This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-3025 Worksheet S Peri od: From 08/01/2022 Parts I-III AND SETTLEMENT SUMMARY 07/31/2023 Date/Time Prepared: 11/15/2023 8: 13 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 11/15/2023 8: 13 am] Manually prepared cost report use only Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. NPR Date:
[12] 13. NPR Date:
[13] 14. NPR Date:
[14] 15. NPR Date:
[15] 15. NPR Date:
[16] 16. NPR Date:
[17] 17. NPR Date:
[18] 17. NPR Date:
[18] 18. NPR Date:
[18] 18. NPR Date:
[18] 19. NPR Da Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

(5) Amended

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 submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ENCOMPASS HEALTH DEACONESS REHABILIT (15-3025) for the cost reporting period beginning 08/01/2022 and ending 07/31/2023 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.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SI GNATURE STATEMENT	
1	Ro	b Wisner	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Rob Wisner			2
3	Signatory Title	SVP - REIMBURSEMENT			3
4	Date	11/15/2023 08: 13: 20 AM			4

			Title	XVIII			
		Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	-261, 273	0	0	88, 167	1.00
2.00	SUBPROVI DER - I PF	0	0	0		0	2.00
3.00	SUBPROVI DER - I RF	0	0	0		0	3. 00
5.00	SWING BED - SNF	0	0	0		0	5. 00
6.00	SWING BED - NF	0				0	6. 00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7. 00
8.00	NURSING FACILITY	0				0	8. 00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9. 00
12.00	CMHC I	0		0		0	12.00
200.00	TOTAL	0	-261, 273	0	0	88, 167	200. 00
		the applicable			ho above comple		200.00

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 number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 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 the 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.

Health Financial Systems ENCOMPASS HEALTH DEACONESS REHABILIT In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-3025 Peri od: Worksheet S-2 From 08/01/2022 To 07/31/2023 Part I Date/Time Prepared: 11/15/2023 8:13 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 9355 WARRICK TRAIL 1.00 PO Box: 1.00 State: IN 2.00 City: NEWBURGH Zip Code: 47630 County: VANDERBURGH 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N) Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 ENCOMPASS HEALTH 153025 21780 5 06/08/1989 Ν 3.00 DEACONESS REHABILIT Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF 7 00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 17. 10 Hospi tal -Based (CORF) I 17.10 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 08/01/2022 07/31/2023 20.00 21.00 Type of Control (see instructions) 5 21.00 1.00 3.00 2.00 Inpatient PPS Information 22. 00 Does this facility qualify and is it currently receiving payments for N N 22.00 disproportionate share hospital adjustment, 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 Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim UCPs, including supplemental UCPs, for Ν 22.01 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) 22.02 Is this a newly merged hospital that requires a final UCP to be 22.02 Ν Ν 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. 22.03 Did this hospital receive a geographic reclassification from urban to Ν Ν N 22.03 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. 22.04 Did this hospital receive a geographic reclassification from urban to 22 04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? 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. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 3 Ν 23.00 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.

near tr	Financial Systems ENCOMPASS HE	ALTH DEACON	IESS REHABIL	J.T	_	In Lieu	u of For	m CMS-	2552-10
HOSPI	TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA	Provider CC	N: 15-3025	Period: From 08/0 To 07/3	1/2022 1/2023	Worksho Part I Date/Ti 11/15/2	ime Pre	pared:
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medica HMO da	ys Med	ther di cai d days	
24. 00	If this provider is an IPPS hospital, enter the	1.00	2.00	3.00	4. 00	5. 00	0	5. 00	24.00
25. 00	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.	258			205		560		25. 00
					Urban/R				
26. 00	Enter your standard geographic classification (not wa	age) status	at the bed	inning of t	1. (1	2.	00	26. 00
27. 00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not we reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi	r rural. age) status r "2" for r ication in	at the end ural. If ap column 2.	of the cos oplicable,	t	1			27. 00
35. 00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	e number of	periods SC	H status ir		0			35. 00
					Begi nr 1. (Endi 2.		
36. 00			cript line	36 for numb		50		00	36. 00
37. 00	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter		r of period	ls MDH statu	s	0			37. 00
37. 01	is in effect in the cost reporting period.	he MDH tran	sitional pa	yment in					37. 01
38. 00	instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.	s of MDH st	atus. If li	ne 37 is					38. 00
	jenter subsequent dates.				Y/		Υ/		
39. 00	Does this facility qualify for the inpatient hospital	l payment a	diustment f	for Low volu	1. (me N		2.		39. 00
	hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions)), (ii), or the mileage ii)? Enter	(iii)? Ent requiremen in column 2	er in colum its in !"Y" for ye	in es				
40. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to October in column 2, for discharges on or after October 1.	ber 1. Ente	r "Y" for y				Ņ	I	40.00
	, , , , , , , , , , , , , , , , , , ,					V 1.00	XVIII 2. 00	XIX	
	Prospective Payment System (PPS)-Capital					1.00	2.00	3.00	
45. 00	Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions)	nt for disp	roporti onat	e share in	accordance	N	N	N	45. 00
46. 00	Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete Wks	•		,		N	N	N	46. 00
47. 00 48. 00	00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.							N N	47. 00 48. 00
56. 00	Teaching Hospitals Is this a hospital involved in training residents in	approved G	ME programs	? For cost	reporti na	N	Т		56. 00
	periods beginning prior to December 27, 2020, enter cost reporting periods beginning on or after December the instructions. For column 2, if the response to convolved in training residents in approved GME program are you are impacted by CR 11642 (or applicable of "Y" for yes; otherwise, enter "N" for no in column 2.	"Y" for yes r 27, 2020, olumn 1 is ams in the CRs) MA dir	or "N" for under 42 C "Y", or if prior year	no in colu FR 413.78(b this hospit or penultim	mn 1. For)(2), see al was ate year,				
	For cost reporting periods beginning prior to December	er 27, 2020		66, column 1 IGME progra					57. 00

Health Financial Systems ENCOMPASS HEA	ALTH DE	ACONESS REHABI	LIT	In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provi der CO		Period: From 08/01/2022	Worksheet S-2 Part I	
				o 07/31/2023	Date/Time Pre	
				V	XVIII XIX	13 am
					2.00 3.00	
59.00 Are costs claimed on line 100 of Worksheet A? If yes	, compl	lete Wkst. D-2,		N		59. 00
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qual i fi cati on	
			1710	Little #	Criterion Code	
60.00 Are you claiming nursing and allied health education	(NAHE)	costs for	1. 00 N	2.00	3.00	60.00
any programs that meet the criteria under 42 CFR 413.			14			00.00
instructions) Enter "Y" for yes or "N" for no in col						
is "Y", are you impacted by CR 11642 (or subsequent C adjustment? Enter "Y" for yes or "N" for no in colum		E MA payment				
jaaj as tillottet. Ettest 1 tot 700 St. 11 tot 110 ttl Sot all	Y/N	IME	Direct GME	IME	Direct GME	
	1 00	2.00	2 00	4.00	F 00	
61.00 Did your hospital receive FTE slots under ACA	1. 00 N	2. 00	3. 00	4.00	5.00	61. 00
section 5503? Enter "Y" for yes or "N" for no in						
column 1. (see instructions) 61.01 Enter the average number of unweighted primary care						61, 01
FTEs from the hospital's 3 most recent cost reports						01.01
ending and submitted before March 23, 2010. (see						
instructions) 61.02 Enter the current year total unweighted primary care						61. 02
FTE count (excluding OB/GYN, general surgery FTEs,						
and primary care FTEs added under section 5503 of ACA). (see instructions)						
61.03 Enter the base line FTE count for primary care						61. 03
and/or general surgery residents, which is used for						
determining compliance with the 75% test. (see instructions)						
61.04 Enter the number of unweighted primary care/or						61. 04
surgery allopathic and/or osteopathic FTEs in the						
current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary						61. 05
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)						
61.06 Enter the amount of ACA §5503 award that is being						61. 06
used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						
care or general surgery. (see mistractions)	Pr	ogram Name	Program Code	Unweighted IME	Unwei ghted	
				FTE Count	Direct GME FTE	
		1.00	2. 00	3.00	4. 00	
61.10 Of the FTEs in line 61.05, specify each new program		1.00	2.00	0.00		61. 10
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.						
61.20 Of the FTEs in line 61.05, specify each expanded				0.00	0.00	61. 20
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, the direct GME FTE unweighted count.						
The direct one fire dimensification count.	'					
ACA Draviolana Affactive the Health December 1	n.d.a	Adminiat	(HDCA)		1.00	
ACA Provisions Affecting the Health Resources and Ser 62.00 Enter the number of FTE residents that your hospital				iod for which	0.00	62. 00
your hospital received HRSA PCRE funding (see instruc	tions)					
62.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC program.				your hospital	0.00	62. 01
Teaching Hospitals that Claim Residents in Nonprovide	er Sett	i ngs				
63.00 Has your facility trained residents in nonprovider se					N	63. 00
"Y" for yes or "N" for no in column 1. If yes, comple	ece iine	es 64 through 6	o. (see instr	uctions)	I	l

Health Financial Sy HOSPITAL AND HOSPIT		ENCOMPASS HEALEX IDENTIFICATION DA		NESS REHABII Provider CC		Period: From 08/01/2022 To 07/31/2023		pared:
					Unwei ghted FTEs Nonprovi der Si te	FTEs in	Ratio (col. 1/ (col. 1 + col. 2))	
Soction FEO4	of the ACA Page Ver	r FTE Residents in No	annrovi dor	Cottings -	1.00	2.00	3.00	
peri od that I	begins on or after J	uly 1, 2009 and befor	e June 30), 2010.	s base yea		. epoi triig	
64.00 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) Program Name Program Code Unweighted							0. 000000	64.00
		Program Name	3		Unwei ghted FTEs Nonprovi der Si te	FTES in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
4E 00 Enton in!	ump 1 if line /2	1. 00	2	2. 00	3. 00	4.00	5.00	4E 00
year period, associated w FTEs for each program in w residents. Eithe program column 3, the unweighted presidents at rotations occurred for the properties of the properties of the president for the unweighted president FTE your hospital 5, the ratio	cour facility dents in the base the program name ith primary care in primary care hich you trained her in column 2, code. Enter in e number of rimary care FTE tributable to curring in all settings. Enter in e number of rimary care s that trained in l. Enter in column of (column 3 column 3 + column				O. Unwei ghted		0.00000C	
					FTĔs	FTEs in	(col. 1 + col.	
					Nonprovi der Si te	Hospi tal	2))	
					1. 00	2. 00	3.00	
		Year FTE Residents in 10	n Nonprovi	der Settings	sEffective	for cost report	ing periods	
beginning on or after July 1, 2010 66.00 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)						0.00		
		Program Name	Progr	ram Code	Unwei ghted FTEs Nonprovi der Si te	FTES in	Ratio (col. 3/ (col. 3 + col. 4))	
67 00 Entor in cal	umn 1 the program	1.00	2	2. 00	3. 00	4.00	5.00	67.00
your primary which you tra Enter in col- code. Enter in number of un care FTE res to rotations non-provider column 4, th unweighted president FTE your hospital 5, the ratio	ted with each of care programs in ained residents. Jumn 2, the program in column 3, the weighted primary idents attributable occurring in all settings. Enter in a number of rimary care s that trained in L. Enter in column of (column 3 column 3 + column				0.	0.00	0. 00000C	, 67. UU

	Did this facility establish a new Other subprovider (excluded unit) under	42 CFR Section	1		86. 00
07.00	§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified u	under ceetien		N	87. 00
67.00	1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	under Section		IN	87.00
	TOOO(d)(1)(b)(vi): Litter 1 101 yes of N 101 110.		Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments 2.00	
88. 00	Column 1: Is this hospital approved for a permanent adjustment to the TEFI amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete composed (see instructions) Column 2: Enter the number of approved permanent adjustments.				0 88.00
	cordinar 2. Litter the number of approved permanent adjustments.	Wkst. A Line No.	Effective Date	Approved Permanent Adjustment Amount Per Discharge	
		1. 00	2.00	3. 00	
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.	0.00			0 89.00
	The same same same same same same same sam	'	V	XI X	
			1. 00	2.00	
00 00	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? En	nton "V" for	NI NI	Υ	00.00
90.00	yes or "N" for no in the applicable column.	nter y for	N	Y	90.00
91. 00	Is this hospital reimbursed for title V and/or XIX through the cost reportull or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	Υ	91. 00
	fiult of the part: Enter it for yes or in for no fir the applicable corunni.	1	NI.	92.00	
92. 00	Are title XIX NF patients occupying title XVIII SNF beds (dual certifications) Enter "Y" for yes or "N" for no in the applicable column.	ion)? (see		N	72.00
93. 00	Are title XIX NF patients occupying title XVIII SNF beds (dual certificationstructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and "Y" for yes or "N" for no in the applicable column.	d XIX? Enter	N	N	93. 00
93. 00 94. 00	Are title XIX NF patients occupying title XVIII SNF beds (dual certificationstructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and "Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no applicable column.	d XIX? Enter	N	N N	93. 00
93. 00 94. 00 95. 00	Are title XIX NF patients occupying title XVIII SNF beds (dual certificationstructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and "Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no applicable column. If line 94 is "Y", enter the reduction percentage in the applicable column	d XIX? Enter o in the n.	N 0. 00	N N O. OO	93. 00 94. 00 95. 00
93. 00 94. 00 95. 00 96. 00	Are title XIX NF patients occupying title XVIII SNF beds (dual certificationstructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and "Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no applicable column.	d XIX? Enter o in the n. o in the	N	N N	93.00

Heal th Financial Systems ENCOMPASS HEALTH DEF				u or Form CMS-	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C	F	Period: From 08/01/2022 Fo 07/31/2023	Worksheet S-2 Part I Date/Time Pro	
		'	10 07/31/2023	11/15/2023 8:	
	<u>'</u>	<u>'</u>	V	XI X	
			1. 00	2.00	
98.00 Does title V or XIX follow Medicare (title XVIII) for the ir stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" f column 1 for title V, and in column 2 for title XIX.			N	Y	98. 00
98.01 Does title V or XIX follow Medicare (title XVIII) for the reC, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title XIX.			N	Y	98. 01
98.02 Does title V or XIX follow Medicare (title XVIII) for the cabed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes of			N	Y	98. 02
for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) for a crit reimbursed 101% of inpatient services cost? Enter "Y" for ye 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 outpatient services cost? Enter "Y" for yes or "N" for no ir in column 2 for title XIX.	N	N	98. 04		
98.05 Does title V or XIX follow Medicare (title XVIII) and add ba Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in a column 2 for title XIX.	N	Y	98. 05		
98.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.			N	Υ	98. 06
Rural Providers			<u>'</u>		
105.00 Does this hospital qualify as a CAH? 106.00 If this facility qualifies as a CAH, has it elected the all-	inclusive met	hod of payment	N		105. 00 106. 00
for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for cotraining programs? Enter "Y" for yes or "N" for no in column	1. (see ins	tructions)			107. 00
Column 2: If column 1 is Y and line 70 or line 75 is Y, do approved medical education program in the CAH's excluded IF Enter "Y" for yes or "N" for no in column 2. (see instructi	F and/or IRF				
108.00 is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche		N		108. 00
	Physi cal	Occupati onal	Speech	Respi ratory	
400 001 0 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1. 00	2.00	3. 00	4. 00	100.00
109.00 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 no for each therapy.					109. 00
				1.00	
110.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "complete Worksheet E, Part A, lines 200 through 218, and Worapplicable.	Y" for yes or	"N" for no. I	f yes,	N	110. 00
***************************************			1.00	2.00	111 00
111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this compared in the Testing of the FCHIP demonstration properties of the FCHIP demonstration of the FCHIP d	st reporting lumn 1 is Y, ticipating in	period? Enter enter the column 2.	N		111. 00
		1. 00	2. 00	3. 00	
112.00 Did this hospital participate in the Pennsylvania Rural Heal (PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If come "Y", enter in column 2, the date the hospital began participate demonstration. In column 3, enter the date the hospital cea	porting lumn 1 is ating in the	N			112. 00
participation in the demonstration, if applicable.					4
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, E		N			0 115. 00
in column 2. If column 2 is "E", enter in column 3 either "9 for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider	3" percent includes				
the definition in CMS Pub.15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" "N" for no.	for yes or	N			116. 00
117.00 Is this facility legally-required to carry malpractice insur "Y" for yes or "N" for no.	ance? Enter	Y			117. 00
118.00 is the malpractice insurance a claims-made or occurrence polif the policy is claim-made. Enter 2 if the policy is occurr			1		118. 00
1 2 4 6 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2					

142.00 Street: 9001 LIBERTY PARKWAY PO Box: 143.00 Ci ty: BI RMI NGHAM State: AL Zi p Code:	N N Y	N	121. 00 122. 00 123. 00 125. 00 126. 00 127. 00 128. 00 129. 00 130. 00
122.00 Does the cost report contain healthcare related taxes as defined in \$1903(w)(3) of the Act2Fnter "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. 123.00 Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no. Certified Transplant Center Information 125.00 Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare-certified ing transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 131.00 If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 132.00 If this is a Medicare-certified incestinal transplant program, enter the certification date	Y	N	123. 00 125. 00 126. 00 127. 00 128. 00 129. 00 130. 00 131. 00
123.00 bld the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no. Certified Transplant Center Information 125.00 Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 131.00 If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 132.00 If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 132.00 If this is a hospital-based organ procurement organization (0PO), enter the OPO number in column 1 and termination date, if applicable, in column 2. 134.00 If this is a ho		N	125. 00 126. 00 127. 00 128. 00 129. 00 130. 00 131. 00
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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) 1.00 2.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name home office and enter the home office contractor name and contractor number. 141.00 Name: ENCOMPASS HEALTH Contractor's Name: PALMETTO PO Box: 143.00 City: BIRMINGHAM State: AL Zip Code:		LIDAGAA	
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142. 00 Street: 9001 LI BERTY PARKWAY P0 Box: 143. 00 Ci ty: BI RMI NGHAM State: AL Zi p Code:	and address	or the	
143.00 Ci ty: BI RMI NGHAM State: AL Zi p Code:	s Number: 1000	01	141. 00 142. 00
	3524	42	143. 00
		1.00	-
144.00 Are provider based physicians' costs included in Worksheet A?		Y	144. 00
	1 00	2.00	
145.00 f costs for renal services are claimed on Wkst. A, line 74, are the costs for	1. 00	2.00	145. 00
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.			110.00
146.00 Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "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.			146. 00

Health Financial Systems	ENCOMPASS HEALTH DEA					u of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENIIFICATION DATA	Provi der CC	:N: 15-3025		d: 08/01/2022 07/31/2023	Worksheet S- Part I Date/Time Pr 11/15/2023 8	epared:
147.00 Was there a change in the statisti	cal basis? Enter "V" for y	ves or "N" for	no			1. 00 N	147. 00
148.00 Was there a change in the order of						N N	148. 00
149.00 Was there a change to the simplifi				or no.		N N	149. 00
		Part A	Part B		Title V	Title XIX	1
		1.00	2.00		3. 00	4.00	
Does this facility contain a prov or charges? Enter "Y" for yes or							
155. 00 Hospi tal	10 101 10 101 cach compone	N N	N N). (SCC -	N N	N N	155. 00
156. 00 Subprovi der - I PF		N	N N		N	N N	156. 00
157. 00 Subprovi der - IRF		N	N		N	N	157. 00
158. 00 SUBPROVI DER							158. 00
159. 00 SNF		N	N		N	N	159. 00
160.00 HOME HEALTH AGENCY		N	N		N	N	160.00
161. 00 CMHC			N		N	N	161. 00
161. 10 CORF			N		N	N	161. 10
						1.00	
Multicampus 165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that has one	e or more campu	ıses in dif	ferent C	CBSAs?	N	165. 00
Effect 1 for yes of it for he.	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1. 00	2.00	3. 00	4. 00	5. 00	7
166.00 If line 165 is yes, for each						O. C	0 166. 00
campus enter the name in column							
O, county in column 1, state in							
column 2, zip code in column 3,							
CBSA in column 4, FTE/Campus in							
column 5 (see instructions)							
						1.00	
Health Information Technology (HI				nent Act			
167.00 Is this provider a meaningful user						N	167. 00
168.00 If this provider is a CAH (line 10			e 167 is "Y	"), ente	er the		168. 00
reasonable cost incurred for the I			andifi f	h	adobi n		168. 01
exception under §413.70(a)(6)(ii)					usni p		108.01
169.00 f this provider is a meaningful u					enter the	0.0	00169.00
transition factor. (see instruction		13 1101 4 0/11 (11110 100 1	3 11),	circoi tilo	0.0	79107.00
(222 1122 222				В	egi nni ng	Endi ng	
					1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR I period respectively (mm/dd/yyyy)	peginning date and ending o	date for the re	eporti ng				170. 00
da. jjjj					1 00	2.00	
171 00 If line 147 is "V" does this	don have any days for the	dividual a an!	lod in		1. 00	2. 00	0171 00
171.00 If line 167 is "Y", does this pro- section 1876 Medicare cost plans i "Y" for yes and "N" for no in colu 1876 Medicare days in column 2. (s	reported on Wkst. S-3, Pt. umn 1. If column 1 is yes,	I, line 2, col	. 6? Enter				0 171. 00

PI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider Co	CN: 15-3025	Peri od: From 08/01/2022 To 07/31/2023	Worksheet S-2 Part II Date/Time Pre 11/15/2023 8:	pared
				Y/N	Date	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE	MENT OHESTIONN	IA I DE	1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS			er all dates in t	he	
	Provider Organization and Operation					1
	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in co			N		1.0
	Topor tring portion. IT yes, enter the date of the change in o	01 diii1 2. (300	Y/N	Date	V/I	
			1.00	2. 00	3. 00	
0	Has the provider terminated participation in the Medicare Pryes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.		N			2.
0	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home or or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members or of directors through ownership, control, or family and other	ffices, drug er or its f the board	N			3. (
	relationships? (see instructions)		Y/N	Tuno	Date	
			1.00	7ype 2, 00	3. 00	
0	Financial Data and Reports Column 1: Were the financial statements prepared by a Certification of the Column 2: If yes, enter "A" for Audited, "C" for "D" for Dayland Column 1: "D" for D" for Dayland Column 1: "D" for Dayland Column 1: "D" for Dayland	or Compiled,	Y	A	02/27/2023	4.
	or "R" for Reviewed. Submit complete copy or enter date available column 3. (see instructions) If no, see instructions.	irabre in				
0	Are the cost report total expenses and total revenues differenthose on the filed financial statements? If yes, submit recommendations are total expenses and total revenues differenthose on the filed financial statements?		N			5.
	those on the first our maneral statements. The year submit is a	011011114110111	1	Y/N	Legal Oper.	
				1. 00	2. 00	
0	Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column :	2. If yes is	the provide	r N		6.
U	the legal operator of the program?	2. 11 yes, 13	the provider	IN IN		0.
0	Are costs claimed for Allied Health Programs? If "Y" see in: Were nursing programs and/or allied health programs approved cost reporting period? If yes, see instructions.		ed during the	e N		7. 8.
0	Are costs claimed for Interns and Residents in an approved of program in the current cost report? If yes, see instructions		al education	N		9.
00	Was an approved Intern and Resident GME program initiated of cost reporting period? If yes, see instructions.		he current	N		10.
00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N		11.
					Y/N 1. 00	
	Bad Debts				1.00	
00	Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection provider's bad debt collection provider's bad debt collection provider's bad debt collection provider			ost reporting	Y N	12. 13.
00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsural instructions.	nce amounts wa	nived? If yes,	see	N	14.
	Bed Complement					1
00	Did total beds available change from the prior cost reportion		yes, see ins [.] t A	tructions. Par	N + D	15.
		Y/N	Date	Y/N	Date	
		1. 00	2.00	3. 00	4. 00	
	PS&R Data Was the cost report prepared using the PS&R Report only?	NI .	ı	Y	10 (02 (2022	1,
00	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		1	10/02/2023	16.
00	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)	Υ	10/02/2023	N		17.
00	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 this	N		N		18.
00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	N		N		19.

Heal th	Financial Systems ENCOMPASS HEALTH DE	EACONESS REHABI	LIT	In Lie	u of Form CMS-:	2552-10			
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der 0	CCN: 15-3025	Period: From 08/01/2022 To 07/31/2023	Worksheet S-2 Part II	pared:			
			iption	Y/N	Y/N				
20.00	If line 16 or 17 is yes, were adjustments made to PS&R		0	1. 00 N	3. 00 N	20.00			
20.00	Report data for Other? Describe the other adjustments:			IN	IN	20.00			
		Y/N	Date	Y/N	Date				
		1.00	2.00	3. 00	4. 00				
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00			
					1. 00				
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS I	HOSPI TALS)		1.00				
	Capital Related Cost		,			1			
22. 00	Have assets been relifed for Medicare purposes? If yes, see					22. 00			
23. 00	Have changes occurred in the Medicare depreciation expense	due to apprais	sals made duri	ng the cost		23. 00			
24.00	reporting period? If yes, see instructions.	ad inta dunina	this seat was	onting noniceO		24.00			
24. 00	Were new leases and/or amendments to existing leases entered of the second leases and/or amendments to existing leases entered leases.	ea into auring	this cost rep	or tring periou?		24. 00			
25. 00	Have there been new capitalized leases entered into during	the cost repo	rting period?	If yes, see		25. 00			
	instructions.		0 .						
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the	he cost report	ing period? If	yes, see		26. 00			
27.00	instructions.		na norioda le	voo oubmit		27.00			
27. 00	Has the provider's capitalization policy changed during the copy.	e cost reportii	ng period? II	yes, subiii t		27. 00			
	Interest Expense								
28.00	Were new Loans, mortgage agreements or Letters of credit el	ntered into du	ring the cost	reporti ng		28. 00			
	period? If yes, see instructions.					29. 00			
29. 00	0 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								
30. 00									
30.00	instructions.								
31.00	Has debt been recalled before scheduled maturity without is	ssuance of new	debt? If yes,	see		31. 00			
	instructions.								
32. 00	Purchased Services Have changes or new agreements occurred in patient care set	rvi coc furni ch	od through con	tractual		32. 00			
32.00	arrangements with suppliers of services? If yes, see instru		ed thi ough con	ti actuai		32.00			
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 app		ng to competit	ive bidding? If		33. 00			
	no, see instructions.								
0.4.00	Provi der-Based Physi ci ans					04.00			
34. 00	Were services furnished at the provider facility under an allf yes, see instructions.	arrangement wi	th provider-ba	sed physicians?		34. 00			
35. 00	If line 34 is yes, were there new agreements or amended exi	isting agreeme	nts with the p	rovi der-based		35. 00			
	physicians during the cost reporting period? If yes, see in	5 5							
				Y/N	Date				
	U 066: C+-			1. 00	2. 00				
36. 00	Home Office Costs Were home office costs claimed on the cost report?					36. 00			
37. 00	If line 36 is yes, has a home office cost statement been p	repared by the	home office?			37.00			
	If yes, see instructions.								
38. 00	If line 36 is yes, was the fiscal year end of the home of	fice different	from that of			38. 00			
20.00	the provider? If yes, enter in column 2 the fiscal year end					20.00			
39. 00	If line 36 is yes, did the provider render services to other see instructions.	ei chain compoi	nents: IT yes,			39. 00			
40. 00		home office?	If yes, see			40. 00			
	instructions.								
	Coot Deport Droporor Contact Lafe-westing	1.	. 00	2.	00				
41. 00	Cost Report Preparer Contact Information Enter the first name, last name and the title/position	MATTHEW		LALLONE		41.00			
- 1. 00	held by the cost report preparer in columns 1, 2, and 3,								
	respecti vel y.								
42. 00	Enter the employer/company name of the cost report	ENCOMPASS HEAL	LTH CORPORATIO	N		42. 00			
42.00	preparer.	205 049 7055		MATTHEW LALLON	E@ENCOMPASSUE A	12 00			
43. 00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	205-968-7055		MATTHEW. LALLONI LTH. COM	L@CINCOMPASSHEA	43. 00			
	1	1			!	11			

Heal th	n Financial Systems	ENCOMPASS HEALTH DI	I DEACONESS REHABILIT In Lieu of Form (of Form CMS-	2552-10
H0SPI	TAL AND HOSPITAL HEALTH CARE REIMBURSEMEN	T QUESTI ONNAI RE		Provider CCN:	15-3025	Fr	om 08/01/2022		
						То	07/31/2023	Date/Time Pre 11/15/2023 8:	pared: 13 am
				3. 00					
	Cost Report Preparer Contact Information	1							
41.00	Enter the first name, last name and the		SR.	REI MBURSEMEN	T ACCOUNTAI	T			41.00
	held by the cost report preparer in colu	ımns 1, 2, and 3,							
	respecti vel y.								
42.00	Enter the employer/company name of the o	cost report							42.00
	preparer.								
43.00	Enter the telephone number and email add	dress of the cost							43.00
	report preparer in columns 1 and 2, resp	ecti vel y.							

