## KPMG LLP Compu-Max 2552-10

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

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

**WORKSHEET S**
**PARTS I, II & III**

**PART I - COST REPORT STATUS**

| | | | |
|---|---|---|---|
| Provider use only | 1. [X] Electronically filed cost report Date: 05/11/2016 Time: 14:31<br>2. [ ] Manually submitted cost report<br>3. [ ] If this is an amended report enter the number of times the provider resubmitted the cost report<br>4. [F] Medicare Utilization. Enter 'F' for full or 'L' for low. | | |
| Contractor use only | 5. [ ] Cost Report Status<br>(1) As Submitted<br>(2) Settled without audit<br>(3) Settled with audit<br>(4) Reopened<br>(5) Amended | 6. Date Received: _____<br>7. Contractor No.: _____<br>8. [ ] Initial Report for this Provider CCN<br>9. [ ] Final Report for this Provider CCN | 10. NPR Date: _____<br>11. Contractor's Vendor Code: ___<br>12. [ ] If line 5, column 1 is 4:<br>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.

ECR Encryption: 05/11/2016 14:31
2b6a2pK0GrFan96ifTe5jypMtMsac0
PyRYb0wp:f0OwuuCICZrierbna5LPd
ejmN0PhCQc0OU2kR

PI Encryption: 05/11/2016 14:31
ImCiT.snwz6luPu6uSxTw3K06a22Y0
wh0QP05hSxQVFTxrsShkP:xQPCs2vI
MrUy0Gbkgt0TrR9S

(Signed) Rob Wisner
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 resopnd to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send appilcations, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any corresponence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

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

**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 |

**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**

**WORKSHEET S-2**
**PART I**

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

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

| | | | | | |
|---|---|---|---|---|---|
| Teaching Hospitals | | 1 | 2 | 3 | |
| 56 | Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no. | N | | | 56 |
| 57 | If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable. | N | | | 57 |
| 58 | If line 56 is yes, did this facility elect cost reimbursement for physicians' services ad defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5. | N | | | 58 |
| 59 | Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I. | N | | | 59 |
| 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 osteopathci FTEs in the current cost reporting period. (see instructions) | | | | 61.04 |
| 61.05 | Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) | | | | 61.05 |
| 61.06 | Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) | | | | 61.06 |

Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count 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 reseived HRSA PCRE funding (see instructions) | | | | 62 |
| 62.01 | Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost reporting period of HRSA THC program. (see instructions) | | | | 62.01 |

Teaching Hospitals that Claim Residents in Nonprovider Settings

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

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

**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**

**WORKSHEET S-2**
**PART I**

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

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

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

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

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

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

| Inpatient Psychiatric Faciltiy PPS | | 1 | 2 | 3 | |
|---|---|---|---|---|---|
| 70 | Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no. | N | | | 70 |
| 71 | If line 70 yes:<br>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.<br>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.<br>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:<br>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.<br>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.<br>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 |

**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**

**WORKSHEET S-2**
**PART I**

| | | V | XIX | |
|---|---|---|---|---|
| Title V and XIX Services | | 1 | 2 | |
| 90 | Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column. | N | Y | 90 |
| 91 | Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column. | N | N | 91 |
| 92 | Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column. | | N | 92 |
| 93 | Does this facility operate an ICF/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)<br>If yes, the GME elinination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II. | | | 107 |
| 108 | Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no. | N | | 108 |

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

**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**

**WORKSHEET S-2**
**PART I**

All Providers

| | | 1 | 2 | |
|---|---|---|---|---|
| 140 | Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions) | Y | 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.<br>If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. | N | N | 145 |
| 146 | Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, chapter 40, §4020). If yes, enter the approval date (mm/dd/yyyy) in column 2. | N | | 146 |
| | | | | |
| 147 | Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no. | N | | 147 |
| 148 | Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no. | N | | 148 |
| 149 | Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no. | N | | 149 |

