

**KPMG LLP Compu-Max 2552-10**

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 04/26/2017 Run Time: 10:18 Version: 2017.01 (04/10/2017)
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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY**

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

**PART I - COST REPORT STATUS**

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report Date: 04/26/2017 Time: 10:18 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted the cost report 4. <input checked="" type="checkbox"/> Medicare Utilization. Enter 'F' for full or 'L' for low.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ____ 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

**PART II - CERTIFICATION**

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by VAN MATRE HEALTHSOUTH REHABILITATION (14-3028) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 01/01/2016 and ending 12/31/2016, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) \_\_\_\_\_  
 Officer or Administrator of Provider(s)

ROB WISNER, SVP - REIMBURSEMENT  
 Title

05/04/2017  
 Date

**PART III - SETTLEMENT SUMMARY**

		TITLE XVIII					
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		214,812				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		214,812			-174,401	200

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**

**WORKSHEET S-2  
PART I**

Hospital and Hospital Health Care Complex Address:

1	Street: 950 S MULFORD ROAD	P.O. Box:								1
2	City: ROCKFORD	State: IL	ZIP Code: 61108	County: WINNEBAGO						2

Hospital and Hospital-Based Component Identification:

Component	Component Name	CCN Number	CBSA Number	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 / 2016	To: 12 / 31 / 2016							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.	407	776			1,395		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 is in effect in the cost reporting period.							35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:		Ending:				36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.							37
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with the FY 2016 OPSS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)	N						37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:		Ending:				38

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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**

**WORKSHEET S-2  
PART I**

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40
Prospective Payment System (PPS)-Capital		V	XVIII	XIX
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	1	2	3
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	N	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	48

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

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

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

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

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

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

**Teaching Hospitals that Claim Residents in Nonprovider Settings**

63	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64-67. (see instructions)	N			63
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**WORKSHEET S-2  
PART I**

Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						64
Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)							
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
65		1	2	3	4	5	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))	
67		1	2	3	4	5	67
<b>Inpatient Psychiatric Facility PPS</b>				1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.			N			70
71	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)						71
<b>Inpatient Rehabilitation Facility PPS</b>				1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.			Y			75
76	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N			76
<b>Long Term Care Hospital PPS</b>							
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
<b>TEFRA Providers</b>							
85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no.				N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.						86
87	Is this hospital a 'subclause (II)' LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter 'Y' for yes and 'N' for no.				N		87

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**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

**Rural Providers**

		1	2		
105	Does this hospital qualify as a critical access hospital (CAH)?	N		105	
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106	
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.			107	
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108	
		Physical	Occupational	Speech	Respiratory
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.				109
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.			N	110

**Miscellaneous Cost Reporting Information**

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-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:	50,000	59,985		118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.	N		N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.	N			121
122	Does the cost report contain state health or similar taxes? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.	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, if applicable in column 2.				126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				129
130	If this is a Medicare certified pancreas transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				131
132	If this is a Medicare certified islet transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.				134

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**WORKSHEET S-2  
PART I**

All Providers

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

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

141	Name: HEALTHSOUTH CORPORATION	Contractor's Name: CAHABA GBA	Contractor's Number: 10101	141
142	Street: 3660 GRANDVIEW PKWY, SUITE 200	P.O. Box:		142
143	City: BIRMINGHAM	State: AL	ZIP Code: 35243	143
144	Are provider based physicians' costs included in Worksheet A?	Y		144
145	If costs for renal services are claimed on 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		Title V	Title XIX	
		Part A	Part B			
		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

**KPMG LLP Compu-Max 2552-10**

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 04/26/2017 Run Time: 10:18 Version: 2017.01 (04/10/2017)
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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE**

**WORKSHEET S-2  
PART II**

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

**COMPLETED BY ALL HOSPITALS**

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

		Y/N	Type	Date	
<b>Financial Data and Reports</b>					
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	02/22/2017	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	
<b>Approved Educational Activities</b>				
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N		6
7	Are costs claimed for allied health programs? If yes, see instructions.	N		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N		8
9	Are costs claimed for Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	N		9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10
11	Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11

		Y/N	
<b>Bad Debts</b>			
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

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

		Part A		Part B	
		Y/N	Date	Y/N	Date
<b>PS&amp;R Report Data</b>					
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	03/01/2017	Y	03/01/2017
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N	
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	
20	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	

**KPMG LLP Compu-Max 2552-10**

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 04/26/2017 Run Time: 10:18 Version: 2017.01 (04/10/2017)
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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE**

**WORKSHEET S-2  
PART II**

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

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

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

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

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

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

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

Cost Report Preparer Contact Information			
41	First name: MATTHEW	Last name: LALLONE	Title: REIMBURSEMENT SPECIALIST
42	Employer: HEALTHSOUTH CORPORATION		
43	Phone number: 205-968-6222	E-mail Address: MATTHEW.LALLONE@HEALTHSOUTH.COM	

**KPMG LLP Compu-Max 2552-10**

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 04/26/2017 Run Time: 10:18 Version: 2017.01 (04/10/2017)
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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA**

**WORKSHEET S-3  
PART I**

	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Inpatient Days / Outpatient Visits / Trips			Total All Patients	
						Title V	Title XVIII	Title XIX		
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	61	22,326			11,316	963	19,522	1
2	HMO and other (see instructions)						2,148	1,615		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)		61	22,326			11,316	963	19,522	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)		61	22,326			11,316	963	19,522	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)		61							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

**KPMG LLP Compu-Max 2552-10**

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 04/26/2017 Run Time: 10:18 Version: 2017.01 (04/10/2017)
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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA**

**WORKSHEET S-3  
PART I**

	Component	Full Time Equivalents			DISCHARGES				
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					910	77	1,550	1
2	HMO and other (see instructions)					156	166		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)		186.51			910	77	1,550	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)		186.51						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

**KPMG LLP Compu-Max 2552-10**

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 04/26/2017 Run Time: 10:18 Version: 2017.01 (04/10/2017)
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**HOSPITAL WAGE INDEX INFORMATION**

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

**Part II - Wage Data**

	Wkst A Line No.	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)	
	1	2	3	4	5	6	
<b>SALARIES</b>							
1	200	10,380,834			387,940.80		1
2							2
3							3
4							4
4.01							4.01
5							5
6							6
7	21						7
7.01							7.01
8							8
9	44						9
10			95,980		2,432.13		10
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11		201,056			2,905.00		11
12							12
13		174,450			1,163.00		13
14							14
14.01		520,914			8,915.51		14.01
14.02							14.02
15							15
16							16
<b>WAGE-RELATED COSTS</b>							
17		1,929,334					17
18							18
19		18,005					19
20							20
21							21
22							22
22.01							22.01
23							23
24							24
25							25
25.50		207,962					25.50
25.51							25.51
25.52							25.52
25.53							25.53
<b>OVERHEAD COSTS - DIRECT SALARIES</b>							
26							26
27		1,846,388	-95,980		51,855.87		27
28							28
29							29
30		167,779			6,552.00		30
31							31
32		157,415			12,771.20		32
33							33
34		345,133			21,320.00		34
35							35
36							36
37							37
38		448,829			11,065.60		38
39							39
40							40
41		111,039			5,220.80		41
42		349,426			12,313.60		42
43							43

**Part III - Hospital Wage Index Summary**

1	Net salaries (see instructions)	10,380,834		10,380,834	387,940.80	26.76	1
2	Excluded area salaries (see instructions)		95,980	95,980	2,432.13	39.46	2
3	Subtotal salaries (line 1 minus line 2)	10,380,834	-95,980	10,284,854	385,508.67	26.68	3
4	Subtotal other wages & related costs (see instructions)	896,420		896,420	12,983.51	69.04	4
5	Subtotal wage-related costs (see instructions)	2,137,296		2,137,296		20.78%	5
6	Total (sum of lines 3 through 5)	13,414,550	-95,980	13,318,570	398,492.18	33.42	6
7	Total overhead cost (see instructions)	3,426,009	-95,980	3,330,029	121,099.07	27.50	7

**KPMG LLP Compu-Max 2552-10**

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**HOSPITAL WAGE RELATED COSTS**

**WORKSHEET S-3  
PART IV**

**Part IV - Wage Related Cost**

**Part A - Core List**

		Amount Reported	
	<b>RETIREMENT COST</b>		
1	401K Employer Contributions	180,261	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
	<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization):</b>		
5	401k/TSA Plan Administration Fees		5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees		7
	<b>HEALTH AND INSURANCE COST</b>		
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)	1,363,157	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)	24,117	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	226,765	15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	<b>TAXES</b>		
17	FICA-Employers Portion Only	800,181	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance		19
20	State or Federal Unemployment Taxes	49,003	20
	<b>OTHER</b>		
21	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	Day Care Costs and Allowances	-696,145	22
23	Tuition Reimbursement		23
24	Total Wage Related cost (Sum of lines 1-23)	1,947,339	24

**Part B - Other Than Core Related Cost**

25	OTHER WAGE RELATED COSTs (SPECIFY)		25
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**KPMG LLP Compu-Max 2552-10**

