JAMES S. JACOBS
DAVID C. DEMBERT*
JACOB M. HOROWITZ**
of counsel
CAROLYN JACOBS

* Also Admitted in PA
** Also Admitted in DC

JACOBS & DEMBERT P.A.
LAW OFFICES

Writer's E-mail:
cjacobs@jdlaw.com

One South Street
Suite 2100
Baltimore, Maryland
21202-3280

(410) 727-4433 (v)
(410) 752-8105 (f)

September 11, 2018

VIA PDF & HAND DELIVERY

Ms. Ruby Potter
Health Facilities Coordinator
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Encompass Health Rehabilitation Hospital of Southern Maryland
Matter No. 18-16-2423

Dear Ms. Potter:

Provided below please find the completeness responses of Encompass Health Rehabilitation Hospital of Southern Maryland ("EHRHSM") in connection with its Certificate of Need ("CON") application to establish a 60-bed special hospital rehabilitation in Bowie, Prince George's County.

BUDGET

1. Please provide more information regarding the specific costs associated with the $1,500,000 budget line item for CON Application Assistance.

Response:

The $1,500,000 budget line item for CON Application Assistance represents approximately 4% of the total cost of the Project ($36,698,894). The specific costs represent CON consulting, CON legal (anticipating possible multiple levels of judicial review and appeal), legal - land related, data collection, legal - government relations, and community consultants. Certain significant consulting and data costs are associated with the fact that this Project is based on a new State Health Plan Section and (i) the State Health Plan projects a range of beds rather than an identified bed need and (ii) a new rehabilitation hospital has not been approved in many years by the MHCC.

GENERAL REVIEW STANDARDS

Charity Care Policy.

2. The process for determination of probable eligibility must be compliant with COMAR 10.24.09.04(A)(1)(a)(i). Requiring a completed application with considerable

documentation like tax returns, bank statements, and pay stubs prior to determination of probable eligibility does not comply with the intent of this standard. The intent is to ensure that a procedure is in place to inform a potential charity care recipient of his/her probable eligibility *within two business days of initial inquiry* based on a simple and expeditious process.

A two-step process that allows for a probable determination to be communicated within two days based on an abridged set of information, followed by a final determination based on a completed application with the required documentation is permissible. But the policy must include the more easily navigated determination of probable eligibility. Please remedy this portion of the policy and resubmit.

Response:

Please see Attachment 1.

3. Provide copies of the following materials referenced in the financial assistance policy:

   a. Financial Assistance Application.

Please see Attachment 2.

   b. Plain language summary of the financial assistance policy.

Please see Attachment 3.

   c. Financial assistance signage that will be displayed in the admissions office and main entrance of the hospital.

Please see Attachment 4.

4. Will notices, applications, or other material regarding the financial assistance policy be available in other languages? If so, which documents, and in which languages?

Response:

All materials will be available in Spanish. Materials requested in other languages are provided upon request.

5. What is the amount of charity care provided at Encompass Health's HealthSouth Chesapeake Rehabilitation Hospital for the most recent two years for which data is available.

Response:

Companywide Encompass Health hospitals provide approximately $21 million annually in charity care. Encompass Health's HealthSouth Chesapeake Rehabilitation Hospital provided $1,266 in charity care for 2017 and $8,065 in 2018, which are levels below the Company

average. There are several factors accounting for this all of which will be fully explained in the bed expansion CON application that will be filed on October 5, 2018.

The primary factor for the low charity care is the high occupancy percentage at HealthSouth Chesapeake. A shortage of available beds leads to admission denials. Between May 1, 2016 and August 31, 2018, there have been 762 patients denied admission because of a lack of an available bed. Over that same period, there were 3,623 patients discharged after treatment. That calculates to one patient denied admission for every 4.75 discharges. If approved, the forthcoming HealthSouth Chesapeake bed expansion will commit to at least a 2% charity commitment.

6. Provide a response to COMAR 10.24.09.04(A)(1)(c)(ii), which requires that an applicant demonstrate that it has a specific plan for achieving the level of charitable care provisions to which the applicant committed for the proposed project.

Response:

HSRHSM is committed to meeting its 2% charity care obligation. HSRMSM will collaborate with the Prince George's County Health Department and other community health stakeholders to identify and meet the need for charity care for rehabilitation services. HSRHSM will educate the community it serves about the patient populations it treats (largely stroke, neurological, etc. - largely Medicare) and the services it offers and assure community stakeholders are aware of its charity commitment. EHRHSM staff will "market charity care" to hospital case managers and physicians. HSRHSM also will work with non-profit community-based organizations to assure the community is aware of the availability of its services to those who are unable to pay in part or in full.

Of course, HSRMSM will work closely with University of Maryland Capital Region Health to assure its health care providers and their discharge planners are aware of the availability of rehabilitation services for those who are uninsured or underinsured. In particular, the Trauma Center at University of Maryland Prince George's Hospital Center is anticipated to be a significant referral source (although it is anticipated that both brain injury and spinal cord injury program patients will continue to go to the University of Maryland Rehabilitation & Orthopaedic Institute for services).

Of great significance, HSRHSM anticipates that it will receive permission from the Prince George's County Health Department for Encompass Health to participate as a "stakeholder" (their term for providers) for its "Prioritization Meeting" and thus able to participate in the upcoming, new community needs assessment as a post-acute provider. This will be another avenue to assure HSRHSM is working closely with/collaborating with the County to gain a better understanding of the community need so that EHRHSM can respond accordingly.

