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

#### HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

WORKSHEET S PARTS I, II & III

If this is an amended report enter the number of times the provider resubmitted the cost report				
· 0 <b>-</b> 9.				
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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:61ilEuisFfCF4NLmA5bH0 jeI.x0Bp738dO:E6yudxeabEh4rzVZ f2q50GlZfj06w65f

PI Encryption: 05/09/2019 10:18 BetYBvdlA0rpbcNP257OS110kUn:f0 g.Ptr0icJNgTDugV9RbE2c4hU6gyyE fY:70Hqtmn0:5Da. (Signed) Chief Financial Officer or Administrator of Provider(s)

SVP - REIMBURSEMENT

Title

05/09/2019 10:18

Date

PART III - SETTLEMENT SUMMARY

PARI	III - SETTLEMENT SUMMARY		The second secon				
			TITLE				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5 -	
l	HOSPITAL		-76,846			135,493	1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
Į .	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
5	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
3	NURSING FACILITY						8
)	HOME HEALTH AGENCY						9
0	HEALTH CLINIC - RHC			·			10
1	HEALTH CLINIC - FQHC					.,	11
2	OUTPATIENT REHABILITATION PROVIDER						12
00	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 Office, 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 corresponence 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.

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 IDENTIFICATION DATA

WORKSHEET S-2 PART I

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	Subprovider - IRF		i			l	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			<u> </u>	5
	Subprovider - (OTHER)		- E								6
	Swing Beds - SNF										7
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	Hospital-Based NF							L		<u> </u>	10
	Hospital-Based OLTC				3416 W				20.20 M	<b>60000</b>	11
	Hospital-Based HHA	· · · · · · · · · · · · · · · · · · ·									12
	Separately Certified ASC	·	·								13
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5	Hospital-Based Health Clinic - FQHC						SA				16
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_	yes or 'N' for no. Is this facility subject to 42	CFR8412.00(C)(2)(Fickle amendine	nt nospitati: in c	manin 2, cu	1 DVI for:	uen or 'N' for	no for the		<del>                                     </del>		<b>3</b>
i	Did this hospital receive interim uncompens	sted care payments for this cost repu	rung period / Enu	at in comm	11, 1 101	yes or in ioi	mo tot atc	N	N		22.0
10.5	portion of the cost reporting period occurring	prior to October 1. Enter in column	2 'Y' for yes of '	A. You ha rai	me borno	U of me cost	reporting period	1	^`		M
	occurring on or after October 1. (see instruct	ions)				-0 /		+	<del> </del>		<b>31</b>
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	portion of the cost reporting period on or after	er October 1.						<del> </del>	<del>-</del>	STREET CONTROL	668 B
	Did this hospital receive a geographic reclas	sification from urban to rural as a res	ult of the OMB s	tandards for	ban to rural as a result of the OMB standards for delineating statistical areas adopted by						
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	and or this for no for the portion of the cost re		ne cost repurung	neriod prio:	r to Octobe	ıl. Enkrm	ico:uman 24, 1¥, 140	N	N	א	22.0
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33 3 44 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	but not more than 499 beds (as counted in as Which method is used to determine Medical of discharge. Is the method of identifying the column 2, enter 'Y' for yes or 'N' for no.  If this provider is an IPPS hospital, enter the column 1, in-state Medicaid eligible unpaid Medicaid paid days in column 3, out-of-state column 3, out-of-state column 4, Medicaid thMO paid and eligible outer Medicaid days in column 6.  If this provider is an IRF, enter the in-state 1 state Medicaid days in column 6.  If this provider is an IRF, enter the in-state 1 state Medicaid eligible unpaid days in column 3, out-of-state Medicaid eligible unpaid. He was a state of the medicaid eligible on the medicaid eligible in the state of the state	porting period occurring on or after- cordance with 42 CFR 41(2.103)? E d days on lines 24 and/or 25 below? days in this cost reporting period di in-state Medicaid paid days in days in column 2, out-of-state of the dicaid eligible unpaid days in but unpaid days in column 3, and dedicaid paid days in column 1, in- ur 2, out-of-state Medicaid days in but unpaid days in column 1, in- ur 2, out-of-state Medicaid days in old days in column 4, Medicaid olumn 3.  In (not wage) status at the beginning, in (not wage) status at the cad of the- licable, enter the offective date of the unter the number of periods SCH stat of SCH status. Subscript line 36 for DH), enter the number of periods MI e for the MDH transitional payment	October 1. (see in one in column 3. In column 1, cate ifferent from the in-State Medicaid paid days  423  423  of the cost reporting pee geographic recitus in effect in the intumber of period of status in effect in the intumber of period of status is in effect in the intumber of period of status in effect in the intumber of period of status in effect in the intumber of period of status in effect in the intumber of period of status in effect in the intumber of period of status in effect in the intumber of period of status in effect in the intumber of period of status in effect in the intumber of period of status in effect in the intumber of period of status in effect in the intumber of period of status in effect in the intumber of period of status in effect in the intumber of period of status in effect in the intumber of period of status in effect in the intumber of period of status in effect in the intumber of period of status in effect in the intumber o	In-Sta Medica in grant of the control of the contro	Does this con the price of the	r I. Fanter in hospital comb.  n. 2 if census or cost report strof-State dedicaid anid days  246	column 2, 3-3 din at least 100 days, or 3 if date ing period? In Out-of-State Medicald cligible unpaid days 4	Medicai HMO da	N d h	Other dedicald days	24 25 26 27 35 36
3 3 4 4 5 5 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6	but not more than 499 beds (as counted in as Which method is used to determine Medical of discharge. Is the method of identifying the column 2, enter 'Y' for yes or 'N' for no.  If this provider is an IPPS hospital, enter the calumn 1, in-state Medicaid eligible unpaid Medicaid paid days in column 3, out-of-state column 4, Medicaid HMO paid and eligible often Medicaid days in column 6.  If this provider is an IRF, enter the in-state I state Medicaid days in column 6.  If this provider is an IRF, enter the in-state I state Medicaid days in column 6.  Enter your standard geographic classificatio column 1, "I' for urban or '2' for rural.  Enter your standard geographic classificatio column 1, "I' for urban or '2' for rural. If specolumn 2.  If this is a sole community hospital (SCH), period.  Enter applicable beginning and ending date: one and enter subsequent dates.  If this is a Medicare dependent hospital (Mirrosoftine period.	porting period occurring on or after coordance with 42 CFR 412.1059? Ed days on lines 24 and/or 25 below? days in this cost reporting period di days in this cost reporting period di days in column 2, out-of-state and column 2, out-of-state and column 3, out-of-state and column 4, out-of-state and column 4, out-of-state bedietaid paid days in column 5, and dedicaid paid days in column 1, in-this column 4, out-of-state Medicaid days in column 6, out-of-state Medicaid days in column 6, out-of-state Medicaid days in column 6.  In (not wage) status at the beginning, on (not wage) status at the col of the licable, enter the affective date of the column 5.  In (SCH status, Subscript line 36 for SCH status, Subscript line 36 for the MDH transitional payment of the substrated for the MDH transitional payment of the substrated for the MDH transitional payment of the substrated for the substrated for the substrated for the MDH transitional payment of the substrated for the substr	October 1. (see in often in column 3. In column 1, cate ifferent from the in-State Medicaid paid days  423  423  of the cost reporting pee geographic recitus in effect in the runnber of perio DH status is in eff in accordance wi	In-Sta Medica in grant of the control of the contro	327  Enter In	r I. Fanter in hospital comb.  n. 2 if census or cost report strof-State dedicaid anid days  246	column 2, 3-3 din at least 100 days, or 3 if date ing period? In Out-of-State Medicald cligible unpaid days 4	Medicai HMO da	N d h	Other dedicald days	23 24 25 25 26 27 35 36 37

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#### HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2 PART I

					2	<u> </u>
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 C column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b	K5/(1) or (11) t miner	INCOMMENDED THE	N	N	39
10	yes or N' for no. (see instructions)  Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharge the state of the thac program reduction adjustment?	ges prior to October	I. Enter 'Y' for yes	N	N	40
	or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	v	XVIII	X	IX	
	a company	ì	2		3	
	tive Payment System (PPS)-Capital  Does this facility qualify and receive capital payment for dispreportionate share in accordance with 42 CFR \$412.320?	N	N	1	٧	45
15 16	Does this facility claimly this receive Capital Instrument to Composition of the Compos	N .	N	1	N	46
	Is this a new hospital under 42 CFR \$412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N		N	47
47	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N		N	48
48	Is the facility discharging full reteral capital payment and the years.					
	ng Hospitals	1	2		3	1
<u>1 сасон</u> 56	T'y data a benefited involved in training residents in approved GME programs? Enter Y' for ves or N' for no.	N		- 10		56
57	If line 56 is yes, it this the first cost reporting pariod during which residents in approved GME programs transen at unit facility? Easter 'P' for yes or 'N' for no in column 1. if you'd residents start training in the first month of this cost reporting period? Enter 'P' for yes or 'N' for no in column 2. if column 2 is 'Y', complete Wkst. E-4. if column 1 is not reporting period? Enter 'P' for yes or 'N' for no in column 2. if column 2 is 'Y', complete Wkst. E-4. if column 1 is 'D', and the start of the s	N				57
58	2 is 'v, computer wast. D. Fait the a vy and vy the physicians' services ad defined in CMS Pub 15-1.  If line 56 is yes, did this facility elect cost reimbursement for physicians' services ad defined in CMS Pub 15-1.  chapter 21. section 21487 If yes, complete Wkst. D-5.	N				58
	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. 1.	. N				59
59		NAHE 413.85 Y/N 1	Worksheet A Line # 2	Quali Criter	Through fication ia Code 3	
60	Are you claiming nursing and allied health education (NAHE) costs for any program(s) that meet the criteria under 42 CFR 413.857 (see instructions)	ห				60
	CFR 413.857 (See insulactions)	Y/N	IME 4	Direc	t GME 5	
61	Did your hospital receive FIE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.)(see instructions)	N	<u> </u>	<u> </u>		61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and					61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and					61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining					61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost	200000		1		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care			<u> </u>		61.05
61.06	Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary cure 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 FTB 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 th	e IME FTE unweighted count. Enter in column 4, the orrect	IMP LIE mweigne	0 COMIL		
	 Early in Commer 2 are program code, came at voterne			Unweighted	Unweighted	
ļ		Program Name	Program Code	IME	Direct GME	
- 1		1108.4		FTE Count	FTE Count	
- 1	 	1	2	1 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 Pr	ovisions Affecting the Health Resources and Services Administration (HRSA)		
-	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital		62
	reserved HRSA PCRE funding (see instructions)	· <del>-</del>	(0.0)
62.01	Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost		62.01
	reporting period of HRSA THC program. (see instructions)		<u> </u>
Tarchin	g Hospitals that Claim Residents in Nonprovider Settings		
	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 'Y' for yes or 'N' for	N	63
63	no. If yes, complete lines 64 through 67. (see instructions)		

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	TAL AND HOSPITAL HEALTH CA	RE COMPLEX IDENTIFICATION DATA .			,	WORKSHE PART	
Section legins	on or after July 1, 2009 and before June	ents in Nonprovider SettingsThis base year is your cost rep 30, 2010.		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
4	Enter in column 1, if line 63 is yes, or	your facility trained residents in the base year period, the nu utable to rotations occurring in all nonprovider settings. Ente are resident FTEs that trained in your hospital. Enter in colur	er in column z the				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. Ent 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 FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 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 FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings.						
	resident FTEs that trained in your hos	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
	<del>                                     </del>	1	. 2	3_	4		
55						Ratio	65
ection	Rer July 1, 2016	sidents in Nonprovider Settings-Effective for cost reporting		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	(col. 1/ col. ( + col. 2))	
56		veighted non-primary care resident FTEs attributable to rotat 12 the number of unweighted non-primary care resident FTE of (column 1 divided by (column 1 + column 2)). (see instruc	s mai trained in your				66
	Enter in lines 67-67-49, column 1 the rotations occurring in all non-provide (column 3 divided by (column 3 + co	program name. Enter in column 2 the program code. Enter it is settings. Enter in column 4 the number of unweighted printlumn 4)). (see instructions)	n column 3 the numb tary care resident FTI	er of unweighted prin Es that trained in your	nary care FTE residen hospital. Enter in col	is attributable to umn 5 the ratio of Ratio	
	, command and a second	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	(col. 3/ col. 3 + col. 4))	
		i i i i i i i i i i i i i i i i i i i	2	3	4	5	
67			2	3	4	5	67
			2	3		3	67
Inpatie		1 c Facility (IPF), or does it contain an IPF subprovider? Enter		1	2	3	70
67 Inpatie 70	Is this facility an Inpatient Psychiatri no.  If line 70 is yes: Column 1: Did the facility have a tea	ching program in the most recent cost report filed on or befo	r 'Y' for yes or 'N' for	1		3	200
Inpatie 70	Is this facility an Inpatient Psychiatri no.  If line 70 is yes: Column 1: Did the facility have a tea 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train resis	ching program in the most recent cost report filed on or before	r'Y' for yes or 'N' for ore November 15,	1		3	70
Inpatie 70	Is this facility an Inpatient Psychiatri no.  If line 70 is yes: Column 1: Did the facility have a tea 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train resis	ching program in the most recent cost report filed on or before	r'Y' for yes or 'N' for ore November 15,	1		3	70
Inpatie 70 71	Is this facility an Inpatient Psychiatri no.  If line 70 is yes: Column 1: Did the facility have a tee 2004? Enter "V" for yes or "N" for no. Column 2: Did this facility train resi §412.424(d)(1)(ii)(D)? Enter "V" for Column 3: If column 2 is Y, indicate	ching program in the most recent cost report filed on or before the file of the control of the control of the control of the cost of the c	"Y" for yes or 'N' for ore November 15,	I N		3	70
Inpatie 70 71	Is this facility an Inpatient Psychiatrino.  If line 70 is yes: Column 1: Did the facility have a tea 2004? Enter 'N' for yes or 'N' for no. Column 2: Did this facility train resi- 412.424(4)(1)(ii)(2)(2) Father 'N' for Column 3: If column 2 is Y, indicate ent Rehabilitation Facility PPS Is this facility an Inpatient Rehabilit for no.	ching program in the most recent cost report filed on or before	"Y" for yes or 'N' for ore November 15,	I N		3	70
Inpatie 70 71 Inpatie	Is this facility an Inpatient Psychiatrino,  If line 70 is yes: Column 1: Did the facility have a tee 20047 Enter "Y for yes or 'N' for no. Column 2: Did this facility train resk §412.424(dyl1)(ilii)(D)? Enter 'Y' for Column 3: If column 2 is Y, Indicate ent Rehabilitation Facility PPS Is this facility an Inpatient Rehabilit for no. If line 75 is yes: Column 1: Did the facility have a ter. November 15, 20042 Enter 'Y' for yc Column 2: Did this facility train resi	ching program in the most recent cost report filed on or before the state of Nr for no.  which program year began during this cost reporting period ution Facility (IRF), or does it contain an IRF subprovider? Entering program in the most recent cost reporting period coding or Nr for no. dents in a new teaching program in a coordance with 42 CFR	"Y" for yes or 'N' for ore November 15, (see instructions)	I N		3	70 71 75
Inpatie 70 71 Inpatie 75	Is this facility an Inpatient Psychiatrino.  If line 70 is yes: Column 1: Did the facility have a tea 20047 Enter 'N' for yes or 'N' for no. Column 2: Did this facility train resi- 4412.424(4)(1)(ii)(D) Enter 'N' for Column 3: If column 2 is Y, indicate ent Rehabilitation Facility PPS Is this facility an Inpatient Rehabilit for no. If line 75 is yes: Column 1: Did the facility have a tea November 15, 20042 Enter 'N' for Column 2: Did this facility train resi- \$412.424(3)(1)(ii)(D)? Enter 'N' for Column 3: If column 2 is Y, indicate	ching program in the most recent cost report filed on or before the state of the st	"Y" for yes or 'N' for ore November 15, (see instructions)	I N		3	70
Inpatie 70 71 Inpatie 75 76	Is this facility an Inpatient Psychiatrino.  If line 70 is yes: Column 1: Did the facility have a tea 20047 Enter 'N' for yes or 'N' for no. Column 2: Did this facility train resis 412.244(64)(18)(19)(19) Enter 'N' for Column 3: If column 2 is Y, indicate ent Rehabilitation Facility PPS Is this facility an Inpatient Rehabilit for no.  If line 75 is yes: Column 1: Did the facility have a ter November 15, 2004? Enter 'N' for y Column 2: Did this facility train resis 412.244(64)(16)(19)(19) Enter 'N' for Column 3: If column 2 is Y, indicate Tenn Care Hospital PPS	ching program in the most recent cost report filed on or beforders in a new teaching program in accordance with 42 CFR yes and 'N' for no.  which program year began during this cost reporting period tition Facility (IRF), or does it contain an IRF subprovider? Enthing program in the most recent cost reporting period ending so o'N' for no.  dents in a new teaching program in accordance with 42 CFR yes and 'N' for no.  which program year began during this cost reporting period.	r 'Y' for yes or 'N' for ore November 15,  (see instructions)  Enter 'Y' for yes or 'N' and on or before  1. (see instructions)	I N	2 2 2	3	70 71 75
Inpatie 70 71 Inpatie 75	Is this facility an Inpatient Psychiatrino.  If line 70 is yes: Column 1: Did the facility have a tea 20047 Enter 'N' for yes or 'N' for no. Column 2: Did this facility train resis 412.244(64)(18)(19)(19) Enter 'N' for Column 3: If column 2 is Y, indicate ent Rehabilitation Facility PPS Is this facility an Inpatient Rehabilit for no.  If line 75 is yes: Column 1: Did the facility have a ter November 15, 2004? Enter 'N' for y Column 2: Did this facility train resis 412.244(64)(16)(19)(19) Enter 'N' for Column 3: If column 2 is Y, indicate Tenn Care Hospital PPS	ching program in the most recent cost report filed on or before the state of Nr for no.  which program year began during this cost reporting period ution Facility (IRF), or does it contain an IRF subprovider? Entering program in the most recent cost reporting period coding or Nr for no. dents in a new teaching program in a coordance with 42 CFR	r 'Y' for yes or 'N' for ore November 15,  (see instructions)  Enter 'Y' for yes or 'N' and on or before  1. (see instructions)	I N	2.	3	70 71 75
Inpatie 70 71 Impatie 75 76 Long 80 81 TEFR	Is this facility an Inpatient Psychiatrino.  If line 70 is yes: Column 1: Did the facility have a tee 20047 Enter 'V' for yes or 'N' for no. Column 2: Did this facility train resk \$412.424(6)(1)(ii)(D) Enter 'V' for Column 3: If column 2 is Y, indicate ent Rehabilitation Facility PPS Is this facility an Inpatient Rehabilit for no.  If line 75 is yes: Column 1: Did the facility have a ter. November 15, 20042 Enter 'V' for ye Column 2: Did this facility train resk \$412.424(6)(1)(ii)(D) Enter 'V' for Column 3: If column 2 is Y, indicate Term Care Hospital PPS Is this a Long Term Care Hospital (I Is this a LTCH co-located within an	ching program in the most recent cost report filed on or befordents in a new teaching program in accordance with 42 CFR yes and 'N' for no.  which program year began during this cost reporting period attion Facility (IRF), or does it contain an IRF subprovider? Eaching program in the most recent cost reporting period ending so or 'N' for no.  dents in a new teaching program in accordance with 42 CFR yes and 'N' for no.  which program year began during this cost reporting period continued to the cost reporting period continued to the cost reporting period continued to the cost reporting period? En other Nospital for part or all of the cost reporting period? En other Nospital for part or all of the cost reporting period? En	r 'Y' for yes or 'N' for ore November 15,  (see instructions)  Enter 'Y' for yes or 'N' and on or before  1. (see instructions)	I N	2 2 2	3	70 71 75
Inpatie 70 71 Inpatie 75 76 Long 80 81	Is this facility an Inpatient Psychiatrino.  If line 70 is yes: Column 1: Did the facility have a tea 20047 Enter 'N' for yes or 'N' for no. Column 2: Did this facility train resk 412.2424(6)(18)(19)(D) Enter 'N' for Column 3: If column 2 is Y, indicate ent Rehabilitation Facility PPS Is this facility an Inpatient Rehabilit for no.  If line 75 is yes: Column 1: Did the facility have a ter November 15, 2004? Enter 'N' for ye Column 2: Did this facility train resk 412.2424(6)(16)(19)(D) Enter 'N' for Column 3: If column 2 is Y, indicate Term Care Hospital PPS Is this a LTCH co-located within an Is the Providers Is this a new hospital under 42 CEN.	ching program in the most recent cost report filed on or beforders in a new teaching program in accordance with 42 CFR yes and 'N' for no.  which program year began during this cost reporting period tition Facility (IRF), or does it contain an IRF subprovider? Enthing program in the most recent cost reporting period ending so o'N' for no.  dents in a new teaching program in accordance with 42 CFR yes and 'N' for no.  which program year began during this cost reporting period.	r 'Y' for yes or 'N' for yes November 15,  (see instructions)  Enter 'Y' for yes or 'N' and on or before  i. (see instructions)	I N N N N N N N N N N N N N N N N N N N	2 2 1 1 1 1 1 1 1 1 1 1 1	3	70 71 75

