



COMPU-MAX

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:01 Version: 2014.03
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

WORKSHEET S  
PARTS I, II & III

**PART I - COST REPORT STATUS**

PROVIDER USE ONLY	1. <input checked="" type="checkbox"/> ELECTRONICALLY FILED COST REPORT	DATE: 05/19/2014	TIME: 09:01
	2. <input type="checkbox"/> MANUALLY SUBMITTED COST REPORT		
	3. <input type="checkbox"/> IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THE COST REPORT		
	4. <input checked="" type="checkbox"/> MEDICARE UTILIZATION. ENTER 'F' FOR FULL OR 'L' FOR LOW.		
CONTRACTOR USE ONLY	5. <input type="checkbox"/> COST REPORT STATUS	6. DATE RECEIVED: _____	10. NPR DATE: _____
	1 -AS SUBMITTED	7. CONTRACTOR NO: _____	11. CONTRACTOR'S VENDOR CODE: _____
	2 -SETTLED WITHOUT AUDIT	8. <input type="checkbox"/> INITIAL REPORT FOR THIS PROVIDER CCN	12. <input type="checkbox"/> IF LINE 5, COLUMN 1 IS 4: ENTER NUMBER OF TIMES REOPENED = 0-9.
	3 -SETTLED WITH AUDIT	9. <input type="checkbox"/> FINAL REPORT FOR THIS PROVIDER CCN	
	4 -REOPENED		
	5 -AMENDED		

**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 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE 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 HEALTHSOUTH DEACONESS REHABILITATION (15-3025) {(PROVIDER NAME(S) AND NUMBER(S)} FOR THE COST REPORTING PERIOD BEGINNING 01/01/2013 AND ENDING 12/31/2013, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT 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.

(SIGNED) \_\_\_\_\_  
OFFICER OR ADMINISTRATOR OF PROVIDER(S)

\_\_\_\_\_  
TITLE

\_\_\_\_\_  
DATE

**PART III - SETTLEMENT SUMMARY**

		TITLE XVIII					
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		133,176			68,488	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		133,176			68,488	200

THE ABOVE AMOUNTS REPRESENT 'DUE TO' OR 'DUE FROM' THE APPLICABLE PROGRAM FOR THE ELEMENT OF THE ABOVE COMPLEX INDICATED.

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A VALID OMB CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED 673 HOURS PER RESPONSE, INCLUDING THE TIME TO REVIEW INSTRUCTIONS, SEARCH EXISTING RESOURCES, GATHER THE DATA NEEDED, AND COMPLETE AND REVIEW THE INFORMATION COLLECTION. IF YOU HAVE ANY COMMENTS CONCERNING THE ACCURACY OF THE TIME ESTIMATE(S) OR SUGGESTIONS FOR IMPROVING THIS FORM, PLEASE WRITE TO: CMS, 7500 SECURITY BOULEVARD, ATTN: PRA REPORT CLEARANCE OFFICER, MAIL STOP C4-26-05, BALTIMORE, MARYLAND 21244-1850.



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
PART I

HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX ADDRESS:														
1	STREET: 4100 COVERT AVENUE			P.O. BOX:					1					
2	CITY: EVANSVILLE			STATE: IN		ZIP CODE: 47714		COUNTY: VANDENBURGH						
HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:														
							PAYMENT SYSTEM (P, T, O, OR N)							
0	COMPONENT	1	CCN NUMBER	CBSA NUMBER	PROV- IDER TYPE	DATE CERTIFIED	V	XVIII	XIX					
2		3	4	5	6	7	8	9	10					
3	HOSPITAL	HEALTHSOUTH DEACONESS REHABILITATION	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 / 2013	TO: 12 / 31 / 2013							20			
21	TYPE OF CONTROL (see instructions)		5							21				
INPATIENT PPS INFORMATION								1	2					
22	DOES THIS FACILITY QUALIFY FOR AND RECEIVE DISPROPORTIONATE SHARE HOSPITAL PAYMENT IN ACCORDANCE WITH 42 CFR §412.106 IN COLUMN 1, ENTER 'Y' FOR YES AND '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				
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 COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.									24				
25	IF THIS PROVIDER IS AN IRF, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF STATE MEDICAID DAYS IN COL. 3, OUT-OF STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.							697	94	239	98	169		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 IN EFFECT IN THE COST REPORTING PERIOD.								37					
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.				BEGINNING:		ENDING:		38					
39	DOES THIS FACILITY QUALIFY FOR THE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW VOLUME HOSPITALS IN ACCORDANCE WITH 42 CFR §412.101(b)(2)(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)(ii)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. (see instructions)							N	N	39				



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
PART I

		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 WORKSHEET L, PART III AND L-1, PARTS I THROUGH 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 WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N		57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-5.	N			58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N			59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (see instructions)	N			60
		Y/N	IME	DIRECT GME	
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 BASE LINE FTE COUNT FOR PRIMARY CARE AND/OR GENERAL SURGERY RESIDENTS, WHICH IS USED FOR DETERMINING COMPLIANCE WITH THE 75% TEST. (see instructions)				61.03
61.04	ENTER THE NUMBER OF UNWEIGHTED PRIMARY CARE/OR SURGERY ALLOPATHIC AND/OR OSTEOPATHIC FTEs IN THE CURRENT COST REPORTING PERIOD. (see instructions)				61.04
61.05	ENTER THE DIFFERENCE BETWEEN THE BASELINE PRIMARY AND/OR GENERAL SURGERY FTEs AND THE CURRENT YEAR'S PRIMARY CARE AND/OR GENERAL SURGERY FTE COUNTS (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	ENTER THE AMOUNT OF ACA §5503 AWARD THAT IS BEING USED FOR CAP RELIEF AND/OR FTEs THAT ARE NONPRIMARY CARE OR GENERAL SURGERY. (see instructions)				61.06
OF THE FTEs IN LINE 61.05, SPECIFY EACH NEW PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH NEW PROGRAM (see instructions). ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 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 AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.					
ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)					
62	ENTER THE NUMBER OF FTE RESIDENTS THAT YOUR HOSPITAL TRAINED IN THIS COST REPORTING PERIOD FOR WHICH YOUR HOSPITAL RECEIVED HRSA PCRE FUNDING (see instructions)				62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (see instructions)				62.01
TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS					
63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (see instructions)	N			63



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## HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
PART I

SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER 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 NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (column 1 divided by (column 1 + column 2)). (see instructions)						64
ENTER IN LINES 65-65.49 IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF (column 3 divided by (column 3 ÷ column 4)). (see instructions)							
	PROGRAM NAME	PROGRAM CODE		UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 3/ col. 3 + col. 4))	
	1	2		3	4	5	
65							65
SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER 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 NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (column 1 divided by (column 1 + column 2)). (see instructions)						66
ENTER IN LINES 67-67.49, COLUMN 1 THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF (column 3 divided by (column 3 ÷ column 4)). (see instructions)							
	PROGRAM NAME	PROGRAM CODE		UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 3/ col. 3 + col. 4))	
	1	2		3	4	5	
67							67
INPATIENT PSYCHIATRIC FACILITY PPS				1	2	3	
70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N			70
71	IF LINE 70 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, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.						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 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, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			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
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



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
PART I

TITLE V AND XIX SERVICES		V	XIX	
		1	2	
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.	N	Y	90
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	91
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (dual certification)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.		N	92
93	DOES THIS FACILITY OPERATE AN ICF/MR 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
RURAL PROVIDERS		1	2	
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?	N		105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.			106
107	COLUMN 1: 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. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&RS IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.			107
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.	N		108
109	IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.	N	PHYSICAL OCCUPATIONAL SPEECH RESPIRATORY	109

MISCELLANEOUS COST REPORTING INFORMATION

115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF 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'	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:	33,652	396,636	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

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, IF APPLICABLE, IN COLUMN 2.			126
127	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			127
128	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			128
129	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			129
130	IF THIS IS A MEDICARE CERTIFIED PANCREAS TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			130
131	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			131
132	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			132
133	IF THIS IS A MEDICARE CERTIFIED OTHER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, 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



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## 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.	Y	019005	140		
IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER ON LINES 141 THROUGH 143 THE NAME AND ADDRESS OF THE HOME OFFICE AND ENTER THE HOME OFFICE CONTRACTOR NAME AND CONTRACTOR NUMBER.						
141	NAME: HEALTHSOUTH CORPORATION	CONTRACTOR'S NAME: CAHABA GBA		CONTRACTOR'S NUMBER: 10101		141
142	STREET: 3660 GRANDVIEW PARKWAY, STE 20	P.O. BOX:				142
143	CITY: BIRMINGHAM	STATE: AL	ZIP CODE: 35243	143		
144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y	144			
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, LINE 74 ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.	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, section 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	
155	HOSPITAL	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.	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				
169	IF THIS PROVIDER IS A MEANINGFUL USER (line 167 is 'Y') AND IS NOT A CAH (line 105 is 'N'), ENTER THE TRANSITIONAL 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				



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## HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2  
PART II

GENERAL INSTRUCTION: ENTER Y FOR ALL YES RESPONSES. ENTER N FOR ALL NO RESPONSES.  
ENTER ALL DATES IN THE MM/DD/YYYY FORMAT.

## COMPLETED BY ALL HOSPITALS

		Y/N	DATE		
PROVIDER ORGANIZATION AND OPERATION		1	2		
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (see instructions)	N			1
		Y/N	DATE	V/I	
		1	2	3	
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	N			2
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (e.g., chain home offices, drug or medical supply companies) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (see instructions)	Y			3
FINANCIAL DATA AND REPORTS		Y/N	TYPE	DATE	
		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	C		4
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N			5
APPROVED EDUCATIONAL ACTIVITIES		Y/N		Y/N	
		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 INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N			9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N			10
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N			11
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
		1	2	3	4
PS&R REPORT DATA					
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (see instructions)	N		Y	02/28/2014
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	02/28/2014	N	
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	
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	
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS: SPLIT REV CODE 760 BETWEEN CMS 54 AN	Y		N	
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	



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## HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2  
PART II

GENERAL INSTRUCTION: ENTER Y FOR ALL YES RESPONSES. ENTER N FOR ALL NO RESPONSES.  
ENTER ALL DATES IN THE MM/DD/YYYY FORMAT.

