	123,287	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	RESPIRATORY THERAPY	259,458	8,979	268,437		268,437	-633	267,804	65
66	06600	PHYSICAL THERAPY	1,110,101	26,876	1,136,977		1,136,977	-32	1,136,945	66
67	06700	OCCUPATIONAL THERAPY	961,146	2,529	963,675		963,675		963,675	67
68	06800	SPEECH PATHOLOGY	334,819	4,497	339,316		339,316		339,316	68
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	69,060	248,490	317,550	39,218	356,768	-11	356,757	71
73	07300	DRUGS CHARGED TO PATIENTS	318,722	485,294	804,016		804,016	-2,282	801,734	73
76	03550	PSYCHOLOGY		8,800	8,800	-8,629	171	-171		76
76.01	03951	SPECIAL PROCEDURES		86,847	86,847	-86,847				76.01
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								
113	11300	INTEREST EXPENSE		9,120	9,120		9,120	-9,120		113
192	19200	PHYSICIANS' PRIVATE OFFICES		1,453	1,453	-1,453				192
194	07950	NRCC MARKETING				13,377	13,377		13,377	194
194.01	07951	NRCC MEALS								194.01
194.02	07953	NRCC CLINICAL PSYCH				4,800	4,800		4,800	194.02
194.05	07952	NRCC STAFFING CONTRACT								194.05
200		TOTAL (sum of lines 118-199)	9,941,094	8,541,802	18,482,896		18,482,896	-176,381	18,306,515	200

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RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	INSURANCE	A	CAP REL COSTS-BLDG & FIXT	1		14,845	1
2	INSURANCE	A	CAP REL COSTS-MVBLE EQUIP	2		2,843	2
3	INSURANCE	A					3
500	TOTAL RECLASSIFICATIONS					17,688	500
	CODE LETTER - A						
1	MARKETING	B	NRCC MARKETING	194	12,959	418	1
2	MARKETING	B					2
3	MARKETING	B					3
500	TOTAL RECLASSIFICATIONS				12,959	418	500
	CODE LETTER - B						
1	PHYSICIANS	C	ADULTS & PEDIATRICS	30		28,564	1
2	PHYSICIANS	C					2
3	PHYSICIANS	C					3
500	TOTAL RECLASSIFICATIONS					28,564	500
	CODE LETTER - C						
1	CLINICAL PSYCHOLOGY	D	NRCC CLINICAL PSYCH	194.02		4,800	1
2	CLINICAL PSYCHOLOGY	D					2
500	TOTAL RECLASSIFICATIONS					4,800	500
	CODE LETTER - D						
1	SERVICE UNDER ARRANGEMENT	E	LAB - SUA	60.01		131,141	1
2	SERVICE UNDER ARRANGEMENT	E					2
500	TOTAL RECLASSIFICATIONS					131,141	500
	CODE LETTER - E						
1	ROCKFORD MEMORIAL RECLASS	F	LABORATORY	60		2,000	1
2	ROCKFORD MEMORIAL RECLASS	F					2
500	TOTAL RECLASSIFICATIONS					2,000	500
	CODE LETTER - F						
1	COURIER RECLASS	G	MEDICAL SUPPLIES CHARGED TO P	71	19,609		1
2	COURIER RECLASS	G					2
500	TOTAL RECLASSIFICATIONS				19,609		500
	CODE LETTER - G						
1	COURIER	H	LABORATORY	60		8,884	1
2	COURIER	H					2
3	COURIER	H					3
500	TOTAL RECLASSIFICATIONS					8,884	500
	CODE LETTER - H						
1	OXYGEN	I	MEDICAL SUPPLIES CHARGED TO P	71		19,609	1
2	OXYGEN	I					2
500	TOTAL RECLASSIFICATIONS					19,609	500
	CODE LETTER - I						
1	PHYSICIAN RECLASS	J	ADMINISTRATIVE & GENERAL	5		1,453	1
2	PHYSICIAN RECLASS	J					2
500	TOTAL RECLASSIFICATIONS					1,453	500
	CODE LETTER - J						
1	SPECIAL PROCEDURES	K	RADIOLOGY-DIAGNOSTIC	54		86,847	1
2	SPECIAL PROCEDURES	K					2
500	TOTAL RECLASSIFICATIONS					86,847	500
	CODE LETTER - K						
	GRAND TOTAL (INCREASES)				32,568	301,404	

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

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RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	INSURANCE	A					12	1
2	INSURANCE	A					12	2
3	INSURANCE	A	ADMINISTRATIVE & GENERAL	5		17,688		3
500	TOTAL RECLASSIFICATIONS					17,688		500
	CODE LETTER - A							
1	MARKETING	B						1
2	MARKETING	B	ADMINISTRATIVE & GENERAL	5	12,959	401		2
3	MARKETING	B	DIETARY	10		17		3
500	TOTAL RECLASSIFICATIONS				12,959	418		500
	CODE LETTER - B							
1	PHYSICIANS	C						1
2	PHYSICIANS	C	ADMINISTRATIVE & GENERAL	5		24,735		2
3	PHYSICIANS	C	PSYCHOLOGY	76		3,829		3
500	TOTAL RECLASSIFICATIONS					28,564		500
	CODE LETTER - C							
1	CLINICAL PSYCHOLOGY	D						1
2	CLINICAL PSYCHOLOGY	D	PSYCHOLOGY	76		4,800		2
500	TOTAL RECLASSIFICATIONS					4,800		500
	CODE LETTER - D							
1	SERVICE UNDER ARRANGEMENT	E						1
2	SERVICE UNDER ARRANGEMENT	E	LABORATORY	60		131,141		2
500	TOTAL RECLASSIFICATIONS					131,141		500
	CODE LETTER - E							
1	ROCKFORD MEMORIAL RECLASS	F						1
2	ROCKFORD MEMORIAL RECLASS	F	ADMINISTRATIVE & GENERAL	5		2,000		2
500	TOTAL RECLASSIFICATIONS					2,000		500
	CODE LETTER - F							
1	COURIER RECLASS	G						1
2	COURIER RECLASS	G	OPERATION OF PLANT	7	19,609			2
500	TOTAL RECLASSIFICATIONS				19,609			500
	CODE LETTER - G							
1	COURIER	H						1
2	COURIER	H	OPERATION OF PLANT	7		8,740		2
3	COURIER	H	ADULTS & PEDIATRICS	30		144		3
500	TOTAL RECLASSIFICATIONS					8,884		500
	CODE LETTER - H							
1	OXYGEN	I						1
2	OXYGEN	I	OPERATION OF PLANT	7		19,609		2
500	TOTAL RECLASSIFICATIONS					19,609		500
	CODE LETTER - I							
1	PHYSICIAN RECLASS	J						1
2	PHYSICIAN RECLASS	J	PHYSICIANS' PRIVATE OFFICES	192		1,453		2
500	TOTAL RECLASSIFICATIONS					1,453		500
	CODE LETTER - J							
1	SPECIAL PROCEDURES	K						1
2	SPECIAL PROCEDURES	K	SPECIAL PROCEDURES	76.01		86,847		2
500	TOTAL RECLASSIFICATIONS					86,847		500
	CODE LETTER - K							
	GRAND TOTAL (DECREASES)				32,568	301,404		

(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

			ACQUISITIONS						
	DESCRIPTION	BEGINNING BALANCES	PURCHASES	DONATION	TOTAL	DISPOSALS AND RETIRE-MENTS	ENDING BALANCE	FULLY DEPREC-IATED ASSETS	
		1	2	3	4	5	6	7	
1	LAND								1
2	LAND IMPROVEMENTS	9,720					9,720		2
3	BUILDINGS AND FIXTURES	4,142,414	-115,502		-115,502		4,026,912		3
4	BUILDING IMPROVEMENTS	9,195,585	306,012		306,012	18,400	9,483,197		4
5	FIXED EQUIPMENT								5
6	MOVABLE EQUIPMENT	2,516,192	85,840		85,840	12,792	2,589,240		6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (sum of lines 1-7)	15,863,911	276,350		276,350	31,192	16,109,069		8
9	RECONCILING ITEMS								9
10	TOTAL (line 7 minus line 9)	15,863,911	276,350		276,350	31,192	16,109,069		10

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

		SUMMARY OF CAPITAL							
	DESCRIPTION	DEPREC-IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)	TOTAL(1) (Sum of (cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	CAP REL COSTS-BLDG & FIXT	552,453	158,687					711,140	1
2	CAP REL COSTS-MVBLE EQUIP	150,892	50,394					201,286	2
3	TOTAL (sum of lines 1-2)	703,345	209,081					912,426	3

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	DESCRIPTION	GROSS ASSETS	CAPITAL-IZED LEASES	GROSS ASSETS FOR RATIO (col. 1 - col. 2)	RATIO (see instr.)	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL (sum of (cols. 5 through 7)	
*		9	10	11	12	13	14	15	16	
1	CAP REL COSTS-BLDG & FI	13,519,829		13,519,829	0.839268		169,593		169,593	1
2	CAP REL COSTS-MVBLE EQU	2,589,240		2,589,240	0.160732		32,480		32,480	2
3	TOTAL (sum of lines 1-2)	16,109,069		16,109,069	1.000000		202,073		202,073	3

		SUMMARY OF CAPITAL							
	DESCRIPTION	DEPREC-IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)	TOTAL(2) (sum of (cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	CAP REL COSTS-BLDG & FIXT	694,109		253,975	14,845	186,330		1,149,259	1
2	CAP REL COSTS-MVBLE EQUIP	146,461	50,394		2,843	35,685		235,383	2
3	TOTAL (sum of lines 1-2)	840,570	50,394	253,975	17,688	222,015		1,384,642	3