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2 PART I

			XIX	Τ
		Y	2	
itle V au	d XIX Services		- Ý	90
0	The state of the state of the VEV important hospital consider. Finish Vy for use of NY for no in applicable collish.	N		
	ls 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	N	N	91
i		Face Control of the C	N	92
2	applicable column.  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	N	93
3	Does this facility operate an ICE/III) facility for purposes of title V and XIX? Enter 1 for yes or 11 for its in its applicable contains.			94
4	Dage title V or title X X reduce capital cost/ Enter Y for yes of fx for he in the applicable contain.	И	. М	95
5	If line 94 is 'V' enter the reduction percentage in the applicable column.		<del></del>	
6	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
17	tage of the transfer of the land and the configuration of the configurat			97
18	Does title V or XIX follow Medicare (fille XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, cot. 257	Y	Y	98
	Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.  Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter 'Y' for yes or 'N' for no in column	Y	Y	98.01
10.8	1 for title V, and in column 2 for title XIX.  Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 897 Enter 'Y' for	Y	y	98.02
8.02	yes of N for no in column 1 for title V, and in column 2 for title XIX.  Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter		N	98.03
8.03		N		
8,04	Does title V or XIX follow Medicare (lifle XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter 17 to yes of N 101 no	N	И	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. 1, col. 47 Enter Y for yes or IN	Y	Y	98.05
	for no in column 1 for title V, and in column 2 for title XIX.  Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pks. 1 through IV? Enter 'Y' for yes or 'N' for no in	Y	Y	98.06
98.06	column 1 for title V, and in column 2 for title XIX.			
Rural Pr	oviders	I	2	105
05	- art 1 111 - 110 01110			106
106				8250 100
	If this facility qualifies as a CAH, is it eligible for cost reimbursement for leak training programs / Emer's for yes and N for no me			107
107	column 1. (see instructions)  If yes, the GME elinination is not made on Wkst. B. Pt. I, coi. 25 and the program is cost reimbursed. If yes, complete Wkst, D-2. Pt. II.			108
108	If yes, the CIME elithibation is not finded on Wast D. 1. 1. 100, 25 and the post of the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'V" for yes or 'N' for no.  1s this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'V" for yes or 'N' for no.  Physical Occupational	N Speech	Respiratory	and 100
	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by	, , , , , , , , , , , , , , , , , , ,		109
109	outside supplier? Enter 'Y' for yes or 'N' for each therapy.		L	1.07
	C. V. M	nariod? If yar	1	
	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting	henon n kes'	N	110
110	compolete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.		2	
	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this	1	į.	i
	1. 10 Years of for one of the column I If the recogne to column 1 is Y, chief the integration profit of the	1		111
111	FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for additional beds;	1	i	
	and/or 'C' for tele-healsh services.	l	L	
Miscelli	neous Cost Reporting Information			
	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			1
			1	
	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	!		115
113	hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers)			115
115	hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers)  based on the definition in CMS Pub. 15-J. chapter 22, section 2208.1.			
	hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term nospitals provincers) based on the definition in CMS Pub. 15-1, chapter 22, section 2208.1.  Label: Resilier described as a referral center? Enter V for yes or 'N' for no.	N		116
116	hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term nospirats provincers) based on the definition in CMS Pub. 15-1, chapter 22, section 2208.1.  Is this facility classified as a referral center? Enter 'Y' for yes, or 'N' for no.	Y		11 <u>6</u> 117
116 117	hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term nospirats providers) based on the definition in CMS Pub. 15-1, chapter 22, section 2208.1.  Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.  Is this facility legality required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.  It the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	Y 1	# 10 mm	116 117
116 117	hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term nospitals providers) based on the definition in CMS Pub. 15-1. chapter 22, section 2208.1.  Is this facility classified as a referral center? Enter 'N' for yes or 'N' for no.  Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.  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.  Premiums	Y 1 Paid Losses	Self Insurance	116 117 118
116 117 118	hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term nospirats providers) based on the definition in CMS Pub. 15-1, chapter 22, section 2208.1.  Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.  Is this facility legality required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.  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.  Premiums  7. 11.16	Y 1	Self Insurance	116 117
116 117	hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term nospirats providers) based on the definition in CMS Pub. 15-1, chapter 22, section 2208.1.  Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.  Is this facility legality required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.  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.  Premiums  7. 11.16	Y 1 Paid Losses 27,232	Self Insurance	116 117 118 118.0
116 117 118	hospital or '98' percent for long terms care (includes psychiatric, rehabilitation and long term nospirates provincers) based on the definition in CNS Pub. 15-1, chapter 22, section 2208.1.  15 this facility classified as a referral center? Enter "V for yes or "N" for no.  15 this facility legality required to carry malpractice insurance? Enter "V" for yes or "N" for no.  15 the facility legality required to carry malpractice insurance a claims-made of occurrence policy? Enter "V" for yes or "N" for no.  15 the malpractice insurance a claims-made of occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.  Premiums  1,116  Are malpractice premiums and paid losses:  7,1,16  Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit	Y 1 Paid Losses	Self Insurance	116 117 118
117	hospital or '98' percent for long terms care (includes psychiatric, rehabilitation and long term nospirates provincers) based on the definition in CNS Pub. 15-1, chapter 22, section 2208.1.  15 this facility classified as a referral center? Enter "V for yes or "N" for no.  15 this facility legality required to carry malpractice insurance? Enter "V" for yes or "N" for no.  15 the facility legality required to carry malpractice insurance a claims-made of occurrence policy? Enter "V" for yes or "N" for no.  15 the malpractice insurance a claims-made of occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.  Premiums  1,116  Are malpractice premiums and paid losses:  7,1,16  Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit	Y 1 Paid Losses 27,232	Self Insurance	116 117 118 118.0
116 117 118 118.01 118.02	hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term nospirals providers) based on the definition in CMS Pub. 15-1. Chapter 22, section 2208.1.  Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.  Is this facility legality required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.  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.  Premiums  List amounts of malpractice premiums and paid losses;  7.1.16  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.	Y 1 Paid Losses 27,232 N	Self Insurance	116 117 118 e
116 117 118 118.01	hospital or '98' percent for long terms care (includes psychiatric, rehabilitation and long term nospirates provincers) hased on the definition in CNS Pub. 15-1, chapter 22, section 2208.1.  Is this facility classified as a referral center? Enter 'V' for yes or 'N' for no.  Is this facility legally required to carry malpractice insurance? Enter 'V' for yes or 'N' for no.  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. It is the malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing one content and amounts contained therein.  Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA \$3121 and applicable amendments? (see	Y 1 Paid Losses 27,232		116 117 118 e 118.0
116 117 118 118.01 118.02	hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term nospirats provincers) based on the definition in CNS Pub. 15-1, chapter 22, section 2208.1.  Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.  Is this facility legality required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.  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. Premiums  7 remiums  7 1,116  Are malpractice premiums and paid losses:  7 1,116  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.  Is this a SCH or FACH that qualifies for the Outpattient 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 rule hospital with < 100 beds that qualifies for the Culturalter Hold	Y 1 Paid Losses 27,232 N		116 117 118 e 118.0 118.0
116 117 118 118.01 118.02	hospital or '98' percent for long terms care (includes psychiatric, rehabilitation and long term nospirats provincers) hased on the definition in CNR Pub. 15-1, chapter 22, section 2208.1.  Is this facility classified as a referral center? Enter 'V' for yes or 'N' for no.  Is this facility classified as a referral center? Enter 'V' for yes or 'N' for no.  Is the majoractice insurance a claims-made or occurrence policy? Enter 'I fithe policy is claim-made. Enter 2 if the policy is occurrence. I have been premiums and paid losses:  7.1.16  Are majoractice 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.  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 2 "Y for yes or 'N' for no. I shis 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.	Y 1 Paid Losses 27,232 N N N		116 117 118 e 118.0 120
116 117 118 118.01 118.02 120	hospital or '98' percent for long terms care (includes psychiatric, rehabilitation and long term nospirate provincers) hased on the definition in CNS Pub. 15-1, chapter 22, section 2208.1.  Is this facility classified as a referral center? Enter 'V' for yes or 'N' for no.  Is his facility legally required to carry malpractice insurance? Enter 'V' for yes or 'N' for no.  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.  Is the 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.  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 'V' 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 'V' for yes or 'N' for no.  Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'V' for yes or 'N' for no.  Did the Act 'Enter 'V' for yes or 'N' for no in column Does the cost transcription as take health care related taxes as defined in §3000(w)(3) of the Act? Enter 'V' for yes or 'N' for no in column	Y 1 Paid Losses 27,232 N		116 117 118 e 118.0 118.0
116 117 118 118.01 118.02 120	hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term nospirats provincers) based on the definition in CNS Pub. 15-1, chapter 22, section 2208.1.  Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.  Is this facility legality required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.  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. Premiums  7 remiums  7 1,116  Are malpractice premiums and paid losses:  7 1,116  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.  Is this a SCH or FACH that qualifies for the Outpattient 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 rule hospital with < 100 beds that qualifies for the Culturalter Hold	Y 1 Paid Losses 27,232 N N N		116 117 118 e 118.0 120
116 117 118 118.01 118.02 120 121	hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term nospitals providers) based on the definition in CNS Pub. 15-1, chapter 22, section 2208.1.  Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.  Is this facility legality required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.  Is the malpractice insurance a claims-made or occurrence policy? Enter 'I if the policy is claim-made. Enter 2 if the policy is occurrence.  Premiums  1. List amounts of malpractice premiums and paid losses:  7.1,116  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.  Is this a SCH or FACH 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.  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.	Y I Paid Losses 27,232 N N N N N		116 117 118 118.0 118.0 120 121
116 117 118 118.01 118.02 120 121 122	hospital or '98' percent for long terms care (includes psychiatric, rehabilitation and long term nospirals providers) hased on the definition in CNR Pub. 15-1, chapter 22, section 2208.1.  Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no. Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no. Is this facility legally required to carry malpractice insurance policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence. 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. It is amounts of malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supportings schedule listing onso centers and amounts contained therein.  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 2 'Y' for yes or 'N' for no. Is this a rural hospital with <100 best 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. Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no. Does the cost report contain state health care related taxes as defined in §300(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.	Y 1 Paid Losses 27,232 N N N		116 117 118 9 118.0 120 121 122
116 117 118 118.01 118.02 120 121 122 Transpl	hospital or '98' percent for long terms care (includes psychiatric, rehabilitation and long term nospirats providers) based on the definition in CNS Pub. 15-1, chapter 22, section 2208.1.  Is this facility classified as a referral center? Enter 'W' for yes or 'N' for no.  Is this facility legally required to carry malpractice insurance. Enter 'V' for yes or 'N' for no.  Is this facility legally required to carry malpractice insurance and calman-made or occurrence policy? Enter 1 if the moliev is claim-made. Enter 2 if the policy is occurrence. Premiums  List amounts of malpractice premiums and paid losses:  7.1,116  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.  Is this a SOLO re EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'V' 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 'W' for yes or 'N' for no.  Did this facility incur and report costs for high cost implantable devices charged to nations? Enter 'V' for yes or 'N' for no.  Does the cost report contain state health care related taxes as defined in §1930(w)(3) of the Act? Enter 'V' 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.  Does this facility operate a transplant center? Enter 'V' for yes or 'N' for no in column 1 best qualities for the Column 2 the term in the province of the provin	Y I Paid Losses 27,232 N N N N N		116 117 118 118.0 118.0 120 121 122
116 117 118 118.01 118.02 120 121 122 Transpl 125 126	hospital or '98' percent for long terms care (includes psychiatric, rehabilitation and long term nospirals provincers) hased on the definition in CNB Pub. 15-1, chapter 22, section 2208.1.  Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.  Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.  Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.  Is the melapractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.  Is the melapractice premiums and paid losses:  71.116  Are multipractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing ong centers and amounts contained therein.  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.  Did this facility incur and report costs for high cost involuntable devices charged to nations? Enter 'Y' or yes or 'N' for no.  Does the cost report contain state health care related taxes as defined in §1903(w)(s) 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 laxes are included.  And Center Information  Does the cost little polerate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date in column 2.  If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date in column 2.	Y I Paid Losses 27,232 N N N N N		116 117 118 e 118.0 118.0 120 121 122 122 125 126 127
116 117 118 118.01 118.02 120 121 122 Transpl 125 126 127	hospital or '98' percent for long terms care (includes psychiatric, rehabilitation and long term nospirate provincers) hased on the definition in CNS Pub. 15-1, chapter 22, section 2208.1.  Is this facility classified as a referral center? Enter 'V' for yes or 'N' for no.  Is this facility legality required to carry malpractice insurance? Enter 'V' for yes or 'N' for no.  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.  List amounts of malpractice premiums and paid losses:  71,116  Are mulpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? 'It yes, submit supporting schedule listing cost centers and amounts contained therein.  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 'V' for yes or 'N' for no. Is this a varial hospital with <100 beds that qualifies for the Outpatient Hold Harmless provision in ACA \$3121 and applicable amendments? (see instructions). Enter in column 2 'V' for yes or 'N' for no.  Did (bis facility incur and report costs for high cost implantable devices charged to patients? Enter 'V' for yes or 'N' for no.  Does the cost report contains state health care related taxes as defined in §1000(w)(3) of the Act? Enter 'V' 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.  Does this facility operate a transplant conter? Enter 'V' for yes or 'N' for no. If we, enter certification date in column 1 and termination date in column 2.  If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date in column 2.	Y I Paid Losses 27,232 N N N N N		116 117 118 c 118.0 120 121 122 122 125 126 127 128
116 117 118 118.01 118.02 120 121 122 Transol 125 126 127 128	hospital or '98' percent for long terms care (includes psychiatric, rehabilitation and long term nospirate provincers) hased on the definition in CNS Pub. 15-1, chapter 22, section 2208.1.  Is this facility classified as a referral center? Enter 'V' for yes or 'N' for no.  Is this facility legality required to carry malpractice insurance? Enter 'V' for yes or 'N' for no.  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.  List amounts of malpractice premiums and paid losses:  71,116  Are mulpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? 'It yes, submit supporting schedule listing cost centers and amounts contained therein.  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 'V' for yes or 'N' for no. Is this a varial hospital with <100 beds that qualifies for the Outpatient Hold Harmless provision in ACA \$3121 and applicable amendments? (see instructions). Enter in column 2 'V' for yes or 'N' for no.  Did (bis facility incur and report costs for high cost implantable devices charged to patients? Enter 'V' for yes or 'N' for no.  Does the cost report contains state health care related taxes as defined in §1000(w)(3) of the Act? Enter 'V' 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.  Does this facility operate a transplant conter? Enter 'V' for yes or 'N' for no. If we, enter certification date in column 1 and termination date in column 2.  If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date in column 2.	Y I Paid Losses 27,232 N N N N N		116 117 118 e 118.0 118.0 120 121 122 122 125 126 127
116 117 118 118.01 118.02 120 121 122 Transpl 125 126 127 128 129	hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term nospitals providers) based on the definition in CNS Pub. 15-1, chapter 22, section 2208.1.  Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.  Is this facility legality required to carry malpractice insurance Poter 'Y' for yes or 'N' for no.  Is this facility legality required to carry malpractice insurance policy? Enter 'I' for yes or 'N' for no.  Is the malpractice insurance a claims-made or occurrence policy? Enter 'I fithe policy is claim-made. Enter 2 if the policy is occurrence.  Premiums  I this not	Y I Paid Losses 27,232 N N N N N		116 117 118 c 118.0 120 121 122 122 125 126 127 128
116 117 118 118.01 118.02 120 121 122 Transp 125 126	hospital or '98' percent for long terms care (includes psychiatric, rehabilitation and long term nospirals providers) based on the definition in CNS Pub. 15-1, chapter 22, section 2208.1.  Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no. Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no. Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no. Is this facility legally required to carry malpractice insurance policy? Enter 'I if the policy is claim-made. Enter 2 if the policy is occurrence. Is the malpractice premiums and paid losses;  Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supportings schedule listing ones centers and amounts contained therein.  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.  Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.  Does the cost report contain state health care related taxes as defined in §1000(w)?) 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.  ant Center Information  Does the facility operate a transplant center give refer the certification date in column 1 and termination date in column 2. If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date in column 2. If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date in column	Y I Paid Losses 27,232 N N N N N		116 117 118 118.0 118.0 120 121 122 125 126 127 128 129 130
116 117 118 118.01 118.02 120 121 122 Transpl 125 126 127 128 129 130	hospital or '98' percent for long terms care (includes psychiatric, rehabilitation and long term nospirats providers) based on the definition in CNS Pub. 15-1, chapter 22, section 2208.1.  Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.  Is this facility legally required to carry malpractice insurance. Enter 'Y' for yes or 'N' for no.  Is this facility legally required to carry malpractice insurance a claims-made or occurrence policy? Enter 1 if the molicy is claim-made. Enter 2 if the policy is occurrence. It is the malpractice premiums and paid losses:  7.1,116  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.  It is it is a SOF 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 round 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.  Did this facility incur and report costs for high cost implantable devices charged to nations? Enter 'Y' for yes or 'N' for no.  Does the cost report contain state health care related taxes as defined in §193(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.  And Center Information  Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no in column 1 and termination date in column 2.  If this is a Medicare certified leart transplant center enter the certification date in column 1 and termination date in column 2.  If this is a Medicare certified leart transplant center enter the certification date in column 1 and termination date in column 2.  If this is a Medicare certified leart transplant ce	Y I Paid Losses 27,232 N N N N N		116 117 118 118.6 118.0 120 121 122 125 126 127 128 129 130 131
116 117 118 118.01 120 121 122 Transpl 125 126 127 128 129 130	hospital or '98' percent for long terms care (includes psychiatric, rehabilitation and long term nospirals provincies) hased on the definition in CNR Pub. 15-1, chapter 22, section 2208.1.  Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.  Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.  Is this facility legally required to carry malpractice insurance? Enter 'Y for yes or 'N' for no.  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. It is the malpractice premiums and paid losses:  71.116  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 ones centers and amounts contained therein.  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 2 'Y' for yes or 'N' for no.  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 2 'Y' for yes or 'N' for no.  Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.  Does the cost report contains state health care related taxes as defined in §190(w)(3) of the Act? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', ester in column 2 the Worksheet A line number where these taxes are included.  and Center Information  Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date in column 2. If this is a Medicare certified bedrey transplant center enter the certification date in column 1 and termination date in column 2. If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date in column 2. If this is a Medicare ce	Y I Paid Losses 27,232 N N N N N		116 117 118.6 118.6 118.6 120 121 122 122 125 126 127 128 129 130 131
116 117 118 118.01 118.02 120 121 122 Transpl 125 126 127 128 129 130	hospital or '98' percent for long terms care (includes psychiatric, rehabilitation and long term nospirals providers) based on the definition in CNS Pub. 15-1, chapter 22, section 2208.1.  Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no. Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no. Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no. Is this facility legally required to carry malpractice insurance policy? Enter 'I if the policy is claim-made. Enter 2 if the policy is occurrence. Is the malpractice premiums and paid losses;  Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supportings schedule listing ones centers and amounts contained therein.  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.  Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.  Does the cost report contain state health care related taxes as defined in §1000(w)?) 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.  ant Center Information  Does the facility operate a transplant center give refer the certification date in column 1 and termination date in column 2. If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date in column 2. If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date in column	Y I Paid Losses 27,232 N N N N N		116 117 118 118.6 118.0 120 121 122 125 126 127 128 129 130 131

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2 PART I

All Providers	1	2	
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.	<del></del>		6			141
141	Name: ENCOMPASS HEALTH	Contractor's Name: PAL	METTO	Contractor's Number: 10111			1170
142		P.O. Box:					1112
143			ZIP Code: 35242		7/		144
144	4 unavided has administration of one to included in Worksheet A7				Υ		3177
	If costs for renal services are claimed on Wkst. A, line 74 are th	e costs for inpatient servi-	ces only? Enter 'Y' fo	or yes, or 'N' for no in	1		
145	Landard I				N	N	145
143	If column 1 is no, does the dialysis facility include Medicare uti	lization for this cost repo	rting period? Enter.	Y. for yes or M. for no in			1
	column 2.			1 ( Care C) (C)			1
146	Has the cost allocation methodology changed from the previous	ly filed cost report? Enter	LA, for her and M. B	or no in commin 1. (see CMS)	N		146
140	Pub. 15-2, chapter 40, §4020). If yes, enter the approval date (m	m/dd/yyyy) in column 2.					-1
					N		147
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'I	N' for no.			N N		142
148	Was there a change in the order of allocation? Enter 'Y' for yes	or N for no.			N N		149
140	Was there a change to the simplified cost finding method? Enter	r 'Y' for yes or 'N' for no.			.19	CALL THE STREET, STREE	SN 1-17

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

R §413.13)		Title.	XVIII			
		 Part A	Part B	Title V	Title XIX	
		 1	2	3	4	
5 Hospi		 N	N	N	N	155
	ovider - IPF	N	" N			156
<ol> <li>Subpr</li> <li>Subpr</li> </ol>	ovider - IRF	 N	N			157
Subpi	ovider - Other					
	ovtaer - Omer	 N	N			159
		 N	N			160
HHA			N			161
CMH			f			161.

Multican	pus		Learning States of the Company of th				
1 165	Is this hospital part of a multicampus hospital that has one or n	1 "					165
	different CBSAs? Enter 'Y' for yes or 'N' for no.  If line 165 is yes, for each campus, enter the name in column to	, county in column 1, state in col-	ımn 2, ZIP in column	3, CBSA in column	, FTE/campus in col	umn 5. (see	166
166	instructions)				CBSA	FTE/Campus	
	Name	County	State	ZIP Code	CBSA	r i Liveainpus	-
	0	1	2	] 3	4		

Health Iv	formation Technology (HIT) incentive in the American Recovery and Reinvestment Act		THE RESERVE THE PROPERTY OF TH	
147	Is this provider a meaningful user under \$1886(n)? Enter 'Y' for yes or 'N' for no.			10/
	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred			168
168	for the HIT assets. (see instructions)			
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under			168.01
	\$413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)			
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.			169
	(see instructions)  Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170
170	Telling 167 in 197, does this provides have now dove for individuals enrolled in section 1876 Medicare cost plans reported on West, S-3, Pt.			171
171	1, 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	N	0	
l	a lime 2, only of Entrol 1 to 1 per man 1 to 1 per			]

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 H

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		
rovider Organiz	ation and Operation provider changed ownership immediately prior to the beginning of the cost reporting period?	If you enter the				ü.
Has the	provider changed ownership immediately prior to the beginning of the cost reporting period.	st yes, enter the	N			Π,
date of t	he change in column 2, (see instructions)		Y/N	Date	V/I	
			1	2	3	
Has the	provider terminated participation in the Medicare program? If yes, enter in column 2 the dat	te of termination	N	<del>"</del>		2
				PRODUCTION OF THE PRODUCTION O		
3 chain be manager	outher in volument of 1 on inchessary or the volument of the contracts, with individuals of the ordine in business transactions, including management contracts, with individuals of the offices, drug or medical supply companies) that are related to the provider or its officers ment personnel, or members of the board of directors through ownership, control, or family 4 ships? (see instructions)	. meaicai suitt.	ห			3
			Y/N	Type	Date	1
				2	3	1-
Financial Data a	nd Reports	111.5	<u> </u>			i –
4 Audited	nd Reports  1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If  1. 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in columns. If no, see instructions.	mmi J. (See	Y	Α	02/27/2019	4
JISUUCI Aratha	cost report total expenses and total revenues different from those in the filed financial staten	nents? If yes,	N			5
	reconciliation.					25
1 Shount						т —
				Y/N	Y/N	+
Approved Educ	ational Activities			1	2	+
Cohore	1: Are costs claimed for nursing school?			N		6
6 Column	2: If yes, is the provider the legal operator of the program?			1	FATOMORPH FATOMOTONIA (CO.	7
3 1 1	to stringed for allied health programs? If yes see instructions.			N		
	the cost reporting	ng period?		N		8
	1 A 1 A C - Tuttome and Desidents in approved GME programs claimed on the current cost	report II ves, see	instructions.	N		9
				N		16
A no Cit	approved internance resident Owns program intraces of received in an Approved Teaching Program	n on Worksheet A?	If yes, see	N		2 LI
11 instruct					646,334,364	21
1 mande	10191				L	1-
Bad Debts					Y/N_	1,0
	rovider seeking reimbursement for bad debts? If yes, see instructions.				Y N	12
TOU'-	13 is one did the accordance had debt collection policy change during this cost reporting perio	od? If yes, submit o	ор <u>у.</u>			
14 If line	12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.				<u> </u>	14
14 II DIE	12 13 YES, HEID DENNIE LANGUAGES					-
Bed Compleme	nt .					1:
15 Did tot	al beds available change from the prior cost reporting period? If yes, see instructions.				N	1 1:
וטונטון כו	at both international contract with the contract of the contra					_
			щ A		Part B	+
		Y/N	Date	N/N	Date	┰
	Note	l	22	3	4	+
DE GD Decord F	e cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter	N	1	Y	03/04/2019	10
PS&R Report I		14				+
16 Was th				1		١.
16 Was th	d-through date of the PS&R Report used in columns 2 and 4. (see instructions)					1
16 Was th	d-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	03/04/2019	N		
16 Was the paid Was the 17 allocate	d-through date of the PS&R Report used in columns 2 and 4, (see histurctions) to e cost report prepared using the PS&R Report for totals and the provider's records for ion? If either column 1 or 1 is yes, enter the paid-through date in columns 2 and 4. (see	Y	03/04/2019	N		DHZ GA
16 Was the paid Was the later	d-through date of the PS&R Report used in columns 2 and 4, (see instructions) to cost report prepared using the PS&R Report for totals and the provider's records for ion? If culture column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see	Y	03/04/2019			
16 Was the paid Was the paid was the allocate instruction of the paid was the paid	d-through date of the PS&R Report used in columns 2 and 4, (see instructions) to except report prepared using the PS&R Report for totals and the provider's records for ion? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4, (see itions)  the PT's was ween adjustments made to PS&R Report data for additional claims that	Y	03/04/2019	N		1:
16 Was the paid Was the paid Was the allocate instruction 18 have better the paid was the paid w	d-through date of the PS&R Report used in columns 2 and 4, (see instructions) et cost report prepared using the PS&R Report for totals and the provider's records for ion? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see itions)  16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that een billed but are not included on the PS&R Report used to file the cost report? If yes, see		03/04/2019			1
16 Was the paid Was the allocate instructory of the laws by the laws by the laws to the la	d-through date of the PS&R Report used in columns 2 and 4, (see instructions) et cost report prepared using the PS&R Report for totals and the provider's records for lone? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see itions) for 17 is yes, were adjustments made to PS&R Report data for additional claims that each billed but are not included on the PS&R Report used to file the cost report? If yes, see	N	03/04/2019	N		
16 Was th the pai Was th allocat instruc If line have instruc	d-through date of the PS&R Report used in columns 2 and 4, (see instructions) et cost report prepared using the PS&R Report for totals and the provider's records for ion? If either column 1 or 3 is yes, cuter the paid-through date in columns 2 and 4. (see itions) do not 1 is yes, were adjustments made to PS&R Report data for additional claims that een billed but are not included on the PS&R Report used to file the cost report? If yes, see itions.  1 or 17 is yes, were adjustments made to PS&R Report data for corrections of other		03/04/2019			
16 Was the paid was the paid was the allocate instruction of the paid was been supported by the page of the page o	d-through date of the PS&R Report used in columns 2 and 4, (see instructions) to exact report prepared using the PS&R Report for totals and the provider's records for ion? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see itions) I for 17 is yes, were adjustments made to PS&R Report data for additional claims that can billed but are not included on the PS&R Report used to file the cost report? If yes, see tions.  16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other Psecular Information? If yes, see intructions.	N N	03/04/2019	N		1:
the pai Was th allocat instruc If line have instruc If line ps&R If line	d-through date of the PS&R Report used in columns 2 and 4, (see instructions) et cost report prepared using the PS&R Report for totals and the provider's records for ion? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see itions) If or 17 is yes, were adjustments made to PS&R Report data for additional claims that ear billed but are not included on the PS&R Report used to file the cost report? If yes, see itions.  16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other Report information? If yes, see instructions.	N	03/04/2019	N		
16 Was the paid Was the paid Was the allocated instruction of the paid was the second of the paid was the pai	d-through date of the PS&R Report used in columns 2 and 4, (see instructions) to exact report prepared using the PS&R Report for totals and the provider's records for ion? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see itions) I for 17 is yes, were adjustments made to PS&R Report data for additional claims that can billed but are not included on the PS&R Report used to file the cost report? If yes, see itions.  16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other Psecular formation?	N N	03/04/2019	N		1

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

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 unn/dd/yyyy format.

