

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 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: 05/12/2022 Time: 10:23
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 ENCOMPASS HEALTH DEACONESS REHABILIT (15-3025) {(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	CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
1	1 ROB WISNER	2 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	05/12/2022		4

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		304,908			216,515	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		304,908			216,515	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: 9355 WARRICK TRAIL	P.O. Box:		1
2	City: NEWBURGH	State: IN	ZIP Code: 47630	County: VANDERBURGH

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	ENCOMPASS HEALTH DEACONESS REHABILIT	15-3025	21780	5	06 / 08 / 1989	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.	358	250	146	441	3,684		25
26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.			1				26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.			1				27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status is in effect in the cost reporting period.							35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			Beginning:		Ending:		36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.							37
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with the FY 2016 OPSS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)							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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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) 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)			107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108
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.	Physical	Occupational	Speech
			Respiratory	

		1	2	
110	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N		110
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
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.	1	2	3
		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
118.01	List amounts of malpractice premiums and paid losses:	Premiums	Paid Losses	Self Insurance	
		43,097	20,447		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

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 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.	N	N	145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, chapter 40, §4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N		147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N		148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	N		149

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

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

Multicampus

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

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

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

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 Version: 2022.01 (03/16/2022)
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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		Y	03/02/2022	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

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 Version: 2022.01 (03/16/2022)
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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.	

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 Version: 2022.01 (03/16/2022)
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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	98	35,770			19,307	466	33,409	1
2	HMO and other (see instructions)						5,833	4,413		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)		98	35,770			19,307	466	33,409	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)		98	35,770			19,307	466	33,409	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)		98							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

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 Version: 2022.01 (03/16/2022)
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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)					1,489	32	2,580	1
2	HMO and other (see instructions)					426	348		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)		264.68			1,489	32	2,580	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)		264.68						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

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 Version: 2022.01 (03/16/2022)
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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	17,523,409	1		550,555.20		1
2 Non-physician anesthetist Part A							2
3 Non-physician anesthetest Part B							3
4 Physician-Part A - Administrative		112,788			789.00		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)			267,516		6,329.33		10
OTHER WAGES & RELATED COSTS							
11 Contract labor (see instructions)		1,103,534			16,936.00		11
12 Contract management and administrative services							12
13 Contract labor: Physician-Part A - Administrative		112,788			789.00		13
14 Home office salaries & wage-related costs							14
14.01 Home office salaries		966,401			17,712.68		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)		4,889,948					17
18 Wage-related costs (other)(see instructions)							18
19 Excluded areas		75,808					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		413,855					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		2,355,361	-267,516		54,510.67		27
28 Administrative & General under contract (see instructions)		45,163			385.82		28
29 Maintenance & Repairs							29
30 Operation of Plant		331,142			11,336.00		30
31 Laundry & Linen Service							31
32 Housekeeping		319,266			22,796.80		32
33 Housekeeping under contract (see instructions)							33
34 Dietary		477,837			24,835.20		34
35 Dietary under contract (see instructions)							35
36 Cafeteria							36
37 Maintenance of Personnel							37
38 Nursing Administration		917,075			23,628.80		38
39 Central Services and Supply							39
40 Pharmacy							40
41 Medical Records & Medical Records Library		109,885			5,699.20		41
42 Social Service		692,640			20,841.60		42
43 Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		17,568,572	1	17,568,573	550,941.02	31.89	1
2	Excluded area salaries (see instructions)			267,516	267,516	6,329.33	42.27	2
3	Subtotal salaries (line 1 minus line 2)		17,568,572	-267,515	17,301,057	544,611.69	31.77	3
4	Subtotal other wages & related costs (see instructions)		2,182,723		2,182,723	35,437.68	61.59	4
5	Subtotal wage-related costs (see instructions)		5,303,803		5,303,803		30.66%	5
6	Total (sum of lines 3 through 5)		25,055,098	-267,515	24,787,583	580,049.37	42.73	6
7	Total overhead cost (see instructions)		5,248,369	-267,516	4,980,853	164,034.09	30.36	7

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 Version: 2022.01 (03/16/2022)
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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	268,131	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)	3,846,383	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)	18,418	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	183,572	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	1,293,176	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance		19
20	State or Federal Unemployment Taxes	37,017	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	-680,941	22
23	Tuition Reimbursement		23
24	Total Wage Related cost (Sum of lines 1-23)	4,965,756	24

Part B - Other Than Core Related Cost

25	Other Wage Related Costs (SPECIFY)		25
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Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 Version: 2022.01 (03/16/2022)
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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	1,216,322	4,965,756	1
2	Hospital	1,216,322	4,889,948	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		75,808	18

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 Version: 2022.01 (03/16/2022)
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HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

WORKSHEET S-5

RENAL DIALYSIS STATISTICS

	DESCRIPTION	Outpatient		Training		Home		
		Regular	High Flux	Hemo-dialysis	CAPD CCPD	Hemo-dialysis	CAPD CCPD	
		1	2	3	4	5	6	
1	Number of patients in program at end of cost reporting period							1
2	Number of times per week patient receives dialysis							2
3	Average patient dialysis time including setup							3
4	CAPD exchanges per day							4
5	Number of days in year dialysis furnished							5
6	Number of stations							6
7	Treatment capacity per day per station							7
8	Utilization (see instructions)							8
9	Average times dialyzers re-used							9
10	Percentage of patients re-using dialyzers							10

ESRD PPS

		1	2	
10.01	Is the dialysis facility approved as a low-volume facility for this cost reporting period? Enter 'Y' for yes or 'N' for no. (see instructions)			10.01
10.02	Did your facility elect 100% PPS effective January 1, 2011? Enter 'Y' for yes or 'N' for no. (see instructions for 'new' providers)			10.02
10.03	If you responded 'N' to line 10.02, enter in column 1 the year of transition for periods prior to January 1 and enter in column 2 the year of transition for periods after December 31. (see instructions)		4	10.03

TRANSPLANT INFORMATION

11	Number of patients on transplant list		11
12	Number of patients transplanted during the cost reporting period		12

EPOETIN

13	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider		13
14	Epoetin amount from Worksheet A for home dialysis program		14
15	Number of EPO units furnished relating to the renal dialysis department		15
16	Number of EPO units furnished relating to the home dialysis department		16

ARANESP

17	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider		17
18	ARANESP amount from Worksheet A for home dialysis program		18
19	Number of ARANESP units furnished relating to the renal dialysis department		19
20	Number of ARANESP units furnished relating to the home dialysis department		20

PHYSICIAN PAYMENT METHOD (Enter 'X' for applicable method(s))

21	MCP	INITIAL METHOD	
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Erythropoiesis-Stimulating Agents (ESA) Statistics:		ESA Description	Net Cost of ESAs for Renal Patients	Net Cost of ESAs for Home Patients	Number of ESA Units - Renal Dialysis Dept.	Number of ESA Units - Home Dialysis Dept.	
		1	2	3	4	5	
22	Enter in column 1 the ESA description. Enter in column 2 the net costs of ESAs furnished to all renal dialysis patients. Enter in column 3 the net cost of ESAs furnished to all home dialysis program patients. Enter in column 4 the number of ESA units furnished to patients in the renal dialysis department. Enter in column 5 the number of units furnished to patients in the home dialysis program. (see instructions)						22

LOW VOLUME		CCN	Treatments			
		1	2			
23	If line 10.01 is yes, enter in column 1 the CCN for each renal dialysis facility listed on Worksheet S-2, Part I, line 18 and its subscripts. Enter in column 2, the total treatments for each CCN. (see instructions)					23