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 04/26/2017 Run Time: 10:18 Version: 2017.01 (04/10/2017)
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**HOSPITAL CONTRACT LABOR AND BENEFIT COST**

**WORKSHEET S-3  
PART V**

**Part V - Contract Labor and Benefit Cost**

**Hospital and Hospital-Based Component Identification:**

	Component	Contract Labor	Benefit Cost	
	0	1	2	
1	Total facility contract labor and benefit cost	201,056	1,947,339	1
2	Hospital	201,056	1,929,334	2
3	Subprovider - IPF			3
4	Subprovider - IRF			4
5	Subprovider - (OTHER)			5
6	Swing Beds - SNF			6
7	Swing Beds - NF			7
8	Hospital-Based SNF			8
9	Hospital-Based NF			9
10	Hospital-Based OLTC			10
11	Hospital-Based HHA			11
12	Separately Certified ASC			12
13	Hospital-Based Hospice			13
14	Hospital-Based Health Clinic - RHC			14
15	Hospital-Based Health Clinic - FQHC			15
16	Hospital-Based - CMHC			16
17	Renal Dialysis			17
18	Other		18,005	18

**KPMG LLP Compu-Max 2552-10**

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 04/26/2017 Run Time: 10:18 Version: 2017.01 (04/10/2017)
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**RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES**

**WORKSHEET A**

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		<b>GENERAL SERVICE COST CENTERS</b>								
1	00100	Cap Rel Costs-Bldg & Fixt		923,742	923,742	167,388	1,091,130	304,528	1,395,658	1
2	00200	Cap Rel Costs-Mvble Equip		461,676	461,676	41,421	503,097	10,154	513,251	2
3	00300	Other Cap Rel Costs		184,533	184,533	-184,533			-0-	3
4	00400	Employee Benefits Department		2,289,085	2,289,085		2,289,085	-349,004	1,940,081	4
5	00500	Administrative & General	1,846,388	3,427,774	5,274,162	-153,050	5,121,112	-902,216	4,218,896	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	167,779	547,152	714,931		714,931	-70,033	644,898	7
8	00800	Laundry & Linen Service		185,274	185,274		185,274	374	185,648	8
9	00900	Housekeeping	157,415	57,846	215,261		215,261	-2,550	212,711	9
10	01000	Dietary	345,133	325,679	670,812		670,812	-21,478	649,334	10
11	01100	Cafeteria								11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	448,829	3,765	452,594		452,594	-19	452,575	13
14	01400	Central Services & Supply								14
15	01500	Pharmacy								15
16	01600	Medical Records & Library	111,039	25,822	136,861		136,861	-298	136,563	16
17	01700	Social Service	349,426	6,148	355,574		355,574	-9	355,565	17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	Paramed Ed Prgm-(specify)								23
		<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30	03000	Adults & Pediatrics	3,811,782	52,279	3,864,061	30,450	3,894,511	-9,996	3,884,515	30
		<b>ANCILLARY SERVICE COST CENTERS</b>								
54	05400	Radiology-Diagnostic	45,006	110,699	155,705	189	155,894	-17,063	138,831	54
60	06000	Laboratory		345,838	345,838		345,838	-74,617	271,221	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	284,695	16,898	301,593	-189	301,404		301,404	65
66	06600	Physical Therapy	1,230,037	186,055	1,416,092		1,416,092	240	1,416,332	66
67	06700	Occupational Therapy	908,193	124,195	1,032,388		1,032,388		1,032,388	67
68	06800	Speech Pathology	305,688	3,223	308,911		308,911		308,911	68
71	07100	Medical Supplies Charged to Patients	42,064	241,893	283,957		283,957	-206	283,751	71
73	07300	Drugs Charged to Patients	327,360	467,278	794,638		794,638		794,638	73
76.01	03951	SPECIAL PROCEDURES		111,112	111,112		111,112	-6,081	105,031	76.01
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		<b>OUTPATIENT SERVICE COST CENTERS</b>								
92	09200	Observation Beds (Non-Distinct Part)								92
		<b>OTHER REIMBURSABLE COST CENTERS</b>								
		<b>SPECIAL PURPOSE COST CENTERS</b>								
113	11300	Interest Expense		6,192	6,192		6,192	-6,192		113
118		SUBTOTALS (sum of lines 1-117)	10,380,834	10,104,158	20,484,992	-98,324	20,386,668	-1,144,466	19,242,202	118
		<b>NONREIMBURSABLE COST CENTERS</b>								
192	19200	Physicians' Private Offices		1,537	1,537	-1,537				192
194	07950	NRCC MARKETING				99,861	99,861		99,861	194
194.01	07951	NRCC MEALS								194.01
200		TOTAL (sum of lines 118-199)	10,380,834	10,105,695	20,486,529		20,486,529	-1,144,466	19,342,063	200

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**RECLASSIFICATIONS**

**WORKSHEET A-6**

EXPLANATION OF RECLASSIFICATION(S)		CODE (1)	INCREASES					
			COST CENTER	LINE #	SALARY	OTHER		
1	2	3	4	5	6	7		
1	INSURANCE	A	Cap Rel Costs-Bldg & Fixt	1		19,460	1	
2	INSURANCE	A	Cap Rel Costs-Mvble Equip	2		4,816	2	
3	INSURANCE	A					3	
500	Total reclassifications					24,276	500	
	Code Letter - A							
1	MARKETING	B	NRCC MARKETING	194		95,980	3,881	1
2	MARKETING	B						2
500	Total reclassifications					95,980	3,881	500
	Code Letter - B							
1	PHYSICIANS	C	Adults & Pediatrics	30			30,450	1
2	PHYSICIANS	C						2
500	Total reclassifications						30,450	500
	Code Letter - C							
1	RMH RECLASS	D	Radiology-Diagnostic	54			189	1
2	RMH RECLASS	D						2
500	Total reclassifications						189	500
	Code Letter - D							
1	MISC RECLASS	E	Administrative & General	5			1,537	1
2	MISC RECLASS	E						2
500	Total reclassifications						1,537	500
	Code Letter - E							
<b>GRAND TOTAL (Increases)</b>						<b>95,980</b>	<b>60,333</b>	

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

**KPMG LLP Compu-Max 2552-10**

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**RECLASSIFICATIONS**

**WORKSHEET A-6**

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	INSURANCE	A					12	
2	INSURANCE	A					12	
3	INSURANCE	A	Administrative & General	5		24,276	3	
500	Total reclassifications					24,276	500	
	Code letter - A							
1	MARKETING	B					1	
2	MARKETING	B	Administrative & General	5	95,980	3,881	2	
500	Total reclassifications				95,980	3,881	500	
	Code letter - B							
1	PHYSICIANS	C					1	
2	PHYSICIANS	C	Administrative & General	5		30,450	2	
500	Total reclassifications					30,450	500	
	Code letter - C							
1	RMH RECLASS	D					1	
2	RMH RECLASS	D	Respiratory Therapy	65		189	2	
500	Total reclassifications					189	500	
	Code letter - D							
1	MISC RECLASS	E					1	
2	MISC RECLASS	E	Physicians' Private Offices	192		1,537	2	
500	Total reclassifications					1,537	500	
	Code letter - E							
	<b>GRAND TOTAL (Decreases)</b>				95,980	60,333		

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

**KPMG LLP Compu-Max 2552-10**

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**RECONCILIATION OF CAPITAL COST CENTERS**

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

**PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES**

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
			Purchases	Donation	Total				
		1	2	3	4	5	6	7	
1	Land								1
2	Land Improvements	9,720					9,720		2
3	Buildings and Fixtures	3,954,606					3,954,606		3
4	Building Improvements	12,529,412	38,949		38,949	6,173	12,562,188		4
5	Fixed Equipment	3,915,236	157,763		157,763	20,283	4,052,716		5
6	Movable Equipment	36,820					36,820		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	20,445,794	196,712		196,712	26,456	20,616,050		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	20,445,794	196,712		196,712	26,456	20,616,050		10

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

	Description	SUMMARY OF CAPITAL							Total (1) (sum of cols. 9 through 14)	
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt	759,131	164,611					923,742	1	
2	Cap Rel Costs-Mvble Equip	347,733	113,943					461,676	2	
3	Total (sum of lines 1-2)	1,106,864	278,554					1,385,418	3	

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

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

**PART III - RECONCILIATION OF CAPITAL COST CENTERS**

	Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	16,526,514		16,526,514	0.801633		147,928		147,928	1
2	Cap Rel Costs-Mvble Equip	4,089,536		4,089,536	0.198367		36,605		36,605	2
3	Total (sum of lines 1-2)	20,616,050		20,616,050	1.000000		184,533		184,533	3

	Description	SUMMARY OF CAPITAL							Total (2) (sum of cols. 9 through 14)	
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt	825,903	1,020	335,501	19,460	213,774		1,395,658	1	
2	Cap Rel Costs-Mvble Equip	341,593	113,943		4,816	52,899		513,251	2	
3	Total (sum of lines 1-2)	1,167,496	114,963	335,501	24,276	266,673		1,908,909	3	