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

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ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	WKST A-7 REF.	
		1	2	3	4	5	
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (chapter 2)			CAP REL COSTS-BLDG & FIXT	1		1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (chapter 2)			CAP REL COSTS-MVBLE EQUIP	2		2
3	INVESTMENT INCOME-OTHER (chapter 2)						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	-11,138				10
11	SALE OF SCRAP, WASTE, ETC. (chapter 23)						11
12	RELATED ORGANIZATION TRANSACTIONS (chapter 10)	WKST A-8-1	962,291				12
13	LAUNDRY AND LINEN SERVICE						13
14	CAFETERIA - EMPLOYEES AND GUESTS						14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS						16
17	SALE OF DRUGS TO OTHER THAN PATIENTS						17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS						18
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)						19
20	VENDING MACHINES						20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (chapter 21)						21
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENTS						22
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		RESPIRATORY THERAPY	65		23
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		PHYSICAL THERAPY	66		24
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (chapter 21)			UTILIZATION REVIEW-SNF	114		25
26	DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1		26
27	DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2		27
28	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19		28
29	PHYSICIANS' ASSISTANT						29
30	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67		30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		SPEECH PATHOLOGY	68		31
32	CAH HIT ADJ FOR DEPRECIATION AND						32
33							33
34							34
35							35
36							36
37	INTEREST	A	-9,120	INTEREST EXPENSE	113	11	37
37.03	INSURANCE	A	-303,805	EMPLOYEE BENEFITS DEPARTMENT	4		37.03
37.04	INSURANCE	A	228,247	ADMINISTRATIVE & GENERAL	5		37.04
37.05	PROPERTY TAX	A	16,737	CAP REL COSTS-BLDG & FIXT	1	13	37.05
37.06	PROPERTY TAX	A	3,205	CAP REL COSTS-MVBLE EQUIP	2	13	37.06
37.07	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-28,349	ADMINISTRATIVE & GENERAL	5		37.07
37.08	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-324	OPERATION OF PLANT	7		37.08
37.09	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-21,153	DIETARY	10		37.09
37.10	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-90	ADULTS & PEDIATRICS	30		37.10
37.11	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-19	PHYSICAL THERAPY	66		37.11
37.12	PATIENT TELEPHONE	A	-1,629	CAP REL COSTS-MVBLE EQUIP	2	9	37.12
37.13	PATIENT TELEPHONE	A	-12,451	EMPLOYEE BENEFITS DEPARTMENT	4		37.13
37.14	PATIENT TELEPHONE	A	-25,599	ADMINISTRATIVE & GENERAL	5		37.14
37.15	PATIENT TELEVISION	A	-2,802	CAP REL COSTS-MVBLE EQUIP	2	9	37.15
37.16	PATIENT TELEVISION	A	-6,242	OPERATION OF PLANT	7		37.16
37.17	PRINTING	A	-3,936	ADMINISTRATIVE & GENERAL	5		37.17
37.18	PRINTING	A	-1	OPERATION OF PLANT	7		37.18
37.19	PRINTING	A	-25	ADULTS & PEDIATRICS	30		37.19
37.20	PRINTING	A	-13	PHYSICAL THERAPY	66		37.20
37.21	PRINTING	A	-11	MEDICAL SUPPLIES CHARGED TO PATIENTS	71		37.21
37.22	LOBBYING EXPENSE	A	-498	EMPLOYEE BENEFITS DEPARTMENT	4		37.22
37.23	LOBBYING EXPENSE	A	-12,605	ADMINISTRATIVE & GENERAL	5		37.23
37.24	MISCELLANEOUS INCOME	B	-53,595	ADMINISTRATIVE & GENERAL	5		37.24
37.25	MISCELLANEOUS INCOME	B	-12	HOUSEKEEPING	9		37.25
37.26	MISCELLANEOUS INCOME	B	-30,112	DIETARY	10		37.26
37.27	MISCELLANEOUS INCOME	B	-250	MEDICAL RECORDS & LIBRARY	16		37.27
37.28	MISCELLANEOUS INCOME	B	-950	RADIOLOGY-DIAGNOSTIC	54		37.28

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ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	WKST A-7 REF.	
		1	2	3	4	5	
37.29	MISCELLANEOUS INCOME	B	-633	RESPIRATORY THERAPY	65		37.29
37.30	MISCELLANEOUS INCOME	B	-2,282	DRUGS CHARGED TO PATIENTS	73		37.30
37.31	PATIENT TRANSPORTATION	A	-1,262	EMPLOYEE BENEFITS DEPARTMENT	4		37.31
37.32	PATIENT TRANSPORTATION	A	-19,571	OPERATION OF PLANT	7		37.32
37.33	MISC. TAX	A	-826,523	ADMINISTRATIVE & GENERAL	5		37.33
37.34	PROFESSIONAL FEES	A	-6,762	ADMINISTRATIVE & GENERAL	5		37.34
37.35	PROFESSIONAL FEES	A	-1,440	RADIOLOGY-DIAGNOSTIC	54		37.35
37.36	WAYPORT WIRELESS	A	-3,488	ADMINISTRATIVE & GENERAL	5		37.36
37.37	PHYSICIAN	A	-171	PSYCHOLOGY	76		37.37
38							38
39							39
40							40
41							41
42							42
43							43
44							44
45							45
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-176,381				50

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

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

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STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS **WORKSHEET A-8-1**

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

	LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT INCLUDED IN WKST. A COLUMN 5	NET ADJUST-MENTS (col. 4 minus col. 5)*	WKST. A-7 REF.	
	1	2	3	4	5	6	7	
1	5	ADMINISTRATIVE & GENERAL	TO OFFSET MANAGEMENT FEES		737,087	-737,087		1
2	1	CAP REL COSTS-BLDG & FIXT	TO INCLUDE ALLOWABLE HOME OFFICE COS	141,656		141,656	9	2
3	1	CAP REL COSTS-BLDG & FIXT	TO INCLUDE ALLOWABLE HOME OFFICE COS	253,975		253,975	11	3
3.01	5	ADMINISTRATIVE & GENERAL	TO INCLUDE ALLOWABLE HOME OFFICE COS	1,279,148		1,279,148		3.01
3.02	5	ADMINISTRATIVE & GENERAL	TO INCLUDE ALLOWABLE HOME OFFICE COS	235,763		235,763		3.02
3.03	2	CAP REL COSTS-MVBLE EQUIP	INTERCOMPANY WAGE AND EXPENSE TRANSF	770	770		10	3.03
3.04	4	EMPLOYEE BENEFITS DEPARTMENT	INTERCOMPANY WAGE AND EXPENSE TRANSF	1,586,940	1,586,940			3.04
3.05	5	ADMINISTRATIVE & GENERAL	INTERCOMPANY WAGE AND EXPENSE TRANSF	2,335,209	2,335,209			3.05
3.06	7	OPERATION OF PLANT	INTERCOMPANY WAGE AND EXPENSE TRANSF	17,815	17,815			3.06
3.07	9	HOUSEKEEPING	INTERCOMPANY WAGE AND EXPENSE TRANSF	1,989	1,989			3.07
3.08	10	DIETARY	INTERCOMPANY WAGE AND EXPENSE TRANSF	-2,757	-2,757			3.08
3.09	13	NURSING ADMINISTRATION	INTERCOMPANY WAGE AND EXPENSE TRANSF	729	729			3.09
3.10	16	MEDICAL RECORDS & LIBRARY	INTERCOMPANY WAGE AND EXPENSE TRANSF	-2,258	-2,258			3.10
3.11	30	ADULTS & PEDIATRICS	INTERCOMPANY WAGE AND EXPENSE TRANSF	5,644	5,644			3.11
3.12	54	RADIOLOGY-DIAGNOSTIC	INTERCOMPANY WAGE AND EXPENSE TRANSF	270	270			3.12
3.13	65	RESPIRATORY THERAPY	INTERCOMPANY WAGE AND EXPENSE TRANSF	82	82			3.13
3.14	66	PHYSICAL THERAPY	INTERCOMPANY WAGE AND EXPENSE TRANSF	1,061	1,061			3.14
3.15	67	OCCUPATIONAL THERAPY	INTERCOMPANY WAGE AND EXPENSE TRANSF	-1,411	-1,411			3.15
3.16	68	SPEECH PATHOLOGY	INTERCOMPANY WAGE AND EXPENSE TRANSF	328	328			3.16
3.17	71	MEDICAL SUPPLIES CHARGED TO PATIENTS	INTERCOMPANY WAGE AND EXPENSE TRANSF	-2,830	-2,830			3.17
3.18	73	DRUGS CHARGED TO PATIENTS	INTERCOMPANY WAGE AND EXPENSE TRANSF	455,753	455,753			3.18
3.19	113	INTEREST EXPENSE	INTERCOMPANY WAGE AND EXPENSE TRANSF	9,081	9,081		11	3.19
3.20	192	PHYSICIANS' PRIVATE OFFICES	INTERCOMPANY WAGE AND EXPENSE TRANSF	32	32			3.20
3.21	5	ADMINISTRATIVE & GENERAL	RELATED PARTY - MOTORIKA	2,584	2,584			3.21
3.22	1	CAP REL COSTS-BLDG & FIXT	RELATED PARTY RENT		158,687	-158,687	10	3.22
3.23	4	EMPLOYEE BENEFITS DEPARTMENT	LEASED EMP FROM RMH	139,397	139,397			3.23
3.24	5	ADMINISTRATIVE & GENERAL	LEASED EMP FROM RMH	26,071	26,071			3.24
3.25	13	NURSING ADMINISTRATION	LEASED EMP FROM RMH	236,039	236,039			3.25
3.26	17	SOCIAL SERVICE	LEASED EMP FROM RMH	86,988	86,988			3.26
3.27	30	ADULTS & PEDIATRICS	LEASED EMP FROM RMH	125,401	125,401			3.27
3.28	67	OCCUPATIONAL THERAPY	LEASED EMP FROM RMH	51,527	51,527			3.28
3.29	5	ADMINISTRATIVE & GENERAL	LEASED EMP TO RMH	291,682	291,694	-12		3.29
3.30	30	ADULTS & PEDIATRICS	LEASED EMP TO RMH	806	806			3.30
3.31	54	RADIOLOGY-DIAGNOSTIC	LEASED EMP TO RMH	10,818	45,075	-34,257		3.31
3.32	60	LABORATORY	LEASED EMP TO RMH	162,212	172,566	-10,354		3.32
3.33	60.01	LAB - SUA	LEASED EMP TO RMH	123,039	130,893	-7,854		3.33
3.34	4	EMPLOYEE BENEFITS DEPARTMENT		-223,545	-223,545			3.34
3.35	66	PHYSICAL THERAPY		-532,874	-532,874			3.35
3.36	67	OCCUPATIONAL THERAPY		-182,040	-182,040			3.36
3.37	68	SPEECH PATHOLOGY		-128,652	-128,652			3.37
4								4
5	TOTALS (SUM OF LINES 1-4) TRANSFER COLUMN 6, LINE 5 TO WORKSHEET A-8, COLUMN 2, LINE 12			6,506,442	5,544,151	962,291		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.