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 Version: 2022.01 (03/16/2022)
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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt		1,846,763	1,846,763	191,858	2,038,621	352,226	2,390,847	1
2	00200	Cap Rel Costs-Mvble Equip		936,380	936,380	44,748	981,128	-66,249	914,879	2
3	00300	Other Cap Rel Costs		201,497	201,497	-201,497			-0-	3
4	00400	Employee Benefits Department		3,563,939	3,563,939		3,563,939	1,361,561	4,925,500	4
5	00500	Administrative & General	2,355,361	4,789,733	7,145,094	-341,004	6,804,090	-1,439,906	5,364,184	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	331,142	765,124	1,096,266		1,096,266	-66,301	1,029,965	7
8	00800	Laundry & Linen Service		294,166	294,166		294,166		294,166	8
9	00900	Housekeeping	319,266	89,384	408,650		408,650	-1,975	406,675	9
10	01000	Dietary	477,837	635,516	1,113,353		1,113,353	-189,218	924,135	10
11	01100	Cafeteria								11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	917,075	39,277	956,352		956,352	-643	955,709	13
14	01400	Central Services & Supply								14
15	01500	Pharmacy								15
16	01600	Medical Records & Library	109,885	1,031	110,916		110,916	-2,112	108,804	16
17	01700	Social Service	692,640	10,469	703,109		703,109	-6	703,103	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	7,214,464	1,708,495	8,922,959	63,133	8,986,092	-162,736	8,823,356	30
		ANCILLARY SERVICE COST CENTERS								
54	05400	Radiology-Diagnostic		247,287	247,287	-56,269	191,018	-13,246	177,772	54
54.01	05401	RADIOLOGY-SUA				56,269	56,269	-3,211	53,058	54.01
60	06000	Laboratory		779,709	779,709	-58	779,651	-25,447	754,204	60
60.01	06001	LAB - SUA				58	58		58	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	485,125	8,807	493,932		493,932		493,932	65
66	06600	Physical Therapy	1,545,630	90,846	1,636,476	-62,469	1,574,007		1,574,007	66
67	06700	Occupational Therapy	1,727,765	31,669	1,759,434	48,382	1,807,816	-232	1,807,584	67
68	06800	Speech Pathology	637,126	5,370	642,496	14,087	656,583	-11	656,572	68
71	07100	Medical Supplies Charged to Patients	82,953	431,452	514,405	-31,825	482,580	-37,767	444,813	71
73	07300	Drugs Charged to Patients	627,140	722,458	1,349,598		1,349,598	-2,476	1,347,122	73
76.01	03951	SPECIAL PROCEDURES		158,291	158,291	-135,989	22,302	-7,958	14,344	76.01
76.02	03952	SPECIAL PROCEDURES - SUA				135,989	135,989	-48,125	87,864	76.02
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
92	09200	Observation Beds (Non-Distinct Part)								92
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM								93.99
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
113	11300	Interest Expense		4,689	4,689		4,689	-4,689		113
118		SUBTOTALS (sum of lines 1-117)	17,523,409	17,362,352	34,885,761	-274,587	34,611,174	-358,521	34,252,653	118
		NONREIMBURSABLE COST CENTERS								
194	07950	NRCC MARKETING				274,587	274,587		274,587	194
194.01	07951	NRCC DIETARY								194.01
200		TOTAL (sum of lines 118-199)	17,523,409	17,362,352	34,885,761		34,885,761	-358,521	34,527,240	200

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 Version: 2022.01 (03/16/2022)
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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		28,470	1
2	INSURANCE	A	Cap Rel Costs-Mvble Equip	2		6,639	2
3	INSURANCE	A					3
500	Total reclassifications					35,109	500
	Code Letter - A						
1	MARKETING	B	NRCC MARKETING	194	267,516	7,071	1
2	MARKETING	B					2
500	Total reclassifications				267,516	7,071	500
	Code Letter - B						
1	PHYSICIANS	C	Adults & Pediatrics	30		31,308	1
2	PHYSICIANS	C					2
500	Total reclassifications					31,308	500
	Code Letter - C						
1	COMS RECLASS (MEDICAL SUPPLIES)	D	Adults & Pediatrics	30		31,825	1
2	COMS RECLASS (MEDICAL SUPPLIES)	D					2
500	Total reclassifications					31,825	500
	Code Letter - D						
1	SERVICE UNDER ARRANGEMENT	E	RADIOLOGY-SUA	54.01		56,269	1
2	SERVICE UNDER ARRANGEMENT	E	LAB - SUA	60.01		58	2
3	SERVICE UNDER ARRANGEMENT	E	SPECIAL PROCEDURES - SUA	76.02		135,989	3
4	SERVICE UNDER ARRANGEMENT	E					4
5	SERVICE UNDER ARRANGEMENT	E					5
6	SERVICE UNDER ARRANGEMENT	E					6
500	Total reclassifications					192,316	500
	Code Letter - E						
1	DEPT 283 RECLASS	F	Occupational Therapy	67	47,941	441	1
2	DEPT 283 RECLASS	F	Speech Pathology	68	13,959	128	2
3	DEPT 283 RECLASS	F					3
500	Total reclassifications				61,900	569	500
	Code Letter - F						
	GRAND TOTAL (Increases)				329,416	298,198	

(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.

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 Version: 2022.01 (03/16/2022)
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RECLASSIFICATIONS

WORKSHEET A-6

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	INSURANCE	A					12	1
2	INSURANCE	A					12	2
3	INSURANCE	A	Administrative & General	5		35,109		3
500	Total reclassifications					35,109		500
	Code letter - A							
1	MARKETING	B						1
2	MARKETING	B	Administrative & General	5	267,516	7,071		2
500	Total reclassifications				267,516	7,071		500
	Code letter - B							
1	PHYSICIANS	C						1
2	PHYSICIANS	C	Administrative & General	5		31,308		2
500	Total reclassifications					31,308		500
	Code letter - C							
1	COMS RECLASS (MEDICAL SUPPLIES)	D						1
2	COMS RECLASS (MEDICAL SUPPLIES)	D	Medical Supplies Charged to P	71		31,825		2
500	Total reclassifications					31,825		500
	Code letter - D							
1	SERVICE UNDER ARRANGEMENT	E						1
2	SERVICE UNDER ARRANGEMENT	E						2
3	SERVICE UNDER ARRANGEMENT	E						3
4	SERVICE UNDER ARRANGEMENT	E	Radiology-Diagnostic	54		56,269		4
5	SERVICE UNDER ARRANGEMENT	E	Laboratory	60		58		5
6	SERVICE UNDER ARRANGEMENT	E	SPECIAL PROCEDURES	76.01		135,989		6
500	Total reclassifications					192,316		500
	Code letter - E							
1	DEPT 283 RECLASS	F						1
2	DEPT 283 RECLASS	F						2
3	DEPT 283 RECLASS	F	Physical Therapy	66	61,899	570		3
500	Total reclassifications				61,899	570		500
	Code letter - F							
	GRAND TOTAL (Decreases)				329,415	298,199		

(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.

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 Version: 2022.01 (03/16/2022)
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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	1,675,024					1,675,024		1
2	Land Improvements	356,682					356,682		2
3	Buildings and Fixtures	24,940,126	1,293		1,293		24,941,419		3
4	Building Improvements	1,823,669	2,550		2,550		1,826,219		4
5	Fixed Equipment	6,209,071	184,581		184,581	161,793	6,231,859		5
6	Movable Equipment	94,584					94,584		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	35,099,156	188,424		188,424	161,793	35,125,787		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	35,099,156	188,424		188,424	161,793	35,125,787		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	1,399,194	447,569					1,846,763	1
2	Cap Rel Costs-Mvble Equip	747,457	188,923					936,380	2
3	Total (sum of lines 1-2)	2,146,651	636,492					2,783,143	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	27,124,320		27,124,320	0.810873		163,388		163,388	1
2	Cap Rel Costs-Mvble Equip	6,326,443		6,326,443	0.189127		38,109		38,109	2
3	Total (sum of lines 1-2)	33,450,763		33,450,763	1.000000		201,497		201,497	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	1,494,664	447,569	256,756	28,470	163,388		2,390,847	1
2	Cap Rel Costs-Mvble Equip	692,081	178,050		6,639	38,109		914,879	2
3	Total (sum of lines 1-2)	2,186,745	625,619	256,756	35,109	201,497		3,305,726	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.)