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

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**ADJUSTMENTS TO EXPENSES**

**WORKSHEET A-8**

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		
				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	-9,808			10
11	Sale of scrap, waste, etc. (chapter 23)					11
12	Related organization transactions (chapter 10)	Wkst A-8-1	868,284			12
13	Laundry and linen service					13
14	Cafeteria - employees and guests					14
15	Rental of quarters to employees & others					15
16	Sale of medical and surgical supplies to other than patients					16
17	Sale of drugs to other than patients					17
18	Sale of medical records and abstracts					18
19	Nursing school (tuition,fees,books,etc.)					19
20	Vending machines					20
21	Income from imposition of interest, finance or penalty charges (chapter 21)					21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments					22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65	23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66	24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114	25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1	26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2	27
28	Non-physician anesthetist			Nonphysician Anesthetists	19	28
29	Physicians' assistant					29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67	30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68	31
32	CAH HIT Adj for Depreciation					32
33						33
34						34
35						35
36						36
37	INTEREST	A	-6,192	Interest Expense	113	37
37.03	INSURANCE	A	-341,745	Employee Benefits Department	4	37.03
37.04	INSURANCE	A	-286,107	Administrative & General	5	37.04
37.05	PROPERTY TAX	A	65,846	Cap Rel Costs-Bldg & Fixt	1	37.05
37.06	PROPERTY TAX	A	16,294	Cap Rel Costs-Mvble Equip	2	37.06
37.07	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-26,711	Administrative & General	5	37.07
37.08	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-1,917	Operation of Plant	7	37.08
37.09	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	374	Laundry & Linen Service	8	37.09
37.10	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-2,550	Housekeeping	9	37.10
37.11	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-20,144	Dietary	10	37.11
37.12	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-179	Adults & Pediatrics	30	37.12
37.13	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	240	Physical Therapy	66	37.13
37.14	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-206	Medical Supplies Charged to Patients	71	37.14
37.15	PATIENT TELEPHONE	A	-1,809	Cap Rel Costs-Mvble Equip	2	37.15
37.16	PATIENT TELEPHONE	A	-3,232	Employee Benefits Department	4	37.16
37.17	PATIENT TELEPHONE	A	-27,460	Administrative & General	5	37.17
37.18	PATIENT TELEVISION	A	-4,237	Cap Rel Costs-Mvble Equip	2	37.18
37.19	PATIENT TELEVISION	A	-5,706	Operation of Plant	7	37.19
37.20	PRINTING	A	-2,593	Administrative & General	5	37.20
37.21	PRINTING	A	-3	Operation of Plant	7	37.21
37.22	PRINTING	A	-19	Nursing Administration	13	37.22
37.23	PRINTING	A	-9	Social Service	17	37.23
37.24	PRINTING	A	-9	Adults & Pediatrics	30	37.24
37.25	LOBBYING EXPENSE	A	-153	Administrative & General	5	37.25
37.26	MISCELLANEOUS INCOME	B	-65,194	Administrative & General	5	37.26
37.27	MISCELLANEOUS INCOME	B	-1,334	Dietary	10	37.27
37.28	MISCELLANEOUS INCOME	B	-298	Medical Records & Library	16	37.28
37.29	PATIENT TRANSPORTATION	A	-94	Cap Rel Costs-Mvble Equip	2	37.29
37.30	PATIENT TRANSPORTATION	A	-4,027	Employee Benefits Department	4	37.30

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**ADJUSTMENTS TO EXPENSES**

**WORKSHEET A-8**

DESCRIPTION(1)		BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		Wkst. A-7 Ref.
				COST CENTER	LINE#	
		1	2	3	4	5
37.31	PATIENT TRANSPORTATION	A	-21,468	Administrative & General	5	37.31
37.32	PATIENT TRANSPORTATION	A	-62,407	Operation of Plant	7	37.32
37.33	MISC. TAX	A	-1,192,723	Administrative & General	5	37.33
37.34	PROFESSIONAL FEES	A	-7,170	Administrative & General	5	37.34
38						38
39						39
40						40
41						41
42						42
43						43
44						44
45						45
46						46
47						47
48						48
49						49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-1,144,466			50

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

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

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

**WORKSHEET A-8-1**

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

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
1	2	3	4	5	6	7	
1	Administrative & General	TO OFFSET MANAGEMENT FEES		861,904	-861,904		1
2	Cap Rel Costs-Bldg & Fixt	TO INCLUDE ALLOWABLE HOME OFFICE COS	66,772		66,772	9	2
3	Cap Rel Costs-Bldg & Fixt	TO INCLUDE ALLOWABLE HOME OFFICE COS	335,501		335,501	11	3
3.01	Administrative & General	TO INCLUDE ALLOWABLE HOME OFFICE COS	1,320,995		1,320,995		3.01
3.02	Administrative & General	TO INCLUDE ALLOWABLE HOME OFFICE COS	273,444		273,444		3.02
3.03	Cap Rel Costs-Mvble Equip	INTERCOMPANY WAGE AND EXPENSE TRANSF	274	274		9	3.03
3.04	Employee Benefits Department	INTERCOMPANY WAGE AND EXPENSE TRANSF	1,897,613	1,897,613			3.04
3.05	Administrative & General	INTERCOMPANY WAGE AND EXPENSE TRANSF	3,079,292	3,079,292			3.05
3.06	Operation of Plant	INTERCOMPANY WAGE AND EXPENSE TRANSF	6,346	6,346			3.06
3.07	Housekeeping	INTERCOMPANY WAGE AND EXPENSE TRANSF	455	455			3.07
3.08	Dietary	INTERCOMPANY WAGE AND EXPENSE TRANSF	-7,434	-7,434			3.08
3.09	Medical Records & Library	INTERCOMPANY WAGE AND EXPENSE TRANSF	17	17			3.09
3.10	Social Service	INTERCOMPANY WAGE AND EXPENSE TRANSF	1,220	1,220			3.10
3.11	Adults & Pediatrics	INTERCOMPANY WAGE AND EXPENSE TRANSF	630	630			3.11
3.12	Radiology-Diagnostic	INTERCOMPANY WAGE AND EXPENSE TRANSF	356	356			3.12
3.13	Laboratory	INTERCOMPANY WAGE AND EXPENSE TRANSF	-1,170	-1,170			3.13
3.14	Physical Therapy	INTERCOMPANY WAGE AND EXPENSE TRANSF	-55,536	-55,536			3.14
3.15	Occupational Therapy	INTERCOMPANY WAGE AND EXPENSE TRANSF	-26,842	-26,842			3.15
3.16	Speech Pathology	INTERCOMPANY WAGE AND EXPENSE TRANSF	-18,556	-18,556			3.16
3.17	Medical Supplies Charged to Patients	INTERCOMPANY WAGE AND EXPENSE TRANSF	-6,704	-6,704			3.17
3.18	Drugs Charged to Patients	INTERCOMPANY WAGE AND EXPENSE TRANSF	391,051	391,051			3.18
3.19	76.01 SPECIAL PROCEDURES	INTERCOMPANY WAGE AND EXPENSE TRANSF	-18	-18			3.19
3.20	113 Interest Expense	INTERCOMPANY WAGE AND EXPENSE TRANSF	6,192	6,192		11	3.20
3.21	1 Cap Rel Costs-Bldg & Fixt	RELATED PARTY - GROUND LEASE		163,591	-163,591	10	3.21
3.22	4 Employee Benefits Department	RELATED PARTY - LEASED TO	-214,462	-214,462			3.22
3.23	66 Physical Therapy	RELATED PARTY - LEASED TO	-412,703	-412,703			3.23
3.24	67 Occupational Therapy	RELATED PARTY - LEASED TO	-239,398	-239,398			3.24
3.25	68 Speech Pathology	RELATED PARTY - LEASED TO	-157,188	-157,188			3.25
3.26	4 Employee Benefits Department	RELATED PARTY - LEASED FROM	15,306	15,306			3.26
3.27	13 Nursing Administration	RELATED PARTY - LEASED FROM	30,436	30,436			3.27
3.28	30 Adults & Pediatrics	RELATED PARTY - LEASED FROM	21,323	21,323			3.28
3.29	67 Occupational Therapy	RELATED PARTY - LEASED FROM	5,999	5,999			3.29
3.30	5 Administrative & General	RELATED PARTY - RHS	54	5,226	-5,172		3.30
3.31	54 Radiology-Diagnostic	RELATED PARTY - RHS	8,989	26,052	-17,063		3.31
3.32	60 Laboratory	RELATED PARTY - RHS	252,255	326,872	-74,617		3.32
3.33	76.01 SPECIAL PROCEDURES	RELATED PARTY - RHS	7,118	13,199	-6,081		3.33
4							4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12		6,581,627	5,713,343	868,284		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.

