

KPMG LLP Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/18/2020 Run Time: 13:38 Version: 2018.12 (04/03/2020)
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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. ☒ Electronically filed cost report Date: 05/18/2020 Time: 13:38 2. ☐ Manually submitted cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted the cost report 4. ☐ Medicare Utilization. Enter 'F' for full or 'L' for low.	
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ____ 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by VAN MATRE ENCOMPASS HEALTH REHABILIT (14-3028) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 01/01/2019 and ending 12/31/2019, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

SVP, REIMBURSEMENT
Title

05/18/2020 13:38
Date

PART III - SETTLEMENT SUMMARY

		TITLE XVIII						
		TITLE V	PART A	PART B	HIT	TITLE XIX		
		1	2	3	4	5		
1	HOSPITAL		-11,494			-117,636	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		-11,494			-117,636	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 SOUTH 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	V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	VAN MATRE ENCOMPASS HEALTH REHABILIT	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 / 2019	To: 12 / 31 / 2019		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 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.	244	313	72	103	1,860	25

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2 PART I

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40
		V	XVIII	XIX
	Prospective Payment System (PPS)-Capital	1	2	3
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	N	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
		NAHE 413.85 Y/N 1	Worksheet A Line # 2	Pass-Through Qualification Criteria Code 3
60	Are you claiming nursing and allied health education (NAHE) costs for any program(s) that meet the criteria under 42 CFR 413.85? (see instructions)	N		60
		Y/N 1	IME 4	Direct GME 5
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.(see instructions)	N		61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)			61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions)			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)			61.06

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

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

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

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

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

Teaching Hospitals that Claim Residents in Nonprovider Settings

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

Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						64
Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)							
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
65							65
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						66
Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)							
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
67							67

Inpatient Psychiatric Facility PPS

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

Inpatient Rehabilitation Facility PPS

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

Long Term Care Hospital PPS

80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.	N		80
81	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no.	N		81

TEFRA Providers

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

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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
98	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06

Rural Providers

		1	2	
105	Does this hospital qualify as a CAH?	N		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions)			107
	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.			
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	
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.	Speech	Respiratory	109

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

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1.	N		115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.	Y		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118
		Premiums	Paid Losses	Self Insurance
118.01	List amounts of malpractice premiums and paid losses:	52,110	225,453	118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.	N	N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.	N		121
122	Does the cost report contain state health care related taxes as defined in §1903(w)(3) of the Act? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	122

Transplant Center Information

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

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

All Providers

		1	2	
140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)	Y	HB1911	140

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

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

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

		Title XVIII				
		Part A	Part B	Title V	Title XIX	
		1	2	3	4	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N			156
157	Subprovider - IRF	N	N			157
158	Subprovider - Other					158
159	SNF	N	N			159
160	HHA	N	N			160
161	CMHC		N			161
161.10	CORF					161.10

Multicampus

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

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

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE**WORKSHEET S-2
PART II**

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

COMPLETED BY ALL HOSPITALS

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

		Y/N	Type	Date	
Financial Data and Reports		1	2	3	
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	Y	A	02/27/2020	4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N			5

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N		16
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	03/04/2020	N		17
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	Y		N		18
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19
20	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments: SPLIT REVENUE CODES DUE TO SERVICES	Y		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE**WORKSHEET S-2
PART II**

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

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

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

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

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

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

	Y/N	Date	
	1	2	
Home Office Costs			
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: DERRICK	Last name: KEITH	Title: REIMBURSEMENT ACCOUNTANT
42	Employer: ENCOMPASS HEALTH CORPORATION		
43	Phone number: 205-970-7812	E-mail Address: DERRICK.KEITH@ENCOMPASSHEALTH.COM	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
**WORKSHEET S-3
PART I**

		Inpatient Days / Outpatient Visits / Trips								
	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	65	23,725			12,175	472	20,530	1
2	HMO and other (see instructions)						2,936	2,120		2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF									5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		65	23,725			12,175	472	20,530	7
8	Intensive Care Unit	31								8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	Other Special Care (specify)	35								12
13	Nursery	43								13
14	Total (see instructions)		65	23,725			12,175	472	20,530	14
15	CAH Visits									15
16	Subprovider - IPF	40								16
17	Subprovider - IRF	41								17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44								19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101								22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116								24
24.10	Hospice (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	Total (sum of lines 14-26)		65							27
28	Observation Bed Days									28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)									32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33
33.01	LTCH site neutral days and discharges									33.01

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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)					997	38	1,644	1
2	HMO and other (see instructions)					216	164		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)		175.59			997	38	1,644	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)		175.59						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32.01
33	LTCH non-covered days								33
33.01	LTCH site neutral days and discharges								33.01

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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3 PARTS II-III

Part II - Wage Data

		Wkst A Line No.	Amount Reported	Reclass- ification of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)	
		1	2	3	4	5	6	
	SALARIES							
1	Total salaries (see instructions)	200	12,020,538			365,268.80		1
2	Non-physician anesthetist Part A							2
3	Non-physician anesthetist Part B							3
4	Physician-Part A - Administrative							4
4.01	Physician-Part A - Teaching							4.01
5	Physician-Part B							5
6	Non-physician-Part B							6
7	Interns & residents (in an approved program)	21						7
7.01	Contracted interns & residents (in an approved program)							7.01
8	Home office and/or related organization personnel							8
9	SNF	44						9
10	Excluded area salaries (see instructions)			154,708		3,406.42		10
	OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)		68,972			1,074.61		11
12	Contract management and administrative services							12
13	Contract labor: Physician-Part A - Administrative		188,350			1,258.67		13
14	Home office salaries & wage-related costs							14
14.01	Home office salaries		743,514			10,870.00		14.01
14.02	Related organization salaries							14.02
15	Home office: Physician Part A - Administrative							15
16	Home office & Contract Physicians Part A - Teaching							16
	WAGE-RELATED COSTS							
17	Wage-related costs (core)(see instructions)		3,071,504					17
18	Wage-related costs (other)(see instructions)							18
19	Excluded areas		40,047					19
20	Non-physician anesthetist Part A							20
21	Non-physician anesthetist Part B							21
22	Physician Part A - Administrative							22
22.01	Physician Part A - Teaching							22.01
23	Physician Part B							23
24	Wage-related costs (RHC/FQHC)							24
25	Interns & residents (in an approved program)							25
25.50	Home office wage-related		347,380					25.50
25.51	Related organization wage-related							25.51
25.52	Home office: Physician Part A - Administrative - wage-related							25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related							25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26	Employee Benefits Department							26
27	Administrative & General		1,835,728	-154,708		40,772.78		27
28	Administrative & General under contract (see instructions)		72,418			946.23		28
29	Maintenance & Repairs							29
30	Operation of Plant		205,156			5,387.20		30
31	Laundry & Linen Service							31
32	Housekeeping		168,696			12,708.80		32
33	Housekeeping under contract (see instructions)							33
34	Dietary		339,152			18,470.40		34
35	Dietary under contract (see instructions)							35
36	Cafeteria							36
37	Maintenance of Personnel							37
38	Nursing Administration		669,656			17,222.40		38
39	Central Services and Supply							39
40	Pharmacy							40
41	Medical Records & Medical Records Library		86,576			3,432.00		41
42	Social Service		413,184			13,249.60		42
43	Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		12,092,956		12,092,956	366,215.03	33.02	1
2	Excluded area salaries (see instructions)			154,708	154,708	3,406.42	45.42	2
3	Subtotal salaries (line 1 minus line 2)		12,092,956	-154,708	11,938,248	362,808.61	32.91	3
4	Subtotal other wages & related costs (see instructions)		1,000,836		1,000,836	13,203.28	75.80	4
5	Subtotal wage-related costs (see instructions)		3,418,884		3,418,884		28.64%	5
6	Total (sum of lines 3 through 5)		16,512,676	-154,708	16,357,968	376,011.89	43.50	6
7	Total overhead cost (see instructions)		3,790,566	-154,708	3,635,858	112,189.41	32.41	7

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

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions	179,051	1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Nonqualified Defined Benefit Plan Cost (see instructions)		3
4	Qualified Defined Benefit Plan Cost (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA Plan Administration Fees		5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees		7
	HEALTH AND INSURANCE COST		
8	Health Insurance (Purchased or Self Funded)		8
8.01	Health Insurance (Self Funded without a Third Party Administrator)		8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	2,266,328	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)	24,513	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	165,629	15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-Employers Portion Only	867,772	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance		19
20	State or Federal Unemployment Taxes	39,978	20
	OTHER		
21	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)	-431,720	21
22	Day Care Costs and Allowances		22
23	Tuition Reimbursement		23
24	Total Wage Related cost (Sum of lines 1-23)	3,111,551	24

Part B - Other Than Core Related Cost

25	Other Wage Related Costs (SPECIFY)		25
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HOSPITAL CONTRACT LABOR AND BENEFIT COST**WORKSHEET S-3****Part V - Contract Labor and Benefit Cost****PART V****Hospital and Hospital-Based Component Identification:**

	Component	Contract Labor	Benefit Cost	
	0	1	2	
1	Total facility contract labor and benefit cost	257,322	3,111,551	1
2	Hospital	257,322	3,071,504	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		40,047	18