In Lieu of Form CMS-2552-10
Worksheet S-3
Part I
31/2023 Part I
11/15/2023 8: 13 am
I/P Days / 0/P
Visits / Trips
 Heal th Financial
 Systems
 ENCOMPASS HEALTH DEACONESS REHABILIT

 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provider CCN: 1
 Provider CCN: 15-3025 Peri od: From 08/01/2022 To 07/31/2023

						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days Available	CAH/REH Hours	Title V	
		<u>Li ne No.</u> 1. 00	2. 00	3. 00	4. 00	5. 00	
	PART I - STATISTICAL DATA	1.00	2.00	3.00	4.00	3.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	98	35, 770	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and	00.00	, ,	00,770	0.00	ŭ.	
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2. 00
3.00	HMO IPF Subprovider						3. 00
4.00	HMO IRF Subprovider						4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6. 00
7.00	Total Adults and Peds. (exclude observation		98	35, 770	0.00	0	7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31. 00	0	0	0.00	0	8. 00
9.00	CORONARY CARE UNIT	32. 00	0	0	0.00	0	9. 00
10.00	BURN INTENSIVE CARE UNIT	33. 00	0	0	0.00	0	10.00
11. 00	SURGICAL INTENSIVE CARE UNIT	34. 00	0	0	0.00	0	11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43. 00				0	13.00
14.00	Total (see instructions)		98	35, 770	0.00	0	14.00
15.00	CAH visits					0	15.00
15. 10	REH hours and visits						15. 10
16.00	SUBPROVI DER - I PF	40. 00	0	0		0	16.00
17. 00	SUBPROVI DER - I RF	41. 00	0	0		0	17.00
18. 00	SUBPROVI DER						18.00
19. 00	SKILLED NURSING FACILITY	44. 00	0	0		0	19.00
20.00	NURSING FACILITY	45. 00	0	0		0	20.00
21. 00	OTHER LONG TERM CARE	46. 00	0	0			21. 00
22. 00	HOME HEALTH AGENCY	101. 00				0	22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	115. 00					23. 00
24.00	HOSPI CE	116. 00	0	0			24. 00
24. 10	HOSPICE (non-distinct part)	30. 00					24. 10
25. 00	CMHC - CMHC	99. 00				0	25. 00
25. 10	CMHC - CORF	99. 10				0	25. 10
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27. 00	Total (sum of lines 14-26)		98				27. 00
28. 00	Observation Bed Days					0	28. 00
29. 00	Ambul ance Tri ps						29. 00
30. 00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31. 00
32. 00	Labor & delivery days (see instructions)		0	0			32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	3						33. 00
	LTCH site neutral days and discharges						33. 01
34. 00	Temporary Expansion COVID-19 PHE Acute Care	30. 00	0	0		0	34. 00

Health Financial Systems ENCOMPASS HEAT HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-3025

Peri od: Worksheet S-3
From 08/01/2022 Part I
To 07/31/2023 Date/Time Prepared: 11/15/2023 8:13 am

						11/15/2023 8:	13 am
		I/P Days	/ O/P Visits	/ Irips	Full lime I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Intorna	Employees On	
	Component	II tie viii	II LIE ALA	Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7. 00	8. 00	9. 00	10.00	
	PART I - STATISTICAL DATA	0.00	7.00	0.00	7. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	17, 351	235	31, 174			1.00
	8 exclude Swing Bed, Observation Bed and	,		,			
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	6, 414	3, 095				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO IRF Subprovider	0	0				4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF	47.054	0	0			6.00
7. 00	Total Adults and Peds. (exclude observation	17, 351	235	31, 174			7. 00
8. 00	beds) (see instructions)		0	0			8. 00
9. 00	INTENSIVE CARE UNIT	0	0	0			9.00
10.00	BURN INTENSIVE CARE UNIT	0	0	0			10.00
11. 00	SURGICAL INTENSIVE CARE UNIT	0	0	0			11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)		O	0			12.00
13. 00	NURSERY		0	0			13. 00
14. 00	Total (see instructions)	17, 351	235	31, 174	0.00	234. 25	•
15. 00	CAH visits	0	0	0			15. 00
15. 10	REH hours and visits						15. 10
16.00	SUBPROVI DER - I PF	0	0	0	0.00	0.00	16. 00
17.00	SUBPROVI DER - I RF	O	0	0	0.00	0.00	17. 00
18.00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	
20. 00	NURSING FACILITY		0	0	0.00	0.00	1
21. 00	OTHER LONG TERM CARE			0	0.00	0.00	1
22. 00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	1
23. 00	AMBULATORY SURGICAL CENTER (D. P.)				0.00	0.00	1
24. 00	HOSPI CE	O	0	0	0.00	0.00	
24. 10	HOSPICE (non-distinct part)		0	0	0.00	0.00	24. 10 25. 00
25. 00 25. 10	CMHC - CMHC CMHC - CORF	0	0	0	0. 00 0. 00	0. 00 0. 00	ł
26. 00	RURAL HEALTH CLINIC		U	U	0.00	0.00	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	٥	0	0	0.00	0.00	•
27. 00	Total (sum of lines 14-26)		J	0	0.00	234. 25	1
28. 00	Observation Bed Days		0	0		201.20	28. 00
29. 00	Ambulance Trips	0	J	· ·			29. 00
30.00	Employee discount days (see instruction)			0			30. 00
31. 00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	O	0	0			32. 00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days	0					33. 00
33. 01	LTCH site neutral days and discharges	0					33. 01
34. 00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34. 00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-3025

Peri od: Worksheet S-3 From 08/01/2022 Part I To 07/31/2023 Date/Time Prepared:

11/15/2023 8:13 am Full Time Di scharges Equi val ents Title XVIII Total All Component Nonpai d Title V Title XIX Workers Pati ents 15.00 12.00 13.00 14.00 11.00 PART I - STATISTICAL DATA Hospital Adults & Peds. (columns 5, 6, 7 and 1.00 1, 375 18 2, 436 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HMO and other (see instructions) 479 236 2.00 3.00 HMO IPF Subprovider 3.00 4.00 HMO IRF Subprovider ol 4.00 Hospital Adults & Peds. Swing Bed SNF 5.00 5 00 6.00 Hospital Adults & Peds. Swing Bed NF 6.00 Total Adults and Peds. (exclude observation 7.00 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 8.00 9.00 CORONARY CARE UNIT 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 OTHER SPECIAL CARE (SPECIFY) 12.00 12.00 13.00 NURSERY 13.00 Total (see instructions) 2, 436 14.00 0.00 0 1, 375 18 14.00 CAH visits 15.00 15.00 15.10 REH hours and visits 15. 10 16.00 SUBPROVIDER - IPF 0.00 0 0 0 16.00 SUBPROVIDER - IRF 17.00 0.00 0 17.00 0 18 00 SUBPROVI DER 18 00 SKILLED NURSING FACILITY 19.00 0.00 19.00 20.00 NURSING FACILITY 0.00 20.00 OTHER LONG TERM CARE 21.00 0.00 21.00 HOME HEALTH AGENCY 22 00 0 00 22 00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 0.00 23.00 24. 00 HOSPI CE 0.00 24.00 24. 10 HOSPICE (non-distinct part) 24. 10 CMHC - CMHC CMHC - CORF 25.00 0 00 25 00 25. 10 0.00 25. 10 26.00 RURAL HEALTH CLINIC 26.00 FEDERALLY QUALIFIED HEALTH CENTER 26, 25 0.00 26, 25 27 00 Total (sum of lines 14-26) 0 00 27 00 28. 00 Observation Bed Days 28.00 29.00 Ambul ance Trips 29.00 30.00 Employee discount days (see instruction) 30.00 31.00 Employee discount days - IRF 31.00 Labor & delivery days (see instructions) 32.00 32.00 Total ancillary labor & delivery room 32.01 32.01 outpatient days (see instructions) 33.00 LTCH non-covered days 0 33.00 33. 01 LTCH site neutral days and discharges 33.01 34.00 Temporary Expansi on COVID-19 PHE Acute Care 34.00

| Peri od: | Worksheet S-3 | From 08/01/2022 | Part II | To 07/31/2023 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION ENCOMPASS HEALTH DEACONESS REHABILIT
Provider CCN: 15-3025

					To	07/31/2023	Date/Time Prep 11/15/2023 8:1	
		Wkst. A Line	Amount	Reclassi fi cati	,	Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries (from Wkst.	Sal ari es (col.2 ± col.	Related to Salaries in	Wage (col. 4 ÷ col. 5)	
		1 00	2.00	A-6)	3)	col . 4	, 00	
	PART II - WAGE DATA	1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
1 00	SALARI ES	202.00	15 002 020		15 002 020	407 225 00	22.42	1 00
1. 00	Total salaries (see instructions)	200. 00	15, 803, 030	0	15, 803, 030	487, 235. 90	32. 43	1. 00
2. 00	Non-physician anesthetist Part		0	0	0	0. 00	0. 00	2. 00
3.00	Non-physician anesthetist Part		0	0	0	0. 00	0. 00	3. 00
4. 00	Physician-Part A - Administrative		150, 413	0	150, 413	1, 050. 00	143. 25	4. 00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		0	0		0. 00 0. 00	1	4. 01 5. 00
6. 00	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC		0	0	О	0.00	0. 00	6. 00
7. 00	services Interns & residents (in an	21. 00	0	0	0	0. 00	0. 00	7. 00
7. 01	approved program) Contracted interns and residents (in an approved		0	0	0	0. 00	0. 00	7. 01
8. 00	programs) Home office and/or related		0	0	0	0. 00	0. 00	8. 00
9. 00	organization personnel	44. 00	0	0	0	0.00	0.00	9. 00
10. 00	Excluded area salaries (see instructions)		0	164, 354	164, 354	4, 112. 34	39. 97	10. 00
11. 00	OTHER WAGES & RELATED COSTS Contract labor: Direct Patient		3, 245, 476	0	3, 245, 476	42, 885. 38	75. 68	11. 00
12. 00	Care Contract labor: Top level management and other		0	0	0	0. 00	0.00	12. 00
	management and other management and administrative services							
13. 00	Contract Labor: Physician-Part A - Administrative		150, 413	0	150, 413	1, 050. 00	143. 25	13. 00
14. 00	Home office and/or related organization salaries and wage-related costs		0	0	0	0. 00	0.00	14. 00
14. 01	Home office salaries		921, 955	0	921, 955	18, 642. 55		14. 01
14. 02 15. 00	Related organization salaries Home office: Physician Part A		0	0	0	0. 00 0. 00		14. 02 15. 00
	- Administrative		O		Ĭ			
16. 00	Home office and Contract Physicians Part A - Teaching		0	0	0	0. 00	0. 00	16. 00
16. 01	Home office Physicians Part A		0	0	0	0.00	0. 00	16. 01
16. 02	- Teaching Home office contract		0	0	0	0.00	0.00	16. 02
	Physicians Part A - Teaching							
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		3, 546, 768	0	3, 546, 768			17. 00
18. 00	instructions) Wage-related costs (other)							18. 00
19. 00 20. 00	(see instructions) Excluded areas Non-physician anesthetist Part		37, 275 0	0	37, 275 0			19. 00 20. 00
21. 00	A Non-physician anesthetist Part		0	0	0			21. 00
22. 00	B Physician Part A -		0	0	0			22. 00
22. 01	Administrative Physician Part A - Teaching		0	0	0			22. 01
23. 00	Physician Part B		0	0	0			23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		0	0	0			24. 00 25. 00
25. 50	approved program) Home office wage-related		327, 374	0	327, 374			25. 50
25. 51	(core) Related organization		0					25. 51
	wage-related (core)		U]				
25. 52	Home office: Physician Part A - Administrative - wage-related (core)		0	O	0			25. 52

Records Library Social Service

43.00 Other General Service

42.00

21, 398. 48

0 00

34. 24 42. 00

0.00 43.00

HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 15-3025 Peri od: Worksheet S-3 From 08/01/2022 Part II Date/Time Prepared: 07/31/2023 11/15/2023 8:13 am Wkst. A Line Amount Recl assi fi cati Adj usted Paid Hours Average Hourly Number on of Salaries Sal ari es Related to Wage (col. 4 Reported col . 5) (from Wkst. (col.2 ± col. Salaries in A-6)3) col. 4 1.00 2.00 5.00 6.00 3.00 4.00 25.53 Home office: Physicians Part A 0 25.53 - Teaching - wage-related (core) OVERHÉAD COSTS - DIRECT SALARIES 26.00 Employee Benefits Department 4. 00 26.00 00 0.00 27.00 Administrative & General 5.00 2, 427, 218 -164, 354 2, 262, 864 60, 692. 98 37. 28 27.00 28.00 Administrative & General under 161, 885 161, 885 599.44 270.06 28.00 contract (see inst.) Maintenance & Repairs 6.00 29.00 0.00 0.00 29.00 0 Operation of Plant 205, 347 0 205, 347 7, 492. 79 27. 41 30.00 7.00 30.00 31.00 Laundry & Linen Service 8.00 0 0.00 0.00 31.00 Housekeepi ng 32.00 9.00 361, 731 0 361, 731 20, 903. 04 17. 31 32.00 33.00 Housekeeping under contract 0 0.00 0.00 33.00 (see instructions) 34.00 Di etary 10.00 533, 197 0 533, 197 26, 229. 52 20. 33 34.00 Di etary under contract (see instructions) 0.00 35.00 0 0.00 35.00 0 C 36.00 0.00 Cafeteri a 11.00 0 0 0.00 36.00 Maintenance of Personnel 0.00 37.00 12.00 Λ 0 0 0.00 37.00 38.00 Nursing Administration 13.00 963, 283 963, 283 23, 436. 91 41. 10 38.00 39.00 Central Services and Supply 14.00 0 0.00 0.00 39.00 0 0 40.00 40.00 Pharmacy 15.00 0 0.00 0.00 41.00 Medical Records & Medical 16.00 95, 032 95, 032 4, 825. 64 19. 69 41.00

732, 646

0

732, 646

17.00

Total overhead cost (see

instructions)

7.00

32.11

7.00

HOSPITAL WAGE INDEX INFORMATION Worksheet S-3 Part III Date/Time Prepared: Provi der CCN: 15-3025 Peri od: From 08/01/2022 To 07/31/2023 11/15/2023 8:13 am Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 (col . 2 ± col . col. 5) (from Salaries in Works<u>heet A-6)</u> 3) col. 4 1.00 6.00 2.00 5.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 15, 964, 915 15, 964, 915 487, 835. 34 32. 73 1.00 instructions) 2.00 Excluded area salaries (see 0 164, 354 164, 354 4, 112. 34 39. 97 2.00 instructions) 3.00 Subtotal salaries (line 1 15, 964, 915 -164, 354 15, 800, 561 483, 723.00 32.66 3.00 minus line 2) 4.00 Subtotal other wages & related 4, 317, 844 4, 317, 844 62, 577. 93 69.00 4.00 costs (see inst.) Subtotal wage-related costs 5.00 3, 874, 142 C 3, 874, 142 0.00 24. 52 5.00 (see inst.) 23, 992, 547 Total (sum of lines 3 thru 5) 6.00 6.00 24, 156, 901 -164, 354 546, 300. 93 43 92

5, 480, 339

-164, 354

5, 315, 985

165, 578. 80

Health Financial Systems

ENCOMPASS HEALTH DEACONESS REHABILIT

In Lieu of Form CMS-2552-10

Provider CCN: 15-3025

Period:
From 08/01/2022
To 07/31/2023

Part IV
Date/Time Prepared:
11/15/2023 8: 13 am

Amount
Reported
1.00

		117 137 2023 0.	15 aiii
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	242, 350	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	2, 618, 370	8. 02
8. 03	Health Insurance (Purchased)	0	1
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	0	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	18, 373	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15.00	'Workers' Compensation Insurance	159, 891	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Noncumulative portion)		
	TAXES		
17.00	FICA-Employers Portion Only	1, 153, 417	17. 00
18.00	Medicare Taxes - Employers Portion Only	0	18. 00
19.00	Unemployment Insurance	0	19. 00
20.00	State or Federal Unemployment Taxes	31, 772	20. 00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21. 00
	instructions))		
22. 00	Day Care Cost and Allowances	-640, 131	22. 00
23.00	Tuition Reimbursement	0	23. 00
24.00	Total Wage Related cost (Sum of lines 1 -23)	3, 584, 042	24. 00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00

Health Financial Systems	ENCOMPASS HEALTH DEACONESS REHABILIT	u of Form CMS-2552-10	
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-3025	Peri od: From 08/01/2022	

		To 07/31/2023	Date/Time Prep 11/15/2023 8:	
	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1. 00	Total facility's contract labor and benefit cost	3, 395, 889		1.00
2.00	Hospi tal	3, 395, 889	3, 546, 768	2. 00
3.00	SUBPROVI DER - I PF	0	0	3. 00
4.00	SUBPROVI DER - I RF	0	0	4. 00
5.00	Subprovi der - (Other)	0	0	5. 00
6.00	Swing Beds - SNF	0	0	6. 00
7. 00	Swing Beds - NF	0	0	7. 00
8. 00	SKILLED NURSING FACILITY	0	0	8. 00
9. 00	NURSING FACILITY	0	0	9. 00
10. 00	OTHER LONG TERM CARE I			10.00
	Hospi tal -Based HHA	0	0	11. 00
	AMBULATORY SURGICAL CENTER (D. P.) I	0	0	12.00
	Hospi tal -Based Hospi ce	0	0	13. 00
	Hospital-Based Health Clinic RHC			14. 00
	Hospital-Based Health Clinic FQHC			15. 00
	Hospi tal -Based-CMHC	0	0	16. 00
	Hospi tal -Based-CMHC 10	0	0	16. 10
	RENAL DIALYSIS I	0	0	17. 00
18. 00	Other	0	37, 275	18. 00

LASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (MPASS HEALTH DEAG OF EXPENSES	Provi der Co	CN: 15-3025 F	Peri od:	worksheet A	
				From 08/01/2022 o 07/31/2023		
Cost Center Description	Sal ari es	0ther		Reclassificati	Recl assi fi ed	13 a
			+ col . 2)	ons (See A-6)	Trial Balance (col. 3 +-	
					col . 4)	
OFFICE AND ADDRESS OF A STATE OF	1.00	2. 00	3. 00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS 0 00100 CAP REL COSTS-BLDG & FIXT		1, 845, 618	1, 845, 618	594, 215	2, 439, 833	1.
0 00200 CAP REL COSTS-MVBLE EQUIP		746, 789				2.
0 00300 OTHER CAP REL COSTS		704, 910				3.
0 00400 EMPLOYEE BENEFITS DEPARTMENT	0	3, 351, 571			-,,	4.
O 00500 ADMINISTRATIVE & GENERAL O 00700 OPERATION OF PLANT	2, 427, 218 205, 347	4, 841, 470 856, 731		· ·	6, 995, 373 1, 062, 078	
0 00800 LAUNDRY & LINEN SERVICE	203, 347	346, 216	1		346, 216	1
0 00900 HOUSEKEEPI NG	361, 731	76, 821	1		438, 552	
00 01000 DI ETARY	533, 197	733, 691	1		1, 266, 888	1
00 01100 CAFETERIA 00 01300 NURSING ADMINISTRATION	963, 283	0 36, 498	1	,	0 999, 781	
00 01600 MEDICAL RECORDS & LIBRARY	95, 032	722	1		95, 754	
00 01700 SOCIAL SERVICE	732, 646	14, 796	1			1
INPATIENT ROUTINE SERVICE COST CENTERS	T					
00 03000 ADULTS & PEDIATRICS 00 03100 NTENSIVE CARE UNIT	5, 522, 571	3, 857, 411 0			l	1
00 03200 CORONARY CARE UNIT		0		1		1
00 03300 BURN INTENSIVE CARE UNIT		Ö		o o	ő	
00 03400 SURGICAL INTENSIVE CARE UNIT	0	0	C	0	0	
00 04000 SUBPROVI DER - I PF 00 04100 SUBPROVI DER - I RF	0	0		0	0	
00 04100 SUBPROVI DER - 1 RF 00 04300 NURSERY		0			0	1
00 04400 SKILLED NURSING FACILITY	o	0		o o	ő	1
00 04500 NURSING FACILITY	0	0	C	0	0	
00 04600 OTHER LONG TERM CARE	0	0) 0	0	46
ANCILLARY SERVICE COST CENTERS 00 05000 OPERATING ROOM	O	0) 0	0	50.
00 05100 RECOVERY ROOM		0		o o	0	
00 05200 DELIVERY ROOM & LABOR ROOM	0	0	c c	0	0	52
00 05300 ANESTHESI OLOGY	0	0	010.045	0	0	
00 05400 RADI OLOGY-DI AGNOSTI C 01 05401 RADI OLOGY - DI AGNOSTI C - SUA	0	213, 245	213, 245			
00 05500 RADI OLOGY-THERAPEUTI C		0		0 70,037	0 70,037	1
00 05600 RADI 0I SOTOPE	0	0	o c	0	0	56
00 05700 CT SCAN	0	0	C	0	0	1
00 05800 MAGNETIC RESONANCE I MAGING (MRI) 00 05900 CARDIAC CATHETERIZATION	0	0		0	0	
00 06000 LABORATORY	138, 136	489, 002	627, 138		627, 138	
01 06001 BLOOD LABORATORY	0	0	(0	0	1
00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0	(0	0	
00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	
00 06400 I NTRAVENOUS THERAPY		0			0	
00 06500 RESPIRATORY THERAPY	430, 452	6, 211	436, 663	0	436, 663	
00 06600 PHYSI CAL THERAPY	1, 484, 248	159, 829				
00 06700 OCCUPATI ONAL THERAPY 00 06800 SPEECH PATHOLOGY	1, 698, 193	33, 686	1			
00 06900 ELECTROCARDI OLOGY	512, 128	10, 350 0		12, 865	l	1
00 07000 ELECTROENCEPHALOGRAPHY	Ö	Ō		o o	Ö	
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	82, 590	280, 873	363, 463	0	363, 463	
00 07200 IMPL. DEV. CHARGED TO PATIENTS	(14, 250	0 477 015	1 204 073	0	1 204 073	1
00 07300 DRUGS CHARGED TO PATIENTS 00 07400 RENAL DIALYSIS	616, 258	677, 815 0	1, 294, 073	0	1, 294, 073 0	1
00 07500 ASC (NON-DISTINCT PART)	o	0		o o	ő	1
00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	C	0	0	
01 03950 SPECI AL PROCEDURES	0	186, 047	186, 047		l .	
02 03951 SPECIAL PROCEDURES - SUA 00 07700 ALLOGENEI C HSCT ACQUISITION	0	0) 186, 047) 0		1
00 07800 CAR T-CELL IMMUNOTHERAPY		0				
OUTPATIENT SERVICE COST CENTERS]
00 09000 CLI NI C	0	0				1
00 09100 EMERGENCY	0	0	C	0	0	
00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92
00 09400 HOME PROGRAM DIALYSIS	0	0		0	0	94
00 09500 AMBULANCE SERVICES	Ó	0	d	o o	0	95
00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0	0	
00 09700 DURABLE MEDICAL EQUIP-SOLD 00 09900 CMHC	0	0		0	0	
10 09910 CORF		0) 0 0	0	
. 00 10000 I &R SERVI CES-NOT APPRVD PRGM		0	ا ا	م م		100

Health Financial Systems ENCON	MPASS HEALTH DEAC	ONESS REHABIL	LIT	In Lie	eu of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CC		eri od:	Worksheet A	
				rom 08/01/2022 o 07/31/2023	Date/Time Pre	narodi
			'	0 07/31/2023	11/15/2023 8:	
Cost Center Description	Sal ari es	Other	Total (col. 1	Reclassi fi cati		
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col . 4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
101.00 10100 HOME HEALTH AGENCY	0	0	0	0		101. 00
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS		ام				405 00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	0	0		105.00
106.00 10600 HEART ACQUISITION 107.00 10700 LIVER ACQUISITION	0	0	0	0		106. 00 107. 00
107. 00 10700 LIVER ACQUISITION 108. 00 10800 LUNG ACQUISITION	0	0	0	0		107.00
109. 00 10900 PANCREAS ACQUISITION	0	0	0	0		109.00
110. 00 11000 NTESTINAL ACQUISITION		0	0	0		110.00
111. 00 11100 ISLET ACQUISITION		0	0	0		111.00
113. 00 11300 NTEREST EXPENSE	١	4, 644	4, 644	0		113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF	0	1, 011	1, 511	0		114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	l ol	o	0	0		115. 00
116. 00 11600 HOSPI CE	o	o	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	15, 803, 030	19, 474, 946	35, 277, 976	-168, 525	35, 109, 451	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
194. 00 07950 MARKETI NG NRCC	0	0	0	168, 525		
194. 01 07951 GUEST MEALS	0	0	0	0	_	194. 01
200.00 TOTAL (SUM OF LINES 118 through 199)	15, 803, 030	19, 474, 946	35, 277, 976	0	35, 277, 976	200. 00

Peri od: From 08/01/2022 To 07/31/2023

Date/Time Prepared: 11/15/2023 8: 13 am

				11/15/2023 8:	<u>13 am</u>
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For Allocation		
	OFNEDAL CEDIMOS COCT OFNEDO	6. 00	7. 00		
4 00	GENERAL SERVICE COST CENTERS	207 (74	0.747.504		4 00
1.00	00100 CAP REL COSTS-BLDG & FIXT	307, 671			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P	-32, 244			2.00
3.00	00300 OTHER CAP REL COSTS	0			3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	217, 063			4.00
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	-1, 373, 447			5. 00 7. 00
		-46, 813			1
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE	-3, 092			8.00
	00900 HOUSEKEEPI NG 01000 DI ETARY	-2, 128			9.00
10. 00 11. 00		-279, 271	987, 617 0		10.00
		0	_		
13.00		-4, 426			13.00
16.00	1	-1, 827			16.00
17. 00	'	0	747, 442		17. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	247 221	0 220 520		30.00
30.00	1	-247, 331			1
31. 00 32. 00	1	0			31. 00 32. 00
33. 00					33.00
34. 00					34.00
40. 00					40.00
41. 00	1				41.00
43. 00	1				43.00
44. 00	1	0	0		44. 00
45. 00	1	0			45. 00
46. 00	1	0			46.00
40.00	ANCI LLARY SERVI CE COST CENTERS	0	U		40.00
50. 00		0	0		50.00
51. 00	1	0			51.00
52. 00		0			52.00
53. 00	1	0			53.00
54. 00		-1, 331			54.00
54. 01		-26, 543			54. 01
55. 00		20, 343			55. 00
56. 00		0			56. 00
57. 00		0	0		57. 00
58. 00		0	o o		58.00
59. 00		0	0		59. 00
60. 00	1	-38, 894	588, 244		60.00
60. 01		00,071	000, 211		60. 01
61. 00		0	0		61.00
62. 00		o o			62.00
63. 00	1	0	o o		63.00
64. 00	1	o o	0		64.00
65. 00	1	o o			65. 00
66. 00	1	-85			66.00
67. 00	1 1	-215			67. 00
68. 00	1	-108			68.00
	06900 ELECTROCARDI OLOGY	0	0		69.00
	07000 ELECTROENCEPHALOGRAPHY	0	o o		70.00
71. 00		-31, 598	331, 865		71. 00
72. 00		0	0		72. 00
	07300 DRUGS CHARGED TO PATIENTS	-2, 011	1, 292, 062		73. 00
74. 00	1	0	0		74. 00
	07500 ASC (NON-DISTINCT PART)	0	0		75. 00
76. 00	1 1 ,	0	0		76. 00
76. 01		0	0		76. 01
76. 02		-51, 053	134, 994		76. 02
77. 00		0.7000	0		77. 00
78. 00		0	o		78. 00
	OUTPATIENT SERVICE COST CENTERS				
90. 00		0	0		90.00
91. 00		0			91.00
92. 00					92.00
. 2. 00	OTHER REIMBURSABLE COST CENTERS				1 30
94. 00		0	0		94. 00
95. 00	1	0			95. 00
96. 00	1	0			96.00
97. 00			0		97. 00
	09900 CMHC		0		99.00
	09910 CORF		0		99. 10
	0 10000 I &R SERVICES-NOT APPRVD PRGM	0	n		100.00
	0 10100 HOME HEALTH AGENCY	0			101.00
	0 10200 OPI OI D TREATMENT PROGRAM	0			102.00
	1 11 11 11 11 11 11 11 11 11 11 11 11 1			1	

Heal th FinancialSystemsENCOMPASS HEALTHRECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provi der CCN: 15-3025

Peri od: Worksheet A From 08/01/2022 To 07/31/2023 Date/Time Prepared: 11/15/2023 8:13 am

			11/15/2023 8:13 am
Cost Center Description	Adjustments	Net Expenses	
	(See A-8)	For Allocation	
	6.00	7. 00	
SPECIAL PURPOSE COST CENTERS			
105. 00 10500 KIDNEY ACQUISITION	0	0	105. 00
106.00 10600 HEART ACQUISITION	0	0	106. 00
107.00 10700 LIVER ACQUISITION	0	0	107. 00
108.00 10800 LUNG ACQUISITION	0	0	108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	110.00
111.00 11100 ISLET ACQUISITION	0	0	111.00
113.00 11300 INTEREST EXPENSE	-4, 644	0	113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF	0	0	114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	115. 00
116. 00 11600 HOSPI CE	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-1, 622, 327	33, 487, 124	118. 00
NONREI MBURSABLE COST CENTERS			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190. 00
191. 00 19100 RESEARCH	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	192. 00
193.00 19300 NONPALD WORKERS	0	0	193. 00
194. 00 07950 MARKETI NG NRCC	0	168, 525	194. 00
194.01 07951 GUEST MEALS	0	0	194. 01
200.00 TOTAL (SUM OF LINES 118 through 199)	-1, 622, 327	33, 655, 649	200. 00

					 To 07/31/2023	Date/Time Pro 11/15/2023 8:	epared: :13 am_
		Increases					
	Cost Center	Li ne #	Sal ary	0ther			
	2. 00	3. 00	4. 00	5. 00			
	A - INSURANCE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	29, 297			1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0_				2. 00
	TOTALS		0	36, 557			
	B - MARKETING						
1.00	MARKETING_NRCC	194.00	164, 354	4, 171			1.00
	TOTALS		164, 354	4, 171			
	C - PHYSICIANS						
1.00	ADULTS & PEDIATRICS	30.00	0	6 <u>8, 2</u> 33			1.00
	TOTALS		0	68, 233			
	D - SERVICE UNDER ARRANGEMENT						
1.00	RADIOLOGY - DIAGNOSTIC - SUA	54. 01	0	78, 039			1. 00
2.00	SPECIAL PROCEDURES - SUA	76. 02	0	186, 047			2. 00
	TOTALS	- $ -$		264, 086			
	E - DEPT 283 RECLASS						
1.00	OCCUPATI ONAL THERAPY	67.00	60, 293	174			1. 00
2.00	SPEECH PATHOLOGY	68. 00	12, 828	37			2. 00
	TOTALS	- $ -$	73, 121	211			
	F - TELEMETRY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	0	27, 645			1. 00
	TOTALS			27, 645			
500.00	Grand Total: Increases		237, 475	400, 903			500.00
	· ·	•	•				

Health Financial Systems RECLASSIFICATIONS Peri od: Worksheet A-6
From 08/01/2022
To 07/31/2023 Date/Time Pren Provider CCN: 15-3025

					То	07/31/2023 D	Date/Time Prepared: 1/15/2023 8:13 am
		Decreases					17 137 2023 6. 13 dill
	Cost Center	Li ne #	Salary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8.00	9. 00	10.00		
	A - INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	36, 557	12		1. 00
2.00		0.00	0_	0	12		2. 00
	TOTALS		0	36, 557			
	B - MARKETING						
1.00	ADMI NI STRATI VE & GENERAL	500	<u> </u>	<u>4, 1</u> 71			1. 00
	TOTALS		164, 354	4, 171			
	C - PHYSICIANS						
1.00	ADMI NI STRATI VE & GENERAL	5. 00	0_	6 <u>8, 2</u> 33			1. 00
	TOTALS		0	68, 233			
	D - SERVICE UNDER ARRANGEMENT						
1.00	RADI OLOGY-DI AGNOSTI C	54.00	0	78, 039			1.00
2.00	SPECIAL PROCEDURES	<u>76.</u> 01	0_	18 <u>6, 0</u> 47			2. 00
	TOTALS		0	264, 086			
	E - DEPT 283 RECLASS						
1.00	PHYSI CAL THERAPY	66. 00	73, 121	211	0		1. 00
2.00		0.00	•	0	0		2. 00
	TOTALS		73, 121	211			
	F - TELEMETRY RECLASS						
1.00	RADI OLOGY-DI AGNOSTI C	54.00	0_	2 <u>7, 6</u> 45			1. 00
	TOTALS		0	27, 645			
500.00	Grand Total: Decreases	I	237, 475	400, 903			500. 00

Subtotal (sum of lines 1-7)

Reconciling Items

10.00 Total (line 8 minus line 9)

8.00

9.00

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-3025 Peri od: Worksheet A-7 From 08/01/2022 Part I 07/31/2023 Date/Time Prepared: 11/15/2023 8:13 am Acqui si ti ons Begi nni ng Purchases Total Di sposal s and Donati on Bal ances Retirements 2.00 3.00 4. 00 5. 00 1 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 1, 675, 024 0 1.00 0 2.00 Land Improvements 356, 682 0 0 2.00 0 3.00 24, 941, 419 3.00 Buildings and Fixtures 0 0 4.00 Building Improvements 1, 826, 219 7, 205 7, 205 0 4.00 5.00 Fixed Equipment 0 5.00 0 6.00 Movable Equipment 6, 576, 306 501, 951 501, 951 354, 841 6.00 0 7.00 HIT designated Assets 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 35, 375, 650 509, 156 509, 156 354, 841 8.00 9.00 Reconciling Items 0 9.00 35, 375, 65₀ Total (line 8 minus line 9) 509, 156 509, 156 354, 841 10.00 0 10.00 Endi ng Bal ance Fully Depreci ated Assets 6.00 7. 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 1, 675, 024 0 1.00 2.00 Land Improvements 356, 682 0 2.00 3.00 Buildings and Fixtures 24. 941. 419 0 3.00 0 4.00 Building Improvements 1, 833, 424 4.00 5.00 Fi xed Equipment 0 5.00 Movable Equipment 0 6.00 6, 723, 416 6.00 7. 00 7.00 HIT designated Assets 0

35, 529, 965

35, 529, 965

0

0

Health Financial Systems ENCO	MPASS HEALTH DE	ACONESS REHABI	LIT	In Lie	In Lieu of Form CMS-2		
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Peri od: From 08/01/2022	Worksheet A-7		
					Date/Time Pre		
		SL	JMMARY OF CAPI	TAL	1117 107 2020 0.	10 a	
Cost Center Description	Depreciation	Lease	Interest	Insurance (see			
				instructions)	instructions)		
	9. 00	10.00	11. 00	12.00	13.00		

			SU	IMMARY OF CAPI	ΓAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
					instructions)	instructions)	
		9. 00	10. 00	11. 00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	1, 391, 163	454, 455	(0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	537, 546	209, 243	(0	0	2.00
3.00	Total (sum of lines 1-2)	1, 928, 709	663, 698	(0	0	3.00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	0ther	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	1, 845, 618				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	746, 789				2.00
3.00	Total (sum of lines 1-2)	0	2, 592, 407				3. 00

Heal th	n Financial Systems ENCOM	MPASS HEALTH DE	ACONESS REHABI	LIT	In Lie	u of Form CMS-	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der CCN: 15-3025		Period: Worksheet A-From 08/01/2022 Part III		
					Го 07/31/2023	Date/Time Pre 11/15/2023 8:	pared: 13 am
		COME	PUTATION OF RAT	TIOS	ALLOCATION OF		
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
	, , , , , , , , , , , , , , , , , , ,		Leases	for Ratio	instructions)		
				(col. 1 - col.			
				2)			
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE		г _	T			
1.00	CAP REL COSTS-BLDG & FIXT	27, 131, 525		27, 131, 52!		0	1
2.00	CAP REL COSTS-MVBLE EQUIP	6, 723, 416		6, 723, 410		0	2. 00
3.00	Total (sum of lines 1-2)	33, 854, 941		33, 854, 94			3. 00
		ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY 0	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
	·		Capi tal -Relate	cols. 5			
			d Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS					
1.00	CAP REL COSTS-BLDG & FLXT	564, 918	0	564, 918	1, 485, 054	454, 455	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	139, 992	0	139, 992	510, 315	204, 230	2.00
3.00	Total (sum of lines 1-2)	704, 910	0	704, 910	1, 995, 369	658, 685	3.00
			Sl	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
	· ·		instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
	d Costs (see through 14)						
					instructions)	,	
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CARITAL COSTS CENTERS						

213, 780

0 213, 780

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS
CAP REL COSTS-BLDG & FIXT

CAP REL COSTS-MVBLE EQUIP Total (sum of lines 1-2)

29, 297 7, 260 36, 557

564, 918 139, 992 704, 910

2, 747, 504 1. 00 861, 797 2. 00 3, 609, 301 3. 00

0 0 0

1.00

Peri od: Worksheet A-8 From 08/01/2022 To 07/31/2023 Date/Time Prepared:

				To	07/31/2023	Date/Time Prep 11/15/2023 8:	
				Expense Classification on To/From Which the Amount is		117 137 2023 6.	is ai
				10/11 oil wit cit the Allouit 13	to be haj astea		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center		Wkst. A-7 Ref.	
00	Investment income - CAP REL	1.00	2. 00	3.00 CAP REL COSTS-BLDG & FLXT	4. 00 1. 00	5. 00	1.
00	COSTS-BLDG & FLXT (chapter 2)		0	THE COSTS BEDG & TIXI	1.00	Ĭ	١.
00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2.
00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3.
00	(chapter 2)		0		0.00	ŏ	0.
00	Trade, quantity, and time		0		0. 00	0	4.
00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5.
00	expenses (chapter 8)		0		0.00	Ĭ	0.
00	Rental of provider space by		0		0.00	0	6.
00	suppliers (chapter 8) Telephone services (pay		0		0. 00	0	7.
00	stations excluded) (chapter		0		0.00	Ö	,.
	21)		_				_
00	Television and radio service (chapter 21)		0		0. 00	0	8.
00	Parking Lot (chapter 21)		0		0. 00	0	9.
. 00	Provi der-based physician	A-8-2	-21, 154			О	10
. 00	adjustment Sale of scrap, waste, etc.		0		0. 00	0	11.
. 00	(chapter 23)		0		0.00	Ŭ	
. 00	Related organization	A-8-1	-940, 471			o	12
00	transactions (chapter 10) Laundry and linen service		0		0. 00	0	13
00	Cafeteria-employees and guests		0		0.00	0	14
00	Rental of quarters to employee		0		0. 00	O	15
00	and others Sale of medical and surgical		0		0. 00	0	16
00	supplies to other than		0		0.00	Ö	10
	pati ents		_			_	
00	Sale of drugs to other than patients		0		0. 00	0	17
00	Sale of medical records and		0		0. 00	0	18
00	abstracts		0		0.00		4.0
00	Nursing and allied health education (tuition, fees,		0		0. 00	0	19
	books, etc.)						
00	Vending machines		0		0.00	0	20
00	Income from imposition of interest, finance or penalty		0		0. 00	0	21
	charges (chapter 21)						
00	Interest expense on Medicare		0		0. 00	0	22
	overpayments and borrowings to repay Medicare overpayments						
00	Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65. 00		23
	therapy costs in excess of						
00	limitation (chapter 14) Adjustment for physical	A-8-3	0	 PHYSI CAL THERAPY	66.00		24
	therapy costs in excess of		_				
00	limitation (chapter 14)		0	UTILLIZATION DEVLEW ONE	114 00		٥٢
00	Utilization review - physicians' compensation		U	UTILIZATION REVIEW-SNF	114. 00		25
	(chapter 21)						
00	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	26
00	COSTS-BLDG & FLXT Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27
	COSTS-MVBLE EQUIP						
00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28
00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATIONAL THERAPY	0. 00 67. 00	0	29 30
	therapy costs in excess of		0		27.00		
00	limitation (chapter 14)		^	ADULTS & DEDLATRICS	20.00		20
99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30. 00		30
00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00	ļ	31
	pathology costs in excess of						
. 00	limitation (chapter 14) CAH HIT Adjustment for		0		0. 00	0	32.
	Depreciation and Interest		0		0.00	ď	٥2.