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

**WORKSHEET A-8-1**

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

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

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

Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office		
			Name	Percentage of Ownership	Type of Business
1	2	3	4	5	6

Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office		
			Name	Percentage of Ownership	Type of Business
1	2	3	4	5	6
6	B	50.00	HEALTHSOUTH CORPORATION		6
7	B	50.00	ROCKFORD HEALTH SYSTEM		7
8	G		ROCKFORD MEMORIAL HOSPITAL		8
9					9
10					10

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

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

**KPMG LLP Compu-Max 2552-10**

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 04/26/2017 Run Time: 10:18 Version: 2017.01 (04/10/2017)
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**PROVIDER-BASED PHYSICIANS ADJUSTMENTS**

**WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun- eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	30	Adults & Pediatrics PHYSICIAN ADJUS	30,450		30,450	211,500	203	20,642	1,032	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	30,450		30,450		203	20,642	1,032	200

**KPMG LLP Compu-Max 2552-10**

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 04/26/2017 Run Time: 10:18 Version: 2017.01 (04/10/2017)
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**PROVIDER-BASED PHYSICIANS ADJUSTMENTS**

**WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	30	Adults & Pediatrics PHYSICIAN ADJUS					20,642	9,808	9,808	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					20,642	9,808	9,808	200

**KPMG LLP Compu-Max 2552-10**

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 04/26/2017 Run Time: 10:18 Version: 2017.01 (04/10/2017)
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**COST ALLOCATION - GENERAL SERVICE COSTS**

**WORKSHEET B  
PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINISTRATIVE & GENERAL	
		0	1	2	4	4A	5	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt	1,395,658	1,395,658					1
2	Cap Rel Costs-Mvble Equip	513,251		513,251				2
4	Employee Benefits Department	1,940,081			1,940,081			4
5	Administrative & General	4,218,896	31,806	11,696	327,136	4,589,534	4,589,534	5
6	Maintenance & Repairs							6
7	Operation of Plant	644,898	381,587	140,328	31,356	1,198,169	372,753	7
8	Laundry & Linen Service	185,648	7,262	2,671		195,581	60,846	8
9	Housekeeping	212,711	9,432	3,469	29,419	255,031	79,341	9
10	Dietary	649,334	74,849	27,526	64,502	816,211	253,925	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	452,575	37,039	13,621	83,882	587,117	182,653	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	136,563	13,388	4,923	20,752	175,626	54,638	16
17	Social Service	355,565	9,331	3,431	65,305	433,632	134,904	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
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	3,884,515	494,935	182,011	712,385	5,273,846	1,640,696	30
	<b>ANCILLARY SERVICE COST CENTERS</b>							
54	Radiology-Diagnostic	138,831	1,623	597	8,411	149,462	46,498	54
60	Laboratory	271,221				271,221	84,377	60
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>							62.30
65	Respiratory Therapy	301,404	8,783	3,230	53,207	366,624	114,057	65
66	Physical Therapy	1,416,332	131,543	48,375	229,883	1,826,133	568,114	66
67	Occupational Therapy	1,032,388	152,132	55,946	169,733	1,410,199	438,716	67
68	Speech Pathology	308,911	5,680	2,089	57,130	373,810	116,293	68
71	Medical Supplies Charged to Patients	283,751	11,055	4,065	7,861	306,732	95,425	71
73	Drugs Charged to Patients	794,638	12,698	4,670	61,181	873,187	271,650	73
76.01	<b>SPECIAL PROCEDURES</b>	105,031				105,031	32,675	76.01
76.97	<b>CARDIAC REHABILITATION</b>							76.97
76.98	<b>HYPERBARIC OXYGEN THERAPY</b>							76.98
76.99	<b>LITHOTRIPSY</b>							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
	<b>SPECIAL PURPOSE COST CENTERS</b>							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	19,242,202	1,383,143	508,648	1,922,143	19,207,146	4,547,561	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
192	Physicians' Private Offices		11,521	4,237		15,758	4,902	192
194	NRCC MARKETING	99,861	994	366	17,938	119,159	37,071	194
194.01	NRCC MEALS							194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	<b>TOTAL (sum of lines 118-201)</b>	<b>19,342,063</b>	<b>1,395,658</b>	<b>513,251</b>	<b>1,940,081</b>	<b>19,342,063</b>	<b>4,589,534</b>	<b>202</b>

**KPMG LLP Compu-Max 2552-10**

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 04/26/2017 Run Time: 10:18 Version: 2017.01 (04/10/2017)
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**COST ALLOCATION - GENERAL SERVICE COSTS**

**WORKSHEET B  
PART I**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7	8	9	10	11	13	
	<b>GENERAL SERVICE COST CENTERS</b>							
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	1,570,922						7
8	Laundry & Linen Service	11,614	268,041					8
9	Housekeeping	15,085		349,457				9
10	Dietary	119,705		27,089	1,216,930			10
11	Cafeteria				59,296	59,296		11
12	Maintenance of Personnel							12
13	Nursing Administration	59,236		13,405		3,343	845,754	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	21,411		4,845		827		16
17	Social Service	14,923		3,377		2,603		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
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	791,542	268,041	179,125	1,010,853	28,395	845,754	30
	<b>ANCILLARY SERVICE COST CENTERS</b>							
54	Radiology-Diagnostic	2,595		587		335		54
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	14,047		3,179		2,121		65
66	Physical Therapy	210,375		47,608		9,163		66
67	Occupational Therapy	243,302		55,059		6,765		67
68	Speech Pathology	9,083		2,056		2,277		68
71	Medical Supplies Charged to Patients	17,680		4,001		313		71
73	Drugs Charged to Patients	20,308		4,596		2,439		73
76.01	SPECIAL PROCEDURES							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
	<b>SPECIAL PURPOSE COST CENTERS</b>							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	1,550,906	268,041	344,927	1,070,149	58,581	845,754	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
192	Physicians' Private Offices	18,426		4,170				192
194	NRCC MARKETING	1,590		360		715		194
194.01	NRCC MEALS				146,781			194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,570,922	268,041	349,457	1,216,930	59,296	845,754	202

**KPMG LLP Compu-Max 2552-10**

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 04/26/2017 Run Time: 10:18 Version: 2017.01 (04/10/2017)
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**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	
	<b>GENERAL SERVICE COST CENTERS</b>						
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	257,347					16
17	Social Service		589,439				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
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>						
30	Adults & Pediatrics	105,680	589,439	10,733,371		10,733,371	30
	<b>ANCILLARY SERVICE COST CENTERS</b>						
54	Radiology-Diagnostic	2,840		202,317		202,317	54
60	Laboratory	23,715		379,313		379,313	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	5,094		505,122		505,122	65
66	Physical Therapy	37,970		2,699,363		2,699,363	66
67	Occupational Therapy	35,254		2,189,295		2,189,295	67
68	Speech Pathology	10,419		513,938		513,938	68
71	Medical Supplies Charged to Patients	9,202		433,353		433,353	71
73	Drugs Charged to Patients	26,482		1,198,662		1,198,662	73
76.01	SPECIAL PROCEDURES	691		138,397		138,397	76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
92	Observation Beds (Non-Distinct Part)						92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
	<b>SPECIAL PURPOSE COST CENTERS</b>						
113	Interest Expense						113
118	SUBTOTALS (sum of lines 1-117)	257,347	589,439	18,993,131		18,993,131	118
	<b>NONREIMBURSABLE COST CENTERS</b>						
192	Physicians' Private Offices			43,256		43,256	192
194	NRCC MARKETING			158,895		158,895	194
194.01	NRCC MEALS			146,781		146,781	194.01
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	257,347	589,439	19,342,063		19,342,063	202

**KPMG LLP Compu-Max 2552-10**

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 04/26/2017 Run Time: 10:18 Version: 2017.01 (04/10/2017)
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**ALLOCATION OF CAPITAL-RELATED COSTS**

**WORKSHEET B  
PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	ADMINIS- TRATIVE & GENERAL	OPERATION OF PLANT	
		0	1	2	2A	5	7	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General		31,806	11,696	43,502	43,502		5
6	Maintenance & Repairs							6
7	Operation of Plant		381,587	140,328	521,915	3,533	525,448	7
8	Laundry & Linen Service		7,262	2,671	9,933	577	3,885	8
9	Housekeeping		9,432	3,469	12,901	752	5,046	9
10	Dietary		74,849	27,526	102,375	2,407	40,039	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration		37,039	13,621	50,660	1,731	19,813	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		13,388	4,923	18,311	518	7,162	16
17	Social Service		9,331	3,431	12,762	1,279	4,991	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
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics		494,935	182,011	676,946	15,550	264,758	30
	<b>ANCILLARY SERVICE COST CENTERS</b>							
54	Radiology-Diagnostic		1,623	597	2,220	441	868	54
60	Laboratory					800		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		8,783	3,230	12,013	1,081	4,698	65
66	Physical Therapy		131,543	48,375	179,918	5,385	70,367	66
67	Occupational Therapy		152,132	55,946	208,078	4,159	81,381	67
68	Speech Pathology		5,680	2,089	7,769	1,102	3,038	68
71	Medical Supplies Charged to Patients		11,055	4,065	15,120	905	5,914	71
73	Drugs Charged to Patients		12,698	4,670	17,368	2,575	6,793	73
76.01	SPECIAL PROCEDURES					310		76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
	<b>SPECIAL PURPOSE COST CENTERS</b>							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)		1,383,143	508,648	1,891,791	43,105	518,753	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
192	Physicians' Private Offices		11,521	4,237	15,758	46	6,163	192
194	NRCC MARKETING		994	366	1,360	351	532	194
194.01	NRCC MEALS							194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		1,395,658	513,251	1,908,909	43,502	525,448	202

