

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/18/2022 Run Time: 07:58 Version: 2022.01 (03/16/2022)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY**WORKSHEET S
PARTS I, II & III****PART I - COST REPORT STATUS**

Provider use only	1. ☒ Electronically prepared cost report 2. ☐ Manually prepared cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted the cost report 4. ☐ Medicare Utilization. Enter 'F' for full or 'L' for low.		Date: 05/18/2022 Time: 07:58
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ____ 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by VAN MATRE ENCOMPASS HEALTH REHABILIT (14-3028) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 01/01/2021 and ending 12/31/2021, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR 1	CHECKBOX 2	ELECTRONIC SIGNATURE STATEMENT	
1	ROB WISNER	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	ROB WISNER		2
3	Signatory Title	SVP REIMBURSEMENT		3
4	Date	05/18/2022		4

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V 1	PART A 2	PART B 3	HIT 4	TITLE XIX 5	
1	HOSPITAL		99,713			-47,627	1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		99,713			-47,627	200

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

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2 PART I

Hospital and Hospital Health Care Complex Address:

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

Hospital and Hospital-Based Component Identification:

								Payment System (P, T, O, or N)		
	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	VAN MATRE ENCOMPASS HEALTH REHABILIT	14-3028	40420	5	04 / 11 / 2002	N	P	O	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF									7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC									15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 01 / 01 / 2021	To: 12 / 31 / 2021	20
21	Type of control (see instructions)	5		21

Inpatient PPS Information

		1	2	3	
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR §412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	N	N		22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, 'Y' for yes or 'N' for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, 'Y' for yes or 'N' for no.	N	N	N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY2021? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, 'Y' for yes or 'N' for no.	N	N	N	22.04
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter 'Y' for yes or 'N' for no.	3	N		23

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.							24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	214	307	67	23	2,669		25
26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.			1				26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.			1				27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status is in effect in the cost reporting period.							35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			Beginning:		Ending:		36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.							37
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)							37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			Beginning:		Ending:		38

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2 PART I

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

	Teaching Hospitals	1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no in column 1. For column 2, if the response to column 1 is 'Y', or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and you are impacted by CR 11642 (or subsequent CR), MA GME payment reduction, enter 'Y' for yes; otherwise, enter 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
		NAHE 413.85 Y/N 1	NAHE MA Y/N 2	3	
60	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter 'Y' for yes or 'N' for no in column 2.	N			60
		1	Worksheet A Line # 2	Pass-Through Qualification Criteria Code 3	
		Y/N 1	IME 4	Direct GME 5	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathci FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

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

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

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

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

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

Teaching Hospitals that Claim Residents in Nonprovider Settings

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

WORKSHEET S-2 PART I

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

Inpatient Psychiatric Facility PPS

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

Inpatient Rehabilitation Facility PPS

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

Long Term Care Hospital PPS

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

TEFRA Providers

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

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WORKSHEET S-2 PART I

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

Rural Providers			1	2	
105	Does this hospital qualify as a CAH?		N		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106
107	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
	Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&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	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.		N		108
		Physical	Occupational	Speech	Respiratory
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.				109

				1	
110	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.		N		110
			1	2	
111	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for additional beds; and/or 'C' for tele-health services.		N		111
			1	2	
112	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.		N		112

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	N			116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.	Y			117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	44,572	177,253		118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.	N	N		120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.	N			121
122	Does the cost report contain state health care related taxes as defined in §1903(w)(3) of the Act? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.	N			122

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VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/18/2022 Run Time: 07:58 Version: 2022.01 (03/16/2022)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**WORKSHEET S-2
PART I****Transplant Center Information**

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

All Providers

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

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

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

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

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

Multicampus

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

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

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2 PART II

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

COMPLETED BY ALL HOSPITALS

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

		Y/N	Type	Date	
Financial Data and Reports		1	2	3	
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	Y	A	02/25/2022	4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N			5

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N		16
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	03/02/2022	N		17
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N		18
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19
20	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

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

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

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

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

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

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

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

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

Cost Report Preparer Contact Information			
41	First name: ELIZABETH	Last name: HENDERSON	Title: REIMBURSEMENT ACCOUNTANT
42	Employer: ENCOMPASS HEALTH		
43	Phone number: 2059705848	E-mail Address: ELIZABETH.HENDERSON@ENCOMPASSHEALTH.	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3 PART I

		Inpatient Days / Outpatient Visits / Trips								
	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	Hospital Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	65	23,725			9,549	290	19,827	1
2	HMO and other (see instructions)						3,854	2,990		2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF									5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		65	23,725			9,549	290	19,827	7
8	Intensive Care Unit	31								8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	Other Special Care (specify)	35								12
13	Nursery	43								13
14	Total (see instructions)		65	23,725			9,549	290	19,827	14
15	CAH Visits									15
16	Subprovider - IPF	40								16
17	Subprovider - IRF	41								17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44								19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101								22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116								24
24.10	Hospice (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	Total (sum of lines 14-26)		65							27
28	Observation Bed Days									28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)									32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33
33.01	LTCH site neutral days and discharges									33.01

Health Financial Systems Compu-Max 2552-10

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3 PART I

	Component	Full Time Equivalents			DISCHARGES				
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					749	22	1,510	1
2	HMO and other (see instructions)					261	244		2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider								4
5	Hospital Adults & Peds. Swing Bed SNF								5
6	Hospital Adults & Peds. Swing Bed NF								6
7	Total Adults & Peds. (exclude observation beds) (see instructions)								7
8	Intensive Care Unit								8
9	Coronary Care Unit								9
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
12	Other Special Care (specify)								12
13	Nursery								13
14	Total (see instructions)		170.45			749	22	1,510	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency								22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	Total (sum of lines 14-26)		170.45						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32.01
33	LTCH non-covered days								33
33.01	LTCH site neutral days and discharges								33.01

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HOSPITAL WAGE INDEX INFORMATION**WORKSHEET S-3
PARTS II-III****Part II - Wage Data**

	Wkst A Line No.	Amount Reported	Reclassif- ication of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)	
	1	2	3	4	5	6	
SALARIES							
1 Total salaries (see instructions)	200	12,933,262			354,515.20		1
2 Non-physician anesthetist Part A							2
3 Non-physician anesthetest Part B							3
4 Physician-Part A - Administrative		211,200			1,407.00		4
4.01 Physician-Part A - Teaching							4.01
5 Physician-Part B							5
6 Non-physician-Part B							6
7 Interns & residents (in an approved program)	21						7
7.01 Contracted interns & residents (in an approved program)							7.01
8 Home office and/or related organization personnel							8
9 SNF	44						9
10 Excluded area salaries (see instructions)			184,297		3,742.27		10
OTHER WAGES & RELATED COSTS							
11 Contract labor (see instructions)		478,410			5,305.17		11
12 Contract management and administrative services							12
13 Contract labor: Physician-Part A - Administrative		211,200			1,407.00		13
14 Home office salaries & wage-related costs							14
14.01 Home office salaries		743,478			13,626.82		14.01
14.02 Related organization salaries							14.02
15 Home office: Physician Part A - Administrative							15
16 Home office & Contract Physicians Part A - Teaching							16
16.01 Home office Physicians Part A - Teaching							16.01
16.02 Home office contract Physicians Part A - Teaching							16.02
WAGE-RELATED COSTS							
17 Wage-related costs (core)(see instructions)		2,580,801					17
18 Wage-related costs (other)(see instructions)							18
19 Excluded areas		37,308					19
20 Non-physician anesthetist Part A							20
21 Non-physician anesthetist Part B							21
22 Physician Part A - Administrative							22
22.01 Physician Part A - Teaching							22.01
23 Physician Part B							23
24 Wage-related costs (RHC/FQHC)							24
25 Interns & residents (in an approved program)							25
25.50 Home office wage-related		318,390					25.50
25.51 Related organization wage-related							25.51
25.52 Home office: Physician Part A - Administrative - wage-related							25.52
25.53 Home office: Physicians Part A - Teaching - wage-related (core)							25.53
OVERHEAD COSTS - DIRECT SALARIES							
26 Employee Benefits Department							26
27 Administrative & General		1,804,265	-184,297		43,494.53		27
28 Administrative & General under contract (see instructions)		34,745			296.82		28
29 Maintenance & Repairs							29
30 Operation of Plant		252,039			6,198.40		30
31 Laundry & Linen Service							31
32 Housekeeping		123,547			7,716.80		32
33 Housekeeping under contract (see instructions)							33
34 Dietary		470,856			20,529.60		34
35 Dietary under contract (see instructions)							35
36 Cafeteria							36
37 Maintenance of Personnel							37
38 Nursing Administration		893,872			19,884.80		38
39 Central Services and Supply							39
40 Pharmacy							40
41 Medical Records & Medical Records Library		71,435			3,078.40		41
42 Social Service		443,005			12,916.80		42
43 Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		12,968,007		12,968,007	354,812.02	36.55	1
2	Excluded area salaries (see instructions)			184,297	184,297	3,742.27	49.25	2
3	Subtotal salaries (line 1 minus line 2)		12,968,007	-184,297	12,783,710	351,069.75	36.41	3
4	Subtotal other wages & related costs (see instructions)		1,433,088		1,433,088	20,338.99	70.46	4
5	Subtotal wage-related costs (see instructions)		2,899,191		2,899,191		22.68%	5
6	Total (sum of lines 3 through 5)		17,300,286	-184,297	17,115,989	371,408.74	46.08	6
7	Total overhead cost (see instructions)		4,093,764	-184,297	3,909,467	114,116.15	34.26	7