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

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

Multicampus

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

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

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

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

**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE**

**WORKSHEET S-2**
**PART II**

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

## COMPLETED BY ALL HOSPITALS

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

| | | Y/N | Type | Date | |
|---|---|---|---|---|---|
| Financial Data and Reports | | 1 | 2 | 3 | |
| 4 | Column 1: Were the financial statements prepared by a Certified Public Accnountant? 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 | | 1 | 2 | |
| 6 | Column 1: Are costs claimed for nursing school?<br>Column 2: If yes, is the provider the legal operator of the program? | N | | 6 |
| 7 | Are costs claimed for allied health programs? If yes, see instructions. | N | | 7 |
| 8 | Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? | N | | 8 |
| 9 | Are costs claimed for Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions. | N | | 9 |
| 10 | Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructinos. | N | | 10 |
| 11 | Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions. | N | | 11 |

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

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

| | | Part A | | Part B | | |
|---|---|---|---|---|---|---|
| | | Y/N | Date | Y/N | Date | |
| PS&R Report Data | | 1 | 2 | 3 | 4 | |
| 16 | Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions) | N | | Y | 02/29/2016 | 16 |
| 17 | Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) | Y | 02/29/2016 | N | | 17 |
| 18 | If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions. | N | | N | | 18 |
| 19 | If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions. | N | | N | | 19 |
| 20 | If line 16 or 17 is yes, were adjustments made to PS&R Reoprt data for Other? Describe the other adjustments: | N | | N | | 20 |
| 21 | Was the cost report prepared only using the provider's records? If yes, see instructions. | N | | N | | 21 |

**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE**

**WORKSHEET S-2**
**PART II**

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

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

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

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

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

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

| | | Y/N | Date | |
|---|---|---|---|---|
| Home Office Costs | | 1 | 2 | |
| 36 | Are home office costs claimed on the cost report? | | | 36 |
| 37 | If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions. | | | 37 |
| 38 | If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. | | | 38 |
| 39 | If line 36 is yes, did the provider render servcies 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 | 41 |
| 42 | Employer: HEALTHSOUTH CORPORATION | | | 42 |
| 43 | Phone number: 205-968-7055 | E-mail Address: COURTNEY.CAMERON@HEALTHSOUTH.COM | | 43 |

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

**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA**

**WORKSHEET S-3**
**PART I**

| | | | | | | Inpatient Days / Outpatient Visits / Trips | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Component | Wkst A Line No. | No. of Beds | Bed Days Available | CAH Hours | Title V | Title XVIII | Title XIX | Total All Patients | |
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | |
| 1 | Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) | 30 | 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 |

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

**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA**

**WORKSHEET S-3**
**PART I**

| | | Full Time Equivalents | | | DISCHARGES | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Component | Total Interns & Residents | Employees On Payroll | Nonpaid Workers | Title V | Title XVIII | Title XIX | Total All Patients | |
| | | 9 | 10 | 11 | 12 | 13 | 14 | 15 | |
| 1 | Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) | | | | | 1,255 | 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 |

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

**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/FQHC) | | | | | | | 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 salarles (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 |

**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 |

| | | | |
|---|---|---|---|
| HEALTHSOUTH DEACONESS REHABILITATION<br>Provider CCN: 15-3025 | Supporting Exhibit for Form<br>**CMS-2552-10** | Period :<br>From: 01/01/2015<br>To: 12/31/2015 | Run Date: 05/11/2016<br>Run Time: 14:31<br>Version: 2015.10 (04/20/2016) |

**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)** | **CONTRIB-UTION(S)** | 11 |
| 12 | Total Calendar Months Included in Averaging Period (36 unless Step 2 completed) | | | 12 |
| 13 | Total Contributions Made During Averaging Period | | | 13 |
| 14 | Average Monthly Contribution (Line 13 divided by Line 12) | | | 14 |
| 15 | Number of MOnths in Provider Cost Reporting Period on Line 2 | | | 15 |
| 16 | Average Pension Contributions (Line 14 times Line 15) | | | 16 |
| | **STEP 4: TOTAL PENSION COST FOR WAGE INDEX** | | | |
| 17 | Annual Prefunding Installment (see instructions) | | | 17 |
| 18 | Reportable Prefunding Installment ((Line 17 times Line 15) divided by 12) | | | 18 |
| 19 | Total Pension Cost for Wage Index (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4) | | | 19 |

