Health Financial Systems ENCOMPASS HEALTH	+ DEACONES	S REHABILIT	In Lieu	of Form CMS-2552-10
This report is required by law (42 USC 1395g; 42 CFR 413.20(b)	). Failure	to report can resu	lt in all interim	FORM APPROVED
payments made since the beginning of the cost reporting period	being dee	med overpayments (4	2 USC 1395g).	OMB NO. 0938-0050
				EXPI RES 03-31-2022
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFIC	ATION Pro	ovider CCN: 15-3025	Peri od:	Worksheet S
AND SETTLEMENT SUMMARY			From 01/01/2022	Parts I-III
			To 07/31/2022	Date/Time Prepared: 11/22/2022 12:05 pm
PART I – COST REPORT STATUS				1172272022 12.00 pm
Provider 1. [X] Electronically prepared cost report			Date: 11/22/20	022 Time: 12:05 pm
use only 2. [] Manually prepared cost report				•
3. [ 0 ] If this is an amended report enter the r	number of t	times the provider n	resubmitted this co	ost report
4. [ F ] Medicare Utilization. Enter "F" for full	or "L" fo	prlow.		-
Contractor 5. [1] Cost Report Status 6. Date Received:			NPR Date:	
use only (1) As Submitted 7. Contractor No.		11. 000112	Contractor's Vendo	or Code: 4
(2) Settled without Audit 8. [N] Initial Rep (2) Settled with Audit 9. [N] Final Repor	OFT FOR THE	NS Provider CCN 12.		
(3) Settled with Addit				es reopened = 0-9.
(4) Reopened (5) Amended				
(5) Allended				
PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINI	STRATOR OF	PROVIDER(S)		
MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINE	D IN THIS	COST REPORT MAY BE	PUNI SHABLE BY CRIM	INAL, CIVIL AND
ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL	LAW. FURT	HERMORE, IF SERVICE	S IDENTIFIED IN TH	IS REPORT WERE
PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTL	Y OF A KIC	KBACK OR WERE OTHER	WISE ILLEGAL, CRIM	INAL, CIVIL AND
ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.				
CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRA	TOR OF PRO	VIDER(S)		
I HEREBY CERTIFY that I have read the above certificat	ion stator	ont and that I have	a avaminad the acco	mpanying
electronically filed or manually submitted cost report				
Statement of Revenue and Expenses prepared by ENCOMPAS				
reporting period beginning 01/01/2022 and ending 07/31				
report and statement are true, correct, complete and p				
accordance with applicable instructions, except as not				
regulations regarding the provision of health care ser				
report were provided in compliance with such laws and				
SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX		ELECTRONI C	
	2	SLO	SNATURE STATEMENT	
	<u> ۲</u>	510		

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONI C	
		1		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	11/22/2022 12:05:58 PM			4

		Title XVIII				
Cost Center Description	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 Hospital	0	56, 075	- 3	0	58, 862	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	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
200. 00 Total	0	56, 075	- 3	0	58, 862	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 valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving 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.

	TAL AND HOSPITAL HEALTH CARE COMPLEX	DENTIFICATION DATA	Provi d	er CCN:		Period: From 01/01/	2022	Workshe Part I	eet S-2	
						Γο 07/31/		Date/Ti 11/22/2		
	1.00	2.00		3.00		4	4.00	11/22/2	1022 12	
	Hospital and Hospital Health Care Co									
00	Street: 9355 WARRICK TRAIL	PO Box:	Zin Code	. 4742	0 Count		DCU			1.
00	City: NEWBURGH	State: IN Component Name	Zip Code	CBSA		y: VANDERBU		nt Syst	om (D	2.
			Number	Numbe		Certified		0, or		
							V V	XVIII		1
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Componer		_							
00	Hospi tal	ENCOMPASS HEALTH	153025	21780	0 5	06/08/1989	N	P	0	3.
0	Subprovider - IPF	DEACONESS REHABILIT								4.
0	Subprovider - IRF									5.
0	Subprovider - (Other)									6.
0	Swing Beds - SNF									7
0	Swing Beds - NF									8.
0	Hospital-Based SNF									9.
00	Hospital-Based NF									10.
00	Hospi tal -Based OLTC									11
00	Hospital-Based HHA									12
	Separately Certified ASC									13
	Hospi tal -Based Hospi ce									14
	Hospital -Based Health Clinic - RHC								-	15
00	Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) I									17
	Renal Dialysis									18
	0ther									19
	1	1	1			From:		То	:	
						1.00		2.0	00	
00	Cost Reporting Period (mm/dd/yyyy)					01/01/2	022	07/31/	/2022	20
00	Type of Control (see instructions)					5				21
				_	1.00					-
	Innationt DDS Information				1.00	2.00		3. (	00	-
00	Inpatient PPS Information Does this facility qualify and is it	currently, receiving pr	wmonts for		N	N				22
00	disproportionate share hospital adju	3 0 1	2		IN IN	IN IN				22
	§412. 106? In column 1, enter "Y" fo									
	facility subject to 42 CFR Section §									
	hospital?) In column 2, enter "Y" fo	r yes or "N" for no.								
01	Did this hospital receive interim ur	1 1 2			Ν	N				22
	cost reporting period? Enter in colu									
	the portion of the cost reporting pe									
	Enter in column 2, "Y" for yes or "N			ost						
02	reporting period occurring on or aft Is this a newly merged hospital that		,		Ν	N				22
02	payments to be determined at cost re				IN IN					22
	Enter in column 1, "Y" for yes or "N			5,						
	cost reporting period prior to Octob			yes						
	or "N" for no, for the portion of th	e cost reporting period	d on or aft	er						
	October 1.									
02	Did this hospital receive a geograph				Ν	N		N		22
03	rural as a result of the OMB standar									
03	adopted by CMS in FY2015? Enter in c									
03	for the nortion of the cost reportion	γ μείτου μίτοι το οστοί	JOI I. EIILE	'						
03	for the portion of the cost reportin	no for the portion of t	the cost							
03	in column 2, "Y" for yes or "N" for									
03		er October 1. (see inst	ructions)	s						
03	in column 2, "Y" for yes or "N" for reporting period occurring on or aft	er October 1. (see inst 100 but not more than 4	ructions) 199 beds (a							
03	in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no.	er October 1. (see inst 100 but not more than 4 2.105)? Enter in columr	ructions) 199 beds (a n 3, "Y" fo	r						
	in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph	er October 1. (see inst 100 but not more than 4 2.105)? Enter in column ic reclassification fro	tructions) 199 beds (a 1 3, "Y" fo om urban to	r	Ν	N		N	l	22
	in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OME	er October 1. (see inst 100 but not more than 4 2.105)? Enter in column ic reclassification fro delineations for stati	ructions) 199 beds (a n 3, "Y" fo om urban to stical are	r as	Ν	N		N	l	22.
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04	in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Me	er October 1. (see inst 100 but not more than 4 2.105)? Enter in column ic reclassification fro delineations for stati column 1, "Y" for yes o g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4 2.105)? Enter in colum dicaid days on lines 24 of admission, 2 if cens of identifying the days	ructions) 199 beds (a 1 3, "Y" fo stical are or "N" for ber 1. Ente the cost rructions) 199 beds (a 10 3, "Y" f 1 and/or 25 Sus days, o 5 in this c	r as no r s or r 3				Ν	I	

ealth Financial Systems ENCOMPASS HEA OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DAT		Provider CC		Peri od:	III LIE		orm CMS- heet S-2	
					1/2022	11/22	Time Pre /2022 12	
	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		Other edi cai d days	
	1.00	2.00	3.00	4.00	5.00		6.00	1
<ul> <li>4.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.</li> <li>5.00 If this provider is an IRF, enter the in-state Medicaid eligible unpaid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid days in column 4, Medicaid eligible unpaid days in column 4, Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.</li> </ul>	0 197	241		0 166	1,	991	C	24.00
			I				of Geogr	
6.00 Enter your standard geographic classification (not way	ne) status	at the beg	inning of t	1. (	<u>)0</u> 1	2	. 00	26.00
<ul> <li>cost reporting period. Enter "1" for urban or "2" for</li> <li>7.00 Enter your standard geographic classification (not wag reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassification</li> </ul>	rural. ge) status "2" for ru	at the end ural. If ap	of the cos		1			27.00
5.00 If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	number of	periods SC	H status in		0			35.00
erreet in the cost reporting perrou.				Begi ni			li ng:	
6.00 Enter applicable beginning and ending dates of SCH sta	atus Subso	cript line	36 for numb	1. ( er	00	2	. 00	36.00
of periods in excess of one and enter subsequent dates 7.00 If this is a Medicare dependent hospital (MDH), enter	S.	•			0			37.00
<ul> <li>is in effect in the cost reporting period.</li> <li>7.01 Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for instructions.</li> </ul>								37.01
<ul> <li>instructions)</li> <li>8.00 If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.</li> </ul>								38.00
				Y/			<u>//N</u> . 00	-
<ul> <li>9.00 Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i), 1 "Y" for yes or "N" for no. Does the facility meet th accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii or "N" for no. (see instructions)</li> <li>0.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to October</li> </ul>	, (İi), or he mileage i)? Enter i adjustment	(iii)? Ent requiremen n column 2 t? Enter "Y	er in colum its in ""Y" for ye " for yes o	me N n s r N			N	39.00 40.00
no in column 2, for discharges on or after October 1.	(see instr	ructions)			V	XVII	I XIX	
					1.00	_	_	
Prospective Payment System (PPS)-Capital 5.00 Does this facility qualify and receive Capital payment							N	45.00
	t for disn	conorti onat	e share in	accordance	N	N		10.00
with 42 CFR Section §412.320? (see instructions) 6.00 Is this facility eligible for additional payment excep	ption for e	extraordi na	ry circumst	ances	N	N N	N	46.00
<ul> <li>with 42 CFR Section §412.320? (see instructions)</li> <li>6.00 Is this facility eligible for additional payment excepture pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. Pt. III.</li> </ul>	ption for e . L, Pt. II	extraordina I and Wkst	ry circumst . L-1, Pt.	ances I through	N	N	N	46.00
<ul> <li>with 42 CFR Section §412.320? (see instructions)</li> <li>6.00 Is this facility eligible for additional payment exceptorsuant to 42 CFR §412.348(f)? If yes, complete Wkst. Pt. III.</li> <li>7.00 Is this a new hospital under 42 CFR §412.300(b) PPS cars.</li> <li>8.00 Is the facility electing full federal capital payment? Teaching Hospitals</li> </ul>	ption for e . L, Pt. II apital? Er ? Enter "\	extraordina I and Wkst nter "Y for (" for yes	ry circumst . L-1, Pt. yes or "N" or "N" for	ances I through for no. no.	N N N			47.00 48.00
<ul> <li>with 42 CFR Section §412.320? (see instructions)</li> <li>6.00 Is this facility eligible for additional payment except pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. Pt. III.</li> <li>7.00 Is this a new hospital under 42 CFR §412.300(b) PPS carrow is the facility electing full federal capital payment? Teaching Hospitals</li> <li>6.00 Is this a hospital involved in training residents in a "N" for no in column 1. For column 2, if the response was involved in training residents in approved GME proyear, and are you are impacted by CR 11642 (or application)</li> </ul>	ption for e . L, Pt. II apital? Er ? Enter "\ approved GM to column ograms in 1 able CRs) M	extraordina 1 and Wkst nter "Y for (" for yes ME programs 1 is "Y", the prior y	ry circumst . L-1, Pt. or "N" for ? Enter "Y" or if this rear or penu	ances I through for no. no. for yes or hospital I timate	N N N	N	N	47.00 48.00
<ul> <li>with 42 CFR Section §412.320? (see instructions)</li> <li>6.00 Is this facility eligible for additional payment exceptorsuant to 42 CFR §412.348(f)? If yes, complete Wkst. Pt. III.</li> <li>7.00 Is this a new hospital under 42 CFR §412.300(b) PPS cates a set of the facility electing full federal capital payment? Teaching Hospitals</li> <li>6.00 Is this a hospital involved in training residents in a "N" for no in column 1. For column 2, if the response was involved in training residents in approved GME proyear, and are you are impacted by CR 11642 (or application for yes, is this the first cost reporting programs trained at this facility? Enter "Y" for yes?</li> </ul>	ption for e L, Pt. II apital? Er ? Enter ") approved GM to column ograms in 1 able CRs) M umn 2. eriod durir yes or "N h of this c ", complete	extraordina I and Wkst nter "Y for (" for yes <u>ME programs</u> 1 is "Y", the prior y MA direct G ng which re for no in cost report Worksheet	ry circumst . L-1, Pt. yes or "N" or "N" for ? Enter "Y" or if this ear or penu ME payment sidents in column 1. ing period?	ances I through for no. no. for yes of hospital Itimate reduction? approved If column	N N N N N	N	N	46. 00 47. 00 48. 00 56. 00 57. 00
<ul> <li>with 42 CFR Section §412.320? (see instructions)</li> <li>6.00 Is this facility eligible for additional payment exceptorsuant to 42 CFR §412.348(f)? If yes, complete Wkst. Pt. III.</li> <li>7.00 Is this a new hospital under 42 CFR §412.300(b) PPS care is the facility electing full federal capital payment? Teaching Hospitals</li> <li>6.00 Is this a hospital involved in training residents in a "N" for no in column 1. For column 2, if the response was involved in training residents in approved GME proyear, and are you are impacted by CR 11642 (or application of the first cost reporting payment of the first cost capital the first cost capital payment of the first cost capital payment of the programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first montile of the first cost capital payment of the first cost cap</li></ul>	ption for e . L, Pt. II apital? Er ? Enter "\ approved GM to column ograms in 1 able CRs) M umn 2. eriod durir yes or "N" h of this c ", complete , if applic ursement for	A direct G A direct G A direct G A direct G A direct G a which re for no in cost report e Worksheet cable. or physicia	ry circumst . L-1, Pt. yes or "N" or "N" for ? Enter "Y" or if this ear or penu ME payment sidents in column 1. ing period? E-4. If co	ances I through for no. no. for yes or hospital Itimate reduction? approved If column Enter "Y' lumn 2 is	N N N N N	N	N	47.00 48.00 56.00

	Financial Systems ENCOMPASS HEA AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		ACONESS REHABI Provider CO	CN: 15-3025	Period: From 01/01/2022	eu of Form CMS-2 Worksheet S-2 Part I	
					To 07/31/2022		pared: :05 pr
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
				1.00	2.00	3.00	
0.00	Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C adjustement? Enter "Y" for yes or "N" for no in colu	85? (s umn 1. R) NAHE	see If column 1	N			60.0
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
1. 00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.C
1. 01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see						61.0
1. 02	instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of						61.0
1. 03	ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.0
1. 04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the						61.0
1. 05	current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line						61. C
1. 06	61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61. (
		Pro	ogram Name	Program Code		Unweighted Direct GME FTE Count	
1 10	Of the FTFe in Line (1 OF enceify each new program		1.00	2.00	3.00	4.00	
1. 10	Of the FTEs in line 61.05, specify each new program special ty, 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. Of the FTEs in line 61.05, specify each expanded program special ty, 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.				0. OC 0. OC		61. 1
						1.00	-
2.00	ACA Provisions Affecting the Health Resources and Ser Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruc	trai ned			iod for which		62.0
2. 01	Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	ı Teachi ıram. (s	<u>see instructio</u>		your hospital	0.00	62.0
3.00	Teaching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ettings	during this co			N	63.0
				Unweighted FTEs Nonprovider Site		Ratio (col. 1/ (col. 1 + col. 2))	-
	Section 5504 of the ACA Base Year FTE Residents in No			1.00 This base year	2.00 ris your cost r	3.00 reporting	
4. 00	period that begins on or after July 1, 2009 and befor Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted non resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in	y train -primar all non I non-pr	ed residents y care provider imary care	0. 0	0.00	0. 000000	64.(

	EX IDENTIFICATION DA	TA Provider C		eriod: rom 01/01/2022	Worksheet S-2 Part I	
			To	07/31/2022	Date/Time Pre 11/22/2022 12	pared:
	Program Name	Program Code	Unweighted	Unweighted	Ratio (col. 3/	
	3	3	FTĔs Nonprovider	FTEs in Hospital	(col. 3 + col. 4))	
			Si te	nooprear	.,,,	
	1.00	2.00	3.00	4.00	5.00	
5.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column			0.00	0. 00	0. 000000	65.0
5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			Si te	nospi tui	2))	
			1.00	2.00	3.00	1
Section 5504 of the ACA Current Y beginning on or after July 1, 201		n Nonprovider Setting	gsEffective fo	or cost reporti	ing periods	
5.00 Enter in column 1 the number of u FTEs attributable to rotations oc Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	ccurring in all nonpr unweighted non-primar al. Enter in column 3	ovider settings. Ty care resident the ratio of	0.00 Unweighted FTEs Nonprovider	0.00 Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
_	1.00	2.00	Si te 3. 00	4.00	5.00	-
7.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable			0.00	0. 00	0. 000000	67.0
to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)						
to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column				1.0	0 2.00 3.00	
to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)				1.0		
to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	chiatric Facility (I	PF), or does it cont	ain an IPF subp			70. (
to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility PF ls this facility an Inpatient Psy Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did recent cost report filed on or be 42 CFR 412.424(d)(1)(iii)(c)) Col program in accordance with 42 CFR Column 3: If column 2 is Y, indic (see instructions)	chiatric Facility (I the facility have an fore November 15, 20 umn 2: Did this faci & 412.424 (d)(1)(iii) cate which program ye	approved GME teachi 104? Enter "Y" for y lity train residents (D)? Enter "Y" for y	ng program in t ves or "N" for n s in a new teach ves or "N" for n	rovider? N he most o. (see ing o.		
to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	chiatric Facility (I the facility have an ofore November 15, 20 umn 2: Did this faci 2 412.424 (d)(1)(iii) cate which program ye <u>7 PPS</u> nabilitation Facility	approved GME teachi 004? Enter "Y" for y lity train residents (D)? Enter "Y" for y ear began during this	ng program in t ves or "N" for n in a new teach ves or "N" for n cost reporting	rovider? N he most o. (see ing o.	0	70. C 71. C

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 01/01/2022 To 07/31/2022 Part I Date/Time Prepared: 11/22/2022 12:05 pm 1.00 Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 80.00 Ν 81.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter Ν 81.00 for yes and "N" for no. TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. Ν 85 00 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 87 00 Ν 87.00 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. V XIX 1.00 2.00 Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for Ν Υ 90 00 ves or "N" for no in the applicable column.  $|I\,s\,$  this hospital reimbursed for title V and/or XIX through the cost report either in 91 00 Ν γ 91 00 full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) 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 XIX? Enter "Y" for yes or "N" for no in the applicable column. 92.00 Ν 92.00 93.00 Ν Ν 93.00 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the Ν Ν 94 00 applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 0 00 0 00 95.00 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the Ν Ν 96.00 applicable column 97.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 97 00 0 00 0.00 98.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post Ν 98.00 Υ stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. Υ 98.01 98.01 Ν C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation Ν γ 98.02 bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) Ν 98.03 Ν reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V. and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and Ν 98.04 Ν in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in 98.05 γ 98.05 Ν column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Ν Υ 98.06 Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Rural Providers 105.00 Does this hospital qualify as a CAH? Ν 105 00 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment 106.00 for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) 107.00 column 2: If column 1 is Y and line 70 or line 75 is Y, do you train L&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions) 108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no. Ν 108.00 Physi cal Occupati onal Speech Respi ratory 1 00 2 00 3 00 4 00 109.00 If this hospital qualifies as a CAH or a cost provider, are 109.00 therapy services provided by outside supplier? Enter " for yes or "N" for no for each therapy. 1.00

110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable. 110.00

Ν

Health Financial Systems ENCOMPA	ASS HEALTH DEACONESS REHAB	ILIT	In Lieu	ı of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICAT	ION DATA Provider (		eriod: com 01/01/2022 o 07/31/2022	Worksheet S-2 Part I Date/Time Pre 11/22/2022 12	epared:
			1.00	2.00	_
111.00 If this facility qualifies as a CAH, did it par Health Integration Project (FCHIP) demonstratio "Y" for yes or "N" for no in column 1. If the r integration prong of the FCHIP demo in which th Enter all that apply: "A" for Ambulance service for tele-health services.	on for this cost reporting response to column 1 is Y, nis CAH is participating in	period? Enter enter the ר column 2.	N		111.00
		1.00	2.00	3.00	-
112.00 Did this hospital participate in the Pennsylvar demonstration for any portion of the current co Enter "Y" for yes or "N" for no in column 1. I in column 2, the date the hospital began partic demonstration. In column 3, enter the date the participation in the demonstration, if applicat	ost reporting period? f column 1 is "Y", enter cipating in the e hospital ceased	N N	2.00	3.00	112.00
Miscellaneous Cost Reporting Information 115.00 s this an all-inclusive rate provider? Enter "	'Y" for yes or "N" for no	N		(	0115.00
in column 1. If column 1 is yes, enter the meth in column 2. If column 2 is "E", enter in colum for short term hospital or "98" percent for lor psychiatric, rehabilitation and long term hospi the definition in CMS Pub. 15-1, chapter 22, §22	nod used (A, B, or E only) nn 3 either "93" percent ng term care (includes tals providers) based on			· · · · · · · · · · · · · · · · · · ·	
116.00 Is this facility classified as a referral center		N			116. 00
"N" for no. 117.00 Is this facility legally-required to carry malp "Y" for yes or "N" for no.	practice insurance? Enter	Y			117.00
118.00 Is the malpractice insurance a claims-made or c if the policy is claim-made. Enter 2 if the pol		1			118.00
		Premi ums	Losses	Insurance	
		1.00	2.00	3.00	_
118.01 List amounts of malpractice premiums and paid I	OSSES:	25, 161	1, 980		0118.01
			1.00		_
118.02 Are malpractice premiums and paid losses report	ed in a cost center other	than the	1.00 N	2.00	118.02
Administrative and General? If yes, submit sup and amounts contained therein. 119.00 DO NOT USE THIS LINE					119.00
120.00 Is this a SCH or EACH that qualifies for the Ou §3121 and applicable amendments? (see instructi "N" for no. Is this a rural hospital with < 100 Hold Harmless provision in ACA §3121 and applic Enter in column 2, "Y" for yes or "N" for no.	ons) Enter in column 1, ") ) beds that qualifies for 1	for yes or the Outpatient	Ν	Ν	120.00
121.00 Did this facility incur and report costs for hi patients? Enter "Y" for yes or "N" for no.	gh cost implantable device	es charged to	Ν		121.00
122.00 Does the cost report contain healthcare related Act?Enter "Y" for yes or "N" for no in column 1 the Worksheet A line number where these taxes a	I. If column 1 is "Y", ent∈		N		122.00
Transplant Center Information 125.00 Does this facility operate a transplant center?	? Enter "Y" for yes and "N'	'for no. If	N		125.00
yes, enter certification date(s) (mm/dd/yyyy) b 126.00 If this is a Medicare certified kidney transpla	bel ow.				126.00
in column 1 and termination date, if applicable 127.00 If this is a Medicare certified heart transplar		fication date			127.00
in column 1 and termination date, if applicable 128.00 If this is a Medicare certified liver transplar	nt center, enter the certif	fication date			128.00
in column 1 and termination date, if applicable 129.00 If this is a Medicare certified lung transplant	center, enter the certifi	cation date in			129. 00
column 1 and termination date, if applicable, i 130.00 If this is a Medicare certified pancreas transp	olant center, enter the cer	rti fi cati on			130. 00
date in column 1 and termination date, if appli 131.00 If this is a Medicare certified intestinal tran	nsplant center, enter the o	certification			131.00
date in column 1 and termination date, if appli 132.00 If this is a Medicare certified islet transplar	nt center, enter the certif	fication date			132.00
in column 1 and termination date, if applicable 133.00 Removed and reserved 134.00 If this is an organ procurement organization (0		in column 1			133. 00 134. 00
All Providers					134.00
140.00 Are there any related organization or home offi chapter 10? Enter "Y" for yes or "N" for no in are claimed, enter in column 2 the home office	column 1. If yes, and home	e office costs	Y	HB1911	140.00

JOITTAL AND HOSTITAL HEALTH CARE COMPLE	EX IDENTIFICATION DATA	Provider CC	CN: 15-3025		: 1/01/2022	Worksheet S-	-2
					1/01/2022	Date/Time Pr	
1.00		2.00			3.00	11/22/2022 1	12:05
If this facility is part of a cha	in organization, enter		ugh 143 th	ne name an		of the	
home office and enter the home of							
1.00 Name: ENCOMPASS HEALTH 2.00 Street: 9001 LIBERTY PARKWAY	Contractor's Name PO Box:	: PALMEITO	Contr	actor's Nu	umber: 1010	)1	141.
3. 00 City: BIRMINGHAM	State:	AL	Zip C	ode:	3524	12	142.
		1.40				1.00	1.1.1
14.00 Are provider based physicians' co	sts included in worksne	et A?				Y	144.
					1.00	2.00	-
5.00 If costs for renal services are c	laimed on Wkst. A, line	74, are the costs	s for				145.
inpatient services only? Enter "Y no, does the dialysis facility in							
period? Enter "Y" for yes or "N"		TOIL TOIL THIS COST	терог стпу				
6.00 Has the cost allocation methodolog		viously filed cost	t report?		Ν		146.
Enter "Y" for yes or "N" for no i		b. 15-2, chapter 4	40, §4020)	lf			
yes, enter the approval date (mm/	aa/yyyy) in column 2.						
						1.00	
7.00 Was there a change in the statist						N	147.
48.00 Was there a change in the order o				£		N	148.
19.00 Was there a change to the simplif	ied cost finding method	Part A	Part		ītle V	N Title XIX	149.
		1.00	2.00		3.00	4.00	-
Does this facility contain a prov		an exemption from	m the appl	ication o	f the lowe		
or charges? Enter "Y" for yes or	"N" for no for each com			B. (See 4			
55.00Hospi tal 56.00Subprovi der – IPF		N N	N N		N N	N N	155. 156.
57. 00 Subprovider - IRF		N	N		N	N	157.
58. 00 SUBPROVI DER							158.
59. 00 SNF		Ν	N		Ν	N	159.
50.00 HOME HEALTH AGENCY 51.00 CMHC		N	N N		N N	N N	160. 161.
					IN	11	101.
						1.00	
Multicampus							
							165.
55.00 Is this hospital part of a Multica	ampus hospital that has	one or more campu	uses in di	fferent Cl	BSAs?	N	100.
55.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.							
Enter "Y" for yes or "N" for no.	ampus hospital that has Name 0	one or more campu County 1.00	uses in di State 2.00	fferent Cl Zip Code 3.00		FTE/Campus 5.00	_
Enter "Y" for yes or "N" for no.	Name	County	State	Zip Code	CBSA	FTE/Campus 5.00	
Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column	Name	County	State	Zip Code	CBSA	FTE/Campus 5.00	
Enter "Y" for yes or "N" for no.	Name	County	State	Zip Code	CBSA	FTE/Campus 5.00	
Enter "Y" for yes or "N" for no. 56.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in	Name	County	State	Zip Code	CBSA	FTE/Campus 5.00	
Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3,	Name	County	State	Zip Code	CBSA	FTE/Campus 5.00	
Enter "Y" for yes or "N" for no. 56.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in	Name	County	State	Zip Code	CBSA	FTE/Campus 5.00 0.(	
Enter "Y" for yes or "N" for no. 56.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in	Name O	County 1.00	State 2.00	Zip Code 3.00	CBSA	FTE/Campus 5.00	
Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 57.00 Is this provider a meaningful use	Name 0 T) incentive in the Ame r under §1886(n)? Ente	County 1.00 erican Recovery and r "Y" for yes or '	State 2.00 d Rei nvest	Zip Code 3.00	CBSA 4.00	FTE/Campus 5.00 0.(	167.
Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 57.00 Is this provider a meaningful use 88.00 If this provider is a CAH (line 10	Name 0 T) incentive in the Ame r under §1886(n)? Ente 05 is "Y") and is a mea	County 1.00 Prican Recovery and r "Y" for yes or ' ningful user (line	State 2.00 d Rei nvest	Zip Code 3.00	CBSA 4.00	FTE/Campus 5.00 0.0	167.
Enter "Y" for yes or "N" for no. 6.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 7.00 Is this provider a meaningful use 8.00 If this provider is a CAH (line 10 reasonable cost incurred for the line 10	Name 0 0 T) incentive in the Ame r under §1886(n)? Ente 05 is "Y") and is a mea HIT assets (see instruc	County 1.00 ri can Recovery and r "Y" for yes or ' ningful user (line tions)	d Reinvest 'N" for no e 167 is "	Zip Code 3.00	CBSA 4.00	FTE/Campus 5.00 0.0	00 166. 166.
Enter "Y" for yes or "N" for no. Enter "Y" for yes or "N" for each "State" in the "State"	Name 0 T) incentive in the Ame r under §1886(n)? Ente 05 is "Y") and is a mea HIT assets (see instruc not a meaningful user, ? Enter "Y" for yes or	County 1.00 erican Recovery and r "Y" for yes or ' ningful user (line tions) does this provider "N" for no. (see i	d Reinvest N" for no 167 is " qualify nstructio	Zip Code 3.00 (ment Act ), Y"), enter for a haro	CBSA 4.00	FTE/Campus 5.00 0.0	167. 168.
Enter "Y" for yes or "N" for no. Enter "Y" for yes or "N" for each or "N" for no. Enter "Y" for yes or "N" for each or "N" for no. Enter "Y" for yes or "N" for each or "N" for each or "N" for the "N" for the "N" for the "State" or "N" for the "State" or "	Name 0 T) incentive in the Ame r under §1886(n)? Ente D5 is "Y") and is a mea HIT assets (see instruc not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y")	County 1.00 erican Recovery and r "Y" for yes or ' ningful user (line tions) does this provider "N" for no. (see i	d Reinvest N" for no 167 is " qualify nstructio	Zip Code 3.00 (ment Act ), Y"), enter for a haro	CBSA 4.00	FTE/Campus 5.00 0.0	167. 168.
Enter "Y" for yes or "N" for no. 6.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 7.00 Is this provider a meaningful use 8.00 If this provider is a CAH (line 11 reasonable cost incurred for the 1 8.01 If this provider is a CAH and is in exception under §413.70(a) (6) (ii)	Name 0 T) incentive in the Ame r under §1886(n)? Ente D5 is "Y") and is a mea HIT assets (see instruc not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y")	County 1.00 erican Recovery and r "Y" for yes or ' ningful user (line tions) does this provider "N" for no. (see i	d Reinvest N" for no 167 is " qualify nstructio	Zip Code 3.00 tment Act Y"), enter for a hard is "N"), o	CBSA 4.00	FTE/Campus 5.00 0.0 1.00 N	167. 168.
Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 77.00 Is this provider a meaningful use 88.00 If this provider is a CAH (line 11 reasonable cost incurred for the 11 exception under §413.70(a) (6) (ii) 99.00 If this provider is a meaningful use	Name 0 T) incentive in the Ame r under §1886(n)? Ente D5 is "Y") and is a mea HIT assets (see instruc not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y")	County 1.00 erican Recovery and r "Y" for yes or ' ningful user (line tions) does this provider "N" for no. (see i	d Reinvest N" for no 167 is " qualify nstructio	Zip Code 3.00 tment Act Y"), enter for a hard is "N"), o	CBSA 4.00 - the dship enter the eginning	FTE/Campus 5.00 0.( 1.00 N 0.( Endi ng	167. 168.
Enter "Y" for yes or "N" for no. 56.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 57.00 Is this provider a meaningful use 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the I exception under §413.70(a)(6)(ii)' 59.00 If this provider is a meaningful transition factor. (see instruction	Name 0 T) incentive in the Ame r under §1886(n)? Ente 05 is "Y") and is a mea HIT assets (see instruc not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y") ons)	County 1.00 rican Recovery and r "Y" for yes or ' ningful user (line tions) does this provider "N" for no. (see i and is not a CAH (	d Reinvest 'N" for no e 167 is " r qualify nstructio (line 105	Zip Code 3.00 tment Act Y"), enter for a hard is "N"), o	CBSA 4.00	FTE/Campus 5.00 0.0 1.00 N	167. 168. 168. 00 169.
Enter "Y" for yes or "N" for no. 56.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 57.00 Is this provider a meaningful use 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the I exception under §413.70(a)(6)(ii)' 59.00 If this provider is a meaningful transition factor. (see instruction	Name 0 T) incentive in the Ame r under §1886(n)? Ente 05 is "Y") and is a mea HIT assets (see instruc not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y") ons)	County 1.00 rican Recovery and r "Y" for yes or ' ningful user (line tions) does this provider "N" for no. (see i and is not a CAH (	d Reinvest 'N" for no e 167 is " r qualify nstructio (line 105	Zip Code 3.00 tment Act Y"), enter for a hard is "N"), o	CBSA 4.00 - the dship enter the eginning	FTE/Campus 5.00 0.( 1.00 N 0.( Endi ng	167. 168. 168. 00 169.
Enter "Y" for yes or "N" for no. Enter "Y" for yes or "N" for each and the enter "State "State"	Name 0 T) incentive in the Ame r under §1886(n)? Ente 05 is "Y") and is a mea HIT assets (see instruc not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y") ons)	County 1.00 rican Recovery and r "Y" for yes or ' ningful user (line tions) does this provider "N" for no. (see i and is not a CAH (	d Reinvest 'N" for no e 167 is " r qualify nstructio (line 105	Zip Code 3.00 tment Act Y"), enter for a hard is "N"), o	CBSA 4.00 - the dship enter the eginning 1.00	FTE/Campus 5.00 0.0 1.00 N 0.0 Endi ng 2.00	167. 168. 168. 00 169.
Enter "Y" for yes or "N" for no. 56.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 57.00 Is this provider a meaningful use 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the 1 seception under §413.70(a) (6) (ii) 59.00 If this provider is a meaningful use transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR I period respectively (mm/dd/yyyy)	Name         0         1         incentive in the Ame         r under §1886(n)? Ente         05 is "Y") and is a mea         HIT assets (see instruct         not a meaningful user,         ? Enter "Y" for yes or         user (line 167 is "Y")         ons)	County 1.00 erican Recovery and r "Y" for yes or ' ningful user (line tions) does this provider "N" for no. (see i and is not a CAH ( ng date for the re	State 2.00 d Reinvest 'N" for no e 167 is " r qualify nstructio (line 105 eporting	Zip Code 3.00 tment Act Y"), enter for a hard is "N"), o	CBSA 4.00 - the dship enter the eginning	FTE/Campus 5.00 0.( 1.00 N 0.( Endi ng	166. 166. 167. 168. 168. 00 169. 170. 170.
Enter "Y" for yes or "N" for no. 56.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 57.00 Is this provider a meaningful use 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the 1 seception under §413.70(a) (6) (ii) 59.00 If this provider is a meaningful use exception factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR	Name         0         1) incentive in the Ame         r under §1886(n)? Ente         D5 is "Y") and is a mea         HIT assets (see instruction to a meaningful user,         ? Enter "Y" for yes or user (line 167 is "Y") ons)         beginning date and endi         vider have any days for	County 1.00 ri can Recovery and r "Y" for yes or ' ningful user (line tions) does this provider "N" for no. (see i and is not a CAH ( ng date for the re individuals enrol	State 2.00 d Reinvest 'N" for no e 167 is " r qualify nstructio (line 105 eporting led in	Zip Code 3.00 	CBSA 4.00 - the dship enter the eginning 1.00	FTE/Campus 5.00 0.0 1.00 N 0.0 Endi ng 2.00	167. 168. 168. 00 169.

