

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 04/28/2015 Run Time: 09:46 Version: 2015.03 (04/22/2015)
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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 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.		Date: 04/28/2015 Time: 09:46
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ____ 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HEALTHSOUTH DEACONESS REHABILITATION (15-3025) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 01/01/2014 and ending 12/31/2014, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

ROB WISNER, SVP-REIMBURSEMENT
Title

05/05/2015
Date

PART III - SETTLEMENT SUMMARY

		TITLE XVIII					
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		105,951			126,265	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		105,951			126,265	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. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:

1	Street: 4100 COVERT AVENUE	P.O. Box:				1
2	City: EVANSVILLE	State: IN	ZIP Code: 47714	County: VANDENBURGH		2

Hospital and Hospital-Based Component Identification:

Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
						V	XVIII	XIX		
0	1	2	3	4	5	6	7	8	3	
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 / 2014	To: 12 / 31 / 2014		20
21	Type of control (see instructions)	5			21

Inpatient PPS Information

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.							24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	799	249	286	158	394		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 of periods in excess of one and enter subsequent dates.	Beginning:		Ending:				38

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

			1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(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
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)		N	N	40
		V	XVIII	XIX	
	Prospective Payment System (PPS)-Capital	1	2	3	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	N	N	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N	48

	Teaching Hospitals	1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub 15-1, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
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 baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

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

63	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64-67. (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 Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						64
Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)							
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
65							65
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						66
Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)							
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
67							67
Inpatient Psychiatric Facility PPS				1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.			N			70
71	If line 70 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 fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program, enter 6 in column 3. (see instructions)						71
Inpatient Rehabilitation Facility PPS				1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.			Y			75
76	If line 75 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 fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program, enter 6 in column 3. (see instructions)			N			76
Long Term Care Hospital PPS							
80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.				N		80
81	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no.				N		81
TEFRA Providers							
85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA? Enter 'Y' for yes or 'N' for no.				N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.						86

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XIX	
Title V and XIX Services		1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	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? (see instructions)			106
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elimination would not be on Wkst. B, Pt. I, col. 25 and the program would be cost reimbursed. If yes, complete Wkst. D-2, Pt. II.			107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108
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.	Physical	Occupational Speech Respiratory	109
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.		N	110

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, Section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	N			116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.	Y			117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	58,699	18,161		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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WORKSHEET S-2
PART I

All Providers

140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)	1 Y	2 019005	140
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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, SUITE	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 the 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		Title V	Title XIX	
		Part A	Part B			
		1	2	3	4	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N			156
157	Subprovider - IRF	N	N			157
158	Subprovider - Other					158
159	SNF	N	N			159
160	HHA	N	N			160
161	CMHC		N			161
161.10	CORF					161.10

Multicampus

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

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

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	N				167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)					168
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
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no. (see instructions)				N	171

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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

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

		Y/N	Y/N
Approved Educational Activities		1	2
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N	6
7	Are costs claimed for allied health programs? If yes, see instructions.	N	7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N	8
9	Are costs claimed for 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

		Y/N
Bad Debts		Y/N
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y
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
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N

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

		Part A		Part B	
		Y/N	Date	Y/N	Date
PS&R Report Data		1	2	3	4
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		Y	02/28/2015
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	02/28/2015	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:	N		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 Cost			
22	Have assets been relifed for Medicare purposes? If yes, see instructions.		22
23	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		23
24	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.		24
25	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25
26	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26
27	Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.		27

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

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

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

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

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

**WORKSHEET S-3
PART I**

	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Inpatient Days / Outpatient Visits / Trips			Total All Patients	
						Title V	Title XVIII	Title XIX		
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	85	31,025			18,228	698	24,747	1
2	HMO and other (see instructions)						939	1,188		2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF									5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		85	31,025			18,228	698	24,747	7
8	Intensive Care Unit	31								8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	Other Special Care (specify)	35								12
13	Nursery	43								13
14	Total (see instructions)		85	31,025			18,228	698	24,747	14
15	CAH Visits									15
16	Subprovider - IPF	40								16
17	Subprovider - IRF	41								17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44								19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101								22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116								24
24.10	Hospice (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	Total (sum of lines 14-26)		85							27
28	Observation Bed Days									28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)									32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 04/28/2015 Run Time: 09:46 Version: 2015.03 (04/22/2015)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	Component	Full Time Equivalents			DISCHARGES				
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					1,337	47	1,794	1
2	HMO and other (see instructions)					68	75		2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider								4
5	Hospital Adults & Peds. Swing Bed SNF								5
6	Hospital Adults & Peds. Swing Bed NF								6
7	Total Adults & Peds. (exclude observation beds) (see instructions)								7
8	Intensive Care Unit								8
9	Coronary Care Unit								9
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
12	Other Special Care (specify)								12
13	Nursery								13
14	Total (see instructions)		217.01			1,337	47	1,794	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency								22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	Total (sum of lines 14-26)		217.01						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 04/28/2015 Run Time: 09:46 Version: 2015.03 (04/22/2015)
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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	
SALARIES							
1	Total salaries (see instructions)	200	11,285,881		451,380.80		1
2	Non-physician anesthetist Part A						2
3	Non-physician anesthetest Part B						3
4	Physician-Part A - Administrative						4
4.01	Physician-Part A - Teaching						4.01
5	Physician-Part B						5
6	Non-physician-Part B						6
7	Interns & residents (in an approved program)	21					7
7.01	Contracted interns & residents (in an approved program)						7.01
8	Home office personnel						8
9	SNF	44					9
10	Excluded area salaries (see instructions)			8,024	249.60		10
OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)		22,408		963.75		11
12	Contract management and administrative services						12
13	Contract labor: Physician-Part A - Administrative		83,152		568.00		13
14	Home office salaries & wage-related costs		899,450		11,695.00		14
15	Home office: Physician Part A - Administrative						15
16	Home office & Contract Physicians Part A - Teaching						16
WAGE-RELATED COSTS							
17	Wage-related costs (core)(see instructions)		2,625,541				17
18	Wage-related costs (other)(see instructions)						18
19	Excluded areas		1,868				19
20	Non-physician anesthetist Part A						20
21	Non-physician anesthetist Part B						21
22	Physician Part A - Administrative						22
22.01	Physician Part A - Teaching						22.01
23	Physician Part B						23
24	Wage-related costs (RHC/FOHC)						24
25	Interns & residents (in an approved program)						25
OVERHEAD COSTS - DIRECT SALARIES							
26	Employee Benefits Department						26
27	Administrative & General		1,761,560	-8,024	54,683.20		27
28	Administrative & General under contract (see instructions)		9,384		29.10		28
29	Maintenance & Repairs						29
30	Operation of Plant		226,553		9,755.20		30
31	Laundry & Linen Service			25,476	2,019.00		31
32	Housekeeping		263,207	-25,476	19,281.60		32
33	Housekeeping under contract (see instructions)						33
34	Dietary		284,476		21,652.80		34
35	Dietary under contract (see instructions)						35
36	Cafeteria						36
37	Maintenance of Personnel						37
38	Nursing Administration		365,524		12,105.60		38
39	Central Services and Supply						39
40	Pharmacy						40
41	Medical Records & Medical Records Library		119,142		6,510.40		41
42	Social Service		583,397		21,132.80		42
43	Other General Service						43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		11,295,265		11,295,265	451,409.90	25.02	1
2	Excluded area salaries (see instructions)			8,024	8,024	249.60	32.15	2
3	Subtotal salaries (line 1 minus line 2)		11,295,265	-8,024	11,287,241	451,160.30	25.02	3
4	Subtotal other wages & related costs (see instructions)		1,005,010		1,005,010	13,226.75	75.98	4
5	Subtotal wage-related costs (see instructions)		2,625,541		2,625,541		23.26%	5
6	Total (sum of lines 3 through 5)		14,925,816	-8,024	14,917,792	464,387.05	32.12	6
7	Total overhead cost (see instructions)		3,613,243	-8,024	3,605,219	147,169.70	24.50	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	
	RETIREMENT COST		
1	401K Employer Contributions	155,316	1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Nonqualified Defined Benefit Plan Cost (see instructions)		3
4	Qualified Defined Benefit Plan Cost (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA Plan Administration Fees		5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees		7
	HEALTH AND INSURANCE COST		
8	Health Insurance (Purchased or Self Funded)	1,717,707	8
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan		10
11	Life Insurance (If employee is owner or beneficiary)	23,482	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)		13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	294,393	15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-Employers Portion Only	822,243	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance		19
20	State or Federal Unemployment Taxes	81,025	20
	OTHER		
21	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	Day Care Costs and Allowances	-466,757	22
23	Tuition Reimbursement		23
24	Total Wage Related cost (Sum of lines 1-23)	2,627,409	24