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

COMPLETED BY COST REIMBURSED AND TEXAN MOST TALLS OF AN ACCOUNT (CAROLINIA CONTRACT CAROLINIA CONTRACTARINIA CONTRACT CAROLINIA CONTRACT CAROLINIA CONTRACT CAROLINIA			
Capital Related Cost			22
. United at the second If was non-instructions			23
to the first deposition appeared the to appraisals made during the cost reporting period? If yes, see insudences.			24
Lack 133 www.laces and description leaves entered into during this cost reporting period? If yes, see instructions.			25
The state have been your capitalized leases entered into during the cost reporting period? If yes, see instructions.			
as 111 As the Case 2214 of DEER A acquired during the cost reporting period? If yes, see instructions.			26
26 Were assets supper to Sec. 2314 of Districts address the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.			
{Zi ] This do provide a supplier			1
Interest Expense			28
	N 10		1
Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fand) treated as a funded depreciation account and/or bond funds (Debt Service Reserve Fand) treated as a funded depreciation account and/or bond funds (Debt Service Reserve Fand) treated as a funded depreciation account and/or bond funds (Debt Service Reserve Fand) treated as a funded depreciation account and/or bond funds (Debt Service Reserve Fand) treated as a funded depreciation account and/or bond funds (Debt Service Reserve Fand) treated as a funded depreciation account and/or bond funds (Debt Service Reserve Fand) treated as a funded depreciation account and/or bond funds (Debt Service Reserve Fand) treated as a funded depreciation account and/or bond funds (Debt Service Reserve Fand) treated as a funded depreciation account and the funds (Debt Service Reserve Fand) treated as a funded depreciation account and the funds (Debt Service Reserve Fand) treated as a funded depreciation account and the funds (Debt Service Reserve Fand) treated as a funded depreciation account and the funds (Debt Service Reserve Fand) treated as a funded depreciation account and the funds (Debt Service Reserve Fand) treated as a funded depreciation account and the funds (Debt Service Reserve Fand) treated as a fundament and the funds (Debt Service Reserve Fand) and the fundament and t	ti Acs' acc		29
129			30
22 The existing dabt been sepleced prior to its scheduled maturity with new debt? If yes, see instructions,	******		31
30 Has existing their recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			
Purchased Services 15	es secinstructions.		32
Purchased Services  12 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If	rea, be o mean and and		33
Have changes of new agreements occurred at patient accounts an account of the second o			
Provider-Based Physicians			34
Provider-Based Physicians  4 Are services firmished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions,  4 Are services firmished at the provider facility under an arrangement with the provider-based physicians during the cost reporting per  1 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting per	iod? If yes, see		35
If line 34 is yes, were there new agreements or amenaed existing agreements with the provided but the provided by the second sec			33
instructions.			
	Y/N	Date	
	1	2	
Home Office Costs  36 Are home office costs claimed on the cost report?			36
the home office? If yes, see instructions,			37
37 If Jine 36 is yes, has a home office cost statement peen prepared by the point of the provider? If yes, enter in column 2 the fiscal year end  [16] If Jine 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			38
18 line 36 is yes, was the liscal year tile of the dollar distriction with the dollar			
of the home office.  39 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39
			40
40 If Jine 36 is yes, did the provider render services to the home officer If yes, see institutions.			
Cost Report Preparer Contact Information			
	IMBURSEME <u>NT</u> S	PECIALIS	41 42
The state of the s			42
42 Employer: ENCOMPASS HEALTH 43 Phone number: 205-969-8265 E-mail Address: JAMES.WYATT@ENCOMPASSHE	ALTH.COM		1 43
45 Trumphanon, 405 55			

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-J PART I

	·	1				Ing	atient Days / Outp	atient Visits / T	rips	
	Component	Wkst A Line No.	No. of Beds	Hed Days Available	CAH Hours	Title V	Title XVIII	Title XIX	Total All Patients 8	
		1_1	2	3	4	5	6	7	0	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bod 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)					V-2000	1,901	2,787		3
3	HMO IPF Subprovider						<b>-</b>			4
4	HMO IRF Subprovider						<b></b>			
5	Hospital Adults & Peds. Swing Bed SNF		0.000				1985 compression			5
6	Hospital Adults & Peds. Swing Bed NF									0
7	Total Adults & Peds. (exclude observation beds) (see instructions)	100	103	37,595			21,427	398	29,698	7
8	Intensive Care Unit	31								8_
9	Coronary Care Unit	32							<u></u>	9
10	Burg Intensive Care Unit	33				1	l			10
11	Surgical Intensive Care Unit	34		-						11
12	Other Special Care (specify)	35								12
13	Nursery	43						<u></u>		13
14	Total (see instructions)		103	37,595			21,427	398	29,698	
15	CAH Visits									15
16	Subprovider - IPF	40							ļ	16
17	Subprovider - IRF	41								17
18	Subprovider I	42				4				18
19	Skilled Nursing Facility	44								19
20	Nursing Facility	45			<u> </u>	¥			<u> </u>	20
21	Other Long Term Care	46				(B) Ye (A)			Ų <u>.</u>	21
22	Home Health Agency	101					7	enners INZamento com	versame biology servers	22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116							<u> </u>	24
24.10	Hospice (non-distinct part)	30							<b>]</b>	24.1
25	CMHC	99				<b>3</b>			ļ	25
26	RHC	88					- College - Constant - College - Col		and the State of t	26
27	Total (sum of fines 14-26)		103						450000000000000000000000000000000000000	28
28	Observation Bed Days							WHO WAS A SHARE TO SHARE THE SHARE		1 28 29
29	Ambulance Trips					<u> </u>	Maria de la companio		4	30
30	Employee discount days (see instructions)								<u> </u>	
31	Employee discount days-IRF								<b>!</b>	31
32	Labor & delivery (see instructions)				l de la company		To the second se	ENDERSON AND STREET	RPL	32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.0
33	LTCH non-covered days									33
33.01	LTCH site neutral days and discharges									33.4

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3 PART I

		F F	ill Time Equivale	nts		DISCHA	ROES		Ι
	Сотролен	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Tide XIX	Total All Patients	
		9 _	10	11	12	13	14	15	1
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospico 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		3
3	HMO IPF Subprovider					4			4
4	HMO IRF Subprovider								5
5	Hospital Adults & Peds, Swing Bed SNF								6
6	Hospital Adults & Peds. Swing Bed NF								110
7	Total Adults & Peds. (exclude observation beds) (see instructions)								7
8	Intensive Care Unit			<u> </u>					9
9	Coronary Care Unit								110
10	Burn Intensive Care Unit								11
11	Surgical Intensive Care Unit			(20)/25/01/01/05	200000000000000000000000000000000000000				112
12	Other Special Care (specify)								13
13	Nurserv							2,206	
14	Total (see instructions)	1	249.71		and the same of th	1,624	27	7 205	115
15	CAH Visits								16
16	Subprovider - IPF	<u></u>			<del> </del>		<u> </u>	<del> </del> -	17
17	Subprovider - IRF								18
18	Subprovider I	<u> </u>			EZakWar aurowan XX	Maryanananananananananananananananananana	Severammente version	A CONTRACTOR OF THE PARTY OF TH	19
19	Skilled Nursing Facility	<u> </u>							20
20	Nursing Facility	1							21
21	Other Long Term Care								21
22	Home Health Agency			ļ					23
23	ASC (Distinct Part)	<u> </u>	ļ	-					24
24	Hospice (Distinct Part)	The state of the s	Carried and district and an area			Note the second second			24,10
24.10	Hospice (non-distinct part)		V-2/-52-22-22-22-22-22-22-22-22-22-22-22-22-						25
25	CMHC		1						26
26	RHC								27
27	Total (sum of lines 14-26)		249.71		II.				200
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32.01 33
33	LTCH non-covered days				1	<b>1</b>			33.0
33.01	LTCH site neutral days and discharges					ā			. ۵. د د اهم

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 WAGE INDEX INFORMATION

WORKSHEET S-3 PARTS II-III

	Wage Data	Wkst A Line No.	Amount Reported	Reclassif- ication of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)	
		1	2	3	4	5	6	
-	SALARIES							1
	Total salaries (see instructions)	200	13,880.090					
	Non-physician anesthetist Part A							2
	Non-physician anesthetest Part B					<u></u>		3
								4
	Physician-Part A - Administrative							4.01
.01	Physician-Part A - Teaching	<b>300</b>				<u> </u>	ļ. <u> </u>	5
	Physician-Part B							6
	Non-physician-Part B	2 i				·	.i	.7.
	Interns & residents (in an approved program)		i - i				I	7.01
.01	Contracted interns & residents (in an approved program)						l	8
·	Home office and/or related organization personnel	44	<del>-</del> -					9
	SNF	144 1800346364		187,950			T .	10
0	Excluded area salaries (see instructions)			107,720				2
	OTHER WAGES & RELATED COSTS				Manager			11_
1	Contract labor (see instructions)					<del></del>	T-	12
2	Contract management and administrative services		<b></b>				1	13
3	Contract labor: Physician-Part A - Administrative					+		14
4	Home office salaries & wage-related costs					<del> </del>	<u> </u>	14.0
4.01_	Home office salaries				<u> </u>	+		14.0
4.02	Related organization salaries						<del> </del>	15
5 _	Home office: Physician Part A - Administrative						<del></del>	16
6	Home office & Contract Physicians Part A - Teaching		4					SEM 10
<u>.                                    </u>	WAGE-RELATED COSTS							17
7	Wage-related costs (core)(see instructions)	9///						18
	Wage-related costs (other)(see instructions)							19
8	Excluded areas	Z38					1	
9	Non-physician anesthetist Part A						4 4 4 4 4 4	20
0	Non-physician anesthetist Part A		å					21
1	Non-physician anesthetist Part B		8					22
12	Physician Port A - Administrative							22.0
2.01	Physician Part A - Teaching		<b>3</b>					23_
3	Physician Part B		S		· · -			24
24	Wage-related costs (RHC/FQHC)				·			25
25	Interns & residents (in an approved program)							25.5
25.50	Home office wage-related		<u> </u>	<del></del>				25.
25.51	Related organization wage-related	10000000000000000000000000000000000000						25.
25,52	Home office: Physician Part A - Administrative - wage-related		Ž		1			<b>33</b> 1
	Home office & Contract Physicians Part A - Teaching - wage-		8		1		40-9-7-2	25
25.53	related			**************************************	ART ALL STATE OF THE STATE OF T			<b>##</b>
	OVERHEAD COSTS - DIRECT SALARIES							26
26	Employee Benefits Department			122.000		-		27
27	Administrative & General		2,120,134	-187.950	<u> </u>			28
28	Administrative & General under contract (see instructions)				<del> </del>			29
29	Maintenance & Repairs	2400	<b>8</b>	ļ <u> </u>		<del></del>	<del></del>	30
30	Operation of Plant		277,086					31
31	Laundry & Linen Service		3			<del></del>	<del> </del>	32
32	Housekeeping		339,945		<u> </u>			33
33	Housekeeping under contract (see instructions)							34
34	Dietary		342,8 <u>18</u>		ļ			34
35	Dictary under contract (see instructions)	700			<u> </u>	<del></del>		
	Cafeteria Cafeteria							36
36		7	<b>S</b>					37
37	Maintenance of Personnel		499,861	<u> </u>				38
38	Nursing Administration		<b>a</b>	1				39
39	Central Services and Supply			T				40
40	Pharmacy		128.861	· · · · · · · · · · · · · · · · · · ·	·			41
41	Medical Records & Medical Records Library	200000000000000000000000000000000000000	604,364	<del>                                     </del>	<del></del>			42
42	Social Service		504,354	<del></del>				43
43	Other General Service		<b>24</b>	1				

Part II	I - Hospital Wage Index Summary				14.000.000	 	
	Net salaries (see instructions)		13,880,090		13,880,090	 	13
	Excluded area salaries (see instructions)			187,950	187,950	 	1 -
2	Subtotal salaries (line 1 minus line 2)		13,880,090	-187.950	13,692,140	 	1
3	Subtotal other wages & related costs (see instructions)						14
. 4	Subtolal other wages & related costs (see histochous)				Γ		1.5
5	Subtotal wage-related costs (see instructions)		13,880,090	-187,950	13.692.140	l	6
6	Total (sum of lines 3 through 5)		4.313,069	-187,950	4,125,119		7
7	Total overhead cost (see instructions)	200200000000	4.313,009	-101,550		 	

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HOSPITAL WAGE RELATED COSTS

Part IV - Wage Related Cost

WORKSHEET S-3 PART IV

IREMENT COST  Employer Contributions Sheltered Annuity (TSA) Employer Contribution  publified Defined Benefit Plan Cost (see instructions) Index Defined Benefit Plan Cost (see instructions) IN ADMINISTRATIVE COSTS (Paid to External Organization): "TSA Plan Administration Fees Id/Accounting/Management Fees-Pension Plan loyee Managed Care Program Administration Fees Id/Accounting/Management Administration Fees Id/INTHAND INSURANCE COST Ith Insurance (Purchased or Self Funded) Ith Insurance (Self Funded without a Third Party Administrator) Ith Insurance (Self Funded with a Third Party Administrator) Ith Insurance (Self Funded with a Third Party Administrator) Ith Insurance (Purchased)  cription Drug Plan	Reported	3 3 4 5 6
Employer Contributions Sheltered Annuity (TSA) Employer Contribution qualified Defined Benefit Plan Cost (see instructions) (ifed Defined Benefit Plan Cost (see instructions) N ADMINISTRATIVE COSTS (Paid to External Organization); /TSA Plan Administration Fees //// Plan Administration Fees //// Counting/Management Fees-Pension Plan loyee Managed Care Program Administration Fees /// TAND INSURANCE COST (b) Insurance (Furchased or Self Funded) th Insurance (Self Funded without a Third Party Administrator) th Insurance (Self Funded with a Third Party Administrator) th Insurance (Self Funded with a Third Party Administrator) th Insurance (Purchased or Self Funded)		3 4
Employer Contributions Sheltered Annuity (TSA) Employer Contribution qualified Defined Benefit Plan Cost (see instructions) (ifed Defined Benefit Plan Cost (see instructions) N ADMINISTRATIVE COSTS (Paid to External Organization); /TSA Plan Administration Fees //// Plan Administration Fees //// Counting/Management Fees-Pension Plan loyee Managed Care Program Administration Fees /// TAND INSURANCE COST (b) Insurance (Furchased or Self Funded) th Insurance (Self Funded without a Third Party Administrator) th Insurance (Self Funded with a Third Party Administrator) th Insurance (Self Funded with a Third Party Administrator) th Insurance (Purchased or Self Funded)		3 4
Sheltered Ananjity (TSA) Employer Contribution pullified Defined Benefit Plan Cost (see instructions) (fied Defined Benefit Plan Cost (see instructions) N ADMINISTRATIVE COSTS (Paid to External Organization); (TSA Plan Administration Fees		3 4
pualified Defined Benefit Plan Cost (see instructions) ified Defined Benefit Plan Cost (see instructions) N ADMINISTRATIVE COSTS (Pald to External Organization); //TSA Plan Administration Pres //TSA Plan Administration Pres //JOACOUNTINE/Manuerment Fees-Pension Plan loyee Managed Care Program Administration Fees //JTH AND INSURANCE COST //JTH Insurance (Self Funded without a Third Party Administrator) th Insurance (Self Funded without a Third Party Administrator) th Insurance (Purchased)		2
ified Defined Benefit Plan Cott (see instructions)  N ADMINISTRATIVE COSTS (Paid to External Organization);  TYSA Plan Administration Fees  It/Accounting/Management Fees-Pension Plan loyee Managed Care Program Administration Fees  LITH AND INSURANCE COST  th Insurance (Purchased or Self Funded)  th Insurance (Self Funded without a Third Party Administrator)  th Insurance (Self Funded with a Third Party Administrator)  th Insurance (Self Punded with a Third Party Administrator)  th Insurance (Purchased)		2
N ADMINISTRATIVE COSTS (Paid to External Organization):  I/Accounting/Management Fees-Pension Plan loyse Managed Care Program Administration Fees  ALTH AND INSURANCE COST  th Insurance (Purchased or Self Funded)  th Insurance (Self Funded without a Third Party Administrator) th Insurance (Self Funded with a Third Party Administrator) th Insurance (Purchased or Self Funded With a Third Party Administrator) th Insurance (Purchased)		
ATSA Plan Administration Fees AlfAccounting/Management Fees-Pension Plan AlfAccounting/Management Fees-Pension Plan AlfAccounting/Management Fees-Pension Plan AlfAction Fees ALTH AND INSURANCE COST Bit Insurance (Self Funded) Bit Insurance (Self Funded without a Third Party Administrator) Bit Insurance (Self Funded with a Third Party Administrator) Bit Insurance (Self Funded with a Third Party Administrator) Bit Insurance (Purchased)		
Il/Accounting/Management Fers-Pension Plan loyse Managed Care Program Administration Fees VLTH AND INSURANCE COST th Insurance (Purchased or Self Funded) th Insurance (Self Funded with a Third Party Administrator) th Insurance (Self Funded with a Third Party Administrator) th Insurance (Self Funded with a Third Party Administrator) th Insurance (Purchased)		
loyee Managed Care Program Administration Fees LTH AND INSURANCE COST th Insurance (Purchased or Self Funded) th Insurance (Self Funded without a Third Party Administrator) th Insurance (Self Funded with a Third Party Administrator) th Insurance (Self Funded with a Third Party Administrator) th Insurance (Purchased)		
ALTH AND INSURANCE COST th Insurance (Purchased or Self Funded) th Insurance (Self Funded without a Third Party Administrator) th Insurance (Self Funded with a Third Party Administrator) th Insurance (Self Funded with a Third Party Administrator) th Insurance (Purchased)		
th Insurance (Purchased or Self Funded) th Insurance (Self Funded without a Third Party Administrator) th Insurance (Self Funded with a Third Party Administrator) th Insurance (Purchased) th Insurance (Purchased)		
th Insurance (Self Funded without a Third Party Administrator) th Insurance (Self Funded with a Third Party Administrator) th Insurance (Purchased)		1
th Insurance (Self Funded with a Third Party Administrator)  (th Insurance (Purchased)	ļ	
th Insurance (Purchased)	<del> </del>	
		-
		1
coption Dug Tan	<del></del>	-1
just rice in the mily over it owner or beneficiary)		T,
Insurance (If employee is owner or beneficiary)	<del> </del>	1
frient insurance (If employee is owner or beneficiary)	<del>                                      </del>	+
ignity insurance in temptate is owner of beneficiary)  e-Term Care Insurance (if employee is owner of beneficiary)		+
	<del></del>	+
rkers' Compensation lusurance rement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	<del></del>	+
		+
XES Declar Only	ļ —	+
A-Employers Fortion Only	<del></del>	-
	<del> </del>	十
		-
		+
HER	+	-+
pentive Deterred Compensation (Other Frank Kentering), Cost 1752		+
y Care Costs and Allowances	<del></del>	-
tion Remoursement		_
al Wage Related cost (Sum of times 1-23)		
	- <u> </u>	
d to I	A-Employers Portion Only icare Taxes - Employers Portion Only imployment Insurance or Federal Unemployment Taxes  IER nutive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 gbove)(see instructions)  Care Costs and Allowances for Reimbursement I Wage Related cost (Sum of lines 1-23)	A-Employers Portion Only

ENCOMPASS HEALTH DEACONESS REHABILIT
Provider CCN: 15-3025

In Lieu of Form Period:
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 CONTRACT LABOR AND BENEFIT COST

Part V - Contract Labor and Benefit Cost

WORKSHEET S-3 PART V

lospital and Hospital-Based Component identification:	Contract	Benefit	
Component	Labor	Cost	
	1	2	ــــــــــــــــــــــــــــــــــــــ
Total facility contract labor and benefit cost		3,573,531	1
		3,525,142	_2
Hospital			_ 3
Subprovider - IPF		i i	, 4
Subprovider - IRF			5
Subprovider (OTHER)			6
Swing Beds - SNF			
Swing Beds - NF			5
Hospital-Based SNF			
Hospital-Based NF			1
Hospital-Based OLTC			î
Hospital-Based HHA			1
Separately Certified ASC			ī
Hospital-Based Hospice			i
Hospital-Based Health Clinic - RHC			1
Hospital-Based Health Clinic - FOHC			ī
6 Hospitai-Based - CMHC			1
7 Renal Dialysis		48,389	ī
P. Other			_

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)

# 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 1	2	3	4	5	6	7	<u> </u>
		GENERAL SERVICE COST CENTERS						115,212	2.360.812	1
	00100	Cap Rel Costs-Bldg & Fixt		2,119,550	2,119,550	126,050	2,245,600		821,768	2
	00100	Cap Rel Costs-Myble Equip		881,146	881,146	93,740	974,886	-153,118	-0-	3
	00200	Other Cap Rel Costs		202,312	202,312	-202,312		350,112	3,557,673	4
	00300	Employee Benefits Department		3,207.561	3,207.561		3,207.561	-665,832	5,111,321	
	00400	Administrative & General	2,120,134	3,878,284	5,998,418	221,265	5,777,153	-003,034	3,111,321	6
5	00600	Maintenance & Repairs					961,126	-46,760	914,366	
6	00700	Operation of Plant	277,086	684.040	961,126		961,126 47,189	-31,754	15,435	
7	00800	Laundry & Linen Service		47,189	47,189		434,711	-14,949	419.762	
8	00900	Housekeeping	339.945	94,766	434,711	ļ	900,428	-166,497	733,931	
9	01000	Dietary	342.818	557.610	900,428		900,428	-100,427	7,55,7,52	111
0	01100	Cafeteria	T				ļ			12
2	01200	Maintenance of Personnel					528,289	-247	528,042	
	01300	Nursing Administration	499,861	28,428	528,289	ļ	326,269	21/	3244 <u>1</u> 2	14
13	01400	Central Services & Supply	T				<del> </del>		-	15
14	01500	Pharmacy				ļ <u> </u>	158,125	-33	158,092	
15	01600	Medical Records & Library	128,861	29,264	158,125		621,800		621,369	
16	01700	Social Service	604,364	17.436	621,800		621,800	31		19
17	01900	Nonphysician Anesthetists	T'				-			20
9	02000	Nursing School					<u> </u>	<del> </del>		21
20	02100	I&R Services-Salary & Fringes Approd				<del></del>	<del></del>	<del> </del>	ļ	22
21	02200	i&R Services-Other Prom Costs Appred		<u> </u>		ļ	<del> </del>	<del> </del>	-	23
22	02300	Paramed Ed Prem-(specify)		l			Secretary Statements			200
23	02300	INPATIENT ROUTINE SERVICE COST		K - 16 - 16 - 17				14-20-5	4	<b>3</b>
		CENTERS					5,224,868	-64.048	5,160,820	30
30	03000	A Julea & Dadistries	4,947,462	287,859	5,235,321	-10,453	3,224,000	101,010		<b>201</b>
30	03000	ANCILLARY SERVICE COST CENTERS				-49,08	121,960		121,960	0 54
54	05400	Radiology-Diagnostic		171,048	171,04	49,088				
54.01	05401	RADIOLOGY-SUA					629,555			
60	06000			629,555	629,55	`	029,222		4	64
60.01	06001	CAD CITA				-	<del></del>	+		63
62,30	06250			ļ. <u>.                                   </u>	100.10		483,484	-7.98	475,50	1 6
65	06500		467,249							
66	06600		1,467,409							
67	06700		1,472.086					·		
68	06800		630,615				386,119			
71	07100		74,705				1,358,01			
73	07300		507.495	<u>850.516</u>	1,358.01	<del>' </del> -	1,30,011	1,200		1 7
76	03950			·		7 -62,25	7 173,510	1	173,51	0 7
76.01	03951			235,767	235,76	78,01				
76.02	03952				+	18.01	18,01	72,29	1	7
76.97		CARDIAC REHABILITATION		1	<del> </del>					7
76,98		The state of the s			+			1		7
76.99		LITHOTRIPSY		Silver Charles and San Annual Control	S MAN COMMISSION AND	The second second				
10.72	1 0.922	OUTPATIENT SERVICE COST CENTERS	10-20-0							
92	09200	Observation Beds (Non-Distinct Part)		<del> </del>	<del> </del>			1 -		_ 9
93.99		PARTIAL HOSPITALIZATION PROGRAM								<b>300</b>
23.77	17,232	OTHER REIMBURSABLE COST CENTERS		4	-					
	+	SPECIAL PURPOSE COST CENTERS					5.63	1 -5,63	31	i
113	11300	Interest Expense		5.63	5,6					14 1
118	1	SUBTOTALS (sum of lines 1-117)	13,880,09	0 14,303,08	7 28,183,1	//  -198,47	27,764,09		7.12/7.7/12/22	經濟
110	_	NONREIMBURSABLE COST CENTERS				ro l	99,35	n -99.3	50 l	- 1
192	1920			99.35	0 99.3.				198,4	
194	0795				<del></del>	198,4	130,40	-		<u> </u>
194.0							28,282.52	7 -907.3	32 27,375,1	
124.0	10123	TOTAL (sum of lines 118-199)	13,880,09	0 14,402,43	7 28.282.5	2/	48,464 <u>.3</u> 2			

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RECLASSIFICATIONS

		T		NCREASES			
	EXPLANATION OF RECLASSIFICATION(S)	CODE	COST CENTER	LINE#	SALARY	OTHER	
-+		1	2	3	4	5	
	THOUTH LANCE	À	Cap Rel Costs-Bldg & Fixt			10,029	
	INSURANCE INSURANCE	A	Cap Rel Costs-Myble Equip	2		7,449	
	INSURANCE					17,478	
00	Total reclassifications						
	Code Letter - A						
		В	NRCC MARKETING	194	187,950	10.531	
	MARKETING	В	7000300				
	MARKETING				187,950	10,531	
500	Total reclassifications						
	Code Letter - B	1000000					
_		c	Adults & Pediatrics	30		<u>5,306</u>	
1	PHYSICIANS	c	Augila de l'edinates				
	PHYSICIANS	ESCHOOL SEC.				5,306	
500	Total reclassifications						
	Code Letter - C						
		a	RADIOLOGY-SUA	54.01		49,088	
		D	SPECIAL PROCEDURES SUA	76.02		78.016	
2		D	SPECIAL PROCEDURES SUA	- 10,00			
3	SERVICE UNDER ARRANGEMENT	1 b					
4		D D				127,104	
500	Total reclassifications						
	Code Letter - D	200020002			-		
		<u>-</u>	SPECIAL PROCEDURES	76.01		15,759	
_1	TRANSPORTATION	E	SPECIAL PROCEDURES				_
	TRANSPORTATION	E				15,759	
500	Total reclassifications	_					
	Code Letter - E						
	<u> </u>			67		364	
1	DAY TREATMENT		Occupational Therapy	68		441	_
2		F	Speech Pathology				
	DAY TREATMENT	F			i	805	
500	Total reclassifications				ă		
	Code Letter - F				f		
	T	1			187.950	176,983	

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

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RECLASSIFICATIONS

		1	DE	CREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE#	SALARY	OTHER	Wkst A-7 Ref.	
			б	7	8	9	10	
_	C. VOT TO LAND	<u> </u>					12	
	INSURANCE	A					12	
2	INSURANCE	1 A	Administrative & General	5		17,478		
	INSURANCE		ACMINISTRATION OF COMMUNICATION OF COMUNICATION OF COMMUNICATION OF COMMUN	V. 200 - 100 - 100 - 100 - 100 - 100 - 100 - 100 - 100 - 100 - 100 - 100 - 100 - 100 - 100 - 100 - 100 - 100 -		17,478_		
500	Total reclassifications							
	Code letter - A	100000000000000000000000000000000000000						
1	MARKETING	В		5	187,950	10.531		
2	MARKETING	8	Administrative & General		187,950	10,531		
500	Total reclassifications	55000		<del></del>	167,720	10(331		
	Code letter - B				-			
Ŧ	PHYSICIANS	c .						_
2	PHYSICIANS	С	Administrative & General	5		5,306		
	Total reclassifications					5,306		-
300	Code letter - C			1/10 1/2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			<del>  -  </del>	⊢
	Cond textor							_
1	SERVICE UNDER ARRANGEMENT	D						
- ;	SERVICE UNDER ARRANGEMENT	T_D				49,088		-
3		D	Radiology-Diagnostic	54		78,016		├
4	SERVICE UNDER ARRANGEMENT	D	SPECIAL PROCEDURES	76.01		127,104	<del> </del>	H
	Total reclassifications					127,104	1	-
	Code letter - D							
1	TRANSPORTATION	Е					I	<del> </del>
- 2	TRANSPORTATION	E	Adults & Pediatrics	30		15,759	<del> </del>	⊢
	Total reclassifications				<u> </u>	15,759		╢
500	Code letter - E					- · <del>- ·</del>		f
	TO A STATE A PROPERTY.	F						Г
	DAY TREATMENT DAY TREATMENT	F					ļ	┡
	DAY TREATMENT	F	Physical Therapy	66		805		1
						805	<u> </u>	1
500	Total reclassifications				3			$\vdash$
	Code letter - F	KS/ME/MANAGE			1			┺
	GRAND TOTAL (Decreases)				187,950	176,983	<u> </u>	ᆚ