# ENCOMPASS HEALTH DEACONESS REHABILIT

lealth Financial Systems ENCOMPAS	S HEALTH DEA	CONESS REHABI	LIT	In Li	eu of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIC		Provider C	CN: 15-3025	Period: From 01/01/2022 To 07/31/2022	Worksheet S-2 Part II	2
				10 0//01/2022	11/22/2022 12	
				Y/N	Date	
				1.00	2.00	
General Instruction: Enter Y for all YES response mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	es. Enter N 1	for all NO re	esponses. Ente	r all dates in	the	_
Provider Organization and Operation		hand and an af	++	N		1 1 00
.00 Has the provider changed ownership immediately p reporting period? If yes, enter the date of the				N		1.00
reporting period? IT yes, enter the date of the	change in co	Tullit 2. (See	Y/N	Date	V/I	
			1.00	2.00	3.00	-
.00 Has the provider terminated participation in the yes, enter in column 2 the date of termination a voluntary or "1" for involuntary.			N	2.00	0.00	2.00
100 Is the provider involved in business transaction contracts, with individuals or entities (e.g., c or medical supply companies) that are related to officers, medical staff, management personnel, o of directors through ownership, control, or fami relationships? (see instructions)	chain home of the provide or members of	fices, drug r or its the board	N			3. 00
			Y/N	Туре	Date	
			1.00	2.00	3.00	
Financial Data and Reports						
Column 1: Were the financial statements prepare Accountant? Column 2: If yes, enter "A" for Aud or "R" for Reviewed. Submit complete copy or ent column 3. (see instructions) If no, see instruct	lited, "C" fo ter date avai	r Compiled,	Y	A	02/25/2022	4.00
6.00 Are the cost report total expenses and total rev those on the filed financial statements? If yes,	enues differ		N			5.00
,				Y/N	Legal Oper.	
				1.00	2.00	
Approved Educational Activities						
.00 Column 1: Are costs claimed for a nursing progr	am? Column 2	: If yes, is	s the provider	N		6.00
is the legal operator of the program?		3				
.00 Are costs claimed for Allied Health Programs? If	'"Y" see ins	tructions.		N		7.00
00 Were nursing programs and/or allied health progr cost reporting period? If yes, see instructions.	rams approved	and/or renew	0			8.00
00 Are costs claimed for Interns and Residents in a program in the current cost report? If yes, see	instructions.			N		9.00
0.00 Was an approved Intern and Resident GME program		renewed in t	the current	N		10.00
cost reporting period? If yes, see instructions.						
1.00 Are GME cost directly assigned to cost centers o		& R in an App	proved	N		11.00
Teaching Program on Worksheet A? If yes, see ins	structions.				N/ /N	-
					Y/N	
					1.00	
Bad Debts	hto2 lf yoo	and instruct	lana		V	1 1 2 00
2.00 Is the provider seeking reimbursement for bad de 3.00 If line 12 is yes, did the provider's bad debt c				ot conceting	Y N	12.00
period? If yes, submit copy.		5 0	0			13.00
4.00 If line 12 is yes, were patient deductibles and/ Bed Complement					N	14.00
5.00 Did total beds available change from the prior c	<u>ost reportin</u>				N	15.00
			rt A		rt B	
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	-
<ul> <li>6.00 Was the cost report prepared using the PS&amp;R Report of the PS&amp;R Report for the paid-t date of the PS&amp;R Report used in columns 2 and 4</li> </ul>	through	N	10/04/2022	Y	10/04/2022	16.00
<ul> <li>instructions)</li> <li>.00 Was the cost report prepared using the PS&amp;R Report totals and the provider's records for allocation either column 1 or 3 is yes, enter the paid-thro</li> </ul>	n? If	Y	10/04/2022	Ν	10/04/2022	17.00
<ul> <li>in columns 2 and 4. (see instructions)</li> <li>B.00 If line 16 or 17 is yes, were adjustments made t Report data for additional claims that have been but are not included on the PS&amp;R Report used to</li> </ul>	n billed	Ν		Ν		18.00
<ul> <li>cost report? If yes, see instructions.</li> <li>9.00 If line 16 or 17 is yes, were adjustments made t Report data for corrections of other PS&amp;R Report</li> </ul>		Ν		Ν		19. 00

	ENCOMPASS	HEALTH	DEACONESS	REHABI LI T
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	FINANCIAI SYSTEMS ENCOMPASS REALTH DE							
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	F	Period: From 01/01/2022 Fo 07/31/2022	Worksheet S-2 Part II Date/Time Pre 11/22/2022 12	pared:		
		Descri	ption	Y/N	Y/N			
		(	)	1.00	3.00			
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	Ν	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 H	OSPI TALS)					
	Capital Related Cost		,					
22.00	Have assets been relifed for Medicare purposes? If yes, see	e instructions				22.00		
23.00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprais	als made durir	ng the cost		23.00		
24.00	Were new leases and/or amendments to existing leases entere If yes, see instructions	ed into during	this cost repo	orting period?		24.00		
25.00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period? I	f yes, see		25.00		
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the instructions.	yes, see		26.00				
27.00	Has the provider's capitalization policy changed during the copy.	e cost reportin	g period?lf	/es, submit		27.00		
	Interest Expense							
28.00								
29.00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst		bt Service Res	serve Fund)		29.00		
30.00	Has existing debt been replaced prior to its scheduled maturinstructions.		debt? If yes,	see		30.00		
31.00	1.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see							
	instructions. Purchased Services							
32.00	Have changes or new agreements occurred in patient care set arrangements with suppliers of services? If yes, see instru		d through cont	tractual		32.00		
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.	olied pertainin	g to competiti	ve bidding? If		33.00		
	Provi der-Based Physi ci ans							
34.00	Are services furnished at the provider facility under an an If yes, see instructions.	rrangement with	provi der-base	ed physi ci ans?		34.00		
35.00	If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in		ts with the pr	rovi der-based		35.00		
				Y/N	Date			
	Home Office Costs			1.00	2.00			
36.00	Were home office costs claimed on the cost report?					36.00		
	If line 36 is yes, has a home office cost statement been p	repared by the	home office?			37.00		
38.00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of					38.00		
39.00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe					39.00		
40.00	see instructions. If line 36 is yes, did the provider render services to the	home office?	lf yes, see			40.00		
	instructions.							
		1.	00	2.	00	1		
41.00	Cost Report Preparer Contact Information Enter the first name, last name and the title/position	MATTHEW		LALLONE		41.00		
	held by the cost report preparer in columns 1, 2, and 3, respectively.							
42.00	Enter the employer/company name of the cost report preparer.	ENCOMPASS HEAL	TH CORPORATION	1		42.00		
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	E@ENCOMPASSHEA	43.00		

Health Financial Sy	stems	ACONESS REHABI	LIT	In Lieu of Form CMS-2552-10				
HOSPITAL AND HOSPIT	AL HEALTH CARE REIMBURSEMEN	C QUESTI ONNAI RE	Provider CO	CN: 15-3025	Peri od:	(2022	Worksheet S-2	2
					From 01/01/ To 07/31/		Date/Time Pre 11/22/2022 12	epared: 2:05 pm
			3.	00				
Cost Report	Preparer Contact Information							
41.00 Enter the fi	rst name, last name and the	ti tl e/posi ti on	SR. REIMBURSEM	ENT ACCOUNTAI	T			41.00
held by the	cost report preparer in colu	imns 1, 2, and 3,						
respecti vel y								
42.00 Enter the em	ployer/company name of the c	cost report						42.00
preparer.								
43.00 Enter the te	lephone number and email add	lress of the cost						43.00
report prepa	rer in columns 1 and 2, resp	ecti vel y.						

	Financial Systems ENCOM AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	IPASS HEALTH DEA AL DATA	Provi der CO		Period:	u of Form CMS-2 Worksheet S-3	
					From 01/01/2022 To 07/31/2022	Part I Date/Time Pre 11/22/2022 12	
						I/P Days / O/P Visits / Trips	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions)	30. 00	98	20, 7	76 0.00	0	1.00
2.00 3.00 4.00 5.00 6.00	HMO IPF Subprovider HMO IRF Subprovider HOspital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF					0	3.00 4.00 5.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		98	20, 7	0.00	0	7.00
8.00 9.00 10.00 11.00 12.00 13.00 14.00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY		98	20.7	76 0.00	0	8.00 9.00 10.00 11.00 12.00 13.00 14.00
14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00 24.00	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE		98	20, 7	76 0.00	0	14.00 15.00 16.00 17.00 18.00 20.00 21.00 22.00 23.00 24.00
24. 10 25. 00 26. 00	HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC	30. 00					24.10 25.00 26.00
26.00 26.25 27.00 28.00 29.00 30.00 31.00 32.00 32.01	RUKAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	89.00	98 0		0	0	26. 00 26. 25 27. 00 28. 00 30. 00 31. 00 32. 00 32. 01
33. 00 33. 01	LTCH non-covered days LTCH si te neutral days and di scharges						33. 00 33. 01

IOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-3025		eriod: com 01/01/2022 o 07/31/2022	Worksheet S-3 Part I Date/Time Pre 11/22/2022 12	pared:
		I/P Days	/ O/P Visits	/ Trips		Full Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients		Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00		9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	9, 459	170		59			1.0
2.00	HMO and other (see instructions)	4, 500	2, 460					2.0
3.00	HMO IPF Subprovider	0	0					3.0
4.00	HMO IRF Subprovider	0	0					4.0
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0		0			5.0
5.00	Hospital Adults & Peds. Swing Bed NF	0.150	0		0			6.0
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	9, 459	170	19, 3	59			7.0
3. 00	INTENSIVE CARE UNIT							8.0
, 00 , 00	CORONARY CARE UNIT							9.0
0.00	BURN I NTENSI VE CARE UNI T							10.0
1.00	SURGI CAL I NTENSI VE CARE UNI T							11.0
2.00	OTHER SPECIAL CARE (SPECIFY)							12.0
3.00	NURSERY							13.0
4.00	Total (see instructions)	9, 459	170	19, 3	59	0.00	263.51	14.0
5.00	CAH visits	0	0		0			15.0
6.00	SUBPROVIDER - IPF							16. (
7.00	SUBPROVIDER - IRF							17. (
8.00	SUBPROVI DER							18. (
9.00	SKILLED NURSING FACILITY							19. (
0.00	NURSING FACILITY							20.
1.00	OTHER LONG TERM CARE							21.
2.00	HOME HEALTH AGENCY							22.
3.00	AMBULATORY SURGICAL CENTER (D. P. )							23.
4.00	HOSPICE				0			24.
4.10 5.00	HOSPICE (non-distinct part) CMHC - CMHC				0			24.
6.00	RURAL HEALTH CLINIC							26.0
6.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0.00	0.00	
7.00	Total (sum of lines 14-26)	0	0		0	0.00	263.51	
8.00	Observation Bed Days		0		0	0.00	200.01	28.
9.00	Ambul ance Trips	0	-		-			29.0
0.00	Employee discount days (see instruction)				0			30.0
1.00	Employee discount days - IRF				0			31.0
2.00	Labor & delivery days (see instructions)	0	0		0			32.
2. 01	Total ancillary labor & delivery room				0			32. (
	outpatient days (see instructions)							
33.00	LTCH non-covered days	0						33. (
3. 01	LTCH site neutral days and discharges	0						33.

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider C	CN: 15-3025	Period: From 01/01/2022 To 07/31/2022	Worksheet S-3 Part I Date/Time Pre 11/22/2022 12	pared:
		Full Time Equivalents	Di s		charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
$\begin{array}{c} 1.\ 00\\ \\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ \\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 13.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00\\ 24.\ 00\\ 24.\ 00\\ 24.\ 00\\ 25.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 28.\ 00\\ 29.\ 00\\ 30.\ 00\\ 31.\ 00\\ 32.\ 00\\ \end{array}$	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSI VE CARE UNIT CORONARY CARE UNIT BURN INTENSI VE CARE UNIT SURGICAL INTENSI VE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P. ) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instructions)	0. 00 0. 00 0. 00	0	3	40 15 19 183 0 0 40 15	1, 450	$\begin{array}{c} 1. \ 00\\ \\ 2. \ 00\\ \\ 3. \ 00\\ \\ 4. \ 00\\ \\ 5. \ 00\\ \\ 6. \ 00\\ \\ 7. \ 00\\ \\ 8. \ 00\\ \\ 9. \ 00\\ \\ 10. \ 00\\ \\ 10. \ 00\\ \\ 11. \ 00\\ \\ 12. \ 00\\ \\ 13. \ 00\\ \\ 13. \ 00\\ \\ 13. \ 00\\ \\ 14. \ 00\\ \\ 15. \ 00\\ \\ 14. \ 00\\ \\ 15. \ 00\\ \\ 22. \ 00\\ \\ 22. \ 00\\ \\ 23. \ 00\\ \\ 24. \ 10\\ \\ 25. \ 00\\ \\ 26. \ 00\\ \\ 26. \ 00\\ \\ 26. \ 00\\ \\ 26. \ 00\\ \\ 26. \ 00\\ \\ 26. \ 00\\ \\ 27. \ 00\\ \\ 28. \ 00\\ \\ 29. \ 00\\ \\ 30. \ 00\\ \\ 31. \ 00\\ \\ 32. \ 00\\ \end{array}$
32. 01 33. 00 33. 01	Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges				0 0		32. 01 33. 00 33. 01

ENCOMPASS	HEALTH	DEACONESS	REHABI LI T

	Financial Systems AL WAGE INDEX INFORMATION			EACONESS REHABII Provider CC	CN: 15-3025	Period:	worksheet S-3	
						From 01/01/2022 To 07/31/2022	Date/Time Pre	par
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst.	Adjusted Salaries (col.2 ± col.	Related to Salaries in	11/22/2022 12 Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	A-6) 3.00	3) 4.00	<u>col. 4</u> 5. 00	6.00	
	PART II - WAGE DATA							
00	SALARIES Total salaries (see	200.00	10, 361, 509		10, 361, 50	318, 336. 99	32. 55	
00	instructions) Non-physician anesthetist Part		(	0 0	(	0.00		
0	A Non-physician anesthetist Part R		C	0 0	(	0.00	0.00	:
0	Physician-Part A - Administrative		66, 630	0 0	66, 630	489.00	136. 26	
1 0	Physicians - Part A - Teaching Physician and Non		(	° I	(	0.00		
00	Physician-Part B Non-physician-Part B for hospital-based RHC and FOHC services		C	0 0	(	0.00	0. 00	
00	Interns & residents (in an approved program)	21.00	C	0 0	(	0.00	0.00	
01	Contracted interns and residents (in an approved programs)		C	0 0	(	0.00	0.00	
00	Home office and/or related organization personnel		C	0 0	(	0.00	0.00	
00 00	SNF Excluded area salaries (see instructions)	44.00	(	0 102, 747	( 102, 74	0.00 7 2,561.05		
00	OTHER WAGES & RELATED COSTS Contract Labor: Direct Patient		509, 031	0	509, 03	1 6, 473. 97	78.63	1
00	Contract Tabor: Direct Patrent Care Contract Labor: Top Level		509, 03			0.00		
	management and other management and administrative services							
00	Contract Labor: Physician-Part A - Administrative		68, 345		66, 630			
00	Home office and/or related organization salaries and wage-related costs		C	0 0	(	0.00	0.00	1
01	Home office salaries		559, 986	0	559, 980	6 10, 263. 70	54. 56	1
02 00	Related organization salaries Home office: Physician Part A		(	0 0 0 0	(	0.00 0.00		
00	- Administrative Home office and Contract		C	0 0	(	0.00	0.00	1
01	Physicians Part A - Teaching Home office Physicians Part A - Teaching		C	0 0	(	0.00	0. 00	1
02	Home office contract Physicians Part A - Teaching		(	0 0	(	0.00	0.00	1
00	WAGE-RELATED COSTS Wage-related costs (core) (see instructions)		2, 348, 451	0	2, 348, 45	1		1
00	Wage-related costs (other) (see instructions)							1
00 00	Excluded areas Non-physician anesthetist Part		23, 521 (	0	23, 52 <sup>-</sup> (	1		1
00	A Non-physician anesthetist Part B		C	0 0	(	D		2
00	- Physician Part A - Administrative		C	0 0	(			2
01	Physician Part A - Teaching Physician Part B		(		(			2
00 00 00	Physician Part B Wage-related costs (RHC/FQHC) Interns & residents (in an		(		(			222
50	approved program) Home office wage-related		239, 810	0	239, 810	D		2
51	(core) Related organization		C	0 0	(	D		2
52	wage-related (core) Home office: Physician Part A - Administrative - wage-related (core)		C	0 0	(			2

Heal th	Financial Systems	ENCOM	PASS HEALTH DE	ACONESS REHABI	LIT	In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider C		eriod: rom 01/01/2022 o 07/31/2022		pared:
		Wkst. A Line		Reclassi fi cati			Average Hourly	
		Number	Reported	on of Salaries (from Wkst.	Salaries (col.2 ± col.	Related to Salaries in	Wage (col. 4 ÷ col. 5)	
				A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A		0	0	0			25.53
	- Teaching - wage-related							
	(core) OVERHEAD COSTS - DIRECT SALARII							
26.00	Employee Benefits Department	4.00	0	0	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	1, 415, 219	-102,747	1, 312, 472			
28.00	Administrative & General under		26, 170	0	26, 170			
	contract (see inst.)		,	-				
29.00	Maintenance & Repairs	6. 00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	179, 881	0	179, 881	6, 475. 47	27.78	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeepi ng	9.00	197, 603	0	197, 603	12, 491. 86	15. 82	32.00
33.00	Housekeeping under contract		0	0	0	0.00	0.00	33.00
	(see instructions)							
34.00	Dietary	10.00	297, 608	0	297, 608			34.00
35.00	Dietary under contract (see		0	0	0	0.00	0.00	35.00
	instructions)							
36.00	Cafeteria	11.00	0	0	0	0.00		36.00
37.00	Maintenance of Personnel	12.00	0	0	0 (10, 277	0.00		
38.00	Nursing Administration	13.00	618, 377	0	618, 377	14, 992. 65		
39.00	Central Services and Supply	14.00	0	0	0	0.00		
40.00	Pharmacy	15.00	0	0		0.00		
41.00	Medical Records & Medical Records Library	16.00	63, 064	0	63, 064	3, 201. 49	19. 70	41.00
42.00	Social Service	17.00	397, 561	n	397, 561	11, 416. 64	34 82	42.00
43.00	Other General Service	18.00	0,,, 301	0	0,7,301	0.00		43.00
			0			5.00		

Heal th	Financial Systems	ENCOM	PASS HEALTH DE	ACONESS REHABI	LIT	In Lie	eu of Form CMS-2	2552-10
HOSPI	FAL WAGE INDEX INFORMATION			Provider CC		Period: From 01/01/2022 To 07/31/2022		
		Worksheet A		Recl assi fi cati	,		Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	(col.2 ± col.		col. 5)	
				Worksheet A-6)	3)	col. 4		
	-	1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY				_		
1.00	Net salaries (see		10, 387, 679	0	10, 387, 67	9 318, 560. 99	32.61	1.00
	instructions)							
2.00	Excluded area salaries (see		0	102, 747	102, 74	7 2, 561. 05	40. 12	2.00
	instructions)							
3.00	Subtotal salaries (line 1		10, 387, 679	-102, 747	10, 284, 93	2 315, 999. 94	32.55	3.00
	minus line 2)							
4.00	Subtotal other wages & related		1, 137, 362	-1, 715	1, 135, 64	7 17, 226. 67	65. 92	4.00
F 00	costs (see inst.)		2 500 2/1		2 500 24	1 0.00	05 17	F 00
5.00	Subtotal wage-related costs (see inst.)		2, 588, 261	0	2, 588, 26	0.00	25. 17	5.00
6.00	Total (sum of lines 3 thru 5)		14, 113, 302	-104, 462	14, 008, 84	333, 226, 61	42.04	6.00
7.00	Total overhead cost (see		3, 195, 483					7.00
	instructions)		-,,					

OSPI T	AL WAGE RELATED COSTS	Provider CCN: 15-3025	Peri od: From 01/01/2022 To 07/31/2022	Date/Time Pre 11/22/2022 12	pare
				Amount Reported	
				1.00	
	PART IV - WAGE RELATED COSTS			1.00	
	Part A - Core List				
	RETI REMENT COST				
00	401K Employer Contributions			167, 883	1.
00	Tax Sheltered Annuity (TSA) Employer Contribution			0	2.
00	Nonqualified Defined Benefit Plan Cost (see instructions)			0	3.
00	Qualified Defined Benefit Plan Cost (see instructions)			0	4.
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
00	401K/TSA Plan Administration fees			0	5
00	Legal/Accounting/Management Fees-Pension Plan			0	6
00	Employee Managed Care Program Administration Fees			0	7
	HEALTH AND INSURANCE COST				
00	Health Insurance (Purchased or Self Funded)			0	8
01	Health Insurance (Self Funded without a Third Party Administr			0	8
02	Health Insurance (Self Funded with a Third Party Administrato	nr)		1, 728, 723	8
03	Heal th Insurance (Purchased)			0	8
00	Prescription Drug Plan			0	9
. 00	Dental, Hearing and Vision Plan			0	
	Life Insurance (If employee is owner or beneficiary)			11, 665	
. 00	Accident Insurance (If employee is owner or beneficiary)			0	
	Disability Insurance (If employee is owner or beneficiary)			0	
. 00	Long-Term Care Insurance (If employee is owner or beneficiary			0	14
. 00	'Workers' Compensation Insurance Retirement Health Care Cost (Only current year, not the extra	and name account name	d by FACD 10/	90, 947 0	
. 00	Non cumulative portion)	lordinary accruai require	ed by FASB 106.	0	10
	TAXES				
00	FICA-Employers Portion Only			761, 044	17
	Medicare Taxes - Employers Portion Only			0	
	Unemployment Insurance			0	19
	State or Federal Unemployment Taxes			28, 725	
	OTHER				
. 00	Executive Deferred Compensation (Other Than Retirement Cost R instructions))	eported on lines 1 throu	igh 4 above. (see	0	21
. 00	Day Care Cost and Allowances			-417, 014	22
. 00	Tuition Reimbursement			0	23
. 00	Total Wage Related cost (Sum of lines 1 -23)			2, 371, 973	24
	Part B - Other than Core Related Cost				

Heal th	Financial Systems	ENCOMPASS HEALTH DEACOM	IESS REHABILIT	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-3025	Peri od:	Worksheet S-3	
				From 01/01/2022	Part V	
				To 07/31/2022	Date/Time Pre 11/22/2022 12	
	Cost Center Description			Contract Labor		. 00 pm
				1.00	2.00	
	PART V - Contract Labor and Benefit C	ost				
	Hospital and Hospital-Based Component	I denti fi cati on:				
1.00	Total facility's contract labor and b			575, 661	2, 371, 972	1.00
2.00	Hospi tal			575, 661	2, 348, 451	2.00
3.00	SUBPROVI DER – I PF					3.00
4.00	SUBPROVI DER – I RF					4.00
5.00	Subprovider - (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					8.00
9.00	NURSING FACILITY					9.00
10.00	OTHER LONG TERM CARE I					10.00
11.00	Hospital-Based HHA					11.00
	AMBULATORY SURGICAL CENTER (D. P. ) I					12.00
13.00	Hospi tal -Based Hospi ce					13.00
14.00	Hospital-Based Health Clinic RHC					14.00
15.00	Hospital-Based Health Clinic FQHC					15.00
16.00	Hospital-Based-CMHC					16.00
17.00	RENAL DIALYSIS I					17.00
18.00	Other			0	23, 521	18.00

	Financial Systems AL RENAL DIALYSIS DEPARTMENT STA		PASS HEALTH DEA	Provider CC	CN: 15-3025 F	Period:	worksheet S-5	
						rom 01/01/2022 o 07/31/2022	Date/Time Pre	
		Outpat	ient	Trai	ni ng	Home	11/22/2022 12	<u>. 05 p</u>
		Regul ar	High Flux	Hemodialysis	CAPD / CCPD	Hemodi al ysi s	CAPD / CCPD	
		1.00	2.00	3.00	4.00	5.00	6.00	
00	Number of patients in program at end of cost reporting period	0	0	0	C	0 0	0	1.0
00	Number of times per week patient receives dialysis	0.00	0.00	0.00	0.00	0.00	0.00	2.0
00	Average patient dialysis time including setup	0.00	0.00	0.00	0.00			3.0
)0 )0	CAPD exchanges per day Number of days in year	0	О		0.00	)	0.00	4. ( 5. (
00	dialysis furnished Number of stations	0	0	0	C			6.0
00	Treatment capacity per day per station	0	0	0				7.0
)0 )0	Utilization (see instructions) Average times dialyzers	0. 00 0. 00	0.00 0.00					8. 0 9. 0
00	re-used Percentage of patients re-using dialyzers	0.00	0.00					10. 0
			I				Y/N 1.00	
	ESRD PPS	· · ·		<u> </u>		10 5 1 11/1		
	Is the dialysis facility approv for yes or "N" for no. (see ins Did your facility elect 100% PF	structions)	5		1 31		N Y	10. 0 10. 0
	instructions for "new" provider	rs. )	-		-	Prior to 1/1	After 12/31	
03	If you responded "N" to line 10					1.00	2.00	10. (
00	periods prior to January 1 and after December 31. (see instruct TRANSPLANT INFORMATION Number of patients on transplar	nt list		11. (				
00	Number of patients transplanted EPOETIN	during the cos	st reporting p	eriod		0		12.0
00 00	Net costs of Epoetin furnished Epoetin amount from Worksheet A			patients by th	e provider.			13. ( 14. (
00 00	Number of EPO units furnished r Number of EPO units furnished r							15. ( 16. (
00	ARANESP Net costs of ARANESP furnished	to all mainten	ance dialveis i	nationts by th	e provider		1	17.0
00	ARANESP amount from Worksheet A Number of ARANESP units furnish	for Home Dial	ysis program	5				17. ( 18. ( 19. (
00	Number of ARANESP units furnish	ned relating to	the home dial	ysis departmen	t			20. (
						MCP 1.00	INITIAL METHOD	
	PHYSICIAN PAYMENT METHOD					1.00	2.00	
00	Enter "X" if method(s) is appli	cabl e						21.0
		ESA Desci		Net Cost of ESAs for Renal Patients	Net Cost of ESAs for Home Patients	Number of ESA Units - Renal Dialysis Dept	Number of ESA Units - Home Dialysis Dept.	
		1.0	0	2.00	3.00	4. 00	5. 00	
	ESAs				-		1	
00	Enter in column 1 the ESA description. Enter in column 2 the net costs of ESAs furnished to all renal dialysis patients. Enter in column 3 the net cost of ESAs furnished to all home dialysis program patients. Enter in column 4 the number of ESA units furnished to patients in the renal dialysis department. Enter in column 5 the number of units furnished to patients			0	C	) 0	0	22. (

Health Financial Systems	ONESS REHABILIT	In Lieu of Form CMS-2552-				
HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICA	Perio	d: 01/01/2022	Worksheet S-5			
					Date/Time Pre 11/22/2022 12	
				CCN	Treatments	
				1.00	2.00	
23.00 If line 10.01 is yes, enter in column listed on Worksheet S-2, Part I, line total treatments for each CCN. (see ins	8, and its subscripts.				0	23.00

RECLASS		IPASS HEALTH DEAC				u of Form CMS-2	2552-10
	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CC	CN: 15-3025	Period: From 01/01/2022	Worksheet A	
					To 07/31/2022	Date/Time Pre	pared:
	Cast Capton Description	Colorico	Other	Tatal (agl	1 Deel eesi fi eeti	11/22/2022 12 Reclassi fi ed	:05 pm
	Cost Center Description	Sal ari es	Uther	+ col. 2	1 Reclassificati ons (See A-6)	Trial Balance	
				+ COL 2)	UIIS (366 A-0)	(col. 3 +-	
						col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT		1,079,627	1, 079, 62	7 158, 119	1, 237, 746	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		594,077	594, 07	7 38, 335	632, 412	2.00
	00300 OTHER CAP REL COSTS		176, 150	176, 15	-176, 150	0	3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	О	2, 168, 981	2, 168, 98		2, 168, 981	4.00
	00500 ADMI NI STRATI VE & GENERAL	1, 415, 219	2, 753, 005	4, 168, 22			5.00
7.00	00700 OPERATION OF PLANT	179, 881	463, 125	643, 00		643,006	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	188, 556	188, 55	6 0	188, 556	8.00
	00900 HOUSEKEEPI NG	197, 603	44, 180	241, 78		241, 783	9,00
	01000 DI ETARY	297, 608	407, 395	705, 00		705, 003	10.00
	01100 CAFETERI A	0	0		0 0	0	11.00
	01300 NURSI NG ADMI NI STRATI ON	618, 377	24, 316	642, 69	3 0	642, 693	13.00
	01600 MEDICAL RECORDS & LIBRARY	63, 064	1, 627	64, 69		64, 691	16.00
	01700 SOCIAL SERVICE	397, 561	7, 203	404, 76		404, 764	17.00
	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0		0 0	0	21.00
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	o	0		0 0	0	22.00
	INPATIENT ROUTINE SERVICE COST CENTERS	-1	-		-		
	03000 ADULTS & PEDIATRICS	4, 245, 043	872, 827	5, 117, 87	0 17,630	5, 135, 500	30.00
	ANCI LLARY SERVI CE COST CENTERS	· · · · · ·					
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	145, 305	145, 30	-51, 699	93, 606	54.00
54.01	05401 RADI OLOGY – SUA	0	0		0 51, 699	51, 699	54.01
60.00	06000 LABORATORY	0	456, 263	456, 26	3 0	456, 263	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0	62.30
65.00	06500 RESPI RATORY THERAPY	273, 454	4, 922	278, 37	6 0	278, 376	65.00
66.00	06600 PHYSI CAL THERAPY	866, 443	94, 123	960, 56			66.00
	06700 OCCUPATI ONAL THERAPY	1,032,842	22, 640	1, 055, 48			67.00
68.00	06800 SPEECH PATHOLOGY	336, 146	4, 643	340, 78		349, 236	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	48,674	181, 491	230, 16		230, 165	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	389, 594	390, 345	779, 93	9 0	779, 939	73.00
76.00	03020 PSYCH	0	0		0 0	0	76.00
76.01	03951 SPECIAL PROCEDURES	О	84, 667	84, 66	-84, 667	0	76.01
	03950 SPECIAL PROCEDURES - SUA	0	0		0 84,667	84, 667	76.02
	07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76.97
	07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0	76.98
76.99	07699 LI THOTRI PSY	О	0		0 0	0	76.99
	OUTPATIENT SERVICE COST CENTERS						1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0	0		0 0	0	93.99
	SPECIAL PURPOSE COST CENTERS						]
113.00	11300 INTEREST EXPENSE		2, 914	2, 91			113.00
	SUBTOTALS (SUM OF LINES 1 through 117)	10, 361, 509	10, 168, 382	20, 529, 89	-105, 975	20, 423, 916	118.00
118.00							1
	NONREIMBURSABLE COST CENTERS						
194.00	07950 MARKETING NRCC	0	0		0 105, 975	105, 975	194.00
194.00		0 0 10, 361, 509	0 0 10, 168, 382		0 0	0	194.01

LASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	EXPENSES	Provider CCN: 15	5-3025	Period: From 01/01/2022 To 07/31/2022	Worksheet A Date/Time Pre 11/22/2022 12	epare 2:05
Cost Center Description		Net Expenses				
		or Allocation				
	6.00	7.00				
GENERAL SERVICE COST CENTERS						4
0 00100 CAP REL COSTS-BLDG & FIXT	193, 141	1, 430, 887				1
0 00200 CAP REL COSTS-MVBLE EQUIP	-45,880	586, 532				2
0 00300 OTHER CAP REL COSTS	0	0				3
0 00400 EMPLOYEE BENEFITS DEPARTMENT	188, 886	2, 357, 867				4
0 00500 ADMI NI STRATI VE & GENERAL	-746, 300	3, 278, 015				5
0 00700 OPERATION OF PLANT	-29, 745	613, 261				7
0 00800 LAUNDRY & LINEN SERVICE	0	188, 556				8
0 00900 HOUSEKEEPI NG	-1, 161	240, 622				9
00 01000 DI ETARY	-136, 162	568, 841				10
00 01100 CAFETERIA	0	0				11
00 01300 NURSING ADMINISTRATION	-2, 925	639, 768				13
00 01600 MEDI CAL RECORDS & LI BRARY	-1,827	62, 864				16
00 01700 SOCIAL SERVICE	0	404, 764				17
00 02100 I &R SERVI CES-SALARY & FRI NGES APPRV	0	0				21
00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0	0				_ 22
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	110 (04	5 945 944				4
00 03000 ADULTS & PEDI ATRI CS	-119, 684	5, 015, 816				30
ANCI LLARY SERVI CE COST CENTERS 00 05400 RADI OLOGY-DI AGNOSTI C	-956	92, 650				54
01 05400 RADIOLOGY - DIAGNOSTIC 01 05401 RADIOLOGY - SUA	-23, 707	92, 650 27, 992				54
00 06000 LABORATORY	-30, 993	425, 270				60
30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	-30, 773	425, 270				62
00 06500 RESPIRATORY THERAPY	0	278, 376				65
00 06600 PHYSI CAL THERAPY	0	916, 796				66
00 06700 OCCUPATI ONAL THERAPY	0	1, 090, 805				67
00 06800 SPEECH PATHOLOGY	0	349, 236				68
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	-20, 206	209, 959				71
00 07300 DRUGS CHARGED TO PATIENTS	-2, 338	777, 601				73
00 03020 PSYCH	2, 330	0				76
01 03951 SPECIAL PROCEDURES	0	0				76
02 03950 SPECIAL PROCEDURES - SUA	-23, 874	60, 793				76
97 07697 CARDI AC REHABI LI TATI ON	20,0,1	0				76
98 07698 HYPERBARI C OXYGEN THERAPY	Ő	0				76
99 07699 LI THOTRI PSY	0	0				76
OUTPATIENT SERVICE COST CENTERS						
00 09200 OBSERVATION BEDS (NON-DISTINCT PART						7 92
99 09399 PARTIAL HOSPITALIZATION PROGRAM	0	0				93
SPECIAL PURPOSE COST CENTERS	-					1
. 00 11300 I NTEREST EXPENSE	-2, 914	0				113
.00 SUBTOTALS (SUM OF LINES 1 through 117)	-806, 645	19, 617, 271				118
NONREI MBURSABLE COST CENTERS						
. 00 07950 MARKETI NG NRCC	0	105, 975				194
.0107951 GUEST MEALS	0	0				194
.00 TOTAL (SUM OF LINES 118 through 199)	-806, 645	19, 723, 246				200

Heal th	Financial Systems	ENCO	MPASS HEALTH DEA	CONESS REHAB	ILIT	In Lie	u of Form CMS	-2552-10
RECLASS	SEFECATIONS			Provider (	CCN: 15-3025	Peri od:	Worksheet A-	6
						From 01/01/2022 To 07/31/2022	Date/Time Pr	epared
						10 0//01/2022	Date/Time Pr 11/22/2022 1	<u>2:05 pm</u>
		Increases						
	Cost Center	Line #	Salary	Other				
	2.00	3.00	4.00	5.00				
	A – I NSURANCE				1			
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	16, 343				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	<u>3, 9</u> 61				2.00
	TOTALS		0	20, 304				
	B – MARKETING							
1.00	MARKETING_NRCC	194.00	10 <u>2, 7</u> 47	3, 228				1.00
	TOTALS		102, 747	3, 228				
	C – PHYSI CI ANS							
1.00	ADULTS & PEDIATRICS	30.00	0	1 <u>7,6</u> 30				1.00
	TOTALS		0	17, 630				
	D - SERVICE UNDER ARRANGEMENT				T.			
1.00	RADI OLOGY - SUA	54.01	0	51, 699				1.00
2.00	SPECIAL PROCEDURES - SUA		0	<u> </u>				2.00
	TOTALS		0	136, 366				
	E - DEPT 283 RECLASS				r			
1.00	OCCUPATI ONAL THERAPY	67.00	35, 058	265				1.00
2.00	SPEECH PATHOLOGY		<u> </u>	64				2.00
	TOTALS		43, 441	329				
500.00	Grand Total: Increases		146, 188	177, 857				500.00