**KPMG LLP Compu-Max 2552-10**

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 04/26/2017 Run Time: 10:18 Version: 2017.01 (04/10/2017)
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**ALLOCATION OF CAPITAL-RELATED COSTS**

**WORKSHEET B  
PART II**

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
		8	9	10	11	13	16	
	<b>GENERAL SERVICE COST CENTERS</b>							
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	14,395						8
9	Housekeeping		18,699					9
10	Dietary		1,450	146,271				10
11	Cafeteria			7,127	7,127			11
12	Maintenance of Personnel							12
13	Nursing Administration		717			73,323		13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		259		99		26,349	16
17	Social Service		181		313			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
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	14,395	9,586	121,501	3,413	73,323	10,809	30
	<b>ANCILLARY SERVICE COST CENTERS</b>							
54	Radiology-Diagnostic		31		40		291	54
60	Laboratory						2,430	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		170		255		522	65
66	Physical Therapy		2,547		1,101		3,890	66
67	Occupational Therapy		2,946		813		3,612	67
68	Speech Pathology		110		274		1,068	68
71	Medical Supplies Charged to Patients		214		38		943	71
73	Drugs Charged to Patients		246		293		2,713	73
76.01	SPECIAL PROCEDURES						71	76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
	<b>SPECIAL PURPOSE COST CENTERS</b>							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	14,395	18,457	128,628	7,041	73,323	26,349	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
192	Physicians' Private Offices		223					192
194	NRCC MARKETING		19		86			194
194.01	NRCC MEALS			17,643				194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	14,395	18,699	146,271	7,127	73,323	26,349	202

**KPMG LLP Compu-Max 2552-10**

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 04/26/2017 Run Time: 10:18 Version: 2017.01 (04/10/2017)
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**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		
	<b>GENERAL SERVICE COST CENTERS</b>						
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	19,526					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
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>						
30	Adults & Pediatrics	19,526	1,209,807		1,209,807		30
	<b>ANCILLARY SERVICE COST CENTERS</b>						
54	Radiology-Diagnostic		3,891		3,891		54
60	Laboratory		3,230		3,230		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy		18,739		18,739		65
66	Physical Therapy		263,208		263,208		66
67	Occupational Therapy		300,989		300,989		67
68	Speech Pathology		13,361		13,361		68
71	Medical Supplies Charged to Patients		23,134		23,134		71
73	Drugs Charged to Patients		29,988		29,988		73
76.01	SPECIAL PROCEDURES		381		381		76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
92	Observation Beds (Non-Distinct Part)						92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
	<b>SPECIAL PURPOSE COST CENTERS</b>						
113	Interest Expense						113
118	SUBTOTALS (sum of lines 1-117)	19,526	1,866,728		1,866,728		118
	<b>NONREIMBURSABLE COST CENTERS</b>						
192	Physicians' Private Offices		22,190		22,190		192
194	NRCC MARKETING		2,348		2,348		194
194.01	NRCC MEALS		17,643		17,643		194.01
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	19,526	1,908,909		1,908,909		202

**KPMG LLP Compu-Max 2552-10**

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**COST ALLOCATION - STATISTICAL BASIS**

**WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECONCILIATION	ADMINISTRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt	68,805						1
2	Cap Rel Costs-Mvble Equip		68,805					2
4	Employee Benefits Department			10,380,834				4
5	Administrative & General	1,568	1,568	1,750,408	-4,589,534	14,752,529		5
6	Maintenance & Repairs							6
7	Operation of Plant	18,812	18,812	167,779		1,198,169	48,425	7
8	Laundry & Linen Service	358	358			195,581	358	8
9	Housekeeping	465	465	157,415		255,031	465	9
10	Dietary	3,690	3,690	345,133		816,211	3,690	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	1,826	1,826	448,829		587,117	1,826	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	660	660	111,039		175,626	660	16
17	Social Service	460	460	349,426		433,632	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
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	24,400	24,400	3,811,782		5,273,846	24,400	30
	<b>ANCILLARY SERVICE COST CENTERS</b>							
54	Radiology-Diagnostic	80	80	45,006		149,462	80	54
60	Laboratory					271,221		60
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>							62.30
65	Respiratory Therapy	433	433	284,695		366,624	433	65
66	Physical Therapy	6,485	6,485	1,230,037		1,826,133	6,485	66
67	Occupational Therapy	7,500	7,500	908,193		1,410,199	7,500	67
68	Speech Pathology	280	280	305,688		373,810	280	68
71	Medical Supplies Charged to Patients	545	545	42,064		306,732	545	71
73	Drugs Charged to Patients	626	626	327,360		873,187	626	73
76.01	<b>SPECIAL PROCEDURES</b>					105,031		76.01
76.97	<b>CARDIAC REHABILITATION</b>							76.97
76.98	<b>HYPERBARIC OXYGEN THERAPY</b>							76.98
76.99	<b>LITHOTRIPSY</b>							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	68,188	68,188	10,284,854	-4,589,534	14,617,612	47,808	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
192	Physicians' Private Offices	568	568			15,758	568	192
194	NRCC MARKETING	49	49	95,980		119,159	49	194
194.01	NRCC MEALS							194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,395,658	513,251	1,940,081		4,589,534	1,570,922	202
203	Unit Cost Multiplier (Wkst. B, Part I)	20.284253	7.459501	0.186891		0.311102	32.440310	203
204	Cost to be allocated (Per Wkst. B, Part II)					43,502	525,448	204
205	Unit Cost Multiplier (Wkst. B, Part II)					0.002949	10.850759	205

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**COST ALLOCATION - STATISTICAL BASIS**

**WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE PATIENT DAYS	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA GROSS SALARIES	NURSING ADMINISTRATION PATIENT DAYS	MEDICAL RECORDS & LIBRARY GROSS REVENUE	
		8	9	10	11	13	16	
	<b>GENERAL SERVICE COST CENTERS</b>							
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	19,522						8
9	Housekeeping		47,602					9
10	Dietary		3,690	70,455				10
11	Cafeteria			3,433	7,960,099			11
12	Maintenance of Personnel							12
13	Nursing Administration		1,826		448,829	19,522		13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		660		111,039		43,942,779	16
17	Social Service		460		349,426			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
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	19,522	24,400	58,524	3,811,782	19,522	18,043,324	30
	<b>ANCILLARY SERVICE COST CENTERS</b>							
54	Radiology-Diagnostic		80		45,006		484,949	54
60	Laboratory						4,049,628	60
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>							62.30
65	Respiratory Therapy		433		284,695		869,833	65
66	Physical Therapy		6,485		1,230,037		6,484,027	66
67	Occupational Therapy		7,500		908,193		6,020,127	67
68	Speech Pathology		280		305,688		1,779,247	68
71	Medical Supplies Charged to Patients		545		42,064		1,571,464	71
73	Drugs Charged to Patients		626		327,360		4,522,197	73
76.01	<b>SPECIAL PROCEDURES</b>						117,983	76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	19,522	46,985	61,957	7,864,119	19,522	43,942,779	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
192	Physicians' Private Offices		568					192
194	NRCC MARKETING		49		95,980			194
194.01	NRCC MEALS			8,498				194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	268,041	349,457	1,216,930	59,296	845,754	257,347	202
203	Unit Cost Multiplier (Wkst. B, Part I)	13.730202	7.341225	17.272443	0.007449	43.323123	0.005856	203
204	Cost to be allocated (Per Wkst. B, Part II)	14,395	18,699	146,271	7,127	73,323	26,349	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.737373	0.392820	2.076091	0.000895	3.755916	0.000600	205

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**COST ALLOCATION - STATISTICAL BASIS**

**WORKSHEET B-1**

COST CENTER DESCRIPTIONS	SOCIAL SERVICE  PATIENT DAYS 17						
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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	19,522					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	19,522					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
76.01	SPECIAL PROCEDURES						76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)						92
OTHER REIMBURSABLE COST CENTERS							
SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	19,522					118
NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices						192
194	NRCC MARKETING						194
194.01	NRCC MEALS						194.01
200	Cross foot adjustments						200
201	Negative cost centers						201
202	Cost to be allocated (Per Wkst. B, Part I)	589,439					202
203	Unit Cost Multiplier (Wkst. B, Part I)	30.193576					203
204	Cost to be allocated (Per Wkst. B, Part II)	19,526					204
205	Unit Cost Multiplier (Wkst. B, Part II)	1.000205					205

**KPMG LLP Compu-Max 2552-10**

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**POST STEPDOWN ADJUSTMENTS**

**WORKSHEET B-2**

	WORKSHEET			
DESCRIPTION	PART	LINE NO.	AMOUNT	
1	2	3	4	

**KPMG LLP Compu-Max 2552-10**

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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
PART I