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

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions	204,426	1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Nonqualified Defined Benefit Plan Cost (see instructions)		3
4	Qualified Defined Benefit Plan Cost (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA Plan Administration Fees		5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees		7
	HEALTH AND INSURANCE COST		
8	Health Insurance (Purchased or Self Funded)		8
8.01	Health Insurance (Self Funded without a Third Party Administrator)		8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	1,502,198	8.02
8.03	Health Insurance (Purchased)		8.03
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan		10
11	Life Insurance (If employee is owner or beneficiary)	15,044	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)		13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	342,746	15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-Employers Portion Only	962,637	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance		19
20	State or Federal Unemployment Taxes	53,545	20
	OTHER		
21	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	Day Care Costs and Allowances	-462,488	22
23	Tuition Reimbursement		23
24	Total Wage Related cost (Sum of lines 1-23)	2,618,108	24

Part B - Other Than Core Related Cost

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

	Component	Contract Labor	Benefit Cost	
	0	1	2	
1	Total facility contract labor and benefit cost	689,610	2,618,109	1
2	Hospital	689,610	2,580,801	2
3	Subprovider - IPF			3
4	Subprovider - IRF			4
5	Subprovider - (OTHER)			5
6	Swing Beds - SNF			6
7	Swing Beds - NF			7
8	Hospital-Based SNF			8
9	Hospital-Based NF			9
10	Hospital-Based OLTC			10
11	Hospital-Based HHA			11
12	Separately Certified ASC			12
13	Hospital-Based Hospice			13
14	Hospital-Based Health Clinic - RHC			14
15	Hospital-Based Health Clinic - FQHC			15
16	Hospital-Based - CMHC			16
17	Renal Dialysis			17
18	Other		37,308	18

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt		952,049	952,049	218,495	1,170,544	213,802	1,384,346	1
2	00200	Cap Rel Costs-Mvble Equip		456,755	456,755	46,505	503,260	-4,273	498,987	2
3	00300	Other Cap Rel Costs		253,908	253,908	-253,908			-0-	3
4	00400	Employee Benefits Department		2,696,285	2,696,285		2,696,285	-98,630	2,597,655	4
5	00500	Administrative & General	1,804,265	3,663,920	5,468,185	-266,194	5,201,991	-400,162	4,801,829	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	252,039	681,288	933,327	-13,984	919,343	-194,512	724,831	7
8	00800	Laundry & Linen Service		138,158	138,158		138,158		138,158	8
9	00900	Housekeeping	123,547	68,938	192,485		192,485		192,485	9
10	01000	Dietary	470,856	354,986	825,842		825,842	-16,061	809,781	10
11	01100	Cafeteria								11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	893,872	15,686	909,558		909,558	-1,211	908,347	13
14	01400	Central Services & Supply								14
15	01500	Pharmacy								15
16	01600	Medical Records & Library	71,435	1,828	73,263		73,263		73,263	16
17	01700	Social Service	443,005	25,069	468,074		468,074	-171	467,903	17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing Program								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	5,002,566	508,927	5,511,493	173,970	5,685,463	-23,351	5,662,112	30
		ANCILLARY SERVICE COST CENTERS								
54	05400	Radiology-Diagnostic		218,769	218,769	-114,020	104,749	-6,302	98,447	54
54.01	05401	RADIOLOGY-SUA				272,027	272,027	-16,367	255,660	54.01
60	06000	Laboratory		617,052	617,052	159,330	776,382	-321,316	455,066	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	363,005	12,130	375,135		375,135		375,135	65
66	06600	Physical Therapy	1,383,474	47,242	1,430,716	-61,815	1,368,901		1,368,901	66
67	06700	Occupational Therapy	1,166,267	17,113	1,183,380	48,898	1,232,278		1,232,278	67
68	06800	Speech Pathology	399,393	16,464	415,857	12,917	428,774		428,774	68
71	07100	Medical Supplies Charged to Patients	34,254	524,967	559,221	-92,706	466,515	-7	466,508	71
73	07300	Drugs Charged to Patients	525,284	483,388	1,008,672		1,008,672	-18	1,008,654	73
76.01	03951	SPECIAL PROCEDURES		317,337	317,337	-317,337				76.01
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
92	09200	Observation Beds (Non-Distinct Part)								92
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM								93.99
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
113	11300	Interest Expense		5,623	5,623		5,623	-5,623		113
118		SUBTOTALS (sum of lines 1-117)	12,933,262	12,077,882	25,011,144	-187,822	24,823,322	-874,202	23,949,120	118
		NONREIMBURSABLE COST CENTERS								
192	19200	Physicians' Private Offices								192
194	07950	NRCC MARKETING				187,822	187,822		187,822	194
194.01	07951	NRCC GUEST MEALS								194.01
200		TOTAL (sum of lines 118-199)	12,933,262	12,077,882	25,011,144		25,011,144	-874,202	24,136,942	200

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RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				
			COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	INSURANCE	A	Cap Rel Costs-Bldg & Fixt	1		9,209	1
2	INSURANCE	A	Cap Rel Costs-Mvble Equip	2		1,963	2
3	INSURANCE	A					3
500	Total reclassifications					11,172	500
	Code Letter - A						
1	MARKETING	B	NRCC MARKETING	194	184,297	3,525	1
2	MARKETING	B					2
500	Total reclassifications				184,297	3,525	500
	Code Letter - B						
1	PHYSICIANS	C	Adults & Pediatrics	30		67,200	1
2	PHYSICIANS	C					2
500	Total reclassifications					67,200	500
	Code Letter - C						
1	COMS RECLASS (MEDICAL SUPPLIES)	D	Adults & Pediatrics	30		106,770	1
2	COMS RECLASS (MEDICAL SUPPLIES)	D					2
500	Total reclassifications					106,770	500
	Code Letter - D						
1	SERVICE UNDER ARRANGEMENT	E	RADIOLOGY-SUA	54.01		272,027	1
2	SERVICE UNDER ARRANGEMENT	E					2
500	Total reclassifications					272,027	500
	Code Letter - E						
1	RECLASS EXPENSE FROM CMS 76.01	F	Radiology-Diagnostic	54		158,007	1
2	RECLASS EXPENSE FROM CMS 76.01	F	Laboratory	60		159,330	2
3	RECLASS EXPENSE FROM CMS 76.01	F					3
500	Total reclassifications					317,337	500
	Code Letter - F						
1	DEPT 283 RECLASS	G	Occupational Therapy	67	48,514	384	1
2	DEPT 283 RECLASS	G	Speech Pathology	68	12,816	101	2
3	DEPT 283 RECLASS	G					3
500	Total reclassifications				61,330	485	500
	Code Letter - G						
1	OXYGEN RECLASS	H	Medical Supplies Charged to P	71		14,064	1
2	OXYGEN RECLASS	H					2
3	OXYGEN RECLASS	H					3
500	Total reclassifications					14,064	500
	Code Letter - H						
	GRAND TOTAL (Increases)				245,627	792,580	

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

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RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	DECREASES				Wkst A-7 Ref.	
			COST CENTER	LINE #	SALARY	OTHER		
		1	6	7	8	9	10	
1	INSURANCE	A					12	1
2	INSURANCE	A					12	2
3	INSURANCE	A	Administrative & General	5		11,172		3
500	Total reclassifications					11,172		500
	Code letter - A							
1	MARKETING	B						1
2	MARKETING	B	Administrative & General	5	184,297	3,525		2
500	Total reclassifications				184,297	3,525		500
	Code letter - B							
1	PHYSICIANS	C						1
2	PHYSICIANS	C	Administrative & General	5		67,200		2
500	Total reclassifications					67,200		500
	Code letter - C							
1	COMS RECLASS (MEDICAL SUPPLIES)	D						1
2	COMS RECLASS (MEDICAL SUPPLIES)	D	Medical Supplies Charged to P	71		106,770		2
500	Total reclassifications					106,770		500
	Code letter - D							
1	SERVICE UNDER ARRANGEMENT	E						1
2	SERVICE UNDER ARRANGEMENT	E	Radiology-Diagnostic	54		272,027		2
500	Total reclassifications					272,027		500
	Code letter - E							
1	RECLASS EXPENSE FROM CMS 76.01	F						1
2	RECLASS EXPENSE FROM CMS 76.01	F						2
3	RECLASS EXPENSE FROM CMS 76.01	F	SPECIAL PROCEDURES	76.01		317,337		3
500	Total reclassifications					317,337		500
	Code letter - F							
1	DEPT 283 RECLASS	G						1
2	DEPT 283 RECLASS	G						2
3	DEPT 283 RECLASS	G	Physical Therapy	66	61,330	485		3
500	Total reclassifications				61,330	485		500
	Code letter - G							
1	OXYGEN RECLASS	H						1
2	OXYGEN RECLASS	H	Cap Rel Costs-Mvble Equip	2		80	10	2
3	OXYGEN RECLASS	H	Operation of Plant	7		13,984		3
500	Total reclassifications					14,064		500
	Code letter - H							
	GRAND TOTAL (Decreases)				245,627	792,580		