Part B - Other Than Core Related Cost

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

EXHIBIT 3

STEP 1: 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)	CONTRIBUTION(S) 11
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 1	Benefit Cost 2	
	0			
1	Total facility contract labor and benefit cost	31,791	2,627,409	1
2	Hospital	31,791	2,625,541	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		1,868	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	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt		912,898	912,898	116,321	1,029,219	221,234	1,250,453	1
2	00200	Cap Rel Costs-Mvble Equip		578,859	578,859	118,071	696,930	-24,579	672,351	2
3	00300	Other Cap Rel Costs		206,953	206,953	-206,953			-0-	3
4	00400	Employee Benefits Department		2,361,752	2,361,752		2,361,752	255,828	2,617,580	4
5	00500	Administrative & General	1,761,560	3,525,184	5,286,744	-72,666	5,214,078	-710,241	4,503,837	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	226,553	588,387	814,940		814,940	-28,436	786,504	7
8	00800	Laundry & Linen Service		11,656	11,656	25,476	37,132		37,132	8
9	00900	Housekeeping	263,207	70,448	333,655	-25,476	308,179		308,179	9
10	01000	Dietary	284,476	370,515	654,991	-2	654,989	-20,504	634,485	10
11	01100	Cafeteria								11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	365,524	14,360	379,884		379,884	-84	379,800	13
14	01400	Central Services & Supply								14
15	01500	Pharmacy								15
16	01600	Medical Records & Library	119,142	72,685	191,827		191,827	-281	191,546	16
17	01700	Social Service	583,397	19,713	603,110		603,110		603,110	17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	3,770,712	234,797	4,005,509	-5,330	4,000,179	-43,293	3,956,886	30
		ANCILLARY SERVICE COST CENTERS								
54	05400	Radiology-Diagnostic		184,492	184,492	242,382	426,874	-38,951	387,923	54
54.01	05401	RADIOLOGY-SUA				94,550	94,550	-74,953	19,597	54.01
60	06000	Laboratory		359,173	359,173	24,418	383,591	-240,304	143,287	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	295,688	5,177	300,865		300,865	-247	300,618	65
66	06600	Physical Therapy	1,284,586	37,198	1,321,784	-48,002	1,273,782	-402	1,273,380	66
67	06700	Occupational Therapy	1,099,212	9,172	1,108,384	30,069	1,138,453		1,138,453	67
68	06800	Speech Pathology	698,893	6,803	705,696	17,933	723,629	-8	723,621	68
71	07100	Medical Supplies Charged to Patients	57,825	255,773	313,598		313,598	-31,234	282,364	71
73	07300	Drugs Charged to Patients	475,769	712,836	1,188,605		1,188,605	-2,111	1,186,494	73
76	03550	PSYCHOLOGY	-663		-663	663				76
76.01	03951	SPECIAL PROCEDURES		336,932	336,932	-320,251	16,681		16,681	76.01
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
113	11300	Interest Expense		6,176	6,176		6,176	-6,176		113
118		SUBTOTALS (sum of lines 1-117)	11,285,881	10,881,939	22,167,820	-8,797	22,159,023	-744,742	21,414,281	118
		NONREIMBURSABLE COST CENTERS								
192	19200	Physicians' Private Offices		651	651		651		651	192
194	07950	MARKETING NRCC				8,797	8,797		8,797	194
194.01	07951	NRCC GUEST MEALS								194.01
200		TOTAL (sum of lines 118-199)	11,285,881	10,882,590	22,168,471		22,168,471	-744,742	21,423,729	200

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RECLASSIFICATIONS

WORKSHEET A-6

		INCREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	INSURANCE	A	Cap Rel Costs-Bldg & Fixt	1		13,617	1
2	INSURANCE	A	Cap Rel Costs-Mvble Equip	2		13,822	2
3	INSURANCE	A					3
500	Total reclassifications					27,439	500
	Code Letter - A						
1	MARKETING	B	MARKETING NRCC	194	8,024	773	1
2	MARKETING	B					2
3	MARKETING	B					3
500	Total reclassifications				8,024	773	500
	Code Letter - B						
1	PHYSICIANS	C	Adults & Pediatrics	30		11,351	1
2	PHYSICIANS	C					2
500	Total reclassifications					11,351	500
	Code Letter - C						
1	SERVICE UNDER ARRANGEMENT	D	RADIOLOGY-SUA	54.01		94,550	1
2	SERVICE UNDER ARRANGEMENT	D					2
500	Total reclassifications					94,550	500
	Code Letter - D						
1	RELATED PARTY DEACONESS	E	Laboratory	60		24,418	1
2	RELATED PARTY DEACONESS	E					2
500	Total reclassifications					24,418	500
	Code Letter - E						
1	SPECIAL PROCEDURES	F	Radiology-Diagnostic	54		336,932	1
2	SPECIAL PROCEDURES	F					2
500	Total reclassifications					336,932	500
	Code Letter - F						
1	PATIENT TRANSPORTATION	G	SPECIAL PROCEDURES	76.01		16,681	1
2	PATIENT TRANSPORTATION	G					2
500	Total reclassifications					16,681	500
	Code Letter - G						
1	LAUNDRY RECLASS	H	Occupational Therapy	67		871	1
2	LAUNDRY RECLASS	H	Speech Pathology	68		1,139	2
3	LAUNDRY RECLASS	H					3
500	Total reclassifications					2,010	500
	Code Letter - H						
1	LAUNDRY RECLASS	I	Laundry & Linen Service	8	25,476		1
2	LAUNDRY RECLASS	I					2
500	Total reclassifications				25,476		500
	Code Letter - I						
1	REHAB TECH RECLASS	J	Occupational Therapy	67	29,198		1
2	REHAB TECH RECLASS	J	Speech Pathology	68	16,794		2
3	REHAB TECH RECLASS	J					3
500	Total reclassifications				45,992		500
	Code Letter - J						
1	SALARY RECLASS	K					1
2	SALARY RECLASS	K	PSYCHOLOGY	76		663	2
500	Total reclassifications					663	500
	Code Letter - K						
	GRAND TOTAL (Increases)				79,492	514,817	

(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		27,439	3	
500	Total reclassifications					27,439	500	
	Code letter - A							
1	MARKETING	B					1	
2	MARKETING	B	Administrative & General	5	8,024	771	2	
3	MARKETING	B	Dietary	10		2	3	
500	Total reclassifications				8,024	773	500	
	Code letter - B							
1	PHYSICIANS	C					1	
2	PHYSICIANS	C	Administrative & General	5		11,351	2	
500	Total reclassifications					11,351	500	
	Code letter - C							
1	SERVICE UNDER ARRANGEMENT	D					1	
2	SERVICE UNDER ARRANGEMENT	D	Radiology-Diagnostic	54		94,550	2	
500	Total reclassifications					94,550	500	
	Code letter - D							
1	RELATED PARTY DEACONESS	E					1	
2	RELATED PARTY DEACONESS	E	Administrative & General	5		24,418	2	
500	Total reclassifications					24,418	500	
	Code letter - E							
1	SPECIAL PROCEDURES	F					1	
2	SPECIAL PROCEDURES	F	SPECIAL PROCEDURES	76.01		336,932	2	
500	Total reclassifications					336,932	500	
	Code letter - F							
1	PATIENT TRANSPORTATION	G					1	
2	PATIENT TRANSPORTATION	G	Adults & Pediatrics	30		16,681	2	
500	Total reclassifications					16,681	500	
	Code letter - G							
1	LAUNDRY RECLASS	H					1	
2	LAUNDRY RECLASS	H					2	
3	LAUNDRY RECLASS	H	Physical Therapy	66		2,010	3	
500	Total reclassifications					2,010	500	
	Code letter - H							
1	LAUNDRY RECLASS	I					1	
2	LAUNDRY RECLASS	I	Housekeeping	9	25,476		2	
500	Total reclassifications				25,476		500	
	Code letter - I							
1	REHAB TECH RECLASS	J					1	
2	REHAB TECH RECLASS	J					2	
3	REHAB TECH RECLASS	J	Physical Therapy	66	45,992		3	
500	Total reclassifications				45,992		500	
	Code letter - J							
1	SALARY RECLASS	K	Administrative & General	5		663	1	
2	SALARY RECLASS	K					2	
500	Total reclassifications					663	500	
	Code letter - K							
	GRAND TOTAL (Decreases)				79,492	514,817		