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

**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 |

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

**HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA** **WORKSHEET S-5**

RENAL DIALYSIS STATISTICS

| | | Outpatient | | Training | | Home | | |
|---|---|---|---|---|---|---|---|---|
| | DESCRIPTION | 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 mrthod(s))

| | | | |
|---|---|---|---|
| 21 | MCP | INITIAL METHOD | |

| | 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 |

**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 | 274,325 | 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 |

**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.

**RECLASSIFICATIONS** **WORKSHEET A-6**

| | | | DECREASES | | | | | |
|---|---|---|---|---|---|---|---|---|
| | EXPLANATION OF RECLASSIFICATION(S) | CODE (1) | COST CENTER | LINE # | SALARY | OTHER | Wkst A-7 Ref. | |
| | | 1 | 6 | 7 | 8 | 9 | 10 | |
| 1 | INSURANCE | A | | | | | 12 | 1 |
| 2 | INSURANCE | A | | | | | 12 | 2 |
| 3 | INSURANCE | A | Administrative & General | 5 | | 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.

**RECONCILIATION OF CAPITAL COST CENTERS**

**WORKSHEET A-7**
**PARTS I, II & III**

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

| | | | Acquisitions | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Description | Beginning Balances | Purchases | Donation | Total | Disposals and Retirements | Ending Balance | Fully Depreciated Assets | |
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| 1 | Land | | | | | | | | 1 |
| 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**

| | | SUMMARY OF CAPITAL | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Description | Depreciation | Lease | Interest | Insurance (see instructions) | Taxes (see instructions) | Other Capital-Related Costs (see instructions) | Total (1) (sum of cols. 9 through 14) | |
| * | | 9 | 10 | 11 | 12 | 13 | 14 | 15 | |
| 1 | Cap Rel Costs-Bldg & Fixt | 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**

| | | COMPUTATION OF RATIOS | | | | ALLOCATION OF OTHER CAPITAL | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Description | Gross Assets | Capitalized Leases | Gross Assets for Ratio (col. 1 - col. 2) | Ratio (see instructions) | Insurance | Taxes | Other Capital-Related Costs | Total (sum of cols. 5 through 7) | |
| * | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | |
| 1 | Cap Rel Costs-Bldg & Fi | 5,365,427 | | 5,365,427 | 0.574185 | | 105,678 | | 105,678 | 1 |
| 2 | Cap Rel Costs-Mvble Equ | 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 |

| | | SUMMARY OF CAPITAL | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Description | Depreciation | Lease | Interest | Insurance (see instructions) | Taxes (see instructions) | Other Capital-Related Costs (see instructions) | Total (2) (sum of cols. 9 through 14) | |
| * | | 9 | 10 | 11 | 12 | 13 | 14 | 15 | |
| 1 | Cap Rel Costs-Bldg & Fixt | 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.)

**ADJUSTMENTS TO EXPENSES** **WORKSHEET A-8**

| | | | | EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED | | | |
|---|---|---|---|---|---|---|---|
| | DESCRIPTION(1) | BASIS/ CODE (2) | AMOUNT | COST CENTER | LINE# | Wkst. A-7 Ref. | |
| | | 1 | 2 | 3 | 4 | 5 | |
| 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 | 13 | 37.05 |
| 37.06 | PROPERTY TAX | A | 2,523 | Cap Rel Costs-Mvble Equip | 2 | 13 | 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 | 9 | 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 | 9 | 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 |

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

**ADJUSTMENTS TO EXPENSES** **WORKSHEET A-8**

| | | | | EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED | | | |
|---|---|---|---|---|---|---|---|
| | DESCRIPTION(1) | BASIS/ CODE (2) | AMOUNT | COST CENTER | LINE# | Wkst. A-7 Ref. | |
| | | 1 | 2 | 3 | 4 | 5 | |
| 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)<br>(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.

**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

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

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

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

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

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

the information requested under Part B of this worksheet.

