VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/14/2019 Run Time: 11:56 Version: 2018.12 (03/07/2019)

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

WORKSHEET S
PARTS I, II & III

PART I - COST REPORT STATUS

Provider use only	1. [X] Electronically filed cost report Date: 05/14/2019 Time: 11:56 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 CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by VAN MATRE HEALTHSOUTH REHABILITATION (14-3028) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 01/01/2018 and ending 12/31/2018, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) ROB WISNER
Chief Financial Officer or Administrator of Provider(s)

SVP REIMBURSEMENT
Title

05/14/2019 11:56
Date

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		69,145			-34,935	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		69,145			-34,935	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 resopnd to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send appilcations, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any corresponence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:

1	Street: 950 S MULFORD RD	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	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	VAN MATRE HEALTHSOUTH REHABILITATION	14-3028	40420	5	04 / 12 / 2002	N	P	O	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 / 2018	To: 12 / 31 / 2018	20
21	Type of control (see instructions)	5		21

	Inpatient PPS Information	1	2	3	
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR§412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	N	N		22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, 'Y' for yes or 'N' for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, 'Y' for yes or 'N' for no.	N	N	N	22.03
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter 'Y' for yes or 'N' for no.	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 column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.							24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	370	262	63		1,941		25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	1		26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.			35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.			37
37.01	Is this hospital a former MDH that is eilgible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)			37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40

		V	XVIII	XIX	
Prospective Payment System (PPS)-Capital		1	2	3	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	N	N	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	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 Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services ad defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
		NAHE 413.85 Y/N 1	Worksheet A Line # 2	Pass-Through Qualification Criteria Code 3	
60	Are you claiming nursing and allied health education (NAHE) costs for any program(s) that meet the criteria under 42 CFR 413.85? (see instructions)	N			60
		Y/N 1	IME 4	Direct GME 5	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.)(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathci FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

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

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

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

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

62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital reseived HRSA PCRE funding (see instructions)				62
62.01	Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost reporting period of HRSA THC program. (see instructions)				62.01

Teaching Hospitals that Claim Residents in Nonprovider Settings

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in oolumn 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				64

Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
65							65

	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				66

Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
67							67

Inpatient Psychiatric Faciltiy PPS		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	N			70
71	If line 70 is yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				71

Inpatient Rehabilitation Facility PPS		1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.	Y			75
76	If line 75 is yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	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
81	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no.	N		81

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XIX	
Title V and XIX Services		1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	Y	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92
93	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97
98	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06

Rural Providers				1	2	
105	Does this hospital qualify as a CAH?			N		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elinination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.					107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.			N		108
		Physical	Occupational	Speech	Respiratory	
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.					109

		1	
110	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? If yes, compolete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110
		1	2	
111	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for additional beds; and/or 'C' for tele-healsh services.			111

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.		N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.		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:	46,517	354,652		118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.		N	N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.		N		121
122	Does the cost report contain state health care related taxes as defined in §1903(w)(3) of the Act? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.		Y	5.00	122

Transplant Center Information

125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.	N		125
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date in column 2.			126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date in column 2.			127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date in column 2.			128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date in column 2.			129
130	If this is a Medicare cetfified pancreas transplant center enter the certification date in column 1 and termination date in column 2.			130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date in column 2.			131
132	If this is a Medicare cetfified islet transplant center enter the certification date in column 1 and termination date in column 2.			132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date in column 2.			133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.			134

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

All Providers

		1	2	
140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)	Y	019005	140

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

141	Name: ENCOMPASS HEALTH CORPORATION	Contractor's Name: PALMETTO GBA		Contractor's Number: 10111	141
142	Street: 9001 LIBERTY PARKWAY	P.O. Box:			142
143	City: BIRMINGHAM	State: AL	ZIP Code: 35242		143
144	Are provider based physicians' costs included in Worksheet A?			Y	144
145	If costs for renal services are claimed on Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.			N	N 145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, chapter 40, §4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.			N	146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.			N	147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.			N	148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.			N	149

Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter 'Y' for yes or 'N' for no for each component for Part A and Part B. See 42 CFR §413.13)

		Title XVIII				
		Part A	Part B	Title V	Title XIX	
		1	2	3	4	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N			156
157	Subprovider - IRF	N	N			157
158	Subprovider - Other					158
159	SNF	N	N			159
160	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. (see instructions)		166

	Name	County	State	ZIP Code	CBSA	FTE/Campus	
	0	1	2	3	4	5	

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

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

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	02/27/2019	4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N			5

		Y/N	Y/N	
Approved Educational Activities		1	2	
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N		6
7	Are costs claimed for allied health programs? If yes, see instructions.	N		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N		8
9	Are costs claimed for Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	N		9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructinos.	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)	Y	03/04/2019	N		16
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N		18
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19
20	If line 16 or 17 is yes, were adjustments made to PS&R Reoprt data for Other? Describe the other adjustments:	N		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

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

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

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

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

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

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

Cost Report Preparer Contact Information				
41	First name: COURTNEY	Last name: RIVERS	Title: REIMBURSEMENT SPECIALIST	41
42	Employer: ENCOMPASS HEALTH CORPORATION			42
43	Phone number: 205-968-7088	E-mail Address: COURTNEY.RIVERS@ENCOMPASSHEALTH.COM		43

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/14/2019 Run Time: 11:56 Version: 2018.12 (03/07/2019)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						Inpatient Days / Outpatient Visits / Trips				
	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	65	23,725			11,954	561	19,921	1
2	HMO and other (see instructions)						2,413	2,075		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)		65	23,725			11,954	561	19,921	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)		65	23,725			11,954	561	19,921	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)		65							27
28	Observation Bed Days									28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)									32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33
33.01	LTCH site neutral days and discharges									33.01

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/14/2019 Run Time: 11:56 Version: 2018.12 (03/07/2019)

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)					978	46	1,590	1
2	HMO and other (see instructions)					182	153		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)		174.88			978	46	1,590	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)		174.88						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32.01
33	LTCH non-covered days								33
33.01	LTCH site neutral days and discharges								33.01

