

KPMG LLP Compu-Max 2552-10

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/11/2016 Run Time: 14:31 Version: 2015.10 (04/20/2016)
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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: 05/11/2016 Time: 14:31
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 01/01/2015 and ending 12/31/2015, 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

05/17/2016
Date

PART III - SETTLEMENT SUMMARY

		TITLE XVIII					
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		269,823			120,464	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		269,823			120,464	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	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 / 2015	To: 12 / 31 / 2015							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.	513	135	341	119	1,062		25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	1						26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1						27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.							35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:		Ending:				36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.							37
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:		Ending:				38

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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
Prospective Payment System (PPS)-Capital		V	XVIII	XIX
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	1	2	3
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	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	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	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, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
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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**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))	
65		1	2	3	4	5	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))	
67		1	2	3	4	5	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, indicate which program year began during this cost reporting period. (see instructions)						71
Inpatient Rehabilitation Facility PPS				1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.			Y			75
76	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N			76
Long Term Care Hospital PPS							
80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.				N		80
81	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no.				N		81
TEFRA Providers							
85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no.				N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.						86
87	Is this hospital a 'subclause (II)' LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter 'Y' for yes and 'N' for no.				N		87

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**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/IID facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97

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 is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.			107	
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108	
		Physical	Occupational	Speech	Respiratory
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.				109
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-I, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	N			116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.	Y			117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	64,155	6,817		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

		1	2	
140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)	Y	019005	140

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

141	Name: HEALTHSOUTH CORPORATION	Contractor's Name: CAHABA GBA	Contractor's Number: 10101	141
142	Street: 3660 GRANDVIEW PARKWAY, 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 Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.	N	N	145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, chapter 40, §4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N		147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N		148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	N		149

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

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

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HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/11/2016 Run Time: 14:31 Version: 2015.10 (04/20/2016)
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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	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	
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					
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	Y	A	02/25/2016	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				
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N		6
7	Are costs claimed for allied health programs? If yes, see instructions.	N		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N		8
9	Are costs claimed for Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	N		9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see 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			
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12
13	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14

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

		Part A		Part B	
		Y/N	Date	Y/N	Date
PS&R Report Data					
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		Y	02/29/2016
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	02/29/2016	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 relieved for Medicare purposes? If yes, see instructions.	22
23	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	23
24	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.	24
25	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	25
26	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	26
27	Has the provider's 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: COURTNEY	Last name: CAMERON	Title: REIMBURSEMENT SPECIALIST
42	Employer: HEALTHSOUTH CORPORATION		
43	Phone number: 205-968-7055	E-mail Address: COURTNEY.CAMERON@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	103	31,331			16,955	385	24,887	1
2	HMO and other (see instructions)						2,019	1,785		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)		103	31,331			16,955	385	24,887	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)		103	31,331			16,955	385	24,887	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)		103							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

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HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/11/2016 Run Time: 14:31 Version: 2015.10 (04/20/2016)
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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)					1,255	27	1,849	1
2	HMO and other (see instructions)					145	124		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)		225.34			1,255	27	1,849	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)		225.34						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

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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	11,738,179		468,716.00		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)			90,029	2,751.00		10
OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)						11
12	Contract management and administrative services						12
13	Contract labor: Physician-Part A - Administrative						13
14	Home office salaries & wage-related costs		889,938		11,468.00		14
15	Home office: Physician Part A - Administrative		80,562		530.00		15
16	Home office & Contract Physicians Part A - Teaching						16
WAGE-RELATED COSTS							
17	Wage-related costs (core)(see instructions)		2,457,667				17
18	Wage-related costs (other)(see instructions)						18
19	Excluded areas		18,996				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		1,886,961	-90,029	62,638.00		27
28	Administrative & General under contract (see instructions)		35,799		105.00		28
29	Maintenance & Repairs						29
30	Operation of Plant		227,953		9,244.00		30
31	Laundry & Linen Service			26,855	2,094.00		31
32	Housekeeping		299,145	-26,855	22,445.00		32
33	Housekeeping under contract (see instructions)						33
34	Dietary		277,326		19,970.00		34
35	Dietary under contract (see instructions)						35
36	Cafeteria						36
37	Maintenance of Personnel						37
38	Nursing Administration		400,162		13,021.00		38
39	Central Services and Supply						39
40	Pharmacy						40
41	Medical Records & Medical Records Library		126,734		6,529.00		41
42	Social Service		556,520		20,291.00		42
43	Other General Service						43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		11,773,978		11,773,978	468,821.00	25.11	1
2	Excluded area salaries (see instructions)			90,029	90,029	2,751.00	32.73	2
3	Subtotal salaries (line 1 minus line 2)		11,773,978	-90,029	11,683,949	466,070.00	25.07	3
4	Subtotal other wages & related costs (see instructions)		970,500		970,500	11,998.00	80.89	4
5	Subtotal wage-related costs (see instructions)		2,457,667		2,457,667		21.03%	5
6	Total (sum of lines 3 through 5)		15,202,145	-90,029	15,112,116	478,068.00	31.61	6
7	Total overhead cost (see instructions)		3,810,600	-90,029	3,720,571	156,337.00	23.80	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	155,102	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)	1,637,122	8
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan		10
11	Life Insurance (If employee is owner or beneficiary)	23,108	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	243,167	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	846,404	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance		19
20	State or Federal Unemployment Taxes	85,432	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	-513,671	22
23	Tuition Reimbursement		23
24	Total Wage Related cost (Sum of lines 1-23)	2,476,664	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)		25
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HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	Supporting Exhibit for Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/11/2016 Run Time: 14:31 Version: 2015.10 (04/20/2016)
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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 MOonths in Provider Cost Reporting Period on Line 2		15
16	Average Pension Contributions (Line 14 times Line 15)		16
STEP 4: TOTAL PENSION COST FOR WAGE INDEX			
17	Annual Prefunding Installment (see instructions)		17
18	Reportable Prefunding Installment ((Line 17 times Line 15) divided by 12)		18
19	Total Pension Cost for Wage Index (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)		19

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HOSPITAL CONTRACT LABOR AND BENEFIT COST

**WORKSHEET S-3
PART V**

Part V - Contract Labor and Benefit Cost

Hospital and Hospital-Based Component Identification:

	Component	Contract Labor	Benefit Cost	
	0	1	2	
1	Total facility contract labor and benefit cost		2,476,663	1
2	Hospital		2,457,667	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		18,996	18

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HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

WORKSHEET S-5

RENAL DIALYSIS STATISTICS

	DESCRIPTION	Outpatient		Training		Home		
		Regular	High Flux	Hemo-dialysis	CAPD CCPD	Hemo-dialysis	CAPD CCPD	
		1	2	3	4	5	6	
1	Number of patients in program at end of cost reporting period							1
2	Number of times per week patient receives dialysis							2
3	Average patient dialysis time including setup							3
4	CAPD exchanges per day							4
5	Number of days in year dialysis furnished							5
6	Number of stations							6
7	Treatment capacity per day per station							7
8	Utilization (see instructions)							8
9	Average times dialyzers re-used							9
10	Percentage of patients re-using dialyzers							10

ESRD PPS

		1	2	
10.01	Is the dialysis facility approved as a low-volume facility for this cost reporting period? Enter 'Y' for yes or 'N' for no. (see instructions)			10.01
10.02	Did your facility elect 100% PPS effective January 1, 2011? Enter 'Y' for yes or 'N' for no. (see instructions for 'new' providers)			10.02
10.03	If you responded 'N' to line 10.02, enter in column 1 the year of transition for periods prior to January 1 and enter in column 2 the year of transition for periods after December 31. (see instructions)		4	10.03