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

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

			Acquisitions						
	Description	Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		1	2	3	4	5	6	7	
1	Land								1
2	Land Improvements	15,880					15,880		2
3	Buildings and Fixtures	3,576,258				1,007,341	2,568,917		3
4	Building Improvements	14,326,670	6,146,376		6,146,376	290,969	20,182,077		4
5	Fixed Equipment	4,673,451	575,384		575,384	394,754	4,854,081		5
6	Movable Equipment								6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	22,592,259	6,721,760		6,721,760	1,693,064	27,620,955		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	22,592,259	6,721,760		6,721,760	1,693,064	27,620,955		10

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

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	778,839	173,210					952,049	1
2	Cap Rel Costs-Mvble Equip	227,822	228,933					456,755	2
3	Total (sum of lines 1-2)	1,006,661	402,143					1,408,804	3

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

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	22,766,874		22,766,874	0.824261		209,286		209,286	1
2	Cap Rel Costs-Mvble Equip	4,854,081		4,854,081	0.175739		44,622		44,622	2
3	Total (sum of lines 1-2)	27,620,955		27,620,955	1.000000		253,908		253,908	3

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	964,807	1,140	199,904	9,209	209,286		1,384,346	1
2	Cap Rel Costs-Mvble Equip	223,549	228,853		1,963	44,622		498,987	2
3	Total (sum of lines 1-2)	1,188,356	229,993	199,904	11,172	253,908		1,883,333	3

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

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		Wkst. A-7 Ref.	
				COST CENTER	LINE#		
		1	2	3	4	5	
1	Investment income-buildings & fixtures (chapter 2)			Cap Rel Costs-Bldg & Fixt	1		1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)						7
8	Television and radio service (chapter 21)						8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-21,748				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1	920,584				12
13	Laundry and linen service						13
14	Cafeteria - employees and guests						14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients						16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts						18
19	Nursing and allied health education (tuition, fees, books, etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation						32
33							33
34							34
35							35
36							36
37	INTEREST	A	-5,623	Interest Expense	113	11	37
37.01	DEPRECIATION	A	112,418	Cap Rel Costs-Bldg & Fixt	1	9	37.01
37.03	INSURANCE	A	-91,850	Employee Benefits Department	4		37.03
37.04	INSURANCE	A	-219,337	Administrative & General	5		37.04
37.05	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-51,554	Administrative & General	5		37.05
37.06	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-1,190	Operation of Plant	7		37.06
37.07	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-370	Dietary	10		37.07
37.08	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-1,211	Nursing Administration	13		37.08
37.09	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-171	Social Service	17		37.09
37.10	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-1,603	Adults & Pediatrics	30		37.10
37.11	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-7	Medical Supplies Charged to Patients	71		37.11
37.12	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-18	Drugs Charged to Patients	73		37.12
37.13	PATIENT TELEPHONE	A	-6,780	Employee Benefits Department	4		37.13
37.14	PATIENT TELEPHONE	A	-44,404	Administrative & General	5		37.14
37.15	PATIENT TELEVISION	A	-4,273	Cap Rel Costs-Mvble Equip	2	9	37.15
37.16	PATIENT TELEVISION	A	-6,701	Operation of Plant	7		37.16
37.17	PRINTING	A	-3,174	Administrative & General	5		37.17
37.18	PRINTING	A	-12	Operation of Plant	7		37.18
37.19	LOBBYING EXPENSE	A	-1,109	Administrative & General	5		37.19
37.20	MISCELLANEOUS INCOME	B	-11,428	Administrative & General	5		37.20
37.21	MISCELLANEOUS INCOME	B	-15,691	Dietary	10		37.21
37.22	PATIENT TRANSPORTATION	A	-186,609	Operation of Plant	7		37.22
37.23	MISC. TAX	A	-1,222,175	Administrative & General	5		37.23
37.24	PROFESSIONAL FEES	A	-10,166	Administrative & General	5		37.24
38							38
39							39
40							40
41							41
42							42

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.
		1	2	3	4	5
43						43
44						44
45						45
46						46
47						47
48						48
49						49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-874,202			50

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

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

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

WORKSHEET A-8-1

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

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1	5	Administrative & General	TO OFFSET MANAGEMENT FEES		545,279	-545,279		1
2	1	Cap Rel Costs-Bldg & Fixt	TO INCLUDE ALLOWABLE HOME OFFICE COS	73,550		73,550	9	2
3	1	Cap Rel Costs-Bldg & Fixt	TO INCLUDE ALLOWABLE HOME OFFICE COS	199,904		199,904	11	3
3.01	5	Administrative & General	TO INCLUDE ALLOWABLE HOME OFFICE COS	1,564,849		1,564,849		3.01
3.02	5	Administrative & General	TO INCLUDE ALLOWABLE HOME OFFICE COS	169,866		169,866		3.02
3.03	1	Cap Rel Costs-Bldg & Fixt	INTERCOMPANY WAGE AND EXPENSE TRANSF	-112,417	-112,417		9	3.03
3.04	2	Cap Rel Costs-Mvble Equip	INTERCOMPANY WAGE AND EXPENSE TRANSF	623	623		10	3.04
3.05	4	Employee Benefits Department	INTERCOMPANY WAGE AND EXPENSE TRANSF	1,943,077	1,943,077			3.05
3.06	5	Administrative & General	INTERCOMPANY WAGE AND EXPENSE TRANSF	2,561,516	2,561,516			3.06
3.07	7	Operation of Plant	INTERCOMPANY WAGE AND EXPENSE TRANSF	18,784	18,784			3.07
3.08	8	Laundry & Linen Service	INTERCOMPANY WAGE AND EXPENSE TRANSF	-547	-547			3.08
3.09	10	Dietary	INTERCOMPANY WAGE AND EXPENSE TRANSF	-14,287	-14,287			3.09
3.10	17	Social Service	INTERCOMPANY WAGE AND EXPENSE TRANSF	-680	-680			3.10
3.11	30	Adults & Pediatrics	INTERCOMPANY WAGE AND EXPENSE TRANSF	-1,266	-1,266			3.11
3.12	54	Radiology-Diagnostic	INTERCOMPANY WAGE AND EXPENSE TRANSF	-22	-22			3.12
3.13	60	Laboratory	INTERCOMPANY WAGE AND EXPENSE TRANSF	-916	-916			3.13
3.14	66	Physical Therapy	INTERCOMPANY WAGE AND EXPENSE TRANSF	388	388			3.14
3.15	67	Occupational Therapy	INTERCOMPANY WAGE AND EXPENSE TRANSF	-3,347	-3,347			3.15
3.16	71	Medical Supplies Charged to Patients	INTERCOMPANY WAGE AND EXPENSE TRANSF	54,893	54,893			3.16
3.17	73	Drugs Charged to Patients	INTERCOMPANY WAGE AND EXPENSE TRANSF	452,140	452,140			3.17
3.18	76.01	SPECIAL PROCEDURES	INTERCOMPANY WAGE AND EXPENSE TRANSF	-185	-185			3.18
3.19	113	Interest Expense	INTERCOMPANY WAGE AND EXPENSE TRANSF	5,623	5,623		11	3.19
3.20	5	Administrative & General	RELATED PARTY - RMH	8,381	34,632	-26,251		3.20
3.21	54	Radiology-Diagnostic	RELATED PARTY - RMH	10,531	16,833	-6,302		3.21
3.22	54.01	RADIOLOGY-SUA	RELATED PARTY - RMH	27,830	44,197	-16,367		3.22
3.23	60	Laboratory	RELATED PARTY - RMH	267,995	589,311	-321,316		3.23
3.24	1	Cap Rel Costs-Bldg & Fixt	RELATED PARTY GROUND LEASE		172,070	-172,070	10	3.24
4								4
5		TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12		7,226,283	6,305,699	920,584		5

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

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

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

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

				Related Organization(s) and/or Home Office			
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
6	B		50.00	ENCOMPASS HEALTH CORPORATION		HEALTHCARE	6

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VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/18/2022 Run Time: 07:58 Version: 2022.01 (03/16/2022)
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STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

WORKSHEET A-8-1

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

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

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

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

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

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

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun- eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	30	Adults & Pediatrics AGGREGATE	67,200		67,200	211,500	447	45,452	2,273	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	67,200		67,200		447	45,452	2,273	200

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/18/2022 Run Time: 07:58 Version: 2022.01 (03/16/2022)
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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	30	Adults & Pediatrics AGGREGATE					45,452	21,748	21,748	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL					45,452	21,748	21,748	200

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/18/2022 Run Time: 07:58 Version: 2022.01 (03/16/2022)
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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B PART I