In summary, EHRHSM will work with health care providers (in particular acute care hospitals), the local county health department, human service agencies, and private organizations to identify

uninsured or underinsured persons needing acute rehabilitation services in its service area and educate the community about its charity care commitment.

Quality of Care.

7. Staff notes the applicant's favorable comparisons among the industry, including those utilizing the UDSMR benchmarks. To the extent possible, please provide benchmarks compared to peer groups in Maryland and the region, along similar metrics, specifically: cost effectiveness, FIM gain, length of stay efficiency, percent of patients discharged to the community, length of stay, and PEM score, as presented in the application, if available.

Response:

Please see Attachment 5.

PROJECT REVIEW STANDARDS

Impact.

8. Please provide more detailed analysis of the estimated impact on patient volume at MedStar National Rehabilitation Hospital and George Washington University Hospital, each separately.

Response:

Volume projections for the new hospital are based, in part, on anticipated volume shifts from MedStar National Rehabilitation Hospital ("NRH") and George Washington University Hospital ("GWU") to the new EHRHSM. The projected volume shift from NRH and GWU was based exclusively on *service area volume* at NRH and GWU. This volume is documented below:

Acute Rehabilitation Discharges
Age 18+ years
Residents of Encompass Health service area, only
CY2016

Hospital	Total # Discharges	# Discharges from EHRHSM service area
MedStar National Rehabilitation	2,104	788
George Washington University	366	65
Total, Washington DC providers	2,470	853

EHRHSM assumes that 40% of the discharges that originated from the EHRHSM service area could be expected to shift to the new hospital. This figure is consistent with the overall market share projected for the new hospital. Assuming that the shift is comparable across the two hospitals, this translates into the following projection, using CY2016 discharge volume:

Acute Rehabilitation Discharges
Age 18+ years
Residents of Encompass Health service area, only
CY2016

	Total # Discharges	# Discharges from EHRHSM service area	40% shift
MedStar National Rehabilitation	2,104	788	315
George Washington University	366	65	26
Total, Washington DC providers	2,470	853	341

EHRHSM expects that the projected volume shift from NRH and GWU (volume "loss") will be offset by the demographic growth projected for the service area of these two hospitals; population growth across the Montgomery County, Washington DC, and northern Virginia market will generate new demand to offset this shift of 341 discharges. A "loss" of 341 discharges would amount to only 12-13 occupied beds. In fact, the MHCC's 2021 bed need projection documents the need for *up to 32 additional beds in Montgomery County, alone* which is not a target market for EHRHSM; this market would continue to rely heavily on NRH and GWU to meet the growing demand for inpatient rehabilitation.

CRITERIA

9. The application does not include a response to COMAR 10.24.01.08G(3)(e) Compliance with Conditions of Previous Certificates of Need. Please provide a response to this criterion.

Response:

This applicant has never received nor applied for a Certificate of Need in Maryland. With respect to related Encompass entities in Maryland, Rehabilitation Hospital Corporation of America, LLC, d/b/a HealthSouth Chesapeake Rehabilitation Hospital has not received a CON; the hospital was purchased April 1, 1995 as part of a larger Novacare acquisition.

Sincerely,

Carolyn Jacobs

Please see attached signature pages.

JAMES S. JACOBS
DAVID C. DEMBERT*
JACOB M. HOROWITZ**
of counsel
CAROLYN JACOBS

* Also Admitted in PA
** Also Admitted in DC

JACOBS & DEMBERT P.A.
LAW OFFICES

Writer's E-mail:
cjacobs@jdlaw.com

One South Street
Suite 2100
Baltimore, Maryland
21202-3280

(410) 727-4433 (v)
(410) 752-8105 (f)

I hereby declare and affirm under the penalties of perjury that the facts stated in this Completeness Responses of Encompass Health Rehabilitation Hospital of Southern Maryland and its attachments are true and correct to the best of my knowledge, information, and belief.

David Klementz

Name: David Klementz

Date: 9.11.2018

ATTACHMENT 1

Financial Assistance Policy

Street, MD zip
xxx-xxx-xxxx
www.encompasshealthlocations.com/

PURPOSE

This policy outlines the circumstances under which the hospital will provide free or discounted emergency or other medically necessary care to eligible patients who are unable to pay for their care, as determined by the hospital in accordance with the eligibility criteria and other terms specified in this policy. Patients are expected to cooperate with the hospital's procedures for obtaining Financial Assistance, securing insurance or other forms of payment, and contributing to the cost of their care based on their ability to pay.

SCOPE

This policy applies to emergency or medically necessary care provided by the hospital. This policy does not apply to care delivered by physicians or other healthcare providers who bill "privately." See Attachment A for additional information about physicians and other healthcare providers providing care within the hospital.

This policy does not apply to care that is not emergency or medically necessary care, including elective services or items that are solely for the comfort or convenience of a patient.

Financial Assistance does not apply to amounts that are covered by insurance, governmental programs or other funding sources (which may include, but are not limited to, workers' compensation, automobile or other liability insurance, crime victims' compensation funds, and litigation recoveries). To be eligible for Financial Assistance, a patient is expected to apply for and comply with all processes related to seeking assistance from other insurers and/or third-party sources of payment (including all applicable governmental programs) as requested by hospital staff. Patients who are noncompliant or uncooperative in attempting to obtain insurance coverage, qualification under governmental programs, or payment from third-party sources will not be eligible for Financial Assistance.

A patient will be ineligible for Financial Assistance if the patient, or his or her representative, provides false information or falsified documentation of household size, income, assets, or other pertinent information.