<sup>(1)</sup> 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

10,214,361

10,214,361

Period: From: 01/01/2018 To: 12/31/2018

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11,725,359

1,838,117

3,349,115

RECONCILIATION OF CAPITAL COST CENTERS

Reconciling Items
Total (line 7 minus line 9)

WORKSHEET A-7 PARTS I, II & HI

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES Acquisitions Disposals and Retirements Fully Depreciated Ending Balance Beginning Balances Total Description 6 1,600,057 4 3,200,115 5 1,600,058 3,200,115 Land Improvements
Buildings and Fixtures
Building Improvements 5.806,616 17,822 5,815,507 17.822 Fixed Equipment
Movable Equipment
HIT-designated Assets
Subtotal (sum of lines 1-7) 211,346 4,318,686 131.178 4,398,854 131,178 1,838,117 11,725,359 3,349,115 3,349,115

PART	T II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 AND 2  SUMMARY OF CAPITAL									
-	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital- Related Costs (see instructions)	Total (1) (sum of cols, 9 through 14)		
-		9	10	[1	12	13	14	15		
H-	Cap Rel Costs-Bldg & Fixt	972,308	1,147,242					2,119,550	1	
1		581,735	299,411		i			881,146	2	
2	Cap Rel Costs-Myble Equip	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	THE RECONCILIATION OF CAP	<u>ITAL COST CEN</u>	TERS			PART III - RECONCILIATION OF CAPITAL COST CENTERS  COMPUTATION OF RATIOS  ALLOCATION OF OTHER CAPITAL												
	T		COMPUTATION	ON OF RATIOS		/	LLUCATION OF											
	Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	losurance	Taxes	Other Capital- Related Costs	Total (sum of cols. 5 through 7)									
<u> </u>		1	2	3	4	5	6	7	8									
1	2 2 10 - DU 4 2	5,806,616	<del></del>	5.806.616	0.573476		116,021		116,023	1								
1	Cap Rel Costs-Bidg & Fi	4,318,686		4,318,686	0.426524		86,291		86,291	2								
2	Cap Rel Costs-Mvble Equ			10,125,302	1.000000		202,312		202,312	3								
3	Total (sum of lines 1-2)	10,125,302		10.121,302	1.000000		L											

F	1		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital- Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
1		9	10	11	12	13	14	15	1	
1	Can Rel Costs-Bldg & Fixt	937.820	1,146,375	150,567	10,029	116,021		2,360,812	1	
1		450,942	277,086		7,449	86,291		821,768	2	
3	Cap Rel Costs-Myble Equip Total (sum of lines 1-2)	1,388,762	1,423,461	150,567	17,478	202,312	Ľ	3,182,580	_3	

(2) The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, times 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

		-		EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED	<del></del> -		
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5 .	-
	Investment income-buildings & fixtures (chapter 2)			Cap Rel Costs-Bldg & Fixt	1 2		2
1	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Myble Equip	+	-	3
	Investment income-other (chapter 2)				<del> </del>		4
	Trade, quantity, and time discounts (chapter 8)				1 -	·	5_
, ,	Refunds and repates of expenses (chapter 8)				"		6
; ]	Rental of provider space by suppliers (chapter 8)				-		7
r	Telephone services (pay stations excl) (chapter 21)		· · · · · · ·			f	8
	Television and radio service (chapter 21)						9
	Parking lot (chapter 21)	Wkst					10
0	Provider-based physician adjustment	A-8-2	-1,645				11
2	Sale of scrap, waste, etc. (chapter 23)  Related organization transactions (chapter 10)	Wkst A-8-1	-390,085				12
	Laundry and linen service	1.0.				<del> </del>	13
3	Cafeteria - employees and guests				+	ļ	14
<u>4</u> 5	Pental of quarters to comployees & others					1	15
6	Sale of medical and surgical supplies to other than patients						16
7	Sale of drugs to other than patients						17
	Sale of medical records and abstracts		·		+	<b> </b>	18
9	Nursing and allied health education (tuition, fees, books, etc.)					1-	19_
0	Vending machines	L			<del></del>	-	20
l	Income from imposition of interest, finance or penalty charges (chapter 21)	ļ <u>.</u>				<del> </del>	21
2	Interest exp on Medicare overpayments & borrowings to repay Medicare		_			werengozzeni	22
3 .	overpayments  Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
4	Adj for physical therapy costs in excess of limitation (chapter 14)	Wksi A-8-3		Physical Therapy	66		24
		1103		Utilization Review-SNF	114		25_
5	Util review-physicians' compensation (chapter 21)			Cap Rel Costs-Bldg & Fixt	1	<u> </u>	26
26	Depreciation-buildings & fixtures			Cap Rel Costs-Myble Equip	2		27
27	Depreciation-movable equipment	<b>-</b> -		Nonphysician Anesthetists	19		28
28	Non-physician anesthetist Physicians' assistant		· · · <del>- · ·</del>				29
9	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
32	CAH HIT Adj for Depreciation					+	33
3 .	<u> </u>					-	34
34		ļ	<u> </u>		+	<del> </del>	35
5						+	36
36		-		T	113	11	37
37	INTEREST	A_	-5,631	Interest Expense	- 115	9	37.0
7.01	DEPRECIATION	<u> </u>	-136,737		2	9	37.0
7.02	DEPRECIATION	<u> </u>		Cap Rel Costs-Myble Equip Employee Benefits Department	1_4	-	37.6
7.03	INSURANCE	<del>                                     </del>			5		37.6
37.04	INSURANCE	<del>                                     </del>		Administrative & General Administrative & General	5		37.0
17,05	NON-ALLOWABLE EXPENSES ADJUSTMENT	A		Housekeeping	9	1	37.
7.06	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-108		10		37.
7.07	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-247		13		37.
7.08	NON-ALLOWABLE EXPENSES ADJUSTMENT	A A	-431		17		37.
7.09	NON-ALLOWABLE EXPENSES ADJUSTMENT	T A		Adults & Pediatrics	30		37.
7.10	NON-ALLOWABLE EXPENSES ADJUSTMENT		-101		67		37.
37.11	NON-ALLOWABLE EXPENSES ADJUSTMENT NON-ALLOWABLE EXPENSES ADJUSTMENT	1- A	-345		68		37.
	I MON ALLOWARI E EXPENSES ADJUSTMENT	<del>  ^</del>	-4.07		2	9	37.
	NOTIFICATIONE		-4.325		4		37
7.13	PATIENT TELEPHONE	A			5		37
7.13 7.14	PATIENT TELEPHONE PATIENT TELEPHONE	A		Administrative & General			37
7.13 7.14 7.15	PATIENT TELEPHONE PATIENT TELEPHONE PATIENT TELEPHONE	A_	-21,024	Administrative & General Care Rel Costs-Myble Equip	2	9	
7.13 7.14 7.15 7.16	PATIENT TELEPHONE PATIENT TELEPHONE PATIENT TELEPHONE PATIENT TELEVISION	A	-21,024 -6.672	Cap Rel Costs-Myble Equip	5	9	37
7.13 7.14 7.15 7.16 7.17	PATIENT TELEPHONE PATIENT TELEPHONE PATIENT TELEPHONE PATIENT TELEVISION PATIENT TELEVISION	A A A	-21,024 -6.677 -1,43	Cap Rel Costs-Myble Equip     Administrative & General	2	9	37
7.13 7.14 7.15 7.16 7.17 7.18	PATIENT TELEPHONE PATIENT TELEPHONE PATIENT TELEPHONE PATIENT TELEVISION PATIENT TELEVISION PATIENT TELEVISION PRINTING	A A A	-21,024 -6.673 -1,43 -3,77	Cap Rel Costs-Myble Equip     Administrative & General     Administrative & General     Administrative & General	5 5 7	9	37 37 37
7.13 7.14 7.15 7.16 7.17 7.18 7.19	PATIENT TELEPHONE PATIENT TELEPHONE PATIENT TELEPHONE PATIENT TELEVISION PATIENT TELEVISION PRINTING PRINTING	A A A	-21,024 -6,677 -1,43 -3,777	Cap Rel Costs-Myble Equip     Administrative & General     Administrative & General     Operation of Plant	2 5 5	9	37 37 37
7.13 7.14 7.15 7.16 7.17 7.18 7.19 7.20	PATIENT TELEPHONE PATIENT TELEPHONE PATIENT TELEPHONE PATIENT TELEVISION PATIENT TELEVISION PRINTING PRINTING PRINTING	A A A A	-21,02- -6.677 -1,43 -3,777	Cap Rel Costs-Myble Equip     Administrative & General     Administrative & General     Operation of Plant     Dietary	5 5 7		37 37 37 37 37
7,13 7,14 7,15 7,16 7,17 7,18 7,19 7,20 7,21	PATIENT TELEPHONE PATIENT TELEPHONE PATIENT TELEPHONE PATIENT TELEPHONE PATIENT TELEVISION PATIENT TELEVISION PRINTING PRINTING PRINTING PRINTING PRINTING LOBBYING EXPENSE	A A A A	-21,02- -6.67: -1,43 -3,77:	Cap Rel Costs-Myble Equip   Administrative & General   Administrative & General   Operation of Plant   Dietary   Administrative & General	2 5 5 7 10	9	37 37 37 37 37 37
7,13 7,14 7,15 7,16 7,17 7,18 7,19 7,20 7,21	PATIENT TELEPHONE PATIENT TELEPHONE PATIENT TELEPHONE PATIENT TELEVISION PATIENT TELEVISION PRINTING PRINTING PRINTING PRINTING PRINTING MISCELLANGOUS INCOME	A A A A B	-21,02- -6.67: -1,43: -3,77: -2,59	Cop Rel Costs-Myble Equip    Administrative & General   Administrative & General   Operation of Plant   Dietary   Administrative & General   Octor   Octor   Octor     Administrative & General   Cap Rel Costs-Bldg & Fixt	2 5 5 7 10 5		37 37 37 37 37 37
7,13 7,14 7,15 7,16 7,17 17,18 17,19 17,20 17,21 17,22	PATIENT TELEPHONE PATIENT TELEPHONE PATIENT TELEPHONE PATIENT TELEVISION PATIENT TELEVISION PRINTING PRINTING PRINTING LOBBYING EXPENSE MISCELLANEOUS INCOME MISCELLANEOUS INCOME	A A A A B B B	-21,024 -6.677 -1,43 -3,777 -2,59 -10 -5,48	Cap Rel Costs-Myble Equip   Administrative & General   Administrative & General   Operation of Plant   Dietary   Administrative & General   Cap Rel Costs-Bidg & Fixt   Administrative & General   Administrative & General	2 5 5 7 10 5		37 37 37 37 37 37 37
7,13 17,14 17,15 17,16 17,17 17,18 17,19 17,20 17,21 17,22 17,23 17,23	PATIENT TELEPHONE PATIENT TELEPHONE PATIENT TELEPHONE PATIENT TELEPHONE PATIENT TELEVISION PRINTING PRINTING PRINTING PRINTING PRINTING MISCELLANEOUS INCOME MISCELLANEOUS INCOME MISCELLANEOUS INCOME MISCELLANEOUS INCOME	A A A A A B B B	-21,02* -6.67: -1,43 -3,77: -2,59 -10 -5,48 -18,99	Cap Rel Costs-Myble Equip   Administrative & General   Administrative & General   Operation of Plant   Dietary   Administrative & General   Cap Rel Costs-Bldg & Fixt   Administrative & General   Dietary   Dietary	2 5 5 7 10 5	11	37 37 37 37 37 37 37 37 37
37.14 37.15 37.16 37.17 37.18 37.19 37.20 37.21 37.22 37.23 37.23	PATIENT TELEPHONE PATIENT TELEPHONE PATIENT TELEPHONE PATIENT TELEVISION PATIENT TELEVISION PRINTING PRINTING PRINTING PRINTING PRINTING MISCELLANEOUS INCOME MISCELLANEOUS INCOME MISCELLANEOUS INCOME MISCELLANEOUS INCOME	A A A A A B B B B	-21,02- -6,67: -1,43: -3,77: -2,59 -10: -5,48: -18,99	Cap Rel Costs-Myble Equip   Administrative & General   Administrative & General   Operation of Plant   Dietary   Administrative & General   Ocap Rel Costs-Bildg & Fist   Administrative & General   Ocap Rel Costs-Bildg & Fist   Administrative & General   Dietary   Medical Recognis & Library	2 5 5 7 10 5 1 5		37 37 37 37 37 37 37 37 37 37
37.12 37.13 37.14 37.15 37.16 37.17 37.18 37.19 37.20 37.21 37.22 37.23 37.24 37.25 37.26 37.27	PATIENT TELEPHONE PATIENT TELEPHONE PATIENT TELEPHONE PATIENT TELEPHONE PATIENT TELEVISION PRINTING PRINTING PRINTING PRINTING PRINTING MISCELLANEOUS INCOME MISCELLANEOUS INCOME MISCELLANEOUS INCOME MISCELLANEOUS INCOME	A A A A A B B B	-21,02- -6,67: -1,43: -3,77: -2,59: -10: -5,48: -18,99: -8,83:	Cap Rel Costs-Myble Equip   Administrative & General   Administrative & General   Operation of Plant   Dietary   Administrative & General   Cap Rel Costs-Bldg & Fixt   Administrative & General   Dietary   Dietary	2 5 5 7 10 5 1 1 5	11	37 37 37 37 37 37 37 37 37

KPMG LLP Compu-Max 2552-10			
10.000	In Lieu of Form	Period:	Run Date: 05/09/2019
ENCOMPASS HEALTH DEACONESS REHABILIT	CMS-2552-10	From: 01/01/2018	Run Time: 10:18 Version: 2018.12 (03/07/2019)
Provider CCN: 15-3025	<u> </u>	To: 12/31/2018	Version: 2010.12 (03/07/2017)

#### 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.			
		121	2	3	44	5	↓		
77.20	PATIENT TRANSPORTATION	Á	-62,297	Adults & Pediatrics	30		37,29		
37.29 37.30	RENT RECONCILIATION	A	-867		!	10_	37,30		
37.30 37.31	PROFESSIONAL FEES	A	-9,593	Administrative & General	5		37.32		
37.32	PHYSICIAN FEES	Α	_4,755		192		37.33		
37.33	COMPHEALTH	A	-99,350	Physicians' Private Offices	197		38		
38	COMMITTED		•				39		
39					<del></del>	-	40		
40							41		
41					-   -		42		
42						_	43		
43							44		
44							45		
45	<u> </u>					_	46		
46							47		
47							48		
48			-			L	49		
49 50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-907,332				50		

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

<sup>(1)</sup> 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.

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

	Line No.	ED HOME OFFICE COSTS:  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 (22.75)	-2,492.855	7	+-
	5	Administrative & General	TO OFFSET MANAGEMENT FEES	100.040	2,492.855	102,249	9	2
	_1	Cap Rel Costs-Bidg & Fixt	TO INCLUDE ALLOWABLE HOME OFFICE COS	102,249		150,667	11	3
	1	Cap Rel Costs-Bidg & Fixt	TO INCLUDE ALLOWABLE HOME OFFICE COS	150,667			!!	3.0
.01	. 5	Administrative & General	TO INCLUDE ALLOWABLE HOME OFFICE COS	1,863,502		1,863,502		3.0
.02	5	Administrative & General	TO INCLUDE ALLOWABLE HOME OFFICE COS	341,715		341.715		3.0
.03	3	Cap Rel Costs-Myble Equip	INTERCOMPANY WAGE AND EXPENSE TRANSF	14,987	14,987		10	
.04	3	Other Cap Rei Costs	INTERCOMPANY WAGE AND EXPENSE TRANSF	42,260	42,260		11	3.4
.05	4	Employee Benefits Department	INTERCOMPANY WAGE AND EXPENSE TRANSF	2,609,540	2,609,540			3.0
.06	5	Administrative & General -	INTERCOMPANY WAGE AND EXPENSE TRANSF	3,199,937	3,199,937			3.0
.07	7	Operation of Plant	INTERCOMPANY WAGE AND EXPENSE TRANSF	14,709	14,709			3.0
80.	8	Laundry & Linen Service	INTERCOMPANY WAGE AND EXPENSE TRANSF	-3	-3			3.0
3.09	9	Housekeeping	INTERCOMPANY WAGE AND EXPENSE TRANSF	-1,895	-1,895			3.0
3.10	10	Dietary	INTERCOMPANY WAGE AND EXPENSE TRANSF	-4,868	-4,868			3.1
3.11	13	Nursing Administration	INTERCOMPANY WAGE AND EXPENSE TRANSF	-1,540	-1,540			3.1
3.12	16	Medical Records & Library	INTERCOMPANY WAGE AND EXPENSE TRANSF	95	95			3
3,13	17	Social Service	INTERCOMPANY WAGE AND EXPENSE TRANSF	1,720	1,720			3.
3.14	30	Adults & Pediatrics	INTERCOMPANY WAGE AND EXPENSE TRANSF	15,740	15,740			3.
3.15	54	Radiology-Diagnostic	INTERCOMPANY WAGE AND EXPENSE TRANSF	24	24			3.
3.16	60	Laboratory	INTERCOMPANY WAGE AND EXPENSE TRANSF	-141	-141			3.
3.17	65	Respiratory Therapy	INTERCOMPANY WAGE AND EXPENSE TRANSF	-3	-3			3.
3.18	66	Physical Therapy	INTERCOMPANY WAGE AND EXPENSE TRANSF	-7,893	-7,893			3,
3.19	67	Occupational Therapy	INTERCOMPANY WAGE AND EXPENSE TRANSF	-2,937	-2,937			3.
3.20	68	Speech Pathology	INTERCOMPANY WAGE AND EXPENSE TRANSF	2,434	2,434			3,
3.21	71	Medical Supplies Charged to Patients	INTERCOMPANY WAGE AND EXPENSE TRANSF	-48,711	-48,711			3.
3,22	73	Drugs Charged to Patients	INTERCOMPANY WAGE AND EXPENSE TRANSF	761,237	761,237			3.
3.23	113	Interest Expense	INTERCOMPANY WAGE AND EXPENSE TRANSP	5,631	5,631			3
3,24	1	Cap Rel Costs-Bldg & Fixt	DEACONESS HOSPITAL	417,132	417.132		10	3
,24 ,25	2	Cap Rel Costs-Myble Equip	DEACONESS HOSPITAL	6,461	28,786	-22,325	10	_ 3
1,26	5	Administrative & General	DEACONESS HOSPITAL	4,456	19,855	-15.399	1	3
3.27	8	Laundry & Linen Service	DEACONESS HOSPITAL	9,190	40,944	-31,754		3
3.28	9	Housekeeping	DEACONESS HOSPITAL	4,294	19.129			3
3.29	10	Dietary	DEACONESS HOSPITAL	42,656	190,048			3
1.30	13	Nursing Administration	DEACONESS HOSPITAL	200	200			- 2
.3U	17	Social Service	DEACONESS HOSPITAL	231	231		<u> </u>	_ 3
1.32	30	Adults & Pediatrics	DEACONESS HOSPITAL	266	271			3
3.33	54.01	RADIOLOGY-SUA	DEACONESS HOSPITAL	37,202	49,088	-11.886		
3.34	60	Laboratory	DEACONESS HOSPITAL	322,340	343,339	-20,999		3
3.35	65	Respiratory Therapy	DEACONESS HOSPITAL	752	8,735		]	3
		Physical Therapy	DEACONESS HOSPITAL	7	41			- 3
3.36	66	Occupational Therapy	DEACONESS HOSPITAL	12	67			1 2
3.37	67	Medical Supplies Charged to Patients	DEACONESS HOSPITAL	15,052				1 3
3.38	71	Medical outpiles Charged to Fallents	DEACONESS HOSPITAL	3,469	13,471	-10,002		2
3.39	73	Drugs Charged to Patients SPECIAL PROCEDURES SUA	DEACONESS HOSPITAL	22,813			Ţ	;
3,40	76.02							- 1 -

<sup>•</sup> 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 in Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

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

WORKSHEET A-8-1

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

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

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

		·		Related Org	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 8 of this worksheet.

This information is used by the Centers for Medicare and Medicald 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 Org	nization(s) and/or	Home Office	
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
		3	3	4	5	6	<b></b>
	D D		72.50	ENCOMPASS HEALTH		HEALTHCARE	6
2	В В			DEACONESS HOSPITAL		HEALTHCARE	7
-/-	G	ENCOMPASS HEALTH	27122			EXPENSE TRANSFERS	8
8		ENCOMI ABSTILAZITI	·				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 and 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:

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

### 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	<del>  -,  </del>
1	30	Adults & Pediatrics AGGREGATE	5,306		5,306	211,500	36	3,661	183	1
2	30	210012 01 0000000 11000								2
3	<del>                                     </del>				1					3
4										5
5	<del> </del>									6
6	<del>                                     </del>		· .L							7
7										8
8										9
9	1			· ·	l				·	10
10										11
11	i						<del></del>			12
12_	·									13
13	1					<del> </del> -				14
14	1									15
15					-			<del></del>		16
16					L				-	17
17										18
18	Τ''			<u> </u>	ļ — —		<del> </del>	<del> </del>	·	19
19	L			<del>-</del> -	·	<del>-</del>	<del> </del>			20
20				<del> </del>	5 206		36	3,661	183	
200		TOTAL	5,306	<u> </u>	3,300		30	1 2,000		

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	
		11	12	13	14	15	16	17	18	$\sqcup$
	10						3,661	1,645	_1,645	1_
I	30	Adults & Pediatrics AGGREGATE								2
2										3
3			<del> </del>				·			4
4			<del> </del>							5
5			<del>  -</del>							6
6								-		7
7			<del> </del>		<del> </del>		<u> </u>			8
8	Γ									9
9		<u> </u>		ļ		·	1		l	10
10		<u> </u>		-		<del></del>				11
11			1	ļ		<del> </del>		<del></del>		12
12						<del>  -</del>	<del></del>			13
13						<del> </del>	<del></del>			14
14					1		<del></del>			15
15										16
16			_	ļ	<del></del>	ļ	<del></del>			17
17						<del></del>	<del> </del>	<del>                                     </del>		18
18	_				ļ	ļ	<del></del>	<del> </del>	<b>-</b>	19
19	1				<u> </u>		<del> </del>	1		20
20	_			<u> </u>		ļ	3,661	1,645	1,645	
200	<del> </del>	TOTAL			J	J	3,001	1,043	1,093	1 200

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

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							B
1	Cap Rel Costs-Bldg & Fixt	2,360,812	2,360,812					1
2	Cap Rel Costs-Myble 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				<u> </u>			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	2
10	Diclary	733,931	127,876	44,512	88,261	9 <u>94,58</u> 0	290,575	10
1)	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
	Pharmacy							15
15	Medical Records & Library	158.092	13.560	4,720	33.176	209,548	61,221	16
		621,369	28.975	10,086	155,597	816,027	238.410	17
17	Social Service Nonphysician Anesthetists	021,507			1			19
19		<del> </del>			·			20
20	Nursing School							21
21	1&R Services-Salary & Fringes Apprvd				· · · · · · · · · · · · · · · · · · ·			22
22	I&R Services-Other Prem Costs Apprvd	<del>-</del>	<b></b> -				-	23
23	Paramed Ed Prgm-(specify)	THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TWO IS NAM		2023-00-00-00-00-00-00-00-00-00-00-00-00-00				<b>a</b>
	INPATIENT ROUTINE SERV COST CENTERS	5.140.000	1,036,076	360.644	1,273,759	7.831,299	2,287,991	T 30
30	Adults & Pediatrics	5,160,820	1,030.074	ESECUTION   100.044				R .
	ANCILLARY SERVICE COST CENTERS	121,960				121,960	35,632	54
54	Radiology-Diagnostic					37.202		54.01
54.01	RADIOLOGY-SUA	37.202	1,460	508		610.524	178.370	60
60	Laboratory	608,556	1,400	300		0,0.021	*10,31 <u>9</u>	60.01
60,01	LABSUA							62.30
62.30	BLOOD CLOTTING FOR HEMOPHILIACS		6 220	2,343	120,296	604,870	176,718	65
65	Respiratory Therapy	475,501	6,730		377,793	2,106,117	615,321	66
66	Physical Therapy	1,490,756	176,226	61,342	378,997	2,066,999	603,892	
67	Occupational Therapy	1,487,861	148,463	51,678		872,100	254,792	
68	Speech Pathology	638,527	52,828	18,389		443,200	129,485	
71	Medical Supplies Charged to Patients	368,628	41,050	14,289		1,495,646	436,966	
73	Drugs Charged to Patients	1,348,009	12,595	4,384	130,658	1,493,040	+30,500	76
76	OTHER ANCILLARY		<b></b>			173,510	50.693	76,01
76.01	SPECIAL PROCEDURES	173.510					30.693	76.0
76.02	SPECIAL PROCEDURES SUA	22,813				22,813		76.9
76.97	CARDIAC REHABILITATION			<u> </u>	ļ		ļ	76.9
76.98	HYPERBARIC OXYGEN THERAPY							76.99
76.99	LITHOTRIPSY				and the second second second	Transport Control of the Control of	A THE STATE OF THE	1 /0.93
	OUTPATIENT SERVICE COST CENTERS			<u> </u>		4		#
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM					j		93.9
2012	OTHER REIMBURSABLE COST CENTERS							4
	SPECIAL PURPOSE COST CENTERS							<b>\$1</b>
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	1 118
.,,,	NONREIMBURSABLE COST CENTERS							<b>#</b>
	Physicians' Private Offices		140.174			188,967		
102		198,481		1,955		254,442	74.338	
192					1			194.0
194	NRCC MARKETING	170,461		1		l		
194 194.01	NRCC MARKETING GUEST MEALS	176,481						200
194	NRCC MARKETING	175,461					6,176,006	200 201