	COST CENTER DESCRIPTIONS	COSTS					
		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30	Adults & Pediatrics	10,733,371		10,733,371	9,808	10,743,179	30
	<b>ANCILLARY SERVICE COST CENTERS</b>						
54	Radiology-Diagnostic	202,317		202,317		202,317	54
60	Laboratory	379,313		379,313		379,313	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	505,122		505,122		505,122	65
66	Physical Therapy	2,699,363		2,699,363		2,699,363	66
67	Occupational Therapy	2,189,295		2,189,295		2,189,295	67
68	Speech Pathology	513,938		513,938		513,938	68
71	Medical Supplies Charged to Patients	433,353		433,353		433,353	71
73	Drugs Charged to Patients	1,198,662		1,198,662		1,198,662	73
76.01	SPECIAL PROCEDURES	138,397		138,397		138,397	76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
92	Observation Beds (Non-Distinct Part)						92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	18,993,131		18,993,131	9,808	19,002,939	200
201	Less Observation Beds						201
202	Total (line 200 minus line 201)	18,993,131		18,993,131		19,002,939	202

**KPMG LLP Compu-Max 2552-10**

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 04/26/2017 Run Time: 10:18 Version: 2017.01 (04/10/2017)
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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
PART I

	COST CENTER DESCRIPTIONS	CHARGES			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		Inpatient	Outpatient	Total (column 6 + column 7)				
		6	7	8				
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30	Adults & Pediatrics	18,043,324		18,043,324				30
	<b>ANCILLARY SERVICE COST CENTERS</b>							
54	Radiology-Diagnostic	482,876	2,073	484,949	0.417192	0.417192	0.417192	54
60	Laboratory	4,049,477	151	4,049,628	0.093666	0.093666	0.093666	60
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>							62.30
65	Respiratory Therapy	869,833		869,833	0.580711	0.580711	0.580711	65
66	Physical Therapy	5,033,125	1,450,902	6,484,027	0.416310	0.416310	0.416310	66
67	Occupational Therapy	5,199,101	821,026	6,020,127	0.363663	0.363663	0.363663	67
68	Speech Pathology	1,097,060	682,187	1,779,247	0.288851	0.288851	0.288851	68
71	Medical Supplies Charged to Patients	1,570,694	770	1,571,464	0.275764	0.275764	0.275764	71
73	Drugs Charged to Patients	4,522,197		4,522,197	0.265062	0.265062	0.265062	73
76.01	<b>SPECIAL PROCEDURES</b>	117,983		117,983	1.173025	1.173025	1.173025	76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	40,985,670	2,957,109	43,942,779				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	40,985,670	2,957,109	43,942,779				202

**KPMG LLP Compu-Max 2552-10**

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 04/26/2017 Run Time: 10:18 Version: 2017.01 (04/10/2017)
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**APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS**

**WORKSHEET D  
PART I**

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

	Capital Related Cost (from Wkst. B, Part II, (col. 26))	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)		
(A)	1	2	3	4	5	6	7		
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30	Adults & Pediatrics General Routine Care)	1,209,807		1,209,807	19,522	61.97	11,316	701,253	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)	1,209,807		1,209,807	19,522		11,316	701,253	200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 04/26/2017 Run Time: 10:18 Version: 2017.01 (04/10/2017)
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**APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS**

**COMPONENT CCN: 14-3028**

**WORKSHEET D  
PART II**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	<b>ANCILLARY SERVICE COST CENTERS</b>						
54	Radiology-Diagnostic	3,891	484,949	0.008024	342,397	2,747	54
60	Laboratory	3,230	4,049,628	0.000798	2,428,059	1,938	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	18,739	869,833	0.021543	529,430	11,406	65
66	Physical Therapy	263,208	6,484,027	0.040593	2,943,082	119,469	66
67	Occupational Therapy	300,989	6,020,127	0.049997	3,047,497	152,366	67
68	Speech Pathology	13,361	1,779,247	0.007509	580,411	4,358	68
71	Medical Supplies Charged to Pat	23,134	1,571,464	0.014721	944,506	13,904	71
73	Drugs Charged to Patients	29,988	4,522,197	0.006631	2,547,678	16,894	73
76.01	SPECIAL PROCEDURES	381	117,983	0.003229	94,500	305	76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
92	Observation Beds (Non-Distinct						92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
200	Total (sum of lines 50-199)	656,921	25,899,455		13,457,560	323,387	200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 04/26/2017 Run Time: 10:18 Version: 2017.01 (04/10/2017)
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**APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS**

**WORKSHEET D  
PART III**

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

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

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 04/26/2017 Run Time: 10:18 Version: 2017.01 (04/10/2017)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D  
PART III**

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

		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	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30	Adults & Pediatrics (General Routine Care)	19,522		11,316		30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	19,522		11,316		200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 04/26/2017 Run Time: 10:18 Version: 2017.01 (04/10/2017)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 14-3028**

**WORKSHEET D  
PART IV**

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

		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2	3	4	5	6	
	<b>ANCILLARY SERVICE COST CENTERS</b>							
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
76.01	SPECIAL PROCEDURES							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
92	Observation Beds (Non-Distinct)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 04/26/2017 Run Time: 10:18 Version: 2017.01 (04/10/2017)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 14-3028**

**WORKSHEET D  
PART IV**

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

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		7	8	9	10	11	12	13	
	<b>ANCILLARY SERVICE COST CENTERS</b>								
54	Radiology-Diagnostic	484,949			342,397		2,073		54
60	Laboratory	4,049,628			2,428,059				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	869,833			529,430				65
66	Physical Therapy	6,484,027			2,943,082				66
67	Occupational Therapy	6,020,127			3,047,497				67
68	Speech Pathology	1,779,247			580,411				68
71	Medical Supplies Charged to Pat	1,571,464			944,506				71
73	Drugs Charged to Patients	4,522,197			2,547,678				73
76.01	SPECIAL PROCEDURES	117,983			94,500				76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
92	Observation Beds (Non-Distinct)								92
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	Total (sum of lines 50-199)	25,899,455			13,457,560		2,073		200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 04/26/2017 Run Time: 10:18 Version: 2017.01 (04/10/2017)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-3028

WORKSHEET D  
PART V

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

(A)	Cost Center Description	Program Charges				Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
		1	2	3	4	5	6	7	
	<b>ANCILLARY SERVICE COST CENTERS</b>								
54	Radiology-Diagnostic	0.417192	2,073			865			54
60	Laboratory	0.093666							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.580711							65
66	Physical Therapy	0.416310							66
67	Occupational Therapy	0.363663							67
68	Speech Pathology	0.288851							68
71	Medical Supplies Charged to Pat	0.275764							71
73	Drugs Charged to Patients	0.265062							73
76.01	SPECIAL PROCEDURES	1.173025							76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
92	Observation Beds (Non-Distinct)								92
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	Subtotal (see instructions)		2,073			865			200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		2,073			865			202

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 04/26/2017 Run Time: 10:18 Version: 2017.01 (04/10/2017)
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**APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS**

**WORKSHEET D  
PART I**

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

		Capital Related Cost (from Wkst. B, Part II, (col. 26))	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30	Adults & Pediatrics General Routine Care)	1,209,807		1,209,807	19,522	61.97	963	59,677	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)	1,209,807		1,209,807	19,522		963	59,677	200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 04/26/2017 Run Time: 10:18 Version: 2017.01 (04/10/2017)
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**APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS**

**COMPONENT CCN: 14-3028**

**WORKSHEET D  
PART II**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	<b>ANCILLARY SERVICE COST CENTERS</b>						
54	Radiology-Diagnostic	3,891	484,949	0.008024	23,630	190	54
60	Laboratory	3,230	4,049,628	0.000798	169,046	135	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	18,739	869,833	0.021543	51,319	1,106	65
66	Physical Therapy	263,208	6,484,027	0.040593	237,413	9,637	66
67	Occupational Therapy	300,989	6,020,127	0.049997	243,438	12,171	67
68	Speech Pathology	13,361	1,779,247	0.007509	66,710	501	68
71	Medical Supplies Charged to Pat	23,134	1,571,464	0.014721	90,097	1,326	71
73	Drugs Charged to Patients	29,988	4,522,197	0.006631	239,904	1,591	73
76.01	SPECIAL PROCEDURES	381	117,983	0.003229	5,100	16	76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
92	Observation Beds (Non-Distinct)						92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
200	Total (sum of lines 50-199)	656,921	25,899,455		1,126,657	26,673	200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 04/26/2017 Run Time: 10:18 Version: 2017.01 (04/10/2017)
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**APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS**

**WORKSHEET D  
PART III**

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

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

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 04/26/2017 Run Time: 10:18 Version: 2017.01 (04/10/2017)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D  
PART III**

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

		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	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30	Adults & Pediatrics (General Routine Care)	19,522		963		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)	19,522		963		200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 04/26/2017 Run Time: 10:18 Version: 2017.01 (04/10/2017)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 14-3028**