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 Version: 2022.01 (03/16/2022)
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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	-10,260				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1	-803,654				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	-4,689	Interest Expense	113	11	37
37.01	DEPRECIATION	A	1	Cap Rel Costs-Bldg & Fixt	1	9	37.01
37.02	DEPRECIATION	A	4,395	Cap Rel Costs-Mvble Equip	2	9	37.02
37.03	INSURANCE	A	1,383,667	Employee Benefits Department	4		37.03
37.04	INSURANCE	A	-364,013	Administrative & General	5		37.04
37.05	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-175,894	Administrative & General	5		37.05
37.06	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-219	Dietary	10		37.06
37.07	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-349	Nursing Administration	13		37.07
37.08	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-21	Adults & Pediatrics	30		37.08
37.09	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-232	Occupational Therapy	67		37.09
37.10	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-11	Speech Pathology	68		37.10
37.11	PATIENT TELEPHONE	A	-9,974	Cap Rel Costs-Mvble Equip	2	9	37.11
37.12	PATIENT TELEPHONE	A	-5,675	Employee Benefits Department	4		37.12
37.13	PATIENT TELEPHONE	A	-26,983	Administrative & General	5		37.13
37.14	PATIENT TELEVISION	A	-34,669	Cap Rel Costs-Mvble Equip	2	9	37.14
37.15	PATIENT TELEVISION	A	-15,941	Administrative & General	5		37.15
37.16	PRINTING	A	-7,604	Administrative & General	5		37.16
37.17	PRINTING	A	-4	Operation of Plant	7		37.17
37.18	PRINTING	A	-294	Nursing Administration	13		37.18
37.19	PRINTING	A	-6	Social Service	17		37.19
37.20	LOBBYING EXPENSE	A	-943	Administrative & General	5		37.20
37.21	MISCELLANEOUS INCOME	B	-134	Cap Rel Costs-Bldg & Fixt	1	9	37.21
37.22	MISCELLANEOUS INCOME	B	-45	Administrative & General	5		37.22
37.23	MISCELLANEOUS INCOME	B	-872	Operation of Plant	7		37.23
37.24	MISCELLANEOUS INCOME	B	-22,381	Dietary	10		37.24
37.25	MISCELLANEOUS INCOME	B	-2,112	Medical Records & Library	16		37.25
37.26	PATIENT TRANSPORTATION	A	-15,128	Cap Rel Costs-Mvble Equip	2	9	37.26
37.27	PATIENT TRANSPORTATION	A	-16,431	Employee Benefits Department	4		37.27
37.28	PATIENT TRANSPORTATION	A	-65,425	Operation of Plant	7		37.28

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 Version: 2022.01 (03/16/2022)
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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
37.29	PATIENT TRANSPORTATION	A	-152,455	Adults & Pediatrics	30	37.29
37.30	PROFESSIONAL FEES	A	-10,166	Administrative & General	5	37.30
38						38
39						39
40						40
41						41
42						42
43						43
44						44
45						45
46						46
47						47
48						48
49						49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-358,521			50

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

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

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 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

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		3,083,615	-3,083,615		1
2	1	Cap Rel Costs-Bldg & Fixt	TO INCLUDE ALLOWABLE HOME OFFICE COS	95,603		95,603	9	2
3	1	Cap Rel Costs-Bldg & Fixt	TO INCLUDE ALLOWABLE HOME OFFICE COS	256,756		256,756	11	3
3.01	5	Administrative & General	TO INCLUDE ALLOWABLE HOME OFFICE COS	2,034,051		2,034,051		3.01
3.02	5	Administrative & General	TO INCLUDE ALLOWABLE HOME OFFICE COS	220,818		220,818		3.02
3.03	2	Cap Rel Costs-Mvble Equip	INTERCOMPANY WAGE AND EXPENSE TRANSF	17,178	17,178		10	3.03
3.04	3	Other Cap Rel Costs	INTERCOMPANY WAGE AND EXPENSE TRANSF	46,962	46,962		13	3.04
3.05	4	Employee Benefits Department	INTERCOMPANY WAGE AND EXPENSE TRANSF	2,624,090	2,624,090			3.05
3.06	5	Administrative & General	INTERCOMPANY WAGE AND EXPENSE TRANSF	3,906,486	3,906,486			3.06
3.07	7	Operation of Plant	INTERCOMPANY WAGE AND EXPENSE TRANSF	12,034	12,034			3.07
3.08	8	Laundry & Linen Service	INTERCOMPANY WAGE AND EXPENSE TRANSF	149	149			3.08
3.09	9	Housekeeping	INTERCOMPANY WAGE AND EXPENSE TRANSF	2,215	2,215			3.09
3.10	10	Dietary	INTERCOMPANY WAGE AND EXPENSE TRANSF	-9,623	-9,623			3.10
3.11	13	Nursing Administration	INTERCOMPANY WAGE AND EXPENSE TRANSF	4,336	4,336			3.11
3.12	16	Medical Records & Library	INTERCOMPANY WAGE AND EXPENSE TRANSF	160	160			3.12
3.13	17	Social Service	INTERCOMPANY WAGE AND EXPENSE TRANSF	2,349	2,349			3.13
3.14	30	Adults & Pediatrics	INTERCOMPANY WAGE AND EXPENSE TRANSF	20,645	20,645			3.14
3.15	54	Radiology-Diagnostic	INTERCOMPANY WAGE AND EXPENSE TRANSF	70	70			3.15
3.16	60	Laboratory	INTERCOMPANY WAGE AND EXPENSE TRANSF	-1,193	-1,193			3.16
3.17	65	Respiratory Therapy	INTERCOMPANY WAGE AND EXPENSE TRANSF	544	544			3.17
3.18	66	Physical Therapy	INTERCOMPANY WAGE AND EXPENSE TRANSF	3,237	3,237			3.18
3.19	67	Occupational Therapy	INTERCOMPANY WAGE AND EXPENSE TRANSF	1,667	1,667			3.19
3.20	68	Speech Pathology	INTERCOMPANY WAGE AND EXPENSE TRANSF	684	684			3.20
3.21	71	Medical Supplies Charged to Patients	INTERCOMPANY WAGE AND EXPENSE TRANSF	-11,693	-11,693			3.21
3.22	73	Drugs Charged to Patients	INTERCOMPANY WAGE AND EXPENSE TRANSF	595,723	595,723			3.22
3.23	76.01	SPECIAL PROCEDURES	INTERCOMPANY WAGE AND EXPENSE TRANSF	1,038	1,038			3.23
3.24	113	Interest Expense	INTERCOMPANY WAGE AND EXPENSE TRANSF	4,689	4,689		11	3.24
3.25	1	Cap Rel Costs-Bldg & Fixt	RELATED PARTY - DEACONESS	449,206	449,206		10	3.25
3.26	2	Cap Rel Costs-Mvble Equip	RELATED PARTY - DEACONESS	3,153	14,026	-10,873	10	3.26
3.27	5	Administrative & General	RELATED PARTY - DEACONESS	5,276	14,847	-9,571		3.27
3.28	8	Laundry & Linen Service	RELATED PARTY - DEACONESS	17,339	17,339			3.28
3.29	9	Housekeeping	RELATED PARTY - DEACONESS	573	2,548	-1,975		3.29
3.30	10	Dietary	RELATED PARTY - DEACONESS	48,326	214,944	-166,618		3.30
3.31	13	Nursing Administration	RELATED PARTY - DEACONESS	761	761			3.31
3.32	30	Adults & Pediatrics	RELATED PARTY - DEACONESS	24,266	24,266			3.32
3.33	54	Radiology-Diagnostic	RELATED PARTY - DEACONESS	25,649	38,895	-13,246		3.33
3.34	54.01	RADIOLOGY-SUA	RELATED PARTY - DEACONESS	7,113	10,324	-3,211		3.34
3.35	60	Laboratory	RELATED PARTY - DEACONESS	279,546	304,993	-25,447		3.35
3.36	71	Medical Supplies Charged to Patients	RELATED PARTY - DEACONESS	15,851	53,618	-37,767		3.36
3.37	73	Drugs Charged to Patients	RELATED PARTY - DEACONESS	862	3,338	-2,476		3.37
3.38	76.01	SPECIAL PROCEDURES	RELATED PARTY - DEACONESS	11,603	19,561	-7,958		3.38
3.39	76.02	SPECIAL PROCEDURES - SUA	RELATED PARTY - DEACONESS	70,167	118,292	-48,125		3.39
4								4
5		TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12		10,788,666	11,592,320	-803,654		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.