TRANSPLANT INFORMATION

11	Number of patients on transplant list			11
12	Number of patients transplanted during the cost reporting period			12

EPOETIN

13	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider			13
14	Epoetin amount from Worksheet A for home dialysis program			14
15	Number of EPO units furnished relating to the renal dialysis department			15
16	Number of EPO units furnished relating to the home dialysis department			16

ARANESP

17	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider			17
18	ARANESP amount from Worksheet A for home dialysis program			18
19	Number of ARANESP units furnished relating to the renal dialysis department			19
20	Number of ARANESP units furnished relating to the home dialysis department			20

PHYSICIAN PAYMENT METHOD (Enter 'X' for applicable method(s))

21	MCP	INITIAL METHOD	
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	Erythropoiesis-Stimulating Agents (ESA) Statistics:	ESA Description	Net Cost of ESAs for Renal Patients	Net Cost of ESAs for Home Patients	Number of ESA Units - Renal Dialysis Dept.	Number of ESA Units - Home Dialysis Dept.	
		1	2	3	4	5	
22	Enter in column 1 the ESA description. Enter in column 2 the net costs of ESAs furnished to all renal dialysis patients. Enter in column 3 the net cost of ESAs furnished to all home dialysis program patients. Enter in column 4 the number of ESA units furnished to patients in the renal dialysis department. Enter in column 5 the number of units furnished to patients in the home dialysis program. (see instructions)						22

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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		989,285	989,285	120,777	1,110,062	218,129	1,328,191	1
2	00200	Cap Rel Costs-Mvble Equip		583,229	583,229	89,569	672,798	-7,948	664,850	2
3	00300	Other Cap Rel Costs		184,049	184,049	-184,049			-0-	3
4	00400	Employee Benefits Department		2,472,719	2,472,719		2,472,719	-5,320	2,467,399	4
5	00500	Administrative & General	1,886,961	3,428,857	5,315,818	-133,453	5,182,365	-1,052,162	4,130,203	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	227,953	549,883	777,836		777,836	-32,810	745,026	7
8	00800	Laundry & Linen Service		10,240	10,240	26,855	37,095	-1,232	35,863	8
9	00900	Housekeeping	299,145	84,110	383,255	-26,855	356,400	-712	355,688	9
10	01000	Dietary	277,326	379,983	657,309	-163	657,146	-27,668	629,478	10
11	01100	Cafeteria								11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	400,162	23,712	423,874		423,874	-95	423,779	13
14	01400	Central Services & Supply								14
15	01500	Pharmacy								15
16	01600	Medical Records & Library	126,734	82,244	208,978		208,978		208,978	16
17	01700	Social Service	556,520	22,012	578,532		578,532		578,532	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	4,028,943	251,702	4,280,645	-81,292	4,199,353	-3,473	4,195,880	30
		ANCILLARY SERVICE COST CENTERS								
54	05400	Radiology-Diagnostic		168,587	168,587	-21,156	147,431	-2,536	144,895	54
54.01	05401	RADIOLOGY-SUA				36,222	36,222	-23,928	12,294	54.01
60	06000	Laboratory		415,505	415,505	213,996	629,501	-348,416	281,085	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	307,213	8,527	315,740		315,740	-1,399	314,341	65
66	06600	Physical Therapy	1,307,953	35,242	1,343,195	-54,968	1,288,227	-29	1,288,198	66
67	06700	Occupational Therapy	1,130,222	14,229	1,144,451	34,348	1,178,799	-10	1,178,789	67
68	06800	Speech Pathology	640,714	4,352	645,066	20,621	665,687		665,687	68
71	07100	Medical Supplies Charged to Patients		62,977	337,302		337,302	-12,947	324,355	71
73	07300	Drugs Charged to Patients	485,356	783,730	1,269,086		1,269,086	-3,643	1,265,443	73
76	03550	PSYCH								76
76.01	03951	SPECIAL PROCEDURES		417,295	417,295	-177,014	240,281	-32,856	207,425	76.01
76.02	03950	SPECIAL PROCEDURES SUA				38,004	38,004	-25,408	12,596	76.02
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
113	11300	Interest Expense		5,050	5,050		5,050	-5,050		113
118		SUBTOTALS (sum of lines 1-117)	11,738,179	11,188,867	22,927,046	-98,558	22,828,488	-1,369,513	21,458,975	118
		NONREIMBURSABLE COST CENTERS								
192	19200	Physicians' Private Offices		869	869		869		869	192
194	07950	MARKETING				98,558	98,558		98,558	194
194.01	07951	GUEST MEALS								194.01
200		TOTAL (sum of lines 118-199)	11,738,179	11,189,736	22,927,915		22,927,915	-1,369,513	21,558,402	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		15,099	1
2	INSURANCE	A	Cap Rel Costs-Mvble Equip	2		11,198	2
3	INSURANCE	A					3
500	Total reclassifications					26,297	500
	Code Letter - A						
1	MARKETING	B	MARKETING	194	90,029	8,529	1
2	MARKETING	B					2
3	MARKETING	B					3
500	Total reclassifications				90,029	8,529	500
	Code Letter - B						
1	PHYSICIANS	C	Adults & Pediatrics	30		8,761	1
2	PHYSICIANS	C					2
500	Total reclassifications					8,761	500
	Code Letter - C						
1	SERVICE UNDER ARRANGEMENT	D	RADIOLOGY-SUA	54.01		36,222	1
2	SERVICE UNDER ARRANGEMENT	D	SPECIAL PROCEDURES SUA	76.02		38,004	2
3	SERVICE UNDER ARRANGEMENT	D					3
4	SERVICE UNDER ARRANGEMENT	D					4
500	Total reclassifications					74,226	500
	Code Letter - D						
1	PATIENT TRANSPORTATION	E	SPECIAL PROCEDURES	76.01		90,053	1
2	PATIENT TRANSPORTATION	E					2
500	Total reclassifications					90,053	500
	Code Letter - E						
1	LAUNDRY	F	Laundry & Linen Service	8	26,855		1
2	LAUNDRY	F					2
500	Total reclassifications				26,855		500
	Code Letter - F						
1	SPECIAL PROCEDURES	G	Radiology-Diagnostic	54		15,066	1
2	SPECIAL PROCEDURES	G	Laboratory	60		213,996	2
3	SPECIAL PROCEDURES	G					3
500	Total reclassifications					229,062	500
	Code Letter - G						
1	THERAPY SALARY	H	Occupational Therapy	67	33,467		1
2	THERAPY SALARY	H	Speech Pathology	68	19,376		2
3	THERAPY SALARY	H					3
500	Total reclassifications				52,843		500
	Code Letter - H						
1	DAY TREATMENT	I	Occupational Therapy	67		881	1
2	DAY TREATMENT	I	Speech Pathology	68		1,245	2
3	DAY TREATMENT	I					3
500	Total reclassifications					2,126	500
	Code Letter - I						
	GRAND TOTAL (Increases)				169,727	439,054	