**WORKSHEET D  
PART IV**

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

		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2	3	4	5	6	
	<b>ANCILLARY SERVICE COST CENTERS</b>							
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
76.01	SPECIAL PROCEDURES							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
92	Observation Beds (Non-Distinct)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 04/26/2017 Run Time: 10:18 Version: 2017.01 (04/10/2017)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 14-3028**

**WORKSHEET D  
PART IV**

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

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
7	8	9	10	11	12	13			
	<b>ANCILLARY SERVICE COST CENTERS</b>								
54	Radiology-Diagnostic	484,949			23,630				54
60	Laboratory	4,049,628			169,046				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	869,833			51,319				65
66	Physical Therapy	6,484,027			237,413				66
67	Occupational Therapy	6,020,127			243,438				67
68	Speech Pathology	1,779,247			66,710				68
71	Medical Supplies Charged to Pat	1,571,464			90,097				71
73	Drugs Charged to Patients	4,522,197			239,904				73
76.01	SPECIAL PROCEDURES	117,983			5,100				76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
92	Observation Beds (Non-Distinct)								92
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	Total (sum of lines 50-199)	25,899,455			1,126,657				200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 04/26/2017 Run Time: 10:18 Version: 2017.01 (04/10/2017)
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**APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS**

**COMPONENT CCN: 14-3028**

**WORKSHEET D  
PART V**

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

(A)	Cost Center Description	Program Charges				Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
		1	2	3	4	5	6	7	
	<b>ANCILLARY SERVICE COST CENTERS</b>								
54	Radiology-Diagnostic	0.417192							54
60	Laboratory	0.093666							60
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>								62.30
65	Respiratory Therapy	0.580711							65
66	Physical Therapy	0.416310							66
67	Occupational Therapy	0.363663							67
68	Speech Pathology	0.288851							68
71	Medical Supplies Charged to Pat	0.275764							71
73	Drugs Charged to Patients	0.265062							73
76.01	<b>SPECIAL PROCEDURES</b>	1.173025							76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
92	Observation Beds (Non-Distinct)								92
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 04/26/2017 Run Time: 10:18 Version: 2017.01 (04/10/2017)
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**COMPUTATION OF INPATIENT OPERATING COST**

**COMPONENT CCN: 14-3028**

**WORKSHEET D-1  
PART I**

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

**PART I - ALL PROVIDER COMPONENTS**

**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	19,522	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	19,522	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)	19,522	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)	11,316	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

**SWING-BED ADJUSTMENT**

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	10,743,179	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	10,743,179	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)	10,743,179	37

**KPMG LLP Compu-Max 2552-10**

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 04/26/2017 Run Time: 10:18 Version: 2017.01 (04/10/2017)
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**COMPUTATION OF INPATIENT OPERATING COST**

**COMPONENT CCN: 14-3028**

**WORKSHEET D-1  
PART II**

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

**PART II - HOSPITALS AND SUBPROVIDERS ONLY**

**PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS**

							1	
38	Adjusted general inpatient routine service cost per diem (see instructions)						550.31	38
39	Program general inpatient routine service cost (line 9 x line 38)						6,227,308	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)							40
41	Total Program general inpatient routine service cost (line 39 + line 40)						6,227,308	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
	<b>Intensive Care Type Inpatient Hospital Units</b>							
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)						4,225,471	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						10,452,779	49
	<b>PASS THROUGH COST ADJUSTMENTS</b>							
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						701,253	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						323,387	51
52	Total Program excludable cost (sum of lines 50 and 51)						1,024,640	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						9,428,139	53
	<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
54	Program discharges							54
55	Target amount per discharge							55
56	Target amount (line 54 x line 55)							56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)							57
58	Bonus payment (see instructions)							58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.							59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.							60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)							61
62	Relief payment (see instructions)							62
63	Allowable Inpatient cost plus incentive payment (see instructions)							63
	<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)							64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)							65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)							66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)							67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)							68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)							69

**KPMG LLP Compu-Max 2552-10**

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 04/26/2017 Run Time: 10:18 Version: 2017.01 (04/10/2017)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-3028

WORKSHEET D-1  
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)		87				
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	550.31	88				
89	Observation bed cost (line 87 x line 88) (see instructions)		89				
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

**KPMG LLP Compu-Max 2552-10**

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 04/26/2017 Run Time: 10:18 Version: 2017.01 (04/10/2017)
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**COMPUTATION OF INPATIENT OPERATING COST**

**COMPONENT CCN: 14-3028**

**WORKSHEET D-1  
PART I**

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

**PART I - ALL PROVIDER COMPONENTS**

**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	19,522	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	19,522	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)	19,522	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)	963	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

**SWING-BED ADJUSTMENT**

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	10,733,371	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	10,733,371	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)	10,733,371	37

**KPMG LLP Compu-Max 2552-10**

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 04/26/2017 Run Time: 10:18 Version: 2017.01 (04/10/2017)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-3028

WORKSHEET D-1  
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

**PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS**

							1	
38	Adjusted general inpatient routine service cost per diem (see instructions)						549.81	38
39	Program general inpatient routine service cost (line 9 x line 38)						529,467	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)						529,467	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
	<b>Intensive Care Type Inpatient Hospital Units</b>							
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)						356,546	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						886,013	49
	<b>PASS THROUGH COST ADJUSTMENTS</b>							
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						59,677	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						26,673	51
52	Total Program excludable cost (sum of lines 50 and 51)						86,350	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)							53
	<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
54	Program discharges							54
55	Target amount per discharge							55
56	Target amount (line 54 x line 55)							56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)							57
58	Bonus payment (see instructions)							58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.							59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.							60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)							61
62	Relief payment (see instructions)							62
63	Allowable Inpatient cost plus incentive payment (see instructions)							63
	<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)							64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)							65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)							66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)							67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)							68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)							69

**KPMG LLP Compu-Max 2552-10**

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 04/26/2017 Run Time: 10:18 Version: 2017.01 (04/10/2017)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-3028

WORKSHEET D-1  
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

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

**KPMG LLP Compu-Max 2552-10**

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 04/26/2017 Run Time: 10:18 Version: 2017.01 (04/10/2017)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-3028

WORKSHEET D-3

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30	Adults & Pediatrics		10,455,366		30
	<b>ANCILLARY SERVICE COST CENTERS</b>				
54	Radiology-Diagnostic	0.417192	342,397	142,845	54
60	Laboratory	0.093666	2,428,059	227,427	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.580711	529,430	307,446	65
66	Physical Therapy	0.416310	2,943,082	1,225,234	66
67	Occupational Therapy	0.363663	3,047,497	1,108,262	67
68	Speech Pathology	0.288851	580,411	167,652	68
71	Medical Supplies Charged to Patients	0.275764	944,506	260,461	71
73	Drugs Charged to Patients	0.265062	2,547,678	675,293	73
76.01	SPECIAL PROCEDURES	1.173025	94,500	110,851	76.01
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>				
92	Observation Beds (Non-Distinct Part)				92
	<b>OTHER REIMBURSABLE COST CENTERS</b>				
200	Total (sum of lines 50-94, and 96-98)		13,457,560	4,225,471	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		13,457,560		202

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 04/26/2017 Run Time: 10:18 Version: 2017.01 (04/10/2017)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-3028

WORKSHEET D-3

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30	Adults & Pediatrics		890,667		30
	<b>ANCILLARY SERVICE COST CENTERS</b>				
54	Radiology-Diagnostic	0.417192	23,630	9,858	54
60	Laboratory	0.093666	169,046	15,834	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.580711	51,319	29,802	65
66	Physical Therapy	0.416310	237,413	98,837	66
67	Occupational Therapy	0.363663	243,438	88,529	67
68	Speech Pathology	0.288851	66,710	19,269	68
71	Medical Supplies Charged to Patients	0.275764	90,097	24,846	71
73	Drugs Charged to Patients	0.265062	239,904	63,589	73
76.01	SPECIAL PROCEDURES	1.173025	5,100	5,982	76.01
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>				
92	Observation Beds (Non-Distinct Part)				92
	<b>OTHER REIMBURSABLE COST CENTERS</b>				
200	Total (sum of lines 50-94, and 96-98)		1,126,657	356,546	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		1,126,657		202

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 04/26/2017 Run Time: 10:18 Version: 2017.01 (04/10/2017)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-3028

WORKSHEET E  
PART B

Check applicable box:       Hospital       IPF       IRF       SUB (Other)       SNF

**PART B - MEDICAL AND OTHER HEALTH SERVICES**

		1	1.01	1.02	
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under OPPTS (see instructions)	865			2
3	PPS payments	152			3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)				11
	<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
	<b>REASONABLE CHARGES</b>				
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
	<b>CUSTOMARY CHARGES</b>				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)				21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)	152			24
	<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	31			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)	121			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)	121			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	121			32
	<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
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)	121			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)	121			40
40.01	Sequestration adjustment (see instructions)	2			40.01
41	Interim payments	119			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)				43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

**TO BE COMPLETED BY CONTRACTOR**

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

**KPMG LLP Compu-Max 2552-10**

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 04/26/2017 Run Time: 10:18 Version: 2017.01 (04/10/2017)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-3028