7.00

30.00

73.00

5 00

37.30

37.31

37.32

37 33

50.00

ADJUSTMENTS TO EXPENSES Provider CCN: 15-3025 Peri od: Worksheet A-8 From 08/01/2022 07/31/2023 Date/Time Prepared: 11/15/2023 8:13 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Cost Center Line # Wkst. A-7 Ref. Amount 2.00 3.00 4. 00 5.00 33.00 OTHER ADJUSTMENTS (SPECIFY) 33. 00 0.00 (3)37.00 INTEREST Α -4, 644 I NTEREST EXPENSE 113.00 11 37.00 37.01 DEPRECIATION Α OCAP REL COSTS-BLDG & FIXT 1.00 37.01 37. 02 DEPRECIATION 3, 721 CAP REL COSTS-MVBLE EQUI P 2.00 37.02 Α 229, 788 EMPLOYEE BENEFITS DEPARTMENT LNSURANCE 0 37.03 37.03 Α 4.00 37.04 **I NSURANCE** Α -293, 645 ADMINI STRATI VE & GENERAL 5.00 0 37.04 NON-ALLOWABLE EXPENSES -113, 931 ADMI NI STRATI VE & GENERAL 37.05 Α 5.00 37.05 ADJUSTME NON-ALLOWABLE EXPENSES -49 OPERATION OF PLANT 37.06 Α 7.00 0 37.06 AD.JUSTMF NON-ALLOWABLE EXPENSES 37.07 Α -148HOUSEKEEPING 9.00 37.07 ADJUSTME NON-ALLOWABLE EXPENSES -19, 264 DI ETARY 37.08 Α 10.00 37.08 ADJUSTME 37 09 NON-ALLOWABLE EXPENSES -4. 426 NURSING ADMINISTRATION 13 00 O 37 09 Α AD JUSTME 37. 10 NON-ALLOWABLE EXPENSES 1 RADI OLOGY-DI AGNOSTI C 54.00 37. 10 Α **ADJUSTME** 37.11 NON-ALLOWABLE EXPENSES -85 PHYSICAL THERAPY 66.00 37.11 **ADJUSTME** 37 12 NON-ALLOWABLE EXPENSES -215 OCCUPATIONAL THERAPY 67 00 37 12 Α AD JUSTME NON-ALLOWABLE EXPENSES -108 SPEECH PATHOLOGY 37.13 Α 68.00 37.13 ADJUSTME NON-ALLOWABLE EXPENSES OMEDICAL SUPPLIES CHARGED TO Α 71.00 37.14 ADJUSTME PATI ENTS 37. 15 PATIENT TELEPHONE -9, 882 CAP REL COSTS-MVBLE EQUIP 37. 15 2.00 Α PATIENT TELEPHONE -4, 353 EMPLOYEE BENEFITS DEPARTMENT 37. 16 Α 4.00 37.16 37. 17 PATI ENT TELEPHONE -23, 733 ADMINI STRATI VE & GENERAL 5.00 37.17 Α PATIENT TELEVISION -13, 186 CAP REL COSTS-MVBLE EQUIP 2.00 37.18 37.18 Α PATIENT TELEVISION -6, 260 OPERATION OF PLANT 37.19 7.00 ol 37.19 Α 37. 20 PRINTING -3, 643 ADMINI STRATI VE & GENERAL 5.00 0 37. 20 Α PRI NTI NG -99 MEDICAL SUPPLIES CHARGED TO 37. 21 Α 71.00 37. 21 PATI ENTS 37. 22 LOBBYING EXPENSE Α -1, 210 ADMI NI STRATI VE & GENERAL 5.00 37. 22 -1, 104 ADMINI STRATI VE & GENERAL LEGAL FEES 0 37.23 Δ 5.00 37. 23 37. 24 MI SCELLANEOUS INCOME В 6 ADMINISTRATIVE & GENERAL 5.00 37.24 -621 OPERATION OF PLANT 37, 25 MISCELLANEOUS INCOME В 7.00 37. 25 MI SCELLANEOUS I NCOME -105, 940DI ETARY 37. 26 В 10.00 ol 37. 26 MISCELLANEOUS INCOME -1, 827 MEDI CAL RECORDS & LI BRARY 37.27 В 16.00 37.27 37. 28 PATIENT TRANSPORTATION -7, 884 CAP REL COSTS-MVBLE EQUIP 2.00 37. 28 Α 37. 29 PATIENT TRANSPORTATION Α -8, 372 EMPLOYEE BENEFITS DEPARTMENT 4.00 37. 29

-36, 913 OPERATION OF PLANT

-221, 015 ADULTS & PEDIATRICS

-1, 622, 327

-309 DRUGS CHARGED TO PATIENTS

-11, 352 ADMINI STRATI VE & GENERAL

Α

Α

Α

Α

TOTAL (sum of lines 1 thru 49)

PATIENT TRANSPORTATION

PATIENT TRANSPORTATION

PATIENT TRANSPORTATION

(Transfer to Worksheet A, column 6, line 200.)

PROFESSI ONAL FEES

37.30

37. 31

37.32

37 33

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

⁽²⁾ Basis for adjustment (see instructions)

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

B. Amount Received - if cost cannot be determined.

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

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

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

Period:
From 08/01/2022
To 07/31/2023 8: 13 am

Line No. Cost Center Expense I tens Anount of All awable Cost Included in Wiss. A. column but a comment of All awable Cost Included in Wiss. A. column but a comment of All awable Cost Included in Wiss. A. column but a comment of All awable Cost Included in Wiss. A. column but a comment of All awable Cost Included in Wiss. A. column but a comment of All awable Costs Included in Wiss. A. column but a comment of All awable Costs Included in Wiss. A. column but a comment of All awable Costs Included in Wiss. A. column but a comment of All awable Costs Included in Wiss. A. column but a comment of All awable Costs Included in Wiss. A. column but a comment of All awable Costs Included in Wiss. A. column but a comment of All awable Costs Included in Wiss. A. column but a comment of All awable Costs Included in Wiss. A. column but a comment of All awable Costs Included in Wiss. A. column but a comment of All awable Costs Included in Wiss. A. column but a comment of All awable Costs Included in Wiss. A. column but a comment of All awable Costs Included in Wiss. A. column but a comment of All awable Costs Included in Wiss. A. column but a comment of All awable Costs Included in Wiss. A. column but a comment of All awable Costs Included in Wiss. A. column but a column bu					10 07/31/2023	11/15/2023 8:	
A. COSTS INCRRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OF CLAIMED 1.00 A. COSTS INCRRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OF CLAIMED 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.		Line No	Cost Center	Evnense Items	Amount of		13 alli
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED		ETTIC NO.	COST CENTER	Expense i tells			
A. COSTS INDURRED AND ADJUSTNERNIS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED **MONE OFFICE COSTS**: 5. OOLADMIN STRATIVE & GENERAL 1. OO					/ Towaste cost		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELIATED ORGANIZATIONS OR CLAIM MED 1. 000 1. 00(CAP REL. COSTS-BLDG & FIXT 1) 1. 00(CAP REL. COS							
HOME OFFICE COSTS: HOME OFFICE COSTS: SO		1.00	2.00	3. 00	4. 00	5. 00	
1.00			MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAIMED	
1.00 CAP REL COSTS-BLOS & FIXT TO INCLUDE ALLOWABLE HOME OF 93,891 0 2.00 3.01 5.00 CAP REL COSTS-BLOS & FIXT TO INCLUDE ALLOWABLE HOME OF 213,780 0 3.00 3.01 3.02 3.03 2.00 CAP REL COSTS-MUBLE EQUIP TO INCLUDE ALLOWABLE HOME OF 179,727 0 3.02 3.03 3.04 3.00 CHERCAP REL COSTS - MUBLE EQUIP TO INCLUDE ALLOWABLE HOME OF 179,727 0 3.02 3.03 3.04 3.00 CHERCAP REL COSTS - MUBLE EQUIP TO INCLUDE ALLOWABLE HOME OF 179,727 0 3.02 3.03 3.04 3.00 CHERCAP REL COSTS - MUBLE EQUIP TO INCLUDE ALLOWABLE HOME OF 179,727 0 3.02 3.05 3.05 4.00 CMD IN ISTRATI VE & GENERAL INTERCOMPANY WAGE AND EXPENS 46,691 46,691 46,971 3.05 3.0	1 00		ADMINISTRATIVE & GENERAL	TO DEESET MANAGEMENT EEES	1 0	3 011 561	1 00
1.00 AP REL COSTS-BLDG & FIXT TO INCLIDE ALLOWABLE HOME OF 1,91,156 0,30 0,00 0			li .		1	1 ' ' 1	
3. 01 5. 00 0.00		•	li .				
2. 02 S. 00 ADMINISTRATIVE & GENERAL 2. 00 CAP REL COSTS SIMPLE EQUIP 1 NTERCOMPANY WAGE AND EXPENS 4. 698 4. 698 3. 00			li .				
2. 00 CAP REL COSTS-WINELE COULP INTERCOMPANY WAGE AND EXPENS 4,698 4,698 3,08 3,04 3.00 COTHER CAP REL COSTS INTERCOMPANY WAGE AND EXPENS 46,971 3,04 3,05 3,06		•	li .				
3.06 4.00 GMPLICYEE BINFEITS DEPARTMENT INTERCOMPANY WAGE AND EXPENS 46,971 46,971 3.04 3.05 3.05 3.05 3.06 5.00 ADMINISTRATIVE & GENERAL 1.00 OPERATION OF PLANT 1.00 OPERATI			l			-	
3.06 1.00							
3.06 S. OO ADMINI STRATIVE & GENERAL INTERCOMPANY WAGE AND EXPENS 3,760,023 3,760,023 3,060 3,080 3,090 3,00		•	li .				
3.08		•	1		1		
3.08 8.00 LAUNDRY & LINEN SERVICE INTERCOMPANY WAGE AND EXPENS 111 111 3.08 9.00 HOUSEKEEPING INTERCOMPANY WAGE AND EXPENS 481 481 3.09 3.10 10.00 ETARY 11.00 11.00 11.00 11.00 11.00 11.00 11.00 3.11 13.00 NURSI NG ADMINI STRATION INTERCOMPANY WAGE AND EXPENS 8,937 8,937 3.10 3.12 16.00 MEDICAL RECORDS & LIBRARY INTERCOMPANY WAGE AND EXPENS 1.22 1.22 3.12 3.13 17.00 SOCIAL SERVICE INTERCOMPANY WAGE AND EXPENS 1.22 1.22 3.12 3.14 30.00 ADULTS & PEDIATRICS INTERCOMPANY WAGE AND EXPENS 1.887 1.887 3.13 3.15 5.40.00 RADIOLOGY-DI AGNOSTIC INTERCOMPANY WAGE AND EXPENS 3.261 32.361 33.241 3.15 3.16 60.00 LABORATORY INTERCOMPANY WAGE AND EXPENS 3.261 32.361 3.14 3.17 65.00 RESPI RATORY THERAPY INTERCOMPANY WAGE AND EXPENS 1.881 1.881 3.16 3.18 66.00 PHYSICAL THERAPY INTERCOMPANY WAGE AND EXPENS 1.881 1.881 3.16 3.19 67.00 COLUPATIONAL THERAPY INTERCOMPANY WAGE AND EXPENS 1.881 1.381 3.17 3.22 73.00 DRUGS CHARGED TO PATIEST INTERCOMPANY WAGE AND EXPENS 1.89 21.819 3.17 3.22 73.00 DRUGS CHARGED TO PATIEST INTERCOMPANY WAGE AND EXPENS 1.381 1.381 3.20 3.24 71.00 MEDICAL SUPPLIES CHARGED TO PATIEST INTERCOMPANY WAGE AND EXPENS 1.381 1.381 3.20 3.25 70.00 PHYSICI LANS' PRIVATE OFFICES INTERCOMPANY WAGE AND EXPENS 1.1472 -11.472							
3.00 9.00 9.00 9.00 10.00 EXEEPING INTERCOMPANY WAGE AND EXPENS 481 481 3.09							
3.10 10.00 ETARY 13.00 ETARY 13.00 ETARY 13.00 13.00 14.00 13.00 15.00 13.00 15.00 13.00 15.00 13.00 15.00					ł .		
3.11 13. 00 NURSING ADMINISTRATION INTERCOMPANY WAGE AND EXPENS 8, 937 8, 937 3. 11 16. 00 MEDICAL RECORDS & LIBRARY INTERCOMPANY WAGE AND EXPENS 122 3.12 3.13 17. 00 SOCI AL SERVICE INTERCOMPANY WAGE AND EXPENS 1.887 1.887 3. 13 3. 14 30. 00 ADULITS & PEDI ATRIC S INTERCOMPANY WAGE AND EXPENS 1.887 1.887 3. 13 3. 15 54. 00 RADIO LOGY-DI AGNOSTI C INTERCOMPANY WAGE AND EXPENS 3.2, 361 3.2, 361 3. 14 3. 15 54. 00 RADIO LOGY-DI AGNOSTI C INTERCOMPANY WAGE AND EXPENS -181 -181 3. 15 3. 16 65. 00 RESPIRATORY THERAPY INTERCOMPANY WAGE AND EXPENS -181 -181 3. 15 3. 18 3. 17 3. 18 66. 00 PHYSI CAL THERAPY INTERCOMPANY WAGE AND EXPENS 1.889 21, 819 21, 819 3. 18 3. 17 3. 12 3. 12 3. 12 3. 12 3. 12 3. 13 3. 13 3. 13 3. 13 3. 13 3. 13 3. 13 3. 13 3. 13 3. 13 3. 13 3. 13 3. 13 3. 13 3. 13 3. 13 3. 20 3. 24 3. 13 3. 14 1. 30 INTERCOMPANY WAGE AND EXPENS -868 -868 3. 19 INTERCOMPANY WAGE AND EXPENS -868 -868 3. 19 INTERCOMPANY WAGE AND EXPENS -869 -868 3. 19 INTERCOMPANY WAGE AND EXPENS -869 -869 3. 22 3. 24 3. 13 3. 34							
3. 12		•	1				
3. 13 17. 00 SOCI AL SERVICE INTERCOMPANY WAGE AND EXPENS 1, 887 3, 13 3. 14 30.00 ADULTS & PEDI ATRICS INTERCOMPANY WAGE AND EXPENS 32, 361 32, 361 3. 14 31. 15 54. 00 RADI 0L.0GY-DI AGNOSTI C INTERCOMPANY WAGE AND EXPENS -181 -181 3. 15 3. 16 60.00 LABORATORY INTERCOMPANY WAGE AND EXPENS -181 -181 3. 16 3. 16 65. 00 RESPIRATORY THERAPY INTERCOMPANY WAGE AND EXPENS 138 138 138 138 3. 18 3. 19 67. 00 OCCUPATI ONAL THERAPY INTERCOMPANY WAGE AND EXPENS -181 -181 3. 16 3. 16 3. 10 3. 20 68. 00 SPEECH PATHOLOGY INTERCOMPANY WAGE AND EXPENS -184 21, 819 21, 819 3. 18 3. 10 3. 20 68. 00 SPEECH PATHOLOGY INTERCOMPANY WAGE AND EXPENS -868 -868 3. 19 3. 18 3. 20 3. 21 71. 00 MEDI CALL SUPPLIES CHARGED TO TO PATI ENTS TO			1				
3. 14 30. 00 ADULTS & PEDIATRICS INTERCOMPANY WAGE AND EXPENS 32, 361 32, 361 3. 14 54. 00 RADIOLOGY-DIAGNOSTIC INTERCOMPANY WAGE AND EXPENS -181 -181 3. 15 65. 00 RESPIRATORY THERAPY INTERCOMPANY WAGE AND EXPENS 138 138 138 138 66. 00 PHYSICAL THERAPY INTERCOMPANY WAGE AND EXPENS 138 138 138 3. 17 83. 19		•	1		l .		
3.15					1		
1.16							
3.17 66.00 RESPIRATORY THERAPY INTERCOMPANY WAGE AND EXPENS 138 138 3.17 3.18 3.19 66.00 PHYSI CAL THERAPY INTERCOMPANY WAGE AND EXPENS 21,819 21,819 3.18 3.19 3.20 68.00 SPEECH PATHOLOGY INTERCOMPANY WAGE AND EXPENS -668 -868 3.19 3.20 71.00 MEDICAL SUPPLIES CHARGED TO 73.00 DRUGS CHARGED TO PATIENTS 1.00 REDICAL SUPPLIES CHARGED TO PATIENTS 1.00 REDICAL SUPPLIES CHARGED TO PATIENTS 1.00 REDICAL SUPPLIES CHARGED TO PATIENTS 1.00 RESPONS 1.00 RE					ł .		
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3. 19 67. 00 67. 00 68. 00 5PECI AL PROCEDURES INTERCOMPANY WAGE AND EXPENS 1, 381 1, 381 3. 20 1 1 1 1 1 1 1 1 1							
3. 20 68. 00 SPEECH PATHOLOGY 71. 00 MEDI CAL SUPPLIES CHARGED TO PATIENTS 73. 00 DRUGS CHARGED TO PATIENTS 73. 00 DRUGS CHARGED TO PATIENTS 73. 00 DRUGS CHARGED TO PATIENTS 74. 01 SPECIAL PROCEDURES 75. 00 DRUGS CHARGED TO PATIENTS 75. 00 DRUGS CHARGED TO PATIENT					1		
3. 21							
3. 22 73. 00 DRUGS CHARGED TO PATIENTS 76. 01 SPECI AL PROCEDURES 76. 01 SPECI AL PROCEDURE 76. 01 SPECI AL PROCEDURE 76. 01 SPECI AL PROCEDURE 76. 01 SPECI							
3. 23 3. 24 3. 24 3. 25 3. 25 3. 25 3. 26 3. 27 3. 28 3. 28 3. 27 3. 28 3. 28 3. 29 3. 29 3. 29 3. 29 3. 29 3. 29 3. 29 3. 29 3. 20 3. 27 3. 28 3. 29 3. 29 3. 29 3. 29 3. 29 3. 29 3. 20 3. 20 3. 27 3. 28 3. 29 3. 29 3. 20 3. 29 3. 20 3. 29 3. 20 3. 20 3. 27 3. 28 3. 29 3. 20 3. 29 3. 20 3. 29 3. 20 3. 29 3. 20 4. 60 4. 644 4. 644 4. 644 3. 24 4. 64			li-				
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3. 26 3. 27 3. 28 3. 28 3. 29 3. 29 3. 29 3. 29 3. 20 3. 29 3. 29 3. 30 3. 30 3. 31 3. 31 3. 32 3. 32 3. 33 3. 32 3. 33 3. 34 3. 30 3. 30 3. 31 3. 32 3. 33 3. 33 3. 34 3. 35 3. 35 3. 37 3. 37 3. 30							
3. 27 3. 28 3. 29 3. 29 3. 30 3. 30 3. 30 3. 31 3. 31 3. 32 3. 32 3. 33 3. 32 3. 33 3. 34 3. 35 3. 35 3. 36 3. 36 3. 37 3. 30 3. 38 3. 37 3. 30					1		
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3. 30		•	li .				
3. 31 9. 00 HOUSEKEEPING RELATED PARTY - DEACONESS 548 3. 31 32 32 33 33 34 30. 00 JADULTS & PEDIATRICS RELATED PARTY - DEACONESS 44, 177 198, 244 3. 32 33 33 34 54. 00 RADI OLOGY - DI AGNOSTI C 3. 35 54. 01 RADI OLOGY - DI AGNOSTI C - SUA 3. 36 60. 00 LABORATORY RELATED PARTY - DEACONESS 549, 202 75, 745 3. 35 33 34 35 36 36 60. 00 LABORATORY RELATED PARTY - DEACONESS 549, 202 75, 745 3. 35 36 37 30. 00 RUGS CHARGED TO 71. 00 MEDI CAL SUPPLIES CHARGED TO 72. 38 8 39 76. 02 SPECI AL PROCEDURES - SUA 8 RELATED PARTY - DEACONESS 70 10, 287, 295 11, 227, 766 5. 00 10, 28		•	li .		1		
3. 32							
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3. 37		•	ł				
3.38			1		1		
3.39							
4.00		•	1		1		
5.00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2,		•	1	DEMOGNESS) 1, 302 n		
Transfer column 6, line 5 to Worksheet A-8, column 2,					10. 287 295	١	
Worksheet A-8, column 2,	5.00	,			.0,20,,270	, 22., 700	5. 50
		· ·					
		line 12.					

* The amounts on lines 1-4 (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 has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

			Related Organization(s) and/or Home Office			
Symbol (1)	Name	Percentage of	Name	Percentage of		
		Ownershi p		Ownershi p		
1. 00	2.00	3. 00	4. 00	5. 00		
B. INTERRELATIONSHIP TO 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 request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	В	0.00 ENCOMPASS HEALT 72.5	0 6.00
7. 00	В	0. OO DEACONESS HOSPI 27. 5	0 7.00
8. 00		0.00	0 8.00
9. 00		0.00	0 9.00
	'	·	

Health Financial Systems	ENCOMPASS HEALTH DEAC	ONESS REHABILIT	In Lie	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FF	ROM RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-3025	Peri od: From 08/01/2022	
			To 07/31/2023	Date/Time Prepared:

					11/15/2023 8:	<u>13 am</u>
				Related Organization(s) and/	or Home Office	
				ů , ,		
	Symbol (1)	Name	Percentage of	Name	Percentage of	
			Ownershi p		Ownershi p	
	1. 00	2. 00	3. 00	4. 00	5. 00	
10.00			0.00		0. 00	10.00
100.00	G. Other (financial or					100.00
	non-financial) specify:					

- (1) Use the following symbols to indicate 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 organi zati on.
- 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 provi der.

* The amounts on lines 1-4 (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 has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

4.00

0

1103 110	t been posted to norkaneet A,	cordinas i anazor 2, the amount arrowable should be mareated in cordina 4 or this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6. 00		
	B. INTERRELATIONSHIP TO RELAT	TED 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 request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	HEALTHCARE	6. 00
	HEALTHCARE	7. 00
8.00		8. 00
9. 00 10. 00		9. 00 10. 00
10.00		10.00
100.00		100.00

4.00

5.00

-940, 471

Health Financial Systems	ENCOMPASS HEALTH DEAC	ONESS REHABILIT	In Lie	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOME	Provi der CCN: 15-3025	Peri od: From 08/01/2022	Worksheet A-8-1
OFFICE COSTS			To 07/31/2023	Date/Time Prepared: 11/15/2023 8:13 am
Related Organization(s) and/or Home Office				
Type of Business				
6. 00				

- (1) Use the following symbols to indicate 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 organi zati on.
- 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 provi der.

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Peri od: Worksheet A-8-2 From 08/01/2022 To 07/31/2023 Date/Time Prepared: Provider CCN: 15-3025

					-	Го 07/31/2023	B Date/Time Pre 11/15/2023 8:	epared: 13 am
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
				·	·		Hours	
	1. 00	2. 00	3.00	4. 00	5. 00	6. 00	7. 00	
1.00		AGGREGATE-ADULTS &	68, 233	0	68, 233	211, 500	463	1. 00
		PEDI ATRI CS						
2. 00	0.00		0		_	1		
3.00	0.00		0	-	0	0	0	
4.00	0.00		0		0	0	0	
5.00	0.00		0	0	0	0	0	
6. 00	0.00		0	0	0	0	0	
7.00	0.00		0	0	0	0	0	
8.00	0.00		0	0	0	0	0	8. 00
9.00	0.00		0	0	0	0	0	9.00
10.00	0. 00		(0.222	0	(0.222	0	0	10.00
200.00	Wkst. A Line #	Cost Center/Physician	68, 233 Unadj usted RCE		68, 233 Cost of		463 Physician Cost	
	WKSt. A Line #	I denti fi er						
		rdentiffer	LIMIL	Limit	Memberships & Continuing	Component Share of col.	of Malpractice Insurance	
				LIIIII	Education	12	Trisui ance	
	1.00	2. 00	8.00	9. 00	12. 00	13. 00	14. 00	
1. 00		AGGREGATE-ADULTS &	47, 079					1. 00
		PEDI ATRI CS		,				
2.00	0.00		0	0	0	0	0	2. 00
3.00	0.00		0	0	0	0	0	3. 00
4.00	0.00		0	0	0	0	0	4. 00
5.00	0.00		0	0	0	0	0	5. 00
6.00	0.00		0	0	0	0	0	6. 00
7.00	0.00		0	0	0	0	0	7. 00
8.00	0.00		0	0	0	0	0	8. 00
9.00	0.00		0	0	0	0	0	9. 00
10.00	0.00		0	0	0	0	-	
200.00			47, 079			0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		ldenti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	2. 00	14 15. 00	16. 00	17. 00	18. 00	-	
1. 00		AGGREGATE-ADULTS &	15.00			21, 154		1. 00
1.00	PEDI ATRI CS			47,079	21, 134	21, 134		1.00
2. 00	0.00	EDIATRI 65	0	0	0	0		2. 00
3. 00	0.00		0	1		0		3. 00
4. 00	0.00		0	0	-	0		4. 00
5. 00	0.00		0	0	0	0		5. 00
6. 00	0.00		0	0	0	Ö		6. 00
7. 00	0.00		l o	l o	O	l o		7. 00
8. 00	0.00		l o	0	0	Ö		8. 00
9.00	0.00		0	0	0	0		9. 00
10.00	0.00		0	0	0	0		10.00
200.00			0	47, 079	21, 154	21, 154		200.00

Health Financial Systems ENCOMPASS HEALTH DEACONESS REHABILIT In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-3025 Peri od: Worksheet B From 08/01/2022 Part I Date/Time Prepared: 07/31/2023 11/15/2023 8:13 am CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal for Cost **BENEFITS** DEPARTMENT All ocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 2, 747, 504 2, 747, 504 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 861, 797 861, 797 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 3, 568, 634 4, 291 3, 586, 605 4.00 13,680 00500 ADMINISTRATIVE & GENERAL 5 00 5, 621, 926 109, 073 513 573 6, 278, 784 5 00 34, 212 7.00 00700 OPERATION OF PLANT 1,015,265 87, 817 27, 545 46,605 1, 177, 232 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 343, 124 8, 006 2, 511 353, 641 8.00 00900 HOUSEKEEPI NG 436, 424 15, 797 4, 955 82,097 539, 273 9.00 9.00 01000 DI ETARY 46, 912 1, 305, 104 10 00 10.00 987, 617 149, 562 121,013 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 995, 355 3, 916 1, 230, 379 13.00 12, 484 218, 624 13.00 01600 MEDICAL RECORDS & LIBRARY 93, 927 11, 134 3, 492 16, 00 21, 568 130, 121 16, 00 01700 SOCIAL SERVICE 16, 173 17.00 747, 442 51, 561 166, 279 981, 455 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 9, 228, 529 1,826,946 573, 051 1, 253, 384 12, 881, 910 30.00 03100 INTENSIVE CARE UNIT 31.00 31.00 0 0 32 00 03200 CORONARY CARE UNIT 0 0 0 0 32 00 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 33.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 O 34.00 0 0 04000 SUBPROVIDER - IPF 40.00 0 40.00 0 0 04100 SUBPROVI DER - I RF 0 41.00 0 41.00 0 04300 NURSERY 0 0 43.00 43.00 44.00 04400 SKILLED NURSING FACILITY 0 44.00 45.00 04500 NURSING FACILITY 0 0 0 45.00 C 0 04600 OTHER LONG TERM CARE 46.00 0 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 0 0 0 50.00 0 0 0 51.00 05100 RECOVERY ROOM 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0 52.00 53.00 05300 ANESTHESI OLOGY 0 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 106, 230 0 106, 230 54 00 54 00 54.01 05401 RADIOLOGY - DIAGNOSTIC - SUA 51, 496 51, 496 54.01 05500 RADI OLOGY-THERAPEUTI C 0 55.00 0 0 0 55.00 05600 RADI OI SOTOPE 0 o 56.00 56.00 0 0 ol 05700 CT SCAN 0 0 57.00 0 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 59.00 0 06000 LABORATORY 588. 244 36, 808 11, 545 667. 948 60 00 31, 351 60 00 60.01 06001 BLOOD LABORATORY 0 C 0 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 62.00 0 0 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 63 00 63 00 0 0 64.00 06400 I NTRAVENOUS THERAPY 64.00 06500 RESPI RATORY THERAPY 10, 183 97, 694 547, 734 65.00 436, 663 3.194 65.00 66.00 06600 PHYSI CAL THERAPY 1,570,660 213, 822 67,068 320, 265 2, 171, 815 66, 00 06700 OCCUPATI ONAL THERAPY 1, 792, 131 33, 799 399, 101 2, 332, 785 67.00 107, 754 67 00 68.00 06800 SPEECH PATHOLOGY 535, 235 31, 409 9,852 119, 142 695, 638 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 0 |07100|MEDICAL SUPPLIES CHARGED TO PATIENTS 397, 753 71.00 331, 865 35, 887 11, 257 18.744 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 07300 DRUGS CHARGED TO PATIENTS 73 00 1, 292, 062 22, 514 7,062 139, 864 1, 461, 502 73.00 07400 RENAL DIALYSIS 74 00 C 0 74 00 75.00 07500 ASC (NON-DISTINCT PART) 0 75.00 0 0 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 76.00 0 0 76.00 0 03950 SPECIAL PROCEDURES 76.01 0 0 76.01 0 03951 SPECIAL PROCEDURES - SUA 0 134, 994 76.02 134, 994 Ω 76.02 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 0 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 0 Ω 0 0 0 90.00 09100 EMERGENCY 0 0 0 0 91.00 91.00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 Ω 0 0 0 94.00 09500 AMBULANCE SERVICES 0 0 0 0 0 95.00 0 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 96.00 96.00 0

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09900 CMHC

97 00

99.00

09700 DURABLE MEDICAL EQUIP-SOLD

Health Financial Systems ENCO	MPASS HEALTH DE	ACONESS REHABI	LIT	In Lie	eu of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO		Period: From 08/01/2022 To 07/31/2023		epared: 13 am
		CAPI TAL REI	LATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
	0	1. 00	2. 00	4. 00	4A	
99. 10 09910 CORF	0	0		0	0	
100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM	0	0		0		100.00
101. 00 10100 HOME HEALTH AGENCY	0	0		0		101.00
102.00 10200 OPI 0I D TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0		<u>U </u>	0	102. 00
105. 00 10500 KI DNEY ACQUI SI TI ON						105. 00
106. 00 10600 HEART ACQUISITION	0	0		0		106.00
107. 00 10700 LIVER ACQUISITION	0	0		0		107. 00
108. 00 10800 LUNG ACQUISITION	0	0		0 0		108.00
109. 00 10900 PANCREAS ACQUISITION	0	0		0 0		109.00
110.00 11000 INTESTINAL ACQUISITION	0	0		0		110.00
111. 00 11100 SLET ACQUISITION	0	0		0 0		111.00
113. 00 11300 NTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0	0	115. 00
116. 00 11600 HOSPI CE	0	0		0 0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	33, 487, 124	2, 744, 437	860, 83	5 3, 549, 304	33, 445, 794	118. 00
NONREI MBURSABLE COST CENTERS				_		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190. 00
191. 00 19100 RESEARCH	0	0		0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0		192. 00
193. 00 19300 NONPAI D WORKERS	0	0		0		193. 00
194. 00 07950 MARKETI NG NRCC	168, 525	3, 067	96	2 37, 301	209, 855	
194. 01 07951 GUEST MEALS	0	0		U 0		194. 01
200.00 Cross Foot Adjustments		_				200.00
201.00 Negative Cost Centers	22 (55 (40	0 747 504	0/1 70	0 2 504 405		201. 00
202.00 TOTAL (sum lines 118 through 201)	33, 655, 649	2, 747, 504	861, 79	7 3, 586, 605	33, 655, 649	1202.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-3025 Peri od: Worksheet B From 08/01/2022 Part I To 07/31/2023 Date/Time Prepared:

				1	0 07/31/2023	Date/lime Pre 11/15/2023 8:	
	Cost Center Description	ADMINISTRATIVE & GENERAL	PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
	CENIEDAL SEDVICE COST CENTEDS	5.00	7. 00	8.00	9. 00	10. 00	
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	6, 278, 784					5. 00
7.00	00700 OPERATION OF PLANT	271, 845	1, 449, 077				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	81, 662	4, 573	439, 876			8. 00
9.00	00900 HOUSEKEEPI NG	124, 528	9, 023	0	672, 824		9. 00
10.00	01000 DI ETARY	301, 373	85, 428	0	40, 041	1, 731, 946	1
11. 00	01100 CAFETERI A	0	0	0	0	425, 282	1
13. 00	01300 NURSI NG ADMI NI STRATI ON	284, 118	7, 131	0	3, 342	0	13. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	30, 047	6, 360	1	, , , ,	0	16.00
17. 00	01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	226, 637	29, 451	0	13, 804	0	17. 00
30. 00	03000 ADULTS & PEDIATRICS	2, 974, 688	1, 043, 537	439, 876	489, 117	1, 301, 182	30.00
31. 00	03100 INTENSIVE CARE UNIT	2, 774, 000	1, 043, 337	1	0	1, 301, 102	1
32. 00	03200 CORONARY CARE UNIT	o o	0	_	0	0	
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	ō	o	0	33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00	04000 SUBPROVI DER - I PF	0	0	0	0	0	40.00
41.00	04100 SUBPROVI DER - I RF	0	0	0	0	0	41.00
43.00	04300 NURSERY	0	0	0	0	0	43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	
45. 00	04500 NURSI NG FACI LI TY	0	0		0	0	
46. 00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46. 00
EO 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	O	0	0	ol	0	E0 00
50. 00 51. 00	05100 RECOVERY ROOM	0	0			0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0		0	0	52.00
53. 00	05300 ANESTHESI OLOGY		0			0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	24, 531	0	Ö	0	0	54.00
54. 01	05401 RADI OLOGY - DI AGNOSTI C - SUA	0	0	ō	o	0	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	o	0	0	55. 00
56.00	05600 RADI OI SOTOPE	0	0	0	0	0	56. 00
57.00	05700 CT SCAN	0	0	0	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60.00	06000 LABORATORY	154, 242	21, 024	0	9, 854	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	0	
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	63.00
65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	126, 482	5, 817	0	2, 726	0	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	501, 513	122, 133	1	57, 245	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	538, 684	61, 548	1	28, 848	0	67.00
68. 00	06800 SPEECH PATHOLOGY	160, 636	17, 941	1		0	1
	06900 ELECTROCARDI OLOGY	0	. 0	1	0	0	
	07000 ELECTROENCEPHALOGRAPHY	o	0	0	0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	91, 849	20, 499	0	9, 608	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	337, 489	12, 860	0	6, 028	0	73. 00
	07400 RENAL DIALYSIS	0	0	0	0	0	74. 00
	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0	0	0	76. 00
	03950 SPECIAL PROCEDURES	0	0	0	0	0	76. 01
	03951 SPECIAL PROCEDURES - SUA	0	0		0	0	
	07700 ALLOGENEIC HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY	0	0		0	0	77. 00 78. 00
76.00	OUTPATIENT SERVICE COST CENTERS	J O		<u> </u>	<u> </u>	0	78.00
90. 00	09000 CLINIC	0	0	0	0	0	90.00
	09100 EMERGENCY	0	0		o	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		· ·		J	ŭ	92.00
	OTHER REIMBURSABLE COST CENTERS						1
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94. 00
	09500 AMBULANCE SERVICES	0	0	0	0	0	1
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96. 00
	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	
	09900 CMHC	0	0	0	0	0	
	09910 CORF	0	0	0	0	0	
	10000 I &R SERVI CES-NOT APPRVD PRGM	0	0	0	0		100.00
	10100 HOME HEALTH AGENCY	0	0	0	0		101.00
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	ıj 0	0	0	102. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-3025

					11/15/2023 8: 13 am
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY
	& GENERAL	PLANT	LINEN SERVICE		
	5.00	7.00	8. 00	9. 00	10.00
SPECIAL PURPOSE COST CENTERS					
105.00 10500 KIDNEY ACQUISITION	0	0	0	0	0 105. 00
106.00 10600 HEART ACQUISITION	0	0	0	0	0 106. 00
107.00 10700 LIVER ACQUISITION	0	0	0	0	0 107. 00
108.00 10800 LUNG ACQUISITION	0	0	0	0	0 108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0 109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0 110. 00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0 111. 00
113.00 11300 INTEREST EXPENSE					113. 00
114.00 11400 UTILIZATION REVIEW-SNF					114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0 115. 00
116. 00 11600 H0SPI CE	0	0	0	0	0 116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	6, 230, 324	1, 447, 325	439, 876	672, 003	1, 726, 464 118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190. 00
191. 00 19100 RESEARCH	0	0	0	0	0 191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0 193. 00
194. 00 07950 MARKETI NG NRCC	48, 460	1, 752	0	821	0 194. 00
194. 01 07951 GUEST MEALS	0	0	0	0	5, 482 194. 01
200.00 Cross Foot Adjustments					200. 00
201.00 Negative Cost Centers	0	0	0	0	0 201. 00
202.00 TOTAL (sum lines 118 through 201)	6, 278, 784	1, 449, 077	439, 876	672, 824	1, 731, 946 202. 00

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 08/01/2022 | Part |
| To 07/31/2023 | Date/Time Prepared: | 11/15/2023 8: 13 am

			'	0 07/31/2023	11/15/2023 8:	
Cost Center Description	CAFETERI A	NURSI NG	MEDI CAL	SOCIAL SERVICE	Subtotal	
		ADMI NI STRATI ON	RECORDS &			
	11.00	13.00	16. 00	17. 00	24. 00	
GENERAL SERVICE COST CENTERS	11.00	13.00	10.00	17.00	24.00	
1.00 O0100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5. 00
7. 00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LI NEN SERVI CE 9.00 00900 HOUSEKEEPI NG						8. 00 9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A	425, 282					11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	32, 932	1, 557, 902				13. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	3, 249		172, 758	3		16. 00
17. 00 01700 SOCIAL SERVICE	25, 047	0	C	1, 276, 394		17. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	188, 799	1, 557, 902	84, 949	1, 276, 394	22, 238, 354	30.00
31. 00 03100 INTENSIVE CARE UNIT	0	0	C		0	31.00
32.00 03200 CORONARY CARE UNIT 33.00 03300 BURN INTENSIVE CARE UNIT	0	0	C		0	32. 00 33. 00
34. 00 03400 SURGICAL INTENSIVE CARE UNIT	0				0	34.00
40. 00 04000 SUBPROVI DER - PF	0	Ö	C	ol ol	0	40.00
41. 00 04100 SUBPROVI DER - RF	Ō	o	C	o	0	41. 00
43. 00 04300 NURSERY	0	o	C	o	0	43. 00
44.00 04400 SKILLED NURSING FACILITY	0	0	C	0	0	44. 00
45. 00 04500 NURSING FACILITY	0	0	C	1 1	0	45. 00
46. 00 O4600 OTHER LONG TERM CARE	0	0	C	0	0	46. 00
ANCILLARY SERVICE COST CENTERS		ا		ار	0	 EO OO
50.00 05000 0PERATING ROOM 51.00 05100 RECOVERY ROOM	0	1	C	_	0	50. 00 51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0				0	52.00
53. 00 05300 ANESTHESI OLOGY	0	Ö	(0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	o o	l ol	855	ol ol	131, 616	54.00
54. 01 05401 RADIOLOGY - DIAGNOSTIC - SUA	0	o	C		51, 496	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	o	C	o	0	55. 00
56. 00 05600 RADI OI SOTOPE	0	0	C	0	0	56. 00
57. 00 05700 CT SCAN	0	0	C	0	0	57. 00
58. 00 05800 MAGNETI C RESONANCE MAGING (MRI)	0	0	C	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	4 024	0	0	59.00
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	4, 722	0	4, 931	J	862, 721 0	60. 00 60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	١	C	,	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	o	C	ol	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	Ō	o	C	o	0	63. 00
64.00 06400 INTRAVENOUS THERAPY	0	o	C	o	0	64. 00
65. 00 06500 RESPI RATORY THERAPY	14, 716	0	2, 547	0	700, 022	65. 00
66. 00 06600 PHYSI CAL THERAPY	48, 242	0	24, 227		2, 925, 175	1
67. 00 06700 OCCUPATI ONAL THERAPY	60, 117	0	26, 992		3, 048, 974	1
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	17, 947	0	5, 766	0	906, 337	
70. 00 07000 ELECTROCARDI OLOGY	0	0			0	69. 00 70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 824		2, 054		524, 587	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	l ő	2, 00 1	ol ol	021,007	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	21, 068	o	20, 437	o	1, 859, 384	73. 00
74.00 07400 RENAL DIALYSIS	0	O	C	o	0	74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	C	0	0	75. 00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	C	0	0	76. 00
76. 01 03950 SPECIAL PROCEDURES	0	0	C	0	0	76. 01
76. 02 03951 SPECIAL PROCEDURES - SUA	0	0	(134, 994	76. 02
77.00 07700 ALLOGENEIC HSCT ACQUISITION 78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	(0	77. 00 78. 00
OUTPATIENT SERVICE COST CENTERS	0	l ol) U	0	76.00
90. 00 09000 CLINIC	0	ol	C	ol	0	90.00
91. 00 09100 EMERGENCY	Ö	l I	C	_	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	C	0	0	94. 00
95. 00 09500 AMBULANCE SERVI CES	0	이	C	이	0	95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	C		0	96.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 99. 00 09900 CMHC	0		C		0	97. 00 99. 00
99. 10 09910 CORF			(0	99.00
100.00 10000 I &R SERVI CES-NOT APPRVD PRGM			(100.00
101. 00 10100 HOME HEALTH AGENCY	0	l ől	C	ol ol		101.00
102. 00 10200 OPI OI D TREATMENT PROGRAM	Ö		C	ol ol		102. 00
	•	. '				

266, 507 194. 00

33, 655, 649 202. 00

5, 482 194. 01

0 200. 00

0 201. 00

0

0

172, 758

0

1, 276, 394

0

1, 557, 902

COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-3025 Peri od: Worksheet B From 08/01/2022 Part I 07/31/2023 Date/Time Prepared: 11/15/2023 8:13 am Cost Center Description CAFETERI A NURSI NG MEDI CAL SOCIAL SERVICE Subtotal ADMI NI STRATI ON RECORDS & LI BRARY 11. 00 13.00 17.00 24.00 16, 00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 105. 00 0 0 106. 00 10600 HEART ACQUISITION 0 0 106. 00 0 0 107.00 107. 00 10700 LIVER ACQUISITION 0 0 0 108.00 10800 LUNG ACQUISITION 0 0 108.00 0 109. 00 10900 PANCREAS ACQUISITION 0 109. 00 0 110.00 11000 INTESTINAL ACQUISITION 0 0 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 0 111.00 113.00 11300 I NTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115.00 0 0 116. 00 11600 HOSPI CE 0 0 116, 00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 419, 663 1, 557, 902 172, 758 1, 276, 394 33, 383, 660 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 0 0 0 191. 00 19100 RESEARCH 0 0 0 191.00 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 192. 00 0 193. 00 19300 NONPALD WORKERS 0 0 0 193.00

5,619

425, 282

194. 00 07950 MARKETI NG NRCC

Cross Foot Adjustments

TOTAL (sum lines 118 through 201)

Negative Cost Centers

194. 01 07951 GUEST MEALS

200.00

201.00

202.00

| Peri od: | Worksheet B | From 08/01/2022 | Part | | To 07/31/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-3025

				To 07/31/2023	Date/Time Prepared: 11/15/2023 8:13 am
	Cost Center Description	Intern &	Total		117 137 2023 6. 13 aiii
		Residents Cost			
		& Post Stepdown			
		Adjustments			
	GENERAL SERVICE COST CENTERS	25. 00	26. 00		
1.00	00100 CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP				2. 00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL				4. 00 5. 00
7. 00	00700 OPERATION OF PLANT				7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE				8. 00
9.00	00900 HOUSEKEEPI NG				9. 00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A				10.00
13. 00	01300 NURSI NG ADMI NI STRATI ON				13. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY				16. 00
17. 00					17. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	0	22, 238, 354		30.00
31. 00	03100 NTENSI VE CARE UNI T	O	0		31. 00
32.00	03200 CORONARY CARE UNIT	0	0		32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0		33.00
34. 00 40. 00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF		0		34. 00 40. 00
41. 00	04100 SUBPROVI DER – I RF	O	Ö		41. 00
43. 00	04300 NURSERY	0	O		43. 00
44. 00 45. 00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	0		44. 00 45. 00
46. 00	04600 OTHER LONG TERM CARE	0	0		46. 00
	ANCILLARY SERVICE COST CENTERS		-1		
50.00	05000 OPERATING ROOM	0	0		50.00
51. 00 52. 00	O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM	0	0		51. 00 52. 00
53. 00	05300 ANESTHESI OLOGY	O	o		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	131, 616		54. 00
54. 01	05401 RADI OLOGY - DI AGNOSTI C - SUA	0	51, 496		54. 01
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE		0		55. 00 56. 00
57. 00	05700 CT SCAN	0	ō		57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		58. 00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	0 862, 721		59. 00 60. 00
60. 01	06001 BLOOD LABORATORY	0	002, 721		60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0		61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62. 00 63. 00
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY		0		64. 00
65. 00	06500 RESPI RATORY THERAPY	O	700, 022		65. 00
	06600 PHYSI CAL THERAPY	0	2, 925, 175		66. 00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	3, 048, 974 906, 337		67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	900, 337		69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	O		70. 00
71. 00	1 1	0	524, 587		71.00
72. 00 73. 00	· ·		0 1, 859, 384		72. 00 73. 00
74. 00	07400 RENAL DIALYSIS	O	0		74. 00
	07500 ASC (NON-DISTINCT PART)	0	0		75. 00
76. 00 76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 03950 SPECI AL PROCEDURES	0	0		76. 00 76. 01
76. 01			134, 994		76. 02
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		78. 00
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	0	0		90. 00
91. 00		Ö	Ö		91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			92. 00
94 00	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S		ol		94. 00
	09500 AMBULANCE SERVICES		0		95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	ō		96. 00
97. 00		0	0		97. 00
	09900		0		99. 00 99. 10
	10000 I&R SERVICES-NOT APPRVD PRGM		o		100.00

Health Financial Systems ENCO	ICOMPASS HEALTH DEACONESS REHABILIT		In Lieu	u of Form CMS-2552-10	
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CC	N: 15-3025	Peri od: From 08/01/2022 To 07/31/2023	Worksheet B Part I Date/Time Prepared: 11/15/2023 8:13 am
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total			
	25. 00	26. 00			
101.00 10100 HOME HEALTH AGENCY	0	0			101. 00
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0			102. 00
SPECIAL PURPOSE COST CENTERS					
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0			105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0			106. 00
107.00 10700 LIVER ACQUISITION	0	0			107. 00
108.00 10800 LUNG ACQUISITION	0	0			108. 00
109.00 10900 PANCREAS ACQUISITION	0	0			109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0			110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	0			111. 00
113.00 11300 INTEREST EXPENSE					113. 00
114.00 11400 UTILIZATION REVIEW-SNF					114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0			115. 00
116. 00 11600 HOSPI CE	0	0			116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	33, 383, 660			118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			190. 00
191. 00 19100 RESEARCH	0	0			191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0			192. 00
193. 00 19300 NONPALD WORKERS	0	0			193. 00
194. 00 07950 MARKETI NG NRCC	0	266, 507			194. 00
194.01 07951 GUEST MEALS	0	5, 482			194. 01
200.00 Cross Foot Adjustments	0	0			200. 00
201.00 Negative Cost Centers	0	o			201. 00
202.00 TOTAL (sum lines 118 through 201)	O	33, 655, 649			202. 00

| Peri od: | Worksheet B | From 08/01/2022 | Part II | To 07/31/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS ENCOMPASS HEALTH DEACONESS REHABILIT
Provider CCN: 15-3025

				To	07/31/2023	Date/Time Pre 11/15/2023 8:	pared: 13 am
			CAPI TAL REI	LATED COSTS		117 137 2023 0.	15 dill
	Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New				BENEFI TS	
		Capital Related Costs				DEPARTMENT	
	T	0	1.00	2.00	2A	4. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	0	13, 680 109, 073		17, 971 143, 285		4. 00 5. 00
7. 00	00700 OPERATION OF PLANT	Ö	87, 817		115, 362		7. 00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0	8, 006 15, 797		10, 517		8. 00 9. 00
10.00	01000 DI ETARY	0	149, 562		20, 752 196, 474		10.00
11.00	01100 CAFETERI A	0	0	-	0	0	11.00
13. 00 16. 00	01300 NURSI NG ADMI NI STRATI ON 01600 MEDI CAL RECORDS & LI BRARY	0	12, 484 11, 134		16, 400 14, 626		13. 00 16. 00
17. 00	01700 SOCIAL SERVICE	0	51, 561		67, 734		17. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	0	1, 826, 946	573, 051	2, 399, 997	6, 284	30. 00
31. 00	03100 INTENSIVE CARE UNIT	o o	0	0	0	0	31. 00
32. 00 33. 00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0 0	32. 00 33. 00
34. 00	03400 SURGI CAL INTENSI VE CARE UNI T	0	0	0	0	0	34. 00
40.00	04000 SUBPROVI DER - I PF	0	0	0	0	0	40.00
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	0	0	0	0	0 0	41. 00 43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
45. 00 46. 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0	0 0		0		45. 00 46. 00
10. 00	ANCILLARY SERVICE COST CENTERS						10.00
50. 00 51. 00	O5000 OPERATI NG ROOM O5100 RECOVERY ROOM	0	0		0		50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	Ö	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 05401 RADI OLOGY - DI AGNOSTI C - SUA	0	0	0	0	0	54. 00 54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
56. 00 57. 00	05600	0	0	0	0	0	56. 00 57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	Ö	0	0	58. 00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	0 36, 808	0 11, 545	0 48, 353	0 157	59. 00 60. 00
60. 01	06001 BLOOD LABORATORY	0	30, 808	0	46, 353	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				0		61.00
62. 00 63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	62. 00 63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64. 00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	10, 183 213, 822		13, 377 280, 890	489 1, 604	•
67.00	06700 OCCUPATI ONAL THERAPY	0	107, 754	33, 799	141, 553	1, 999	67. 00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	31, 409 0	· ·	41, 261 0	597 0	68. 00 69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	Ö	Ö	0	0	70. 00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	35, 887	11, 257	47, 144	94	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	22, 514	7, 062	29, 576	701	73. 00
74.00	07400 RENAL DI ALYSI S	0	0	0	0	0	74.00
75. 00 76. 00	07500 ASC (NON-DISTINCT PART) 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	75. 00 76. 00
76. 01	03950 SPECIAL PROCEDURES	0	0	0	0	0	76. 01
76. 02 77. 00	03951 SPECIAL PROCEDURES - SUA 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	76. 02 77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0		78. 00
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	0	0	0	0	0	90. 00
90.00	09100 EMERGENCY	0	0		0	_	90.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92. 00
94. 00	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S	0	0	O	0	0	94. 00
95.00	09500 AMBULANCE SERVICES	0	0	Ō	0	0	95. 00
96. 00 97. 00	09600 DURABLE MEDICAL EQUIP-RENTED 09700 DURABLE MEDICAL EQUIP-SOLD	0) 0	0	0	0 0	96. 00 97. 00
99. 00	09900 CMHC	0	Ö	Ö	Ö	0	99. 00
99. 10	09910 CORF	0	0	0	0	0	99. 10

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3,067

2, 747, 504

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861, 797

962

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4, 029

3, 609, 301

0 190. 00

0 191.00

0 192. 00

0 193. 00

0 194. 01

0 201. 00

17, 971 202. 00

200.00

187 194. 00

190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118 through 201)

192. 00 19200 PHYSICIANS' PRIVATE OFFICES

191. 00 19100 RESEARCH

193. 00 19300 NONPALD WORKERS

194. 00 07950 MARKETING NRCC

194. 01 07951 GUEST MEALS

200.00

201.00

202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-3025 | Period: From 08/01/2

| In Lieu of Form CMS-2552-10 | Period: Worksheet B | From 08/01/2022 Part II | To 07/31/2023 Part II Date/Time Prepared: 11/15/2023 8: 13 am

	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	11/15/2023 8: DI ETARY	
	cost center bescription	& GENERAL	PLANT	LINEN SERVICE			
	GENERAL SERVICE COST CENTERS	5. 00	7.00	8.00	9. 00	10. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	145 050					4.00
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	145, 858 6, 315	l e				5. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	1, 897	385	1			8.00
9.00	00900 HOUSEKEEPI NG	2, 893	l .	l			9. 00
10. 00		7, 001	7, 187	0	1, 477	212, 745	
11.00		0	0	1	0	52, 240	
13.00		6,600	l	l .	123	0	1
16. 00 17. 00	1	698 5, 265	l	1	110 509	0	
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	0,200	2, 170		007		17.00
30.00		69, 105	87, 792	12, 799	18, 041	159, 832	30. 00
31. 00	1	0	0	0	0	0	
32. 00	1	0	0	0	0	0	
33. 00 34. 00	1 I	0	0	0	0	0 0	
40. 00	1 1	0		0	0	0	
41. 00	1 1	0	Ö	ő	Ö	Ö	
43.00	04300 NURSERY	0	o	0	0	0	43. 00
44. 00	1	0	0	0	0	0	
45. 00	1	0	0	0	0	0	
46. 00	04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	46. 00
50. 00		T 0	0	0	0	0	50.00
51. 00		0	Ö		0	Ö	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	o	0	0	0	52. 00
53.00	· ·	0	0	0	0	0	
54. 00		570	l .	0	0	0	
54. 01 55. 00		0		0	0	0	
56. 00		0		0	0	0	
57. 00	1	0	Ö	ő	Ö	Ö	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	o	0	0	0	58. 00
59. 00	1	0	0	0	0	0	
60.00	1	3, 583	1, 769	0	363	0	
60. 01 61. 00	1	0	0	0	0	0	60.01
62. 00	1 1	0	0	0	0	0	
63. 00	1 1	0	Ö	ő	0	0	
64.00	1 1	0	o	0	0	0	64.00
65. 00	1 I	2, 938		1	101	0	
66. 00	1	11, 650	1	1	2, 111	0	
67. 00	1	12, 513	5, 178	1	1, 064	0	
68. 00 69. 00	1 I	3, 731	1, 509	1	310	0 0	
70. 00	1 1	0	ĺ	Ö	_	0	
71. 00		2, 134	1, 725	Ō	354	0	
72. 00		0	0	0	0	0	72. 00
73. 00		7, 839	1, 082	0	222	0	
74. 00 75. 00	1	0	0	0	0	0	
76. 00	1 1 7	0		0	0	0	
	03950 SPECIAL PROCEDURES	0	ĺ	Ö	0	0	
76. 02	1 1	0	O	0	0	0	1
77. 00		0	0	0	0	0	
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
00 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	1 0		1 0	0	0	00 00
90. 00 91. 00	1	0		0	0	0	
92. 00	1		Ĭ		0		92. 00
20	OTHER REIMBURSABLE COST CENTERS						1
94. 00	1	0	0	0	0	0	
95.00	1	0	0	0	0	0	
96.00	1	0	0	0	0	0	
97. 00 99. 00	1	0		0	0	0 0	
	09910 CORF	0	l o	0	0	0	
	0 10000 I &R SERVICES-NOT APPRVD PRGM	0	Ö	Ö	0	-	100.00
101.0	0 10100 HOME HEALTH AGENCY	0	0	0	0		101. 00
102.0	0 10200 OPI OI D TREATMENT PROGRAM	0] 0	0	0	0	102. 00

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-3025 Peri od: Worksheet B From 08/01/2022 Part II 07/31/2023 Date/Time Prepared: 11/15/2023 8: 13 am ADMINISTRATIVE OPERATION OF Cost Center Description LAUNDRY & HOUSEKEEPI NG DI ETARY & GENERAL PLANT LINEN SERVICE 9. 00 5.00 7.00 8.00 10.00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 0 0 0 0 0 0 0 0 106.00 10600 HEART ACQUISITION 0 107. 00 10700 LIVER ACQUISITION 0 0 0 108.00 10800 LUNG ACQUISITION 0 109.00 10900 PANCREAS ACQUISITION 0 0 110.00 11000 INTESTINAL ACQUISITION 0 0

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-3025

Peri od: Worksheet B From 08/01/2022 Part II To 07/31/2023 Date/Time Prepared:

11/15/2023 8: 13 am Cost Center Description CAFETERI A NURSI NG MEDI CAL SOCIAL SERVICE Subtotal RECORDS & ADMI NI STRATI ON LI BRARY 11. 00 13.00 17. 00 24.00 16.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 52, 240 11.00 01300 NURSING ADMINISTRATION 4, 045 13.00 28, 863 13.00 01600 MEDICAL RECORDS & LIBRARY 16.00 399 16, 476 16.00 17.00 01700 SOCIAL SERVICE 3,076 79, 895 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 23, 195 8,096 79,895 2, 893, 899 30.00 28, 863 31.00 03100 INTENSIVE CARE UNIT 0 Ω 31.00 03200 CORONARY CARE UNIT 0 32.00 0 0 32.00 0 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 33.00 C 0 0 03400 SURGICAL INTENSIVE CARE UNIT 0 34 00 C 0 34 00 40.00 04000 SUBPROVI DER - I PF C 0 0 40.00 04100 SUBPROVI DER - I RF 0 41.00 0 0 0 0 41.00 04300 NURSERY 0 43.00 43.00 0 0 0 04400 SKILLED NURSING FACILITY 44.00 0 0 44.00 45.00 04500 NURSING FACILITY 0 0 0 0 0 45.00 04600 OTHER LONG TERM CARE 0 46.00 0 0 0 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 0 0 0 50.00 05100 RECOVERY ROOM 0 0 0 0 51.00 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 52.00 05300 ANESTHESI OLOGY 0 53.00 0 Λ 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 82 652 54.00 54.01 05401 RADIOLOGY - DIAGNOSTIC - SUA 0 0 0 0 0 0 54.01 05500 RADI OLOGY-THERAPEUTI C 55 00 Ω O 55 00 0 05600 RADI OI SOTOPE 56.00 0 0 0 56.00 05700 CT SCAN 0 0 0 57.00 57.00 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 0 58.00 0 0 05900 CARDIAC CATHETERIZATION 59 00 Ω 0 59 00 0 06000 LABORATORY 0 60.00 580 C 471 55, 276 60.00 06001 BLOOD LABORATORY 60.01 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 62 00 62 00 0 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 0 64.00 06400 INTRAVENOUS THERAPY C 0 64.00 06500 RESPIRATORY THERAPY 1,807 19, 444 65.00 243 65.00 06600 PHYSI CAL THERAPY 314, 767 66.00 5, 925 0 2.312 66.00 67.00 06700 OCCUPATIONAL THERAPY 7,384 2,576 0 0 0 172, 267 67.00 68 00 06800 SPEECH PATHOLOGY 2, 204 550 50, 162 68.00 06900 ELECTROCARDI OLOGY 69.00 0 69.00 0 0 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 Λ 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS o 51, 994 71.00 347 196 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 O 72.00 C 07300 DRUGS CHARGED TO PATIENTS 73.00 2.588 1, 950 43, 958 73.00 74.00 07400 RENAL DIALYSIS C 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 75.00 0 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 76.00 0 0 0 76.00 76. 01 03950 SPECIAL PROCEDURES Ω 0 0 76.01 03951 SPECIAL PROCEDURES - SUA 0 0 0 76.02 0 76.02 0 o 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 77.00 0 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 o 09100 EMERGENCY 0 C 0 0 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 94.00 0 95.00 09500 AMBULANCE SERVICES 00000 0 0 0 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 0 0 96.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 97.00 0 99.00 09900 CMHC 0 0 0 0 99.00 99. 10 09910 CORF Ω 0 99. 10 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 C 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 101.00 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 102.00

200.00

201.00

202.00

Cross Foot Adjustments

TOTAL (sum lines 118 through 201)

Negative Cost Centers

0 200.00

0 201. 00

3, 609, 301 202. 00

0

16, 476

79, 895

28, 863

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-3025 Peri od: Worksheet B From 08/01/2022 Part II 07/31/2023 Date/Time Prepared: 11/15/2023 8: 13 am Cost Center Description CAFETERI A NURSI NG MEDI CAL SOCIAL SERVICE Subtotal ADMI NI STRATI ON RECORDS & LI BRARY 11. 00 13.00 17.00 24.00 16, 00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 0 105. 00 106. 00 10600 HEART ACQUISITION 0 0 106. 00 0 0 0 0 0 107.00 107. 00 10700 LIVER ACQUISITION 0 0 108.00 10800 LUNG ACQUISITION 0 0 108.00 0 109. 00 10900 PANCREAS ACQUISITION 0 109. 00 0 110.00 11000 INTESTINAL ACQUISITION 0 0 0 110.00 0 111. 00 11100 | SLET ACQUI SI TI ON 0 0 0 111.00 113.00 11300 I NTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115.00 0 0 0 116. 00 11600 HOSPI CE O 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 51, 550 28, 863 16, 476 79, 895 3, 602, 419 118. 00 NONREI MBURSABLE COST CENTERS 0 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 191. 00 19100 RESEARCH 0 0 0 0 191.00 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 0 192. 00 193. 00 19300 NONPALD WORKERS 0 0 0 0 0 193.00 6, 209 194. 00 194. 00 07950 MARKETI NG NRCC 0 0 0 0 690 194. 01 07951 GUEST MEALS 0 C 0 673 194. 01

52, 240

In Lieu of Form CMS-2552-10
Worksheet B
Part II
B1/2023 Date/Time Prepared:
11/15/2023 8: 13 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025 Peri od: From 08/01/2022 To 07/31/2023 Intern & Residents Cost Cost Center Description Total & Post Stepdown Adjustments

		25. 00	26. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT				1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP				2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT				4. 00
5.00	00500 ADMINISTRATIVE & GENERAL				5. 00
7.00	00700 OPERATION OF PLANT				7.00
8. 00 9. 00	O0800 LAUNDRY & LINEN SERVICE O0900 HOUSEKEEPING				8. 00 9. 00
10.00	01000 DI ETARY				10.00
11. 00	01100 CAFETERI A				11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON				13. 00
16.00	01600 MEDICAL RECORDS & LIBRARY				16. 00
17. 00	01700 SOCIAL SERVICE				17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
	03000 ADULTS & PEDI ATRI CS	0	2, 893, 899		30. 00
31.00	03100 I NTENSI VE CARE UNI T	0	0		31.00
32.00	03200 CORONARY CARE UNIT	0	0		32.00
33. 00 34. 00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0		33. 00 34. 00
40. 00	04000 SUBPROVI DER - I PF		0		40.00
41. 00	04100 SUBPROVI DER - I RF	0	0		41. 00
	04300 NURSERY	o	0		43. 00
44.00	04400 SKILLED NURSING FACILITY	0	0		44. 00
45.00	04500 NURSING FACILITY	0	0		45. 00
46. 00	04600 OTHER LONG TERM CARE	0	0		46. 00
	ANCI LLARY SERVI CE COST CENTERS				4
50.00	05000 OPERATI NG ROOM	0	0		50.00
51.00	05100 RECOVERY ROOM	0	0		51.00
52. 00 53. 00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	0		52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C		652		54.00
54. 01	05401 RADI OLOGY - DI AGNOSTI C - SUA	0	0		54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	o	0		55. 00
56.00	05600 RADI OI SOTOPE	0	0		56.00
57.00	05700 CT SCAN	0	0		57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		59. 00
60.00	06000 LABORATORY	0	55, 276		60.00
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	U	0		60. 01
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0		62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.		0		63.00
64. 00	06400 I NTRAVENOUS THERAPY	o	0		64. 00
65.00	06500 RESPI RATORY THERAPY	0	19, 444		65. 00
66.00	06600 PHYSI CAL THERAPY	0	314, 767		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	172, 267		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	50, 162		68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0		69.00
	07000 ELECTROENCEPHALOGRAPHY	0	U E1 004		70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 I MPL. DEV. CHARGED TO PATIENTS		51, 994 0		71.00
	07300 DRUGS CHARGED TO PATIENTS		43, 958		73. 00
	07400 RENAL DIALYSIS	0	0,700		74.00
	07500 ASC (NON-DISTINCT PART)	o	0		75. 00
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		76. 00
76. 01	03950 SPECI AL PROCEDURES	0	0		76. 01
	03951 SPECI AL PROCEDURES - SUA	0	0		76. 02
	07700 ALLOGENEIC HSCT ACQUISITION	0	0		77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		78. 00
00 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	l ol	0		90.00
	09100 EMERGENCY		0		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		U		92.00
, 00	OTHER REIMBURSABLE COST CENTERS	<u> </u>		<u> </u>	1 .2.00
94. 00	09400 HOME PROGRAM DI ALYSI S	O	0		94. 00
	09500 AMBULANCE SERVICES	0	0		95.00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		96. 00
	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		97. 00
	09900 CMHC	0	0		99. 00
	10004010005		^		99. 10
	09910 CORF 10000 L&R SERVICES-NOT APPRVD PRGM	0	0		100.00

