KPMG LLP Compu-Max 2552-10

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

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. [X] Electronically filed cost report Date: 05/09/2019 Time: 10:18 2. [ ] Manually submitted cost report 3. [ ] If this is an amended report enter the number of times the provider resubmitted the cost report 4. [F] Medicare Utilization. Enter 'F' for full or 'L' for low.		
Contractor use only	5. [ ] Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. [ ] Initial Report for this Provider CCN 9. [ ] Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ___ 12. [ ] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ENCOMPASS HEALTH DEACONESS REHABILIT (15-3025) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 01/01/2018 and ending 12/31/2018, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

ECR Encryption: 05/09/2019 10:18
I8iHAm4v:61llEuisFfCF4NLmA5bH0
jeI.x0Bp738dO:E6yudxeabEh4rzVZ
f2q50GlZfj06w65f

PI Encryption: 05/09/2019 10:18
BetYBvdIA0rpbcNP257OS110kUn:t0
g.Ptr0icJNgTDugV9RbE2c4hU6gyyE
fY:70Hqtmn0:5Da.

(Signed) Rob Wisney
Chief Financial Officer or Administrator of Provider(s)

SVP - REIMBURSEMENT
Title

05/09/2019 10:18
Date

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		-76,846			135,493	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		-76,846			135,493	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 resopnd 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: 4100 COVERT AVE	P.O. Box:		1
2	City: EVANSVILLE	State: IN	ZIP Code: 47714	County: VANDERBURGH 2

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) 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 / 2018	To: 12 / 31 / 2018	20
21	Type of control (see instructions)	5		21

Inpatient PPS Information

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.							24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid 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.	423	327	246	243	1,946		25

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40

		V	XVIII	XIX	
	Prospective Payment System (PPS)-Capital	1	2	3	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	N	N	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N	48

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

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

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

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

	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)			
62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)			62
62.01	Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost reporting period of HRSA THC program. (see instructions)			62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings			
63	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64 through 67. (see instructions)	N		63

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				64

Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
	1	2	3	4	5	
65						65

	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				66

Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
	1	2	3	4	5	
67						67

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

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

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

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

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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	N	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.	Y	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.	Y	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.	Y	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.	Y	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.	Y	Y	98.06

				1	2	
	Rural Providers					
105	Does this hospital qualify as a CAH?			N		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.					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
		Physical	Occupational	Speech	Respiratory	
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.					109

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

	Miscellaneous Cost Reporting Information				
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.		N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.		Y		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1		118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	71,116	27,232		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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

All Providers

		1	2	
140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)	Y	019005	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 PARK	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

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

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		
		1	2		
Provider Organization and Operation					
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	
		1	2	3	
Financial Data and Reports					
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	Y	A	02/27/2019	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	
		1	2	
Approved Educational Activities				
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N		6
7	Are costs claimed for allied health programs? If yes, see instructions.	N		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N		8
9	Are costs claimed for Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	N		9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10
11	Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11

		Y/N	
Bad Debts			
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	
		1	2	3	4	
PS&R Report Data						
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	03/04/2019	16
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	03/04/2019	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 Reopt 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

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

Cost Report Preparer Contact Information				
41	First name: JIM	Last name: WYATT	Title: SR REIMBURSEMENT SPECIALIS	41
42	Employer: ENCOMPASS HEALTH			42
43	Phone number: 205-969-8265	E-mail Address: JAMES.WYATT@ENCOMPASSHEALTH.COM		43

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Inpatient Days / Outpatient Visits / Trips				
						Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	103	37,595			21,427	398	29,698	1
2	HMO and other (see instructions)						1,901	2,787		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)		103	37,595			21,427	398	29,698	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)		103	37,595			21,427	398	29,698	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)		103							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

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

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)					1,624	27	2,206	1
2	HMO and other (see instructions)					130	194		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)		249.71			1,624	27	2,206	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)		249.71						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

Part II - Wage Data

		Wkst A Line No.	Amount Reported	Reclassification 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
1	Total salaries (see instructions)	200	13,880,090					2
2	Non-physician anesthetist Part A							3
3	Non-physician anesthetest Part B							4
4	Physician-Part A - Administrative							4.01
4.01	Physician-Part A - Teaching							5
5	Physician-Part B							6
6	Non-physician-Part B							7
7	Interns & residents (in an approved program)	21						7.01
7.01	Contracted interns & residents (in an approved program)							8
8	Home office and/or related organization personnel							9
9	SNF	44		187,950				10
10	Excluded area salaries (see instructions)							
	OTHER WAGES & RELATED COSTS							11
11	Contract labor (see instructions)							12
12	Contract management and administrative services							13
13	Contract labor: Physician-Part A - Administrative							14
14	Home office salaries & wage-related costs							14.01
14.01	Home office salaries							14.02
14.02	Related organization salaries							15
15	Home office: Physician Part A - Administrative							16
16	Home office & Contract Physicians Part A - Teaching							
	WAGE-RELATED COSTS							17
17	Wage-related costs (core)(see instructions)							18
18	Wage-related costs (other)(see instructions)							19
19	Excluded areas							20
20	Non-physician anesthetist Part A							21
21	Non-physician anesthetist Part B							22
22	Physician Part A - Administrative							22.01
22.01	Physician Part A - Teaching							23
23	Physician Part B							24
24	Wage-related costs (RHC/FQHC)							25
25	Interns & residents (in an approved program)							25.50
25.50	Home office wage-related							25.51
25.51	Related organization wage-related							25.52
25.52	Home office: Physician Part A - Administrative - wage-related							25.53
25.53	Home office & Contract Physicians Part A - Teaching - wage-related							
	OVERHEAD COSTS - DIRECT SALARIES							26
26	Employee Benefits Department		2,120,134	-187,950				27
27	Administrative & General							28
28	Administrative & General under contract (see instructions)							29
29	Maintenance & Repairs		277,086					30
30	Operation of Plant							31
31	Laundry & Linen Service		339,945					32
32	Housekeeping							33
33	Housekeeping under contract (see instructions)		342,818					34
34	Dietary							35
35	Dietary under contract (see instructions)							36
36	Cafeteria							37
37	Maintenance of Personnel		499,861					38
38	Nursing Administration							39
39	Central Services and Supply							40
40	Pharmacy		128,861					41
41	Medical Records & Medical Records Library		604,364					42
42	Social Service							43
43	Other General Service							

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)	13,880,090		13,880,090			1
2	Excluded area salaries (see instructions)		187,950	187,950			2
3	Subtotal salaries (line 1 minus line 2)	13,880,090	-187,950	13,692,140			3
4	Subtotal other wages & related costs (see instructions)						4
5	Subtotal wage-related costs (see instructions)						5
6	Total (sum of lines 3 through 5)	13,880,090	-187,950	13,692,140			6
7	Total overhead cost (see instructions)	4,313,069	-187,950	4,125,119			7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

Part IV - Wage Related Cost

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

	Part B - Other Than Core Related Cost		
25	OTHER WAGE RELATED COSTs (SPECIFY)		25

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HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

Part V - Contract Labor and Benefit Cost

Hospital and Hospital-Based Component Identification:

	Component	Contract Labor	Benefit Cost	
	0	1	2	
1	Total facility contract labor and benefit cost		3,573,531	1
2	Hospital		3,525,142	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		48,389	18

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		2,119,550	2,119,550	126,050	2,245,600	115,212	2,360,812	1
2	00200	Cap Rel Costs-Mvble Equip		881,146	881,146	93,740	974,886	-153,118	821,768	2
3	00300	Other Cap Rel Costs		202,312	202,312	-202,312			-0-	3
4	00400	Employee Benefits Department		3,207,561	3,207,561		3,207,561	350,112	3,557,673	4
5	00500	Administrative & General	2,120,134	3,878,284	5,998,418	-221,265	5,777,153	-665,832	5,111,321	5
6	00600	Maintenance & Repairs	277,086	684,040	961,126		961,126	-46,760	914,366	6
7	00700	Operation of Plant		47,189	47,189		47,189	-31,754	15,435	7
8	00800	Laundry & Linen Service	339,945	94,766	434,711		434,711	-14,949	419,762	8
9	00900	Housekeeping	342,818	557,610	900,428		900,428	-166,497	733,931	9
10	01000	Dietary								10
11	01100	Cafeteria								11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	499,861	28,428	528,289		528,289	-247	528,042	13
14	01400	Central Services & Supply								14
15	01500	Pharmacy								15
16	01600	Medical Records & Library	128,861	29,264	158,125		158,125	-33	158,092	16
17	01700	Social Service	604,364	17,436	621,800		621,800	-431	621,369	17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	4,947,462	287,859	5,235,321	-10,453	5,224,868	-64,048	5,160,820	30
		ANCILLARY SERVICE COST CENTERS								54
54	05400	Radiology-Diagnostic		171,048	171,048	-49,088	121,960		121,960	54.01
54.01	05401	RADIOLOGY-SUA				49,088	49,088	-11,886	37,202	60
60	06000	Laboratory		629,555	629,555		629,555	-20,999	608,556	60.01
60.01	06001	LAB SUA								62.30
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								65
65	06500	Respiratory Therapy	467,249	16,235	483,484		483,484	-7,983	475,501	66
66	06600	Physical Therapy	1,467,409	24,186	1,491,595	-805	1,490,790	-34	1,490,756	67
67	06700	Occupational Therapy	1,472,086	15,474	1,487,560	364	1,487,924	-63	1,487,861	68
68	06800	Speech Pathology	630,615	7,816	638,431	441	638,872	-345	638,527	71
71	07100	Medical Supplies Charged to Patients	74,705	311,414	386,119		386,119	-17,491	368,628	73
73	07300	Drugs Charged to Patients	507,495	850,516	1,358,011		1,358,011	-10,002	1,348,009	76
76	03950	OTHER ANCILLARY								76.01
76.01	03951	SPECIAL PROCEDURES		235,767	235,767	-62,257	173,510		173,510	76.02
76.02	03952	SPECIAL PROCEDURES SUA				78,016	78,016	-55,203	22,813	76.97
76.97	07697	CARDIAC REHABILITATION								76.98
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.99
76.99	07699	LITHOTRIPSY								
		OUTPATIENT SERVICE COST CENTERS								92
92	09200	Observation Beds (Non-Distinct Part)								93.99
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM								
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								113
113	11300	Interest Expense		5,631	5,631		5,631	-5,631		118
118		SUBTOTALS (sum of lines 1-117)	13,880,090	14,303,087	28,183,177	-198,481	27,984,696	-807,982	27,176,714	
		NONREIMBURSABLE COST CENTERS								192
192	19200	Physicians' Private Offices		99,350	99,350		99,350	-99,350		194
194	07950	NRCC MARKETING				198,481	198,481		198,481	194.01
194.01	07951	GUEST MEALS								200
200		TOTAL (sum of lines 118-199)	13,880,090	14,402,437	28,282,527		28,282,527	-907,332	27,375,195	