Heal th	Financial Systems	ENCO	IPASS HEALTH DEA	CONESS REHAB	ILIT	In Lie	u of Form CMS	-2552-10
RECLAS	SI FI CATI ONS			Provider (	CCN: 15-3025	Peri od:	Worksheet A-	6
						From 01/01/2022 To 07/31/2022	Date/Time Pr 11/22/2022 1	epared: 2:05 pm
		Decreases						
	Cost Center	Line #	Sal ary	0ther	Wkst. A-7 Ref			
	6.00	7.00	8.00	9.00	10.00			
	A – INSURANCE							
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	20, 304				1.00
2.00		0.00	0	0	1	2		2.00
	TOTALS		0	20, 304				
	B - MARKETING							
1.00	ADMI NI STRATI VE & GENERAL	5.00	10 <u>2, 7</u> 47	3, 228		o		1.00
	TOTALS		102, 747	3, 228				
	C - PHYSICIANS							
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	<u> </u>		ol		1.00
	TOTALS		0	17, 630				
	D - SERVICE UNDER ARRANGEMENT				T.	1		
1.00	RADI OLOGY-DI AGNOSTI C	54.00	0	51, 699		o		1.00
2.00	SPECIAL PROCEDURES		0	<u> </u>		ol		2.00
	TOTALS		0	136, 366				
	E - DEPT 283 RECLASS					- 1		
1.00	PHYSI CAL THERAPY	66.00	43, 441	329		0		1.00
2.00		0.00	0	0		이		2.00
	TOTALS		43, 441	329		_		
500.00	Grand Total: Decreases		146, 188	177, 857				500.00

#### ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025 Period:

In Lieu of Form CMS-2552-10 Worksheet A-7

RECURCILIATION OF CAPITAL COSTS CENT	ERS		JN: 15-3025		)1/01/2022 )7/31/2022	Part I Date/Time Prep 11/22/2022 12:	
			Acqui si ti on	s			
	Begi nni ng	Purchases	Donati on		Total	Disposals and	
	Bal ances					Retirements	
	1.00	2.00	3.00		4.00	5.00	
PART I - ANALYSIS OF CHANGES	IN CAPITAL ASSET BALANCES		_				
1.00 Land	1, 675, 024	0		0	0	0	1.00
2.00 Land Improvements	356, 682	0		0	0	0	2.00
3.00 Buildings and Fixtures	24, 941, 419	0		0	0	0	3.00
4.00 Building Improvements	1, 826, 219	0		0	0	0	4.00
5.00 Fixed Equipment	6, 231, 859	0		0	0	0	5.00
6.00 Movable Equipment	94, 584	259, 021		0	259, 021	9, 158	6.00
7.00 HIT designated Assets	0	0		0	0	0	7.00
8.00 Subtotal (sum of lines 1-7)	35, 125, 787	259, 021		0	259, 021	9, 158	8.00
9.00 Reconciling Items	0	0		0	0	0	9.00
10.00 Total (line 8 minus line 9)	35, 125, 787	259, 021		0	259, 021	9, 158	10.00
	Ending Balance	Fully					
		Depreciated					
		Assets					
	6.00	7.00					
	IN CAPITAL ASSET BALANCES						
1.00 Land	1, 675, 024						1.00
2.00 Land Improvements	356, 682						2.00
3.00 Buildings and Fixtures	24, 941, 419						3.00
4.00 Building Improvements	1, 826, 219	0					4.00
5.00 Fixed Equipment	6, 231, 859	0					5.00
6.00 Movable Equipment	344, 447	0					6.00
7.00 HIT designated Assets	0	0					7.00
8.00 Subtotal (sum of lines 1-7)	35, 375, 650	0					8.00
9.00 Reconciling Items	0	0					9.00
10.00 Total (line 8 minus line 9)	35, 375, 650	0				l	10.00

Heal th Financia	al Systems		
RECONCI LI ATI ON	OF CAPITAL	COSTS	CENTERS

# ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025

In Lieu of Form CMS-2552-10 Period: Worksheet A-7 From 01/01/2022 Part II To 07/31/3022 Date/Time December 4

				To 07/31/2022		
		SU	IMMARY OF CAPI	TAL		
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)		
	9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUN	IN 2, LINES 1 a	nd 2			
1.00 CAP REL COSTS-BLDG & FIXT	816, 278	263, 349	(	0 0	0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	444, 999	149, 078	(	0 0	0	2.00
3.00 Total (sum of lines 1-2)	1, 261, 277		(	0 0	0	3.00
	SUMMARY O	F CAPITAL				
Cost Center Description	Other	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	SHEET A, COLUN		nd 2			
1.00 CAP REL COSTS-BLDG & FIXT	0	1, 079, 627				1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	594, 077				2.00
3.00  Total (sum of lines 1-2)	0	1, 673, 704				3.00

		MPASS HEALTH DE				u of Form CMS-2	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider CO		Period: From 01/01/2022 To 07/31/2022	Worksheet A-7 Part III Date/Time Prep 11/22/2022 12:	pared:
		COM	PUTATION OF RAT	-1 0S	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00	CAP REL COSTS-BLDG & FIXT	27, 124, 320		27, 124, 32		0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	6, 576, 306		6, 576, 30		0	2.00
3.00	Total (sum of lines 1-2)	33, 700, 626	TION OF OTHER (	33, 700, 62	6 1.000000 SUMMARY 0		3.00
		ALLUCA	TION OF OTHER (	APITAL	SUMMARY U	F CAPITAL	
	Cost Center Description	Taxes	Other Capital-Relate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C		1.00	0.00	7.00	10.00	
1.00	CAP REL COSTS-BLDG & FIXT	141, 776	0	141, 77	6 860, 641	263, 349	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	34, 374	0	34, 37	4 403, 589	144, 608	2.00
3.00	Total (sum of lines 1-2)	176, 150	0	176, 15	0 1, 264, 230	407, 957	3.00
			SL	IMMARY OF CAPI			
	Cost Center Description	Interest	Insurance (see instructions)		Other Capital-Relate d Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	148, 778				1, 430, 887	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3, 961	34, 37	4 0	586, 532	2.00
3.00	Total (sum of lines 1-2)	148, 778	20, 304	176, 15	0 0	2, 017, 419	3.00

### ENCOMPASS HEALTH DEACONESS REHABILLT

	Financial Systems	ENCOM	PASS HEALTH DEA	ACONESS REHABILIT		u of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES			Provider CCN: 15-3025	Period: From 01/01/2022 To 07/31/2022	Worksheet A-8 Date/Time Pre	pared:
			-	Expense Classification o To/From Which the Amount is		11/22/2022 12	:05 pm
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4.00	5.00	1.00
	COSTS-BLDG & FIXT (chapter 2)						
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time		0		0.00	0	4.00
5.00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5.00
5.00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6.00
	suppliers (chapter 8)		0				
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8. 00	Television and radio service (chapter 21)		0		0.00	0	8.00
9. 00 0. 00	Parking lot (chapter 21) Provider-based physician adjustment	A-8-2	0 -3, 496		0.00	0 0	9. 00 10. 00
1.00	Sale of scrap, waste, etc.		0		0.00	0	11.00
12.00	(chapter 23) Related organization transactions (chapter 10)	A-8-1	-487, 852			0	12.00
	Laundry and linen service Cafeteria-employees and guests		0		0.00 0.00	0	13.00 14.00
	Rental of quarters to employee		0		0.00	0	15.00
6. 00	and others Sale of medical and surgical supplies to other than		0		0.00	0	16.00
7.00	patients Sale of drugs to other than patients		0		0.00	0	17.00
8.00	Sale of medical records and abstracts		0		0.00	0	18.00
9. 00	Nursing and allied health education (tuition, fees,		0		0.00	0	19.00
20.00	books, etc.) Vending machines		о		0.00	0	20.00
1. 00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
2. 00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
3. 00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	OF	RESPI RATORY THERAPY	65.00		23.00
4. 00	Adjustment for physical therapy costs in excess of	A-8-3	OF	PHYSICAL THERAPY	66.00		24.00
5. 00	limitation (chapter 14) Utilization review - physicians' compensation		0,	*** Cost Center Deleted ***	114.00		25.00
. 00	(chapter 21) Depreciation - CAP REL COSTS-BLDG & FIXT		o	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
7.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		00	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
	Non-physician Anesthetist		0,	*** Cost Center Deleted ***			28.00
	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	0	DCCUPATI ONAL THERAPY	0.00 67.00	0	29.00 30.00
0. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
1. 00	instructions) Adjustment for speech pathology costs in excess of	A-8-3	os	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		О		0. 00	0	32.00

#### ENCOMPASS HEALTH DEACONESS REHABILIT

Health Financial Systems	ENCON	ASS HEALTH DE	EACONESS REHABILIT		u of Form CMS-2	
ADJUSTMENTS TO EXPENSES				Period:	Worksheet A-8	
				rom 01/01/2022 o 07/31/2022	Date/Time Pre	nared
				0 0775172022	11/22/2022 12	
			Expense Classification on	Worksheet A		
			To/From Which the Amount is	to be Adjusted		
Cost Center Descripti		Amount	Cost Center		Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
33.00 OTHER ADJUSTMENTS (SPECIFY)	)	C		0.00	0	33.0
(3) 37. 00 INTEREST	•	2 014	INTEDECT EVDENCE	112.00	11	27.0
	A		INTEREST EXPENSE	113.00	11	
	A		CAP REL COSTS-BLDG & FIXT	1.00	9	
37. 02 DEPRECIATION			CAP REL COSTS-MVBLE EQUIP	2.00		
37. 03 I NSURANCE	A		EMPLOYEE BENEFITS DEPARTMENT		0	
37. 04 I NSURANCE	A		ADMI NI STRATI VE & GENERAL	5.00	0	
37. 05 NON-ALLOWABLE EXPENSES	A	-25,039	ADMI NI STRATI VE & GENERAL	5.00	0	37.0
ADJUSTME	^	7 (7)		10.00	0	27.0
37.06 NON-ALLOWABLE EXPENSES	A	-/,0/0	DI ETARY	10.00	0	37.0
37. 07 NON-ALLOWABLE EXPENSES	А	2 025	NURSING ADMINISTRATION	13.00	0	37.0
ADJUSTME	A	-2,920	NURSING ADMINISTRATION	13.00	0	37.0
37. 08 NON-ALLOWABLE EXPENSES	А	7 /	RADI OLOGY-DI AGNOSTI C	54.00	0	37.0
ADJUSTME	A	- / 4	RADI OLOGI - DI AGNOSTI C	54.00	0	37.0
37. 09 NON-ALLOWABLE EXPENSES	А	_ 20	MEDICAL SUPPLIES CHARGED TO	71.00	0	37.0
ADJUSTME	A	-20	PATIENT	71.00	0	37.0
37. 10 PATIENT TELEPHONE	А	-5 765	CAP REL COSTS-MVBLE EQUIP	2.00	9	37.1
37. 11 PATIENT TELEPHONE	A		EMPLOYEE BENEFITS DEPARTMENT		9	
37. 12 PATIENT TELEPHONE	A		ADMI NI STRATI VE & GENERAL	5.00	0	
37. 13 PATIENT TELEVISION	A		CAP REL COSTS-MVBLE EQUIP	2.00	9	
				7.00	9	
37. 14 PATIENT TELEVISION 37. 15 PRINTING	A		OPERATION OF PLANT ADMINISTRATIVE & GENERAL	5.00	0	•
	A				0	
	A		ADMI NI STRATI VE & GENERAL	5.00	-	
37. 17 MI SCELLANEOUS I NCOME	В		ADMI NI STRATI VE & GENERAL	5.00	0	
37. 18 MI SCELLANEOUS I NCOME	В		OPERATION OF PLANT	7.00	0	
37. 19 MI SCELLANEOUS I NCOME	В		DIETARY	10.00	0	
37. 20 MI SCELLANEOUS I NCOME	В		MEDI CAL RECORDS & LI BRARY	16.00	0	
37. 21 PATIENT TRANSPORTATION	A		CAP REL COSTS-MVBLE EQUIP	2.00	9	
37. 22 PATIENT TRANSPORTATION	A		EMPLOYEE BENEFITS DEPARTMENT		0	
37. 23 PATIENT TRANSPORTATION	A		ADMI NI STRATI VE & GENERAL	5.00	0	
37. 24 PATI ENT TRANSPORTATI ON	A		OPERATION OF PLANT	7.00	0	
37. 25 PATIENT TRANSPORTATION	A		ADULTS & PEDIATRICS	30.00	0	
37. 26 PATIENT TRANSPORTATION	A		DRUGS CHARGED TO PATIENTS	73.00	0	
37. 27 PROFESSI ONAL FEES	A		ADMINISTRATIVE & GENERAL	5.00	0	
37. 28 PHYSI CI ANS	A		ADMI NI STRATI VE & GENERAL	5.00	0	37.2
50.00 TOTAL (sum of lines 1 thru	49)	-806, 645				50.0
(Transfer to Worksheet A,						
column 6, line 200.)						
(1) Description - all chapter refe	erences in this col	umn pertain to	o CMS Pub. 15-1.			
(2) Basis for adjustment (see inst	tructions).					
A. Costs - if cost, including ap	oplicable overhead,	can be deter	mi ned.			
B. Amount Received - if cost car	nnot be determined.					
(3) Additional adjustments may be						
Note: See instructions for column	- F					

Heal th	Financial Systems	ENCOMPASS HEALTH D	DEACONESS REHABILIT	In Lie	eu of Form CMS-	2552-10
	ENT OF COSTS OF SERVICES FROM			Peri od:	Worksheet A-8	
OFFI CE	COSTS			From 01/01/2022		
				To 07/31/2022	2 Date/Time Pre 11/22/2022 12	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	. 05 piii
	21110 1101			Allowable Cost		
					Wks. A, column	
					5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTM	IENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:		L			
1.00		ADMI NI STRATI VE & GENERAL	TO OFFSET MANAGEMENT FEES	0		1.00
2.00		CAP REL COSTS-BLDG & FIXT	TO INCLUDE ALLOWABLE HOME OF			2.00
3.00		CAP REL COSTS-BLDG & FIXT	TO INCLUDE ALLOWABLE HOME OF			3.00
3.01		ADMI NI STRATI VE & GENERAL	TO INCLUDE ALLOWABLE HOME OF			3.01
3.02		ADMI NI STRATI VE & GENERAL	TO INCLUDE ALLOWABLE HOME OF			3.02
3.03		CAP REL COSTS-MVBLE EQUIP	INTERCOMPANY WAGE AND EXPENS			3.03
3.04 3.05		OTHER CAP REL COSTS	INTERCOMPANY WAGE AND EXPENS			3. 04 3. 05
3.05		EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	INTERCOMPANY WAGE AND EXPENS INTERCOMPANY WAGE AND EXPENS			3.05
		OPERATION OF PLANT	INTERCOMPANY WAGE AND EXPENSION			
3.07 3.08		LAUNDRY & LINEN SERVICE	INTERCOMPANY WAGE AND EXPENS			3. 07 3. 08
3.08		HOUSEKEEPING	INTERCOMPANY WAGE AND EXPENS			3.08
3. 10		DI ETARY	INTERCOMPANY WAGE AND EXPENSION			3. 09
3.10		NURSING ADMINISTRATION	INTERCOMPANY WAGE AND EXPENSION			3.10
3.11		SOCIAL SERVICE	INTERCOMPANY WAGE AND EXPENS			3. 12
3.12		ADULTS & PEDIATRICS	INTERCOMPANY WAGE AND EXPENS			3. 12
3.13		RADI OLOGY-DI AGNOSTI C	INTERCOMPANY WAGE AND EXPENS			3.13
3.15		LABORATORY	INTERCOMPANY WAGE AND EXPENS			3.15
3.16		RESPI RATORY THERAPY	INTERCOMPANY WAGE AND EXPENSE			3, 16
3.17		PHYSI CAL THERAPY	INTERCOMPANY WAGE AND EXPENS			3.17
3.18		OCCUPATIONAL THERAPY	INTERCOMPANY WAGE AND EXPENS			3. 18
3.19		SPEECH PATHOLOGY	INTERCOMPANY WAGE AND EXPENS			3.19
3.20		MEDICAL SUPPLIES CHARGED TO	INTERCOMPANY WAGE AND EXPENS			3. 20
3.21		DRUGS CHARGED TO PATIENTS	INTERCOMPANY WAGE AND EXPENS			3. 21
3.22	76.01	SPECIAL PROCEDURES	INTERCOMPANY WAGE AND EXPENS	343	343	3. 22
3.23	113.00	INTEREST EXPENSE	INTERCOMPANY WAGE AND EXPENS	2, 914	2, 914	3. 23
3.24	1.00	CAP REL COSTS-BLDG & FIXT	RELATED PARTY - DEACONESS	268, 029	268, 029	3.24
3.25	2.00	CAP REL COSTS-MVBLE EQUIP	RELATED PARTY - DEACONESS	1, 249	5, 719	3. 25
3.26	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY - DEACONESS	1, 536	7,034	3.26
3.27		LAUNDRY & LINEN SERVICE	RELATED PARTY - DEACONESS	6, 604		3. 27
3.28		HOUSEKEEPING	RELATED PARTY - DEACONESS	325		3. 28
3.29		DI ETARY	RELATED PARTY - DEACONESS	26, 211		3. 29
3.30		ADULTS & PEDIATRICS	RELATED PARTY - DEACONESS	6, 127		3.30
3.31		RADI OLOGY-DI AGNOSTI C	RELATED PARTY - DEACONESS	0	002	3.31
3.32		RADIOLOGY - SUA	RELATED PARTY - DEACONESS	25, 288		3.32
3.33		LABORATORY	RELATED PARTY - DEACONESS	128, 396		3.33
3.34		MEDICAL SUPPLIES CHARGED TO	RELATED PARTY - DEACONESS	5, 188		3.34
3.35		DRUGS CHARGED TO PATIENTS	RELATED PARTY - DEACONESS	579		3.35
3.36		SPECIAL PROCEDURES - SUA	RELATED PARTY - DEACONESS	41, 399		3.36
3.37	0.00			0		3.37
4.00	0.00			0	-	4.00
5.00	TOTALS (sum of lines 1-4).			6, 283, 411	6, 771, 263	5.00
	Transfer column 6, line 5 to Worksheet A-8, column 2,					
	line 12.					
* Tho	amounts on Lines 1.4 (and sub		I transformed in detail to Ward			L

\* 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.

	been posted to norkaneet n,				or this part.	
				Related Organization(s) and/	or Home Office	
				3 ()		
	Symbol (1)	Name	Percentage of	Name	Percentage of	
			Ownership		Ownershi p	
-	1.00	2.00		4.00		
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELAT	FED ORGANIZATION(S) AND/OR HO	ME_OFFLCE:			

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		72.50 ENCOMPASS HEALT	0.00	6.00
7.00	В		27.50 DEACONESS HOSPI	0.00	7.00
8.00	G	ENCOMPASS HEALT	0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00

Heal th	Financial Systems	ENCOMPASS HEALTH DEACONESS REHABILIT			In Lieu of Form CMS-2552-10		
		RELATED ORGANIZATIONS AND HO	ME Provider (	CCN: 15-3025	Peri od:	Worksheet A-8	3-1
OFFICE	COSTS				From 01/01/2022	2 Date/Time Pre	enared.
					10 0773172022	11/22/2022 12	2:05 pm
				Related Orga	nization(s) and/	or Home Office	
	Symbol (1)	Name	Percentage of		Vame	Percentage of	
		Nume	Ownership		unio	Ownershi p	
	1.00	2.00	3.00	4	4. 00	5.00	
100.00	G. Other (financial or	FINANCIAL					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 organization. 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.

ATEME	NT OF COSTS OF	ems SERVI	CES FROM	RELATED ORGANIZATIONS AND HOME	Provider CCN	: 15-3025	Peri od:	Worksheet A-8-1
	COSTS						From 01/01/2022 To 07/31/2022	Date/Time Prepar
	Net	Wkst	A-7 Ref.					11/22/2022 12:05
	Adjustments	WICS C.	A / Ker.					
	(col. 4 minus							
	col. 5)*							
	6.00	7	. 00	•				
				L MENTS REQUIRED AS A RESULT OF TH	ANSACTIONS WIT		OPCANI ZATI ONS OP	
	HOME OFFICE CO		D ADJUJIN	IENTS RECORED AS A RESULT OF T	ANSAGITONS WIT		UNUANI ZATI UNUU UNU	
00	-1, 788, 544		0					
00	55, 398		9					
00	148, 778		11					
)0 )1			0					
	1, 178, 640							
)2	127, 954		0					
)3	0		9					
)4	0		9					
)5	0		0					
)6	0		0					
)7	0		0					
)8	0		0					
)9	0		0					
0	0		0					
1	0		0					
12	0		0					
13	0		0					
14	0		0					
15	0		0					
16	0		0					
17	0		0					
18	0		0					
19	0		0					
20	0		0					
21	0		0					
22	0		0					
23	0		11					
24	0		10					
25	-4, 470		10					
26	-5, 498		0					
27	0		0					
28	-1, 161		0					
29	-93, 804		0					
30	-3, 386		0					
31	-882		0					
32	-23, 707		0					
33	-30, 993		0					
34	-20, 186		0					
35	-2, 117		0					
36	-23, 874		0					
37	0		0					
00	0		0					
00	-487, 852		0					
	107,002	I						

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

 Type of Business

 6.00

 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.

 reinbursement under title XVIII.
 6.00

 6.00
 HEALTHCARE
 6.00

 7.00
 HEALTHCARE
 7.00

 8.00
 HEALTHCARE
 8.00

 9.00
 9.00
 9.00

 10.00
 100.00
 100.00

#### ENCOMPASS HEALTH DEACONESS REHABILIT

In Lieu of Form CMS-2552-10

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider CCN: 15-3025 Peri od: Worksheet A-8-1 From 01/01/2022 To 07/31/2022 OFFICE COSTS Date/Time Prepared: 11/22/2022 12:05 pm -

	Organization(s) r Home Office		
Typ	of Business		
l i jp	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.

Hearth	Financial Syste	ems Encu	JMPASS HEALTH D	EACONESS REHAB	ILII	IN LI	eu or Form CMS-	2552-10
PROVI DE	ER BASED PHYSICI	AN ADJUSTMENT		Provi der		Period:	Worksheet A-8	3-2
						From 01/01/2022 To 07/31/2022		
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identifier	Remunerati on	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	AGGREGATE-ADULTS &	17, 630	(	17,630	211, 500	139	1.00
		PEDI ATRI CS						
2.00	0.00		0	C	C	0	0	2.00
3.00	0.00		0	C	0	0	0	3.00
4.00	0.00		0	C	0	0	0	4.00
5.00	0.00		0	(	C	0	0	5.00
6.00	0.00		0	0	0 0	0	0	6.00
7.00	0.00		0	0	0 0	0	0	7.00
8.00	0.00		0	C	0	0	0	8.00
9.00	0.00		0	C	0	0	0	9.00
10.00	0.00		0	(		0	0	
200.00	0.00		17,630	(	-	-	-	200.00
200100	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
	intot. A Erno "	I denti fi er			Memberships &	Component	of Malpractice	
		ruonti i i oi	Erini c	Limit	Conti nui ng	Share of col.	Insurance	
				21.111.1	Educati on	12	inisur unee	
	1,00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		AGGREGATE-ADULTS &	14, 134	707				1.00
1.00		PEDI ATRI CS		, , , ,		0	Ű	1.00
2.00	0.00	EDIATIO	0	C	0 0	0	0	2.00
3.00	0.00		0	(	-	-	0	3.00
4.00	0.00		0	(	-	-	0	
5.00	0.00		0			-	0	5.00
6.00	0.00						0	6.00
7.00	0.00					-	0	7.00
8.00	0.00						0	8.00
9.00	0.00				, o	e e e e e e e e e e e e e e e e e e e	0	
10.00	0.00					-	0	10.00
200.00	0.00		14, 134	707	-	-	0	
200.00	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	0	200.00
	WKSL A LINE #	I denti fi er	Component	Limit	Di sal l owance	Aujustment		
		rdentrirer	Share of col.		DI Sal i owance			
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		AGGREGATE-ADULTS &	0					1.00
		PEDI ATRI CS			0,1,0	0,170		
2.00	0.00		l o	0	) C	0	1	2.00
3.00	0.00		0	C C				3.00
4.00	0.00		0		-			4.00
5.00	0.00		0	(				5.00
6.00	0.00		0		-	-		6.00
7.00	0.00		0					7.00
8.00	0.00		0	(		0		8.00
9.00	0.00		0	(		0		9.00
10.00	0.00		0		, s	-		10.00
200.00			0		-	-		200.00
200.00	ı		. 0	1 1, 10-	0, 170	1 3, 170	i I	

COST ALL	OCATION - GENERAL SERVICE COSTS	Provider C		Period: From 01/01/2022 To 07/31/2022	Worksheet B Part I Date/Time Pre 11/22/2022 12		
			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	
	NERAL SERVICE COST CENTERS						
	0100 CAP REL COSTS-BLDG & FIXT	1, 430, 887	1, 430, 887				1.00
	D200 CAP REL COSTS-MVBLE EQUIP	586, 532		586, 53			2.00
	0400 EMPLOYEE BENEFITS DEPARTMENT	2, 357, 867	7, 124				4.00
	0500 ADMI NI STRATI VE & GENERAL	3, 278, 015	55, 718				5.00
	0700 OPERATION OF PLANT	613, 261	45, 734			718, 850	
	D800 LAUNDRY & LINEN SERVICE	188, 556	4, 169				
	0900 HOUSEKEEPI NG	240, 622	8, 227				
	1000 DI ETARY	568, 841	77, 890				•
	1100 CAFETERI A	0	0		0 0	0	
	1300 NURSING ADMINISTRATION	639, 768	6, 501				•
	1600 MEDI CAL RECORDS & LI BRARY	62, 864	5, 799			85, 452	
	1700 SOCIAL SERVICE	404, 764	26, 853				
	2100 I &R SERVI CES-SALARY & FRI NGES APPRV	0	0		0 0		
	2200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	(	0 0	0	22.00
	IPATI ENT ROUTI NE SERVI CE COST CENTERS 3000 ADULTS & PEDI ATRI CS	E 01E 01(	951, 454	390, 00	9 970, 116	7 227 205	1 20 00
	ICI LLARY SERVICE COST CENTERS	5, 015, 816	951, 454	390, 00	9 970, 116	7, 327, 395	30.00
	5400 RADI OLOGY-DI AGNOSTI C	92, 650	0		0 0	92, 650	54.00
	5401 RADI OLOGY - SUA	27, 992	0		0 0		
	5000 LABORATORY	425, 270	19, 185		-	452, 319	
	5250 BLOOD CLOTTING FOR HEMOPHILIACS	423, 270	17, 109	7,00		0	
	5500 RESPIRATORY THERAPY	278, 376	5, 303	2, 17	4 62, 492	348, 345	
	5600 PHYSI CAL THERAPY	916, 796	111, 356			1, 261, 879	
	5700 OCCUPATIONAL THERAPY	1, 090, 805	56, 117			1, 413, 972	
	5800 SPEECH PATHOLOGY	349, 236	16, 358				
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	209, 959	18, 690				
	7300 DRUGS CHARGED TO PATIENTS	777, 601	11, 725				
	3020 PSYCH	0	0		0 0	0	
	3951 SPECIAL PROCEDURES	0	0	(	0 0	0	76.01
76.02 03	3950 SPECIAL PROCEDURES - SUA	60, 793	0	(	0 0	60, 793	76.02
	7697 CARDI AC REHABI LI TATI ON	0	0	(	0 0	0	
76.98 07	7698 HYPERBARI C OXYGEN THERAPY	0	0	(	o o	0	76.98
76.99 07	7699 LI THOTRI PSY	0	0	(	0 0	0	76.99
OU	ITPATIENT SERVICE COST CENTERS						
92.00 09	9200 OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
	9399 PARTIAL HOSPITALIZATION PROGRAM	0	0	(	0 0	0	93.99
	PECIAL PURPOSE COST CENTERS						
	1300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	19, 617, 271	1, 428, 203	585, 43	2 2, 344, 430	19, 590, 006	118.00
	ONREI MBURSABLE COST CENTERS						
	7950 MARKETING NRCC	105, 975	2, 684				
	7951 GUEST MEALS	0	0		0 C		194. 01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers		0		0 0		201.00
202.00	TOTAL (sum lines 118 through 201)	19, 723, 246	1, 430, 887	586, 53	2, 367, 911	19, 723, 246	202.00

Heal th	Fi nanci al	Systems	
OOCT A		OFNEDAL	OOCTO

COST A	LLOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 01/01/2022 To 07/31/2022	Worksheet B Part I Date/Time Prepared 11/22/2022 12:05 p	
	Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY &	HOUSEKEEPING	DI ETARY	
		5.00	7.00	8.00	9.00	10.00	
	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	3, 656, 511					5.00
7.00	00700 OPERATION OF PLANT	164, 507	883, 357				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	44, 496	2, 785	241, 71	5		8.00
9.00	00900 HOUSEKEEPI NG	68, 054	5, 496		0 370, 929		9.00
10.00	01000 DI ETARY	170, 873	52, 034		0 22, 056	991, 634	10.00
11.00	01100 CAFETERI A	0	0		0 0	147, 518	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	180, 847	4, 343		0 1, 841	0	13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	19, 555	3, 874		0 1, 642	0	16.00
17.00	01700 SOCIAL SERVICE	122, 085	17, 939		0 7,604	0	17.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0		0 0	0	21.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0		0 0	0	22.00
	INPATIENT ROUTINE SERVICE COST CENTERS						1
30.00	03000 ADULTS & PEDI ATRI CS	1, 676, 857	635, 608	241, 71	5 269, 423	823, 790	30.00
	ANCI LLARY SERVICE COST CENTERS			•			1
54.00	05400 RADI OLOGY-DI AGNOSTI C	21, 203	0		0 0	0	54.00
54.01	05401 RADI OLOGY - SUA	0	0		0 0	0	54.01
60.00	06000 LABORATORY	103, 512	12, 816		0 5, 433	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0	62.30
65.00	06500 RESPI RATORY THERAPY	79, 718	3, 543		0 1, 502	0	65.00
66.00	06600 PHYSI CAL THERAPY	288, 777	74, 390		0 31, 533	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	323, 583	37, 489		0 15, 891	0	67.00
68.00	06800 SPEECH PATHOLOGY	103, 218	10, 928		0 4, 632	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	56, 624	12, 486		0 5, 292	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	202, 110	7, 833		0 3, 320	0	73.00
76.00	03020 PSYCH	0	0		0 0	0	76.00
76.01	03951 SPECIAL PROCEDURES	0	0		0 0	0	76.01
76.02	03950 SPECIAL PROCEDURES - SUA	0	0		0 0	0	76.02
76.97	07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76.97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0	76.98
76.99	07699 LI THOTRI PSY	0	0		0 0	0	76.99
	OUTPATIENT SERVICE COST CENTERS			•			1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0	0		o o	0	93.99
	SPECIAL PURPOSE COST CENTERS			•			1
113.00	11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	3, 626, 019	881, 564	241, 71	5 370, 169	971, 308	118.00
	NONREI MBURSABLE COST CENTERS						1
194.00	07950 MARKETING NRCC	30, 492	1, 793		0 760	0	194.00
	07951 GUEST MEALS	0	0		0 0		194.01
200.00							200.00
201.00		0	0		o 0	0	201.00
202.00		3, 656, 511	883, 357	241, 71	5 370, 929		

eal th	Financial Systems ENCON	IPASS HEALTH DE	ACONESS REHABII	_IT	In Lie	u of Form CMS-:	2552-
OST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC		Peri od:	Worksheet B	
					rom 01/01/2022	Part I	
					o 07/31/2022	Date/Time Pre 11/22/2022 12	parec
						I NTERNS &	
	Cost Center Description	CAFETERI A	NURSI NG	MEDI CAL	SOCIAL SERVICE	RESIDENTS	
	cost center bescription	CAFEIERIA			SUCIAL SERVICE		
			ADMI NI STRATI ON	RECORDS &		Y & FRINGES	
		11.00	10.00	LIBRARY	17.00	APPRV	
		11.00	13.00	16.00	17.00	21.00	
~~	GENERAL SERVICE COST CENTERS	1			1		
. 00	00100 CAP REL COSTS-BLDG & FIXT						1.
. 00	00200 CAP REL COSTS-MVBLE EQUIP						2.
. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.
. 00	00500 ADMINI STRATI VE & GENERAL						5.
. 00	00700 OPERATION OF PLANT						7.
. 00	00800 LAUNDRY & LINEN SERVICE						8.
. 00	00900 HOUSEKEEPI NG						9.
0.00	01000 DI ETARY						10.
1.00	01100 CAFETERI A	147, 518					11.
	01300 NURSI NG ADMI NI STRATI ON	10, 893					13.
	01600 MEDICAL RECORDS & LIBRARY	1, 111		111, 634	1		16.
	01700 SOCIAL SERVICE	7,003		(111, 03			17.
						0	
	02100 I &R SERVICES-SALARY & FRINGES APPRV	0		(		0	
2.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	(	00		22.
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
0. 00	03000 ADULTS & PEDIATRICS	74, 785	988, 176	54, 456	688, 110	0	30.
	ANCILLARY SERVICE COST CENTERS				1		
	05400 RADI OLOGY-DI AGNOSTI C	0		673	3 0	0	54.
4. 01	05401 RADI OLOGY - SUA	0	0	(	0 0	0	54.
0.00	06000 LABORATORY	0	0	4, 404	1 0	0	60.
2.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	(	o o	0	62.
	06500 RESPI RATORY THERAPY	4, 817	0	1, 587	7 O	0	65.
	06600 PHYSI CAL THERAPY	14, 498		15, 277		0	
	06700 OCCUPATI ONAL THERAPY	18, 812	0	16, 616		0	
	06800 SPEECH PATHOLOGY	6, 069	-	4, 143		0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	857		1, 512		0	
	07300 DRUGS CHARGED TO PATIENTS	6, 863		12, 966		0	
	03020 PSYCH	0	0	(		0	
	03951 SPECIAL PROCEDURES	0	0	(	-	0	
	03950 SPECIAL PROCEDURES - SUA	0	0	(		0	
	07697 CARDI AC REHABI LI TATI ON	0	0	(	0 0	0	
6. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	(	0 0	0	76.
6. 99	07699 LI THOTRI PSY	0	0	(	0 0	0	76.
	OUTPATIENT SERVICE COST CENTERS						
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.
3.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0	0	(	ol ol	0	93.
	SPECIAL PURPOSE COST CENTERS					-	1
13, 00	11300 I NTEREST EXPENSE						1113.
18.00		145, 708	988, 176	111, 634	688, 110	0	118.
.0.00	NONREI MBURSABLE COST CENTERS	143,700	700, 170	111,032	000, 110	0	1 10.
04 00		1.010				^	104
	07950 MARKETING NRCC	1, 810		(			194.
	07951 GUEST MEALS	0	0	(	0 0		194.
00.00							200.
01 00	Negative Cost Centers	0	0	(	0 0	0	201.
201.00	1			111, 634			

In Lieu of Form CMS-2552-10 Period: Worksheet B From 01/01/2022 Part I To 07/31/2022 Date/Time Prepared:

			T	o 07/31/2022	
	INTERNS &				11/22/2022 12:05 pm
	RESI DENTS				
Cost Center Description	SERVI CES-OTHER	Subtotal	Intern &	Total	
	PRGM COSTS		Residents Cost		
	APPRV		& Post		
			Stepdown		
			Adjustments		
	22.00	24.00	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 ADMI NI STRATI VE & GENERAL 7. 00 00700 OPERATI ON OF PLANT					5.00
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE					7.00
9. 00 00900 HOUSEKEEPING					8.00 9.00
10. 00 01000 DI ETARY					10.00
11. 00 01100 CAFETERIA					11.00
13. 00 01300 NURSING ADMINISTRATION					13.00
16. 00 01600 MEDICAL RECORDS & LIBRARY					16.00
17. 00 01700 SOCIAL SERVICE					17.00
21. 00 02100 I &R SERVICES-SALARY & FRINGES A	PPR\/				21.00
22. 00 02200 I &R SERVICES-OTHER PRGM COSTS A					22.00
INPATIENT ROUTINE SERVICE COST CENTER			I		22.00
30. 00 03000 ADULTS & PEDIATRICS	0	12, 780, 315	0	12, 780, 315	30.00
ANCI LLARY SERVICE COST CENTERS		12,700,010		12, 700, 010	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	114, 526	0	114, 526	54.00
54. 01 05401 RADI OLOGY - SUA	o	27, 992			54.01
60. 00 06000 LABORATORY	0	578, 484	0		60,00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS		0	0		62.30
65.00 06500 RESPI RATORY THERAPY	0	439, 512	0	439, 512	65.00
66.00 06600 PHYSI CAL THERAPY	0	1, 686, 354	0	1, 686, 354	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	1, 826, 363	0	1, 826, 363	67.00
68.00 06800 SPEECH PATHOLOGY	0	580, 024	0		68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	I ENT O	324, 204	0	324, 204	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	1, 116, 258	0	1, 116, 258	73.00
76.00 03020 PSYCH	0	0	0	0	76.00
76.01 03951 SPECIAL PROCEDURES	0	0	0	0	76.01
76.02 03950 SPECIAL PROCEDURES - SUA	0	60, 793	0	60, 793	76.02
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	76. 98
76. 99 07699 LI THOTRI PSY	0	0	0	0	76. 99
OUTPATIENT SERVICE COST CENTERS				1	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT			0		92.00
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	1 0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS			1	1	
113.00 11300 INTEREST EXPENSE					113.00
118.00 SUBTOTALS (SUM OF LINES 1 throu	igh 117) 0	19, 534, 825	0	19, 534, 825	118.00
NONREI MBURSABLE COST CENTERS					
194.00 07950 MARKETING NRCC	0	168, 095			194.00
194.0107951 GUEST MEALS	0	20, 326			194.01
200.00 Cross Foot Adjustments	0	0	0		200.00
201.00 Negative Cost Centers	0	0	0		201.00
202.00  TOTAL (sum lines 118 through 20	0)	19, 723, 246	0	19, 723, 246	202.00

	TION OF CAPITAL RELATED COSTS		Provi der C	CN: 15-3025 P	eriod: rom 01/01/2022	Worksheet B Part II Date/Time Pre 11/22/2022 12	
			CAPI TAL REL	ATED COSTS			
	Cost Conton Decerintion	Directly	BLDG & FIXT	MVBLE EQUIP	Subtatal		
	Cost Center Description	Directly Assigned New	BLUG & FIXI	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS	
		Capi tal				DEPARTMENT	
		Related Costs				DELARTMENT	
		0	1.00	2.00	2A	4.00	
	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	0	7, 124			10, 044	4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	0	55, 718			1, 272	5.00
7.00	00700 OPERATION OF PLANT	0	45, 734			174	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	4, 169			0	
9.00	00900 HOUSEKEEPI NG	0	8, 227	3, 372		191	9.00
10.00	01000 DI ETARY	0	77, 890			288	
11.00	01100 CAFETERI A	0	0	0	-	0	
13.00	01300 NURSI NG ADMI NI STRATI ON	0	6, 501			599	
	01600 MEDI CAL RECORDS & LI BRARY	0	5, 799			61	16.00
17.00	01700 SOCIAL SERVICE	0	26, 853			385	
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	-	0	21.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		051 454	200,000	1 241 4/2	4 110	1 20 00
30.00	03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS	0	951, 454	390, 009	1, 341, 463	4, 118	30.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	54.00
54.00 54.01	05401 RADI OLOGY - SUA	0	0	0	-	0	
60.00	06000 LABORATORY	0	19, 185	7, 864	-	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	17,100	,, 004 0	27,047	0	
65.00	06500 RESPI RATORY THERAPY	0	5, 303	2, 174	7,477	265	
66.00	06600 PHYSI CAL THERAPY	0	111, 356	45, 646		797	•
67.00	06700 OCCUPATI ONAL THERAPY	0	56, 117	23, 003		1,035	•
68.00	06800 SPEECH PATHOLOGY	0	16, 358			334	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	18, 690			47	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	11, 725			378	
76.00	03020 PSYCH	0	0	0		0	76.00
76.01	03951 SPECIAL PROCEDURES	0	0	0	0	0	76.01
76.02	03950 SPECIAL PROCEDURES - SUA	0	0	0	0	0	76.02
	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76.97
76.98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 98
76.99	07699 LI THOTRI PSY	0	0	0	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS						
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113.00
118.00		0	1, 428, 203	585, 432	2, 013, 635	9, 944	118.00
	NONREI MBURSABLE COST CENTERS						
	07950 MARKETING NRCC	0	2, 684	1, 100			194.00
	07951 GUEST MEALS	0	0	0		0	194.01
200.00			-	-	0	-	200.00
201.00			0		0		201.00
202.00	TOTAL (sum lines 118 through 201)	0	1, 430, 887	586, 532	2, 017, 419	10, 044	202.00

Heal th	Fi nanci	i al	Syste	ems		
		CA		DEL	ATED	(

ENCOMPASS	HEALTH	DEACO	NESS	REHA	3I LI T		
			Prov	i der	CCN	15-3025	Perio

In Lieu of Form CMS-2552-10 Worksheet B

Health Financial Systems ENCO	MPASS HEALTH DE	ACONESS REHABI	LIT	In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		eri od:	Worksheet B	
				rom 01/01/2022	Part II	
			T	o 07/31/2022	Date/Time Pre	
Cost Conton Deparintian		OPERATION OF		HOUSEKEEPI NG	11/22/2022 12	:05 pm
Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HUUSEKEEPING	DI ETARY	
	& GENERAL	PLANT 7.00	LINEN SERVICE	9.00	10.00	
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	70,000					4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL	79, 829	10.04/				5.00
7.00 00700 OPERATION OF PLANT	3, 591	68, 246				7.00
8.00 00800 LAUNDRY & LINEN SERVICE	971	215	7,064			8.00
9.00 00900 HOUSEKEEPI NG	1, 486	425	0	13, 701		9.00
10. 00 01000 DI ETARY	3, 730	4, 020	0	815	118, 671	10.00
11. 00 01100 CAFETERI A	0	0	0	0	17, 654	
13.00 01300 NURSING ADMINISTRATION	3, 948	336	0	68	0	13.00
16.00 01600 MEDI CAL RECORDS & LI BRARY	427	299	0	61	0	16.00
17.00 01700 SOCIAL SERVICE	2,665	1, 386	0	281	0	17.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS			•			1
30. 00 03000 ADULTS & PEDI ATRI CS	36, 613	49, 105	7,064	9, 951	98, 585	30.00
ANCI LLARY SERVI CE COST CENTERS				· · ·		1
54.00 05400 RADI OLOGY-DI AGNOSTI C	463	0	0	0	0	54.00
54. 01 05401 RADI OLOGY - SUA	0	l o	0	o	0	54.01
60. 00 06000 LABORATORY	2,260	990	0	201	0	60,00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	1,740	274	0	55	0	65.00
66. 00 06600 PHYSI CAL THERAPY	6, 304	5, 747	0	1, 165	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	7,064	2, 896	0	587	0	
68. 00 06800 SPEECH PATHOLOGY	2, 253	844	0	171	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 236	965	0	195	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	4, 412	605	0	123	0	
76. 00  03020 PSYCH	4,412	003	0	123	0	
76. 01 03951 SPECIAL PROCEDURES	0	0		0	0	76.00
76. 02 03950 SPECIAL PROCEDURES - SUA	0	0		0	0	76.01
	0	0	-	0	-	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	
76. 99 07699 LI THOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS	1					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS	1					
113.00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	79, 163	68, 107	7, 064	13, 673	116, 239	118.00
NONREI MBURSABLE COST CENTERS						
194.0007950 MARKETI NG NRCC	666	139	0	28		194.00
194.0107951 GUEST MEALS	0	0	0	0	2, 432	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)	79, 829	68, 246	7, 064	13, 701	118, 671	202.00
				,		

## ENCOMPASS HEALTH DEACONESS REHABILIT

Health Fin	ancial Systems ENCOM	IPASS HEALTH DE	EACONESS REHABI	LIT	In Lie	u of Form CMS-2	<u>2552-10</u>
ALLOCATI ON	I OF CAPITAL RELATED COSTS		Provi der C		eri od:	Worksheet B	
					rom 01/01/2022	Part II	
					07/31/2022	Date/Time Pre	pared:
						11/22/2022 12	05 pill
						INTERNS &	
	Cost Costos Decesistics					RESI DENTS	
	Cost Center Description	CAFETERI A	NURSI NG	MEDICAL	SOCIAL SERVICE		
			ADMI NI STRATI ON			Y & FRINGES	
		11.00	10.00	LIBRARY	17.00	APPRV	
0.511		11.00	13.00	16.00	17.00	21.00	
	ERAL SERVICE COST CENTERS		1	1	1		
	DO CAP REL COSTS-BLDG & FIXT						1.00
	00 CAP REL COSTS-MVBLE EQUIP						2.00
	00 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 0050	00 ADMINISTRATIVE & GENERAL						5.00
7.00 0070	OO OPERATION OF PLANT						7.00
8.00 0080	00 LAUNDRY & LINEN SERVICE						8.00
	DO HOUSEKEEPI NG						9.00
	DO DI ETARY						10.00
	DO CAFETERI A	17, 654					11.00
	00 NURSI NG ADMI NI STRATI ON	1, 304					13.00
	00 MEDI CAL RECORDS & LI BRARY	133		9, 157			16.00
	00 SOCIAL SERVICE	838					17.00
21.00 0210	00 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00 0220	00 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0		22.00
I NPA	ATIENT ROUTINE SERVICE COST CENTERS						1
30.00 0300	00 ADULTS & PEDI ATRI CS	8, 950	15, 421	4, 464	43, 415		30.00
ANCI	LLARY SERVICE COST CENTERS						1
	00 RADI OLOGY-DI AGNOSTI C	0	) 0	55	0		54.00
	01 RADI OLOGY - SUA	0					54.01
	DO LABORATORY	0			0		60.00
	50 BLOOD CLOTTING FOR HEMOPHILIACS	0	-		0		62.30
		-	-	-	0		
		576			0		65.00
-	00 PHYSI CAL THERAPY	1, 735			0		66.00
-	00 OCCUPATIONAL THERAPY	2, 251		.,	0		67.00
	00 SPEECH PATHOLOGY	726			0		68.00
	00 MEDICAL SUPPLIES CHARGED TO PATIENT	103	0	124	0		71.00
73.00 0730	DO DRUGS CHARGED TO PATIENTS	821	0	1, 064	0		73.00
76.00 0302	20 PSYCH	0	0	0	0		76.00
76.01 039	51 SPECIAL PROCEDURES	0	0 0	0	0		76.01
76.02 039	50 SPECIAL PROCEDURES - SUA	0	ol o	0	0		76.02
	97 CARDI AC REHABI LI TATI ON	0		0	0		76.97
	98 HYPERBARI C OXYGEN THERAPY	0	-	-	0		76.98
	99 LI THOTRI PSY		-		-		
		0	<u> </u>	ıj 0	U U		76.99
	PATIENT SERVICE COST CENTERS			1			
	00 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	99 PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0		93.99
	CIAL PURPOSE COST CENTERS						
113.00 1130	00 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	17, 437	15, 421	9, 157	43, 415	0	118.00
NONE	REIMBURSABLE COST CENTERS						1
	50 MARKETING NRCC	217	0	0	0		194.00
	51 GUEST MEALS	0		0	0		194.01
200.00	Cross Foot Adjustments	Ĭ		l		Ο	200.00
201.00	Negative Cost Centers	0		0	0		201.00
201.00	TOTAL (sum lines 118 through 201)	17,654	15, 421	9, 157	43, 415		201.00
202.00	Trance (sum trics fro through 201)	1 17,004	1 15,421	7,137	45,415	0	202.00

In Lieu of Form CMS-2552-10									
15-3025	Period: From 01/01/2022 To 07/31/2022	Worksheet B Part II Date/Time Prepared: 11/22/2022 12:05 pm							

				·	0 0770172022	11/22/2022 12:05 pm
		INTERNS &				
		RESIDENTS				
	Cost Center Description	SERVI CES-OTHER	Subtotal	Intern &	Total	
	cost center beschiption	PRGM COSTS	30010121	Residents Cost		
		APPRV		& Post		
				Stepdown		
				Adjustments		
		22.00	24.00	25.00	26.00	
	GENERAL SERVICE COST CENTERS	1		-	1	
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 ADMI NI STRATI VE & GENERAL					5.00
7.00	00700 OPERATION OF PLANT					7.00
8.00	00800 LAUNDRY & LINEN SERVICE					8.00
9.00	00900 HOUSEKEEPING					9.00
10.00	01000 DI ETARY					10.00
11.00	01100 CAFETERI A					11.00
13.00	01300 NURSING ADMINISTRATION					13.00
16.00	01600 MEDI CAL RECORDS & LI BRARY					16.00
17.00	01700 SOCIAL SERVICE					17.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV					21.00
22.00		0				22.00
22.00	INPATIENT ROUTINE SERVICE COST CENTERS	9				22.00
30.00	03000 ADULTS & PEDIATRICS		1, 619, 149	0	1, 619, 149	30.00
30.00	ANCI LLARY SERVICE COST CENTERS		1,017,147	1 0	1,017,147	30.00
54.00	05400 RADI OLOGY-DI AGNOSTI C		E10	0	E10	54.00
			518			
54.01	05401 RADI OLOGY - SUA		0	-	-	
60.00	06000 LABORATORY		30, 862			
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS		C	-		
65.00	06500 RESPI RATORY THERAPY		10, 517	0	10, 517	65.00
66.00	06600 PHYSI CAL THERAPY		174, 004	0	174, 004	66.00
67.00	06700 OCCUPATI ONAL THERAPY		94, 317	0	94, 317	67.00
68.00	06800 SPEECH PATHOLOGY		27, 731	0	27, 731	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		29, 021			71.00
73.00	07300 DRUGS CHARGED TO PATIENTS		23, 934			73.00
				1		
76.00	03020 PSYCH		0			
76.01	03951 SPECIAL PROCEDURES		C	-		76.01
76.02	03950 SPECIAL PROCEDURES - SUA		C	-		76.02
76.97	07697 CARDI AC REHABI LI TATI ON		0	0		
76.98	07698 HYPERBARI C OXYGEN THERAPY		C	0	0	76. 98
76.99	07699 LI THOTRI PSY		0	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS					
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART			0		92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM		C	0 0	0	93.99
/01///	SPECIAL PURPOSE COST CENTERS	1 1		1		
113 00	D 11300 I NTEREST EXPENSE					113.00
118.00		0	2 010 052		2 010 052	
110.00	NONREIMBURSABLE COST CENTERS	U	2,010,053	0	2, 010, 053	118.00
104 04		1	4.024		4 024	104.00
	07950 MARKETING NRCC		4, 934			
	07951 GUEST MEALS		2, 432			
200.00	5	0	C			
201.00	5	0	0	, U		201.00
202.00	) TOTAL (sum lines 118 through 201)	0	2,017,419	0	2, 017, 419	202.00

## ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025 Period:

In Lieu of Form CMS-2552-10 Worksheet B-1

COST A	LLOCATION - STATISTICAL BASIS	Provider CCN: 15-3025		Period: Worksheet B-1 From 01/01/2022			
					o 07/31/2022		
		CAPITAL REI	ATED COSTS			11/22/2022 12	:05 pm
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Decenciliation	ADMI NI STRATI VE	
	cost center bescription	(SQUARE FEET)	(SQUARE FEET)	BENEFITS	Reconciliation	& GENERAL	
				DEPARTMENT		(ACCUM COST)	
				(GROSS SALARI ES)			
		1.00	2.00	4.00	5A	5.00	
	GENERAL SERVICE COST CENTERS		L			L	
1.00	00100 CAP REL COSTS-BLDG & FIXT	89, 575					1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	446	89, 575 446	10, 361, 509			2.00 4.00
4.00 5.00	00500 ADMINI STRATI VE & GENERAL	3, 488		1, 312, 472		15, 977, 950	1
7.00	00700 OPERATION OF PLANT	2,863				718, 850	1
8.00	00800 LAUNDRY & LINEN SERVICE	261	261	C	0 0	194, 434	8.00
9.00	00900 HOUSEKEEPI NG	515		197, 603		297, 379	1
	01000 DI ETARY	4, 876		297, 608	0	746, 671	
	01100 CAFETERIA	0	0	( 410.277			
	01300 NURSING ADMINISTRATION 01600 MEDICAL RECORDS & LIBRARY	407	407	618, 377 63, 064		790, 252 85, 452	
	01700 SOCIAL SERVICE	1, 681	1, 681	397, 561		533, 479	
	02100 I &R SERVICES-SALARY & FRINGES APPRV	0		C			1
	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	C	0	0	22.00
	INPATIENT ROUTINE SERVICE COST CENTERS	50.540	50.540			7 007 005	
30.00	03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS	59, 562	59, 562	4, 245, 043	0	7, 327, 395	30.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	C	0	92, 650	54.00
	05401 RADI OLOGY - SUA	0	0			0	1
60.00	06000 LABORATORY	1, 201	1, 201	C		452, 319	1
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	C	0 0	0	62.30
65.00	06500 RESPI RATORY THERAPY	332		273, 454		348, 345	1
66.00	06600 PHYSI CAL THERAPY	6, 971	6, 971	823, 002		1, 261, 879	
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	3, 513 1, 024		1, 067, 900 344, 529		1, 413, 972 451, 034	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 024		48, 674		247, 433	1
	07300 DRUGS CHARGED TO PATIENTS	734		389, 594		883, 166	1
	03020 PSYCH	0	0	C		0	1
	03951 SPECIAL PROCEDURES	0	0	C		0	76.01
	03950 SPECIAL PROCEDURES - SUA	0	0	C		0	
	07697 CARDI AC REHABI LI TATI ON	0	0	C	-	0	
	07698 HYPERBARI C OXYGEN THERAPY 07699 LI THOTRI PSY	0	0		-	0	
	OUTPATIENT SERVICE COST CENTERS	0	0		<u>,                                     </u>	0	/0. //
	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0	0	C	0	0	93.99
	SPECIAL PURPOSE COST CENTERS	1			1		
113.00 118.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	89, 407	89, 407	10, 258, 762	-3, 745, 296		113.00
	NONREI MBURSABLE COST CENTERS	09,407	09,407	10, 236, 702	-3, 743, 290	15, 844, 710	1110.00
	07950 MARKETI NG NRCC	168	168	102, 747	0	133, 240	194.00
	07951 GUEST MEALS	0		C	0 0		194.01
200.00	5						200.00
201.00		4 400 007	50/ 500				201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1, 430, 887	586, 532	2, 367, 911		3, 656, 511	202.00
203.00		15. 974178	6. 547943	0. 228530		0. 228847	203 00
200.00		10. // 11/0		10, 044			204.00
	Part II)						
205.00				0.000969		0. 004996	205.00
204 00	11) NAME adjustment amount to be allocated						204 00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00							207.00
	Parts III and IV)						

Heal th	Fi nanci al	Systems	
COCT A			

## ENCOMPASS HEALTH DEACONESS REHABILIT

Health	Financial Systems ENCON	MPASS HEALTH DE	ACONESS REHABI		In Lie	u of Form CMS-:	2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provider CO		eriod:	Worksheet B-1	
					rom 01/01/2022 o 07/31/2022	Date/Time Pre	narod
				1	0 07/31/2022	11/22/2022 12	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE		(MEALS SERVED)	(GROSS	
			(TOTAL PATIENT		· · · · · · · · · · · · · · · · · · ·	SALARI ES)	
		,	DAYS)				
		7.00	8.00	9.00	10.00	11.00	
	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 ADMINI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT	82,778					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	261	19, 359				8.00
9.00	00900 HOUSEKEEPI NG	515		82, 002			9.00
10.00	01000 DI ETARY	4,876	0	4, 876	69, 910		10.00
11.00	01100 CAFETERI A	0		0		8, 373, 945	
13.00	01300 NURSING ADMINISTRATION	407	0	407		618, 377	1
16.00	01600 MEDICAL RECORDS & LIBRARY	363		363		63, 064	1
17.00	01700 SOCIAL SERVICE	1, 681		1, 681		397, 561	
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0		0	0	0	1
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0		0	0	0	
22.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		<u> </u>		<u> </u>	0	22.00
30.00	03000 ADULTS & PEDIATRICS	59, 562	19, 359	59, 562	58, 077	4, 245, 043	30.00
50.00	ANCI LLARY SERVICE COST CENTERS	57, 302	17,007	57, 502	50, 077	4, 240, 040	30.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	54.00
54.00	05401 RADI OLOGY - SUA	0		0		0	
60.00	06000 LABORATORY	1, 201	-	1, 201	-	0	
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	1,201		1, 201		0	
65.00	06500 RESPIRATORY THERAPY	332	-	332	-		
66. 00	06600 PHYSI CAL THERAPY	6, 971		6, 971		273, 454 823, 002	
	06700 OCCUPATI ONAL THERAPY						
67.00		3, 513		3, 513		1, 067, 900	
68.00	06800 SPEECH PATHOLOGY	1,024		1, 024		344, 529	
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	1, 170		1, 170		48, 674	
73.00	07300 DRUGS CHARGED TO PATIENTS	734		734		389, 594	
76.00		0	0	0	0	0	
76.01	03951 SPECIAL PROCEDURES	0	0	0	0	0	
76.02	03950 SPECIAL PROCEDURES - SUA	0	0	0	0	0	
76.97	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	
76.98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	
76.99		0	0 0	0	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS	1	1		1		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0	0 0	0	0	0	93.99
110.00	SPECIAL PURPOSE COST CENTERS	1	1				110 00
	11300 I NTEREST EXPENSE	00 (10	10.050	01.001	10 177	0 074 400	113.00
118.00		82, 610	19, 359	81, 834	68, 477	8, 271, 198	118.00
40.4	NONREI MBURSABLE COST CENTERS					100 7	104.00
	07950 MARKETING NRCC	168		168		102, 747	
	07951 GUEST MEALS	0	0	0	1, 433	0	194.01
200.00							200.00
201.00							201.00
202.00	1 1	883, 357	241, 715	370, 929	991, 634	147, 518	202.00
	Part I)						
203.00		10. 671398		4. 523414		0.017616	
204.00		68, 246	7, 064	13, 701	118, 671	17, 654	204.00
	Part II)						
205.00		0. 824446	0. 364895	0. 167081	1. 697482	0.002108	205.00
							001 00
	NAHE adjustment amount to be allocated	1	1				206.00
206.00							
	(per Wkst. B-2)						207 20
206.00 207.00	(per Wkst. B-2)						207.00