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

CAPITAL RELATED COSTS			
22	HAVE ASSETS BEEN RELIEVED 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 CAPITALIZED 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
HOME OFFICE COSTS		Y/N	DATE
36	WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT?	1	2
37	IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.		
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.		
39	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO OTHER CHAIN COMPONENTS? IF YES, SEE INSTRUCTIONS.		
40	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.		
COST REORT PREPARER INFORMATION			
41	FIRST NAME: JIM	LAST NAME: WYATT	TITLE: SR REIMBURSEMENT SPECIALIS
42	EMPLOYER: HEALTHSOUTH CORPORATION		
43	PHONE NUMBER: 205-969-8265	E-MAIL ADDRESS: JAMES.WYATT@HEALTHSOUTH.COM	







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## HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3  
PARTS II-III

## PART II - WAGE DATA

	WKST A LINE NO.	AMOUNT REPORTED	RECLASSIF- ICATION OF SALARIES (from Worksheet A-6)	ADJUSTED SALARIES (column 2 ± column 3)	PAID HOURS RELATED TO SALARIES IN COLUMN 4	AVERAGE HOURLY WAGE (column 4 ± column 5)	
	1	2	3	4	5	6	
<b>SALARIES</b>							
1	200	10,934,150			451,547.20		1
2							2
3							3
4							4
4.01							4.01
5							5
6							6
7	21						7
7.01							7.01
8							8
9	44						9
10			17,718		526.20		10
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11		25,155			519.25		11
12							12
13		82,280			583.00		13
14		916,020			11,086.00		14
15							15
16							16
<b>WAGE-RELATED COSTS</b>							
17		2,297,037					17
18							18
19		3,728					19
20							20
21							21
22							22
22.01							22.01
23							23
24							24
25							25
<b>OVERHEAD COSTS - DIRECT SALARIES</b>							
26							26
27		1,734,386	-16,903		57,054.40		27
28		13,271			38.90		28
29							29
30		229,985			11,148.80		30
31			25,713		2,070.25		31
32		271,840	-25,713		20,289.75		32
33							33
34		284,349			22,547.20		34
35							35
36							36
37							37
38		336,938			11,273.60		38
39							39
40							40
41		124,311			7,030.40		41
42		544,744			19,635.20		42
43							43

## PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (see instructions)		10,947,421		10,947,421	451,586.10	24.24	1
2	EXCLUDED AREA SALARIES (see instructions)			17,718	17,718	526.20	33.67	2
3	SUBTOTAL SALARIES (line 1 minus line 2)		10,947,421	-17,718	10,929,703	451,059.90	24.23	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (see instructions)		1,023,455		1,023,455	12,188.25	83.97	4
5	SUBTOTAL WAGE-RELATED COSTS (see instructions)		2,297,037		2,297,037		21.02%	5
6	TOTAL (sum of lines 3 through 5)		14,267,913	-17,718	14,250,195	463,248.15	30.76	6
7	TOTAL OVERHEAD COST (see instructions)		3,539,824	-16,903	3,522,921	151,088.50	23.32	7



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## HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3  
PART IV

## PART IV - WAGE RELATED COST

## PART A - CORE LIST

		AMOUNT REPORTED	
	<b>RETIREMENT COST</b>		
1	401K EMPLOYER CONTRIBUTIONS	151,580	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
	<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization):</b>		
5	401k/TSA PLAN ADMINISTRATION FEES		5
6	LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7	EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
	<b>HEALTH AND INSURANCE COST</b>		
8	HEALTH INSURANCE (Purchased or Self Funded)	1,544,373	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN		10
11	LIFE INSURANCE (If employee is owner or beneficiary)	22,213	11
12	ACCIDENTAL 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	161,466	15
16	RETIREMENT HEALTH CARE COST (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	<b>TAXES</b>		
17	FICA-EMPLOYERS PORTION ONLY	793,339	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE		19
20	STATE OR FEDERAL UNEMPLOYMENT TAXES	75,354	20
	<b>OTHER</b>		
21	EXECUTIVE DEFERRED COMPENSATION (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	DAY CARE COSTS AND ALLOWANCES	-447,561	22
23	TUITION REIMBURSEMENT		23
24	TOTAL WAGE RELATED COST (Sum of lines 1-23)	2,300,764	24

## PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE REL		25
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WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3, Part IV, Line 4)

EXHIBIT 3

STEP 2: DETERMINE THE 3-YEAR AVERAGING PERIOD			
1	WAGE INDEX FISCAL YEAR ENDING DATE		1
2	PROVIDER'S COST REPORTING PERIOD USED FOR WAGE INDEX YEAR ON LINE 1 (FYB in Col. 1, FYE in Col. 2)		2
3	MIDPOINT OF PROVIDER'S COST REPORTING PERIOD SHOWN ON LINE 2, ADJUSTED TO FIRST OF MONTH		3
4	DATE BEGINNING THE 3-YEAR AVERAGING PERIOD (subtract 18 months from midpoint shown on Line 3)		4
5	DATE ENDING THE 3-YEAR AVERAGING PERIOD (add 18 months to midpoint shown on Line 3)		5
STEP 2 (OPTIONAL): ADJUST AVERAGING PERIOD FOR A NEW PLAN (see instructions)			
6	EFFECTIVE DATE OF PENSION PLAN		6
7	FIRST DAY OF THE PROVIDER COST REPORTING PERIOD CONTAINING THE PENSION PLAN EFFECTIVE DATE		7
8	STARTING DATE OF THE ADJUSTED AVERAGING PERIOD (date on Line 7, adjusted to first of month)		8

IF THIS DATE OCCURS AFTER THE PERIOD SHOWN ON LINE 2, STOP HERE AND SEE INSTRUCTIONS

STEP 3: AVERAGE PENSION CONTRIBUTIONS DURING THE AVERAGING PERIOD			
9	BEGINNING DATE OF AVERAGING PERIOD FROM LINE 4 OR LINE 8, AS APPLICABLE		9
10	ENDING DATE OF AVERAGING PERIOD FROM LINE 5		10
11	ENTER PROVIDER CONTRIBUTIONS MADE DURING AVERAGING PERIOD ON LINES 9 & 10	DEPOSIT DATE(S)	CONTRIB-UTION(S)
12	TOTAL CALENDAR MONTHS INCLUDED IN AVERAGING PERIOD (36 unless Step 2 completed)		12
13	TOTAL CONTRIBUTIONS MADE DURING AVERAGING PERIOD		13
14	AVERAGE MONTHLY CONTRIBUTION (Line 13 divided by Line 12)		14
15	NUMBER OF MONTHS IN PROVIDER COST REPORTING PERIOD ON LINE 2		15
16	AVERAGE PENSION CONTRIBUTIONS (Line 14 times Line 15)		16
STEP 4: TOTAL PENSION COST FOR WAGE INDEX			
17	ANNUAL PREFUNDING INSTALLMENT (see instructions)		17
18	REPORTABLE PREFUNDING INSTALLMENT ((Line 17 times Line 15) divided by 12)		18
19	TOTAL PENSION COST FOR WAGE INDEX (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)		19



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**HOSPITAL CONTRACT LABOR AND BENEFIT COST**

**WORKSHEET S-3  
PART V**

**PART V - CONTRACT LABOR AND BENEFIT COST**

**HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:**

	COMPONENT	CONTRACT LABOR	BENEFIT COST	
	0	1	2	
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST	38,425	2,300,765	1
2	HOSPITAL	38,425	2,297,037	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		3,728	18



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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		<b>GENERAL SERVICE COST CENTERS</b>								
1	00100	CAP REL COSTS-BLDG & FIXT		925,094	925,094	103,258	1,028,352	213,278	1,241,630	1
2	00200	CAP REL COSTS-MVBLE EQUIP		262,995	262,995	94,676	357,671	11,437	369,108	2
3	00300	OTHER CAP REL COSTS		170,350	170,350	-170,350			-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT		2,231,833	2,231,833		2,231,833	56,392	2,288,225	4
5	00500	ADMINISTRATIVE & GENERAL	1,734,386	2,927,019	4,661,405	-56,362	4,605,043	-205,313	4,399,730	5
6	00600	MAINTENANCE & REPAIRS								6
7	00700	OPERATION OF PLANT	229,985	521,933	751,918		751,918	-46,258	705,660	7
8	00800	LAUNDRY & LINEN SERVICE		11,624	11,624	25,713	37,337		37,337	8
9	00900	HOUSEKEEPING	271,840	52,348	324,188	-25,713	298,475	-25	298,450	9
10	01000	DIETARY	284,349	368,593	652,942	-5	652,937	-20,887	632,050	10
11	01100	CAFETERIA								11
12	01200	MAINTENANCE OF PERSONNEL								12
13	01300	NURSING ADMINISTRATION	336,938	10,340	347,278		347,278	-81	347,197	13
14	01400	CENTRAL SERVICES & SUPPLY								14
15	01500	PHARMACY								15
16	01600	MEDICAL RECORDS & LIBRARY	124,311	99,171	223,482		223,482		223,482	16
17	01700	SOCIAL SERVICE	544,744	15,004	559,748		559,748	-91	559,657	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
		<b>INPATIENT ROUTINE SERV COST CENTERS</b>								
30	03000	ADULTS & PEDIATRICS	3,630,123	235,383	3,865,506	-16,430	3,849,076	-54,407	3,794,669	30
		<b>ANCILLARY SERVICE COST CENTERS</b>								
54	05400	RADIOLOGY-DIAGNOSTIC		224,937	224,937	363,551	588,488	-97,750	490,738	54
60	06000	LABORATORY		393,712	393,712		393,712	-246,700	147,012	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	RESPIRATORY THERAPY	267,228	11,322	278,550		278,550	-302	278,248	65
66	06600	PHYSICAL THERAPY	1,188,984	34,427	1,223,411	2,120	1,225,531	-469	1,225,062	66
67	06700	OCCUPATIONAL THERAPY	1,147,293	11,360	1,158,653	-1,045	1,157,608		1,157,608	67
68	06800	SPEECH PATHOLOGY	641,992	6,922	648,914	-1,075	647,839	-230	647,609	68
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	58,233	251,287	309,520		309,520	-30,585	278,935	71
73	07300	DRUGS CHARGED TO PATIENTS	427,835	555,931	983,766		983,766	-2,527	981,239	73
76	03550	PSYCHOLOGY	45,909	11	45,920		45,920		45,920	76
76.01	03951	SPECIAL PROCEDURES		363,551	363,551	-336,987	26,564		26,564	76.01
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		<b>OUTPATIENT SERVICE COST CENTERS</b>								
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)								92
		<b>OTHER REIMBURSABLE COST CENTERS</b>								
		<b>SPECIAL PURPOSE COST CENTERS</b>								
113	11300	INTEREST EXPENSE		8,317	8,317		8,317	-8,317		113
192	19200	PHYSICIANS' PRIVATE OFFICES		645	645	815	1,460	-15	1,445	192
194	07950	NRCC MARKETING				17,834	17,834		17,834	194
194.01	07951	NRCC GUEST MEALS								194.01
200		TOTAL (sum of lines 118-199)	10,934,150	9,694,109	20,628,259		20,628,259	-432,850	20,195,409	200



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RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				
			COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	INSURANCE	A	CAP REL COSTS-BLDG & FIXT	1		14,390	1
2	INSURANCE	A	CAP REL COSTS-MVBLE EQUIP	2		13,194	2
3	INSURANCE	A					3
500	TOTAL RECLASSIFICATIONS					27,584	500
	CODE LETTER - A						
1	MARKETING	B	NRCC MARKETING	194		16,903	931
2	MARKETING	B					2
3	MARKETING	B					3
500	TOTAL RECLASSIFICATIONS				16,903	931	500
	CODE LETTER - B						
1	PHYSICIANS	C	ADULTS & PEDIATRICS	30		10,949	1
2	PHYSICIANS	C					2
500	TOTAL RECLASSIFICATIONS					10,949	500
	CODE LETTER - C						
1	PATIENT TRANSPORTATION	D	SPECIAL PROCEDURES	76.01		26,564	1
2	PATIENT TRANSPORTATION	D					2
500	TOTAL RECLASSIFICATIONS					26,564	500
	CODE LETTER - D						
1	DAY TREATMENT	E	PHYSICAL THERAPY	66		2,120	1
2	DAY TREATMENT	E					2
3	DAY TREATMENT	E					3
500	TOTAL RECLASSIFICATIONS					2,120	500
	CODE LETTER - E						
1	LAUNDRY	F	LAUNDRY & LINEN SERVICE	8		25,713	1
2	LAUNDRY	F					2
500	TOTAL RECLASSIFICATIONS					25,713	500
	CODE LETTER - F						
1	RADIOLOGY RECLASS	G	RADIOLOGY-DIAGNOSTIC	54		363,551	1
2	RADIOLOGY RECLASS	G					2
500	TOTAL RECLASSIFICATIONS					363,551	500
	CODE LETTER - G						
1	PHYSICIAN SUPPORT	H	PHYSICIANS' PRIVATE OFFICES	192		815	1
2	PHYSICIAN SUPPORT	H					2
500	TOTAL RECLASSIFICATIONS					815	500
	CODE LETTER - H						
	GRAND TOTAL (INCREASES)					43,431	431,699

(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.