DEFINITIONS

Covered Services – emergency or medically necessary care provided by the hospital. Covered Services do not include services that are not emergency or medically necessary care, or care that is provided by physicians or other healthcare providers who bill "privately."

Emergency or medically necessary care – services that are necessary and appropriate to sustain life or to prevent serious deterioration in the health of the patient from injury or disease. Medically necessary will be determined by the treating physician.

Family – includes spouse/domestic partner, children, and any other persons treated as "dependents" for federal income tax purposes.

Financial Assistance – reduction of an eligible patient's account balance for Covered Services under the terms of this policy.

Patient – the individual receiving medical treatment and/or, in the case of an unemancipated minor or other dependent, the parent, legal guardian or other person (guarantor) who is financially responsible for the patient.

Uninsured – a patient who does not have health insurance coverage, is unable to obtain affordable coverage, and is ineligible for government healthcare programs or other third-party payment sources.

Underinsured – a patient who is not uninsured, but whose out-of-pocket medical expenses exceed his or her financial ability to pay.

POLICY

Subject to the terms of this policy, Financial Assistance is provided to eligible patients who are uninsured or underinsured. Eligibility for Financial Assistance, and the amount of Financial Assistance that will be provided, are based on an individualized assessment by the hospital of a patient's financial need, generally determined by measuring the patient's gross family income against the Federal Poverty Guidelines, provided that the patient does not have other financial resources that could be used to pay for his or her care. The Financial Assistance Discount Guidelines are adjusted annually to reflect changes in the Federal Poverty Guidelines.

A patient determined to be eligible for Financial Assistance will not be billed more than the amount generally billed for emergency or other medically necessary care by hospital to individuals who have insurance covering such care. If a patient is underinsured and is determined to be eligible for Financial Assistance, discounts will only apply to the balance due from the patient after insurance payments and other third-party payment sources have been applied to the account.

See Attachment B for additional information regarding criteria for eligibility and the "amount generally billed" limitation.

For purposes of this policy, "income" includes, but is not limited to, revenue from the following sources (before taxes):

- Wages
- Tips
- Payments from Social Security
- Retirement benefit payments
- Unemployment compensation
- Worker's compensation
- Veterans' benefits

- Public assistance
- Alimony
- Child support
- Pensions
- Regular insurance or annuity payments
- Investment income

For purposes of this policy, "other financial resources" includes, but is not limited to the following:

- Savings
- Checking account
- Medical savings account, healthcare savings account and/or flexible spending account
- Trust fund
- Retirement accounts
- Investment assets
- Other liquid assets
- Equity value of real estate, other than the patient's primary residence
- Benefits from charity organizations
- Pending litigation

PROCEDURES

Hospital will provide a financial assistance probable eligibility determination to the patient within two business days from receipt of the initial financial assistance application. At a minimum, patient must initially provide information about family size and income in order for hospital to make a determination of probable eligibility. Hospital will notify applicant in writing of the decision along with a request for additional documentation needed to make final determination of eligibility. Final determination will be made and communicated to the patient based on receipt and review of completed Financial Assistance application. A complete Financial Assistance Application is inclusive of, but not limited to, disclosure of household size, employment information, income, assets and other resources, outstanding financial obligations, and supporting documents (such as recent tax returns, bank statements and pay stubs), as detailed in the Financial Assistance Application and the associated instructions. Undocumented residents (non-U.S. citizens living as residents in the U.S.) and patients who are without a home address may apply for Financial Assistance. Failure to provide the required information and documentation in a timely manner may result in ineligibility for Financial Assistance.

Complete Financial Assistance Applications should be submitted to the hospital. A hospital representative will review the application for completeness. Financial Assistance determinations must be approved by the Facility Controller, and in certain circumstances, by the hospital CEO.

Copies of this policy, a plain language summary of this policy, the Financial Assistance Application, and the associated instructions are available free of charge upon request by writing to the address above. These can be found in the admitting/registration areas of the hospital. The documents may also be downloaded at hospital's website.

All patient billing statements contain information about the availability of financial assistance and provide a telephone number where they may receive more information, as well as web site address where Financial Assistance Policy, application and plain language summary may be found.

All patients will be offered a plain language summary of the Financial Assistance Policy during discharge or intake.

Annually, hospital will review and disseminate the availability of financial assistance in patient access sites and other places within the community served by the hospital.

Further information about this Financial Assistance Policy and assistance with the application process are available by calling xxx-xxx-xxxx, or in person during normal business hours or by appointment from a hospital finance representative.

When a patient does not qualify for Financial Assistance under this policy but has special circumstances, other discounts may be available that are not part of this Financial Assistance policy. In these situations, hospital staff will review all available information (including documentation of income, liquid and illiquid assets, and other resources, amount of outstanding medical bills and other financial obligations) and make a case-by-case determination of the patient's eligibility for other potential discounts.

Once a patient has been discharged and the patient's balance due has been determined, the Billing Office will mail the patient monthly account statements and make phone calls in an attempt to collect the outstanding balance. If no payment has been received for 120 days, the account may be sent to a third-party collection agency.

The hospital, and any third-parties acting on its behalf, does not engage in extraordinary collection actions such as lawsuits, liens, foreclosures, wage garnishment or reporting adverse information to credit agencies.

For additional information, please see the Billing and Collections Policy, which may be downloaded from hospital website. Copies are also available upon request, free of charge, by mail and in admitting/registration areas of the Hospital.