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	11,171,251					1
2	Non-physician anesthetist Part A							2
3	Non-physician anesthetest Part B							3
4	Physician-Part A - Administrative							4
4.01	Physician-Part A - Teaching							4.01
5	Physician-Part B							5
6	Non-physician-Part B							6
7	Interns & residents (in an approved program)	21						7
7.01	Contracted interns & residents (in an approved program)							7.01
8	Home office and/or related organization personnel							8
9	SNF	44						9
10	Excluded area salaries (see instructions)			103,939				10
	OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)							11
12	Contract management and administrative services							12
13	Contract labor: Physician-Part A - Administrative							13
14	Home office salaries & wage-related costs							14
14.01	Home office salaries							14.01
14.02	Related organization salaries							14.02
15	Home office: Physician Part A - Administrative							15
16	Home office & Contract Physicians Part A - Teaching							16
	WAGE-RELATED COSTS							
17	Wage-related costs (core)(see instructions)							17
18	Wage-related costs (other)(see instructions)							18
19	Excluded areas							19
20	Non-physician anesthetist Part A							20
21	Non-physician anesthetist Part B							21
22	Physician Part A - Administrative							22
22.01	Physician Part A - Teaching							22.01
23	Physician Part B							23
24	Wage-related costs (RHC/FQHC)							24
25	Interns & residents (in an approved program)							25
25.50	Home office wage-related							25.50
25.51	Related organization wage-related							25.51
25.52	Home office: Physician Part A - Administrative - wage-related							25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related							25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26	Employee Benefits Department							26
27	Administrative & General		1,844,957	-103,939				27
28	Administrative & General under contract (see instructions)							28
29	Maintenance & Repairs							29
30	Operation of Plant		125,829					30
31	Laundry & Linen Service							31
32	Housekeeping		184,989					32
33	Housekeeping under contract (see instructions)							33
34	Dietary		335,905					34
35	Dietary under contract (see instructions)							35
36	Cafeteria							36
37	Maintenance of Personnel							37
38	Nursing Administration		535,782					38
39	Central Services and Supply							39
40	Pharmacy							40
41	Medical Records & Medical Records Library		85,640					41
42	Social Service		357,823					42
43	Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		11,171,251		11,171,251			1
2	Excluded area salaries (see instructions)			103,939	103,939			2
3	Subtotal salarles (line 1 minus line 2)		11,171,251	-103,939	11,067,312			3
4	Subtotal other wages & related costs (see instructions)							4
5	Subtotal wage-related costs (see instructions)							5
6	Total (sum of lines 3 through 5)		11,171,251	-103,939	11,067,312			6
7	Total overhead cost (see instructions)		3,470,925	-103,939	3,366,986			7

HOSPITAL WAGE RELATED COSTS **WORKSHEET S-3 PART IV**

Part IV - Wage Related Cost

Part A - Core List

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

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)		25

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/14/2019 Run Time: 11:56 Version: 2018.12 (03/07/2019)

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

Part V - Contract Labor and Benefit Cost

Hospital and Hospital-Based Component Identification:

	Component	Contract Labor	Benefit Cost	
	0	1	2	
1	Total facility contract labor and benefit cost	458,779	2,602,040	1
2	Hospital	458,779	2,577,830	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		24,210	18

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		989,204	989,204	224,964	1,214,168	124,013	1,338,181	1
2	00200	Cap Rel Costs-Mvble Equip		503,394	503,394	56,088	559,482	-8,918	550,564	2
3	00300	Other Cap Rel Costs		263,793	263,793	-263,793			-0-	3
4	00400	Employee Benefits Department		2,445,849	2,445,849		2,445,849	149,705	2,595,554	4
5	00500	Administrative & General	1,844,957	3,783,485	5,628,442	-131,083	5,497,359	-212,221	5,285,138	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	125,829	571,695	697,524		697,524	-117,630	579,894	7
8	00800	Laundry & Linen Service		154,891	154,891		154,891		154,891	8
9	00900	Housekeeping	184,989	50,031	235,020	971	235,991		235,991	9
10	01000	Dietary	335,905	369,039	704,944		704,944	-16,110	688,834	10
11	01100	Cafeteria								11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	535,782	13,272	549,054		549,054		549,054	13
14	01400	Central Services & Supply								14
15	01500	Pharmacy								15
16	01600	Medical Records & Library	85,640	7,388	93,028		93,028	-18	93,010	16
17	01700	Social Service	357,823	8,184	366,007		366,007	-25	365,982	17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	4,324,998	220,347	4,545,345	10,200	4,555,545	-3,286	4,552,259	30
		ANCILLARY SERVICE COST CENTERS								
54	05400	Radiology-Diagnostic		313,216	313,216	-94,618	218,598	-21,594	197,004	54
60	06000	Laboratory		418,362	418,362	94,618	512,980	-202,705	310,275	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	311,457	10,771	322,228		322,228	-145	322,083	65
66	06600	Physical Therapy	1,263,477	252,623	1,516,100		1,516,100	-2,000	1,514,100	66
67	06700	Occupational Therapy	1,060,605	78,746	1,139,351		1,139,351		1,139,351	67
68	06800	Speech Pathology	350,800	5,612	356,412		356,412		356,412	68
71	07100	Medical Supplies Charged to Patients	29,083	334,975	364,058		364,058		364,058	71
73	07300	Drugs Charged to Patients	359,906	566,753	926,659		926,659	-20	926,639	73
76	03550	PSYCHOLOGY								76
76.01	03951	SPECIAL PROCEDURES		87,302	87,302		87,302	-11,177	76,125	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
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM								93.99
		OTHER REIMBURSABLE COST CENTERS								
101	10100	Home Health Agency		971	971	-971				101
		SPECIAL PURPOSE COST CENTERS								
113	11300	Interest Expense		6,732	6,732		6,732	-6,732		113
118		SUBTOTALS (sum of lines 1-117)	11,171,251	11,456,635	22,627,886	-103,624	22,524,262	-328,863	22,195,399	118
		NONREIMBURSABLE COST CENTERS								
192	19200	Physicians' Private Offices		5,476	5,476	-5,476				192
194	07950	MARKETING NRCC				109,100	109,100		109,100	194
194.01	07951	GUEST MEALS								194.01
194.02	07952	VACANT SPACE								194.02
200		TOTAL (sum of lines 118-199)	11,171,251	11,462,111	22,633,362		22,633,362	-328,863	22,304,499	200

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/14/2019 Run Time: 11:56 Version: 2018.12 (03/07/2019)

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		13,814	1
2	INSURANCE	A	Cap Rel Costs-Mvble Equip	2		3,445	2
3	INSURANCE	A					3
500	Total reclassifications					17,259	500
	Code Letter - A						
1	MARKETING	B	MARKETING NRCC	194	103,939	5,161	1
2	MARKETING	B					2
500	Total reclassifications				103,939	5,161	500
	Code Letter - B						
1	PHYSICIANS	C	Adults & Pediatrics	30		10,200	1
2	PHYSICIANS	C					2
500	Total reclassifications					10,200	500
	Code Letter - C						
1	MISC RECLASS	D	Administrative & General	5		5,476	1
2	MISC RECLASS	D	Housekeeping	9		971	2
3	MISC RECLASS	D	Laboratory	60		94,618	3
4	MISC RECLASS	D					4
5	MISC RECLASS	D					5
6	MISC RECLASS	D					6
500	Total reclassifications					101,065	500
	Code Letter - D						
	GRAND TOTAL (Increases)				103,939	133,685	

(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.

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/14/2019 Run Time: 11:56 Version: 2018.12 (03/07/2019)

RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	INSURANCE	A					12	1
2	INSURANCE	A					12	2
3	INSURANCE	A	Administrative & General	5		17,259		3
500	Total reclassifications					17,259		500
	Code letter - A							
1	MARKETING	B						1
2	MARKETING	B	Administrative & General	5	103,939	5,161		2
500	Total reclassifications				103,939	5,161		500
	Code letter - B							
1	PHYSICIANS	C						1
2	PHYSICIANS	C	Administrative & General	5		10,200		2
500	Total reclassifications					10,200		500
	Code letter - C							
1	MISC RECLASS	D						1
2	MISC RECLASS	D						2
3	MISC RECLASS	D						3
4	MISC RECLASS	D	Radiology-Diagnostic	54		94,618		4
5	MISC RECLASS	D	Home Health Agency	101		971		5
6	MISC RECLASS	D	Physicians' Private Offices	192		5,476		6
500	Total reclassifications					101,065		500
	Code letter - D							
	GRAND TOTAL (Decreases)				103,939	133,685		

(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.