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RECLASSIFICATIONS

WORKSHEET A-6

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	INSURANCE	A					12	
2	INSURANCE	A					12	
3	INSURANCE	A	ADMINISTRATIVE & GENERAL	5		27,584	3	
500	TOTAL RECLASSIFICATIONS					27,584	500	
	CODE LETTER - A							
1	MARKETING	B					1	
2	MARKETING	B	ADMINISTRATIVE & GENERAL	5	16,903	926	2	
3	MARKETING	B	DIETARY	10		5	3	
500	TOTAL RECLASSIFICATIONS				16,903	931	500	
	CODE LETTER - B							
1	PHYSICIANS	C					1	
2	PHYSICIANS	C	ADMINISTRATIVE & GENERAL	5		10,949	2	
500	TOTAL RECLASSIFICATIONS					10,949	500	
	CODE LETTER - C							
1	PATIENT TRANSPORTATION	D					1	
2	PATIENT TRANSPORTATION	D	ADULTS & PEDIATRICS	30		26,564	2	
500	TOTAL RECLASSIFICATIONS					26,564	500	
	CODE LETTER - D							
1	DAY TREATMENT	E					1	
2	DAY TREATMENT	E	OCCUPATIONAL THERAPY	67		1,045	2	
3	DAY TREATMENT	E	SPEECH PATHOLOGY	68		1,075	3	
500	TOTAL RECLASSIFICATIONS					2,120	500	
	CODE LETTER - E							
1	LAUNDRY	F					1	
2	LAUNDRY	F	HOUSEKEEPING	9	25,713		2	
500	TOTAL RECLASSIFICATIONS				25,713		500	
	CODE LETTER - F							
1	RADIOLOGY RECLASS	G					1	
2	RADIOLOGY RECLASS	G	SPECIAL PROCEDURES	76.01		363,551	2	
500	TOTAL RECLASSIFICATIONS					363,551	500	
	CODE LETTER - G							
1	PHYSICIAN SUPPORT	H					1	
2	PHYSICIAN SUPPORT	H	ADULTS & PEDIATRICS	30	815		2	
500	TOTAL RECLASSIFICATIONS				815		500	
	CODE LETTER - H							
	GRAND TOTAL (DECREASES)				43,431	431,699		

(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.



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## RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7  
PARTS I, II & III

## PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

	DESCRIPTION	BEGINNING BALANCES	ACQUISITIONS			DISPOSALS AND RETIRE- MENTS	ENDING BALANCE	FULLY DEPREC- IATED ASSETS	
			PURCHASES	DONATION	TOTAL				
		1	2	3	4	5	6	7	
1	LAND								1
2	LAND IMPROVEMENTS								2
3	BUILDINGS AND FIXTURES								3
4	BUILDING IMPROVEMENTS	2,151,643	363,973		363,973		2,515,616		4
5	FIXED EQUIPMENT								5
6	MOVABLE EQUIPMENT	2,091,925	225,642		225,642	11,016	2,306,551		6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (sum of lines 1-7)	4,243,568	589,615		589,615	11,016	4,822,167		8
9	RECONCILING ITEMS								9
10	TOTAL (line 7 minus line 9)	4,243,568	589,615		589,615	11,016	4,822,167		10

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

	DESCRIPTION	SUMMARY OF CAPITAL							TOTAL(1) (Sum of cols. 9 through 14)	
		DEPRECIATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL- RELATED COSTS (see instr.)			
*		9	10	11	12	13	14	15		
1	CAP REL COSTS-BLDG & FIXT	150,376	774,718						925,094	1
2	CAP REL COSTS-MVBLE EQUIP	149,117	113,878						262,995	2
3	TOTAL (sum of lines 1-2)	299,493	888,596						1,188,089	3

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

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

## PART III - RECONCILIATION OF CAPITAL COST CENTERS

	DESCRIPTION	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL					
		GROSS ASSETS	CAPITAL- IZED LEASES	GROSS ASSETS FOR RATIO (col. 1 - col. 2)	RATIO (see instr.)	INSURANCE	TAXES	OTHER CAPITAL- RELATED COSTS	TOTAL (sum of cols. 5 through 7)		
*		9	10	11	12	13	14	15	16		
1	CAP REL COSTS-BLDG & FI	2,515,616		2,515,616	0.521677		88,868			88,868	1
2	CAP REL COSTS-MVBLE EQU	2,306,551		2,306,551	0.478323		81,482			81,482	2
3	TOTAL (sum of lines 1-2)	4,822,167		4,822,167	1.000000		170,350			170,350	3

	DESCRIPTION	SUMMARY OF CAPITAL							TOTAL(2) (sum of cols. 9 through 14)	
		DEPRECIATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL- RELATED COSTS (see instr.)			
*		9	10	11	12	13	14	15		
1	CAP REL COSTS-BLDG & FIXT	298,344	774,718	57,194	14,390	96,984			1,241,630	1
2	CAP REL COSTS-MVBLE EQUIP	155,046	111,944		13,194	88,924			369,108	2
3	TOTAL (sum of lines 1-2)	453,390	886,662	57,194	27,584	185,908			1,610,738	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.)



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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		
				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	-4,769			10
11	SALE OF SCRAP, WASTE, ETC. (chapter 23)					11
12	RELATED ORGANIZATION TRANSACTIONS (chapter 10)	WKST A-8-1	-492,343			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 SCHOOL (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 AND					32
33						33
34						34
35						35
36						36
37	INTEREST	A	-8,317	INTEREST EXPENSE	113	37
37.02	DEPRECIATION	A	20,344	CAP REL COSTS-MVBLE EQUIP	2	37.02
37.03	INSURANCE	A	68,932	EMPLOYEE BENEFITS DEPARTMENT	4	37.03
37.04	INSURANCE	A	307,127	ADMINISTRATIVE & GENERAL	5	37.04
37.05	PROPERTY TAX	A	8,116	CAP REL COSTS-BLDG & FIXT	1	37.05
37.06	PROPERTY TAX	A	7,442	CAP REL COSTS-MVBLE EQUIP	2	37.06
37.07	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-128,866	ADMINISTRATIVE & GENERAL	5	37.07
37.08	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-140	OPERATION OF PLANT	7	37.08
37.09	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-25	HOUSEKEEPING	9	37.09
37.10	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	2,221	DIETARY	10	37.10
37.11	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-49	NURSING ADMINISTRATION	13	37.11
37.12	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-115	ADULTS & PEDIATRICS	30	37.12
37.13	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-40	PHYSICAL THERAPY	66	37.13
37.15	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-122	SPEECH PATHOLOGY	68	37.15
37.16	PATIENT TELEPHONE	A	-4,569	EMPLOYEE BENEFITS DEPARTMENT	4	37.16
37.17	PATIENT TELEPHONE	A	-27,286	ADMINISTRATIVE & GENERAL	5	37.17
37.18	PATIENT TELEVISION	A	-14,415	CAP REL COSTS-MVBLE EQUIP	2	37.18
37.19	PATIENT TELEVISION	A	-560	ADMINISTRATIVE & GENERAL	5	37.19
37.20	PRINTING	A	-7,454	ADMINISTRATIVE & GENERAL	5	37.20
37.22	LOBBYING EXPENSE	A	-55	EMPLOYEE BENEFITS DEPARTMENT	4	37.22
37.23	LOBBYING EXPENSE	A	-1,513	ADMINISTRATIVE & GENERAL	5	37.23
37.24	MISCELLANEOUS INCOME	B	-13,380	CAP REL COSTS-BLDG & FIXT	1	37.24
37.25	MISCELLANEOUS INCOME	B	-3,402	ADMINISTRATIVE & GENERAL	5	37.25
37.26	MISCELLANEOUS INCOME	B	-23,108	DIETARY	10	37.26
37.27	PATIENT TRANSPORTATION	A	-7,832	EMPLOYEE BENEFITS DEPARTMENT	4	37.27
37.28	PATIENT TRANSPORTATION	A	-46,118	OPERATION OF PLANT	7	37.28
37.29	PATIENT TRANSPORTATION	A	-49,500	ADULTS & PEDIATRICS	30	37.29



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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF.	
				COST CENTER	LINE#		
		1	2	3	4	5	
37.30	PROFESSIONAL FEES	A	-8,012	ADMINISTRATIVE & GENERAL	5		37.30
37.31	COMMUNITY EVENTS	A	-84	EMPLOYEE BENEFITS DEPARTMENT	4		37.31
37.32	COMMUNITY EVENTS	A	-386	ADMINISTRATIVE & GENERAL	5		37.32
37.33	COMMUNITY EVENTS	A	-108	SPEECH PATHOLOGY	68		37.33
37.34	PHYSICIAN PRIVATE OFFICE	A	-15	PHYSICIANS' PRIVATE OFFICES	192		37.34
37.35	WAYPORT WIRELESS	A	-4,168	ADMINISTRATIVE & GENERAL	5		37.35
37.36	PHYSICIAN	A	-281	ADMINISTRATIVE & GENERAL	5		37.36
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)		-432,850				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.



HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:01 Version: 2014.03
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STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

