ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/19/2020 Run Time: 18:44 Version: 2018.12 (04/03/2020)

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

WORKSHEET S
PARTS I, II & III

PART I - COST REPORT STATUS

Provider use only	1. [X] Electronically filed cost report Date: 05/19/2020 Time: 18:44 2. [ ] Manually submitted cost report 3. [ ] If this is an amended report enter the number of times the provider resubmitted the cost report 4. [F] Medicare Utilization. Enter 'F' for full or 'L' for low.		
Contractor use only	5. [ ] Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. [ ] Initial Report for this Provider CCN 9. [ ] Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ___ 12. [ ] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ENCOMPASS HEALTH DEACONESS REHABILIT (15-3025) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 01/01/2019 and ending 12/31/2019, 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.

(Signed) _____
Chief Financial Officer or Administrator of Provider(s)

SVP REIMBURSEMENT
Title

_____
Date

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		25,574			170,127	1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		25,574			170,127	200

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

According to the Paperwork Reduction Act of 1995, no persons are required to resopnd to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send appilcations, 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.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:

1	Street: 9355 WARRICK TRAIL	P.O. Box:			1
2	City: NEWBURGH	State: IN	ZIP Code: 47630	County: VANDERBURGH	2

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	ENCOMPASS HEALTH DEACONESS REHABILIT	15-3025	21780	5	06 / 08 / 1989	N	P	O	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF									7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC									15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 01 / 01 / 2019	To: 12 / 31 / 2019	20
21	Type of control (see instructions)	5		21

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.							24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	367	291	242	234	2,076		25

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

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/19/2020 Run Time: 18:44 Version: 2018.12 (04/03/2020)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

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

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

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

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

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

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

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

Teaching Hospitals that Claim Residents in Nonprovider Settings

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

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

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

Rural Providers		1	2	
105	Does this hospital qualify as a CAH?	N		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elinination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.			107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108

		Physical	Occupational	Speech	Respiratory	
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.					109

		1	
110	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? If yes, compolete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110

		1	2	
111	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for additional beds; and/or 'C' for tele-healsh services.			111

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.		N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.		Y		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1		118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	33,872	44,398		118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.		N	N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.		N		121
122	Does the cost report contain state health care related taxes as defined in §1903(w)(3) of the Act? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.		N		122

Transplant Center Information

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

All Providers

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

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

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

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

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

Multicampus

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

	Name	County	State	ZIP Code	CBSA	FTE/Campus	
	0	1	2	3	4	5	

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

COMPLETED BY ALL HOSPITALS

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

		Y/N	Type	Date	
Financial Data and Reports		1	2	3	
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	Y	A	02/27/2020	4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N			5

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N		16
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	03/04/2020	N		17
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N		18
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19
20	If line 16 or 17 is yes, were adjustments made to PS&R Reoprt data for Other? Describe the other adjustments:	N		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

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

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

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

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

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

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

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

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/19/2020 Run Time: 18:44 Version: 2018.12 (04/03/2020)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						Inpatient Days / Outpatient Visits / Trips				
	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	98	37,055			20,040	367	28,509	1
2	HMO and other (see instructions)						2,381	2,843		2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF									5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		98	37,055			20,040	367	28,509	7
8	Intensive Care Unit	31								8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	Other Special Care (specify)	35								12
13	Nursery	43								13
14	Total (see instructions)		98	37,055			20,040	367	28,509	14
15	CAH Visits									15
16	Subprovider - IPF	40								16
17	Subprovider - IRF	41								17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44								19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101								22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116								24
24.10	Hospice (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	Total (sum of lines 14-26)		98							27
28	Observation Bed Days									28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)									32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33
33.01	LTCH site neutral days and discharges									33.01

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/19/2020 Run Time: 18:44 Version: 2018.12 (04/03/2020)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		Full Time Equivalents			DISCHARGES				
	Component	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					1,521	26	2,145	1
2	HMO and other (see instructions)					159	219		2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider								4
5	Hospital Adults & Peds. Swing Bed SNF								5
6	Hospital Adults & Peds. Swing Bed NF								6
7	Total Adults & Peds. (exclude observation beds) (see instructions)								7
8	Intensive Care Unit								8
9	Coronary Care Unit								9
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
12	Other Special Care (specify)								12
13	Nursery								13
14	Total (see instructions)		233.95			1,521	26	2,145	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency								22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	Total (sum of lines 14-26)		233.95						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32.01
33	LTCH non-covered days								33
33.01	LTCH site neutral days and discharges								33.01

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

Part II - Wage Data

		Wkst A Line No.	Amount Reported	Reclassif-ication of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)	
		1	2	3	4	5	6	
	SALARIES							
1	Total salaries (see instructions)	200	13,225,842			486,657.60		1
2	Non-physician anesthetist Part A							2
3	Non-physician anesthetest Part B							3
4	Physician-Part A - Administrative							4
4.01	Physician-Part A - Teaching							4.01
5	Physician-Part B							5
6	Non-physician-Part B							6
7	Interns & residents (in an approved program)	21						7
7.01	Contracted interns & residents (in an approved program)							7.01
8	Home office and/or related organization personnel							8
9	SNF	44						9
10	Excluded area salaries (see instructions)			201,937		5,928.00		10
	OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)		150,340			2,719.64		11
12	Contract management and administrative services							12
13	Contract labor: Physician-Part A - Administrative		86,744			645.00		13
14	Home office salaries & wage-related costs							14
14.01	Home office salaries		859,964			12,571.94		14.01
14.02	Related organization salaries							14.02
15	Home office: Physician Part A - Administrative							15
16	Home office & Contract Physicians Part A - Teaching							16
	WAGE-RELATED COSTS							
17	Wage-related costs (core)(see instructions)		3,495,895					17
18	Wage-related costs (other)(see instructions)							18
19	Excluded areas		54,204					19
20	Non-physician anesthetist Part A							20
21	Non-physician anesthetist Part B							21
22	Physician Part A - Administrative							22
22.01	Physician Part A - Teaching							22.01
23	Physician Part B							23
24	Wage-related costs (RHC/FQHC)							24
25	Interns & residents (in an approved program)							25
25.50	Home office wage-related		401,787					25.50
25.51	Related organization wage-related							25.51
25.52	Home office: Physician Part A - Administrative - wage-related							25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related							25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26	Employee Benefits Department							26
27	Administrative & General		1,858,541	-201,937		51,459.20		27
28	Administrative & General under contract (see instructions)		87,919			1,108.72		28
29	Maintenance & Repairs							29
30	Operation of Plant		279,713			11,502.40		30
31	Laundry & Linen Service							31
32	Housekeeping		344,785			25,625.60		32
33	Housekeeping under contract (see instructions)							33
34	Dietary		352,873			21,132.80		34
35	Dietary under contract (see instructions)							35
36	Cafeteria							36
37	Maintenance of Personnel							37
38	Nursing Administration		549,851			16,452.80		38
39	Central Services and Supply							39
40	Pharmacy							40
41	Medical Records & Medical Records Library		106,892			5,907.20		41
42	Social Service		546,896			18,470.40		42
43	Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		13,313,761		13,313,761	487,766.32	27.30	1
2	Excluded area salaries (see instructions)			201,937	201,937	5,928.00	34.06	2
3	Subtotal salarles (line 1 minus line 2)		13,313,761	-201,937	13,111,824	481,838.32	27.21	3
4	Subtotal other wages & related costs (see instructions)		1,097,048		1,097,048	15,936.58	68.84	4
5	Subtotal wage-related costs (see instructions)		3,897,682		3,897,682		29.73%	5
6	Total (sum of lines 3 through 5)		18,308,491	-201,937	18,106,554	497,774.90	36.37	6
7	Total overhead cost (see instructions)		4,127,470	-201,937	3,925,533	151,659.12	25.88	7