(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		26,297	3	
500	Total reclassifications					26,297	500	
	Code letter - A							
1	MARKETING	B					1	
2	MARKETING	B	Administrative & General	5	90,029	8,366	2	
3	MARKETING	B	Dietary	10		163	3	
500	Total reclassifications				90,029	8,529	500	
	Code letter - B							
1	PHYSICIANS	C					1	
2	PHYSICIANS	C	Administrative & General	5		8,761	2	
500	Total reclassifications					8,761	500	
	Code letter - C							
1	SERVICE UNDER ARRANGEMENT	D					1	
2	SERVICE UNDER ARRANGEMENT	D					2	
3	SERVICE UNDER ARRANGEMENT	D	Radiology-Diagnostic	54		36,222	3	
4	SERVICE UNDER ARRANGEMENT	D	SPECIAL PROCEDURES	76.01		38,004	4	
500	Total reclassifications					74,226	500	
	Code letter - D							
1	PATIENT TRANSPORTATION	E					1	
2	PATIENT TRANSPORTATION	E	Adults & Pediatrics	30		90,053	2	
500	Total reclassifications					90,053	500	
	Code letter - E							
1	LAUNDRY	F					1	
2	LAUNDRY	F	Housekeeping	9	26,855		2	
500	Total reclassifications				26,855		500	
	Code letter - F							
1	SPECIAL PROCEDURES	G					1	
2	SPECIAL PROCEDURES	G					2	
3	SPECIAL PROCEDURES	G	SPECIAL PROCEDURES	76.01		229,063	3	
500	Total reclassifications					229,063	500	
	Code letter - G							
1	THERAPY SALARY	H					1	
2	THERAPY SALARY	H					2	
3	THERAPY SALARY	H	Physical Therapy	66	52,843		3	
500	Total reclassifications				52,843		500	
	Code letter - H							
1	DAY TREATMENT	I					1	
2	DAY TREATMENT	I					2	
3	DAY TREATMENT	I	Physical Therapy	66		2,125	3	
500	Total reclassifications					2,125	500	
	Code letter - I							
	GRAND TOTAL (Decreases)				169,727	439,054		

(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	3,594,413	1,773,031		1,773,031	2,017	5,365,427		4
5	Fixed Equipment								5
6	Movable Equipment	3,648,491	669,753		669,753	339,252	3,978,992		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	7,242,904	2,442,784		2,442,784	341,269	9,344,419		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	7,242,904	2,442,784		2,442,784	341,269	9,344,419		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	240,030	749,255						989,285	1
2	Cap Rel Costs-Mvble Equip	369,998	213,231						583,229	2
3	Total (sum of lines 1-2)	610,028	962,486						1,572,514	3

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

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	5,365,427		5,365,427	0.574185		105,678		105,678	1
2	Cap Rel Costs-Mvble Equip	3,978,992		3,978,992	0.425815		78,371		78,371	2
3	Total (sum of lines 1-2)	9,344,419		9,344,419	1.000000		184,049		184,049	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	372,164	749,255	82,592	15,099	109,081		1,328,191	1	
2	Cap Rel Costs-Mvble Equip	359,527	213,231		11,198	80,894		664,850	2	
3	Total (sum of lines 1-2)	731,691	962,486	82,592	26,297	189,975		1,993,041	3	

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

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		
				COST CENTER	LINE#	Wkst. A-7 Ref.
		1	2	3	4	5
1	Investment income-buildings & fixtures (chapter 2)			Cap Rel Costs-Bldg & Fixt	1	1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2	2
3	Investment income-other (chapter 2)					3
4	Trade, quantity, and time discounts (chapter 8)					4
5	Refunds and rebates of expenses (chapter 8)					5
6	Rental of provider space by suppliers (chapter 8)					6
7	Telephone services (pay stations excl) (chapter 21)					7
8	Television and radio service (chapter 21)					8
9	Parking lot (chapter 21)					9
10	Provider-based physician adjustment	Wkst A-8-2	-3,473			10
11	Sale of scrap, waste, etc. (chapter 23)					11
12	Related organization transactions (chapter 10)	Wkst A-8-1	-752,817			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	-5,050	Interest Expense	113	37
37.03	INSURANCE	A	5,880	Employee Benefits Department	4	37.03
37.04	INSURANCE	A	-319,764	Administrative & General	5	37.04
37.05	PROPERTY TAX	A	3,403	Cap Rel Costs-Bldg & Fixt	1	37.05
37.06	PROPERTY TAX	A	2,523	Cap Rel Costs-Mvble Equip	2	37.06
37.07	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-148,950	Administrative & General	5	37.07
37.08	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-18	Operation of Plant	7	37.08
37.09	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-451	Housekeeping	9	37.09
37.10	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-111	Dietary	10	37.10
37.11	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-95	Nursing Administration	13	37.11
37.12	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-10	Occupational Therapy	67	37.12
37.13	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-55	Medical Supplies Charged to Patients	71	37.13
37.14	PATIENT TELEPHONE	A	-1,988	Cap Rel Costs-Mvble Equip	2	37.14
37.15	PATIENT TELEPHONE	A	-4,940	Employee Benefits Department	4	37.15
37.16	PATIENT TELEPHONE	A	-27,120	Administrative & General	5	37.16
37.17	PATIENT TELEVISION	A	-5,173	Cap Rel Costs-Mvble Equip	2	37.17
37.18	PATIENT TELEVISION	A	-792	Operation of Plant	7	37.18
37.19	PRINTING	A	-5,160	Administrative & General	5	37.19
37.20	PRINTING	A	-15	Medical Supplies Charged to Patients	71	37.20
37.21	LOBBYING EXPENSE	A	-236	Employee Benefits Department	4	37.21
37.22	LOBBYING EXPENSE	A	-2,098	Administrative & General	5	37.22
37.23	LEGAL FEES	A	-15,631	Administrative & General	5	37.23
37.24	MISCELLANEOUS INCOME	B	-8,878	Administrative & General	5	37.24
37.25	MISCELLANEOUS INCOME	B	-21,647	Dietary	10	37.25
37.26	PATIENT TRANSPORTATION	A	-6,024	Employee Benefits Department	4	37.26
37.27	PATIENT TRANSPORTATION	A	-32,000	Operation of Plant	7	37.27
37.28	PATIENT TRANSPORTATION	A	-8,059	SPECIAL PROCEDURES	76.01	37.28
37.29	PROFESSIONAL FEES	A	-10,764	Administrative & General	5	37.29
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)		-1,369,513				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	5	Administrative & General	MANAGEMENT FEES		1,984,407	-1,984,407		1
2	1	Cap Rel Costs-Bldg & Fixt	HOME OFFICE COSTS	132,134		132,134	9	2
3	1	Cap Rel Costs-Bldg & Fixt	HOME OFFICE COSTS	82,592		82,592	11	3
3.01	5	Administrative & General	HOME OFFICE COSTS	1,296,630		1,296,630		3.01
3.02	5	Administrative & General	HOME OFFICE COSTS	194,840		194,840		3.02
3.03	2	Cap Rel Costs-Mvble Equip	INTERCOMPANY WAGE AND EXPENSE TRANSF	15,124	15,124		10	3.03
3.04	4	Employee Benefits Department	INTERCOMPANY WAGE AND EXPENSE TRANSF	1,894,855	1,894,855			3.04
3.05	5	Administrative & General	INTERCOMPANY WAGE AND EXPENSE TRANSF	2,666,698	2,666,698			3.05
3.06	7	Operation of Plant	INTERCOMPANY WAGE AND EXPENSE TRANSF	14,790	14,790			3.06
3.07	8	Laundry & Linen Service	INTERCOMPANY WAGE AND EXPENSE TRANSF	160	160			3.07
3.08	9	Housekeeping	INTERCOMPANY WAGE AND EXPENSE TRANSF	6,056	6,056			3.08
3.09	10	Dietary	INTERCOMPANY WAGE AND EXPENSE TRANSF	-9,785	-9,785			3.09
3.10	13	Nursing Administration	INTERCOMPANY WAGE AND EXPENSE TRANSF	2,268	2,268			3.10
3.11	16	Medical Records & Library	INTERCOMPANY WAGE AND EXPENSE TRANSF	73	73			3.11
3.12	17	Social Service	INTERCOMPANY WAGE AND EXPENSE TRANSF	881	881			3.12
3.13	30	Adults & Pediatrics	INTERCOMPANY WAGE AND EXPENSE TRANSF	-222	-222			3.13
3.14	60	Laboratory	INTERCOMPANY WAGE AND EXPENSE TRANSF	-4	-4			3.14
3.15	65	Respiratory Therapy	INTERCOMPANY WAGE AND EXPENSE TRANSF	-4	-4			3.15
3.16	66	Physical Therapy	INTERCOMPANY WAGE AND EXPENSE TRANSF	-9,262	-9,262			3.16
3.17	67	Occupational Therapy	INTERCOMPANY WAGE AND EXPENSE TRANSF	1,382	1,382			3.17
3.18	68	Speech Pathology	INTERCOMPANY WAGE AND EXPENSE TRANSF	1,029	1,029			3.18
3.19	71	Medical Supplies Charged to Patients	INTERCOMPANY WAGE AND EXPENSE TRANSF	-8,844	-8,844			3.19
3.20	73	Drugs Charged to Patients	INTERCOMPANY WAGE AND EXPENSE TRANSF	724,240	724,240			3.20
3.21	113	Interest Expense	INTERCOMPANY WAGE AND EXPENSE TRANSF	5,047	5,047			3.21
3.22	192	Physicians' Private Offices	INTERCOMPANY WAGE AND EXPENSE TRANSF	30	30			3.22
3.23	1	Cap Rel Costs-Bldg & Fixt	RELATED PARTY - DEACONESS	33,017	33,017		9	3.23
3.24	2	Cap Rel Costs-Mvble Equip	RELATED PARTY - DEACONESS	1,032	4,342	-3,310	9	3.24
3.25	5	Administrative & General	RELATED PARTY - DEACONESS	6,504	27,364	-20,860		3.25
3.26	8	Laundry & Linen Service	RELATED PARTY - DEACONESS	384	1,616	-1,232		3.26
3.27	9	Housekeeping	RELATED PARTY - DEACONESS	81	342	-261		3.27
3.28	10	Dietary	RELATED PARTY - DEACONESS	1,843	7,753	-5,910		3.28
3.29	54	Radiology-Diagnostic	RELATED PARTY - DEACONESS	1,303	3,839	-2,536		3.29
3.30	54.01	RADIOLOGY-SUA	RELATED PARTY - DEACONESS	12,294	36,222	-23,928		3.30
3.31	60	Laboratory	RELATED PARTY - DEACONESS	66,943	415,359	-348,416		3.31
3.32	65	Respiratory Therapy	RELATED PARTY - DEACONESS	299	1,698	-1,399		3.32
3.33	66	Physical Therapy	RELATED PARTY - DEACONESS	5	34	-29		3.33
3.34	71	Medical Supplies Charged to Patients	RELATED PARTY - DEACONESS	23,196	36,073	-12,877		3.34
3.35	73	Drugs Charged to Patients	RELATED PARTY - DEACONESS	1,269	4,912	-3,643		3.35
3.36	76.01	SPECIAL PROCEDURES	RELATED PARTY - DEACONESS	12,293	37,090	-24,797		3.36
3.37	76.02	SPECIAL PROCEDURES SUA	RELATED PARTY - DEACONESS	12,596	38,004	-25,408		3.37
4								4
5		TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12		7,183,767	7,936,584	-752,817		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