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS- TRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	1,384,346	1,384,346					1
2	Cap Rel Costs-Mvble Equip	498,987		498,987				2
4	Employee Benefits Department	2,597,655			2,597,655			4
5	Administrative & General	4,801,829	181,180	65,306	325,372	5,373,687	5,373,687	5
6	Maintenance & Repairs							6
7	Operation of Plant	724,831	195,543	70,484	50,622	1,041,480	302,394	7
8	Laundry & Linen Service	138,158				138,158	40,114	8
9	Housekeeping	192,485			24,815	217,300	63,093	9
10	Dietary	809,781	100,078	36,073	94,572	1,040,504	302,110	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	908,347	64,585	23,280	179,535	1,175,747	341,378	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	73,263	4,429	1,596	14,348	93,636	27,187	16
17	Social Service	467,903	10,768	3,881	88,978	571,530	165,944	17
19	Nonphysician Anesthetists							19
20	Nursing Program							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	5,662,112	529,440	190,836	1,004,766	7,387,154	2,144,868	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	98,447				98,447	28,584	54
54.01	RADIOLOGY-SUA	255,660				255,660		54.01
60	Laboratory	455,066				455,066	132,128	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	375,135	5,059	1,823	72,910	454,927	132,088	65
66	Physical Therapy	1,368,901	108,732	39,193	265,554	1,782,380	517,514	66
67	Occupational Therapy	1,232,278	108,732	39,193	243,990	1,624,193	471,584	67
68	Speech Pathology	428,774	24,156	8,707	82,793	544,430	158,075	68
71	Medical Supplies Charged to Patients	466,508	28,869	10,406	6,880	512,663	148,852	71
73	Drugs Charged to Patients	1,008,654	11,804	4,255	105,504	1,130,217	328,159	73
76.01	SPECIAL PROCEDURES							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	23,949,120	1,373,375	495,033	2,560,639	23,897,179	5,304,072	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		9,203	3,317		12,520	3,635	192
194	NRCC MARKETING	187,822	1,768	637	37,016	227,243	65,980	194
194.01	NRCC GUEST MEALS							194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	24,136,942	1,384,346	498,987	2,597,655	24,136,942	5,373,687	202

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VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/18/2022 Run Time: 07:58 Version: 2022.01 (03/16/2022)
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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B PART I

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	1,343,874						7
8	Laundry & Linen Service		178,272					8
9	Housekeeping			280,393				9
10	Dietary	133,474		27,849	1,503,937			10
11	Cafeteria				203,776	203,776		11
12	Maintenance of Personnel							12
13	Nursing Administration	86,138		17,972		17,403	1,638,638	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	5,907		1,232		1,391		16
17	Social Service	14,361		2,996		8,625		17
19	Nonphysician Anesthetists							19
20	Nursing Program							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	706,119	178,272	147,328	1,292,469	97,391	1,638,638	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic							54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	6,747		1,408		7,067		65
66	Physical Therapy	145,017		30,257		25,741		66
67	Occupational Therapy	145,017		30,257		23,651		67
68	Speech Pathology	32,217		6,722		8,025		68
71	Medical Supplies Charged to Patients	38,503		8,034		667		71
73	Drugs Charged to Patients	15,743		3,285		10,227		73
76.01	SPECIAL PROCEDURES							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	1,329,243	178,272	277,340	1,496,245	200,188	1,638,638	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	12,274		2,561				192
194	NRCC MARKETING	2,357		492		3,588		194
194.01	NRCC GUEST MEALS				7,692			194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,343,874	178,272	280,393	1,503,937	203,776	1,638,638	202

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/18/2022 Run Time: 07:58 Version: 2022.01 (03/16/2022)
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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B PART I

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL		
		16	17	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	129,353						16
17	Social Service		763,456					17
19	Nonphysician Anesthetists							19
20	Nursing Program							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	63,673	763,456	14,419,368		14,419,368		30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	442		127,473		127,473		54
54.01	RADIOLOGY-SUA			255,660		255,660		54.01
60	Laboratory	5,382		592,576		592,576		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,968		605,205		605,205		65
66	Physical Therapy	17,689		2,518,598		2,518,598		66
67	Occupational Therapy	17,525		2,312,227		2,312,227		67
68	Speech Pathology	4,630		754,099		754,099		68
71	Medical Supplies Charged to Patients	422		709,141		709,141		71
73	Drugs Charged to Patients	16,622		1,504,253		1,504,253		73
76.01	SPECIAL PROCEDURES							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	129,353	763,456	23,798,600		23,798,600		118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices			30,990		30,990		192
194	NRCC MARKETING			299,660		299,660		194
194.01	NRCC GUEST MEALS			7,692		7,692		194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	129,353	763,456	24,136,942		24,136,942		202

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	ADMINIS- TRATIVE & GENERAL	OPERATION OF PLANT	
		0	1	2	2A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General		181,180	65,306	246,486	246,486		5
6	Maintenance & Repairs							6
7	Operation of Plant		195,543	70,484	266,027	13,870	279,897	7
8	Laundry & Linen Service					1,840		8
9	Housekeeping					2,894		9
10	Dietary		100,078	36,073	136,151	13,857	27,800	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration		64,585	23,280	87,865	15,659	17,940	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		4,429	1,596	6,025	1,247	1,230	16
17	Social Service		10,768	3,881	14,649	7,612	2,991	17
19	Nonphysician Anesthetists							19
20	Nursing Program							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		529,440	190,836	720,276	98,383	147,068	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic					1,311		54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory					6,061		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		5,059	1,823	6,882	6,059	1,405	65
66	Physical Therapy		108,732	39,193	147,925	23,738	30,204	66
67	Occupational Therapy		108,732	39,193	147,925	21,631	30,204	67
68	Speech Pathology		24,156	8,707	32,863	7,251	6,710	68
71	Medical Supplies Charged to Patients		28,869	10,406	39,275	6,828	8,019	71
73	Drugs Charged to Patients		11,804	4,255	16,059	15,052	3,279	73
76.01	SPECIAL PROCEDURES							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)		1,373,375	495,033	1,868,408	243,293	276,850	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		9,203	3,317	12,520	167	2,556	192
194	NRCC MARKETING		1,768	637	2,405	3,026	491	194
194.01	NRCC GUEST MEALS							194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		1,384,346	498,987	1,883,333	246,486	279,897	202

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B PART II

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	MEDICAL RECORDS & LIBRARY	
		8	9	10	11	13	16	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	1,840						8
9	Housekeeping		2,894					9
10	Dietary		287	178,095				10
11	Cafeteria			24,131	24,131			11
12	Maintenance of Personnel							12
13	Nursing Administration		185		2,060	123,709		13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		13		165		8,680	16
17	Social Service		31		1,021			17
19	Nonphysician Anesthetists							19
20	Nursing Program							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,840	1,522	153,053	11,535	123,709	4,283	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic						30	54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory						360	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		15		837		199	65
66	Physical Therapy		312		3,048		1,184	66
67	Occupational Therapy		312		2,800		1,173	67
68	Speech Pathology		69		950		310	68
71	Medical Supplies Charged to Patients		83		79		28	71
73	Drugs Charged to Patients		34		1,211		1,113	73
76.01	SPECIAL PROCEDURES							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	1,840	2,863	177,184	23,706	123,709	8,680	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		26					192
194	NRCC MARKETING		5		425			194
194.01	NRCC GUEST MEALS			911				194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,840	2,894	178,095	24,131	123,709	8,680	202

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B PART II

	COST CENTER DESCRIPTIONS	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL			
		17	24	25	26			
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service	26,304						17
19	Nonphysician Anesthetists							19
20	Nursing Program							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	26,304	1,287,973		1,287,973			30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic		1,341		1,341			54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory		6,421		6,421			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		15,397		15,397			65
66	Physical Therapy		206,411		206,411			66
67	Occupational Therapy		204,045		204,045			67
68	Speech Pathology		48,153		48,153			68
71	Medical Supplies Charged to Patients		54,312		54,312			71
73	Drugs Charged to Patients		36,748		36,748			73
76.01	SPECIAL PROCEDURES							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	26,304	1,860,801		1,860,801			118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		15,269		15,269			192
194	NRCC MARKETING		6,352		6,352			194
194.01	NRCC GUEST MEALS		911		911			194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	26,304	1,883,333		1,883,333			202