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

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

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

**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 |

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

**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 |

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

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

| | COST CENTER DESCRIPTIONS | NET EXP FOR COST ALLOCATION (from Wkst A, col.7) | CAP BLDGS & FIXTURES | CAP MOVABLE EQUIPMENT | EMPLOYEE BENEFITS DEPARTMENT | SUBTOTAL (cols.0-4) | ADMINIS-TRATIVE & GENERAL | |
|---|---|---|---|---|---|---|---|---|
| | | 0 | 1 | 2 | 4 | 4A | 5 | |
| | **GENERAL SERVICE COST CENTERS** | | | | | | | |
| 1 | Cap Rel Costs-Bldg & Fixt | 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 |

**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 |

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

**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 |

**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 |

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

| | COST CENTER DESCRIPTIONS | OPERATION OF PLANT | LAUNDRY & LINEN SERVICE | HOUSE-KEEPING | DIETARY | CAFETERIA | NURSING ADMINIS-TRATION | |
|---|---|---|---|---|---|---|---|---|
| | | 7 | 8 | 9 | 10 | 11 | 13 | |
| | **GENERAL SERVICE COST CENTERS** | | | | | | | |
| 1 | Cap Rel Costs-Bldg & Fixt | | | | | | | 1 |
| 2 | Cap Rel Costs-Mvble Equip | | | | | | | 2 |
| 4 | Employee Benefits Department | | | | | | | 4 |
| 5 | Administrative & General | | | | | | | 5 |
| 6 | Maintenance & Repairs | | | | | | | 6 |
| 7 | Operation of Plant | 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 |

**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 |

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

| | COST CENTER DESCRIPTIONS | CAP BLDGS & FIXTURES SQUARE FEET | CAP MOVABLE EQUIPMENT SQUARE FEET | EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES | RECON-CILIATION | ADMINIS-TRATIVE & GENERAL ACCUM COST | OPERATION OF PLANT SQUARE FEET | |
|---|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 4 | 5A | 5 | 7 | |
| | **GENERAL SERVICE COST CENTERS** | | | | | | | |
| 1 | Cap Rel Costs-Bldg & Fixt | 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 |

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

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

| | COST CENTER DESCRIPTIONS | LAUNDRY & LINEN SERVICE PATIENT DAYS | HOUSE-KEEPING SQUARE FEET | DIETARY MEALS SERVED | CAFETERIA GROSS SALARIES | NURSING ADMINIS-TRATION PATIENT DAYS | MEDICAL RECORDS & LIBRARY 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 |

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

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

| | COST CENTER DESCRIPTIONS | SOCIAL SERVICE<br><br>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 |

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

**POST STEPDOWN ADJUSTMENTS** **WORKSHEET B-2**

| | | WORKSHEET | | | |
|---|---|---|---|---|---|
| | DESCRIPTION | PART | LINE NO. | AMOUNT | |
| | 1 | 2 | 3 | 4 | |

**COMPUTATION OF RATIO OF COST TO CHARGES**

**WORKSHEET C**
**PART I**

| | | | | COSTS | | | |
|---|---|---|---|---|---|---|---|
| | COST CENTER DESCRIPTIONS | Total Cost (from Wkst. B, Part I, col. 26) | Therapy Limit Adj. | Total Costs | RCE Dis-allowance | Total Costs | |
| | | 1 | 2 | 3 | 4 | 5 | |
| | **INPATIENT ROUTINE SERVICE COST CENTERS** | | | | | | |
| 30 | Adults & Pediatrics | 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 |

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

**COMPUTATION OF RATIO OF COST TO CHARGES**

**WORKSHEET C**
**PART I**

| | | CHARGES | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | COST CENTER DESCRIPTIONS | Inpatient | Outpatient | Total (column 6 + column 7) | Cost or Other Ratio | TEFRA Inpatient Ratio | PPS Inpatient Ratio | |
| | | 6 | 7 | 8 | 9 | 10 | 11 | |
| | **INPATIENT ROUTINE SERVICE COST CENTERS** | | | | | | | |
| 30 | Adults & Pediatrics | 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 |

**APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS**

**WORKSHEET D**
**PART I**

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

| | | Capital Related Cost (from Wkst. B, Part II, (col. 26) | Swing Bed Adjust-ment | Reduced Capital Related Cost (col. 1 minus col. 2) | Total Patient Days | Per Diem (col. 3 ÷ col. 4) | Inpatient Program Days | Inpatient Program Capital Cost (col. 5 x col. 6) | |
|---|---|---|---|---|---|---|---|---|---|
| (A) | Cost Center Description | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| | **INPATIENT ROUTINE SERVICE COST CENTERS** | | | | | | | | |
| 30 | Adults & Pediatrics General Routine Care) | 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