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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

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	
6	B	78.00	HEALTHSOUTH CORPORATION		HEALTHCARE	6
7	B	22.00	DEACONESS HOSPITAL		HEALTHCARE	7
8	G		HEALTHSOUTH CORPORATION		HEALTHCARE	8
9	G		DEACONESS HOSPITAL		HEALTHCARE	9
10						10

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

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

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun- eration	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	8,761		8,761	211,500	52	5,288	264	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	8,761		8,761		52	5,288	264	200

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HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/11/2016 Run Time: 14:31 Version: 2015.10 (04/20/2016)
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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					5,288	3,473	3,473	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					5,288	3,473	3,473	200

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HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/11/2016 Run Time: 14:31 Version: 2015.10 (04/20/2016)
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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	1,328,191	1,328,191					1
2	Cap Rel Costs-Mvble Equip	664,850		664,850				2
4	Employee Benefits Department	2,467,399	7,720	3,864	2,478,983			4
5	Administrative & General	4,130,203	273,542	136,926	379,494	4,920,165	4,920,165	5
6	Maintenance & Repairs							6
7	Operation of Plant	745,026	50,396	25,226	48,141	868,789	257,298	7
8	Laundry & Linen Service	35,863	11,749	5,881	5,672	59,165	17,522	8
9	Housekeeping	355,688	8,477	4,243	57,505	425,913	126,137	9
10	Dietary	629,478	84,095	42,095	58,568	814,236	241,142	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	423,779	8,477	4,243	84,510	521,009	154,300	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	208,978	8,912	4,461	26,765	249,116	73,777	16
17	Social Service	578,532	15,568	7,793	117,531	719,424	213,062	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	4,195,880	513,046	256,817	850,872	5,816,615	1,722,639	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	144,895	10,218	5,115		160,228	47,453	54
54.01	RADIOLOGY-SUA	12,294				12,294		54.01
60	Laboratory	281,085	967	484		282,536	83,675	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	314,341	3,642	1,823	64,880	384,686	113,927	65
66	Physical Therapy	1,288,198	87,237	43,668	265,067	1,684,170	498,779	66
67	Occupational Therapy	1,178,789	97,439	48,775	245,759	1,570,762	465,192	67
68	Speech Pathology	665,687	38,308	19,176	139,404	862,575	255,458	68
71	Medical Supplies Charged to Patients	324,355	21,886	10,955	13,300	370,496	109,725	71
73	Drugs Charged to Patients	1,265,443	6,527	3,267	102,502	1,377,739	408,027	73
76	PSYCH							76
76.01	SPECIAL PROCEDURES	207,425				207,425	61,430	76.01
76.02	SPECIAL PROCEDURES SUA	12,596				12,596		76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	21,458,975	1,248,206	624,812	2,459,970	21,319,939	4,849,543	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	869	77,600	38,844		117,313	34,743	192
194	MARKETING	98,558	2,385	1,194	19,013	121,150	35,879	194
194.01	GUEST MEALS							194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	21,558,402	1,328,191	664,850	2,478,983	21,558,402	4,920,165	202

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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 ADMINIS- TRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	1,126,087						7
8	Laundry & Linen Service	13,276	89,963					8
9	Housekeeping	9,579		561,629				9
10	Dietary	95,027		48,376	1,198,781			10
11	Cafeteria				164,797	164,797		11
12	Maintenance of Personnel							12
13	Nursing Administration	9,579		4,877		7,218	696,983	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	10,071		5,127		2,286		16
17	Social Service	17,592		8,956		10,038		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	579,744	89,963	295,133	968,472	72,667	696,983	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	11,546		5,878				54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory	1,093		556				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	4,116		2,095		5,541		65
66	Physical Therapy	98,579		50,184		22,638		66
67	Occupational Therapy	110,106		56,053		20,989		67
68	Speech Pathology	43,289		22,037		11,906		68
71	Medical Supplies Charged to Patients	24,731		12,590		1,136		71
73	Drugs Charged to Patients	7,376		3,755		8,754		73
76	PSYCH							76
76.01	SPECIAL PROCEDURES							76.01
76.02	SPECIAL PROCEDURES SUA							76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	1,035,704	89,963	515,617	1,133,269	163,173	696,983	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	87,688		44,640				192
194	MARKETING	2,695		1,372		1,624		194
194.01	GUEST MEALS				65,512			194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,126,087	89,963	561,629	1,198,781	164,797	696,983	202