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

$\neg$	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	
1		7-1	8	9	10	11	13	
	and the second s	- CHESSIAN CONTRACTOR					i i	
	GENERAL SERVICE COST CENTERS	P-00/2000						
1	Cap Rel Costs-Bldg & Fixt	<del></del>						2
2	Cap Rel Costs-Mybin Equip							4_
4	Employee Benefits Department	-						_5
5	Administrative & General							6_
6	Maintenance & Repairs	1,419.026						7 8
7	Operation of Plant	13,741	64,806					9
8	Laundry & Linen Service	11,439		692,833				10
9	Housekeeping	98,360		48,891	1,432,406			11
0	Dietary				144,838	144,838		12
ļi .	Cafeteria	·					914,475	13
12	Maintenance of Personnel	15,759		7,833		6,589	914,475	34
3	Nursing Administration							15
14	Central Services & Supply			_::		1 500	<del></del>	16
15	Pharmacy	10.430		5,184		1,699		17
16	Medical Records & Library	22,287		11,078		7,966	ļ <del>-</del> -	19
17	Social Service					<u> </u>		20
<u>19</u>	Nonphysician Anesthetists		_					21
20	Nursing School							22
21	I&R Services-Salary & Fringes Approd							23
22	I&R Services-Other Prem Costs Apprvd		·			The second substitution of the second	A THE CONTRACT OF THE PARTY OF	1 23
23	Paramed Ed Prem-(specify)						914,475	30
	INPATIENT ROUTINE SERV COST CENTERS	796,929	64,806	396,128	1,256.375	65,216	914,475	<u> </u>
30	Adults & Pediatries ANCILLARY SERVICE COST CENTERS							54
	ANCILLARY SERVICE COST CERTERS					ļ		54.0
54	Radiology-Diagnostic		<u> </u>					60
54.01_	RADIOLOGY-SUA	1,123		558				60.0
60	Laboratory LAB SUA			L				62.
60,01	BLOOD CLOTTING FOR HEMOPHILIACS					6,159		65
62,30	BLOOD COUTTING TOX THE STOTE TO	5,177		2,573		19,342		66
65	Respiratory Therapy	135,550		67,377		19,404		67
66	Physical Therapy Occupational Therapy	114,195		56,762				68
67	Speech Pathology	40,634		20,198		8,312 985		71
68	Medical Supplies Charged to Patients	31,575		15,695				73
71	Drugs Charged to Patients	9.688		4,815		6,689	<del></del>	76
73	OTHER ANCILLARY						<del>                                     </del>	76.
76	SPECIAL PROCEDURES				<u> </u>			76.
76.01	SPECIAL PROCEDURES SUA				<u> </u>		<del></del>	76.
	SPECIAL PROCEDURES BOX			1		<del></del>	<del> </del>	76.
76.02	CARDIA C DELIADE ITATION	1						
76.97	CARDIAC REHABILITATION				<u> </u>			
76.97 76.98	CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY							
76.97	CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY LUTHOTRIPSY							7 <u>6.</u>
76.97 76.98 76.99	CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY LITHOTRIPSY OUTPATTENT SERVICE COST CENTERS							76. 92
76.97 76.98 76.99	CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS Observation Reds (Non-Distinct Part)	70.577			1900 P. C.		100 100 100 100 100 100 100 100 100 100	7 <u>6</u> 92
76.97 76.98 76.99	CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY LITHOTRESY OUTPATIENT SERVICE COST CENTERS Observation Bods (Non-Distinct Part). PARTIAL HOSPITALIZATION PROGRAM					0.000		76 92
76.97 76.98 76.99	CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS Observation Beds (Non-Distinct Part) PARTIAL HOSPITALIZATION PROGRAM OTHER REHIBBURSABLE COST CENTERS							7 <u>6</u> 92 93
76.97 76.98 76.99 92 93.99	CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY LITHOTRIPSY OUTPATTENT SERVICE COST CENTERS Observation Beds (Non-Distinct Part) PARTIAL HOSPITALIZATION PROGRAM OTHER REIMBURSABLE COST CENTERS SPECIAL PURPOSE COST CENTERS						01442	76 92 93
76.97 76.98 76.99 92 93.99	CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS Observation Beds (Non-Distinct Part). PARTIAL HOSPITALIZATION PROGRAM OTHER REIMBURSABLE COST CENTERS SPECIAL PURPOSE COST CENTERS Interest Expense	1,306,883	64,800	637,092	1,401,213	3 142,36	1 914,47.	76 92 93
76.97 76.98 76.99 92 93.99	CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY LITHOTRIPSY OUTPATTENT SERVICE COST CENTERS Observation Beds (Non-Distinct Part) PARTIAL HOSPITALIZATION PROGRAM OTHER REIMBURSABLE COST CENTERS SPECIAL PURPOSE COST CENTERS Interest Expense SUBTOTALIS (sum of lines 1-117)	1,306,887	7 64,800			3 142,36	1 914,47.	76 92 93 11 5 11
76.97 76.98 76.99 92 93.99 113 118	CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS Observation Bods (Non-Distinct Part) PARTIAL HOSPITALIZATION PROGRAM OTHER REIMBURNABLE COST CENTERS SPECIAL PURPOSE COST CENTERS Interest Expense SUBTOTALS (sum of lines 1-117) NONREIMBURNABLE COST CENTERS	1,306,887		53,592				76 92 93 11 5 11 19
76.97 76.98 76.99 92 93.99 113 118	CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY LITHOTRIPSY OUTPATTENT SERVICE COST CENTERS Observation Beds (Noa-Distinct Part) PARTIAL HOSPITALIZATION PROGRAM OTHER REHIBBURSABLE COST CENTERS SPECIAL PURPOSE COST CENTERS Interest Expense SUBTOTALIS (sum of lines 1-117) NONNEIMBURSABLE COST CENTERS Physicians Private Officer Physicians Ph					2,47		76 92 93 11 5 11 19 19
76.97 76.98 76.99 92 93.99 113 118	CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY LITHOTRESY OUTPATTENT SERVICE COST CENTERS Observation Beds (Non-Distinct Part) PARTIAL HOSPITALIZATION PROGRAM OTHER REIMBURSABLE COST CENTERS SPECIAL PURPOSE COST CENTERS Interest Expense SUBTOTALIS (sum of lines 1-117) NONREIMBURSABLE COST CENTERS Physicians' Private Offices NRCC MARKETING	107.819		53,592		2,47		76 92 93 11: 5 11: 5 11: 19 19
76.97 76.98 76.99 92 93.99 113 118 192 194 194.0	CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS Observation Beds (Non-Distinct Pat) PARTIAL HOSPITALIZATION PROGRAM OTHER REIMBURSABLE COST CENTERS SPECIAL PURPOSE COST CENTERS Integest Expense SUBTOTALS (sum of lines 1-117) NONREIMBURSABLE COST CENTERS Physicians' Private Offices NRCC MARKELING GUEST MEALS	107.819		53,592		2,47		76. 92. 93. 11. 5. 11. 19. 19. 19. 12. 20.
76.97 76.98 76.99 92 93.99 113 118	CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY LITHOTRESY OUTPATTENT SERVICE COST CENTERS Observation Beds (Non-Distinct Part) PARTIAL HOSPITALIZATION PROGRAM OTHER REIMBURSABLE COST CENTERS SPECIAL PURPOSE COST CENTERS Interest Expense SUBTOTALIS (sum of lines 1-117) NONREIMBURSABLE COST CENTERS Physicians' Private Offices NRCC MARKETING	107.819		53,592	31,39	2.47	7	76. 92. 93. 112. 5 118. 192. 194. 194. 200. 20.

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	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26		
		16	17	- 24				
	GENERAL SERVICE COST CENTERS							1
	Cap Rel Costs-Bldg & Fixt	ļ i						2
	Cap Rel Costs-Myble Equip							4
4	Employee Benefits Department	ļ						5
5.	Administrative & General							6
6	Maintenance & Repairs							7
	Operation of Plant					<del></del>		8
	Laundry & Linen Service							9
	Housekeeping					<del> </del>		10
	Dietary				·			ΪΪ
	Cafeteria					<del> </del>		12
	Maintenance of Personnel					-		13
	Nursing Administration	T				-		14
	Central Services & Supply					<del>                                     </del>		15
	Pharmacy				L <u>-</u>	l		16
	Medical Records & Library	288.082				ļ		17
	Social Service		1,095,768					17
	Social Service				<u> </u>	ļ		
	Nonphysician Anesthetists	<del></del>						20
20	Nursing School		Ţ			l		21_
	I&R Services-Salary & Fringes Apprvd		-			1		22
22	I&R Services-Other Prem Costs Approd							23_
23	Paramed Ed Prgm-(specify)							<u> </u>
	INPATIENT ROUTINE SERV COST CENTERS	127,232	1,095,768	14,836,219		14,836,219		30
30	Adults & Pediatrics	121.232	1,072,700					<u> </u>
	ANCILLARY SERVICE COST CENTERS	891		158,483		158,483		54
	Radiology-Diagnostic	931		37,202		37.202		54.0
54.01	RADIOLOGY-SUA	10,630		801,205		801,205		60
60	Laboratory	10,630		601,202	1			60.0
60.01	LAB SUA							62.3
62,30	BLOOD CLOTTING FOR HEMOPHILIACS		<u> </u>	805,014		805,014		65
65	Respiratory Therapy	9,517		2,981.629		2.981.629		66
66	Physical Therapy	37,922		2,898,296	<del> </del>	2,898,296		67
67	Occupational Therapy	37,044				1,211,443		68
68	Speech Pathology	15,407	<u> </u>	1,211,443		631,041		71
71	Medical Supplies Charged to Patients	10.101		631.041		1,991,477		73
73	Drugs Charged to Patients	37,673		1,991,477	<del> </del>	1,991,477		76
76	OTHER ANCILLARY				<del></del>	225,868		76.
76.01	SPECIAL PROCEDURES	1,665		225,868		223,000		76.
76.02	SPECIAL PROCEDURES SUA			22,813	<del> </del>	22,813		76
76.97	CARDIAC DEHABILITATION			L	1	<del> </del>		76.
76.98	HYPERBARIC OXYGEN THERAPY		<u> </u>		<del> </del>			76.
	I ITELATOREV		1	L		and the state of the state of the state of	CONTRACTOR OF THE PROPERTY OF THE PARTY OF T	J /0.
76.99	OUTPATIENT SERVICE COST CENTERS					4	<u> </u>	92
- <u>-</u> -	Observation Beds (Non-Distinct Part)			V.	<u> </u>			93
92	PARTIAL HOSPITALIZATION PROGRAM		1				CONTRACTOR STORY	1 7.j.
93.99	OTHER REIMBURSABLE COST CENTERS			<b>200</b>				#4 #4
	SPECIAL PURPOSE COST CENTERS							
			1					113
113	Interest Expense	288,08	1,095,768	26,600,69	)	26,600.690		1118
118	SUBTOTALS (sum of lines 1-117)	206,00		d v				<b>4</b>
	NONREIMBURSABLE COST CENTERS			405,58	7	405,587		19:
192	Physicians' Private Offices		<del>-</del>	337,72		337.725		19
194	NRCC MARKETING			31,19		31,193		19
194.01	GUEST MEALS			31,17	<u> </u>	- /152		20
200	Cross Foot Adjustments							20
201	Negative Cost Centers			37,276.10	-	27,375,195		20
	TOTAL (sum of lines 118-201)	288.08	2 1,095,76	27,375,19	J 1	A - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -		

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	DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL_	EMPLOYEE BENEFITS DEPARTMENT 4	ADMINIS- TRATIVE & GENERAL S	
		V						1
	GENERAL SERVICE COST CENTERS							1
1	Cap Rei Costs-Bldg & Fixt							2
2	Cap Rel Costs-Myble 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		420,102					6
6	Maintenance & Repairs	<del></del>	83.436	29,043	112,479	316	29,583	
7	Operation of Plant		17.865	6.219	24.084		1,065	8
8	Laundry & Linen Service	<del></del>	14.871	5,176	20,047	388	14,205	
9	Housekeeping		127,876	44,512	172,388	391	26,792	
10	Dietary	<del></del>	151,070	7 7472				111
11	Cafeteria							12
12	Maintenance of Personnel		20,488	7,132	27,620	570	18.435	
13	Nursing Administration	<del></del>	20.400	711.42				14
14	Central Services & Supply	<del>-  </del>	<del> </del>					15
15	Pharmacy	<del> </del>	13,560	4,720	18,280	147	5,645	16
J6	Medical Records & Library	<del></del>	28,975	10.086	39,061	690	21,982	17
17	Social Service		- 6,513	10,000				19
19	Nonphysician Anesthetists	<del></del>	<del> </del>					20
20	Nursing School			<del> </del>				21
21	I&R Services-Salary & Fringes Apprvd							22
22	I&R Services-Other Prem Costs Apprvd							23
23	Paramed Ed Prem-(specify)	(Thomas mondifican				2000		9
	INPATIENT ROUTINE SERV COST CENTERS		1.036.076	360,644	1,396,720	5,652	210.950	30
30	Adults & Pediatrics	AND DESCRIPTION OF THE PARTY OF	1,020,070	100,041			Y	<b>3</b>
	ANCILLARY SERVICE COST CENTERS	200 200 200 200 200 200 200 200 200 200					3,285	
54	Radiology-Diagnostic		ļ ·					54.
54.01	RADIOLOGY-SUA		1,460	508	1.968		16.446	
60	Laboratory		1,460	300	7,700			60.
60.01	LAB SUA		1					62.
62.30	BLOOD CLOTTING FOR HEMOPHILIACS		6,730	2,343	9,073	533	16,294	65
65	Respiratory Therapy		176,226			1,674	56,735	66
66	Physical Therapy		148,463				55,681	
67	Occupational Therapy		52,828				23,493	
68	Speech Pathology		41.050			85	11.939	
71	Medical Supplies Charged to Patients		12,595				40,290	73
73	Drugs Charged to Patients		12,393	7,301	19,712			76
76	OTHER ANCILLARY		<del></del>				4,674	4 76
76.01	SPECIAL PROCEDURES				†			76
76.02	SPECIAL PROCEDURES SUA		<b> -</b>	<del> </del>				76
76.97	CARDIAC REHABILITATION							76
76.98	HYPERBARIC OXYGEN THERAPY		ļ		<del></del>	<u> </u>		76
76.99	LITHOTRIPSY							<b>3</b>
	OUTPATIENT SERVICE COST CENTERS		4					92
92	Observation Beds (Non-Distinct Part)							93
93.99	PARTIAL HOSPITALIZATION PROGRAM							<b>39</b>
	OTHER REIMBURSABLE COST CENTERS	1				To do do		
	SPECIAL PURPOSE COST CENTERS							11
113	Interest Expense			771.020	2.986.04	15,630	557,49	4 11
118	SUBTOTALS (sum of lines 1-117)		2,215,02	1/1,020	J 2,760,04			
	NONREIMBURSABLE COST CENTERS			40.00	188,96		5.09	0 19
192	Physicians' Private Offices		140,17					
194	NRCC MARKETING		5,61	1,95	1,37.	<u> </u>	T	15
194.0					1			20
200	Cross Foot Adjustments							20
201	Negative Cost Centers		<b>24</b>		8 3,182,58	15,84	569,43	
	TOTAL (sum of lines 118-201)	1	2,360,81	2 821,76	51 <u>3,162,38</u>	13,64		

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	J3	ļ
	GENERAL SERVICE COST CENTERS							1
	Cap Rel Costs-Bidg & Fixt							<u> </u>
2	Cap Rel Costs-Myble Equip							2
4	Employee Benefits Department							5
5	Administrative & General		-					
6	Maintenance & Repairs							7
7	Operation of Plant	142.378						8
8	Laundry & Linen Service	1,379	26,528	26 700				9
9	Housekeeping	1.148		35,788	211,965			10
10	Dietary	9,869		2,525	21,433	21,433	<u> </u>	11
11	Cafeleria				21.433	21,433		12
12	Maintenance of Personnel			405		975	49,586	
13	Nursing Administration	1.581		403		713	43,360	14
14	Central Services & Supply						İ	1.5
15	Pharmacy	1		268		251	<del>                                     </del>	16
16	Medical Records & Library	1.046		572		1,179		17
17	Social Service	2,236		312		1,113		19
19	Nonphysician Anesthetists	1					<del></del>	20
20	Nursing School							21
21	I&R Services-Salary & Fringes Appryd							22
22	I&R Services-Other Prem Costs Apprvd	-						23
23	Paramed Ed Prgm-(specify)	100000000000000000000000000000000000000			Secretaria de Nova de Como de	umatamas saudad		到 2.5
	INPATIENT ROUTINE SERV COST CENTERS	79.961		20.462	185,916	9,648	49,586	30
30	Adults & Pediatries	/9.961	26,528	20,462	163,910	2,048	47,780	# <u></u>
	ANCILLARY SERVICE COST CENTERS	200000000000000000000000000000000000000				100000000000000000000000000000000000000		54
54	Radiology-Diagnostic						·	54.0
54.01	RADIOLOGY-SUA	113		29				60
60	Laboratory							60.0
60.01	BLOOD CLOTTING FOR HEMOPHILIACS							62.3
62.30		519		133		912		65
65	Respiratory Therapy	13,600		3,480		2,863		66
66	Physical Therapy	11,458		2,932		2,872		67
67	Occupational Therapy	4,077		1.043		1,230		68
68	Speech Pathology	3,168		811	-	146		71
71	Medical Supplies Charged to Patients	972		249		990		73
73	OTHER ANCILLARY	574.		232	-			76
76								76.0
76.01	SPECIAL PROCEDURES SPECIAL PROCEDURES SUA	-						76.0
76.02 76.97	CARDIAC REHABILITATION						1	76.9
76.98	HYPERBARIC OXYGEN THERAPY							76.9
76.98	LITHOTRIPSY						1	76.9
70.93	OUTPATIENT SERVICE COST CENTERS				- 10 TO 10 T	S		1
92	Observation Beds (Non-Distinct Part)							92
93,99	PARTIAL HOSPITALIZATION PROGRAM							93.9
73.77	OTHER REIMBURSABLE COST CENTERS							<b>a</b>
	SPECIAL PURPOSE COST CENTERS							
	Interest Expense							113
112	SUBTOTALS (sum of lines 1-117)	131,127	26,528	32,909	207.349	21,066	49,586	
		DESCRIPTION OF THE PROPERTY OF THE PARTY OF	20,726	2-1707				
						i	7	192
118	NONREIMBURSABLE COST CENTERS	[0.818		2.768	i			
113 118 192	NONREIMBURSABLE COST CENTERS Physicians' Private Offices	10,818		2,768 111		367		194
118 192 194	NONREIMBURSABLE COST CENTERS Physicians' Private Offices NRCC MARKETING	10,818 433			4,616	367		194
118 192 194 194.01	NONREIMBURSABLE COST CENTERS Physicians' Private Offices NRCC MARKETING GUEST MEALS				4,616	367		194
118	NONREIMBURSABLE COST CENTERS Physicians' Private Offices NRCC MARKETING				4,616	367		194 194.0

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B PART II

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL		
		16	17	24	25	26		
	GENERAL SERVICE COST CENTERS						1	
1	Can Rel Costs-Bldg & Fixt						1 2	
2	Cop Rel Costs-Myble Equip							
4	Employee Benefits Department							
5	Administrative & General							6
6	Maintenance & Repairs	1						7
7	Operation of Plant							8
8	Laundry & Linen Service	7						9
9	Housekeeping							10
10	Dietary							11
11	Cafeteria					·		12
12	Maintenance of Personnel					ļ		13
13	Nursing Administration							14
14	Central Services & Supply					ļ		15
15	Pharmacy	_l				ļ		16
16	Medical Records & Library	25,637				-		17 17
17	Social Service		65,720			<u> </u>		19
19	Nonphysician Anesthetists					<del>                                     </del>		20
20	Nursing School					<del></del>		21
21	1&R Services-Salary & Fringes Approd					<del>-</del> -		22
22	I&R Services-Other Prem Costs Appred					ļ		23
23	Paramed Ed Prem-(specify)			Care and the same of the same	and the second s	i necessiones Theresenson		
	INPATIENT ROUTINE SERV COST CENTERS					200		30
30	Adults & Pediatries	11.325	65,720	2,062.468		2,062,468		30
<u> </u>	ANCILLARY SERVICE COST CENTERS					3,364		54
54	Radiology-Diagnostic	79		3,364		3,304		54.01
54.01	RADIOLOGY-SUA					19,502		60
60	Laboratory	946		19,502		19,302		60.01
60.01	LAB SUA	İ				<del>                                       </del>		62.30
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					28,311		65
65	Respiratory Therapy	847		28,311		319,294		66
66	Physical Therapy	3,374		319.294		278,060		67
67	Occupational Therapy	3,296		278,060	ļ. <u> </u>	103,151		68
68	Speech Pathology	1,371		103,151		72,387		71
71	Medical Supplies Charged to Patients	899		72,387		63,411		73
73	Drugs Charged to Patients	3,352		63,413	<del></del>	03,4:1		76
76	OTHER ANCILLARY				ļ.—. ——	4.822		76.0
76.01	SPECIAL PROCEDURES	148	<u> </u>	4,822	+	4,824		76.0
76.02	SPECIAL PROCEDURES SUA			<del></del> -	<del> </del>	<del> </del>		76.9
76.97	CARDIAC REHABILITATION				·	<del></del>		76.9
76,98				ļ	<del> </del>	<del> </del>		76.9
76.99	LITHOTRIPSY						400000000000000000000000000000000000000	
1	OUTPATIENT SERVICE COST CENTERS					4		92
92	Observation Beds (Non-Distinct Part)				4			93.9
93.99	PARTIAL HOSPITALIZATION PROGRAM							10.1
75.75	OTHER REIMBURSABLE COST CENTERS				4			
<u> </u>	SPECIAL PURPOSE COST CENTERS				220/2002/2007/2005			113
113	Interest Expense					2,954,770		118
118	SUBTOTALS (sum of lines 1-117)	25,637	65,720	2,954,770		2,9,14,770		***
14.55	NONREIMBURSABLE COST CENTERS	K				207.643		192
192	Physicians' Private Offices			207,643		15,551		194
194	NRCC MARKETING		ļ <u>.</u>	15.551		4,616		194.
194.01			l'	4,616	4	4,610		200
	Cross Foot Adjustments			<u> </u>				201
200								
200	Negative Cost Centers	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

	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	
	· <del></del>	1	2	4	5A	5	7	ļ
	GENERAL SERVICE COST CENTERS							9 .
1	Cap Rei Costs-Bidg & Fixt	95.410						2
2	Cap Rel Costs-Myble Equip	tor.	95,410	13,880,090				4
4	Employee Benefits Department	475	475 17,005	1,932,184	-6,176,006	21,139,174		5
5	Administrative & General	17,005	17,005	1,932,164	-0,170,000	21,137,114	•	6
7	Maintenance & Repairs Operation of Plant	3,372	3,372	277.086		1,098,182	74,558	7
8	Laundry & Linen Service	722	722	277.040		39,519	722	
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		717.50					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	L&R Services-Other Prgm Costs Approd							22
23	Paramed Ed Prem-(specify)					THE PERSON NAMED IN COLUMN TWO IS NOT THE OWNER.		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
54	Radiology-Diagnostic		-		20.000	121,960		54.
54.01	RADIOLOGY-SUA				-37,202	(10.534	59	60
60	Laboratory	59	59			610,524	39	60.
60.01	1.AB SUA							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS		272	467.249		604,870	272	65
65	Respiratory Therapy	7,122	7,122	1,467,409		2,106,117	7,122	66
66	Physical Therapy	6.000	6,000	1,472.086		2,066,999	6,000	
67	Occupational Therapy Speech Pathology	2,135	2.135	630,615		872,100	2,135	68
68	Medical Supplies Charged to Patients	1,659	1,659	74,705		443,200	1,659	71
71 73	Drugs Charged to Patients	509	- 509	507,495		1,495,646	509	
<del>/3</del> 76	OTHER ANCILLARY			3071132		-1		76
76.01	SPECIAL PROCEDURES					173,510		76.
76.02	SPECIAL PROCEDURES SUA				-22,813			76
76.97	CARDIAC REHABILITATION							76
76.98	HYPERBARIC OXYGEN THERAPY							76
76,99	LITHOTRIPSY					L	l	76
	OUTPATIENT SERVICE COST CENTERS							<u>L</u>
92	Observation Beds (Non-Distinct Part)							92
93,99	PARTIAL HOSPITALIZATION PROGRAM							93
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							<b>#</b>
118	SUBTOTALS (sum of lines 1-117)	89,518	89.518	13,692,140	-6.236,021	20,695,765	68,666	1118
	NONREIMBURSABLE COST CENTERS							₽
192	Physicians Private Offices	5,665	5,665	ļ		188,967	5,665 227	
194	NRCC MARKETING	227	227	187,950		254,442	221	19
194.01	GUEST MEALS			}				19
200	Cross foot adjustments							20
201	Negative cost centers						1 416 002	20
202	Cost to be allocated (Per Wkst. B, Part I)	2,360,812				6,176,006	1,419,026	
203	Unit Cost Multiplier (Wkst, B, Part I)	24.743863	8.613018	0.257456		0.292159	19.032512 142.378	
204	Cost to be allocated (Per Wkst. B, Part II)			15,844		569,438	1.909627	
	Unit Cost Multiplier (Wkst. B, Part II)	PROSESSED AND AND AND AND AND AND AND AND AND AN		0,001141		0.026938	1.909627	1 20
205	NAHE adjustment amount to be allocated (per Wkst. B-			THE STATE OF THE PARTY OF THE P			CONTRACTOR CONTRACTOR	120