HOSPITAL WAGE RELATED COSTS **WORKSHEET S-3 PART IV**

Part IV - Wage Related Cost

Part A - Core List

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions	193,293	1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Nonqualified Defined Benefit Plan Cost (see instructions)		3
4	Qualified Defined Benefit Plan Cost (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA Plan Administration Fees		5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees		7
	HEALTH AND INSURANCE COST		
8	Health Insurance (Purchased or Self Funded)		8
8.01	Health Insurance (Self Funded without a Third Party Administrator)	2,681,358	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		8.02
8.03	Health Insurance (Purchased)		8.03
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan		10
11	Life Insurance (If employee is owner or beneficiary)	26,194	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)		13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	250,540	15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-Employers Portion Only	970,854	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance		19
20	State or Federal Unemployment Taxes	37,468	20
	OTHER		
21	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	Day Care Costs and Allowances	-609,608	22
23	Tuition Reimbursement		23
24	Total Wage Related cost (Sum of lines 1-23)	3,550,099	24

Part B - Other Than Core Related Cost

25	Other Wage Related Costs (SPECIFY)		25

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/19/2020 Run Time: 18:44 Version: 2018.12 (04/03/2020)

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

Part V - Contract Labor and Benefit Cost

Hospital and Hospital-Based Component Identification:

	Component	Contract Labor	Benefit Cost	
	0	1	2	
1	Total facility contract labor and benefit cost	237,084	3,550,099	1
2	Hospital	237,084	3,495,895	2
3	Subprovider - IPF			3
4	Subprovider - IRF			4
5	Subprovider - (OTHER)			5
6	Swing Beds - SNF			6
7	Swing Beds - NF			7
8	Hospital-Based SNF			8
9	Hospital-Based NF			9
10	Hospital-Based OLTC			10
11	Hospital-Based HHA			11
12	Separately Certified ASC			12
13	Hospital-Based Hospice			13
14	Hospital-Based Health Clinic - RHC			14
15	Hospital-Based Health Clinic - FQHC			15
16	Hospital-Based - CMHC			16
17	Renal Dialysis			17
18	Other		54,204	18

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES **WORKSHEET A**

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt		2,757,982	2,757,982	160,717	2,918,699	132,307	3,051,006	1
2	00200	Cap Rel Costs-Mvble Equip		826,606	826,606	104,430	931,036	-98,992	832,044	2
3	00300	Other Cap Rel Costs		223,149	223,149	-223,149			-0-	3
4	00400	Employee Benefits Department		3,001,093	3,001,093		3,001,093	503,778	3,504,871	4
5	00500	Administrative & General	1,858,541	3,850,666	5,709,207	-281,560	5,427,647	-668,873	4,758,774	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	279,713	585,921	865,634		865,634	-48,797	816,837	7
8	00800	Laundry & Linen Service		108,719	108,719		108,719	-28,426	80,293	8
9	00900	Housekeeping	344,785	86,937	431,722		431,722	-2,080	429,642	9
10	01000	Dietary	352,873	671,463	1,024,336	-18	1,024,318	-297,926	726,392	10
11	01100	Cafeteria								11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	549,851	26,203	576,054		576,054	-320	575,734	13
14	01400	Central Services & Supply								14
15	01500	Pharmacy								15
16	01600	Medical Records & Library	106,892	3,892	110,784		110,784	-1,726	109,058	16
17	01700	Social Service	546,896	23,187	570,083		570,083	-21	570,062	17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	5,090,599	453,902	5,544,501	20,381	5,564,882	-7,644	5,557,238	30
		ANCILLARY SERVICE COST CENTERS								
54	05400	Radiology-Diagnostic		172,880	172,880	-49,088	123,792	-360	123,432	54
54.01	05401	RADIOLOGY-SUA				49,088	49,088	-2,971	46,117	54.01
60	06000	Laboratory		554,382	554,382	4,028	558,410		558,410	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	463,910	22,499	486,409		486,409	-15,962	470,447	65
66	06600	Physical Therapy	1,221,063	40,732	1,261,795	-42,074	1,219,721	-143	1,219,578	66
67	06700	Occupational Therapy	1,332,444	14,425	1,346,869	31,740	1,378,609		1,378,609	67
68	06800	Speech Pathology	513,660	5,867	519,527	10,334	529,861		529,861	68
71	07100	Medical Supplies Charged to Patients	74,594	322,286	396,880		396,880	-17,541	379,339	71
73	07300	Drugs Charged to Patients	490,021	764,053	1,254,074		1,254,074	-2,748	1,251,326	73
76	03953	PSYCH								76
76.01	03951	SPECIAL PROCEDURES		159,935	159,935	-78,016	81,919		81,919	76.01
76.02	03952	SPECIAL PROCEDURES SUA				78,016	78,016	-13,458	64,558	76.02
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
92	09200	Observation Beds (Non-Distinct Part)								92
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM								93.99
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
113	11300	Interest Expense		5,455	5,455		5,455	-5,455		113
118		SUBTOTALS (sum of lines 1-117)	13,225,842	14,682,234	27,908,076	-215,171	27,692,905	-577,358	27,115,547	118
		NONREIMBURSABLE COST CENTERS								
192	19200	Physicians' Private Offices		-28,400	-28,400		-28,400	28,400		192
194	07950	NRCC MARKETING				215,171	215,171		215,171	194
194.01	07951	GUEST MEALS								194.01
200		TOTAL (sum of lines 118-199)	13,225,842	14,653,834	27,879,676		27,879,676	-548,958	27,330,718	200

RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	INSURANCE	A	Cap Rel Costs-Bldg & Fixt	1		32,746	1
2	INSURANCE	A	Cap Rel Costs-Mvble Equip	2		9,252	2
3	INSURANCE	A					3
500	Total reclassifications					41,998	500
	Code Letter - A						
1	MARKETING	B	NRCC MARKETING	194	201,937	13,234	1
2	MARKETING	B					2
3	MARKETING	B					3
500	Total reclassifications				201,937	13,234	500
	Code Letter - B						
1	PHYSICIANS	C	Adults & Pediatrics	30		24,409	1
2	PHYSICIANS	C					2
500	Total reclassifications					24,409	500
	Code Letter - C						
1	SERVICE UNDER ARRANGEMENT	D	RADIOLOGY-SUA	54.01		49,088	1
2	SERVICE UNDER ARRANGEMENT	D	SPECIAL PROCEDURES SUA	76.02		78,016	2
3	SERVICE UNDER ARRANGEMENT	D					3
4	SERVICE UNDER ARRANGEMENT	D					4
500	Total reclassifications					127,104	500
	Code Letter - D						
1	RELATED PARTY	E	Laboratory	60		4,028	1
2	RELATED PARTY	E					2
500	Total reclassifications					4,028	500
	Code Letter - E						
1	DEPT 283	F	Occupational Therapy	67	31,463	277	1
2	DEPT 283	F	Speech Pathology	68	10,244	90	2
3	DEPT 283	F					3
500	Total reclassifications				41,707	367	500
	Code Letter - F						
	GRAND TOTAL (Increases)				243,644	211,140	