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HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/11/2016 Run Time: 14:31 Version: 2015.10 (04/20/2016)
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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	340,377					16
17	Social Service		969,072				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	131,751	969,072	11,343,039		11,343,039	30
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	2,158		227,263		227,263	54
54.01	RADIOLOGY-SUA			12,294		12,294	54.01
60	Laboratory	13,359		381,219		381,219	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	28,895		539,260		539,260	65
66	Physical Therapy	43,696		2,398,046		2,398,046	66
67	Occupational Therapy	41,218		2,264,320		2,264,320	67
68	Speech Pathology	23,530		1,218,795		1,218,795	68
71	Medical Supplies Charged to Patients	7,153		525,831		525,831	71
73	Drugs Charged to Patients	46,492		1,852,143		1,852,143	73
76	PSYCH						76
76.01	SPECIAL PROCEDURES	2,125		270,980		270,980	76.01
76.02	SPECIAL PROCEDURES SUA			12,596		12,596	76.02
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
113	Interest Expense						113
118	SUBTOTALS (sum of lines 1-117)	340,377	969,072	21,045,786		21,045,786	118
	NONREIMBURSABLE COST CENTERS						
192	Physicians' Private Offices			284,384		284,384	192
194	MARKETING			162,720		162,720	194
194.01	GUEST MEALS			65,512		65,512	194.01
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	340,377	969,072	21,558,402		21,558,402	202

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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		7,720	3,864	11,584	11,584		4
5	Administrative & General		273,542	136,926	410,468	1,774	412,242	5
6	Maintenance & Repairs							6
7	Operation of Plant		50,396	25,226	75,622	225	21,558	7
8	Laundry & Linen Service		11,749	5,881	17,630	27	1,468	8
9	Housekeeping		8,477	4,243	12,720	269	10,569	9
10	Dietary		84,095	42,095	126,190	274	20,204	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration		8,477	4,243	12,720	395	12,928	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		8,912	4,461	13,373	125	6,182	16
17	Social Service		15,568	7,793	23,361	549	17,852	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		513,046	256,817	769,863	3,973	144,332	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic		10,218	5,115	15,333		3,976	54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory		967	484	1,451		7,011	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		3,642	1,823	5,465	303	9,546	65
66	Physical Therapy		87,237	43,668	130,905	1,239	41,791	66
67	Occupational Therapy		97,439	48,775	146,214	1,149	38,977	67
68	Speech Pathology		38,308	19,176	57,484	652	21,404	68
71	Medical Supplies Charged to Patients		21,886	10,955	32,841	62	9,193	71
73	Drugs Charged to Patients		6,527	3,267	9,794	479	34,187	73
76	PSYCH							76
76.01	SPECIAL PROCEDURES						5,147	76.01
76.02	SPECIAL PROCEDURES SUA							76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)		1,248,206	624,812	1,873,018	11,495	406,325	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		77,600	38,844	116,444		2,911	192
194	MARKETING		2,385	1,194	3,579	89	3,006	194
194.01	GUEST MEALS							194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		1,328,191	664,850	1,993,041	11,584	412,242	202

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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	97,405						7
8	Laundry & Linen Service	1,148	20,273					8
9	Housekeeping	829		24,387				9
10	Dietary	8,220		2,101	156,989			10
11	Cafeteria				21,581	21,581		11
12	Maintenance of Personnel							12
13	Nursing Administration	829		212		945	28,029	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	871		223		299		16
17	Social Service	1,522		389		1,315		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	50,146	20,273	12,814	126,829	9,515	28,029	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	999		255				54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory	95		24				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	356		91		726		65
66	Physical Therapy	8,527		2,179		2,965		66
67	Occupational Therapy	9,524		2,434		2,749		67
68	Speech Pathology	3,744		957		1,559		68
71	Medical Supplies Charged to Patients	2,139		547		149		71
73	Drugs Charged to Patients	638		163		1,146		73
76	PSYCH							76
76.01	SPECIAL PROCEDURES							76.01
76.02	SPECIAL PROCEDURES SUA							76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	89,587	20,273	22,389	148,410	21,368	28,029	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	7,585		1,938				192
194	MARKETING	233		60		213		194
194.01	GUEST MEALS				8,579			194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	97,405	20,273	24,387	156,989	21,581	28,029	202

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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	21,073					16
17	Social Service		44,988				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	8,161	44,988	1,218,923		1,218,923	30
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	134		20,697		20,697	54
54.01	RADIOLOGY-SUA						54.01
60	Laboratory	827		9,408		9,408	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	1,788		18,275		18,275	65
66	Physical Therapy	2,704		190,310		190,310	66
67	Occupational Therapy	2,551		203,598		203,598	67
68	Speech Pathology	1,456		87,256		87,256	68
71	Medical Supplies Charged to Patients	443		45,374		45,374	71
73	Drugs Charged to Patients	2,877		49,284		49,284	73
76	PSYCH						76
76.01	SPECIAL PROCEDURES	132		5,279		5,279	76.01
76.02	SPECIAL PROCEDURES SUA						76.02
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
113	Interest Expense						113
118	SUBTOTALS (sum of lines 1-117)	21,073	44,988	1,848,404		1,848,404	118
	NONREIMBURSABLE COST CENTERS						
192	Physicians' Private Offices			128,878		128,878	192
194	MARKETING			7,180		7,180	194
194.01	GUEST MEALS			8,579		8,579	194.01
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	21,073	44,988	1,993,041		1,993,041	202

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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	82,413						1
2	Cap Rel Costs-Mvble Equip		82,413					2
4	Employee Benefits Department	479	479	11,738,179				4
5	Administrative & General	16,973	16,973	1,796,932	-4,920,165	16,613,347		5
6	Maintenance & Repairs							6
7	Operation of Plant	3,127	3,127	227,953		868,789	61,834	7
8	Laundry & Linen Service	729	729	26,855		59,165	729	8
9	Housekeeping	526	526	272,290		425,913	526	9
10	Dietary	5,218	5,218	277,326		814,236	5,218	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	526	526	400,162		521,009	526	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	553	553	126,734		249,116	553	16
17	Social Service	966	966	556,520		719,424	966	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	31,834	31,834	4,028,943		5,816,615	31,834	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	634	634			160,228	634	54
54.01	RADIOLOGY-SUA				-12,294			54.01
60	Laboratory	60	60			282,536	60	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	226	226	307,213		384,686	226	65
66	Physical Therapy	5,413	5,413	1,255,110		1,684,170	5,413	66
67	Occupational Therapy	6,046	6,046	1,163,689		1,570,762	6,046	67
68	Speech Pathology	2,377	2,377	660,090		862,575	2,377	68
71	Medical Supplies Charged to Patients	1,358	1,358	62,977		370,496	1,358	71
73	Drugs Charged to Patients	405	405	485,356		1,377,739	405	73
76	PSYCH							76
76.01	SPECIAL PROCEDURES					207,425		76.01
76.02	SPECIAL PROCEDURES SUA				-12,596			76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	77,450	77,450	11,648,150	-4,945,055	16,374,884	56,871	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	4,815	4,815			117,313	4,815	192
194	MARKETING	148	148	90,029		121,150	148	194
194.01	GUEST MEALS							194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,328,191	664,850	2,478,983		4,920,165	1,126,087	202
203	Unit Cost Multiplier (Wkst. B, Part I)	16.116280	8.067295	0.211190		0.296157	18.211453	203
204	Cost to be allocated (Per Wkst. B, Part II)			11,584		412,242	97,405	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000987		0.024814	1.575266	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	24,887						8
9	Housekeeping		60,579					9
10	Dietary		5,218	91,896				10
11	Cafeteria			12,633	9,136,823			11
12	Maintenance of Personnel							12
13	Nursing Administration		526		400,162	24,887		13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		553		126,734		55,727,528	16
17	Social Service		966		556,520			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	24,887	31,834	74,241	4,028,943	24,887	21,571,391	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic		634				353,229	54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory		60				2,187,107	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		226		307,213		4,730,638	65
66	Physical Therapy		5,413		1,255,110		7,153,958	66
67	Occupational Therapy		6,046		1,163,689		6,748,178	67
68	Speech Pathology		2,377		660,090		3,852,399	68
71	Medical Supplies Charged to Patients		1,358		62,977		1,171,007	71
73	Drugs Charged to Patients		405		485,356		7,611,680	73
76	PSYCH							76
76.01	SPECIAL PROCEDURES						347,941	76.01
76.02	SPECIAL PROCEDURES SUA							76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	24,887	55,616	86,874	9,046,794	24,887	55,727,528	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		4,815					192
194	MARKETING		148		90,029			194
194.01	GUEST MEALS			5,022				194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	89,963	561,629	1,198,781	164,797	696,983	340,377	202
203	Unit Cost Multiplier (Wkst. B, Part I)	3.614859	9.271018	13.044975	0.018037	28.005907	0.006108	203
204	Cost to be allocated (Per Wkst. B, Part II)	20,273	24,387	156,989	21,581	28,029	21,073	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.814602	0.402565	1.708333	0.002362	1.126251	0.000378	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	24,887						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	24,887						30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic							54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients							73
76	PSYCH							76
76.01	SPECIAL PROCEDURES							76.01
76.02	SPECIAL PROCEDURES SUA							76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	24,887						118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices							192
194	MARKETING							194
194.01	GUEST MEALS							194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	969,072						202
203	Unit Cost Multiplier (Wkst. B, Part I)	38.938884						203
204	Cost to be allocated (Per Wkst. B, Part II)	44,988						204
205	Unit Cost Multiplier (Wkst. B, Part II)	1.807691						205