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

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

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

| | | Capital Related Cost (from Wkst. B, Part II (col. 26) | Total Charges (from Wkst. C, Part I, (col. 8) | Ratio of Cost to Charges (col. 1 ÷ col. 2) | Inpatient Program Charges | Capital Costs (col. 3 x col. 4) | |
|---|---|---|---|---|---|---|---|
| (A) | Cost Center Description | 1 | 2 | 3 | 4 | 5 | |
| | **ANCILLARY SERVICE COST CENTERS** | | | | | | |
| 54 | Radiology-Diagnostic | 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

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

**APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS**

**WORKSHEET D**
**PART III**

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

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

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

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

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

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

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

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

(A) Worksheet A line numbers

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

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

| | | Total Charges (from Wkst. C, Part I, col. 8) | Ratio of Cost to Charges (col. 5÷ col. 7) | Outpatient Ratio of Cost to Charges (col. 6÷ col. 7) | Inpatient Program Charges | Inpatient Program Pass-Through Costs (col. 8 x col. 10) | Outpatient Program Charges | Outpatient Program Pass-Through Costs (col. 9 x col. 12) | |
|---|---|---|---|---|---|---|---|---|---|
| (A) | Cost Center Description | 7 | 8 | 9 | 10 | 11 | 12 | 13 | |
| | **ANCILLARY SERVICE COST CENTERS** | | | | | | | | |
| 54 | Radiology-Diagnostic | 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

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

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

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

| | | | Program Charges | | | Program Cost | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Cost to Charge Ratio (from Wkst C, Part I, col. 9) | PPS Reim-bursed Services (see inst.) | Cost Reim-bursed Subject to Ded. & Coins. (see inst.) | Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.) | PPS Services (see inst.) | Cost Reim-bursed Subject to Ded. & Coins. (see inst.) | Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.) | |
| (A) | Cost Center Description | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| | **ANCILLARY SERVICE COST CENTERS** | | | | | | | | |
| 54 | Radiology-Diagnostic | 0.643387 | 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

**APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS**

**WORKSHEET D**
**PART I**

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

| | | Capital Related Cost (from Wkst. B, Part II, (col. 26) | Swing Bed Adjust-ment | Reduced Capital Related Cost (col. 1 minus col. 2) | Total Patient Days | Per Diem (col. 3 ÷ col. 4) | Inpatient Program Days | Inpatient Program Capital Cost (col. 5 x col. 6) | |
|---|---|---|---|---|---|---|---|---|---|
| (A) | Cost Center Description | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| | **INPATIENT ROUTINE SERVICE COST CENTERS** | | | | | | | | |
| 30 | Adults & Pediatrics General Routine Care) | 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

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

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

| | | Capital Related Cost (from Wkst. B, Part II (col. 26) | Total Charges (from Wkst. C, Part I, (col. 8) | Ratio of Cost to Charges (col. 1 ÷ col. 2) | Inpatient Program Charges | Capital Costs (col. 3 x col. 4) | |
|---|---|---|---|---|---|---|---|
| (A) | Cost Center Description | 1 | 2 | 3 | 4 | 5 | |
| | **ANCILLARY SERVICE COST CENTERS** | | | | | | |
| 54 | Radiology-Diagnostic | 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

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

**APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS**

**WORKSHEET D**
**PART III**

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

| | | Nursing School | 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

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

**APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS**

**WORKSHEET D**
**PART III**

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

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

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

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

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

(A) Worksheet A line numbers

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

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

| | | Total Charges (from Wkst. C, Part I, col. 8) | Ratio of Cost to Charges (col. 5÷ col. 7) | Outpatient Ratio of Cost to Charges (col. 6÷ col. 7) | Inpatient Program Charges | Inpatient Program Pass-Through Costs (col. 8 x col. 10) | Outpatient Program Charges | Outpatient Program Pass-Through Costs (col. 9 x col. 12) | |
|---|---|---|---|---|---|---|---|---|---|
| (A) | Cost Center Description | 7 | 8 | 9 | 10 | 11 | 12 | 13 | |
| | **ANCILLARY SERVICE COST CENTERS** | | | | | | | | |
| 54 | Radiology-Diagnostic | 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