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

RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	INSURANCE	A					12	1
2	INSURANCE	A					12	2
3	INSURANCE	A	Administrative & General	5		41,998		3
500	Total reclassifications					41,998		500
	Code letter - A							
1	MARKETING	B						1
2	MARKETING	B	Administrative & General	5	201,937	13,216		2
3	MARKETING	B	Dietary	10		18		3
500	Total reclassifications				201,937	13,234		500
	Code letter - B							
1	PHYSICIANS	C						1
2	PHYSICIANS	C	Administrative & General	5		24,409		2
500	Total reclassifications					24,409		500
	Code letter - C							
1	SERVICE UNDER ARRANGEMENT	D						1
2	SERVICE UNDER ARRANGEMENT	D						2
3	SERVICE UNDER ARRANGEMENT	D	Radiology-Diagnostic	54		49,088		3
4	SERVICE UNDER ARRANGEMENT	D	SPECIAL PROCEDURES	76.01		78,016		4
500	Total reclassifications					127,104		500
	Code letter - D							
1	RELATED PARTY	E						1
2	RELATED PARTY	E	Adults & Pediatrics	30		4,028		2
500	Total reclassifications					4,028		500
	Code letter - E							
1	DEPT 283	F						1
2	DEPT 283	F						2
3	DEPT 283	F	Physical Therapy	66	41,707	367		3
500	Total reclassifications				41,707	367		500
	Code letter - F							
	GRAND TOTAL (Decreases)				243,644	211,140		

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

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

			Acquisitions						
	Description	Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		1	2	3	4	5	6	7	
1	Land	1,600,057					1,600,057		1
2	Land Improvements								2
3	Buildings and Fixtures								3
4	Building Improvements	5,806,616					5,806,616		4
5	Fixed Equipment								5
6	Movable Equipment	4,318,686					4,318,686		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	11,725,359					11,725,359		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	11,725,359					11,725,359		10

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

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	888,175	1,869,807					2,757,982	1
2	Cap Rel Costs-Mvble Equip	596,520	230,086					826,606	2
3	Total (sum of lines 1-2)	1,484,695	2,099,893					3,584,588	3

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

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	5,806,616		5,806,616	0.573476		127,971		127,971	1
2	Cap Rel Costs-Mvble Equ	4,318,686		4,318,686	0.426524		95,178		95,178	2
3	Total (sum of lines 1-2)	10,125,302		10,125,302	1.000000		223,149		223,149	3

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	836,072	1,869,807	184,410	32,746	127,971		3,051,006	1
2	Cap Rel Costs-Mvble Equip	515,920	211,694		9,252	95,178		832,044	2
3	Total (sum of lines 1-2)	1,351,992	2,081,501	184,410	41,998	223,149		3,883,050	3

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

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
1	Investment income-buildings & fixtures (chapter 2)			Cap Rel Costs-Bldg & Fixt	1		1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)						7
8	Television and radio service (chapter 21)						8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-7,631				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1	-245,779				12
13	Laundry and linen service						13
14	Cafeteria - employees and guests						14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients						16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts						18
19	Nursing and allied health education (tuition, fees, books, etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation						32
33							33
34							34
35							35
36							36
37	INTEREST	A	-5,455	Interest Expense	113	11	37
37.01	DEPRECIATION	A	-138,492	Cap Rel Costs-Bldg & Fixt	1	9	37.01
37.02	DEPRECIATION	A	-63,009	Cap Rel Costs-Mvble Equip	2	9	37.02
37.03	INSURANCE	A	539,723	Employee Benefits Department	4		37.03
37.04	INSURANCE	A	-282,823	Administrative & General	5		37.04
37.05	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-80,631	Administrative & General	5		37.05
37.06	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	1	Dietary	10		37.06
37.07	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-320	Nursing Administration	13		37.07
37.08	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-21	Social Service	17		37.08
37.09	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	1	Adults & Pediatrics	30		37.09
37.10	PATIENT TELEPHONE	A	-9,430	Cap Rel Costs-Mvble Equip	2	9	37.10
37.11	PATIENT TELEPHONE	A	-4,187	Employee Benefits Department	4		37.11
37.12	PATIENT TELEPHONE	A	-21,566	Administrative & General	5		37.12
37.13	PATIENT TELEVISION	A	-8,161	Cap Rel Costs-Mvble Equip	2	9	37.13
37.14	PATIENT TELEVISION	A	-888	Administrative & General	5		37.14
37.15	PRINTING	A	-5,341	Administrative & General	5		37.15
37.16	PRINTING	A	-7	Operation of Plant	7		37.16
37.18	LOBBYING EXPENSE	A	-116	Employee Benefits Department	4		37.18
37.19	LOBBYING EXPENSE	A	-2,919	Administrative & General	5		37.19
37.20	MISCELLANEOUS INCOME	B	-2,289	Cap Rel Costs-Bldg & Fixt	1	11	37.20
37.21	MISCELLANEOUS INCOME	B	-1,145	Administrative & General	5		37.21
37.22	MISCELLANEOUS INCOME	B	-17,386	Dietary	10		37.22
37.23	MISCELLANEOUS INCOME	B	-1,726	Medical Records & Library	16		37.23
37.24	MISCELLANEOUS INCOME	B	-20	Drugs Charged to Patients	73		37.24
37.25	PATIENT TRANSPORTATION	A	-14,345	Cap Rel Costs-Bldg & Fixt	1	9	37.25
37.26	PATIENT TRANSPORTATION	A	-31,642	Employee Benefits Department	4		37.26
37.27	PATIENT TRANSPORTATION	A	-861	Administrative & General	5		37.27
37.28	PATIENT TRANSPORTATION	A	-48,790	Operation of Plant	7		37.28
37.29	PROFESSIONAL FEES	A	9,548	Administrative & General	5		37.29

ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
37.30	COMP HEALTH	A	-131,651	Dietary	10		37.30
37.31	COMP HEALTH	A	28,400	Physicians' Private Offices	192		37.31
38							38
39							39
40							40
41							41
42							42
43							43
44							44
45							45
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-548,958				50

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS **WORKSHEET A-8-1**

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

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1	5	Administrative & General	TO OFFSET MANAGEMENT FEES		2,318,397	-2,318,397		1
2	1	Cap Rel Costs-Bldg & Fixt	TO INCLUDE ALLOWABLE HOME OFFICE COS	100,734		100,734	9	2
3	1	Cap Rel Costs-Bldg & Fixt	TO INCLUDE ALLOWABLE HOME OFFICE COS	186,699		186,699	11	3
3.01	5	Administrative & General	TO INCLUDE ALLOWABLE HOME OFFICE COS	1,832,944		1,832,944		3.01
3.02	5	Administrative & General	TO INCLUDE ALLOWABLE HOME OFFICE COS	210,724		210,724		3.02
3.03	2	Cap Rel Costs-Mvble Equip	INTERCOMPANY WAGE AND EXPENSE TRANSF	19,734	19,734		10	3.03
3.04	3	Other Cap Rel Costs	INTERCOMPANY WAGE AND EXPENSE TRANSF	48,499	48,499		13	3.04
3.05	4	Employee Benefits Department	INTERCOMPANY WAGE AND EXPENSE TRANSF	2,370,403	2,370,403			3.05
3.06	5	Administrative & General	INTERCOMPANY WAGE AND EXPENSE TRANSF	3,030,462	3,030,462			3.06
3.07	7	Operation of Plant	INTERCOMPANY WAGE AND EXPENSE TRANSF	28,409	28,409			3.07
3.08	9	Housekeeping	INTERCOMPANY WAGE AND EXPENSE TRANSF	-4,027	-4,027			3.08
3.09	10	Dietary	INTERCOMPANY WAGE AND EXPENSE TRANSF	-7,880	-7,880			3.09
3.10	13	Nursing Administration	INTERCOMPANY WAGE AND EXPENSE TRANSF	2,589	2,589			3.10
3.11	17	Social Service	INTERCOMPANY WAGE AND EXPENSE TRANSF	563	563			3.11
3.12	30	Adults & Pediatrics	INTERCOMPANY WAGE AND EXPENSE TRANSF	3,041	3,041			3.12
3.13	54	Radiology-Diagnostic	INTERCOMPANY WAGE AND EXPENSE TRANSF	-1,083	-1,083			3.13
3.14	60	Laboratory	INTERCOMPANY WAGE AND EXPENSE TRANSF	-311	-311			3.14
3.15	66	Physical Therapy	INTERCOMPANY WAGE AND EXPENSE TRANSF	-8,959	-8,959			3.15
3.16	67	Occupational Therapy	INTERCOMPANY WAGE AND EXPENSE TRANSF	-10,348	-10,348			3.16
3.17	68	Speech Pathology	INTERCOMPANY WAGE AND EXPENSE TRANSF	1,626	1,626			3.17
3.18	71	Medical Supplies Charged to Patients	INTERCOMPANY WAGE AND EXPENSE TRANSF	-41,232	-41,232			3.18
3.19	73	Drugs Charged to Patients	INTERCOMPANY WAGE AND EXPENSE TRANSF	653,442	653,442			3.19
3.20	113	Interest Expense	INTERCOMPANY WAGE AND EXPENSE TRANSF	5,455	5,455		11	3.20
3.21	1	Cap Rel Costs-Bldg & Fixt	DEACONESS	427,560	427,560		10	3.21
3.22	2	Cap Rel Costs-Mvble Equip	DEACONESS	5,323	23,715	-18,392	10	3.22
3.23	5	Administrative & General	DEACONESS	11,700	19,218	-7,518		3.23
3.24	8	Laundry & Linen Service	DEACONESS	8,227	36,653	-28,426		3.24
3.25	9	Housekeeping	DEACONESS	602	2,682	-2,080		3.25
3.26	10	Dietary	DEACONESS	43,238	192,128	-148,890		3.26
3.27	17	Social Service	DEACONESS	32	32			3.27
3.28	30	Adults & Pediatrics	DEACONESS	4,798	4,812	-14		3.28
3.29	54	Radiology-Diagnostic	DEACONESS		360	-360		3.29
3.30	54.01	RADIOLOGY-SUA	DEACONESS	52,047	55,018	-2,971		3.30
3.31	60	Laboratory	DEACONESS	299,023	299,023			3.31
3.32	65	Respiratory Therapy	DEACONESS	1,590	17,552	-15,962		3.32
3.33	66	Physical Therapy	DEACONESS	30	173	-143		3.33
3.34	71	Medical Supplies Charged to Patients	DEACONESS	15,096	32,637	-17,541		3.34
3.35	73	Drugs Charged to Patients	DEACONESS	947	3,675	-2,728		3.35
3.36	76.02	SPECIAL PROCEDURES SUA	DEACONESS	32,483	45,941	-13,458		3.36
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12			9,324,180	9,569,959	-245,779		5