WORKSHEET A-8-1

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

	LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT INCLUDED IN WKST. A COLUMN 5	NET ADJUSTMENTS (col. 4 minus col. 5)*	WKST. A-7 REF.	
	1	2	3	4	5	6	7	
1	5	ADMINISTRATIVE & GENERAL	TO OFFSET MANAGEMENT FEES		1,901,511	-1,901,511		1
2	1	CAP REL COSTS-BLDG & FIXT	TO INCLUDE ALLOWABLE HOME OFFICE COS	147,968		147,968	9	2
3	1	CAP REL COSTS-BLDG & FIXT	TO INCLUDE ALLOWABLE HOME OFFICE COS	70,574		70,574	11	3
3.01	5	ADMINISTRATIVE & GENERAL	TO INCLUDE ALLOWABLE HOME OFFICE COS	1,336,393		1,336,393		3.01
3.02	5	ADMINISTRATIVE & GENERAL	TO INCLUDE ALLOWABLE HOME OFFICE COS	248,813		248,813		3.02
3.03	2	CAP REL COSTS-MVBLE EQUIP	INTERCOMPANY WAGE AND EXPENSE TRANSF	11,564	11,564		10	3.03
3.04	4	EMPLOYEE BENEFITS DEPARTMENT	INTERCOMPANY WAGE AND EXPENSE TRANSF	1,651,136	1,651,136			3.04
3.05	5	ADMINISTRATIVE & GENERAL	INTERCOMPANY WAGE AND EXPENSE TRANSF	2,172,325	2,172,325			3.05
3.06	7	OPERATION OF PLANT	INTERCOMPANY WAGE AND EXPENSE TRANSF	13,331	13,331			3.06
3.07	9	HOUSEKEEPING	INTERCOMPANY WAGE AND EXPENSE TRANSF	3,686	3,686			3.07
3.08	10	DIETARY	INTERCOMPANY WAGE AND EXPENSE TRANSF	-6,368	-6,368			3.08
3.09	13	NURSING ADMINISTRATION	INTERCOMPANY WAGE AND EXPENSE TRANSF	1,332	1,332			3.09
3.10	16	MEDICAL RECORDS & LIBRARY	INTERCOMPANY WAGE AND EXPENSE TRANSF	50	50			3.10
3.11	17	SOCIAL SERVICE	INTERCOMPANY WAGE AND EXPENSE TRANSF	1,872	1,872			3.11
3.12	30	ADULTS & PEDIATRICS	INTERCOMPANY WAGE AND EXPENSE TRANSF	-3,555	-3,555			3.12
3.13	54	RADIOLOGY-DIAGNOSTIC	INTERCOMPANY WAGE AND EXPENSE TRANSF	-653	-653			3.13
3.14	65	RESPIRATORY THERAPY	INTERCOMPANY WAGE AND EXPENSE TRANSF	102	102			3.14
3.15	66	PHYSICAL THERAPY	INTERCOMPANY WAGE AND EXPENSE TRANSF	-623	-623			3.15
3.16	67	OCCUPATIONAL THERAPY	INTERCOMPANY WAGE AND EXPENSE TRANSF	-2,507	-2,507			3.16
3.17	68	SPEECH PATHOLOGY	INTERCOMPANY WAGE AND EXPENSE TRANSF	2,929	2,929			3.17
3.18	71	MEDICAL SUPPLIES CHARGED TO PATIENTS	INTERCOMPANY WAGE AND EXPENSE TRANSF	-5,046	-5,046			3.18
3.19	73	DRUGS CHARGED TO PATIENTS	INTERCOMPANY WAGE AND EXPENSE TRANSF	501,378	501,378			3.19
3.20	76.01	SPECIAL PROCEDURES	INTERCOMPANY WAGE AND EXPENSE TRANSF	-2,440	-2,440			3.20
3.21	113	INTEREST EXPENSE	INTERCOMPANY WAGE AND EXPENSE TRANSF	4,758	4,758		11	3.21
3.22	5	ADMINISTRATIVE & GENERAL	RELATED PARTY - MOTORIKA	3,223	3,223			3.22
3.23	66	PHYSICAL THERAPY	RELATED PARTY - MOTORIKA	53	53			3.23
3.24	2	CAP REL COSTS-MVBLE EQUIP	RELATED PARTY - DEACONESS	709	2,643	-1,934	10	3.24
3.25	5	ADMINISTRATIVE & GENERAL	RELATED PARTY - DEACONESS	5,212	19,419	-14,207		3.25
3.26	13	NURSING ADMINISTRATION	RELATED PARTY - DEACONESS	12	44	-32		3.26
3.27	17	SOCIAL SERVICE	RELATED PARTY - DEACONESS	34	125	-91		3.27
3.28	30	ADULTS & PEDIATRICS	RELATED PARTY - DEACONESS	88	111	-23		3.28
3.29	54	RADIOLOGY-DIAGNOSTIC	RELATED PARTY - DEACONESS	48,386	146,136	-97,750		3.29
3.30	60	LABORATORY	RELATED PARTY - DEACONESS	147,012	393,712	-246,700		3.30
3.31	65	RESPIRATORY THERAPY	RELATED PARTY - DEACONESS	106	408	-302		3.31
3.32	66	PHYSICAL THERAPY	RELATED PARTY - DEACONESS	118	547	-429		3.32
3.33	71	MEDICAL SUPPLIES CHARGED TO PATIENTS	RELATED PARTY - DEACONESS	9,643	40,228	-30,585		3.33
3.34	73	DRUGS CHARGED TO PATIENTS	RELATED PARTY - DEACONESS	838	3,365	-2,527		3.34
4								4
5		TOTALS (SUM OF LINES 1-4) TRANSFER COLUMN 6, LINE 5 TO WORKSHEET A-8, COLUMN 2, LINE 12		6,362,453	6,854,796	-492,343		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



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

WORKSHEET A-8-1

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

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

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

	SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	RELATED ORGANIZATION(S) AND/OR HOME OFFICE			
				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.

	SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	RELATED ORGANIZATION(S) AND/OR HOME OFFICE			
				NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS	
	1	2	3	4	5	6	
6	B		78.00	HEALTHSOUTH CORPORATION			6
7	B		22.00	DEACONESS			7
8	G	HEALTHSOUTH CORPORATION					8
9	G	MOTORIKA					9
10							10

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

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



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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN- ERATION	PROFESS- IONAL COMPON- ENT	PROVIDER COMPON- ENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPON- ENT HOURS	UNADJ- USTED RCE LIMIT	5 PERCENT OF UNADJ- USTED RCE LIMIT	
	1	2	3	4	5	6	7	8	9	
1	30	ADULTS & PEDIATRICS AGRREGATE	10,949		10,949	171,400	75	6,180	309	1
200		TOTAL	10,949		10,949		75	6,180	309	200



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HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:01 Version: 2014.03
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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBER- SHIPS & CONTIN- UING EDUCATION	PROVIDER COMPON- ENT SHARE OF COL. 12	PHYSICIAN COST OF MALPRACT- ICE INSURANCE	PROVIDER COMPON- ENT SHARE OF COL. 14	ADJUSTED RCE LIMIT	RCE DISALLOW- ANCE	ADJUST- MENT	
	10	11	12	13	14	15	16	17	18	
1	30	ADULTS & PEDIATRICS AGRREGATE					6,180	4,769	4,769	1
200		TOTAL					6,180	4,769	4,769	200





HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:01 Version: 2014.03
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3  
PARTS V-VI

CHECK APPLICABLE BOX:  OCCUPATIONAL       PHYSICAL       RESPIRATORY       SPEECH PATHOLOGY

**PART V - OVERTIME COMPUTATION**

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
<b>CALCULATION OF LIMIT</b>							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked in column 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
<b>DETERMINATION OF OVERTIME ALLOWANCE</b>							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

**PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT**

57	SALARY EQUIVALENCY AMOUNT (from line 23)						57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)						58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)						59
60	OVERTIME ALLOWANCE (from column 5, line 56)						60
61	EQUIPMENT COST (see instructions)						61
62	SUPPLIES (see instructions)						62
63	TOTAL ALLOWANCE (sum of lines 57-62)						63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)						64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)						65





HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:01 Version: 2014.03
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3  
PARTS V-VI

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [XX] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
<b>CALCULATION OF LIMIT</b>							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked in column 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
<b>DETERMINATION OF OVERTIME ALLOWANCE</b>							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)						57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)						58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)						59
60	OVERTIME ALLOWANCE (from column 5, line 56)						60
61	EQUIPMENT COST (see instructions)						61
62	SUPPLIES (see instructions)						62
63	TOTAL ALLOWANCE (sum of lines 57-62)						63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)						64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)						65





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## REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3  
PARTS V-VI

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [ ] PHYSICAL [XX] RESPIRATORY [ ] SPEECH PATHOLOGY

## PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
<b>CALCULATION OF LIMIT</b>							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked in column 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
<b>DETERMINATION OF OVERTIME ALLOWANCE</b>							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

## PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)						57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)						58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)						59
60	OVERTIME ALLOWANCE (from column 5, line 56)						60
61	EQUIPMENT COST (see instructions)						61
62	SUPPLIES (see instructions)						62
63	TOTAL ALLOWANCE (sum of lines 57-62)						63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)						64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)						65





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## REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3  
PARTS V-VI

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [XX] SPEECH PATHOLOGY

## PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
<b>CALCULATION OF LIMIT</b>							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked in column 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
<b>DETERMINATION OF OVERTIME ALLOWANCE</b>							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

## PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)						57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)						58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)						59
60	OVERTIME ALLOWANCE (from column 5, line 56)						60
61	EQUIPMENT COST (see instructions)						61
62	SUPPLIES (see instructions)						62
63	TOTAL ALLOWANCE (sum of lines 57-62)						63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)						64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)						65



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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
PART I

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINISTRATIVE & GENERAL	
		0	1	2	4	4A	5	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	CAP REL COSTS-BLDG & FIXT	1,241,630	1,241,630					1
2	CAP REL COSTS-MVBLE EQUIP	369,108		369,108				2
4	EMPLOYEE BENEFITS DEPARTMENT	2,288,225	4,078	1,212	2,293,515			4
5	ADMINISTRATIVE & GENERAL	4,399,730	122,051	36,283	360,254	4,918,318	4,918,318	5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	705,660	24,673	7,335	48,241	785,909	253,016	7
8	LAUNDRY & LINEN SERVICE	37,337	13,821	4,109	5,393	60,660	19,529	8
9	HOUSEKEEPING	298,450	10,050	2,988	51,627	363,115	116,902	9
10	DIETARY	632,050	88,215	26,224	59,644	806,133	259,527	10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	347,197	10,442	3,104	70,675	431,418	138,891	13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY	223,482	9,385	2,790	26,075	261,732	84,262	16
17	SOCIAL SERVICE	559,657	10,238	3,043	114,264	687,202	221,238	17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APRVVD							21
22	I&R SERVICES-OTHER PRGM COSTS APRVVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS	3,794,669	518,112	154,023	761,273	5,228,077	1,683,128	30
	<b>ANCILLARY SERVICE COST CENTERS</b>							
54	RADIOLOGY-DIAGNOSTIC	490,738	10,988	3,267		504,993	162,578	54
60	LABORATORY	147,012	921	274		148,207	47,714	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	278,248	2,628	781	56,053	337,710	108,723	65
66	PHYSICAL THERAPY	1,225,062	155,511	46,230	249,398	1,676,201	539,638	66
67	OCCUPATIONAL THERAPY	1,157,608	80,878	24,043	240,653	1,503,182	483,936	67
68	SPEECH PATHOLOGY	647,609	42,384	12,600	134,662	837,255	269,547	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	278,935	21,329	6,340	12,215	318,819	102,641	71
73	DRUGS CHARGED TO PATIENTS	981,239	6,825	2,029	89,741	1,079,834	347,643	73
76	PSYCHOLOGY	45,920	717	213	9,630	56,480	18,183	76
76.01	SPECIAL PROCEDURES	26,564				26,564	8,552	76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
	<b>SPECIAL PURPOSE COST CENTERS</b>							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	20,176,130	1,133,246	336,888	2,289,798	20,031,809	4,865,648	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
192	PHYSICIANS' PRIVATE OFFICES	1,445	108,213	32,169	171	141,998	45,715	192
194	NRCC MARKETING	17,834	171	51	3,546	21,602	6,955	194
194.01	NRCC GUEST MEALS							194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	20,195,409	1,241,630	369,108	2,293,515	20,195,409	4,918,318	202



COMPU-MAX

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:01 Version: 2014.03
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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
PART I

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT A, col.7) 7	LAUNDRY & LINEN SERVICE 8	HOUSE-KEEPING EQUIPMENT 9	DIETARY BENEFITS DEPARTMENT 10	CAFETERIA SUBTOTAL (cols.0-4) 11	NURSING ADMINISTRATION 13	
	<b>GENERAL SERVICE COST CENTERS</b>							
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	1,038,925						7
8	LAUNDRY & LINEN SERVICE	13,163	93,352					8
9	HOUSEKEEPING	9,572		489,589				9
10	DIETARY	84,018		40,479	1,190,157			10
11	CAFETERIA				174,295	174,295		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	9,946		4,792		6,966	592,013	13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY	8,938		4,306		2,570		16
17	SOCIAL SERVICE	9,751		4,698		11,262		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
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS	493,458	93,352	237,743	957,993	75,035	592,013	30
	<b>ANCHLLARY SERVICE COST CENTERS</b>							
54	RADIOLOGY-DIAGNOSTIC	10,466		5,042				54
60	LABORATORY	878		423				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	2,503		1,206		5,525		65
66	PHYSICAL THERAPY	148,111		71,358		24,581		66
67	OCCUPATIONAL THERAPY	77,030		37,112		23,719		67
68	SPEECH PATHOLOGY	40,367		19,449		13,273		68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,314		9,787		1,204		71
73	DRUGS CHARGED TO PATIENTS	6,500		3,132		8,845		73
76	PSYCHOLOGY	683		329		949		76
76.01	SPECIAL PROCEDURES							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
	<b>SPECIAL PURPOSE COST CENTERS</b>							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	935,698	93,352	439,856	1,132,288	173,929	592,013	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
192	PHYSICIANS' PRIVATE OFFICES	103,064		49,655		17		192
194	NRCC MARKETING	163		78		349		194
194.01	NRCC GUEST MEALS				57,869			194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	1,038,925	93,352	489,589	1,190,157	174,295	592,013	202