In Lieu of Form CMS-2552-10 Worksheet B-1

From         01/01/2022         Durbance           Cost Center Description         AMURSING AMUNSING AMUNSING COST Center Description         MEDICAL AMUNSING AMUNSING COSTAL PATENT A COSTAL PATENT DAYS)         MEDICAL MEDICAL APRW (CESS REV UE DAYS)         SOCIAL SERVICES-SALARS SERVICES- COSTAL SERVICE COST (TOTAL PATENT A APRW (CESS REV UE DAYS)         SOCIAL SERVICES COST (TOTAL PATENT A APRW (CESS REV UE DAYS)         APRW (CE APSY) (TSSICAPE (COST CENTERS)         APRW (CE APSY) (COST CENTERS)         APRW (CE APSW) (COST CENTERS)         AP	alth Fina	ancial Systems ENCO	MPASS HEALTH DE	ACONESS REHABI	LIT	In Lie	u of Form CMS-	2552-10	
To         0.7/31/2022         DeterTime           INTERNS & RESIDENTS           Cost Center Description           NURSING ADMINISTRATION           ADMINISTRATION           LIBRARY (TOTAL PATLENT (CROSS REV MED DAYS)           COLAL SERVICE COST CENTERS           1.00           COLA COST CENTERS           1.00           COLAL SERVICE COST CENTERS           1.00           COLATION OF TATURE OF TAT				Provider C	CN: 15-3025 P		Worksheet B-1		
Cost Center Description         NURSING ADMINISTRATION         NURSING NURSING ADMINISTRATION         NURSING NEECORDS & LINERS & LINES & L									
Cost Center Description         NURSING ADMINISTRATION ADMINISTRATION DAYS)         MEDICAL RECORDS & LISERVICES-SALARSERVICES-SALARSERVICES-OF UTAL_PATIENT DAYS)         SOCIAL SERVICES-SALARSERVICES-OF ASSING DAYS)         INTERNS & RESIDENTS ASSING DAYS)         SOCIAL SERVICES-SALARSERVICES-OF ASSING DAYS)           EENERAL SERVICE COST CENTERS         (107AL_PATIENT DAYS)         17.00         21.00         22.00           1.00         00100 (CAP FEL COST-SHUE & FIXT DAYS)         17.00         21.00         22.00           0.00         00000 (AP FEL COST-SHUE & FIXT DAYS)         17.00         21.00         22.00           0.00         00000 (AP FEL COST-SHUE & FIXT DAYS)         17.00         21.00         22.00           0.0000 (AP FEL COST-SHUE & EVENTERS         0         0         0         0         0           0.0000 (CAP FEL COST-SHUE & FIXT DAYS)         0         0         0         0         0         0           0.0000 (CAR FEL COST-SHUE & FIXT DAYS)         0<					T	o 07/31/2022	Date/Time Pre	epared:	
Cost Center Description         NURSING ADMINISTRATION DAYS         NEDICAL RECORDS & LIBRARY (TOTAL PATIENT (OTAL PATIENT DAYS)         SOCIAL SERVICE Y & FRINCES DAYS)         SERVICES-SALAR/SERVICES- TOTAL PATIENT (ASSIGNED DAYS)           10         001000 (AP FLL COST-SHORE & FUT 00200 (AP FEL COST-SHORE & FUT 000000 (ADMINSTRATIVE & GENERAL 7:0000000  (ADMINSTRATIVE & GENERAL 7:0000000 (ADMINSTRATIVE & GENERAL 7:00000000 (ADMINSTRATIVE & GENERAL 7:00000000 (ADMINSTRATIVE & GENERAL 7:000000000 (ADMINSTRATIVE & GENERAL 7:000000000 (ADMINSTRATIVE & GENERAL 7:00000000 (ADMINSTRATIVE & GENERAL 7:00000000 (ADMINSTRATIVE & GENERAL 7:000000000 (ADMINSTRATIVE & GENERAL 7:000000000 (ADMINSTRATIVE & GENERAL 7:000000000000000000000000000000000000							11/22/2022 12	05 pm	
ADMI NI STRATION         RECORDS & LI BRARY         Y & FIN NGES APPRV (ASSIGNED TIME)         PROV COST APPRV (ASSIGNED TIME)           100         DENERAL SERVICE COST CENTERS         13.00         16.00         17.00         21.00         22.00           100         DOTOG CAP REL COSTS-HUBE & FIN TE TIME)         13.00         16.00         17.00         21.00         22.00           100         DOTOG CAP REL COSTS-HUBE & FULP         13.00         16.00         17.00         21.00         22.00           100         DOTOG CAP REL COSTS-HUBE & FULP         10.00						INTERNS &	RESI DENTS		
ADMI NI STRATION         RECORDS & LI BRARY         Y & FIN NGES APPRV (ASSIGNED TIME)         PROV COST APPRV (ASSIGNED TIME)           100         DENERAL SERVICE COST CENTERS         13.00         16.00         17.00         21.00         22.00           100         DOTOG CAP REL COSTS-HUBE & FIN TE TIME)         13.00         16.00         17.00         21.00         22.00           100         DOTOG CAP REL COSTS-HUBE & FULP         13.00         16.00         17.00         21.00         22.00           100         DOTOG CAP REL COSTS-HUBE & FULP         10.00									
ADMINISTRATION         PECORDS & LIBRARY         Y & FIN NCES APPRV (CTOTAL PATIENT DAYS)         PREN NCES APPRV (ASSIGNED TIME)         PREN NCES APPRV (ASSIGNED TIME)         PREN NCES APPRV (ASSIGNED TIME)           00100         CAP REL COSTS-HLDG & FIXT DOTOD (CAP REL COSTS-HUBE & CUIP 4.00         13.00         16.00         17.00         21.00         22.00           1.00         00100         CAP REL COSTS-HUBE & CUIP 4.00         00400         PRENCES DAYS)         10.00         10.00         21.00         22.00           0.00         00400         EMPERAL SERVICE COST CENTERS         10.00         0 <td< td=""><td></td><td>Cost Center Description</td><td>NURSI NG</td><td>MEDI CAL</td><td>SOCIAL SERVICE</td><td>SERVI CES-SALAR</td><td>SERVI CES-OTHER</td><td></td></td<>		Cost Center Description	NURSI NG	MEDI CAL	SOCIAL SERVICE	SERVI CES-SALAR	SERVI CES-OTHER		
Intervent         Intervent <t< td=""><td></td><td>···· · · · · · · · · ·</td><td>ADMI NI STRATI ON</td><td>RECORDS &amp;</td><td></td><td></td><td></td><td></td></t<>		···· · · · · · · · · ·	ADMI NI STRATI ON	RECORDS &					
Image: constraint of the server of									
DAYS         REC         TIME)         TIME)           13.00         16.00         17.00         21.00         22.00           0         00100 (AP REL COSTS-BUDG & FIXT         0         0         00100 (AP REL COSTS-WDELE EQUIP         0           4.00         0400 (AP REL COSTS-WDELE EQUIP         0         0         0         0           5.00         00500 (APM RET TS DEPARTNEETT         0         0         0         0           5.00         00500 (ADMINISTRATIVE & GENERAL         0         0         0         0           10.00         01000 (DEFATEN OF PLANT         0         0         0         0           10.00         01000 (DEFATEN OF PLANT         19, 359         0         0         0           10.00         01000 (DEFATEN OF PLANT         19, 359         0         0         0         0           10.00         01000 (DEFATEN OF PLANT         19, 359         0         0         0         0         0         0           10.00         01000 (DEFATEN OF PLANT         19, 359         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0									
CENERAL SERVICE COST CENTERS         13.00         16.00         17.00         21.00         22.00           1.00         OOTOO CAP REL COSTS-BLOG & FLXT					DAYS)				
CENTRAL SERVICE COST CENTERS           1.00         ODIO CAP REL COSTS-BUDG & FINT           2.00         00200 CAP REL COSTS-WULE FOU P           4.00         04000 CAP REL COSTS-WULE FOU P           5.00         00500 ADMI NI STRATIVE & GENERAL           7.00         07000 OPERATI ON 0F PLANT           8.00         00800 LAIMDRY & LINEN SERVICE           9.00         0900 OPERATION 0F PLANT           11.00         01100 CAFETERI A           13.00         01300 NURSING ANNI STRATION           13.00         01300 NURSING ANNI STRATION           13.00         01300 AULS SERVICE S-ALARY & FRINCES APPRY         0           00         00         0           17.00         10700 SOCIAL SERVICE COST CENTERS         19,359           20.00         0000 ADULTS & FRINCES CONTECTENTES         19,359           30.00         000 ADULTS & PEDIATRICS         19,359           40.00         000 ADULTS & PEDIATRICS         19,359           54.01         05400 RADI FRONCH THEAPY         0         255,682         0           54.01         05401 RADI FLOCH THEAPY         0         603,360         0           65.00         06200 COUCHTING FOR HEMOPHILLIACS         0         0         0           66.00									
1.00         00100 CAP REL COSTS -MULE COUP            2.00         00200 CAP REL COSTS -MULE COUP            4.00         00400 EMPLOYEE BENEFITS DEPARTMENT            5.00         0550 ADMIN ISTRATION OF PLANT            8.00         06800 LANDRY & LINEN SERVICE            9.00         00900 HOUSEKEEPING             10.00         01000 IETARY             11.00         01100 CAFETERIA             10.00         01000 MIRSING ADMINISTRATION         19, 359            10.00         01400 MESING ADMINISTRATION         19, 359            10.00         10400 MESING ADMINISTRATION         19, 359            10.00         10400 ADMINISTRATICE COST CENTER S             10.00         10400 ADMINISTRATICE COST CENTERS <t< td=""><td></td><td></td><td>13.00</td><td>16.00</td><td>17.00</td><td>21.00</td><td>22.00</td><td></td></t<>			13.00	16.00	17.00	21.00	22.00		
2.00 00200 CAP. REL COSTSMURLE EQUIP 4.00 00400 EMPLOYEE BERNET TS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT 8.00 00500 LAUNDRY & LINEN SERVICE 9.00 00500 HOUSEKEEPING 1.00 01000 DIETARY 1.00 01100 CAFETERIA 1.00 01100 CAFETERIA 1.00 01100 CAFETERIA 1.00 01100 CAFETERIA 1.00 01100 CAFETERIA 1.00 01100 INER SERVICES SALARY & FRINCES APPRV 0 0 0 0 0 0 0 0 0 1.00 01101 RAS SERVICES-SALARY & FRINCES APPRV 0 0 0 0 0 0 1.00 0100 IRS SERVICES SALARY & FRINCES APPRV 0 0 0 0 0 0 1.00 0100 IRS SERVICES SALARY & FRINCES SAPPRV 0 0 0 0 0 0 1.00 0100 IRS SERVICES SALARY & FRINCES SAPPRV 0 0 0 0 1.00 0100 IRS SERVICE COST CENTERS 0.00 0000 ILS A PEDIATRICE 0.00 0000 ILS A PEDIATRICE 1.00 0100 ILS A PEDIATRICE 0.00 0000 LUCUTI NONOSTIC 0.00 0000 LUCUTI NONOSTIC 0.00 0000 LUCUTI NONOSTIC 0.00 0000 CUCUTI NONOSTIC 0.00 0000 CUCUTI NON FOR HEMOPHI LI ACS 0 0 0 0 0.00 0 0.0	GENE	ERAL SERVICE COST CENTERS							
4.00         00400 EMPLOYEE BENEFITS DEPARTMENT	00 0010	00 CAP REL COSTS-BLDG & FIXT						1.00	
4.00         00400 EMPLOYEE BENEFITS DEPARTMENT	00 0020	OO CAP REL COSTS-MUBLE FOULP						2.00	
5.00         00500         ADMINISTRATIVE & GENERAL.								4.00	
7.00         00700         OPERATION OF PLANT         Image: Construction of the image: Construction of th									
8.00 00500 LANDRY & LINEN SERVICE 9.00 00500 HUSEKEEPINS 10.00 0100 DIETARY 11.00 01100 CAFETERIA 13.00 01300 KURSING ADMINISTRATION 19.359 0 10.00 0100 CAFETERIA 13.00 01300 KURSING ADMINISTRATION 19.359 0 10.00 0100 CAFETERIA 13.00 01300 KURSING ADMINISTRATION 19.359 0 10.00 0100 CAFETERIA 10.00 0500 CALLSTS APPRV 0 0 0 0 10.00 000 CALLSTS APPRV 0 0 0 0 10.00 000 CALLSTS APPRV 0 0 0 0 10.00 000 CALLSTS APPRV 0 0 0 0 0 0 10.00 000 CALLSTS APPRV 0 0 0 0 0 0 0 10.00 000 CARDIALSTS APPRV 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								5.00	
9.00 00900 HOUSEKEEPING 9.00 HOUSEKEEPING 9.00 HOUSEKEEPING 9.00 HIFTARY 9.00 HIFTA								7.00	
9.00 00900 HOUSEKEEPING 9.00 HOUSEKEEPING 9.00 HOUSEKEEPING 9.00 HIERARY 9.00 HIERARY 9.00 HIERARY 9.00 HIERARY 9.00 HIERARY 9.00 1100 CAFETERIA 9.00 HIERARY 9.00 42,433,793 19.00 1700 SOCIAL SERVICE 9.00 19.359 9.00 HIERARY 9.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	00 0080	DO LAUNDRY & LINEN SERVICE						8.00	
10. 00       01000       DI FARY       Image: Construction of the co								9.00	
11.00       01100       CAFETERIA       1         13.00       0100       NURSI NG ADMI NI STRATION       19,359         16.00       01700       Soci AL SERVICE       0       0         17.00       01700       Soci AL SERVICES       0       0       0         17.00       02100       IAR SERVICES-SALARY & FRINCES APPRV       0       0       0       0         17.00       02200       IAR SERVICES-CHER PROM COSTS APPRV       0       0       0       0         10.00       02200       IAR SERVICES-CONTERS TENTERS       19,359       20,701,570       19,359       0         ANCLLARY SERVICE COST CENTERS       19,359       0       0       0       0       0         30.00       06200       LARY SERVICE COST CENTERS       0       0       0       0         40.0       O6400       RADIOLOCY-DI AGNOSTIC       0       20,701,570       19,359       0         60.00       06500       RESPIRATORY THERAPY       0       1,673,840       0       0       0         61.00       06500       RESPIRATORY THERAPY       0       5,3662,390       0       0       0       0       0       0       0       0       0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>10.00</td>								10.00	
13:00       NURSI NG ADMI NI STRATI ON       19:359         16:00       01600       MEDI CAL RECORDS & LI BARY       0       42:433,793         17:00       01700       SOCI AL SERVI CE       0       0       0         01:00       02100       IAS SERVI CES-SALARY & FRI NGES APPRV       0       0       0       0         01:00       02100       IAS SERVI CES-OTHER PROM COSTS APPRV       0       0       0       0         00       0000       0000       0       0       0       0       0         00       0000 RADULTS & SERVI CE COST CENTERS       19:359       20:701.570       19:359       0         ANCI LLARY SERVICE COST CENTERS									
16:00       NEDICAL RECORDS & LIBRARY       0       42,433,793         17:00       01700       SOCIAL SERVICES       0       0         17:00       01700       SOCIAL SERVICES-SALARY & FRINCES APPRV       0       0       0         10:00       02200       IAR SERVICES-OTHER PROM COSTS APPRV       0       0       0       0         10:00       02000       ABSERVICES-COST CENTERS       19,359       20,701.570       19,359       0         ANCILLARY SERVICE COST CENTERS       19,359       20,701.570       19,359       0         ANCILLARY SERVICE COST CENTERS       0       0       0       0       0         54.00       05400       RADILLARY SERVICE COST CENTERS       0       1,673,840       0       0         54.00       05400       RADILARY SERVICE COST CENTERS       0       0       0       0         65.00       06000       RADIRATORY       0       1,673,840       0       0       0         66.00       00       00       0								11.00	
17.00     01700     SCIAL SERVICE     0     0     19,359       21.00     02100     IAR SERVICES-SALARY & FRINGES APPRV     0     0     0       INPATIENT ROUTINE SERVICE S-OTHER PRGM COSTS APPRV       00     00000 ADULTS & PEDIATRICS     19,359     0       ANCILLARY SERVICE COST CENTERS       54.00     05400 RADIOLOGY - SUA     0     0     0       ANCILLARY SERVICE COST CENTERS       54.00     05401 RADIOLOGY - SUA     0     0     0       000       ANCILLARY SERVICE COST CENTERS       54.00     05401 RADIOLOGY - SUA     0     0     0       0     0       ANCILLARY SERVICE COST CENTERS       54.00     05401 RADIOLOGY - SUA     0     0     0       0     0     0     0       0     0     0       0     0     0       0     0     0       0     0     0       0     0     0       0     0     0       0     0     0       0     0     0 <td col<="" td=""><td></td><td></td><td>19, 359</td><td></td><td></td><td></td><td></td><td>13.00</td></td>	<td></td> <td></td> <td>19, 359</td> <td></td> <td></td> <td></td> <td></td> <td>13.00</td>			19, 359					13.00
21.00         02100         LAR SERVI CES-SALARY & FRINCES APPRY         0         0         0           1000         02200         LAR SERVI CES-OTHER PROM COSTS APPRY         0         0         0           1000         LAR SERVI CES-OTHER PROM COSTS APPRY         0         0         0         0           30:00         0001LTS & PEDIATRI CS         19.359         20.701,570         19.359         0           ANCILLARY SERVICE COST CENTERS         0         0         0         0         0         0           400         05400         RADIOLOGY-DI AGNOSTIC         0         255,682         0         0           60.00         LAROY ENEVICE COST CENTERS         0         0         0         0         0           61.01         RADIOLOGY-J SUAL         0         0         0         0         0           62.00         OCOD RESPI RATORY THERAPY         0         63.36         0         0         0           63.00         OBCOD CALLARY THERAPY         0         63.315,444         0         0         0           71.00         OTAGO BRUGELAL SUPPLIES CHARGED TO PATIENT         0         574,643         0         0         0           70.00         DATOTO CALL P	b. 00 0160	DO MEDICAL RECORDS & LIBRARY	0	42, 433, 793	5			16.00	
21.00         02100         LAR SERVI CES-SALARY & FRINCES APPRY         0         0         0           1000         02200         LAR SERVI CES-OTHER PROM COSTS APPRY         0         0         0           1000         LAR SERVI CES-OTHER PROM COSTS APPRY         0         0         0         0           30:00         0001LTS & PEDIATRI CS         19.359         20.701,570         19.359         0           ANCILLARY SERVICE COST CENTERS         0         0         0         0         0         0           400         05400         RADIOLOGY-DI AGNOSTIC         0         255,682         0         0           60.00         LAROY ENEVICE COST CENTERS         0         0         0         0         0           61.01         RADIOLOGY-J SUAL         0         0         0         0         0           62.00         OCOD RESPI RATORY THERAPY         0         63.36         0         0         0           63.00         OBCOD CALLARY THERAPY         0         63.315,444         0         0         0           71.00         OTAGO BRUGELAL SUPPLIES CHARGED TO PATIENT         0         574,643         0         0         0           70.00         DATOTO CALL P			0	ſ				17.00	
22.00         0         0         0         0         0           INPATIENT ROUTINE SERVICE COST CENTERS			0	0	-			21.00	
INPATI ENT ROUTINE SERVICE COST CENTERS         19,359         20,00           300.00         ADULTS & PEDIATRICS         19,359         20,701,570         19,359         0           ANCILLARY SERVICE COST CENTERS         0         255,682         0         0         0         0         0           40.01         OS400 RADI OLOCY-DI ARNOSTIC         0         255,682         0         0         0         0         0           64.00         0.6000         LABORATORY         0         1,673,840         0			0	0					
30.00       03000 ADULTS & PEDIATRICS       19,359       20,701,570       19,359       0         ANCILLARY SERVICE COST CENTERS       0       0       0       0       0         54.00       05400 RADIOLOGY - DI AGNOSTIC       0       0       0       0         60.00       6000 LABORATORY       0       1,673,840       0       0         62.30       06200 RESPI RATORY THERAPY       0       603,360       0       0         66.00       06600 PHYSICAL THERAPY       0       6,315,444       0       0         67.00       0700 DECUPATI ONAL THERAPY       0       5,806,390       0       0         67.00       0600 SPEECH PATHOLOGY       0       1,574,663       0       0         71.00       07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT       0       574,633       0       0         73.00       07300 DRUSC CHARGED TO PATI ENTS       0       0       0       0       0         76.01       03951 SPECI AL PROCEDURES - SUA       0       0       0       0       0       0         76.97       CARDI AC REHABI LI TATI ON       0       0       0       0       0       0       0       0         70       07691			0	0	00		0	22.00	
ANCLLLARY SERVICE COST CENTERS         Image: Control of the con	I NPA	ATIENT ROUTINE SERVICE COST CENTERS							
ANCLLLARY SERVICE COST CENTERS         Image: Control of the con	). 00 0300	00 ADULTS & PEDIATRICS	19, 359	20, 701, 570	19, 359	0	0	30.00	
54.00         05400         RADI OLOGY-JI AGNOSTI C         0         255, 682         0         0           54.01         05401         RADI OLOGY - SUA         0         0         0         0           60.00         06000         LABORATORY         0         1, 673, 840         0         0           62.30         06250         BLOOD CLOTTI NG FOR HEMOPHI LI ACS         0         0         0         0           66.00         06600         PHYSI CAL THERAPY         0         5, 806, 390         0         0           67.00         06700         OCCUPATI ONAL THERAPY         0         5, 806, 390         0         0           68.00         06600         SPECH PATHOLOGY         0         1, 574, 661         0         0           71.00         07100         MEDI CAL SUPPLIES CHARGED TO PATI ENT         0         574, 633         0         0           73.00         07300         RUGS CHARGED TO PATI ENTS         0         0         0         0         0         0           76.00         03020         PSYCH         0         0         0         0         0         0         0         0         0         0         0         0         0 <td></td> <td></td> <td></td> <td>., ., .</td> <td>1 / **</td> <td></td> <td></td> <td></td>				., ., .	1 / **				
54.01       05401 RADI OLOGY - SUA       0			0	255 402		0	0	54.00	
60.00         06000         LABORATORY         0         1, 673, 840         0         0           62.30         06250         BLOOD CLOTTI NG FOR HEMOPHI LI ACS         0         0         0         0           65.00         06500         RESPI RATORY THERAPY         0         633, 360         0         0           66.00         06600         PHYSI CAL THERAPY         0         5, 806, 390         0         0           66.00         067.00         OCCUPATI ONAL THERAPY         0         6, 315, 444         0         0           68.00         06800         SPECECH PATHOLOGY         0         1, 574, 661         0         0           73.00         07300         DRUSS CHARGED TO PATIENT         0         574, 633         0         0         0           73.00         DRUSS CHARGED TO PATIENTS         0         4, 928, 213         0			1	200,002					
62.30         06250         BLOOD CLOTTING FOR HEMOPHILIACS         0         0         0           65.00         06500         RESPIRATORY THERAPY         0         603,360         0         0           66.00         06600         PKS1CAL THERAPY         0         6,315,444         0         0           67.00         06700         0CCUPATIONAL THERAPY         0         6,315,444         0         0           68.00         0FSCIAL SUPPLIES CHARGED TO PATIENT         0         1,574,661         0         0           71.00         07100         MEICAL SUPPLIES CHARGED TO PATIENTS         0         4,928,213         0         0           76.00         03202         PSYCH         0         0         0         0         0           76.01         03951         SPECIAL PROCEDURES         0         0         0         0         0         0           76.02         03950         SPECIAL PROCEDURES         SUA         0         0         0         0         0         0           76.97         CARDIA C REHABILLTATION         0         0         0         0         0         0         0         0         0         0         0         0			0	0	-		0		
65.00       06500       RESPIRATORY THERAPY       0       603,360       0         66.00       06600       PHYSI CAL THERAPY       0       5,806,390       0         67.00       0500       0CCUPATI ONAL THERAPY       0       6,315,444       0       0         68.00       06800       SPEECH PATHOLOGY       0       1,574,661       0       0         71.00       WEDI CAL SUPPLIES CHARGED TO PATIENT       0       574,633       0       0         73.00       70300       PRUSC CHARGED TO PATIENTS       0       4,928,213       0       0         76.01       03951       SPECIAL PROCEDURES       0       0       0       0       0         76.02       03950       SPECIAL PROCEDURES       0       0       0       0       0         76.02       03950       SPECIAL PROCEDURES       0       0       0       0       0         76.97       CARDIA C REHABILITATION       0       0       0       0       0       0         76.97       CARDIA C REHABILITATION       0       0       0       0       0       0       0         76.99       LTAPURATIENT SERVICE COST CENTERS       0       0	). 00  0600	00  LABORATORY	0	1, 673, 840	0	0	0	60.00	
65.00       06500       RESPIRATORY THERAPY       0       603,360       0         66.00       06600       PHYSI CAL THERAPY       0       5,806,390       0         67.00       06700       000000       06700       0       0         68.00       06800       SPEECH PATHOLOGY       0       1,574,661       0         071.00       MEDI CAL SUPPLIES CHARGED TO PATIENT       0       574,633       0         073.00       70300       RUGS CHARGED TO PATIENTS       0       4,928,213       0       0         076.01       03951       SPECIAL PROCEDURES       0       0       0       0         076.02       03950       SPECIAL PROCEDURES - SUA       0       0       0       0         076.07       07697       CARDIAC REHABILITATION       0       0       0       0         076.97       07697       CARDIAC REHABILITATION       0       0       0       0         09       07699       LITHOTRIPSY       0       0       0       0       0         09       09399       PARTIAL HOSPITALISATION PROGRAM       0       0       0       0       0         00       000       0       0	2.30 0625	50 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30	
66.00         06600         PHYSI CAL THERAPY         0         5, 806, 390         0         0           67.00         0CCUPATI ONAL THERAPY         0         6, 315, 444         0         0           68.00         0SEECH PATHOLOGY         0         1, 574, 661         0         0           71.00         07100         MEDI CAL SUPPLIES CHARGED TO PATIENT         0         574, 633         0           73.00         07300         DRUGS CHARGED TO PATIENTS         0         4, 928, 213         0         0           76.00         03202         PSYCH         0         0         0         0         0           76.01         03951         SPECI AL PROCEDURES         0         0         0         0         0         0           76.92         03950         SPECI AL PROCEDURES - SUA         0         0         0         0         0         0           76.97         7677         CARDI AC REHABI LI TATI ON         0 </td <td></td> <td></td> <td>0</td> <td>603 360</td> <td></td> <td>0</td> <td>0</td> <td>65.00</td>			0	603 360		0	0	65.00	
67.00         06700         OCCUPATIONAL THERAPY         0         6, 315, 444         0         0           68.00         06800         SPEECH PATHOLOGY         0         1, 574, 661         0         0           71.00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENT         0         574, 633         0         0           73.00         07300         DRUGS CHARGED TO PATI ENTS         0         4, 928, 213         0         0           76.00         03020         PSYCH         0         0         0         0           76.01         03951         SPECI AL PROCEDURES         0         0         0         0           76.92         03950         SPECI AL PROCEDURES         SUA         0         0         0         0           76.97         CARDI AC REHABI LI TATI ON         0			0			0	0	66.00	
68.00         06800         SPEECH PATHOLOGY         0         1, 574, 661         0         0           71.00         07100         MEDICAL SUPPLIES CHARGED TO PATIENT         0         574, 633         0         0           73.00         07300         DRUGS CHARGED TO PATIENTS         0         4, 928, 213         0         0           76.00         03020         PSYCH         0         0         0         0           76.01         03951         SPECIAL PROCEDURES         0         0         0         0           76.07         CARDI AC REHABILITATION         0         0         0         0         0           76.97         CARDI AC REHABILITATION         0         0         0         0         0           76.99         07699         LITHOTRIPSY         0         0         0         0         0           0         07699         LINDTRIN SERVICE COST CENTERS         0			0			0	-		
71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       0       574,633       0         73.00       07300       DRUGS CHARGED TO PATIENTS       0       4,928,213       0       0         76.00       03020       PSYCH       0       0       0       0       0         76.01       03951       SPECI AL PROCEDURES       0       0       0       0       0         76.02       03950       SPECI AL PROCEDURES - SUA       0       0       0       0       0         76.97       CARDI AC REHABILITATI ON       0       0       0       0       0       0         76.98       07698       HYPERBARI C OXYGEN THERAPY       0 <td< td=""><td></td><td></td><td>0</td><td></td><td></td><td>0</td><td>0</td><td></td></td<>			0			0	0		
73.00       07300       DRUGS CHARGED TO PATIENTS       0       4,928,213       0       0         76.00       03020       PSYCH       0       0       0       0         76.01       03951       SPECI AL PROCEDURES       0       0       0       0         76.02       03950       SPECI AL PROCEDURES - SUA       0       0       0       0         76.92       07697       CARDI AC REHABILITATION       0       0       0       0         76.93       07698       HYPERBARI C 0XYGEN THERAPY       0       0       0       0         76.99       LI THOTRI PSY       0       0       0       0       0         76.99       07699       LI THOTRI PSY       0       0       0       0         77.99       09200       OBSERVATION BEDS (NON-DI STINCT PART       0       0       0       0         713.00       11300       INTEREST EXPENSE       113.00       INTEREST EXPENSE       0       0       0       0         794.01       07950       MARKETING NRCC       0       0       0       0       0         7950       0750       GREST MEALS       0       0       0       0	3.00 0680	00 SPEECH PATHOLOGY	0	1, 574, 661	0	0	0	68.00	
73.00       07300       DRUGS CHARGED TO PATIENTS       0       4,928,213       0       0         76.00       03020       PSYCH       0       0       0       0         76.01       03951       SPECIAL PROCEDURES       0       0       0       0         76.02       03950       SPECIAL PROCEDURES - SUA       0       0       0       0         76.92       07697       CARDIAC REHABILITATION       0       0       0       0         76.93       07698       HYPERBARI C 0XYGEN THERAPY       0       0       0       0         76.94       07699       LITHOTRIPSY       0       0       0       0       0         76.99       07699       LITHOTRIPSY       0       0       0       0       0         77.99       09200       OBSERVATION BEDS (NON-DI STINCT PART       0 <td< td=""><td>. 00 0710</td><td>OO MEDICAL SUPPLIES CHARGED TO PATIENT</td><td>0</td><td>574,633</td><td>0</td><td>0</td><td>0</td><td>71.00</td></td<>	. 00 0710	OO MEDICAL SUPPLIES CHARGED TO PATIENT	0	574,633	0	0	0	71.00	
76.00       03020       PSYCH       0       0       0         76.01       03951       SPECI AL PROCEDURES       0       0       0         76.02       03950       SPECI AL PROCEDURES - SUA       0       0       0         76.02       03950       SPECI AL PROCEDURES - SUA       0       0       0         76.97       CARDI AC REHABILI TATI ON       0       0       0       0         76.98       07698       HYPERBARI C OXYGEN THERAPY       0       0       0       0         76.99       LI THOTRI PSY       0       0       0       0       0         010000       085ERVATI ON BEDS (NON-DI STI NCT PART       0       0       0       0         92.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART       0       0       0       0         93.99       09399       PARTI AL HOSPI TALI ZATI ON PROGRAM       0       0       0       0         93.99       09309       PARTI AL HOSPI TALI ZATI ON PROGRAM       0       0       0       0         113.00       INTEREST EXPENSE       113.00       INTEREST EXPENSE       0       0       0         194.00       07950       MARKETI NG NRCC       <			0			0	0	73.00	
76. 01       03951       SPECIAL PROCEDURES       0       0       0         76. 02       03950       SPECIAL PROCEDURES - SUA       0       0       0         76. 97       OARDIAC REHABILITATION       0       0       0       0         76. 97       OARDIAC REHABILITATION       0       0       0       0         76. 98       MARKETIND       0       0       0       0       0         76. 99       OF699       LITHOTRIPSY       0       0       0       0       0         01000       OUTPATIENT SERVICE COST CENTERS       0       0       0       0       0       0         90       09200       OBSERVATION BEDS (NON-DI STINCT PART       0			0	1, 720, 210		0	0		
76. 02       03950       SPECIAL PROCEDURES - SUA       0       0       0         76. 97       O7697       CARDIAC REHABILITATION       0       0       0         76. 98       O7698       HYPERBARIC OXYGEN THERAPY       0       0       0       0         76. 99       D7699       LITHOTRIPSY       0       0       0       0       0         76. 99       DITPATI ENT SERVICE COST CENTERS       0       0       0       0       0         92. 00       O9200       OBSERVATION BEDS (NON-DISTINCT PART       0       0       0       0         93. 99       PARTIAL HOSPITALIZATION PROGRAM       0       0       0       0       0         913.00       INTEREST EXPENSE       5<			0	0	0	0			
76. 97       07697       CARDI AC REHABI LI TATI ON       0       0       0         76. 98       07698       HYPERBARI C 0XYGEN THERAPY       0       0       0       0         76. 98       07699       LI THOTRI PSY       0       0       0       0       0         76. 99       07699       LI THOTRI PSY       0       0       0       0       0         0UTPATI ENT SERVICE COST CENTERS       0       0       0       0       0       0         92. 00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART       0       0       0       0         93. 99       09399       PARTI AL HOSPI TALI ZATI ON PROGRAM       0       0       0       0       0         91.300       INTEREST EXPENSE       113.00       INTEREST EXPENSE       0       0       0       0         113.00       SUBTOTALS (SUM OF LINES 1 through 117)       19, 359       42, 433, 793       19, 359       0       0         NONREI MBURSABLE COST CENTERS       11100       0       0       0       0       0       0         194. 00       07950       MARKETI NG NRCC       0       0       0       0       0       0       0       0			0	U	0	0	0		
76.98       07698       HYPERBARI C 0XYGEN THERAPY       0       0       0       0         76.98       07699       LI THOTRI PSY       0       0       0       0         0UTPATI ENT SERVICE COST CENTERS       0       0       0       0       0         92.00       09209       DBSERVATI ON BEDS (NON-DI STI NCT PART       0       0       0       0         93.99       PARTI AL HOSPI TALI ZATI ON PROGRAM       0       0       0       0       0         91.300       INTEREST EXPOSE COST CENTERS	). 02  0395	50 SPECIAL PROCEDURES - SUA	0	0	0	0	0	76.02	
76. 98       07698       HYPERBARI C 0XYGEN THERAPY       0       0       0       0         76. 98       07699       LI THOTRI PSY       0       0       0       0         0UTPATI ENT SERVICE COST CENTERS       0       0       0       0       0         92. 00       09200       0BSERVATI ON BEDS (NON-DI STI NCT PART       0       0       0       0         93. 99       PARTI AL HOSPI TALI ZATI ON PROGRAM       0       0       0       0       0         93. 99       PARTI AL HOSPI TALI ZATI ON PROGRAM       0       0       0       0       0         93. 99       PARTI AL HOSPI TALI ZATI ON PROGRAM       0       0       0       0       0         91.100       INTEREST EXPENSE       113.00       INTEREST EXPENSE       0       0       0       0         118. 00       SUBTOTALS (SUM OF LINES 1 through 117)       19, 359       42, 433, 793       19, 359       0         194. 00       07950       MARKETI NG NRCC       0       0       0       0         194. 00       07951       GUEST MEALS       0       0       0       0         200. 00       Cross Foot Adj ustments       2       2       0       0<	b. 97 0769	97 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76.97	
76.99         07699         LI THOTRI PSY         0         0         0           OUTPATI ENT SERVICE COST CENTERS			0	0	0	0	0	76.98	
OUTPATIENT SERVICE COST CENTERS92.00092000BSERVATION BEDS (NON-DISTINCT PART 093.9993.9909399PARTIAL HOSPITALIZATION PROGRAM SPECIAL PURPOSE COST CENTERS0113.00INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)19, 35942, 433, 793118.00SUBTOTALS (SUM OF LINES 1 through 117)19, 35942, 433, 793194.0007950MARKETING NRCC00007950MARKETING NRCC00194.0107951GUEST MEALS00200.00Cross Foot Adjustments 201.00000202.00Cost to be allocated (per Wkst. B, Part I)988, 176111, 634688, 110			0	0			0		
92.00       09200       0BSERVATI ON BEDS (NON-DI STINCT PART 09399       0       0       0       0       0         93.99       09399       PARTI AL HOSPI TALI ZATI ON PROGRAM SPECI AL PURPOSE COST CENTERS       0       0       0       0         113.00       INTEREST EXPENSE       5       5       5       5       5       5         118.00       SUBTOTALS (SUM OF LINES 1 through 117)       19, 359       42, 433, 793       19, 359       0         NONREI MBURSABLE COST CENTERS         194.00       07950       MARKETING NRCC       0       0       0       0         194.01       07951       GUEST MEALS       0       0       0       0       0         200.00       Cross Foot Adj ustments       0       0       0       0       0       0         201.00       Negative Cost Centers       988, 176       111, 634       688, 110       0       0         202.00       Cost to be al located (per Wkst. B, Part I)       988, 176       111, 634       688, 110       0			0	0	ν <u>ι</u> υ	U	0	70.99	
93.99         09399         PARTIAL HOSPITALIZATION PROGRAM         0         0         0           SPECIAL PURPOSE COST CENTERS           113.00         INTEREST EXPENSE         5UBTOTALS (SUM OF LINES 1 through 117)         19,359         42,433,793         19,359         0           NONREI MBURSABLE COST CENTERS           194.00         07950         MARKETING NRCC         0         0         0         0           194.00         07950         GUEST MEALS         0 <t< td=""><td></td><td></td><td></td><td></td><td>1</td><td>i</td><td></td><td></td></t<>					1	i			
SPECIAL PURPOSE COST CENTERS           113.00         INTEREST EXPENSE           113.00         INTEREST EXPENSE           118.00         SUBTOTALS (SUM OF LINES 1 through 117)         19,359         42,433,793           194.00         O7950         MARKETING NRCC         0         0           194.00         O7950         GUEST MEALS         0         0         0           200.00         Cross Foot Adjustments         0         0         0         0           201.00         Negative Cost Centers         0         0         0         0           202.00         Cost to be allocated (per Wkst. B, 988, 176         111, 634         688, 110         0								92.00	
113.00       11300       INTEREST EXPENSE       SUBTOTALS (SUM OF LINES 1 through 117)       19,359       42,433,793       19,359       0         NONREL MBURSABLE COST CENTERS         194.00       07950       MARKETI NG NRCC       0       0       0         194.00       07950       MARKETI NG NRCC       0       0       0       0         194.01       07951       GUEST MEALS       0       0       0       0         200.00       Cross Foot Adjustments       0       0       0       0         201.00       Negative Cost Centers       0       111, 634       688, 110       0         202.00       Cost to be allocated (per Wkst. B, P88, 176       111, 634       688, 110       0	. 99 0939	99 PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99	
113.00       11300       INTEREST EXPENSE         118.00       SUBTOTALS (SUM OF LINES 1 through 117)       19,359       42,433,793       19,359       0         NONREL MBURSABLE COST CENTERS         194.00       07950       MARKETING NRCC       0       0       0         194.00       07950       MARKETING NRCC       0       0       0       0         194.01       07951       GUEST MEALS       0       0       0       0         200.00       Cross Foot Adjustments       0       0       0       0         201.00       Negative Cost Centers       202.00       Cost to be allocated (per Wkst. B, 988, 176       111, 634       688, 110       0         Part I)       0       0       0       0       0       0	SPEC	CLAL PURPOSE COST CENTERS							
118.00         SUBTOTALS (SUM OF LINES 1 through 117)         19,359         42,433,793         19,359         0           NONREL MBURSABLE COST CENTERS           194.00         07950         MARKETING NRCC         0								113.00	
NONREI MBURSABLE COST CENTERS           194.00         07950         MARKETI NG NRCC         0         0         0           194.01         07951         GUEST MEALS         0         0         0         0           200.00         Cross Foot Adjustments         0         0         0         0         0           201.00         Negative Cost Centers         202.00         Cost to be allocated (per Wkst. B, P88, 176         111, 634         688, 110         0			10 250	רחד ככו כו	10.350		^		
194.00       07950       MARKETING NRCC       0       0       0         194.01       07951       GUEST MEALS       0       0       0         200.00       Cross Foot Adjustments       0       0       0       0         201.00       Negative Cost Centers       988,176       111,634       688,110       0         202.00       Cost to be allocated (per Wkst. B, Part I)       988,176       111,634       688,110       0			19, 359	42, 433, 793	19, 359	0	0	118.00	
194. 01       07951       GUEST MEALS       0       0       0         200. 00       Cross Foot Adjustments       0       0       0         201. 00       Negative Cost Centers       111, 634       688, 110       0         202. 00       Cost to be allocated (per Wkst. B, Part I)       988, 176       111, 634       688, 110       0								-	
194. 01       07951       GUEST MEALS       0       0       0         200. 00       Cross Foot Adjustments	4.000795	50 MARKETING NRCC	0	0	0 0	0	0	194.00	
200.00Cross Foot Adjustments201.00Negative Cost Centers202.00Cost to be allocated (per Wkst. B, Part I)			0	0	0			194.01	
201. 00         Negative Cost Centers           202. 00         Cost to be allocated (per Wkst. B, Part I)							0	200.00	
202.00 Cost to be allocated (per Wkst. B, 988, 176 111, 634 688, 110 0 Part I) 0								200.00	
Part I)			000 1-			_	-		
	2.00		988, 176	111, 634	688, 110	0	0	202.00	
		Part I)							
203.00 Unit cost multiplier (Wkst. B, Part I) 51.044785 0.002631 35.544708 0.00000 0.0000	3.00	Unit cost multiplier (Wkst. B, Part I)	51.044785	0. 002631	35. 544708	0.000000	0.000000	203.00	
204.00 Cost to be allocated (per Wkst. B, 15, 421 9, 157 43, 415 0			1					204.00	
Part II)			13,421	7, 107	+3, +13	0	0	207.00	
			0 70/500	0.000077	0.040/07	0 000000	0.000000	005 00	
	5.00		U. 796580	0. 000216	2. 242626	0.000000	0.00000	205.00	
		11)							
206.00 NAHE adjustment amount to be allocated	6.00							206.00	
(per Wkst. B-2)	[								
207.00 NAHE unit cost multiplier (Wkst. D,	17 00							207.00	
								207.00	
Parts III and IV)		(Parts III and IV)	1		I			I	

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2022 To 07/31/2022	Date/Time Pre 11/22/2022 12	pared: :05 pm
		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)	0.00			5.00	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1	1				
30. 00 03000 ADULTS & PEDI ATRI CS	12, 780, 315		12, 780, 31	5 3, 496	12, 783, 811	30.00
ANCI LLARY SERVI CE COST CENTERS				-		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	114, 526		114, 52		114, 526	
54. 01 05401 RADI OLOGY - SUA	27, 992		27, 99		27, 992	
60. 00 06000 LABORATORY	578, 484		578, 48	4 0	578, 484	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0			0 0	0	
65. 00 06500 RESPI RATORY THERAPY	439, 512				439, 512	1
66. 00 06600 PHYSI CAL THERAPY	1, 686, 354		1, 686, 35		1, 686, 354	
67.00 06700 OCCUPATI ONAL THERAPY	1, 826, 363		1, 826, 36		1, 826, 363	
68.00 06800 SPEECH PATHOLOGY	580, 024		580, 02		580, 024	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	324, 204		324, 20		324, 204	
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 116, 258		1, 116, 25	8 0	1, 116, 258	
76. 00 03020 PSYCH	0			0 0	0	
76. 01 03951 SPECIAL PROCEDURES	0			0 0	0	
76. 02 03950 SPECIAL PROCEDURES - SUA	60, 793		60, 79	3 0	60, 793	
76. 97 07697 CARDI AC REHABI LI TATI ON	0			0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0			0 0	0	76. 98
76. 99 07699 LI THOTRI PSY	0			0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	0			0 0	0	93.99
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	19, 534, 825	0	19, 534, 82	5 3, 496	19, 538, 321	200.00
201.00 Less Observation Beds	0			0		201.00
202.00 Total (see instructions)	19, 534, 825	0	19, 534, 82	5 3, 496	19, 538, 321	202.00

Health Financial Systems ENCON	MPASS HEALTH DEA	ACONESS REHABI	LII	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Peri od:	Worksheet C	
				From 01/01/2022		
				To 07/31/2022		
			e XVIII	Hospi tal	11/22/2022 12 PPS	:05 pili
· · · · · · · · · · · · · · · · · · ·		Charges			PP3	
Cost Center Description	Inpatient	Outpatient	Total (col	6 Cost or Other	TEFRA	
cost center bescription	Thpatrent	outpatrent	+ col. 7	Ratio	Inpatient	
			+ cor. 7)	Ratio	Ratio	
	6.00	7.00	8,00	9,00	10.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0.00	7.00	0.00	7.00	10.00	
30. 00 03000 ADULTS & PEDIATRICS	20, 701, 570		20, 701, 57	0		30,00
ANCI LLARY SERVICE COST CENTERS	20,701,070		20,701,07	0	L	00.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	254, 968	714	255, 68	2 0. 447924	0,000000	54.00
54. 01 05401 RADI OLOGY - SUA	134, 839	0	134, 83			
60. 00 06000 LABORATORY	1, 673, 840	0	1, 673, 84			
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	1,075,040	0	1,073,04	0 0.000000		
65. 00 06500 RESPI RATORY THERAPY	603, 360	0	603, 36		0.000000	•
66. 00 06600 PHYSI CAL THERAPY	5, 806, 390	0	5, 806, 39		0.000000	
67. 00 06700 OCCUPATI ONAL THERAPY	6, 315, 444	0	6, 315, 44			
68. 00 06800 SPEECH PATHOLOGY	1, 574, 661	0	1, 574, 66		0.000000	•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	574, 633	0	574, 63		0. 000000	•
73. 00 07300 DRUGS CHARGED TO PATIENTS	4, 928, 213	0	4, 928, 21		0.000000	
76. 00 03020 PSYCH	1, 720, 210	0	1, 720, 21	0 0.000000	0. 000000	
76. 01 03951 SPECIAL PROCEDURES	0	0		0 0.000000		
76. 02 03950 SPECIAL PROCEDURES - SUA	176, 437	0	176, 43			
76. 97 07697 CARDI AC REHABI LI TATI ON	170, 437	0	170,40	0.000000		
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0.000000		
76. 99 07699 LI THOTRI PSY	0	0		0 0.000000		
OUTPATIENT SERVICE COST CENTERS	0	0	1	0.00000	0.000000	/0. //
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 0.00000	0,000000	92.00
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	0	0		0 0.000000		
SPECIAL PURPOSE COST CENTERS			1	0.00000	0.000000	/0. //
113.0011300 I NTEREST EXPENSE						1113.00
200.00 Subtotal (see instructions)	42, 744, 355	714	42, 745, 06	9		200.00
201.00 Less Observation Beds	.2, / 11, 000	/ ! !	.2, , 10, 00		1	201.00
202.00 Total (see instructions)	42, 744, 355	714	42, 745, 06	9	1	202.00
	.2, , 000	/ ! !	1 .2,3, 00	-1	1. 	