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 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	

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		72.50	ENCOMPASS HEALTH		HEALTHCARE	6
7	B		27.50	DEACONESS HOSPITAL		HEALTHCARE	7
8	G	ENCOMPASS HEALTH				HEALTHCARE	8
9							9
10							10

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

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

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 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	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	31,308		31,308	211,500	207	21,048	1,052	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	31,308		31,308		207	21,048	1,052	200

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 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					21,048	10,260	10,260	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					21,048	10,260	10,260	200

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 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	2,390,847	2,390,847					1
2	Cap Rel Costs-Mvble Equip	914,879		914,879				2
4	Employee Benefits Department	4,925,500	11,904	4,555	4,941,959			4
5	Administrative & General	5,364,184	93,073	35,615	588,814	6,081,686	6,081,686	5
6	Maintenance & Repairs							6
7	Operation of Plant	1,029,965	76,417	29,242	93,389	1,229,013	264,073	7
8	Laundry & Linen Service	294,166	6,966	2,666		303,798	65,276	8
9	Housekeeping	406,675	13,746	5,260	90,039	515,720	110,811	9
10	Dietary	924,135	130,147	49,802	134,760	1,238,844	266,185	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	955,709	10,863	4,157	258,633	1,229,362	264,148	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	108,804	9,689	3,708	30,990	153,191	32,916	16
17	Social Service	703,103	44,868	17,169	195,338	960,478	206,374	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	8,823,356	1,589,788	608,345	2,034,630	13,056,119	2,805,313	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	177,772				177,772	38,197	54
54.01	RADIOLOGY-SUA	53,058				53,058		54.01
60	Laboratory	754,204	32,056	12,267		798,527	171,576	60
60.01	LAB - SUA	58				58		60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	493,932	8,862	3,391	136,815	643,000	138,159	65
66	Physical Therapy	1,574,007	186,065	71,199	418,442	2,249,713	483,387	66
67	Occupational Therapy	1,807,584	93,767	35,881	500,785	2,438,017	523,847	67
68	Speech Pathology	656,572	27,332	10,459	183,619	877,982	188,648	68
71	Medical Supplies Charged to Patients	444,813	31,229	11,950	23,394	511,386	109,879	71
73	Drugs Charged to Patients	1,347,122	19,591	7,497	176,866	1,551,076	333,273	73
76.01	SPECIAL PROCEDURES	14,344				14,344	3,082	76.01
76.02	SPECIAL PROCEDURES - SUA	87,864				87,864		76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	34,252,653	2,386,363	913,163	4,866,514	34,171,008	6,005,144	118
	NONREIMBURSABLE COST CENTERS							
194	NRCC MARKETING	274,587	4,484	1,716	75,445	356,232	76,542	194
194.01	NRCC DIETARY							194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	34,527,240	2,390,847	914,879	4,941,959	34,527,240	6,081,686	202

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 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	1,493,086						7
8	Laundry & Linen Service	4,708	373,782					8
9	Housekeeping	9,289		635,820				9
10	Dietary	87,950		37,807	1,630,786			10
11	Cafeteria				165,646	165,646		11
12	Maintenance of Personnel							12
13	Nursing Administration	7,341		3,156		10,618	1,514,625	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	6,548		2,815		1,272		16
17	Social Service	30,321		13,034		8,019		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	1,074,332	373,782	461,826	1,463,782	83,526	1,514,625	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic							54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory	21,663		9,312				60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	5,988		2,574		5,617		65
66	Physical Therapy	125,738		54,051		17,179		66
67	Occupational Therapy	63,365		27,239		20,559		67
68	Speech Pathology	18,470		7,940		7,538		68
71	Medical Supplies Charged to Patients	21,104		9,072		960		71
73	Drugs Charged to Patients	13,239		5,691		7,261		73
76.01	SPECIAL PROCEDURES							76.01
76.02	SPECIAL PROCEDURES - SUA							76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	1,490,056	373,782	634,517	1,629,428	162,549	1,514,625	118
	NONREIMBURSABLE COST CENTERS							
194	NRCC MARKETING	3,030		1,303		3,097		194
194.01	NRCC DIETARY				1,358			194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,493,086	373,782	635,820	1,630,786	165,646	1,514,625	202

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 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	196,742						16
17	Social Service		1,218,226					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	94,312	1,218,226	22,145,843		22,145,843		30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	1,553		217,522		217,522		54
54.01	RADIOLOGY-SUA			53,058		53,058		54.01
60	Laboratory	8,083		1,009,161		1,009,161		60
60.01	LAB - SUA			58		58		60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	5,884		801,222		801,222		65
66	Physical Therapy	26,635		2,956,703		2,956,703		66
67	Occupational Therapy	28,057		3,101,084		3,101,084		67
68	Speech Pathology	8,169		1,108,747		1,108,747		68
71	Medical Supplies Charged to Patients	573		652,974		652,974		71
73	Drugs Charged to Patients	23,304		1,933,844		1,933,844		73
76.01	SPECIAL PROCEDURES	172		17,598		17,598		76.01
76.02	SPECIAL PROCEDURES - SUA			87,864		87,864		76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	196,742	1,218,226	34,085,678		34,085,678		118
	NONREIMBURSABLE COST CENTERS							
194	NRCC MARKETING			440,204		440,204		194
194.01	NRCC DIETARY			1,358		1,358		194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	196,742	1,218,226	34,527,240		34,527,240		202