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

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

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

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS **WORKSHEET A-8-1**

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

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

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

				Related Organization(s) and/or Home Office			
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	

services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

				Related Organization(s) and/or Home Office			
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
6	B		72.50	ENCOMPASS HEALTH		HEALTHCARE	6
7	B		27.50	DEACONESS HOSPITAL		HEALTHCARE	7
8	G	ENCOMPASS HEALTH				HEALTHCARE	8
9							9
10							10

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

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

PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun-eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	30	Adults & Pediatrics AGGREGATE	24,409		24,409	211,500	165	16,778	839	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	24,409		24,409		165	16,778	839	200

PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	30	Adults & Pediatrics AGGREGATE					16,778	7,631	7,631	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL					16,778	7,631	7,631	200

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS-TRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	3,051,006	3,051,006					1
2	Cap Rel Costs-Mvble Equip	832,044		832,044				2
4	Employee Benefits Department	3,504,871	15,543	4,239	3,524,653			4
5	Administrative & General	4,758,774	434,772	118,567	441,480	5,753,593	5,753,593	5
6	Maintenance & Repairs							6
7	Operation of Plant	816,837	107,534	29,326	74,543	1,028,240	275,596	7
8	Laundry & Linen Service	80,293	19,779	5,394		105,466	28,268	8
9	Housekeeping	429,642	19,212	5,239	91,884	545,977	146,337	9
10	Dietary	726,392	169,339	46,181	94,040	1,035,952	277,663	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	575,734	50,798	13,853	146,534	786,919	210,916	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	109,058	16,510	4,503	28,486	158,557	42,498	16
17	Social Service	570,062	43,694	11,916	145,746	771,418	206,761	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	5,557,238	1,559,374	425,258	1,356,634	8,898,504	2,385,041	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	123,432				123,432	33,083	54
54.01	RADIOLOGY-SUA	46,117				46,117		54.01
60	Laboratory	558,410	12,508	3,411		574,329	153,936	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	470,447	9,606	2,620	123,631	606,304	162,506	65
66	Physical Therapy	1,219,578	225,207	61,417	314,295	1,820,497	487,942	66
67	Occupational Therapy	1,378,609	177,144	48,309	363,477	1,967,539	527,354	67
68	Speech Pathology	529,861	42,126	11,488	139,619	723,094	193,809	68
71	Medical Supplies Charged to Patients	379,339	50,732	13,835	19,879	463,785	124,307	71
73	Drugs Charged to Patients	1,251,326	19,012	5,185	130,589	1,406,112	376,876	73
76	PSYCH							76
76.01	SPECIAL PROCEDURES	81,919				81,919	21,957	76.01
76.02	SPECIAL PROCEDURES SUA	64,558				64,558		76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	27,115,547	2,972,890	810,741	3,470,837	26,962,312	5,654,850	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		59,871	16,327		76,198	20,423	192
194	NRCC MARKETING	215,171	18,245	4,976	53,816	292,208	78,320	194
194.01	GUEST MEALS							194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	27,330,718	3,051,006	832,044	3,524,653	27,330,718	5,753,593	202

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	1,303,836						7
8	Laundry & Linen Service	10,344	144,078					8
9	Housekeeping	10,047		702,361				9
10	Dietary	88,559		48,463	1,450,637			10
11	Cafeteria				126,793	126,793		11
12	Maintenance of Personnel							12
13	Nursing Administration	26,566		14,538		6,582	1,045,521	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	8,634		4,725		1,280		16
17	Social Service	22,850		12,505		6,547		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	815,499	144,078	446,281	1,302,928	60,938	1,045,521	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic							54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory	6,541		3,580				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	5,024		2,749		5,553		65
66	Physical Therapy	117,776		64,452		14,118		66
67	Occupational Therapy	92,640		50,697		16,327		67
68	Speech Pathology	22,031		12,056		6,272		68
71	Medical Supplies Charged to Patients	26,531		14,519		893		71
73	Drugs Charged to Patients	9,943		5,441		5,866		73
76	PSYCH							76
76.01	SPECIAL PROCEDURES							76.01
76.02	SPECIAL PROCEDURES SUA							76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	1,262,985	144,078	680,006	1,429,721	124,376	1,045,521	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	31,310		17,134				192
194	NRCC MARKETING	9,541		5,221		2,417		194
194.01	GUEST MEALS				20,916			194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,303,836	144,078	702,361	1,450,637	126,793	1,045,521	202

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		16	17	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	215,694						16
17	Social Service		1,020,081					17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	100,213	1,020,081	16,219,084		16,219,084		30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	730		157,245		157,245		54
54.01	RADIOLOGY-SUA			46,117		46,117		54.01
60	Laboratory	9,010		747,396		747,396		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	7,613		789,749		789,749		65
66	Physical Therapy	25,982		2,530,767		2,530,767		66
67	Occupational Therapy	26,723		2,681,280		2,681,280		67
68	Speech Pathology	8,871		966,133		966,133		68
71	Medical Supplies Charged to Patients	6,982		637,017		637,017		71
73	Drugs Charged to Patients	28,746		1,832,984		1,832,984		73
76	PSYCH							76
76.01	SPECIAL PROCEDURES	824		104,700		104,700		76.01
76.02	SPECIAL PROCEDURES SUA			64,558		64,558		76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	215,694	1,020,081	26,777,030		26,777,030		118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices			145,065		145,065		192
194	NRCC MARKETING			387,707		387,707		194
194.01	GUEST MEALS			20,916		20,916		194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	215,694	1,020,081	27,330,718		27,330,718		202