## COMPU-MAX

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:01 Version: 2014.03
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## COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
PART I

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		16	17	24	25	26	
	<b>GENERAL SERVICE COST CENTERS</b>						
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	361,808					16
17	SOCIAL SERVICE		934,151				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
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>						
30	ADULTS & PEDIATRICS	115,926	934,151	10,410,876		10,410,876	30
	<b>ANCILLARY SERVICE COST CENTERS</b>						
54	RADIOLOGY-DIAGNOSTIC	7,377		690,456		690,456	54
60	LABORATORY	8,031		205,253		205,253	60
62.30	BLOOD CLOTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	40,056		495,723		495,723	65
66	PHYSICAL THERAPY	62,951		2,522,840		2,522,840	66
67	OCCUPATIONAL THERAPY	61,938		2,186,917		2,186,917	67
68	SPEECH PATHOLOGY	31,131		1,211,022		1,211,022	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,371		460,136		460,136	71
73	DRUGS CHARGED TO PATIENTS	23,654		1,469,608		1,469,608	73
76	PSYCHOLOGY	2,566		79,190		79,190	76
76.01	SPECIAL PROCEDURES	807		35,923		35,923	76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
	<b>SPECIAL PURPOSE COST CENTERS</b>						
113	INTEREST EXPENSE						113
118	SUBTOTALS (sum of lines 1-117)	361,808	934,151	19,767,944		19,767,944	118
	<b>NONREIMBURSABLE COST CENTERS</b>						
192	PHYSICIANS' PRIVATE OFFICES			340,449		340,449	192
194	NRCC MARKETING			29,147		29,147	194
194.01	NRCC GUEST MEALS			57,869		57,869	194.01
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (sum of lines 118-201)	361,808	934,151	20,195,409		20,195,409	202



## COMPU-MAX

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:01 Version: 2014.03
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## ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS- TRATIVE & GENERAL	
		0	1	2	2A	4	5	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT		4,078	1,212	5,290	5,290		4
5	ADMINISTRATIVE & GENERAL		122,051	36,283	158,334	831	159,165	5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT		24,673	7,335	32,008	111	8,188	7
8	LAUNDRY & LINEN SERVICE		13,821	4,109	17,930	12	632	8
9	HOUSEKEEPING		10,050	2,988	13,038	119	3,783	9
10	DIETARY		88,215	26,224	114,439	138	8,399	10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		10,442	3,104	13,546	163	4,495	13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY		9,385	2,790	12,175	60	2,727	16
17	SOCIAL SERVICE		10,238	3,043	13,281	264	7,160	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
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS		518,112	154,023	672,135	1,757	54,465	30
	<b>ANCILLARY SERVICE COST CENTERS</b>							
54	RADIOLOGY-DIAGNOSTIC		10,988	3,267	14,255		5,262	54
60	LABORATORY		921	274	1,195		1,544	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		2,628	781	3,409	129	3,519	65
66	PHYSICAL THERAPY		155,511	46,230	201,741	575	17,464	66
67	OCCUPATIONAL THERAPY		80,878	24,043	104,921	555	15,662	67
68	SPEECH PATHOLOGY		42,384	12,600	54,984	311	8,723	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		21,329	6,340	27,669	28	3,322	71
73	DRUGS CHARGED TO PATIENTS		6,825	2,029	8,854	207	11,251	73
76	PSYCHOLOGY		717	213	930	22	588	76
76.01	SPECIAL PROCEDURES						277	76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
	<b>SPECIAL PURPOSE COST CENTERS</b>							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)		1,133,246	336,888	1,470,134	5,282	157,461	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
192	PHYSICIANS' PRIVATE OFFICES		108,213	32,169	140,382		1,479	192
194	NRCC MARKETING		171	51	222	8	225	194
194.01	NRCC GUEST MEALS							194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)		1,241,630	369,108	1,610,738	5,290	159,165	202



COMPU-MAX

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## ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
PART II

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT COSTS 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING EQUIPMENT 9	DIETARY SUBTOTAL 10	CAFETERIA BENEFITS DEPARTMENT 11	NURSING ADMINIS- TRATION 13	
	<b>GENERAL SERVICE COST CENTERS</b>							
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	40,307						7
8	LAUNDRY & LINEN SERVICE	511	19,085					8
9	HOUSEKEEPING	371		17,311				9
10	DIETARY	3,260		1,431	127,667			10
11	CAFETERIA				18,697	18,697		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	386		169		747	19,506	13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY	347		152		276		16
17	SOCIAL SERVICE	378		166		1,208		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
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS	19,145	19,085	8,406	102,762	8,048	19,506	30
	<b>ANCILLARY SERVICE COST CENTERS</b>							
54	RADIOLOGY-DIAGNOSTIC	406		178				54
60	LABORATORY	34		15				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	97		43		593		65
66	PHYSICAL THERAPY	5,746		2,523		2,637		66
67	OCCUPATIONAL THERAPY	2,989		1,312		2,545		67
68	SPEECH PATHOLOGY	1,566		688		1,424		68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	788		346		129		71
73	DRUGS CHARGED TO PATIENTS	252		111		949		73
76	PSYCHOLOGY	26		12		102		76
76.01	SPECIAL PROCEDURES							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
	<b>SPECIAL PURPOSE COST CENTERS</b>							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	36,302	19,085	15,552	121,459	18,658	19,506	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
192	PHYSICIANS' PRIVATE OFFICES	3,999		1,756		2		192
194	NRCC MARKETING	6		3		37		194
194.01	NRCC GUEST MEALS				6,208			194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	40,307	19,085	17,311	127,667	18,697	19,506	202



## COMPU-MAX

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:01 Version: 2014.03
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## ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
PART II

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		16	17	24	25	26	
	<b>GENERAL SERVICE COST CENTERS</b>						
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	15,737					16
17	SOCIAL SERVICE		22,457				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
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>						
30	ADULTS & PEDIATRICS	5,042	22,457	932,808		932,808	30
	<b>ANCLLARY SERVICE COST CENTERS</b>						
54	RADIOLOGY-DIAGNOSTIC	321		20,422		20,422	54
60	LABORATORY	349		3,137		3,137	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	1,742		9,532		9,532	65
66	PHYSICAL THERAPY	2,738		233,424		233,424	66
67	OCCUPATIONAL THERAPY	2,694		130,678		130,678	67
68	SPEECH PATHOLOGY	1,354		69,050		69,050	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	321		32,603		32,603	71
73	DRUGS CHARGED TO PATIENTS	1,029		22,653		22,653	73
76	PSYCHOLOGY	112		1,792		1,792	76
76.01	SPECIAL PROCEDURES	35		312		312	76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
	<b>SPECIAL PURPOSE COST CENTERS</b>						
113	INTEREST EXPENSE						113
118	SUBTOTALS (sum of lines 1-117)	15,737	22,457	1,456,411		1,456,411	118
	<b>NONREIMBURSABLE COST CENTERS</b>						
192	PHYSICIANS' PRIVATE OFFICES			147,618		147,618	192
194	NRCC MARKETING			501		501	194
194.01	NRCC GUEST MEALS			6,208		6,208	194.01
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (sum of lines 118-201)	15,737	22,457	1,610,738		1,610,738	202



## COMPU-MAX

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:01 Version: 2014.03
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## COST ALLOCATION - STATISTICAL BASIS

## WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECONCILIATION	ADMINISTRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	CAP REL COSTS-BLDG & FIXT	72,768						1
2	CAP REL COSTS-MVBLE EQUIP		72,768					2
4	EMPLOYEE BENEFITS DEPARTMENT	239	239	10,934,150				4
5	ADMINISTRATIVE & GENERAL	7,153	7,153	1,717,483	-4,918,318	15,277,091		5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	1,446	1,446	229,985		785,909	63,930	7
8	LAUNDRY & LINEN SERVICE	810	810	25,713		60,660	810	8
9	HOUSEKEEPING	589	589	246,127		363,115	589	9
10	DIETARY	5,170	5,170	284,349		806,133	5,170	10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	612	612	336,938		431,418	612	13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY	550	550	124,311		261,732	550	16
17	SOCIAL SERVICE	600	600	544,744		687,202	600	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
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS	30,365	30,365	3,629,308		5,228,077	30,365	30
	<b>ANCILLARY SERVICE COST CENTERS</b>							
54	RADIOLOGY-DIAGNOSTIC	644	644			504,993	644	54
60	LABORATORY	54	54			148,207	54	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	154	154	267,228		337,710	154	65
66	PHYSICAL THERAPY	9,114	9,114	1,188,984		1,676,201	9,114	66
67	OCCUPATIONAL THERAPY	4,740	4,740	1,147,293		1,503,182	4,740	67
68	SPEECH PATHOLOGY	2,484	2,484	641,992		837,255	2,484	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,250	1,250	58,233		318,819	1,250	71
73	DRUGS CHARGED TO PATIENTS	400	400	427,835		1,079,834	400	73
76	PSYCHOLOGY	42	42	45,909		56,480	42	76
76.01	SPECIAL PROCEDURES					26,564		76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	66,416	66,416	10,916,432	-4,918,318	15,113,491	57,578	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
192	PHYSICIANS' PRIVATE OFFICES	6,342	6,342	815		141,998	6,342	192
194	NRCC MARKETING	10	10	16,903		21,602	10	194
194.01	NRCC GUEST MEALS							194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	1,241,630	369,108	2,293,515		4,918,318	1,038,925	202
203	UNIT COST MULT-WS B PT I	17,062,857	5,072,394	0,209,757		0,321,941	16,250,978	203
204	COST TO BE ALLOC PER B PT II			5,290		159,165	40,307	204
205	UNIT COST MULT-WS B PT II			0,000,484		0,010,419	0,630,486	205



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE PATIENT DAYS	HOUSE-KEEPING EQUIPMENT SQUARE FEET	DIETARY BENEFITS DEPARTMENT MEALS SERVED	CAFETERIA RECON-CILIATION GROSS SALARIES	NURSING ADMINIS-TRATION PATIENT DAYS	MEDICAL RECORDS & LIBRARY GROSS REVENUE	
		8	9	10	11	13	16	
	<b>GENERAL SERVICE COST CENTERS</b>							
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	24,534						8
9	HOUSEKEEPING		62,531					9
10	DIETARY		5,170	91,439				10
11	CAFETERIA			13,391	8,430,493			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		612		336,938	24,534		13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY		550		124,311		61,948,411	16
17	SOCIAL SERVICE		600		544,744			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
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS	24,534	30,365	73,602	3,629,308	24,534	19,845,345	30
	<b>ANCILLARY SERVICE COST CENTERS</b>							
54	RADIOLOGY-DIAGNOSTIC		644				1,263,189	54
60	LABORATORY		54				1,375,113	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		154		267,228		6,858,824	65
66	PHYSICAL THERAPY		9,114		1,188,984		10,779,263	66
67	OCCUPATIONAL THERAPY		4,740		1,147,293		10,605,890	67
68	SPEECH PATHOLOGY		2,484		641,992		5,330,578	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		1,250		58,233		1,262,204	71
73	DRUGS CHARGED TO PATIENTS		400		427,835		4,050,428	73
76	PSYCHOLOGY		42		45,909		439,454	76
76.01	SPECIAL PROCEDURES						138,123	76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	24,534	56,179	86,993	8,412,775	24,534	61,948,411	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
192	PHYSICIANS' PRIVATE OFFICES		6,342		815			192
194	NRCC MARKETING		10		16,903			194
194.01	NRCC GUEST MEALS			4,446				194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	93,352	489,589	1,190,157	174,295	592,013	361,808	202
203	UNIT COST MULT-WS B PT I	3.805005	7.829541	13.015858	0.020674	24.130309	0.005840	203
204	COST TO BE ALLOC PER B PT II	19,085	17,311	127,667	18,697	19,506	15,737	204
205	UNIT COST MULT-WS B PT II	0.777900	0.276839	1.396199	0.002218	0.795060	0.000254	205