(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 Retirements	Ending Balance	Fully Depreciated 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	2,515,616	1,078,797		1,078,797		3,594,413		4
5	Fixed Equipment								5
6	Movable Equipment	2,301,193	1,466,385		1,466,385	119,087	3,648,491		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	4,816,809	2,545,182		2,545,182	119,087	7,242,904		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	4,816,809	2,545,182		2,545,182	119,087	7,242,904		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 instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt	173,704	739,194						912,898	1
2	Cap Rel Costs-Mvble Equip	391,686	187,173						578,859	2
3	Total (sum of lines 1-2)	565,390	926,367						1,491,757	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 line 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	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	3,594,413		3,594,413	0.496267		102,704		102,704	1
2	Cap Rel Costs-Mvble Equip	3,648,491		3,648,491	0.503733		104,249		104,249	2
3	Total (sum of lines 1-2)	7,242,904		7,242,904	1.000000		206,953		206,953	3

	Description	SUMMARY OF CAPITAL							Total (2) (sum of cols. 9 through 14)	
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt	327,663	739,194	72,654	13,617	97,325		1,250,453	1	
2	Cap Rel Costs-Mvble Equip	376,568	183,172		13,822	98,789		672,351	2	
3	Total (sum of lines 1-2)	704,231	922,366	72,654	27,439	196,114		1,922,804	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	Trace, 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	-5,088			10
11	Sale of scrap, waste, etc. (chapter 23)					11
12	Related organization transactions (chapter 10)	Wkst A-8-1	-387,247			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					32
33						33
34						34
35						35
36						36
37	INTEREST	A	-6,176	Interest Expense	113	37
37.01	DEPRECIATION	A	278	Cap Rel Costs-Mvble Equip	2	37.01
37.02	INSURANCE	A	265,656	Employee Benefits Department	4	37.02
37.03	INSURANCE	A	-287,372	Administrative & General	5	37.03
37.04	PROPERTY TAX	A	-5,379	Cap Rel Costs-Bldg & Fixt	1	37.04
37.05	PROPERTY TAX	A	-5,460	Cap Rel Costs-Mvble Equip	2	37.05
37.06	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-154,147	Administrative & General	5	37.06
37.07	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-139	Operation of Plant	7	37.07
37.08	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-18	Dietary	10	37.08
37.09	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-84	Nursing Administration	13	37.09
37.10	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-113	Adults & Pediatrics	30	37.10
37.11	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-97	Physical Therapy	66	37.11
37.12	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-8	Speech Pathology	68	37.12
37.13	PATIENT TELEPHONE	A	-4,828	Employee Benefits Department	4	37.13
37.14	PATIENT TELEPHONE	A	-24,505	Administrative & General	5	37.14
37.15	PATIENT TELEVISION	A	-15,396	Cap Rel Costs-Mvble Equip	2	37.15
37.16	PATIENT TELEVISION	A	-740	Administrative & General	5	37.16
37.17	PRINTING	A	-7,788	Administrative & General	5	37.17
37.18	PRINTING	A	-2	Drugs Charged to Patients	73	37.18
37.19	LOBBYING EXPENSE	A	-431	Administrative & General	5	37.19
37.20	MISCELLANEOUS INCOME	B	-1,838	Cap Rel Costs-Bldg & Fixt	1	37.20
37.21	MISCELLANEOUS INCOME	B	-3,714	Administrative & General	5	37.21
37.22	MISCELLANEOUS INCOME	B	-20,486	Dietary	10	37.22
37.23	MISCELLANEOUS INCOME	B	-281	Medical Records & Library	16	37.23
37.24	PATIENT TRANSPORTATION	A	-5,194	Employee Benefits Department	4	37.24
37.25	PATIENT TRANSPORTATION	A	-28,297	Operation of Plant	7	37.25
37.26	PATIENT TRANSPORTATION	A	-38,013	Adults & Pediatrics	30	37.26
37.27	PROFESSIONAL FEES	A	-7,835	Administrative & General	5	37.27
38						38

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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	
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)		-744,742				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.

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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	Administrative & General	TO OFFSET MANAGEMENT FEES		1,926,838	-1,926,838		1	
	2	Cap Rel Costs-Bldg & Fixt	TO INCLUDE ALLOWABLE HOME OFFICE COS	153,959		153,959	9	2	
	3	Cap Rel Costs-Bldg & Fixt	TO INCLUDE ALLOWABLE HOME OFFICE COS	74,492		74,492	11	3	
	3.01	Administrative & General	TO INCLUDE ALLOWABLE HOME OFFICE COS	1,440,533		1,440,533		3.01	
	3.02	Administrative & General	TO INCLUDE ALLOWABLE HOME OFFICE COS	260,084		260,084		3.02	
	3.03	Cap Rel Costs-Mvble Equip	INTERCOMPANY WAGE AND EXPENSE TRANSF	11,564	11,564		10	3.03	
	3.04	Employee Benefits Department	INTERCOMPANY WAGE AND EXPENSE TRANSF	1,769,442	1,769,442			3.04	
	3.05	Administrative & General	INTERCOMPANY WAGE AND EXPENSE TRANSF	2,720,053	2,720,053			3.05	
	3.06	Operation of Plant	INTERCOMPANY WAGE AND EXPENSE TRANSF	25,425	25,425			3.06	
	3.07	Housekeeping	INTERCOMPANY WAGE AND EXPENSE TRANSF	5,862	5,862			3.07	
	3.08	Dietary	INTERCOMPANY WAGE AND EXPENSE TRANSF	-7,947	-7,947			3.08	
	3.09	Nursing Administration	INTERCOMPANY WAGE AND EXPENSE TRANSF	2,196	2,196			3.09	
	3.10	Medical Records & Library	INTERCOMPANY WAGE AND EXPENSE TRANSF	476	476			3.10	
	3.11	Social Service	INTERCOMPANY WAGE AND EXPENSE TRANSF	1,520	1,520			3.11	
	3.12	Adults & Pediatrics	INTERCOMPANY WAGE AND EXPENSE TRANSF	-8,145	-8,145			3.12	
	3.13	Laboratory	INTERCOMPANY WAGE AND EXPENSE TRANSF	-5	-5			3.13	
	3.14	Respiratory Therapy	INTERCOMPANY WAGE AND EXPENSE TRANSF	154	154			3.14	
	3.15	Physical Therapy	INTERCOMPANY WAGE AND EXPENSE TRANSF	-2,568	-2,568			3.15	
	3.16	Occupational Therapy	INTERCOMPANY WAGE AND EXPENSE TRANSF	-8,987	-8,987			3.16	
	3.17	Speech Pathology	INTERCOMPANY WAGE AND EXPENSE TRANSF	2,759	2,759			3.17	
	3.18	Medical Supplies Charged to Patients	INTERCOMPANY WAGE AND EXPENSE TRANSF	-9,220	-9,220			3.18	
	3.19	Drugs Charged to Patients	INTERCOMPANY WAGE AND EXPENSE TRANSF	678,059	678,059			3.19	
	3.20	Interest Expense	INTERCOMPANY WAGE AND EXPENSE TRANSF	6,170	6,170		11	3.20	
	3.21	Physicians' Private Offices	INTERCOMPANY WAGE AND EXPENSE TRANSF	36	36			3.21	
	3.22	Administrative & General	RELATED PARTY - MOTORIKA	241	241			3.22	
	3.23	Cap Rel Costs-Mvble Equip	RELATED PARTY - DEACONESS	1,468	5,469	-4,001	10	3.23	
	3.24	Employee Benefits Department	RELATED PARTY - DEACONESS	-71	-265	194		3.24	
	3.25	Administrative & General	RELATED PARTY - DEACONESS	-922	-3,434	2,512		3.25	
	3.26	Adults & Pediatrics	RELATED PARTY - DEACONESS	303	382	-79		3.26	
	3.27	Radiology-Diagnostic	RELATED PARTY - DEACONESS	8,504	47,455	-38,951		3.27	
	3.28	54.01 RADIOLOGY-SUA	RELATED PARTY - DEACONESS	16,364	91,317	-74,953		3.28	
	3.29	60 Laboratory	RELATED PARTY - DEACONESS	143,200	383,504	-240,304		3.29	
	3.30	65 Respiratory Therapy	RELATED PARTY - DEACONESS	86	333	-247		3.30	
	3.31	66 Physical Therapy	RELATED PARTY - DEACONESS	84	389	-305		3.31	
	3.32	71 Medical Supplies Charged to Patients	RELATED PARTY - DEACONESS	9,847	41,081	-31,234		3.32	
	3.33	73 Drugs Charged to Patients	RELATED PARTY - DEACONESS	700	2,809	-2,109		3.33	
	4							4	
	5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12			7,295,716	7,682,963	-387,247		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 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