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

RECLASSIFICATIONS

WORKSHEET A-6

		INCREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	INSURANCE	A	Cap Rel Costs-Bldg & Fixt	1		10,029	1
2	INSURANCE	A	Cap Rel Costs-Mvble Equip	2		7,449	2
3	INSURANCE	A					3
500	Total reclassifications					17,478	500
	Code Letter - A						
1	MARKETING	B	NRCC MARKETING	194	187,950	10,531	1
2	MARKETING	B					2
500	Total reclassifications				187,950	10,531	500
	Code Letter - B						
1	PHYSICIANS	C	Adults & Pediatrics	30		5,306	1
2	PHYSICIANS	C					2
500	Total reclassifications					5,306	500
	Code Letter - C						
1	SERVICE UNDER ARRANGEMENT	D	RADIOLOGY-SUA	54.01		49,088	1
2	SERVICE UNDER ARRANGEMENT	D	SPECIAL PROCEDURES SUA	76.02		78,016	2
3	SERVICE UNDER ARRANGEMENT	D					3
4	SERVICE UNDER ARRANGEMENT	D					4
500	Total reclassifications					127,104	500
	Code Letter - D						
1	TRANSPORTATION	E	SPECIAL PROCEDURES	76.01		15,759	1
2	TRANSPORTATION	E					2
500	Total reclassifications					15,759	500
	Code Letter - E						
1	DAY TREATMENT	F	Occupational Therapy	67		364	1
2	DAY TREATMENT	F	Speech Pathology	68		441	2
3	DAY TREATMENT	F					3
500	Total reclassifications					805	500
	Code Letter - F						
	GRAND TOTAL (Increases)				187,950	176,983	

(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.

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

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		17,478		3
500	Total reclassifications					17,478		500
	Code letter - A							
								1
1	MARKETING	B						2
2	MARKETING	B	Administrative & General	5	187,950	10,531		500
500	Total reclassifications				187,950	10,531		
	Code letter - B							
								1
1	PHYSICIANS	C						2
2	PHYSICIANS	C	Administrative & General	5		5,306		500
500	Total reclassifications					5,306		
	Code letter - C							
								1
1	SERVICE UNDER ARRANGEMENT	D						2
2	SERVICE UNDER ARRANGEMENT	D						3
3	SERVICE UNDER ARRANGEMENT	D	Radiology-Diagnostic	54		49,088		4
4	SERVICE UNDER ARRANGEMENT	D	SPECIAL PROCEDURES	76.01		78,016		500
500	Total reclassifications					127,104		
	Code letter - D							
								1
1	TRANSPORTATION	E						2
2	TRANSPORTATION	E	Adults & Pediatrics	30		15,759		500
500	Total reclassifications					15,759		
	Code letter - E							
								1
1	DAY TREATMENT	F						2
2	DAY TREATMENT	F						3
3	DAY TREATMENT	F	Physical Therapy	66		805		500
500	Total reclassifications					805		
	Code letter - F							
	GRAND TOTAL (Decreases)				187,950	176,983		

(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.

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

	Description	Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		1	2	3	4	5	6	7	
1	Land		3,200,115		3,200,115	1,600,058	1,600,057		1
2	Land Improvements								2
3	Buildings and Fixtures								3
4	Building Improvements	5,815,507	17,822		17,822	26,713	5,806,616		4
5	Fixed Equipment								5
6	Movable Equipment	4,398,854	131,178		131,178	211,346	4,318,686		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	10,214,361	3,349,115		3,349,115	1,838,117	11,725,359		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	10,214,361	3,349,115		3,349,115	1,838,117	11,725,359		10

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

	Description	SUMMARY OF CAPITAL: Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	972,308	1,147,242					2,119,550	1
2	Cap Rel Costs-Mvble Equip	581,735	299,411					881,146	2
3	Total (sum of lines 1-2)	1,554,043	1,446,653					3,000,696	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

	Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	5,806,616		5,806,616	0.573476		116,021		116,021	1
2	Cap Rel Costs-Mvble Equ	4,318,686		4,318,686	0.426524		86,291		86,291	2
3	Total (sum of lines 1-2)	10,125,302		10,125,302	1.000000		202,312		202,312	3

	Description	SUMMARY OF CAPITAL: Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	937,820	1,146,375	150,567	10,029	116,021		2,360,812	1
2	Cap Rel Costs-Mvble Equip	450,942	277,086		7,449	86,291		821,768	2
3	Total (sum of lines 1-2)	1,388,762	1,423,461	150,567	17,478	202,312		3,182,580	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.)

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

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 COST CENTER	LINE#	Wkst. A-7 Ref.	
		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	-1,645				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1	-390,085				12
13	Laundry and linen service						13
14	Cafeteria - employees and guests						14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients						16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts						18
19	Nursing and allied health education (tuition, fees, books, etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation						32
33							33
34							34
35							35
36							36
37	INTEREST	A	-5,631	Interest Expense	113	11	37
37.01	DEPRECIATION	A	-136,737	Cap Rel Costs-Bldg & Fixt	1	9	37.01
37.02	DEPRECIATION	A	-111,209	Cap Rel Costs-Mvble Equip	2	9	37.02
37.03	INSURANCE	A	365,714	Employee Benefits Department	4		37.03
37.04	INSURANCE	A	-219,828	Administrative & General	5		37.04
37.05	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-94,309	Administrative & General	5		37.05
37.06	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-114	Housekeeping	9		37.06
37.07	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-108	Dietary	10		37.07
37.08	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-247	Nursing Administration	13		37.08
37.09	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-431	Social Service	17		37.09
37.10	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-101	Adults & Pediatrics	30		37.10
37.11	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-8	Occupational Therapy	67		37.11
37.12	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-345	Speech Pathology	68		37.12
37.13	PATIENT TELEPHONE	A	-4,075	Cap Rel Costs-Mvble Equip	2	9	37.13
37.14	PATIENT TELEPHONE	A	-4,329	Employee Benefits Department	4		37.14
37.15	PATIENT TELEPHONE	A	-21,024	Administrative & General	5		37.15
37.16	PATIENT TELEVISION	A	-6,672	Cap Rel Costs-Mvble Equip	2	9	37.16
37.17	PATIENT TELEVISION	A	-1,431	Administrative & General	5		37.17
37.18	PRINTING	A	-3,775	Administrative & General	5		37.18
37.19	PRINTING	A	-3	Operation of Plant	7		37.19
37.20	PRINTING	A	-4	Dietary	10		37.20
37.21	LOBBYING EXPENSE	A	-2,591	Administrative & General	5		37.21
37.22	MISCELLANEOUS INCOME	B	-100	Cap Rel Costs-Bldg & Fixt	1	11	37.22
37.23	MISCELLANEOUS INCOME	B	-5,489	Administrative & General	5		37.23
37.24	MISCELLANEOUS INCOME	B	-18,993	Dietary	10		37.24
37.25	MISCELLANEOUS INCOME	B	-33	Medical Records & Library	16		37.25
37.26	PATIENT TRANSPORTATION	A	-8,837	Cap Rel Costs-Mvble Equip	2	9	37.26
37.27	PATIENT TRANSPORTATION	A	-11,273	Employee Benefits Department	4		37.27
37.28	PATIENT TRANSPORTATION	A	-46,757	Operation of Plant	7		37.28

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	-62,297	Adults & Pediatrics	30		37.29
37.30	RENT RECONCILIATION	A	-867	Cap Rel Costs-Bldg & Fixt	1	10	37.30
37.31	PROFESSIONAL FEES	A	-9,593	Administrative & General	5		37.31
37.32	PHYSICIAN FEES	A	-4,755	Administrative & General	5		37.32
37.33	COMPHEALTH	A	-99,350	Physicians' Private Offices	192		37.33
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)		-967,332				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.