NONDISCRIMINATION & EMERGENCY MEDICAL CARE

Hospital does not have a dedicated emergency department. The hospital will appraise emergencies, provide initial treatment, and refer or transfer an individual to another hospital/facility, when appropriate, without discrimination and without regard to whether the individual is eligible for Financial Assistance. Hospital will not engage in actions that discourage individuals from seeking emergency medical care, such as demanding that an individual pay before receiving initial treatment for emergency medical conditions or permitting debt collection activities that interfere with hospital's appraisal and provision, without discrimination, of such initial treatment.

Encompass Health

Physician/Provider Listing

Attachment A

Services may be provided in Encompass Health Rehabilitation Hospital of [ ] by the hospital as well as by other health care practitioners, who may or may not participate with the same health insurers or health maintenance organizations (HMOs) as Encompass Health Rehabilitation Hospital of [ ] and who may bill you separately. These providers are encouraged, but not required, to follow the financial assistance policy of Encompass Health Rehabilitation Hospital of [ ]. You should contact the health care practitioner who will provide services to you to determine which health insurers and HMOs the practitioner participates in as a network provider or preferred provider. Contact information for practitioners who may provide services to you during your stay at Encompass Health Rehabilitation Hospital of [ ] is provided below.

You may request from Encompass Health Rehabilitation Hospital of [ ] and other health care providers a personalized estimate of reasonably anticipated charges for the treatment of your specific condition.

This listing is updated quarterly and additional providers or physicians may be added and/or presented under an alternate name that may be different from what is listed below. Please call us directly at xxx-xxx- and ask to speak with [ ], so that we can assist you with the most current and accurate information.

Physician or Provider Name	Mailing Address	Telephone

Attachment B – 2018 Financial Assistance Discount Guidelines

2018		Family Income as a Percent of Federal Poverty Guidelines		
Discount Provided		100% discount	75% discount	50% discount
Family Size	Federal Poverty Guideline *	Income less than or equal to 200% of FPG	Income of 201% - 300% of FPG	Income of 301% - 400% of FPG
1	$12,140	$0 - $24,280	$24,281 - $36,420	$36,421 - $48,560
2	$16,460	$0 - $32,920	$32,921 - $49,380	$49,381 - $65,840
3	$20,780	$0 - $41,560	$41,561 - $62,340	$62,341 - $83,120
4	$25,100	$0 - $50,200	$50,201 - $75,300	$75,301 - $100,400
5	$29,420	$0 - $58,840	$58,841 - $88,260	$88,261 - $117,680
6	$33,740	$0 - $67,480	$67,481 - $101,220	$101,221 - $134,960
7	$38,060	$0 - $76,120	$76,121 - $114,180	$111,421 - $152,240
8	$42,380	$0 - $84,760	$84,761 - $127,140	$127,141 - $169,520

** For family units with more than 8 persons, add $4,320 for each additional person.*

Amounts charged to a patient eligible for Financial Assistance under this policy will be based on the applicable discount stated in the table above multiplied by the gross charges otherwise billable to the patient, subject to the "AGB" limitation described below.

In accordance with Internal Revenue Code section 501(r), a patient eligible for Financial Assistance under this policy will not be charged more than the amount generally billed to individuals who have insurance covering such care ("AGB").

Facility has initially elected to calculate AGB under the "prospective Medicare method" described in applicable Treasury Regulations, using the billing and coding process the Facility would use if the individual were a Medicare fee-for-service beneficiary and setting AGB for the care at the amount the Facility determines would be the total amount Medicare would allow for the care (including both the amounts that would be reimbursed by Medicare and the amount the beneficiary would be personally responsible for paying in the form of co-payments, co-insurance, and deductibles).

ATTACHMENT 2

Instructions - financial assistance application

Section A – patient and guarantor information

1. Patient Name: Clearly print on the blank line the first name, middle initial, and last name of the patient.
2. Date: Clearly print on the blank line the date of the application.
3. Guarantor: Clearly print on the blank line the first name, middle initial, and last name of the patient's parent, legal guardian or other responsible person ("guarantor").
4. Relationship: Clearly print on the blank line the relationship to the patient of the guarantor.
5. Address: Clearly print on the blank line the address where the patient lives including the city, state and zip.
6. Phone: Clearly print on the blank line the patient's phone number.
7. Patient's Employer: Clearly print on the blank line the name of the company for which the patient works.
8. Title: Clearly print on the blank line the job title of the patient.
9. Years Employed: Clearly print on the blank line the start date of employment.
10. Spouse's Name: Clearly print on the blank line the first name, middle initial, and last name of the patient/ guarantor's spouse.
11. Spouse's Phone: Clearly print on the blank line the patient's phone number.
12. Spouse's Employer: Clearly print on the blank line the name of the company for which your spouse works.
13. Title: Clearly print on the blank line the job title of your spouse.
14. Years Employed: Clearly print on the blank line the start date of employment of your spouse.
15. Length of Time at Current Residence: Clearly print on the blank line the dates you have lived at the address provided on the application.
16. Total number of Dependents: Clearly print on the blank line the number of dependents in your household, including yourself. Dependents are those that generally qualify as your dependent for federal income tax purposes.
17. Health Insurance Provider: Clearly print on the blank line the name of your health insurance carrier (including Medicare, Medicaid or other governmental coverage you may have).
18. Policy number: Clearly print on the blank line the policy or account number of your insurance policy.