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS-TRATIVE & GENERAL	
		0	1	2	2A	4	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department		15,543	4,239	19,782	19,782		4
5	Administrative & General		434,772	118,567	553,339	2,478	555,817	5
6	Maintenance & Repairs							6
7	Operation of Plant		107,534	29,326	136,860	418	26,623	7
8	Laundry & Linen Service		19,779	5,394	25,173		2,731	8
9	Housekeeping		19,212	5,239	24,451	516	14,136	9
10	Dietary		169,339	46,181	215,520	528	26,823	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration		50,798	13,853	64,651	823	20,375	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		16,510	4,503	21,013	160	4,105	16
17	Social Service		43,694	11,916	55,610	818	19,974	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		1,559,374	425,258	1,984,632	7,612	230,408	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic						3,196	54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory		12,508	3,411	15,919		14,871	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		9,606	2,620	12,226	694	15,698	65
66	Physical Therapy		225,207	61,417	286,624	1,764	47,136	66
67	Occupational Therapy		177,144	48,309	225,453	2,040	50,944	67
68	Speech Pathology		42,126	11,488	53,614	784	18,722	68
71	Medical Supplies Charged to Patients		50,732	13,835	64,567	112	12,008	71
73	Drugs Charged to Patients		19,012	5,185	24,197	733	36,407	73
76	PSYCH							76
76.01	SPECIAL PROCEDURES						2,121	76.01
76.02	SPECIAL PROCEDURES SUA							76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)		2,972,890	810,741	3,783,631	19,480	546,278	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		59,871	16,327	76,198		1,973	192
194	NRCC MARKETING		18,245	4,976	23,221	302	7,566	194
194.01	GUEST MEALS							194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		3,051,006	832,044	3,883,050	19,782	555,817	202

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	163,901						7
8	Laundry & Linen Service	1,300	29,204					8
9	Housekeeping	1,263		40,366				9
10	Dietary	11,132		2,785	256,788			10
11	Cafeteria				22,445	22,445		11
12	Maintenance of Personnel							12
13	Nursing Administration	3,340		836		1,165	91,190	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	1,085		272		227		16
17	Social Service	2,872		719		1,159		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	102,515	29,204	25,647	230,640	10,788	91,190	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic							54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory	822		206				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	632		158		983		65
66	Physical Therapy	14,805		3,704		2,499		66
67	Occupational Therapy	11,646		2,914		2,890		67
68	Speech Pathology	2,769		693		1,110		68
71	Medical Supplies Charged to Patients	3,335		834		158		71
73	Drugs Charged to Patients	1,250		313		1,038		73
76	PSYCH							76
76.01	SPECIAL PROCEDURES							76.01
76.02	SPECIAL PROCEDURES SUA							76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	158,766	29,204	39,081	253,085	22,017	91,190	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	3,936		985				192
194	NRCC MARKETING	1,199		300		428		194
194.01	GUEST MEALS				3,703			194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	163,901	29,204	40,366	256,788	22,445	91,190	202

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		16	17	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	26,862						16
17	Social Service		81,152					17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	12,491	81,152	2,806,279		2,806,279		30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	91		3,287		3,287		54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory	1,121		32,939		32,939		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	947		31,338		31,338		65
66	Physical Therapy	3,233		359,765		359,765		66
67	Occupational Therapy	3,326		299,213		299,213		67
68	Speech Pathology	1,104		78,796		78,796		68
71	Medical Supplies Charged to Patients	869		81,883		81,883		71
73	Drugs Charged to Patients	3,577		67,515		67,515		73
76	PSYCH							76
76.01	SPECIAL PROCEDURES	103		2,224		2,224		76.01
76.02	SPECIAL PROCEDURES SUA							76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	26,862	81,152	3,763,239		3,763,239		118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices			83,092		83,092		192
194	NRCC MARKETING			33,016		33,016		194
194.01	GUEST MEALS			3,703		3,703		194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	26,862	81,152	3,883,050		3,883,050		202

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	91,473						1
2	Cap Rel Costs-Mvble Equip		91,473					2
4	Employee Benefits Department	466	466	13,225,842				4
5	Administrative & General	13,035	13,035	1,656,604	-5,753,593	21,466,450		5
6	Maintenance & Repairs							6
7	Operation of Plant	3,224	3,224	279,713		1,028,240	74,748	7
8	Laundry & Linen Service	593	593			105,466	593	8
9	Housekeeping	576	576	344,785		545,977	576	9
10	Dietary	5,077	5,077	352,873		1,035,952	5,077	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	1,523	1,523	549,851		786,919	1,523	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	495	495	106,892		158,557	495	16
17	Social Service	1,310	1,310	546,896		771,418	1,310	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	46,752	46,752	5,090,599		8,898,504	46,752	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic					123,432		54
54.01	RADIOLOGY-SUA				-46,117			54.01
60	Laboratory	375	375			574,329	375	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	288	288	463,910		606,304	288	65
66	Physical Therapy	6,752	6,752	1,179,356		1,820,497	6,752	66
67	Occupational Therapy	5,311	5,311	1,363,907		1,967,539	5,311	67
68	Speech Pathology	1,263	1,263	523,904		723,094	1,263	68
71	Medical Supplies Charged to Patients	1,521	1,521	74,594		463,785	1,521	71
73	Drugs Charged to Patients	570	570	490,021		1,406,112	570	73
76	PSYCH							76
76.01	SPECIAL PROCEDURES					81,919		76.01
76.02	SPECIAL PROCEDURES SUA				-64,558			76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	89,131	89,131	13,023,905	-5,864,268	21,098,044	72,406	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	1,795	1,795			76,198	1,795	192
194	NRCC MARKETING	547	547	201,937		292,208	547	194
194.01	GUEST MEALS							194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	3,051,006	832,044	3,524,653		5,753,593	1,303,836	202
203	Unit Cost Multiplier (Wkst. B, Part I)	33.354170	9.096061	0.266497		0.268027	17.443089	203
204	Cost to be allocated (Per Wkst. B, Part II)			19,782		555,817	163,901	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.001496		0.025892	2.192714	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE PATIENT DAYS	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA GROSS SALARIES	NURSING ADMINIS-TRATION PATIENT DAYS	MEDICAL RECORDS & LIBRARY TIME SPENT	
		8	9	10	11	13	16	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	28,509						8
9	Housekeeping		73,579					9
10	Dietary		5,077	95,223				10
11	Cafeteria			8,323	10,591,867			11
12	Maintenance of Personnel							12
13	Nursing Administration		1,523		549,851	28,509		13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		495		106,892		60,177,460	16
17	Social Service		1,310		546,896			17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	28,509	46,752	85,527	5,090,599	28,509	27,955,860	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic						203,802	54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory		375				2,514,047	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		288		463,910		2,124,176	65
66	Physical Therapy		6,752		1,179,356		7,249,545	66
67	Occupational Therapy		5,311		1,363,907		7,456,306	67
68	Speech Pathology		1,263		523,904		2,475,067	68
71	Medical Supplies Charged to Patients		1,521		74,594		1,948,195	71
73	Drugs Charged to Patients		570		490,021		8,020,554	73
76	PSYCH							76
76.01	SPECIAL PROCEDURES						229,908	76.01
76.02	SPECIAL PROCEDURES SUA							76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	28,509	71,237	93,850	10,389,930	28,509	60,177,460	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		1,795					192
194	NRCC MARKETING		547		201,937			194
194.01	GUEST MEALS			1,373				194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	144,078	702,361	1,450,637	126,793	1,045,521	215,694	202
203	Unit Cost Multiplier (Wkst. B, Part I)	5.053772	9.545672	15.234103	0.011971	36.673366	0.003584	203
204	Cost to be allocated (Per Wkst. B, Part II)	29,204	40,366	256,788	22,445	91,190	26,862	204
205	Unit Cost Multiplier (Wkst. B, Part II)	1.024378	0.548608	2.696701	0.002119	3.198639	0.000446	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	SOCIAL SERVICE PATIENT DAYS						
		17						
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service	28,509						17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	28,509						30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic							54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients							73
76	PSYCH							76
76.01	SPECIAL PROCEDURES							76.01
76.02	SPECIAL PROCEDURES SUA							76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	28,509						118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices							192
194	NRCC MARKETING							194
194.01	GUEST MEALS							194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,020,081						202
203	Unit Cost Multiplier (Wkst. B, Part I)	35.781017						203
204	Cost to be allocated (Per Wkst. B, Part II)	81,152						204
205	Unit Cost Multiplier (Wkst. B, Part II)	2.846540						205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/19/2020 Run Time: 18:44 Version: 2018.12 (04/03/2020)