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

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		2,492,855	-2,492,855		1
2	1	Cap Rel Costs-Bldg & Fixt	TO INCLUDE ALLOWABLE HOME OFFICE COS	102,249		102,249	9	2
3	1	Cap Rel Costs-Bldg & Fixt	TO INCLUDE ALLOWABLE HOME OFFICE COS	150,667		150,667	11	3
3.01	5	Administrative & General	TO INCLUDE ALLOWABLE HOME OFFICE COS	1,863,502		1,863,502		3.01
3.02	5	Administrative & General	TO INCLUDE ALLOWABLE HOME OFFICE COS	341,715		341,715		3.02
3.03	2	Cap Rel Costs-Mvble Equip	INTERCOMPANY WAGE AND EXPENSE TRANSF	14,987	14,987		10	3.03
3.04	3	Other Cap Rel Costs	INTERCOMPANY WAGE AND EXPENSE TRANSF	42,260	42,260		11	3.04
3.05	4	Employee Benefits Department	INTERCOMPANY WAGE AND EXPENSE TRANSF	2,609,540	2,609,540			3.05
3.06	5	Administrative & General	INTERCOMPANY WAGE AND EXPENSE TRANSF	3,199,937	3,199,937			3.06
3.07	7	Operation of Plant	INTERCOMPANY WAGE AND EXPENSE TRANSF	14,709	14,709			3.07
3.08	8	Laundry & Linen Service	INTERCOMPANY WAGE AND EXPENSE TRANSF	-3	-3			3.08
3.09	9	Housekeeping	INTERCOMPANY WAGE AND EXPENSE TRANSF	-1,895	-1,895			3.09
3.10	10	Dietary	INTERCOMPANY WAGE AND EXPENSE TRANSF	-4,868	-4,868			3.10
3.11	13	Nursing Administration	INTERCOMPANY WAGE AND EXPENSE TRANSF	-1,540	-1,540			3.11
3.12	16	Medical Records & Library	INTERCOMPANY WAGE AND EXPENSE TRANSF	95	95			3.12
3.13	17	Social Service	INTERCOMPANY WAGE AND EXPENSE TRANSF	1,720	1,720			3.13
3.14	30	Adults & Pediatrics	INTERCOMPANY WAGE AND EXPENSE TRANSF	15,740	15,740			3.14
3.15	54	Radiology-Diagnostic	INTERCOMPANY WAGE AND EXPENSE TRANSF	24	24			3.15
3.16	60	Laboratory	INTERCOMPANY WAGE AND EXPENSE TRANSF	-141	-141			3.16
3.17	65	Respiratory Therapy	INTERCOMPANY WAGE AND EXPENSE TRANSF	-3	-3			3.17
3.18	66	Physical Therapy	INTERCOMPANY WAGE AND EXPENSE TRANSF	-7,893	-7,893			3.18
3.19	67	Occupational Therapy	INTERCOMPANY WAGE AND EXPENSE TRANSF	-2,937	-2,937			3.19
3.20	68	Speech Pathology	INTERCOMPANY WAGE AND EXPENSE TRANSF	2,434	2,434			3.20
3.21	71	Medical Supplies Charged to Patients	INTERCOMPANY WAGE AND EXPENSE TRANSF	-48,711	-48,711			3.21
3.22	73	Drugs Charged to Patients	INTERCOMPANY WAGE AND EXPENSE TRANSF	761,237	761,237			3.22
3.23	113	Interest Expense	INTERCOMPANY WAGE AND EXPENSE TRANSF	5,631	5,631			3.23
3.24	1	Cap Rel Costs-Bldg & Fixt	DEACONESS HOSPITAL	417,132	417,132		10	3.24
3.25	2	Cap Rel Costs-Mvble Equip	DEACONESS HOSPITAL	6,461	28,786	-22,325	10	3.25
3.26	5	Administrative & General	DEACONESS HOSPITAL	4,456	19,855	-15,399		3.26
3.27	8	Laundry & Linen Service	DEACONESS HOSPITAL	9,190	40,944	-31,754		3.27
3.28	9	Housekeeping	DEACONESS HOSPITAL	4,294	19,129	-14,835		3.28
3.29	10	Dietary	DEACONESS HOSPITAL	42,656	190,048	-147,392		3.29
3.30	13	Nursing Administration	DEACONESS HOSPITAL	200	200			3.30
3.31	17	Social Service	DEACONESS HOSPITAL	231	231			3.31
3.32	30	Adults & Pediatrics	DEACONESS HOSPITAL	266	271	-5		3.32
3.33	54.01	RADIOLOGY-SUA	DEACONESS HOSPITAL	37,202	49,088	-11,886		3.33
3.34	60	Laboratory	DEACONESS HOSPITAL	322,340	343,339	-20,999		3.34
3.35	65	Respiratory Therapy	DEACONESS HOSPITAL	752	8,735	-7,983		3.35
3.36	66	Physical Therapy	DEACONESS HOSPITAL	7	41	-34		3.36
3.37	67	Occupational Therapy	DEACONESS HOSPITAL	12	67	-55		3.37
3.38	71	Medical Supplies Charged to Patients	DEACONESS HOSPITAL	15,052	32,543	-17,491		3.38
3.39	73	Drugs Charged to Patients	DEACONESS HOSPITAL	3,469	13,471	-10,002		3.39
3.40	76.02	SPECIAL PROCEDURES SUA	DEACONESS HOSPITAL	22,813	78,016	-55,203		3.40
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12			9,944,989	10,335,074	-390,085		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.

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				EXPENSE TRANSFERS	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:

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

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	5,306		5,306	211,500	36	3,661	183	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	5,306		5,306		36	3,661	183	200

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

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					3,661	1,645	1,645	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					3,661	1,645	1,645	200

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

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	2,360,812	2,360,812					1
2	Cap Rel Costs-Mvble Equip	821,768		821,768				2
4	Employee Benefits Department	3,557,673	11,753	4,091	3,573,517			4
5	Administrative & General	5,111,321	420,769	146,464	497,452	6,176,006	6,176,006	5
6	Maintenance & Repairs							6
7	Operation of Plant	914,366	83,436	29,043	71,337	1,098,182	320,844	7
8	Laundry & Linen Service	15,435	17,865	6,219		39,519	11,546	8
9	Housekeeping	419,762	14,871	5,176	87,521	527,330	154,064	9
10	Dietary	733,931	127,876	44,512	88,261	994,580	290,575	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	528,042	20,488	7,132	128,692	684,354	199,940	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	158,092	13,560	4,720	33,176	209,548	61,221	16
17	Social Service	621,369	28,975	10,086	155,597	816,027	238,410	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	1&R Services-Salary & Fringes Apprvd							21
22	1&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	5,160,820	1,036,076	360,644	1,273,759	7,831,299	2,287,991	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	121,960				121,960	35,632	54
54.01	RADIOLOGY-SUA	37,202				37,202		54.01
60	Laboratory	608,556	1,460	508		610,524	178,370	60
60.01	LAB SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	475,501	6,730	2,343	120,296	604,870	176,718	65
66	Physical Therapy	1,490,756	176,226	61,342	377,793	2,106,117	615,321	66
67	Occupational Therapy	1,487,861	148,463	51,678	378,997	2,066,999	603,892	67
68	Speech Pathology	638,527	52,828	18,389	162,356	872,100	254,792	68
71	Medical Supplies Charged to Patients	368,628	41,050	14,289	19,233	443,200	129,485	71
73	Drugs Charged to Patients	1,348,009	12,595	4,384	130,658	1,495,646	436,966	73
76	OTHER ANCILLARY							76
76.01	SPECIAL PROCEDURES	173,510				173,510	50,693	76.01
76.02	SPECIAL PROCEDURES SUA	22,813				22,813		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)	27,176,714	2,215,021	771,020	3,525,128	26,931,786	6,046,460	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		140,174	48,793		188,967	55,208	192
194	NRCC MARKETING	198,481	5,617	1,955	48,389	254,442	74,338	194
194.01	GUEST MEALS							194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	27,375,195	2,360,812	821,768	3,573,517	27,375,195	6,176,006	202

	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
1	Cap Rel Costs-Bldg & Fixt							2
2	Cap Rel Costs-Mvble Equip							4
4	Employee Benefits Department							5
5	Administrative & General							6
6	Maintenance & Repairs							7
7	Operation of Plant	1,419,026						8
8	Laundry & Linen Service	13,741	64,806					9
9	Housekeeping	11,439		692,833				10
10	Dietary	98,360		48,891	1,432,406			11
11	Cafeteria				144,838	144,838		12
12	Maintenance of Personnel							13
13	Nursing Administration	15,759		7,833		6,589	914,475	14
14	Central Services & Supply							15
15	Pharmacy							16
16	Medical Records & Library	10,430		5,184		1,699		17
17	Social Service	22,287		11,078		7,966		19
19	Nonphysician Anesthetists							20
20	Nursing School							21
21	I&R Services-Salary & Fringes Apprvd							22
22	I&R Services-Other Prem Costs Apprvd							23
23	Paramed Ed Prgm-(specify)							
	INPATIENT ROUTINE SERV COST CENTERS	796,929	64,806	396,128	1,256,375	65,216	914,475	30
30	Adults & Pediatrics							54
	ANCILLARY SERVICE COST CENTERS							54.01
54	Radiology-Diagnostic							60
54.01	RADIOLOGY-SUA	1,123		558				60.01
60	Laboratory							62.30
60.01	LAB SUA							65
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							66
65	Respiratory Therapy	5,177		2,573		6,159		67
66	Physical Therapy	135,550		67,377		19,342		68
67	Occupational Therapy	114,195		56,762		19,404		71
68	Speech Pathology	40,634		20,198		8,312		73
71	Medical Supplies Charged to Patients	31,575		15,695		985		76
73	Drugs Charged to Patients	9,688		4,815		6,689		76.01
76	OTHER ANCILLARY							76.02
76.01	SPECIAL PROCEDURES							76.97
76.02	SPECIAL PROCEDURES SUA							76.98
76.97	CARDIAC REHABILITATION							76.99
76.98	HYPERBARIC OXYGEN THERAPY							
76.99	LITHOTRIPSY							92
	OUTPATIENT SERVICE COST CENTERS							93.99
92	Observation Beds (Non-Distinct Part)							
93.99	PARTIAL HOSPITALIZATION PROGRAM							113
	OTHER REIMBURSABLE COST CENTERS							118
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense	1,306,887	64,806	637,092	1,401,213	142,361	914,475	192
118	SUBTOTALS (sum of lines 1-117)							194
	NONREIMBURSABLE COST CENTERS	107,819		53,593				194.01
192	Physicians' Private Offices	4,320		2,148		2,477		200
194	NRCC MARKETING				31,193			201
194.01	GUEST MEALS							202
200	Cross Foot Adjustments							
201	Negative Cost Centers							
202	TOTAL (sum of lines 118-201)	1,419,026	64,806	692,833	1,432,406	144,838	914,475	