	OWINSS HEALTH DEAC	UNESS REHADIELL	III LIEU	1 01 1 01 III CM3=2332	1-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-3025	Period: From 01/01/2022 To 07/31/2022	Worksheet C Part I Date/Time Prepare 11/22/2022 12:05	
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient		· · · ·		
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS				30	0. 00
ANCILLARY SERVICE COST CENTERS					
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 447924				. 00
54. 01 05401 RADI OLOGY - SUA	0. 207596				. 01
60. 00 06000 LABORATORY	0. 345603			60.	0. 00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000				2. 30
65. 00 06500 RESPI RATORY THERAPY	0. 728441			65	6. 00
66. 00 06600 PHYSI CAL THERAPY	0. 290431			66	. 00
67.00 06700 OCCUPATI ONAL THERAPY	0. 289190			67	. 00
68.00 06800 SPEECH PATHOLOGY	0. 368348			68	8.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 564193			71	. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 226504			73	8.00
76.00 03020 PSYCH	0. 000000			76	. 00
76. 01 03951 SPECIAL PROCEDURES	0. 000000			76	o. 01
76. 02 03950 SPECI AL PROCEDURES - SUA	0. 344559			76	. 02
76. 97 07697 CARDIAC REHABILITATION	0. 000000			76	. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000			76	. 98
76. 99 07699 LI THOTRI PSY	0. 000000			76	. 99
OUTPATIENT SERVICE COST CENTERS					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92	2. 00
93.99 09399 PARTIAL HOSPITALIZATION PROGRAM	0. 000000			93	8. 99
SPECIAL PURPOSE COST CENTERS					
113.00 11300 INTEREST EXPENSE				113	8.00
200.00 Subtotal (see instructions)				200	0. 00
201.00 Less Observation Beds				201	. 00
202.00 Total (see instructions)				202	. 00
				•	

Hearth Financial Systems Encom	MPASS HEALTH DE	ACONESS REHABI		In Lie	U OI FOIM CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Peri od:	Worksheet C	
				From 01/01/2022		
				To 07/31/2022		
		T: +1	e XIX	Hospi tal	11/22/2022 12 Cost	:05 pm
· · · · · · · · · · · · · · · · · · ·		111		Costs	LOSI	
Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
cost center bescription	(from Wkst. B,	Adj.	TOTAL COSTS	Di sal l owance	TUTAL COSTS	
	Part I, col.	Auj .		DISALLOWALICE		
	26)					
	1.00	2.00	3.00	4.00	5.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1.00	2.00	5.00	4.00	5.00	
30. 00 03000 ADULTS & PEDIATRICS	12, 780, 315		12, 780, 31	5 3, 496	12, 783, 811	30.00
ANCI LLARY SERVICE COST CENTERS	12,700,313		12,700,31	3 3,470	12,703,011	30.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	114, 526		114, 52	6 0	114, 526	54.00
54. 01 05401 RADI OLOGY - SUA	27, 992		27, 99		27, 992	
60. 00 06000 LABORATORY	578, 484		578, 48		578, 484	60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0,0,101		0,0,10	0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	439, 512	0	439, 51	2 0	439, 512	
66. 00 06600 PHYSI CAL THERAPY	1, 686, 354	0	1, 686, 35		1, 686, 354	
67. 00 06700 OCCUPATI ONAL THERAPY	1, 826, 363	0	1, 826, 36		1, 826, 363	
68. 00 06800 SPEECH PATHOLOGY	580, 024	0	580, 02		580, 024	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	324, 204	0	324, 20		324, 204	
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 116, 258		1, 116, 25		1, 116, 258	
76. 00 03020 PSYCH	0		1, 110/20	0 0	0	76.00
76. 01 03951 SPECIAL PROCEDURES	0			0 0	0	76.01
76. 02 03950 SPECIAL PROCEDURES - SUA	60, 793		60, 79	3 0	60, 793	
76. 97 07697 CARDI AC REHABI LI TATI ON	00,170		00,77	0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0			0 0	0	76.98
76. 99 07699 LI THOTRI PSY	0			0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS	-			-		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	0			0 0	0	93.99
SPECIAL PURPOSE COST CENTERS				<u> </u>		
113.00 11300 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	19, 534, 825	0	19, 534, 82	3, 496	19, 538, 321	200.00
201.00 Less Observation Beds	0			0		201.00
202.00 Total (see instructions)	19, 534, 825	0	19, 534, 82	3, 496		
				1 2 2 2 2		

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CC		Period: From 01/01/2022 To 07/31/2022	Worksheet C Part I Date/Time Pre 11/22/2022 12	
		Ti tl	e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpatient	Outpati ent		6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpati ent	
					Rati o	
	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	20, 701, 570		20, 701, 57	0		30.00
ANCI LLARY SERVI CE COST CENTERS						
54.00 05400 RADI OLOGY-DI AGNOSTI C	254, 968	714	255, 68		0.00000	
54. 01 05401 RADI OLOGY - SUA	134, 839	0	134, 83		0.00000	
60. 00 06000 LABORATORY	1, 673, 840	0	1, 673, 84		0. 000000	
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0.000000	0.00000	
65. 00 06500 RESPI RATORY THERAPY	603, 360	0	603, 36		0.00000	
66. 00 06600 PHYSI CAL THERAPY	5, 806, 390	0	5, 806, 39		0.00000	
67.00 06700 OCCUPATI ONAL THERAPY	6, 315, 444	0	6, 315, 44		0.00000	
68.00 06800 SPEECH PATHOLOGY	1, 574, 661	0	1, 574, 66		0. 000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	574, 633	0	574, 63		0. 000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 928, 213	0	4, 928, 21		0.00000	
76.00 03020 PSYCH	0	0		0 0.000000	0.00000	
76. 01 03951 SPECIAL PROCEDURES	0	0		0 0.000000	0.00000	•
76. 02 03950 SPECIAL PROCEDURES - SUA	176, 437	0	176, 43		0.00000	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0.000000	0.00000	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0.000000	0.00000	
76. 99 07699 LI THOTRI PSY	0	0		0 0.00000	0. 000000	76.99
OUTPATIENT SERVICE COST CENTERS						
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 0.000000	0.00000	
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	0	0		0 0. 000000	0.00000	93.99
SPECIAL PURPOSE COST CENTERS						
113.00 11300 I NTEREST EXPENSE			10 715			113.00
200.00 Subtotal (see instructions)	42, 744, 355	714	42, 745, 06	9		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	42, 744, 355	714	42, 745, 06	9		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-3025	Peri od: From 01/01/2022 To 07/31/2022	Worksheet C Part I Date/Time Pr 11/22/2022 1	
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
ANCI LLARY SERVI CE COST CENTERS					
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
54. 01 05401 RADI OLOGY - SUA	0. 000000				54.01
60. 00 06000 LABORATORY	0. 000000				60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000				62.30
65. 00 06500 RESPI RATORY THERAPY	0. 000000				65.00
66.00 06600 PHYSI CAL THERAPY	0. 000000				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000				68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000				71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
76.00 03020 PSYCH	0. 000000				76.00
76. 01 03951 SPECIAL PROCEDURES	0. 000000				76.01
76. 02 03950 SPECIAL PROCEDURES - SUA	0.000000				76. 02
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000				76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0.000000				76. 98
76. 99 07699 LI THOTRI PSY	0. 000000				76.99
OUTPATIENT SERVICE COST CENTERS	1 1				
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000				92.00
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	0. 000000				93.99
SPECIAL PURPOSE COST CENTERS	1 1				
113.00 11300 INTEREST EXPENSE					113.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00  Total (see instructions)					202.00

Health Financial Systems	ENCOMPASS HEALTH DE	ACONESS REHABI	LIT	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAP	ITAL COSTS	Provider C		Period: From 01/01/2022 To 07/31/2022		pared: :05 pm
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col.	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col	Days	Per Diem (col. 3 / col. 4)	
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 619, 149	0	1, 619, 14	9 19, 359	83.64	30.00
200.00 Total (lines 30 through 199)	1, 619, 149		1, 619, 14	9 19, 359		200.00
Cost Center Description		Inpatient Program Capital Cost (col. 5 x col. 6)				
	6.00	7.00			-	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS 200.00 Total (lines 30 through 199)	9, 459 9, 459					30. 00 200. 00

Health Financial Systems ENC	OMPASS HEALTH DE	ACONESS REHABI	LIT	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPI	TAL COSTS	Provider C		Period: From 01/01/2022 To 07/31/2022		
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cost	Inpati ent	Capital Costs	
	Related Cost	(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
54. 00 05400 RADI OLOGY-DI AGNOSTI C	518	255, 682	0. 00202	6 147, 994	300	54.00
54. 01 05401 RADI OLOGY - SUA	0	134, 839	0.00000	0 78, 051	0	54.01
60. 00 06000 LABORATORY	30, 862	1, 673, 840	0. 01843	8 955, 685	17, 621	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.00000	0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	10, 517	603, 360	0.01743	1 324, 806	5, 662	65.00
66. 00 06600 PHYSI CAL THERAPY	174,004	5, 806, 390	0. 02996	8 2, 865, 560	85, 875	66.00
67.00 06700 OCCUPATIONAL THERAPY	94, 317	6, 315, 444	0. 01493	4 3, 151, 472	47, 064	67.00
68.00 06800 SPEECH PATHOLOGY	27, 731	1, 574, 661	0. 01761	1 712, 927	12, 555	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	29, 021	574, 633	0. 05050	4 318, 876	16, 105	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	23, 934	4, 928, 213	0. 00485	7 2, 427, 811	11, 792	73.00
76.00 03020 PSYCH	0	0	0.00000	0 0	0	76.00
76. 01 03951 SPECIAL PROCEDURES	0	0	0.00000	0 0	0	76.01
76.02 03950 SPECIAL PROCEDURES - SUA	0	176, 437	0.00000	0 23, 016	0	76.02
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0.00000	0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0.00000	0 0	0	76.98
76. 99 07699 LI THOTRI PSY	0	0	0.00000	0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS						1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.00000	0 0	0	92.00
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	0	0	0.00000	0 0	0	93.99
200.00 Total (lines 50 through 199)	390, 904	22, 043, 499		11, 006, 198	196, 974	200.00
		•				•

Health Financial Systems ENCO	MPASS HEALTH DE	EACON	NESS REHABI	LIT	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS	Provider CC		Period: From 01/01/2022 To 07/31/2022	Date/Time Pre 11/22/2022 12	
			Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursing Program Post-Stepdown Adjustments	F	Nursi ng Program	Allied Healt Post-Stepdow Adjustments		All Other Medical Education Cost	
	1A		1.00	2A	2,00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		-		2.1.	2.00	0.00	
30.00 03000 ADULTS & PEDIATRICS 200.00 Total (lines 30 through 199)	0		0 0		0 0		30.00
Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	(sur 1 t	tal Costs m of cols. through 3, us col. 4)	Total Patien Days	t Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4.00		5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 03000 ADULTS & PEDIATRICS 200. 00 Total (lines 30 through 199)	0	D	0 0	19, 35 19, 35			30.00 200.00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x <u>col. 8)</u> 9.00	(					
INPATIENT ROUTINE SERVICE COST CENTERS		_					
30.00 03000 ADULTS & PEDLATRICS 200.00 Total (Lines 30 through 199)	0						30. 00 200. 00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCIELLARY SERVICE OTHER PASS THROUGH COSTS         Provider CCN: 15-3025         Period: From 01/01/2022 To 07/31/2022         Porched Dart IV Dart IV Dart IV 2022 12: 05 pm 11/22/2022 12: 05 pm Program Pr	Health Financial Systems ENCO	MPASS HEALTH DE	ACONESS REHABI	LIT	In Lieu of Form CMS-2552-10			
Interview         To         07/31/2022         Date/Time Prepared: 1/22/2022           Cost Center Description         Non Physician Anesthetist Cost         Nursing Program Post-Stepdown Adjustments         Nursing Program         Allied Health Post-Stepdown Adjustments         Allied Health Post-Stepdown Adjustments         Allied Health Post-Stepdown Adjustments           54.00         05400 RADI OLOGY-DI AGNOSTI C         0         0         0         0         54.00           54.00         05400 RADI OLOGY -DI AGNOSTI C         0         0         0         0         0         0         54.00           54.00         05400 RADI OLOGY -DI AGNOSTI C         0 <td< td=""><td></td><td>RVICE OTHER PASS</td><td>6 Provider C</td><td>CN: 15-3025</td><td></td><td></td><td></td></td<>		RVICE OTHER PASS	6 Provider C	CN: 15-3025				
Anci LLARY SERVICE COST CENTERS         Non Physician Acjustments         Nursing Program Acjustments         Nursing Program Acjustments         Al lied Health Acjustments         Al lied Health Acjustments           4.00         05400 RADIOLOGY - DIAGNOSTIC         0         0         0         0         0         54.00           54.00         05400 RADIOLOGY - SUA         0         0         0         0         0         54.00           65.00         06500 RESPIRATORY         0         0         0         0         0         54.00           66.00         06600 LABORATORY         0         0         0         0         0         66.00           65.00         06500 RESPIRATORY THERAPY         0         0         0         0         66.00           66.00         06600 SPECH PATHORY THERAPY         0         0         0         66.00         66.00         66.00         66.00         66.00         66.00         67.00         66.00         67.00         66.00         67.00         66.00         67.00         66.00         66.00         66.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         66.00	THROUGH COSTS						nared	
Title XVIII         Hospital         PPS           Cost Center Description         Nursing Program         Nursing Program         All Lied Heal th All Lied Heal th Post-Stepdown Adjustments           ANCILLARY SERVICE COST CENTERS         Nursing Post-Stepdown Adjustments         All Lied Heal th Post-Stepdown Adjustments         All Lied Heal th Post-Stepdown Adjustments           ANCILLARY SERVICE COST CENTERS           4.00         05400         RADI 0L0GY-DI AGNOSTIC         0         0         0         0         54.00           54.00         05400         RADI 0L0GY-DI AGNOSTIC         0         0         0         0         0         54.00           62.30         06500         LABORATORY         0         0         0         0         0         0         0         65.00           65.00         06500         LABORATORY         0					10 0773172022	11/22/2022 12	:05 pm	
Anesthetist Cost         Program Post-Stepdown Adjustments         Program Adjustments         Program Adjustments           1.00         2A         2.00         3A         3.00           54.00         05400         RADI OLOGY - DI AGNOSTI C         0         0         0         0         54.00           54.00         05400         RADI OLOGY - DI AGNOSTI C         0         0         0         0         0         0         54.00           54.01         05401         RADI OLOGY - SUA         0			Title	XVIII		PPS		
Cost         Post-Stepdown Adjustments         Adjustments         Adjustments           ANCILLARY SERVICE COST CENTERS         1.00         2A         2.00         3A         3.00           54.00         05400         RADIOLOGY-DIAGNOSTIC         0         0         0         0         54.00           60.00         06000         LABORATORY         0         0         0         0         54.01           60.00         06000         LABORATORY         0         0         0         0         60.00           62.30         06250         BLODD CLOTTING FOR HEMOPHILLIACS         0         0         0         0         62.30           65.00         06500         RESPIRATORY THERAPY         0         0         0         0         66.00           66.00         06000         PHATORY THERAPY         0         0         0         66.00         67.00         68.00         0         0         0         67.00         68.00         0         0         0         0         0         0         0         0         71.00           71.00         07100         MEDICAL SUPPLIES CHARGED TO PATIENT         0         0         0         0         0         0	Cost Center Description		Nursi ng			Allied Health		
Adjustments         Adjustments         Adjustments           1.00         2A         2.00         3A         3.00           54.00         05400         RADI OLOGY - DI AGNOSTI C         0         0         0         0         54.00           54.01         05401         RADI OLOGY - DI AGNOSTI C         0         0         0         0         0         0           60.00         LABORATORY         0				Program				
1.00         2A         2.00         3A         3.00           ANCI LLARY SERVICE COST CENTERS         0         0         0         0         54.00         05400 [ABDI 0LOGY-DI AGNOSTI C         0         0         0         0         0         0         54.00         0		Cost			Adjustments			
ANCI LLARY SERVICE COST CENTERS           54. 00         05400         RADI OLOGY-DI AGNOSTI C         0         0         0         54. 01           54. 01         05401         RADI OLOGY - DI AGNOSTI C         0         0         0         0         54. 01           54. 01         05401         RADI OLOGY - SUA         0         0         0         0         54. 01           60. 00         06000 LABORATORY         0		1.00						
54.00       05400       RADI OLOGY - DI AGNOSTI C       0		1.00	2A	2.00	3A	3.00		
54.01       05401       RADIOLOGY - SUA       0 <td></td> <td></td> <td>0</td> <td>1</td> <td>0</td> <td>0</td> <td>F 4 00</td>			0	1	0	0	F 4 00	
60.00       06000       LABORATORY       0		0	0		0 0	-		
62.30       06250       BLOOD CLOTTING FOR HEMOPHILIACS       0       0       0       0       62.30         65.00       06500       RESPI RATORY THERAPY       0       0       0       0       65.00         66.00       06600       PHYSI CAL THERAPY       0       0       0       0       66.00         67.00       06700       0CUPATI ONAL THERAPY       0       0       0       0       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       0       0       68.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0       0       0       0       71.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       0       0       73.00         76.01       03951       SPECI AL PROCEDURES       0       0       0       0       76.00         76.02       03950       SPECI AL PROCEDURES       SUA       0       0       0       76.01         76.97       07697       CARDI AC REHABI LI TATI ON       0       0       0       0       76.97         76.98       07698       HYPERBARI C OXYGEN THERAPY       0       0       0 <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>u u u u u u u u u u u u u u u u u u u</td> <td></td>		0	0		0 0	u u u u u u u u u u u u u u u u u u u		
65.00       06500       RESPIRATORY THERAPY       0       0       0       0       0       65.00         66.00       06600       PHYSI CAL THERAPY       0       0       0       0       0       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0       0       0       0       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       0       0       68.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0       0       0       0       71.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       0       0       73.00         76.00       03020       PSYCH       0       0       0       0       0       73.00         76.01       03951       SPECI AL PROCEDURES       SUA       0       0       0       0       76.01         76.92       07697       CARDI AC REHABI LI TATI ON       0       0       0       0       76.97         76.98       07698       HYPERBARI C OXYGEN THERAPY       0       0       0       0       0       76.98         76.99       07698       HYPERBARI C OX		0	0		0 0	-		
66.00       06600       PHYSI CAL THERAPY       0       0       0       0       0       66.00         67.00       06700       OCCUPATI ONAL THERAPY       0       0       0       0       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       0       0       0       68.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0       0       0       0       71.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       0       0       73.00         76.00       03020       PSYCH       0       0       0       0       73.00         76.01       03951       SPECI AL PROCEDURES       0       0       0       0       76.00         76.02       03950       SPECI AL PROCEDURES       SUA       0       0       0       0       76.02         76.97       07697       CARDI AC REHABI LI TATI ON       0       0       0       0       76.97         76.98       07698       HYPERBARI C OXYGEN THERAPY       0       0       0       0       0       76.98         76.99       07699 LI THOTI PRSY       0 <td< td=""><td></td><td>0</td><td>0</td><td></td><td>0 0</td><td>Ű</td><td></td></td<>		0	0		0 0	Ű		
67.00       06700       OCCUPATIONAL THERAPY       0       0       0       0       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       0       0       0       68.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0       0       0       0       0       71.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       0       0       73.00         76.00       03020       PSYCH       0       0       0       0       73.00         76.01       03951       SPECI AL PROCEDURES       0       0       0       0       76.01         76.02       03950       SPECI AL PROCEDURES       SUA       0       0       0       0       76.02         76.97       07697       CARDI AC REHABI LI TATI ON       0       0       0       0       76.92         76.98       07698       HYPERBARI C OXYGEN THERAPY       0       0       0       0       0       76.98         76.98       07699       LI THOTRI PSY       0       0       0       0       0       0       0       97         76.99       017HOTI		0	0		0 0	Ű		
68.00       06800       SPEECH PATHOLOGY       0       0       0       0       0       68.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0       0       0       0       71.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       0       0       73.00         76.00       03020       PSYCH       0       0       0       0       76.00         76.10       03951       SPECI AL PROCEDURES       0       0       0       0       76.01         76.01       03951       SPECI AL PROCEDURES       SUA       0       0       0       0       76.01         76.02       03950       SPECI AL PROCEDURES - SUA       0       0       0       0       76.02         76.97       07697       CARDI AC REHABILI TATI ON       0       0       0       76.97         76.98       07698 HYPERBARI C OXYGEN THERAPY       0       0       0       0       76.98         976.99       07699 LI THOTRI PSY       0       0       0       0       76.99         92.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART       0       0       0       92.00 </td <td></td> <td>0</td> <td>0</td> <td></td> <td></td> <td>-</td> <td></td>		0	0			-		
71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       0       0       0       0       71.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       0       0       73.00         76.00       03020       PSYCH       0       0       0       0       76.00         76.01       03951       SPECI AL PROCEDURES       0       0       0       0       76.01         76.02       03950       SPECI AL PROCEDURES - SUA       0       0       0       0       76.02         76.97       07697       CARDI AC REHABILITATION       0       0       0       0       76.92         76.98       07698       HYPERBARIC OXYGEN THERAPY       0       0       0       0       76.98         97.699       07699       LI THOTRIPSY       0       0       0       0       76.98         90       07699       LI THOTRIPSY       0       0       0       0       76.98         91       01290       OBSERVATION BEDS (NON-DI STINCT PART       0       0       0       92.00         93.99       09399       PATIAL HOSPITALIZATION PROGRAM       0       0       0       0       93.		0	0		0 0	Ű		
73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       0       0       73.00         76.00       03020       PSYCH       0       0       0       0       76.00         76.01       03951       SPECI AL PROCEDURES       0       0       0       0       76.00         76.02       03950       SPECI AL PROCEDURES - SUA       0       0       0       0       76.02         76.97       07697       CARDIA C REHABILITATION       0       0       0       0       76.92         76.98       07698       HYPERBARI C OXYGEN THERAPY       0       0       0       0       76.98         76.99       07699       LI THOTRI PSY       0       0       0       0       76.98         09200       OBSERVATI ON BEDS (NON-DI STINCT PART       0       0       0       92.00       92.00         93.99       09399       PATIAL HOSPI TALI ZATI ON PROGRAM       0       0       0       0       93.99		0	0		0 0	u u u u u u u u u u u u u u u u u u u		
76.00       03020       PSYCH       0       0       0       0       76.00         76.01       03951       SPECI AL       PROCEDURES       0       0       0       0       76.00         76.02       03950       SPECI AL       PROCEDURES - SUA       0       0       0       0       76.01         76.02       03950       SPECI AL       PROCEDURES - SUA       0       0       0       0       76.02         76.97       OASPO       CARDIA C       REHABI LI TATI ON       0       0       0       0       76.97         76.98       OY697       CARDIA C       REHABI LI TATI ON       0       0       0       0       76.97         76.98       OY698       HYPERBARI C       OXYGEN THERAPY       0       0       0       0       76.98         76.99       OTFATI ENT SERVICE       COST CENTERS       0       0       0       0       0       99         0       0200       OBSERVATI ON BEDS (NON-DI STI NCT PART       0       0       0       92.00       93.99       PATI AL HOSPI TALI ZATI ON PROGRAM       0       0       0       0       93.99		0	0		0 0	-		
76. 02       03950       SPECIAL PROCEDURES - SUA       0       0       0       0       0       76. 02         76. 07       07697       CARDIAC REHABILITATION       0       0       0       0       76. 97         76. 98       07698       HYPERBARI C 0XYGEN THERAPY       0       0       0       0       76. 98         76. 99       07699       LI THOTRI PSY       0       0       0       0       76. 99         00       07699       LI THOTRI PSY       0       0       0       0       76. 99         00       07699       LI THOTRI PSY       0       0       0       0       0       76. 99         01       01       0       0       0       0       0       0       76. 99         0200       0BSERVATI ON BEDS (NON-DI STINCT PART       0       0       0       92. 00       93.99       93.99       90.9399       9ATTI AL HOSPI TALI ZATI ON PROGRAM       0       0       0       0       93. 99		0	0		0 0	0		
76. 97       07697       CARDI AC REHABI LI TATI ON       0       0       0       0       76. 97         76. 98       07698       HYPERBARI C 0XYGEN THERAPY       0       0       0       0       76. 98         76. 99       07699       LI THOTRI PSY       0       0       0       0       76. 99         00       07699       LI THOTRI PSY       0       0       0       0       76. 99         00       07699       LI THOTRI PSY       0       0       0       0       76. 99         00       07699       LI THOTRI PSY       0       0       0       0       76. 99         00       07699       LI THOTRI PSY       0       0       0       0       76. 99         00       09200       0BSERVATI ON BEDS (NON-DI STI NCT PART       0       0       0       92. 00         93. 99       09399       PARTI AL HOSPI TALI ZATI ON PROGRAM       0       0       0       0       93. 99	76. 01 03951 SPECIAL PROCEDURES	0	0		0 0	0	76.01	
76. 98         07698         HYPERBARI C 0XYGEN THERAPY         0         0         0         0         76. 98           76. 99         07699         LI THOTRI PSY         0         0         0         0         0         76. 98           00         01         0         0         0         0         0         0         76. 98           01         01         0         0         0         0         0         76. 99           01         01         0         0         0         0         0         9           92. 00         09200         0BSERVATI ON BEDS (NON-DI STI NCT PART         0         0         0         92. 00           93. 99         09399         PARTI AL HOSPI TALI ZATI ON PROGRAM         0         0         0         0         93. 99	76. 02 03950 SPECIAL PROCEDURES - SUA	0	0		0 0	0	76. 02	
76.99         O7699         LI THOTRI PSY         O         O         O         O         76.99           OUTPATI ENT SERVICE COST CENTERS         0         0         0         0         0         92.00         09200         0BSERVATI ON BEDS (NON-DI STI NCT PART         0         0         0         92.00         93.99         PARTI AL HOSPI TALI ZATI ON PROGRAM         0         0         0         0         93.99	76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76.97	
OUTPATI ENT_SERVICE_COST_CENTERS           92.00         09200         OBSERVATI ON BEDS (NON-DI STI NCT PART         0         0         0         92.00           93.99         09399         PARTI AL HOSPI TALI ZATI ON PROGRAM         0         0         0         0         93.99	76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0	76. 98	
92.00         09200         OBSERVATI ON         BEDS         (NON-DI STI NCT PART         0         0         9         9         9         9         9         9         PARTI AL         HOSPI TALI ZATI ON         PROGRAM         0         0         0         0         9         9         9         9         9         1 <th1< th=""> <th1< th=""> <th1< th=""> <t< td=""><td>76. 99 07699 LI THOTRI PSY</td><td>0</td><td>0</td><td></td><td>0 0</td><td>0</td><td>76.99</td></t<></th1<></th1<></th1<>	76. 99 07699 LI THOTRI PSY	0	0		0 0	0	76.99	
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM 0 0 0 0 93. 99	OUTPATIENT SERVICE COST CENTERS							
		0			0	0		
200.00           Total (lines 50 through 199)         0		0	0		0 0	-	_	
	200.00   Total (lines 50 through 199)	0	0		0 0	0	200. 00	

Health Financial Systems ENCO	MPASS HEALTH DE	ACONESS REHABI	LIT	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	6 Provider C		Period: From 01/01/2022	Worksheet D Part IV	
				To 07/31/2022		
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS						
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 255, 682		
54. 01 05401 RADI OLOGY - SUA	0	0		0 134, 839		
60. 00 06000 LABORATORY	0	0		0 1, 673, 840		
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0.00000	
65. 00 06500 RESPI RATORY THERAPY	0	0		0 603, 360		65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 5, 806, 390		66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 6, 315, 444		
68.00 06800 SPEECH PATHOLOGY	0	0		0 1, 574, 661		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 574, 633		
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 4, 928, 213	0.000000	73.00
76. 00 03020 PSYCH	0	0		0 0	0.000000	76.00
76. 01 03951 SPECIAL PROCEDURES	0	0		0 0	0.000000	76.01
76. 02 03950 SPECIAL PROCEDURES – SUA	0	0		0 176, 437	0.00000	76.02
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0.00000	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0.00000	76.98
76. 99 07699 LI THOTRI PSY	0	0		0 0	0.00000	76.99
OUTPATIENT SERVICE COST CENTERS						
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 0	0. 000000	
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	0	0		0 0	0.00000	93.99
200.00   Total (lines 50 through 199)	0	0		0 22, 043, 499		200. 00

Health Financial Systems ENC	OMPASS HEALTH DEA	CONESS REHABI	LIT	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS	Provider C		Period: From 01/01/2022 To 07/31/2022		pared: :05 pm_
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8	;	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS			1	- F	-	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	147, 994		D 714	0	54.00
54. 01 05401 RADI OLOGY – SUA	0. 000000	78, 051		0 0	0	54.01
60. 00 06000 LABORATORY	0. 000000	955, 685		0 0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0		0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	0. 000000	324, 806		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	2, 865, 560		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	3, 151, 472		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	712, 927		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	318, 876		0 0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	2, 427, 811		0 0	0	73.00
76.00 03020 PSYCH	0. 000000	0		0 0	0	76.00
76. 01 03951 SPECIAL PROCEDURES	0. 000000	0		0 0	0	76.01
76. 02 03950 SPECIAL PROCEDURES - SUA	0. 000000	23, 016		0 0	0	76.02
76. 97 07697 CARDI AC REHABI LI TATI ON	0, 000000	0		o o	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0, 000000	0		0 0	0	76.98
76. 99 07699 LI THOTRI PSY	0. 000000	0		0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS			1			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0		0 0	0	92.00
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	0. 000000	0		0 0	0	93.99
200.00 Total (lines 50 through 199)		11, 006, 198		0 714	0	200.00

Health Financial S	Systems ENCO	MPASS HEALTH DE	ACONESS REHABI	LIT	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF M	APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND		Provider C		Period: From 01/01/2022 To 07/31/2022		
			Title	XVIII	Hospi tal	PPS	
				Charges		Costs	
Cost (	Center Description	Cost to Charge			Cost	PPS Services	
			Services (see		Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
	ERVICE COST CENTERS			1	-		
	LOGY-DI AGNOSTI C	0. 447924			0 0	320	
54.01 05401 RADI 0I		0. 207596			0 0	0	
60.00 06000 LABOR/		0. 345603			0 0	0	
	CLOTTING FOR HEMOPHILIACS	0. 000000	0		0 0	0	
	RATORY THERAPY	0. 728441	0		0 0	0	
66.00 06600 PHYSI (	CAL THERAPY	0. 290431	0		0 0	0	66.00
	ATI ONAL THERAPY	0. 289190			0 0	0	
68.00 06800 SPEECI		0. 368348	0		0 0	0	68.00
71.00 07100 MEDI CA	AL SUPPLIES CHARGED TO PATIENT	0. 564193	0		0 0	0	71.00
	CHARGED TO PATIENTS	0. 226504	0		0 0	0	73.00
76.00 03020 PSYCH		0. 000000	0		0 0	0	76.00
76.01 03951 SPECI	AL PROCEDURES	0. 000000	0		0 0	0	76.01
76.02 03950 SPECI	AL PROCEDURES – SUA	0. 344559	0		0 0	0	76.02
76. 97 07697 CARDI	AC REHABILITATION	0. 000000	0		0 0	0	76.97
76. 98 07698 HYPERI	BARIC OXYGEN THERAPY	0. 000000	0		0 0	0	76.98
76. 99 07699 LI THO	TRI PSY	0. 000000	0		0 0	0	76.99
OUTPATI ENT	SERVICE COST CENTERS		•	•			1
92.00 09200 OBSER	VATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	0	92.00
93. 99 09399 PARTI	AL HOSPITALIZATION PROGRAM	0. 000000	0		0 0	0	93.99
200.00 Subto	tal (see instructions)		714		0 0	320	200.00
201.00 Less I	PBP Clinic Lab. Services-Program				0 0		201.00
	Charges						
202.00 Net Cl	harges (line 200 - line 201)		714		0 0	320	202.00

Health Financial Systems ENCO APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	D VACCINE COST	Provider C		Peri od: From 01/01/2022 To 07/31/2022	11/22/2022 12	
			XVIII	Hospi tal	PPS	
		sts	-			
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed Services Not				
	Servi ces Subj ect To					
		Subject To Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00	-			
ANCI LLARY SERVI CE COST CENTERS	0.00	1.00	1			
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.0
54. 01 05401 RADI OLOGY - SUA	0	0				54.0
50. 00 06000 LABORATORY	0	o o				60.0
52. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0				62.3
65. 00 06500 RESPI RATORY THERAPY	0	0 0				65.0
56. 00 06600 PHYSI CAL THERAPY	0	0 0				66.0
67. 00 06700 OCCUPATI ONAL THERAPY	0	0 0				67.0
58.00 06800 SPEECH PATHOLOGY	0	0				68.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.0
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.0
76. 00 03020 PSYCH	0	0				76.0
76. 01 03951 SPECIAL PROCEDURES	0	0				76. (
76. 02 03950 SPECIAL PROCEDURES - SUA	0	0				76.0
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0				76.9
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0				76.9
76. 99 07699 LI THOTRI PSY	0	0 0				76. 9
OUTPATIENT SERVICE COST CENTERS	-	-	1			-
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	0	0				92.0
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	0	0				93.9
200.00 Subtotal (see instructions)		0				200. C
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0					201.0
202.00 Net Charges (line 200 - line 201)		0				202.0
202.00 Inter charges (The 200 - The 201)	1 0	'I U	1			1202.