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	CODE	LINE NO.	AMOUNT	
	1	2	3	4	

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	16,219,084		16,219,084	7,631	16,226,715	30
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	157,245		157,245		157,245	54
54.01	RADIOLOGY-SUA	46,117		46,117		46,117	54.01
60	Laboratory	747,396		747,396		747,396	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	789,749		789,749		789,749	65
66	Physical Therapy	2,530,767		2,530,767		2,530,767	66
67	Occupational Therapy	2,681,280		2,681,280		2,681,280	67
68	Speech Pathology	966,133		966,133		966,133	68
71	Medical Supplies Charged to Patients	637,017		637,017		637,017	71
73	Drugs Charged to Patients	1,832,984		1,832,984		1,832,984	73
76	PSYCH						76
76.01	SPECIAL PROCEDURES	104,700		104,700		104,700	76.01
76.02	SPECIAL PROCEDURES SUA	64,558		64,558		64,558	76.02
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct Part)						92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	26,777,030		26,777,030	7,631	26,784,661	200
201	Less Observation Beds						201
202	Total (line 200 minus line 201)	26,777,030		26,777,030		26,784,661	202

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/19/2020 Run Time: 18:44 Version: 2018.12 (04/03/2020)

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	27,955,860		27,955,860				30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	210,314	427	210,741	0.746153	0.746153	0.746153	54
54.01	RADIOLOGY-SUA	83,565		83,565	0.551870	0.551870	0.551870	54.01
60	Laboratory	2,514,035	12	2,514,047	0.297288	0.297288	0.297288	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,124,176		2,124,176	0.371791	0.371791	0.371791	65
66	Physical Therapy	7,249,545		7,249,545	0.349093	0.349093	0.349093	66
67	Occupational Therapy	7,456,306		7,456,306	0.359599	0.359599	0.359599	67
68	Speech Pathology	2,475,067		2,475,067	0.390346	0.390346	0.390346	68
71	Medical Supplies Charged to Patients	1,947,820	375	1,948,195	0.326978	0.326978	0.326978	71
73	Drugs Charged to Patients	8,020,554		8,020,554	0.228536	0.228536	0.228536	73
76	PSYCH							76
76.01	SPECIAL PROCEDURES	165,201		165,201	0.633773	0.633773	0.633773	76.01
76.02	SPECIAL PROCEDURES SUA	157,332		157,332	0.410330	0.410330	0.410330	76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	60,359,775	814	60,360,589				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	60,359,775	814	60,360,589				202

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

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	16,219,084		16,219,084	7,631	16,226,715	30
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	157,245		157,245		157,245	54
54.01	RADIOLOGY-SUA	46,117		46,117		46,117	54.01
60	Laboratory	747,396		747,396		747,396	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	789,749		789,749		789,749	65
66	Physical Therapy	2,530,767		2,530,767		2,530,767	66
67	Occupational Therapy	2,681,280		2,681,280		2,681,280	67
68	Speech Pathology	966,133		966,133		966,133	68
71	Medical Supplies Charged to Patients	637,017		637,017		637,017	71
73	Drugs Charged to Patients	1,832,984		1,832,984		1,832,984	73
76	PSYCH						76
76.01	SPECIAL PROCEDURES	104,700		104,700		104,700	76.01
76.02	SPECIAL PROCEDURES SUA	64,558		64,558		64,558	76.02
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct Part)						92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	26,777,030		26,777,030	7,631	26,784,661	200
201	Less Observation Beds						201
202	Total (line 200 minus line 201)	26,777,030		26,777,030	7,631	26,784,661	202

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

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	27,955,860		27,955,860				30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	210,314	427	210,741	0.746153	0.746153	0.746153	54
54.01	RADIOLOGY-SUA	83,565		83,565	0.551870	0.551870	0.551870	54.01
60	Laboratory	2,514,035	12	2,514,047	0.297288	0.297288	0.297288	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,124,176		2,124,176	0.371791	0.371791	0.371791	65
66	Physical Therapy	7,249,545		7,249,545	0.349093	0.349093	0.349093	66
67	Occupational Therapy	7,456,306		7,456,306	0.359599	0.359599	0.359599	67
68	Speech Pathology	2,475,067		2,475,067	0.390346	0.390346	0.390346	68
71	Medical Supplies Charged to Patients	1,947,820	375	1,948,195	0.326978	0.326978	0.326978	71
73	Drugs Charged to Patients	8,020,554		8,020,554	0.228536	0.228536	0.228536	73
76	PSYCH							76
76.01	SPECIAL PROCEDURES	165,201		165,201	0.633773	0.633773	0.633773	76.01
76.02	SPECIAL PROCEDURES SUA	157,332		157,332	0.410330	0.410330	0.410330	76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	60,359,775	814	60,360,589				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	60,359,775	814	60,360,589				202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	2,806,279		2,806,279	28,509	98.43	20,040	1,972,537	30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	2,806,279		2,806,279	28,509		20,040	1,972,537	200

(A) Worksheet A line numbers

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

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

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	3,287	210,741	0.015597	168,929	2,635	54
54.01	RADIOLOGY-SUA		83,565		66,986		54.01
60	Laboratory	32,939	2,514,047	0.013102	1,849,494	24,232	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	31,338	2,124,176	0.014753	1,612,449	23,788	65
66	Physical Therapy	359,765	7,249,545	0.049626	5,103,568	253,270	66
67	Occupational Therapy	299,213	7,456,306	0.040129	5,276,409	211,737	67
68	Speech Pathology	78,796	2,475,067	0.031836	1,670,818	53,192	68
71	Medical Supplies Charged to Pat	81,883	1,948,195	0.042030	1,326,398	55,749	71
73	Drugs Charged to Patients	67,515	8,020,554	0.008418	5,661,172	47,656	73
76	PSYCH						76
76.01	SPECIAL PROCEDURES	2,224	165,201	0.013462	125,354	1,688	76.01
76.02	SPECIAL PROCEDURES SUA		157,332		119,382		76.02
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct						92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	956,960	32,404,729		22,980,959	673,947	200

(A) Worksheet A line numbers

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/19/2020 Run Time: 18:44 Version: 2018.12 (04/03/2020)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS **WORKSHEET D PART III**

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

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

(A) Worksheet A line numbers

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/19/2020 Run Time: 18:44 Version: 2018.12 (04/03/2020)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS **WORKSHEET D PART III**

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

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	28,509		20,040		30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	28,509		20,040		200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 15-3025** | **WORKSHEET D PART IV**

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

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

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 15-3025** | **WORKSHEET D PART IV**