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt		1,005,998	1,005,998	213,892	1,219,890	34,459	1,254,349	1
2	00200	Cap Rel Costs-Mvble Equip		484,069	484,069	52,163	536,232	-8,695	527,537	2
3	00300	Other Cap Rel Costs		239,334	239,334	-239,334			-0-	3
4	00400	Employee Benefits Department		2,471,514	2,471,514		2,471,514	615,241	3,086,755	4
5	00500	Administrative & General	1,835,728	3,779,471	5,615,199	-227,743	5,387,456	-630,287	4,757,169	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	205,156	614,819	819,975	-14,265	805,710	-119,092	686,618	7
8	00800	Laundry & Linen Service		165,265	165,265		165,265		165,265	8
9	00900	Housekeeping	168,696	48,710	217,406	323	217,729		217,729	9
10	01000	Dietary	339,152	395,748	734,900		734,900	-14,549	720,351	10
11	01100	Cafeteria								11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	669,656	14,574	684,230		684,230	-253	683,977	13
14	01400	Central Services & Supply								14
15	01500	Pharmacy								15
16	01600	Medical Records & Library	86,576	4,193	90,769		90,769		90,769	16
17	01700	Social Service	413,184	14,016	427,200		427,200	-538	426,662	17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	4,751,189	87,736	4,838,925	44,350	4,883,275	-14,112	4,869,163	30
		ANCILLARY SERVICE COST CENTERS								
54	05400	Radiology-Diagnostic		52,789	52,789	-35,321	17,468	-2,088	15,380	54
54.01	05401	RADIOLOGY-SUA				57,447	57,447		57,447	54.01
60	06000	Laboratory		577,043	577,043	149,588	726,631	-304,634	421,997	60
60.01	06001	LAB - SUA								60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	326,984	22,749	349,733		349,733	-35	349,698	65
66	06600	Physical Therapy	1,347,735	43,173	1,390,908	-58,696	1,332,212		1,332,212	66
67	06700	Occupational Therapy	1,066,358	33,844	1,100,202	47,345	1,147,547		1,147,547	67
68	06800	Speech Pathology	367,872	8,322	376,194	11,351	387,545		387,545	68
71	07100	Medical Supplies Charged to Patients	29,673	376,026	405,699	14,265	419,964	-87	419,877	71
71.01	07101	COMS - SUA								71.01
73	07300	Drugs Charged to Patients	412,579	552,779	965,358		965,358	-322	965,036	73
76	03550	PSYCHOLOGY								76
76.01	03951	SPECIAL PROCEDURES		233,492	233,492	-231,426	2,066	-406	1,660	76.01
76.02	03952	SPECIAL PROCEDURES - SUA				59,712	59,712		59,712	76.02
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
92	09200	Observation Beds (Non-Distinct Part)								92
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM								93.99
		OTHER REIMBURSABLE COST CENTERS								
101	10100	Home Health Agency		323	323	-323				101
		SPECIAL PURPOSE COST CENTERS								
113	11300	Interest Expense		6,563	6,563		6,563	-6,563		113
118		SUBTOTALS (sum of lines 1-117)	12,020,538	11,232,550	23,253,088	-156,672	23,096,416	-451,961	22,644,455	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen		680	680	-680				190
192	19200	Physicians' Private Offices		2,310	2,310		2,310		2,310	192
194	07950	MARKETING				157,352	157,352		157,352	194
194.01	07951	GUEST MEALS								194.01
194.02	07952	CLINICAL PSYCH								194.02
194.03	07953	NON-CERT O/P CLINIC								194.03
194.04	07954	OPENING/NON-CERT PERIOD								194.04
194.05	07955	STAFFING CONTRACT								194.05
194.06	07956	VACANT SPACE-NON PHYSICIAN								194.06
194.07	07957	PATIENT LODGING								194.07
194.08	07958	HHA DROP SITE								194.08
194.09	07959	IP DEVELOPMENT								194.09
194.10	07960	OTHER NRCC								194.10
200		TOTAL (sum of lines 118-199)	12,020,538	11,235,540	23,256,078		23,256,078	-451,961	22,804,117	200

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RECLASSIFICATIONS

WORKSHEET A-6

		INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER
		1	2	3	4	5
1	INSURANCE	A	Cap Rel Costs-Bldg & Fixt	1		21,481
2	INSURANCE	A	Cap Rel Costs-Mvble Equip	2		5,240
3	INSURANCE	A				
500	Total reclassifications					26,721
	Code Letter - A					
1	MARKETING	B	MARKETING	194	154,708	2,644
2	MARKETING	B				
500	Total reclassifications				154,708	2,644
	Code Letter - B					
1	PHYSICIANS	C	Adults & Pediatrics	30		44,350
2	PHYSICIANS	C				
500	Total reclassifications					44,350
	Code Letter - C					
1	SERVICE UNDER ARRANGEMENT	D	RADIOLOGY-SUA	54.01		57,447
2	SERVICE UNDER ARRANGEMENT	D	SPECIAL PROCEDURES - SUA	76.02		59,712
3	SERVICE UNDER ARRANGEMENT	D				
4	SERVICE UNDER ARRANGEMENT	D				
500	Total reclassifications					117,159
	Code Letter - D					
1	DEPT 283 REHAB TECH EXPENSE	E	Occupational Therapy	67	47,345	
2	DEPT 283 REHAB TECH EXPENSE	E	Speech Pathology	68	11,351	
3	DEPT 283 REHAB TECH EXPENSE	E				
500	Total reclassifications				58,696	
	Code Letter - E					
1	RCL 6511 TO CC71	F	Medical Supplies Charged to P	71		14,265
2	RCL 6511 TO CC71	F				
500	Total reclassifications					14,265
	Code Letter - F					
1	MISC RECLASS - HOME HEALTH	G	Housekeeping	9		323
2	MISC RECLASS - HOME HEALTH	G				
500	Total reclassifications					323
	Code Letter - G					
1	MISC RECLASS - RENAL DIALYSIS	H	Laboratory	60		171,714
2	MISC RECLASS - RENAL DIALYSIS	H				
500	Total reclassifications					171,714
	Code Letter - H					
1	RCL 7544 TO LAB	I				
2	RCL 7544 TO LAB	I	Radiology-Diagnostic	54		22,126
500	Total reclassifications					22,126
	Code Letter - I					
1	RCL	J	Administrative & General	5		680
2	RCL	J				
500	Total reclassifications					680
	Code Letter - J					
	GRAND TOTAL (Increases)				213,404	399,982

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

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RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	DECREASES				Wkst A-7 Ref.	
			COST CENTER	LINE #	SALARY	OTHER		
		1	6	7	8	9	10	
1	INSURANCE	A					12	1
2	INSURANCE	A					12	2
3	INSURANCE	A	Administrative & General	5		26,721		3
500	Total reclassifications					26,721		500
	Code letter - A							
1	MARKETING	B						1
2	MARKETING	B	Administrative & General	5	154,708	2,644		2
500	Total reclassifications				154,708	2,644		500
	Code letter - B							
1	PHYSICIANS	C						1
2	PHYSICIANS	C	Administrative & General	5		44,350		2
500	Total reclassifications					44,350		500
	Code letter - C							
1	SERVICE UNDER ARRANGEMENT	D						1
2	SERVICE UNDER ARRANGEMENT	D						2
3	SERVICE UNDER ARRANGEMENT	D	Radiology-Diagnostic	54		57,447		3
4	SERVICE UNDER ARRANGEMENT	D	SPECIAL PROCEDURES	76.01		59,712		4
500	Total reclassifications					117,159		500
	Code letter - D							
1	DEPT 283 REHAB TECH EXPENSE	E						1
2	DEPT 283 REHAB TECH EXPENSE	E						2
3	DEPT 283 REHAB TECH EXPENSE	E	Physical Therapy	66	58,696			3
500	Total reclassifications				58,696			500
	Code letter - E							
1	RCL 6511 TO CC71	F						1
2	RCL 6511 TO CC71	F	Operation of Plant	7		14,265		2
500	Total reclassifications					14,265		500
	Code letter - F							
1	MISC RECLASS - HOME HEALTH	G						1
2	MISC RECLASS - HOME HEALTH	G	Home Health Agency	101		323		2
500	Total reclassifications					323		500
	Code letter - G							
1	MISC RECLASS - RENAL DIALYSIS	H						1
2	MISC RECLASS - RENAL DIALYSIS	H	SPECIAL PROCEDURES	76.01		171,714		2
500	Total reclassifications					171,714		500
	Code letter - H							
1	RCL 7544 TO LAB	I	Laboratory	60		22,126		1
2	RCL 7544 TO LAB	I						2
500	Total reclassifications					22,126		500
	Code letter - I							
1	RCL	J						1
2	RCL	J	Gift, Flower, Coffee Shop & C	190		680		2
500	Total reclassifications					680		500
	Code letter - J							
	GRAND TOTAL (Decreases)				213,404	399,982		

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

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RECONCILIATION OF CAPITAL COST CENTERS**WORKSHEET A-7
PARTS I, II & III****PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES**

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
			Purchases	Donation	Total				
		1	2	3	4	5	6	7	
1	Land								1
2	Land Improvements	9,720	6,160		6,160		15,880		2
3	Buildings and Fixtures	3,589,249				11,728	3,577,521		3
4	Building Improvements	14,197,783	105,415		105,415	27,757	14,275,441		4
5	Fixed Equipment	4,400,174	133,441		133,441	175,926	4,357,689		5
6	Movable Equipment	36,820				36,820			6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	22,233,746	245,016		245,016	252,231	22,226,531		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	22,233,746	245,016		245,016	252,231	22,226,531		10

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

	Description	SUMMARY OF CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital- Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		9	10	11	12	13	14	15	
*									
1	Cap Rel Costs-Bldg & Fixt	823,906	182,092					1,005,998	1
2	Cap Rel Costs-Mvble Equip	326,652	157,417					484,069	2
3	Total (sum of lines 1-2)	1,150,558	339,509					1,490,067	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	17,868,842		17,868,842	0.803942		192,411		192,411	1
2	Cap Rel Costs-Mvble Equ	4,357,689		4,357,689	0.196058		46,923		46,923	2
3	Total (sum of lines 1-2)	22,226,531		22,226,531	1.000000		239,334		239,334	3