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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

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	
6	B	78.00	HEALTHSOUTH CORPORATION		HEALTHCARE	6
7	B	22.00	DEACONESS HOSPITAL		HEALTHCARE	7
8	G		HEALTHSOUTH CORPORATION		HEALTHCARE	8
9	G		MOTORIKA		MEDICAL EQUIPMENT	9
9.01	G		DEACONESS HOSPITAL		HEALTHCARE	9.01
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:

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun- eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	30	Adults & Pediatrics AGGREGATE	11,351		11,351	171,400	76	6,263	313	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	11,351		11,351		76	6,263	313	200

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 04/28/2015 Run Time: 09:46 Version: 2015.03 (04/22/2015)
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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	30	Adults & Pediatrics AGGREGATE					6,263	5,088	5,088	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL					6,263	5,088	5,088	200

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 04/28/2015 Run Time: 09:46 Version: 2015.03 (04/22/2015)
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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	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	1,250,453	1,250,453					1
2	Cap Rel Costs-Mvble Equip	672,351		672,351				2
4	Employee Benefits Department	2,617,580	7,326	3,939	2,628,845			4
5	Administrative & General	4,503,837	262,265	141,016	408,300	5,315,418	5,315,418	5
6	Maintenance & Repairs							6
7	Operation of Plant	786,504	47,611	25,600	52,771	912,486	301,469	7
8	Laundry & Linen Service	37,132	11,139	5,989	5,934	60,194	19,887	8
9	Housekeeping	308,179	8,022	4,313	55,375	375,889	124,187	9
10	Dietary	634,485	79,747	42,879	66,264	823,375	272,028	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	379,800	7,959	4,279	85,142	477,180	157,652	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	191,546	8,449	4,543	27,752	232,290	76,744	16
17	Social Service	603,110	14,620	7,861	135,892	761,483	251,580	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	3,956,886	479,469	257,803	878,323	5,572,481	1,841,044	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	387,923	8,924	4,798		401,645	132,696	54
54.01	RADIOLOGY-SUA	19,597				19,597		54.01
60	Laboratory	143,287	918	493		144,698	47,806	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	300,618	3,449	1,855	68,875	374,797	123,826	65
66	Physical Therapy	1,273,380	83,766	45,040	288,508	1,690,694	558,575	66
67	Occupational Therapy	1,138,453	92,074	49,507	262,843	1,542,877	509,739	67
68	Speech Pathology	723,621	34,288	18,436	166,706	943,051	311,567	68
71	Medical Supplies Charged to Patients	282,364	20,538	11,043	13,469	327,414	108,172	71
73	Drugs Charged to Patients	1,186,494	6,123	3,293	110,822	1,306,732	431,721	73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES	16,681				16,681	5,511	76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	21,414,281	1,176,687	632,687	2,626,976	21,298,982	5,274,204	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	651	73,592	39,570		113,813	37,602	192
194	MARKETING NRCC	8,797	174	94	1,869	10,934	3,612	194
194.01	NRCC GUEST MEALS							194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	21,423,729	1,250,453	672,351	2,628,845	21,423,729	5,315,418	202

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 04/28/2015 Run Time: 09:46 Version: 2015.03 (04/22/2015)
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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	1,213,955						7
8	Laundry & Linen Service	14,490	94,571					8
9	Housekeeping	10,435		510,511				9
10	Dietary	103,734		44,538	1,243,675			10
11	Cafeteria				126,591	126,591		11
12	Maintenance of Personnel							12
13	Nursing Administration	10,353		4,445		5,283	654,913	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	10,991		4,719		1,722		16
17	Social Service	19,018		8,165		8,432		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	623,680	94,571	267,778	1,039,396	54,498	654,913	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	11,608		4,984				54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory	1,194		513				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	4,487		1,926		4,274		65
66	Physical Therapy	108,962		46,783		17,901		66
67	Occupational Therapy	119,767		51,422		16,309		67
68	Speech Pathology	44,601		19,150		10,344		68
71	Medical Supplies Charged to Patients	26,716		11,470		836		71
73	Drugs Charged to Patients	7,965		3,420		6,876		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
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	1,118,001	94,571	469,313	1,165,987	126,475	654,913	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	95,728		41,101				192
194	MARKETING NRCC	226		97		116		194
194.01	NRCC GUEST MEALS				77,688			194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,213,955	94,571	510,511	1,243,675	126,591	654,913	202

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 04/28/2015 Run Time: 09:46 Version: 2015.03 (04/22/2015)
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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		16	17	24	25	26	
	GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5	Administrative & General						5
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library	326,466					16
17	Social Service		1,048,678				17
19	Nonphysician Anesthetists						19
20	Nursing School						20
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
23	Paramed Ed Prgm-(specify)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	Adults & Pediatrics	106,789	1,048,678	11,303,828		11,303,828	30
	ANCLLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	4,766		555,699		555,699	54
54.01	RADIOLOGY-SUA			19,597		19,597	54.01
60	Laboratory	6,474		200,685		200,685	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	28,761		538,071		538,071	65
66	Physical Therapy	55,538		2,478,453		2,478,453	66
67	Occupational Therapy	52,221		2,292,335		2,292,335	67
68	Speech Pathology	30,037		1,358,750		1,358,750	68
71	Medical Supplies Charged to Patients	5,464		480,072		480,072	71
73	Drugs Charged to Patients	35,745		1,792,459		1,792,459	73
76	PSYCHOLOGY						76
76.01	SPECIAL PROCEDURES	671		22,863		22,863	76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
113	Interest Expense						113
118	SUBTOTALS (sum of lines 1-117)	326,466	1,048,678	21,042,812		21,042,812	118
	NONREIMBURSABLE COST CENTERS						
192	Physicians' Private Offices			288,244		288,244	192
194	MARKETING NRCC			14,985		14,985	194
194.01	NRCC GUEST MEALS			77,688		77,688	194.01
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	326,466	1,048,678	21,423,729		21,423,729	202

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 04/28/2015 Run Time: 09:46 Version: 2015.03 (04/22/2015)
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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	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department		7,326	3,939	11,265	11,265		4
5	Administrative & General		262,265	141,016	403,281	1,749	405,030	5
6	Maintenance & Repairs							6
7	Operation of Plant		47,611	25,600	73,211	226	22,972	7
8	Laundry & Linen Service		11,139	5,989	17,128	25	1,515	8
9	Housekeeping		8,022	4,313	12,335	237	9,463	9
10	Dietary		79,747	42,879	122,626	284	20,728	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration		7,959	4,279	12,238	365	12,013	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		8,449	4,543	12,992	119	5,848	16
17	Social Service		14,620	7,861	22,481	582	19,170	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		479,469	257,803	737,272	3,766	140,285	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic		8,924	4,798	13,722		10,111	54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory		918	493	1,411		3,643	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		3,449	1,855	5,304	295	9,436	65
66	Physical Therapy		83,766	45,040	128,806	1,236	42,563	66
67	Occupational Therapy		92,074	49,507	141,581	1,126	38,842	67
68	Speech Pathology		34,288	18,436	52,724	714	23,741	68
71	Medical Supplies Charged to Patients		20,538	11,043	31,581	58	8,243	71
73	Drugs Charged to Patients		6,123	3,293	9,416	475	32,897	73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES						420	76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)		1,176,687	632,687	1,809,374	11,257	401,890	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		73,592	39,570	113,162		2,865	192
194	MARKETING NRCC		174	94	268	8	275	194
194.01	NRCC GUEST MEALS							194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		1,250,453	672,351	1,922,804	11,265	405,030	202

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 04/28/2015 Run Time: 09:46 Version: 2015.03 (04/22/2015)
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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	96,409						7
8	Laundry & Linen Service	1,151	19,819					8
9	Housekeeping	829		22,864				9
10	Dietary	8,238		1,995	153,871			10
11	Cafeteria				15,662	15,662		11
12	Maintenance of Personnel							12
13	Nursing Administration	822		199		654	26,291	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	873		211		213		16
17	Social Service	1,510		366		1,043		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	49,531	19,819	11,993	128,597	6,742	26,291	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	922		223				54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory	95		23				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	356		86		529		65
66	Physical Therapy	8,653		2,095		2,215		66
67	Occupational Therapy	9,512		2,303		2,018		67
68	Speech Pathology	3,542		858		1,280		68
71	Medical Supplies Charged to Patients	2,122		514		103		71
73	Drugs Charged to Patients	633		153		851		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
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	88,789	19,819	21,019	144,259	15,648	26,291	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	7,602		1,841				192
194	MARKETING NRCC	18		4		14		194
194.01	NRCC GUEST MEALS				9,612			194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	96,409	19,819	22,864	153,871	15,662	26,291	202