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

**Check Applicable Boxes:**

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

| | | | Program Charges | | | Program Cost | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Cost to Charge Ratio (from Wkst C, Part I, col. 9) | PPS Reim-bursed Services (see inst.) | Cost Reim-bursed Subject to Ded. & Coins. (see inst.) | Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.) | PPS Services (see inst.) | Cost Reim-bursed Subject to Ded. & Coins. (see inst.) | Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.) | |
| (A) | Cost Center Description | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| | **ANCILLARY SERVICE COST CENTERS** | | | | | | | | |
| 54 | Radiology-Diagnostic | 0.643387 | | | | | | | 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

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

**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 |

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

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

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

**PART II - HOSPITALS AND SUBPROVIDERS ONLY**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | **PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS** | | | | | 1 | |
| 38 | Adjusted general inpatient routine service cost per diem (see instructions) | | | | | 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 |
| | | | | | | 1 | |
| 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 etner zero (see instructions) | | | | | | 61 |
| 62 | Relief payment (see instructions) | | | | | | 62 |
| 63 | Allowable Inpatient cost plus incentive payment (see instructions) | | | | | | 63 |
| | **PROGRAM INPATIENT ROUTINE SWING BED COST** | | | | | | |
| 64 | Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) | | | | | | 64 |
| 65 | Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) | | | | | | 65 |
| 66 | Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions) | | | | | | 66 |
| 67 | Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) | | | | | | 67 |
| 68 | Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) | | | | | | 68 |
| 69 | Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) | | | | | | 69 |

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

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

**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** | **[ ] PPS** |
| **Applicable** | **[ ] Title XVIII, Part A** | **[ ] IPF** | **[ ] SNF** | | **[ ] TEFRA** |
| **Boxes:** | **[XX] Title XIX - I/P** | **[ ] IRF** | **[ ] NF** | | **[XX] Other** |

**PART I - ALL PROVIDER COMPONENTS**

| | | | |
|---|---|---|---|
| | **INPATIENT DAYS** | | |
| 1 | Inpatient days (including private room days and swing-bed days, excluding newborn) | 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 |

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

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

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

**PART II - HOSPITALS AND SUBPROVIDERS ONLY**

**PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS**

| | | 1 | |
|---|---|---|---|
| 38 | Adjusted general inpatient routine service cost per diem (see instructions) | 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 etner zero (see instructions) | | 61 |
| 62 | Relief payment (see instructions) | | 62 |
| 63 | Allowable Inpatient cost plus incentive payment (see instructions) | | 63 |

**PROGRAM INPATIENT ROUTINE SWING BED COST**

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

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

**COMPUTATION OF INPATIENT OPERATING COST** **COMPONENT CCN: 15-3025** **WORKSHEET D-1**
**PARTS III & IV**

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

**PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST**

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

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

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

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

| (A) | COST CENTER DESCRIPTION | Ratio of Cost To Charges<br>1 | Inpatient Program Charges<br>2 | Inpatient Program Costs (col. 1 x col. 2)<br>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**

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

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

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

| | | Ratio of Cost To Charges | Inpatient Program Charges | Inpatient Program Costs (col. 1 x col. 2) | |
|---|---|---|---|---|---|
| (A) | COST CENTER DESCRIPTION | 1 | 2 | 3 | |
| | **INPATIENT ROUTINE SERVICE COST CENTERS** | | | | |
| 30 | Adults & Pediatrics | | 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**

**PART B - MEDICAL AND OTHER HEALTH SERVICES**

| | | 1 | 1.01 | 1.02 | |
|---|---|---|---|---|---|
| 1 | Medical and other services (see instructions) | | | | 1 |
| 2 | Medical and other services reimbursed under OPPS (see instructions) | 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 ressonable cost (complete only if line 18 exceeds line 11 (see instructions) | | | | 19 |
| 20 | Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions) | | | | 20 |
| 21 | Lesser of cost or charges (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 (sse instructions) | | | | 91 |
| 92 | The rate used to calculate the Time Value of Money | | | | 92 |
| 93 | Time Value of Money (see instructions) | | | | 93 |
| 94 | Total (sum of lines 91 and 93) | | | | 94 |