Health Financial Systems ENCO	MPASS HEALTH DEA	CONESS REHABILI	ΙT	In Lieu	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CCN	l: 15-3025	Peri od: From 08/01/2022 To 07/31/2023	Worksheet B Part II Date/Time Prepared: 11/15/2023 8:13 am
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments 25.00	Total			
101.00 10100 HOME HEALTH AGENCY	0	0			101. 00
102.00 10200 OPI OI D TREATMENT PROGRAM	o	o			102.00
SPECIAL PURPOSE COST CENTERS	· · · · · · · · · · · · · · · · · · ·	- 1			
105.00 10500 KIDNEY ACQUISITION	0	0			105. 00
106.00 10600 HEART ACQUISITION	0	O			106. 00
107.00 10700 LIVER ACQUISITION	0	0			107. 00
108.00 10800 LUNG ACQUISITION	0	0			108. 00
109.00 10900 PANCREAS ACQUISITION	0	0			109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0			110. 00
111.00 11100 SLET ACQUISITION	0	0			111. 00
113. 00 11300 I NTEREST EXPENSE					113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF					114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0			115. 00
116. 00 11600 HOSPI CE	0	0			116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	3, 602, 419			118. 00
NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN					190. 00
191.00 19100 RESEARCH		O O			190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES		0			192.00
193. 00 19300 NONPALD WORKERS		0			193. 00
194. 00 07950 MARKETI NG NRCC		6, 209			194. 00
194. 01 07951 GUEST MEALS		673			194. 01
200.00 Cross Foot Adjustments		0/9			200. 00
201.00 Negative Cost Centers		0			201. 00
202.00 TOTAL (sum lines 118 through 201)	o	3, 609, 301			202. 00
					•

Health Financial Systems ENCOMPASS HEALTH DEACONESS REHABILIT In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-3025 Peri od: Worksheet B-1 From 08/01/2022 07/31/2023 Date/Time Prepared: 11/15/2023 8:13 am CAPITAL RELATED COSTS BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliation ADMINISTRATIVE Cost Center Description (SQUARE FEET) (SQUARE FEET) BENEFITS & GENERAL (ACCUM. COST) DEPARTMENT (GROSS SALARI ES) 1.00 2.00 5. 00 4.00 5A GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 89.574 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 89, 574 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 446 15, 803, 030 4.00 446 00500 ADMINISTRATIVE & GENERAL 27, 190, 375 5 00 3 556 2, 262, 864 -6, 278, 784 5 00 3 556 7.00 00700 OPERATION OF PLANT 2,863 2,863 205, 347 1, 177, 232 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 261 261 353, 641 8.00 0 00900 HOUSEKEEPI NG 515 515 361, 731 539, 273 9.00 9.00 01000 DI ETARY 10 00 10 00 4,876 4,876 533, 197 1, 305, 104 11.00 01100 CAFETERI A 0 11.00 01300 NURSING ADMINISTRATION 407 407 1, 230, 379 13.00 963, 283 13.00 01600 MEDICAL RECORDS & LIBRARY 0 16, 00 363 95. 032 130, 121 16, 00 363 17.00 01700 SOCIAL SERVICE 1,681 1, 681 732, 646 981, 455 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 59, 562 59, 562 5, 522, 571 12, 881, 910 30.00 0 03100 INTENSIVE CARE UNIT 31.00 31.00 0 C 0 32 00 03200 CORONARY CARE UNIT 0 C 0 0 0 32 00 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 33.00 34 00 03400 SURGICAL INTENSIVE CARE UNIT 0 O 34.00 0 04000 SUBPROVIDER - IPF 40.00 0 40.00 C 0 04100 SUBPROVI DER - I RF 0 41.00 0 41.00 0 0 04300 NURSERY 0 43.00 43.00 44.00 04400 SKILLED NURSING FACILITY 0 44.00 ol 04500 NURSING FACILITY 0 0 45.00 45 00 C 0 04600 OTHER LONG TERM CARE 46.00 0 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 0 0 0 50.00 0 0 0 51.00 05100 RECOVERY ROOM 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 52.00 53.00 05300 ANESTHESI OLOGY 0 0 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 106, 230 54 00 C 0 54 00 54.01 05401 RADIOLOGY - DIAGNOSTIC - SUA -51, 496 0 54.01 0 05500 RADI OLOGY-THERAPEUTI C 55.00 0 0 0 55.00 05600 RADI OI SOTOPE 0 0 56.00 56.00 0 0 0 05700 CT SCAN 0 57.00 0 Λ 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 C 0 0 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0 C 0 59.00 0 06000 LABORATORY 1, 200 1, 200 667. 948 60 00 138 136 60 00 60.01 06001 BLOOD LABORATORY 0 C 0 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 63 00 63 00 0 64.00 06400 INTRAVENOUS THERAPY 64.00 06500 RESPI RATORY THERAPY 430, 452 547, 734 65.00 332 332 0 65.00 66.00 06600 PHYSI CAL THERAPY 6,971 6, 971 1, 411, 127 2, 171, 815 66, 00 06700 OCCUPATI ONAL THERAPY 3, 513 67.00 3 513 1, 758, 486 2, 332, 785 67 00 68.00 06800 SPEECH PATHOLOGY 1,024 1,024 524, 956 695, 638 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 0 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 \cap 0 397, 753 |07100|MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 1, 170 1, 170 82, 590 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73 00 734 734 616, 258 1, 461, 502 73.00 07400 RENAL DIALYSIS 74 00 0 0 0 0 74 00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 75.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 76.00 76.00 0 0 03950 SPECIAL PROCEDURES 76.01 0 0 0 76.01 0 03951 SPECIAL PROCEDURES - SUA 0 76.02 Ω -134, 994 0 76.02 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 77.00 77.00 C 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 0 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 0 Ω 0 0 0 90.00 09100 EMERGENCY 0 0 0 0 0 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 Ω 0 0 0 94.00 95.00 09500 AMBULANCE SERVICES 0 0 0 0 0 95.00 0

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96.00

97.00

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0

0 99.00

09900 CMHC

96.00

97 00

99.00

09600 DURABLE MEDICAL EQUIP-RENTED

09700 DURABLE MEDICAL EQUIP-SOLD

Health Financial Systems ENCOMPASS HEALTH DEACONESS REHABILIT In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-3025 Peri od: Worksheet B-1 From 08/01/2022 07/31/2023 Date/Time Prepared: 11/15/2023 8:13 am CAPITAL RELATED COSTS MVBLE EQUIP Reconciliation ADMINISTRATIVE Cost Center Description BLDG & FIXT **EMPLOYEE** (SQUARE FEET) (SQUARE FEET) **BENEFITS** & GENERAL (ACCUM. COST) DEPARTMENT (GROSS SALARI ES) 1.00 2.00 5A 5. 00 99. 10 09910 CORF 0 0 99. 10 0 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 0 0 100.00 C 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101.00 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 102. 00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 105. 00 0 0 106.00 10600 HEART ACQUISITION 0 0 0 0 106.00 107. 00 10700 LIVER ACQUISITION 0 0 0 107. 00 0 0 0 108.00 10800 LUNG ACQUISITION 0 0 108 00 Ω 109.00 10900 PANCREAS ACQUISITION 0 0 0 109. 00 110.00 11000 INTESTINAL ACQUISITION 0 0 0 0 110.00 111.00 11100 | SLET ACQUISITION 0 0 ol 0 111.00 113.00 11300 INTEREST EXPENSE 113. 00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115.00 116. 00 11600 HOSPI CE 0 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 89, 474 89<u>, 474</u> 15, 638, 676 -6, 465, 274 26, 980, 520 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190. 00 0 191. 00 19100 RESEARCH 0 191. 00 0 0 0 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 0 192. 00 Ω 193. 00 19300 NONPALD WORKERS 0 0 0 0 193.00 194. 00 07950 MARKETING NRCC 100 164, 354 209, 855 194. 00 100 194. 01 07951 GUEST MEALS 0 194. 01 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 2, 747, 504 861, 797 3, 586, 605 6, 278, 784 202. 00 Part I) 0. 230919 203. 00 203.00 Unit cost multiplier (Wkst. B, Part I) 30.673008 9.621062 0.226957 204.00 Cost to be allocated (per Wkst. B, 145, 858 204. 00 17, 971 Part II) 205.00 0.001137 0.005364 205.00 Unit cost multiplier (Wkst. B, Part II)206. 00 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207. 00

Parts III and IV)

Health Financial Systems In Lieu of Form CMS-2552-10 ENCOMPASS HEALTH DEACONESS REHABILIT COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-3025 Peri od: Worksheet B-1 From 08/01/2022 07/31/2023 Date/Time Prepared: 11/15/2023 8:13 am Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A LINEN SERVICE (SQUARE FEET) (MEALS SERVED) PLANT (GROSS (SQUARE FEET) (TOTAL PATIENT SALARI ES) DAYS) 7.00 10.00 11.00 8.00 9.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 7.00 00700 OPERATION OF PLANT 82, 709 7 00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 261 31, 174 00900 HOUSEKEEPI NG 9.00 515 81, 933 9.00 10.00 01000 DI ETARY 4,876 0 4,876 124.483 10.00 01100 CAFETERI A 30, 567 12, 439, 891 11.00 C 11.00 C 01300 NURSING ADMINISTRATION 407 407 963, 283 13.00 C 13.00 16.00 01600 MEDICAL RECORDS & LIBRARY 363 C 363 0 95, 032 16.00 17.00 01700 SOCIAL SERVICE 1,681 1,681 0 732, 646 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 5, 522, 571 30.00 03000 ADULTS & PEDIATRICS 59, 562 31, 174 59, 562 93, 522 30.00 03100 INTENSIVE CARE UNIT 0 31.00 31.00 32.00 03200 CORONARY CARE UNIT 0 0 0 0 0 0 32.00 03300 BURN INTENSIVE CARE UNIT 33 00 Ω 0 0 33 00 34.00 03400 SURGICAL INTENSIVE CARE UNIT C 0 0 34.00 04000 SUBPROVI DER - I PF 0 0 0 0 40.00 40.00 0 0 0 04100 SUBPROVI DER - I RF 41.00 0 41.00 0 04300 NURSERY 0 43 00 Ω 0 43 00 0 44.00 04400 SKILLED NURSING FACILITY 0 0 0 0 44.00 0 0 45.00 04500 NURSING FACILITY 0 0 45.00 46.00 04600 OTHER LONG TERM CARE Ω 0 0 0 46 00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 0 0 50.00 0 0 51.00 05100 RECOVERY ROOM 0 0 0 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 Ω 52 00 0 0 53.00 05300 ANESTHESI OLOGY 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 0 0 0 54.00 54.01 05401 RADIOLOGY - DIAGNOSTIC - SUA 0 0 0 54.01 05500 RADI OLOGY-THERAPEUTI C 0 55 00 Ω 0 55 00 0 56.00 05600 RADI OI SOTOPE 0 0 0 56.00 05700 CT SCAN 0 57.00 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 0 0 58.00 0 05900 CARDIAC CATHETERIZATION 59 00 0 0 0 0 59 00 60.00 06000 LABORATORY 1, 200 1, 200 0 138, 136 60.00 60.01 06001 BLOOD LABORATORY 0 C 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61, 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 0 0 Λ 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 0 0 63.00 64.00 06400 I NTRAVENOUS THERAPY 0 0 64.00 06500 RESPIRATORY THERAPY 65.00 332 0 332 430, 452 65.00 06600 PHYSI CAL THERAPY 6, 971 66.00 6.971 0 1, 411, 127 66.00 67.00 06700 OCCUPATIONAL THERAPY 3, 513 3, 513 1, 758, 486 67.00 06800 SPEECH PATHOLOGY 0 524, 956 68.00 1.024 1.024 68.00 06900 ELECTROCARDI OLOGY 69 00 0 C C 0 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1, 170 1, 170 0 0 82, 590 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 C 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 734 734 616, 258 73.00 74.00 07400 RENAL DIALYSIS 0 C 0 74.00 0 0 07500 ASC (NON-DISTINCT PART) 75.00 75.00 0 0 0 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76.00 0 0 0 76.00 76. 01 03950 SPECIAL PROCEDURES 0 C 0 0 0 76.01 03951 SPECIAL PROCEDURES - SUA 0 0 76.02 0 0 76.02 0 ol 07700 ALLOGENEIC HSCT ACQUISITION 0 0 77.00 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 0 0 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 0 0 90.00 91 00 09100 EMERGENCY 0 0 0 0 91 00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS C 0 94.00 09500 AMBULANCE SERVICES 0 0 0 95 00 95 00 C 0 0 96, 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 97.00 97.00 0 0 99.00 09900 CMHC 0 0 99.00 0 0 99. 10 99. 10 09910 CORF 0 0 0 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 0 100.00

0 101.00

101.00 10100 HOME HEALTH AGENCY

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-3025 Peri od: Worksheet B-1 From 08/01/2022 07/31/2023 Date/Time Prepared: 11/15/2023 8:13 am Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A LINEN SERVICE (SQUARE FEET) (MEALS SERVED) (GROSS PLANT (SQUARE FEET) (TOTAL PATIENT SALARI ES) DAYS) 7.00 11. 00 9.00 10.00 8.00 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102. 00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION 0 0 105. 00 0 0 0 106.00 10600 HEART ACQUISITION 0 0 0 106.00 0 107. 00 10700 LIVER ACQUISITION 0 0 0 107. 00 0 108.00 10800 LUNG ACQUISITION 0 0 108.00 0 0 0 109. 00 10900 PANCREAS ACQUISITION 0 109.00 0 0 110.00 11000 INTESTINAL ACQUISITION 0 0 0 110.00 111.00 11100 | SLET ACQUISITION 0 0 0 111. 00 113.00 11300 INTEREST EXPENSE 113. 00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 C 0 0 115. 00 116. 00 11600 HOSPI CE 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117)
NONREIMBURSABLE COST CENTERS 118.00 82,609 31, 174 81, 833 124, 089 12, 275, 537 118. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190. 00 191. 00 19100 RESEARCH 0 0 0 0 0 191.00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES o 0 0 192.00 0 193. 00 19300 NONPALD WORKERS 0 0 0 0 0 193. 00 194. 00 07950 MARKETING NRCC 100 0 100 164, 354 194. 00 194. 01 07951 GUEST MEALS 0 194. 01 394 C 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 1, 449, 077 439, 876 672, 824 1, 731, 946 425, 282 202. 00 Part I) 203.00 14. 110348 13. 913113 0. 034187 203. 00 Unit cost multiplier (Wkst. B, Part I) 17. 520185 8. 211880 204.00 Cost to be allocated (per Wkst. B, 121, 910 12, 799 24, 815 212, 745 52, 240 204. 00 Part II) Unit cost multiplier (Wkst. B, Part 1. 473963 0. 410566 0.302869 1.709029 0.004199 205.00 205.00 II) 206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00 207. 00 Parts III and IV)

Provider CCN: 15-3025

				11	o 07/31/2023 Date/lime Pr 11/15/2023 8	
	Cost Center Description	NURSI NG	MEDI CAL	SOCIAL SERVICE	1171372023	. 15 diii
	·	ADMI NI STRATI ON	RECORDS &			
			LI BRARY	(TOTAL PATIENT		
		(TOTAL PATIENT	(GROSS	DAYS)		
		DAYS) 13. 00	CHARGES) 16. 00	17. 00		
	GENERAL SERVICE COST CENTERS	13.00	10.00	17.00		
1.00	00100 CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP					2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5.00	00500 ADMINISTRATIVE & GENERAL					5. 00
7.00	00700 OPERATION OF PLANT					7. 00
8.00	00800 LAUNDRY & LINEN SERVICE					8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY					9. 00 10. 00
11. 00	01100 CAFETERI A					11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	31, 174				13. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	69, 259, 384			16. 00
17. 00	01700 SOCIAL SERVICE	0	0	31, 174		17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00	03000 ADULTS & PEDIATRICS	31, 174	34, 051, 000			30. 00
31.00	03100 I NTENSI VE CARE UNI T	0	0	0		31.00
32.00	03200 CORONARY CARE UNIT	0	0	0		32.00
33. 00 34. 00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0			33. 00 34. 00
40. 00	04000 SUBPROVI DER - I PF	0	0			40. 00
41. 00	04100 SUBPROVI DER – I RF		0	o o		41. 00
43. 00	04300 NURSERY	0	0	o		43. 00
44.00	04400 SKILLED NURSING FACILITY	0	0	0		44. 00
45.00	04500 NURSING FACILITY	0	0	0		45. 00
46. 00	04600 OTHER LONG TERM CARE	0	0	0		46. 00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0			50.00
51. 00 52. 00	O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM	0	0	1		51. 00 52. 00
53. 00	05300 ANESTHESI OLOGY	0	0			53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C		342, 953	0		54. 00
54. 01	05401 RADI OLOGY - DI AGNOSTI C - SUA	0	0	o o		54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0		55. 00
56.00	05600 RADI 0I SOTOPE	0	0	0		56. 00
57. 00	05700 CT SCAN	0	0	0		57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0		58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	1 077 004	0		59.00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	0	1, 977, 086			60. 00 60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0	,		61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	o o		63. 00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0		64. 00
		0	1, 021, 276			65. 00
	06600 PHYSI CAL THERAPY	0	9, 714, 208			66. 00
	06700 OCCUPATI ONAL THERAPY	0	10, 822, 740			67. 00
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	2, 312, 037			68. 00 69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	0			70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		823, 450			71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS		020, 100	o o		72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	8, 194, 634	0		73. 00
74.00	07400 RENAL DIALYSIS	0	0	0		74. 00
	07500 ASC (NON-DISTINCT PART)	0	0	0		75. 00
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0		76. 00
		0	0	0		76. 01
	03951 SPECIAL PROCEDURES - SUA 07700 ALLOGENEIC HSCT ACQUISITION	0	0			76. 02
	07700 ALLOGENETC HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY	0	0			77. 00 78. 00
76.00	OUTPATIENT SERVICE COST CENTERS	ı o		<u> </u>		76.00
90. 00	09000 CLINIC	0	0	0		90.00
	09100 EMERGENCY	0	0	0		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)					92. 00
	OTHER REIMBURSABLE COST CENTERS					
94. 00	09400 HOME PROGRAM DIALYSIS	0	0	0		94. 00
	09500 AMBULANCE SERVICES	0	0	0		95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
	09700 DURABLE MEDI CAL EQUI P-SOLD 09900 CMHC		0			97. 00 99. 00
	09910 CORF		0	0		99. 00
	10000 I &R SERVICES-NOT APPRVD PRGM	0	0	0		100.00
	,	<u>, </u>				

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS ENCOMPASS HEALTH DEACONESS REHABILIT In Lieu of Form CMS-2552-10 Provider CCN: 15-3025

				10	11/15/2023 8: 13	
	Cost Center Description	NURSI NG	MEDI CAL	SOCIAL SERVICE	1	
	· ·	ADMI NI STRATI ON	RECORDS &			
			LI BRARY	(TOTAL PATIENT		
		(TOTAL PATIENT	(GROSS	DAYS)		
		DAYS)	CHARGES)			
		13. 00	16. 00	17. 00		
	HOME HEALTH AGENCY	0	0	- 1	1	01. 00
	OPIOID TREATMENT PROGRAM	0	0	0	10	02.00
	AL PURPOSE COST CENTERS					
	KIDNEY ACQUISITION	0	0		1	05.00
	HEART ACQUISITION	0	0	0		06.00
	LIVER ACQUISITION	0	0	0		07. 00
	LUNG ACQUISITION	0	0	0		08.00
	PANCREAS ACQUISITION	0	0	0		09. 00
	INTESTINAL ACQUISITION	0	0	0		10.00
	I SLET ACQUI SITI ON	0	0	0		11.00
	I NTEREST EXPENSE					13.00
	UTILIZATION REVIEW-SNF	_	_			14.00
	AMBULATORY SURGICAL CENTER (D. P.)	0	0	0		15.00
116. 00 11600		0	(0.050.004	0		16.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	31, 174	69, 259, 384	31, 174	11	18. 00
	I MBURSABLE COST CENTERS				1.5	20.00
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		90.00
191. 00 19100		0	U	0		91. 00 92. 00
	PHYSICIANS' PRIVATE OFFICES NONPAID WORKERS	0	0		I	92. 00 93. 00
	MARKETING NRCC		0			93.00 94.00
	GUEST MEALS		0		I	94. 00 94. 01
200. 00	Cross Foot Adjustments	٩	U		I	00.00
201. 00	Negative Cost Centers					01. 00
202. 00	Cost to be allocated (per Wkst. B,	1, 557, 902	172, 758	1, 276, 394	1	02.00
202.00	Part I)	1, 557, 402	172, 750	1, 270, 374	20	J2. UU
203. 00	Unit cost multiplier (Wkst. B, Part I)	49, 974402	0. 002494	40. 944184	20	03. 00
204. 00	Cost to be allocated (per Wkst. B,	28, 863	16, 476			04. 00
201.00	Part II)	20,000	10, 170	77,070		31.00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 925868	0. 000238	2. 562873	20	05. 00
	11)					
206. 00	NAHE adjustment amount to be allocated				20	06. 00
	(per Wkst. B-2)					
207. 00	NAHE unit cost multiplier (Wkst. D,				20	07.00
	Parts III and IV)					

Total Cent Property Propert	COMPU	ATION OF RATIO OF COSTS TO CHARGES	WI ASS HEALTH DE	Provi der C	CN: 15-3025 F	Period: From 08/01/2022 Fo 07/31/2023	Worksheet C Part I Date/Time Pre 11/15/2023 8:	pared:
Desire D				Titl∈	XVIII			
1.00 2.00 3.00 4.00 5.00 5.00 3.00 4.00 5.00		Cost Center Description	(from Wkst. B, Part I, col.		Total Costs	RCE	Total Costs	
30.00 30.000 ADULLIS & PENTANTICS 22, 238, 354 21, 154 22, 239, 398 30.0				2.00	3.00	4. 00	5. 00	
31.00	20.00		22 220 254		22 220 25	1 21 154	22 250 500	30.00
3.2.0 3.0.			22, 230, 334		22, 230, 332) 21,154		
34.00 03400 SURRELEAN INTERSITY CARE INFIT 0			0			0		
40.00 GOODD SUBPROVIDER - 1 FF			0		(0	_	1
41.00 04.00 SURPERVIVER - LIFE 0 0 0 0 43.00			0			0	_	1
43.00 04.00 MIRSENT			0				0	
45.00 04500 MURSING FACILITY 0 0 0 45.00	43.00	04300 NURSERY	0			0	0	
46.00 04.00 04.00 04.00 0 0 0 0 0 0 0 0 0			0		(0	_	1
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10.00 05100 RECOVERY ROOM 1.00 0 0 0 0 0 0 0 0 0	.0.00					,	<u> </u>	10.00
52.00 05/00 OFLI VERY RODM & LABOR ROW 0 0 0 0 52.00		1 1	0		(1		
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54 00 05400 RADI OLOGY - DI ARNOSTIC 131, 616 131, 616 54.00 05500 RADI OLOGY - DI ARNOSTIC 50 0 0 0 0 0 0 55.00 05500 RADI OLOGY - THERAPEUTIC 0 0 0 0 0 0 55.00 05500 RADI OLOGY - THERAPEUTIC 0 0 0 0 0 0 55.00 05500 RADI OLOGY - THERAPEUTIC 0 0 0 0 0 0 55.00 05500 RADI OLOGY - THERAPEUTIC 0 0 0 0 0 0 55.00 05500 RADI OLOGY - THERAPEUTIC 0 0 0 0 0 0 55.00 05500 RADI OLOGY - THERAPEUTIC 0 0 0 0 0 0 55.00 05500 RADI OLOGY - THERAPEUTIC 0 0 0 0 0 0 55.00 05500 RADI OLOGY - THERAPEUTIC 0 0 0 0 0 0 0 55.00 05500 RADI OLOGY - THERAPEUTIC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0				_	
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56.00 05-000 RADIO ISOTOPE 0 0 0 0 55-0.00 57-0.00 57-0.00 57-0.00 57-0.00 57-0.00 58-0.00 05-00 05-0.00			51, 496		51, 496	0		
57.00 05700 CT SCAM 0 0 0 0 0 0 58.00			0			0	_	1
58. 00 G8500 MAGNETT C RESONANCE IMAGING (MRI) 0 0 0 58. 00 59. 00 6500 CARDIA C ATHIETER ZATION 0 0 0 0 59. 00 60. 00		1 1	0				0	
60. 00 06000 LABORATORY		05800 MAGNETIC RESONANCE IMAGING (MRI)	0			0	0	•
0.00 0.000 0.000 0.000 0.00			0		(()	0	_	
0.0 0.0		1 1	862, 721		862, 72	0		•
62.00 06-200 NHOLE BLOOD & PACKED RED BLOOD CELLS 0			0					
64.00 0.0400 INTRAVENOUS THERAPY 0 0 0 0 0 0 0 6.4.00			0			0	0	•
65.00 0.6500 RESPIRATORY THERAPY 700, 0.022 0 700, 0.022 65.00 66.00 0.6600 PHYSI CAL THERAPY 2, 925, 175 0 2, 925, 175 0 2, 925, 175 66.00 66.00 0.6600 PHYSI CAL THERAPY 3, 0.48, 974 0 3, 0.48, 974 0 3, 0.48, 974 67.00 67.00 0.6700 0.6CUPATI ONAL THERAPY 906, 337 0 906, 337 0 906, 337 0 0.6900 68.00 0.6800 SPEECH PHATOLOGY 906, 337 0 906, 337 0 0.6900 69.00 0.6900 ELECTROCARDI OLOGY 0 0 0 0 0 0.00 69.00 0.6900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 70.00 0.7000 ELECTROCARDI ALOGRAPHY 0 0 0 0 0 0 0 70.00 0.7000 ELECTROCARDI ALOGRAPHY 0 0 0 0 0 0 71.00 0.7100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 524, 587 0 524, 587 0 524, 587 72.00 0.7200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 72.00 73.00 0.73			0		(0	0	
66.00 06600 PHYSI CAL THERAPY 2, 925, 175 0 2, 925, 175 0 3, 048, 974 0 3, 048, 974 0 3, 048, 974 0 3, 048, 974 0 3, 048, 974 0 3, 048, 974 0 3, 048, 974 0 3, 048, 974 0 0 0 0 0 0 0 0 0			700 022	_	700.02			1
68.00 06800 SPECH PATHOLOGY 906, 337 0 906, 337 0 0 0 0 0 0 0 0 0			1	0				1
69.00 06900 ELECTROCARDI OLOCY 0 0 0 0 0 0 0 0 0				0				
70.00 07000 12-CT 12-C			906, 337	0				
171.00		1 1	0					
73.00 07300 DRUGS CHARGED TO PATIENTS			524, 587		524, 587	7 0		
74. 00 07400 RENAL DIALYSIS 0 0 0 0 0 0 74. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 75. 00 76. 01 03950 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 0 0 0 0 0 0 0 76. 01 76. 01 03950 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 0 0 0 0 0 0 0 76. 01 76. 01 03950 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 0 0 0 0 0 0 0 76. 01 76. 02 03951 SPECIAL PROCEDURES - SUA 134, 994 134, 994 0 134, 994 76. 02 77. 00 07700 ALLOGENEIC HISCT ACQUISITION 0 0 0 0 0 0 0 77. 00 78. 00 07300 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 0 0 77. 00 78. 00 07300 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0		1 050 00	0	0	
75. 00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 0 575. 00 76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 0 76. 00 76. 01 03950 SPECI AL PROCEDURES 50 0 0 0 0 0 76. 00 76. 02 03951 SPECI AL PROCEDURES 5UA 134, 994 134, 994 0 134, 994 76. 02 77. 00 07700 ALLOGENEIC HSCT ACQUI SI TI ON 0 0 0 0 0 0 0 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 0 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 79. 00 09000 CLINI IC 0 0 0 0 0 0 0 0 79. 00 09000 CLINI IC 0 0 0 0 0 0 0 79. 00 09000 CLINI IC 0 0 0 0 0 0 0 79. 00 09000 DEBRASATION BEIS (NON-DI STINCT PART) 0 0 0 0 0 0 79. 00 09400 HOME PROGRAM DI ALYSI S 0 0 0 0 0 0 79. 00 09400 HOME PROGRAM DI ALYSI S 0 0 0 0 0 0 79. 00 09700 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 79. 00 09700 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 79. 00 09900 CURBLE MEDI CAL EQUI P-SOLD 0 0 0 0 79. 01 09910 CORF 0 0 0 0 0 79. 02 09900 CORF 0 0 0 0 79. 01 09910 CORF 0 0 0 0 70. 00 01000 RAS SERVI CES-NOT APPRVD PRGM 0 0 0 0 70. 00 01000 TREATMENT PROGRAM 0 0 0 0 70. 00 01000 LIVER ACQUI SI TI ON 0 0 0 70. 00 01000 LIVER ACQUI SI TI ON 0 0 0 70. 00 01000 LIVER ACQUI SI TI ON 0 0 0 70. 00 01000 LIVER ACQUI SI TI ON 0 0 0 70. 00 01000 LIVER ACQUI SI TI ON 0 0 0 70. 00 01000 LIVER ACQUI SI TI ON 0 0 0 70. 00 01000 LIVER ACQUI SI TI ON 0 0 0 70. 00 01000 LIVER ACQUI SI TI ON 0 0 0 70. 00 01000 LIVER ACQUI SI TI ON 0 0 0 70. 00 01000 LIVER ACQUI SI TI ON 0 0 0 70. 00 01000 LIVER ACQUI SI TI ON 0 0 0 70. 00 01000 LIVER ACQUI SI T			1, 859, 384		1, 859, 384	1 0		1
76. 01 03950 SPECI AL PROCEDURES 0 0 0 0 76. 01 76. 02 03951 SPECI AL PROCEDURES - SUA 134, 994 134, 994 0 134, 994 77. 00 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 0 78. 00 0 0 0 0 0 0 0 0 78. 00 0 0 0 0 0 0 0 78. 00 0 0 0 0 0 0 78. 00 0 0 0 0 0 0 78. 00 0 0 0 0 0 0 78. 00 0 0 0 0 0 0 78. 00 0 0 0 0 0 78. 00 0 0 0 0 0 78. 00 0 0 0 0 0 78. 00 0 0 0 0 0 78. 00 0 0 0 0 0 78. 00 0 0 0 0 0 78. 00 0 0 0 0 0 78. 00 0 0 0 0 0 79. 00 0 0 0 0 0 79. 00 0 0 0 0 79. 00 0 0 0 0 79. 00 0 0 0 0 79. 00 0 0 0 0 79. 00 0 0 0 0 79. 00 0 0 0 0 79. 00 0 0 0 0 79. 00 0 0 0 79. 00 0 0 0 79. 00 0 0 0 79. 00 0 0 0 79. 00 0 0 0 79. 00 0 0 0 79. 00 0 0 0 79. 00			0					
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77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 78. 00 0UTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 0 0 0 0 0 0 90. 00 91. 00 09000 CLINIC 0 0 0 0 0 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 92. 00 0THER REIMBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DI ALYSIS 0 0 0 0 95. 00 95. 00 09500 AMBULANCE SERVI CES 0 0 0 0 95. 00 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 96. 00 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 97. 00 99. 00 09900 CMHC 0 0 0 0 99. 10 101. 00 10000 LAR SERVI CES-NOT APPRVD PRGM 0 0 0 99. 10 101. 00 10100 HOME HEALTH AGENCY 0 0 0 101. 00 102. 00 SPECI AL PURPOSE COST CENTERS 105. 00 10500 KI DIEKY ACQUISITION 0 0 0 105. 00 107. 00 10700 LIVER ACQUISITION 0 0 0 107. 00 108. 00 10900 LIVER ACQUISITION 0 0 0 109. 00 110. 00 10900 INTESTINAL ACQUISITION 0 0 0 110. 00 111. 00 11100 INTERTINAL ACQUISITION 0 0 0 111. 00 111. 00 11100 INTERTINAL ACQUISITION 0 0 111. 00 111. 00 11100 INTERTINAL ACQUISITION 0 0 111. 00 111. 00 11100 INTERTINAL ACQUISITION 0 0 111. 00 111. 00 11100 INTERTINAL ACQUISITION 0 0 111. 00 111. 00 11100 INTERTINAL ACQUISITION 0 0 111. 00 111. 00 11100 INTERTINAL ACQUISITION 0 0 111. 00 111. 00 11100 INTERTINAL ACQUISITION 0 0 111. 00 111. 00 11100 INTERTINAL ACQUISITION 0 0 111. 00 111. 00 11100 INTERTINAL ACQUISITION 0 0 111. 00 111. 00 11100 INTERTINAL ACQUISITION 0 0 111. 00 111. 00 11100 11100 INTERTINAL ACQUISITION 0 0 111. 00 111. 00 11100 11100 11100 11100 11100 11100 11100 11100 11100 11100 11100 11100 11100 11100 11100 11100 11100 11100					124.00	0		
78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 78. 00			134, 994		134, 992	0		
90. 00 09000 CLINIC 0 0 0 0 0 0 90. 00 91. 00 09100 EMERGENCY 0 0 0 0 0 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 92. 00 0THER REIMBURSABLE COST CENTERS 90 0 0 0 0 94. 00 95. 00 09400 HOME PROGRAM DI ALYSIS 0 0 0 0 0 94. 00 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 95. 00 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 97. 00 99. 10 09900 CMHC 0 0 0 0 0 99. 10 99. 10 09910 CORF 0 0 0 0 0 99. 10 101. 00 10000 I&R SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 101. 00 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 101. 00 107. 00 10700 LIVER ACQUI SITI ON 0 0 0 107. 00 108. 00 10800 LIVER ACQUI SITI ON 0 0 0 109. 00 109. 00 10900 PANCREAS ACQUI SITI ON 0 0 0 109. 00 111. 00 11000 INTESTI NAL ACQUI SITI ON 0 0 0 110. 00 111. 00 11100 INTERSTI NAL ACQUI SITI ON 0 0 0 111. 00 1113. 00 11300 INTEREST EXPENSE 11300			0			0		
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92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) O O O O THER REI MBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DI ALYSI S O O O O 95. 00 09500 AMBULANCE SERVI CES O O O O 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED O O O 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD O O O 99. 00 09900 CMPC O O O 99. 10 09910 CORF O O O 100. 00 10000 LAR SERVI CES-NOT APPRVD PRGM O O O 101. 00 10100 HOME HEALTH AGENCY O O O 101. 00 10100 PI OI TREATMENT PROGRAM O O 102. 00 10200 OPI OI D TREATMENT PROGRAM O O 105. 00 10500 KI DNEY ACQUI SI TI ON O O 107. 00 10700 LI VER ACQUI SI TI ON O O 108. 00 10800 LING ACQUI SI TI ON O O 109. 00 10900 PANCREAS ACQUI SI TI ON O O 101. 00 11000 INTESTI NAL ACQUI SI TI ON O O 101. 00 11100 INTESTI NAL ACQUI SI TI ON O O 101. 00 11100 INTESTI NAL ACQUI SI TI ON O O 101. 00 11100 INTESTI NAL ACQUI SI TI ON O O 111. 00 11100 INTESTI NAL ACQUI SI TI ON O O 111. 00 11100 INTESTI NAL ACQUI SI TI ON O O 111. 00 11100 INTESTI NAL ACQUI SI TI ON O O 111. 00 11100 INTESTI NAL ACQUI SI TI ON O O 111. 00 11100 INTESTI NAL ACQUI SI TI ON O O 111. 00 11100 INTESTI NAL ACQUI SI TI ON O O 111. 00 11100 INTESTI NAL ACQUI SI TI ON O O 111. 00 11100 INTESTI NAL ACQUI SI TI ON O O 111. 00 11100 INTESTI NAL ACQUI SI TI ON O O 111. 00 11100 INTESTI NAL ACQUI SI TI ON O O 111. 00 11100 INTESTI NAL ACQUI SI TI ON O O 111. 00 11100 INTESTI NAL ACQUI SI TI ON O O 113. 00 1130 INTEREST EXPENSE		1 1						
94. 00		1 1			•			
95. 00	0.4.00				1			
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97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 97. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 10 09910 CORF 0 0 0 0 99. 10 100. 00 100. 00 18 R SERVI CES-NOT APPRVD PRGM 0 0 0 1010. 00 10100 HOME HEALTH AGENCY 0 0 0 1010. 00 10200 0910 ID TREATMENT PROGRAM 0 0 0 102. 00 0910 ID TREATMENT PROGRAM 0 0 0 102. 00 0910 ID TREATMENT PROGRAM 0 0 0 0 102. 00 0910 ID TREATMENT PROGRAM 0 0 0 0 105. 00 106. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 106. 00 107. 00 107. 00 107. 00 108. 00 108. 00 108. 00 108. 00 108. 00 108. 00 109. 00 PANCREAS ACQUI SI TI ON 0 0 0 108. 00 109. 00 10900 PANCREAS ACQUI SI TI ON 0 0 0 109. 0			0					
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100. 00 10000 1 &R SERVI CES-NOT APPRVD PRGM 0 0 1010. 00 1010. 00 1010. 00 1010. 00 1010. 00 1010. 00 1010. 00 1010. 00 1010. 00 1010. 00 1010. 00 1010. 00 1010. 00 1010. 00 1020. 00 1020. 00 1020. 00 1050. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 1050. 00 1060. 00 1060. 00 1060. 00 1070			0				_	
101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 102.00 10200 OPI 0I D TREATMENT PROGRAM 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS			0				_	
SPECIAL PURPOSE COST CENTERS			0					
105. 00	102.00		0		(0	102. 00
106. 00 10600 HEART ACQUISITION	105 00		Ι ο		Τ	<u>1</u>	0	105 00
108.00 10800 LUNG ACQUISITION			Ö		l e			
109. 00 10900 PANCREAS ACQUISITION	107.00	10700 LIVER ACQUISITION	0				0	107. 00
110. 00 11000 INTESTINAL ACQUISITION			0					
111. 00 11100 I SLET ACQUI SI TI ON 0 0 1111. 00 113. 00 1130 I NTEREST EXPENSE 0 113. 00			0			ol l		
	111.00	11100 ISLET ACQUISITION	0					111. 00
334 (00)334(00)11111 (01) (00) (00)								
114. 00 11400 UTILIZATION REVIEW-SNF 114. 00	114.00	7 11400 UIILIZAIIUN KEVIEW-SNF	<u> </u>	<u> </u>	1			1114.00