	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
1	Cap Rel Costs-Bldg & Fixt							2
2	Cap Rel Costs-Mvble Equip							4
4	Employee Benefits Department							5
5	Administrative & General							6
6	Maintenance & Repairs							7
7	Operation of Plant							8
8	Laundry & Linen Service							9
9	Housekeeping							10
10	Dietary							11
11	Cafeteria							12
12	Maintenance of Personnel							13
13	Nursing Administration							14
14	Central Services & Supply							15
15	Pharmacy							16
16	Medical Records & Library	288,082						17
17	Social Service		1,095,768					19
19	Nonphysician Anesthetists							20
20	Nursing School							21
21	I&R Services-Salary & Fringes Apprvd							22
22	I&R Services-Other Prgm Costs Apprvd							23
23	Paramed Ed Prgm-(specify)							
	INPATIENT ROUTINE SERV COST CENTERS							30
30	Adults & Pediatrics	127,232	1,095,768	14,836,219		14,836,219		
	ANCILLARY SERVICE COST CENTERS							54
54	Radiology-Diagnostic	891		158,483		158,483		54.01
54.01	RADIOLOGY-SUA			37,202		37,202		60
60	Laboratory	10,630		801,205		801,205		60.01
60.01	LAB SUA							62.30
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							65
65	Respiratory Therapy	9,517		805,014		805,014		66
66	Physical Therapy	37,922		2,981,629		2,981,629		67
67	Occupational Therapy	37,044		2,898,296		2,898,296		68
68	Speech Pathology	15,407		1,211,443		1,211,443		71
71	Medical Supplies Charged to Patients	10,101		631,041		631,041		73
73	Drugs Charged to Patients	37,673		1,991,477		1,991,477		76
76	OTHER ANCILLARY							76.01
76.01	SPECIAL PROCEDURES	1,665		225,868		225,868		76.02
76.02	SPECIAL PROCEDURES SUA			22,813		22,813		76.97
76.97	CARDIAC REHABILITATION							76.98
76.98	HYPERBARIC OXYGEN THERAPY							76.99
76.99	LITHOTRIPSY							
	OUTPATIENT SERVICE COST CENTERS							92
92	Observation Beds (Non-Distinct Part)							93.99
93.99	PARTIAL HOSPITALIZATION PROGRAM							
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							113
113	Interest Expense							118
118	SUBTOTALS (sum of lines 1-117)	288,082	1,095,768	26,600,690		26,600,690		
	NONREIMBURSABLE COST CENTERS							192
192	Physicians' Private Offices			405,587		405,587		194
194	NRCC MARKETING			337,725		337,725		194.01
194.01	GUEST MEALS			31,193		31,193		200
200	Cross Foot Adjustments							201
201	Negative Cost Centers							202
202	TOTAL (sum of lines 118-201)	288,082	1,095,768	27,375,195		27,375,195		

	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
1	Cap Rel Costs-Bldg & Fixt							2
2	Cap Rel Costs-Mvble Equip		11,753	4,091	15,844	15,844		4
4	Employee Benefits Department		420,769	146,464	567,233	2,205	569,438	5
5	Administrative & General							6
6	Maintenance & Repairs		83,436	29,043	112,479	316	29,583	7
7	Operation of Plant		17,865	6,219	24,084		1,065	8
8	Laundry & Linen Service		14,871	5,176	20,047	388	14,205	9
9	Housekeeping		127,876	44,512	172,388	391	26,792	10
10	Dietary							11
11	Cafeteria							12
12	Maintenance of Personnel		20,488	7,132	27,620	570	18,435	13
13	Nursing Administration							14
14	Central Services & Supply							15
15	Pharmacy		13,560	4,720	18,280	147	5,645	16
16	Medical Records & Library		28,975	10,086	39,061	690	21,982	17
17	Social Service							19
19	Nonphysician Anesthetists							20
20	Nursing School							21
21	I&R Services-Salary & Fringes Apprvd							22
22	I&R Services-Other Prgm Costs Apprvd							23
23	Paramed Ed Prgm-(specify)							
	INPATIENT ROUTINE SERV COST CENTERS		1,036,076	360,644	1,396,720	5,652	210,950	30
30	Adults & Pediatrics							
	ANCILLARY SERVICE COST CENTERS						3,285	54
54	Radiology-Diagnostic							54.01
54.01	RADIOLOGY-SUA		1,460	508	1,968		16,446	60
60	Laboratory							60.01
60.01	LAB SUA							62.30
62.30	BLOOD CLOTTING FOR HEMOPHILIACS		6,730	2,343	9,073	533	16,294	65
65	Respiratory Therapy		176,226	61,342	237,568	1,674	56,735	66
66	Physical Therapy		148,463	51,678	200,141	1,680	55,681	67
67	Occupational Therapy		52,828	18,389	71,217	720	23,493	68
68	Speech Pathology		41,050	14,289	55,339	85	11,939	71
71	Medical Supplies Charged to Patients		12,595	4,384	16,979	579	40,290	73
73	Drugs Charged to Patients							76
76	OTHER ANCILLARY						4,674	76.01
76.01	SPECIAL PROCEDURES							76.02
76.02	SPECIAL PROCEDURES SUA							76.97
76.97	CARDIAC REHABILITATION							76.98
76.98	HYPERBARIC OXYGEN THERAPY							76.99
76.99	LITHOTRIPSY							
	OUTPATIENT SERVICE COST CENTERS							92
92	Observation Beds (Non-Distinct Part)							93.99
93.99	PARTIAL HOSPITALIZATION PROGRAM							
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							113
113	Interest Expense		2,215,021	771,020	2,986,041	15,630	557,494	118
118	SUBTOTALS (sum of lines 1-117)							
	NONREIMBURSABLE COST CENTERS		140,174	48,793	188,967		5,090	192
192	Physicians' Private Offices		5,617	1,955	7,572	214	6,854	194
194	NRCC MARKETING							194.01
194.01	GUEST MEALS							200
200	Cross Foot Adjustments							201
201	Negative Cost Centers							202
202	TOTAL (sum of lines 118-201)		2,360,812	821,768	3,182,580	15,844	569,438	

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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	142,378						7
8	Laundry & Linen Service	1,379	26,528					8
9	Housekeeping	1,148		35,788				9
10	Dietary	9,869		2,525	211,965			10
11	Cafeteria				21,433	21,433		11
12	Maintenance of Personnel							12
13	Nursing Administration	1,581		405		975	49,586	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	1,046		268		251		16
17	Social Service	2,236		572		1,179		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prem Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	79,961	26,528	20,462	185,916	9,648	49,586	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic							54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory	113		29				60
60.01	LAB SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	519		133		912		65
66	Physical Therapy	13,600		3,480		2,863		66
67	Occupational Therapy	11,458		2,932		2,872		67
68	Speech Pathology	4,077		1,043		1,230		68
71	Medical Supplies Charged to Patients	3,168		811		146		71
73	Drugs Charged to Patients	972		249		990		73
76	OTHER ANCILLARY							76
76.01	SPECIAL PROCEDURES							76.01
76.02	SPECIAL PROCEDURES SUA							76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	131,127	26,528	32,909	207,349	21,066	49,586	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	10,818		2,768				192
194	NRCC MARKETING	433		111		367		194
194.01	GUEST MEALS				4,616			194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	142,378	26,528	35,788	211,965	21,433	49,586	202

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

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	25,637						16
17	Social Service		65,720					17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	11,325	65,720	2,062,468		2,062,468		30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	79		3,364		3,364		54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory	946		19,502		19,502		60
60.01	LAB SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	847		28,311		28,311		65
66	Physical Therapy	3,374		319,294		319,294		66
67	Occupational Therapy	3,296		278,060		278,060		67
68	Speech Pathology	1,371		103,151		103,151		68
71	Medical Supplies Charged to Patients	899		72,387		72,387		71
73	Drugs Charged to Patients	3,352		63,411		63,411		73
76	OTHER ANCILLARY							76
76.01	SPECIAL PROCEDURES	148		4,822		4,822		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)	25,637	65,720	2,954,770		2,954,770		118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices			207,643		207,643		192
194	NRCC MARKETING			15,551		15,551		194
194.01	GUEST MEALS			4,616		4,616		194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	25,637	65,720	3,182,580		3,182,580		202