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STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS **WORKSHEET A-8-1**

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

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

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

				RELATED ORGANIZATION(S) AND/OR HOME OFFICE			
	SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS	
	1	2	3	4	5	6	

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

				RELATED ORGANIZATION(S) AND/OR HOME OFFICE			
	SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS	
	1	2	3	4	5	6	
6	B		50.00	HEALTHSOUTH CORPORATION			6
7	B		50.00	ROCKFORD HEALTH SYSTEM			7
8	G	ROCKFORD MEMORIAL HOSPITAL					8
9	G	MOTORIKA					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: FINANCIAL

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

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN-ERATION	PROFESS-IONAL COMPON-ENT	PROVIDER COMPON-ENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPON-ENT HOURS	UNADJ-USTED RCE LIMIT	5 PERCENT OF UNADJ-USTED RCE LIMIT	
	1	2	3	4	5	6	7	8	9	
1	30	ADULTS & PEDIATRICS AGGREGATE	24,735		24,735	171,400	165	13,597	680	1
2	76	PSYCHOLOGY AGGREGATE	3,829		3,829	142,500	134	9,180	459	2
200		TOTAL	28,564		28,564		299	22,777	1,139	200

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

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBER-SHIPS & CONTIN-UING EDUCATION	PROVIDER COMPON-ENT SHARE OF COL. 12	PHYSICIAN COST OF MALPRACT-ICE INSURANCE	PROVIDER COMPON-ENT SHARE OF COL. 14	ADJUSTED RCE LIMIT	RCE DISALLOW-ANCE	ADJUST-MENT	
	10	11	12	13	14	15	16	17	18	
1	30	ADULTS & PEDIATRICS AGGREGATE					13,597	11,138	11,138	1
2	76	PSYCHOLOGY AGGREGATE					9,180			2
200		TOTAL					22,777	11,138	11,138	200

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS I-IV**

CHECK APPLICABLE BOX: [XX] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)						1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK						2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)						3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions)						6
7	STANDARD TRAVEL EXPENSE RATE						7
8	OPTIONAL TRAVEL EXPENSE RATE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED						9
10	AHSEA (see instructions)						10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)						11
12	NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions)						12
12.01	NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions)						12.01
13	NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions)						13
13.01	NUMBER OF MILES DRIVEN (OFFSITE) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (column 1, line 9 times column 1, line 10)		14
15	THERAPISTS (column 2, line 9 times column 2, line 10)		15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)		16
17	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		17
18	AIDES (column 4, line 9 times column 4, line 10)		18
19	TRAINEES (column 5, line 9 times column 5, line 10)		19
20	TOTAL ALLOWANCE AMOUNT (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		20
	IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23.		
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)		21
22	WEIGHTED ALLOWANCE EXCUDING AIDES AND TRAINEES (line 2 times line 21)		22
23	TOTAL SALARY EQUIVALENCY (see instructions)		23

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

STANDARD TRAVEL ALLOWANCE			
24	THERAPISTS (line 3 times column 2, line 11)		24
25	ASSISTANTS (line 4 times column 3, line 11)		25
26	SUBTOTAL (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		26
27	STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (sum of lines 26 and 27)		28
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE			
29	THERAPISTS (column 2, line 10 times the sum of columns 1 and 2, line 12)		29
30	ASSISTANTS (column 3, line 10 times column 3, line 12)		30
31	SUBTOTAL (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		31
32	OPTIONAL TRAVEL EXPENSE (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (line 28)		33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 27 and 31)		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 31 and 32)		35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

STANDARD TRAVEL EXPENSE			
36	THERAPISTS (line 5 times column 2, line 11)		36
37	ASSISTANTS (line 6 times column 3, line 11)		37
38	SUBTOTAL (sum of lines 36 and 37)		38
39	STANDARD TRAVEL EXPENSE (line 7 times the sum of lines 5 and 6)		39
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE			
40	THERAPISTS (sum of columns 1 and 2, line 9 times column 2, line 10)		40
41	ASSISTANTS (column 3, line 9 times column 3, line 10)		41
42	SUBTOTAL (sum of lines 40 and 41)		42
43	OPTIONAL TRAVEL EXPENSE (line 8 times the sum of columns 1-3, line 13)		43
TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES: COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46, AS APPROPRIATE.			
44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 38 and 39) (see instructions)		44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 39 and 42) (see instructions)		45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 42 and 43) (see instructions)		46

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VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

CHECK APPLICABLE BOX: [XX] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)		57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)		58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)		59
60	OVERTIME ALLOWANCE (from column 5, line 56)		60
61	EQUIPMENT COST (see instructions)		61
62	SUPPLIES (see instructions)		62
63	TOTAL ALLOWANCE (sum of lines 57-62)		63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)		64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)		65

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VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [XX] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)						1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK						2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)						3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions)						6
7	STANDARD TRAVEL EXPENSE RATE						7
8	OPTIONAL TRAVEL EXPENSE RATE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED						9
10	AHSEA (see instructions)						10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)						11
12	NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions)						12
12.01	NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions)						12.01
13	NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions)						13
13.01	NUMBER OF MILES DRIVEN (OFFSITE) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (column 1, line 9 times column 1, line 10)		14
15	THERAPISTS (column 2, line 9 times column 2, line 10)		15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)		16
17	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		17
18	AIDES (column 4, line 9 times column 4, line 10)		18
19	TRAINEES (column 5, line 9 times column 5, line 10)		19
20	TOTAL ALLOWANCE AMOUNT (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		20
	IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23.		
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)		21
22	WEIGHTED ALLOWANCE EXCUDING AIDES AND TRAINEES (line 2 times line 21)		22
23	TOTAL SALARY EQUIVALENCY (see instructions)		23

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

STANDARD TRAVEL ALLOWANCE			
24	THERAPISTS (line 3 times column 2, line 11)		24
25	ASSISTANTS (line 4 times column 3, line 11)		25
26	SUBTOTAL (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		26
27	STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (sum of lines 26 and 27)		28
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE			
29	THERAPISTS (column 2, line 10 times the sum of columns 1 and 2, line 12)		29
30	ASSISTANTS (column 3, line 10 times column 3, line 12)		30
31	SUBTOTAL (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		31
32	OPTIONAL TRAVEL EXPENSE (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (line 28)		33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 27 and 31)		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 31 and 32)		35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

STANDARD TRAVEL EXPENSE			
36	THERAPISTS (line 5 times column 2, line 11)		36
37	ASSISTANTS (line 6 times column 3, line 11)		37
38	SUBTOTAL (sum of lines 36 and 37)		38
39	STANDARD TRAVEL EXPENSE (line 7 times the sum of lines 5 and 6)		39
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE			
40	THERAPISTS (sum of columns 1 and 2, line 9 times column 2, line 10)		40
41	ASSISTANTS (column 3, line 9 times column 3, line 10)		41
42	SUBTOTAL (sum of lines 40 and 41)		42
43	OPTIONAL TRAVEL EXPENSE (line 8 times the sum of columns 1-3, line 13)		43
TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES: COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46, AS APPROPRIATE.			
44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 38 and 39) (see instructions)		44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 39 and 42) (see instructions)		45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 42 and 43) (see instructions)		46

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VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [XX] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)		57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)		58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)		59
60	OVERTIME ALLOWANCE (from column 5, line 56)		60
61	EQUIPMENT COST (see instructions)		61
62	SUPPLIES (see instructions)		62
63	TOTAL ALLOWANCE (sum of lines 57-62)		63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)		64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)		65