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

COST ALLOCATION - STATISTICAL BASIS

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE PATIENT DAYS	HOUSE- KEEPING SQUARE FEET	MEALS SERVED	CAFETERIA GROSS SALARIES	NURSING ADMINIS- TRATION PATIENT DAYS	MEDICAL RECORDS & LIBRARY GROSS REVENUE	
!		8	9	10	11	13	10	
	GENERAL SERVICE COST CENTERS	100000000000000000000000000000000000000						-
<u> </u>	Cap Rel Costs-Bide & Fixt							2
2	Cap Rel Costs-Myble Equip	1						4
4	Employee Benefits Department  Administrative & General							5
5						. —		6
6	Maintenance & Repairs Operation of Plant							7
, B	Laundry & Linen Service	29,698					,	8
9	Housekeeping	27,070	73,235					9
0	Dietary	1	5.168	101,577				10
1	Cafeteria	<del>-</del>		10,271	10,988,057			11
2	Maintenance of Personnel	1		10,2,1,	13(1-2-1-1)			12
3	Nursing Administration		828		499,861	29,698		13
4	Central Services & Supply	1		·		.5.1422		14
5	Pharmacy	-i						15
6	Medical Records & Library		548		128,861		63,769,122	16
17	Social Service		1,171		604.364			17
9	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Approd	<del></del>						21
22	1&R Services-Other Prem Costs Appred	1						22
23	Paramed Ed Prem-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							11
10	Adults & Pediatrics	29,698	41,872	89,094	4,947,462	29,698	28,166,882	30
	ANCILLARY SERVICE COST CENTERS							1
54	Radiology-Diagnostic						197,235	54
54.01	RADIOLOGY-SUA							54
50	Laboratory		59				2.352,735	60
50.01	LAB SUA							60.
52.30	BLOOD CLOTTING FOR HEMOPHILIACS							62
55	Respiratory Therapy		272		467,249		2,106,527	65
56	Physical Therapy		7,122		1,467,409		8,393,558	66
67	Occupational Therapy		6,000		1,472,086		8,199,237	
58	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
76.02	SPECIAL PROCEDURES SUA							76
76.97	CARDIAC REHABILITATION					. '		76
76.98	HYPERBARIC OXYGEN THERAPY							.76
76.99	LITHOTRIPSY						Section VIII Commission (III III III III III III III III III I	76
	OUTPATIENT SERVICE COST CENTERS							<b>.</b>
92	Observation Beds (Non-Distinct Part)							92
93,99	PARTIAL HOSPITALIZATION PROGRAM	(WINDOWS TO THE TOTAL THE TOTAL TOTAL TO THE TOTAL TO THE TOTAL TO THE TOTAL TO THE TOTAL TO THE	Manager Company of the Company of th		CONTRACTOR OF THE OWNER, WHICH	ATTENDO WATER STREET		93
	OTHER REIMBURSABLE COST CENTERS							81 31
	SPECIAL PURPOSE COST CENTERS	100200000000000000000000000000000000000				20.722	63.769.122	₹
18	SUBTOTALS (sum of lines 1-117)	29,698	67.343	99,365	10,800,107	29,698	5 63,769,122	<u>, , , [</u> 244
	NONREIMBURSABLE COST CENTERS							19:
92	Physicians' Private Offices		5,665	<u> </u>	187,950	l	<del> </del>	19
94	NRCC MARKETING	-	227	2.212	187,950	<b>-</b>		19
94.01	GUEST MEALS			2,212				1 20
100	Cross foot adjustments							20
101	Negative cost centers		(02.22	1470 101	144.930	014.425	288,082	
202	Cost to be allocated (Per Wkst, B, Part I)	64,806		1,432,406		914,475		
203	Unit Cost Multiplier (Wkst. B, Part I)	2.182167	9,460408	14.101677	0.013181	30.792478	0.004518 25,637	
	Cost to be allocated (Per Wkst. B, Part II)	26,528	35,788	211,965	21,433	49,586		
204								
204 205 206	Unit Cost Multiplier (Wkst. B. Part II)  NAHE adjustment amount to be allocated (por Wkst. B-2	0.893259	0.488673	2,086742	0.001951	1,669675	0.000402	第20

	In Lieu of Form	Period:	Run Date: 05/09/2019
ENCOMPASS HEALTH DEACONESS REHABILIT		From: 01/01/2018 To: 12/31/2018	Run Time: 10:18 Version: 2018.12 (03/07/2019)
Provider CCN: 15-3025		10, 1201/2010	

COST ALLOCATION - STATISTICAL BASIS

		SOCIAL SERVICE						
	COST CENTER DESCRIPTIONS	PATIENT						
$\dashv$		DAYS 17						
	GENERAL SERVICE COST CENTERS			T.		1		<b>1</b>
. 1	Can Rel Costs-Bldg & Fixt							1 2
2	Cap Rei Costs-Myble Equip							4
5	Employee Benefits Department				<del></del>		· <del></del> -	5
5	Administrative & General							6
6	Maintenance & Repairs			<del>  -</del>				7
7	Operation of Plant Laundry & Linen Service							8
8	Housekeeping							] 9
0	Dietary							10
1	Cafeteria					ļ <u></u> .		11
2	Maintenance of Personnel			<del>-</del>		<del></del>		13
3	Nursing Administration	·	·	<del>  -</del>	<del> </del>	· · · · · · · · · · · · · · · · · · ·		14
4	Central Services & Supply			<del> </del>	1		1	15
15 16	Pharmacy Medical Records & Library	· · · · · · · · · · · · · · · · · · ·				<u> </u>		16
17	Social Service	29,698						17
19	Nonphysician Anesthetists							19
20	Nursing School							20
2)	I&R Services-Salary & Fringes Apprvd			<u></u>	·		<del></del>	22
22	1&R Services-Other Prgm Costs Apprvd				<del> </del>	+	·	23
23	Paramed Ed Prem-(specify)			V 2 V 2 20 2 1 2 2		1		
	INPATIENT ROUTINE SERV COST CENTERS Adults & Pediatrics	29,698				T		30
30	ANCILLARY SERVICE COST CENTERS	27,070		XX 2000				₩
54	Radiology-Diagnostic					ļ		54
54.01	RADIOLOGY-SUA						ļ	54
60	Laboratory						<del> </del> -	60
60.01	LAB SUA				-	<del>                                     </del>		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS			<del> </del>				6:
65	Respiratory Therapy Physical Therapy	·						6
66 67	Occupational Therapy					ļ <u>.</u>		_ 6
68	Speech Pathology					<u> </u>		7
71	Medical Supplies Charged to Patients		·				+	1 2
73	Drugs Charged to Patients						<del> </del>	1 7
76	OTHER ANCILLARY							7
76.01	SPECIAL PROCEDURES		·		<b>-</b>			7
76.02	SPECIAL PROCEDURES SUA CARDIAC REHABILITATION		-	-			<u> </u>	7
76.97 76.98	HYPERBARIC OXYGEN THERAPY						ļ	
76.99	LITHOTRIPSY			1			and the second second second second	7
	OUTPATIENT SERVICE COST CENTERS							9
92	Observation Beds (Non-Distinct Part)							9
93.99	PARTIAL HOSPITALIZATION PROGRAM	Name and the second second second second second second second second second second second second second second						
	OTHER REIMBURSABLE COST CENTERS							<b>20</b>
118	SPECIAL PURPOSE COST CENTERS SUBTOTALS (sum of lines 1-117)	29,698						11
110	NONREIMBURSABLE COST CENTERS							22
192	Physicians' Private Offices					<del> </del>	<del></del>	15
194	NRCC MARKETING					<del>-</del>	<del> </del>	19
194.01	GUEST MEALS	Charles and the same of the sa						2
200	Cross foot adjustments							2
201	Negative cost centers	1,095,768						2
202	Cost to be allocated (Per Wkst. B, Part I) Unit Cost Multiplier (Wkst. B, Part I)	36.897030	5					. 2
203	Cost to be allocated (Per Wkst, B, Part II)	65,720						2
204	Unit Cost Multiplier (Wkst. B, Part II)	2.21294					1	2
	NAHE adjustment amount to be allocated (per Wkst, B-2)							2
206	NAHE unit Cost Multiplier (Wkst. D, Parts III and IV)	And the second s						<b>2</b> 1 2

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025

In Lieu of Form CMS-2552-10

Period: From: 01/01/2018 To: 12/31/2018

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POST STEPDOWN ADJUSTMENTS

		RKSHEET	AMOUNT	
DESCRIPTION	CODE	LINE NO.	AMOUNT	
1		3		

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

#### COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C PART I

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	<u> </u>
	INPATIENT ROUTINE SERVICE COST CENTERS						ļ
30	Adults & Pediatrics	14,836,219		14,836,219	1,645	14,837,864	30
	ANCILLARY SERVICE COST CENTERS						54
54	Radiology-Diagnostic	158,483		158,483		158,483	54.01
54.01	RADIOLOGY-SUA	37,202		37,202		37,202	60
60	Laboratory	801,205		801,205		801,205	60.01
60.01	LAB SUA						62.30
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					805.014	65
65	Respiratory Therapy	805,014		805,014			66
66	Physical Therapy	2,981,629		2,981,629		2.981,629	
67	Occupational Therapy	2,898,296		2,898,296		2,898,296	
68	Speech Pathology	1,211,443	7-4	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		W 3 4 5 4 5 4 5 4 5 4 5 4 5 4 5 4 5 4 5 4	<u></u>			76
76.01	SPECIAL PROCEDURES	225,868		225,868		225.868	76.01
76.02	SPECIAL PROCEDURES SUA	22,813		22.813		22,813	
76.97	CARDIAC REHABILITATION						76.9
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY			l		annon-traditional description	76.99
	OUTPATIENT SERVICE COST CENTERS						4
92	Observation Beds (Non-Distinct Part)			<u></u>			92
93.99	PARTIAL HOSPITALIZATION PROGRAM			1		THE THE PERSON WAS ARREST TO THE PERSON WHEN	93.99
	OTHER REIMBURSABLE COST CENTERS						對
113	Interest Expense			I		L	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

### COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C PART 1

			CHARGES					
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	<u></u>
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	28,166.882		28,166.882	200			30
	ANCILLARY SERVICE COST CENTERS							4
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	
68	Speech Pathology	2,682,005	728,122	3,410,127	0.355249	0.355249	0.355249	
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	Ī., .						76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
74.54	OUTPA'TIENT SERVICE COST CENTERS							<u> </u>
92	Observation Bods (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
70.77	OTHER REIMBURSABLE COST CENTERS	70.00						4
113	Interest Expense			~				113
200	Subtotal (sum of lines 30 thru 199)	61,626,203	2,405,154	64,031.357				<b>200</b>
201	Less Observation Beds	75 C 1 C 1 C 1 C 1 C 1 C 1 C 1 C 1 C 1 C						201
202	Total (line 200 minus line 201)	61,626,203	2,405,154	64,031.357				202

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

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

WORKSHEET

				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						<b>4</b>
0	Adults & Pediatrics					Contractions (Three Contract	j 30
	ANCILLARY SERVICE COST CENTERS		A				≇
4	Radiology-Diagnostic				_		54
4.01	RADIOLOGY-SUA						54
0	Laboratory						60
0.01	LAB SUA						60
2.30	BLOOD CLOTTING FOR HEMOPHILIACS				<u> </u>		6
5	Respiratory Therapy						16
5	Physical Therapy				- <b></b>		6
7	Occupational Therapy				-		+6
8	Speech Pathology		**************************************				1 7
1	Medical Supplies Charged to Patients				<del>                                     </del>		++
3	Drugs Charged to Patients				+		1-9
5	OTHER ANCILLARY						17
5.01	SPECIAL PROCEDURES						+7
5.02	SPECIAL PROCEDURES SUA						+÷
5.97	CARDIAC REHABILITATION						+ 7
5.98	HYPERBARIC OXYGEN THERAPY						1 7
5.99	LITHOTRIPSY						<b>⊗b</b> ′
	OUTPATIENT SERVICE COST CENTERS			<u> </u>	1		1 9
3.99	Observation Beds (Non-Distinct Part) PARTIAL HOSPITALIZATION PROGRAM				process and the second	i	9
1,99	OTHER REIMBURSABLE COST CENTERS						<b>201</b>
3	Interest Expense						1
<u></u>	Subtotal (sum of lines 30 thru 199)					Ĭ	2
1	Less Observation Beds		100200000000000000000000000000000000000	1			2
2	Total (line 200 minus line 201)				1	T	20

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

WORKSHEET C PART I

		CHARGES					<del> </del>
COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
	6	7	8	9	10	11	
INPATIENT ROUTINE SERVICE COST CENTERS							30
30 Adults & Pediatrics	28,166.882		28,166,882				- JU
ANCILLARY SERVICE COST CENTERS							54
54 Radiology-Diagnostic	196,743	492	197,235				54.01
54.01 RADIOLOGY-SUA	79,384		79,384				60
60 Laboratory	2.352,735		2,352,735				60.01
60.01 LAB SUA					<del></del>	<del> </del>	62.30
62.30 BLOOD CLOTTING FOR HEMOPHILIACS			2,106,527		<del> </del>	-	65
65 Respiratory Therapy	2,106,527		8,393,558				65
66 Physical Therapy	7,330,720	1,062,838	8,199,237				67
67 Occupational Therapy	7,596,993	602,244	3,410,127				68
68 Speech Pathology	2,682,005	728,122	2,235,738				71
71 Medical Supplies Charged to Patients	2,224,280	11,458	8,338,526			-	73
73 Drugs Charged to Patients	8,338,526		<u>0,330,320</u>			1	76
76 OTHER ANCILLARY			368,557				76.01
76.01 SPECIAL PROCEDURES	368,557		368,337 182,851		<del></del>		76.02
76.02 SPECIAL PROCEDURES SUA	182,851		162,831		<del></del>		76.97
76.97 CARDIAC REHABILITATION							76.98
76.98 HYPERBARIC OXYGEN THERAPY	<del></del>					1	76.99
76.99 LITHOTRIPSY	Company of the Control of the Contro	anno de Santa de Carres			3		
OUTPATIENT SERVICE COST CENTERS							92
92 Observation Beds (Non-Distinct Part)							93.99
93.99 PARTIAL HOSPITALIZATION PROGRAM						9 Y 30 C	
OTHER REIMBURSABLE COST CENTERS							113
113 Interest Expense	41.606.000	2,405,154	64,031.357		le de la companya de la companya de la companya de la companya de la companya de la companya de la companya de		200
200 Subtotal (sum of lines 30 thru 199)	61,626,203	2,405,154	04,031.337				201
201 Less Observation Beds		2,405,154	64.031.357				202
202 Total (line 200 minus line 201)	61,626.203	2,405,154	<u>04,031.337</u>	1 house of the sam			

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

COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2551-10 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- altowance	Total Costs	
	<u></u>	1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						<u> </u>
30	Adults & Pediatrics	14,836,219		14,836,219	1,645	14,837,864	36
30	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	158,483		158,483		158,483	54 54.01
54.01	RADIOLOGY-SUA	37,202		37,202		37,202	
60	Laboratory	801,205		801,205		801,205	60.01
10.00	LAB SUA			I			62.30
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					805,014	65.51
65	Respiratory Therapy	805,014		805,014			66
66	Physical Therapy	2.981,629		2,981.629		2.981.629 2.898,296	
67	Occupational Therapy	2,898,296		2,898,296			68
68	Speech Pathology	1.211,443	- Control of the Cont	1,211,443		1.211,443 631,041	71
71	Medical Supplies Charged to Patients	631,041		631,041		1,991,477	73
73	Drugs Charged to Patients	1,991,477		1,991.477		1,991,477	76
76	OTHER ANCILLARY					225,868	76.0
76.01	SPECIAL PROCEDURES	225.868		225,868		22,813	76.0
76.02	SPECIAL PROCEDURES SUA	22,813		22,813		22,813	76.9
76.97	CARDIAC REHABILITATION			1			76.9
76.98	HYPERBARIC OXYGEN THERAPY			9			76.9
76.99	LITHOTRIPSY	a library and a second a second and a second					70.5
	OUTPATIENT SERVICE COST CENTERS				r	I	92
92	Observation Beds (Non-Distinct Part)			<b>2</b>			93.9
93.99	PARTIAL HOSPITALIZATION PROGRAM						1 33.37
	OTHER REIMBURSABLE COST CENTERS			40000000000000000000000000000000000000		i	113
113	Interest Expense			37 (00 (00	1,645	26,602,335	200
200	Subtotal (sum of lines 30 thru 199)	26,600,690	\$27.000000000000000000000000000000000000	26,600,690	1,043	20,004,333	201
201	Less Observation Beds			26.600.600	1.645	26.602.335	
202	Total (line 200 minus line 201)	26,600.690	L	26,600,690	1,645	20,002,332	1 202

· · · · · · · · · · · · · · · · · · ·	In Lieu of Form	Period:	Run Date: 05/09/2019
ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025		From: 01/01/2018 To: 12/31/2018	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

		<del></del>	CHARGES					
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	4
	INPATIENT ROUTINE SERVICE COST CENTERS		i i					30
30	Adults & Pediatrics	28,166,882		28,166.882	l=====================================			H 20
22	ANCILLARY SERVICE COST CENTERS						0.803524	54
54	Radiology-Diagnostic	196,743	492	197,235	0.803524	0,803524	0.468633	54.01
54.01	RADIOLOGY-SUA	79.384		79,384	0.468633	0.468633	0.408633	60
60	Laboratory	2,352,735		2,352,735	0.340542	0.340542	0.340342	60.01
60.01	LAB SUA							62.30
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						0.382152	65
65	Respiratory Therapy	2,106,527		2,106,527	0.382152	0.382152		66
66	Physical Therapy	7,330,720	1,062,838	8,393,558	0.355228	0.355228	0,355228	67
67	Occupational Therapy	7,596,993	602,244	8,199,237	0.353484	0.353484		68
68	Speech Pathology	2,682,005	728,122	3,410,127	0.355249	0,355249	0.355249	71
71	Medical Supplies Charged to Patients	2,224.280	51,458	2,235,738	0.282252	0.282252		73
73	Drugs Charged to Patients	8,338,526		8,338,526	0.238828	0.238828	0.238828	76
76	OTHER ANCILLARY						0.440044	
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
76.98	HYPERBARIC OXYGEN THERAPY							76.99
76.99	LITHOTRIPSY					en en en en en en en en en en en en en e		1 /0.99
10.77	OUTPATIENT SERVICE COST CENTERS							92
92	Observation Beds (Non-Distinct Part)							93.99
93.99	PARTIAL HOSPITALIZATION PROGRAM					***		93,99
20.72	OTHER REIMBURSABLE COST CENTERS							# 113
113	Interest Expense						- <del></del>	200
200	Subtotal (sum of lines 30 thru 199)	61,626.203	2,405,154	64,031,357				201
201	Less Observation Beds			7/20 7/20 - 60 - 60 - 60 - 60 - 60 - 60 - 60 -				202
202	Total (line 200 minus line 201)	61,626,203	2,405,154	64,031,357				29 ZUZ

| In Lieu of Form | Period : Run Date: 05/09/2019 | ENCOMPASS HEALTH DEACONESS REHABILIT | CMS-2552-10 | From: 01/01/2018 | Run Time: 10:18 | Version: 2018.12 (03/07/2019) |

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY

WORKSHEET C PART II

[ ] Title V

ĮXXĮ Title XIX

	COST CENTER DESCRIPTIONS	Total Cost (Wkst B, Part I, col. 26)	Capital Cost (Wkst B, Part II, col. 26	Operating Cost Not of Capital Cost (col. 1 - col. 2)	Capital Reduction	
	(NOTA - DI INDIANA DE CONTROL DE	1	2		4	-
L	ANCILLARY SERVICE COST CENTERS	158,483	3,364	155,119		54
54	Radiology-Diagnostic	37,202	3,309	37.202		54.01
54.01	RADIOLOGY-SUA		19,502	781,703		60
60	Laboratory	801,205	19,302	/61,/03		60.01
60.01	LAB SUA	ļ'				62.30
62.30	BLOOD CLOTTING FOR HEMOPHILIACS	805.014	28,311	776,703		65
65	Respiratory Therapy	2.981.629	319,294	2.662.335		66
66	Physical Therapy		278,060			67
67	Occupational Therapy	2,898,296	103.151	2,620,236 1,108,292		68
68	Speech Pathology	1,211,443				71
71	Medical Supplies Charged to Patients	631,041	72,387	558,654		73
73	Drugs Charged to Patients	1.991,477	63,411	1,928,066		
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
$\Box$	OUTPATIENT SERVICE COST CENTERS					
92	Observation Beds (Non-Distinct Part)					92
93.99	PARTIAL HOSPITALIZATION PROGRAM	L				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	i				201
202	Total	11.764.471	892,302	10,872,169		202

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

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	88	
	ANCILLARY SERVICE COST CENTERS			. <u> </u>		
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	
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
1	OUTPATIENT SERVICE COST CENTERS					H
92	Observation Beds (Non-Distinct Part)					92
93.99	PARTIAL HOSPITALIZATION PROGRAM		L			93.99
	OTHER REIMBURSABLE COST CENTERS					<b>4</b>
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

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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D PART I

Check Applicable Boxes;

[ ] Title V
[XX] Title XVIII, Part A
[ ] 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 Dzys	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	
(71)	INPATIENT ROUTINE								
	SERVICE COST CENTERS	2.062,468		2.062,468	29,698	69.45	21,427	1,488,105	30
30	Adults & Pediatrics General Routine Care)	2,002,400		I IJGGER 100					31
31	Intensive Care Unit	··	W. W. W. W.						32
32	Coronary Care Unit			i i					33
33	Burn Intensive Care Unit	<del> </del>		<b></b>					34
34	Surgical Intensive Care Unit	<del> </del>		I					35
35	Other Special Care (specify)								40
40	Subprovider - IPF			<b>!-</b>					41
41	Subprovider - IRF								42
42	Subprovider I								43
43	Nursery	<u> </u>				·			44
44	Skilled Nursing Facility							<del>-</del>	45
45	Nursing Facility			2,062.468	20.609		21,427	1,488,105	200
200	Total (lines 30-199)	2,062,468	100	2,002.408	29,098	Philippe Company of the Company of t	1 21,7 <u>2-7</u>	111001705	,

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

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-3025

WORKSHEET D PART II

Check Applicable	[ ] Title V [XX] Title XVIII, Part A	[XX] Hospital	[ ] SUB (Other)	[XX] PPS [ ] TEFF
Boxes:	[ ] 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	h -
	ANCILLARY SERVICE COST CENTERS				106.013	4 171	54
54	Radiology-Diagnostic	3,364	197,235	0.017056	186,012	3,173	
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	63.431	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	
76.02	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
12,75	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct						92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS			1000 No. 2000	Section of the second		射
200	Total (sum of lines 50-199)	892,302	35,864,475		24,246,960	585,012	200

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

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

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

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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D PART III

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

		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	<u> </u>
1//	INPATIENT ROUTINE SERVICE COST CENTERS					₹——
	Adults & Pediatrics	29,698		21,427		30
30	(General Routine Care)					33
31	Intensive Care Unit					32
32	Coronary Care Unit					33
33	Burn Intensive Care Unit					34
34	Surgical Intensive Care Unit					35
35	Other Special Care (specify)					40
40	Subprovider - IPF					41
41	Subprovider - IRF					42
42	Subprovider 1					43
43	Nursery	-			·	44
44	Skilled Nursing Facility					45
45	Nursing Facility	20.608		21,427		200
200	Total (lines 30-199)	27,078				

	In Lieu of Form	Period:	Run Date: 05/09/2019
ENCOMPASS HEALTH DEACONESS REHABILIT		From: 01/01/2018	Run Time: 10:18
		To: 12/31/2018	Version: 2018.12 (03/07/2019)
Provider CCN: 15-3025		1 40. 12/01/20/0	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-3015

WORKSHEET D PART IV

Check [ ] Title Applicable [XX] Title Boxes: [ ] Title	XVIII, Part A [ ]	Hospital [ IPF [ IRF [	] SUB (CI ] SNF ] NF	ther) [	] ICF/IID	ī	PPS TEFRA Other
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		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	JA Commission					1
	ANCILLARY SERVICE COST CENTERS				the page 1000 to the total					54
54	Radiology-Diagnostic					-	-	·		54.01
54.01	RADIOLOGY-SUA									60
60	Laboratory					-	<del> </del> -	ļ		60.01
60.01	LAB SUA									62.30
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						<del> </del>	<u> </u>		65
65	Respiratory Therapy	<u> </u>		<u> </u>			<del> </del>		<del></del>	66
66	Physical Therapy							·		67
67	Occupational Therapy			ļ			<del> </del>			68
68	Speech Pathology						<u> </u>			71
71	Medical Supplies Charged to Pat			ļ						73
73	Drugs Charged to Patients			<u> </u>	ļ <u>-</u>			<del> </del>		76
76	OTHER ANCILLARY				<del> </del>		<del> </del>			76.01
76.01	SPECIAL PROCEDURES	ļ							i	76.02
76.02	SPECIAL PROCEDURES SUA				<b></b>		<del> </del>	<del> </del> -		76.97
76.97	CARDIAC REHABILITATION				<del>  </del>	·		<del>                                     </del>		76.98
76.98	HYPERBARIC OXYGEN THERAPY		ļ <u> </u>		<b>_</b>	ļ. <del></del>		<del> </del>	<del> </del>	76.99
76.99	LITHOTRIPSY	promachinistifalmona	I management of the second	Commence (Commence			No.			1
	OUTPATIENT SERVICE COST CENTERS					#				92
92	Observation Beds (Non-Distinct			<del></del>		₹	<del> </del>	<del> </del>	<del> </del>	93.99
93.99	PARTIAL HOSPITALIZATION PROGRAM	The same of the sa	A CONTRACTOR OF THE PARTY OF TH							1
	OTHER REIMBURSABLE COST CENTERS						4			200
200	Total (sum of lines 50-199)	L	<u> </u>		<u>.l</u>		l	1	1	, 200

<sup>(</sup>A) Worksheet A line numbers

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTRER PASS THROUGH COSTS

COMPONENT CCN: 15-3025

WORKSHEET D PART IV

		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								3
54	Radiology-Diagnostic	197,235			186.012		492		54
54.01	RADIOLOGY-SUA	79.384			68,038				54.01
60	Laboratory	2,352,735			1,663,098		ļ.		60
60.01	LAB SUA	T							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62,30
65	Respiratory Therapy	2,106,527		1	1,671,201		1		65
66	Physical Therapy	8,393,558			5,294,264				66
67	Occupational Therapy	8,199,237			5,480.655				67
68	Speech Pathology	3,410.127		ļ	1,913,221				68
71	Medical Supplies Charged to Pat	2,235,738	L.,		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	162,851			141,898				76.02
76.97	CARDIAC REHABILITATION								76.97
76,98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY	]		1				CONTRACTOR OF A CONTRACT	76.99
	OUTPATIENT SERVICE COST CENTERS		7-20-6-50						舞
92	Observation Beds (Non-Distinct	1							92
93.99	PARTIAL HOSPITALIZATION PROGRAM		L					rounders warm branches with Co	93.99
	OTHER REIMBURSABLE COST CENTERS								<b>期</b>
200	Total (sum of lines 50-199)	35,864,475			24,246,960		1,136		200

COMO	I I P	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)	
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-3025