ENCOMPASS	HEALTH	DEACONESS	REHABI LI T	

leal th	Financial Systems ENCOMPASS HEALTH DEACC	NESS REHABILIT	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-3025	Period: From 01/01/2022 To 07/31/2022	Worksheet D-1 Date/Time Prep 11/22/2022 12:	pared:
		Title XVIII	Hospi tal	PPS	. US pili
	Cost Center Description				
				1.00	
	PART I - ALL PROVIDER COMPONENTS				-
. 00	Inpatient days (including private room days and swing-bed days	s. excluding newborn)		19, 359	1.00
2.00	Inpatient days (including private room days, excluding swing-b			19, 359	2.00
8.00	Private room days (excluding swing-bed and observation bed day	ys). If you have only p	rivate room days,	0	3.00
	do not complete this line.			10.050	1.00
. 00 . 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo		or 31 of the cost	19, 359 0	4.00 5.00
. 00	reporting period	Sin days) thi ough becenbe	er of the cost	0	5.00
. 00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)				
. 00	Total swing-bed NF type inpatient days (including private room	n days) through December	- 31 of the cost	0	7.00
3. 00	reporting period Total swing-bed NF type inpatient days (including private room	m davs) after December '	31 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)			0	0.00
9.00	Total inpatient days including private room days applicable to	o the Program (excluding	g swing-bed and	9, 459	9.00
	newborn days) (see instructions)				10.00
0.00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct		room days)	0	10.00
1.00	Swing-bed SNF type inpatient days applicable to title XVIII or		room davs) after	0	11.00
	December 31 of the cost reporting period (if calendar year, er			_	
2.00	Swing-bed NF type inpatient days applicable to titles V or XLX	K only (including privat	te room days)	0	12.00
12 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI)	K oply (including privat	to room daya)	0	12.00
3.00	after December 31 of the cost reporting period (if calendar ve			0	13.00
4.00	Medically necessary private room days applicable to the Progra			0	14.00
	Total nursery days (title V or XIX only)		5 /	0	15.00
6.00	Nursery days (title V or XIX only)			0	16.00
	SWING BED ADJUSTMENT	a through December 21	of the east	0.00	17.00
7.00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through becember 31 (	on the cost	0.00	17.00
8.00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18.00
	reporting period				
19.00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	f the cost	0.00	19.00
20.00	reporting period Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	the cost	0.00	20.00
-0.00	reporting period			0100	20100
	Total general inpatient routine service cost (see instructions			12, 783, 811	
22.00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ting period (line	0	22.00
23.00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	na period (line 6	0	23.00
_0.00	x line 18)		ig period (inite o	0	20.00
24.00	Swing-bed cost applicable to NF type services through December	r 31 of the cost reporti	ng period (line	0	24.00
	7 x line 19)				
25.00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	g period (line 8	0	25.00
26.00	Total swing-bed cost (see instructions)			0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (	(line 21 minus line 26)		12, 783, 811	
	PRIVATE ROOM DI FFERENTI AL ADJUSTMENT		<u> </u>		
	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	d and observation bed ch	narges)	0	
9.00 0.00	Semi-private room charges (excluding swing-bed charges)			0	
1.00	General inpatient routine service cost/charge ratio (line 27 -	÷line 28)		0. 000000	
2.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.0
3.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
4.00	Average per diem private room charge differential (line 32 mir Average per diem private room cost differential (line 34 x lin		ctions)	0.00	
35.00 36.00	Private room cost differential adjustment (line 3 x line 35)			0.00 0	
37.00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	12, 783, 811	
	27 minus line 36)		<b>x</b>		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			((0.25	20 00
00 00				660.35	38.00
	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line				39 01
39.00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progra	38)		6, 246, 251 0	

		COMPASS HEALTH DE	ACONESS REHAB	ILIT	In Lie	eu of Form CMS-2	
OMPUT	TATION OF INPATIENT OPERATING COST		Provi der (		Period: From 01/01/2022		
					To 07/31/2022	Date/Time Pre 11/22/2022 12	
			Ti tl	e XVIII	Hospi tal	PPS	. 05
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Day	sDiem (col. 1	÷	(col. 3 x col.	
		1.00		col . 2)		4)	_
00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42
. 00	Intensive Care Type Inpatient Hospital Uni	ts					42
00	INTENSIVE CARE UNIT						43
. 00	CORONARY CARE UNI T						44
. 00	BURN INTENSIVE CARE UNIT						45
00	SURGICAL INTENSIVE CARE UNIT						46
00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47
						1.00	1
00	Program inpatient ancillary service cost (	Wkst. D-3, col. 3	5, line 200)			3, 393, 356	48
00	Total Program inpatient costs (sum of line	s 41 through 48)(	see instructi	ons)		9, 639, 607	49
00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program i	postiont pouting	aamulaaa (fra	m Wkat D aum	of Donto L and	701 151	1 50
00	(111)	npatrent routine	services (ind	III WKSL. D, SUIII	of Parts I and	791, 151	50
. 00	Pass through costs applicable to Program i	npatient ancillar	y services (f	rom Wkst. D, s	um of Parts II	196, 974	51
	and IV)		<i>.</i>				
. 00	Total Program excludable cost (sum of line				- + : - + ·	988, 125	
. 00	Total Program inpatient operating cost exc medical education costs (line 49 minus lin		elated, non-ph	ysician anesth	etist, and	8, 651, 482	53
	TARGET AMOUNT AND LIMIT COMPUTATION	6 52)				1	
. 00	Program di scharges					0	54
. 00	Target amount per discharge					0.00	
00	Target amount (line 54 x line 55)					0	
00 00	Difference between adjusted inpatient oper Bonus payment (see instructions)	ating cost and ta	irget amount (	line 56 minus	line 53)	0	
00	Lesser of lines 53/54 or 55 from the cost	reporting period	endi na 1996	updated and co	mpounded by the	-	-
	market basket	· · · · · · · · · · · · · · · · · · ·	;				
00	Lesser of lines 53/54 or 55 from prior yea					0.00	
00	If line 53/54 is less than the lower of li					0	6
	which operating costs (line 53) are less t amount (line 56), otherwise enter zero (se		s (lines 54 x	60), or 1% or	the target		
. 00	Relief payment (see instructions)					0	62
00	Allowable Inpatient cost plus incentive pa	yment (see instru	ictions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST					1	
00	5 1	osts through Dece	ember 31 of th	e cost reporti	ng period (See	0	64
00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine c	osts after Decemb	er 31 of the	cost reporting	period (See	0	65
	instructions)(title XVIII only)						
. 00	Total Medicare swing-bed SNF inpatient rou	tine costs (line	64 plus line	65)(title XVII	l only). For	0	66
00	CAH (see instructions)	ing goots through	December 21	of the east re	norting poriod	0	
. 00	Title V or XIX swing-bed NF inpatient rout (line 12 x line 19)	The costs through	December 31	of the cost re	porting period	0	67
. 00	Title V or XIX swing-bed NF inpatient rout	ine costs after D	ecember 31 of	the cost repo	rting period	0	68
	(line 13 x line 20)						
. 00						0	69
. 00	PART III - SKILLED NURSING FACILITY, OTHER Skilled nursing facility/other nursing fac						70
. 00	Adjusted general inpatient routine service	3					71
. 00	Program routine service cost (line 9 x lin			<i>,</i>			72
00	5 51 11	0	•				73
00	Total Program general inpatient routine se			·	opt 11 1		74
00	Capital-related cost allocated to inpatien 26, line 45)	t routine service	e COSTS (Trom	worksneet B, P	art II, COLUMN		75
00	Per diem capital-related costs (line 75 ÷	line 2)					76
00	Program capital-related costs (line 9 x li						77
00	Inpatient routine service cost (line 74 mi						78
00	Aggregate charges to beneficiaries for exc	• •		· · · · · · · · · · · · · · · · · · ·	us line 70)		79
00 00	Total Program routine service costs for co Inpatient routine service cost per diem li	•	UST IIMITATIC	n (ine /8 min	us i ne 79)		80
00	Inpatient routine service cost per drem ri Inpatient routine service cost limitation		)				8
00	Reasonable inpatient routine service costs	•	· .				83
00	Program inpatient ancillary services (see	instructions)					84
00	Utilization review - physician compensatio						85
$\Omega \Omega$			rough 85)				86
00	PART IV - COMPUTATION OF OBSERVATION BED P.					0	E
. 00	Total observation bed days (see instruction	ns)					א וי
. 00	Total observation bed days (see instruction Adjusted general inpatient routine cost pe		line 2)			0.00	

Health Financial Systems ENCO	ACONESS REHABI	LIT	In Lieu of Form CMS-2552-10			
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 01/01/2022 To 07/31/2022		
		Title	XVIII	Hospi tal	PPS	
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	1, 619, 149	12, 783, 811	0. 12665	6 0	0	90.00
91.00 Nursing Program cost	0	12, 783, 811	0.00000	0 0	0	91.00
92.00 Allied health cost	0	12, 783, 811	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	12, 783, 811	0.00000	0 0	0	93.00

Heal th	Financial Systems ENCOMPASS HEALTH DEACO	ONESS REHABILIT	In Lie	u of Form CMS-2	2552-10		
	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-3025	Peri od:	Worksheet D-1			
			From 01/01/2022 To 07/31/2022	Date/Time Pre 11/22/2022 12	pared: :05 pm		
		Title XIX	Hospi tal	Cost			
	Cost Center Description			1.00			
	PART I - ALL PROVIDER COMPONENTS			1.00			
	I NPATI ENT DAYS				1		
1.00	Inpatient days (including private room days and swing-bed days			19, 359	1.00		
2.00 3.00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed day do not complete this line.		ivate room days,	19, 359 0	2.00 3.00		
4.00 5.00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	19, 359 0	4.00 5.00		
6.00	reporting period Total swing-bed SNF type inpatient days (including private roo			0	6.00		
7.00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7.00		
8.00	reporting period Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	m days) after December 3	1 of the cost	0	8.00		
9.00	Total inpatient days including private room days applicable to newborn days) (see instructions)	o the Program (excluding	swing-bed and	170	9.00		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII on through December 31 of the cost reporting period (see instruc	tions)		0			
11.00	Swing-bed SNF type inpatient days applicable to title XVIII on December 31 of the cost reporting period (if calendar year, en	nter 0 on this line)		0			
12.00 13.00	Swing-bed NF type inpatient days applicable to titles V or XL through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XL	5	0				
	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr.	0					
15.00	Total nursery days (title V or XIX only)		5 /	0			
16.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16.00		
17.00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 c	of the cost	0.00	17.00		
18.00	Medicare rate for swing-bed SNF services applicable to service reporting period	the cost	0.00	18.00			
19. 00							
20.00 21.00	Medicaid rate for swing-bed NF services applicable to services reporting period Total general inpatient routine service cost (see instructions		he cost	0. 00 12, 780, 315	20.00		
21.00	Swing-bed cost applicable to SNF type services through December $5 \times 1$ ine 17)		ing period (line	12, 780, 313			
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportir	ng period (line 6	0	23.00		
24.00	Swing-bed cost applicable to NF type services through December 7 x line 19)		0 1 1		24.00		
	Swing-bed cost applicable to NF type services after December : x line 20)	31 of the cost reporting	period (line 8	0			
26.00 27.00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		0 12, 780, 315	26.00 27.00		
28.00	General inpatient routine service charges (excluding swing-be	d and observation bed ch	narges)	0	28.00		
29.00	Private room charges (excluding swing-bed charges)			0			
30.00	Semi-private room charges (excluding swing-bed charges)	Lino 29)		0	30.00		
31.00 32.00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	- IINE 28)		0. 000000 0. 00			
33.00	Average semi-private room per diem charge (line 29 ÷ line 3)			0.00			
33.00		nus line 33)(see instruc	tions)	0.00			
35.00							
36.00	Private room cost differential adjustment (line 3 x line 35)			0. 00 0	35.00 36.00		
37.00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	and private room cost di	fferential (line	12, 780, 315			
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				-		
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			(10.17			
38.00	Adjusted general inpatient routine service cost per diem (see	-		660.17			
39.00 40.00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progra	-		112, 229 0	39.00 40.00		
	Total Program general inpatient routine service cost (line 39			112, 229			

	Financial Systems ENCO	MPASS HEALTH DE	ACONESS REHABI	LIT	In Lie	eu of Form CMS-	2552
UNPUTA	TION OF INPATIENT OPERATING COST		Provi der C		Peri od:	Worksheet D-1	
					From 01/01/2022		
					To 07/31/2022	Date/Time Pre 11/22/2022 12	
			Ti †I	e XIX	Hospi tal	Cost	. 05
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
			Inpatient Days			$(col \cdot 3 \times col \cdot$	
				col. 2)		4)	
		1.00	2.00	3.00	4.00	5.00	
	NURSERY (title V & XIX only)						42
I	ntensive Care Type Inpatient Hospital Units						
. 00	INTENSIVE CARE UNIT						43
. 00	CORONARY CARE UNIT						44
. 00	BURN INTENSIVE CARE UNIT						45
. 00	SURGICAL INTENSIVE CARE UNIT						46
. 00	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description						
		_				1.00	
. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3, line 200)			60, 747	48
	Total Program inpatient costs (sum of lines	41 through 48)(	(see instructio	ns)		172, 976	49
-	PASS THROUGH COST ADJUSTMENTS						
	Pass through costs applicable to Program inp	atient routine	services (from	Wkst. D, sum	of Parts I and	0	50
	Pass through costs applicable to Program inp	atient ancillar	ry services (fr	om Wkst. D, si	um of Parts II	0	51
	and IV)						
	Total Program excludable cost (sum of lines					0	
	Total Program inpatient operating cost exclu		elated, non-phy	sician anesthe	etist, and	0	53
	medical education costs (line 49 minus line	52)					
	FARGET AMOUNT AND LIMIT COMPUTATION						1
1	Program di scharges					0	
	Target amount per discharge					0.00	
1	Target amount (line 54 x line 55)					0	
	Difference between adjusted inpatient operat	ing cost and ta	arget amount (l	ine 56 minus	line 53)	0	
	Bonus payment (see instructions)					0	
	Lesser of lines 53/54 or 55 from the cost re	porting period	ending 1996, u	pdated and cor	mpounded by the	0.00	59
	market basket						
	Lesser of lines 53/54 or 55 from prior year					0.00	
	If line 53/54 is less than the lower of line					0	61
	which operating costs (line 53) are less tha		ts (lines 54 x	60), or 1% of	the target		
	amount (line 56), otherwise enter zero (see	instructions)					
	Relief payment (see instructions)					0	
	Allowable Inpatient cost plus incentive paym	ent (see instru	uctions)			0	63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	cost reporti	ng period (See	0	64
	instructions)(title XVIII only)						
	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of the c	ost reporting	period (See	0	65
	instructions)(title XVIII only)						
	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVII	l only). ⊦or	0	66
	CAH (see instructions)			<b>C</b> 11			
	Title V or XIX swing-bed NF inpatient routin	e costs through	n December 31 d	t the cost re	porting period	0	67
	(line 12 x line 19)	<del>C</del> t P	)				
	Title V or XIX swing-bed NF inpatient routin	e costs after L	Jecember 31 01	the cost repo	rting period	0	68
1	(line 13 x line 20) Tatal title V or XIX swing had NE inpatient	routino costa (	(line 47 · line	40)			40
	Total title V or XIX swing-bed NF inpatient					0	69
-	PART III - SKILLED NURSING FACILITY, OTHER N						1 70
1	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c						70
	Adjusted general inpatient routine service c Program routine service cost (line 9 x line			~)			72
	5		n (lino 14 v li	no 25)			73
	Medically necessary private room cost applic	Ű		ne 35)			
. 00	Total Program general inpatient routine serv			larkebact P	ort II colum-		74
	Capital-related cost allocated to inpatient	ioutine service	CUSIS (From W	ULKSNEET B, Pa	artir, column		75
. 00	26, line 45)						76
. 00	Por diam capital related costs (line 75	$n_0(2)$					
. 00	Per diem capital-related costs (line 75 ÷ li						
00 00 00	Program capital-related costs (line 9 x line	76)					77
00 00 00 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu	576) sline 77)					77
00 00 00 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces	576) s line 77) s costs (from p					77 78 79
00 00 00 00 00 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces Total Program routine service costs for comp	76) s line 77) s costs (from p arison to the c			us line 79)		77 78 79 80
. 00 . 00 . 00 . 00 . 00 . 00 . 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces Total Program routine service costs for comp Inpatient routine service cost per diem limi	576) s line 77) s costs (from p arison to the c tation	cost limitation		us line 79)		77 78 79 80 81
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces Total Program routine service costs for comp Inpatient routine service cost per diem limi Inpatient routine service cost limitation (l	576) s line 77) s costs (from p arison to the c tation ine 9 x line 81	cost limitation 1)		us line 79)		77 78 79 80 81 82
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces Total Program routine service costs for comp Inpatient routine service cost per diem limi	576) s line 77) s costs (from p arison to the c tation ine 9 x line 81	cost limitation 1)		us line 79)		77 78 79 80 81 82 83
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces Total Program routine service costs for comp Inpatient routine service cost per diem limi Inpatient routine service cost limitation (l	576) s line 77) s costs (from p arison to the c tation ine 9 x line 81 see instruction	cost limitation 1)		us line 79)		77 78 79 80 81 82 83
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces Total Program routine service costs for comp Inpatient routine service cost per diem limi Inpatient routine service cost limitation (l Reasonable inpatient routine service costs (	76) s line 77) s costs (from p arison to the c tation ine 9 x line 81 see instruction structions)	cost limitation 1) ns)		us line 79)		77 78 79 80 81 82 83 83 84
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces Total Program routine service costs for comp Inpatient routine service cost per diem limi Inpatient routine service cost limitation (l Reasonable inpatient routine service costs ( Program inpatient ancillary services (see in Utilization review - physician compensation Total Program inpatient operating costs (sum	5 76) s line 77) s costs (from p arison to the c tation ine 9 x line 81 see instruction structions) (see instruction of lines 83 th	cost limitation 1) ns) ons)		us line 79)		77 78 79 80 81 82 83 84 85
5. 00       1         5. 00       1         5. 00       1         7. 00       1         8. 00       1         9. 00       1         9. 00       1         9. 00       1         9. 00       1         9. 00       1         9. 00       1         9. 00       1         9. 00       1         9. 00       1         9. 00       1         9. 00       1         9. 00       1         9. 00       1         9. 00       1	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces Total Program routine service costs for comp Inpatient routine service cost per diem limi Inpatient routine service cost limitation (l Reasonable inpatient routine service costs ( Program inpatient ancillary services (see in Utilization review - physician compensation	5 76) s line 77) s costs (from p arison to the c tation ine 9 x line 81 see instruction structions) (see instruction of lines 83 th	cost limitation 1) ns) ons)		us line 79)		70 77 78 79 80 81 82 83 84 85 86
5. 00 6. 00 7. 00 8. 00 9. 00 9. 00 9. 00 9. 00 9. 00 1.	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces Total Program routine service costs for comp Inpatient routine service cost per diem limi Inpatient routine service cost limitation (l Reasonable inpatient routine service costs ( Program inpatient ancillary services (see in Utilization review - physician compensation Total Program inpatient operating costs (sum	5 76) s line 77) s costs (from p arison to the c tation ine 9 x line 81 see instruction structions) (see instruction (see instruction of lines 83 th S THROUGH COST	cost limitation 1) ns) ons)		us line 79)	0	77 78 79 80 81 82 83 84 85 86
. 00 . 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces Total Program routine service costs for comp Inpatient routine service cost per diem limi Inpatient routine service cost limitation (l Reasonable inpatient routine service costs ( Program inpatient ancillary services (see in Utilization review - physician compensation Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS	<pre>&gt; 76) s line 77) s costs (from p arison to the c tation ine 9 x line 81 see instruction structions) (see instruction of lines 83 th S THROUGH COST ) diem (line 27 ÷</pre>	cost limitation ) hs) hrough 85) F line 2)		us line 79)	0.00	77 78 79 80 81 82 83 84 85 86 86 86

Health Financial Systems ENCO	ACONESS REHABI	LIT	In Lieu of Form CMS-2552-10			
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 01/01/2022 To 07/31/2022	Date/Time Pre 11/22/2022 12	
		Titl	e XIX	Hospi tal	Cost	
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	1, 619, 149	12, 780, 315	0. 12669	1 0	0	90.00
91.00 Nursing Program cost	0	12, 780, 315	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	12, 780, 315	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	12, 780, 315	0. 00000	0 0	0	93.00

Health Financial Systems	ENCOMPASS HEALTH DEA				eu of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APP	PORTIONMENT	Provider C	CN: 15-3025	Peri od:	Worksheet D-3	
				From 01/01/2022 To 07/31/2022		narod
				10 0773172022	11/22/2022 12	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description			Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
	T. 05117500		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COS	I CENTERS		1	10 102 702	1	
30. 00 03000 ADULTS & PEDIATRICS ANCI LLARY SERVICE COST CENTER	6			10, 103, 793		30.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	5		0, 44792	24 147, 994	66, 290	54.00
54. 01 05401 RADIOLOGY - SUA			0. 2075			
60. 00 06000 LABORATORY			0. 3456			
62. 30 06250 BLOOD CLOTTING FOR HEMO	ρητισ		0.0000			62.30
65. 00 06500 RESPIRATORY THERAPY			0. 7284		-	65.00
66. 00 06600 PHYSI CAL THERAPY			0. 2904			
67.00 06700 OCCUPATI ONAL THERAPY			0. 2891			•
68.00 06800 SPEECH PATHOLOGY			0. 3683			•
71.00 07100 MEDICAL SUPPLIES CHARGEI	D TO PATIENT		0. 5641	318, 876	179, 908	71.00
73.00 07300 DRUGS CHARGED TO PATIEN	TS		0. 22650	2, 427, 811	549, 909	73.00
76.00 03020 PSYCH			0.0000	0 00	0	76.00
76.01 03951 SPECIAL PROCEDURES			0.0000	0 00	0	76.0
76. 02 03950 SPECIAL PROCEDURES - SU	Ą		0. 3445		7, 930	76.02
76. 97 07697 CARDI AC REHABI LI TATI ON			0.0000		0	
76. 98 07698 HYPERBARI C OXYGEN THERA	РҮ		0.0000		0	
76. 99 07699 LI THOTRI PSY			0.0000	000	0	76. 99
OUTPATIENT SERVICE COST CENTE			1			
92.00 09200 OBSERVATI ON BEDS (NON-D			0.0000			92.00
93. 99 09399 PARTI AL HOSPI TALI ZATI ON			0.0000		0	1
	through 94 and 96 through 98)	(1) (1)		11, 006, 198		
	bry Services-Program only charge	es (line 61)		0		201.00
202.00 Net charges (line 200 m	inus line 201)			11, 006, 198	1	202.00

	inancial Systems T ANCILLARY SERVICE COST APPORT	ENCOMPASS HEALTH DEAC	Provider C		Peri od:	worksheet D-3	
	IT ANGLERART SERVICE COST AFFORT	IONMENT	FIOVICEI C	CN. 15-3025	From 01/01/2022	WOLKSHEEL D-3	2
					To 07/31/2022		
						11/22/2022 12	2:05 pm
			Titl	e XIX	Hospi tal	Cost	
	Cost Center Description			Ratio of Cos		Inpati ent	
				To Charges		Program Costs	
					Charges	(col. 1 x col.	
						2)	
				1.00	2.00	3.00	
	NPATIENT ROUTINE SERVICE COST CI	INTERS					
	3000 ADULTS & PEDIATRICS				182, 070		30.00
	NCILLARY SERVICE COST CENTERS						
	5400 RADI OLOGY-DI AGNOSTI C			0. 4479			
	5401 RADI OLOGY – SUA			0. 2075		-	
	5000 LABORATORY			0. 3456		1, 939	
	6250 BLOOD CLOTTING FOR HEMOPHIL	I ACS		0.0000		0	
	5500 RESPI RATORY THERAPY			0. 7284			
	6600 PHYSI CAL THERAPY			0. 2904		15, 922	2 66.00
	6700 OCCUPATI ONAL THERAPY			0. 2891	90 56, 008	16, 197	67.0
68.00 06	5800 SPEECH PATHOLOGY			0. 3683	48 11, 119	4, 096	68.0
71.00 07	7100 MEDICAL SUPPLIES CHARGED TO	PATI ENT		0. 5641	93 7, 829	4, 417	7 71.0
73.00 07	7300 DRUGS CHARGED TO PATIENTS			0. 2265	04 51, 706	11, 712	2 73.0
76.00 03	3020 PSYCH			0.0000	00 0	0	76.0
76.01 03	3951 SPECIAL PROCEDURES			0.0000	00 0	0	76.0
76. 02 03	3950 SPECIAL PROCEDURES - SUA			0. 3445	59 0	0	76.0
76.97 07	7697 CARDIAC REHABILITATION			0.0000	00 0	0	76.9
76.98 07	7698 HYPERBARI C OXYGEN THERAPY			0.0000	00 0	0	76.9
76.99 07	7699 LI THOTRI PSY			0.0000	00 0	0	76.9
OL	JTPATIENT SERVICE COST CENTERS						
92.00 09	9200 OBSERVATION BEDS (NON-DISTI	NCT PART		0.0000	00 00	C	92.0
93.99 09	9399 PARTIAL HOSPITALIZATION PRO	GRAM		0.0000	00 00	0	93.9
200.00	Total (sum of lines 50 thro	ugh 94 and 96 through 98)			196, 712	60, 747	200. 0
201.00		Servi ces-Program only charges	s (line 61)		0		201.0
202.00	Net charges (line 200 minus		. ,		196, 712		202.00

			To 07/31/2022	Doto/Time Dree	
				Date/Time Pre 11/22/2022 12	
		Title XVIII	Hospi tal	PPS	
				1.00	
1 00 100	RT B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1	dical and other services (see instructions)	tions)		0 320	
	dical and other services reimbursed under OPPS (see instruc PS payments	trons)		320 474	2.00 3.00
4	tlier payment (see instructions)			0	4.00
	tlier reconciliation amount (see instructions)			0	4.01
	ter the hospital specific payment to cost ratio (see instru ne 2 times line 5	CTIONS)		0. 000 0	
	m of lines 3, 4, and 4.01, divided by line 6			0.00	•
	ansitional corridor payment (see instructions)			0	
	cillary service other pass through costs from Wkst. D, Pt. gan acquisitions	IV, col. 13, line 200		0	9.00 10.00
	tal cost (sum of lines 1 and 10) (see instructions)			0	•
	MPUTATION OF LESSER OF COST OR CHARGES				
	asonable charges cillary service charges			0	12.00
	gan acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0	
14.00 Tot	tal reasonable charges (sum of lines 12 and 13)	·		0	14.00
	stomary charges gregate amount actually collected from patients liable for	navmont for sorvices on	a chargo basi s	0	15.00
	ounts that would have been realized from patients liable fo			0	
had	d such payment been made in accordance with 42 CFR §413.13(		5		
	tio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
	tal customary charges (see instructions) cess of customary charges over reasonable cost (complete on	lvifline 18 exceeds li	ne 11) (see	0	
i ns	structions)	5	, ,	-	
	cess of reasonable cost over customary charges (complete on structions)	ly if line 11 exceeds li	ne 18) (see	0	20.00
	ser of cost or charges (see instructions)			0	21.00
22.00 Int	terns and residents (see instructions)			0	
	st of physicians' services in a teaching hospital (see inst	ructions)		0	23.00
	tal prospective payment (sum of lines 3, 4, 4.01, 8 and 9) MPUTATION OF REIMBURSEMENT SETTLEMENT			474	24.00
	ductibles and coinsurance amounts (for CAH, see instruction	s)		0	
	ductibles and Coinsurance amounts relating to amount on lin	•		95	
	btotal [(lines 21 and 24 minus the sum of lines 25 and 26) structions)	plus the sum of lines 22	and 23] (see	379	27.00
	rect graduate medical education payments (from Wkst. E-4, I	ine 50)		0	28.00
	RD direct medical education costs (from Wkst. E-4, line 36)			0	
	btotal (sum of lines 27 through 29) imary payer payments			379	
	btotal (line 30 minus line 31)			-	32.00
	LOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)			
	mposite rate ESRD (from Wkst. I-5, line 11) Iowable bad debts (see instructions)			0	33.00 34.00
	justed reimbursable bad debts (see instructions)			0	
	lowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
	btotal (see instructions) P-LCC reconciliation amount from PS&R			379	37.00 38.00
	HER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50 Pi o	oneer ACO demonstration payment adjustment (see instruction	s)			39.50
	monstration payment adjustment amount before sequestration	and daviana (and instruc	ti ana)	0	
	rtial or full credits received from manufacturers for repla COVERY OF ACCELERATED DEPRECIATION	ced devices (see instruc	tions)	0	39.98 39.99
	btotal (see instructions)			379	
	questration adjustment (see instructions)			3	40.01
1	monstration payment adjustment amount after sequestration questration adjustment-PARHM pass-throughs			0	40.02
	terim payments			379	
41.01   Int	terim payments-PARHM				41.01
	ntative settlement (for contractors use only) ntative settlement-PARHM (for contractor use only)			0	42.00 42.01
	lance due provider/program (see instructions)			-3	42.01
43.01 Bal	lance due provider/program-PARHM (see instructions)				43.01
	otested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	chapter 1,	0	44.00
	15.2 BE COMPLETED BY CONTRACTOR				1
90.00 Ori	iginal outlier amount (see instructions)			0	
1	tlier reconciliation adjustment amount (see instructions)				91.00
	e rate used to calculate the Time Value of Money me Value of Money (see instructions)			0.00	92.00 93.00
	tal (sum of lines 91 and 93)				94.00

Health Financial Systems	ENCOMPASS HEALTH DEACONESS REHABILIT	In Lie	u of Form CMS-255	2-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-3025	Peri od:	Worksheet E	
		From 01/01/2022 To 07/31/2022	Date/Time Prepar	-ed·
		10 0770172022	11/22/2022 12:05	5 pm
	Title XVIII	Hospi tal	PPS	
			1.00	
MEDICARE PART B ANCILLARY COSTS				
200.00 Part B Combined Billed Days			0 200	0. 00

NALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CO	CN: 15-3025	Period: From 01/01/2022 To 07/31/2022		pared
		Title	XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment		16, 351, 2 <sup>-</sup>	0	379 0	1. C 2. C 3. C
	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					
01	ADJUSTMENTS TO PROVIDER			0	0	3.0
02				0	0	3.0
03				0	0	3.
04 05				0	0	3. 3.
05	Provider to Program	1			0	
50	ADJUSTMENTS TO PROGRAM			0	0	3.
51				0	0	
52				0	0	3.
53 54				0	0	3. 3.
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0	0	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR		16, 351, 21	19	379	4.
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					0.
01	TENTATI VE TO PROVIDER			0	0	5.
02				0	0	5.
03				0	0	5.
-	Provider to Program TENTATIVE TO PROGRAM			0	0	5.
50 51	TENTATIVE TO PROGRAM			0	0	5
52				0	0	5.
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)					6.
01 02	SETTLEMENT TO PROVIDER		56, 0		0	6.
)2 )0	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		16, 407, 29	0	3 376	6. 7.
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			10, 107, 2	Contractor Number	NPR Date (Mo/Day/Yr)	
		(	)	1.00	2.00	

Heal th	Financial Systems ENCOMPASS HEALTH DEACO	DNESS REHABILIT	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-3025	Period:	Worksheet E-1	
			From 01/01/2022 To 07/31/2022	Part II Date/Time Pre	narod
			10 0773172022	11/22/2022 12	
		Title XVIII	Hospi tal	PPS	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				-
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.				1.00
2.00	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8	8 through 12, and plus f	or cost		2.00
2.00	reporting periods beginning on or after 10/01/2013, line 32)				2.00
3.00 4.00	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines	I, and 8 through 12, and	plus for cost		4.00
5.00	reporting periods beginning on or after 10/01/2013, line 32) Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
5.00 6.00	Total hospital charity care charges from Wkst. S-10, col. 3 li	ino 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of co		What S 2 Dt I		7.00
7.00	lline 168	er till ed hill technology	WKSL 3-2, PL I		7.00
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9,00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	×			
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and li	ine 31) (see instruction	s)		32.00

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-3025	Period: From 01/01/2022 To 07/31/2022	Worksheet E-3 Part III Date/Time Prep	
			Hocpi tal	11/22/2022 12 PPS	:05 pr
		Title XVIII	Hospi tal	PPS	
				1.00	
00	PART III - MEDICARE PART A SERVICES - IRF PPS			45 0/5 074	
. 00	Net Federal PPS Payment (see instructions)			15, 965, 874	1.0
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0437	2.0
. 00	Inpatient Rehabilitation LIP Payments (see instructions)			860, 561	3.0
. 00 . 00	Outlier Payments Unweighted intern and resident FTE count in the most recent to November 15, 2004 (see instructions)	cost reporting period en	nding on or prior	11, 148 0. 00	4. ( 5. (
. 01	to November 15, 2004 (see instructions) Cap increases for the unweighted intern and resident FTE cou	int for residents that we	e displaced by	0.00	5.0
. 01	program or hospital closure, that would not be counted with (CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00	5. (
. 00	New Teaching program adjustment. (see instructions)			0.00	6. (
. 00	Current year's unweighted FTE count of I&R excluding FTEs in	n the new program growth p	period of a "new	0.00	7.0
	teaching program" (see instructions)				
8. 00	Current year's unweighted I&R FTE count for residents within teaching program" (see instructions)	n the new program growth p	period of a "new	0.00	8. (
0. 00	Intern and resident count for IRF PPS medical education adju	stment (see instructions)	)	0.00	9. (
0.00	Average Daily Census (see instructions)			91. 316038	
1.00	Teaching Adjustment Factor (see instructions)			0. 000000	
2.00	Teaching Adjustment (see instructions)			0	12.
3.00	Total PPS Payment (see instructions)			16, 837, 583	
4.00	Nursing and Allied Health Managed Care payments (see instruc	ction)		0	
5.00	Organ acquisition (DO NOT USE THIS LINE)				15.
	Cost of physicians' services in a teaching hospital (see ins	structions)		0	
	Subtotal (see instructions)			16, 837, 583	
	Primary payer payments			10, 500	
	Subtotal (line 17 less line 18).			16, 827, 083	
	Deductibles			241,834	
	Subtotal (line 19 minus line 20)			16, 585, 249	
	Coinsurance			120, 266	
	Subtotal (line 21 minus line 22)	(coc) (coc instructions)		16, 464, 983 94, 308	
	Allowable bad debts (exclude bad debts for professional serv Adjusted reimbursable bad debts (see instructions)	(see fistinctions)		61, 300	
	Allowable bad debts for dual eligible beneficiaries (see ins	structions)		67, 077	
	Subtotal (sum of lines 23 and 25)			16, 526, 283	
	Direct graduate medical education payments (from Wkst. E-4,	line 49)		10, 320, 203	28.
	Other pass through costs (see instructions)			0	29.0
0.00	Outlier payments reconciliation			0	30.0
1.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	31.0
1.50	Pioneer ACO demonstration payment adjustment (see instruction	ons)		0	31.
1. 98	Recovery of accel erated depreciation.	,		0	31.
1.99	Demonstration payment adjustment amount before sequestration	1		0	31.
2.00	Total amount payable to the provider (see instructions)			16, 526, 283	32.
2. 01	Sequestration adjustment (see instructions)			118, 989	32.
2. 02	Demonstration payment adjustment amount after sequestration			0	32.
3.00	Interim payments			16, 351, 219	33. (
4.00	Tentative settlement (for contractor use only)			0	34.0
5.00	Balance due provider/program (line 32 minus lines 32.01, 32.	02, 33, and 34)		56, 075	35.0
6. 00	Protested amounts (nonallowable cost report items) in accord §115.2	lance with CMS Pub. 15-2,	chapter 1,	494, 400	36. (
	TO BE COMPLETED BY CONTRACTOR				
0. 00	Original outlier amount from Wkst. E-3, Pt. III, line 4			11, 148	50. (
1.00	Outlier reconciliation adjustment amount (see instructions)			0	51.0
2.00	The rate used to calculate the Time Value of Money			0.00	
3.00	Time Value of Money (see instructions)			0	53.