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VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [ ] PHYSICAL [XX] RESPIRATORY [ ] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)						1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK						2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)						3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions)						6
7	STANDARD TRAVEL EXPENSE RATE						7
8	OPTIONAL TRAVEL EXPENSE RATE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED						9
10	AHSEA (see instructions)						10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)						11
12	NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions)						12
12.01	NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions)						12.01
13	NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions)						13
13.01	NUMBER OF MILES DRIVEN (OFFSITE) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (column 1, line 9 times column 1, line 10)		14
15	THERAPISTS (column 2, line 9 times column 2, line 10)		15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)		16
17	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		17
18	AIDES (column 4, line 9 times column 4, line 10)		18
19	TRAINEES (column 5, line 9 times column 5, line 10)		19
20	TOTAL ALLOWANCE AMOUNT (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		20
	IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23.		
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)		21
22	WEIGHTED ALLOWANCE EXCUDING AIDES AND TRAINEES (line 2 times line 21)		22
23	TOTAL SALARY EQUIVALENCY (see instructions)		23

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

STANDARD TRAVEL ALLOWANCE			
24	THERAPISTS (line 3 times column 2, line 11)		24
25	ASSISTANTS (line 4 times column 3, line 11)		25
26	SUBTOTAL (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		26
27	STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (sum of lines 26 and 27)		28
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE			
29	THERAPISTS (column 2, line 10 times the sum of columns 1 and 2, line 12)		29
30	ASSISTANTS (column 3, line 10 times column 3, line 12)		30
31	SUBTOTAL (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		31
32	OPTIONAL TRAVEL EXPENSE (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (line 28)		33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 27 and 31)		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 31 and 32)		35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

STANDARD TRAVEL EXPENSE			
36	THERAPISTS (line 5 times column 2, line 11)		36
37	ASSISTANTS (line 6 times column 3, line 11)		37
38	SUBTOTAL (sum of lines 36 and 37)		38
39	STANDARD TRAVEL EXPENSE (line 7 times the sum of lines 5 and 6)		39
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE			
40	THERAPISTS (sum of columns 1 and 2, line 9 times column 2, line 10)		40
41	ASSISTANTS (column 3, line 9 times column 3, line 10)		41
42	SUBTOTAL (sum of lines 40 and 41)		42
43	OPTIONAL TRAVEL EXPENSE (line 8 times the sum of columns 1-3, line 13)		43
TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES: COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46, AS APPROPRIATE.			
44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 38 and 39) (see instructions)		44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 39 and 42) (see instructions)		45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 42 and 43) (see instructions)		46

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VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [ ] PHYSICAL [XX] RESPIRATORY [ ] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)		57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)		58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)		59
60	OVERTIME ALLOWANCE (from column 5, line 56)		60
61	EQUIPMENT COST (see instructions)		61
62	SUPPLIES (see instructions)		62
63	TOTAL ALLOWANCE (sum of lines 57-62)		63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)		64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)		65

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VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [XX] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)						1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK						2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)						3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions)						6
7	STANDARD TRAVEL EXPENSE RATE						7
8	OPTIONAL TRAVEL EXPENSE RATE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED						9
10	AHSEA (see instructions)						10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)						11
12	NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions)						12
12.01	NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions)						12.01
13	NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions)						13
13.01	NUMBER OF MILES DRIVEN (OFFSITE) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (column 1, line 9 times column 1, line 10)		14
15	THERAPISTS (column 2, line 9 times column 2, line 10)		15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)		16
17	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		17
18	AIDES (column 4, line 9 times column 4, line 10)		18
19	TRAINEES (column 5, line 9 times column 5, line 10)		19
20	TOTAL ALLOWANCE AMOUNT (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		20
	IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23.		
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)		21
22	WEIGHTED ALLOWANCE EXCUDING AIDES AND TRAINEES (line 2 times line 21)		22
23	TOTAL SALARY EQUIVALENCY (see instructions)		23

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

STANDARD TRAVEL ALLOWANCE			
24	THERAPISTS (line 3 times column 2, line 11)		24
25	ASSISTANTS (line 4 times column 3, line 11)		25
26	SUBTOTAL (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		26
27	STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (sum of lines 26 and 27)		28
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE			
29	THERAPISTS (column 2, line 10 times the sum of columns 1 and 2, line 12)		29
30	ASSISTANTS (column 3, line 10 times column 3, line 12)		30
31	SUBTOTAL (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		31
32	OPTIONAL TRAVEL EXPENSE (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (line 28)		33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 27 and 31)		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 31 and 32)		35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

STANDARD TRAVEL EXPENSE			
36	THERAPISTS (line 5 times column 2, line 11)		36
37	ASSISTANTS (line 6 times column 3, line 11)		37
38	SUBTOTAL (sum of lines 36 and 37)		38
39	STANDARD TRAVEL EXPENSE (line 7 times the sum of lines 5 and 6)		39
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE			
40	THERAPISTS (sum of columns 1 and 2, line 9 times column 2, line 10)		40
41	ASSISTANTS (column 3, line 9 times column 3, line 10)		41
42	SUBTOTAL (sum of lines 40 and 41)		42
43	OPTIONAL TRAVEL EXPENSE (line 8 times the sum of columns 1-3, line 13)		43
TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES: COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46, AS APPROPRIATE.			
44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 38 and 39) (see instructions)		44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 39 and 42) (see instructions)		45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 42 and 43) (see instructions)		46

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VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [XX] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)		57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)		58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)		59
60	OVERTIME ALLOWANCE (from column 5, line 56)		60
61	EQUIPMENT COST (see instructions)		61
62	SUPPLIES (see instructions)		62
63	TOTAL ALLOWANCE (sum of lines 57-62)		63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)		64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)		65

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VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS-TRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	1,149,259	1,149,259					1
2	CAP REL COSTS-MVBLE EQUIP	235,383		235,383				2
4	EMPLOYEE BENEFITS DEPARTMENT	1,759,240			1,759,240			4
5	ADMINISTRATIVE & GENERAL	4,471,739	30,569	6,261	276,414	4,784,983	4,784,983	5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	528,259	344,348	70,527	21,319	964,453	351,243	7
8	LAUNDRY & LINEN SERVICE	131,559	6,553	1,342		139,454	50,788	8
9	HOUSEKEEPING	237,248	8,512	1,743	30,217	277,720	101,143	9
10	DIETARY	540,933	67,544	13,834	53,284	675,595	246,044	10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	537,978	33,424	6,846	95,021	673,269	245,197	13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY	213,464	12,081	2,474	26,624	254,643	92,738	16
17	SOCIAL SERVICE	426,565	8,420	1,725	74,842	511,552	186,302	17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	3,624,013	364,446	74,642	626,977	4,690,078	1,708,069	30
	ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC	249,284	1,464	300	8,448	259,496		54
60	LABORATORY	193,896				193,896	70,615	60
60.01	LAB - SUA	123,287				123,287		60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	267,804	7,926	1,623	45,915	323,268	117,731	65
66	PHYSICAL THERAPY	1,136,945	127,529	26,120	196,450	1,487,044	541,565	66
67	OCCUPATIONAL THERAPY	963,675	100,676	20,620	170,090	1,255,061	457,079	67
68	SPEECH PATHOLOGY	339,316	5,125	1,050	59,252	404,743	147,403	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	356,757	9,976	2,043	15,691	384,467	140,019	71
73	DRUGS CHARGED TO PATIENTS	801,734	11,459	2,347	56,403	871,943	317,552	73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES							76.01
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							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	18,288,338	1,140,052	233,497	1,756,947	18,274,952	4,773,488	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES		9,079	1,860		10,939	3,984	192
194	NRCC MARKETING	13,377	128	26	2,293	15,824	5,763	194
194.01	NRCC MEALS							194.01
194.02	NRCC CLINICAL PSYCH	4,800				4,800	1,748	194.02
194.05	NRCC STAFFING CONTRACT							194.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	18,306,515	1,149,259	235,383	1,759,240	18,306,515	4,784,983	202

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VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT A, col.7)	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING EQUIPMENT	DIETARY BENEFITS DEPARTMENT	CAFETERIA SUBTOTAL (cols.0-4)	NURSING ADMINIS-TRATION	
		7	8	9	10	11	13	
	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	1,315,696						7
8	LAUNDRY & LINEN SERVICE	11,134	201,376					8
9	HOUSEKEEPING	14,462		393,325				9
10	DIETARY	114,765		34,990	1,071,394			10
11	CAFETERIA				206,776	206,776		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	56,792		17,315		14,259	1,006,832	13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY	20,527		6,258		3,995		16
17	SOCIAL SERVICE	14,307		4,362		11,231		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	619,237	201,376	188,791	822,055	94,077	1,006,832	30
	ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC	2,488		759		1,268		54
60	LABORATORY							60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	13,467		4,106		6,890		65
66	PHYSICAL THERAPY	216,686		66,063		29,479		66
67	OCCUPATIONAL THERAPY	171,059		52,153		25,523		67
68	SPEECH PATHOLOGY	8,708		2,655		8,891		68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,950		5,168		2,355		71
73	DRUGS CHARGED TO PATIENTS	19,470		5,936		8,464		73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES							76.01
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							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	1,300,052	201,376	388,556	1,028,831	206,432	1,006,832	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES	15,426		4,703				192
194	NRCC MARKETING	218		66		344		194
194.01	NRCC MEALS				42,563			194.01
194.02	NRCC CLINICAL PSYCH							194.02
194.05	NRCC STAFFING CONTRACT							194.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	1,315,696	201,376	393,325	1,071,394	206,776	1,006,832	202