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	68,140						1
2	Cap Rel Costs-Mvble Equip		68,140					2
4	Employee Benefits Department			12,933,262				4
5	Administrative & General	8,918	8,918	1,619,968	-5,373,687	18,507,595		5
6	Maintenance & Repairs							6
7	Operation of Plant	9,625	9,625	252,039		1,041,480	49,597	7
8	Laundry & Linen Service					138,158		8
9	Housekeeping			123,547		217,300		9
10	Dietary	4,926	4,926	470,856		1,040,504	4,926	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	3,179	3,179	893,872		1,175,747	3,179	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	218	218	71,435		93,636	218	16
17	Social Service	530	530	443,005		571,530	530	17
19	Nonphysician Anesthetists							19
20	Nursing Program							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	26,060	26,060	5,002,566		7,387,154	26,060	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic					98,447		54
54.01	RADIOLOGY-SUA				-255,660			54.01
60	Laboratory					455,066		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	249	249	363,005		454,927	249	65
66	Physical Therapy	5,352	5,352	1,322,144		1,782,380	5,352	66
67	Occupational Therapy	5,352	5,352	1,214,781		1,624,193	5,352	67
68	Speech Pathology	1,189	1,189	412,209		544,430	1,189	68
71	Medical Supplies Charged to Patients	1,421	1,421	34,254		512,663	1,421	71
73	Drugs Charged to Patients	581	581	525,284		1,130,217	581	73
76.01	SPECIAL PROCEDURES							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	67,600	67,600	12,748,965	-5,629,347	18,267,832	49,057	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	453	453			12,520	453	192
194	NRCC MARKETING	87	87	184,297		227,243	87	194
194.01	NRCC GUEST MEALS							194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,384,346	498,987	2,597,655		5,373,687	1,343,874	202
203	Unit Cost Multiplier (Wkst. B, Part I)	20.316202	7.322967	0.200851		0.290350	27.095873	203
204	Cost to be allocated (Per Wkst. B, Part II)					246,486	279,897	204
205	Unit Cost Multiplier (Wkst. B, Part II)					0.013318	5.643426	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE PATIENT DAYS	HOUSE- KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA GROSS SALARIES	NURSING ADMINIS- TRATION PATIENT DAYS	MEDICAL RECORDS & LIBRARY TIME SPENT	
		8	9	10	11	13	16	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	19,827						8
9	Housekeeping		49,597					9
10	Dietary		4,926	69,213				10
11	Cafeteria			9,378	10,466,852			11
12	Maintenance of Personnel							12
13	Nursing Administration		3,179		893,872	19,827		13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		218		71,435		43,307,579	16
17	Social Service		530		443,005			17
19	Nonphysician Anesthetists							19
20	Nursing Program							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	19,827	26,060	59,481	5,002,566	19,827	21,319,036	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic						148,051	54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory						1,801,750	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		249		363,005		993,529	65
66	Physical Therapy		5,352		1,322,144		5,922,045	66
67	Occupational Therapy		5,352		1,214,781		5,867,121	67
68	Speech Pathology		1,189		412,209		1,549,937	68
71	Medical Supplies Charged to Patients		1,421		34,254		141,362	71
73	Drugs Charged to Patients		581		525,284		5,564,748	73
76.01	SPECIAL PROCEDURES							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	19,827	49,057	68,859	10,282,555	19,827	43,307,579	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		453					192
194	NRCC MARKETING		87		184,297			194
194.01	NRCC GUEST MEALS			354				194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	178,272	280,393	1,503,937	203,776	1,638,638	129,353	202
203	Unit Cost Multiplier (Wkst. B, Part I)	8.991375	5.653427	21.729112	0.019469	82.646795	0.002987	203
204	Cost to be allocated (Per Wkst. B, Part II)	1,840	2,894	178,095	24,131	123,709	8,680	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.092803	0.058350	2.573144	0.002305	6.239421	0.000200	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	SOCIAL SERVICE PATIENT DAYS						
		17						

	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service	19,827						17
19	Nonphysician Anesthetists							19
20	Nursing Program							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	19,827						30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic							54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients							73
76.01	SPECIAL PROCEDURES							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	19,827						118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices							192
194	NRCC MARKETING							194
194.01	NRCC GUEST MEALS							194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	763,456						202
203	Unit Cost Multiplier (Wkst. B, Part I)	38.505876						203
204	Cost to be allocated (Per Wkst. B, Part II)	26,304						204
205	Unit Cost Multiplier (Wkst. B, Part II)	1.326676						205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

		WORKSHEET			
	DESCRIPTION	CODE	LINE NO.	AMOUNT	
	1	2	3	4	

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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C PART I

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	14,419,368		14,419,368	21,748	14,441,116	30
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	127,473		127,473		127,473	54
54.01	RADIOLOGY-SUA	255,660		255,660		255,660	54.01
60	Laboratory	592,576		592,576		592,576	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	605,205		605,205		605,205	65
66	Physical Therapy	2,518,598		2,518,598		2,518,598	66
67	Occupational Therapy	2,312,227		2,312,227		2,312,227	67
68	Speech Pathology	754,099		754,099		754,099	68
71	Medical Supplies Charged to Patients	709,141		709,141		709,141	71
73	Drugs Charged to Patients	1,504,253		1,504,253		1,504,253	73
76.01	SPECIAL PROCEDURES						76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct Part)						92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	23,798,600		23,798,600	21,748	23,820,348	200
201	Less Observation Beds						201
202	Total (line 200 minus line 201)	23,798,600		23,798,600		23,820,348	202

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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C PART I

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	21,319,036		21,319,036				30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	148,051		148,051	0.861007	0.861007	0.861007	54
54.01	RADIOLOGY-SUA	384,478		384,478	0.664954	0.664954	0.664954	54.01
60	Laboratory	1,801,750		1,801,750	0.328889	0.328889	0.328889	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	501,289		501,289	1.207298	1.207298	1.207298	65
66	Physical Therapy	5,922,045		5,922,045	0.425292	0.425292	0.425292	66
67	Occupational Therapy	5,867,121		5,867,121	0.394099	0.394099	0.394099	67
68	Speech Pathology	1,549,937		1,549,937	0.486535	0.486535	0.486535	68
71	Medical Supplies Charged to Patients	633,602		633,602	1.119222	1.119222	1.119222	71
73	Drugs Charged to Patients	5,564,747		5,564,747	0.270318	0.270318	0.270318	73
76.01	SPECIAL PROCEDURES							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	43,692,056		43,692,056				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	43,692,056		43,692,056				202

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

**WORKSHEET C
PART I**

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	14,419,368		14,419,368	21,748	14,441,116	30
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	127,473		127,473		127,473	54
54.01	RADIOLOGY-SUA	255,660		255,660		255,660	54.01
60	Laboratory	592,576		592,576		592,576	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	605,205		605,205		605,205	65
66	Physical Therapy	2,518,598		2,518,598		2,518,598	66
67	Occupational Therapy	2,312,227		2,312,227		2,312,227	67
68	Speech Pathology	754,099		754,099		754,099	68
71	Medical Supplies Charged to Patients	709,141		709,141		709,141	71
73	Drugs Charged to Patients	1,504,253		1,504,253		1,504,253	73
76.01	SPECIAL PROCEDURES						76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct Part)						92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	23,798,600		23,798,600	21,748	23,820,348	200
201	Less Observation Beds						201
202	Total (line 200 minus line 201)	23,798,600		23,798,600	21,748	23,820,348	202

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/18/2022 Run Time: 07:58 Version: 2022.01 (03/16/2022)
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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)

**WORKSHEET C
PART I**

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	21,319,036		21,319,036				30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	148,051		148,051	0.861007	0.861007	0.861007	54
54.01	RADIOLOGY-SUA	384,478		384,478	0.664954	0.664954	0.664954	54.01
60	Laboratory	1,801,750		1,801,750	0.328889	0.328889	0.328889	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	501,289		501,289	1.207298	1.207298	1.207298	65
66	Physical Therapy	5,922,045		5,922,045	0.425292	0.425292	0.425292	66
67	Occupational Therapy	5,867,121		5,867,121	0.394099	0.394099	0.394099	67
68	Speech Pathology	1,549,937		1,549,937	0.486535	0.486535	0.486535	68
71	Medical Supplies Charged to Patients	633,602		633,602	1.119222	1.119222	1.119222	71
73	Drugs Charged to Patients	5,564,747		5,564,747	0.270318	0.270318	0.270318	73
76.01	SPECIAL PROCEDURES							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	43,692,056		43,692,056				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	43,692,056		43,692,056				202

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/18/2022 Run Time: 07:58 Version: 2022.01 (03/16/2022)
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CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

WORKSHEET C PART II

[] Title V

[XX] Title XIX

	COST CENTER DESCRIPTIONS	Total Cost (Wkst B, Part I, col. 26)	Capital Cost (Wkst B, Part II, col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	
		1	2	3	4	
	ANCILLARY SERVICE COST CENTERS					
54	Radiology-Diagnostic	127,473	1,341	126,132		54
54.01	RADIOLOGY-SUA	255,660		255,660		54.01
60	Laboratory	592,576	6,421	586,155		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy	605,205	15,397	589,808		65
66	Physical Therapy	2,518,598	206,411	2,312,187		66
67	Occupational Therapy	2,312,227	204,045	2,108,182		67
68	Speech Pathology	754,099	48,153	705,946		68
71	Medical Supplies Charged to Patients	709,141	54,312	654,829		71
73	Drugs Charged to Patients	1,504,253	36,748	1,467,505		73
76.01	SPECIAL PROCEDURES					76.01
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
92	Observation Beds (Non-Distinct Part)					92
93.99	PARTIAL HOSPITALIZATION PROGRAM					93.99
	OTHER REIMBURSABLE COST CENTERS					
113	Interest Expense					113
200	Subtotal	9,379,232	572,828	8,806,404		200
201	Less Observation Beds					201
202	Total	9,379,232	572,828	8,806,404		202