WORKSHEET D PART V

				Program Charges			Program Cost		
	·	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim- bursed Services (see inst.)	Cost Reim- bursed Subject to Ded. & Coins. (see inst.)	Cost Reim- bursed Not Subject to Ded, & Coins. (see inst.)	PPS Services (see inst.)	Cost 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	1	<u></u>
	ANCILLARY SERVICE COST CENTERS					395			54
54	Radiology-Diagnostic	0,803524	492		ļ.—				54.01
54.01	RADIOLOGY-SUA	0.468633							60
60	Laboratory	0.340542							60.01
60.01	LAB SUA								62.30
62.30	BLOOD CLOTTING FOR HEMOPHILIACS			ļ <u>-</u>	<del></del>				65
65	Respiratory Therapy	0.382152			-				66
66	Physical Therapy	0.355228			<del> </del>	<del> </del>	-		67
67	Occupational Therapy	0.353484			·		<del></del>	·	68
68	Speech Pathology	0.355249			·	182			71
71	Medical Supplies Charged to Pat	0.282252	644						73
73	Drugs Charged to Policuts	0.238828		ļ	<del>-</del>				76
76	OTHER ANCILLARY					<del> </del>		1	76.01
76.01	SPECIAL PROCEDURES	0.612844				<del> </del>			76.02
76.02	SPECIAL PROCEDURES SUA	0.124763		<del></del>		<del> </del>			76,97
76.97	CARDIAC REHABILITATION			<del> </del>		· · · · · · · · · · · · · · · · · · ·	<del>                                     </del>		76.98
76.98	HYPERBARIC OXYGEN THERAPY			<del> </del>		<del> </del>		· · - · · ·	76.99
76.99	LITHOTRIPSY	Andrews Water Company of the Company						700000000000000000000000000000000000000	
	OUTPATIENT SERVICE COST CENTERS								92
.92	Observation Beds (Non-Distinct					<del> </del>	·		93.99
93.99	PARTIAL HOSPITALIZATION PROGRAM			170000000000000000000000000000000000000				i de la companya de la companya de la companya de la companya de la companya de la companya de la companya de	20
	OTHER REIMBURSABLE COST CENTERS		1 130			577			200
200	Subtotal (see instructions)		1,136		+		a	1	201
201	Less PBP Clinic Lab. Services-Program Only Charges		1,136	P —	<del> </del>	577			202
202	Net Charges (line 200 - line 201)		1,136	L		1			

<sup>(</sup>A) Worksheet A line numbers

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

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	ļ
	INPATIENT ROUTINE SERVICE COST CENTERS								7
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)		A	L					35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery	ļ							43
44	Skilled Nursing Facility			_					45
45	Nursing Facility			200010	29,698	KONTON NO.	398	27,641	
200	Total (lines 30-199)	2,062,468		2,062,468	29,698		398	47,041	1 700

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

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-3025

WORKSHEET D PART II

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

		Capital Related Cost (from Wisst. 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		
757	ANCILLARY SERVICE COST CENTERS				1563	27	54
54	Radiology-Diagnostic	3,364	197,235	0.017056	1,563		54.01
54.01	RADIOLOGY-SUA		79,384		34,869	289	60
60	Laboratory	19,502	2,352,735	0.008289	34,809	203	60.01
60.01	LAB SUA				·		62,30
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				14.679	197	65
65	Respiratory Therapy	28,311	2,106,527	0.013440	106.678	4,058	66
66	Physical Therapy	319,294	8,393,558	0.038040	110.688	3,754	
67	Occupational Therapy	278,060	8.199.237	0.033913	23,659	716	
68	Speech Pathology	103,151	3,410,127	0.030248	31,764	1.028	71
71	Medical Supplies Charged to Pat	72,387	2,235,738		113,347	862	73
73	Drues Charged to Patients	63.411	8,338,526	0.007605	113,347	- 002	76
76	OTHER ANCILLARY		·	2012022	2,646	35	76.01
76.01	SPECIAL PROCEDURES	4.822	368,557	0.013083	1,313		76.02
76.02	SPECIAL PROCEDURES SUA		182.851		1,515		76.97
76.97	CARDIAC REHABILITATION						76.98
76.98	HYPERBARIC OXYGEN THERAPY					<del> </del>	76.99
76.99	LITHOTRIPSY			-		V 100	謝
	OUTPATIENT SERVICE COST CENTERS						92
92	Observation Beds (Non-Distinct		L	<del></del>	<del></del>		93.99
93.99	PARTIAL HOSPITALIZATION PROGRAM	PROPERTY AND DESCRIPTION OF THE PROPERTY AND DESCRIPTION OF TH	operandi liikuva karisi	1	LESS TO SECURITION		<b>a</b> i
	OTHER REIMBURSABLE COST CENTERS		25.054.475		441.835	10,966	200
200	Total (sum of lines 50-199)	892,302	35,864,475	The state of the s	441,03,1		

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D PART III

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

[ ] TEFRA

		Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjust- ment Amount (see instruct- ions)	Total Costs (sum of cols. I through 3 minus col 4.)	
(A)	Cost Center Description	IA	1	2A -	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)								30
31	Intensive Care Unit							1	31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit			<u> </u>				1	34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery					No. of the Control of			43
44	Skilled Nursing Facility								44
45	Nursing Facility								200
200	TOTAL (lines 30-199)								[ Z00

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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D PART III

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

		Total Patient Days	Per Dicm (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	
(23)	INPATIENT ROUTINE SERVICE COST CENTERS					1
30	Adults & Pediatrics	29,698		398		30
{	(General Routine Care)					31
31	Intensive Care Unit					32
32	Coronary Care Unit					33
33	Burn Intensive Care Unit	<del></del>				34
34	Surgical Intensive Care Unit				· · · · · · · · · · · · · · · · · · ·	35
35	Other Special Care (specify)					40
40	Subprovider - IPF				·	41
41	Supprovider - IRF					42
42	Supprovider 1					43
43	Nursery					44
44	Skilled Nursing Facility	<del></del>				45
45	Nursing Facility	20 698		398	1	200_
200	Total (lines 30-199)	27,078		a		

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-3025

WORKSHEET D PART IV

Chack Applicable Boxes:	[ ] Title V [ ] Title XVIII, Part A [XX] Title XIX	[XX] Hospital [ ] IPF [ ] IRF	[ ] SUB (Other) [ ] SNF [ ] NF	( ) ICF/IID	[ ] PPS [ ] TEFRA [XX] Other
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		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Atlied Health Post- Stepdown Adjustments	Aliicd Health	All Other Medical Education Cost	Total Cost (sum of col. i through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	i	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									2
54	Radiology-Diagnostic									54
54.01	RADIOLOGY-SUA		ļ				<u> </u>			54.01
60	Laboratory						ļ			60
60.01	LABSUA									60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						ļ			62.30
65	Respiratory Therapy		<u></u>							65
66	Physical Therapy									66
67	Occupational Therapy						ļ			67
68	Speech Pathology	<u> </u>								68
71	Medical Supplies Charged to Pat									71
73	Drugs Charged to Patients	L								73
76	OTHER ANCILLARY	l.,								76
76.01	SPECIAL PROCEDURES									76.01
76,02	SPECIAL PROCEDURES SUA	ļ					ļ			76.02
76.97	CARDIAC REHABILITATION	<u> </u>	1					ļ		76.97
76.98	HYPERBARIC OXYGEN THERAPY	1		ļ			ļ			76.98
76.99	LITHOTRIPSY				Transition of the second second	anneausene mei er Miller	arkson many account of		The second secon	76.99
	OUTPATIENT SERVICE COST CENTERS									100
92	Observation Beds (Non-Distinct			<b>!</b>			<del> </del>			92
93.99	PARTIAL HOSPITALIZATION PROGRAM		l			***************************************		#2/23/10-20/20/20/20/20/20/20/20/20/20/20/20/20/2		93.99
	OTHER REIMBURSABLE COST CENTERS									200
200	Total (sum of lines 50-199)		L		1		J	L	l	200

ENCOMPASS HEALTH DEACONESS REHABIL	In Lieu of			Period : From: 01/01/2018			Run Date: 05/09/2019 Run Time: 10:18			
encompass health deaconess rehabile Provider CCN: 15-3025	[] CN15-255	2-10		12/31/2018			12 (03/07/201	9)		
APPORTIONMENT OF INPATIENT/OUTPATIENT ANC OTHER PASS THROUGH COSTS	E	COMPONENT CCN: 15-3025				WORKSHEET I PART IV				
theck [ ] Title V pplicable [ ] Title XVIII, Fart A loxes: [XX] Title XIX	[XX] Hospit [ ] IRF [ ] IRF	[ ]	SUB (Other)   SNF   NF	I	] ICF/II	į į	PPS TEFRA Other			
	Total Charges (from Wkst. C, Part I, cot. 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	384		
ANCILLARY SERVICE COST CENTERS								54		
54 Radiology-Diagnostic	197,235		<b></b>	1,563		<del> </del>	_	54.0		
54.01 RADIOLOGY-SUA	79.384			629			<del></del>	60		
50 Laboratory	2,352,735		<u> </u>	34,869		<del> </del>	_	60.0		
50.01 LAB SUA							<b></b>	62.2		
62.30 BLOOD CLOTTING FOR HEMOPHILIACS			ļ					65		
S5 Respiratory Therapy	2,106,527			14,679				66		
66 Physical Therapy	8,393,558			106,678		<del></del>	<del> </del>	67		
67 Occupational Therapy	8,199,237			110.688				68		
58 Speech Pathology	3,410,127			23,659				71		
71 Medical Supplies Charged to Pat	2,235,738		4	31,764		<del> </del>	<del> </del>	73		
23 Drugs Charged to Patients	8,338,526			113,347	•	- <del> </del>		76		
76 OTHER ANCILLARY			4					76.0		
P6.01 SPECIAL PROCEDURES	368,557			2,646		<b> </b>		76.		
76.02 SPECIAL PROCEDURES SUA	182,851			1.313				76.		
76.97 CARDIAC REHABILITATION				<u> </u>		<del> </del>	1	76.		
76.98 HYPERBARIC OXYGEN THERAPY						-	<del> </del>	76.		
76.99 LITHOTRIPSY			The state of the s	NAME OF THE PERSON OF THE PERS	THE RESERVE OF THE PERSON NAMED IN COLUMN	; 		79.		
OUTPATIENT SERVICE COST CENTERS		W 28 28 5						92		
92 Observation Beds (Non-Distinct			-				<del></del>	93.		
93.99 PARTIAL HOSPITALIZATION PROGRAM			4	HIDDOOR AND AND AND AND AND AND AND AND AND AND	20102007600002607607			93.5  開		
OTHER REIMBURSABLE COST CENTERS			4		<u> </u>			200		
200 Total (sum of lines 50-199)	35,864,475			441,835		_1		1,200		

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

KPMG	111	Compu-	Max	2552-10

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

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-3025

WORKSHEET D PART V

Check	[ ] Title V - O/P	[XX] Hospital	[ ] SUB (Other)	[ ] Swing Bed SNF
Applicable	[ ] Title XVIII, Part B	[ ] IPF	[ ] SNF	[ ] Swing Bed NF
Boxes:	[XX] 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 Reim- bursed Subject to Ded. & Coins, (see inst.)	Cost Reimbursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reinn- bursed 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	
LAI.	ANCILLARY SERVICE COST CENTERS								<b>4</b>
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	B! OOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.382152							65
66	Physical Therapy	0.355228		21,293			7,564		67
67	Occupational Therapy	0.353484		20,009			7.073		68
68	Speech Pathology	0.355249		1,709			607		71
71	Medical Supplies Charged to Pat	0.282252		67_		l	19		73
73	Drugs Charged to Patients	0.238828						<del></del>	76
76	OTHER ANCILLARY								76.01
76,01	SPECIAL PROCEDURES	0.612844							76.02
76.02	SPECIAL PROCEDURES SUA	0.124763		ļ		· · · · · ·			76.97
76.97	CARDIAC REHABILITATION				·				76.98
76.98	HYPERBARIC OXYGEN THERAPY	<u> </u>	ļ		ļ ··-		<del> </del>		76.99
76.99	LITHOTRIPSY	processor of the control of the cont			 				2B
	OUTPATIENT SERVICE COST CENTERS								92
92	Observation Beds (Non-Distinct		<del> </del> -	<del> </del>	<del></del>		<del> </del>		93.99
93.99	PARTIAL HOSPITALIZATION PROGRAM	NOT TORSE TO MINISTER			i Brasila (Sansala)		255255555		24 T
	OTHER REIMBURSABLE COST CENTERS			43,078			15,263		200
200	Subtotal (see instructions)			45,0/8		1	12.203		201
201	Less PBP Clinic Lab. Services-Program Only Charges			43,078			15,263		202
202	Net Charges (line 200 - line 201)		I	43,078	1	<u> </u>	13,402	٠	

<sup>(</sup>A) Worksheet A line numbers

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

COMPUTATION	N OF INPATIENT OPERATING COST				co	MI ONEK	i CCi	1,13-3023			PART I	
Chack Applicable Boxes;	[ ] Title V - I/P [XX] Title XVIII, Part A [ ] Title XIX - I/P	<pre>{XX] Hospital {</pre>	ĵ	] SI ] SI			1	] ICF/IID		PPS TEFRA		
PART I - ALL P	ROVIDER COMPONENTS	INPATIEN	T DAY	s								
I Inpatient day	ys (including private room days and swing-be	d days, excluding newborn)									29,698	
2 Inpatient day	ys (including private room days, excluding sw	ing-bed and newborn days)									29,698	
3 Private room	days (excluding swing-bed private room day	s). If you have only private	room d	lays, d	not complete this	line.					1,427	
	room days (excluding swing-bed private roo										28,271	₽
5 Total swing-	bed SNF type inpatient days (including priva	te room days) through Dece	mber 31	of the	cost reporting peri	ba						Ļ
6 Total swing-	hed SNF type inpatient days (including priva	te room days) after Decemb	<u>er 31 ot</u>	the co	st reporting period	(if calendar	year,	enter 0 on this line)				₽
7 Total swing-	bed NF type inpatient days (including private	room days) through Decen	ıber 31	of the	ost reporting perio	<u>d</u>		<u> </u>				1
8 Total swing-	bed NF type inpatient days (including private	room days) after Decembe	<u>r 31 of t</u>	he cos	reporting period (i	f calendar y	ear, ei	iter 0 on this line)		-		₽
9 Total inpatie	nt days including private room days applicab	le to the Program (excluding	g swing	-bed at	d newborn days)					_	21,427	١.
10 Swing-bed S	NF type inpatient days applicable to title XV	III only (including private r	oom dav	ys) (hr	ugh December 31	of the cost re	eportin	ig period (see instr	nctions)			۲
on this line)	SNF type inpatient days applicable to title XV								year, enter	0		Ľ
12 Swing-bed N	NF type inpatient days applicable to titles V o	r XIX only (including privat	е гоот	days)	hrough December :	31 of the cos	t repe	eting period				Ŀ
13 Swing-bed N	VF type inpatient days applicable to titles V or	XIX only (including privat	le room	days)	ifter December 31 o	of the cost re	porti	ng period (if calend	ar year, en	ier		ŀ
14 Medically ne	ecessary private room days applicable to the r	rogram (excluding swing-b	ed days	)								11
15 Total nursery	y days (title V or XIX only)											IJ
16 Nursery day	s (title V or XIX only)											Ц
		SWING-BED A										
17 Medicare rat	te for swing-bed SNF services applicable to s	rvices through December 3	1 of the	COSLI	porting period					$\rightarrow$		1
18 Medicare rat	te for swing-bed SNF services applicable to s	ervices after December 31 o	f the co	st repo	rting period					_		1
19 Medicald rat	te for swing-bed NF services applicable to ser	vices through December 31	of the c	ost re	orting period							1
	te for swing-bed NF services applicable to ser		the cost	repor	ing period					+	14,837,864	
21 Total genera	il inpatient routine service cost (see instructio	us)								-	14,637,604	13
22 Swing-bed c	cost applicable to SNF type services through I cost applicable to SNF type services after Dec	December 31 of the cost rep	orung p	enoa (	( - 1 - 10)					-+-		Ŀ
										$\rightarrow$		t
	cost applicable to NF type services through Dece											t
	bed cost (see instructions)	meer 31 of the cost reported	g perior	1 (111)5	X IIIIC ZUJ					_		T:
	-bed cost (see instructions) alient routine service cost net of swing-bed co	of Clina 21 prints line 261								<u> </u>	14.837.864	Ħ
27 General inpa		RIVATE ROOM DIFFER	ENTIA	1. AD	HISTMENT						1 (102)(00)	-
29 Ganaral inna	atient routine service charges (excluding swin				OB I MERCI					$\neg$	27,935,132	T
	n charges (excluding swing-bed charges)	E Dec and Coper Facility Cop	man Hou								1.376.342	T
30 Semi-morate	e room charges (excluding swing-bed charges	}									26,558,790	Т
31 General inna	atient routine service cost/charge ratio (line 2'	2 ÷ lîne 28)			***						0.531154	
	vate room per diem charge (line 29 ÷ line 3)										964.50	T
	ni-private room per diem charge (line 30 + lin	e 4)									939.44	L
34 Average per	diem private room charge differential (line 3	2 minus line 33) (see instru	ctions)								25,06	
35 Average ner	diem private room cost differential (line 34 >	line 31)									13.31	
36 Private room	cost differential adjustment (line 3 x line 35	3								_	18.993	
37 General inpa	alient routine service cost net of swing-bed co	st and private room cost dif	ferenția	l (line	27 minus line 36)					$\perp$	14,818,871	Ľ

ZDMC	HD	Compu	May	2552-10
K PANG	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1 -4 31 4 74 74 74 74	-10175	2004-10

	In Lieu of Form	Period:	Run Date: 05/09/2019
ENCOMPASS HEALTH DEACONESS REHABILIT	1	From: 01/01/2018	Run Time: 10:18 Version: 2018.12 (03/07/2019)
Provider CCN: 15-3025		10. 12.011.2010	

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-3025

WORKSHEET D-1 PART II

 Check
 [ ] Title V - I/P
 [XX] Bospital
 [ ] SUB (Other)
 [XX] FPS

 Applicable
 [XX] Title XVIII, Part A
 [ ] IFF
 [ ] TEFFA

 Boxes:
 [ ] Title XIX - I/P
 [ ] IRF
 [ ] Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS					499.63	38
<u>B</u>	Adjusted general inpatient routine service cost per diem (see instructions)					10,705,572	
9	Program general inpatient routing service cost (line 9 x line 38)						40
3	Medically necessary private room cost applicable to the Program (line 14 x line 35)  Total Program general inpatient routine service cost (line 39 + line 40)					10,705,572	41
1	Total Program general inpatient follone service cost time 35 1 line 401		Total	Average		Program	
		Total	Inpatient	Per Diem	Program	Cost	ļ
		Inpatient	Days	(col. i ÷	Days	(col. 3 x	1
		Cost	Days	cal. 2)		col. 4)	⊢
		T1	2	3	4	. 5	42
2	Nursery (Titles V and XIX only)			Fig. 100			42
4	Intensive Care Type Inpatient Hospital Units					(1) (1) (1) (1) (1) (1) (1) (1) (1) (1)	43
3	Intensive Care Unit			ļ			44
4	Coronary Care Unit		<u> </u>	<del> </del> -		*****	45
15	Burn Intensive Care Unit	ļ		-	<u> </u>		46
46	Surgical Intensive Care Unit				<del></del>		47
17	Other Special Care (specify)	!	1	L		I	1
						7,947,377	48
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					18,652,949	45
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)  PASS THROUGH COST ADJUS*	CATENTS					
	PASS THROUGH COST ADJOS.	Lend DD				1,488,105 585,012	
50	Pass through costs applicable to Program inputient routine services (from Wkst. D, sum of Parts I and III)						
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Par					2,073,117	
52	Total Program excludable cost (sum of lines 50 and 51)  Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and manufacture of the control of the c	edical education of	osts (line 49 min	ıs line 52)		16,579,832	5:
53	Total Program inpatient operating cost excitating capital related, nonpayablant and LIMIT CO	MPUTATION					_
	Program discharges						52
54 55	Program discharges Target amount per discharge						55
56	Towns amount (line 64 v line 55)						5
30 57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					ļ <u>-</u>	5
58							59
59	I was of the 52 - line 54 or line 55 from the cost reporting period ending 1996, updated and co	mpounded by the	market basket.				6
60				1 4	-to I seems Olma SA		
	Teling 53 4 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount	y which operating	g costs (line 53) a	re less man expe	cten costs (title 24		6
61	x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)						6
62	Relief payment (see instructions)					<del> </del>	6
63	Allowable Inpatient cost plus incentive payment (see instructions)	INIO DED COCI					, -
	PROGRAM INPATIENT ROUTINE SY	ING BED COST	nd Gille YUIII o	olso)		T	6
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting per	(Can instructions)	Hitle YVIII only	١		l	6
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period  Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period	(SEC INSTRUCTIONS)	Gur villa omi			·	6
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only, For CAH, see instructi	unaj nariod (line 12 v	line 19)				6
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting pe	ried (line 13 v lin	20)				6
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting per Total title V or XIX swing-bed NF inpatient routine costs (line 62 + line 68)	HOL CHIE 13 X RB				1	T 6

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 Versiou: 2018.12 (03/07/2019)

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-3025

WORKSHEET D-1 PARTS III & IV

	a XVIII, Part A [ ]	IPF [ ]	SUB (Other)   SNF   NF	[ ]	ICF/IID	[XX] [	PP TE Ot
--	---------------------	---------	------------------------------	-----	---------	-----------	----------------

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 88	Total observation bed days (see instructions)  Adjusted general impatient routine cost per diem (line 27 + line 2)					499.63	87 88
89	Observation bed cost (line 87 x line 88) (see instructions)	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	89
90	Capital related cost	1	2	3	4	instructions) 5	90
91 92	Nursing School Allied Health						9i 92 93
93	Other Medical Education		1	·	l,	1 <u>-</u>	1 73

KPMG LLP Compu-Max 2552-10	In Lieu of Form	Period:	Run Date: 05/09/	
ENCOMPASS HEALTH DEACONESS REHABILIT	CMS-2552-10	From: 01/01/2018	Run Time: 10:18	
	0.125 1.55	To: 12/31/2018	Version: 2018.12	(03/0 <u>7/2019)</u>
Provider CCN: 15-3025				
				WORKSHEET I
COMPUTATION OF INPATIENT OPERATING COST		COMPONENT CCN:	15-3025	PARTI
Chack [ ] Title V - I/P			ICF/IID [ ] PI	
Applicable [ ] Title XVIII, Part A [	,	SNF	[ ] TE	
Boxes: {XX} Title XIX - I/P [	] IRF [ ]	NE	[xx] 0	TIET
PART 1 - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS			29,698
1 Impatient days (including private room days and swing-bed days	excluding newborn)			29,698
- l - · · · · · · · · · · · · · · · · ·	d and newborn days)	. I		1,427
Inpatient days (including private toom days, excluding swing-bed private room days). If	you have only private room day	s, do not complete ans inte.		28,271
4 Semi-private room days (excluding swing-bed private room day 5 Total swing-bed SNF type inpatient days (including private room		Othe cost reporting period		
c ten . 1 . 1 . 4 PATE same functions done finely diese writeste mon	n Asus) after December 31 of th	s cost tedolenia bellog (it exicting Acut et	er 0 on this line)	
			r 0 on this line)	398
			fod (if calendar year enter 0	
Swing-bed SNF type inpatient days applicable to title XVIII on	y (meluding private room days)	after December 31 of the cost reporting po	104 (It cuttimes July 4444 -	i
on this line)	only finelyding private room da	vs) through December 31 of the cost report	ng period	
12 Swing-bed NF type inpatient days applicable to filles V or XIX  Swing-bed NF type inpatient days applicable to titles V or XIX	only (including private room da	vs) after December 31 of the cost reporting	period (if calendar year, enter	
10 to access				
14 Medically necessary private room days applicable to the progra	n (excluding swing-bed days)			
15 Total nursery days (title V or XIX only)			·-·	
16 Nursery days (title V or XIX only)	SWING-BED ADJUSTM	PNT		
17 Medicare rate for swing-bed SNF services applicable to service	through December 31 of the co	nst reporting period		
			·	
as last the terminal had NIC sensions applicable to services	through December 31 Of the COS	I reporting perion		
20 Medicaid rate for swing-bed NF services applicable to services	after December 31 of the cost re	porting period		14,836,219
				14,030,413
The last the state of the control of	her 31 of the cost reporting per	(ii-a f n line 19)		
Swing-bed cost applicable to SNF type services after Decembe     Swing-bed cost applicable to NF type services through December     Swing-bed cost applicable to NF type services through December.	(3) of the cost reporting period	d fling 7 x line 19)		
	31 of the cost reporting period (	line 8 x line 20)		
25 Swing-bed cost applicable to NF type services after December 26 Total swing-bed cost (see instructions)	or brain costs open takes y			
and the state of the service aget and of coving hed cost (its	e 21 minus line 26)			[4.836,219]
PRIVA	TE ROOM DIFFERENTIAL	ADJUSTMENT		27,935,132
28 General inpatient routine service charges (excluding swing-bed	and observation bed charges)			1,376,342
20 Private room charges (excluding swing-bed charges)	<del></del>			26,558,790
30 Semi-private mom charges (excluding swing-bed charges)	ne 78)			0.531095
31 General inpatient routine service cost/charge ratio (line 27 ÷ line 27 ÷ line 27 ÷ line 27 ÷ line 3)	IO #-01			964.50
22 A summar cami private room per diem charge (line 30 ÷ line 4)				939.44
34 Average per diem private room charge differential (line 32 mi)	us line 33) (see instructions)			25.06 13.31
35 Average per diem private room cost differential (line 34 x line	31)			18,993
36 Private room cost differential adjustment (line 3 x line 35) 37 General inpatient routine service cost net of swing-bed cost an		d: - 27 : 1! 26\		14,817,226

KPMG LLP Compu-Max 2552-10			
ENCOMPASS HEALTH DEACONESS REHABILIT	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

theck [ ] Title V - pplicable [ ] Title XVI poxes; [XX] Title XIX	II, Part A [	Hospital [ IPF IRF	3	SUB	(Other)		1	PPS TEFR Othe
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PART II - HOSPITALS AND SUBPROVIDERS ONLY