	Description	SUMMARY OF CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital- Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		9	10	11	12	13	14	15	
*									
1	Cap Rel Costs-Bldg & Fixt	911,915	340	128,202	21,481	192,411		1,254,349	1
2	Cap Rel Costs-Mvble Equip	317,957	157,417		5,240	46,923		527,537	2
3	Total (sum of lines 1-2)	1,229,872	157,757	128,202	26,721	239,334		1,781,886	3

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

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ADJUSTMENTS TO EXPENSES**WORKSHEET A-8**

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		Wkst. A-7 Ref.	
				COST CENTER	LINE#		
		1	2	3	4	5	
1	Investment income-buildings & fixtures (chapter 2)			Cap Rel Costs-Bldg & Fixt	1		1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)						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	-13,947				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1	623,313				12
13	Laundry and linen service						13
14	Cafeteria - employees and guests						14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients						16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts						18
19	Nursing and allied health education (tuition, fees, books, etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation						32
33							33
34							34
35							35
36							36
37	INTEREST	A	-6,563	Interest Expense	113	11	37
37.03	INSURANCE	A	622,481	Employee Benefits Department	4		37.03
37.04	INSURANCE	A	-277,077	Administrative & General	5		37.04
37.05	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-112,170	Administrative & General	5		37.05
37.06	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-2,092	Operation of Plant	7		37.06
37.07	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-383	Dietary	10		37.07
37.08	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-253	Nursing Administration	13		37.08
37.09	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-214	Social Service	17		37.09
37.10	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-165	Adults & Pediatrics	30		37.10
37.11	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-35	Respiratory Therapy	65		37.11
37.12	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-87	Medical Supplies Charged to Patients	71		37.12
37.13	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-322	Drugs Charged to Patients	73		37.13
37.14	PATIENT TELEPHONE	A	-300	Cap Rel Costs-Mvble Equip	2	9	37.14
37.15	PATIENT TELEPHONE	A	-7,240	Employee Benefits Department	4		37.15
37.16	PATIENT TELEPHONE	A	-45,266	Administrative & General	5		37.16
37.17	PATIENT TELEVISION	A	-8,376	Cap Rel Costs-Mvble Equip	2	9	37.17
37.18	PATIENT TELEVISION	A	-6,160	Operation of Plant	7		37.18
37.19	PRINTING	A	-2,948	Administrative & General	5		37.19
37.20	PRINTING	A	-2	Operation of Plant	7		37.20
37.21	LOBBYING EXPENSE	A	-1,094	Administrative & General	5		37.21
37.22	MISCELLANEOUS INCOME	B	-8,459	Administrative & General	5		37.22
37.23	MISCELLANEOUS INCOME	B	-14,166	Dietary	10		37.23
37.24	MISCELLANEOUS INCOME	B	-324	Social Service	17		37.24
37.25	PATIENT TRANSPORTATION	A	-19	Cap Rel Costs-Mvble Equip	2	9	37.25
37.26	PATIENT TRANSPORTATION	A	-110,838	Operation of Plant	7		37.26
37.27	MISC. TAX	A	-1,069,657	Administrative & General	5		37.27
37.28	PROFESSIONAL FEES	A	-9,548	Administrative & General	5		37.28
37.29	PHYSICIANS	A	-50	Administrative & General	5		37.29
38							38

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ADJUSTMENTS TO EXPENSES**WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
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)		-451,961				50

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1

(2) Basis for adjustment (see instructions)

A. Costs - if cost, including applicable overhead, can be determined

B. Amount Received - if cost cannot be determined

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

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STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS**WORKSHEET A-8-1****A: COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS
OR CLAIMED HOME OFFICE COSTS:**

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1	5	Administrative & General	TO OFFSET MANAGEMENT FEES		887,306	-887,306		1
2	1	Cap Rel Costs-Bldg & Fixt	TO INCLUDE ALLOWABLE HOME OFFICE COS	88,009		88,009	9	2
3	1	Cap Rel Costs-Bldg & Fixt	TO INCLUDE ALLOWABLE HOME OFFICE COS	128,202		128,202	11	3
3.01	5	Administrative & General	TO INCLUDE ALLOWABLE HOME OFFICE COS	1,601,469		1,601,469		3.01
3.02	5	Administrative & General	TO INCLUDE ALLOWABLE HOME OFFICE COS	184,362		184,362		3.02
3.03	2	Cap Rel Costs-Mvble Equip	INTERCOMPANY WAGE AND EXPENSE TRANSF	2,262	2,262		10	3.03
3.04	4	Employee Benefits Department	INTERCOMPANY WAGE AND EXPENSE TRANSF	1,802,022	1,802,022			3.04
3.05	5	Administrative & General	INTERCOMPANY WAGE AND EXPENSE TRANSF	2,966,917	2,966,917			3.05
3.06	7	Operation of Plant	INTERCOMPANY WAGE AND EXPENSE TRANSF	26,841	26,841			3.06
3.07	8	Laundry & Linen Service	INTERCOMPANY WAGE AND EXPENSE TRANSF	92	92			3.07
3.08	9	Housekeeping	INTERCOMPANY WAGE AND EXPENSE TRANSF	130	130			3.08
3.09	10	Dietary	INTERCOMPANY WAGE AND EXPENSE TRANSF	-5,388	-5,388			3.09
3.10	13	Nursing Administration	INTERCOMPANY WAGE AND EXPENSE TRANSF	97	97			3.10
3.11	16	Medical Records & Library	INTERCOMPANY WAGE AND EXPENSE TRANSF	1,928	1,928			3.11
3.12	17	Social Service	INTERCOMPANY WAGE AND EXPENSE TRANSF	2,402	2,402			3.12
3.13	30	Adults & Pediatrics	INTERCOMPANY WAGE AND EXPENSE TRANSF	647	647			3.13
3.14	54	Radiology-Diagnostic	INTERCOMPANY WAGE AND EXPENSE TRANSF	-6	-6			3.14
3.15	60	Laboratory	INTERCOMPANY WAGE AND EXPENSE TRANSF	-241	-241			3.15
3.16	66	Physical Therapy	INTERCOMPANY WAGE AND EXPENSE TRANSF	1,443	1,443			3.16
3.17	67	Occupational Therapy	INTERCOMPANY WAGE AND EXPENSE TRANSF	181	181			3.17
3.18	68	Speech Pathology	INTERCOMPANY WAGE AND EXPENSE TRANSF	-698	-698			3.18
3.19	71	Medical Supplies Charged to Patients	INTERCOMPANY WAGE AND EXPENSE TRANSF	-8,906	-8,906			3.19
3.20	73	Drugs Charged to Patients	INTERCOMPANY WAGE AND EXPENSE TRANSF	472,375	472,375			3.20
3.21	76.01	SPECIAL PROCEDURES	INTERCOMPANY WAGE AND EXPENSE TRANSF	-3,536	-3,536			3.21
3.22	113	Interest Expense	INTERCOMPANY WAGE AND EXPENSE TRANSF	6,563	6,563			3.22
3.23	1	Cap Rel Costs-Bldg & Fixt	RELATED PARTY - GROUND LEASE		181,752	-181,752	10	3.23
3.24	5	Administrative & General	RELATED PARTY - RMH	1,909	4,452	-2,543		3.24
3.25	54	Radiology-Diagnostic	RELATED PARTY - RMH	667	2,755	-2,088		3.25
3.26	60	Laboratory	RELATED PARTY - RMH	153,789	458,423	-304,634		3.26
3.27	76.01	SPECIAL PROCEDURES	RELATED PARTY - RMH	195	601	-406		3.27
4								4
5		TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12		7,423,727	6,800,414	623,313		5

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

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

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

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

				Related Organization(s) and/or Home Office	
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STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS**WORKSHEET A-8-1****B. INTERRELATIONSHIP OF RELATED ORGANIZATION(S) AND/OR HOME OFFICE:**

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

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

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

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
6	B		50.00	ENCOMPASS HEALTH CORPORATION		HEALTHCARE	6
7	B		50.00	ROCKFORD HEALTH SYSTEM VENTURE		HEALTHCARE	7
8	G	ENCOMPASS HEALTH CORPORATION				HEALTHCARE	8
9	G	ROCKFORD HEALTH SYSTEM				HEALTHCARE	9
10							10

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

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

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun- eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	30	Adults & Pediatrics AGGREGATE	44,350		44,350	211,500	299	30,403	1,520	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	44,350		44,350		299	30,403	1,520	200

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VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/18/2020 Run Time: 13:38 Version: 2018.12 (04/03/2020)
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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 AGGREGATE					30,403	13,947	13,947	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					30,403	13,947	13,947	200