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 Retirements	Ending Balance	Fully Depreciated Assets	
		1	2	3	4	5	6	7	
1	Land								1
2	Land Improvements	9,720	13,204		13,204	13,204	9,720		2
3	Buildings and Fixtures	3,753,652				164,403	3,589,249		3
4	Building Improvements	13,133,512	1,090,621		1,090,621	26,350	14,197,783		4
5	Fixed Equipment	4,098,301	314,716		314,716	12,843	4,400,174		5
6	Movable Equipment	36,820					36,820		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	21,032,005	1,418,541		1,418,541	216,800	22,233,746		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	21,032,005	1,418,541		1,418,541	216,800	22,233,746		10

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

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	818,160	171,044					989,204	1
2	Cap Rel Costs-Mvble Equip	322,569	180,825					503,394	2
3	Total (sum of lines 1-2)	1,140,729	351,869					1,492,598	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	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	17,796,752		17,796,752	0.800439		211,150		211,150	1
2	Cap Rel Costs-Mvble Equ	4,436,994		4,436,994	0.199561		52,643		52,643	2
3	Total (sum of lines 1-2)	22,233,746		22,233,746	1.000000		263,793		263,793	3

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	904,918	1,020	207,279	13,814	211,150		1,338,181	1
2	Cap Rel Costs-Mvble Equip	313,651	180,825		3,445	52,643		550,564	2
3	Total (sum of lines 1-2)	1,218,569	181,845	207,279	17,259	263,793		1,888,745	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.)

				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	-3,286				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1	925,581				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 and allied health education (tuition, fees, books, etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation						32
33							33
34							34
35							35
36							36
37	INTEREST	A	-6,732	Interest Expense	113	11	37
37.02	DEPRECIATION	A	1	Cap Rel Costs-Mvble Equip	2	9	37.02
37.03	INSURANCE	A	156,048	Employee Benefits Department	4		37.03
37.04	INSURANCE	A	-101,092	Administrative & General	5		37.04
37.05	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-68,262	Administrative & General	5		37.05
37.06	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-2,377	Operation of Plant	7		37.06
37.07	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-18	Medical Records & Library	16		37.07
37.08	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-145	Respiratory Therapy	65		37.08
37.09	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-2,000	Physical Therapy	66		37.09
37.10	PATIENT TELEPHONE	A	-1,828	Cap Rel Costs-Mvble Equip	2	9	37.10
37.11	PATIENT TELEPHONE	A	-6,224	Employee Benefits Department	4		37.11
37.12	PATIENT TELEPHONE	A	-47,005	Administrative & General	5		37.12
37.13	PATIENT TELEVISION	A	-6,986	Cap Rel Costs-Mvble Equip	2	9	37.13
37.14	PATIENT TELEVISION	A	-6,906	Operation of Plant	7		37.14
37.15	PRINTING	A	-1,450	Administrative & General	5		37.15
37.16	PRINTING	A	-112	Operation of Plant	7		37.16
37.17	LOBBYING EXPENSE	A	-119	Employee Benefits Department	4		37.17
37.18	LOBBYING EXPENSE	A	-2,338	Administrative & General	5		37.18
37.19	LOBBYING EXPENSE	A	-156	Operation of Plant	7		37.19
37.20	MISCELLANEOUS INCOME	B	-5,313	Administrative & General	5		37.20
37.21	MISCELLANEOUS INCOME	B	-16,110	Dietary	10		37.21
37.22	MISCELLANEOUS INCOME	B	-25	Social Service	17		37.22
37.23	MISCELLANEOUS INCOME	B	-20	Drugs Charged to Patients	73		37.23
37.24	PATIENT TRANSPORTATION	A	-105	Cap Rel Costs-Mvble Equip	2	9	37.24
37.25	PATIENT TRANSPORTATION	A	-108,079	Operation of Plant	7		37.25
37.26	MISC. TAX	A	-1,014,212	Administrative & General	5		37.26
37.27	PROFESSIONAL FEES	A	-9,593	Administrative & General	5		37.27
38							38
39							39

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/14/2019 Run Time: 11:56 Version: 2018.12 (03/07/2019)

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	
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)		-328,863				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.

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

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

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1	5	Administrative & General	TO OFFSET MANAGEMENT FEES		827,079	-827,079		1
2	1	Cap Rel Costs-Bldg & Fixt	TO INCLUDE ALLOWABLE HOME OFFICE COS	86,758		86,758	9	2
3	1	Cap Rel Costs-Bldg & Fixt	TO INCLUDE ALLOWABLE HOME OFFICE COS	207,279		207,279	11	3
3.01	5	Administrative & General	TO INCLUDE ALLOWABLE HOME OFFICE COS	1,581,000		1,581,000		3.01
3.02	5	Administrative & General	TO INCLUDE ALLOWABLE HOME OFFICE COS	289,018		289,018		3.02
3.03	1	Cap Rel Costs-Bldg & Fixt	INTERCOMPANY WAGE AND EXPENSE TRANSF	-104,628	-104,628		9	3.03
3.04	2	Cap Rel Costs-Mvble Equip	INTERCOMPANY WAGE AND EXPENSE TRANSF	298	298		9	3.04
3.05	4	Employee Benefits Department	INTERCOMPANY WAGE AND EXPENSE TRANSF	1,855,199	1,855,199			3.05
3.06	5	Administrative & General	INTERCOMPANY WAGE AND EXPENSE TRANSF	2,283,208	2,283,208			3.06
3.07	7	Operation of Plant	INTERCOMPANY WAGE AND EXPENSE TRANSF	14,282	14,282			3.07
3.08	9	Housekeeping	INTERCOMPANY WAGE AND EXPENSE TRANSF	-101	-101			3.08
3.09	10	Dietary	INTERCOMPANY WAGE AND EXPENSE TRANSF	-7,323	-7,323			3.09
3.10	17	Social Service	INTERCOMPANY WAGE AND EXPENSE TRANSF	4,663	4,663			3.10
3.11	30	Adults & Pediatrics	INTERCOMPANY WAGE AND EXPENSE TRANSF	245	245			3.11
3.12	60	Laboratory	INTERCOMPANY WAGE AND EXPENSE TRANSF	-228	-228			3.12
3.13	66	Physical Therapy	INTERCOMPANY WAGE AND EXPENSE TRANSF	-2,968	-2,968			3.13
3.14	67	Occupational Therapy	INTERCOMPANY WAGE AND EXPENSE TRANSF	-11,466	-11,466			3.14
3.15	71	Medical Supplies Charged to Patients	INTERCOMPANY WAGE AND EXPENSE TRANSF	-21,002	-21,002			3.15
3.16	73	Drugs Charged to Patients	INTERCOMPANY WAGE AND EXPENSE TRANSF	496,435	496,435			3.16
3.17	113	Interest Expense	INTERCOMPANY WAGE AND EXPENSE TRANSF	6,732	6,732			3.17
3.18	1	Cap Rel Costs-Bldg & Fixt	RELATED PARTY - GROUND LEASE		170,024	-170,024	10	3.18
3.19	5	Administrative & General	RELATED PARTY - RMH	232	6,127	-5,895		3.19
3.20	54	Radiology-Diagnostic	RELATED PARTY - RMH	6,267	27,861	-21,594		3.20
3.21	60	Laboratory	RELATED PARTY - RMH	283,230	485,935	-202,705		3.21
3.22	76.01	SPECIAL PROCEDURES	RELATED PARTY - RMH	6,798	17,975	-11,177		3.22
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12			6,973,928	6,048,347	925,581		5