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/18/2022 Run Time: 07:58 Version: 2022.01 (03/16/2022)
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CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

WORKSHEET C PART II

[] Title V

[XX] Title XIX

	COST CENTER DESCRIPTIONS	Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Wkst C, Part I, col. 8)	Outpatient Cost to Charge Ratio(col. 6 ÷ col. 7)	
		5	6	7	8	
	ANCILLARY SERVICE COST CENTERS					
54	Radiology-Diagnostic		127,473	148,051	0.861007	54
54.01	RADIOLOGY-SUA		255,660	384,478	0.664954	54.01
60	Laboratory		592,576	1,801,750	0.328889	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy		605,205	501,289	1.207298	65
66	Physical Therapy		2,518,598	5,922,045	0.425292	66
67	Occupational Therapy		2,312,227	5,867,121	0.394099	67
68	Speech Pathology		754,099	1,549,937	0.486535	68
71	Medical Supplies Charged to Patients		709,141	633,602	1.119222	71
73	Drugs Charged to Patients		1,504,253	5,564,747	0.270318	73
76.01	SPECIAL PROCEDURES					76.01
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
92	Observation Beds (Non-Distinct Part)					92
93.99	PARTIAL HOSPITALIZATION PROGRAM					93.99
	OTHER REIMBURSABLE COST CENTERS					
113	Interest Expense					113
200	Subtotal		9,379,232	22,373,020		200
201	Less Observation Beds					201
202	Total		9,379,232	22,373,020		202

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/18/2022 Run Time: 07:58 Version: 2022.01 (03/16/2022)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check
Applicable
Boxes:

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

☒ Hospital
☐ PARHM Demonstration

☒ PPS
☐ TEFRA

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust- ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	1,287,973		1,287,973	19,827	64.96	9,549	620,303	30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,287,973		1,287,973	19,827		9,549	620,303	200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/18/2022 Run Time: 07:58 Version: 2022.01 (03/16/2022)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-3028

WORKSHEET D
PART II

Check
Applicable
Boxes:

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

☒ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)
PARHM Demo

☒ PPS
☐ TEFRA

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	1,341	148,051	0.009058	70,038	634	54
54.01	RADIOLOGY-SUA		384,478		181,897		54.01
60	Laboratory	6,421	1,801,750	0.003564	979,136	3,490	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	15,397	501,289	0.030715	241,150	7,407	65
66	Physical Therapy	206,411	5,922,045	0.034855	2,866,510	99,912	66
67	Occupational Therapy	204,045	5,867,121	0.034778	2,846,735	99,004	67
68	Speech Pathology	48,153	1,549,937	0.031068	685,215	21,288	68
71	Medical Supplies Charged to Pat	54,312	633,602	0.085719	306,077	26,237	71
73	Drugs Charged to Patients	36,748	5,564,747	0.006604	2,678,507	17,689	73
76.01	SPECIAL PROCEDURES						76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct						92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	572,828	22,373,020		10,855,265	275,661	200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/18/2022 Run Time: 07:58 Version: 2022.01 (03/16/2022)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

☐ Title V

☒ Title XVIII, Part A

☐ Title XIX

☒ Hospital

☐ PARHM Demonstration

☒ PPS

☐ TEFRA

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

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/18/2022 Run Time: 07:58 Version: 2022.01 (03/16/2022)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

☐ Title V

☒ Title XVIII, Part A

☐ Title XIX

☒ Hospital

☐ PARHM Demonstration

☒ PPS

☐ TEFRA

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass- Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	19,827		9,549		30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	19,827		9,549		200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/18/2022 Run Time: 07:58 Version: 2022.01 (03/16/2022)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-3028

WORKSHEET D
PART IV

Check
Applicable
Boxes:

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

☒ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☒ PPS
☐ TEFRA
☐ Other

		Non Physician Anesth- etist Cost	Nursing Program Post- Stepdown Adjustments	Nursing Program	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
54	Radiology-Diagnostic									54
54.01	RADIOLOGY-SUA									54.01
60	Laboratory									60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
71	Medical Supplies Charged to Pat									71
73	Drugs Charged to Patients									73
76.01	SPECIAL PROCEDURES									76.01
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
92	Observation Beds (Non-Distinct									92
93.99	PARTIAL HOSPITALIZATION PROGRAM									93.99
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/18/2022 Run Time: 07:58 Version: 2022.01 (03/16/2022)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-3028

WORKSHEET D
PART IV

Check
Applicable
Boxes:

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

☒ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☒ PPS
☐ TEFRA
☐ Other

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass- Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass- Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	148,051			70,038				54
54.01	RADIOLOGY-SUA	384,478			181,897				54.01
60	Laboratory	1,801,750			979,136				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	501,289			241,150				65
66	Physical Therapy	5,922,045			2,866,510				66
67	Occupational Therapy	5,867,121			2,846,735				67
68	Speech Pathology	1,549,937			685,215				68
71	Medical Supplies Charged to Pat	633,602			306,077				71
73	Drugs Charged to Patients	5,564,747			2,678,507				73
76.01	SPECIAL PROCEDURES								76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	22,373,020			10,855,265				200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/18/2022 Run Time: 07:58 Version: 2022.01 (03/16/2022)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-3028

WORKSHEET D
PART V

Check
Applicable
Boxes:

☐ Title V - O/P
☒ Title XVIII, Part B
☐ Title XIX - O/P

☒ Hospital
☐ IPF
☐ IRF
☐ SUB
(Other)

☐ SNF
☐ NF
☐ Swing Bed SNF
☐ Swing Bed NF

☐ ICF/IID
☐ PARHM Demonstration
☐ PARHM CAH Swing Bed SNF

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	0.861007							54
54.01	RADIOLOGY-SUA	0.664954							54.01
60	Laboratory	0.328889							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	1.207298							65
66	Physical Therapy	0.425292							66
67	Occupational Therapy	0.394099							67
68	Speech Pathology	0.486535							68
71	Medical Supplies Charged to Pat	1.119222							71
73	Drugs Charged to Patients	0.270318							73
76.01	SPECIAL PROCEDURES								76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/18/2022 Run Time: 07:58 Version: 2022.01 (03/16/2022)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check
Applicable
Boxes:

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

☒ Hospital
☐ PARHM Demonstration

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust- ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	1,287,973		1,287,973	19,827	64.96	290	18,838	30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,287,973		1,287,973	19,827		290	18,838	200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/18/2022 Run Time: 07:58 Version: 2022.01 (03/16/2022)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-3028

WORKSHEET D
PART II

Check
Applicable
Boxes:

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

☒ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)
☐ PARHM Demo

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	1,341	148,051	0.009058	585	5	54
54.01	RADIOLOGY-SUA		384,478		1,519		54.01
60	Laboratory	6,421	1,801,750	0.003564	15,465	55	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	15,397	501,289	0.030715	4,495	138	65
66	Physical Therapy	206,411	5,922,045	0.034855	89,615	3,124	66
67	Occupational Therapy	204,045	5,867,121	0.034778	87,724	3,051	67
68	Speech Pathology	48,153	1,549,937	0.031068	17,465	543	68
71	Medical Supplies Charged to Pat	54,312	633,602	0.085719	3,424	294	71
73	Drugs Charged to Patients	36,748	5,564,747	0.006604	59,383	392	73
76.01	SPECIAL PROCEDURES						76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct						92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	572,828	22,373,020		279,675	7,602	200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/18/2022 Run Time: 07:58 Version: 2022.01 (03/16/2022)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

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

☒ Hospital
☐ PARHM Demonstration

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

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/18/2022 Run Time: 07:58 Version: 2022.01 (03/16/2022)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

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

☒ Hospital
☐ PARHM Demonstration

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass- Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	19,827		290		30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	19,827		290		200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/18/2022 Run Time: 07:58 Version: 2022.01 (03/16/2022)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-3028

WORKSHEET D
PART IV

Check
Applicable
Boxes:

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

☒ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☐ PPS
☐ TEFRA
☒ Other

		Non Physician Anesth- etist Cost	Nursing Program Post- Stepdown Adjustments	Nursing Program	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
54	Radiology-Diagnostic									54
54.01	RADIOLOGY-SUA									54.01
60	Laboratory									60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
71	Medical Supplies Charged to Pat									71
73	Drugs Charged to Patients									73
76.01	SPECIAL PROCEDURES									76.01
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
92	Observation Beds (Non-Distinct									92
93.99	PARTIAL HOSPITALIZATION PROGRAM									93.99
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/18/2022 Run Time: 07:58 Version: 2022.01 (03/16/2022)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-3028

WORKSHEET D
PART IV

Check
Applicable
Boxes:

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

☒ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☐ PPS
☐ TEFRA
☒ Other

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass- Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass- Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	148,051			585				54
54.01	RADIOLOGY-SUA	384,478			1,519				54.01
60	Laboratory	1,801,750			15,465				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	501,289			4,495				65
66	Physical Therapy	5,922,045			89,615				66
67	Occupational Therapy	5,867,121			87,724				67
68	Speech Pathology	1,549,937			17,465				68
71	Medical Supplies Charged to Pat	633,602			3,424				71
73	Drugs Charged to Patients	5,564,747			59,383				73
76.01	SPECIAL PROCEDURES								76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	22,373,020			279,675				200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/18/2022 Run Time: 07:58 Version: 2022.01 (03/16/2022)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-3028