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VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/18/2020 Run Time: 13:38 Version: 2018.12 (04/03/2020)
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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)	ADMINIS- TRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	1,254,349	1,254,349					1
2	Cap Rel Costs-Mvble Equip	527,537		527,537				2
4	Employee Benefits Department	3,086,755			3,086,755			4
5	Administrative & General	4,757,169	25,505	10,726	431,669	5,225,069	5,225,069	5
6	Maintenance & Repairs							6
7	Operation of Plant	686,618	342,464	144,029	52,682	1,225,793	366,790	7
8	Laundry & Linen Service	165,265	6,517	2,741		174,523	52,222	8
9	Housekeeping	217,729	8,465	3,560	43,319	273,073	81,711	9
10	Dietary	720,351	67,175	28,251	87,091	902,868	270,162	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	683,977	33,242	13,980	171,961	903,160	270,250	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	90,769	12,015	5,053	22,232	130,069	38,920	16
17	Social Service	426,662	8,374	3,522	106,102	544,660	162,977	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	4,869,163	444,191	186,812	1,220,059	6,720,225	2,010,872	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	15,380	1,456	612		17,448	5,221	54
54.01	RADIOLOGY-SUA	57,447				57,447		54.01
60	Laboratory	421,997				421,997	126,273	60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	349,698	7,883	3,315	83,966	444,862	133,115	65
66	Physical Therapy	1,332,212	118,057	49,651	331,012	1,830,932	547,864	66
67	Occupational Therapy	1,147,547	138,537	58,264	285,988	1,630,336	487,841	67
68	Speech Pathology	387,545	5,097	2,144	97,381	492,167	147,270	68
71	Medical Supplies Charged to Patients	419,877	9,921	4,173	7,620	441,591	132,136	71
71.01	COMS - SUA							71.01
73	Drugs Charged to Patients	965,036	11,396	4,793	105,946	1,087,171	325,311	73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES	1,660				1,660	497	76.01
76.02	SPECIAL PROCEDURES - SUA	59,712				59,712		76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	22,644,455	1,240,295	521,626	3,047,028	22,584,763	5,159,432	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices	2,310	12,889	5,421		20,620	6,170	192
194	MARKETING	157,352	1,165	490	39,727	198,734	59,467	194
194.01	GUEST MEALS							194.01
194.02	CLINICAL PSYCH							194.02
194.03	NON-CERT O/P CLINIC							194.03
194.04	OPENING/NON-CERT PERIOD							194.04
194.05	STAFFING CONTRACT							194.05
194.06	VACANT SPACE-NON PHYSICIAN							194.06
194.07	PATIENT LODGING							194.07
194.08	HHA DROP SITE							194.08
194.09	IP DEVELOPMENT							194.09
194.10	OTHER NRCC							194.10
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	22,804,117	1,254,349	527,537	3,086,755	22,804,117	5,225,069	202

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VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/18/2020 Run Time: 13:38 Version: 2018.12 (04/03/2020)
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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 ADMINIS- TRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	1,592,583						7
8	Laundry & Linen Service	11,710	238,455					8
9	Housekeeping	15,210		369,994				9
10	Dietary	120,695		28,522	1,322,247			10
11	Cafeteria				129,026	129,026		11
12	Maintenance of Personnel							12
13	Nursing Administration	59,726		14,114		8,975	1,256,225	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	21,588		5,102		1,160		16
17	Social Service	15,046		3,556		5,538		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	798,089	238,455	188,602	1,158,918	63,681	1,256,225	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	2,617		618				54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory							60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	14,163		3,347		4,383		65
66	Physical Therapy	212,115		50,127		17,277		66
67	Occupational Therapy	248,913		58,822		14,927		67
68	Speech Pathology	9,158		2,164		5,083		68
71	Medical Supplies Charged to Patients	17,826		4,213		398		71
71.01	COMS - SUA							71.01
73	Drugs Charged to Patients	20,476		4,839		5,530		73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES							76.01
76.02	SPECIAL PROCEDURES - SUA							76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	1,567,332	238,455	364,026	1,287,944	126,952	1,256,225	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices	23,158		5,473				192
194	MARKETING	2,093		495		2,074		194
194.01	GUEST MEALS				34,303			194.01
194.02	CLINICAL PSYCH							194.02
194.03	NON-CERT O/P CLINIC							194.03
194.04	OPENING/NON-CERT PERIOD							194.04
194.05	STAFFING CONTRACT							194.05
194.06	VACANT SPACE-NON PHYSICIAN							194.06
194.07	PATIENT LODGING							194.07
194.08	HHA DROP SITE							194.08
194.09	IP DEVELOPMENT							194.09
194.10	OTHER NRCC							194.10
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,592,583	238,455	369,994	1,322,247	129,026	1,256,225	202

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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		
	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	196,839						16
17	Social Service		731,777					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	93,874	731,777	13,260,718		13,260,718		30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	578		26,482		26,482		54
54.01	RADIOLOGY-SUA			57,447		57,447		54.01
60	Laboratory	8,720		556,990		556,990		60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	4,840		604,710		604,710		65
66	Physical Therapy	26,049		2,684,364		2,684,364		66
67	Occupational Therapy	24,682		2,465,521		2,465,521		67
68	Speech Pathology	5,918		661,760		661,760		68
71	Medical Supplies Charged to Patients	7,108		603,272		603,272		71
71.01	COMS - SUA							71.01
73	Drugs Charged to Patients	25,057		1,468,384		1,468,384		73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES	13		2,170		2,170		76.01
76.02	SPECIAL PROCEDURES - SUA			59,712		59,712		76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	196,839	731,777	22,451,530		22,451,530		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices			55,421		55,421		192
194	MARKETING			262,863		262,863		194
194.01	GUEST MEALS			34,303		34,303		194.01
194.02	CLINICAL PSYCH							194.02
194.03	NON-CERT O/P CLINIC							194.03
194.04	OPENING/NON-CERT PERIOD							194.04
194.05	STAFFING CONTRACT							194.05
194.06	VACANT SPACE-NON PHYSICIAN							194.06
194.07	PATIENT LODGING							194.07
194.08	HHA DROP SITE							194.08
194.09	IP DEVELOPMENT							194.09
194.10	OTHER NRCC							194.10
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	196,839	731,777	22,804,117		22,804,117		202

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGs & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	ADMINIS- TRATIVE & GENERAL	OPERATION OF PLANT	
		0	1	2	2A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General		25,505	10,726	36,231	36,231		5
6	Maintenance & Repairs							6
7	Operation of Plant		342,464	144,029	486,493	2,544	489,037	7
8	Laundry & Linen Service		6,517	2,741	9,258	362	3,596	8
9	Housekeeping		8,465	3,560	12,025	567	4,670	9
10	Dietary		67,175	28,251	95,426	1,873	37,062	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration		33,242	13,980	47,222	1,874	18,340	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		12,015	5,053	17,068	270	6,629	16
17	Social Service		8,374	3,522	11,896	1,130	4,620	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		444,191	186,812	631,003	13,943	245,071	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic		1,456	612	2,068	36	804	54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory					876		60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		7,883	3,315	11,198	923	4,349	65
66	Physical Therapy		118,057	49,651	167,708	3,799	65,135	66
67	Occupational Therapy		138,537	58,264	196,801	3,383	76,434	67
68	Speech Pathology		5,097	2,144	7,241	1,021	2,812	68
71	Medical Supplies Charged to Patients		9,921	4,173	14,094	916	5,474	71
71.01	COMS - SUA							71.01
73	Drugs Charged to Patients		11,396	4,793	16,189	2,256	6,287	73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES					3		76.01
76.02	SPECIAL PROCEDURES - SUA							76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)		1,240,295	521,626	1,761,921	35,776	481,283	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices		12,889	5,421	18,310	43	7,111	192
194	MARKETING		1,165	490	1,655	412	643	194
194.01	GUEST MEALS							194.01
194.02	CLINICAL PSYCH							194.02
194.03	NON-CERT O/P CLINIC							194.03
194.04	OPENING/NON-CERT PERIOD							194.04
194.05	STAFFING CONTRACT							194.05
194.06	VACANT SPACE-NON PHYSICIAN							194.06
194.07	PATIENT LODGING							194.07
194.08	HHA DROP SITE							194.08
194.09	IP DEVELOPMENT							194.09
194.10	OTHER NRCC							194.10
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		1,254,349	527,537	1,781,886	36,231	489,037	202

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VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/18/2020 Run Time: 13:38 Version: 2018.12 (04/03/2020)
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ALLOCATION OF CAPITAL-RELATED COSTS
**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	MEDICAL RECORDS & LIBRARY	
		8	9	10	11	13	16	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	13,216						8
9	Housekeeping		17,262					9
10	Dietary		1,331	135,692				10
11	Cafeteria			13,241	13,241			11
12	Maintenance of Personnel							12
13	Nursing Administration		658		921	69,015		13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		238		119		24,324	16
17	Social Service		166		568			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	13,216	8,799	118,931	6,538	69,015	11,605	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic		29				71	54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory						1,077	60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		156		450		598	65
66	Physical Therapy		2,339		1,772		3,218	66
67	Occupational Therapy		2,744		1,531		3,049	67
68	Speech Pathology		101		521		731	68
71	Medical Supplies Charged to Patients		197		41		878	71
71.01	COMS - SUA							71.01
73	Drugs Charged to Patients		226		567		3,095	73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES						2	76.01
76.02	SPECIAL PROCEDURES - SUA							76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	13,216	16,984	132,172	13,028	69,015	24,324	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices		255					192
194	MARKETING		23		213			194
194.01	GUEST MEALS			3,520				194.01
194.02	CLINICAL PSYCH							194.02
194.03	NON-CERT O/P CLINIC							194.03
194.04	OPENING/NON-CERT PERIOD							194.04
194.05	STAFFING CONTRACT							194.05
194.06	VACANT SPACE-NON PHYSICIAN							194.06
194.07	PATIENT LODGING							194.07
194.08	HHA DROP SITE							194.08
194.09	IP DEVELOPMENT							194.09
194.10	OTHER NRCC							194.10
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	13,216	17,262	135,692	13,241	69,015	24,324	202