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

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	210,741			168,929		427		54
54.01	RADIOLOGY-SUA	83,565			66,986				54.01
60	Laboratory	2,514,047			1,849,494		12		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	2,124,176			1,612,449				65
66	Physical Therapy	7,249,545			5,103,568				66
67	Occupational Therapy	7,456,306			5,276,409				67
68	Speech Pathology	2,475,067			1,670,818				68
71	Medical Supplies Charged to Pat	1,948,195			1,326,398		375		71
73	Drugs Charged to Patients	8,020,554			5,661,172				73
76	PSYCH								76
76.01	SPECIAL PROCEDURES	165,201			125,354				76.01
76.02	SPECIAL PROCEDURES SUA	157,332			119,382				76.02
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	32,404,729			22,980,959		814		200

(A) Worksheet A line numbers

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

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	0.746153	427			319			54
54.01	RADIOLOGY-SUA	0.551870							54.01
60	Laboratory	0.297288	12			4			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.371791							65
66	Physical Therapy	0.349093							66
67	Occupational Therapy	0.359599							67
68	Speech Pathology	0.390346							68
71	Medical Supplies Charged to Pat	0.326978	375			123			71
73	Drugs Charged to Patients	0.228536							73
76	PSYCH								76
76.01	SPECIAL PROCEDURES	0.633773							76.01
76.02	SPECIAL PROCEDURES SUA	0.410330							76.02
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		814			446			200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		814			446			202

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	2,806,279		2,806,279	28,509	98.43	367	36,124	30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	2,806,279		2,806,279	28,509		367	36,124	200

(A) Worksheet A line numbers

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

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

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	3,287	210,741	0.015597	11,004	172	54
54.01	RADIOLOGY-SUA		83,565		622		54.01
60	Laboratory	32,939	2,514,047	0.013102	42,787	561	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	31,338	2,124,176	0.014753	29,490	435	65
66	Physical Therapy	359,765	7,249,545	0.049626	90,389	4,486	66
67	Occupational Therapy	299,213	7,456,306	0.040129	89,474	3,591	67
68	Speech Pathology	78,796	2,475,067	0.031836	12,694	404	68
71	Medical Supplies Charged to Pat	81,883	1,948,195	0.042030	41,284	1,735	71
73	Drugs Charged to Patients	67,515	8,020,554	0.008418	139,289	1,173	73
76	PSYCH						76
76.01	SPECIAL PROCEDURES	2,224	165,201	0.013462	2,929	39	76.01
76.02	SPECIAL PROCEDURES SUA		157,332		1,931		76.02
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct						92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	956,960	32,404,729		461,893	12,596	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

		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	5	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)								30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	TOTAL (lines 30-199)								200

(A) Worksheet A line numbers

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/19/2020 Run Time: 18:44 Version: 2018.12 (04/03/2020)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS **WORKSHEET D PART III**

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

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	28,509		367		30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	28,509		367		200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 15-3025** | **WORKSHEET D PART IV**

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

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

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 15-3025** | **WORKSHEET D PART IV**

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

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	210,741			11,004				54
54.01	RADIOLOGY-SUA	83,565			622				54.01
60	Laboratory	2,514,047			42,787				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	2,124,176			29,490				65
66	Physical Therapy	7,249,545			90,389				66
67	Occupational Therapy	7,456,306			89,474				67
68	Speech Pathology	2,475,067			12,694				68
71	Medical Supplies Charged to Pat	1,948,195			41,284				71
73	Drugs Charged to Patients	8,020,554			139,289				73
76	PSYCH								76
76.01	SPECIAL PROCEDURES	165,201			2,929				76.01
76.02	SPECIAL PROCEDURES SUA	157,332			1,931				76.02
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	32,404,729			461,893				200

(A) Worksheet A line numbers

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

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	0.746153							54
54.01	RADIOLOGY-SUA	0.551870							54.01
60	Laboratory	0.297288							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.371791							65
66	Physical Therapy	0.349093							66
67	Occupational Therapy	0.359599							67
68	Speech Pathology	0.390346							68
71	Medical Supplies Charged to Pat	0.326978							71
73	Drugs Charged to Patients	0.228536							73
76	PSYCH								76
76.01	SPECIAL PROCEDURES	0.633773							76.01
76.02	SPECIAL PROCEDURES SUA	0.410330							76.02
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

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

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	28,509	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	28,509	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.	1,724	3
4	Semi-private room days (excluding swing-bed private room days)	26,785	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	20,040	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)	933	14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	16,226,715	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	16,226,715	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)	27,623,274	28
29	Private room charges (excluding swing-bed charges)	1,682,251	29
30	Semi-private room charges (excluding swing-bed charges)	25,941,023	30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.587429	31
32	Average private room per diem charge (line 29 ÷ line 3)	975.78	32
33	Average semi-private room per diem charge (line 30 ÷ line 4)	968.49	33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)	7.29	34
35	Average per diem private room cost differential (line 34 x line 31)	4.28	35
36	Private room cost differential adjustment (line 3 x line 35)	7,379	36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	16,219,336	37

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

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

		1	
38	Adjusted general inpatient routine service cost per diem (see instructions)	569.18	38
39	Program general inpatient routine service cost (line 9 x line 38)	11,406,367	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40
41	Total Program general inpatient routine service cost (line 39 + line 40)	11,406,367	41

		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47

		1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	7,499,466	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	18,905,833	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	1,972,537	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	673,947	51
52	Total Program excludable cost (sum of lines 50 and 51)	2,646,484	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	16,259,349	53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)						87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					569.18	88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

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

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	28,509	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	28,509	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.	1,724	3
4	Semi-private room days (excluding swing-bed private room days)	26,785	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	367	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	16,219,084	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	16,219,084	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)	27,623,274	28
29	Private room charges (excluding swing-bed charges)	1,682,251	29
30	Semi-private room charges (excluding swing-bed charges)	25,941,023	30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.587153	31
32	Average private room per diem charge (line 29 ÷ line 3)	975.78	32
33	Average semi-private room per diem charge (line 30 ÷ line 4)	968.49	33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)	7.29	34
35	Average per diem private room cost differential (line 34 x line 31)	4.28	35
36	Private room cost differential adjustment (line 3 x line 35)	7,379	36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	16,211,705	37

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/19/2020 Run Time: 18:44 Version: 2018.12 (04/03/2020)

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

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

		1	
38	Adjusted general inpatient routine service cost per diem (see instructions)	568.65	38
39	Program general inpatient routine service cost (line 9 x line 38)	208,695	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40
41	Total Program general inpatient routine service cost (line 39 + line 40)	208,695	41

		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47

		1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	148,902	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	357,597	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	36,124	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	12,596	51
52	Total Program excludable cost (sum of lines 50 and 51)	48,720	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)		53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

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

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

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		19,398,356		30
	ANCILLARY SERVICE COST CENTERS				
54	Radiology-Diagnostic	0.746153	168,929	126,047	54
54.01	RADIOLOGY-SUA	0.551870	66,986	36,968	54.01
60	Laboratory	0.297288	1,849,494	549,832	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.371791	1,612,449	599,494	65
66	Physical Therapy	0.349093	5,103,568	1,781,620	66
67	Occupational Therapy	0.359599	5,276,409	1,897,391	67
68	Speech Pathology	0.390346	1,670,818	652,197	68
71	Medical Supplies Charged to Patients	0.326978	1,326,398	433,703	71
73	Drugs Charged to Patients	0.228536	5,661,172	1,293,782	73
76	PSYCH				76
76.01	SPECIAL PROCEDURES	0.633773	125,354	79,446	76.01
76.02	SPECIAL PROCEDURES SUA	0.410330	119,382	48,986	76.02
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
92	Observation Beds (Non-Distinct Part)				92
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		22,980,959	7,499,466	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		22,980,959		202

(A) Worksheet A line numbers

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/19/2020 Run Time: 18:44 Version: 2018.12 (04/03/2020)