Health Financial Systems E	NCOMPASS HEALTH DE	ACONESS REHABI	LIT	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO	F	Period: From 08/01/2022 To 07/31/2023	Worksheet C Part I Date/Time Pre 11/15/2023 8:	pared: 13 am
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3.00	4. 00	5. 00	
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0		(D	0	115. 00
116. 00 11600 HOSPI CE	0		(0	116. 00
200.00 Subtotal (see instructions)	33, 383, 660	0	33, 383, 660	21, 154	33, 404, 814	200.00
201.00 Less Observation Beds	0		(0	201. 00
202.00 Total (see instructions)	33, 383, 660	0	33, 383, 660	21, 154	33, 404, 814	202.00

Provider CCN: 15-3025

Peri od:

Part I

From 08/01/2022 Date/Time Prepared: 07/31/2023 11/15/2023 8:13 am Title XVIII Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 34, 051, 000 34, 051, 000 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 03200 CORONARY CARE UNIT 0 32.00 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 34 00 34 00 40.00 04000 SUBPROVIDER - IPF 40.00 04100 SUBPROVIDER - IRF 41.00 0 0 41.00 04300 NURSERY 0 43.00 43.00 0 04400 SKILLED NURSING FACILITY 44.00 44 00 45.00 04500 NURSING FACILITY 0 45.00 46.00 04600 OTHER LONG TERM CARE 46.00 ANCILLARY SERVICE COST CENTERS 0 0.000000 50.00 05000 OPERATING ROOM 0 0.000000 50.00 05100 RECOVERY ROOM 0 0.000000 0.000000 51.00 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0.000000 0.000000 C 52.00 05300 ANESTHESI OLOGY 0.000000 53 00 Ω Ω 0.000000 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 341, 253 1,700 342, 953 0.383773 0.000000 54.00 0.000000 54.01 05401 RADIOLOGY - DIAGNOSTIC - SUA 202, 838 202, 838 0.253877 54.01 05500 RADI OLOGY-THERAPEUTI C 0.000000 55.00 0.000000 55.00 0 C 56.00 05600 RADI OI SOTOPE 0 0 0 0.000000 0.000000 56.00 57.00 05700 CT SCAN 0 C 0 0.000000 0.000000 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 0 0 0.000000 0.000000 58.00 59 00 05900 CARDIAC CATHETERIZATION 0 Ω O 0.000000 0 000000 59 00 60.00 06000 LABORATORY 1, 977, 074 12 1, 977, 086 0.436360 0.000000 60.00 06001 BLOOD LABORATORY 0.000000 0.000000 60.01 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 0 0.000000 0.000000 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 62.00 0 0 0.000000 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS 0 0 0.000000 0.000000 63.00 64.00 06400 I NTRAVENOUS THERAPY 0 C 0.000000 0.000000 64.00 65 00 06500 RESPIRATORY THERAPY 1 021 276 1 021 276 0 685439 0 000000 65 00 06600 PHYSI CAL THERAPY 66.00 9, 714, 208 9, 714, 208 0.301123 0.000000 66.00 06700 OCCUPATIONAL THERAPY 10, 822, 740 10, 822, 740 0.281719 0.000000 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 2, 312, 037 2, 312, 037 0.392008 0.000000 68.00 06900 FLECTROCARDLOLOGY 69 00 0.000000 0.000000 69 00 0 C 70.00 07000 ELECTROENCEPHALOGRAPHY C 0.000000 0.000000 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 823, 450 0.000000 71.00 823, 450 0.637060 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 8, 194, 634 8, 194, 634 73 00 0 0.226903 0.000000 73 00 74.00 07400 RENAL DIALYSIS 0.000000 0.000000 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0.000000 0.000000 75.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76.00 0 0.000000 0.000000 0 0 76.00 76.01 03950 SPECIAL PROCEDURES 0 0 0 0.000000 0.000000 76.01 76.02 03951 SPECIAL PROCEDURES - SUA 450, 609 0 450, 609 0.299581 0.000000 76.02 77 00 07700 ALLOGENEIC HSCT ACQUISITION C 0.000000 0.000000 77 00 07800 CAR T-CELL IMMUNOTHERAPY 0 78.00 0 0 0.000000 0.000000 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 0.000000 0 0 90.00 0 91.00 09100 EMERGENCY 0 0 0.000000 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0 0 0 0.000000 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 0 0.000000 0.000000 94.00 09500 AMBULANCE SERVICES 0 0 95.00 0 0.000000 0.000000 95.00 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED Ω 0.000000 0.000000 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0.000000 97.00 97.00 0 0 0 0.000000 99. 00 09900 CMHC 0 0 99.00 99.10 09910 CORF 0 0 99.10 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 C 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 102.00 10200 OPI OID TREATMENT PROGRAM 0 102.00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 0 105.00 0 106. 00 10600 HEART ACQUISITION 0 0 0 0 106.00 107.00 10700 LIVER ACQUISITION 0 0 107.00 108.00 10800 LUNG ACQUISITION 0 0 108.00 109. 00 10900 PANCREAS ACQUISITION 0 0 0 109.00 0 110.00 11000 INTESTINAL ACQUISITION 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 C 111 00 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 115.00

Health Financial Systems	ENCOMPASS HEALTH DE	ACONESS REHABI	LIT	In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der Co		Period: From 08/01/2022	Worksheet C Part I		
				Γο 07/31/2023	Date/Time Pre	epared: 13 am	
		Title	xVIII	Hospi tal	PPS		
		Charges					
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA		
			+ col. 7)	Rati o	I npati ent		
					Ratio		
	6. 00	7. 00	8. 00	9. 00	10.00		
116. 00 11600 HOSPI CE	0	0	(D		116. 00	
200.00 Subtotal (see instructions)	69, 911, 119	1, 712	69, 912, 831	1		200.00	
201.00 Less Observation Beds						201.00	
202.00 Total (see instructions)	69, 911, 119	1, 712	69, 912, 83°	1		202. 00	

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 08/01/2022 | Part | | Date/Time Prepared: | 11/15/2023 8: 13 am | Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-3025

		T: 11 NO.11 1		11/15/2023 8: 13 am
Cost Center Description	PPS Inpatient	Title XVIII	Hospi tal	PPS
cost center bescription	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS	T			
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT				30. 00 31. 00
32. 00 03200 CORONARY CARE UNIT				32.00
33. 00 03300 BURN INTENSIVE CARE UNIT				33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT				34.00
40. 00 04000 SUBPROVI DER - I PF				40. 00
41. 00 04100 SUBPROVI DER - RF				41.00
43. 00 04300 NURSERY 44. 00 04400 SKI LLED NURSI NG FACI LI TY				43. 00 44. 00
44.00 04400 SKILLED NURSING FACILITY 45.00 04500 NURSING FACILITY				45. 00
46.00 O4600 OTHER LONG TERM CARE				46. 00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 000000			50. 00
51. 00 05100 RECOVERY ROOM	0. 000000			51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	0. 000000 0. 000000			52. 00 53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0. 383773			54. 00
54. 01 05401 RADI OLOGY - DI AGNOSTI C - SUA	0. 253877			54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			55. 00
56. 00 05600 RADI 0I SOTOPE	0. 000000			56. 00
57. 00 05700 CT SCAN	0. 000000			57. 00
58. 00 05800 MAGNETI C RESONANCE I MAGING (MRI) 59. 00 05900 CARDI AC CATHETERI ZATI ON	0.000000			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	0. 000000 0. 436360			59. 00 60. 00
60. 01 06001 BLOOD LABORATORY	0. 000000			60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0.000000			64. 00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0. 685439 0. 301123			65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 281719			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 392008			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70. 00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0. 637060			71.00
72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS 73.00 O7300 DRUGS CHARGED TO PATIENTS	0.000000			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS	0. 226903 0. 000000			73. 00 74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0. 000000			75. 00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000			76. 00
76. 01 03950 SPECI AL PROCEDURES	0. 000000			76. 01
76. 02 03951 SPECIAL PROCEDURES - SUA	0. 299581			76. 02
77.00 07700 ALLOGENEI C HSCT ACQUISITION 78.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000 0. 000000			77. 00 78. 00
OUTPATIENT SERVICE COST CENTERS	0.000000			78.00
90. 00 09000 CLI NI C	0. 000000			90.00
91. 00 09100 EMERGENCY	0. 000000			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92. 00
OTHER REIMBURSABLE COST CENTERS	0.000000			04.00
94. 00 09400 HOME PROGRAM DI ALYSI S 95. 00 09500 AMBULANCE SERVI CES	0. 000000			94. 00 95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000			96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000			97. 00
99. 00 09900 CMHC				99. 00
99. 10 09910 CORF				99. 10
100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM				100.00
101.00 10100 HOME HEALTH AGENCY 102.00 10200 OPIOID TREATMENT PROGRAM				101. 00 102. 00
SPECIAL PURPOSE COST CENTERS				102.00
105. 00 10500 KI DNEY ACQUI SI TI ON				105. 00
106. 00 10600 HEART ACQUI SI TI ON				106. 00
107.00 10700 LIVER ACQUISITION				107. 00
108. 00 10800 LUNG ACQUISITION				108. 00
109. 00 10900 PANCREAS ACQUISITION				109.00
110.00 11000 INTESTINAL ACQUISITION				110.00
111. 00 11100 ISLET ACQUISITION 113. 00 11300 INTEREST EXPENSE				111. 00 113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF				114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)				115. 00
116. 00 11600 HOSPI CE				116. 00
200.00 Subtotal (see instructions)				200. 00
				

Health Fina	ancial Systems	ENCOMPASS HEALTH DEAC	ONESS REHABILIT	In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-3025	Peri od: From 08/01/2022	Worksheet C Part I		
					Date/Time Pre 11/15/2023 8:		
			Title XVIII	Hospi tal	PPS		
	Cost Center Description	PPS Inpatient					
		Ratio					
		11.00					
201.00	Less Observation Beds					201. 00	
202.00	Total (see instructions)					202. 00	
·						•	

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-3025 Peri od: Worksheet C From 08/01/2022 Part I Date/Time Prepared: 07/31/2023 11/15/2023 8:13 am Title XIX Hospi tal Cost Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs (from Wkst. B, Adj Di sal I owance Part I, col 26) 4. 00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 30 00 03000 ADULTS & PEDIATRICS 22, 238, 354 22, 238, 354 21, 154 22, 259, 508 03100 INTENSIVE CARE UNIT 31.00 31.00 0 0 32.00 03200 CORONARY CARE UNIT 0 32.00 0 0 03300 BURN INTENSIVE CARE UNIT 33.00 0 33.00 0 0 0 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 34.00 04000 SUBPROVIDER - IPF 0 40.00 0 0 40.00 04100 SUBPROVI DER - I RF 0 41.00 41.00 0 04300 NURSERY 0 43.00 Λ 43.00 44.00 04400 SKILLED NURSING FACILITY 0 0 0 Ω 44.00 45.00 04500 NURSING FACILITY o 0 45.00 04600 OTHER LONG TERM CARE 0 0 46.00 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 0 0 50.00 05100 RECOVERY ROOM 0 0 0 51.00 0 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 0 52 00 0 53.00 05300 ANESTHESI OLOGY 0 Ω Λ 53.00 05400 RADI OLOGY-DI AGNOSTI C 131, 616 131, 616 0 131, 616 54.00 54.00 0 54.01 05401 RADIOLOGY - DIAGNOSTIC - SUA 51, 496 51, 496 51, 496 54.01 05500 RADI OLOGY-THERAPEUTI C 55 00 0 0 0 55 00 56.00 0 05600 RADI 0I S0T0PE 0 0 0 56.00 57.00 05700 CT SCAN 0 0 0 57.00 0 58 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 0 58 00 0 05900 CARDIAC CATHETERIZATION 59.00 0 Ω Λ 59.00 0 06000 LABORATORY 862, 721 862, 721 862, 721 60.00 60.00 60.01 06001 BLOOD LABORATORY 0 60.01 0 0 0 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 0 61 00 0 61 00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 0 0 0 0 0 0 0 63.00 64.00 06400 I NTRAVENOUS THERAPY 0 Ω 64.00 n 06500 RESPI RATORY THERAPY 700, 022 700.022 700, 022 65 00 65 00 66.00 06600 PHYSI CAL THERAPY 2, 925, 175 2, 925, 175 2, 925, 175 66.00 06700 OCCUPATIONAL THERAPY 3, 048, 974 67.00 3, 048, 974 3, 048, 974 67.00 68.00 06800 SPEECH PATHOLOGY 906.337 906, 337 906, 337 68.00 06900 ELECTROCARDI OLOGY 69 00 0 C 0 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 70.00 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 524, 587 524, 587 0 524, 587 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 72.00 07300 DRUGS CHARGED TO PATIENTS 1, 859, 384 1, 859, 384 73.00 1, 859, 384 73.00 74.00 07400 RENAL DIALYSIS 0 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 75.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 76.00 0 0 76.00 0 76.01 03950 SPECIAL PROCEDURES 0 0 Ω 76.01 76.02 03951 SPECIAL PROCEDURES - SUA 134.994 134.994 0 134, 994 76.02 o 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 77.00 0 C 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 0 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 n 90.00 91.00 09100 EMERGENCY 0 0 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 94.00 09500 AMBULANCE SERVICES 0 0 0 95.00 Λ 95.00 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 96.00 0 0 0 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 109900 CMHC 0 99.00 99.00 0 09910 CORE 0 99. 10 99.10 0 0 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 102 00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 0 0 105. 00 106.00 10600 HEART ACQUISITION 0 0 0 0 0 106.00 0 107. 00 10700 LIVER ACQUISITION 0 107 00 108.00 10800 LUNG ACQUISITION 0 0 108.00 109.00 10900 PANCREAS ACQUISITION 0 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 1111.00 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTI LI ZATI ON REVI EW-SNF 114.00

Health Financial Systems	ENCOMPASS HEALTH DE	ACONESS REHABI	LIT	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO	F	Period: From 08/01/2022 To 07/31/2023	Worksheet C Part I Date/Time Pre 11/15/2023 8:	pared: 13 am
		Ti tl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0		(0	115. 00
116. 00 11600 HOSPI CE	0		(0	116.00
200.00 Subtotal (see instructions)	33, 383, 660	0	33, 383, 660	21, 154	33, 404, 814	200.00
201.00 Less Observation Beds	0		(0	201.00
202.00 Total (see instructions)	33, 383, 660	0	33, 383, 660	21, 154	33, 404, 814	202.00

Peri od: Worksheet C From 08/01/2022 Part I To 07/31/2023 Date/Time Prepared: 11/15/2023 8:13 am

					11/15/2023 8:	<u>13 am</u>
			e XIX	Hospi tal	Cost	
Cost Center Description	Inpati ent	Charges Outpatient	Total (col. 6	Cost or Other	TEFRA	
cost center bescription	Tripatrent	outpatrent	+ col . 7)	Ratio	Inpati ent	
			,		Ratio	
	6.00	7. 00	8. 00	9. 00	10. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	24 051 000		24 051 000			20.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	34, 051, 000		34, 051, 000			30. 00 31. 00
32. 00 03200 CORONARY CARE UNIT						32.00
33. 00 03300 BURN INTENSIVE CARE UNIT						33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	o		(34.00
40. 00 04000 SUBPROVI DER - I PF	0		(40. 00
41. 00 04100 SUBPROVI DER - I RF	0		(41. 00
43. 00 04300 NURSERY 44. 00 04400 SKI LLED NURSI NG FACI LI TY	0		(43. 00
44.00 04400 SKILLED NURSING FACILITY 45.00 04500 NURSING FACILITY						44. 00 45. 00
46. 00 04600 OTHER LONG TERM CARE				ó		46. 00
ANCILLARY SERVICE COST CENTERS	-1					1
50. 00 05000 OPERATING ROOM	0	0	(0.000000	0. 000000	50.00
51. 00 05100 RECOVERY ROOM	0	0	(0.00000	0. 000000	1
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0	0			0.000000	
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	241 252	1, 700	342, 953	0.00000	0. 000000 0. 000000	
54. 00 05400 RADI OLOGY - DI AGNOSTI C - SUA	341, 253 202, 838	1, 700	202, 838		0. 000000	
55. 00 05500 RADI OLOGY - THERAPEUTI C	202, 838	0	202, 636	0. 000000	0. 000000	
56. 00 05600 RADI 01 SOTOPE		0			0. 000000	1
57. 00 05700 CT SCAN		0		0. 000000	0. 000000	1
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0. 000000	0.000000	1
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	(0. 000000	0.000000	
60. 00 06000 LABORATORY	1, 977, 074	12	1, 977, 086	0. 436360	0. 000000	60.00
60. 01 06001 BLOOD LABORATORY	0	0	(0. 000000	0.000000	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	(0. 000000	0. 000000	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	(0. 000000	0. 000000	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	(0. 000000	0. 000000	1
64. 00 06400 I NTRAVENOUS THERAPY	0	0	(0.000000	0. 000000	1
65. 00 06500 RESPIRATORY THERAPY	1, 021, 276	0	1, 021, 276		0.000000	1
66. 00 06600 PHYSI CAL THERAPY	9, 714, 208	0	9, 714, 208		0.000000	
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	10, 822, 740 2, 312, 037	0	10, 822, 740	1	0. 000000 0. 000000	
69. 00 06900 ELECTROCARDI OLOGY	2, 312, 037	0	2, 312, 037		0. 000000	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0		0. 000000	0. 000000	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	823, 450	0	823, 450		0. 000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(0.000000	0. 000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	8, 194, 634	0	8, 194, 634	0. 226903	0.000000	73. 00
74. 00 07400 RENAL DI ALYSI S	0	0	(0. 000000	0.000000	74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	(0. 000000	0. 000000	
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	(0. 000000	0. 000000	
76. 01 03950 SPECIAL PROCEDURES	0	0	((((((((((((((((((((0.000000	0. 000000	
76. 02 03951 SPECIAL PROCEDURES - SUA	450, 609	0	450, 609		0.000000	
77.00 O7700 ALLOGENEIC HSCT ACQUISITION 78.00 O7800 CAR T-CELL IMMUNOTHERAPY	0	0		0. 000000 0. 000000	0. 000000 0. 000000	1
OUTPATIENT SERVICE COST CENTERS	l ol			0.000000	0.000000	78.00
90. 00 09000 CLINIC	0	0		0. 000000	0. 000000	90.00
91. 00 09100 EMERGENCY	o	0			0. 000000	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	(0. 000000	0. 000000	92. 00
OTHER REIMBURSABLE COST CENTERS						1
94.00 09400 HOME PROGRAM DIALYSIS	0	0			0. 000000	1
95. 00 09500 AMBULANCE SERVI CES	0	0			0. 000000	1
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	(0. 000000	1
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0. 000000	0. 000000	
99. 00 09900 CMHC 99. 10 09910 CORF		0	(99. 00 99. 10
100.00 10000 I & SERVI CES-NOT APPRVD PRGM		0				100.00
101. 00 10100 HOME HEALTH AGENCY		0				100.00
102. 00 10200 OPI OI D TREATMENT PROGRAM		0				102.00
SPECIAL PURPOSE COST CENTERS	<u>. </u>					1
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	(0. 000000	0. 000000	105. 00
106. 00 10600 HEART ACQUI SI TI ON	o	0	(0. 000000	0. 000000	106. 00
107. 00 10700 LI VER ACQUI SI TI ON	o	0	(0. 000000	0. 000000	
108.00 10800 LUNG ACQUISITION	0	0	(0. 000000	0. 000000	
109. 00 10900 PANCREAS ACQUISITION	0	0	(0. 000000	
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0	(0. 000000	
111. 00 11100 I SLET ACQUI SI TI ON	0	0	(0. 000000	0. 000000	
113. 00 11300 INTEREST EXPENSE 114. 00 11400 UTILIZATION REVIEW-SNF	1					113. 00 114. 00
114.00 11400 UTLLIZATION REVIEW-SNF 115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	o	0		,		115.00
113. OUTTOOUTAMBULATURT SURGICAL CENTER (D. P.)	<u>ı</u>	0	1	'l		1113.00

Health Fina	ncial Systems	ENCOMPASS HEALTH DE	NCOMPASS HEALTH DEACONESS REHABILIT			In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES			Provi der C		Peri od: From 08/01/2022				
				To 07/31/2023	Part I Date/Time Pre 11/15/2023 8:	epared: 13 am			
		Title XIX			Hospi tal	Cost			
			Charges						
	Cost Center Description	I npati ent	Outpati ent	Total (col.	Cost or Other	TEFRA			
				+ col. 7)	Ratio	I npati ent			
						Ratio			
		6.00	7. 00	8. 00	9. 00	10.00			
116. 00 1160	0 HOSPI CE	0	0		0		116. 00		
200. 00	Subtotal (see instructions)	69, 911, 119	1, 712	69, 912, 83	1		200. 00		
201. 00	Less Observation Beds						201. 00		
202. 00	Total (see instructions)	69, 911, 119	1, 712	69, 912, 83	1		202. 00		

In Lieu of Form CMS-2552-10
Worksheet C
Part I
B1/2023 Date/Time Prepared:
11/15/2023 8:13 am Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-3025 Peri od: From 08/01/2022 To 07/31/2023

			Title XIX	Hospi tal	11/15/2023 8: Cost	13 am_
	Cost Center Description	PPS Inpatient	THE XIX	1103pi tui	0031	
		Ratio				
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00				
30. 00						30. 00
31. 00	03100 INTENSIVE CARE UNIT					31. 00
32. 00						32. 00
33. 00 34. 00						33. 00 34. 00
40. 00						40. 00
41. 00						41. 00
43.00						43.00
44. 00						44. 00
45. 00						45. 00
46. 00	04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS					46. 00
50. 00		0. 000000				50. 00
51. 00		0. 000000				51.00
52. 00		0. 000000				52. 00
53. 00 54. 00	1	0.000000				53.00
54. 00	05401 RADI OLOGY - DI AGNOSTI C - SUA	0. 000000 0. 000000				54. 00 54. 01
55. 00		0. 000000				55. 00
56. 00	1	0. 000000				56. 00
57. 00		0. 000000				57. 00
58. 00		0. 000000 0. 000000				58. 00
59. 00 60. 00		0. 000000				59. 00 60. 00
60. 01	06001 BLOOD LABORATORY	0. 000000				60. 01
61. 00		0. 000000				61. 00
62. 00		0. 000000				62. 00
63. 00	· · · · · · · · · · · · · · · · · · ·	0. 000000				63.00
64. 00 65. 00		0. 000000 0. 000000				64. 00 65. 00
66. 00		0. 000000				66. 00
67. 00		0. 000000				67. 00
68. 00		0. 000000				68. 00
69. 00		0. 000000				69. 00
70.00		0.000000				70.00
71. 00 72. 00		0. 000000 0. 000000				71. 00 72. 00
73. 00		0. 000000				73. 00
74. 00		0. 000000				74. 00
75. 00	1 1 ,	0. 000000				75. 00
76. 00 76. 01		0. 000000 0. 000000				76. 00 76. 01
76. 01	1	0. 000000				76. 01
77. 00		0. 000000				77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000				78. 00
	OUTPATIENT SERVICE COST CENTERS	0.00000				
90. 00 91. 00		0. 000000 0. 000000				90. 00 91. 00
92. 00		0. 000000				92.00
	OTHER REIMBURSABLE COST CENTERS	2. 222222				
94. 00		0. 000000				94. 00
95.00	1	0.000000				95. 00
96. 00 97. 00		0. 000000 0. 000000				96. 00 97. 00
99. 00		0.000000				99. 00
	09910 CORF					99. 10
	0 10000 I&R SERVICES-NOT APPRVD PRGM					100. 00
	0 10100 HOME HEALTH AGENCY					101.00
102. 0	0 10200 0PIOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS					102. 00
105 0	0 10500 KIDNEY ACQUISITION	0. 000000				105. 00
	0 10600 HEART ACQUISITION	0. 000000				106. 00
107.0	0 10700 LIVER ACQUISITION	0. 000000				107. 00
	0 10800 LUNG ACQUISITION	0. 000000				108.00
	0 10900 PANCREAS ACQUISITION	0.000000				109.00
	O 11000 INTESTINAL ACQUISITION O 11100 ISLET ACQUISITION	0. 000000 0. 000000				110. 00 111. 00
	0 11300 INTEREST EXPENSE	3. 330000				111.00
	0 11400 UTI LI ZATI ON REVI EW-SNF					114. 00
	0 11500 AMBULATORY SURGICAL CENTER (D. P.)					115. 00
116. 0 200. 0	0 11600 HOSPICE 0 Subtotal (see instructions)					116. 00 200. 00
200.0	o _{l l} oubtotal (see FlistFuctFuis)	<u> </u>				200.00

Heal th Fin	ancial Systems	ENCOMPASS HEALTH	ENCOMPASS HEALTH DEACONESS REHABILIT			In Lieu of Form CMS-2552-10			
COMPUTATIO	ON OF RATIO OF COSTS TO CHARGES			Provi der CCN: 15-3025	Peri od: From 08/01/2022	Worksheet C			
						Date/Time Pre 11/15/2023 8:			
				Title XIX	Hospi tal	Cost			
	Cost Center Description	PPS Inpatie	nt						
	·	Ratio							
		11. 00							
201.00	Less Observation Beds						201. 00		
202 00	Total (see instructions)						202 00		

Health Financial Systems ENCOM	PASS HEALTH DE	ACONESS DELIADI	LIT	In Lie	u of Form CMS-	2552 10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL (Provi der C		Peri od: From 08/01/2022 To 07/31/2023	Worksheet D Part I Date/Time Pre 11/15/2023 8:	
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capi tal Rel ated Cos (col . 1 - col 2)		Per Diem (col. 3 / col. 4)	
	1. 00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT 32.00 CORONARY CARE UNIT 33.00 BURN INTENSIVE CARE UNIT 34.00 SURGICAL INTENSIVE CARE UNIT 40.00 SUBPROVIDER - IPF 41.00 SUBPROVIDER - IRF 43.00 NURSERY 44.00 SKILLED NURSING FACILITY 45.00 NURSING FACILITY 200.00 Total (lines 30 through 199) Cost Center Description	2, 893, 899 0 0 0 0 0 0 0 0 2, 893, 899 Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col.	2, 893, 89	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 43. 00
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT 32.00 CORONARY CARE UNIT 33.00 BURN INTENSIVE CARE UNIT 34.00 SURGICAL INTENSIVE CARE UNIT 40.00 SUBPROVIDER - IPF 41.00 SUBPROVIDER - IRF 43.00 NURSERY 44.00 SKILLED NURSING FACILITY NURSING FACILITY 200.00 Total (lines 30 through 199)	17, 351 0 0 0 0 0 0 0 0 0 0 0					30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 43. 00 44. 00 45. 00 200. 00