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VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		16	17	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							15
16	MEDICAL RECORDS & LIBRARY	378,161						16
17	SOCIAL SERVICE		727,754					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	160,962	727,754	10,219,231		10,219,231		30
	ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC			264,011		264,011		54
60	LABORATORY	12,569		277,080		277,080		60
60.01	LAB - SUA			123,287		123,287		60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	12,111		477,573		477,573		65
66	PHYSICAL THERAPY	67,469		2,408,306		2,408,306		66
67	OCCUPATIONAL THERAPY	67,033		2,027,908		2,027,908		67
68	SPEECH PATHOLOGY	17,986		590,386		590,386		68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,248		558,207		558,207		71
73	DRUGS CHARGED TO PATIENTS	30,783		1,254,148		1,254,148		73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES							76.01
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							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	378,161	727,754	18,200,137		18,200,137		118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES			35,052		35,052		192
194	NRCC MARKETING			22,215		22,215		194
194.01	NRCC MEALS			42,563		42,563		194.01
194.02	NRCC CLINICAL PSYCH			6,548		6,548		194.02
194.05	NRCC STAFFING CONTRACT							194.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	378,161	727,754	18,306,515		18,306,515		202

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VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

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		30,569	6,261	36,830	36,830		5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT		344,348	70,527	414,875	2,703	417,578	7
8	LAUNDRY & LINEN SERVICE		6,553	1,342	7,895	391	3,534	8
9	HOUSEKEEPING		8,512	1,743	10,255	778	4,590	9
10	DIETARY		67,544	13,834	81,378	1,894	36,424	10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		33,424	6,846	40,270	1,887	18,025	13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY		12,081	2,474	14,555	714	6,515	16
17	SOCIAL SERVICE		8,420	1,725	10,145	1,434	4,541	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		364,446	74,642	439,088	13,150	196,534	30
	ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC		1,464	300	1,764		790	54
60	LABORATORY					543		60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		7,926	1,623	9,549	906	4,274	65
66	PHYSICAL THERAPY		127,529	26,120	153,649	4,168	68,772	66
67	OCCUPATIONAL THERAPY		100,676	20,620	121,296	3,518	54,291	67
68	SPEECH PATHOLOGY		5,125	1,050	6,175	1,134	2,764	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		9,976	2,043	12,019	1,078	5,380	71
73	DRUGS CHARGED TO PATIENTS		11,459	2,347	13,806	2,444	6,179	73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES							76.01
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							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)		1,140,052	233,497	1,373,549	36,742	412,613	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES		9,079	1,860	10,939	31	4,896	192
194	NRCC MARKETING		128	26	154	44	69	194
194.01	NRCC MEALS							194.01
194.02	NRCC CLINICAL PSYCH					13		194.02
194.05	NRCC STAFFING CONTRACT							194.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)		1,149,259	235,383	1,384,642	36,830	417,578	202

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VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING FIXTURES	DIETARY MOVABLE EQUIPMENT	CAFETERIA SUBTOTAL	NURSING ADMINIS-TRATION	MEDICAL RECORDS & LIBRARY	
		8	9	10	11	13	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	11,820						8
9	HOUSEKEEPING		15,623					9
10	DIETARY		1,390	121,086				10
11	CAFETERIA			23,369	23,369			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		688		1,611	62,481		13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY		249		451		22,484	16
17	SOCIAL SERVICE		173		1,269			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	11,820	7,498	92,907	10,635	62,481	9,565	30
	ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC		30		143			54
60	LABORATORY						748	60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		163		779		720	65
66	PHYSICAL THERAPY		2,624		3,331		4,013	66
67	OCCUPATIONAL THERAPY		2,072		2,884		3,987	67
68	SPEECH PATHOLOGY		105		1,005		1,070	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		205		266		550	71
73	DRUGS CHARGED TO PATIENTS		236		956		1,831	73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES							76.01
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							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	11,820	15,433	116,276	23,330	62,481	22,484	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES		187					192
194	NRCC MARKETING		3		39			194
194.01	NRCC MEALS			4,810				194.01
194.02	NRCC CLINICAL PSYCH							194.02
194.05	NRCC STAFFING CONTRACT							194.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	11,820	15,623	121,086	23,369	62,481	22,484	202

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VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	SOCIAL SERVICE SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL			
		17	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							15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE	17,562						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	17,562	861,240		861,240			30
	ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC		2,727		2,727			54
60	LABORATORY		1,291		1,291			60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		16,391		16,391			65
66	PHYSICAL THERAPY		236,557		236,557			66
67	OCCUPATIONAL THERAPY		188,048		188,048			67
68	SPEECH PATHOLOGY		12,253		12,253			68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		19,498		19,498			71
73	DRUGS CHARGED TO PATIENTS		25,452		25,452			73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES							76.01
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							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	17,562	1,363,457		1,363,457			118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES		16,053		16,053			192
194	NRCC MARKETING		309		309			194
194.01	NRCC MEALS		4,810		4,810			194.01
194.02	NRCC CLINICAL PSYCH		13		13			194.02
194.05	NRCC STAFFING CONTRACT							194.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	17,562	1,384,642		1,384,642			202

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VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	62,785						1
2	CAP REL COSTS-MVBLE EQUIP		62,785					2
4	EMPLOYEE BENEFITS DEPARTMENT			9,941,094				4
5	ADMINISTRATIVE & GENERAL	1,670	1,670	1,561,962	-4,784,983	13,138,749		5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	18,812	18,812	120,470		964,453	42,303	7
8	LAUNDRY & LINEN SERVICE	358	358			139,454	358	8
9	HOUSEKEEPING	465	465	170,752		277,720	465	9
10	DIETARY	3,690	3,690	301,097		675,595	3,690	10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	1,826	1,826	536,944		673,269	1,826	13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY	660	660	150,446		254,643	660	16
17	SOCIAL SERVICE	460	460	422,920		511,552	460	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	19,910	19,910	3,542,892		4,690,078	19,910	30
	ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC	80	80	47,737	-259,496		80	54
60	LABORATORY					193,896		60
60.01	LAB - SUA				-123,287			60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	433	433	259,458		323,268	433	65
66	PHYSICAL THERAPY	6,967	6,967	1,110,101		1,487,044	6,967	66
67	OCCUPATIONAL THERAPY	5,500	5,500	961,146		1,255,061	5,500	67
68	SPEECH PATHOLOGY	280	280	334,819		404,743	280	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	545	545	88,669		384,467	545	71
73	DRUGS CHARGED TO PATIENTS	626	626	318,722		871,943	626	73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES							76.01
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)	62,282	62,282	9,928,135	-5,167,766	13,107,186	41,800	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES	496	496			10,939	496	192
194	NRCC MARKETING	7	7	12,959		15,824	7	194
194.01	NRCC MEALS							194.01
194.02	NRCC CLINICAL PSYCH					4,800		194.02
194.05	NRCC STAFFING CONTRACT							194.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	1,149,259	235,383	1,759,240		4,784,983	1,315,696	202
203	UNIT COST MULT-WS B PT I	18.304675	3.749032	0.176966		0.364189	31.101719	203
204	COST TO BE ALLOC PER B PT II					36,830	417,578	204
205	UNIT COST MULT-WS B PT II					0.002803	9.871120	205

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VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE PATIENT DAYS	HOUSE-KEEPING EQUIPMENT SQUARE FEET	DIETARY BENEFITS DEPARTMENT MEALS SERVED	CAFETERIA RECON-CILIATION GROSS SALARIES	NURSING ADMINIS-TRATION PATIENT DAYS	MEDICAL RECORDS & LIBRARY GROSS REVENUE	
		8	9	10	11	13	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	17,698						8
9	HOUSEKEEPING		41,480					9
10	DIETARY		3,690	69,198				10
11	CAFETERIA			13,355	7,786,813			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		1,826		536,944	17,698		13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY		660		150,446		35,200,548	16
17	SOCIAL SERVICE		460		422,920			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	17,698	19,910	53,094	3,542,892	17,698	14,982,728	30
	ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC		80		47,737			54
60	LABORATORY						1,169,946	60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		433		259,458		1,127,381	65
66	PHYSICAL THERAPY		6,967		1,110,101		6,280,299	66
67	OCCUPATIONAL THERAPY		5,500		961,146		6,239,730	67
68	SPEECH PATHOLOGY		280		334,819		1,674,210	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		545		88,669		860,883	71
73	DRUGS CHARGED TO PATIENTS		626		318,722		2,865,371	73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES							76.01
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)	17,698	40,977	66,449	7,773,854	17,698	35,200,548	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES		496					192
194	NRCC MARKETING		7		12,959			194
194.01	NRCC MEALS			2,749				194.01
194.02	NRCC CLINICAL PSYCH							194.02
194.05	NRCC STAFFING CONTRACT							194.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	201,376	393,325	1,071,394	206,776	1,006,832	378,161	202
203	UNIT COST MULT-WS B PT I	11.378461	9.482281	15.483020	0.026555	56.889592	0.010743	203
204	COST TO BE ALLOC PER B PT II	11,820	15,623	121,086	23,369	62,481	22,484	204
205	UNIT COST MULT-WS B PT II	0.667872	0.376639	1.749848	0.003001	3.530399	0.000639	205

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VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	SOCIAL SERVICE SERVICE PATIENT DAYS						
		17						
	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							16
17	SOCIAL SERVICE	17,698						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	17,698						30
	ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC							54
60	LABORATORY							60
60.01	LAB - SUA							60.01
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
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES							76.01
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)	17,698						118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES							192
194	NRCC MARKETING							194
194.01	NRCC MEALS							194.01
194.02	NRCC CLINICAL PSYCH							194.02
194.05	NRCC STAFFING CONTRACT							194.05
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	727,754						202
203	UNIT COST MULT-WS B PT I	41.120692						203
204	COST TO BE ALLOC PER B PT II	17,562						204
205	UNIT COST MULT-WS B PT II	0.992316						205