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	SOCIAL SERVICE SERVICE PATIENT DAYS						
		17						

	<b>GENERAL SERVICE COST CENTERS</b>							
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	24,534						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
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS	24,534						30
	<b>ANCILLARY SERVICE COST CENTERS</b>							
54	RADIOLOGY-DIAGNOSTIC							54
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	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	24,534						118
	<b>NONREIMBURSABLE COST CENTERS</b>							
192	PHYSICIANS' PRIVATE OFFICES							192
194	NRCC MARKETING							194
194.01	NRCC GUEST MEALS							194.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	934,151						202
203	UNIT COST MULT-WS B PT I	38,075,772						203
204	COST TO BE ALLOC PER B PT II	22,457						204
205	UNIT COST MULT-WS B PT II	0,915,342						205



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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		
		PART	LINE NO.	AMOUNT
	1	2	3	4



## COMPU-MAX

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:01 Version: 2014.03
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## COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
PART I

	COST CENTER DESCRIPTIONS	COSTS					
		TOTAL COST (from Wkst. B, Part I, col. 26)	THERAPY LIMIT ADJ.	TOTAL COSTS	RCE DISALLOW- ANCE	TOTAL COSTS	
		1	2	3	4	5	
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>						
30	ADULTS & PEDIATRICS	10,410,876		10,410,876	4,769	10,415,645	30
	<b>ANCILLARY SERVICE COST CENTERS</b>						
54	RADIOLOGY-DIAGNOSTIC	690,456		690,456		690,456	54
60	LABORATORY	205,253		205,253		205,253	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	495,723		495,723		495,723	65
66	PHYSICAL THERAPY	2,522,840		2,522,840		2,522,840	66
67	OCCUPATIONAL THERAPY	2,186,917		2,186,917		2,186,917	67
68	SPEECH PATHOLOGY	1,211,022		1,211,022		1,211,022	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	460,136		460,136		460,136	71
73	DRUGS CHARGED TO PATIENTS	1,469,608		1,469,608		1,469,608	73
76	PSYCHOLOGY	79,190		79,190		79,190	76
76.01	SPECIAL PROCEDURES	35,923		35,923		35,923	76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
113	INTEREST EXPENSE						113
200	SUBTOTAL (SEE INSTRUCTIONS)	19,767,944		19,767,944	4,769	19,772,713	200
201	LESS OBSERVATION BEDS						201
202	TOTAL (SEE INSTRUCTIONS)	19,767,944		19,767,944		19,772,713	202



COMPU-MAX

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:01 Version: 2014.03
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## COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
PART I

	COST CENTER DESCRIPTIONS	CHARGES			COST OR OTHER RATIO	TEFRA INPATIENT RATIO	PPS INPATIENT RATIO	
		INPATIENT	OUTPATIENT	TOTAL (column 6 + column 7)				
		6	7	8	9	10	11	
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS	19,845,345		19,845,345				30
	<b>ANCILLARY SERVICE COST CENTERS</b>							
54	RADIOLOGY-DIAGNOSTIC	1,261,754	1,435	1,263,189	0.546598	0.546598	0.546598	54
60	LABORATORY	1,375,068	45	1,375,113	0.149263	0.149263	0.149263	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	6,858,824		6,858,824	0.072275	0.072275	0.072275	65
66	PHYSICAL THERAPY	9,354,031	1,425,232	10,779,263	0.234046	0.234046	0.234046	66
67	OCCUPATIONAL THERAPY	9,724,548	881,342	10,605,890	0.206198	0.206198	0.206198	67
68	SPEECH PATHOLOGY	4,424,134	906,444	5,330,578	0.227184	0.227184	0.227184	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,251,648	10,556	1,262,204	0.364550	0.364550	0.364550	71
73	DRUGS CHARGED TO PATIENTS	4,050,428		4,050,428	0.362828	0.362828	0.362828	73
76	PSYCHOLOGY	438,230	1,224	439,454	0.180201	0.180201	0.180201	76
76.01	SPECIAL PROCEDURES	138,123		138,123	0.260080	0.260080	0.260080	76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
113	INTEREST EXPENSE							113
200	SUBTOTAL (SEE INSTRUCTIONS)	58,722,133	3,226,278	61,948,411				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	58,722,133	3,226,278	61,948,411				202



COMPU-MAX

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:01 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D  
PART I

CHECK  TITLE V  PPS  
 APPLICABLE  TITLE XVIII, PART A  TEFRA  
 BOXES:  TITLE XIX

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26))	SWING BED ADJUSTMENT	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)	
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>	1	2	3	4	5	6	7	
30	ADULTS & PEDIATRICS (General Routine Care)	932,808		932,808	24,534	38.02	19,365	736,257	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)	932,808		932,808	24,534		19,365	736,257	200

(A) Worksheet A line numbers



COMPU-MAX

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:01 Version: 2014.03
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-3025

WORKSHEET D  
PART II

CHECK [ ] TITLE V [XX] HOSPITAL [ ] SUB (OTHER) [XX] PPS  
 APPLICABLE [XX] TITLE XVIII, PART A [ ] IPF [ ] TEFRA  
 BOXES: [ ] TITLE XIX [ ] IRF

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26))	TOTAL CHARGES (from Wkst. C, Part I, (col. 8))	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
		1	2	3	4	5	
	<b>ANCILLARY SERVICE COST CENTERS</b>						
54	RADIOLOGY-DIAGNOSTIC	20,422	1,263,189	0.016167	1,120,912	18,122	54
60	LABORATORY	3,137	1,375,113	0.002281	1,113,643	2,540	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	9,532	6,858,824	0.001390	5,868,297	8,157	65
66	PHYSICAL THERAPY	233,424	10,779,263	0.021655	7,266,378	157,353	66
67	OCCUPATIONAL THERAPY	130,678	10,605,890	0.012321	7,615,633	93,832	67
68	SPEECH PATHOLOGY	69,050	5,330,578	0.012954	3,434,847	44,495	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	32,603	1,262,204	0.025830	819,942	21,179	71
73	DRUGS CHARGED TO PATIENTS	22,653	4,050,428	0.005593	3,307,745	18,500	73
76	PSYCHOLOGY	1,792	439,454	0.004078	323,890	1,321	76
76.01	SPECIAL PROCEDURES	312	138,123	0.002259	110,008	249	76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
200	TOTAL (sum of lines 50-199)	523,603	42,103,066		30,981,295	365,748	200

(A) Worksheet A line numbers



COMPU-MAX

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:01 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
PART III

CHECK  TITLE V  PPS  
 APPLICABLE  TITLE XVIII, PART A  TEFRA  
 BOXES:  TITLE XIX

(A)	COST CENTER DESCRIPTION	NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUSTMENT AMOUNT (see instructions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)	
	INPATIENT ROUTINE SERV COST CENTERS	1	2	3	4	5	
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



COMPU-MAX

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:01 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
PART III

CHECK  TITLE V  PPS  
 APPLICABLE  TITLE XVIII, PART A  TEFRA  
 BOXES:  TITLE XIX

	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS	PER DIEM (col. 5 ÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>					
30	ADULTS & PEDIATRICS (General Routine Care)	24,534		19,365		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)	24,534		19,365		200

(A) Worksheet A line numbers



COMPU-MAX

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:01 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-3025

WORKSHEET D  
PART IV

CHECK  TITLE V  HOSPITAL  SUB (OTHER)  ICF/MR  PPS  
 APPLICABLE  TITLE XVIII, PART A  IPF  SNF  TEFRA  
 BOXES:  TITLE XIX  IRF  NF

(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
		NON PHYSICIAN ANESTH- ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT- IENT COST (sum of col. 2, 3, and 4)	
	<b>ANCILLARY SERVICE COST CENTERS</b>							
54	RADIOLOGY-DIAGNOSTIC							54
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	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers



COMPU-MAX

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:01 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-3025

WORKSHEET D  
PART IV

CHECK [ ] TITLE V [XX] HOSPITAL [ ] SUB (OTHER) [ ] ICF/MR [XX] PPS  
 APPLICABLE [XX] TITLE XVIII, PART A [ ] IPF [ ] SNF [ ] TEFRA  
 BOXES: [ ] TITLE XIX [ ] IRF [ ] NF

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)
	<b>ANCILLARY SERVICE COST CENTERS</b>							
54	RADIOLOGY-DIAGNOSTIC	1,263,189			1,120,912		905	54
60	LABORATORY	1,375,113			1,113,643			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	6,858,824			5,868,297			65
66	PHYSICAL THERAPY	10,779,263			7,266,378			66
67	OCCUPATIONAL THERAPY	10,605,890			7,615,633			67
68	SPEECH PATHOLOGY	5,330,578			3,434,847			68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,262,204			819,942		85	71
73	DRUGS CHARGED TO PATIENTS	4,050,428			3,307,745			73
76	PSYCHOLOGY	439,454			323,890		476	76
76.01	SPECIAL PROCEDURES	138,123			110,008			76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
200	TOTAL (sum of lines 50-199)	42,103,066			30,981,295		1,466	200

(A) Worksheet A line numbers



COMPU-MAX

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:01 Version: 2014.03
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-3025

WORKSHEET D  
PART V

CHECK  TITLE V - O/P  HOSPITAL  SUB (OTHER)  SWING BED SNF  
 APPLICABLE  TITLE XVIII, PART B  IPF  SNF  SWING BED NF  
 BOXES:  TITLE XIX - O/P  IRF  NF  ICF/MR

(A)	COST CENTER DESCRIPTION	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.)
		1	2	3	4	5	6	7
	<b>ANCILLARY SERVICE COST CENTERS</b>							
54	RADIOLOGY-DIAGNOSTIC	0.546598	905			495		54
60	LABORATORY	0.149263						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	0.072275						65
66	PHYSICAL THERAPY	0.234046						66
67	OCCUPATIONAL THERAPY	0.206198						67
68	SPEECH PATHOLOGY	0.227184						68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.364550	85			31		71
73	DRUGS CHARGED TO PATIENTS	0.362828						73
76	PSYCHOLOGY	0.180201	476			86		76
76.01	SPECIAL PROCEDURES	0.260080						76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
200	SUBTOTAL (see instructions)		1,466			612		200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES							201
202	NET CHARGES (line 200 - line 201)		1,466			612		202

(A) Worksheet A line numbers



COMPU-MAX

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:01 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D  
PART I

CHECK  TITLE V  
 APPLICABLE  TITLE XVIII, PART A  
 BOXES:  TITLE XIX

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26))	SWING BED ADJUSTMENT	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)	
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>	1	2	3	4	5	6	7	
30	ADULTS & PEDIATRICS (General Routine Care)	932,808		932,808	24,534	38.02	639	24,295	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)	932,808		932,808	24,534		639	24,295	200

(A) Worksheet A line numbers



COMPU-MAX

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:01 Version: 2014.03
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-3025