IAKI	H-BOSHING WAS GORKO IDEKO ONDI						
	NO COD 134 IND LITHRAT OBED LITHO COCT DEFODE PAS	s.тиропен се	ST ADJUSTME	NTS		3	
		g-IIIIOOGII CO	OX ADDUCTION	413.0	· · · · · · · · · · · · · · · · · · ·	498,93	38
	Adjusted general impatient routine service cost per digit (see historical)					198.574	39
	Program general inpatient routine service cost (line 9 x and 36)		*******				40
	Medically accessary private room cost applicable to the Flogram (time 14 x time 35)					198,574	41
41	Total Program general impation routing service cost (time 27 + mic 40)		m	Average		Program	
				Per Diem	Program	Cost	
	1			(col. 1 ÷	Days	(col. 3 x	
		Cost	Days	col. 2)	]	col. 4)	
$\vdash$		1	2	3	4	5	
12	Nursery (Titles V and VIV only)						42
42	Transfer Care Type Impatient Hospital House	NEW 2007				44	9
42			1	]			43
							44
							45
							46
					<u> </u>		47
-37	Contraction Contraction					1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					142,282	
Total   Inpatient   Cost   Inpatient   Cost   Inpatient   Days   Col. 2		340,856	49				
,	PASS THROUGH COST ADJUS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Part	s I and III)				27,641	
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Pa	rts <u>li and IV)</u>				10,966	
52	Total Program excludable cost (sum of lines 50 and 51)					38,607	53
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and	medical education c	osts (line 49 minu	ıs line 52)			1 23
	TARGET AMOUNT AND LIMIT CO	OMPUTATION					54
54							55
							56
	Target amount (line 54 x line 55)						57
	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						58
	Benus payment (see instructions)		1				59
	Lesser of line 53 + line 54 or line 55 from the cost reporting period ending 1996, updated and	compounded by the	market basket.				60
60	Lesser of line 53 + line 54 or line 55 from prior year cost report, updated by the market basket.		1. 0" . (2)		ted as to Cine 54		1
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 (nne 53) ar	re iess man expec	152 COLS (1110 34		6i
							62
	Relief payment (see instructions)						63
63	Allowable Inpatient cost plus incentive payment (see instructions)	WING BED COST					100
	PROGRAM INPATIENT ROUTINES	WING BED COST	ac) tiila VVIII on	-Int			64
	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting pe	d (Con includations)	title YVIII only				65
	Medicare swing-bed SNF impatient routine costs after December 31 of the cost reporting pend	n roce menacuous)	THIS VALUE OHIA				66
	Total Medicare swing-bed SNF inpatient routine costs (title AVIII only, For CAH, see instruct	guns)	ine 10)				67
	Title V or XIX swing-bed NF impatient routine costs inrough December 31 of the cost reporting	repetito (line 12 X line	20)				68
	Title V or XIX swing-bed NY inpatient routine costs after December 31 of the cost reporting to	erion tune 13 y life	,±v1				69
69	Total little v of X1X swing-bed Mr inpatient founde costs little of \( \tau \) and os \( \text{j} \)						

(PMG LLP Compu-Max 2552-10					= .			Run Date: 05/09	/2010	
ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form CMS-2552-10					od: n: 01/01/2018 12/31/2018		Run Time: 10:15 Version: 2018.1	3	<u>)</u>
COMPUTATION OF INPATIENT OPERATING COST						COMPONENT CO	N: 15-3025		WORKSHE PARTS II	
Check [ ] Title V - I/P { Applicable [ ] Title XVIII, Part A [ Boxes: [XX] Title XIX - I/P [	XX) Hospital   IPF   IRF	]	) SO ) SN ) NE		ier)	t	] 1CF/II	į į <u>r</u>	PS EFRA ther	
PART IV - COMPUTATION OF OBSERVATION BED PASS-1	THROUGH COST								·	87
87 Total observation bed days (see instructions)				_						88
Adjusted general inpatient routine cost per diem (line 27 ÷ li Observation hed cost (line 87 x line 88) (see instructions)	ne 2)									89
89 Observation had cost (line 87 x line 83) (see instructions)					Cost	Routine Cost (from line 21)	col. 1÷col.	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				1		_				91
								<del></del>	<del>                                     </del>	93
92 Allied Health 93 Other Medical Education							·			

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-3025

WORKSHEET D-3

Check Applic Boxes:	[ ] Title V	[ ] Sw:	ing Bed SNF ing Bed NF F/IID	[XX] PPS [ ] TEFRA [ ] Other	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
-tAI	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		20,138,342		30
	ANCILLARY SERVICE COST CENTERS				<u> </u>
54	Radiology-Diagnostic	0.803524	186,012	149,465	54 54.01
54.01	RADIOLOGY-SUA	0,468633	68,038	31,885	
60	Laboratory	0,340542	1,663,098	<u>5</u> 66,355	60.01
60.01	LAB SUA				62.30
62.30	BLOOD CLOTTING FOR HEMOPHILIACS		1 (5) (6)	638,653	
65	Respiratory Therapy	0.382152	1,671,201 5,294,264	1,880,671	
66	Physical Therapy	0.355228	5,294,264	1,580,671	
67	Occupational Therapy	0.353484	1,913,221	679,670	
68	Speech Pathology	0,353249	1,588,865	448,460	
71	Medical Supplies Charged to Patients	0.238828	5,953,696	1,421,909	
73	Drugs Charged to Patients	<u></u>	020,020	1,421,202	76
76	OTHER ANCILLARY	0.612844	286.012	175.281	76.01
76.01	SPECIAL PROCEDURES	0.124763	141,898	17,704	
76.02	SPECIAL PROCEDURES SUA	0.124703	141,020		76.97
76.97	CARDIAC REHABILITATION				76.98
76.98	HYPERBARIC OXYGEN THERAPY			****	76.99
76.99	LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS				<b>A</b>
					92
92	Observation Beds (Non-Distinct Part) PARTIAL HOSPITALIZATION PROGRAM	<b></b>			93.99
93.99	OTHER REIMBURSABLE COST CENTERS				4
200	Total (sum of lines 50-94, and 96-98)		24,246,960	7,947,377	
200	Less PBP Clinic Laboratory Services-Program only charges (line 61)				<b>20</b> 1
201 202	Net Charges (line 200 minus line 201)		24,246,960		202

<sup>(</sup>A) Worksheet A line numbers

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)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT
--

COMPONENT CCN: 15-3025

WORKSHEET D-3

Check Applic Boxes:		į j Sw:	ing Bed SNF ing Bed NF F/IID	[ ] PPS [ ] TEFRA [XX] Other	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs {col, 1 x col, 2}	
(A)	COST CENTER DESCRIPTION	1	2	. <u>3</u>	<u> </u>
101	INPATIENT ROUTINE SERVICE COST CENTERS				1 30
30	Adults & Pediatrics		376,003		# 3U_ #1
-	ANCILLARY SERVICE COST CENTERS	0.002524	1,563	1,256	54
54	Radiology-Diagnostic	0.803524 0.468633	629	295	
54.01	RADIOLOGY-SUA	0.468633	34,869	11.874	
60	Laboratory	0.340342	.34,003	11,074	60,0
60.01	LAB SUA				62.
62.30	BLOOD CLOTTING FOR HEMOPHILIACS	0.382152	14,679	5,610	
65	Respiratory Therapy	0.355228	106,678	37,895	
66	Physical Therapy	0.353484	110,688	39,126	
67	Occupational Therapy	0.355249	23,659	8,405	
68	Speech Pathology	0.282252	31,764	8,965	
71	Medical Supplies Charged to Patients	0.238828	113,347	27,070	73
73	Drugs Charged to Patients	V.250010			76
76	OTHER ANCILLARY	0.612844	2,646	1,622	76.
76.01	SPECIAL PROCEDURES	0.124763	1,313	164	
76.02	SPECIAL PROCEDURES SUA				76.
76.97	CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY				76.
76.98	LITHOTRIPSY				76.
76,99	OUTPATIENT SERVICE COST CENTERS				<u> </u>
	Observation Beds (Non-Distinct Part)				92
92.99	PARTIAL HOSPITALIZATION PROGRAM				93.
73.77	OTHER REIMBURSABLE COST CENTERS				4
200	Total (sum of lines 50-94, and 96-98)		441,835	142,282	
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		441,835		202

<sup>(</sup>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)

[ ] SRF

#### PART B - MEDICAL AND OTHER HEALTH SERVICES

			1.01	1.02	
	Medical and other services (see instructions)	<del>-  </del>			1
	Medical and other services reimbursed under OPPS (see instructions)	577			2
	OPPS payments	213			3
	Outlier payment (see instructions)				4
.01	Outlier reconciliation amount (see instructions)				4.0
5	Enter the hospital specific payment to cost ratio (see instructions)				5
	Line 2 times line 5				6
,	Sum of lines 3, 4, and 4.01, divided by line 6				7
	Transitional corridor payment (see instructions)				8
	Ancillary service other pass through costs from Wkst. D. Pt. IV, col. 13, line 200				9
	Organ acquisition				10
	Total cost (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
2	Ancillary service charges				12
3	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
4	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES		202200000000000000000000000000000000000		
5	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
	Amounts that would have been realized from patients liable for payment for services on a charge basis had such	1			16
6	payment been made in accordance with 42 CFR §413.13(e)				
7	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
8	Total customary charges (see instructions)				18
9	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
0	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
	Lesser of cost or charges (see instructions)				21
2	Interns and residents (see instructions)		2002/02/02/02/02		22
3	Cost of physicians' services in a teaching hospital (see instructions)				23
4	Total prospective payment (sum of lines 3, 4, 4.0), 8 and 9)	213			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
5	Deductibles and coinsurance (see instructions)	43			25
6	Deductibles and coinsurance relating to amount on line 24 (see instructions)				26
7	Subtotal [flines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	170			27 28
8	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
9	ESRD direct medical education costs (from Wkst. E-4, line 36)				30
0	Subtotal (sum of lines 27 through 29)	170			
ì	Primary payer payments				31
2	Subtotal (line 30 minus line 31)	170	1 Vaccional Control		200 J
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				33
3	Composite rate ESRD (from Wkst. I-5, line II)				34
4	Allowable bad debts (see instructions)				35
5	Adjusted reimbursable bad debts (see instructions)				36
6	Allowable bad debts for dual eligible beneficiaries (see instructions)				37
7	Subtotal (see instructions)	170			38
8	MSP-LCC reconciliation amount from PS&R				39
9	Other adjustments (specify) (see instructions)				39.
9.50	Pioneer ACO demonstration payment adjustment (see instructions)	170			40
0	Subtotal (see instructions)	170			40.
0.01	Sequestration adjustment (see instructions)	3			40
0.02	Demonstration payment adjustment amount after sequestration	167			41
1	Interim payments	107			42
2	Tentative settlement (for contractors use only)				43
3	Balance due provider/program (see instructions)  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO RE	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)	91
94	Total (sum of lines 91 and 93)	94

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 15-3025

WORKSHEET E-I PART I

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

T				INPATII PART		PART		
+				nım/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
1	DESCRIPTION	-		1	2	3	4	_
t	the state of the s		1		31,150,147		167	1
1	lotal interim payments payable on individual bills, eitchr submitted or to be st for services rendered in the cost reporting period. If none, write NONE.	ibmitted to the interme	diary					2
ŧ	List separately each retroactive lump sum adjustment	or ciner a zero	.01					3.0
1	amount based on subsequent revision of the interim		.02					3.0
ļ	rate for the cost reporting period. Also show date of	Program	.03					3.0
ł	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.0
	each payment. It home, write NOIVE of cites a zero. (1)	Provider	.05					3.1
ł			.06					3.5
t			.07					3.
ł			.08					3.0
t			.09					3.0
1			.10					3.
Í				04/06/2018	18,357	<u> </u>		3.
İ			.12	07/27/2018	14,331	<del> </del>		3,
ţ			.50					3.
İ			.51					3.
1		Provider	.52					3.
1		lo .	.53	<del>_</del>				3.
		Program	.54					3.
			.56					3.
			.57					3.
			.58					3.
	· · · · · · · · · · · · · · · · · · ·		.59			1		3.
_	CU 2 50 2 00)		.99	FERRIS EN PROPERTIE DE LA CONTRACTION DE LA CONT	32,688			3.
_	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		1.77				167	
ļ	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		-		31,182,835		107	
-	TO BE COMPLETED BY CONTRACTOR		.01			-		5.
	List separately each tentative settlement payment		.01					5.
	after desk review. Also show date of each payment.	Program	03			†		5.
_	If none, write 'NONE' or enter a zero. (1)	to	.04			i		5
_		Provider	.05					5.
		11011001	.06					5
			.07			T"		5
_			08					. 5
-		1	.09					5
-			.10					5
-			.50					5
			.51					5
_		Provider	.52					5
-		to	.53	<u> </u>		<del>   </del>		5
		Program	.54					.5
			.55			<del> </del>		5
			.56					5
			.57	<del></del>		<u> </u>		- 5
			.58			ļ		5
			.59					- 3
_	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					1
ś	Determined net settlement amount (balance due)		01	ļ		1		- 6
_	hased on the cost report (1)		.02				i	Т,
,	Total Medicare program liability (see instructions)					NPR Date (Month/E	lau/Voarl	Ť
3	Name of Contractor			Contractor Number		THE LAST CALOURED	ruse 1 cours	

<sup>(1)</sup> 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 HI - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

		1	1,01	
	Net Federal PPS payment (see instructions)	30.984,279		1
1 .	Medicare SSI ratio (IRF PPS only) (see instructions)	0.043500		2
2	Inpatient Rehabilitation LIP payments (see instructions)	1,412,883		3
3	Impanent Renabilitation Cir payments (see histricators)  Outlier payments	7,310		4
4	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see			5
5	Unweighted intern and resident F LE count in the most recent cost reporting period ending on or prior to reterior 19, 200 (etc.)			3
5.01	Disturbutions)  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(dX1)(iii)(F)(1) OR {2}			5.01
	not be counted without a temporary cap adjustment under 42 CFR (412.424(d.) First) (47.5 CFR)  New teaching program adjustment (see justructions)			6
6	New teaching program agrisament (see testifications)  Current year unweighted FTE count of l&R excluding FTEs in the new program growth period of a 'new teaching program' (see			7
7	Current year unweighted FTE count of feek excluding FTES in the new plogram growth period of E feet feet feet feet			,
	instructions)  Current year unweighted I&R FTE count for residents within the new program growth period of a 'new teaching program' (see instructions)			8
8	Current year unweighted I&R FTE count for residents within the new program growth period of a new teaching modern for the first section adjustment (see instructions)			9
9	Intern and resident count for its PPS medical education adjustment (see insudentins)	81,364384		10
10	Average daily census (see instructions)	*****	<u>-</u>	11
11 _	Teaching Adjustment Factor (see instructions)			12
12	Teaching Adjustment (see instructions)	32,404,472	· · ·	13
13	Total PPS Payment (see instructions)	22,593,172		14
14	Nursing and allied health managed care payments (see instructions)			15
15	Organ acquisition DO NOT USE THIS LINE			16
16	Cost of physicians' services in a teaching hospital (see instructions)	32,404,472		17
17	Subtotal (see instructions)	11.987		18
18	Primary payer payments	32,392,485	·	19
19	Subtotal (line 17 less line 18)	587,972		20
20	Deductibles	31,804,513		21
21	Subtotal (line 19 minus line 20)	230,396	<del> </del>	22
22	Coinsurance	31.574,117		23
23	Subtotal (fine 21 minus line 22)	256,443		24
24	Allowable bad debts (exclude bad debts for professional services) (see instructions)			25
25	Adjusted reimbursable bad debts (see instructions)	166,688		26
26	Allowable bad debts for dual eligible beneficiaries (see instructions)	147,316		27
27	Subtotal (sum of lines 23 and 25)	31,740,805	<del> </del>	28
28	Direct graduate medical education payments (from Wkst. E.4. line 49) (For free standing IRF only)		ļ	29
29	Other pass through costs (see instructions)	<u> </u>		
30	Outlier payments reconciliation			30 31
31	Other adjustments (specify) (see instructions)		222 Continue (1977) (1977) (1977) (1977)	
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	ļ		32,02
33	Interior payments	31,182,835		33_
34	Tentative settlement (for contractor use only)		ļ	34
35	Bajance 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	1	36

TO BE CO	MPLETED BY CONTRACTOR	 · · ·	50
50 Ori	cinal outlier amount from Wkst. E-3, Pt. III, line 4 (see instructions)	 	51
	flier reconciliation adjustment amount (see instructions)	 	52
	e rate used to calculate the Time Value of Money (see instructions)	 	53

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)						

CAL	ĊΠ.	MOITA	ΩF	REIMBURSEMENT	SETTLEMENT

COMPONENT CCN: 15-3025

WORKSHEET E-3 PART VII

Check Applicable Boxes:	[ ] Title V [XX] Title XIX	[XX] Hospital [ ] SUB (Other) [ ] SNF	[ ] ICE/IID	[ ] PPS [ ] TEFRA [XX] Other
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 ${\tt PART\,VII-CALCULATION\,OF\,REIMBURSEMENT-ALL\,OTHER\,HEALTH\,SERVICES\,FOR\,TITLES\,V\,OR\,TITLE\,XIX\,SERVICES}$ 

	THE COUNTY COUNTY OF CONTROLS SERVICES	INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES	340,856		ÆΙ
1	Inpatient hospital/SNF/NF services	2.000	15,263	2
2	Medical and other services			1 3
3	Organ acquisition (certified transplant centers only)	340.856	15,263	4
4	Subtotal (sum of lines 1, 2 and 3)	318,000		5
5	Inpatient primary payer payments			6
6	Outpatient primary payer payments	340,856	15.263	7
7	Subtotal (fine 4 less sum of lines 5 and 6)	510,050	15.20	
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES	376,003		8
8	Routine service charges	441,835	43,078	
9	Ancillary service charges	7-11,033	B-3076	10
10	Organ acquisition charges, net of revenue			111
11	Incestive from target amount computation	817.838	43,078	
12	Total reasonable charges (sum of lines 8-11)	617,030	45,070	-12
	CUSTOMARY CHARGES			13
13	Amount actually collected from patients liable for payment for services on a cabree basis		ļ	1
	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in	ļ		14
14	accordance with 42 CFR §413,13(e)	4 000000	1,000000	1.5
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000		
16	Total customary charges (see instructions)	817,838	43,078	
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	476,982	27,815	
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)		L	20
2]	Cost of covered services (lesser of line 4 or line 16)	340,856	15,263	21
~*	PROSPECTIVE PAYMENT AMOUNT			+
22	Other than outlier payments		<u> </u>	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		<u> </u>	26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XXX PPS covered services only)			28
29	Titles Vor XIX (sum of lines 21 and 27)	340,856	15,263	29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			1-
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	
32	Suborgi Cam of thes 17 and 20, max 27 and 27		<u> </u>	32
	Penetuna Consumero			33
33	Allowable bad debts (see instructions)			34
	Allowands or a decis (see instruction)			35
35	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)	340,856	15,263	
36	OTHER ADJUSTMENTS (SPECIFY) (see instructions)	1		37
37		340,856	15,263	38
38	Subtotal (line 36± line 37)  Direct graduate medical education payments (from Wkst. E-4)	1		39
39	Total amount payable to the provider (sum of lines 38 and 39)	340,856	15,263	40
40		214.317		41
41	Interim payments	126,539		42
42	Balance due provider/program (line 40 minus line 41)  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	1		43

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#### BALANCE SHEET

WORKSHEET G

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

	Assets	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)		2	3	4	_i
	CURRENT ASSETS			, <del></del>		-T-:
í	Cash on hand and in banks	14,177,748				1
2	Temporary investments					2
1	Notes receivable					3
	Accounts receivable	11,397,412		1		4
;	Other receivables					5
,	Allowances for uncollectible notes and accounts receivable	-3,286,871		ļ		- 6
, ,	Inventory	49,358				7
}	Prepaid expenses	42,033		ļ. <b>_</b>		1 8
)	Other current assets					9
0	Due from other funds			1		10
l .	Total current assets (sum of lines 1-10)	22,179,680				111
	FIXED ASSETS			· · · · · · · · · · · · · · · · · · ·		
2	Land	1,600,058				12
3	Land improvements					13
4	Accumulated depreciation			_		14
5	Buildings			ļ		1.1
6	Accumulated depreciation	-52.862				1 50
7	Leasehold improvements	5,809,784				1
8	Accumulated depreciation	-4,319,019				18
9	Fixed equipment			ļ <u></u>		19
0	Accumulated depreciation					20
I	Audomobiles and trucks					2
2	Accumulated depreciation					. 2
3	Major moyable equipment	4,309,371				2
4	Accumulated depreciation	-3,147,359				2
5	Minor equipment depreciable					2
6	Accumulated depreciation					2
7	HIT designated assets					2
8	Accumulated depreciation					2
9	Minor equipment-nondepreciable					_ 2
<u> </u>	Total fixed assets (sum of lines 12-29)	4,199,973		<u>i</u>		3
<u> </u>	OTHER ASSETS			<u></u>		
1	Investments					3
2	Deposits on leases			<u> </u>		_ 3
3	Due from owners/officers					3
4	Other assets	21,648,753				3
5	Total other assets (sum of lines 31-34)	21,648,753				3
6	Total assets (sum of lines 11, 30 and 35)	48,028,406				_   3
_		General	Specific	Endowment	Plant	
	Lightities and Fund Balances	Fund	Purpose Fund	Fund	Fund	

	Lightities and Fund Balances	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	-	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable	2.095,178		Ι΄		37
38	Salaries, wages and fees payable	1,273,429				38
39	Payroll taxes payable			1		39
40	Notes and loans payable (short term)					40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds	1				43
44	Other current liabilities	218,244				44
45	Total current liabilities (sum of lines 37 thru 44)	3.586,851				45
4.3	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		I		51
31	CAPITAL ACCOUNTS					
52	General fund balance	32,005,141				52
53	Specific purpose fund				3.5	53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted			2		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

,	In Lieu of Form	Period:	Run Date: 05/09/2019
		From: 01/01/2018	Run Time: 10:18
ENCOMI ADD MEMBER DE NOTADO NOTADO	CITE 2002 10	To: 12/31/2018	Version: 2018.12 (03/07/2019)
Provider CCN: 15-3025		10, 1201,201	

## STATEMENT OF CHANGES IN FUND BALANCES

#### WORKSHEET G-1

· [	GENERAL FUND		SPECIFIC PURPOSE FUND		_
		2	3	4	
Fund balances at beginning of period		22,216,265			1
Net income (loss) (from Worksheet G-3, line 29)		13.501.899			圖 2
Net income (loss) (from Worksheet O-3, line 29)		35,718,164			3
Total (sum of line 1 and line 2)					4
Additions (credit adjustments) (specify)					<b>3</b> 5
					<b>4</b> 6
			i		图 7
			i		<b>3</b> 8
					<b>3</b> 9
Total additions (sum of lines 4-9)	-				110
Total additions (sum of lines 4-9)		35.718,164			1
Subtotal (line 3 plus line 10)					S 12
Deductions (debit adjustments) (specify)	3,713,024				1:
DISTRIBUTIONS	3,713,024		1	2000000	<b>3</b> 14
			4		<b>20</b> 1:
			· · · · · · · · · · · · · · · · ·		110
			i		
		3,713,024	4		1
Total deductions (sum of lines 12-17)					119
Fund balance at end of period per balance sheet (line 1) minus line 18)		32,005,140	10	<u>au</u> .	

		ENDOWM	ENT FUND	PLANT	FUND	
		5	6	7	8	
						1
1 Fund balances at beginning of period						1 2
Net income (loss) (from Worksheet G-3, line 29)						3
3 Total (sum of line 1 and line 2)						4
4 Additions (credit adjustments) (specify)						5
5						6
6		<del>                                     </del>				7
7		· · · · · · · · · · · · · · · · · · ·				8
8			and the second second			9
9						10
0 Total additions (sum of lines 4-9)						III
1 Subtotal (line 3 plus line 10)						WH 12
2 Deductions (debit adjustments) (specify)		ļ		B	i	13
3 DISTRIBUTIONS				1		14
4		ļ				15
5		<u> </u>		<b>!</b>		16
6				<del> </del>		17
17		Annow I Sunday and Company of the Co	a de la companya de l			18
18 Total deductions (sum of lines 12-17)			<u> </u>			19
19 Fund balance at end of period per balance sheet (line 11 minu	s line 18)		<u> </u>		<u> </u>	

In Lieu of Form CMS-2552-10 ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025

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

	INPATIENT	OUTPATIENT	TOTAL	
REVENUE CENTER		2	3	
GENERAL INPATIENT ROUTINE CARE SERVICES				
i Hospital	28,166,882		28,166,882	
2 Subprovider IPF				2
3 Subprovider IRF				3
5 Swing Bed - SNF				5
6 Swing Bed - NF				6
7 Skilled nursing facility				- /
8 Nursing facility				8
9 Other long term care				9
10 Total general impatient care services (sum of lines 1-9)	28,166,882		28,166,882	10
INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES		Variation and the Control of the Con		
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 Appillary 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)		<u> </u>		21
22 Home health agency		Į		22
23 Ambulance				23
25 ASC		ļ		25
26 Hospice				26
27 Other (specify)		<u> </u>		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	
				30
30	Add (specify)	·		31
31				32
32			State of the later	22
33				24
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37		\ <u>-</u>		37
	Deduct (specify)			38
38				39
39				40
40				40
41				141
42	Total deductions (surn of lines 37-41)	District Control		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

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

#### STATEMENT OF REVENUES AND EXPENSES

#### WORKSHEET G-3

		r	
	DESCRIPTION		oxdot
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	64,031,359	
1	Less contracting allowaness and discounts on patients' accounts	22,483,764	2
-	Net patient revenues (fine 1 minus time 2)	41,547,595	3
	Net patient revenues unter 1 minus mie 21. Less total operating expenses (from Worksheet G-2, Part II, line 43)	28,282,527	4
14	Less total operating expenses (II of the Worksheet O-2, Falt 1), into 45)	13,265,068	5
1.5	Net income from service to patients (line 3 minus line 4)	13.203,000	

#### OTHER INCOME

6	Contributions, donatious, 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 other than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts		18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and cauteen	-2	20
21	Rental of yending machines	2,048	21
22	Rental of hospital space	92,842	
23	Governmental appropriations		23
24	Other (specify)	2,895	
25	Total other income (sum of lines 6-24)	236,831	
26	Total (line 5 plus line 25)	13,501,899	
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.