99.00Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.0.00000099.0099.01Calculated Teaching Adjustment Factor for the current year.(see instructions)0.00000099.01

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	DNESS REHABILIT Provider CCN: 15-3025	Peri od:	u of Form CMS-2 Worksheet E-3	
			From 01/01/2022	Part VII	
			To 07/31/2022	Date/Time Pre 11/22/2022 12	
		Title XIX	Hospi tal	Cost	<u>. 00 pi</u>
			Inpatient	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEP	RVICES FOR TITLES V OR >	IX SERVICES		-
00	COMPUTATION OF NET COST OF COVERED SERVICES		172, 976		1.0
00	Medical and other services		172, 970	0	
00	Organ acquisition (certified transplant centers only)		0	0	3.0
00	Subtotal (sum of lines 1, 2 and 3)		172, 976	0	
00	Inpatient primary payer payments		0		5.0
00	Outpatient primary payer payments			0	6.0
00	Subtotal (line 4 less sum of lines 5 and 6)		172, 976	0	7.0
	COMPUTATION OF LESSER OF COST OR CHARGES				-
00	Reasonable Charges		102.070		
00 00	Routine service charges Ancillary service charges		182, 070 196, 712	0	8.0 9.0
00	Organ acquisition charges, net of revenue		196, 712	0	10.0
	Incentive from target amount computation		0		11.0
	Total reasonable charges (sum of lines 8 through 11)		378, 782	0	
	CUSTOMARY CHARGES				1
3.00	Amount actually collected from patients liable for payment for	r services on a charge	0	0	13.0
	basi s				
1.00	Amounts that would have been realized from patients liable for		on 0	0	14.0
. 00	a charge basis had such payment been made in accordance with Ratio of line 13 to line 14 (not to exceed 1.000000)	42 CFR §413.13(e)	0, 000000	0.000000	15. C
5.00 5.00	Total customary charges (see instructions)		378, 782	0.000000	16. C
7.00	Excess of customary charges over reasonable cost (complete on	lvifline 16 exceeds	205, 806	0	17.0
	line 4) (see instructions)		200,000	Ū	
3. 00	Excess of reasonable cost over customary charges (complete on	ly if line 4 exceeds lir	ne O	0	18.0
	16) (see instructions)				
	Interns and Residents (see instructions)		0	0	
	Cost of physicians' services in a teaching hospital (see inst		0	0	20.0
I. 00	Cost of covered services (enter the lesser of line 4 or line		172, 976	0	21.0
2.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be Other than outlier payments	compreted for PPS provi	0	0	22.0
3.00	Outlier payments		0	0	
	Program capital payments		0	Ū	24.0
	Capital exception payments (see instructions)		0		25.0
5.00	Routine and Ancillary service other pass through costs		0	0	26. (
7.00	Subtotal (sum of lines 22 through 26)		0	0	27.0
3. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28.0
9.00	Titles V or XIX (sum of lines 21 and 27)		172, 976	0	29.0
00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	1 20 0
). 00 I. 00	Excess of reasonable cost (from line 18) Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6	\ \	0 172, 976	0	30.0
2.00	Deductibles	)	172, 970	0	
3.00	Coi nsurance		0	0	
1.00	Allowable bad debts (see instructions)		0	0	
5.00	Utilization review		0		35.
5.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	d 33)	172, 976	0	
7.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
3.00	Subtotal (line 36 ± line 37)		172, 976	0	
9.00	Direct graduate medical education payments (from Wkst. E-4)		0	~	39.
). 00	Total amount payable to the provider (sum of lines 38 and 39)		172, 976	0	
1.00	Interim payments Balance due provider/program (line 40 minus line 41)		114, 114	0	41.0
2.00 3.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub 15-2	58, 862	0	42.0
	chapter 1, §115.2	nee with owe rub 15-2,	0	0	-5.0

	inancial Systems ENCOMPASS HEALTH DE SHEET (If you are nonproprietary and do not maintain	Provider C		Peri od:	u of Form CMS-2 Worksheet G	
und-typ nly)	be accounting records, complete the General Fund column			From 01/01/2022 To 07/31/2022		pare
		General Fund	Specific Purpose Func	Endowment Fund	11/22/2022 12 Plant Fund	: 05
		1.00	2.00	3.00	4.00	
	JRRENT ASSETS ash on hand in banks	6, 957, 691		0 0	0	1 1.
	emporary investments	0,957,091		0 0	0	
	otes receivable			0 0	0	
	ccounts receivable	10, 843, 463		0 0	0	
	ther receivable	10, 043, 403		0 0	0	
	llowances for uncollectible notes and accounts receivable	-3, 450, 212		0 0	0	6
	nventory	40, 047		0 0	0	
	repaid expenses	10,017		0 0	0	8
	ther current assets	25, 859		0 0	0	9
	ue from other funds	C	)	0 0	0	10
	otal current assets (sum of lines 1-10)	14, 416, 848		0 0	0	
	I XED ASSETS					1
	and	1, 675, 024		0 0	0	112
. 00 L	and improvements	356, 682		0 0	0	13
. 00 A	ccumulated depreciation	-15, 465, 822		0 0	0	14
. 00 B	ui l di ngs	25, 009, 870	)	0 0	0	15
	ccumulated depreciation	0		0 0	0	16
. 00 L	easehold improvements	1, 757, 768		0 0	0	17
	ccumulated depreciation	0		0 0	0	18
	ixed equipment	0		0 0	0	19
	ccumulated depreciation	C		0 0	0	20
	utomobiles and trucks	C		0 0	0	21
	ccumul ated depreciation	0		0 0	0	22
	ajor movable equipment	5, 664, 844		0 0	0	23
	ccumulated depreciation	0		0 0	0	24
	inor equipment depreciable	0		0 0	0	25
	ccumulated depreciation	0		0 0	0	26
	IT designated Assets	0		0 0	0	
	ccumulated depreciation			0 0	0	28
	inor equipment-nondepreciable otal fixed assets (sum of lines 12-29)	18, 998, 366		0 0 0 0	0	29
	THER ASSETS	10, 990, 300	1	0 0	0	1 30
	nvestments	810, 450		0 0	0	31
	eposits on leases			0 0	0	32
	ue from owners/officers			0 0	0	
	ther assets	20, 040, 816		0 0	0	
	otal other assets (sum of lines 31-34)	20, 851, 266		0 0	0	
	otal assets (sum of lines 11, 30, and 35)	54, 266, 480		0 0	0	
	JRRENT LIABILITIES		1	-1 -		1
	ccounts payable	587, 989	1	0 0	0	37
	alaries, wages, and fees payable	1, 433, 667		0 0	0	38
	ayroll taxes payable	0	)	0 0	0	39
). OO N	otes and loans payable (short term)	4, 338, 430		0 0	0	40
	eferred income	0	)	0 0	0	41
2.00 A	ccelerated payments	0				42
3.00 D	ue to other funds	0		0 0	0	43
1.00 0	ther current liabilities	0		0 0	0	44
	otal current liabilities (sum of lines 37 thru 44)	6, 360, 086		0 0	0	45
	ONG TERM LIABILITIES					
	ortgage payable	C		0 0	0	
	otes payable	0		0 0	0	
	nsecured loans			0	0	
	ther long term liabilities	13, 806, 868		0 0	0	
	otal long term liabilities (sum of lines 46 thru 49)	13, 806, 868 20, 166, 954		0 0	0	
	otal liabilities (sum of lines 45 and 50)	20, 100, 954		0 0	0	1 21
	APITAL ACCOUNTS eneral fund balance	34, 099, 526				1 61
	pecific purpose fund	54, 077, 320		0		52
	onor created - endowment fund balance - restricted			~ 		54
	onor created - endowment fund balance - restricted			0		55
	overning body created - endowment fund balance			0		56
1	lant fund balance - invested in plant			0	0	
	lant fund balance - reserve for plant improvement,				0	
	eplacement, and expansion					
	otal fund balances (sum of lines 52 thru 58)	34, 099, 526		0 0	0	59
	otal liabilities and fund balances (sum of lines 51 and	54, 266, 480	1	0 0	0	
. 00 11						

	Financial Systems ENCOM ENT OF CHANGES IN FUND BALANCES	MPASS HEALTH DEA	CONESS REHABIL Provider CC			eu of Form CMS-2	
STATEN	ENT OF CHANGES IN FUND BALANCES		Provider CC	N: 15-3025	Period: From 01/01/2022 To 07/31/2022	Worksheet G-1 Date/Time Pre 11/22/2022 12	pared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
					1.00	5.00	
1.00	Fund balances at beginning of period	1.00	2.00 33,783,388	3.00	4.00	5.00	1.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00	Total additions (sum of line 4-9)	0 0 0 0 0	9, 363, 579 43, 146, 967				2.00 3.00 4.00 5.00 6.00 7.00 8.00
11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total deductions (sum of lines 10)         Deductions (debit adjustments) (specify)         MINORITY INTEREST EXPENSE         DI STRIBUTIONS    Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 2, 574, 984 6, 472, 457 0 0 0	43, 146, 967 9, 047, 441 34, 099, 526				11.00 12.00 13.00 14.00 15.00 16.00
		Endowment Fund	PI ant	Fund			
		6.00	7.00	8.00			
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0 0 0 0	0.00	0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) MINORITY INTEREST EXPENSE DISTRIBUTIONS Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0 0	0 0 0 0 0		0 0 0 0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

Cost Center Description         Ingatient         Outpatient         Total           PART I - PATIENT REVENUES         3.00         3.00           Seneral Ingatient Routine Services         3.00           1.00         Version         3.00           Version         Supervolution         1.00         2.00           1.00         Version         20, 701, 569         20, 701, 569         20, 701, 569           3.00         SUPPROVIDER - IPF         0         0         0           3.00         SUPROVIDER - IPF         0         0         0           5.00         Swing bed - SNF         0         0         0           0.00         Versitive FARLLINY         0         0         700           9.00         OTHER LONG TERM CARE         0         0         701, 569         20, 701, 569           10.01         Intensive Care Type Inpatient Hospital Services         0         701, 50         20, 701, 569         20, 701, 569           10.00         Intensive Care UNIT         1         20, 701, 569         20, 701, 569         20, 701, 569           10.00         Intensive Care UNIT         1         20, 071, 569         20, 701, 569         20, 701, 569         20, 701, 569         20, 701, 569		Financial Systems ENCOMPASS HEALTH DEACO ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CC		Period: From 01/01/202 To 07/31/202		2 epared:
PART 1         - PART I PATIENT REVENUES           General Inpatient Routine Services           1.00           Hospital           200         SUBPROVIDER - IPF           3.00         SUBPROVIDER - IFR           4.00         SUBPROVIDER - IRF           5.00         SWing bed - SNF           6.00         Swing bed - SNF           6.00         Swing bed - SNF           7.00         SKILLED NURSING FACILITY           8.00         NURSING FACILITY           9.00         OTHER LONG TERM CARE           10.01         Intensive Care Type Inpatient Hospital Services           11.00         INTENSIVE CARE UNIT           12.00         COROMARY CARE UNIT           13.00         BURN INTENSIVE CARE UNIT           14.00         SURGICAL INTENSIVE CARE UNIT           14.00         Total Inpatient routine care services (sum of lines 10 and 16)         20, 701, 56           11.15)         Contel Services         20, 000           10.00         Total Inpatient routine care services (sum of lines 10 and 16)         20, 701, 56           10.00         Coronauxer Care Services         20, 01, 50           11.00         Care Services         20, 01, 50             10.00         RefCNY		Cost Center Description		I npati ent	Outpati ent		
General Inpatient Routine Services           100         Hospital         20, 701, 569         20, 701, 569         20, 701, 569           2.00         SUBPROVIDER - IPF         0         0         500         Swing bed - SNF         0				1.00	2.00	3.00	
1.00         Hospital         20, 701, 569         20, 701, 569         20, 701, 569           2.00         SUBPROVIDER - IPF         0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>-</td>							-
2.00         SUBPROVIDER - IPF           0.00         SUBPROVIDER - IFF           5.00         Swing bed - NF           6.00         Swing bed - NF           0.01         SKILLED NURSING FACILITY           0.02         OTHER LONG TERM CARE           0.01         OTHER LONG TERM CARE UNIT           12.00         CORONARY CARE UNIT           13.00         BURN INTENSI VE CARE UNIT           14.00         Tester SPECIAL CARE (SPECIFY)           16.00         Total Intensive care type inpatient hospital services (sum of lines           11.1-15)         OTHER SPECIAL CARE (SPECIFY)           16.00         Total Intervices           0.01         Total Intervices           11.01         Tester Secial Cale CARE (SPECIFY)           12.00         FDERALLY OLALIFIED HEALTH CENTER           0.00         RURAL TORY SWEICAR (SPECIFY)           12.00         FDERALLY OLALIFIED HEALTH CENTER           0.00 <t< td=""><td>1 00</td><td></td><td></td><td>20 701 5</td><td>(0)</td><td>20 701 5/0</td><td>1 1 00</td></t<>	1 00			20 701 5	(0)	20 701 5/0	1 1 00
3.00         SUBPROVIDER - IRF         0         0           4.00         SUBPROVIDER         0         0           5.00         Swing bed - SNF         0         0           6.00         Swing bed - SNF         0         0           7.00         SKILLED NURSING FACILITY         0         0           8.00         NURSING FACILITY         0         0           10.00         Total general inpatient care services (sum of lines 1-9)         20, 701, 569         20, 701, 569           11.00         INTERSIVE CARE UNIT         0         0         0           13.00         BURN INTENSIVE CARE UNIT         0         0         0           11.00         Tintensive Care type inpatient hospital services (sum of lines 10 and 16)         20, 701, 569         20, 701, 569           11.15)         1         1         0         0         0         0           10.00         Ottal inpatient care services (sum of lines 10 and 16)         20, 701, 569         20, 701, 569         20, 701, 569           11.00         RURAL HEALTH CLINIC         0         0         0         0         0           0         0         0         0         0         0         0         0         0				20, 701, 5	69	20, 701, 569	1.00
4.00         SUBPROVIDER         0           00         SWing bed - NF         0           01         SWIng bed - NF         0           02         SWIng bed - NF         0           03         SWIng bed - NF         0           04         SWILLED NURSING FACILITY         0           01         Total general inpatient care services (sum of lines 1-9)         20, 701, 569         20, 701, 569           100         INTENSIVE CARE UNIT         1         1         1         1           100         INTENSIVE CARE UNIT         1         1         1         1           11-15)         0         Total Intensive care type inpatient hospital services (sum of lines 10 and 16)         20, 701, 569         20, 701, 569           11-15)         0         Total inpatient routine care services (sum of lines 10 and 16)         20, 701, 569         20, 701, 569           12, 00         Rotal HARLTY (CLNIC         0         0         0         0           10         Sussian (all HARLTY (CLNIC         0         0         0         0           10         OTHER (SPECILITY         0         0         0         0         0           11         0         OTHER Secold (CLNINC         0							3.00
5.00         Swing bed - SNF         0           6.00         SkilLED NURSING FACILITY         0           8.00         NURSING FACILITY         0           9.00         THERN LONG TEAM CARE         0           10.00         Total general inpatient care services (sum of lines 1-9)         20, 701, 569         20, 701, 56           11.00         INTERSIVE CARE UNIT         20, 701, 569         20, 701, 56           11.00         BURNARY CARE UNIT         1         1         20         CORMARY CARE UNIT         1           13.00         BURN INTENSIVE CARE UNIT         1         1         1         1         20, 701, 569         20, 701, 569           11.01         Total intensive care type inpatient hospital services (sum of lines 10 and 16)         20, 701, 569         20, 701, 569           11.01         Total intensive care type inpatient hospital services (sum of lines 10 and 16)         20, 701, 569         20, 701, 569           11.00         Total intensive care services         0         0         0         0           10.00         Rotal intensive care type inpatient hospital services (sum of lines 10 and 16)         20, 701, 569         22, 043, 49         0           11.00         Rotal intensive care services         0         0         0         0							4.00
6.00         Swingbed - NF         0           7.00         SKILLED NURSING FACILITY         0           8.00         NURSING FACILITY         0           9.00         OTHER LONG TERM CARE         20,701,569         20,701,5           9.01         OTHER LONG TERM CARE         0         20,701,569         20,701,5           1.00         INTENSIVE CARE UNIT         0         0         0         0           1.00         INTENSIVE CARE UNIT         0 </td <td></td> <td></td> <td></td> <td></td> <td>0</td> <td>0</td> <td></td>					0	0	
7.00       SKILTED NURSING FACILITY       20,701,569       20,701,569         8.00       NURSING FACILITY       20,701,569       20,701,569       20,701,569         10.00       Total general inpatient care services (sum of lines 1-9)       20,701,569       20,701,569       20,701,569         11.00       INTENSIVE CARE UNIT       1       2       1       1       1       1       1       1		5			-	0	
8.00 NURSING FACILITY 9.00 OTHER LONG TERM CARE 10.00 Total general inpatient care services (sum of lines 1-9) 20, 701, 569 20, 701, 569 11.00 INTENSIVE CARE UNIT 12.00 CORONARY CARE UNIT 13.00 BURN INTENSIVE CARE UNIT 14.00 SURGICAL INTENSIVE CARE UNIT 15.00 OTHER SPECIAL CARE (SPECIFY) 16.00 Total inpatient routine care services (sum of lines 10 and 16) 20, 701, 569 11.15) 10.00 RURAL HEALTH CLINIC 10.00 RURAL HEALTH AGENCY 10.00 RURAL							7.00
10.00 Intensive Care Type Inpatient care services (sum of lines 1-9)       20, 701, 569       20, 701, 569         11.00       INTENSI VE CARE UNIT       0       0         12.00       CORONARY CARE UNIT       0       0         13.00       BURN INTENSI VE CARE UNIT       0       0         14.00       SURGICAL INTENSI VE CARE UNIT       0       0         14.00       SURGICAL INTENSI VE CARE UNIT       0       0         15.00       OTHER SPECIAL CARE (SPECIFY)       0       0         16.00       Total inpatient routine care services (sum of lines 10 and 16)       20, 701, 569       22, 042, 779         17.00       Total inpatient FIED HEALTH CENTER       0       0       0         00       RURAL HEALTH CLINIC       0       0       0         01.00       FDERALLY OUALFIED HEALTH CENTER       0       0       0         01.00       FDERALLY OUALFIED HEALTH CENTER       0       0       0         02.00       OHME HEALTH AGENCY       0       0       0       0         23.00       AMBULANCE SERVICES       0       0       0       0         24.00       OHME HEALTH AGENCY       0       0       0       0         25.00       AMBULA							8.00
Intensive Care Type Inpatient Hospital Services         11.00       INTENSIVE CARE UNIT         12.00       CORNARY CARE UNIT         13.00       BURN INTENSIVE CARE UNIT         13.00       BURN INTENSIVE CARE UNIT         13.00       ORONARY CARE UNIT         14.00       SURG CAL INTENSIVE CARE UNIT         15.00       OTHER SPECIAL CARE (SPECIFY)         16.00       Total inpatient routine care services (sum of lines 10 and 16)       20, 701, 569         17.00       Total inpatient routine care services (sum of lines 10 and 16)       20, 701, 569         17.00       Total inpatient curves       0         18.00       Ancillary services       0         19.00       Outpatient services       0         10.00       FEDERALLY QUALIFIED HEALTH CENTER       0         10.00       HOME HEALTH AGENCY       0         23.00       AMBULATORY SURGICAL CENTER (D.P.)       0         10.00       HEG (SPECIFY)       0         24.00       CHER (SPECIFY)       0         25.00       AMBULATORY SURGICAL CENTER (D.P.)       0         26.00       HOME (SPECIFY)       0       0         27.00       There (SPECIFY)       0       0         29.00       Op	9.00	OTHER LONG TERM CARE					9.00
11.00       INTENSIVE CARE UNIT         12.00       CORONARY CARE UNIT         12.01       CORONARY CARE UNIT         12.02       CORONARY CARE UNIT         13.00       BURN INTENSIVE CARE UNIT         14.00       SURGICAL INTENSIVE CARE UNIT         15.00       There Special CARE (SPCIFY)         16.00       Total inpatient routine care services (sum of lines 10 and 16)       20, 701, 569         17.00       Total inpatient routine care services (sum of lines 10 and 16)       20, 701, 569         18.00       Ancillary services       0         19.00       QUPAtient services       0         10.00       RURAL HEALTH CLINIC       0         10.00       REPAILY QUALIFIED HEALTH CENTER       0         20.00       RURAL HEALTH ACENCY       0         23.00       AMBULATORY SURGICAL CENTER (D. P. )       0         24.00       CMHC       42, 744, 348         714       42, 745, 0         6-3, line 1)       20, 529, 891         9/20       O       0         9/20       O       0         9/21       O       0         9/20       O       0         9/21       0       0         28.00 <td>10.00</td> <td>Total general inpatient care services (sum of lines 1-9)</td> <td></td> <td>20, 701, 5</td> <td>69</td> <td>20, 701, 569</td> <td>10.00</td>	10.00	Total general inpatient care services (sum of lines 1-9)		20, 701, 5	69	20, 701, 569	10.00
12.00       CORONARY CARE UNIT         13.00       BURN INTENSIVE CARE UNIT         13.00       BURN INTENSIVE CARE UNIT         14.00       SUBCICAL INTENSIVE CARE UNIT         15.00       OTHER SPECIAL CARE (SPECIFY)         16.00       Total intensive care type inpatient hospital services (sum of lines       0         11-15)       11-15       20,701,569         11-150       22,042,779       714         19.00       Outpatient services       22,042,779         19.00       Outpatient services       0         00       0       0         01.00       FEDERALLY OUAL IFED HEALTH CENTER       0         01.00       FEDERALLY OUAL IFIED HEALTH CENTER       0         01.00       FEDERALLY OUAL IFIED HEALTH CENTER       0         23.00       AMBULANCY SURGICAL CENTER (D.P.)       0         04.00       OHHE HEALTH AGENCY       0       0         03.00       OTHER (SPECIFY)       0       0         04.00       OHHE HEALTH REVENES       0       0       0         29.00       OPerating expenses (per Wkst. A, column 3, line 200)       0       20,529,891         30.00       ADD (SPECIFY)       0       0       0		Intensive Care Type Inpatient Hospital Services					
13.00       BURN INTENSIVE CARE UNIT         14.00       SURGICAL INTENSIVE CARE UNIT         15.00       OTHER SPECIAL CARE (SPECIFY)         16.00       Total intensive care type inpatient hospital services (sum of lines 10 and 16)       20, 701, 569         17.00       Total inpatient routine care services (sum of lines 10 and 16)       20, 701, 569       22, 043, 47         17.00       Total inpatient routine care services (sum of lines 10 and 16)       20, 701, 569       22, 043, 47         17.00       Total inpatient routine care services (sum of lines 10 and 16)       20, 701, 569       22, 043, 47         17.00       Total inpatient routine care services (sum of lines 10 and 16)       20, 701, 569       22, 043, 47         17.00       Total inpatient routine care services       0       0       0         18.00       ANBULATORY SURGICAL CENTER       0       0       0         22.00       HOME HEALTH AGENCY       0       0       0         23.00       AMBULATORY SURGICAL CENTER (D.P.)       0       0       0         26.00       OTHER (SPECIFY)       0       0       0       0         27.00       Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst.       42, 744, 348       714       42, 745, 0         27.00       Operating e							11.00
14.00       SURCICAL INTENSIVE CARE UNIT       0         15.00       OTHER SPECIAL CARE (SPECIFY)       0         16.00       Total intensive care type inpatient hospital services (sum of lines 10 and 16)       20, 701, 569       20, 701, 569         17.00       Total intensive care type inpatient hospital services (sum of lines 10 and 16)       20, 701, 569       20, 701, 569         18.00       Ancillary services       0       0         00       Outpatient services       0       0         01.00       FEDERALLY OUALIFIED HEALTH CENTER       0       0         02.00       RURAL HEALTH AGENCY       0       0         03.00       MBULANCE SERVICES       0       0         24.00       OMHC       0       0       0         25.00       AMBULANCE SERVICES       0       0       0         27.00       OTHER (SPECIFY)       0       0       0         0       OUTAI patient revenues (sum of lines 17-27) (transfer column 3 to Wkst.       42, 744, 348       714       42, 745, 0         0       Operating expenses (per Wkst. A, column 3, line 200)       0       0       0       0         0       0       0       0       0       0       0       0       0							12.00
15.00       OTHER SPECIAL CARE (SPECIFY)       0         16.00       Total intensive care type inpatient hospital services (sum of lines 10 and 16)       20, 701, 569       20, 701, 5         17.00       Total inpatient routine care services (sum of lines 10 and 16)       20, 701, 569       22, 042, 779       714         19.00       Outpatient services       0       0       0       0         00       RURAL HEALTH CLINIC       0       0       0       0         01.00       FEDERALLY OUALIFIED HEALTH CENTER       0       0       0         23.00       AMBULANCE SERVICES       0       0       0         24.00       CMHC       0       0       0         25.00       AMBULATORY SURGICAL CENTER (D. P.)       0       0       0         26.00       HOME HEALTH venues (sum of lines 17-27) (transfer column 3 to Wkst.       42, 744, 348       714       42, 745, 0         27.00       Otherating expenses (per Wkst. A, column 3, line 200)       0       20, 529, 891       0         30.00       0       0       0       0       0       0       0       0         28.00       Operating expenses (per Wkst. A, column 3, line 200)       0       0       0       0       0       0 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td>13.00</td></td<>							13.00
16.00       Total intensive care type inpatient hospital services (sum of lines 10 and 16)       20, 701, 559       20, 701, 559         11.15)       22, 042, 779       714       22, 043, 49         19.00       Outpatient services       0       0         00       RURAL HEALTH CLINIC       0       0       0         11.00       FEDERALLY QUALIFIED HEALTH CENTER       0       0       0         21.00       FEDERALLY QUALIFIED HEALTH CENTER       0       0       0         23.00       AMBULANCE SERVICES       0       0       0         24.00       CMHC       0       0       0       0         25.00       AMBULATORY SURGICAL CENTER (D.P.)       0       0       0         26.00       HOSPICE       0       0       0       0         27.00       OTHER (SPECIFY)       0       0       0       0         28.00       Otal patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.       42, 744, 348       714       42, 745, 0         20.01       Operating expenses (per Wkst. A, column 3, line 200)       0       0       0       0         30.00       ADD (SPECIFY)       0       0       0       0       0       0       0							14.00
11-15)       Total inpatient routine care services (sum of lines 10 and 16)       20, 701, 569       20, 701, 5         18.00       Ancillary services       22, 042, 79       714       22, 043, 44         19.00       Outpatient services       0       0       0       0         0.00       RURAL HEALTH CLINIC       0       0       0       0         0.00       RURAL HEALTH CLINIC       0       0       0       0         23.00       AMBULANCE SERVICES       0       0       0       0         24.00       CMHC       EXEVICES       0       0       0         25.00       AMBULATORY SURGICAL CENTER (D. P. )       0       0       0       0         26.00       OTHER (SPECIFY)       0       0       0       0         27.00       OTHER (SPECIFY)       0       0       0       0         29.00       Operating expenses (per Wkst. A, column 3, line 200)       0       0       3       0       0       0         31.00       30       0       0       0       0       0       0       0         32.00       30.00       0       0       0       0       0       0       0       0		. ,					15.00
17.00       Total inpatient routine care services (sum of lines 10 and 16)       20, 701, 569       20, 701, 569         18.00       Ancillary services       22, 042, 779       714         9.00       Qupatient services       0       0         19.00       Qupatient services       0       0         22, 042, 779       714       22, 043, 41         19.00       Qupatient services       0       0         20.00       RURAL HEALTH CLINIC       0       0         21.00       FEDERALLY QUALIFIED HEALTH CENTER       0       0         24.00       GMHE HEALTH AGENCY       0       0         23.00       AMBULATORY SURGICAL CENTER (D. P. )       0       0         24.00       OHKE       GSPCIFY)       0       0         27.00       OTHER (SPECIFY)       0       0       0         29.00       Operating expenses (sum of lines 17-27) (transfer column 3 to Wkst.       42, 744, 348       714       42, 745, 0         9.00       Operating expenses (per Wkst. A, column 3, line 200)       0       0       0       0         30.00       ADD (SPECIFY)       0       0       0       0       0       0         31.00       0       0       0<	16.00		lines		0	0	16.00
18.00       Ancillary services       22,042,779       714       22,043,41         19.00       Outpatient services       0       0         00.00       RURAL HEALTH CLINIC       0       0         10.00       FEDERALLY OUALIFIED HEALTH CENTER       0       0         21.00       HOME HEALTH AGENCY       0       0         23.00       AMBULANCE SERVICES       0       0         24.00       CMHC       0       0         23.00       AMBULATORY SURGICAL CENTER (D.P.)       0       0         40.00       OTHER (SPECIFY)       0       0         27.00       OTHER (SPECIFY)       0       0         23.01       AMBULATORY SURGICAL CENTER (D.P.)       0       0         42,744,348       714       42,745,0       0         27.00       OTHER (SPECIFY)       0       0       42,745,0         9.00       Operating expenses (per Wkst. A, column 3, line 200)       0       20,529,891       42,745,0         9.00       Operating expenses (per Wkst. A, column 3, line 200)       0       0       0       0         31.00       0       0       0       0       0       0       0       0         32.00	17 00		\ \	20 701 E	40	20 701 640	17.00
19.00       Outpatient services       0       0         00.00       RURAL HEALTH CLINIC       0       0         01.00       FEDERALLY OUALIFIED HEALTH CENTER       0       0         02.00       HOME HEALTH AGENCY       0       0         23.00       AMBULANCE SERVICES       0       0         24.00       CMHC       0       0         25.00       AMBULANCE SERVICES       0       0         24.00       CMHC       0       0       0         25.00       AMBULANCE SERVICES       0       0       0         26.00       HOSPICE       0       0       0         27.00       OTHER (SPECIFY)       0       0       0       0         28.00       Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.       42,744,348       714       42,745,0         6-3, line 1)       PART II - OPERATING EXPENSES       20,529,891       0       0         70.00       ADD (SPECI FY)       0       0       0       0         33.00       30.00       30.00       0       0       0       0         33.00       0       0       0       0       0       0       0			)				
20.00       RURÅL HEALTH CLINIC       0       0         21.00       FEDERALLY QUALIFIED HEALTH CENTER       0       0         22.00       HOME HEALTH AGENCY       0       0         23.00       AMBULANCE SERVICES       0       0         24.00       CMHC       0       0         25.00       AMBULANCE SERVICES       0       0         26.00       HOSPICE       0       0         27.00       OTHER (SPECIFY)       0       0         28.00       Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst.       42, 744, 348       714         42, 745, 0       0       0       0       0         29.00       Operating expenses (per Wkst. A, column 3, line 200)       20, 529, 891       0         30.00       30.00       0       0       0         31.00       0       0       0       0         32.00       0       0       0       0         33.00       0       0       0       0         33.00       0       0       0       0         35.00       0       0       0       0         36.00       0       0       0 <td< td=""><td></td><td></td><td></td><td>22,042,7</td><td></td><td></td><td></td></td<>				22,042,7			
21.00       FEDERALLY QUALIFIED HEALTH CENTER       0       0         22.00       HOME HEALTH AGENCY       0       0         23.00       AMBULANCE SERVICES       0       0         24.00       CMHC       5800       AMBULATORY SURGICAL CENTER (D. P.)       0         26.00       HOSPICE       0       0       0         27.00       OTHER (SPECIFY)       0       0       0         28.00       Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst.       42, 744, 348       714       42, 745, 0         00       Operating expenses (per Wkst. A, column 3, line 200)       0       20, 529, 891       0         30.00       ADD (SPECIFY)       0       0       0       0         30.00       ADD (SPECIFY)       0       0       0       0       0         30.00       ADD (SPECIFY)       0							
22.00       HOME HEALTH AGENCY         23.00       AMBULANCE SERVICES         24.00       CMHC         25.00       AMBULATORY SURGICAL CENTER (D.P.)         26.00       HOSPICE         27.00       OTHER (SPECIFY)         00       O         28.00       Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst.         42.744,348       714         42.745,0       O         0       PART 11 - OPERATING EXPENSES         29.00       Operating expenses (per Wkst. A, column 3, line 200)         0       0         33.00       0         34.00       0         35.00       0         36.00       0         37.00       0         0       0         36.00       0         37.00       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0 </td <td></td> <td></td> <td></td> <td></td> <td>-</td> <td></td> <td></td>					-		
24.00       CMHC         25.00       AMBULATORY SURGICAL CENTER (D. P.)         HOSPICE       0         27.00       OTHER (SPECIFY)         0       Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst.         G-3, line 1)       PART II - OPERATING EXPENSES         9.00       Operating expenses (per Wkst. A, column 3, line 200)         ADD (SPECIFY)       0         31.00       0         32.00       0         35.00       0         05.00       0         0							22.00
24.00       CMHC         25.00       AMBULATORY SURGICAL CENTER (D. P.)         40.01       HOSPICE         7.00       OTHER (SPECIFY)         0       Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst.         G-3, line 1)       PART II - OPERATING EXPENSES         9.00       Operating expenses (per Wkst. A, column 3, line 200)         0.00       ADD (SPECIFY)         0       0         31.00       0         32.00       Total additions (sum of lines 30-35)         0       0	23.00	AMBULANCE SERVI CES					23.00
26.00       HOSPICE       0         27.00       OTHER (SPECI FY)       0         28.00       Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst.       42, 744, 348         714       42, 745, 0         G-3, line 1)       PART II - OPERATING EXPENSES         29.00       Operating expenses (per Wkst. A, column 3, line 200)       20, 529, 891         30.00       ADD (SPECI FY)       0         31.00       0       0         32.00       0       0         33.00       0       0         34.00       0       0         35.00       0       0         36.00       Total additions (sum of lines 30-35)       0         0       0       0       0         38.00       0       0       0         39.00       0       0       0         40.00       0       0       0	24.00						24.00
27.00       OTHER (SPECI FY)       0       0         28.00       Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst.       42, 744, 348       714       42, 745, 0         G-3, line 1)       PART II - OPERATING EXPENSES       20, 529, 891       20, 529, 891       1         9.00       Operating expenses (per Wkst. A, column 3, line 200)       0       0       1         30.00       ADD (SPECI FY)       0       0       0         31.00       0       0       0       0         32.00       0       0       0       0         33.00       0       0       0       0         35.00       0       0       0       0         36.00       Total additions (sum of lines 30-35)       0       0       0         38.00       0       0       0       0       0         39.00       0       0       0       0       0         40.00       0       0       0       0       0	25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
28.00         Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst.         42, 744, 348         714         42, 745, 0           PART II - OPERATING EXPENSES         Operating expenses (per Wkst. A, column 3, line 200)         20, 529, 891         20, 529, 891         0           30.00         ADD (SPECIFY)         0							26.00
G-3, line 1)         PART 11 - OPERATING EXPENSES           29.00         Operating expenses (per Wkst. A, column 3, line 200)         20, 529, 891           30.00         ADD (SPECIFY)         0           31.00         0         0           32.00         0         0           34.00         0         0           35.00         0         0           36.00         Total additions (sum of lines 30-35)         0           0         0         0           37.00         DEDUCT (SPECIFY)         0           0         0         0           0         0         0           0         0         0					0	°	
PART II - OPERATING EXPENSES           29.00         Operating expenses (per Wkst. A, column 3, line 200)           ADD (SPECIFY)         0           31.00         0           32.00         0           33.00         0           34.00         0           35.00         0           36.00         Total additions (sum of lines 30-35)           0         0           38.00         0           39.00         0	28.00		to Wkst.	42, 744, 3	48 71	4 42, 745, 062	28.00
29.00       Operating expenses (per Wkst. A, column 3, line 200)       20, 529, 891         30.00       ADD (SPECIFY)       0         31.00       0       0         32.00       0       0         33.00       0       0         34.00       0       0         35.00       0       0         36.00       Total additions (sum of lines 30-35)       0         0       0       0         38.00       0       0         39.00       0       0							-
30. 00       ADD (SPECIFY)       0         31. 00       0         32. 00       0         33. 00       0         34. 00       0         35. 00       0         36. 00       Total additions (sum of lines 30-35)       0         37. 00       DEDUCT (SPECIFY)       0         38. 00       0       0         39. 00       0       0         40. 00       0       0	20.00				20 520 00	1	1 20 00
31.00       0         32.00       0         33.00       0         34.00       0         35.00       0         36.00       Total additions (sum of lines 30-35)       0         37.00       DEDUCT (SPECIFY)       0         38.00       0       0         39.00       0       0         40.00       0       0						1	29.00
32.00       0         33.00       0         34.00       0         35.00       0         36.00       Total additions (sum of lines 30-35)       0         37.00       DEDUCT (SPECIFY)       0         38.00       0       0         39.00       0       0         40.00       0       0		ADD (SPECIFY)					30.00
33.00       0         34.00       0         35.00       0         35.00       0         36.00       Total additions (sum of lines 30-35)         37.00       DEDUCT (SPECIFY)         0       0         38.00       0         39.00       0         40.00       0							32.00
34.00       0         35.00       0         36.00       Total additions (sum of lines 30-35)         37.00       DEDUCT (SPECIFY)         0       0         38.00       0         39.00       0         40.00       0							33.00
35.00       Total additions (sum of lines 30-35)       0         37.00       DEDUCT (SPECIFY)       0         38.00       0       0         39.00       0       0         40.00       0       0					-		34.00
36.00     Total additions (sum of lines 30-35)     0       37.00     DEDUCT (SPECIFY)     0       38.00     0     0       39.00     0     0       40.00     0     0							35.00
37.00       DEDUCT (SPECI FY)       0         38.00       0       0         39.00       0       0         40.00       0       0		Total additions (sum of lines 30-35)			0	0	36.00
38.00     0       39.00     0       40.00     0	37.00				0		37.00
40. 00					0		38.00
	39.00				0		39.00
	40.00				0		40.00
	41.00				0		41.00
42.00 Total deductions (sum of lines 37-41) 0						-	42.00
43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 20, 529, 891 to Wkst. G-3, line 4)	43.00		2)(transfer		20, 529, 89	1	43.00

STATEM	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-3025	Peri od:	Worksheet G-3	
OTATEN			From 01/01/2022		
			To 07/31/2022	Date/Time Prep	
				11/22/2022 12	05 pm
			-	1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, li	ne 28)		42, 745, 062	1.00
2.00	Less contractual allowances and discounts on patients' accou			12, 935, 985	2.00
3.00	Net patient revenues (line 1 minus line 2)			29, 809, 077	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		20, 529, 891	4.00
5.00	Net income from service to patients (line 3 minus line 4)			9, 279, 186	5.00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			84, 393	7.00
8.00	Revenues from telephone and other miscellaneous communication	n servi ces		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			0	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
	Revenue from meals sold to employees and guests			0	14.00
15.00	Revenue from rental of living quarters			0	15.00
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	17.00
18.00	Revenue from sale of medical records and abstracts			0	18.00
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
	Rental of vending machines			0	21.00
22.00	Rental of hospital space			0	22.00
	Governmental appropriations			0	23.00
	OTHER (SPECIFY)			0	24.00
	COVID-19 PHE Funding			0	24.50
	Total other income (sum of lines 6-24)			84, 393	25.00
	Total (line 5 plus line 25)			9, 363, 579	26.00
	OTHER EXPENSES (SPECIFY)			0	27.00
	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)			9, 363, 579	29.00