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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

				WORKSHEET			
DESCRIPTION				PART	LINE NO.	AMOUNT	
1				2	3	4	

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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	11,343,039		11,343,039	3,473	11,346,512	30
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	227,263		227,263		227,263	54
54.01	RADIOLOGY-SUA	12,294		12,294		12,294	54.01
60	Laboratory	381,219		381,219		381,219	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	539,260		539,260		539,260	65
66	Physical Therapy	2,398,046		2,398,046		2,398,046	66
67	Occupational Therapy	2,264,320		2,264,320		2,264,320	67
68	Speech Pathology	1,218,795		1,218,795		1,218,795	68
71	Medical Supplies Charged to Patients	525,831		525,831		525,831	71
73	Drugs Charged to Patients	1,852,143		1,852,143		1,852,143	73
76	PSYCH						76
76.01	SPECIAL PROCEDURES	270,980		270,980		270,980	76.01
76.02	SPECIAL PROCEDURES SUA	12,596		12,596		12,596	76.02
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	21,045,786		21,045,786	3,473	21,049,259	200
201	Less Observation Beds						201
202	Total (line 200 minus line 201)	21,045,786		21,045,786		21,049,259	202

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HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/11/2016 Run Time: 14:31 Version: 2015.10 (04/20/2016)
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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	21,571,391		21,571,391				30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	349,918	3,311	353,229	0.643387	0.643387	0.643387	54
54.01	RADIOLOGY-SUA	95,356		95,356	0.128927	0.128927	0.128927	54.01
60	Laboratory	2,187,060	47	2,187,107	0.174303	0.174303	0.174303	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	4,730,638		4,730,638	0.113993	0.113993	0.113993	65
66	Physical Therapy	5,810,770	1,343,188	7,153,958	0.335205	0.335205	0.335205	66
67	Occupational Therapy	5,994,728	753,450	6,748,178	0.335545	0.335545	0.335545	67
68	Speech Pathology	2,787,447	1,064,952	3,852,399	0.316373	0.316373	0.316373	68
71	Medical Supplies Charged to Patients	1,157,841	13,166	1,171,007	0.449042	0.449042	0.449042	71
73	Drugs Charged to Patients	7,611,680		7,611,680	0.243329	0.243329	0.243329	73
76	PSYCH							76
76.01	SPECIAL PROCEDURES	347,941		347,941	0.778810	0.778810	0.778810	76.01
76.02	SPECIAL PROCEDURES SUA	139,628		139,628	0.090211	0.090211	0.090211	76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	52,784,398	3,178,114	55,962,512				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	52,784,398	3,178,114	55,962,512				202

KPMG LLP Compu-Max 2552-10

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/11/2016 Run Time: 14:31 Version: 2015.10 (04/20/2016)
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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)	1,218,923		1,218,923	24,887	48.98	16,955	830,456	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)	1,218,923		1,218,923	24,887		16,955	830,456	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/11/2016 Run Time: 14:31 Version: 2015.10 (04/20/2016)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-3025

**WORKSHEET D
PART II**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	20,697	353,229	0.058594	289,312	16,952	54
54.01	RADIOLOGY-SUA		95,356		68,189		54.01
60	Laboratory	9,408	2,187,107	0.004302	1,508,341	6,489	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	18,275	4,730,638	0.003863	3,252,059	12,563	65
66	Physical Therapy	190,310	7,153,958	0.026602	3,975,823	105,765	66
67	Occupational Therapy	203,598	6,748,178	0.030171	4,135,277	124,765	67
68	Speech Pathology	87,256	3,852,399	0.022650	1,946,246	44,082	68
71	Medical Supplies Charged to Pat	45,374	1,171,007	0.038748	767,651	29,745	71
73	Drugs Charged to Patients	49,284	7,611,680	0.006475	4,994,828	32,342	73
76	PSYCH						76
76.01	SPECIAL PROCEDURES	5,279	347,941	0.015172	277,830	4,215	76.01
76.02	SPECIAL PROCEDURES SUA		139,628		124,270		76.02
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct						92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	629,481	34,391,121		21,339,826	376,918	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/11/2016 Run Time: 14:31 Version: 2015.10 (04/20/2016)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

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

		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjust- ment Amount (see instruct- ions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	Cost Center Description	1	2	3	4	5	
	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

KPMG LLP Compu-Max 2552-10

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/11/2016 Run Time: 14:31 Version: 2015.10 (04/20/2016)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

Check [] Title V [XX] PPS
Applicable [XX] 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)	24,887		16,955		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)	24,887		16,955		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/11/2016 Run Time: 14:31 Version: 2015.10 (04/20/2016)
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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/IID 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 Pat							71
73	Drugs Charged to Patients							73
76	PSYCH							76
76.01	SPECIAL PROCEDURES							76.01
76.02	SPECIAL PROCEDURES SUA							76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct)							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/11/2016 Run Time: 14:31 Version: 2015.10 (04/20/2016)
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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/IID 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	353,229			289,312		1,564		54
54.01	RADIOLOGY-SUA	95,356			68,189				54.01
60	Laboratory	2,187,107			1,508,341		47		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	4,730,638			3,252,059				65
66	Physical Therapy	7,153,958			3,975,823				66
67	Occupational Therapy	6,748,178			4,135,277				67
68	Speech Pathology	3,852,399			1,946,246				68
71	Medical Supplies Charged to Pat	1,171,007			767,651		48		71
73	Drugs Charged to Patients	7,611,680			4,994,828				73
76	PSYCH								76
76.01	SPECIAL PROCEDURES	347,941			277,830				76.01
76.02	SPECIAL PROCEDURES SUA	139,628			124,270				76.02
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct)								92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	34,391,121			21,339,826		1,659		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/11/2016 Run Time: 14:31 Version: 2015.10 (04/20/2016)
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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/IID

(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	0.643387	1,564			1,006			54
54.01	RADIOLOGY-SUA	0.128927							54.01
60	Laboratory	0.174303	47			8			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.113993							65
66	Physical Therapy	0.335205							66
67	Occupational Therapy	0.335545							67
68	Speech Pathology	0.316373							68
71	Medical Supplies Charged to Pat	0.449042	48			22			71
73	Drugs Charged to Patients	0.243329							73
76	PSYCH								76
76.01	SPECIAL PROCEDURES	0.778810							76.01
76.02	SPECIAL PROCEDURES SUA	0.090211							76.02
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct)								92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		1,659			1,036			200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		1,659			1,036			202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/11/2016 Run Time: 14:31 Version: 2015.10 (04/20/2016)
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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