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

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

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

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

				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	ENCOMPASS HEALTH CORPORATION		HEALTHCARE	6
7	B		50.00	ROCKFORD HEALTH SYSTEM		HEALTHCARE	7
8	G	ENCOMPASS HEALTH CORPORATION				HEALTHCARE	8
9	G	ROCKFORD MEMORIAL HOSPTIAL				HEALTHCARE	9

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/14/2019 Run Time: 11:56 Version: 2018.12 (03/07/2019)

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	
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

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

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun-eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	30	Adults & Pediatrics AGGREGATE	10,200		10,200	211,500	68	6,914	346	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	10,200		10,200		68	6,914	346	200

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

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	30	Adults & Pediatrics AGGREGATE					6,914	3,286	3,286	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL					6,914	3,286	3,286	200

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/14/2019 Run Time: 11:56 Version: 2018.12 (03/07/2019)

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

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP 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	1,338,181	1,338,181					1
2	Cap Rel Costs-Mvble Equip	550,564		550,564				2
4	Employee Benefits Department	2,595,554			2,595,554			4
5	Administrative & General	5,285,138	29,928	12,313	404,512	5,731,891	5,731,891	5
6	Maintenance & Repairs							6
7	Operation of Plant	579,894	365,352	150,316	29,235	1,124,797	389,028	7
8	Laundry & Linen Service	154,891	6,953	2,861		164,705	56,966	8
9	Housekeeping	235,991	9,031	3,716	42,981	291,719	100,895	9
10	Dietary	688,834	71,664	29,485	78,045	868,028	300,221	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	549,054	35,463	14,591	124,485	723,593	250,265	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	93,010	12,818	5,274	19,898	131,000	45,308	16
17	Social Service	365,982	8,934	3,676	83,137	461,729	159,696	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	4,552,259	473,877	194,963	1,004,881	6,225,980	2,153,354	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	197,004	1,554	639		199,197	68,895	54
60	Laboratory	310,275				310,275	107,313	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	322,083	8,409	3,460	72,365	406,317	140,531	65
66	Physical Therapy	1,514,100	125,947	51,818	293,559	1,985,424	686,689	66
67	Occupational Therapy	1,139,351	146,009	60,072	246,423	1,591,855	550,567	67
68	Speech Pathology	356,412	5,438	2,237	81,506	445,593	154,115	68
71	Medical Supplies Charged to Patients	364,058	10,585	4,355	6,757	385,755	133,419	71
73	Drugs Charged to Patients	926,639	12,158	5,002	83,621	1,027,420	355,349	73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES	76,125				76,125	26,329	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
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	22,195,399	1,324,120	544,778	2,571,405	22,151,403	5,678,940	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		13,032	5,362		18,394	6,362	192
194	MARKETING NRCC	109,100	990	408	24,149	134,647	46,570	194
194.01	GUEST MEALS							194.01
194.02	VACANT SPACE		39	16		55	19	194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	22,304,499	1,338,181	550,564	2,595,554	22,304,499	5,731,891	202

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

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	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	1,513,825						7
8	Laundry & Linen Service	11,163	232,834					8
9	Housekeeping	14,499		407,113				9
10	Dietary	115,057		31,476	1,314,782			10
11	Cafeteria				137,801	137,801		11
12	Maintenance of Personnel							12
13	Nursing Administration	56,936		15,576		8,406	1,054,776	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	20,579		5,630		1,344		16
17	Social Service	14,343		3,924		5,614		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	760,811	232,834	208,132	1,140,956	67,850	1,054,776	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	2,494		682				54
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	13,501		3,694		4,886		65
66	Physical Therapy	202,207		55,317		19,823		66
67	Occupational Therapy	234,417		64,129		16,640		67
68	Speech Pathology	8,731		2,388		5,504		68
71	Medical Supplies Charged to Patients	16,994		4,649		456		71
73	Drugs Charged to Patients	19,519		5,340		5,647		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
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	1,491,251	232,834	400,937	1,278,757	136,170	1,054,776	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	20,922		5,724				192
194	MARKETING NRCC	1,590		435		1,631		194
194.01	GUEST MEALS				36,025			194.01
194.02	VACANT SPACE	62		17				194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,513,825	232,834	407,113	1,314,782	137,801	1,054,776	202

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

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SOCIAL 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	203,861						16
17	Social Service		645,306					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	89,678	645,306	12,579,677		12,579,677		30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	1,733		273,001		273,001		54
60	Laboratory	10,818		428,406		428,406		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	5,173		574,102		574,102		65
66	Physical Therapy	29,951		2,979,411		2,979,411		66
67	Occupational Therapy	25,423		2,483,031		2,483,031		67
68	Speech Pathology	8,017		624,348		624,348		68
71	Medical Supplies Charged to Patients	8,247		549,520		549,520		71
73	Drugs Charged to Patients	24,013		1,437,288		1,437,288		73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES	808		103,262		103,262		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
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	203,861	645,306	22,032,046		22,032,046		118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices			51,402		51,402		192
194	MARKETING NRCC			184,873		184,873		194
194.01	GUEST MEALS			36,025		36,025		194.01
194.02	VACANT SPACE			153		153		194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	203,861	645,306	22,304,499		22,304,499		202

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		29,928	12,313	42,241	42,241		5
6	Maintenance & Repairs							6
7	Operation of Plant		365,352	150,316	515,668	2,867	518,535	7
8	Laundry & Linen Service		6,953	2,861	9,814	420	3,824	8
9	Housekeeping		9,031	3,716	12,747	744	4,966	9
10	Dietary		71,664	29,485	101,149	2,213	39,411	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration		35,463	14,591	50,054	1,844	19,502	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		12,818	5,274	18,092	334	7,049	16
17	Social Service		8,934	3,676	12,610	1,177	4,913	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		473,877	194,963	668,840	15,866	260,602	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic		1,554	639	2,193	508	854	54
60	Laboratory					791		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		8,409	3,460	11,869	1,036	4,625	65
66	Physical Therapy		125,947	51,818	177,765	5,061	69,263	66
67	Occupational Therapy		146,009	60,072	206,081	4,058	80,295	67
68	Speech Pathology		5,438	2,237	7,675	1,136	2,991	68
71	Medical Supplies Charged to Patients		10,585	4,355	14,940	983	5,821	71
73	Drugs Charged to Patients		12,158	5,002	17,160	2,619	6,686	73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES					194		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
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)		1,324,120	544,778	1,868,898	41,851	510,802	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		13,032	5,362	18,394	47	7,167	192
194	MARKETING NRCC		990	408	1,398	343	545	194
194.01	GUEST MEALS							194.01
194.02	VACANT SPACE		39	16	55		21	194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		1,338,181	550,564	1,888,745	42,241	518,535	202