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 04/28/2015 Run Time: 09:46 Version: 2015.03 (04/22/2015)
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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		16	17	24	25	26	
	GENERAL SERVICE COST CENTERS						
1	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	20,256					16
17	Social Service		45,152				17
19	Nonphysician Anesthetists						19
20	Nursing School						20
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
23	Paramed Ed Prgm-(specify)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	Adults & Pediatrics	6,638	45,152	1,176,086		1,176,086	30
	ANCLLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	295		25,273		25,273	54
54.01	RADIOLOGY-SUA						54.01
60	Laboratory	401		5,573		5,573	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	1,783		17,789		17,789	65
66	Physical Therapy	3,443		189,011		189,011	66
67	Occupational Therapy	3,237		198,619		198,619	67
68	Speech Pathology	1,862		84,721		84,721	68
71	Medical Supplies Charged to Patients	339		42,960		42,960	71
73	Drugs Charged to Patients	2,216		46,641		46,641	73
76	PSYCHOLOGY						76
76.01	SPECIAL PROCEDURES	42		462		462	76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
113	Interest Expense						113
118	SUBTOTALS (sum of lines 1-117)	20,256	45,152	1,787,135		1,787,135	118
	NONREIMBURSABLE COST CENTERS						
192	Physicians' Private Offices			125,470		125,470	192
194	MARKETING NRCC			587		587	194
194.01	NRCC GUEST MEALS			9,612		9,612	194.01
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	20,256	45,152	1,922,804		1,922,804	202

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 04/28/2015 Run Time: 09:46 Version: 2015.03 (04/22/2015)
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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	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	79,028						1
2	Cap Rel Costs-Mvble Equip		79,028					2
4	Employee Benefits Department	463	463	11,285,879				4
5	Administrative & General	16,575	16,575	1,752,871	-5,315,418	16,088,714		5
6	Maintenance & Repairs							6
7	Operation of Plant	3,009	3,009	226,553		912,486	58,981	7
8	Laundry & Linen Service	704	704	25,476		60,194	704	8
9	Housekeeping	507	507	237,731		375,889	507	9
10	Dietary	5,040	5,040	284,476		823,375	5,040	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	503	503	365,524		477,180	503	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	534	534	119,142		232,290	534	16
17	Social Service	924	924	583,397		761,483	924	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	30,302	30,302	3,770,712		5,572,481	30,302	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	564	564			401,645	564	54
54.01	RADIOLOGY-SUA				-19,597			54.01
60	Laboratory	58	58			144,698	58	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	218	218	295,688		374,797	218	65
66	Physical Therapy	5,294	5,294	1,238,594		1,690,694	5,294	66
67	Occupational Therapy	5,819	5,819	1,128,410		1,542,877	5,819	67
68	Speech Pathology	2,167	2,167	715,687		943,051	2,167	68
71	Medical Supplies Charged to Patients	1,298	1,298	57,825		327,414	1,298	71
73	Drugs Charged to Patients	387	387	475,769		1,306,732	387	73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES					16,681		76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	74,366	74,366	11,277,855	-5,335,015	15,963,967	54,319	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	4,651	4,651			113,813	4,651	192
194	MARKETING NRCC	11	11	8,024		10,934	11	194
194.01	NRCC GUEST MEALS							194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,250,453	672,351	2,628,845		5,315,418	1,213,955	202
203	Unit Cost Multiplier (Wkst. B, Part I)	15.822911	8.507757	0.232932		0.330382	20.582137	203
204	Cost to be allocated (Per Wkst. B, Part II)			11,265		405,030	96,409	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000998		0.025175	1.634577	205

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE PATIENT DAYS	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA GROSS SALARIES	NURSING ADMINISTRATION PATIENT DAYS	MEDICAL RECORDS & LIBRARY GROSS REVENUE	
		8	9	10	11	13	16	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	24,747						8
9	Housekeeping		57,770					9
10	Dietary		5,040	88,832				10
11	Cafeteria			9,042	8,758,772			11
12	Maintenance of Personnel							12
13	Nursing Administration		503		365,524	24,747		13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		534		119,142		62,855,462	16
17	Social Service		924		583,397			17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	24,747	30,302	74,241	3,770,712	24,747	20,561,006	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic		564				917,669	54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory		58				1,246,344	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		218		295,688		5,537,404	65
66	Physical Therapy		5,294		1,238,594		10,692,651	66
67	Occupational Therapy		5,819		1,128,410		10,054,190	67
68	Speech Pathology		2,167		715,687		5,783,026	68
71	Medical Supplies Charged to Patients		1,298		57,825		1,051,963	71
73	Drugs Charged to Patients		387		475,769		6,882,055	73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES						129,154	76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	24,747	53,108	83,283	8,750,748	24,747	62,855,462	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		4,651					192
194	MARKETING NRCC		11		8,024			194
194.01	NRCC GUEST MEALS			5,549				194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	94,571	510,511	1,243,675	126,591	654,913	326,466	202
203	Unit Cost Multiplier (Wkst. B, Part I)	3.821514	8.836957	14.000304	0.014453	26.464339	0.005194	203
204	Cost to be allocated (Per Wkst. B, Part II)	19,819	22,864	153,871	15,662	26,291	20,256	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.800865	0.395776	1.732157	0.001788	1.062391	0.000322	205

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	SOCIAL SERVICE						
		PATIENT DAYS						
		17						

	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service	24,747						17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	24,747						30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic							54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients							73
76	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
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	24,747						118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices							192
194	MARKETING NRCC							194
194.01	NRCC GUEST MEALS							194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,048,678						202
203	Unit Cost Multiplier (Wkst. B, Part I)	42.375965						203
204	Cost to be allocated (Per Wkst. B, Part II)	45,152						204
205	Unit Cost Multiplier (Wkst. B, Part II)	1.824544						205

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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		
		PART	LINE NO.	AMOUNT
	1	2	3	4

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 04/28/2015 Run Time: 09:46 Version: 2015.03 (04/22/2015)
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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 Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	11,303,828		11,303,828	5,088	11,308,916	30
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	555,699		555,699		555,699	54
54.01	RADIOLOGY-SUA	19,597		19,597		19,597	54.01
60	Laboratory	200,685		200,685		200,685	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	538,071		538,071		538,071	65
66	Physical Therapy	2,478,453		2,478,453		2,478,453	66
67	Occupational Therapy	2,292,335		2,292,335		2,292,335	67
68	Speech Pathology	1,358,750		1,358,750		1,358,750	68
71	Medical Supplies Charged to Patients	480,072		480,072		480,072	71
73	Drugs Charged to Patients	1,792,459		1,792,459		1,792,459	73
76	PSYCHOLOGY						76
76.01	SPECIAL PROCEDURES	22,863		22,863		22,863	76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	21,042,812		21,042,812	5,088	21,047,900	200
201	Less Observation Beds						201
202	Total (line 200 minus line 201)	21,042,812		21,042,812		21,047,900	202

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 04/28/2015 Run Time: 09:46 Version: 2015.03 (04/22/2015)
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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	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	20,561,006		20,561,006				30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	916,201	1,468	917,669	0.605555	0.605555	0.605555	54
54.01	RADIOLOGY-SUA	187,353		187,353	0.104599	0.104599	0.104599	54.01
60	Laboratory	1,246,267	77	1,246,344	0.161019	0.161019	0.161019	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	5,537,404		5,537,404	0.097170	0.097170	0.097170	65
66	Physical Therapy	9,325,655	1,366,996	10,692,651	0.231790	0.231790	0.231790	66
67	Occupational Therapy	9,365,903	688,287	10,054,190	0.227998	0.227998	0.227998	67
68	Speech Pathology	4,883,553	899,473	5,783,026	0.234955	0.234955	0.234955	68
71	Medical Supplies Charged to Patients	1,043,367	8,596	1,051,963	0.456358	0.456358	0.456358	71
73	Drugs Charged to Patients	6,882,055		6,882,055	0.260454	0.260454	0.260454	73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES	129,154		129,154	0.177021	0.177021	0.177021	76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	60,077,918	2,964,897	63,042,815				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	60,077,918	2,964,897	63,042,815				202

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 04/28/2015 Run Time: 09:46 Version: 2015.03 (04/22/2015)
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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)	
		1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	1,176,086		1,176,086	24,747	47.52	18,228	866,195	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)	1,176,086		1,176,086	24,747		18,228	866,195	200