Section B – assets

Total Household Income: Clearly print the assets of your household (yourself, your spouse, and dependents). You may attach additional sheets of paper if more space is needed. Provide the cash value as well as any loans or obligations you have on that asset

- If your household has assets that you do not see listed, please indicate that amount on the line for "Other" and provide a description.
- Assets include, but are not limited to savings and checking accounts, medical savings accounts, healthcare savings accounts, flexible spending accounts, trusts, retirement accounts, investment assets, other liquid assets, real estate (other than primary residence), benefits from charity organizations, pending or finalized litigation settlements, etc.
- Years Employed: Clearly print on the blank line the start date of employment.
- Spouse's Name: Clearly print on the blank line the first name, middle initial, and last name of the patient/ guarantor's spouse.
- Spouse's Phone: Clearly print on the blank line the patient's phone number.
- Spouse's Employer: Clearly print on the blank line the name of the company for which your spouse works.
- Title: Clearly print on the blank line the job title of your spouse.

- Years Employed: Clearly print on the blank line the start date of employment of your spouse.
- Length of Time at Current Residence: Clearly print on the blank line the dates you have lived at the address provided on the application.
- Total number of Dependents: Clearly print on the blank line the number of dependents in your household, including yourself. Dependents are those that generally qualify as your dependent for federal income tax purposes.
- Health Insurance Provider: Clearly print on the blank line the name of your health insurance carrier (including Medicare, Medicaid or other governmental coverage you may have).
- Policy number: Clearly print on the blank line the policy or account number of your insurance policy.

Section C – income

Total Household Income: Clearly print the income your household (yourself, your spouse, and dependents) receives from all sources. You may attach additional sheets of paper if more space is needed. Provide the gross amounts and the amounts received after taxes and other deductions.

- If your household receives income from a source that you do not see listed, please indicate that amount on the line for "Other" and provide a description.
- Sources of income include, but are not limited to wages, tips, social security payments, retirement benefits, unemployment, workers' compensation, veteran benefits, public assistance, alimony, child support, pensions, insurance or annuity contracts, investment income, etc.

Section D – debts and obligations

Total Household Debts and Obligations: Clearly print the debts and obligations of your household (yourself, your spouse, and dependents). You may attach additional sheets of paper if more space is needed. Provide the total amount of the liability and the monthly payment amounts.

- If your household has debts or obligations that you do not see listed, please indicate that amount on the line for "Other" and provide a description.
- If your household has debts or obligations that are not paid by you every month, take the total amount due during the past 12 months, divide it by 12, and then indicate that amount on the application.
- Sources of debts and obligations include, but are not limited to real estate mortgages, household utility bills, telephone, food, automobile loans, charge and credit accounts, other loans, etc.

Section E – required documentation

The documents listed in this section are needed to help us determine if you qualify for financial assistance under our Financial Assistance Policy. If you do not have, or cannot produce the items listed, please include an explanation as to why. Please note that additional information or documentation may be requested by a Hospital representative when processing your application.

Section F – Certification

Patient/Guarantor's Signature: Carefully read the acknowledgement statement in this section and then sign and date the application.

Mailing Instructions/Contact Information

Submit the completed Financial Assistance Application along with supporting documentation to the hospital's address.

Further information about the Financial Assistance Policy or assistance with the application process are available from the hospital controller via the hospital phone number, in person at the hospital address or online at the website address. Certain foreign language translations of the Financial Assistance Policy, Plain Language Summary, Financial Assistance Application and Instructions are available upon request.

Encompass Health

PLEASE SEE INSTRUCTIONS FOR ADDITIONAL INFORMATION ON COMPLETING THE APPLICATION

Section A - Patient Information

Patient Name			Date
Guarantor (if other than Patient)		Relationship	
Address			Phone
Patient's Employer	Title		Years Employed
Spouse's Name			Spouse's Phone
Spouse's Employer	Title		Years Employed
Length of Time at Current Address		Total number of Dependents (including yourself)	
17. Health Insurance Provider	18. Policy Number		

Section B - Assets

	Description		Cash Value
Checking Account (List Bank name)			$
Savings Account (List Bank name)			$
Other Account (List Bank name)			$
Item	**Description**	**Balance Owed**	**Cash Value**
3. Home Ownership		$	$
4. Other Real Estate		$	$
5. Automobile(s) Make and Year		$	$
6. Permanent Life Insurance		$	$
7. Other (Explain)		$	$
8. Other (Explain)		$	$
	Totals	$	$

Section C - Income

1. Your Gross Salary	☐ per month ☐ per year	After taxes and deductions
2. Spouse's Gross salary	☐ per month ☐ per year	After taxes and deductions
3. Other Income	☐ per month ☐ per year	After taxes and deductions
4. Other Income	☐ per month ☐ per year	After taxes and deductions
Description of Other Income		After taxes and deductions

Verification is required - please attach copies to show proof of income

Section D - Debts and Obligations

Please List All Debts - Verification is Required

		Total Owed	Monthly Payment
1. Household ☐ Own ☐ Rent		$	$
2. Utilities Electric, Gas, Water, etc			$
3. Telephone			$
4. Food			$
5. Automobile(s)	Payments	$	$
	Insurances	$	$
6. Charge Account(s), Credit Card(s) (List):			
a)		$	$
b)		$	$
c)		$	$
d)		$	$
e)		$	$
f)		$	$
7. Loans a) Finance Company		$	$
b) Bank		$	$
c) Credit Union		$	$
8. Miscellaneous (explain)		$	$
a)		$	$
b)		$	$

9. Liens or Judgments: Do you have any judgments or liens outstanding? ☐ Yes ☐ No

Section E - Required Documentation

Please provide a copy of the most recent income tax return filed with the IRS and documents to support the amounts provided in Sections B, C, and D. This includes copies of the most recent paystubs, account statements, etc.