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VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

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VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

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

				COSTS			
	COST CENTER DESCRIPTIONS	TOTAL COST (from Wkst. B, Part I, col. 26)	THERAPY LIMIT ADJ.	TOTAL COSTS	RCE DISALLOW-ANCE	TOTAL COSTS	
		1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	10,219,231		10,219,231	11,138	10,230,369	30
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC	264,011		264,011		264,011	54
60	LABORATORY	277,080		277,080		277,080	60
60.01	LAB - SUA	123,287		123,287		123,287	60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	477,573		477,573		477,573	65
66	PHYSICAL THERAPY	2,408,306		2,408,306		2,408,306	66
67	OCCUPATIONAL THERAPY	2,027,908		2,027,908		2,027,908	67
68	SPEECH PATHOLOGY	590,386		590,386		590,386	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	558,207		558,207		558,207	71
73	DRUGS CHARGED TO PATIENTS	1,254,148		1,254,148		1,254,148	73
76	PSYCHOLOGY						76
76.01	SPECIAL PROCEDURES						76.01
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						
113	INTEREST EXPENSE						113
200	SUBTOTAL (SEE INSTRUCTIONS)	18,200,137		18,200,137	11,138	18,211,275	200
201	LESS OBSERVATION BEDS						201
202	TOTAL (SEE INSTRUCTIONS)	18,200,137		18,200,137		18,211,275	202

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VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

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

		CHARGES						
	COST CENTER DESCRIPTIONS	INPATIENT	OUTPATIENT	TOTAL (column 6 + column 7)	COST OR OTHER RATIO	TEFRA INPATIENT RATIO	PPS INPATIENT RATIO	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	14,982,728		14,982,728				30
	ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC	577,983		577,983	0.456780	0.456780	0.456780	54
60	LABORATORY	1,169,915	31	1,169,946	0.236831	0.236831	0.236831	60
60.01	LAB - SUA	793,459		793,459	0.155379	0.155379	0.155379	60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	784,364		784,364	0.608867	0.608867	0.608867	65
66	PHYSICAL THERAPY	4,538,013	1,742,286	6,280,299	0.383470	0.383470	0.383470	66
67	OCCUPATIONAL THERAPY	5,168,926	1,070,804	6,239,730	0.324999	0.324999	0.324999	67
68	SPEECH PATHOLOGY	954,258	719,952	1,674,210	0.352636	0.352636	0.352636	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,201,852	2,049	1,203,901	0.463665	0.463665	0.463665	71
73	DRUGS CHARGED TO PATIENTS	2,865,371		2,865,371	0.437691	0.437691	0.437691	73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES							76.01
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							
113	INTEREST EXPENSE							113
200	SUBTOTAL (SEE INSTRUCTIONS)	33,036,869	3,535,122	36,571,991				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	33,036,869	3,535,122	36,571,991				202

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VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26)	SWING BED ADJUST-MENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	861,240		861,240	17,698	48.66	11,880	578,081	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)	861,240		861,240	17,698		11,880	578,081	200

(A) Worksheet A line numbers

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VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-3028** **WORKSHEET D PART II**

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

		CAPITAL RELATED COST (from Wkst. B, Part II (col. 26)	TOTAL CHARGES (from Wkst. C, Part I, (col. 8)	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC	2,727	577,983	0.004718	267,825	1,264	54
60	LABORATORY	1,291	1,169,946	0.001103	812,082	896	60
60.01	LAB - SUA		793,459		550,471		60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	16,391	784,364	0.020897	560,518	11,713	65
66	PHYSICAL THERAPY	236,557	6,280,299	0.037667	3,090,568	116,412	66
67	OCCUPATIONAL THERAPY	188,048	6,239,730	0.030137	3,549,352	106,967	67
68	SPEECH PATHOLOGY	12,253	1,674,210	0.007319	554,687	4,060	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,498	1,203,901	0.016196	863,458	13,985	71
73	DRUGS CHARGED TO PATIENTS	25,452	2,865,371	0.008883	1,938,723	17,222	73
76	PSYCHOLOGY						76
76.01	SPECIAL PROCEDURES						76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	502,217	21,589,263		12,187,684	272,519	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS **WORKSHEET D PART III**

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

		NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUST-MENT AMOUNT (see instruct-ions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS (General Routine Care)						30
31	INTENSIVE CARE UNIT						31
32	CORONARY CARE UNIT						32
33	BURN INTENSIVE CARE UNIT						33
34	SURGICAL INTENSIVE CARE UNIT						34
35	OTHER SPECIAL CARE (SPECIFY)						35
40	SUBPROVIDER - IPF						40
41	SUBPROVIDER - IRF						41
42	SUBPROVIDER I						42
43	NURSERY						43
44	SKILLED NURSING FACILITY						44
45	NURSING FACILITY						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS **WORKSHEET D PART III**

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

		TOTAL PATIENT DAYS	PER DIEM (col. 5÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	17,698		11,880		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)	17,698		11,880		200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-3028** **WORKSHEET D PART IV**

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

		NON PHYSICIAN ANESTH-ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC							54
60	LABORATORY							60
60.01	LAB - SUA							60.01
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
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-3028** **WORKSHEET D PART IV**

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

		TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPATIENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPATIENT PROGRAM CHARGES	OUTPATIENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)	
(A)	COST CENTER DESCRIPTION	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
54	RADIOLOGY-DIAGNOSTIC	577,983			267,825				54
60	LABORATORY	1,169,946			812,082				60
60.01	LAB - SUA	793,459			550,471				60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	784,364			560,518				65
66	PHYSICAL THERAPY	6,280,299			3,090,568		264		66
67	OCCUPATIONAL THERAPY	6,239,730			3,549,352				67
68	SPEECH PATHOLOGY	1,674,210			554,687				68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,203,901			863,458				71
73	DRUGS CHARGED TO PATIENTS	2,865,371			1,938,723				73
76	PSYCHOLOGY								76
76.01	SPECIAL PROCEDURES								76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	OBSERVATION BEDS (NON-DISTINCT PART)								92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	21,589,263			12,187,684		264		200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-3028** **WORKSHEET D PART V**

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

			PROGRAM CHARGES			PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
54	RADIOLOGY-DIAGNOSTIC	0.456780							54
60	LABORATORY	0.236831							60
60.01	LAB - SUA	0.155379							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.608867							65
66	PHYSICAL THERAPY	0.383470	264			101			66
67	OCCUPATIONAL THERAPY	0.324999							67
68	SPEECH PATHOLOGY	0.352636							68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.463665							71
73	DRUGS CHARGED TO PATIENTS	0.437691							73
76	PSYCHOLOGY								76
76.01	SPECIAL PROCEDURES								76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	OBSERVATION BEDS (NON-DISTINCT PART)								92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)		264			101			200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)		264			101			202

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS **WORKSHEET D PART I**

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

		CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26)	SWING BED ADJUST-MENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	861,240		861,240	17,698	48.66	1,032	50,217	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)	861,240		861,240	17,698		1,032	50,217	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-3028** **WORKSHEET D PART II**

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

		CAPITAL RELATED COST (from Wkst. B, Part II (col. 26)	TOTAL CHARGES (from Wkst. C, Part I, (col. 8)	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC	2,727	577,983	0.004718	47,007	222	54
60	LABORATORY	1,291	1,169,946	0.001103	91,812	101	60
60.01	LAB - SUA		793,459				60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	16,391	784,364	0.020897	40,435	845	65
66	PHYSICAL THERAPY	236,557	6,280,299	0.037667	256,350	9,656	66
67	OCCUPATIONAL THERAPY	188,048	6,239,730	0.030137	292,873	8,826	67
68	SPEECH PATHOLOGY	12,253	1,674,210	0.007319	72,540	531	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,498	1,203,901	0.016196	55,479	899	71
73	DRUGS CHARGED TO PATIENTS	25,452	2,865,371	0.008883	179,591	1,595	73
76	PSYCHOLOGY						76
76.01	SPECIAL PROCEDURES						76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	502,217	21,589,263		1,036,087	22,675	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS **WORKSHEET D PART III**

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

		NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUST-MENT AMOUNT (see instruct-ions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS (General Routine Care)						30
31	INTENSIVE CARE UNIT						31
32	CORONARY CARE UNIT						32
33	BURN INTENSIVE CARE UNIT						33
34	SURGICAL INTENSIVE CARE UNIT						34
35	OTHER SPECIAL CARE (SPECIFY)						35
40	SUBPROVIDER - IPF						40
41	SUBPROVIDER - IRF						41
42	SUBPROVIDER I						42
43	NURSERY						43
44	SKILLED NURSING FACILITY						44
45	NURSING FACILITY						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS **WORKSHEET D PART III**

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

		TOTAL PATIENT DAYS	PER DIEM (col. 5÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	17,698		1,032		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)	17,698		1,032		200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-3028** **WORKSHEET D PART IV**

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

		NON PHYSICIAN ANESTH-ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC							54
60	LABORATORY							60
60.01	LAB - SUA							60.01
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
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-3028** **WORKSHEET D PART IV**

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

		TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPATIENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPATIENT PROGRAM CHARGES	OUTPATIENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)	
(A)	COST CENTER DESCRIPTION	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
54	RADIOLOGY-DIAGNOSTIC	577,983			47,007				54
60	LABORATORY	1,169,946			91,812				60
60.01	LAB - SUA	793,459							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	784,364			40,435				65
66	PHYSICAL THERAPY	6,280,299			256,350				66
67	OCCUPATIONAL THERAPY	6,239,730			292,873				67
68	SPEECH PATHOLOGY	1,674,210			72,540				68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,203,901			55,479				71
73	DRUGS CHARGED TO PATIENTS	2,865,371			179,591				73
76	PSYCHOLOGY								76
76.01	SPECIAL PROCEDURES								76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	OBSERVATION BEDS (NON-DISTINCT PART)								92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	21,589,263			1,036,087				200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-3028** **WORKSHEET D PART V**