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

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	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	14,058						8
9	Housekeeping		18,457					9
10	Dietary		1,427	144,200				10
11	Cafeteria			15,113	15,113			11
12	Maintenance of Personnel							12
13	Nursing Administration		706		922	73,028		13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		255		147		25,877	16
17	Social Service		178		616			17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	14,058	9,437	125,136	7,441	73,028	11,377	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic		31				220	54
60	Laboratory						1,374	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		167		536		657	65
66	Physical Therapy		2,508		2,174		3,803	66
67	Occupational Therapy		2,907		1,825		3,229	67
68	Speech Pathology		108		604		1,018	68
71	Medical Supplies Charged to Patients		211		50		1,047	71
73	Drugs Charged to Patients		242		619		3,049	73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES						103	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
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	14,058	18,177	140,249	14,934	73,028	25,877	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		259					192
194	MARKETING NRCC		20		179			194
194.01	GUEST MEALS			3,951				194.01
194.02	VACANT SPACE		1					194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	14,058	18,457	144,200	15,113	73,028	25,877	202

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

	COST CENTER DESCRIPTIONS	SOCIAL 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	19,494						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	19,494	1,205,279		1,205,279			30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic		3,806		3,806			54
60	Laboratory		2,165		2,165			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		18,890		18,890			65
66	Physical Therapy		260,574		260,574			66
67	Occupational Therapy		298,395		298,395			67
68	Speech Pathology		13,532		13,532			68
71	Medical Supplies Charged to Patients		23,052		23,052			71
73	Drugs Charged to Patients		30,375		30,375			73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES		297		297			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
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	19,494	1,856,365		1,856,365			118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		25,867		25,867			192
194	MARKETING NRCC		2,485		2,485			194
194.01	GUEST MEALS		3,951		3,951			194.01
194.02	VACANT SPACE		77		77			194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	19,494	1,888,745		1,888,745			202

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	68,903						1
2	Cap Rel Costs-Mvble Equip		68,903					2
4	Employee Benefits Department			11,171,251				4
5	Administrative & General	1,541	1,541	1,741,018	-5,731,891	16,572,608		5
6	Maintenance & Repairs							6
7	Operation of Plant	18,812	18,812	125,829		1,124,797	48,550	7
8	Laundry & Linen Service	358	358			164,705	358	8
9	Housekeeping	465	465	184,989		291,719	465	9
10	Dietary	3,690	3,690	335,905		868,028	3,690	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	1,826	1,826	535,782		723,593	1,826	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	660	660	85,640		131,000	660	16
17	Social Service	460	460	357,823		461,729	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	24,400	24,400	4,324,998		6,225,980	24,400	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	80	80			199,197	80	54
60	Laboratory					310,275		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	433	433	311,457		406,317	433	65
66	Physical Therapy	6,485	6,485	1,263,477		1,985,424	6,485	66
67	Occupational Therapy	7,518	7,518	1,060,605		1,591,855	7,518	67
68	Speech Pathology	280	280	350,800		445,593	280	68
71	Medical Supplies Charged to Patients	545	545	29,083		385,755	545	71
73	Drugs Charged to Patients	626	626	359,906		1,027,420	626	73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES					76,125		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
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	68,179	68,179	11,067,312	-5,731,891	16,419,512	47,826	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	671	671			18,394	671	192
194	MARKETING NRCC	51	51	103,939		134,647	51	194
194.01	GUEST MEALS							194.01
194.02	VACANT SPACE	2	2			55	2	194.02
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,338,181	550,564	2,595,554		5,731,891	1,513,825	202
203	Unit Cost Multiplier (Wkst. B, Part I)	19.421230	7.990421	0.232342		0.345865	31.180742	203
204	Cost to be allocated (Per Wkst. B, Part II)					42,241	518,535	204
205	Unit Cost Multiplier (Wkst. B, Part II)					0.002549	10.680433	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/14/2019 Run Time: 11:56 Version: 2018.12 (03/07/2019)

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

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE PATIENT DAYS	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA 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	19,921						8
9	Housekeeping		47,727					9
10	Dietary		3,690	68,868				10
11	Cafeteria			7,218	8,783,510			11
12	Maintenance of Personnel							12
13	Nursing Administration		1,826		535,782	19,921		13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		660		85,640		44,485,474	16
17	Social Service		460		357,823			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	19,921	24,400	59,763	4,324,998	19,921	19,570,966	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic		80				378,030	54
60	Laboratory						2,360,388	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		433		311,457		1,128,782	65
66	Physical Therapy		6,485		1,263,477		6,535,200	66
67	Occupational Therapy		7,518		1,060,605		5,547,269	67
68	Speech Pathology		280		350,800		1,749,277	68
71	Medical Supplies Charged to Patients		545		29,083		1,799,545	71
73	Drugs Charged to Patients		626		359,906		5,239,634	73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES						176,383	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
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	19,921	47,003	66,981	8,679,571	19,921	44,485,474	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		671					192
194	MARKETING NRCC		51		103,939			194
194.01	GUEST MEALS			1,887				194.01
194.02	VACANT SPACE		2					194.02
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	232,834	407,113	1,314,782	137,801	1,054,776	203,861	202
203	Unit Cost Multiplier (Wkst. B, Part I)	11.687867	8.530035	19.091334	0.015689	52.947944	0.004583	203
204	Cost to be allocated (Per Wkst. B, Part II)	14,058	18,457	144,200	15,113	73,028	25,877	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.705687	0.386720	2.093861	0.001721	3.665880	0.000582	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/14/2019 Run Time: 11:56 Version: 2018.12 (03/07/2019)

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

	COST CENTER DESCRIPTIONS	SOCIAL 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	19,921						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	19,921						30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic							54
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients							73
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
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	19,921						118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices							192
194	MARKETING NRCC							194
194.01	GUEST MEALS							194.01
194.02	VACANT SPACE							194.02
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	645,306						202
203	Unit Cost Multiplier (Wkst. B, Part I)	32.393253						203
204	Cost to be allocated (Per Wkst. B, Part II)	19,494						204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.978565						205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/14/2019 Run Time: 11:56 Version: 2018.12 (03/07/2019)

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	CODE	LINE NO.	AMOUNT	
	1	2	3	4	

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/14/2019 Run Time: 11:56 Version: 2018.12 (03/07/2019)

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	12,579,677		12,579,677	3,286	12,582,963	30
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	273,001		273,001		273,001	54
60	Laboratory	428,406		428,406		428,406	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	574,102		574,102		574,102	65
66	Physical Therapy	2,979,411		2,979,411		2,979,411	66
67	Occupational Therapy	2,483,031		2,483,031		2,483,031	67
68	Speech Pathology	624,348		624,348		624,348	68
71	Medical Supplies Charged to Patients	549,520		549,520		549,520	71
73	Drugs Charged to Patients	1,437,288		1,437,288		1,437,288	73
76	PSYCHOLOGY						76
76.01	SPECIAL PROCEDURES	103,262		103,262		103,262	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
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency						101
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	22,032,046		22,032,046	3,286	22,035,332	200
201	Less Observation Beds						201
202	Total (line 200 minus line 201)	22,032,046		22,032,046		22,035,332	202

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/14/2019 Run Time: 11:56 Version: 2018.12 (03/07/2019)