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

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

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

| | | | | INPATIENT PART A | | PART B | | |
|---|---|---|---|---|---|---|---|---|
| | | | | mm/dd/yyyy | AMOUNT | mm/dd/yyyy | AMOUNT | |
| | DESCRIPTION | | | 1 | 2 | 3 | 4 | |
| 1 | Total interim payments paid to provider | | | | 22,418,034 | | 397 | 1 |
| 2 | Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero | | | | | | | 2 |
| 3 | List separately each retroactive lump sum adjustment | | .01 | | | | | 3.01 |
| | amount based on subsequent revision of the interim | | .02 | | | | | 3.02 |
| | rate for the cost reporting period. Also show date of | Program | .03 | | | | | 3.03 |
| | each payment. If none, write 'NONE' or enter a zero. (1) | to | .04 | | | | | 3.04 |
| | | Provider | .05 | | | | | 3.05 |
| | | | .06 | | | | | 3.06 |
| | | | .07 | | | | | 3.07 |
| | | | .08 | | | | | 3.08 |
| | | | .09 | | | | | 3.09 |
| | | | .10 | | | | | 3.10 |
| | | | .50 | | | | | 3.50 |
| | | | .51 | | | | | 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 | 4 |
| | | | | | | | | |
| | **TO BE COMPLETED BY CONTRACTOR** | | | | | | | |
| 5 | List separately each tentative settlement payment | | .01 | | | | | 5.01 |
| | after desk review. Also show date of each payment. | | .02 | | | | | 5.02 |
| | If none, write 'NONE' or enter a zero. (1) | Program | .03 | | | | | 5.03 |
| | | to | .04 | | | | | 5.04 |
| | | Provider | .05 | | | | | 5.05 |
| | | | .06 | | | | | 5.06 |
| | | | .07 | | | | | 5.07 |
| | | | .08 | | | | | 5.08 |
| | | | .09 | | | | | 5.09 |
| | | | .10 | | | | | 5.10 |
| | | | .50 | | | | | 5.50 |
| | | | .51 | | | | | 5.51 |
| | | Provider | .52 | | | | | 5.52 |
| | | to | .53 | | | | | 5.53 |
| | | Program | .54 | | | | | 5.54 |
| | | | .55 | | | | | 5.55 |
| | | | .56 | | | | | 5.56 |
| | | | .57 | | | | | 5.57 |
| | | | .58 | | | | | 5.58 |
| | | | .59 | | | | | 5.59 |
| | Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) | | .99 | | | | | 5.99 |
| 6 | Determined net settlement amount (balance due) | | .01 | | | | | 6.01 |
| | based on the cost report (1) | | .02 | | | | | 6.02 |
| 7 | Total Medicare program liability (see instructions) | | | | | | | 7 |
| 8 | Name of Contractor | | | Contractor Number | | NPR Date (Month/Day/Year) | | 8 |
| | | | | | | | | |

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

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

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

| | | 1 | 1.01 | |
|---|---|---|---|---|
| 1 | Net Federal PPS payment (see instructions) | 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 excludnig FTEs in the new program growth period of a 'new teaching program' (see instructions) | | | 7 |
| 8 | Current year unweighted I&R FTE count for residents within the new program growth period of a 'new teaching program' (see instructions) | | | 8 |
| 9 | Intern and resident count for IRF PPS medical education adjustment (see instructions) | | | 9 |
| 10 | Average daily census (see instructions) | 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 |