WORKSHEET D
PART V

Check
Applicable
Boxes:

☐ Title V - O/P

☐ Title XVIII, Part B

☒ Title XIX - O/P

☒ Hospital

☐ IPF

☐ IRF

☐ SUB

(Other)

☐ SNF

☐ NF

☐ Swing Bed SNF

☐ Swing Bed NF

☐ ICF/IID

☐ PARHM Demonstration

☐ PARHM CAH Swing Bed SNF

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	0.861007							54
54.01	RADIOLOGY-SUA	0.664954							54.01
60	Laboratory	0.328889							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	1.207298							65
66	Physical Therapy	0.425292							66
67	Occupational Therapy	0.394099							67
68	Speech Pathology	0.486535							68
71	Medical Supplies Charged to Pat	1.119222							71
73	Drugs Charged to Patients	0.270318							73
76.01	SPECIAL PROCEDURES								76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/18/2022 Run Time: 07:58 Version: 2022.01 (03/16/2022)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-3028****WORKSHEET D-1
PART I**

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

PART I - ALL PROVIDER COMPONENTS**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	19,827	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	19,827	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	19,827	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	9,549	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	14,441,116	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	14,441,116	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	14,441,116	37

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/18/2022 Run Time: 07:58 Version: 2022.01 (03/16/2022)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-3028****WORKSHEET D-1
PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS							1
38	Adjusted general inpatient routine service cost per diem (see instructions)						728.36 38
39	Program general inpatient routine service cost (line 9 x line 38)						6,955,110 39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)						6,955,110 41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
							1
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						4,535,420 48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						11,490,530 49
PASS THROUGH COST ADJUSTMENTS							
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						620,303 50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						275,661 51
52	Total Program excludable cost (sum of lines 50 and 51)						895,964 52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						10,594,566 53
TARGET AMOUNT AND LIMIT COMPUTATION							
54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63
PROGRAM INPATIENT ROUTINE SWING BED COST							
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/18/2022 Run Time: 07:58 Version: 2022.01 (03/16/2022)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-3028

WORKSHEET D-1
PARTS III & IV

Check
Applicable
Boxes:

☐ Title V - I/P

☒ Title XVIII, Part A

☐ Title XIX - I/P

☒ Hospital

☐ IPF

☐ IRF

☐ SUB (Other)

☐ SNF

☐ NF

☐ ICF/IID

PARHM Demo

☒ PPS

☐ TEFRA

☐ Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)						87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					728.36	88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing Program						91
92	Allied Health						92
93	Other Medical Education						93

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/18/2022 Run Time: 07:58 Version: 2022.01 (03/16/2022)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-3028****WORKSHEET D-1
PART I**

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

PART I - ALL PROVIDER COMPONENTS**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	19,827	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	19,827	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	19,827	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	290	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	14,419,368	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	14,419,368	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	14,419,368	37

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/18/2022 Run Time: 07:58 Version: 2022.01 (03/16/2022)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-3028****WORKSHEET D-1
PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS							1
38	Adjusted general inpatient routine service cost per diem (see instructions)						727.26 38
39	Program general inpatient routine service cost (line 9 x line 38)						210,905 39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)						210,905 41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
							1
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						113,093 48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						323,998 49
PASS THROUGH COST ADJUSTMENTS							
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						18,838 50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						7,602 51
52	Total Program excludable cost (sum of lines 50 and 51)						26,440 52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						53
TARGET AMOUNT AND LIMIT COMPUTATION							
54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63
PROGRAM INPATIENT ROUTINE SWING BED COST							
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/18/2022 Run Time: 07:58 Version: 2022.01 (03/16/2022)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-3028

WORKSHEET D-1
PARTS III & IV

Check
Applicable
Boxes:

☐ Title V - I/P

☐ Title XVIII, Part A

☒ Title XIX - I/P

☒ Hospital

☐ IPF

☐ IRF

☐ SUB (Other)

☐ SNF

☐ NF

☐ ICF/IID

☐ PARHM Demo

☐ PPS

☐ TEFRA

☒ Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)						87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					728.36	88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing Program						91
92	Allied Health						92
93	Other Medical Education						93

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/18/2022 Run Time: 07:58 Version: 2022.01 (03/16/2022)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-3028

WORKSHEET D-3

Check
Applicable
Boxes:

☐ Title V

☒ Title XVIII, Part A

☐ Title XIX

☒ Hospital

☐ IPF

☐ IRF

☐ SUB

(Other)

☐ SNF

☐ NF

☐ Swing Bed SNF

☐ Swing Bed NF

☐ ICF/IID

☐ PARHM Demo

☐ PARHM CAH

Swing Bed SNF

☒ PPS

☐ TEFRA

☐ Other

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		10,259,236		30
	ANCILLARY SERVICE COST CENTERS				
54	Radiology-Diagnostic	0.861007	70,038	60,303	54
54.01	RADIOLOGY-SUA	0.664954	181,897	120,953	54.01
60	Laboratory	0.328889	979,136	322,027	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	1.207298	241,150	291,140	65
66	Physical Therapy	0.425292	2,866,510	1,219,104	66
67	Occupational Therapy	0.394099	2,846,735	1,121,895	67
68	Speech Pathology	0.486535	685,215	333,381	68
71	Medical Supplies Charged to Patients	1.119222	306,077	342,568	71
73	Drugs Charged to Patients	0.270318	2,678,507	724,049	73
76.01	SPECIAL PROCEDURES				76.01
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
92	Observation Beds (Non-Distinct Part)				92
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		10,855,265	4,535,420	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		10,855,265		202

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/18/2022 Run Time: 07:58 Version: 2022.01 (03/16/2022)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-3028

WORKSHEET D-3

Check
Applicable
Boxes:

☐ Title V

☐ Title XVIII, Part A

☒ Title XIX

☒ Hospital

☐ IPF

☐ IRF

☐ SUB

(Other)

☐ SNF

☐ NF

☐ Swing Bed SNF

☐ Swing Bed NF

☐ ICF/IID

☐ PARHM Demo

☐ PARHM CAH

Swing Bed SNF

☐ PPS

☐ TEFRA

☒ Other

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		312,040		30
	ANCILLARY SERVICE COST CENTERS				
54	Radiology-Diagnostic	0.861007	585	504	54
54.01	RADIOLOGY-SUA	0.664954	1,519	1,010	54.01
60	Laboratory	0.328889	15,465	5,086	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	1.207298	4,495	5,427	65
66	Physical Therapy	0.425292	89,615	38,113	66
67	Occupational Therapy	0.394099	87,724	34,572	67
68	Speech Pathology	0.486535	17,465	8,497	68
71	Medical Supplies Charged to Patients	1.119222	3,424	3,832	71
73	Drugs Charged to Patients	0.270318	59,383	16,052	73
76.01	SPECIAL PROCEDURES				76.01
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
92	Observation Beds (Non-Distinct Part)				92
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		279,675	113,093	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		279,675		202

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/18/2022 Run Time: 07:58 Version: 2022.01 (03/16/2022)
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CALCULATION OF REIMBURSEMENT SETTLEMENT**COMPONENT CCN: 14-3028****WORKSHEET E
PART B**

Check applicable box: ☒ Hospital ☐ IPF ☐ IRF ☐ SUB (Other) ☐ SNF ☐ PARHM Demonstration

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	OPPS payments				3
4	Outlier payment (see instructions)				4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (see instructions)				21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)				26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)				27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)				30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)				32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)				34
35	Adjusted reimbursable bad debts (see instructions)				35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)				36
37	Subtotal (see instructions)				37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)				40
40.01	Sequestration adjustment (see instructions)				40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
40.03	Sequestration adjustment - PARHM pass-throughs				40.03
41	Interim payments				41
41.01	Interim payments - PARHM				41.01
42	Tentative settlement (for contractors use only)				42
42.01	Tentative settlement - PARHM (for contractor use only)				42.01
43	Balance due provider/program (see instructions)				43
43.01	Balance due provider/program - PARHM (see instructions)				43.01
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/18/2022 Run Time: 07:58 Version: 2022.01 (03/16/2022)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-3028

WORKSHEET E-1
PART I

Check ☒ Hospital ☐ SUB (Other) ☐ PARHM Demonstration
Applicable ☐ IPF ☐ SNF ☐ PARHM CAH Swing Bed-SNF
Boxes: ☐ IRF ☐ Swing Bed SNF