Section F - Certification

I certify that the information on this application is a true and complete statement of the facts according to my best knowledge and belief. I understand that falsification of or failure to provide complete information requested on this application or failure/refusal to complete it, may result in being denied an extended payment plan or may void any payment agreement already in effect.

Signed:_____ Date:_____

Encompass Health Internal Use Only:

Date Received: _____

Controller Review: _____ Date:_____
signature

Administrative Approval/Denial: _____ Date:_____
(circle one) *signature*

ATTACHMENT 3

Financial assistance policy - Plain Language Summary

Our hospital provides free or discounted emergency and other medically necessary care to patients who are uninsured or underinsured and who qualify for assistance under its Financial Assistance Policy. Assistance does not apply to elective services or items that are solely for the comfort or convenience of a patient. This document is only a summary. Please refer to the Financial Assistance Policy for complete details.

Eligibility Requirements and Assistance Offered Under the Financial Assistance Policy

Patients who qualify for assistance are eligible for income/asset-based, sliding scale discounts for emergency and other medically necessary care. In general:

- Patients whose family income is equal to or less than 200% of the Federal Poverty Guidelines are generally eligible for free emergency and medically necessary care.
- Patients whose family income is between 200% and 400% of the Federal Poverty Guidelines are generally eligible for a sliding scale discount ranging from 50% to 75% for emergency and other medically necessary care.

A patient who qualifies for assistance under the Financial Assistance Policy will not be charged more for emergency or medically necessary care than amounts generally billed to patients having insurance covering such care.

How to Obtain Copies of the Financial Assistance Policy and Financial Assistance Application

Copies of the Financial Assistance Policy, this plain language summary, and the Financial Assistance Application and associated instructions are available free of charge upon request by writing to the address above. Copies can also be found in the admitting/registration areas of the hospital. These documents may be found online at the website provided above. Translations of these documents to Spanish are available upon request from our hospital and also may be found online at website address above.

Further information about the Financial Assistance Policy and assistance with the application process are available from the hospital controller via phone number listed above or in person at the address above.

How to Apply for Assistance Under the Financial Assistance Policy

To apply for financial assistance, please submit a complete Financial Assistance Application with supporting documents to the address above.

ATTACHMENT 3

©2018:Encompass Health Corporation:1363233

ATTACHMENT 4

If you are having trouble paying your hospital bill you may be eligible for financial assistance.

A financial assistance application and associated instructions are available on the hospital website, or upon request by writing to the hospital address. Copies can also be found in the admitting/registration areas of the hospital.

ATTACHMENT 4

ATTACHMENT 5

Perhaps the most important characteristic of successful healthcare is the ability to demonstrate superior levels of care and quality. Encompass Health's quality scores exceed industry benchmarks demonstrating a superior level of quality care. As explained above, Encompass Health utilizes the Uniform Data System for Medical Rehabilitation (UDSMR®), the rehabilitation industry's most widely recognized outcomes measurement tool, to monitor overall patient outcomes. UDSMR® also allows Encompass Health to benchmark its rehabilitation hospitals against regional and national performance data. As demonstrated in the following graphs, Encompass Health hospitals achieve superior results when compared to other rehabilitation providers.

Encompass Health Inpatient Discharges, CY2017[1]

	UDS Expected (MD)	UDS Expected (Nation)	Actual (Encompass Health, National)
Average Length of Stay	14.1 days	13.3 days	12.7 days
FIM Score at Admission	58.9	56.4	54.7
FIM Score at Discharge	85.9	88.8	91.1
FIM Gain	26.9	32.4	36.5

Each of these measures is described below:

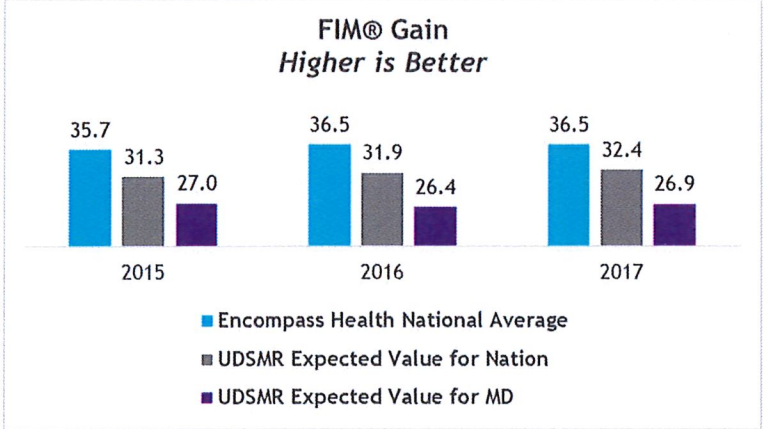
The Uniform Data System for Medical Rehabilitation ("UDSMR") is a data gathering and analysis organization for the rehabilitation industry and is a division of UB Foundation Activities, Inc. Approximately 70% of IRFs utilize UDSMR, including all Encompass Health sites.