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 Version: 2022.01 (03/16/2022)
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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	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS- TRATIVE & GENERAL	
		0	1	2	2A	4	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department		11,904	4,555	16,459	16,459		4
5	Administrative & General		93,073	35,615	128,688	1,960	130,648	5
6	Maintenance & Repairs							6
7	Operation of Plant		76,417	29,242	105,659	311	5,673	7
8	Laundry & Linen Service		6,966	2,666	9,632		1,402	8
9	Housekeeping		13,746	5,260	19,006	300	2,381	9
10	Dietary		130,147	49,802	179,949	449	5,719	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration		10,863	4,157	15,020	861	5,675	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		9,689	3,708	13,397	103	707	16
17	Social Service		44,868	17,169	62,037	650	4,434	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		1,589,788	608,345	2,198,133	6,780	60,259	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic						821	54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory		32,056	12,267	44,323		3,686	60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		8,862	3,391	12,253	456	2,968	65
66	Physical Therapy		186,065	71,199	257,264	1,393	10,385	66
67	Occupational Therapy		93,767	35,881	129,648	1,667	11,254	67
68	Speech Pathology		27,332	10,459	37,791	611	4,053	68
71	Medical Supplies Charged to Patients		31,229	11,950	43,179	78	2,361	71
73	Drugs Charged to Patients		19,591	7,497	27,088	589	7,160	73
76.01	SPECIAL PROCEDURES						66	76.01
76.02	SPECIAL PROCEDURES - SUA							76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)		2,386,363	913,163	3,299,526	16,208	129,004	118
	NONREIMBURSABLE COST CENTERS							
194	NRCC MARKETING		4,484	1,716	6,200	251	1,644	194
194.01	NRCC DIETARY							194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		2,390,847	914,879	3,305,726	16,459	130,648	202

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 Version: 2022.01 (03/16/2022)
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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B PART II

	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	111,643						7
8	Laundry & Linen Service	352	11,386					8
9	Housekeeping	695		22,382				9
10	Dietary	6,576		1,331	194,024			10
11	Cafeteria				19,708	19,708		11
12	Maintenance of Personnel							12
13	Nursing Administration	549		111		1,263	23,479	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	490		99		151		16
17	Social Service	2,267		459		954		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	80,330	11,386	16,257	174,154	9,941	23,479	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic							54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory	1,620		328				60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	448		91		668		65
66	Physical Therapy	9,402		1,903		2,043		66
67	Occupational Therapy	4,738		959		2,445		67
68	Speech Pathology	1,381		279		897		68
71	Medical Supplies Charged to Patients	1,578		319		114		71
73	Drugs Charged to Patients	990		200		864		73
76.01	SPECIAL PROCEDURES							76.01
76.02	SPECIAL PROCEDURES - SUA							76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	111,416	11,386	22,336	193,862	19,340	23,479	118
	NONREIMBURSABLE COST CENTERS							
194	NRCC MARKETING	227		46		368		194
194.01	NRCC DIETARY				162			194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	111,643	11,386	22,382	194,024	19,708	23,479	202

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 Version: 2022.01 (03/16/2022)
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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B PART II

	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	14,947						16
17	Social Service		70,801					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	7,145	70,801	2,658,665		2,658,665		30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	118		939		939		54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory	616		50,573		50,573		60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	448		17,332		17,332		65
66	Physical Therapy	2,029		284,419		284,419		66
67	Occupational Therapy	2,137		152,848		152,848		67
68	Speech Pathology	622		45,634		45,634		68
71	Medical Supplies Charged to Patients	44		47,673		47,673		71
73	Drugs Charged to Patients	1,775		38,666		38,666		73
76.01	SPECIAL PROCEDURES	13		79		79		76.01
76.02	SPECIAL PROCEDURES - SUA							76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	14,947	70,801	3,296,828		3,296,828		118
	NONREIMBURSABLE COST CENTERS							
194	NRCC MARKETING			8,736		8,736		194
194.01	NRCC DIETARY			162		162		194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	14,947	70,801	3,305,726		3,305,726		202

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 Version: 2022.01 (03/16/2022)
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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	89,574						1
2	Cap Rel Costs-Mvble Equip		89,574					2
4	Employee Benefits Department	446	446	17,523,410				4
5	Administrative & General	3,487	3,487	2,087,845	-6,081,686	28,304,574		5
6	Maintenance & Repairs							6
7	Operation of Plant	2,863	2,863	331,142		1,229,013	82,778	7
8	Laundry & Linen Service	261	261			303,798	261	8
9	Housekeeping	515	515	319,266		515,720	515	9
10	Dietary	4,876	4,876	477,837		1,238,844	4,876	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	407	407	917,075		1,229,362	407	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	363	363	109,885		153,191	363	16
17	Social Service	1,681	1,681	692,640		960,478	1,681	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	59,562	59,562	7,214,464		13,056,119	59,562	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic					177,772		54
54.01	RADIOLOGY-SUA				-53,058			54.01
60	Laboratory	1,201	1,201			798,527	1,201	60
60.01	LAB - SUA				-58			60.01
62.30	BLOOD CLOTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	332	332	485,125		643,000	332	65
66	Physical Therapy	6,971	6,971	1,483,731		2,249,713	6,971	66
67	Occupational Therapy	3,513	3,513	1,775,706		2,438,017	3,513	67
68	Speech Pathology	1,024	1,024	651,085		877,982	1,024	68
71	Medical Supplies Charged to Patients	1,170	1,170	82,953		511,386	1,170	71
73	Drugs Charged to Patients	734	734	627,140		1,551,076	734	73
76.01	SPECIAL PROCEDURES					14,344		76.01
76.02	SPECIAL PROCEDURES - SUA				-87,864			76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	89,406	89,406	17,255,894	-6,222,666	27,948,342	82,610	118
	NONREIMBURSABLE COST CENTERS							
194	NRCC MARKETING	168	168	267,516		356,232	168	194
194.01	NRCC DIETARY							194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	2,390,847	914,879	4,941,959		6,081,686	1,493,086	202
203	Unit Cost Multiplier (Wkst. B, Part I)	26.691306	10.213667	0.282020		0.214866	18.037232	203
204	Cost to be allocated (Per Wkst. B, Part II)			16,459		130,648	111,643	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000939		0.004616	1.348704	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

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 Version: 2022.01 (03/16/2022)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE PATIENT DAYS	HOUSE- KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA GROSS SALARIES	NURSING ADMINIS- TRATION PATIENT DAYS	MEDICAL RECORDS & LIBRARY GROSS REVENUE	
		8	9	10	11	13	16	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	33,409						8
9	Housekeeping		82,002					9
10	Dietary		4,876	111,662				10
11	Cafeteria			11,342	14,307,320			11
12	Maintenance of Personnel							12
13	Nursing Administration		407		917,075	33,409		13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		363		109,885		71,686,734	16
17	Social Service		1,681		692,640			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	33,409	59,562	100,227	7,214,464	33,409	34,358,151	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic						565,921	54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory		1,201				2,945,729	60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		332		485,125		2,144,235	65
66	Physical Therapy		6,971		1,483,731		9,706,532	66
67	Occupational Therapy		3,513		1,775,706		10,224,976	67
68	Speech Pathology		1,024		651,085		2,977,212	68
71	Medical Supplies Charged to Patients		1,170		82,953		208,759	71
73	Drugs Charged to Patients		734		627,140		8,492,631	73
76.01	SPECIAL PROCEDURES						62,588	76.01
76.02	SPECIAL PROCEDURES - SUA							76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	33,409	81,834	111,569	14,039,804	33,409	71,686,734	118
	NONREIMBURSABLE COST CENTERS							
194	NRCC MARKETING		168		267,516			194
194.01	NRCC DIETARY			93				194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	373,782	635,820	1,630,786	165,646	1,514,625	196,742	202
203	Unit Cost Multiplier (Wkst. B, Part I)	11.188063	7.753713	14.604664	0.011578	45.335838	0.002744	203
204	Cost to be allocated (Per Wkst. B, Part II)	11,386	22,382	194,024	19,708	23,479	14,947	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.340806	0.272945	1.737601	0.001377	0.702775	0.000209	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