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

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	95,410						1
2	Cap Rel Costs-Mvble Equip		95,410					2
4	Employee Benefits Department	475	475	13,880,090				4
5	Administrative & General	17,005	17,005	1,932,184	-6,176,006	21,139,174		5
6	Maintenance & Repairs							6
7	Operation of Plant	3,372	3,372	277,086		1,098,182	74,558	7
8	Laundry & Linen Service	722	722			39,519	722	8
9	Housekeeping	601	601	339,945		527,330	601	9
10	Dietary	5,168	5,168	342,818		994,580	5,168	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	828	828	499,861		684,354	828	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	548	548	128,861		209,548	548	16
17	Social Service	1,171	1,171	604,364		816,027	1,171	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	41,872	41,872	4,947,462		7,831,299	41,872	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic					121,960		54
54.01	RADIOLOGY-SUA				-37,202			54.01
60	Laboratory	59	59			610,524	59	60
60.01	LAB SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	272	272	467,249		604,870	272	65
66	Physical Therapy	7,122	7,122	1,467,409		2,106,117	7,122	66
67	Occupational Therapy	6,000	6,000	1,472,086		2,066,999	6,000	67
68	Speech Pathology	2,135	2,135	630,615		872,100	2,135	68
71	Medical Supplies Charged to Patients	1,659	1,659	74,705		443,200	1,659	71
73	Drugs Charged to Patients	509	509	507,495		1,495,646	509	73
76	OTHER ANCILLARY							76
76.01	SPECIAL PROCEDURES					173,510		76.01
76.02	SPECIAL PROCEDURES SUA				-22,813			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)	89,518	89,518	13,692,140	-6,236,021	20,695,765	68,666	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	5,665	5,665			188,967	5,665	192
194	NRCC MARKETING	227	227	187,950		254,442	227	194
194.01	GUEST MEALS							194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	2,360,812	821,768	3,573,517		6,176,006	1,419,026	202
203	Unit Cost Multiplier (Wkst. B, Part I)	24.743863	8.613018	0.257456		0.292159	19.032512	203
204	Cost to be allocated (Per Wkst. B, Part II)			15,844		569,438	142,378	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.001141		0.026938	1.909627	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

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

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	29,698						8
9	Housekeeping		73,235					9
10	Dietary		5,168	101,577				10
11	Cafeteria			10,271	10,988,057			11
12	Maintenance of Personnel							12
13	Nursing Administration		828		499,861	29,698		13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		548		128,861		63,769,122	16
17	Social Service		1,171		604,364			17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	29,698	41,872	89,094	4,947,462	29,698	28,166,882	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic						197,235	54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory		59				2,352,735	60
60.01	LAB SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		272		467,249		2,106,527	65
66	Physical Therapy		7,122		1,467,409		8,393,558	66
67	Occupational Therapy		6,000		1,472,086		8,199,237	67
68	Speech Pathology		2,135		630,615		3,410,127	68
71	Medical Supplies Charged to Patients		1,659		74,705		2,235,738	71
73	Drugs Charged to Patients		509		507,495		8,338,526	73
76	OTHER ANCILLARY							76
76.01	SPECIAL PROCEDURES						368,557	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)	29,698	67,343	99,365	10,800,107	29,698	63,769,122	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		5,665					192
194	NRCC MARKETING		227		187,950			194
194.01	GUEST MEALS			2,212				194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	64,806	692,833	1,432,406	144,838	914,475	288,082	202
203	Unit Cost Multiplier (Wkst. B, Part I)	2.182167	9.460408	14.101677	0.013181	30.792478	0.004518	203
204	Cost to be allocated (Per Wkst. B, Part II)	26,528	35,788	211,965	21,433	49,586	25,637	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.893259	0.488673	2.086742	0.001951	1.669675	0.000402	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

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	SOCIAL SERVICE PATIENT DAYS						
		17						
	GENERAL SERVICE COST CENTERS							1
1	Cap Rel Costs-Bldg & Fixt							2
2	Cap Rel Costs-Mvble Equip							4
4	Employee Benefits Department							5
5	Administrative & General							6
6	Maintenance & Repairs							7
7	Operation of Plant							8
8	Laundry & Linen Service							9
9	Housekeeping							10
10	Dietary							11
11	Cafeteria							12
12	Maintenance of Personnel							13
13	Nursing Administration							14
14	Central Services & Supply							15
15	Pharmacy							16
16	Medical Records & Library							17
17	Social Service	29,698						19
19	Nonphysician Anesthetists							20
20	Nursing School							21
21	I&R Services-Salary & Fringes Apprvd							22
22	I&R Services-Other Prgm Costs Apprvd							23
23	Paramed Ed Prgm-(specify)							
	INPATIENT ROUTINE SERV COST CENTERS							30
30	Adults & Pediatrics	29,698						
	ANCILLARY SERVICE COST CENTERS							54
54	Radiology-Diagnostic							54.01
54.01	RADIOLOGY-SUA							60
60	Laboratory							60.01
60.01	LAB SUA							62.30
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							65
65	Respiratory Therapy							66
66	Physical Therapy							67
67	Occupational Therapy							68
68	Speech Pathology							71
71	Medical Supplies Charged to Patients							73
73	Drugs Charged to Patients							76
76	OTHER ANCILLARY							76.01
76.01	SPECIAL PROCEDURES							76.02
76.02	SPECIAL PROCEDURES SUA							76.97
76.97	CARDIAC REHABILITATION							76.98
76.98	HYPERBARIC OXYGEN THERAPY							76.99
76.99	LITHOTRIPSY							
	OUTPATIENT SERVICE COST CENTERS							92
92	Observation Beds (Non-Distinct Part)							93.99
93.99	PARTIAL HOSPITALIZATION PROGRAM							
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							118
118	SUBTOTALS (sum of lines 1-117)	29,698						
	NONREIMBURSABLE COST CENTERS							192
192	Physicians' Private Offices							194
194	NRCC MARKETING							194.01
194.01	GUEST MEALS							200
200	Cross foot adjustments							201
201	Negative cost centers							202
202	Cost to be allocated (Per Wkst. B, Part I)	1,095,768						203
203	Unit Cost Multiplier (Wkst. B, Part I)	36.897030						204
204	Cost to be allocated (Per Wkst. B, Part II)	65,720						205
205	Unit Cost Multiplier (Wkst. B, Part II)	2.212944						206
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							207
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET CODE	WORKSHEET LINE NO.	AMOUNT	
	1	2	3	4	

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	COSTS Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	14,836,219		14,836,219	1,645	14,837,864	30
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	158,483		158,483		158,483	54
54.01	RADIOLOGY-SUA	37,202		37,202		37,202	54.01
60	Laboratory	801,205		801,205		801,205	60
60.01	LAB SUA						60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	805,014		805,014		805,014	65
66	Physical Therapy	2,981,629		2,981,629		2,981,629	66
67	Occupational Therapy	2,898,296		2,898,296		2,898,296	67
68	Speech Pathology	1,211,443		1,211,443		1,211,443	68
71	Medical Supplies Charged to Patients	631,041		631,041		631,041	71
73	Drugs Charged to Patients	1,991,477		1,991,477		1,991,477	73
76	OTHER ANCILLARY						76
76.01	SPECIAL PROCEDURES	225,868		225,868		225,868	76.01
76.02	SPECIAL PROCEDURES SUA	22,813		22,813		22,813	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)	26,600,690		26,600,690	1,645	26,602,335	200
201	Less Observation Beds						201
202	Total (line 200 minus line 201)	26,600,690		26,600,690		26,602,335	202

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	CHARGES			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		Inpatient	Outpatient	Total (column 6 + column 7)				
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	28,166,882		28,166,882				30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	196,743	492	197,235	0.803524	0.803524	0.803524	54
54.01	RADIOLOGY-SUA	79,384		79,384	0.468633	0.468633	0.468633	54.01
60	Laboratory	2,352,735		2,352,735	0.340542	0.340542	0.340542	60
60.01	LAB SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,106,527		2,106,527	0.382152	0.382152	0.382152	65
66	Physical Therapy	7,330,720	1,062,838	8,393,558	0.355228	0.355228	0.355228	66
67	Occupational Therapy	7,596,993	602,244	8,199,237	0.353484	0.353484	0.353484	67
68	Speech Pathology	2,682,005	728,122	3,410,127	0.355249	0.355249	0.355249	68
71	Medical Supplies Charged to Patients	2,224,280	11,458	2,235,738	0.282252	0.282252	0.282252	71
73	Drugs Charged to Patients	8,338,526		8,338,526	0.238828	0.238828	0.238828	73
76	OTHER ANCILLARY							76
76.01	SPECIAL PROCEDURES	368,557		368,557	0.612844	0.612844	0.612844	76.01
76.02	SPECIAL PROCEDURES SUA	182,851		182,851	0.124763	0.124763	0.124763	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)	61,626,203	2,405,154	64,031,357				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	61,626,203	2,405,154	64,031,357				202

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

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

WORKSHEET C
PART I

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (B Part I col 26 plus sum of cols 21 & 22)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics						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	OTHER ANCILLARY						76
76.01	SPECIAL PROCEDURES						76.01
76.02	SPECIAL PROCEDURES SUA						76.02
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct Part)						92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)						200
201	Less Observation Beds						201
202	Total (line 200 minus line 201)						202

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

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

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	CHARGES			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		Inpatient	Outpatient	Total (column 6 + column 7)				
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	28,166,882		28,166,882				30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	196,743	492	197,235				54
54.01	RADIOLOGY-SUA	79,384		79,384				54.01
60	Laboratory	2,352,735		2,352,735				60
60.01	LAB SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,106,527		2,106,527				65
66	Physical Therapy	7,330,720	1,062,838	8,393,558				66
67	Occupational Therapy	7,596,993	602,244	8,199,237				67
68	Speech Pathology	2,682,005	728,122	3,410,127				68
71	Medical Supplies Charged to Patients	2,224,280	11,458	2,235,738				71
73	Drugs Charged to Patients	8,338,526		8,338,526				73
76	OTHER ANCILLARY							76
76.01	SPECIAL PROCEDURES	368,557		368,557				76.01
76.02	SPECIAL PROCEDURES SUA	182,851		182,851				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)	61,626,203	2,405,154	64,031,357				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	61,626,203	2,405,154	64,031,357				202