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

			PROGRAM CHARGES			PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
54	RADIOLOGY-DIAGNOSTIC	0.456780							54
60	LABORATORY	0.236831							60
60.01	LAB - SUA	0.155379							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.608867							65
66	PHYSICAL THERAPY	0.383470							66
67	OCCUPATIONAL THERAPY	0.324999							67
68	SPEECH PATHOLOGY	0.352636							68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.463665							71
73	DRUGS CHARGED TO PATIENTS	0.437691							73
76	PSYCHOLOGY								76
76.01	SPECIAL PROCEDURES								76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	OBSERVATION BEDS (NON-DISTINCT PART)								92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)								200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)								202

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-3028** **WORKSHEET D-1 PART I**

CHECK APPLICABLE BOXES:	[ ] TITLE V - I/P	[XX] HOSPITAL	[ ] SUB (OTHER)	[ ] ICF/MR	[XX] PPS	
	[XX] TITLE XVIII, PART A	[ ] IPF	[ ] SNF		[ ] TEFRA	
	[ ] 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)	17,698	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	17,698	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.	25	3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	17,673	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	11,880	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)	25	14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	10,230,369	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	10,230,369	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)	14,982,726	28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)	21,175	29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)	14,961,551	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)	0.682811	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)	847.00	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)	846.58	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)	0.42	34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)	0.29	35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)	7	36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	10,230,362	37

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VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-3028** **WORKSHEET D-1 PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

		1	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)	578.05	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	6,867,234	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)		40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)	6,867,234	41

		TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (col. 1 ÷ col. 2)	PROGRAM DAYS	PROGRAM COST (col. 3 x col. 4)	
		1	2	3	4	5	
42	NURSERY (Titles V and XIX only)						42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT						43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47

		1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)	4,524,672	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	11,391,906	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	578,081	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	272,519	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	850,600	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)	10,541,306	53

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)		66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)		67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)		68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)		69

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VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-3028** **WORKSHEET D-1 PARTS III & IV**

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)						87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)					578.05	88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)						89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERV-ATION BED COST (from line89)	OBSERV-ATION BED PASS-THROUGH COST col. 3 x col. 4) (see instr-uctions	
		1	2	3	4	5	
90	CAPITAL-RELATED COST						90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

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VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-3028** **WORKSHEET D-1 PART I**

CHECK APPLICABLE BOXES:	[ ] TITLE V - I/P	[XX] HOSPITAL	[ ] SUB (OTHER)	[ ] ICF/MR	[XX] PPS		
	[ ] TITLE XVIII, PART A	[ ] IPF	[ ] SNF		[ ] TEFRA		
	[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)	17,698	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	17,698	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.	25	3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	17,673	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	1,032	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	10,230,369	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	10,230,369	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)	14,982,726	28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)	21,175	29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)	14,961,551	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)	0.682811	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)	847.00	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)	846.58	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)	0.42	34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)	0.29	35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)	7	36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	10,230,362	37

KPMG LLP COMPU-MAX

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-3028** **WORKSHEET D-1 PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

						1	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					578.05	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					596,548	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)					596,548	41
		TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (col. 1 ÷ col. 2)	PROGRAM DAYS	PROGRAM COST (col. 3 x col. 4)	
		1	2	3	4	5	
42	NURSERY (Titles V and XIX only)						42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT						43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47
						1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)					391,231	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					987,779	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	50,217	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	22,675	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	72,892	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)	914,887	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

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-3028** **WORKSHEET D-1 PARTS III & IV**

CHECK	**[ ] TITLE V - I/P**	**[XX] HOSPITAL**	**[ ] SUB (OTHER)**	**[ ] ICF/MR**	**[XX] PPS**
APPLICABLE	**[ ] TITLE XVIII, PART A**	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**
BOXES:	**[XX] 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 27)	column 1 ÷ column 2	TOTAL OBSERV-ATION BED COST (from line89)	OBSERV-ATION BED PASS-THROUGH COST col. 3 x col. 4) (see instr-uctions	
		1	2	3	4	5	
90	CAPITAL-RELATED COST						90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

KPMG LLP COMPU-MAX

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-3028** **WORKSHEET D-3**

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

		RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		10,051,535		30
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
54	RADIOLOGY-DIAGNOSTIC	0.456780	267,825	122,337	54
60	LABORATORY	0.236831	812,082	192,326	60
60.01	LAB - SUA	0.155379	550,471	85,532	60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.608867	560,518	341,281	65
66	PHYSICAL THERAPY	0.383470	3,090,568	1,185,140	66
67	OCCUPATIONAL THERAPY	0.324999	3,549,352	1,153,536	67
68	SPEECH PATHOLOGY	0.352636	554,687	195,603	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.463665	863,458	400,355	71
73	DRUGS CHARGED TO PATIENTS	0.437691	1,938,723	848,562	73
76	PSYCHOLOGY				76
76.01	SPECIAL PROCEDURES				76.01
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)		12,187,684	4,524,672	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		12,187,684		202

(A) Worksheet A line numbers

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VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-3028** **WORKSHEET D-3**

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

		RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		874,104		30
	ANCILLARY SERVICE COST CENTERS				
54	RADIOLOGY-DIAGNOSTIC	0.456780	47,007	21,472	54
60	LABORATORY	0.236831	91,812	21,744	60
60.01	LAB - SUA	0.155379			60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.608867	40,435	24,620	65
66	PHYSICAL THERAPY	0.383470	256,350	98,303	66
67	OCCUPATIONAL THERAPY	0.324999	292,873	95,183	67
68	SPEECH PATHOLOGY	0.352636	72,540	25,580	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.463665	55,479	25,724	71
73	DRUGS CHARGED TO PATIENTS	0.437691	179,591	78,605	73
76	PSYCHOLOGY				76
76.01	SPECIAL PROCEDURES				76.01
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)		1,036,087	391,231	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		1,036,087		202

(A) Worksheet A line numbers

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VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-3028** **WORKSHEET E PART B**

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	MEDICAL AND OTHER SERVICES (see instructions)				1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (see instructions)	101			2
3	PPS PAYMENTS	107			3
4	OUTLIER PAYMENT (see instructions)				4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)				5
6	LINE 2 TIMES LINE 5				6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6				7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200				9
10	ORGAN ACQUISITION				10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES				12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)				13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)				16
17	RATIO OF LINE 15 TO LINE 16 (not to exceed 1.000000)	1.000000			17
18	TOTAL CUSTOMARY CHARGES (see instructions)				18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions)				19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 11 exceeds line 18 (see instructions)				20
21	LESSER OF COST OR CHARGES (line 11 minus line 20) (for CAH, see instructions)				21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)	107			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)				25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)	21			26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	86			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)	86			30
31	PRIMARY PAYER PAYMENTS				31
32	SUBTOTAL (line 30 minus line 31)	86			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)	86			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)	86			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	1			40.01
41	INTERIM PAYMENTS	85			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)				43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2				44

TO BE COMPLETED BY CONTRACTOR

90	ORIGINAL OUTLIER AMOUNT (see instructions)				90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (sse instructions)				91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY				92
93	TIME VALUE OF MONEY (see instructions)				93
94	TOTAL (sum of lines 91 and 93)				94

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VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-3028** **WORKSHEET E-1 PART I**

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

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				16,291,101		85	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. If NONE, WRITE 'NONE' OR ENTER A ZERO							2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT		.01					3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM		.02					3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM	.03					3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO	.04					3.04
		PROVIDER	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		PROVIDER	.52					3.52
		TO	.53					3.53
		PROGRAM	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99					3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				16,291,101		85	4
	TO BE COMPLETED BY CONTRACTOR							
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT		.01					5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.		.02					5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM	.03					5.03
		TO	.04					5.04
		PROVIDER	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		PROVIDER	.52					5.52
		TO	.53					5.53
		PROGRAM	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due)		.01		343,475		1	6.01
	BASED ON THE COST REPORT (1)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				16,634,576		86	7
8	NAME OF CONTRACTOR			CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)		8

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

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VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-3028** **WORKSHEET E-3 PART III**