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 Version: 2022.01 (03/16/2022)
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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	33,409						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	33,409						30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic							54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory							60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients							73
76.01	SPECIAL PROCEDURES							76.01
76.02	SPECIAL PROCEDURES - SUA							76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	33,409						118
	NONREIMBURSABLE COST CENTERS							
194	NRCC MARKETING							194
194.01	NRCC DIETARY							194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,218,226						202
203	Unit Cost Multiplier (Wkst. B, Part I)	36.464007						203
204	Cost to be allocated (Per Wkst. B, Part II)	70,801						204
205	Unit Cost Multiplier (Wkst. B, Part II)	2.119219						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

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 Version: 2022.01 (03/16/2022)
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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

		WORKSHEET			
	DESCRIPTION	CODE	LINE NO.	AMOUNT	
	1	2	3	4	

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 Version: 2022.01 (03/16/2022)
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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	22,145,843		22,145,843	10,260	22,156,103	30
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	217,522		217,522		217,522	54
54.01	RADIOLOGY-SUA	53,058		53,058		53,058	54.01
60	Laboratory	1,009,161		1,009,161		1,009,161	60
60.01	LAB - SUA	58		58		58	60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	801,222		801,222		801,222	65
66	Physical Therapy	2,956,703		2,956,703		2,956,703	66
67	Occupational Therapy	3,101,084		3,101,084		3,101,084	67
68	Speech Pathology	1,108,747		1,108,747		1,108,747	68
71	Medical Supplies Charged to Patients	652,974		652,974		652,974	71
73	Drugs Charged to Patients	1,933,844		1,933,844		1,933,844	73
76.01	SPECIAL PROCEDURES	17,598		17,598		17,598	76.01
76.02	SPECIAL PROCEDURES - SUA	87,864		87,864		87,864	76.02
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct Part)						92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	34,085,678		34,085,678	10,260	34,095,938	200
201	Less Observation Beds						201
202	Total (line 200 minus line 201)	34,085,678		34,085,678		34,095,938	202

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 Version: 2022.01 (03/16/2022)
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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	34,358,151		34,358,151				30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	565,449	472	565,921	0.384368	0.384368	0.384368	54
54.01	RADIOLOGY-SUA	156,896		156,896	0.338173	0.338173	0.338173	54.01
60	Laboratory	2,945,729		2,945,729	0.342584	0.342584	0.342584	60
60.01	LAB - SUA	219		219	0.264840	0.264840	0.264840	60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,325,323		1,325,323	0.604548	0.604548	0.604548	65
66	Physical Therapy	9,706,532		9,706,532	0.304610	0.304610	0.304610	66
67	Occupational Therapy	10,224,976		10,224,976	0.303285	0.303285	0.303285	67
68	Speech Pathology	2,977,212		2,977,212	0.372411	0.372411	0.372411	68
71	Medical Supplies Charged to Patients	1,027,670		1,027,670	0.635393	0.635393	0.635393	71
73	Drugs Charged to Patients	8,492,631		8,492,631	0.227708	0.227708	0.227708	73
76.01	SPECIAL PROCEDURES	62,588		62,588	0.281172	0.281172	0.281172	76.01
76.02	SPECIAL PROCEDURES - SUA	378,418		378,418	0.232188	0.232188	0.232188	76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	72,221,794	472	72,222,266				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	72,221,794	472	72,222,266				202

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 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**

				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	22,145,843		22,145,843	10,260	22,156,103	30
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	217,522		217,522		217,522	54
54.01	RADIOLOGY-SUA	53,058		53,058		53,058	54.01
60	Laboratory	1,009,161		1,009,161		1,009,161	60
60.01	LAB - SUA	58		58		58	60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	801,222		801,222		801,222	65
66	Physical Therapy	2,956,703		2,956,703		2,956,703	66
67	Occupational Therapy	3,101,084		3,101,084		3,101,084	67
68	Speech Pathology	1,108,747		1,108,747		1,108,747	68
71	Medical Supplies Charged to Patients	652,974		652,974		652,974	71
73	Drugs Charged to Patients	1,933,844		1,933,844		1,933,844	73
76.01	SPECIAL PROCEDURES	17,598		17,598		17,598	76.01
76.02	SPECIAL PROCEDURES - SUA	87,864		87,864		87,864	76.02
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct Part)						92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	34,085,678		34,085,678	10,260	34,095,938	200
201	Less Observation Beds						201
202	Total (line 200 minus line 201)	34,085,678		34,085,678	10,260	34,095,938	202

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 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	34,358,151		34,358,151				30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	565,449	472	565,921	0.384368	0.384368	0.384368	54
54.01	RADIOLOGY-SUA	156,896		156,896	0.338173	0.338173	0.338173	54.01
60	Laboratory	2,945,729		2,945,729	0.342584	0.342584	0.342584	60
60.01	LAB - SUA	219		219	0.264840	0.264840	0.264840	60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,325,323		1,325,323	0.604548	0.604548	0.604548	65
66	Physical Therapy	9,706,532		9,706,532	0.304610	0.304610	0.304610	66
67	Occupational Therapy	10,224,976		10,224,976	0.303285	0.303285	0.303285	67
68	Speech Pathology	2,977,212		2,977,212	0.372411	0.372411	0.372411	68
71	Medical Supplies Charged to Patients	1,027,670		1,027,670	0.635393	0.635393	0.635393	71
73	Drugs Charged to Patients	8,492,631		8,492,631	0.227708	0.227708	0.227708	73
76.01	SPECIAL PROCEDURES	62,588		62,588	0.281172	0.281172	0.281172	76.01
76.02	SPECIAL PROCEDURES - SUA	378,418		378,418	0.232188	0.232188	0.232188	76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	72,221,794	472	72,222,266				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	72,221,794	472	72,222,266				202

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 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	217,522	939	216,583		54
54.01	RADIOLOGY-SUA	53,058		53,058		54.01
60	Laboratory	1,009,161	50,573	958,588		60
60.01	LAB - SUA	58		58		60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy	801,222	17,332	783,890		65
66	Physical Therapy	2,956,703	284,419	2,672,284		66
67	Occupational Therapy	3,101,084	152,848	2,948,236		67
68	Speech Pathology	1,108,747	45,634	1,063,113		68
71	Medical Supplies Charged to Patients	652,974	47,673	605,301		71
73	Drugs Charged to Patients	1,933,844	38,666	1,895,178		73
76.01	SPECIAL PROCEDURES	17,598	79	17,519		76.01
76.02	SPECIAL PROCEDURES - SUA	87,864		87,864		76.02
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
92	Observation Beds (Non-Distinct Part)					92
93.99	PARTIAL HOSPITALIZATION PROGRAM					93.99
	OTHER REIMBURSABLE COST CENTERS					
113	Interest Expense					113
200	Subtotal	11,939,835	638,163	11,301,672		200
201	Less Observation Beds					201
202	Total	11,939,835	638,163	11,301,672		202

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 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		217,522	565,921	0.384368	54
54.01	RADIOLOGY-SUA		53,058	156,896	0.338173	54.01
60	Laboratory		1,009,161	2,945,729	0.342584	60
60.01	LAB - SUA		58	219	0.264840	60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy		801,222	1,325,323	0.604548	65
66	Physical Therapy		2,956,703	9,706,532	0.304610	66
67	Occupational Therapy		3,101,084	10,224,976	0.303285	67
68	Speech Pathology		1,108,747	2,977,212	0.372411	68
71	Medical Supplies Charged to Patients		652,974	1,027,670	0.635393	71
73	Drugs Charged to Patients		1,933,844	8,492,631	0.227708	73
76.01	SPECIAL PROCEDURES		17,598	62,588	0.281172	76.01
76.02	SPECIAL PROCEDURES - SUA		87,864	378,418	0.232188	76.02
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
92	Observation Beds (Non-Distinct Part)					92
93.99	PARTIAL HOSPITALIZATION PROGRAM					93.99
	OTHER REIMBURSABLE COST CENTERS					
113	Interest Expense					113
200	Subtotal		11,939,835	37,864,115		200
201	Less Observation Beds					201
202	Total		11,939,835	37,864,115		202