WORKSHEET D  
PART II

CHECK  TITLE V  HOSPITAL  SUB (OTHER)  
 APPLICABLE  TITLE XVIII, PART A  IPF  
 BOXES:  TITLE XIX  IRF

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26))	TOTAL CHARGES (from Wkst. C, Part I, (col. 8))	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
		1	2	3	4	5	
	<b>ANCILLARY SERVICE COST CENTERS</b>						
54	RADIOLOGY-DIAGNOSTIC	20,422	1,263,189	0.016167	35,981	582	54
60	LABORATORY	3,137	1,375,113	0.002281	32,108	73	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	9,532	6,858,824	0.001390	178,830	249	65
66	PHYSICAL THERAPY	233,424	10,779,263	0.021655	252,293	5,463	66
67	OCCUPATIONAL THERAPY	130,678	10,605,890	0.012321	257,180	3,169	67
68	SPEECH PATHOLOGY	69,050	5,330,578	0.012954	122,126	1,582	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	32,603	1,262,204	0.025830	28,532	737	71
73	DRUGS CHARGED TO PATIENTS	22,653	4,050,428	0.005593	108,291	606	73
76	PSYCHOLOGY	1,792	439,454	0.004078	14,960	61	76
76.01	SPECIAL PROCEDURES	312	138,123	0.002259	826	2	76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
200	TOTAL (sum of lines 50-199)	523,603	42,103,066		1,031,127	12,524	200

(A) Worksheet A line numbers



HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:01 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D  
PART III**

CHECK  TITLE V  
 APPLICABLE  TITLE XVIII, PART A  
 BOXES:  TITLE XIX

		NURSING SCHOOL	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	1	2	3	4	5	
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>						
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



HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:01 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D  
PART III**

CHECK  TITLE V  
 APPLICABLE  TITLE XVIII, PART A  
 BOXES:  TITLE XIX

	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS	PER DIEM (col. 5 ÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>					
30	ADULTS & PEDIATRICS (General Routine Care)	24,534		639		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)	24,534		639		200

(A) Worksheet A line numbers



COMPU-MAX

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:01 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-3025

WORKSHEET D  
PART IV

CHECK  TITLE V  HOSPITAL  SUB (OTHER)  ICF/MR  
 APPLICABLE  TITLE XVIII, PART A  IPF  SNF  
 BOXES:  TITLE XIX  IRF  NF

(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
		NON PHYSICIAN ANESTH- ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT- IENT COST (sum of col. 2, 3, and 4)	
	<b>ANCILLARY SERVICE COST CENTERS</b>							
54	RADIOLOGY-DIAGNOSTIC							54
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	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers



COMPU-MAX

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:01 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-3025

WORKSHEET D  
PART IV

CHECK  TITLE V  HOSPITAL  SUB (OTHER)  ICF/MR  
 APPLICABLE  TITLE XVIII, PART A  IPF  SNF  
 BOXES:  TITLE XIX  IRF  NF

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)	
	<b>ANCILLARY SERVICE COST CENTERS</b>								
54	RADIOLOGY-DIAGNOSTIC	1,263,189			35,981				54
60	LABORATORY	1,375,113			32,108				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	6,858,824			178,830				65
66	PHYSICAL THERAPY	10,779,263			252,293				66
67	OCCUPATIONAL THERAPY	10,605,890			257,180				67
68	SPEECH PATHOLOGY	5,330,578			122,126				68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,262,204			28,532				71
73	DRUGS CHARGED TO PATIENTS	4,050,428			108,291				73
76	PSYCHOLOGY	439,454			14,960				76
76.01	SPECIAL PROCEDURES	138,123			826				76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
92	OBSERVATION BEDS (NON-DISTINCT PART)								92
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	TOTAL (sum of lines 50-199)	42,103,066			1,031,127				200

(A) Worksheet A line numbers



COMPU-MAX

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:01 Version: 2014.03
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-3025

WORKSHEET D  
PART V

CHECK  TITLE V - O/P  HOSPITAL  SUB (OTHER)  SWING BED SNF  
 APPLICABLE  TITLE XVIII, PART B  IPF  SNF  SWING BED NF  
 BOXES:  TITLE XIX - O/P  IRF  NF  ICF/MR

(A)	COST CENTER DESCRIPTION	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.)
		1	2	3	4	5	6	7
	<b>ANCILLARY SERVICE COST CENTERS</b>							
54	RADIOLOGY-DIAGNOSTIC	0.546598						54
60	LABORATORY	0.149263						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	0.072275						65
66	PHYSICAL THERAPY	0.234046		65,246			15,271	66
67	OCCUPATIONAL THERAPY	0.206198		36,234			7,471	67
68	SPEECH PATHOLOGY	0.227184		16,422			3,731	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.364550		1,941			708	71
73	DRUGS CHARGED TO PATIENTS	0.362828						73
76	PSYCHOLOGY	0.180201						76
76.01	SPECIAL PROCEDURES	0.260080						76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
200	SUBTOTAL (see instructions)			119,843			27,181	200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES							201
202	NET CHARGES (line 200 - line 201)			119,843			27,181	202

(A) Worksheet A line numbers



COMPU-MAX

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:01 Version: 2014.03
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-3025

WORKSHEET D-1  
PART I

CHECK [ ] TITLE V - I/P [XX] HOSPITAL [ ] SUB (OTHER) [ ] ICF/MR [XX] PPS  
 APPLICABLE [XX] TITLE XVIII, PART A [ ] IPF [ ] SNF [ ] TEFRA  
 BOXES: [ ] TITLE XIX - I/P [ ] IRF [ ] NF [ ] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	24,534	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	24,534	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.	1,749	3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	22,785	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	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	19,365	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)	1,410	14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title 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)	10,415,645	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	10,415,645	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)	19,845,345	28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)	1,448,172	29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)	18,397,173	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)	0.524841	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)	828.00	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)	807.42	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)	20.58	34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)	10.80	35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)	18,889	36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	10,396,756	37



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-3025

WORKSHEET D-1  
PART II

CHECK [ ] TITLE V - I/P [XX] HOSPITAL [ ] SUB (OTHER) [XX] PPS  
 APPLICABLE [XX] TITLE XVIII, PART A [ ] IPF [ ] TEFRA  
 BOXES: [ ] TITLE XIX - I/P [ ] IRF [ ] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

1

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					424.54	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					8,221,217	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)					8,221,217	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
	<b>INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS</b>						
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 (Worksheet D-3, column 3, line 200)					6,840,411	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					15,061,628	49
	<b>PASS-THROUGH COST ADJUSTMENTS</b>						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)					736,257	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)					365,748	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)					1,102,005	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)					13,959,623	53
	<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>						
54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT (line 54 x line 55)						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)						57
58	BONUS PAYMENT (see instructions)						58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET						59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET						60
61	IF LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)						61
62	RELIEF PAYMENT (see instructions)						62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)						63
	<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>						
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



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-3025

WORKSHEET D-1  
PARTS III & IV

CHECK  TITLE V - I/P  HOSPITAL  SUB (OTHER)  ICF/MR  PPS  
 APPLICABLE  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)						424.54	88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)							89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 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 COST							91
92	ALLIED HEALTH COST							92
93	ALL OTHER MEDICAL EDUCATION							93



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HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:01 Version: 2014.03
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-3025

WORKSHEET D-1  
PART I

CHECK  TITLE V - I/P  HOSPITAL  SUB (OTHER)  ICF/MR  PPS  
 APPLICABLE  TITLE XVIII, PART A  IPF  SNF  TEFRA  
 BOXES:  TITLE XIX - I/P  IRF  NF  OTHER

PART I - ALL PROVIDER COMPONENTS

**INPATIENT DAYS**

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	24,534	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	24,534	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.	1,749	3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	22,785	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	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	639	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 Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title 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)	10,410,876	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	10,410,876	27

**PRIVATE ROOM DIFFERENTIAL ADJUSTMENT**

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)	19,845,345	28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)	1,448,172	29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)	18,397,173	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)	0.524600	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)	828.00	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)	807.42	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)	20.58	34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)	10.80	35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)	18,889	36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	10,391,987	37



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-3025

WORKSHEET D-1  
PART II

CHECK  TITLE V - I/P  HOSPITAL  SUB (OTHER)  PPS  
 APPLICABLE  TITLE XVIII, PART A  IPF  TEFRA  
 BOXES:  TITLE XIX - I/P  IRF  OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

1

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					423.57	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					270,661	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)					270,661	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
	<b>INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS</b>						
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 (Worksheet D-3, column 3, line 200)					229,811	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					500,472	49
	<b>PASS-THROUGH COST ADJUSTMENTS</b>						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)					24,295	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)					12,524	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)					36,819	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)						53
	<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>						
54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT (line 54 x line 55)						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)						57
58	BONUS PAYMENT (see instructions)						58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET						59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET						60
61	IF LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)						61
62	RELIEF PAYMENT (see instructions)						62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)						63
	<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>						
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



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-3025

WORKSHEET D-1  
PARTS III & IV

CHECK  TITLE V - I/P  HOSPITAL  SUB (OTHER)  ICF/MR  PPS  
 APPLICABLE  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)						88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)						89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 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 COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93



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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-3025

WORKSHEET D-3

CHECK  TITLE V - O/P  HOSPITAL  SUB (OTHER)  SWING BED SNF  PPS  
 APPLICABLE  TITLE XVIII, PART B  IPF  SNF  SWING BED NF  TEFRA  
 BOXES:  TITLE XIX - O/P  IRF  NF  ICF/MR  OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30	ADULTS & PEDIATRICS		15,650,055		30
43	NURSERY				43
	<b>ANCILLARY SERVICE COST CENTERS</b>				
54	RADIOLOGY-DIAGNOSTIC	0.546598	1,120,912	612,688	54
60	LABORATORY	0.149263	1,113,643	166,226	60
62.30	BLOOD CLOTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.072275	5,868,297	424,131	65
66	PHYSICAL THERAPY	0.234046	7,266,378	1,700,667	66
67	OCCUPATIONAL THERAPY	0.206198	7,615,633	1,570,328	67
68	SPEECH PATHOLOGY	0.227184	3,434,847	780,342	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.364550	819,942	298,910	71
73	DRUGS CHARGED TO PATIENTS	0.362828	3,307,745	1,200,143	73
76	PSYCHOLOGY	0.180201	323,890	58,365	76
76.01	SPECIAL PROCEDURES	0.260080	110,008	28,611	76.01
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>				
92	OBSERVATION BEDS (NON-DISTINCT PART)				92
	<b>OTHER REIMBURSABLE COST CENTERS</b>				
200	TOTAL (sum of lines 50-94, and 96-98)		30,981,295	6,840,411	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		30,981,295		202

(A) Worksheet A line numbers



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HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:01 Version: 2014.03
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-3025

WORKSHEET D-3

CHECK  TITLE V - O/P  HOSPITAL  SUB (OTHER)  SWING BED SNF  PPS  
 APPLICABLE  TITLE XVIII, PART B  IPF  SNF  SWING BED NF  TEFRA  
 BOXES:  TITLE XIX - O/P  IRF  NF  ICF/MR  OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30	ADULTS & PEDIATRICS		517,068		30
	<b>ANCILLARY SERVICE COST CENTERS</b>				
54	RADIOLOGY-DIAGNOSTIC	0.546598	35,981	19,667	54
60	LABORATORY	0.149263	32,108	4,793	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.072275	178,830	12,925	65
66	PHYSICAL THERAPY	0.234046	252,293	59,048	66
67	OCCUPATIONAL THERAPY	0.206198	257,180	53,030	67
68	SPEECH PATHOLOGY	0.227184	122,126	27,745	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.364550	28,532	10,401	71
73	DRUGS CHARGED TO PATIENTS	0.362828	108,291	39,291	73
76	PSYCHOLOGY	0.180201	14,960	2,696	76
76.01	SPECIAL PROCEDURES	0.260080	826	215	76.01
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>				
92	OBSERVATION BEDS (NON-DISTINCT PART)				92
	<b>OTHER REIMBURSABLE COST CENTERS</b>				
200	TOTAL (sum of lines 50-94, and 96-98)		1,031,127	229,811	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		1,031,127		202