Key Terms

- UDSMR Expected Value for MD: State average, assuming that other providers in nation have same case mix as our hospital in Maryland.
- UDSMR Expected Value for Nation: National average, assuming that other providers in nation have the same case mix as our hospitals.
- Encompass Health National Average: Actual outcome for all Encompass Health hospitals nation-wide

FIM® Gain

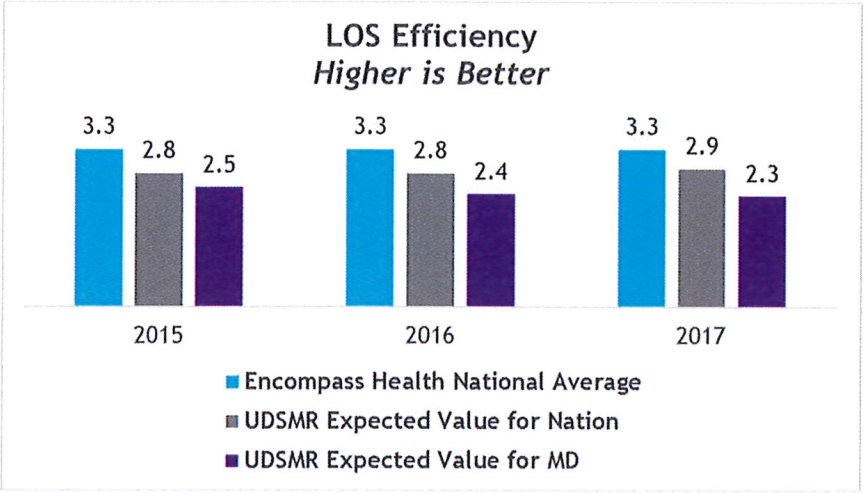
FIM® Gain is a measure of functional improvement from admission to discharge and indicates the degree of practical improvement toward the patient's rehabilitation goals. As explained above, this tool includes 18 cognitive and functional measures including walking, climbing stairs, transfers, bowel and bladder function and dressing. As indicated by the chart below, Encompass Health's FIM® Gain exceeded the UDSMR® expected FIM® Gain for the past three years, at both a national level and state level.



[1] Source: Uniform Data System for Medical Rehabilitation (UDSMR), UB Foundation Activities Inc.
Note: Reflects performance of all Encompass Health hospitals

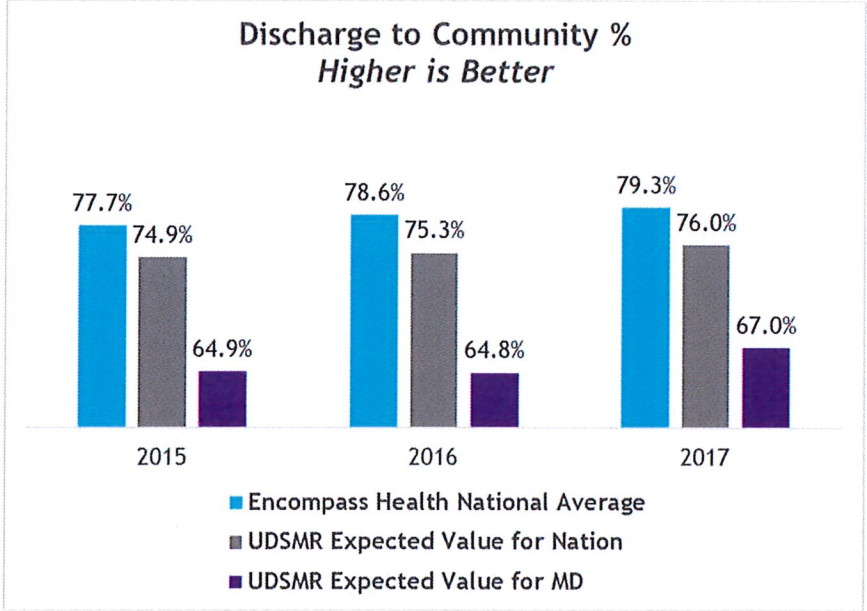
Length of Stay Efficiency

Length of stay efficiency is the measure of change or improvement in functional ability per day. As the following chart demonstrates, patients at Encompass Health hospitals exceed the expected rate of improvement per day at both a national level and state level (as measured by FIM Gain per patient day).



Percent of Patients Discharged to the Community

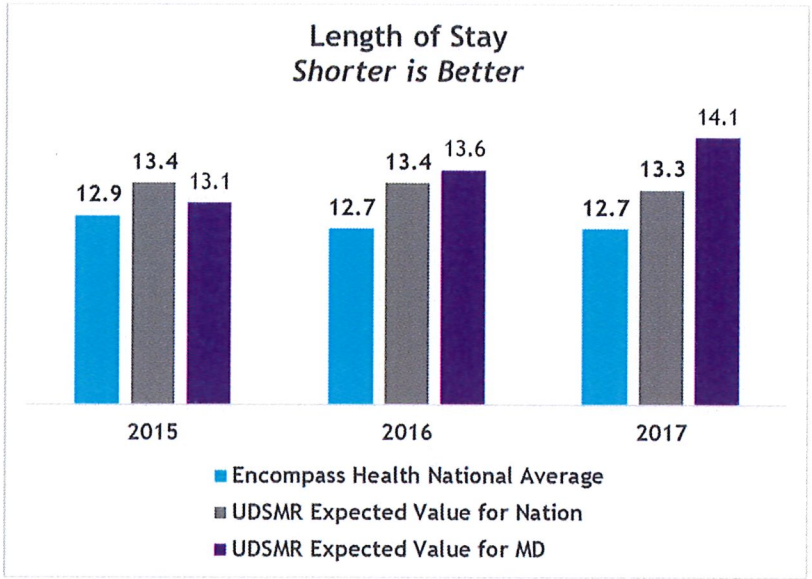
As the following chart demonstrates, Encompass Health also discharges a greater percentage of its patients to the community than the UDSMR® expected national and state discharge rate.