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 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)	2,658,665		2,658,665	33,409	79.58	19,307	1,536,451	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)	2,658,665		2,658,665	33,409		19,307	1,536,451	200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 Version: 2022.01 (03/16/2022)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-3025

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	939	565,921	0.001659	387,967	644	54
54.01	RADIOLOGY-SUA		156,896		107,584		54.01
60	Laboratory	50,573	2,945,729	0.017168	1,778,707	30,537	60
60.01	LAB - SUA		219		178		60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	17,332	1,325,323	0.013078	812,001	10,619	65
66	Physical Therapy	284,419	9,706,532	0.029302	5,612,249	164,450	66
67	Occupational Therapy	152,848	10,224,976	0.014948	5,885,187	87,972	67
68	Speech Pathology	45,634	2,977,212	0.015328	1,685,465	25,835	68
71	Medical Supplies Charged to Pat	47,673	1,027,670	0.046389	656,170	30,439	71
73	Drugs Charged to Patients	38,666	8,492,631	0.004553	4,812,698	21,912	73
76.01	SPECIAL PROCEDURES	79	62,588	0.001262	1,938	2	76.01
76.02	SPECIAL PROCEDURES - SUA		378,418		11,709		76.02
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct						92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	638,163	37,864,115		21,751,853	372,410	200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 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

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 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)	33,409		19,307		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)	33,409		19,307		200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 Version: 2022.01 (03/16/2022)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-3025

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
60.01	LAB - SUA									60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
71	Medical Supplies Charged to Pat									71
73	Drugs Charged to Patients									73
76.01	SPECIAL PROCEDURES									76.01
76.02	SPECIAL PROCEDURES - SUA									76.02
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
92	Observation Beds (Non-Distinct									92
93.99	PARTIAL HOSPITALIZATION PROGRAM									93.99
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 Version: 2022.01 (03/16/2022)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-3025

WORKSHEET D
PART IV

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

		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	565,921			387,967		472		54
54.01	RADIOLOGY-SUA	156,896			107,584				54.01
60	Laboratory	2,945,729			1,778,707				60
60.01	LAB - SUA	219			178				60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	1,325,323			812,001				65
66	Physical Therapy	9,706,532			5,612,249				66
67	Occupational Therapy	10,224,976			5,885,187				67
68	Speech Pathology	2,977,212			1,685,465				68
71	Medical Supplies Charged to Pat	1,027,670			656,170				71
73	Drugs Charged to Patients	8,492,631			4,812,698				73
76.01	SPECIAL PROCEDURES	62,588			1,938				76.01
76.02	SPECIAL PROCEDURES - SUA	378,418			11,709				76.02
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	37,864,115			21,751,853		472		200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 Version: 2022.01 (03/16/2022)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-3025

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	0.384368	472			181			54
54.01	RADIOLOGY-SUA	0.338173							54.01
60	Laboratory	0.342584							60
60.01	LAB - SUA	0.264840							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.604548							65
66	Physical Therapy	0.304610							66
67	Occupational Therapy	0.303285							67
68	Speech Pathology	0.372411							68
71	Medical Supplies Charged to Pat	0.635393							71
73	Drugs Charged to Patients	0.227708							73
76.01	SPECIAL PROCEDURES	0.281172							76.01
76.02	SPECIAL PROCEDURES - SUA	0.232188							76.02
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		472			181			200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		472			181			202

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 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)	2,658,665		2,658,665	33,409	79.58	466	37,084	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)	2,658,665		2,658,665	33,409		466	37,084	200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 Version: 2022.01 (03/16/2022)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-3025

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	939	565,921	0.001659	14,573	24	54
54.01	RADIOLOGY-SUA		156,896		4,041		54.01
60	Laboratory	50,573	2,945,729	0.017168	27,261	468	60
60.01	LAB - SUA		219		3		60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	17,332	1,325,323	0.013078	17,914	234	65
66	Physical Therapy	284,419	9,706,532	0.029302	136,927	4,012	66
67	Occupational Therapy	152,848	10,224,976	0.014948	147,402	2,203	67
68	Speech Pathology	45,634	2,977,212	0.015328	35,481	544	68
71	Medical Supplies Charged to Pat	47,673	1,027,670	0.046389	12,469	578	71
73	Drugs Charged to Patients	38,666	8,492,631	0.004553	144,762	659	73
76.01	SPECIAL PROCEDURES	79	62,588	0.001262			76.01
76.02	SPECIAL PROCEDURES - SUA		378,418				76.02
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct						92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	638,163	37,864,115		540,833	8,722	200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 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

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 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)	33,409		466		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)	33,409		466		200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 Version: 2022.01 (03/16/2022)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-3025

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
60.01	LAB - SUA									60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
71	Medical Supplies Charged to Pat									71
73	Drugs Charged to Patients									73
76.01	SPECIAL PROCEDURES									76.01
76.02	SPECIAL PROCEDURES - SUA									76.02
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
92	Observation Beds (Non-Distinct									92
93.99	PARTIAL HOSPITALIZATION PROGRAM									93.99
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 Version: 2022.01 (03/16/2022)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-3025

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	565,921			14,573				54
54.01	RADIOLOGY-SUA	156,896			4,041				54.01
60	Laboratory	2,945,729			27,261				60
60.01	LAB - SUA	219			3				60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	1,325,323			17,914				65
66	Physical Therapy	9,706,532			136,927				66
67	Occupational Therapy	10,224,976			147,402				67
68	Speech Pathology	2,977,212			35,481				68
71	Medical Supplies Charged to Pat	1,027,670			12,469				71
73	Drugs Charged to Patients	8,492,631			144,762				73
76.01	SPECIAL PROCEDURES	62,588							76.01
76.02	SPECIAL PROCEDURES - SUA	378,418							76.02
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	37,864,115			540,833				200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 Version: 2022.01 (03/16/2022)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-3025

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	0.384368							54
54.01	RADIOLOGY-SUA	0.338173							54.01
60	Laboratory	0.342584							60
60.01	LAB - SUA	0.264840							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.604548							65
66	Physical Therapy	0.304610							66
67	Occupational Therapy	0.303285							67
68	Speech Pathology	0.372411							68
71	Medical Supplies Charged to Pat	0.635393							71
73	Drugs Charged to Patients	0.227708							73
76.01	SPECIAL PROCEDURES	0.281172							76.01
76.02	SPECIAL PROCEDURES - SUA	0.232188							76.02
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 Version: 2022.01 (03/16/2022)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 15-3025****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)	33,409	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	33,409	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)	33,409	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)	19,307	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)	22,156,103	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)	22,156,103	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)	22,156,103	37

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 Version: 2022.01 (03/16/2022)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-3025

**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)						663.18 38
39	Program general inpatient routine service cost (line 9 x line 38)						12,804,016 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)						12,804,016 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)						6,924,004 48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						19,728,020 49
PASS THROUGH COST ADJUSTMENTS							
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						1,536,451 50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						372,410 51
52	Total Program excludable cost (sum of lines 50 and 51)						1,908,861 52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						17,819,159 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

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 Version: 2022.01 (03/16/2022)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-3025

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)					663.18	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

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 Version: 2022.01 (03/16/2022)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-3025

**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)	33,409	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	33,409	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)	33,409	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)	466	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)	22,145,843	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)	22,145,843	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)	22,145,843	37

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 Version: 2022.01 (03/16/2022)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-3025