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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			
	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	18,380						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	18,380	1,136,501		1,136,501			30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic		3,008		3,008			54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory		1,953		1,953			60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		17,674		17,674			65
66	Physical Therapy		243,971		243,971			66
67	Occupational Therapy		283,942		283,942			67
68	Speech Pathology		12,427		12,427			68
71	Medical Supplies Charged to Patients		21,600		21,600			71
71.01	COMS - SUA							71.01
73	Drugs Charged to Patients		28,620		28,620			73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES		5		5			76.01
76.02	SPECIAL PROCEDURES - SUA							76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	18,380	1,749,701		1,749,701			118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices		25,719		25,719			192
194	MARKETING		2,946		2,946			194
194.01	GUEST MEALS		3,520		3,520			194.01
194.02	CLINICAL PSYCH							194.02
194.03	NON-CERT O/P CLINIC							194.03
194.04	OPENING/NON-CERT PERIOD							194.04
194.05	STAFFING CONTRACT							194.05
194.06	VACANT SPACE-NON PHYSICIAN							194.06
194.07	PATIENT LODGING							194.07
194.08	HHA DROP SITE							194.08
194.09	IP DEVELOPMENT							194.09
194.10	OTHER NRCC							194.10
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	18,380	1,781,886		1,781,886			202

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VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/18/2020 Run Time: 13:38 Version: 2018.12 (04/03/2020)
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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	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM. COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	68,903						1
2	Cap Rel Costs-Mvble Equip		68,903					2
4	Employee Benefits Department			12,020,538				4
5	Administrative & General	1,401	1,401	1,681,020	-5,225,069	17,461,889		5
6	Maintenance & Repairs							6
7	Operation of Plant	18,812	18,812	205,156		1,225,793	48,690	7
8	Laundry & Linen Service	358	358			174,523	358	8
9	Housekeeping	465	465	168,696		273,073	465	9
10	Dietary	3,690	3,690	339,152		902,868	3,690	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	1,826	1,826	669,656		903,160	1,826	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	660	660	86,576		130,069	660	16
17	Social Service	460	460	413,184		544,660	460	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	24,400	24,400	4,751,189		6,720,225	24,400	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	80	80			17,448	80	54
54.01	RADIOLOGY-SUA				-57,447			54.01
60	Laboratory					421,997		60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	433	433	326,984		444,862	433	65
66	Physical Therapy	6,485	6,485	1,289,039		1,830,932	6,485	66
67	Occupational Therapy	7,610	7,610	1,113,703		1,630,336	7,610	67
68	Speech Pathology	280	280	379,223		492,167	280	68
71	Medical Supplies Charged to Patients	545	545	29,673		441,591	545	71
71.01	COMS - SUA							71.01
73	Drugs Charged to Patients	626	626	412,579		1,087,171	626	73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES					1,660		76.01
76.02	SPECIAL PROCEDURES - SUA				-59,712			76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	68,131	68,131	11,865,830	-5,342,228	17,242,535	47,918	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices	708	708			20,620	708	192
194	MARKETING	64	64	154,708		198,734	64	194
194.01	GUEST MEALS							194.01
194.02	CLINICAL PSYCH							194.02
194.03	NON-CERT O/P CLINIC							194.03
194.04	OPENING/NON-CERT PERIOD							194.04
194.05	STAFFING CONTRACT							194.05
194.06	VACANT SPACE-NON PHYSICIAN							194.06
194.07	PATIENT LODGING							194.07
194.08	HHA DROP SITE							194.08
194.09	IP DEVELOPMENT							194.09
194.10	OTHER NRCC							194.10
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,254,349	527,537	3,086,755		5,225,069	1,592,583	202
203	Unit Cost Multiplier (Wkst. B, Part I)	18.204563	7.656227	0.256790		0.299227	32.708626	203
204	Cost to be allocated (Per Wkst. B, Part II)					36,231	489,037	204
205	Unit Cost Multiplier (Wkst. B, Part II)					0.002075	10.043890	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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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 ADMINIS- TRATION PATIENT DAYS	MEDICAL RECORDS & LIBRARY GROSS REVENUE	
		8	9	10	11	13	16	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	20,530						8
9	Housekeeping		47,867					9
10	Dietary		3,690	70,270				10
11	Cafeteria			6,857	9,626,514			11
12	Maintenance of Personnel							12
13	Nursing Administration		1,826		669,656	20,530		13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		660		86,576		43,580,494	16
17	Social Service		460		413,184			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	20,530	24,400	61,590	4,751,189	20,530	20,785,250	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic		80				128,054	54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory						1,930,478	60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		433		326,984		1,071,467	65
66	Physical Therapy		6,485		1,289,039		5,766,938	66
67	Occupational Therapy		7,610		1,113,703		5,464,290	67
68	Speech Pathology		280		379,223		1,310,078	68
71	Medical Supplies Charged to Patients		545		29,673		1,573,628	71
71.01	COMS - SUA							71.01
73	Drugs Charged to Patients		626		412,579		5,547,353	73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES						2,958	76.01
76.02	SPECIAL PROCEDURES - SUA							76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	20,530	47,095	68,447	9,471,806	20,530	43,580,494	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices		708					192
194	MARKETING		64		154,708			194
194.01	GUEST MEALS			1,823				194.01
194.02	CLINICAL PSYCH							194.02
194.03	NON-CERT O/P CLINIC							194.03
194.04	OPENING/NON-CERT PERIOD							194.04
194.05	STAFFING CONTRACT							194.05
194.06	VACANT SPACE-NON PHYSICIAN							194.06
194.07	PATIENT LODGING							194.07
194.08	HHA DROP SITE							194.08
194.09	IP DEVELOPMENT							194.09
194.10	OTHER NRCC							194.10
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	238,455	369,994	1,322,247	129,026	1,256,225	196,839	202
203	Unit Cost Multiplier (Wkst. B, Part I)	11.614954	7.729626	18.816664	0.013403	61.189722	0.004517	203
204	Cost to be allocated (Per Wkst. B, Part II)	13,216	17,262	135,692	13,241	69,015	24,324	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.643741	0.360624	1.931009	0.001375	3.361666	0.000558	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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

	COST CENTER DESCRIPTIONS	SOCIAL SERVICE PATIENT DAYS						
		17						

	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service	20,530						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	20,530						30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic							54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory							60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients							71
71.01	COMS - SUA							71.01
73	Drugs Charged to Patients							73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES							76.01
76.02	SPECIAL PROCEDURES - SUA							76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	20,530						118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192
194	MARKETING							194
194.01	GUEST MEALS							194.01
194.02	CLINICAL PSYCH							194.02
194.03	NON-CERT O/P CLINIC							194.03
194.04	OPENING/NON-CERT PERIOD							194.04
194.05	STAFFING CONTRACT							194.05
194.06	VACANT SPACE-NON PHYSICIAN							194.06
194.07	PATIENT LODGING							194.07
194.08	HHA DROP SITE							194.08
194.09	IP DEVELOPMENT							194.09
194.10	OTHER NRCC							194.10
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	731,777						202
203	Unit Cost Multiplier (Wkst. B, Part I)	35.644277						203
204	Cost to be allocated (Per Wkst. B, Part II)	18,380						204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.895275						205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

KPMG LLP Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/18/2020 Run Time: 13:38 Version: 2018.12 (04/03/2020)
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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		AMOUNT	
		CODE	LINE NO.		
	1	2	3	4	

KPMG LLP Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/18/2020 Run Time: 13:38 Version: 2018.12 (04/03/2020)
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COMPUTATION OF RATIO OF COST TO CHARGES
**WORKSHEET C
PART I**

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	13,260,718		13,260,718	13,947	13,274,665	30
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	26,482		26,482		26,482	54
54.01	RADIOLOGY-SUA	57,447		57,447		57,447	54.01
60	Laboratory	556,990		556,990		556,990	60
60.01	LAB - SUA						60.01
62.30	BLOOD CLOTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	604,710		604,710		604,710	65
66	Physical Therapy	2,684,364		2,684,364		2,684,364	66
67	Occupational Therapy	2,465,521		2,465,521		2,465,521	67
68	Speech Pathology	661,760		661,760		661,760	68
71	Medical Supplies Charged to Patients	603,272		603,272		603,272	71
71.01	COMS - SUA						71.01
73	Drugs Charged to Patients	1,468,384		1,468,384		1,468,384	73
76	PSYCHOLOGY						76
76.01	SPECIAL PROCEDURES	2,170		2,170		2,170	76.01
76.02	SPECIAL PROCEDURES - SUA	59,712		59,712		59,712	76.02
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct Part)						92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency						101
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	22,451,530		22,451,530	13,947	22,465,477	200
201	Less Observation Beds						201
202	Total (line 200 minus line 201)	22,451,530		22,451,530		22,465,477	202

KPMG LLP Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/18/2020 Run Time: 13:38 Version: 2018.12 (04/03/2020)
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COMPUTATION OF RATIO OF COST TO CHARGES
**WORKSHEET C
PART I**

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	20,785,250		20,785,250				30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	128,054		128,054	0.206803	0.206803	0.206803	54
54.01	RADIOLOGY-SUA	421,132		421,132	0.136411	0.136411	0.136411	54.01
60	Laboratory	1,930,478		1,930,478	0.288524	0.288524	0.288524	60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,071,467		1,071,467	0.564376	0.564376	0.564376	65
66	Physical Therapy	5,766,938		5,766,938	0.465475	0.465475	0.465475	66
67	Occupational Therapy	5,464,290		5,464,290	0.451206	0.451206	0.451206	67
68	Speech Pathology	1,310,078		1,310,078	0.505130	0.505130	0.505130	68
71	Medical Supplies Charged to Patients	1,573,628		1,573,628	0.383364	0.383364	0.383364	71
71.01	COMS - SUA							71.01
73	Drugs Charged to Patients	5,547,353		5,547,353	0.264700	0.264700	0.264700	73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES	2,958		2,958	0.733604	0.733604	0.733604	76.01
76.02	SPECIAL PROCEDURES - SUA	85,542		85,542	0.698043	0.698043	0.698043	76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	44,087,168		44,087,168				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	44,087,168		44,087,168				202