	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)		
(A)	1	2	3	4	5	6	7		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	1,218,923		1,218,923	24,887	48.98	385	18,857	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)	1,218,923		1,218,923	24,887		385	18,857	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/11/2016 Run Time: 14:31 Version: 2015.10 (04/20/2016)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-3025

**WORKSHEET D
PART II**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	20,697	353,229	0.058594	3,467	203	54
54.01	RADIOLOGY-SUA		95,356		2,410		54.01
60	Laboratory	9,408	2,187,107	0.004302	37,267	160	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	18,275	4,730,638	0.003863	53,328	206	65
66	Physical Therapy	190,310	7,153,958	0.026602	91,322	2,429	66
67	Occupational Therapy	203,598	6,748,178	0.030171	96,268	2,905	67
68	Speech Pathology	87,256	3,852,399	0.022650	59,650	1,351	68
71	Medical Supplies Charged to Pat	45,374	1,171,007	0.038748	15,293	593	71
73	Drugs Charged to Patients	49,284	7,611,680	0.006475	164,467	1,065	73
76	PSYCH						76
76.01	SPECIAL PROCEDURES	5,279	347,941	0.015172			76.01
76.02	SPECIAL PROCEDURES SUA		139,628		8,096		76.02
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct						92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	629,481	34,391,121		531,568	8,912	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/11/2016 Run Time: 14:31 Version: 2015.10 (04/20/2016)
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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	1 Nursing School	2 Allied Health Cost	3 All Other Medical Education Cost	4 Swing-Bed Adjust- ment Amount (see instruct- ions)	5 Total Costs (sum of cols. 1 through 3 minus col 4.)	
	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

KPMG LLP Compu-Max 2552-10

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/11/2016 Run Time: 14:31 Version: 2015.10 (04/20/2016)
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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)	24,887		385		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)	24,887		385		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/11/2016 Run Time: 14:31 Version: 2015.10 (04/20/2016)
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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/IID 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 Pat							71
73	Drugs Charged to Patients							73
76	PSYCH							76
76.01	SPECIAL PROCEDURES							76.01
76.02	SPECIAL PROCEDURES SUA							76.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct)							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/11/2016 Run Time: 14:31 Version: 2015.10 (04/20/2016)
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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/IID 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	353,229			3,467				54
54.01	RADIOLOGY-SUA	95,356			2,410				54.01
60	Laboratory	2,187,107			37,267				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	4,730,638			53,328				65
66	Physical Therapy	7,153,958			91,322				66
67	Occupational Therapy	6,748,178			96,268				67
68	Speech Pathology	3,852,399			59,650				68
71	Medical Supplies Charged to Pat	1,171,007			15,293				71
73	Drugs Charged to Patients	7,611,680			164,467				73
76	PSYCH								76
76.01	SPECIAL PROCEDURES	347,941							76.01
76.02	SPECIAL PROCEDURES SUA	139,628			8,096				76.02
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct)								92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	34,391,121			531,568				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/11/2016 Run Time: 14:31 Version: 2015.10 (04/20/2016)
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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/IID

(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	0.643387							54
54.01	RADIOLOGY-SUA	0.128927							54.01
60	Laboratory	0.174303							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.113993							65
66	Physical Therapy	0.335205		31,502			10,560		66
67	Occupational Therapy	0.335545		26,855			9,011		67
68	Speech Pathology	0.316373		45,948			14,537		68
71	Medical Supplies Charged to Pat	0.449042		19			9		71
73	Drugs Charged to Patients	0.243329							73
76	PSYCH								76
76.01	SPECIAL PROCEDURES	0.778810							76.01
76.02	SPECIAL PROCEDURES SUA	0.090211							76.02
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct								92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			104,324			34,117		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			104,324			34,117		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/11/2016 Run Time: 14:31 Version: 2015.10 (04/20/2016)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-3025

WORKSHEET D-1
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	24,887	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	24,887	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.	2,084	3
4	Semi-private room days (excluding swing-bed private room days)	22,803	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)	16,955	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)	1,291	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)	11,346,512	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)	11,346,512	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)	21,362,560	28
29	Private room charges (excluding swing-bed charges)	1,832,464	29
30	Semi-private room charges (excluding swing-bed charges)	19,530,096	30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.531140	31
32	Average private room per diem charge (line 29 ÷ line 3)	879.30	32
33	Average semi-private room per diem charge (line 30 ÷ line 4)	856.47	33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)	22.83	34
35	Average per diem private room cost differential (line 34 x line 31)	12.13	35
36	Private room cost differential adjustment (line 3 x line 35)	25,279	36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	11,321,233	37

KPMG LLP Compu-Max 2552-10

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/11/2016 Run Time: 14:31 Version: 2015.10 (04/20/2016)
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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

38	Adjusted general inpatient routine service cost per diem (see instructions)					455.92	38
39	Program general inpatient routine service cost (line 9 x line 38)					7,730,124	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)					7,730,124	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

48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					5,952,262	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					13,682,386	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					830,456	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					376,918	51
52	Total Program excludable cost (sum of lines 50 and 51)					1,207,374	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					12,475,012	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

KPMG LLP Compu-Max 2552-10

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/11/2016 Run Time: 14:31 Version: 2015.10 (04/20/2016)
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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/IID 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)						455.92	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

KPMG LLP Compu-Max 2552-10

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/11/2016 Run Time: 14:31 Version: 2015.10 (04/20/2016)
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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/IID 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)	24,887	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	24,887	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.	2,084	3
4	Semi-private room days (excluding swing-bed private room days)	22,803	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)	385	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)	11,343,039	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)	11,343,039	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)	21,362,560	28
29	Private room charges (excluding swing-bed charges)	1,832,464	29
30	Semi-private room charges (excluding swing-bed charges)	19,530,096	30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.530978	31
32	Average private room per diem charge (line 29 ÷ line 3)	879.30	32
33	Average semi-private room per diem charge (line 30 ÷ line 4)	856.47	33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)	22.83	34
35	Average per diem private room cost differential (line 34 x line 31)	12.12	35
36	Private room cost differential adjustment (line 3 x line 35)	25,258	36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	11,317,781	37

KPMG LLP Compu-Max 2552-10

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/11/2016 Run Time: 14:31 Version: 2015.10 (04/20/2016)
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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)						454.77	38
39	Program general inpatient routine service cost (line 9 x line 38)						175,086	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)						175,086	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)						144,520	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						319,606	49
	PASS THROUGH COST ADJUSTMENTS							
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						18,857	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						8,912	51
52	Total Program excludable cost (sum of lines 50 and 51)						27,769	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

KPMG LLP Compu-Max 2552-10

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/11/2016 Run Time: 14:31 Version: 2015.10 (04/20/2016)
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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/IID 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