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

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		328,263		30
	ANCILLARY SERVICE COST CENTERS				
54	Radiology-Diagnostic	0.746153	11,004	8,211	54
54.01	RADIOLOGY-SUA	0.551870	622	343	54.01
60	Laboratory	0.297288	42,787	12,720	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.371791	29,490	10,964	65
66	Physical Therapy	0.349093	90,389	31,554	66
67	Occupational Therapy	0.359599	89,474	32,175	67
68	Speech Pathology	0.390346	12,694	4,955	68
71	Medical Supplies Charged to Patients	0.326978	41,284	13,499	71
73	Drugs Charged to Patients	0.228536	139,289	31,833	73
76	PSYCH				76
76.01	SPECIAL PROCEDURES	0.633773	2,929	1,856	76.01
76.02	SPECIAL PROCEDURES SUA	0.410330	1,931	792	76.02
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
92	Observation Beds (Non-Distinct Part)				92
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		461,893	148,902	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		461,893		202

(A) Worksheet A line numbers

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/19/2020 Run Time: 18:44 Version: 2018.12 (04/03/2020)

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

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under OPPS (see instructions)	446			2
3	OPPS payments	319			3
4	Outlier payment (see instructions)				4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (see instructions)				21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	319			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	64			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	255			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	255			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	255			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)				34
35	Adjusted reimbursable bad debts (see instructions)				35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)				36
37	Subtotal (see instructions)	255			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	255			40
40.01	Sequestration adjustment (see instructions)	5			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	250			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)				43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

ENCOMPASS HEALTH DEACONESS REHABILIT Provider CCN: 15-3025	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2019 To: 12/31/2019	Run Date: 05/19/2020 Run Time: 18:44 Version: 2018.12 (04/03/2020)

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

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

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				29,313,922		250	1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51	04/19/2019	6,248			3.51
		Provider	.52	07/12/2019	20,513			3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		-26,761			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				29,287,161		250	4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due)		.01					6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)							7
8	Name of Contractor			Contractor Number		NPR Date (Month/Day/Year)		8

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

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

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

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

		1	1.01	
1	Net Federal PPS payment (see instructions)	29,227,145		1
2	Medicare SSI ratio (IRF PPS only) (see instructions)	0.040500		2
3	Inpatient Rehabilitation LIP payments (see instructions)	1,353,217		3
4	Outlier payments	19,519		4
5	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			5
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) OR (2)			5.01
6	New teaching program adjustment (see instructions)			6
7	Current year unweighted FTE count of I&R excludnig FTEs in the new program growth period of a 'new teaching program' (see instructions)			7
8	Current year unweighted I&R FTE count for residents within the new program growth period of a 'new teaching program' (see instructions)			8
9	Intern and resident count for IRF PPS medical education adjustment (see instructions)			9
10	Average daily census (see instructions)	78.106849		10
11	Teaching Adjustment Factor (see instructions)			11
12	Teaching Adjustment (see instructions)			12
13	Total PPS Payment (see instructions)	30,599,881		13
14	Nursing and allied health managed care payments (see instructions)			14
15	Organ acquisition DO NOT USE THIS LINE			15
16	Cost of physicians' services in a teaching hospital (see instructions)			16
17	Subtotal (see instructions)	30,599,881		17
18	Primary payer payments	16,826		18
19	Subtotal (line 17 less line 18)	30,583,055		19
20	Deductibles	601,039		20
21	Subtotal (line 19 minus line 20)	29,982,016		21
22	Coinsurance	247,027		22
23	Subtotal (line 21 minus line 22)	29,734,989		23
24	Allowable bad debts (exclude bad debts for professional services) (see instructions)	270,715		24
25	Adjusted reimbursable bad debts (see instructions)	175,965		25
26	Allowable bad debts for dual eligible beneficiaries (see instructions)	170,596		26
27	Subtotal (sum of lines 23 and 25)	29,910,954		27
28	Direct graduate medical education payments (from Wkst. E-4, line 49) (For free standing IRF only)			28
29	Other pass through costs (see instructions)			29
30	Outlier payments reconciliation			30
31	Other adjustments (specify) (see instructions)			31
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			31.50
32	Total amount payable to the provider (see instructions)	29,910,954		32
32.01	Sequestration adjustment (see instructions)	598,219		32.01
32.02	Demonstration payment adjustment amount after sequestration			32.02
33	Interim payments	29,287,161		33
34	Tentative settlement (for contractor use only)			34
35	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33 and 34)	25,574		35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	909,536		36

TO BE COMPLETED BY CONTRACTOR

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

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

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

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	357,597		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	357,597		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	357,597		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges	328,263		8
9	Ancillary service charges	461,893		9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)	790,156		12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahrge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)	790,156		16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	432,559		17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)	357,597		21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)	357,597		29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)			30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	357,597		31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)	357,597		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	357,597		38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)	357,597		40
41	Interim payments	187,470		41
42	Balance due provider/program (line 40 minus line 41)	170,127		42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

BALANCE SHEET **WORKSHEET G**

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

	Assets	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	6,926,314				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	10,161,898				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-2,879,430				6
7	Inventory	63,570				7
8	Prepaid expenses	58,757				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	14,331,109				11
	FIXED ASSETS					
12	Land	1,600,058				12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings	24,821,678				15
16	Accumulated depreciation	-406,761				16
17	Leasehold improvements	1,757,768				17
18	Accumulated depreciation	-748,096				18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	8,002,515				23
24	Accumulated depreciation	-3,629,448				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	31,397,714				30
	OTHER ASSETS					
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	13,732,849				34
35	Total other assets (sum of lines 31-34)	13,732,849				35
36	Total assets (sum of lines 11, 30 and 35)	59,461,672				36

	Liabilities and Fund Balances	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable	1,232,534				37
38	Salaries, wages and fees payable	1,275,765				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)					40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	4,596,151				44
45	Total current liabilities (sum of lines 37 thru 44)	7,104,450				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	15,449,664				49
50	Total long term liabilities (sum of lines 46 thru 49)	15,449,664				50
51	Total liabilities (sum of lines 45 and 50)	22,554,114				51
	CAPITAL ACCOUNTS					
52	General fund balance	36,907,558				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	36,907,558				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	59,461,672				60

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

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	Fund balances at beginning of period		32,005,140			1
2	Net income (loss) (from Worksheet G-3, line 29)		10,966,466			2
3	Total (sum of line 1 and line 2)		42,971,606			3
4	Additions (credit adjustments) (specify)					4
5						5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)		42,971,606			11
12	Deductions (debit adjustments) (specify)					12
13	MINORITY INTEREST	3,015,779				13
14	DISTRIBUTIONS	3,048,269				14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)		6,064,048			18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		36,907,558			19

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	27,955,860		27,955,860	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility				7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	27,955,860		27,955,860	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit				11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)				16
17	Total inpatient routine care services (sum of lines 10 and 16)	27,955,860		27,955,860	17
18	Ancillary services	32,404,729		32,404,729	18
19	Outpatient services				19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	Other (specify)				27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	60,360,589		60,360,589	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		27,879,676	29
30	Add (specify)			30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)			37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		27,879,676	43

STATEMENT OF REVENUES AND EXPENSES **WORKSHEET G-3**

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	60,360,589	1
2	Less contractual allowances and discounts on patients' accounts	21,720,629	2
3	Net patient revenues (line 1 minus line 2)	38,639,960	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	27,879,676	4
5	Net income from service to patients (line 3 minus line 4)	10,760,284	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments	153,653	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts	88	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	19,866	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients	20	17
18	Revenue from sale of medical records and abstracts		18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen	9	20
21	Rental of vending machines	1,493	21
22	Rental of hosptial space	28,284	22
23	Governmental appropriations		23
24	Other (specify)	2,769	24
25	Total other income (sum of lines 6-24)	206,182	25
26	Total (line 5 plus line 25)	10,966,466	26
29	Net income (or loss) for the period (line 26 minus line 28)	10,966,466	29