(A) Worksheet A line numbers

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 04/28/2015 Run Time: 09:46 Version: 2015.03 (04/22/2015)
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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) PPS
 Applicable 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	
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	25,273	917,669	0.027540	713,753	19,657	54
54.01	RADIOLOGY-SUA		187,353		168,575		54.01
60	Laboratory	5,573	1,246,344	0.004471	960,321	4,294	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	17,789	5,537,404	0.003213	3,866,662	12,424	65
66	Physical Therapy	189,011	10,692,651	0.017677	6,793,003	120,080	66
67	Occupational Therapy	198,619	10,054,190	0.019755	6,851,616	135,354	67
68	Speech Pathology	84,721	5,783,026	0.014650	3,686,765	54,011	68
71	Medical Supplies Charged to Patients	42,960	1,051,963	0.040838	745,062	30,427	71
73	Drugs Charged to Patients	46,641	6,882,055	0.006777	4,879,120	33,066	73
76	PSYCHOLOGY						76
76.01	SPECIAL PROCEDURES	462	129,154	0.003577			76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	611,049	42,481,809		28,664,877	409,313	200

(A) Worksheet A line numbers

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 04/28/2015 Run Time: 09:46 Version: 2015.03 (04/22/2015)
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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 Other

(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.)
		1	2	3	4	5
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics General Routine Care)					30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	TOTAL (lines 30-199)					200

(A) Worksheet A line numbers

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 04/28/2015 Run Time: 09:46 Version: 2015.03 (04/22/2015)
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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 Other

(A)	Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
6		7		8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	24,747		18,228		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)	24,747		18,228		200

(A) Worksheet A line numbers

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 04/28/2015 Run Time: 09:46 Version: 2015.03 (04/22/2015)
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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 Other

(A)	Cost Center Description	1	2	3	4	5	6	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic							54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients							73
76	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
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 04/28/2015 Run Time: 09:46 Version: 2015.03 (04/22/2015)
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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 Other

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
7	8	9	10	11	12	13			
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	917,669			713,753		1,464		54
54.01	RADIOLOGY-SUA	187,353			168,575				54.01
60	Laboratory	1,246,344			960,321		23		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	5,537,404			3,866,662				65
66	Physical Therapy	10,692,651			6,793,003				66
67	Occupational Therapy	10,054,190			6,851,616				67
68	Speech Pathology	5,783,026			3,686,765				68
71	Medical Supplies Charged to Patients	1,051,963			745,062		208		71
73	Drugs Charged to Patients	6,882,055			4,879,120				73
76	PSYCHOLOGY								76
76.01	SPECIAL PROCEDURES	129,154							76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct Part)								92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	42,481,809			28,664,877		1,695		200

(A) Worksheet A line numbers

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 04/28/2015 Run Time: 09:46 Version: 2015.03 (04/22/2015)
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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 [XX] Hospital [] SUB (Other) [] Swing Bed SNF
 Applicable [XX] 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	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	0.605555	1,464			887			54
54.01	RADIOLOGY-SUA	0.104599							54.01
60	Laboratory	0.161019	23			4			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.097170							65
66	Physical Therapy	0.231790							66
67	Occupational Therapy	0.227998							67
68	Speech Pathology	0.234955							68
71	Medical Supplies Charged to Patients	0.456358	208			95			71
73	Drugs Charged to Patients	0.260454							73
76	PSYCHOLOGY								76
76.01	SPECIAL PROCEDURES	0.177021							76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct Part)								92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		1,695			986			200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		1,695			986			202

(A) Worksheet A line numbers

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 04/28/2015 Run Time: 09:46 Version: 2015.03 (04/22/2015)
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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)	
		1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	1,176,086		1,176,086	24,747	47.52	698	33,169	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)	1,176,086		1,176,086	24,747		698	33,169	200

(A) Worksheet A line numbers

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 04/28/2015 Run Time: 09:46 Version: 2015.03 (04/22/2015)
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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)
 Applicable [] Title XVIII, Part A [] IPF
 Boxes: [XX] 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	
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	25,273	917,669	0.027540	28,752	792	54
54.01	RADIOLOGY-SUA		187,353		5,875		54.01
60	Laboratory	5,573	1,246,344	0.004471	31,238	140	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	17,789	5,537,404	0.003213	249,259	801	65
66	Physical Therapy	189,011	10,692,651	0.017677	258,067	4,562	66
67	Occupational Therapy	198,619	10,054,190	0.019755	253,083	5,000	67
68	Speech Pathology	84,721	5,783,026	0.014650	130,390	1,910	68
71	Medical Supplies Charged to Patients	42,960	1,051,963	0.040838	31,843	1,300	71
73	Drugs Charged to Patients	46,641	6,882,055	0.006777	212,028	1,437	73
76	PSYCHOLOGY						76
76.01	SPECIAL PROCEDURES	462	129,154	0.003577	984	4	76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	611,049	42,481,809		1,201,519	15,946	200

(A) Worksheet A line numbers

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 04/28/2015 Run Time: 09:46 Version: 2015.03 (04/22/2015)
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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 Other

(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.)
		1	2	3	4	5
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics General Routine Care)					30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	TOTAL (lines 30-199)					200

(A) Worksheet A line numbers

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 04/28/2015 Run Time: 09:46 Version: 2015.03 (04/22/2015)
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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 Other

(A)	Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
6		7		8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	24,747		698		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)	24,747		698		200

(A) Worksheet A line numbers

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 04/28/2015 Run Time: 09:46 Version: 2015.03 (04/22/2015)
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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 Other

(A)	Cost Center Description	1 Non Physician Anesthetist Cost	2 Nursing School	3 Allied Health	4 All Other Medical Education Cost	5 Total Cost (sum of col. 1 through col. 4)	6 Total Outpatient Cost (sum of col. 2, 3, and 4)	
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic							54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory							60
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
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 04/28/2015 Run Time: 09:46 Version: 2015.03 (04/22/2015)
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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 Other

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
7	8	9	10	11	12	13			
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	917,669			28,752				54
54.01	RADIOLOGY-SUA	187,353			5,875				54.01
60	Laboratory	1,246,344			31,238				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	5,537,404			249,259				65
66	Physical Therapy	10,692,651			258,067				66
67	Occupational Therapy	10,054,190			253,083				67
68	Speech Pathology	5,783,026			130,390				68
71	Medical Supplies Charged to Patients	1,051,963			31,843				71
73	Drugs Charged to Patients	6,882,055			212,028				73
76	PSYCHOLOGY								76
76.01	SPECIAL PROCEDURES	129,154			984				76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct Part)								92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	42,481,809			1,201,519				200

(A) Worksheet A line numbers

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 04/28/2015 Run Time: 09:46 Version: 2015.03 (04/22/2015)
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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	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	0.605555							54
54.01	RADIOLOGY-SUA	0.104599							54.01
60	Laboratory	0.161019							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.097170							65
66	Physical Therapy	0.231790		68,346			15,842		66
67	Occupational Therapy	0.227998		19,769			4,507		67
68	Speech Pathology	0.234955		45,487			10,687		68
71	Medical Supplies Charged to Patients	0.456358		223			102		71
73	Drugs Charged to Patients	0.260454							73
76	PSYCHOLOGY								76
76.01	SPECIAL PROCEDURES	0.177021							76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct Part)								92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			133,825			31,138		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			133,825			31,138		202

(A) Worksheet A line numbers

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 04/28/2015 Run Time: 09:46 Version: 2015.03 (04/22/2015)
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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)	24,747	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	24,747	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.	1,663	3
4	Semi-private room days (excluding swing-bed private room days)	23,084	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	18,228	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	11,308,916	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	11,308,916	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)	20,561,006	28
29	Private room charges (excluding swing-bed charges)	1,388,050	29
30	Semi-private room charges (excluding swing-bed charges)	19,172,956	30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.550018	31
32	Average private room per diem charge (line 29 ÷ line 3)	834.67	32
33	Average semi-private room per diem charge (line 30 ÷ line 4)	830.57	33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)	4.10	34
35	Average per diem private room cost differential (line 34 x line 31)	2.26	35
36	Private room cost differential adjustment (line 3 x line 35)	3,758	36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	11,305,158	37

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 04/28/2015 Run Time: 09:46 Version: 2015.03 (04/22/2015)
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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	
		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		
38	Adjusted general inpatient routine service cost per diem (see instructions)					456.98	38	
39	Program general inpatient routine service cost (line 9 x line 38)					8,329,831	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)					8,329,831	41	
42	Nursery (Titles V and XIX only)						42	
	Intensive Care Type Inpatient Hospital Units							
43	Intensive Care Unit						43	
44	Coronary Care Unit						44	
45	Burn Intensive Care Unit						45	
46	Surgical Intensive Care Unit						46	
47	Other Special Care (specify)						47	