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

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 (B Part I col 26 plus sum of cols 21 & 22)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	14,836,219		14,836,219	1,645	14,837,864	30
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	158,483		158,483		158,483	54
54.01	RADIOLOGY-SUA	37,202		37,202		37,202	54.01
60	Laboratory	801,205		801,205		801,205	60
60.01	LAB SUA						60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	805,014		805,014		805,014	65
66	Physical Therapy	2,981,629		2,981,629		2,981,629	66
67	Occupational Therapy	2,898,296		2,898,296		2,898,296	67
68	Speech Pathology	1,211,443		1,211,443		1,211,443	68
71	Medical Supplies Charged to Patients	631,041		631,041		631,041	71
73	Drugs Charged to Patients	1,991,477		1,991,477		1,991,477	73
76	OTHER ANCILLARY						76
76.01	SPECIAL PROCEDURES	225,868		225,868		225,868	76.01
76.02	SPECIAL PROCEDURES SUA	22,813		22,813		22,813	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)	26,600,690		26,600,690	1,645	26,602,335	200
201	Less Observation Beds						201
202	Total (line 200 minus line 201)	26,600,690		26,600,690	1,645	26,602,335	202

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

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

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	CHARGES			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		Inpatient	Outpatient	Total (column 6 + column 7)				
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	28,166,882		28,166,882				30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	196,743	492	197,235	0.803524	0.803524	0.803524	54
54.01	RADIOLOGY-SUA	79,384		79,384	0.468633	0.468633	0.468633	54.01
60	Laboratory	2,352,735		2,352,735	0.340542	0.340542	0.340542	60
60.01	LAB SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,106,527		2,106,527	0.382152	0.382152	0.382152	65
66	Physical Therapy	7,330,720	1,062,838	8,393,558	0.355228	0.355228	0.355228	66
67	Occupational Therapy	7,596,993	602,244	8,199,237	0.353484	0.353484	0.353484	67
68	Speech Pathology	2,682,005	728,122	3,410,127	0.355249	0.355249	0.355249	68
71	Medical Supplies Charged to Patients	2,224,280	11,458	2,235,738	0.282252	0.282252	0.282252	71
73	Drugs Charged to Patients	8,338,526		8,338,526	0.238828	0.238828	0.238828	73
76	OTHER ANCILLARY							76
76.01	SPECIAL PROCEDURES	368,557		368,557	0.612844	0.612844	0.612844	76.01
76.02	SPECIAL PROCEDURES SUA	182,851		182,851	0.124763	0.124763	0.124763	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)	61,626,203	2,405,154	64,031,357				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	61,626,203	2,405,154	64,031,357				202

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

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	158,483	3,364	155,119		54
54.01	RADIOLOGY-SUA	37,202		37,202		54.01
60	Laboratory	801,205	19,502	781,703		60
60.01	LAB SUA					60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy	805,014	28,311	776,703		65
66	Physical Therapy	2,981,629	319,294	2,662,335		66
67	Occupational Therapy	2,898,296	278,060	2,620,236		67
68	Speech Pathology	1,211,443	103,151	1,108,292		68
71	Medical Supplies Charged to Patients	631,041	72,387	558,654		71
73	Drugs Charged to Patients	1,991,477	63,411	1,928,066		73
76	OTHER ANCILLARY					76
76.01	SPECIAL PROCEDURES	225,868	4,822	221,046		76.01
76.02	SPECIAL PROCEDURES SUA	22,813		22,813		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	11,764,471	892,302	10,872,169		200
201	Less Observation Beds					201
202	Total	11,764,471	892,302	10,872,169		202

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

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		158,483	197,235	0.803524	54
54.01	RADIOLOGY-SUA		37,202	79,384	0.468633	54.01
60	Laboratory		801,205	2,352,735	0.340542	60
60.01	LAB SUA					60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy		805,014	2,106,527	0.382152	65
66	Physical Therapy		2,981,629	8,393,558	0.355228	66
67	Occupational Therapy		2,898,296	8,199,237	0.353484	67
68	Speech Pathology		1,211,443	3,410,127	0.355249	68
71	Medical Supplies Charged to Patients		631,041	2,235,738	0.282252	71
73	Drugs Charged to Patients		1,991,477	8,338,526	0.238828	73
76	OTHER ANCILLARY					76
76.01	SPECIAL PROCEDURES		225,868	368,557	0.612844	76.01
76.02	SPECIAL PROCEDURES SUA		22,813	182,851	0.124763	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		11,764,471	35,864,475		200
201	Less Observation Beds					201
202	Total		11,764,471	35,864,475		202

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check Applicable Boxes:
[ ] Title V
[XX] Title XVIII, Part A
[ ] Title XIX
[XX] 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)	2,062,468		2,062,468	29,698	69.45	21,427	1,488,105	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)	2,062,468		2,062,468	29,698		21,427	1,488,105	200

(A) Worksheet A line numbers

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | COMPONENT CCN: 15-3025 | WORKSHEET D PART II

Check Applicable Boxes:
[ ] Title V [XX] Hospital [ ] SUB (Other) [XX] PPS
[XX] Title XVIII, Part A [ ] IPF [ ] TEFRA
[ ] Title XIX [ ] IRF

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	3,364	197,235	0.017056	186,012	3,173	54
54.01	RADIOLOGY-SUA		79,384		68,038		54.01
60	Laboratory	19,502	2,352,735	0.008289	1,663,098	13,785	60
60.01	LAB SUA						60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	28,311	2,106,527	0.013440	1,671,201	22,461	65
66	Physical Therapy	319,294	8,393,558	0.038040	5,294,264	201,394	66
67	Occupational Therapy	278,060	8,199,237	0.033913	5,480,655	185,865	67
68	Speech Pathology	103,151	3,410,127	0.030248	1,913,221	57,871	68
71	Medical Supplies Charged to Pat	72,387	2,235,738	0.032377	1,588,865	51,443	71
73	Drugs Charged to Patients	63,411	8,338,526	0.007605	5,953,696	45,278	73
76	OTHER ANCILLARY						76
76.01	SPECIAL PROCEDURES	4,822	368,557	0.013083	286,012	3,742	76.01
76.02	SPECIAL PROCEDURES SUA		182,851		141,898		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)	892,302	35,864,475		24,246,960	585,012	200

(A) Worksheet A line numbers

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

		Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	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

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	29,698		21,427		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)	29,698		21,427		200

(A) Worksheet A line numbers

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-3015

WORKSHEET D PART IV

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

		Non Physician Anesth-etist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
54	Radiology-Diagnostic									54
54.01	RADIOLOGY-SUA									54.01
60	Laboratory									60
60.01	LAB SUA									60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
71	Medical Supplies Charged to Pat									71
73	Drugs Charged to Patients									73
76	OTHER ANCILLARY									76
76.01	SPECIAL PROCEDURES									76.01
76.02	SPECIAL PROCEDURES SUA									76.02
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
92	Observation Beds (Non-Distinct									92
93.99	PARTIAL HOSPITALIZATION PROGRAM									93.99
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-3025

WORKSHEET D
PART IV

Check Applicable Boxes:	[ ] Title V	[XX] Hospital	[ ] SUB (Other)	[ ] ICF/IID	[XX] PPS
	[XX] Title XVIII, Part A	[ ] IPF	[ ] SNF		[ ] TEFRA
	[ ] 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	197,235			186,013		492		54
54.01	RADIOLOGY-SUA	79,384			68,038				54.01
60	Laboratory	2,352,735			1,663,098				60
60.01	LAB SUA								60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	2,106,527			1,671,291				65
66	Physical Therapy	8,393,558			5,294,364				66
67	Occupational Therapy	8,199,237			5,480,655				67
68	Speech Pathology	3,410,127			1,913,221				68
71	Medical Supplies Charged to Pat	2,235,738			1,588,865		644		71
73	Drugs Charged to Patients	8,338,526			5,953,696				73
76	OTHER ANCILLARY								76
76.01	SPECIAL PROCEDURES	368,557			286,012				76.01
76.02	SPECIAL PROCEDURES SUA	182,851			141,898				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)	35,864,475			24,246,960		1,136		200

(A) Worksheet A line numbers

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS — COMPONENT CCN: 15-3025 — WORKSHEET D PART V

Check Applicable Boxes:	[ ] Title V - O/P	[XX] Hospital	[ ] SUB (Other)	[ ] Swing Bed SNF
	[XX] Title XVIII, Part B	[ ] IPF	[ ] SNF	[ ] Swing Bed NF
	[ ] Title XIX - O/P	[ ] IRF	[ ] NF	[ ] ICF/IID

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reimbursed Services (see inst.)	Cost Reimbursed Subject to Ded. & Coins. (see inst.)	Cost Reimbursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reimbursed Subject to Ded. & Coins. (see inst.)	Cost Reimbursed 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	0.803524	492			395			54
54.01	RADIOLOGY-SUA	0.468633							54.01
60	Laboratory	0.340542							60
60.01	LAB SUA								60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.382152							65
66	Physical Therapy	0.355228							66
67	Occupational Therapy	0.353484							67
68	Speech Pathology	0.355249							68
71	Medical Supplies Charged to Pat	0.282252	644			182			71
73	Drugs Charged to Patients	0.238828							73
76	OTHER ANCILLARY								76
76.01	SPECIAL PROCEDURES	0.612844							76.01
76.02	SPECIAL PROCEDURES SUA	0.124763							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)		1,136			577			200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		1,136			577			202

(A) Worksheet A line numbers

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	2,062,468		2,062,468	29,698	69.45	398	27,641	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)	2,062,468		2,062,468	29,698		398	27,641	200

(A) Worksheet A line numbers

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS — COMPONENT CCN: 15-3025 — WORKSHEET D PART II

Check Applicable Boxes:
[ ] Title V
[ ] Title XVIII, Part A
[XX] Title XIX
[XX] Hospital
[ ] IPF
[ ] IRF
[ ] SUB (Other)