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	19,570,966		19,570,966				30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	378,030		378,030	0.722168	0.722168	0.722168	54
60	Laboratory	2,360,388		2,360,388	0.181498	0.181498	0.181498	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,128,782		1,128,782	0.508603	0.508603	0.508603	65
66	Physical Therapy	5,588,365	946,835	6,535,200	0.455902	0.455902	0.455902	66
67	Occupational Therapy	5,139,131	408,138	5,547,269	0.447613	0.447613	0.447613	67
68	Speech Pathology	1,138,163	611,114	1,749,277	0.356918	0.356918	0.356918	68
71	Medical Supplies Charged to Patients	1,799,545		1,799,545	0.305366	0.305366	0.305366	71
73	Drugs Charged to Patients	5,239,634		5,239,634	0.274311	0.274311	0.274311	73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES	176,383		176,383	0.585442	0.585442	0.585442	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
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	42,519,387	1,966,087	44,485,474				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	42,519,387	1,966,087	44,485,474				202

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/14/2019 Run Time: 11:56 Version: 2018.12 (03/07/2019)

COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)

WORKSHEET C
PART I

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (B Part I col 26 plus sum of cols 21 & 22)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	12,579,677		12,579,677	3,286	12,582,963	30
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	273,001		273,001		273,001	54
60	Laboratory	428,406		428,406		428,406	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	574,102		574,102		574,102	65
66	Physical Therapy	2,979,411		2,979,411		2,979,411	66
67	Occupational Therapy	2,483,031		2,483,031		2,483,031	67
68	Speech Pathology	624,348		624,348		624,348	68
71	Medical Supplies Charged to Patients	549,520		549,520		549,520	71
73	Drugs Charged to Patients	1,437,288		1,437,288		1,437,288	73
76	PSYCHOLOGY						76
76.01	SPECIAL PROCEDURES	103,262		103,262		103,262	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
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency						101
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	22,032,046		22,032,046	3,286	22,035,332	200
201	Less Observation Beds						201
202	Total (line 200 minus line 201)	22,032,046		22,032,046	3,286	22,035,332	202

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/14/2019 Run Time: 11:56 Version: 2018.12 (03/07/2019)

COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)

WORKSHEET C
PART I

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	19,570,966		19,570,966				30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	378,030		378,030	0.722168	0.722168	0.722168	54
60	Laboratory	2,360,388		2,360,388	0.181498	0.181498	0.181498	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,128,782		1,128,782	0.508603	0.508603	0.508603	65
66	Physical Therapy	5,588,365	946,835	6,535,200	0.455902	0.455902	0.455902	66
67	Occupational Therapy	5,139,131	408,138	5,547,269	0.447613	0.447613	0.447613	67
68	Speech Pathology	1,138,163	611,114	1,749,277	0.356918	0.356918	0.356918	68
71	Medical Supplies Charged to Patients	1,799,545		1,799,545	0.305366	0.305366	0.305366	71
73	Drugs Charged to Patients	5,239,634		5,239,634	0.274311	0.274311	0.274311	73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES	176,383		176,383	0.585442	0.585442	0.585442	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
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	42,519,387	1,966,087	44,485,474				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	42,519,387	1,966,087	44,485,474				202

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/14/2019 Run Time: 11:56 Version: 2018.12 (03/07/2019)

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

WORKSHEET C
PART II

[ ] Title V **[XX] Title XIX**

	COST CENTER DESCRIPTIONS	Total Cost (Wkst B, Part I, col. 26)	Capital Cost (Wkst B, Part II, col. 26	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	
		1	2	3	4	
	ANCILLARY SERVICE COST CENTERS					
54	Radiology-Diagnostic	273,001	3,806	269,195		54
60	Laboratory	428,406	2,165	426,241		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy	574,102	18,890	555,212		65
66	Physical Therapy	2,979,411	260,574	2,718,837		66
67	Occupational Therapy	2,483,031	298,395	2,184,636		67
68	Speech Pathology	624,348	13,532	610,816		68
71	Medical Supplies Charged to Patients	549,520	23,052	526,468		71
73	Drugs Charged to Patients	1,437,288	30,375	1,406,913		73
76	PSYCHOLOGY					76
76.01	SPECIAL PROCEDURES	103,262	297	102,965		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
93.99	PARTIAL HOSPITALIZATION PROGRAM					93.99
	OTHER REIMBURSABLE COST CENTERS					
101	Home Health Agency					101
113	Interest Expense					113
200	Subtotal	9,452,369	651,086	8,801,283		200
201	Less Observation Beds					201
202	Total	9,452,369	651,086	8,801,283		202

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

[ ] Title V **[XX] Title XIX**

	COST CENTER DESCRIPTIONS	Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Wkst C, Part I, col. 8)	Outpatient Cost to Charge Ratio(col. 6 ÷ col. 7)	
		5	6	7	8	
	ANCILLARY SERVICE COST CENTERS					
54	Radiology-Diagnostic		273,001	378,030	0.722168	54
60	Laboratory		428,406	2,360,388	0.181498	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy		574,102	1,128,782	0.508603	65
66	Physical Therapy		2,979,411	6,535,200	0.455902	66
67	Occupational Therapy		2,483,031	5,547,269	0.447613	67
68	Speech Pathology		624,348	1,749,277	0.356918	68
71	Medical Supplies Charged to Patients		549,520	1,799,545	0.305366	71
73	Drugs Charged to Patients		1,437,288	5,239,634	0.274311	73
76	PSYCHOLOGY					76
76.01	SPECIAL PROCEDURES		103,262	176,383	0.585442	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
93.99	PARTIAL HOSPITALIZATION PROGRAM					93.99
	OTHER REIMBURSABLE COST CENTERS					
101	Home Health Agency					101
113	Interest Expense					113
200	Subtotal		9,452,369	24,914,508		200
201	Less Observation Beds					201
202	Total		9,452,369	24,914,508		202

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 SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	1,205,279		1,205,279	19,921	60.50	11,954	723,217	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)	1,205,279		1,205,279	19,921		11,954	723,217	200

(A) Worksheet A line numbers

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	3,806	378,030	0.010068	188,522	1,898	54
60	Laboratory	2,165	2,360,388	0.000917	1,491,354	1,368	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	18,890	1,128,782	0.016735	680,502	11,388	65
66	Physical Therapy	260,574	6,535,200	0.039872	3,389,173	135,133	66
67	Occupational Therapy	298,395	5,547,269	0.053791	3,128,102	168,264	67
68	Speech Pathology	13,532	1,749,277	0.007736	608,270	4,706	68
71	Medical Supplies Charged to Pat	23,052	1,799,545	0.012810	1,065,211	13,645	71
73	Drugs Charged to Patients	30,375	5,239,634	0.005797	2,969,473	17,214	73
76	PSYCHOLOGY						76
76.01	SPECIAL PROCEDURES	297	176,383	0.001684	86,055	145	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						92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	651,086	24,914,508		13,606,662	353,761	200

(A) Worksheet A line numbers

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/14/2019 Run Time: 11:56 Version: 2018.12 (03/07/2019)

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

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

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

(A) Worksheet A line numbers

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/14/2019 Run Time: 11:56 Version: 2018.12 (03/07/2019)

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

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

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	19,921		11,954		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)	19,921		11,954		200

(A) Worksheet A line numbers

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/IID | [XX] PPS [ ] TEFRA [ ] Other