(A) Worksheet A line numbers



COMPU-MAX

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:01 Version: 2014.03
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-3025

WORKSHEET E  
PART B

CHECK APPLICABLE BOX:  HOSPITAL     IPF     IRF     SUB (OTHER)     SNF

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)	612			2
3	PPS PAYMENTS	590			3
4	OUTLIER PAYMENT (see instructions)				4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)				5
6	LINE 2 TIMES LINE 5				6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6				7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200				9
10	ORGAN ACQUISITION				10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)				11
	<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES				12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)				13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)				16
17	RATIO OF LINE 15 TO LINE 16 (not to exceed 1.000000)	1.000000			17
18	TOTAL CUSTOMARY CHARGES (see instructions)				18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions))				19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 11 exceeds line 18 (see instructions))				20
21	LESSER OF COST OR CHARGES (line 11 minus line 20) (for CAH, see instructions)				21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)	590			24
	<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25	DEDUCTIBLES AND COINSURANCE (see instructions)				25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)	296			26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	294			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)	294			30
31	PRIMARY PAYER PAYMENTS				31
32	SUBTOTAL (line 30 minus line 31)	294			32
	<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
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)	294			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)	294			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	4			40.01
41	INTERIM PAYMENTS	290			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)				43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2				44

TO BE COMPLETED BY CONTRACTOR

90	ORIGINAL OUTLIER AMOUNT (see instructions)				90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)				91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY				92
93	TIME VALUE OF MONEY (see instructions)				93
94	TOTAL (sum of lines 91 and 93)				94



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HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:01 Version: 2014.03
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 15-3025

WORKSHEET E-1  
PART I

CHECK  HOSPITAL  SUB (OTHER)  
 APPLICABLE  IPF  SNF  
 BOXES:  IRF  SWING BED SNF

	DESCRIPTION	INPATIENT PART A		PART B	
		mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT
		1	2	3	4
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER		23,358,368		290
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO				
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		3.51
		PROVIDER	.52		3.52
		TO	.53		3.53
		PROGRAM	.54		3.54
			.55		3.55
			.56		3.56
			.57		3.57
			.58		3.58
			.59		3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99			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)		23,358,368		290
<b>TO BE COMPLETED BY CONTRACTOR</b>					
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)	

(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.



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HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:01 Version: 2014.03
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## CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-3025

WORKSHEET E-3  
PART III

CHECK [XX] HOSPITAL  
 APPLICABLE [ ] SUBPROVIDER IRF  
 BOX:

## PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

		1	1.01	
1	NET FEDERAL PPS PAYMENT (see instructions)	17,655,508	5,899,917	1
2	MEDICARE SSI RATIO (see instructions)	0.052400		2
3	INPATIENT REHABILITATION LIP PAYMENTS (see instructions)	835,106	190,567	3
4	OUTLIER PAYMENTS	2,926		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 §412.424(d)(1)(iii)(F)(1) OR (2) (SEE INSTRUCTIONS)			5.01
6	NEW TEACHING PROGRAM ADJUSTMENT (see instructions)			6
7	CURRENT YEAR UNWEIGHTED FTE COUNT OF I&R EXCLUDING 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)	67.216438		10
11	TEACHING ADJUSTMENT FACTOR (see instructions)			11
12	TEACHING ADJUSTMENT (see instructions)			12
13	TOTAL PPS PAYMENT (see instructions)	24,584,024		13
14	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENTS (see instructions)			14
15	ORGAN ACQUISITION			15
16	COST OF TEACHING PHYSICIANS (from Worksheet D-5, Part II, col. 3, line 20) (see instructions)			16
17	SUBTOTAL (see instructions)	24,584,024		17
18	PRIMARY PAYER PAYMENTS			18
19	SUBTOTAL (line 17 less line 18)	24,584,024		19
20	DEDUCTIBLES	554,932		20
21	SUBTOTAL (line 19 minus line 20)	24,029,092		21
22	COINSURANCE	338,999		22
23	SUBTOTAL (line 21 minus line 22)	23,690,093		23
24	ALLOWABLE BAD DEBTS (exclude bad debts for professional services) (see instructions)	248,634		24
25	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	161,612		25
26	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	184,346		26
27	SUBTOTAL (sum of lines 23 and 25)	23,851,705		27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4, line 49) (for freestanding IRF only)			28
29	OTHER PASS THROUGH COSTS (see instructions)			29
30	OUTLIER PAYMENTS RECONCILIATION			30
31	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			31
32	TOTAL AMOUNT PAYABLE TO THE PROVIDER (see instructions)	23,851,705		32
32.01	SEQUESTRATION ADJUSTMENT (see instructions)	360,161		32.01
33	INTERIM PAYMENTS	23,358,368		33
34	TENTATIVE SETTLEMENT (for contractor use only)			34
35	BALANCE DUE PROVIDER/PROGRAM (line 32 minus lines 32.01, 33 and 34)	133,176		35
36	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	14,403		36

## TO BE COMPLETED BY CONTRACTOR

50	ORIGINAL OUTLIER AMOUNT FROM WORKSHEET E-3, PART 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



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HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:01 Version: 2014.03
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-3025

WORKSHEET E-3  
PART VII

CHECK  TITLE V  HOSPITAL  NF  PPS  
 APPLICABLE  TITLE XIX  SUB (OTHER)  ICF/MR  TEFRA  
 BOXES:  SNF  OTHER

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
	<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>			
1	INPATIENT HOSPITAL SNF/NF SERVICES	500,472		1
2	MEDICAL AND OTHER SERVICES		27,181	2
3	ORGAN ACQUISITION (certified transplant centers only)			3
4	SUBTOTAL (sum of lines 1, 2 and 3)	500,472	27,181	4
5	INPATIENT PRIMARY PAYER PAYMENTS			5
6	OUTPATIENT PRIMARY PAYER PAYMENTS			6
7	SUBTOTAL (line 4 less sum of lines 5 and 6)	500,472	27,181	7
	<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>			
	REASONABLE CHARGES			
8	ROUTINE SERVICE CHARGES	517,068		8
9	ANCILLARY SERVICE CHARGES	1,031,127	119,843	9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE			10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION			11
12	TOTAL REASONABLE CHARGES (sum of lines 8-11)	1,548,195	119,843	12
	<b>CUSTOMARY CHARGES</b>			
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE 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	1	15
16	TOTAL CUSTOMARY CHARGES (see instructions)	1,548,195	119,843	16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 16 exceeds line 4) (see instructions)	1,047,723	92,662	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 TEACHING PHYSICIANS (see instructions)			20
21	COST OF COVERED SERVICES (lesser of line 4 or line 16) (for CAH, see instructions)	500,472	27,181	21
	<b>PROSPECTIVE PAYMENT AMOUNT</b>			
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	SUM OF LINES 27 AND 21	500,472	27,181	29
	<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>			
30	EXCESS OF REASONABLE COST (from line 18)			30
31	SUBTOTAL (sum of lines 19 and 20 plus 29 minus lines 5 and 6)	500,472	27,181	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)	500,472	27,181	36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	SUBTOTAL (line 36 ± line 37)	500,472	27,181	38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4)			39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (sum of lines 38 and 39)	500,472	27,181	40
41	INTERIM PAYMENTS	441,497	17,668	41
42	BALANCE DUE PROVIDER/PROGRAM (line 40 minus 41)	58,975	9,513	42
43	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			43



## COMPU-MAX

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## BALANCE SHEET

## WORKSHEET G

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

ASSETS (Omit Cents)		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
<b>CURRENT ASSETS</b>						
1	CASH ON HAND AND IN BANKS	4,865,359				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	4,886,191				4
5	OTHER RECEIVABLES					5
6	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE	-1,450,528				6
7	INVENTORY	42,033				7
8	PREPAID EXPENSES	33,644				8
9	OTHER CURRENT ASSETS					9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	8,376,699				11
<b>FIXED ASSETS</b>						
12	LAND					12
13	LAND IMPROVEMENTS					13
14	ACCUMULATED DEPRECIATION					14
15	BUILDINGS					15
16	ACCUMULATED DEPRECIATION					16
17	LEASEHOLD IMPROVEMENTS	2,515,616				17
18	ACCUMULATED AMORTIZATION	-1,974,993				18
19	FIXED EQUIPMENT					19
20	ACCUMULATED DEPRECIATION					20
21	AUTOMOBILES AND TRUCKS					21
22	ACCUMULATED DEPRECIATION					22
23	MAJOR MOVABLE EQUIPMENT	2,306,551				23
24	ACCUMULATED DEPRECIATION	-1,666,025				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)	1,181,149				30
<b>OTHER ASSETS</b>						
31	INVESTMENTS					31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	12,366,498				34
35	TOTAL OTHER ASSETS (sum of lines 31-34)	12,366,498				35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	21,924,346				36
<b>LIABILITIES AND FUND BALANCES</b>						
LIABILITIES AND FUND BALANCES (Omit Cents)		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
<b>CURRENT LIABILITIES</b>						
37	ACCOUNTS PAYABLE	487,760				37
38	SALARIES, WAGES & FEES PAYABLE	681,289				38
39	PAYROLL TAXES PAYABLE					39
40	NOTES & LOANS PAYABLE (short term)					40
41	DEFERRED INCOME					41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS					43
44	OTHER CURRENT LIABILITIES	2,230,122				44
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	3,399,171				45
<b>LONG TERM LIABILITIES</b>						
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE					47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES	4,251,709				49
50	TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49)	4,251,709				50
51	TOTAL LIABILITIES (sum of lines 45 and 50)	7,650,880				51
<b>CAPITAL ACCOUNTS</b>						
52	GENERAL FUND BALANCE	14,273,466				52
53	SPECIFIC PURPOSE FUND BALANCE					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 52-58)	14,273,466				59
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)	21,924,346				60



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STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	FUND BALANCES AT BEGINNING OF PERIOD		13,416,897			1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		11,209,538			2
3	TOTAL (sum of line 1 and line 2)		24,626,435			3
4	ADDITIONS (credit adjustments)					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)		24,626,435			11
12	DEDUCTIONS (debit adjustments)					12
13	MINORITY INTEREST	2,466,098				13
14	DISTRIBUTIONS	7,886,871				14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)		10,352,969			18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)		14,273,466			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)					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)					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



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HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:01 Version: 2014.03
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## STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2  
PARTS I & II

## PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT	OUTPATIENT	TOTAL	
		1	2	3	
	<b>GENERAL INPATIENT ROUTINE CARE SERVICES</b>				
1	HOSPITAL	19,983,468		19,983,468	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)	19,983,468		19,983,468	10
	<b>INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES</b>				
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)	19,983,468		19,983,468	17
18	ANCILLARY SERVICES	38,738,666	3,226,278	41,964,944	18
19	OUTPATIENT SERVICES				19
20	RHC				20
21	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)	58,722,134	3,226,278	61,948,412	28

## PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		20,628,259	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)		20,628,259	43



## COMPU-MAX

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/19/2014 Run Time: 09:01 Version: 2014.03
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## STATEMENT OF REVENUES AND EXPENSES

## WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (from Worksheet G-2, Part I, column 3, line 28)	61,948,412	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	30,256,555	2
3	NET PATIENT REVENUES (line 1 minus line 2)	31,691,857	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	20,628,259	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	11,063,598	5

## OTHER INCOME

6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	21,448	7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS	135	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	33,985	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (fees, sale of textbooks, uniforms, etc.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES	3,246	21
22	RENTAL OF HOSPITAL SPACE	81,878	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (MISC INCOME)	5,248	24
25	TOTAL OTHER INCOME (sum of lines 6-24)	145,940	25
26	TOTAL (line 5 plus line 25)	11,209,538	26
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	11,209,538	29