(A)	Cost Center Description	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)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						54
54	Radiology-Diagnostic	3,364	197,235	0.017056	1,563	27	54.01
54.01	RADIOLOGY-SUA		79,384		629		60
60	Laboratory	19,502	2,352,735	0.008289	34,869	289	60.01
60.01	LAB SUA						62.30
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						65
65	Respiratory Therapy	28,311	2,106,527	0.013440	14,679	197	66
66	Physical Therapy	319,294	8,393,558	0.038040	106,678	4,058	67
67	Occupational Therapy	278,060	8,199,237	0.033913	110,688	3,754	68
68	Speech Pathology	103,151	3,410,127	0.030248	23,659	716	71
71	Medical Supplies Charged to Pat	72,387	2,235,738	0.032377	31,764	1,028	73
73	Drugs Charged to Patients	63,411	8,338,526	0.007605	113,347	862	76
76	OTHER ANCILLARY						76.01
76.01	SPECIAL PROCEDURES	4,822	368,557	0.013083	2,646	35	76.02
76.02	SPECIAL PROCEDURES SUA		182,851		1,313		76.97
76.97	CARDIAC REHABILITATION						76.98
76.98	HYPERBARIC OXYGEN THERAPY						76.99
76.99	LITHOTRIPSY						
	OUTPATIENT SERVICE COST CENTERS						92
92	Observation Beds (Non-Distinct						93.99
93.99	PARTIAL HOSPITALIZATION PROGRAM						
	OTHER REIMBURSABLE COST CENTERS						200
200	Total (sum of lines 50-199)	892,302	35,864,475		441,835	10,966	

(A) Worksheet A line numbers

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

		Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	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

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	29,698		398		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)	29,698		398		200

(A) Worksheet A line numbers

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-3025

WORKSHEET D PART IV

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

(A)	Cost Center Description	1 Non Physician Anesth-etist Cost	2A Nursing School Post-Stepdown Adjustments	2 Nursing School	3A Allied Health Post-Stepdown Adjustments	3 Allied Health	4 All Other Medical Education Cost	5 Total Cost (sum of col. 1 through col. 4)	6 Total Outpatient Cost (sum of col. 2, 3, and 4)	
	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	OTHER ANCILLARY									76
76.01	SPECIAL PROCEDURES									76.01
76.02	SPECIAL PROCEDURES SUA									76.02
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
92	Observation Beds (Non-Distinct									92
93.99	PARTIAL HOSPITALIZATION PROGRAM									93.99
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-3025

WORKSHEET D PART IV

Check Applicable Boxes:	[ ] Title V	[XX] Hospital	[ ] SUB (Other)	[ ] ICF/IID	[ ] PBS	
	[ ] Title XVIII, Part A	[ ] IPF	[ ] SNF		[ ] TEFRA	
	[XX] Title XIX	[ ] IRF	[ ] NF		[XX] 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	197,235			1,563				54
54.01	RADIOLOGY-SUA	79,384			629				54.01
60	Laboratory	2,352,735			34,869				60
60.01	LAB SUA								60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	2,106,527			14,679				65
66	Physical Therapy	8,393,558			106,678				66
67	Occupational Therapy	8,199,237			110,688				67
68	Speech Pathology	3,410,127			23,659				68
71	Medical Supplies Charged to Pat	2,235,738			31,764				71
73	Drugs Charged to Patients	8,338,526			113,347				73
76	OTHER ANCILLARY								76
76.01	SPECIAL PROCEDURES	368,557			2,646				76.01
76.02	SPECIAL PROCEDURES SUA	182,851			1,313				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)	35,864,475			441,835				200

(A) Worksheet A line numbers

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS — COMPONENT CCN: 15-3025 — WORKSHEET D PART V

Check Applicable Boxes:	[ ] Title V - O/P	[XX] Hospital	[ ] SUB (Other)	[ ] Swing Bed SNF
	[ ] Title XVIII, Part B	[ ] IPF	[ ] SNF	[ ] Swing Bed NF
	[XX] Title XIX - O/P	[ ] IRF	[ ] NF	[ ] ICF/IID

			Program Charges			Program Cost			
(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reimbursed Services (see inst.)	Cost Reimbursed Subject to Ded. & Coins. (see inst.)	Cost Reimbursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reimbursed Subject to Ded. & Coins. (see inst.)	Cost Reimbursed Not Subject to Ded. & Coins. (see inst.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	0.803524							54
54.01	RADIOLOGY-SUA	0.468633							54.01
60	Laboratory	0.340542							60
60.01	LAB SUA								60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.382152							65
66	Physical Therapy	0.355228		21,293			7,564		66
67	Occupational Therapy	0.353484		20,009			7,073		67
68	Speech Pathology	0.355249		1,709			607		68
71	Medical Supplies Charged to Pat	0.282252		67			19		71
73	Drugs Charged to Patients	0.238828							73
76	OTHER ANCILLARY								76
76.01	SPECIAL PROCEDURES	0.612844							76.01
76.02	SPECIAL PROCEDURES SUA	0.124763							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)			43,078			15,263		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			43,078			15,263		202

(A) Worksheet A line numbers

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

COMPUTATION OF INPATIENT OPERATING COST — COMPONENT CCN: 15-3025 — WORKSHEET D-1 PART I

Check Applicable Boxes:	[ ] Title V - I/P	[XX] Hospital	[ ] SUB (Other)	[ ] ICF/IID	[XX] PPS
	[XX] Title XVIII, Part A	[ ] IPF	[ ] SNF		[ ] TEFRA
	[ ] 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)	29,698	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	29,698	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.	1,427	3
4	Semi-private room days (excluding swing-bed private room days)	28,271	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)	21,427	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	14,837,864	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	14,837,864	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)	27,935,132	28
29	Private room charges (excluding swing-bed charges)	1,376,342	29
30	Semi-private room charges (excluding swing-bed charges)	26,558,790	30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.531154	31
32	Average private room per diem charge (line 29 ÷ line 3)	964.50	32
33	Average semi-private room per diem charge (line 30 ÷ line 4)	939.44	33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)	25.06	34
35	Average per diem private room cost differential (line 34 x line 31)	13.31	35
36	Private room cost differential adjustment (line 3 x line 35)	18,993	36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	14,818,871	37

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12_(03/07/2019)

COMPUTATION OF INPATIENT OPERATING COST — COMPONENT CCN: 15-3025 — WORKSHEET D-1 PART II

Check Applicable Boxes:	[ ] Title V - I/P	[XX] Hospital	[ ] SUB (Other)	[XX] PPS
	[XX] Title XVIII, Part A	[ ] IPF		[ ] TEFRA
	[ ] Title XIX - I/P	[ ] IRF		[ ] Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

		1	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	Adjusted general inpatient routine service cost per diem (see instructions)	499.63	38
39	Program general inpatient routine service cost (line 9 x line 38)	10,705,572	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)	10,705,572	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)	7,947,377	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	18,652,949	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	1,488,105	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	585,012	51
52	Total Program excludable cost (sum of lines 50 and 51)	2,073,117	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	16,579,832	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

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-3025

WORKSHEET D-1
PARTS III & IV

Check Applicable Boxes:	[ ] Title V - I/P	[XX] Hospital	[ ] SUB (Other)	[ ] ICF/IID	[XX] PPS
	[XX] Title XVIII, Part A	[ ] IPF	[ ] SNF		[ ] TEFRA
	[ ] Title XIX - I/P	[ ] IRF	[ ] NF		[ ] 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)					499.63	88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-3025

WORKSHEET D-1
PART I

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	29,698	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	29,698	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.	1,427	3
4	Semi-private room days (excluding swing-bed private room days)	28,271	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)	398	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	14,836,219	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	14,836,219	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)	27,935,132	28
29	Private room charges (excluding swing-bed charges)	1,376,342	29
30	Semi-private room charges (excluding swing-bed charges)	26,558,790	30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.531095	31
32	Average private room per diem charge (line 29 ÷ line 3)	964.50	32
33	Average semi-private room per diem charge (line 30 ÷ line 4)	939.44	33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)	25.06	34
35	Average per diem private room cost differential (line 34 x line 31)	13.31	35
36	Private room cost differential adjustment (line 3 x line 35)	18,993	36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	14,817,226	37

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

COMPUTATION OF INPATIENT OPERATING COST — COMPONENT CCN: 15-3025 — WORKSHEET D-1 PART II

Check Applicable Boxes:
[ ] Title V - I/P [XX] Hospital [ ] SUB (Other) [ ] PPS
[ ] Title XVIII, Part A [ ] IPF [ ] TEFRA
[XX] Title XIX - I/P [ ] IRF [XX] 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)	498.93	38
39	Program general inpatient routine service cost (line 9 x line 38)	198,574	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)	198,574	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)	142,282	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	340,856	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	27,641	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	10,966	51
52	Total Program excludable cost (sum of lines 50 and 51)	38,607	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 etner 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

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-3025

WORKSHEET D-1
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

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

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT — COMPONENT CCN: 15-3025 — WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		20,138,342		30
	ANCILLARY SERVICE COST CENTERS				
54	Radiology-Diagnostic	0.803524	186,012	149,465	54
54.01	RADIOLOGY-SUA	0.468633	68,038	31,885	54.01
60	Laboratory	0.340542	1,663,098	566,355	60
60.01	LAB SUA				60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.382152	1,671,201	638,653	65
66	Physical Therapy	0.355228	5,294,264	1,880,671	66
67	Occupational Therapy	0.353484	5,480,655	1,937,324	67
68	Speech Pathology	0.355249	1,913,221	679,670	68
71	Medical Supplies Charged to Patients	0.282252	1,588,865	448,460	71
73	Drugs Charged to Patients	0.238828	5,953,696	1,421,909	73
76	OTHER ANCILLARY				76
76.01	SPECIAL PROCEDURES	0.612844	286,012	175,281	76.01
76.02	SPECIAL PROCEDURES SUA	0.124763	141,898	17,704	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)		24,246,960	7,947,377	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		24,246,960		202