**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)						662.87 38
39	Program general inpatient routine service cost (line 9 x line 38)						308,897 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)						308,897 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)						167,652 48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						476,549 49
PASS THROUGH COST ADJUSTMENTS							
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						37,084 50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						8,722 51
52	Total Program excludable cost (sum of lines 50 and 51)						45,806 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

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 Version: 2022.01 (03/16/2022)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-3025

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)					663.18	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

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 Version: 2022.01 (03/16/2022)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-3025

WORKSHEET D-3

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

		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		19,837,353		30
	ANCILLARY SERVICE COST CENTERS				
54	Radiology-Diagnostic	0.384368	387,967	149,122	54
54.01	RADIOLOGY-SUA	0.338173	107,584	36,382	54.01
60	Laboratory	0.342584	1,778,707	609,357	60
60.01	LAB - SUA	0.264840	178	47	60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.604548	812,001	490,894	65
66	Physical Therapy	0.304610	5,612,249	1,709,547	66
67	Occupational Therapy	0.303285	5,885,187	1,784,889	67
68	Speech Pathology	0.372411	1,685,465	627,686	68
71	Medical Supplies Charged to Patients	0.635393	656,170	416,926	71
73	Drugs Charged to Patients	0.227708	4,812,698	1,095,890	73
76.01	SPECIAL PROCEDURES	0.281172	1,938	545	76.01
76.02	SPECIAL PROCEDURES - SUA	0.232188	11,709	2,719	76.02
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
92	Observation Beds (Non-Distinct Part)				92
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		21,751,853	6,924,004	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		21,751,853		202

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 Version: 2022.01 (03/16/2022)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-3025

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		479,124		30
	ANCILLARY SERVICE COST CENTERS				
54	Radiology-Diagnostic	0.384368	14,573	5,601	54
54.01	RADIOLOGY-SUA	0.338173	4,041	1,367	54.01
60	Laboratory	0.342584	27,261	9,339	60
60.01	LAB - SUA	0.264840	3	1	60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.604548	17,914	10,830	65
66	Physical Therapy	0.304610	136,927	41,709	66
67	Occupational Therapy	0.303285	147,402	44,705	67
68	Speech Pathology	0.372411	35,481	13,214	68
71	Medical Supplies Charged to Patients	0.635393	12,469	7,923	71
73	Drugs Charged to Patients	0.227708	144,762	32,963	73
76.01	SPECIAL PROCEDURES	0.281172			76.01
76.02	SPECIAL PROCEDURES - SUA	0.232188			76.02
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
92	Observation Beds (Non-Distinct Part)				92
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		540,833	167,652	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		540,833		202

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 Version: 2022.01 (03/16/2022)
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CALCULATION OF REIMBURSEMENT SETTLEMENT**COMPONENT CCN: 15-3025****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)	181			2
3	OPPS payments	232			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)	232			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	47			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)	185			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)	185			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	185			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)	185			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)	185			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	185			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

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 Version: 2022.01 (03/16/2022)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 15-3025

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			32,751,727		185
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				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	04/30/2021	8,392		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)			4,810		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)			32,756,537		185
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)	

(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

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 Version: 2022.01 (03/16/2022)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-3025

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)	31,908,192		1
2	Medicare SSI ratio (IRF PPS only) (see instructions)	0.043700		2
3	Inpatient Rehabilitation LIP payments (see instructions)	1,809,194		3
4	Outlier payments	41,245		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)	91.531507		10
11	Teaching Adjustment Factor (see instructions)			11
12	Teaching Adjustment (see instructions)			12
13	Total PPS Payment (see instructions)	33,758,631		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)	33,758,631		17
18	Primary payer payments	12,792		18
19	Subtotal (line 17 less line 18)	33,745,839		19
20	Deductibles	469,335		20
21	Subtotal (line 19 minus line 20)	33,276,504		21
22	Coinsurance	362,896		22
23	Subtotal (line 21 minus line 22)	32,913,608		23
24	Allowable bad debts (exclude bad debts for professional services) (see instructions)	227,442		24
25	Adjusted reimbursable bad debts (see instructions)	147,837		25
26	Allowable bad debts for dual eligible beneficiaries (see instructions)	106,919		26
27	Subtotal (sum of lines 23 and 25)	33,061,445		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)	33,061,445		32
32.01	Sequestration adjustment (see instructions)			32.01
32.02	Demonstration payment adjustment amount after sequestration			32.02
33	Interim payments	32,756,537		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)	304,908		35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	949,850		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

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 Version: 2022.01 (03/16/2022)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-3025

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	476,549		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	476,549		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	476,549		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges	479,124		8
9	Ancillary service charges	540,833		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)	1,019,957		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)	1,019,957		16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	543,408		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)	476,549		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)	476,549		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)	476,549		31
32	Deductibles			32
33	Coinsurance			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)	476,549		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	476,549		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)	476,549		40
41	Interim payments	260,034		41
42	Balance due provider/program (line 40 minus line 41)	216,515		42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 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	6,293,716				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	10,343,756				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-3,297,593				6
7	Inventory	40,046				7
8	Prepaid expenses	29,306				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	13,409,231				11
FIXED ASSETS						
12	Land	1,675,024				12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings	25,366,552				15
16	Accumulated depreciation	-2,867,820				16
17	Leasehold improvements	1,757,768				17
18	Accumulated depreciation	-1,096,953				18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	6,326,441				23
24	Accumulated depreciation	-3,722,282				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)	27,438,730				30
OTHER ASSETS						
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	13,243,030				34
35	Total other assets (sum of lines 31-34)	13,243,030				35
36	Total assets (sum of lines 11, 30 and 35)	54,090,991				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	466,667				37
38	Salaries, wages and fees payable	1,356,329				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	4,655,116				44
45	Total current liabilities (sum of lines 37 thru 44)	6,478,112				45
LONG TERM LIABILITIES						
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	13,829,489				49
50	Total long term liabilities (sum of lines 46 thru 49)	13,829,489				50
51	Total liabilities (sum of lines 45 and 50)	20,307,601				51
CAPITAL ACCOUNTS						
52	General fund balance	33,783,390				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)	33,783,390				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	54,090,991				60

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 Version: 2022.01 (03/16/2022)
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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		35,834,199		1
2	Net income (loss) (from Worksheet G-3, line 29)		16,526,664		2
3	Total (sum of line 1 and line 2)		52,360,863		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)		52,360,863		11
12	Deductions (debit adjustments) (specify)				12
13	EQUITY DISTRIBUTION	14,032,639			13
14	MINORITY INTEREST EXPENSE	4,544,834			14
15					15
16					16
17					17
18	Total deductions (sum of lines 12-17)		18,577,473		18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		33,783,390		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

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 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	34,358,151		34,358,151	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)	34,358,151		34,358,151	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)	34,358,151		34,358,151	17
18	Ancillary services	37,864,116		37,864,116	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)	72,222,267		72,222,267	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		34,885,761	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)		34,885,761	43

Health Financial Systems Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2021 To: 12/31/2021	Run Date: 05/12/2022 Run Time: 10:23 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)	72,222,267	1
2	Less contractual allowances and discounts on patients' accounts	20,828,662	2
3	Net patient revenues (line 1 minus line 2)	51,393,605	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	34,885,761	4
5	Net income from service to patients (line 3 minus line 4)	16,507,844	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments	26,696	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts	33	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	22,565	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts		18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines	872	21
22	Rental of hosptial space		22
23	Governmental appropriations		23
24	Other (specify)	-31,346	24
24.50	COVID-19 PHE FUNDING		24.50
25	Total other income (sum of lines 6-24)	18,820	25
26	Total (line 5 plus line 25)	16,526,664	26
29	Net income (or loss) for the period (line 26 minus line 28)	16,526,664	29