WORKSHEET E-1  
PART I

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

		INPATIENT PART A		PART B	
DESCRIPTION		mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT
		1	2	3	4
1	Total interim payments paid to provider		17,591,307		119 1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero				2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)				
		.01			3.01
		.02			3.02
	Program	.03			3.03
	to	.04			3.04
	Provider	.05			3.05
		.06			3.06
		.07			3.07
		.08			3.08
		.09			3.09
		.10			3.10
		.50			3.50
		.51			3.51
	Provider	.52			3.52
	to	.53			3.53
	Program	.54			3.54
		.55			3.55
		.56			3.56
		.57			3.57
		.58			3.58
		.59			3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		17,591,307		119 4
<b>TO BE COMPLETED BY CONTRACTOR</b>					
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)				
		.01			5.01
		.02			5.02
	Program	.03			5.03
	to	.04			5.04
	Provider	.05			5.05
		.06			5.06
		.07			5.07
		.08			5.08
		.09			5.09
		.10			5.10
		.50			5.50
		.51			5.51
	Provider	.52			5.52
	to	.53			5.53
	Program	.54			5.54
		.55			5.55
		.56			5.56
		.57			5.57
		.58			5.58
		.59			5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99			5.99
6	Determined net settlement amount (balance due) based on the cost report (1)	.01			6.01
		.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.

**KPMG LLP Compu-Max 2552-10**

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 04/26/2017 Run Time: 10:18 Version: 2017.01 (04/10/2017)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-3028

WORKSHEET E-3  
PART III

Check [XX] Hospital  
 Applicable [ ] Subprovider IRF  
 Box:

**PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS**

		1	1.01	
1	Net Federal PPS payment (see instructions)	17,661,243		1
2	Medicare SSI ratio (IRF PPS only) (see instructions)	0.016500		2
3	Inpatient Rehabilitation LIP payments (see instructions)	794,756		3
4	Outlier payments	6,736		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 excluding FTEs in the new program growth period of a 'new teaching program' (see instructions)			7
8	Current year unweighted I&R FTE count for residents within the new program growth period of a 'new teaching program' (see instructions)			8
9	Intern and resident count for IRF PPS medical education adjustment (see instructions)			9
10	Average daily census (see instructions)	53.338798		10
11	Teaching Adjustment Factor (see instructions)			11
12	Teaching Adjustment (see instructions)			12
13	Total PPS Payment (see instructions)	18,462,735		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)	18,462,735		17
18	Primary payer payments	18,031		18
19	Subtotal (line 17 less line 18)	18,444,704		19
20	Deductibles	272,832		20
21	Subtotal (line 19 minus line 20)	18,171,872		21
22	Coinsurance	40,894		22
23	Subtotal (line 21 minus line 22)	18,130,978		23
24	Allowable bad debts (exclude bad debts for professional services) (see instructions)	59,279		24
25	Adjusted reimbursable bad debts (see instructions)	38,531		25
26	Allowable bad debts for dual eligible beneficiaries (see instructions)	36,102		26
27	Subtotal (sum of lines 23 and 25)	18,169,509		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)	18,169,509		32
32.01	Sequestration adjustment (see instructions)	363,390		32.01
33	Interim payments	17,591,307		33
34	Tentative settlement (for contractor use only)			34
35	Balance due provider/program (line 32 minus lines 32.01, 33 and 34)	214,812		35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	509,203		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

**KPMG LLP Compu-Max 2552-10**

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 04/26/2017 Run Time: 10:18 Version: 2017.01 (04/10/2017)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-3028

WORKSHEET E-3  
PART VII

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

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

	INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>			
1	886,013		1
2			2
3			3
4	886,013		4
5			5
6			6
7	886,013		7
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>			
<b>REASONABLE CHARGES</b>			
8	890,667		8
9	1,126,657		9
10			10
11			11
12	2,017,324		12
<b>CUSTOMARY CHARGES</b>			
13			13
14			14
15	1.000000	1.000000	15
16	2,017,324		16
17	1,131,311		17
18			18
19			19
20			20
21	886,013		21
<b>PROSPECTIVE PAYMENT AMOUNT</b>			
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29	886,013		29
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>			
30			30
31	886,013		31
32			32
33			33
34			34
35			35
36	886,013		36
37			37
38	886,013		38
39			39
40	886,013		40
41	1,060,414		41
42	-174,401		42
43			43

**KPMG LLP Compu-Max 2552-10**

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 04/26/2017 Run Time: 10:18 Version: 2017.01 (04/10/2017)
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**BALANCE SHEET**

**WORKSHEET G**

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

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
<b>Assets</b> (Omit Cents)		1	2	3	4	
<b>CURRENT ASSETS</b>						
1	Cash on hand and in banks	3,679,599				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	6,774,671				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-2,216,743				6
7	Inventory	132,157				7
8	Prepaid expenses	231,612				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	8,601,296				11
<b>FIXED ASSETS</b>						
12	Land					12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings	16,132,568				15
16	Accumulated depreciation	-6,843,095				16
17	Leasehold improvements	393,946				17
18	Accumulated depreciation	-183,356				18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	4,093,476				23
24	Accumulated depreciation	-2,884,915				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)	10,708,624				30
<b>OTHER ASSETS</b>						
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	2,350,000				34
35	Total other assets (sum of lines 31-34)	2,350,000				35
36	Total assets (sum of lines 11, 30 and 35)	21,659,920				36
<b>Liabilities and Fund Balances</b> (Omit Cents)						
		1	2	3	4	
<b>CURRENT LIABILITIES</b>						
37	Accounts payable	281,429				37
38	Salaries, wages and fees payable	984,905				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	2,360,348				44
45	Total current liabilities (sum of lines 37 thru 44)	3,626,682				45
<b>LONG TERM LIABILITIES</b>						
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	9,016,617				49
50	Total long term liabilities (sum of lines 46 thru 49)	9,016,617				50
51	Total liabilities (sum of lines 45 and 50)	12,643,299				51
<b>CAPITAL ACCOUNTS</b>						
52	General fund balance	9,016,621				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)	9,016,621				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	21,659,920				60

**KPMG LLP Compu-Max 2552-10**

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 04/26/2017 Run Time: 10:18 Version: 2017.01 (04/10/2017)
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**STATEMENT OF CHANGES IN FUND BALANCES**

**WORKSHEET G-1**

		GENERAL FUND		SPECIFIC PURPOSE FUND	
		1	2	3	4
1	Fund balances at beginning of period		9,022,567		1
2	Net income (loss) (from Worksheet G-3, line 29)		8,724,154		2
3	Total (sum of line 1 and line 2)		17,746,721		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)		17,746,721		11
12	Deductions (debit adjustments) (specify)				12
13	EQUITY DISTRIBUTIONS	4,368,021			13
14	MINORITY INTEREST EXPENSE	4,362,079			14
15					15
16					16
17					17
18	Total deductions (sum of lines 12-17)		8,730,100		18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		9,016,621		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	EQUITY DISTRIBUTIONS				13
14	MINORITY INTEREST EXPENSE				14
15					15
16					16
17					17
18	Total deductions (sum of lines 12-17)				18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)				19

**KPMG LLP Compu-Max 2552-10**

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 04/26/2017 Run Time: 10:18 Version: 2017.01 (04/10/2017)
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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

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

**PART I - PATIENT REVENUES**

	REVENUE CENTER	INPATIENT	OUTPATIENT	TOTAL	
		1	2	3	
	<b>GENERAL INPATIENT ROUTINE CARE SERVICES</b>				
1	Hospital	18,043,324		18,043,324	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)	18,043,324		18,043,324	10
	<b>INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES</b>				
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)	18,043,324		18,043,324	17
18	Ancillary services	22,944,419	2,955,037	25,899,456	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)	40,987,743	2,955,037	43,942,780	28

**PART II - OPERATING EXPENSES**

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		20,486,529	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)		20,486,529	43

**KPMG LLP Compu-Max 2552-10**

VAN MATRE HEALTHSOUTH REHABILITATION Provider CCN: 14-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 04/26/2017 Run Time: 10:18 Version: 2017.01 (04/10/2017)
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**STATEMENT OF REVENUES AND EXPENSES**

**WORKSHEET G-3**

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	43,942,780	1
2	Less contractual allowances and discounts on patients' accounts	15,959,732	2
3	Net patient revenues (line 1 minus line 2)	27,983,048	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	20,486,529	4
5	Net income from service to patients (line 3 minus line 4)	7,496,519	5

**OTHER INCOME**

6	Contributions, donations, bequests, etc.		6
7	Income from investments	24,092	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts	81	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	30,606	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	-5,417	21
22	Rental of hosptial space	14,826	22
23	Governmental appropriations		23
24	Other (specify)	1,163,447	24
25	Total other income (sum of lines 6-24)	1,227,635	25
26	Total (line 5 plus line 25)	8,724,154	26
29	Net income (or loss) for the period (line 26 minus line 28)	8,724,154	29