(A) Worksheet A line numbers

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT — COMPONENT CCN: 15-3025 — WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	(A)
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		376,003		30
	ANCILLARY SERVICE COST CENTERS				
54	Radiology-Diagnostic	0.803524	1,563	1,256	54
54.01	RADIOLOGY-SUA	0.468633	629	295	54.01
60	Laboratory	0.340542	34,869	11,874	60
60.01	LAB SUA				60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.382152	14,679	5,610	65
66	Physical Therapy	0.355228	106,678	37,895	66
67	Occupational Therapy	0.353484	110,688	39,126	67
68	Speech Pathology	0.355249	23,659	8,405	68
71	Medical Supplies Charged to Patients	0.282252	31,764	8,965	71
73	Drugs Charged to Patients	0.238828	113,347	27,070	73
76	OTHER ANCILLARY				76
76.01	SPECIAL PROCEDURES	0.612844	2,646	1,622	76.01
76.02	SPECIAL PROCEDURES SUA	0.124763	1,313	164	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)		441,835	142,282	200
201	Less PBP Clinic Laboratory Services Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		441,835		202

(A) Worksheet A line numbers

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

CALCULATION OF REIMBURSEMENT SETTLEMENT — COMPONENT CCN: 15-3025 — WORKSHEET E PART B

Check applicable box: [XX] Hospital [ ] IPF [ ] IRF [ ] SUB (Other) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under OPPS (see instructions)	577			2
3	OPPS payments	213			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)	213			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)	43			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)				26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	170			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)	170			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	170			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)	170			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)	170			40
40.01	Sequestration adjustment (see instructions)	3			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	167			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)				43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED — COMPONENT CCN: 15-3025 — WORKSHEET E-1 PART I

Check Applicable Boxes: [XX] Hospital [ ] SUB (Other) [ ] IPF [ ] SNF [ ] IRF [ ] Swing Bed SNF

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider			[redacted]	31,150,147	[redacted]	167	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero			[redacted]		[redacted]		2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)		.01					3.01
			.02					3.02
		Program	.03					3.03
		to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.11	04/06/2018	18,357			3.11
			.12	07/27/2018	14,331			3.12
			.50					3.50
			.51					3.51
		Provider	.52					3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99	[redacted]	32,688	[redacted]		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)			[redacted]	31,182,835	[redacted]	167	4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)		.01					5.01
			.02					5.02
		Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99	[redacted]		[redacted]		5.99
6	Determined net settlement amount (balance due) based on the cost report (1)		.01					6.01
			.02					6.02
7	Total Medicare program liability (see instructions)			[redacted]		[redacted]		7
8	Name of Contractor			Contractor Number		NPR Date (Month/Day/Year)		8

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

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

CALCULATION OF REIMBURSEMENT SETTLEMENT — COMPONENT CCN: 15-3025 — WORKSHEET E-3 PART III

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

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

		1	1.01	
1	Net Federal PPS payment (see instructions)	30,984,279		1
2	Medicare SSI ratio (IRF PPS only) (see instructions)	0.043500		2
3	Inpatient Rehabilitation LIP payments (see instructions)	1,412,883		3
4	Outlier payments	7,310		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)	81.364384		10
11	Teaching Adjustment Factor (see instructions)			11
12	Teaching Adjustment (see instructions)			12
13	Total PPS Payment (see instructions)	32,404,472		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)	32,404,472		17
18	Primary payer payments	11,987		18
19	Subtotal (line 17 less line 18)	32,392,485		19
20	Deductibles	587,972		20
21	Subtotal (line 19 minus line 20)	31,804,513		21
22	Coinsurance	230,396		22
23	Subtotal (line 21 minus line 22)	31,574,117		23
24	Allowable bad debts (exclude bad debts for professional services) (see instructions)	256,443		24
25	Adjusted reimbursable bad debts (see instructions)	166,688		25
26	Allowable bad debts for dual eligible beneficiaries (see instructions)	147,316		26
27	Subtotal (sum of lines 23 and 25)	31,740,805		27
28	Direct graduate medical education payments (from Wkst. E-4, line 49) (For free standing IRF only)			28
29	Other pass through costs (see instructions)			29
30	Outlier payments reconciliation			30
31	Other adjustments (specify) (see instructions)			31
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			31.50
32	Total amount payable to the provider (see instructions)	31,740,805		32
32.01	Sequestration adjustment (see instructions)	634,816		32.01
32.02	Demonstration payment adjustment amount after sequestration			32.02
33	Interim payments	31,182,835		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)	-76,846		35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	983,480		36

TO BE COMPLETED BY CONTRACTOR

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

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

CALCULATION OF REIMBURSEMENT SETTLEMENT — COMPONENT CCN: 15-3025 — WORKSHEET E-3 PART VII

Check Applicable Boxes:
[ ] Title V [XX] Title XIX
[XX] Hospital [ ] SUB (Other) [ ] SNF
[ ] NF [ ] ICF/IID
[ ] PPS [ ] TEFRA [XX] Other

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

		INPATIENT TITLE V OR TITLE XIX	OUTPATIENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	340,856		1
2	Medical and other services		15,263	2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	340,856	15,263	4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	340,856	15,263	7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges	376,003		8
9	Ancillary service charges	441,835	43,078	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)	817,838	43,078	12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahrge 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)	817,838	43,078	16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	476,982	27,815	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)	340,856	15,263	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)	340,856	15,263	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)	340,856	15,263	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)	340,856	15,263	36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	340,856	15,263	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)	340,856	15,263	40
41	Interim payments	214,317	6,309	41
42	Balance due provider/program (line 40 minus line 41)	126,539	8,954	42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

BALANCE SHEET

WORKSHEET G

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

	Assets	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	14,177,748				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	11,197,412				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-3,286,871				6
7	Inventory	49,358				7
8	Prepaid expenses	42,033				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	22,179,680				11
	FIXED ASSETS					
12	Land	1,600,058				12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings					15
16	Accumulated depreciation	-52,862				16
17	Leasehold improvements	5,809,784				17
18	Accumulated depreciation	-4,319,019				18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	4,309,371				23
24	Accumulated depreciation	-3,147,359				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)	4,199,973				30
	OTHER ASSETS					
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	21,648,753				34
35	Total other assets (sum of lines 31-34)	21,648,753				35
36	Total assets (sum of lines 11, 30 and 35)	48,028,406				36

	Liabilities and Fund Balances	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable	2,095,178				37
38	Salaries, wages and fees payable	1,273,429				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	218,244				44
45	Total current liabilities (sum of lines 37 thru 44)	3,586,851				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	12,436,414				49
50	Total long term liabilities (sum of lines 46 thru 49)	12,436,414				50
51	Total liabilities (sum of lines 45 and 50)	16,023,265				51
	CAPITAL ACCOUNTS					
52	General fund balance	32,005,141				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)	32,005,141				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	48,028,406				60

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

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		22,216,265			1
2	Net income (loss) (from Worksheet G-3, line 29)		13,501,899			2
3	Total (sum of line 1 and line 2)		35,718,164			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)		35,718,164			11
12	Deductions (debit adjustments) (specify)					12
13	DISTRIBUTIONS	3,713,024				13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)		3,713,024			18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		32,005,140			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	Fund balances at beginning of period					1
2	Net income (loss) (from Worksheet G-3, line 29)					2
3	Total (sum of line 1 and line 2)					3
4	Additions (credit adjustments) (specify)					4
5						5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)					11
12	Deductions (debit adjustments) (specify)					12
13	DISTRIBUTIONS					13
14						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

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

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	28,166,882		28,166,882	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)	28,166,882		28,166,882	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)	28,166,882		28,166,882	17
18	Ancillary services	33,459,815	2,404,662	35,864,477	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)	61,626,697	2,404,662	64,031,359	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		28,282,527	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)		28,282,527	43

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2018 To: 12/31/2018	Run Date: 05/09/2019 Run Time: 10:18 Version: 2018.12 (03/07/2019)

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	64,031,359	1
2	Less contractual allowances and discounts on patients' accounts	22,483,764	2
3	Net patient revenues (line 1 minus line 2)	41,547,595	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	28,282,527	4
5	Net income from service to patients (line 3 minus line 4)	13,265,068	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments	113,637	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts	87	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	25,324	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	-2	20
21	Rental of vending machines	2,048	21
22	Rental of hospital space	92,842	22
23	Governmental appropriations		23
24	Other (specify)	2,895	24
25	Total other income (sum of lines 6-24)	236,831	25
26	Total (line 5 plus line 25)	13,501,899	26
29	Net income (or loss) for the period (line 26 minus line 28)	13,501,899	29

Addendum to S-2, Part II Questionnaire
Question 3

Related Organization: Deaconess Hospital

Provider #: 15-3025

FYE: 12/31/2017

Description of Transaction:

HealthSouth Deaconess Rehab is in partnership with Deaconess Hospital who owns a 27.5% minority interest. All services received from Deaconess Hospital have been adjusted to Related Party's cost at Worksheet A-8-1.

Addendum to S-2, Part II Questionnaire
Question 3

Related Organization: Wage and Expense Transfers

Provider #: 15-3025

FYE: 12/31/2017

Description of Transaction:

HealthSouth subsidiaries may sometimes intercompany transfer wages and other expenses for employees and other services performed between facilities. Because of the nature of the transactions and method of accounting via an intercompany account, these expenses are recorded on the facilities' general ledger at cost.