Discharge to the community means that the patient returns home - to family, friends, social activities and possibly even work. The sooner a patient can return to the community, as opposed to another care setting, the better it is for the patient. Discharge to the community also is less costly for the health care system.

Length of Stay

Length of stay is the number of days a patient resides in a hospital from admission to discharge. As the following chart demonstrates, Encompass Health's patients have an average length of stay that is shorter than the UDSMR® expected length of stay at both a national and state level, meaning that patients return home or to a less intensive care setting faster than the UDSMR® expected length of stay.

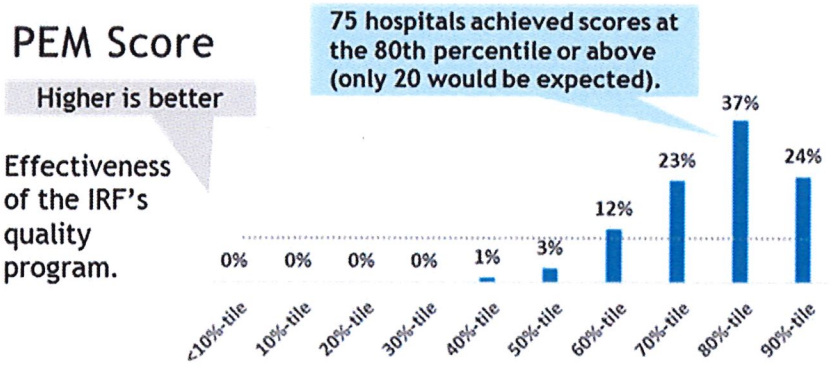


PEM Score

PEM scores are reported to each facility. We are not able to obtain any information on how other facilities perform, nor do we receive benchmark beyond the percentile ranking. We know how our hospitals perform (PEM Score) and where each of our hospitals fall within the nation. The data provided below was provided in our CON application for your reference.

Performance Evaluation Model (PEM) score, reported annually, is a summary statistic of the overall quality of an inpatient rehabilitation hospital. PEM is defined as a case-mix adjusted and severity-adjusted metric tool that provides rehabilitation providers with a composite performance score and percentile ranking drawn from nearly three-quarters of all inpatient rehabilitation hospitals in the country. A higher PEM score demonstrates superior results.

The following chart shows where Encompass Health's hospitals rank in the PEM score distribution. As demonstrated below, Encompass Health operates significantly more hospitals in the higher deciles of the PEM distribution than would be expected from a purely statistical analysis.



Note: PEM Score - Year End 2017, PEM score includes discharge FIM, FIM gain, LOS efficiency, discharge to community and acute care transfers

Cost Effectiveness

FY2018 Average Cost and Average Payment per Discharge[2] By Provider Setting

	Avg. Est. Total Cost per Discharge for FY 2018[3]	Avg. Est. Total Payment per Discharge[4]	# of Discharges[5]	CMI[6]
Encompass Health IRFs				
Encompass Health National Average[7]	$12,903	$19,776	117,433	1.26[8]
Non-Encompass Health				
Non-Encompass Health IRFs in US	$17,363	$20,749	88,308	1.26
Non-Encompass Health Hospital-Based Units in US	$20,798	$21,153	198,261	1.20
Inpatient Rehabilitation Industry				
All Inpatient Rehabilitation in US	$17,753	$20,665	404,002	1.23[9]
IRFs in Maryland[10]				
HealthSouth Chesapeake Rehabilitation Hospital	$11,624.00	$19,967.82	1,225	1.25
Adventist Rehabilitation Hospital of MD	$18,052.00	$19,517.17	1,132	1.18
IRFs in Washington D.C.				
MedStar National Rehabilitation Hospital	$25,040.00	$22,984.20	1,044	1.15
George Washington University Hospital	$15,137.00	$19,411.27	132	1.11

[2] Source: FY 2018 CMS Final Rule Rate Setting File and the last publicly available Medicare cost reports (FYE 2015/2016) or in the case of new IRFs, the June 2017 CMS Provider of Service File.
[3] Estimated FY2018 average total cost per discharge based on FY 2016 Medicare claims data and using the cost-to-charge ratios from the April 2017 update of the Provider Specific File.
[4] Total FY 2018 simulated payments, including outlier payments, incorporating all of the policies outlined in the FY 2018 IRF PPS final rule.
[5] Number of Medicare beneficiary discharges from the FY 2016 analysis file
[6] Measure of the average value of the weight for each case in the FY 2016 analysis file using the CMGs and weights from the FY 2018 final rule. Short stay transfers are credited with only a fraction of the full CMG, with the fraction determined by the length of stay of the case.
[7] Does not include HealthSouth Rehabilitation Hospital of Modesto (opened October 2016); HealthSouth Rehabilitation Hospital of Gulfport (opened April 2017); Mount Carmel Rehabilitation Hospital, in partnership with HealthSouth (opened April 2017); Spire Rehabilitation Hospital, in partnership with HealthSouth (opened July 2017); HealthSouth Rehabilitation Hospital of Pearland (opened October 2017); and HealthSouth Rehabilitation Hospital of Beaumont (sold June 2016). Includes HealthSouth Rehabilitation Hospital of Austin, which was closed August 2016.
[8] Case Mix Index (CMI) from the rate-setting file is adjusted for short-stay transfer cases. The Company's unadjusted CMI for 2016 was 1.36 versus 1.33 for the industry as measured by UDSMR.
[9] The file contains data for 1,140 IRFs. This is based on a file containing 1,141 facilities that submitted at least one IRF claim during FY 2016.
[10] These were the only MD providers listed on the FY 2018 CMS Final Rule Rate Setting File