KPMG LLP Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/18/2020 Run Time: 13:38 Version: 2018.12 (04/03/2020)
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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)
**WORKSHEET C
PART I**

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	13,260,718		13,260,718	13,947	13,274,665	30
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	26,482		26,482		26,482	54
54.01	RADIOLOGY-SUA	57,447		57,447		57,447	54.01
60	Laboratory	556,990		556,990		556,990	60
60.01	LAB - SUA						60.01
62.30	BLOOD CLOTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	604,710		604,710		604,710	65
66	Physical Therapy	2,684,364		2,684,364		2,684,364	66
67	Occupational Therapy	2,465,521		2,465,521		2,465,521	67
68	Speech Pathology	661,760		661,760		661,760	68
71	Medical Supplies Charged to Patients	603,272		603,272		603,272	71
71.01	COMS - SUA						71.01
73	Drugs Charged to Patients	1,468,384		1,468,384		1,468,384	73
76	PSYCHOLOGY						76
76.01	SPECIAL PROCEDURES	2,170		2,170		2,170	76.01
76.02	SPECIAL PROCEDURES - SUA	59,712		59,712		59,712	76.02
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct Part)						92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency						101
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	22,451,530		22,451,530	13,947	22,465,477	200
201	Less Observation Beds						201
202	Total (line 200 minus line 201)	22,451,530		22,451,530	13,947	22,465,477	202

KPMG LLP Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/18/2020 Run Time: 13:38 Version: 2018.12 (04/03/2020)
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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)
**WORKSHEET C
PART I**

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	20,785,250		20,785,250				30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	128,054		128,054	0.206803	0.206803	0.206803	54
54.01	RADIOLOGY-SUA	421,132		421,132	0.136411	0.136411	0.136411	54.01
60	Laboratory	1,930,478		1,930,478	0.288524	0.288524	0.288524	60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,071,467		1,071,467	0.564376	0.564376	0.564376	65
66	Physical Therapy	5,766,938		5,766,938	0.465475	0.465475	0.465475	66
67	Occupational Therapy	5,464,290		5,464,290	0.451206	0.451206	0.451206	67
68	Speech Pathology	1,310,078		1,310,078	0.505130	0.505130	0.505130	68
71	Medical Supplies Charged to Patients	1,573,628		1,573,628	0.383364	0.383364	0.383364	71
71.01	COMS - SUA							71.01
73	Drugs Charged to Patients	5,547,353		5,547,353	0.264700	0.264700	0.264700	73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES	2,958		2,958	0.733604	0.733604	0.733604	76.01
76.02	SPECIAL PROCEDURES - SUA	85,542		85,542	0.698043	0.698043	0.698043	76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	44,087,168		44,087,168				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	44,087,168		44,087,168				202

KPMG LLP Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/18/2020 Run Time: 13:38 Version: 2018.12 (04/03/2020)
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CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY
**WORKSHEET C
PART II**
[] Title V
[XX] Title XIX

	COST CENTER DESCRIPTIONS	Total Cost (Wkst B, Part I, col. 26)	Capital Cost (Wkst B, Part II, col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	
		1	2	3	4	
	ANCILLARY SERVICE COST CENTERS					
54	Radiology-Diagnostic	26,482	3,008	23,474		54
54.01	RADIOLOGY-SUA	57,447		57,447		54.01
60	Laboratory	556,990	1,953	555,037		60
60.01	LAB - SUA					60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy	604,710	17,674	587,036		65
66	Physical Therapy	2,684,364	243,971	2,440,393		66
67	Occupational Therapy	2,465,521	283,942	2,181,579		67
68	Speech Pathology	661,760	12,427	649,333		68
71	Medical Supplies Charged to Patients	603,272	21,600	581,672		71
71.01	COMS - SUA					71.01
73	Drugs Charged to Patients	1,468,384	28,620	1,439,764		73
76	PSYCHOLOGY					76
76.01	SPECIAL PROCEDURES	2,170	5	2,165		76.01
76.02	SPECIAL PROCEDURES - SUA	59,712		59,712		76.02
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
92	Observation Beds (Non-Distinct Part)					92
93.99	PARTIAL HOSPITALIZATION PROGRAM					93.99
	OTHER REIMBURSABLE COST CENTERS					
101	Home Health Agency					101
113	Interest Expense					113
200	Subtotal	9,190,812	613,200	8,577,612		200
201	Less Observation Beds					201
202	Total	9,190,812	613,200	8,577,612		202

KPMG LLP Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/18/2020 Run Time: 13:38 Version: 2018.12 (04/03/2020)
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CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY
**WORKSHEET C
PART II**
☐ Title V

☒ Title XIX

	COST CENTER DESCRIPTIONS	Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Wkst C, Part I, col. 8)	Outpatient Cost to Charge Ratio(col. 6 ÷ col. 7)	
		5	6	7	8	
	ANCILLARY SERVICE COST CENTERS					
54	Radiology-Diagnostic		26,482	128,054	0.206803	54
54.01	RADIOLOGY-SUA		57,447	421,132	0.136411	54.01
60	Laboratory		556,990	1,930,478	0.288524	60
60.01	LAB - SUA					60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy		604,710	1,071,467	0.564376	65
66	Physical Therapy		2,684,364	5,766,938	0.465475	66
67	Occupational Therapy		2,465,521	5,464,290	0.451206	67
68	Speech Pathology		661,760	1,310,078	0.505130	68
71	Medical Supplies Charged to Patients		603,272	1,573,628	0.383364	71
71.01	COMS - SUA					71.01
73	Drugs Charged to Patients		1,468,384	5,547,353	0.264700	73
76	PSYCHOLOGY					76
76.01	SPECIAL PROCEDURES		2,170	2,958	0.733604	76.01
76.02	SPECIAL PROCEDURES - SUA		59,712	85,542	0.698043	76.02
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
92	Observation Beds (Non-Distinct Part)					92
93.99	PARTIAL HOSPITALIZATION PROGRAM					93.99
	OTHER REIMBURSABLE COST CENTERS					
101	Home Health Agency					101
113	Interest Expense					113
200	Subtotal		9,190,812	23,301,918		200
201	Less Observation Beds					201
202	Total		9,190,812	23,301,918		202

KPMG LLP Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/18/2020 Run Time: 13:38 Version: 2018.12 (04/03/2020)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust- ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	1,136,501		1,136,501	20,530	55.36	12,175	674,008	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)	1,136,501		1,136,501	20,530		12,175	674,008	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/18/2020 Run Time: 13:38 Version: 2018.12 (04/03/2020)
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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

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	3,008	128,054	0.023490	67,589	1,588	54
54.01	RADIOLOGY-SUA		421,132		222,281		54.01
60	Laboratory	1,953	1,930,478	0.001012	1,195,807	1,210	60
60.01	LAB - SUA						60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	17,674	1,071,467	0.016495	682,323	11,255	65
66	Physical Therapy	243,971	5,766,938	0.042305	3,443,356	145,671	66
67	Occupational Therapy	283,942	5,464,290	0.051963	3,250,102	168,885	67
68	Speech Pathology	12,427	1,310,078	0.009486	720,697	6,837	68
71	Medical Supplies Charged to Pat	21,600	1,573,628	0.013726	982,277	13,483	71
71.01	COMS - SUA						71.01
73	Drugs Charged to Patients	28,620	5,547,353	0.005159	3,256,943	16,803	73
76	PSYCHOLOGY						76
76.01	SPECIAL PROCEDURES	5	2,958	0.001690	1,339	2	76.01
76.02	SPECIAL PROCEDURES - SUA		85,542		38,711		76.02
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct						92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	613,200	23,301,918		13,861,425	365,734	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/18/2020 Run Time: 13:38 Version: 2018.12 (04/03/2020)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D PART III

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

☒ PPS
☐ TEFRA
☐ Other

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

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/18/2020 Run Time: 13:38 Version: 2018.12 (04/03/2020)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

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

☒ PPS
☐ TEFRA
☐ Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass- Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	20,530		12,175		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)	20,530		12,175		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/18/2020 Run Time: 13:38 Version: 2018.12 (04/03/2020)
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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 Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
54	Radiology-Diagnostic									54
54.01	RADIOLOGY-SUA									54.01
60	Laboratory									60
60.01	LAB - SUA									60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
71	Medical Supplies Charged to Pat									71
71.01	COMS - SUA									71.01
73	Drugs Charged to Patients									73
76	PSYCHOLOGY									76
76.01	SPECIAL PROCEDURES									76.01
76.02	SPECIAL PROCEDURES - SUA									76.02
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
92	Observation Beds (Non-Distinct									92
93.99	PARTIAL HOSPITALIZATION PROGRAM									93.99
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/18/2020 Run Time: 13:38 Version: 2018.12 (04/03/2020)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-3028

WORKSHEET D
PART IV

Check
Applicable
Boxes:

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

☒ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☒ PPS
☐ TEFRA
☐ Other

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass- Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass- Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	128,054			67,589				54
54.01	RADIOLOGY-SUA	421,132			222,281				54.01
60	Laboratory	1,930,478			1,195,807				60
60.01	LAB - SUA								60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	1,071,467			682,323				65
66	Physical Therapy	5,766,938			3,443,356				66
67	Occupational Therapy	5,464,290			3,250,102				67
68	Speech Pathology	1,310,078			720,697				68
71	Medical Supplies Charged to Pat	1,573,628			982,277				71
71.01	COMS - SUA								71.01
73	Drugs Charged to Patients	5,547,353			3,256,943				73
76	PSYCHOLOGY								76
76.01	SPECIAL PROCEDURES	2,958			1,339				76.01
76.02	SPECIAL PROCEDURES - SUA	85,542			38,711				76.02
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	23,301,918			13,861,425				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/18/2020 Run Time: 13:38 Version: 2018.12 (04/03/2020)
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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 [XX] Hospital [] SUB (Other) [] Swing Bed SNF
Applicable [XX] Title XVIII, Part B [] IPF [] SNF [] Swing Bed NF
Boxes: [] Title XIX - O/P [] IRF [] NF [] ICF/IID

(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost			
			PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
	ANCILLARY SERVICE COST CENTERS	1	2	3	4	5	6	7	
54	Radiology-Diagnostic	0.206803							54
54.01	RADIOLOGY-SUA	0.136411							54.01
60	Laboratory	0.288524							60
60.01	LAB - SUA								60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.564376							65
66	Physical Therapy	0.465475							66
67	Occupational Therapy	0.451206							67
68	Speech Pathology	0.505130							68
71	Medical Supplies Charged to Pat	0.383364							71
71.01	COMS - SUA								71.01
73	Drugs Charged to Patients	0.264700							73
76	PSYCHOLOGY								76
76.01	SPECIAL PROCEDURES	0.733604							76.01
76.02	SPECIAL PROCEDURES - SUA	0.698043							76.02
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/18/2020 Run Time: 13:38 Version: 2018.12 (04/03/2020)
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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 Adjust- ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	1,136,501		1,136,501	20,530	55.36	472	26,130	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)	1,136,501		1,136,501	20,530		472	26,130	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/18/2020 Run Time: 13:38 Version: 2018.12 (04/03/2020)
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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

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	3,008	128,054	0.023490	1,975	46	54
54.01	RADIOLOGY-SUA		421,132		6,496		54.01
60	Laboratory	1,953	1,930,478	0.001012	41,486	42	60
60.01	LAB - SUA						60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	17,674	1,071,467	0.016495	21,190	350	65
66	Physical Therapy	243,971	5,766,938	0.042305	129,660	5,485	66
67	Occupational Therapy	283,942	5,464,290	0.051963	124,535	6,471	67
68	Speech Pathology	12,427	1,310,078	0.009486	34,380	326	68
71	Medical Supplies Charged to Pat	21,600	1,573,628	0.013726	17,802	244	71
71.01	COMS - SUA						71.01
73	Drugs Charged to Patients	28,620	5,547,353	0.005159	122,555	632	73
76	PSYCHOLOGY						76
76.01	SPECIAL PROCEDURES	5	2,958	0.001690			76.01
76.02	SPECIAL PROCEDURES - SUA		85,542				76.02
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct						92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	613,200	23,301,918		500,079	13,596	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/18/2020 Run Time: 13:38 Version: 2018.12 (04/03/2020)
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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 Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjust- ment Amount (see instruct- ions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	Cost Center Description	1A	1	2A	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)								30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	TOTAL (lines 30-199)								200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/18/2020 Run Time: 13:38 Version: 2018.12 (04/03/2020)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

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

☐ PPS
☐ TEFRA
☒ Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass- Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	20,530		472		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)	20,530		472		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/18/2020 Run Time: 13:38 Version: 2018.12 (04/03/2020)
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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 Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
54	Radiology-Diagnostic									54
54.01	RADIOLOGY-SUA									54.01
60	Laboratory									60
60.01	LAB - SUA									60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
71	Medical Supplies Charged to Pat									71
71.01	COMS - SUA									71.01
73	Drugs Charged to Patients									73
76	PSYCHOLOGY									76
76.01	SPECIAL PROCEDURES									76.01
76.02	SPECIAL PROCEDURES - SUA									76.02
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
92	Observation Beds (Non-Distinct									92
93.99	PARTIAL HOSPITALIZATION PROGRAM									93.99
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/18/2020 Run Time: 13:38 Version: 2018.12 (04/03/2020)
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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)	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	128,054			1,975				54
54.01	RADIOLOGY-SUA	421,132			6,496				54.01
60	Laboratory	1,930,478			41,486				60
60.01	LAB - SUA								60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	1,071,467			21,190				65
66	Physical Therapy	5,766,938			129,660				66
67	Occupational Therapy	5,464,290			124,535				67
68	Speech Pathology	1,310,078			34,380				68
71	Medical Supplies Charged to Pat	1,573,628			17,802				71
71.01	COMS - SUA								71.01
73	Drugs Charged to Patients	5,547,353			122,555				73
76	PSYCHOLOGY								76
76.01	SPECIAL PROCEDURES	2,958							76.01
76.02	SPECIAL PROCEDURES - SUA	85,542							76.02
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	23,301,918			500,079				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/18/2020 Run Time: 13:38 Version: 2018.12 (04/03/2020)
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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	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost			
			PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
	ANCILLARY SERVICE COST CENTERS	1	2	3	4	5	6	7	
54	Radiology-Diagnostic	0.206803							54
54.01	RADIOLOGY-SUA	0.136411							54.01
60	Laboratory	0.288524							60
60.01	LAB - SUA								60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.564376							65
66	Physical Therapy	0.465475							66
67	Occupational Therapy	0.451206							67
68	Speech Pathology	0.505130							68
71	Medical Supplies Charged to Pat	0.383364							71
71.01	COMS - SUA								71.01
73	Drugs Charged to Patients	0.264700							73
76	PSYCHOLOGY								76
76.01	SPECIAL PROCEDURES	0.733604							76.01
76.02	SPECIAL PROCEDURES - SUA	0.698043							76.02
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/18/2020 Run Time: 13:38 Version: 2018.12 (04/03/2020)
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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)	20,530	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	20,530	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)	20,530	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)	12,175	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)	13,274,665	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)	13,274,665	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 31)		32
33	Average semi-private room per diem charge (line 30 ÷ line 31)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	13,274,665	37

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VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/18/2020 Run Time: 13:38 Version: 2018.12 (04/03/2020)
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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)						646.60 38
39	Program general inpatient routine service cost (line 9 x line 38)						7,872,355 39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)						7,872,355 41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
							1
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						5,474,401 48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						13,346,756 49
PASS THROUGH COST ADJUSTMENTS							
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						674,008 50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						365,734 51
52	Total Program excludable cost (sum of lines 50 and 51)						1,039,742 52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						12,307,014 53
TARGET AMOUNT AND LIMIT COMPUTATION							
54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63
PROGRAM INPATIENT ROUTINE SWING BED COST							
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

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VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/18/2020 Run Time: 13:38 Version: 2018.12 (04/03/2020)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-3028

WORKSHEET D-1
PARTS III & IV

Check
Applicable
Boxes:

☐ Title V - I/P

☒ Title XVIII, Part A

☐ Title XIX - I/P

☒ Hospital

☐ IPF

☐ IRF

☐ SUB (Other)

☐ SNF

☐ NF

☐ ICF/IID

☒ PPS

☐ TEFRA

☐ Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)						87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					646.60	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

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VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/18/2020 Run Time: 13:38 Version: 2018.12 (04/03/2020)
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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)	20,530	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	20,530	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)	20,530	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)	472	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)	13,260,718	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)	13,260,718	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 31)		32
33	Average semi-private room per diem charge (line 30 ÷ line 31)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	13,260,718	37

KPMG LLP Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/18/2020 Run Time: 13:38 Version: 2018.12 (04/03/2020)
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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)						645.92 38
39	Program general inpatient routine service cost (line 9 x line 38)						304,874 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)						304,874 41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
							1
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						198,398 48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						503,272 49
PASS THROUGH COST ADJUSTMENTS							
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						26,130 50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						13,596 51
52	Total Program excludable cost (sum of lines 50 and 51)						39,726 52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						53
TARGET AMOUNT AND LIMIT COMPUTATION							
54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63
PROGRAM INPATIENT ROUTINE SWING BED COST							
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

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VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/18/2020 Run Time: 13:38 Version: 2018.12 (04/03/2020)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-3028

WORKSHEET D-1
PARTS III & IV

Check
Applicable
Boxes:

☐ Title V - I/P

☐ Title XVIII, Part A

☒ Title XIX - I/P

☒ Hospital

☐ IPF

☐ IRF

☐ SUB (Other)

☐ SNF

☐ NF

☐ ICF/IID

☐ PPS

☐ TEFRA

☒ Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

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

KPMG LLP Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/18/2020 Run Time: 13:38 Version: 2018.12 (04/03/2020)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-3028