48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					6,593,934	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					14,923,765	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					866,195	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					409,313	51
52	Total Program excludable cost (sum of lines 50 and 51)					1,275,508	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					13,648,257	53

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

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

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 04/28/2015 Run Time: 09:46 Version: 2015.03 (04/22/2015)
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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)						456.98	88
89	Observation bed cost (line 87 x line 88) (see instructions)							89
		Cost	Routine Cost (from line 27)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)		
		1	2	3	4	5		
90	Capital-related cost							90
91	Nursing School							91
92	Allied Health							92
93	Other Medical Education							93

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 04/28/2015 Run Time: 09:46 Version: 2015.03 (04/22/2015)
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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)	24,747	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	24,747	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.	1,663	3
4	Semi-private room days (excluding swing-bed private room days)	23,084	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	698	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	11,303,828	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	11,303,828	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)	20,561,006	28
29	Private room charges (excluding swing-bed charges)	1,388,050	29
30	Semi-private room charges (excluding swing-bed charges)	19,172,956	30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.549770	31
32	Average private room per diem charge (line 29 ÷ line 3)	834.67	32
33	Average semi-private room per diem charge (line 30 ÷ line 4)	830.57	33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)	4.10	34
35	Average per diem private room cost differential (line 34 x line 31)	2.25	35
36	Private room cost differential adjustment (line 3 x line 35)	3,742	36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	11,300,086	37

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 04/28/2015 Run Time: 09:46 Version: 2015.03 (04/22/2015)
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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)						456.62	38
39	Program general inpatient routine service cost (line 9 x line 38)						318,721	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)						318,721	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1	2	3	4	5		
42	Nursery (Titles V and XIX only)							42
	Intensive Care Type Inpatient Hospital Units							
43	Intensive Care Unit							43
44	Coronary Care Unit							44
45	Burn Intensive Care Unit							45
46	Surgical Intensive Care Unit							46
47	Other Special Care (specify)							47
							1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						265,361	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						584,082	49
	PASS THROUGH COST ADJUSTMENTS							
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						33,169	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						15,946	51
52	Total Program excludable cost (sum of lines 50 and 51)						49,115	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)							53
	TARGET AMOUNT AND LIMIT COMPUTATION							
54	Program discharges							54
55	Target amount per discharge							55
56	Target amount (line 54 x line 55)							56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)							57
58	Bonus payment (see instructions)							58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.							59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.							60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)							61
62	Relief payment (see instructions)							62
63	Allowable Inpatient cost plus incentive payment (see instructions)							63
	PROGRAM INPATIENT ROUTINE SWING BED COST							
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)							64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)							65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)							66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)							67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)							68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)							69

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 04/28/2015 Run Time: 09:46 Version: 2015.03 (04/22/2015)
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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)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 04/28/2015 Run Time: 09:46 Version: 2015.03 (04/22/2015)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-3025

WORKSHEET D-3

Check Title V Hospital SUB (Other) Swing Bed SNF PPS
 Applicable Title XVIII, Part A IPF SNF Swing Bed NF TEFRA
 Boxes: Title XIX 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			
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		15,131,824		30
	ANCILLARY SERVICE COST CENTERS				
54	Radiology-Diagnostic	0.605555	713,753	432,217	54
54.01	RADIOLOGY-SUA	0.104599	168,575	17,633	54.01
60	Laboratory	0.161019	960,321	154,630	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.097170	3,866,662	375,724	65
66	Physical Therapy	0.231790	6,793,003	1,574,550	66
67	Occupational Therapy	0.227998	6,851,616	1,562,155	67
68	Speech Pathology	0.234955	3,686,765	866,224	68
71	Medical Supplies Charged to Patients	0.456358	745,062	340,015	71
73	Drugs Charged to Patients	0.260454	4,879,120	1,270,786	73
76	PSYCHOLOGY				76
76.01	SPECIAL PROCEDURES	0.177021			76.01
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
92	Observation Beds (Non-Distinct Part)				92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		28,664,877	6,593,934	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		28,664,877		202

(A) Worksheet A line numbers

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 04/28/2015 Run Time: 09:46 Version: 2015.03 (04/22/2015)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-3025

WORKSHEET D-3

Check Title V Hospital SUB (Other) Swing Bed SNF PPS
 Applicable Title XVIII, Part A IPF SNF Swing Bed NF TEFRA
 Boxes: Title XIX 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	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		579,330		30
	ANCILLARY SERVICE COST CENTERS				
54	Radiology-Diagnostic	0.605555	28,752	17,411	54
54.01	RADIOLOGY-SUA	0.104599	5,875	615	54.01
60	Laboratory	0.161019	31,238	5,030	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.097170	249,259	24,220	65
66	Physical Therapy	0.231790	258,067	59,817	66
67	Occupational Therapy	0.227998	253,083	57,702	67
68	Speech Pathology	0.234955	130,390	30,636	68
71	Medical Supplies Charged to Patients	0.456358	31,843	14,532	71
73	Drugs Charged to Patients	0.260454	212,028	55,224	73
76	PSYCHOLOGY				76
76.01	SPECIAL PROCEDURES	0.177021	984	174	76.01
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
92	Observation Beds (Non-Distinct Part)				92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		1,201,519	265,361	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		1,201,519		202

(A) Worksheet A line numbers

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 04/28/2015 Run Time: 09:46 Version: 2015.03 (04/22/2015)
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HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION

EXHIBIT 5

	(Amt. from Wkst. E, Pt. A or L Pt. I)	Prior to 10/1		On or after 10/1		Total (cols. 2 and 3)	
	(1)	(2)	(2.01)	(3)	(3.01)	(4)	
1	DRG Amounts Other Than Outlier Payments						1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1						1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1						1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1						1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1						1.04
2	Outlier payments for discharges						2
2.01	Outlier payment for discharges for Model 4 BPCI						2.01
3	Operating outlier reconciliation						3
4	Managed Care Simulated Payments						4
	Indirect Medical Education Adjustment						
5	Amount from Worksheet E Part A, line 21						5
6	IME payment adjustment						6
6.01	IME payment adjustment for managed care						6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7	IME payment adjustment factor						7
8	IME add-on adjustment amount						8
8.01	IME payment adjustment add-on for managed care						8.01
9	Total IME payment (sum of lines 6 and 8)						9
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)						9.01
	Disproportionate Share Adjustment						
10	Allowable disproportionate share percentage						10
11	Disproportionate share adjustment						11
11.01	Uncompensated care payments						11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12	Total ESRD additional payment						12
13	Subtotal						13
14	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.)						14
15	Total payment for inpatient operating costs SCH and MDH only						15
16	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)						16
17	Special add-on payments for new technologies						17
17.01	Net organ acquisition cost (Wkst. D-4 Pt. III, col 1, line 69)						17.01
17.02	Credits received from manufacturers for replaced devices applicable to MS-DRG						17.02
18	Capital outlier reconciliation adjustment amount						18
19	SUBTOTAL						19
20	Capital DRG other than outlier						20
20.01	Model 4 BPCI Capital DRG other than outlier						20.01
21	Capital DRG outlier payments						21
21.01	Model 4 BPCI Capital DRG outlier payments						21.01
22	Indirect medical education percentage						22
23	Indirect medical education adjustment						23
24	Allowable disproportionate share percentage						24
25	Disproportionate share adjustment						25
26	Total prospective capital payments						26
27							27
28	Low volume adjustment prior to October 1						28
29	Low volume adjustment on or after October 1						29
30	HVBP payment adjustment						30
30.01	HVBP payment adjustment for HSP bonus payment						30.01
31	HRR adjustment						31
31.01	HRR adjustment for HSP bonus payment						31.01
32	HAC Reduction Program adjustment						32