			INPATIENT PART A		PART B	
DESCRIPTION			mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4
1	Total interim payments paid to provider			16,746,237		1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero					2
3	List separately each retroactive lump sum adjustment					3.01
	amount based on subsequent revision of the interim					3.02
	rate for the cost reporting period. Also show date of	Program	08/31/2021	58,577		3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to				3.04
		Provider				3.05
						3.06
						3.07
						3.08
						3.09
						3.10
						3.50
						3.51
		Provider	04/27/2021	7,092		3.52
		to				3.53
		Program				3.54
						3.55
						3.56
						3.57
						3.58
						3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			51,485		3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)			16,797,722		4
TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment					5.01
	after desk review. Also show date of each payment.					5.02
	If none, write 'NONE' or enter a zero. (1)	Program				5.03
		to				5.04
		Provider				5.05
						5.06
						5.07
						5.08
						5.09
						5.10
						5.50
						5.51
		Provider				5.52
		to				5.53
		Program				5.54
						5.55
						5.56
						5.57
						5.58
						5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)					5.99
6	Determined net settlement amount (balance due)					6.01
	based on the cost report (1)					6.02
7	Total Medicare program liability (see instructions)					7
8	Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)	8

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

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/18/2022 Run Time: 07:58 Version: 2022.01 (03/16/2022)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-3028

WORKSHEET E-3
PART III

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

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

		1	1.01	
1	Net Federal PPS payment (see instructions)	16,128,599		1
2	Medicare SSI ratio (IRF PPS only) (see instructions)	0.040300		2
3	Inpatient Rehabilitation LIP payments (see instructions)	987,070		3
4	Outlier payments	36,910		4
5	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			5
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) OR (2)			5.01
6	New teaching program adjustment (see instructions)			6
7	Current year unweighted FTE count of I&R excludnig FTEs in the new program growth period of a 'new teaching program' (see instructions)			7
8	Current year unweighted I&R FTE count for residents within the new program growth period of a 'new teaching program' (see instructions)			8
9	Intern and resident count for IRF PPS medical education adjustment (see instructions)			9
10	Average daily census (see instructions)	54.320548		10
11	Teaching Adjustment Factor (see instructions)			11
12	Teaching Adjustment (see instructions)			12
13	Total PPS Payment (see instructions)	17,152,579		13
14	Nursing and allied health managed care payments (see instructions)			14
15	Organ acquisition DO NOT USE THIS LINE			15
16	Cost of physicians' services in a teaching hospital (see instructions)			16
17	Subtotal (see instructions)	17,152,579		17
18	Primary payer payments			18
19	Subtotal (line 17 less line 18)	17,152,579		19
20	Deductibles	188,164		20
21	Subtotal (line 19 minus line 20)	16,964,415		21
22	Coinsurance	118,121		22
23	Subtotal (line 21 minus line 22)	16,846,294		23
24	Allowable bad debts (exclude bad debts for professional services) (see instructions)	78,679		24
25	Adjusted reimbursable bad debts (see instructions)	51,141		25
26	Allowable bad debts for dual eligible beneficiaries (see instructions)	51,897		26
27	Subtotal (sum of lines 23 and 25)	16,897,435		27
28	Direct graduate medical education payments (from Wkst. E-4, line 49) (For free standing IRF only)			28
29	Other pass through costs (see instructions)			29
30	Outlier payments reconciliation			30
31	Other adjustments (specify) (see instructions)			31
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			31.50
31.98	Recovery of accelerated depreciation			31.98
31.99	Demonstration payment adjustment amount before sequestration			31.99
32	Total amount payable to the provider (see instructions)	16,897,435		32
32.01	Sequestration adjustment (see instructions)			32.01
32.02	Demonstration payment adjustment amount after sequestration			32.02
33	Interim payments	16,797,722		33
34	Tentative settlement (for contractor use only)			34
35	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33 and 34)	99,713		35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	473,076		36
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE			
99	Enter Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020	0.000000		99
99.01	Calculated Teaching Adjustment Factor for the current year (see instructions.)	0.000000		99.01
	Transfer the higher of Line 99 or Line 99.01 to Line 11.			

TO BE COMPLETED BY CONTRACTOR

50	Original outlier amount from Wkst. E-3, Pt. III, line 4 (see instructions)			50
51	Outlier reconciliation adjustment amount (see instructions)			51
52	The rate used to calculate the Time Value of Money (see instructions)			52
53	Time Value of Money (see instructions)			53

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/18/2022 Run Time: 07:58 Version: 2022.01 (03/16/2022)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-3028

WORKSHEET E-3
PART VII

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

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	323,998		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	323,998		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	323,998		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges	312,040		8
9	Ancillary service charges	279,675		9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)	591,715		12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahрге basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)	591,715		16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	267,717		17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)	323,998		21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)	323,998		29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)			30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	323,998		31
32	Deductibles			32
33	Coinsurance	91,463		33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)	232,535		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	232,535		38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)	232,535		40
41	Interim payments	280,162		41
42	Balance due provider/program (line 40 minus line 41)	-47,627		42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

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VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/18/2022 Run Time: 07:58 Version: 2022.01 (03/16/2022)
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BALANCE SHEET

WORKSHEET G

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

	Assets (Omit Cents)	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	6,363,332				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	5,230,298				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-1,561,638				6
7	Inventory	79,979				7
8	Prepaid expenses	74,968				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	10,186,939				11
	FIXED ASSETS					
12	Land					12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings	22,059,820				15
16	Accumulated depreciation	-10,347,770				16
17	Leasehold improvements	707,054				17
18	Accumulated depreciation	-517,943				18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	5,442,935				23
24	Accumulated depreciation	-3,699,415				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	13,644,681				30
	OTHER ASSETS					
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	3,081,663				34
35	Total other assets (sum of lines 31-34)	3,081,663				35
36	Total assets (sum of lines 11, 30 and 35)	26,913,283				36
	Liabilities and Fund Balances (Omit Cents)	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable	1,070,717				37
38	Salaries, wages and fees payable	1,012,330				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)					40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	4,092,300				44
45	Total current liabilities (sum of lines 37 thru 44)	6,175,347				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	10,645,364				49
50	Total long term liabilities (sum of lines 46 thru 49)	10,645,364				50
51	Total liabilities (sum of lines 45 and 50)	16,820,711				51
	CAPITAL ACCOUNTS					
52	General fund balance	10,092,572				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	10,092,572				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	26,913,283				60

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

		GENERAL FUND		SPECIFIC PURPOSE FUND	
		1	2	3	4
1	Fund balances at beginning of period		11,471,369		1
2	Net income (loss) (from Worksheet G-3, line 29)		4,665,421		2
3	Total (sum of line 1 and line 2)		16,136,790		3
4	Additions (credit adjustments) (specify)				4
5					5
6					6
7					7
8					8
9					9
10	Total additions (sum of lines 4-9)				10
11	Subtotal (line 3 plus line 10)		16,136,790		11
12	Deductions (debit adjustments) (specify)				12
13	EQUITY DISTRIBUTION	3,711,506			13
14	MINORITY INTEREST EXPENSE	2,332,712			14
15					15
16					16
17					17
18	Total deductions (sum of lines 12-17)		6,044,218		18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		10,092,572		19

		ENDOWMENT FUND		PLANT FUND	
		5	6	7	8
1	Fund balances at beginning of period				1
2	Net income (loss) (from Worksheet G-3, line 29)				2
3	Total (sum of line 1 and line 2)				3
4	Additions (credit adjustments) (specify)				4
5					5
6					6
7					7
8					8
9					9
10	Total additions (sum of lines 4-9)				10
11	Subtotal (line 3 plus line 10)				11
12	Deductions (debit adjustments) (specify)				12
13	EQUITY DISTRIBUTION				13
14	MINORITY INTEREST EXPENSE				14
15					15
16					16
17					17
18	Total deductions (sum of lines 12-17)				18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)				19

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VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/18/2022 Run Time: 07:58 Version: 2022.01 (03/16/2022)
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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES**WORKSHEET G-2
PARTS I & II****PART I - PATIENT REVENUES**

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	21,319,036		21,319,036	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility				7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	21,319,036		21,319,036	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit				11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)				16
17	Total inpatient routine care services (sum of lines 10 and 16)	21,319,036		21,319,036	17
18	Ancillary services	22,373,021		22,373,021	18
19	Outpatient services				19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	Other (specify)				27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	43,692,057		43,692,057	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		25,011,144	29
30	Add (specify)			30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)			37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		25,011,144	43

Health Financial Systems Compu-Max 2552-10

VAN MATRE ENCOMPASS HEALTH REHABILIT Provider CCN: 14-3028	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/18/2022 Run Time: 07:58 Version: 2022.01 (03/16/2022)
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STATEMENT OF REVENUES AND EXPENSES**WORKSHEET G-3**

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	43,692,057	1
2	Less contractual allowances and discounts on patients' accounts	14,571,235	2
3	Net patient revenues (line 1 minus line 2)	29,120,822	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	25,011,144	4
5	Net income from service to patients (line 3 minus line 4)	4,109,678	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments	12,338	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts	10	10
11	Rebates and refunds of expenses		11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests	16,283	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to other than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts		18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hospital space	15,227	22
23	Governmental appropriations		23
24	Other (specify)	511,885	24
24.50	COVID-19 PHE FUNDING		24.50
25	Total other income (sum of lines 6-24)	555,743	25
26	Total (line 5 plus line 25)	4,665,421	26
29	Net income (or loss) for the period (line 26 minus line 28)	4,665,421	29