Health Financial Systems ENCO	MPASS HEALTH DE	ACONESS REHABI	LIT	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der Co	CN: 15-3025	Peri od:	Worksheet D	
				From 08/01/2022	Part II	
				To 07/31/2023	Date/Time Pre	pared:
					11/15/2023 8:	<u>13 am</u>
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col 1 ÷ col		column 4)	
	Part II, col.	8)	2)			
	26)	",	-/			
	1.00	2.00	3.00	4. 00	5. 00	
ANGLI LADV. CEDVI CE COCT CENTEDO	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS		1	0.0000			
50. 00 05000 OPERATI NG ROOM	0	0	0. 00000		0	
51.00 05100 RECOVERY ROOM	0	0			0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.00000	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0.00000	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	652	342, 953	0. 00190	336, 145	639	54.00
54. 01 05401 RADI OLOGY - DI AGNOSTI C - SUA	0				0	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C		202,030			_	55.00
	0	0	0.00000		0	
56. 00 05600 RADI 0I SOTOPE	0	0	0.00000		0	56. 00
57. 00 05700 CT SCAN	0	0	0.00000	0 0	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.00000	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0.00000	0	0	59.00
60. 00 06000 LABORATORY	55, 276	1, 977, 086	0. 02795	8 1, 155, 811	32, 314	60.00
60. 01 06001 BLOOD LABORATORY	00,2,0	1,777,000	0.00000		02,011	60. 01
		0	0.00000	0	l o	1
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0. 00000		0	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.00000	0 0	0	63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0.00000	0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	19, 444	1, 021, 276	0. 01903	9 582, 949	11, 099	65. 00
66. 00 06600 PHYSI CAL THERAPY	314, 767		0. 03240	5, 448, 548	176, 549	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	172, 267		l .		96, 841	67. 00
68. 00 06800 SPEECH PATHOLOGY	50, 162		0. 02169			1
69. 00 06900 ELECTROCARDI OLOGY	0	0	0. 00000		0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.00000		0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	51, 994	823, 450	0. 06314	2 489, 964	30, 937	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.00000	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	43, 958	8, 194, 634	0.00536	4, 397, 439	23, 588	73. 00
74. 00 07400 RENAL DI ALYSI S	1,	1 0,,	0.00000		0	74. 00
75. 00 07500 ASC (NON-DISTINCT PART)			0. 00000		0	1
	0	0			_	1
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0. 00000		0	76. 00
76. 01 03950 SPECI AL PROCEDURES	0	0	0.00000		0	76. 01
76. 02 03951 SPECI AL PROCEDURES - SUA	0	450, 609	0.00000	94, 010	0	76. 02
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.00000	0	0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0.00000	0	0	78. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	1 0	0	0.00000	0 0	0	90.00
	0				0	
					Ĭ	,
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.00000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0.00000	0 0	0	94.00
95. 00 09500 AMBULANCE SERVICES						95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.00000	0	0	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0		0. 00000		0	
200.00 Total (lines 50 through 199)	708, 520	35, 861, 831		19, 987, 947	-	
200.00 Total (Titles 50 till ough 199)	100, 320] 33,001,031	I	17, 701, 941	370, 109	₁ 200.00

	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	0	0	0	30.00
31. 00 03100 I NTENSI VE CARE UNIT		ol o	0	0	o o	
32. 00 03200 CORONARY CARE UNIT				0	0	
33. 00 03300 BURN INTENSIVE CARE UNIT			1	0		33. 00
1 1				0		1
	0		0	0	-	
40. 00 04000 SUBPROVI DER - 1 PF	0		0	0	0	40. 00
41. 00 04100 SUBPROVI DER - RF	0	0	0	0	0	41. 00
43. 00 04300 NURSERY	0) 0	0	0	0	43. 00
44.00 O4400 SKILLED NURSING FACILITY	0) 0	0	0		44. 00
45.00 O4500 NURSING FACILITY	0	0	0	0		45. 00
200.00 Total (lines 30 through 199)	0	·	0	0		200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	I npati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)	minus col. 4)				
	4.00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	31, 174	0.00	17, 351	30.00
31.00 03100 INTENSIVE CARE UNIT		0	0	0.00	0	31.00
32. 00 03200 CORONARY CARE UNIT		0	0	0.00	0	32.00
33. 00 03300 BURN INTENSIVE CARE UNIT		0	0	0.00	1	
34.00 03400 SURGI CAL INTENSI VE CARE UNI T		0	ا ا	0.00	1	
40. 00 04000 SUBPROVI DER - PF	0		١	0.00	1	1
41. 00 04100 SUBPROVI DER				0.00	1	41. 00
43. 00 04300 NURSERY		,		0.00		43. 00
· · · · · · · · · · · · · · · · · · ·		0				1
44. 00 04400 SKILLED NURSING FACILITY		0	1	0.00		44. 00
45. 00 04500 NURSING FACILITY		0		0. 00	•	
200.00 Total (lines 30 through 199)		0	31, 174		17, 351	200. 00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0)				30.00
31.00 03100 INTENSIVE CARE UNIT	0)				31.00
32. 00 03200 CORONARY CARE UNIT	0					32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0					33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0					34.00
40. 00 04000 SUBPROVI DER - 1 PF	0					40.00
41. 00 04100 SUBPROVI DER - RF		1				41. 00
43. 00 04300 NURSERY						43. 00
44. 00 04400 SKILLED NURSING FACILITY						44. 00
45. 00 04400 SKILLED NORSING FACILITY						45. 00
		•				1
200.00 Total (lines 30 through 199)	0	'				200. 00

 Heal th Financial
 Systems
 ENCOMPASS
 HEALTH DEACONESS
 REHABILIT

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE OTHER PASS
 Provider CCN: 15-3025
 THROUGH COSTS

					"	07/31/2023	11/15/2023 8:	
			Ti 1	le XVII	I	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng		ursi ng	Allied Health	Allied Health	
	·	Anestheti st	Program	19	rogram	Post-Stepdown		
		Cost	Post-Stepdo	vn	J	Adjustments		
			Adjustment	5		•		
		1.00	2A		2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATI NG ROOM	0		0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0		0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		0	0	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0		0	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0		0	0	0	0	54.00
54.01	05401 RADIOLOGY - DIAGNOSTIC - SUA	0		0	0	0	0	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0		o	0	0	0	55. 00
56.00	05600 RADI OI SOTOPE	0		o	0	0	0	56. 00
57.00	05700 CT SCAN	0		o	0	0	0	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		o	0	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0		o	0	0	0	59. 00
60.00	06000 LABORATORY	0		o	0	0	0	60.00
60. 01	06001 BLOOD LABORATORY	0		ol	0	0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			İ				61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		ol	0	0	0	62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0		ol	0	0	0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0		o	0	0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0		o	0	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0		o	0	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0		ō	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0		0	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0		0	0	0	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0		0	Ö	0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0			0	0	Ö	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0			0	0	0	73. 00
74. 00	07400 RENAL DIALYSIS	0			0	0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0			0	0	0	75. 00
76. 00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0			0	0	0	76.00
76. 00	03950 SPECIAL PROCEDURES	0			0	0	0	76. 00
76. 01	03951 SPECIAL PROCEDURES - SUA	0			0	0	0	76. 02
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0		o	0	0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY			o	0	0	0	78.00
70.00	OUTPATIENT SERVICE COST CENTERS	0		<u> </u>	U	0	U	78.00
90. 00	09000 CLINIC	0		ol	0	0	0	90.00
91. 00	09100 EMERGENCY	0	l	0	0	0	0	91.00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		l	٩	0	U	0	91.00
92.00		0			U		U	92.00
04.00	OTHER REIMBURSABLE COST CENTERS	1 0		ol	0	0	0	04.00
94.00	09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES	0		۷	U	Ü	U	94.00
95.00	I I			0	0	0		95. 00
96. 00 97. 00	09600 DURABLE MEDICAL EQUIP-RENTED			-	0	0	0	96.00
	09700 DURABLE MEDICAL EQUIP-SOLD	0		0	0	0		97. 00
200.00	Total (lines 50 through 199)	1	I	이	U	U	ا	200. 00

In Lieu of Form CMS-2552-10 Health Financial Systems ENCOMPASS HEALTH DEACONESS REHABILIT APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-3025 Peri od: Worksheet D From 08/01/2022 To 07/31/2023 THROUGH COSTS Part IV Date/Time Prepared: 11/15/2023 8:13 am Title XVIII Hospi tal Ratio of Cost Cost Center Description All Other Total Cost Total Total Charges to Charges Medi cal (from Wkst. C, (sum of cols. Outpati ent Education Cost Cost (sum of Part I, col. 1, 2, 3, and l(col. 5 ÷ col 4) 8) col s. 2. 3. 7) and 4) (see instructions) 4.00 5.00 6.00 7. 00 8.00 ANCILLARY SERVICE COST CENTERS 0 50.00 05000 OPERATING ROOM 0.000000 50.00 05100 RECOVERY ROOM 0 0 0 0.000000 51.00 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0000000000 0 0 0 0.000000 52.00 05300 ANESTHESI OLOGY 0 0 0.000000 53 00 53 00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 342, 953 0.000000 54.00 05401 RADIOLOGY - DIAGNOSTIC - SUA 202, 838 0.000000 54.01 05500 RADI OLOGY-THERAPEUTI C 0 0 0.000000 55 00 55 00 0 56.00 05600 RADI OI SOTOPE 0 0 0.000000 56.00 57.00 05700 CT SCAN 0 0.000000 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0 0 0 0.000000 58.00 05900 CARDI AC CATHETERI ZATI ON 0 59 00 59 00 Ω 0 0.000000 60.00 06000 LABORATORY 0 0 1, 977, 086 0.000000 60.00 06001 BLOOD LABORATORY 0 0.000000 60.01 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 62 00 000000000000000000 Ω 0 62 00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0.000000 63.00 06400 I NTRAVENOUS THERAPY 0.000000 64.00 64.00 06500 RESPIRATORY THERAPY 0 0 1, 021, 276 0.000000 65.00 65.00 06600 PHYSI CAL THERAPY 0 66.00 0 9, 714, 208 0.000000 66.00 67.00 06700 OCCUPATIONAL THERAPY 10, 822, 740 0.000000 67.00 06800 SPEECH PATHOLOGY 2, 312, 037 68.00 0.000000 68.00 06900 ELECTROCARDI OLOGY 69.00 0 0.000000 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 Ω 0.000000 70 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 823, 450 0.000000 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 8, 194, 634 0.000000 73.00 74.00 07400 RENAL DIALYSIS C 0 0.000000 74.00 07500 ASC (NON-DISTINCT PART) 0.000000 75.00 75.00 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0.000000 76.00 03950 SPECIAL PROCEDURES 0 76.01 C 0.000000 76.01 0 76. 02 03951 SPECIAL PROCEDURES - SUA 0 450, 609 0.000000 76.02 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 C 0 0.000000 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 78.00 78.00 0 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 0.000000 90.00 91.00 09100 EMERGENCY 0 0 0 o 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 92.00 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 0.000000 94.00 09500 AMBULANCE SERVICES

0

0

0

0

0

0

0

35, 861, 831

95.00

96.00

97.00

200.00

0.000000

0.000000

95.00

96.00

200.00

09600 DURABLE MEDICAL EQUIP-RENTED

Total (lines 50 through 199)

97. 00 09700 DURABLE MEDICAL EQUIP-SOLD

Heal th	Financial Systems ENCO	MPASS HEALTH DEA	CONESS REHABI	LIT	In Lie	u of Form CMS-:	2552-10
APPORT	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provi der Co	CN: 15-3025	Peri od:	Worksheet D	
THROUG	SH COSTS				From 08/01/2022	Part IV	
	555.5				To 07/31/2023		
						11/15/2023 8:	13 am
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Outpati ent	Inpatient	Inpatient	Outpati ent	Outpati ent	
	•	Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col . 6 ÷ col .	onal goo	Costs (col.		Costs (col. 9	
		7)		x col . 10)		x col . 12)	
		9.00	10.00		12.00		
	ANCILL ADV. CEDVI CE. COCT. CENTEDO	9.00	10. 00	11.00	12.00	13. 00	
	ANCILLARY SERVICE COST CENTERS	0.00000					
50. 00	05000 OPERATI NG ROOM	0. 000000	0		0	0	
51. 00	05100 RECOVERY ROOM	0. 000000	0)	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0)	0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 000000	0	ol	0 0	Ō	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	336, 145	:	0 1, 700	0	54.00
54. 01	05401 RADI OLOGY - DI AGNOSTI C - SUA	0. 000000	194, 018		0 0	, O	
		1		1	-	ı	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0	•	0 0	0	00.00
56. 00	05600 RADI 0I SOTOPE	0. 000000	0	1	0	0	56. 00
57. 00	05700 CT SCAN	0. 000000	0)	0	0	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0)	0 0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0	ol .	0 0	Ō	59.00
60.00	06000 LABORATORY	0. 000000	1, 155, 811		0 12	0	
60. 01	06001 BLOOD LABORATORY	0. 000000	., .00, 0		0 0	o o	
	1 1	0.000000	O	1	0	0	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0	9	0	0	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0)	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	0)	0 0	0	64.00
65.00	06500 RESPI RATORY THERAPY	0. 000000	582, 949		0 0	0	65.00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	5, 448, 548		0 0	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	6, 084, 135	•	0 0	0	
68. 00	06800 SPEECH PATHOLOGY	0. 000000	1, 204, 928	1	0 0	, O	1
69. 00	06900 ELECTROCARDI OLOGY	1		1		ı	69.00
	1 1	0. 000000	0	1		0	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0	1	0	0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	489, 964		0	0	,
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0)	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	4, 397, 439		0 0	0	73.00
74.00	07400 RENAL DIALYSIS	0. 000000	0	1	0	0	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	
76. 00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	0	1	0 0	Ö	1
76. 00	03950 SPECIAL PROCEDURES		0	1	0 0	0	
		0. 000000	· ·	1	-	Ŭ	76. 01
76. 02	03951 SPECIAL PROCEDURES - SUA	0. 000000	94, 010	1	0	0	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0)	0	0	77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0.000000	0)	0 0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS]
90.00	09000 CLI NI C	0. 000000	0		0 0	0	90.00
91. 00	09100 EMERGENCY	0. 000000	0	1	0 0	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0	l	0 0	_	
92.00		0.000000	0	′	0 0	U	92.00
	OTHER REIMBURSABLE COST CENTERS						
94. 00	09400 HOME PROGRAM DIALYSIS	0. 000000	0	7	0	0	
95. 00	09500 AMBULANCE SERVICES						95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0)	0 0	0	96. 00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	0)	0 0	0	97.00
200.00			19, 987, 947	·	0 1, 712	0	200. 00
		. '		•			•

			Title	: XVIII	Hospi tal	PPS	
	·			Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	cost center bescription	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	(366 11131.)	
			11151.)				
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1. 00	2. 00	3. 00	4. 00	5. 00	
	CILLARY SERVICE COST CENTERS						
50.00 05	000 OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00 05	100 RECOVERY ROOM	0. 000000	0	l c	0	0	51.00
52. 00 05	200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	52.00
	300 ANESTHESI OLOGY	0. 000000	0	0	0	0	53.00
	400 RADI OLOGY-DI AGNOSTI C	0. 383773	1, 700		0	652	54. 00
	401 RADI OLOGY - DI AGNOSTI C - SUA	0. 253877	1, 700			0	54. 01
	l e e e e e e e e e e e e e e e e e e e		_		_	-	
	500 RADI OLOGY-THERAPEUTI C	0. 000000	0		_	0	55. 00
	600 RADI OI SOTOPE	0. 000000	0	l ~	_	0	56. 00
	700 CT SCAN	0. 000000	0		_	0	57. 00
58. 00 05	800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0	C	0	0	58. 00
59.00 05	900 CARDI AC CATHETERI ZATI ON	0.000000	0	0	0	0	59. 00
60.00 06	000 LABORATORY	0. 436360	12	l	0	5	60.00
60. 01 06	001 BLOOD LABORATORY	0. 000000	0	l c	0	0	60. 01
	100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000	Ĭ	Ö		Ĭ	61. 00
	200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0	l ~		0	62. 00
		1	_	1	_	1	1
	300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0			1	63.00
	400 INTRAVENOUS THERAPY	0. 000000	0			0	64. 00
	500 RESPI RATORY THERAPY	0. 685439	0	0	0	0	65. 00
66. 00 06	600 PHYSI CAL THERAPY	0. 301123	0	0	0	0	66. 00
67.00 06	700 OCCUPATI ONAL THERAPY	0. 281719	0	C	0	0	67. 00
68. 00 06	800 SPEECH PATHOLOGY	0. 392008	0	l c	0	0	68. 00
	900 ELECTROCARDI OLOGY	0. 000000	0	l c	0	0	69. 00
	000 ELECTROENCEPHALOGRAPHY	0. 000000	0			l o	70.00
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 637060	0		Ö	1	71.00
	200 IMPL. DEV. CHARGED TO PATIENTS		0			1	72.00
		0. 000000				-	1
	300 DRUGS CHARGED TO PATIENTS	0. 226903	0			0	73. 00
	400 RENAL DIALYSIS	0. 000000	0			0	74. 00
	500 ASC (NON-DISTINCT PART)	0. 000000	0	0	0	1	75. 00
76. 00 03	550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	0	C	0	0	76. 00
76. 01 03	950 SPECIAL PROCEDURES	0.000000	0	C	0	0	76. 01
76, 02 03	951 SPECIAL PROCEDURES - SUA	0. 299581	0	l c	0	0	76. 02
	700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0	0	77. 00
	800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		_	1	78. 00
	TPATIENT SERVICE COST CENTERS	0.000000	0		1 0		70.00
	000 CLINIC	0. 000000	0		0	0	90.00
	l e e e e e e e e e e e e e e e e e e e						
	100 EMERGENCY	0. 000000	0				91. 00
	200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0	0	0	0	92. 00
ОТІ	HER REIMBURSABLE COST CENTERS						
94.00 09	400 HOME PROGRAM DIALYSIS	0. 000000		C	0		94. 00
95. 00 09	500 AMBULANCE SERVICES	0. 000000		C			95. 00
	600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0	l c	0	0	96.00
	700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	n	Ö	_	0	97. 00
200.00	Subtotal (see instructions)	0.00000	1, 712	l ~	0	-	200. 00
201.00	Less PBP Clinic Lab. Services-Program		1, /12			057	201. 00
201.00					,		201.00
202 00	Only Charges		1 710			/	202 00
202. 00	Net Charges (line 200 - line 201)		1, 712	[C	0	J 657	202. 00

	Financial Systems ENCOMPASS HEALTH DEACO			u of Form CMS-2		
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-3025	Peri od: From 08/01/2022	Worksheet D-1		
				Date/Time Pre 11/15/2023 8:	pared:	
		Title XVIII	Hospi tal	PPS	IS alli	
	Cost Center Description					
	PART I - ALL PROVIDER COMPONENTS			1. 00		
	INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days			31, 174	1. 00	
2.00	Inpatient days (including private room days, excluding swing-b			31, 174	2.00	
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	(s). If you have only pr	ivate room days,	0	3. 00	
1. 00	Semi-private room days (excluding swing-bed and observation be	ed days)		31, 174	4. 00	
. 00						
. 00	reporting period Total swing-bed SNF type inpatient days (including private roo	um days) after December	21 of the cost	0	6. 00	
. 00	reporting period (if calendar year, enter 0 on this line)	on days) after becember	31 OF the Cost	U	6.00	
. 00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7. 00	
00	reporting period) -£t D 2	1 -6 -1	0	0.00	
. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost 0 8.0 reporting period (if calendar year, enter 0 on this line)					
. 00	D Total inpatient days including private room days applicable to the Program (excluding swing-bed and 17,351 9.					
0. 00	newborn days) (see instructions) 0 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)					
). 00	through December 31 of the cost reporting period (see instruct	0	10.00			
1. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after				11. 00	
0 00	December 31 of the cost reporting period (if calendar year, er		40.00			
2. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	toniy (including privat	e room days)	0	12. 00	
3. 00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13. 00	
4 00	after December 31 of the cost reporting period (if calendar ye				44.00	
	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	im (excluding swing-bed	days)	0		
	Nursery days (title V or XIX only)			0		
	SWING BED ADJUSTMENT					
7. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0. 00	17. 00	
8. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00	
	reporting period					
9. 00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0. 00	19. 00	
0. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20. 00	
	reporting period					
1. 00				22, 259, 508		
2. 00	Swing-bed cost applicable to SNF type services through December 5×1 line 17)	er 31 of the cost report	ing period (line	0	22. 00	
3. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00	
	x line 18)	•				
4. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	31 of the cost reporti	ng period (line	0	24. 00	
5. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00	
	x line 20)	, , ,	,			
6.00	Total swing-bed cost (see instructions)	line 21 minus line 24)		22 250 509		
7. UU	General inpatient routine service cost net of swing-bed cost (PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	irne zi ilinus irne 26)		22, 259, 508	27.00	
8. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28. 00	
29 00	Private room charges (excluding swing-bed charges)			0	29. 00	

	SWING DED ADJUSTIMENT		
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
	reporting period		
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18. 00
10.00	reporting period	0.00	10.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19. 00
20 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20. 00
20.00	report in giperiod	0.00	20.00
21. 00		22, 259, 508	21. 00
22. 00	, , , , , , , , , , , , , , , , , , , ,	0	22. 00
	5 x line 17)		
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
	x line 18)		
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
25. 00	7 x line 19)	0	25. 00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	Ü	25.00
26 00	Total swing-bed cost (see instructions)	0	26. 00
	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	22, 259, 508	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	==/==//	
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29.00	Private room charges (excluding swing-bed charges)	0	29. 00
30.00		0	
31. 00		0.000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)		32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)		33. 00
34.00			34.00
	Average per diem private room cost differential (line 34 x line 31)		35. 00
36. 00		0	00.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	22, 259, 508	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00		714. 04	38. 00
39. 00		12, 389, 308	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40. 00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	12, 389, 308	41.00

		MPASS HEALTH DEAC				eu of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CCN: 1		eriod: fom 08/01/2022 0 07/31/2023	Worksheet D-1 Date/Time Pre 11/15/2023 8:	pared:
	Cost Center Description	Total	Title XVI Total Av	II erage Per	Hospital Program Days	PPS Program Cost	
	oost center bescription		npatient Days Diem	n (col. 1 ÷	Trogram bays	(col. 3 x col.	
		1.00	2.00	col . 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0. 00	0	0	42. 00
43. 00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43. 00
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	0	0. 00 0. 00	0	l e	
46. 00	SURGICAL INTENSIVE CARE UNIT	Ö	Ö	0. 00	0	l	46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
48. 00	Program inpatient ancillary service cost (Wk:	st D_3 col 3	line 200)			1. 00 6, 247, 318	48 00
48. 01	Program inpatient cellular therapy acquisition	on cost (Workshee	et D-6, Part III,		olumn 1)	0	48. 01
49. 00	Total Program inpatient costs (sum of lines - PASS THROUGH COST ADJUSTMENTS	41 through 48.01)	(see instruction	ıs)		18, 636, 626	49. 00
50. 00	Pass through costs applicable to Program inpa	atient routine se	ervices (from Wks	st. D, sum c	f Parts I and	1, 610, 693	50.00
51. 00		atient ancillary	services (from W	/kst. D, sum	of Parts II	398, 109	51.00
52. 00	and IV) Total Program excludable cost (sum of lines!	50 and 51)				2, 008, 802	52.00
53. 00	Total Program inpatient operating cost exclu	ding capital rela	ated, non-physici	an anesthet	ist, and	16, 627, 824	
	medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION	02)					
54. 00 55. 00	Program discharges Target amount per discharge					0	54. 00 55. 00
55. 01	Permanent adjustment amount per discharge					l e	55. 01
55. 02 56. 00	Adjustment amount per discharge (contractor Target amount (line 54 x sum of lines 55, 55					0.00	55. 02 56. 00
57. 00	Difference between adjusted inpatient operation		get amount (line	56 minus li	ne 53)	ő	57. 00
58.00 Bonus payment (see instructions) 59.00 Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996,						0	58. 00 59. 00
updated and compounded by the market basket)							
60.00	60.00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)						60.00
61.00 Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise						0	61.00
enter zero. (see instructions) 62.00 Relief payment (see instructions)							62. 00
63.00 Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST							63. 00
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Decemb	oer 31 of the cos	t reporting	period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	31 of the cost	reporting p	eriod (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routing	ne costs (line 64	1 plus line 65)(t	itle XVIII	only); for	0	66. 00
67. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routing	e costs through (December 31 of th	ne cost reno	arting period	0	67. 00
	(line 12 x line 19)	· ·			0 .		
68. 00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)			·	ing period		68. 00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU					0	69. 00
70.00	Skilled nursing facility/other nursing facil	ty/ICF/IID routi	ne service cost				70.00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ie /u ÷ ITNe 2)				71. 00 72. 00
73. 00 74. 00	Medically necessary private room cost applications and program general inpatient routine services.			35)			73. 00 74. 00
75. 00	Capital -related cost allocated to inpatient	,	,	heet B, Par	t II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line	76)					77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minu: Aggregate charges to beneficiaries for excess		ovi der records)				78. 00 79. 00
80.00	Total Program routine service costs for compa	arison to the cos		ne 78 minus	line 79)		80. 00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I						81. 00 82. 00
83.00	Reasonable inpatient routine service costs (see instructions)				83.00
84. 00 85. 00	Program inpatient ancillary services (see in: Utilization review - physician compensation		s)				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS	of lines 83 thro					86. 00
87. 00	Total observation bed days (see instructions))				0	1
88. 00 89. 00	Adjusted general inpatient routine cost per observation bed cost (line 87 x line 88) (see		ine 2)			l	88. 00 89. 00
	, () () () ()						

Health Financial Systems ENCO	MPASS HEALTH DE	ACONESS REHABII	LIT	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Period: From 08/01/2022	Worksheet D-1	
				To 07/31/2023	Date/Time Pre 11/15/2023 8:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	2, 893, 899	22, 259, 508	0. 13000	7 0	0	90.00
91.00 Nursing Program cost	0	22, 259, 508	0.00000	0	0	91. 00
92.00 Allied health cost	0	22, 259, 508	0.00000	0	0	92. 00
93.00 All other Medical Education	0	22, 259, 508	0. 00000	0 0	0	93. 00

	Financial Systems	ENCOMPASS HEALTH DEACC			u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CCN: 15-3025	Peri od: From 08/01/2022	Worksheet D-1	
				To 07/31/2023	Date/Time Pre 11/15/2023 8:	
			Title XIX	Hospi tal	Cost	ıs allı
	Cost Center Description					
					1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS					
1. 00	Inpatient days (including private roo	m days and swing-hed days	excluding newborn)		31, 174	1.00
2. 00	Inpatient days (including private roo				31, 174	2. 00
3. 00	Private room days (excluding swing-be			ivate room days,	0	3. 00
	do not complete this line.	Ĭ	· , , , , , , , , , , , , , , , , , , ,			
. 00	Semi-private room days (excluding swi				31, 174	
00	Total swing-bed SNF type inpatient da	ys (including private rod	om days) through Decembe	r 31 of the cost	0	5. 00
00	reporting period Total swing-bed SNF type inpatient da	ve (including private rec	om days) after December	21 of the cost	0	6. 00
00	reporting period (if calendar year, e		oli days) arter beceilber	of the cost	U	0.00
00	Total swing-bed NF type inpatient day		n days) through December	31 of the cost	0	7. 00
	reporting period	-				
. 00	Total swing-bed NF type inpatient day		n days) after December 3	1 of the cost	0	8. 00
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and 235					0.00
. 00	newborn days) (see instructions)	e room days appilcable to	the Program (excluding	swing-bed and	235	9. 00
0. 00	Swing-bed SNF type inpatient days app	licable to title XVIII or	nlv (including private r	oom days)	0	10.00
	through December 31 of the cost reporting period (see instructions)					
1. 00	Swing-bed SNF type inpatient days app			oom days) after	0	11. 00
	December 31 of the cost reporting per					40.00
2. 00	Swing-bed NF type inpatient days appl through December 31 of the cost repor		conly (including private	e room days)	0	12. 00
3. 00	Swing-bed NF type inpatient days appl		only (including private	e room days)	0	13. 00
	after December 31 of the cost reporti				_	
4. 00	Medically necessary private room days		am (excluding swing-bed	days)	0	
	Total nursery days (title V or XIX on	ly)			0	
5. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT				0	16. 00
00	Medicare rate for swing-bed SNF servi	ces annlicable to service	es through December 31 o	f the cost	0.00	17. 00
. 00	reporting period	ces appricable to service	23 through becember 31 0	the cost	0.00	17.00
3. 00	Medicare rate for swing-bed SNF servi	ces applicable to service	es after December 31 of	the cost	0.00	18. 00
	reporting period					
9. 00	Medicaid rate for swing-bed NF servic	es applicable to services	s through December 31 of	the cost	0. 00	19. 00
0. 00	reporting period Medicaid rate for swing-bed NF servic	os applicable to services	after December 21 of the	ho cost	0.00	20. 00
J. 00	reporting period	es applicable to services	s arter becember 31 or th	ile cost	0.00	20.00
. 00	Total general inpatient routine servi	ce cost (see instructions	s)		22, 238, 354	21. 00
2. 00	Swing-bed cost applicable to SNF type	services through December	er 31 of the cost report	ing period (line	0	22. 00
	5 x line 17)				_	
3. 00	Swing-bed cost applicable to SNF type x line 18)	services after December	31 of the cost reporting	g period (line 6	0	23. 00
1 00	Swing-bed cost applicable to NF type	services through December	31 of the cost reportion	ng period (line	0	24. 00
r. 00	7 x line 19)	ser vi ces tili odgir becember	of the cost reporting	ng perroa (rrne	O	24.00
. 00	Swing-bed cost applicable to NF type	services after December 3	31 of the cost reporting	period (line 8	0	25. 00
	x line 20)		· -			
	Total swing-bed cost (see instruction		(1) 21		0	
ı. UU	General inpatient routine service cos PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		(Time 21 minus Time 26)		22, 238, 354	27. 00
0 00	Conoral inpatient routine service cha			, ,	0	20 00

28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 28.00 29.00 Private room charges (excluding swing-bed charges) 29.00 Ωl 30.00 Semi-private room charges (excluding swing-bed charges) 0 30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 0.000000 31.00 Average private room per diem charge (line $29 \div line 3$) 32.00 0.00 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 0 00 33.00 33 00 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 0.00 34.00 Average per diem private room cost differential (line 34 x line 31) 0.00 35.00 36.00 Private room cost differential adjustment (line 3 x line 35) 0 36.00 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 22, 238, 354 37.00 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 713.36 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 167, 640 39.00 40.00 | Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 41.00 | Total Program general inpatient routine service cost (line 39 + line 40) 167, 640 41. 00

COMPUT	Financial Systems ENCOM ATION OF INPATIENT OPERATING COST	MPASS HEALTH DE		CCN: 15-3025	Peri od:	eu of Form CMS- Worksheet D-1	
					From 08/01/202 To 07/31/202		
				tle XIX	Hospi tal	Cost	
	Cost Center Description	Total Inpatient Cost	Total	Average Po		Program Cost (col. 3 x col.	
				col . 2)		4)	
42. 00	NURSERY (title V & XIX only)	1.00	2. 00	3. 00 0	4. 00	5.00	42. 00
	Intensive Care Type Inpatient Hospital Units						
43. 00	INTENSIVE CARE UNIT	0		I	0. 00	0 0	
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0		1	0. 00 0. 00	0 0	1
	SURGICAL INTENSIVE CARE UNIT	0			0.00	0 0	•
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wk					90, 967	•
48. 01 49. 00	Program inpatient cellular therapy acquisition Total Program inpatient costs (sum of lines				0, column 1)	0 258, 607	
47.00	PASS THROUGH COST ADJUSTMENTS	41 through 46.0	i) (see Tiisti	uctions)		258, 007	J 49.00
50. 00	Pass through costs applicable to Program inp	atient routine	servi ces (fi	om Wkst. D, s	um of Parts I an	d 0	50.00
51. 00	<pre> Pass through costs applicable to Program inp.</pre>	atient ancillar	v services	(from Wkst D	sum of Parts II	0	51.00
01.00	and IV)	atront unorrian	y services	(11 om Witst. D,	Sum of Full 13 FF		01.00
52.00	Total Program excludable cost (sum of lines		lated ::	abuai ai	thatiat	0	1
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		iateu, NON-	ынуы сган anes	inetist, and	0	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54. 00 55. 00	Program discharges Target amount per discharge					0 00	54. 00 55. 00
55. 01	Permanent adjustment amount per discharge					•	55. 00
55. 02	Adjustment amount per discharge (contractor	use only)				•	55. 02
56. 00	Target amount (line 54 x sum of lines 55, 55	0 0					
57. 00 58. 00							57. 00 58. 00
59. 00							59.00
(0.00	updated and compounded by the market basket)						
60. 00	00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)						60.00
61. 00	On Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise					0	61. 00
62. 00	enter zero. (see instructions) 2.00 Relief payment (see instructions)						
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of	the cost repor	ting period (See	T 0	64. 00
	instructions)(title XVIII only)	3		•	31		
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts after Decemb	er 31 of the	e cost reporti	ng period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	e 65)(title XV	III only); for	0	66. 00
67. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routing	e costs through	December 3	1 of the cost	reporting period	0	67. 00
<i>(</i> 0,00	(line 12 x line 19)	· ·					
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs arter b	ecelliber 31 (or the cost re	portring perrou	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NI					0	69. 00
70. 00	Skilled nursing facility/other nursing facil				7)		70. 00
71. 00	Adjusted general inpatient routine service c		ine 70 ÷ lii	ne 2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applications)	•	(line 14 v	line 35)			72. 00 73. 00
74. 00	Total Program general inpatient routine serv						74.00
75. 00	Capital-related cost allocated to inpatient	routine service	costs (from	m Worksheet B,	Part II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital -related costs (line 9 x line						77. 00
78. 00	Inpatient routine service cost (line 74 minu						78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp.			*.	inus line 70)		79. 00 80. 00
81. 00	Inpatient routine service costs for comp		oot rimitali	SII (TINE 70 III	inus iiic /7)		81.00
82. 00	Inpatient routine service cost limitation (I	ine 9 x line 81	•				82.00
83.00	Reasonable inpatient routine service costs (s)				83. 00 84. 00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ns)				85.00
86. 00	Total Program inpatient operating costs (sum	of lines 83 th					86. 00
07 00	PART IV - COMPUTATION OF OBSERVATION BED PASS						07.00
87. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		line 2)			0.00	87. 00 88. 00
88. 00							