		Non Physician Anesth-etist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
54	Radiology-Diagnostic									54
60	Laboratory									60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
71	Medical Supplies Charged to Pat									71
73	Drugs Charged to Patients									73
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									92
93.99	PARTIAL HOSPITALIZATION PROGRAM									93.99
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

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/IID** | **[XX] PPS** **[ ] TEFRA** **[ ] Other**

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	378,030			188,522				54
60	Laboratory	2,360,388			1,491,354				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	1,128,782			680,502				65
66	Physical Therapy	6,535,200			3,389,173				66
67	Occupational Therapy	5,547,269			3,128,102				67
68	Speech Pathology	1,749,277			608,270				68
71	Medical Supplies Charged to Pat	1,799,545			1,065,211				71
73	Drugs Charged to Patients	5,239,634			2,969,473				73
76	PSYCHOLOGY								76
76.01	SPECIAL PROCEDURES	176,383			86,055				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								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	24,914,508			13,606,662				200

(A) Worksheet A line numbers

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/IID**

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	0.722168							54
60	Laboratory	0.181498							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.508603							65
66	Physical Therapy	0.455902							66
67	Occupational Therapy	0.447613							67
68	Speech Pathology	0.356918							68
71	Medical Supplies Charged to Pat	0.305366							71
73	Drugs Charged to Patients	0.274311							73
76	PSYCHOLOGY								76
76.01	SPECIAL PROCEDURES	0.585442							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								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	1,205,279		1,205,279	19,921	60.50	561	33,941	30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,205,279		1,205,279	19,921		561	33,941	200

(A) Worksheet A line numbers

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)**

		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	3,806	378,030	0.010068	19,949	201	54
60	Laboratory	2,165	2,360,388	0.000917	59,522	55	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	18,890	1,128,782	0.016735	50,354	843	65
66	Physical Therapy	260,574	6,535,200	0.039872	161,872	6,454	66
67	Occupational Therapy	298,395	5,547,269	0.053791	154,971	8,336	67
68	Speech Pathology	13,532	1,749,277	0.007736	22,411	173	68
71	Medical Supplies Charged to Pat	23,052	1,799,545	0.012810	59,742	765	71
73	Drugs Charged to Patients	30,375	5,239,634	0.005797	160,522	931	73
76	PSYCHOLOGY						76
76.01	SPECIAL PROCEDURES	297	176,383	0.001684	1,500	3	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						92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	651,086	24,914,508		690,843	17,761	200

(A) Worksheet A line numbers

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/14/2019 Run Time: 11:56 Version: 2018.12 (03/07/2019)

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

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

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

(A) Worksheet A line numbers

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/14/2019 Run Time: 11:56 Version: 2018.12 (03/07/2019)

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

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

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	19,921		561		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)	19,921		561		200

(A) Worksheet A line numbers

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

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

		Non Physician Anesth-etist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
54	Radiology-Diagnostic									54
60	Laboratory									60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
71	Medical Supplies Charged to Pat									71
73	Drugs Charged to Patients									73
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									92
93.99	PARTIAL HOSPITALIZATION PROGRAM									93.99
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/14/2019 Run Time: 11:56 Version: 2018.12 (03/07/2019)

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

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

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	378,030			19,949				54
60	Laboratory	2,360,388			59,522				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	1,128,782			50,354				65
66	Physical Therapy	6,535,200			161,872				66
67	Occupational Therapy	5,547,269			154,971				67
68	Speech Pathology	1,749,277			22,411				68
71	Medical Supplies Charged to Pat	1,799,545			59,742				71
73	Drugs Charged to Patients	5,239,634			160,522				73
76	PSYCHOLOGY								76
76.01	SPECIAL PROCEDURES	176,383			1,500				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								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	24,914,508			690,843				200

(A) Worksheet A line numbers

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/14/2019 Run Time: 11:56 Version: 2018.12 (03/07/2019)

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** **[XX] Title XIX - O/P** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] SNF** **[ ] NF** **[ ] Swing Bed SNF** **[ ] Swing Bed NF** **[ ] ICF/IID**

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	0.722168							54
60	Laboratory	0.181498							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.508603							65
66	Physical Therapy	0.455902							66
67	Occupational Therapy	0.447613							67
68	Speech Pathology	0.356918							68
71	Medical Supplies Charged to Pat	0.305366							71
73	Drugs Charged to Patients	0.274311							73
76	PSYCHOLOGY								76
76.01	SPECIAL PROCEDURES	0.585442							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								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

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/IID [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)	19,921	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	19,921	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	19,921	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	11,954	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	12,582,963	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	12,582,963	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	12,582,963	37

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/14/2019 Run Time: 11:56 Version: 2018.12 (03/07/2019)

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)					631.64	38
39	Program general inpatient routine service cost (line 9 x line 38)					7,550,625	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)					7,550,625	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
						1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					5,105,559	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					12,656,184	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					723,217	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					353,761	51
52	Total Program excludable cost (sum of lines 50 and 51)					1,076,978	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					11,579,206	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 etner 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

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/IID | [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)					631.64	88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/14/2019 Run Time: 11:56 Version: 2018.12 (03/07/2019)

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

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	19,921	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	19,921	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	19,921	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	561	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	12,579,677	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	12,579,677	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	12,579,677	37

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/14/2019 Run Time: 11:56 Version: 2018.12 (03/07/2019)

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

Check Applicable Boxes: **[ ] Title V - I/P** **[XX] Hospital** **[ ] SUB (Other)** **[ ] PPS**
[ ] Title XVIII, Part A **[ ] IPF** **[ ] TEFRA**
[XX] Title XIX - I/P **[ ] IRF** **[XX] 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)					631.48	38
39	Program general inpatient routine service cost (line 9 x line 38)					354,260	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)					354,260	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
						1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					265,138	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					619,398	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	33,941	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	17,761	51
52	Total Program excludable cost (sum of lines 50 and 51)	51,702	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)		53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner 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

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

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

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/14/2019 Run Time: 11:56 Version: 2018.12 (03/07/2019)

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

Check Applicable Boxes:

[ ] Title V	[XX] Hospital	[ ] SUB (Other)	[ ] Swing Bed SNF	[XX] PPS
[XX] Title XVIII, Part A	[ ] IPF	[ ] SNF	[ ] Swing Bed NF	[ ] TEFRA
[ ] Title XIX	[ ] IRF	[ ] NF	[ ] ICF/IID	[ ] Other

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		11,734,642		30
	ANCILLARY SERVICE COST CENTERS				
54	Radiology-Diagnostic	0.722168	188,522	136,145	54
60	Laboratory	0.181498	1,491,354	270,678	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.508603	680,502	346,105	65
66	Physical Therapy	0.455902	3,389,173	1,545,131	66
67	Occupational Therapy	0.447613	3,128,102	1,400,179	67
68	Speech Pathology	0.356918	608,270	217,103	68
71	Medical Supplies Charged to Patients	0.305366	1,065,211	325,279	71
73	Drugs Charged to Patients	0.274311	2,969,473	814,559	73
76	PSYCHOLOGY				76
76.01	SPECIAL PROCEDURES	0.585442	86,055	50,380	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
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		13,606,662	5,105,559	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		13,606,662		202

(A) Worksheet A line numbers

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/14/2019 Run Time: 11:56 Version: 2018.12 (03/07/2019)