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 04/28/2015 Run Time: 09:46 Version: 2015.03 (04/22/2015)
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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 OPPTS (see instructions)	986			2
3	PPS payments	732			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 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)				21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)	732			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	203			26
27	Subtotal ((lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23) (see instructions)	529			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)	529			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	529			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)				34
35	Adjusted reimbursable bad debts (see instructions)				35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)				36
37	Subtotal (see instructions)	529			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	529			40
40.01	Sequestration adjustment (see instructions)	11			40.01
41	Interim payments	518			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)				43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 04/28/2015 Run Time: 09:46 Version: 2015.03 (04/22/2015)
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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 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4
1	Total interim payments paid to provider		22,730,223		518
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 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)				
		.01			3.01
		.02			3.02
	Program	.03			3.03
	to	.04			3.04
	Provider	.05			3.05
		.06			3.06
		.07			3.07
		.08			3.08
		.09			3.09
		.10			3.10
		.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)		22,730,223		518
TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)				
		.01			5.01
		.02			5.02
	Program	.03			5.03
	to	.04			5.04
	Provider	.05			5.05
		.06			5.06
		.07			5.07
		.08			5.08
		.09			5.09
		.10			5.10
		.50			5.50
		.51			5.51
	Provider	.52			5.52
	to	.53			5.53
	Program	.54			5.54
		.55			5.55
		.56			5.56
		.57			5.57
		.58			5.58
		.59			5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99			5.99
6	Determined net settlement amount (balance due) based on the cost report (1)	.01	571,995		11
		.02			6.02
7	Total Medicare program liability (see instructions)		23,302,218		529
8	Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)
					8

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

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 04/28/2015 Run Time: 09:46 Version: 2015.03 (04/22/2015)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-3025

**WORKSHEET E-3
PART III**

Check 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)	22,944,889		1
2	Medicare SSI ratio (IRF PPS only) (see instructions)	0.046100		2
3	Inpatient Rehabilitation LIP payments (see instructions)	855,844		3
4	Outlier payments	6,528		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)			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)	67.800000		10
11	Teaching Adjustment Factor (see instructions)			11
12	Teaching Adjustment (see instructions)			12
13	Total PPS Payment (see instructions)	23,807,261		13
14	Nursing and allied health managed care payments (see instructions)			14
15	Organ acquisition DO NOT USE THIS LINE			15
16	Cost of physicians' services in a teaching hospital (see instructions)			16
17	Subtotal (see instructions)	23,807,261		17
18	Primary payer payments	13,234		18
19	Subtotal (line 17 less line 18)	23,794,027		19
20	Deductibles	399,584		20
21	Subtotal (line 19 minus line 20)	23,394,443		21
22	Coinsurance	188,040		22
23	Subtotal (line 21 minus line 22)	23,206,403		23
24	Allowable bad debts (exclude bad debts for professional services) (see instructions)	147,407		24
25	Adjusted reimbursable bad debts (see instructions)	95,815		25
26	Allowable bad debts for dual eligible beneficiaries (see instructions)	105,191		26
27	Subtotal (sum of lines 23 and 25)	23,302,218		27
28	Direct graduate medical education payments (from Wkst. E-4, line 49) (For free standing IRF only)			28
29	Other pass through costs (see instructions)			29
30	Outlier payments reconciliation			30
31	Other adjustments (specify) (see instructions)			31
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			31.50
32	Total amount payable to the provider (see instructions)	23,302,218		32
32.01	Sequestration adjustment (see instructions)	466,044		32.01
33	Interim payments	22,730,223		33
34	Tentative settlement (for contractor use only)			34
35	Balance due provider/program (line 32 minus lines 32.01, 33 and 34)	105,951		35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	25,099		36

TO BE COMPLETED BY CONTRACTOR

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

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 04/28/2015 Run Time: 09:46 Version: 2015.03 (04/22/2015)
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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	
COMPUTATION OF NET COST OF COVERED SERVICES			
1	584,082		1
2		31,138	2
3			3
4	584,082	31,138	4
5			5
6			6
7	584,082	31,138	7
COMPUTATION OF LESSER OF COST OR CHARGES			
REASONABLE CHARGES			
8	579,330		8
9	1,201,519	133,825	9
10			10
11			11
12	1,780,849	133,825	12
CUSTOMARY CHARGES			
13			13
14			14
15	1.000000	1.000000	15
16	1,780,849	133,825	16
17	1,196,767	102,687	17
18			18
19			19
20			20
21	584,082	31,138	21
PROSPECTIVE PAYMENT AMOUNT			
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29	584,082	31,138	29
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30			30
31	584,082	31,138	31
32			32
33			33
34			34
35			35
36	584,082	31,138	36
37			37
38	584,082	31,138	38
39			39
40	584,082	31,138	40
41	471,338	17,617	41
42	112,744	13,521	42
43			43

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 04/28/2015 Run Time: 09:46 Version: 2015.03 (04/22/2015)
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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
CURRENT ASSETS					
1	Cash on hand and in banks	3,644,693			1
2	Temporary investments				2
3	Notes receivable				3
4	Accounts receivable	6,015,254			4
5	Other receivables				5
6	Allowances for uncollectible notes and accounts receivable	-1,592,584			6
7	Inventory	55,886			7
8	Prepaid expenses	17,058			8
9	Other current assets				9
10	Due from other funds				10
11	Total current assets (sum of lines 1-10)	8,140,307			11
FIXED ASSETS					
12	Land				12
13	Land improvements				13
14	Accumulated depreciation				14
15	Buildings				15
16	Accumulated depreciation				16
17	Leasehold improvements	3,594,413			17
18	Accumulated depreciation	-2,148,696			18
19	Fixed equipment				19
20	Accumulated depreciation				20
21	Audomobiles and trucks				21
22	Accumulated depreciation				22
23	Major movable equipment	3,655,294			23
24	Accumulated depreciation	-1,970,293			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)	3,130,718			30
OTHER ASSETS					
31	Investments				31
32	Deposits on leases				32
33	Due from owners/officers				33
34	Other assets	12,439,729			34
35	Total other assets (sum of lines 31-34)	12,439,729			35
36	Total assets (sum of lines 11, 30 and 35)	23,710,754			36
Liabilities and Fund Balances (Omit Cents)					
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund
		1	2	3	4
CURRENT LIABILITIES					
37	Accounts payable	315,802			37
38	Salaries, wages and fees payable	789,878			38
39	Payroll taxes payable				39
40	Notes and loans payable (short term)				40
41	Deferred income				41
42	Accelerated payments				42
43	Due to other funds				43
44	Other current liabilities	2,526,039			44
45	Total current liabilities (sum of lines 37 thru 44)	3,631,719			45
LONG TERM LIABILITIES					
46	Mortgage payable				46
47	Notes payable				47
48	Unsecured loans				48
49	Other long term liabilities	4,593,557			49
50	Total long term liabilities (sum of lines 46 thru 49)	4,593,557			50
51	Total liabilities (sum of lines 45 and 50)	8,225,276			51
CAPITAL ACCOUNTS					
52	General fund balance	15,485,478			52
53	Specific purpose fund				53
54	Donor created - endowment fund balance - restricted				54
55	Donor created - endowment fund balance - unrestricted				55
56	Governing body created - endowment fund balance				56
57	Plant fund balance - invested in plant				57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion				58
59	Total fund balances (sum of lines 52 thru 58)	15,485,478			59
60	Total liabilities and fund balances (sum of lines 51 and 59)	23,710,754			60

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 04/28/2015 Run Time: 09:46 Version: 2015.03 (04/22/2015)
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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		14,273,466			1
2	Net income (loss) (from Worksheet G-3, line 29)		10,053,864			2
3	Total (sum of line 1 and line 2)		24,327,330			3
4	Additions (credit adjustments) (specify)					4
5						5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)		24,327,330			11
12	Deductions (debit adjustments) (specify)					12
13	MINORITY INTEREST	2,211,850				13
14	DISTRIBUTIONS	6,630,002				14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)		8,841,852			18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		15,485,478			19

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

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 04/28/2015 Run Time: 09:46 Version: 2015.03 (04/22/2015)
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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

**WORKSHEET G-2
PARTS I & II**

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	20,690,160		20,690,160	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)	20,690,160		20,690,160	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit				11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)				16
17	Total inpatient routine care services (sum of lines 10 and 16)	20,690,160		20,690,160	17
18	Ancillary services	39,387,760	2,964,896	42,352,656	18
19	Outpatient services				19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	Other (specify)				27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	60,077,920	2,964,896	63,042,816	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		22,168,471	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)		22,168,471	43

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 04/28/2015 Run Time: 09:46 Version: 2015.03 (04/22/2015)
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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)	63,042,816	1
2	Less contractual allowances and discounts on patients' accounts	30,928,842	2
3	Net patient revenues (line 1 minus line 2)	32,113,974	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	22,168,471	4
5	Net income from service to patients (line 3 minus line 4)	9,945,503	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments	7,872	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts	105	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	34,722	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts		18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines	2,681	21
22	Rental of hosptial space	83,222	22
23	Governmental appropriations		23
24	Other (specify)	-20,241	24
25	Total other income (sum of lines 6-24)	108,361	25
26	Total (line 5 plus line 25)	10,053,864	26
29	Net income (or loss) for the period (line 26 minus line 28)	10,053,864	29