Health Financial Systems ENCOM	ENCOMPASS HEALTH DEACONESS REHABILIT				In Lieu of Form CMS-2552		
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1		
				From 08/01/2022 To 07/31/2023	Date/Time Pre 11/15/2023 8:		
		Titl	e XIX	Hospi tal	Cost		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on		
		(from line 21)	column 2	Observati on	Bed Pass		
				Bed Cost (from	Through Cost		
				line 89)	(col. 3 x col.		
					4) (see		
					instructions)		
	1.00	2.00	3. 00	4. 00	5. 00		
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST						
90.00 Capital -related cost	2, 893, 899	22, 238, 354	0. 13013	1 0	0	90.00	
91.00 Nursing Program cost	0	22, 238, 354	0.00000	0	0	91. 00	
92.00 Allied health cost	0	22, 238, 354	0.00000	0	0	92. 00	
93.00 All other Medical Education	0	22, 238, 354	0. 00000	0 0	0	93. 00	

Health Financial Systems	ENCOMPASS HEALTH DEAC	ONESS REHABILIT		In Lieu of Form CMS-2552-10
INDATI ENT ANGLI LADV CEDVI CE COCT ADI	ODTI ONMENT	D	D!!	W

	FINANCIAL SYSTEMS ENCOMPASS HEALTH DEACU		In Lie	u or form CMS	
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT		Peri od:	Worksheet D-3	
		F	rom 08/01/2022		
		1	o 07/31/2023	Date/Time Pre	pared:
				11/15/2023 8:	13 am_
		Title XVIII	Hospi tal	PPS	
	Cost Center Description	Ratio of Cost	Inpati ent	Inpati ent	
	555 Conton 5555 Ft. 511	To Charges	Program	Program Costs	
		To charges	9		
			Charges	(col. 1 x col.	
				2)	
		1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDI ATRI CS		18, 935, 439		30.00
	03100 NTENSI VE CARE UNI T		10,700,107		31. 00
			0		1
	03200 CORONARY CARE UNIT		0		32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT		0		33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT		0		34.00
40.00	04000 SUBPROVI DER - I PF		0		40.00
41. 00	04100 SUBPROVI DER – I RF		0		1
	1 1		0		41.00
43. 00	04300 NURSERY				43. 00
	ANCILLARY SERVICE COST CENTERS				[
50. 00	05000 OPERATI NG ROOM	0.000000	0	0	50.00
51.00	05100 RECOVERY ROOM	0. 000000	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000		0	52.00
					1
	05300 ANESTHESI OLOGY	0.000000		0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 383773	336, 145	129, 003	54. 00
54. 01	O5401 RADIOLOGY - DIAGNOSTIC - SUA	0. 253877	194, 018	49, 257	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0	0	55. 00
56. 00	05600 RADI OI SOTOPE	0. 000000		0	56. 00
				-	•
57. 00	05700 CT SCAN	0.000000		0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0.000000	0	0	59. 00
60.00	06000 LABORATORY	0. 436360		504, 350	ı
					1
	06001 BL00D LABORATORY	0.000000		0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000) 0	0	61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000		0	64. 00
				200 574	•
65. 00	06500 RESPI RATORY THERAPY	0. 685439			1
66. 00	06600 PHYSI CAL THERAPY	0. 301123	5, 448, 548	1, 640, 683	66. 00
67. 00	O6700 OCCUPATI ONAL THERAPY	0. 281719	6, 084, 135	1, 714, 016	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 392008	1, 204, 928	472, 341	68. 00
	06900 ELECTROCARDI OLOGY	0. 000000		0	69.00
	07000 ELECTROENCEPHALOGRAPHY				70.00
	1 1	0.000000		0	ı
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 637060		312, 136	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 226903	4, 397, 439	997, 792	73. 00
	07400 RENAL DI ALYSI S	0. 000000		0	74. 00
	07500 ASC (NON-DISTINCT PART)				1
		0.000000		0	75. 00
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0.000000		0	76. 00
76. 01	03950 SPECI AL PROCEDURES	0.000000) 0	0	76. 01
76. 02	03951 SPECI AL PROCEDURES - SUA	0. 299581	94, 010	28, 164	76. 02
	07700 ALLOGENEIC HSCT ACQUISITION	0.000000			1
	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000			1
78.00		0.000000	<u>, </u>	0	76.00
	OUTPATIENT SERVICE COST CENTERS			_	
	09000 CLI NI C	0. 000000		0	1
91. 00	09100 EMERGENCY	0.000000	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS	·			1
94.00	09400 HOME PROGRAM DI ALYSI S	0.000000	0	0	94. 00
	09500 AMBULANCE SERVICES	0.00000	ή		
				_	95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000		0	
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97. 00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		19, 987, 947	6, 247, 318	200.00
201.00		(Line 61)	n		201. 00
202.00		`/	19, 987, 947		202.00
202.00	The sharges (Title 200 millias Title 201)	ı	17, 707, 747	ı	1202.00

Health Financial Systems	ENCOMPASS HEALTH DEACC	DNES	3 REH/	ABI LI T	In Lie	u of Form CMS-2552-10

	ICIAI SYSTEMS ENCUMPASS HEALTH DEACU				eu of Form CMS-2	
INPATIENT AN	NCILLARY SERVICE COST APPORTIONMENT	Provi der C		Period: From 08/01/2022	Worksheet D-3	
				Γο 07/31/2023	Date/Time Pre	
		T: +1	o VIV	Heeni tel	11/15/2023 8:	13 am
	Cost Center Description	11 (1	e XIX Ratio of Cost	Hospi tal Inpati ent	Cost Inpatient	
	Cost Center Description		To Charges	Program	Program Costs	
			10 charges	Charges	(col. 1 x col.	
				onal ges	2)	
			1.00	2. 00	3. 00	
I NPAT	IENT ROUTINE SERVICE COST CENTERS		•	•	•	
30. 00 03000	ADULTS & PEDIATRICS			254, 688		30.00
31.00 03100	INTENSIVE CARE UNIT			0		31.00
32. 00 03200	CORONARY CARE UNIT			0		32. 00
33. 00 03300	BURN INTENSIVE CARE UNIT			0		33. 00
34.00 03400	SURGICAL INTENSIVE CARE UNIT			0		34.00
40. 00 04000	SUBPROVI DER - I PF			0		40. 00
41.00 04100	SUBPROVI DER - I RF			0		41.00
43. 00 04300	NURSERY			0		43.00
	LARY SERVICE COST CENTERS					
	OPERATI NG ROOM		0. 000000		-	50. 00
l l	RECOVERY ROOM		0.000000		_	51.00
	DELIVERY ROOM & LABOR ROOM		0.000000		_	52. 00
	ANESTHESI OLOGY		0.000000		0	53. 00
l l	RADI OLOGY-DI AGNOSTI C		0. 383773			54. 00
l l	RADIOLOGY - DIAGNOSTIC - SUA		0. 25387			54. 01
	RADI OLOGY-THERAPEUTI C		0. 000000		0	55. 00
	RADI OI SOTOPE		0. 000000		0	56. 00
	CT SCAN		0. 000000		0	57. 00
	MAGNETIC RESONANCE IMAGING (MRI)		0. 000000		0	58. 00
	CARDI AC CATHETERI ZATI ON		0.000000		0	59. 00
	LABORATORY		0. 436360			60.00
1	BLOOD LABORATORY		0. 000000		0	60. 01
1	PBP CLINICAL LAB SERVICES-PRGM ONLY		0. 000000		0	61.00
l l	WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 000000		0	62.00
	BLOOD STORING, PROCESSING & TRANS.		0.000000		0	63.00
	I NTRAVENOUS THERAPY		0.000000		0	64.00
l l	RESPI RATORY THERAPY		0. 685439			65.00
l l	PHYSI CAL THERAPY		0. 301123			66.00
l l	OCCUPATIONAL THERAPY		0. 281719			1
	SPEECH PATHOLOGY		0. 392008			68. 00
	ELECTROCARDI OLOGY		0.000000		0	69.00
l l	ELECTROENCEPHALOGRAPHY		0.000000		-	70. 00 71. 00
	MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS		0. 637060 0. 000000		5, 943 0	72.00
	DRUGS CHARGED TO PATTENTS		0. 226903		16, 868	73.00
	RENAL DIALYSIS		0. 000000		0	74.00
1	ASC (NON-DISTINCT PART)		0.000000		0	75. 00
l l	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0.000000		0	76.00
1	SPECIAL PROCEDURES		0.000000			76. 00
1	SPECIAL PROCEDURES - SUA		0. 29958		Ö	76. 02
	ALLOGENEIC HSCT ACQUISITION		0.000000			77. 00
78 00 07800	CAR T-CELL IMMUNOTHERAPY		0. 000000			1
	TIENT SERVICE COST CENTERS		0.00000	<u>, </u>		70.00
	CLINIC		0.00000	0	0	90. 00
	EMERGENCY		0. 000000			91.00
	OBSERVATION BEDS (NON-DISTINCT PART)		0. 000000			92. 00
	REI MBURSABLE COST CENTERS			-		
	HOME PROGRAM DI ALYSI S		0.000000	0	0	94. 00
	AMBULANCE SERVICES					95. 00
	DURABLE MEDICAL EQUIP-RENTED		0. 000000	o o	0	96.00
	DURABLE MEDICAL EQUIP-SOLD		0. 000000		0	97. 00
200.00	Total (sum of lines 50 through 94 and 96 through 98)			288, 120	90, 967	
201.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201. 00
202. 00	Net charges (line 200 minus line 201)			288, 120		202. 00

Health Financial Systems	ENCOMPASS HEALTH DEACONESS REHABILIT	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-3025	Peri od: Worksheet E From 08/01/2022 Part B Date/Time Prepared: 11/15/2023 8:13 am

		Title XVIII	Hospi tal	11/15/2023 8: PPS	
		TI LIE XVIII	поѕрі таі	'	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
1.00	Medical and other services (see instructions)			0	1. 00
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		657	2. 00
3. 00 4. 00	OPPS or REH payments			457 0	3. 00 4. 00
4. 00	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)			0	
5.00	Enter the hospital specific payment to cost ratio (see instruct	i ons)		0. 000	
6.00	Line 2 times line 5			0	
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	1
8. 00 9. 00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. IV	/ col 13 line 200		0	
10. 00	Organ acquisitions	, cor. 13, 11110 200		0	
11.00	Total cost (sum of lines 1 and 10) (see instructions)			0	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
12 00	Reasonable charges Ancillary service charges			0	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Iin	ne 69)		0	
14.00	Total reasonable charges (sum of lines 12 and 13)			0	14. 00
45.00	Customary charges		, , ,		1 45 00
15. 00 16. 00	Aggregate amount actually collected from patients liable for pa Amounts that would have been realized from patients liable for			0	
10.00	had such payment been made in accordance with 42 CFR §413.13(e)		a chargebasi s	O	10.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00
	Total customary charges (see instructions)			0	18. 00
19. 00	Excess of customary charges over reasonable cost (complete only instructions)	if line 18 exceeds lin	e 11) (see	0	19. 00
20. 00	Excess of reasonable cost over customary charges (complete only instructions)	if line 11 exceeds lin	e 18) (see	0	20. 00
21. 00	Lesser of cost or charges (see instructions)			0	21. 00
	Interns and residents (see instructions)			0	22. 00
	Cost of physicians' services in a teaching hospital (see instru	ıctions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			457	24. 00
25. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructions)			0	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line		ctions)	92	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl	us the sum of lines 22	and 23] (see	365	27. 00
20 00	instructions) Direct graduate medical education payments (from Wkst. E-4, lin	no 50)		0	28. 00
28. 50	REH facility payment amount	le 50)		O	28. 50
	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	1
30. 00	Subtotal (sum of lines 27, 28, 28.50 and 29)			365	1
	Primary payer payments			0	31.00
32.00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	S)		365	32. 00
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	<u> </u>		0	33. 00
	Allowable bad debts (see instructions)			0	
	Adjusted reimbursable bad debts (see instructions)	unti ana)		0	
36.00	Allowable bad debts for dual eligible beneficiaries (see instru Subtotal (see instructions)	ictions)		0 365	
38. 00	MSP-LCC reconciliation amount from PS&R			0	1
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			_	39. 50
39. 75 39. 97	N95 respirator payment adjustment amount (see instructions)			0	39. 75 39. 97
39. 97 39. 98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replace	ed devices (see instruct	ions)	0	39. 97 39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	(333 1.131.431	. 0.10)	0	39. 99
40.00	Subtotal (see instructions)			365	40. 00
40. 01	Sequestration adjustment (see instructions)			7	40. 01
	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs			0	40. 02 40. 03
	Interim payments			358	1
41. 01	Interim payments-PARHM				41. 01
	Tentative settlement (for contractors use only)			0	
42. 01 43. 00	Tentative settlement-PARHM (for contractor use only)			0	42. 01 43. 00
43. 00	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)			Ü	43.00
44. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2, c	hapter 1,	0	44. 00
	§115. 2				
00 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90.00
90.00	Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money			0.00	•
93. 00	Time Value of Money (see instructions)			0	
94. 00	Total (sum of lines 91 and 93)			0	94.00

Health Financial Systems	ENCOMPASS HEALTH DEACON	ESS REHABILIT	In Lieu	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	F		Peri od: From 08/01/2022 To 07/31/2023	Worksheet E Part B Date/Time Pre 11/15/2023 8:	
		Title XVIII	Hospi tal	PPS	
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200 00 Part B Combined Billed Days				0	200 00

Contractor

Number

1 00

0

NPR Date (Mo/Day/Yr)

2 00

8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-3025 Peri od: Worksheet E-1 From 08/01/2022 To 07/31/2023 Part I Date/Time Prepared: 11/15/2023 8:13 am Title XVIII Hospi tal PPS Part B Inpatient Part A mm/dd/yyyy mm/dd/yyyy Amount Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 30, 358, 850 358 1. 00 2.00 Interim payments payable on individual bills, either 2.00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment 3.00 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 11/22/2022 42, 221 0 3.01 3.02 0 3.02 3.03 3.03 0 0 3.04 0 0 3.04 3.05 0 0 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 02/17/2023 11, 991 0 3.50 3.51 C 0 3.51 0 0 3.52 3.52 0 3.53 0 3.53 3.54 \cap 0 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 30, 230 0 3.99 3.50-3.98) 30, 389, 080 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 358 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropri ate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATIVE TO PROVIDER 0 0 5.01 5.02 0 0 5.02 0 5.03 0 5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 0 5.50 5.51 0 0 5. 51 0 5.52 0 5.52 5. 99 0 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 5. 99 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1) SETTLEMENT TO PROVIDER 6.01 0 6.01 6 02 SETTLEMENT TO PROGRAM 261, 273 0 6.02 7.00 Total Medicare program liability (see instructions) 30, 127, 807 358 7.00

8.00 Name of Contractor

Health Financial Systems	ENCOMPASS HEALTH DEACO	NESS REHABILIT	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-3025	Peri od: From 08/01/2022 To 07/31/2023	Worksheet E-3 Part III Date/Time Prepared: 11/15/2023 8:13 am
		T1 11 \0.011		DDO

		Title XVIII	Hospi tal	PPS	is alli
	<u> </u>	THE XVIII	nospi tui	113	
				1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			30, 079, 627	1. 00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0359	2. 00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			1, 302, 448	3. 00
4.00	Outlier Payments			20, 731	4. 00
5. 00	Unweighted intern and resident FTE count in the most recent of to November 15, 2004 (see instructions)	ost reporting period en	ding on or prior	0. 00	5. 00
5. 01	Cap increases for the unweighted intern and resident FTE coun- program or hospital closure, that would not be counted without CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		'	0. 00	5. 01
6.00	New Teaching program adjustment. (see instructions)			0.00	6. 00
7. 00	Current year's unweighted FTE count of I&R excluding FTEs in	the new program growth p	eriod of a "new	0. 00	7. 00
	teaching program" (see instructions)				
8. 00	Current year's unweighted I&R FTE count for residents within teaching program" (see instructions)	the new program growth p	eriod of a "new	0. 00	8. 00
9. 00	Intern and resident count for IRF PPS medical education adjust	tment (see instructions)		0.00	9. 00
10.00	Average Daily Census (see instructions)			85. 408219	
11. 00	Teaching Adjustment Factor (see instructions)			0. 000000	
12. 00	Teaching Adjustment (see instructions)			0.000000	12. 00
13. 00	Total PPS Payment (see instructions)			31, 402, 806	
14. 00	Nursing and Allied Health Managed Care payments (see instructi	on)		0.7.027000	14. 00
15. 00	Organ acquisition (DO NOT USE THIS LINE)	5.1.)		١	15. 00
	Cost of physicians' services in a teaching hospital (see insti	ructions)		0	16. 00
17. 00	Subtotal (see instructions)	401.01.0)		31, 402, 806	
	Primary payer payments			19, 193	•
	Subtotal (line 17 less line 18).			31, 383, 613	
	Deducti bl es			519, 536	
	Subtotal (line 19 minus line 20)			30, 864, 077	•
	Coinsurance			262, 260	•
	Subtotal (line 21 minus line 22)			30, 601, 817	•
	Allowable bad debts (exclude bad debts for professional service	ces) (see instructions)		216, 682	•
	Adjusted reimbursable bad debts (see instructions)	, (, , , , , , , , , , , , , , , , , ,		140, 843	•
	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		121, 824	•
	Subtotal (sum of lines 23 and 25)	•		30, 742, 660	•
28. 00	Direct graduate medical education payments (from Wkst. E-4, Li	ne 49)		0	
29. 00	Other pass through costs (see instructions)	,		0	29. 00
				0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	31.00
31. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)		0	31. 50
31. 98	Recovery of accelerated depreciation.			0	31. 98
31. 99	Demonstration payment adjustment amount before sequestration			0	31. 99
32.00	Total amount payable to the provider (see instructions)			30, 742, 660	32.00
32. 01	Sequestration adjustment (see instructions)			614, 853	32. 01
32. 02	Demonstration payment adjustment amount after sequestration			0	32. 02
33.00	Interim payments			30, 389, 080	33. 00
34.00	Tentative settlement (for contractor use only)			0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02	2, 33, and 34)		-261, 273	35. 00
36. 00	Protested amounts (nonallowable cost report items) in accordal §115.2	nce with CMS Pub. 15-2,	chapter 1,	9, 301	36. 00
	TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			20, 731	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0	51.00
52.00	The rate used to calculate the Time Value of Money			0.00	
53.00	Time Value of Money (see instructions)			0	53.00
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND	BEGINNING ON OR BEFORE I	MAY 11, 2023 (THE	END OF	
00.00	THE COVID-19 PHE) Teaching Adjustment Factor for the cost reporting period immediately.	diataly proceding Fahrus	ry 20 2020	0.000000	99. 00
	, 3,	3 1	1 y 29, 2020.	0. 000000 0. 000000	
77. U I	Calculated Teaching Adjustment Factor for the current year. (SEE THSTIUCTIONS)	I	0.000000	77.01

Health Financial Systems	ENCOMPASS HEALTH DEACC	NESS REHABILIT	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-3025	Peri od:	Worksheet E-3
			From 08/01/2022	
		I .	T- 07/21/2022	D-+- /T! D

To 07/31/2023 Date/Time Prepared: 11/15/2023 8:13 am Title XIX Hospi tal Cost Outpati ent Inpati ent 1.00 2.00 PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES COMPUTATION OF NET COST OF COVERED SERVICES 1.00 258, 607 1.00 Inpatient hospital/SNF/NF services Medical and other services 2.00 Λ 2.00 3.00 Organ acquisition (certified transplant programs only) 3.00 4.00 Subtotal (sum of lines 1, 2 and 3) 258, 607 4.00 5.00 Inpatient primary payer payments 5.00 6.00 Outpatient primary payer payments Ω 6.00 7.00 Subtotal (line 4 less sum of lines 5 and 6) 258, 607 Ω 7.00 COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges 8.00 Routine service charges 254, 688 8.00 Ancillary service charges 288, 120 0 9.00 9.00 10.00 Organ acquisition charges, net of revenue 10.00 0 Incentive from target amount computation 11 00 11 00 0 12.00 Total reasonable charges (sum of lines 8 through 11) 542, 808 0 12.00 CUSTOMARY CHARGES Amount actually collected from patients liable for payment for services on a charge 13.00 0 13.00 basi s 14.00 Amounts that would have been realized from patients liable for payment for services on 0 0 14.00 a charge basis had such payment been made in accordance with 42 CFR §413.13(e) 15.00 Ratio of line 13 to line 14 (not to exceed 1.000000) 0.000000 0.000000 15.00 16.00 Total customary charges (see instructions) 542, 808 16.00 284, 201 17.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 17.00 0 line 4) (see instructions) 18.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 0 18.00 (see instructions) 19.00 Interns and Residents (see instructions) 0 19.00 0 20.00 Cost of physicians' services in a teaching hospital (see instructions) 0 20.00 21.00 Cost of covered services (enter the lesser of line 4 or line 16) 258, 607 0 21.00 PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers 22.00 0 0 22.00 Other than outlier payments 0 23.00 Outlier payments Λ 23.00 24.00 Program capital payments 0 24.00 0 25.00 Capital exception payments (see instructions) 25.00 26 00 Routine and Ancillary service other pass through costs 0 26 00 0 27.00 Subtotal (sum of lines 22 through 26) 0 27.00 Customary charges (title V or XIX PPS covered services only) 0 0 28.00 28.00 29.00 Titles V or XIX (sum of lines 21 and 27) 258, 607 0 29.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 30.00 Excess of reasonable cost (from line 18) 0 30.00 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 258, 607 0 31.00 32.00 Deducti bl es 32.00 0 0 33 00 33 00 Coi nsurance 0 0 34.00 Allowable bad debts (see instructions) 0 Λ 34.00 35.00 Utilization review 35.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 36, 00 258, 607 36, 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 37.00 0 37.00 38.00 Subtotal (line 36 ± line 37) 258, 607 38.00 0 39.00 Direct graduate medical education payments (from Wkst. E-4) 39.00 40.00 258, 607 40.00 Total amount payable to the provider (sum of lines 38 and 39) 0 41.00 Interim payments 170, 440 0 41.00 Balance due provider/program (line 40 minus line 41) 42.00 88, 167 0 42.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 43.00 43.00 chapter 1, §115.2

Health Financial Systems ENCOMPASS HEALTH
BALANCE SHEET (If you are nonproprietary and do not maintain
fund-type accounting records, complete the General Fund column onl y)

Provider CCN: 15-3025

| Period: | Worksheet G | From 08/01/2022 | To 07/31/2023 | Date/Time Prepared: | 11/15/2023 8: 13 am

oni y)					11/15/2023 8:	13 am
		General Fund	Specific Purpose Fund	Endowment Fund		
		1.00	2. 00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	9, 328, 823		0	0	1
2. 00 3. 00	Temporary investments Notes receivable	0			0	
4. 00	Accounts receivable	8, 316, 566	1		0	
5. 00	Other recei vabl e	0,010,000		0	0	
6.00	Allowances for uncollectible notes and accounts receivable	-2, 561, 552	2	0	0	
7.00	Inventory	35, 863	s c	0	0	
8. 00	Prepai d expenses	77, 667	1	0	0	
9.00	Other current assets	0		<u> </u>	0	
10. 00 11. 00	Due from other funds Total current assets (sum of lines 1-10)	15, 197, 367) (0	
11.00	FIXED ASSETS	15, 197, 307) 0	0	11.00
12. 00	Land	1, 675, 024	. (0	0	12. 00
13.00	Land improvements	0) (0	0	13. 00
14. 00	Accumulated depreciation	0	0	0	-	1
15. 00	Bui I di ngs	25, 373, 757	1		0	
16.00	Accumulated depreciation	-4, 810, 292	1	_	0 0	1
17. 00 18. 00	Leasehold improvements Accumulated depreciation	1, 757, 768 -1, 361, 923	1	<u> </u>	0	
19. 00	Fi xed equi pment	-1, 301, 723		<u> </u>	0	1
20. 00	Accumulated depreciation	Ö		0	Ö	
21. 00	Automobiles and trucks	0) (0	0	21. 00
22. 00	Accumul ated depreciation	0) (0	0	
23. 00	Major movable equipment	6, 628, 831		0	0	1
24. 00	Accumulated depreciation	-4, 401, 454		0	0	
25. 00 26. 00	Minor equipment depreciable Accumulated depreciation	0		0	0 0	
27. 00	HIT designated Assets				0	
28. 00	Accumulated depreciation	ĺ		o o	0	
29. 00	Mi nor equi pment-nondepreci abl e	0		0	0	
30.00	Total fixed assets (sum of lines 12-29)	24, 861, 711	(0	0	30.00
	OTHER ASSETS	_		_		
31. 00	Investments	0			0 0	
32. 00 33. 00	Deposits on leases Due from owners/officers	0		<u> </u>	0	
34. 00	Other assets	12, 988, 023	1	<u> </u>	Ö	1
35. 00	Total other assets (sum of lines 31-34)	12, 988, 023		Ö	Ō	
36.00	Total assets (sum of lines 11, 30, and 35)	53, 047, 101	(0	0	36. 00
	CURRENT LI ABI LI TI ES					
37. 00	Accounts payable	887, 250	1			1
38. 00 39. 00	Salaries, wages, and fees payable Payroll taxes payable	1, 102, 576		_	0	
40. 00	Notes and Loans payable (short term)					
41. 00	Deferred income	0		0	Ö	
42. 00	Accel erated payments	0			_	42. 00
43.00	Due to other funds	0) (0	0	43. 00
44. 00	Other current liabilities	6, 051, 678	1	1	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	8, 041, 504	. (0	0	45. 00
44 00	LONG TERM LIABILITIES	1 0			0	44 00
46. 00 47. 00	Mortgage payable Notes payable	0		<u> </u>		
48. 00	Unsecured Loans					1
49. 00	Other long term liabilities	12, 819, 795			Ö	
50.00	Total long term liabilities (sum of lines 46 thru 49)	12, 819, 795		0	0	50.00
51. 00	Total liabilities (sum of lines 45 and 50)	20, 861, 299) (0	0	51. 00
	CAPI TAL ACCOUNTS					
52.00	General fund balance	32, 185, 802				52.00
53. 00 54. 00	Specific purpose fund Donor created - endowment fund balance - restricted		C)		53. 00 54. 00
55. 00	Donor created - endowment fund balance - unrestricted			0		55.00
56. 00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement,				0	
-a	replacement, and expansion]]		
59.00	Total fund balances (sum of lines 52 thru 58)	32, 185, 802		0	0	
60. 00	Total liabilities and fund balances (sum of lines 51 and 59)	53, 047, 101		را ا	0	60.00
	''	I	1	1	ı	1

Total deductions (sum of lines 12-17)

sheet (line 11 minus line 18)

Fund balance at end of period per balance

18.00

19.00

0

0

STATEMENT OF CHANGES IN FUND BALANCES Provi der CCN: 15-3025 Peri od: Worksheet G-1 From 08/01/2022 07/31/2023 Date/Time Prepared: 11/15/2023 8:13 am General Fund Special Purpose Fund Endowment Fund 1.00 3.00 4. 00 5. 00 2 00 1.00 Fund balances at beginning of period 34, 099, 526 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 15, 164, 454 2.00 3.00 Total (sum of line 1 and line 2) 49, 263, 980 0 3.00 4.00 Additions (credit adjustments) (specify) 0 4.00 00000 0 5.00 0 5.00 6.00 6.00 0 7.00 0 7.00 0 8.00 0 8.00 0 9.00 0 9.00 10.00 Total additions (sum of line 4-9) 10.00 Subtotal (line 3 plus line 10) 49, 263, 980 0 11.00 11.00 12.00 Deductions (debit adjustments) (specify) 0 12.00 13.00 MINORITY INTEREST EXPENSE 4, 170, 225 13.00 DI STRI BUTI ONS 12, 907, 953 0 14.00 14.00 0 0 15.00 0 0 15.00 16.00 0 0 16.00 17.00 0 17.00 18.00 17, 078, 178 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 19.00 32, 185, 802 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 Total (sum of line 1 and line 2) 3.00 0 0 3.00 4.00 Additions (credit adjustments) (specify) 4.00 5.00 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 10.00 0 Subtotal (line 3 plus line 10) 0 11.00 11.00 12.00 Deductions (debit adjustments) (specify) 12.00 MINORITY INTEREST EXPENSE 13.00 13.00 14.00 DI STRI BUTI ONS 0 14.00 15.00 0 15.00 16.00 16.00 17.00 17.00

0

18.00

19.00

Health Financial Systems ENCOMPASS HEALTH DEACONESS REHABILIT In Lieu of Form CMS-2552-10

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-3025

Provider CCN: 15-3025
From 08/01/2022
To 07/31/2023 Date/Time Prepared:

			10 0//31/2023	Date/IIme Pre 11/15/2023 8:	
	Cost Center Description	Inpatient	Outpati ent	Total	
	•	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	<u> </u>	<u> </u>		
	General Inpatient Routine Services				
1.00	Hospi tal	33, 966, 17	4	33, 966, 174	1. 00
2.00	SUBPROVI DER - I PF		o	0	2. 00
3.00	SUBPROVI DER - I RF		o	0	3. 00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF		o	0	5. 00
6.00	Swing bed - NF		o	0	6. 00
7.00	SKILLED NURSING FACILITY		o	0	7. 00
8.00	NURSING FACILITY		o	0	8. 00
9.00	OTHER LONG TERM CARE		o	0	9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	33, 966, 17	4	33, 966, 174	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT		0	0	11. 00
12.00	CORONARY CARE UNIT		0	0	12.00
13.00	BURN INTENSIVE CARE UNIT		0	0	13.00
14.00	SURGICAL INTENSIVE CARE UNIT		0	0	14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16.00	Total intensive care type inpatient hospital services (sum of lines		0	0	16. 00
	11-15)				
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	33, 966, 17		33, 966, 174	17. 00
18. 00	Ancillary services	35, 944, 94		35, 944, 945	
19. 00	Outpati ent servi ces		0 1, 712	1, 712	
20. 00	RURAL HEALTH CLINIC		0	0	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	_	21. 00
22. 00	HOME HEALTH AGENCY		0	0	22. 00
23. 00	AMBULANCE SERVICES		0	0	23. 00
24. 00	CMHC		0	0	24. 00
24. 10	CORF		0	0	24. 10
25. 00	AMBULATORY SURGICAL CENTER (D. P.)		0 0	0	25. 00
26. 00	HOSPI CE		0 0	0	26. 00
27. 00	OTHER (SPECIFY)		0	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	69, 911, 11	9 1, 712	69, 912, 831	28. 00
	G-3, line 1)				
20.00	PART II - OPERATING EXPENSES		25 277 077		20.00
29. 00	Operating expenses (per Wkst. A, column 3, line 200) ADD (SPECIFY)		35, 277, 976 0		29. 00 30. 00
30. 00 31. 00	ADD (SPECIFY)		0		30.00
32.00			0		31.00
33. 00			0		33. 00
34. 00			0		34.00
35. 00			0		35. 00
36. 00	Total additions (sum of lines 30-35)				36. 00
37. 00	DEDUCT (SPECIFY)		0		37. 00
38. 00	DEBUCT (SECOTE)		0		38. 00
39. 00					39. 00
40. 00			0		40.00
41. 00			o l		41. 00
42. 00	Total deductions (sum of lines 37-41)		<u> </u>		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transf	er	35, 277, 976		43. 00
	to Wkst. G-3, line 4)		33,2,710		10.00
	1	1	1	•	•

Heal th	Financial Systems ENCOMPASS HEALTH DEA	ACONESS REHABILIT	In Lie	u of Form CMS-2	2552-10
	MENT OF REVENUES AND EXPENSES	Provider CCN: 15-3025	Peri od:	Worksheet G-3	
			From 08/01/2022 To 07/31/2023	Date/Time Prep 11/15/2023 8:	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, Ii			69, 912, 831	1.00
2.00	Less contractual allowances and discounts on patients' accounts	unts		19, 720, 172	2. 00
3.00	Net patient revenues (line 1 minus line 2)			50, 192, 659	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	e 43)		35, 277, 976	
5.00	Net income from service to patients (line 3 minus line 4)			14, 914, 683	5.00
	OTHER I NCOME				
6. 00	Contributions, donations, bequests, etc			0	6. 00
7. 00	Income from investments			196, 057	7. 00
8.00	Revenues from telephone and other miscellaneous communication	on services		0	
9.00	Revenue from television and radio service			0	9. 00
10. 00	Purchase di scounts			44	10.00
11. 00	Rebates and refunds of expenses			0	11. 00
12. 00	Parking Lot receipts			0	12. 00
13. 00	Revenue from Laundry and Linen service			0	13. 00
14. 00	Revenue from meals sold to employees and guests			107, 302	14. 00
15. 00	Revenue from rental of living quarters			0	
16. 00	Revenue from sale of medical and surgical supplies to other	than patients		0	16. 00
17. 00	Revenue from sale of drugs to other than patients			0	
18. 00	Revenue from sale of medical records and abstracts			0	
				0	
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00
21. 00	Rental of vending machines			623	
22. 00	Rental of hospital space			0	22. 00
23.00	Governmental appropriations			0	23. 00
24.00	MISC OTHER INCOME			-54, 255	24. 00
24. 50	COVI D-19 PHE Fundi ng			0	24. 50
25.00	Total other income (sum of lines 6-24)			249, 771	25. 00
26.00	Total (line 5 plus line 25)			15, 164, 454	26. 00
27. 00	OTHER EXPENSES (SPECIFY)			0	27. 00
28. 00	Total other expenses (sum of line 27 and subscripts)			0	28. 00
29. 00	Net income (or loss) for the period (line 26 minus line 28)			15, 164, 454	29. 00