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

Check Applicable Boxes:	**[ ] Title V**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] Swing Bed SNF**	**[ ] PPS**
	[ ] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**	**[ ] Swing Bed NF**	**[ ] TEFRA**
	[XX] Title XIX	**[ ] IRF**	**[ ] NF**	**[ ] ICF/IID**	**[XX] 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		550,563		30
	ANCILLARY SERVICE COST CENTERS				
54	Radiology-Diagnostic	0.722168	19,949	14,407	54
60	Laboratory	0.181498	59,522	10,803	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.508603	50,354	25,610	65
66	Physical Therapy	0.455902	161,872	73,798	66
67	Occupational Therapy	0.447613	154,971	69,367	67
68	Speech Pathology	0.356918	22,411	7,999	68
71	Medical Supplies Charged to Patients	0.305366	59,742	18,243	71
73	Drugs Charged to Patients	0.274311	160,522	44,033	73
76	PSYCHOLOGY				76
76.01	SPECIAL PROCEDURES	0.585442	1,500	878	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
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		690,843	265,138	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		690,843		202

(A) Worksheet A line numbers

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

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (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

Check Applicable Boxes: **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] SNF** **[ ] 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				19,364,348			1
2	Interim payments payable on individual bills, eitehr 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	04/20/2018	10,607			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	07/13/2018	11,316			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		-709			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)				19,363,639			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					6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)							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.

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)	19,188,943		1
2	Medicare SSI ratio (IRF PPS only) (see instructions)	0.031500		2
3	Inpatient Rehabilitation LIP payments (see instructions)	947,934		3
4	Outlier payments	9,041		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 closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) OR (2)			5.01
6	New teaching program adjustment (see instructions)			6
7	Current year unweighted FTE count of I&R excludnig 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)	54.578082		10
11	Teaching Adjustment Factor (see instructions)			11
12	Teaching Adjustment (see instructions)			12
13	Total PPS Payment (see instructions)	20,145,918		13
14	Nursing and allied health managed care payments (see instructions)			14
15	Organ acquisition DO NOT USE THIS LINE			15
16	Cost of physicians' services in a teaching hospital (see instructions)			16
17	Subtotal (see instructions)	20,145,918		17
18	Primary payer payments	26,978		18
19	Subtotal (line 17 less line 18)	20,118,940		19
20	Deductibles	262,206		20
21	Subtotal (line 19 minus line 20)	19,856,734		21
22	Coinsurance	86,645		22
23	Subtotal (line 21 minus line 22)	19,770,089		23
24	Allowable bad debts (exclude bad debts for professional services) (see instructions)	91,203		24
25	Adjusted reimbursable bad debts (see instructions)	59,282		25
26	Allowable bad debts for dual eligible beneficiaries (see instructions)	67,508		26
27	Subtotal (sum of lines 23 and 25)	19,829,371		27
28	Direct graduate medical education payments (from Wkst. E-4, line 49) (For free standing IRF only)			28
29	Other pass through costs (see instructions)			29
30	Outlier payments reconciliation			30
31	Other adjustments (specify) (see instructions)			31
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			31.50
32	Total amount payable to the provider (see instructions)	19,829,371		32
32.01	Sequestration adjustment (see instructions)	396,587		32.01
32.02	Demonstration payment adjustment amount after sequestration			32.02
33	Interim payments	19,363,639		33
34	Tentative settlement (for contractor use only)			34
35	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33 and 34)	69,145		35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	589,360		36

TO BE COMPLETED BY CONTRACTOR

50	Original outlier amount from Wkst. E-3, Pt. 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

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

Check Applicable Boxes: **[ ] Title V** **[XX] Title XIX** **[XX] Hospital** **[ ] SUB (Other)** **[ ] SNF** **[ ] NF** **[ ] ICF/IID** **[ ] PPS** **[ ] TEFRA** **[XX] Other**

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	619,398		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	619,398		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	619,398		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges	550,563		8
9	Ancillary service charges	690,843		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)	1,241,406		12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahrge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)	1,241,406		16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	622,008		17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)	619,398		21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)	619,398		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)	619,398		31
32	Deductibles			32
33	Coinsurance	127,870		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)	491,528		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	491,528		38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)	491,528		40
41	Interim payments	526,463		41
42	Balance due provider/program (line 40 minus line 41)	-34,935		42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

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	3,656,259				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	6,245,139				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-1,731,261				6
7	Inventory	105,000				7
8	Prepaid expenses	20,636				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	8,295,773				11
	FIXED ASSETS					
12	Land					12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings	16,887,919				15
16	Accumulated depreciation	-8,202,911				16
17	Leasehold improvements	908,835				17
18	Accumulated depreciation	-319,335				18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	4,442,514				23
24	Accumulated depreciation	-3,542,510				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)	10,174,512				30
	OTHER ASSETS					
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	2,395,191				34
35	Total other assets (sum of lines 31-34)	2,395,191				35
36	Total assets (sum of lines 11, 30 and 35)	20,865,476				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	383,757				37
38	Salaries, wages and fees payable	1,066,132				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)					40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	2,188,791				44
45	Total current liabilities (sum of lines 37 thru 44)	3,638,680				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	8,613,396				49
50	Total long term liabilities (sum of lines 46 thru 49)	8,613,396				50
51	Total liabilities (sum of lines 45 and 50)	12,252,076				51
	CAPITAL ACCOUNTS					
52	General fund balance	8,613,400				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	8,613,400				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	20,865,476				60

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/14/2019 Run Time: 11:56 Version: 2018.12 (03/07/2019)

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

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	Fund balances at beginning of period		9,444,633			1
2	Net income (loss) (from Worksheet G-3, line 29)		7,999,462			2
3	Total (sum of line 1 and line 2)		17,444,095			3
4	Additions (credit adjustments) (specify)					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)		17,444,095			11
12	Deductions (debit adjustments) (specify)					12
13	DISTRIBUTIONS	4,830,965				13
14	MINORITY INTEREST	3,999,730				14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)		8,830,695			18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		8,613,400			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	Fund balances at beginning of period					1
2	Net income (loss) (from Worksheet G-3, line 29)					2
3	Total (sum of line 1 and line 2)					3
4	Additions (credit adjustments) (specify)					4
5						5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)					11
12	Deductions (debit adjustments) (specify)					12
13	DISTRIBUTIONS					13
14	MINORITY INTEREST					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

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	19,570,966		19,570,966	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)	19,570,966		19,570,966	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)	19,570,966		19,570,966	17
18	Ancillary services	22,948,421	1,966,087	24,914,508	18
19	Outpatient services				19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	Other (specify)				27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	42,519,387	1,966,087	44,485,474	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		22,633,362	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)		22,633,362	43

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	44,485,474	1
2	Less contractual allowances and discounts on patients' accounts	14,795,531	2
3	Net patient revenues (line 1 minus line 2)	29,689,943	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	22,633,362	4
5	Net income from service to patients (line 3 minus line 4)	7,056,581	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments	54,782	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts		10
11	Rebates and refunds of expenses		11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests		14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts		18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hosptial space		22
23	Governmental appropriations		23
24	Other (specify)	888,099	24
25	Total other income (sum of lines 6-24)	942,881	25
26	Total (line 5 plus line 25)	7,999,462	26
29	Net income (or loss) for the period (line 26 minus line 28)	7,999,462	29