WORKSHEET D-3

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		12,318,545		30
	ANCILLARY SERVICE COST CENTERS				
54	Radiology-Diagnostic	0.206803	67,589	13,978	54
54.01	RADIOLOGY-SUA	0.136411	222,281	30,322	54.01
60	Laboratory	0.288524	1,195,807	345,019	60
60.01	LAB - SUA				60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.564376	682,323	385,087	65
66	Physical Therapy	0.465475	3,443,356	1,602,796	66
67	Occupational Therapy	0.451206	3,250,102	1,466,466	67
68	Speech Pathology	0.505130	720,697	364,046	68
71	Medical Supplies Charged to Patients	0.383364	982,277	376,570	71
71.01	COMS - SUA				71.01
73	Drugs Charged to Patients	0.264700	3,256,943	862,113	73
76	PSYCHOLOGY				76
76.01	SPECIAL PROCEDURES	0.733604	1,339	982	76.01
76.02	SPECIAL PROCEDURES - SUA	0.698043	38,711	27,022	76.02
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
92	Observation Beds (Non-Distinct Part)				92
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		13,861,425	5,474,401	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		13,861,425		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/18/2020 Run Time: 13:38 Version: 2018.12 (04/03/2020)
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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	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		478,136		30
	ANCILLARY SERVICE COST CENTERS				
54	Radiology-Diagnostic	0.206803	1,975	408	54
54.01	RADIOLOGY-SUA	0.136411	6,496	886	54.01
60	Laboratory	0.288524	41,486	11,970	60
60.01	LAB - SUA				60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.564376	21,190	11,959	65
66	Physical Therapy	0.465475	129,660	60,353	66
67	Occupational Therapy	0.451206	124,535	56,191	67
68	Speech Pathology	0.505130	34,380	17,366	68
71	Medical Supplies Charged to Patients	0.383364	17,802	6,825	71
71.01	COMS - SUA				71.01
73	Drugs Charged to Patients	0.264700	122,555	32,440	73
76	PSYCHOLOGY				76
76.01	SPECIAL PROCEDURES	0.733604			76.01
76.02	SPECIAL PROCEDURES - SUA	0.698043			76.02
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
92	Observation Beds (Non-Distinct Part)				92
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		500,079	198,398	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		500,079		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/18/2020 Run Time: 13:38 Version: 2018.12 (04/03/2020)
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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 OPPS (see instructions)				2
3	OPPS payments				3
4	Outlier payment (see instructions)				4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (see instructions)				21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)				26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)				27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)				30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)				32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)				34
35	Adjusted reimbursable bad debts (see instructions)				35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)				36
37	Subtotal (see instructions)				37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)				40
40.01	Sequestration adjustment (see instructions)				40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments				41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)				43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

KPMG LLP Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/18/2020 Run Time: 13:38 Version: 2018.12 (04/03/2020)
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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	
			mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT
DESCRIPTION			1	2	3	4
1	Total interim payments paid to provider			20,185,625		1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero					2
3	List separately each retroactive lump sum adjustment	.01	05/03/2019	5,466		3.01
	amount based on subsequent revision of the interim	.02	06/28/2019	21,487		3.02
	rate for the cost reporting period. Also show date of	Program				3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to				3.04
		Provider				3.05
		.06				3.06
		.07				3.07
		.08				3.08
		.09				3.09
		.10				3.10
		.50				3.50
		.51				3.51
		Provider				3.52
		to				3.53
		Program				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		26,953		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)			20,212,578		4
TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment	.01				5.01
	after desk review. Also show date of each payment.	.02				5.02
	If none, write 'NONE' or enter a zero. (1)	Program				5.03
		to				5.04
		Provider				5.05
		.06				5.06
		.07				5.07
		.08				5.08
		.09				5.09
		.10				5.10
		.50				5.50
		.51				5.51
		Provider				5.52
		to				5.53
		Program				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)	

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

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VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/18/2020 Run Time: 13:38 Version: 2018.12 (04/03/2020)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-3028

WORKSHEET E-3
PART III

Check ☒ 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)	19,884,882		1
2	Medicare SSI ratio (IRF PPS only) (see instructions)	0.036300		2
3	Inpatient Rehabilitation LIP payments (see instructions)	974,359		3
4	Outlier payments	41,373		4
5	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			5
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) OR (2)			5.01
6	New teaching program adjustment (see instructions)			6
7	Current year unweighted FTE count of I&R excludnig FTEs in the new program growth period of a 'new teaching program' (see instructions)			7
8	Current year unweighted I&R FTE count for residents within the new program growth period of a 'new teaching program' (see instructions)			8
9	Intern and resident count for IRF PPS medical education adjustment (see instructions)			9
10	Average daily census (see instructions)	56.246575		10
11	Teaching Adjustment Factor (see instructions)			11
12	Teaching Adjustment (see instructions)			12
13	Total PPS Payment (see instructions)	20,900,614		13
14	Nursing and allied health managed care payments (see instructions)			14
15	Organ acquisition DO NOT USE THIS LINE			15
16	Cost of physicians' services in a teaching hospital (see instructions)			16
17	Subtotal (see instructions)	20,900,614		17
18	Primary payer payments	10,330		18
19	Subtotal (line 17 less line 18)	20,890,284		19
20	Deductibles	278,016		20
21	Subtotal (line 19 minus line 20)	20,612,268		21
22	Coinsurance	64,419		22
23	Subtotal (line 21 minus line 22)	20,547,849		23
24	Allowable bad debts (exclude bad debts for professional services) (see instructions)	100,773		24
25	Adjusted reimbursable bad debts (see instructions)	65,502		25
26	Allowable bad debts for dual eligible beneficiaries (see instructions)	65,137		26
27	Subtotal (sum of lines 23 and 25)	20,613,351		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)	20,613,351		32
32.01	Sequestration adjustment (see instructions)	412,267		32.01
32.02	Demonstration payment adjustment amount after sequestration			32.02
33	Interim payments	20,212,578		33
34	Tentative settlement (for contractor use only)			34
35	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33 and 34)	-11,494		35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	601,837		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 ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/18/2020 Run Time: 13:38 Version: 2018.12 (04/03/2020)
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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 ☒ Other

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	503,272		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	503,272		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	503,272		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges	478,136		8
9	Ancillary service charges	500,079		9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)	978,215		12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a charge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)	978,215		16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	474,943		17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)	503,272		21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)	503,272		29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)			30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	503,272		31
32	Deductibles			32
33	Coinsurance	220,473		33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)	282,799		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	282,799		38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)	282,799		40
41	Interim payments	400,435		41
42	Balance due provider/program (line 40 minus line 41)	-117,636		42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

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VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/18/2020 Run Time: 13:38 Version: 2018.12 (04/03/2020)
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BALANCE SHEET**WORKSHEET G**

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

	Assets (Omit Cents)	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	3,091,092				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	6,560,619				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-1,552,964				6
7	Inventory	96,396				7
8	Prepaid expenses	19,565				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	8,214,708				11
	FIXED ASSETS					
12	Land					12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings	16,960,007				15
16	Accumulated depreciation	-8,895,950				16
17	Leasehold improvements	908,835				17
18	Accumulated depreciation	-422,500				18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	4,376,322				23
24	Accumulated depreciation	-3,660,962				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	9,265,752				30
	OTHER ASSETS					
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	4,085,560				34
35	Total other assets (sum of lines 31-34)	4,085,560				35
36	Total assets (sum of lines 11, 30 and 35)	21,566,020				36
	Liabilities and Fund Balances (Omit Cents)	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable	601,272				37
38	Salaries, wages and fees payable	1,150,663				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	1,439,037				44
45	Total current liabilities (sum of lines 37 thru 44)	3,190,972				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	9,647,657				49
50	Total long term liabilities (sum of lines 46 thru 49)	9,647,657				50
51	Total liabilities (sum of lines 45 and 50)	12,838,629				51
	CAPITAL ACCOUNTS					
52	General fund balance	8,727,391				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	8,727,391				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	21,566,020				60

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VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/18/2020 Run Time: 13:38 Version: 2018.12 (04/03/2020)
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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		8,613,400		1
2	Net income (loss) (from Worksheet G-3, line 29)		8,748,863		2
3	Total (sum of line 1 and line 2)		17,362,263		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)		17,362,263		11
12	Deductions (debit adjustments) (specify)				12
13	DISTRIBUTIONS	4,260,440			13
14	MINORITY INTEREST EXPENSE	4,374,432			14
15					15
16					16
17					17
18	Total deductions (sum of lines 12-17)		8,634,872		18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		8,727,391		19

		ENDOWMENT FUND		PLANT FUND	
		5	6	7	8
1	Fund balances at beginning of period				1
2	Net income (loss) (from Worksheet G-3, line 29)				2
3	Total (sum of line 1 and line 2)				3
4	Additions (credit adjustments) (specify)				4
5					5
6					6
7					7
8					8
9					9
10	Total additions (sum of lines 4-9)				10
11	Subtotal (line 3 plus line 10)				11
12	Deductions (debit adjustments) (specify)				12
13	DISTRIBUTIONS				13
14	MINORITY INTEREST 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 ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/18/2020 Run Time: 13:38 Version: 2018.12 (04/03/2020)
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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	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	20,785,250		20,785,250	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)	20,785,250		20,785,250	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit				11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)				16
17	Total inpatient routine care services (sum of lines 10 and 16)	20,785,250		20,785,250	17
18	Ancillary services	23,302,005	-87	23,301,918	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)	44,087,255	-87	44,087,168	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		23,256,078	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)		23,256,078	43

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VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/18/2020 Run Time: 13:38 Version: 2018.12 (04/03/2020)
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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)	44,087,168	1
2	Less contractual allowances and discounts on patients' accounts	13,267,123	2
3	Net patient revenues (line 1 minus line 2)	30,820,045	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	23,256,078	4
5	Net income from service to patients (line 3 minus line 4)	7,563,967	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments	57,875	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts	5	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	16,621	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	38	20
21	Rental of vending machines		21
22	Rental of hosptial space	17,746	22
23	Governmental appropriations		23
24	Other (specify)	1,092,611	24
25	Total other income (sum of lines 6-24)	1,184,896	25
26	Total (line 5 plus line 25)	8,748,863	26
29	Net income (or loss) for the period (line 26 minus line 28)	8,748,863	29