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

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

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

| | | INPATIENT TITLE V OR TITLE XIX | OUTPAT-IENT TITLE V OR TITLE XIX | |
|---|---|---|---|---|
| | **COMPUTATION OF NET COST OF COVERED SERVICES** | | | |
| 1 | Inpatient hospital/SNF/NF services | 319,606 | | 1 |
| 2 | Medical and other services | | 34,117 | 2 |
| 3 | Organ acquisition (certified transplant centers only) | | | 3 |
| 4 | Subtotal (sum of lines 1, 2 and 3) | 319,606 | 34,117 | 4 |
| 5 | Inpatient primary payer payments | | | 5 |
| 6 | Outpatient primary payer payments | | | 6 |
| 7 | Subtotal (line 4 less sum of lines 5 and 6) | 319,606 | 34,117 | 7 |
| | **COMPUTATION OF LESSER OF COST OR CHARGES** | | | |
| | REASONABLE CHARGES | | | |
| 8 | Routine service charges | 330,463 | | 8 |
| 9 | Ancillary service charges | 531,568 | 104,324 | 9 |
| 10 | Organ acquisition charges, net of revenue | | | 10 |
| 11 | Incentive from target amount computation | | | 11 |
| 12 | Total reasonable charges (sum of lines 8-11) | 862,031 | 104,324 | 12 |
| | **CUSTOMARY CHARGES** | | | |
| 13 | Amount actually collected from patients liable for payment for services on a cahrge basis | | | 13 |
| 14 | Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e) | | | 14 |
| 15 | Ratio of line 13 to line 14 (not to exceed 1.000000) | 1.000000 | 1.000000 | 15 |
| 16 | Total customary charges (see instructions) | 862,031 | 104,324 | 16 |
| 17 | Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions) | 542,425 | 70,207 | 17 |
| 18 | Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions) | | | 18 |
| 19 | Interns and residents (see instructions) | | | 19 |
| 20 | Cost of physicians' services in a teaching hospital (see instructions) | | | 20 |
| 21 | Cost of covered services (lesser of line 4 or line 16) | 319,606 | 34,117 | 21 |
| | **PROSPECTIVE PAYMENT AMOUNT** | | | |
| 22 | Other than outlier payments | | | 22 |
| 23 | Outlier payments | | | 23 |
| 24 | Program capital payments | | | 24 |
| 25 | Capital exception payments (see instructions) | | | 25 |
| 26 | Routine and ancillary service other pass through costs | | | 26 |
| 27 | Subtotal (sum of lines 22 through 26) | | | 27 |
| 28 | Customary charges (Titles V or XIX PPS covered services only) | | | 28 |
| 29 | Titles V or XIX (sum of lines 21 and 27) | 319,606 | 34,117 | 29 |
| | **COMPUTATION OF REIMBURSEMENT SETTLEMENT** | | | |
| 30 | Excess of reasonable cost (from line 18) | | | 30 |
| 31 | Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) | 319,606 | 34,117 | 31 |
| 32 | Deductibles | | | 32 |
| 33 | Coinsurance | | | 33 |
| 34 | Allowable bad debts (see instructions) | | | 34 |
| 35 | Utilization review | | | 35 |
| 36 | Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33) | 319,606 | 34,117 | 36 |
| 37 | OTHER ADJUSTMENTS (SPECIFY) (see instructions) | | | 37 |
| 38 | Subtotal (line 36 ± line 37) | 319,606 | 34,117 | 38 |
| 39 | Direct graduate medical education payments (from Wkst. E-4) | | | 39 |
| 40 | Total amount payable to the provider (sum of lines 38 and 39) | 319,606 | 34,117 | 40 |
| 41 | Interim payments | 213,970 | 19,289 | 41 |
| 42 | Balance due provider/program (line 40 minus line 41) | 105,636 | 14,828 | 42 |
| 43 | Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 | | | 43 |

**BALANCE SHEET** **WORKSHEET G**

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

| | **Assets** | General Fund | Specific Purpose Fund | Endowment Fund | Plant Fund | |
|---|---|---|---|---|---|---|
| | (Omit Cents) | 1 | 2 | 3 | 4 | |
| | **CURRENT ASSETS** | | | | | |
| 1 | Cash on hand and in banks | 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 | Audomobiles 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** | General Fund | Specific Purpose Fund | Endowment Fund | Plant Fund | |
|---|---|---|---|---|---|---|
| | (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 |

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

**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 |

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

**STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES**

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

**PART I - PATIENT REVENUES**

| | | INPATIENT | OUTPATIENT | TOTAL | |
|---|---|---|---|---|---|
| | REVENUE CENTER | 1 | 2 | 3 | |
| | **GENERAL INPATIENT ROUTINE CARE SERVICES** | | | | |
| 1 | Hospital | 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 |

**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 |