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

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

		1	1.01	
1	NET FEDERAL PPS PAYMENT (see instructions)	12,163,119	4,281,901	1
2	MEDICARE SSI RATIO (see instructions)	0.024700		2
3	INPATIENT REHABILITATION LIP PAYMENTS (see instructions)	558,287	134,452	3
4	OUTLIER PAYMENTS			4
5	UNWEIGHTED INTERN AND RESIDENT FTE COUNT IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR PRIOR TO NOVEMBER 15, 2004 (see instructions)			5
5.01	CAP INCREASES FOR THE UNWEIGHTED INTERN AND RESIDENT FTE COUNT FOR RESIDENTS THAT WERE DISPLACED BY PROGRAM OR HOSPITAL CLOSUE, THAT WOULD NOT BE COUNTED WITHOUT A TEMPORARY CAP ADJUSTMENT UNDER §412.424(d)(1)(iii)(F)(1) OR (2) (SEE INSTRUCTIONS)			5.01
6	NEW TEACHING PROGRAM ADJUSTMENT (see instructions)			6
7	CURRENT YEAR UNWEIGHTED FTE COUNT OF I&R EXCLUDING FTEs IN THE NEW PROGRAM GROWTH PERIOD OF A 'NEW TEACHING PROGRAM' (see instructions)			7
8	CURRENT YEAR UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE NEW PROGRAM GROWTH PERIOD OF A 'NEW TEACHING PROGRAM' (see instructions)			8
9	INTERN AND RESIDENT COUNT FOR IRF PPS MEDICAL EDUCATION ADJUSTMENT (see instructions)			9
10	AVERAGE DAILY CENSUS (see instructions)	48.487671		10
11	TEACHING ADJUSTMENT FACTOR (see instructions)			11
12	TEACHING ADJUSTMENT (see instructions)			12
13	TOTAL PPS PAYMENT (see instructions)	17,137,759		13
14	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENTS (see instructions)			14
15	ORGAN ACQUISITION			15
16	COST OF TEACHING PHYSICIANS (from Worksheet D-5, Part II, col. 3, line 20) (see instructions)			16
17	SUBTOTAL (see instructions)	17,137,759		17
18	PRIMARY PAYER PAYMENTS	25,805		18
19	SUBTOTAL (line 17 less line 18)	17,111,954		19
20	DEDUCTIBLES	452,204		20
21	SUBTOTAL (line 19 minus line 20)	16,659,750		21
22	COINSURANCE	54,352		22
23	SUBTOTAL (line 21 minus line 22)	16,605,398		23
24	ALLOWABLE BAD DEBTS (exclude bad debts for professional services) (see instructions)	44,889		24
25	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	29,178		25
26	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	37,691		26
27	SUBTOTAL (sum of lines 23 and 25)	16,634,576		27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4, line 49) (for freestanding IRF only)			28
29	OTHER PASS THROUGH COSTS (see instructions)			29
30	OUTLIER PAYMENTS RECONCILIATION			30
31	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			31
32	TOTAL AMOUNT PAYABLE TO THE PROVIDER (see instructions)	16,634,576		32
32.01	SEQUESTRATION ADJUSTMENT (see instructions)	251,182		32.01
33	INTERIM PAYMENTS	16,291,101		33
34	TENTATIVE SETTLEMENT (for contractor use only)			34
35	BALANCE DUE PROVIDER/PROGRAM (line 32 minus lines 32.01, 33 and 34)	92,293		35
36	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	14,570		36

TO BE COMPLETED BY CONTRACTOR

50	ORIGINAL OUTLIER AMOUNT FROM WORKSHEET E-3, PART III, LINE 4 (see instructions)			50
51	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)			51
52	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (see instructions)			52
53	TIME VALUE OF MONEY (see instructions)			53

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CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-3028** **WORKSHEET E-3 PART VII**

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

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

		INPATIENT TITLE V OR TITLE XIX	OUTPATIENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	INPATIENT HOSPITAL SNF/NF SERVICES			1
2	MEDICAL AND OTHER SERVICES			2
3	ORGAN ACQUISITION (certified transplant centers only)			3
4	SUBTOTAL (sum of lines 1, 2 and 3)			4
5	INPATIENT PRIMARY PAYER PAYMENTS			5
6	OUTPATIENT PRIMARY PAYER PAYMENTS			6
7	SUBTOTAL (line 4 less sum of lines 5 and 6)			7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	ROUTINE SERVICE CHARGES			8
9	ANCILLARY SERVICE CHARGES	1,036,087		9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE			10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION			11
12	TOTAL REASONABLE CHARGES (sum of lines 8-11)	1,036,087		12
	CUSTOMARY CHARGES			
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)			14
15	RATIO OF LINE 13 TO LINE 14 (not to exceed 1.000000)	1	1	15
16	TOTAL CUSTOMARY CHARGES (see instructions)	1,036,087		16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 16 exceeds line 4) (see instructions)	1,036,087		17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 4 exceeds line 16) (see instructions)			18
19	INTERNS AND RESIDENTS (see instructions)			19
20	COST OF TEACHING PHYSICIANS (see instructions)			20
21	COST OF COVERED SERVICES (lesser of line 4 or line 16) (for CAH, see instructions)			21
	PROSPECTIVE PAYMENT AMOUNT			
22	OTHER THAN OUTLIER PAYMENTS			22
23	OUTLIER PAYMENTS			23
24	PROGRAM CAPITAL PAYMENTS			24
25	CAPITAL EXCEPTION PAYMENTS (see instructions)			25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS			26
27	SUBTOTAL (sum of lines 22 through 26)			27
28	CUSTOMARY CHARGES (Titles V or XIX PPS covered services only)			28
29	SUM OF LINES 27 AND 21			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	EXCESS OF REASONABLE COST (from line 18)			30
31	SUBTOTAL (sum of lines 19 and 20 plus 29 minus lines 5 and 6)			31
32	DEDUCTIBLES			32
33	COINSURANCE			33
34	ALLOWABLE BAD DEBTS (see instructions)			34
35	UTILIZATION REVIEW			35
36	SUBTOTAL (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	SUBTOTAL (line 36 ± line 37)			38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4)			39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (sum of lines 38 and 39)			40
41	INTERIM PAYMENTS			41
42	BALANCE DUE PROVIDER/PROGRAM (line 40 minus 41)			42
43	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			43

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BALANCE SHEET **WORKSHEET G**

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

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	4,029,762				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	4,585,650				4
5	OTHER RECEIVABLES					5
6	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE	-1,245,057				6
7	INVENTORY	108,461				7
8	PREPAID EXPENSES	265,828				8
9	OTHER CURRENT ASSETS					9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	7,744,644				11
	FIXED ASSETS					
12	LAND					12
13	LAND IMPROVEMENTS					13
14	ACCUMULATED DEPRECIATION					14
15	BUILDINGS	13,183,510				15
16	ACCUMULATED DEPRECIATION	-4,776,383				16
17	LEASEHOLD IMPROVEMENTS	336,319				17
18	ACCUMULATED AMORTIZATION	-70,068				18
19	FIXED EQUIPMENT					19
20	ACCUMULATED DEPRECIATION					20
21	AUTOMOBILES AND TRUCKS					21
22	ACCUMULATED DEPRECIATION					22
23	MAJOR MOVABLE EQUIPMENT	2,623,307				23
24	ACCUMULATED DEPRECIATION	-2,170,144				24
25	MINOR EQUIPMENT DEPRECIABLE					25
26	ACCUMULATED DEPRECIATION					26
27	HIT DESIGNATED ASSETS					27
28	ACCUMULATED DEPRECIATION					28
29	MINOR EQUIPMENT-NONDEPRECIABLE					29
30	TOTAL FIXED ASSETS (sum of lines 12-29)	9,126,541				30
	OTHER ASSETS					
31	INVESTMENTS					31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	2,917,715				34
35	TOTAL OTHER ASSETS (sum of lines 31-34)	2,917,715				35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	19,788,900				36

	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	827,684				37
38	SALARIES, WAGES & FEES PAYABLE	747,228				38
39	PAYROLL TAXES PAYABLE					39
40	NOTES & LOANS PAYABLE (short term)					40
41	DEFERRED INCOME					41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS					43
44	OTHER CURRENT LIABILITIES	468,854				44
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	2,043,766				45
	LONG TERM LIABILITIES					
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE					47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES	8,872,565				49
50	TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49)	8,872,565				50
51	TOTAL LIABILITIES (sum of lines 45 and 50)	10,916,331				51
	CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	8,872,569				52
53	SPECIFIC PURPOSE FUND BALANCE					53
54	DONOR CREATED - ENDOWMENT FUND BALANCE - RESTRICTED					54
55	DONOR CREATED - ENDOWMENT FUND BALANCE - UNRESTRICTED					55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BALANCE					56
57	PLANT FUND BALANCE - INVESTED IN PLANT					57
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT, AND EXPANSION					58
59	TOTAL FUND BALANCES (sum of lines 52-58)	8,872,569				59
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)	19,788,900				60

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VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

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

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	FUND BALANCES AT BEGINNING OF PERIOD		7,684,608			1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		6,633,779			2
3	TOTAL (sun of line 1 and line 2)		14,318,387			3
4	ADDITIONS (credit adjustments)					4
5		1				5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)		1			10
11	SUBTOTAL (line 3 plus line 10)		14,318,388			11
12	DEDUCTIONS (debit adjustments)					12
13	MINORITY INTEREST	3,316,891				13
14	DISTRIBUTIONS	2,128,928				14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)		5,445,819			18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)		8,872,569			19

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

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VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	HOSPITAL	14,982,728		14,982,728	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)	14,982,728		14,982,728	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)	14,982,728		14,982,728	17
18	ANCILLARY SERVICES	18,054,140	3,535,121	21,589,261	18
19	OUTPATIENT SERVICES				19
20	RHC				20
21	FQHC				21
22	HOME HEALTH AGENCY				22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	OTHER (SPECIFY)				27
28	TOTAL PATIENT REVENUES (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	33,036,868	3,535,121	36,571,989	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		18,482,896	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)		18,482,896	43

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VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:30 Version: 2014.03

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

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (from Worksheet G-2, Part I, column 3, line 28)	36,571,989	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	13,154,682	2
3	NET PATIENT REVENUES (line 1 minus line 2)	23,417,307	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	18,482,896	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	4,934,411	5

OTHER INCOME

6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	53,401	7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS	44	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	36,061	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (fees, sale of textbooks, uniforms, etc.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE	8,173	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (SPECIFY)	1,601,689	24
25	TOTAL OTHER INCOME (sum of lines 6-24)	1,699,368	25
26	TOTAL (line 5 plus line 25)	6,633,779	26
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	6,633,779	29