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HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/11/2016 Run Time: 14:31 Version: 2015.10 (04/20/2016)
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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/IID 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		14,539,907		30
	ANCILLARY SERVICE COST CENTERS				
54	Radiology-Diagnostic	0.643387	289,312	186,140	54
54.01	RADIOLOGY-SUA	0.128927	68,189	8,791	54.01
60	Laboratory	0.174303	1,508,341	262,908	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.113993	3,252,059	370,712	65
66	Physical Therapy	0.335205	3,975,823	1,332,716	66
67	Occupational Therapy	0.335545	4,135,277	1,387,572	67
68	Speech Pathology	0.316373	1,946,246	615,740	68
71	Medical Supplies Charged to Patients	0.449042	767,651	344,708	71
73	Drugs Charged to Patients	0.243329	4,994,828	1,215,387	73
76	PSYCH				76
76.01	SPECIAL PROCEDURES	0.778810	277,830	216,377	76.01
76.02	SPECIAL PROCEDURES SUA	0.090211	124,270	11,211	76.02
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
92	Observation Beds (Non-Distinct Part)				92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		21,339,826	5,952,262	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		21,339,826		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/11/2016 Run Time: 14:31 Version: 2015.10 (04/20/2016)
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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/IID 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		330,463		30
	ANCILLARY SERVICE COST CENTERS				
54	Radiology-Diagnostic	0.643387	3,467	2,231	54
54.01	RADIOLOGY-SUA	0.128927	2,410	311	54.01
60	Laboratory	0.174303	37,267	6,496	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.113993	53,328	6,079	65
66	Physical Therapy	0.335205	91,322	30,612	66
67	Occupational Therapy	0.335545	96,268	32,302	67
68	Speech Pathology	0.316373	59,650	18,872	68
71	Medical Supplies Charged to Patients	0.449042	15,293	6,867	71
73	Drugs Charged to Patients	0.243329	164,467	40,020	73
76	PSYCH				76
76.01	SPECIAL PROCEDURES	0.778810			76.01
76.02	SPECIAL PROCEDURES SUA	0.090211	8,096	730	76.02
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
92	Observation Beds (Non-Distinct Part)				92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		531,568	144,520	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		531,568		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/11/2016 Run Time: 14:31 Version: 2015.10 (04/20/2016)
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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)	1,036			2
3	PPS payments	521			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)	521			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	116			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)	405			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)	405			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	405			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)	405			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)	405			40
40.01	Sequestration adjustment (see instructions)	8			40.01
41	Interim payments	397			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

KPMG LLP Compu-Max 2552-10

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/11/2016 Run Time: 14:31 Version: 2015.10 (04/20/2016)
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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		22,418,034		397
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				2
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)		22,418,034		397
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			6.01
		.02			6.02
7	Total Medicare program liability (see instructions)				7
8	Name of Contractor		Contractor Number	NPR Date (Month/Day/Year)	8

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

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HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/11/2016 Run Time: 14:31 Version: 2015.10 (04/20/2016)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-3025

WORKSHEET E-3
PART III

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

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

		1	1.01	
1	Net Federal PPS payment (see instructions)	22,637,783		1
2	Medicare SSI ratio (IRF PPS only) (see instructions)	0,048200		2
3	Inpatient Rehabilitation LIP payments (see instructions)	932,677		3
4	Outlier payments	13,772		4
5	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			5
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) OR (2)			5.01
6	New teaching program adjustment (see instructions)			6
7	Current year unweighted FTE count of I&R 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)	68,183562		10
11	Teaching Adjustment Factor (see instructions)			11
12	Teaching Adjustment (see instructions)			12
13	Total PPS Payment (see instructions)	23,584,232		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)	23,584,232		17
18	Primary payer payments	17,532		18
19	Subtotal (line 17 less line 18)	23,566,700		19
20	Deductibles	351,100		20
21	Subtotal (line 19 minus line 20)	23,215,600		21
22	Coinsurance	166,378		22
23	Subtotal (line 21 minus line 22)	23,049,222		23
24	Allowable bad debts (exclude bad debts for professional services) (see instructions)	156,389		24
25	Adjusted reimbursable bad debts (see instructions)	101,653		25
26	Allowable bad debts for dual eligible beneficiaries (see instructions)	97,897		26
27	Subtotal (sum of lines 23 and 25)	23,150,875		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)	23,150,875		32
32.01	Sequestration adjustment (see instructions)	463,018		32.01
33	Interim payments	22,418,034		33
34	Tentative settlement (for contractor use only)			34
35	Balance due provider/program (line 32 minus lines 32.01, 33 and 34)	269,823		35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	679,350		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

KPMG LLP Compu-Max 2552-10

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/11/2016 Run Time: 14:31 Version: 2015.10 (04/20/2016)
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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/IID 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	319,606		1
2		34,117	2
3			3
4	319,606	34,117	4
5			5
6			6
7	319,606	34,117	7
COMPUTATION OF LESSER OF COST OR CHARGES			
REASONABLE CHARGES			
8	330,463		8
9	531,568	104,324	9
10			10
11			11
12	862,031	104,324	12
CUSTOMARY CHARGES			
13			13
14			14
15	1,000,000	1,000,000	15
16	862,031	104,324	16
17	542,425	70,207	17
18			18
19			19
20			20
21	319,606	34,117	21
PROSPECTIVE PAYMENT AMOUNT			
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29	319,606	34,117	29
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30			30
31	319,606	34,117	31
32			32
33			33
34			34
35			35
36	319,606	34,117	36
37			37
38	319,606	34,117	38
39			39
40	319,606	34,117	40
41	213,970	19,289	41
42	105,636	14,828	42
43			43

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BALANCE SHEET

WORKSHEET G

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

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
Assets (Omit Cents)		1	2	3	4	
CURRENT ASSETS						
1	Cash on hand and in banks	4,427,621				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	7,413,399				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-1,912,978				6
7	Inventory	59,505				7
8	Prepaid expenses	-102,068				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	9,885,479				11
FIXED ASSETS						
12	Land					12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings					15
16	Accumulated depreciation					16
17	Leasehold improvements	5,365,426				17
18	Accumulated depreciation	-2,386,708				18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	4,166,822				23
24	Accumulated depreciation	-2,158,667				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)	4,986,873				30
OTHER ASSETS						
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	12,307,841				34
35	Total other assets (sum of lines 31-34)	12,307,841				35
36	Total assets (sum of lines 11, 30 and 35)	27,180,193				36
Liabilities and Fund Balances (Omit Cents)						
		1	2	3	4	
CURRENT LIABILITIES						
37	Accounts payable	534,092				37
38	Salaries, wages and fees payable	904,898				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	2,976,130				44
45	Total current liabilities (sum of lines 37 thru 44)	4,415,120				45
LONG TERM LIABILITIES						
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	5,186,373				49
50	Total long term liabilities (sum of lines 46 thru 49)	5,186,373				50
51	Total liabilities (sum of lines 45 and 50)	9,601,493				51
CAPITAL ACCOUNTS						
52	General fund balance	17,578,700				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)	17,578,700				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	27,180,193				60

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STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

		GENERAL FUND		SPECIFIC PURPOSE FUND	
		1	2	3	4
1	Fund balances at beginning of period		15,485,478		1
2	Net income (loss) (from Worksheet G-3, line 29)		10,238,972		2
3	Total (sum of line 1 and line 2)		25,724,450		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)		25,724,450		11
12	Deductions (debit adjustments) (specify)				12
13	MINORITY INTEREST	2,252,573			13
14	DISTRIBUTIONS	5,893,177			14
15					15
16					16
17					17
18	Total deductions (sum of lines 12-17)		8,145,750		18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		17,578,700		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

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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	21,571,391		21,571,391	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)	21,571,391		21,571,391	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)	21,571,391		21,571,391	17
18	Ancillary services	31,213,054	3,178,067	34,391,121	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)	52,784,445	3,178,067	55,962,512	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		22,927,915	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)		22,927,915	43

KPMG LLP Compu-Max 2552-10

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/11/2016 Run Time: 14:31 Version: 2015.10 (04/20/2016)
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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)	55,962,512	1
2	Less contractual allowances and discounts on patients' accounts	22,889,062	2
3	Net patient revenues (line 1 minus line 2)	33,073,450	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	22,927,915	4
5	Net income from service to patients (line 3 minus line 4)	10,145,535	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments	13,725	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts		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		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		21
22	Rental of hosptial space	83,706	22
23	Governmental appropriations		23
24	Other (specify)	-3,994	24
25	Total other income (sum of lines 6-24)	93,437	25
26	Total (line 5 plus line 25)	10,238,972	26
29	Net income (or loss) for the period (line 26 minus line 28)	10,238,972	29