HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/04/2017 Run Time: 09:36 Version: 2017.01 (04/10/2017)

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: 05/04/2017 Time: 09:36 2. [ ] Manually submitted cost report 3. [ ] If this is an amended report enter the number of times the provider resubmitted the cost report 4. [F] Medicare Utilization. Enter 'F' for full or 'L' for low.		
Contractor use only	5. [ ] Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. [ ] Initial Report for this Provider CCN 9. [ ] Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ___ 12. [ ] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HEALTHSOUTH DEACONESS REHABILITATION (15-3025) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 01/01/2016 and ending 12/31/2016, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

ROB WISNER, SVP-REIMBURSEMENT
Title

05/04/2017
Date

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		361,682			87,736	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		361,682			87,736	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.

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 / 2016	To: 12 / 31 / 2016	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.	492	211	425	334	1,685		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
37.01	Is this hospital a former MDH that is eilgible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)	N		37.01
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

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: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				71

Inpatient Rehabilitation Facility PPS		1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.	Y			75
76	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	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) 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:	66,925	24,811		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
122	Does the cost report contain state health or similar taxes? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.		N		122

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 PKWY, SUITE 200	P.O. Box:		142
143	City: BIRMINGHAM	State: AL	ZIP Code: 35243	143

144	Are provider based physicians' costs included in Worksheet A?	Y		144
145	If costs for renal services are claimed on Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.	N	N	145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, chapter 40, §4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N		147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N		148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	N		149

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

		Title XVIII				
		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 in column 1. If column 1 is 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	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 Accountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	Y	A	02/22/2017	4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N			5

		Y/N	Y/N	
Approved Educational Activities		1	2	
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N		6
7	Are costs claimed for allied health programs? If yes, see instructions.	N		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N		8
9	Are costs claimed for 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.	N	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	03/01/2017	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	03/01/2017	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 services to other chain components? If yes, see instructions.			39
40	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40

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

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/04/2017 Run Time: 09:36 Version: 2017.01 (04/10/2017)

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	37,698			19,199	293	28,711	1
2	HMO and other (see instructions)						2,666	2,854		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	37,698			19,199	293	28,711	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	37,698			19,199	293	28,711	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 Provider CCN: 15-3025	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/04/2017 Run Time: 09:36 Version: 2017.01 (04/10/2017)

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)					1,496	20	2,203	1
2	HMO and other (see instructions)					189	217		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)		246.11			1,496	20	2,203	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)		246.11						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/04/2017 Run Time: 09:36 Version: 2017.01 (04/10/2017)

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	13,032,450			511,908.00		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 and/or related organization personnel							8
9	SNF	44						9
10	Excluded area salaries (see instructions)			204,683		5,865.60		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		97,377			672.00		13
14	Home office salaries & wage-related costs							14
14.01	Home office salaries		627,683			10,742.88		14.01
14.02	Related organization salaries							14.02
15	Home office: Physician Part A - Administrative							15
16	Home office & Contract Physicians Part A - Teaching							16
	WAGE-RELATED COSTS							
17	Wage-related costs (core)(see instructions)		3,305,657					17
18	Wage-related costs (other)(see instructions)							18
19	Excluded areas		52,746					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
25.50	Home office wage-related		250,587					25.50
25.51	Related organization wage-related							25.51
25.52	Home office: Physician Part A - Administrative - wage-related							25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related							25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26	Employee Benefits Department							26
27	Administrative & General		2,079,681	-204,683		57,636.80		27
28	Administrative & General under contract (see instructions)		27,264			81.00		28
29	Maintenance & Repairs							29
30	Operation of Plant		277,475			11,502.40		30
31	Laundry & Linen Service			19,024		1,584.00		31
32	Housekeeping		308,922	-19,024		23,022.40		32
33	Housekeeping under contract (see instructions)							33
34	Dietary		300,649			22,006.40		34
35	Dietary under contract (see instructions)							35
36	Cafeteria							36
37	Maintenance of Personnel							37
38	Nursing Administration		459,614			14,414.40		38
39	Central Services and Supply							39
40	Pharmacy							40
41	Medical Records & Medical Records Library		140,773			7,259.20		41
42	Social Service		592,037			20,904.00		42
43	Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		13,059,714		13,059,714	511,989.00	25.51	1
2	Excluded area salaries (see instructions)			204,683	204,683	5,865.60	34.90	2
3	Subtotal salarles (line 1 minus line 2)		13,059,714	-204,683	12,855,031	506,123.40	25.40	3
4	Subtotal other wages & related costs (see instructions)		725,060		725,060	11,414.88	63.52	4
5	Subtotal wage-related costs (see instructions)		3,556,244		3,556,244		27.66%	5
6	Total (sum of lines 3 through 5)		17,341,018	-204,683	17,136,335	517,538.28	33.11	6
7	Total overhead cost (see instructions)		4,186,415	-204,683	3,981,732	158,410.60	25.14	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	193,969	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)		8
8.01	Health Insurance (Self Funded without a Third Party Administrator)		8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	2,463,599	8.02
8.03	Health Insurance (Purchased)		8.03
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan		10
11	Life Insurance (If employee is owner or beneficiary)	26,244	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	302,691	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	940,795	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance		19
20	State or Federal Unemployment Taxes	45,702	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	-614,597	22
23	Tuition Reimbursement		23
24	Total Wage Related cost (Sum of lines 1-23)	3,358,403	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)		25

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/04/2017 Run Time: 09:36 Version: 2017.01 (04/10/2017)

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	27,264	3,358,403	1
2	Hospital	27,264	3,305,657	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		52,746	18

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		1,592,559	1,592,559	135,829	1,728,388	253,205	1,981,593	1
2	00200	Cap Rel Costs-Mvble Equip		725,037	725,037	100,308	825,345	-23,804	801,541	2
3	00300	Other Cap Rel Costs		195,312	195,312	-195,312			-0-	3
4	00400	Employee Benefits Department		3,014,087	3,014,087		3,014,087	320,760	3,334,847	4
5	00500	Administrative & General	2,079,681	3,711,879	5,791,560	-290,106	5,501,454	-831,066	4,670,388	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	277,475	626,681	904,156		904,156	-42,500	861,656	7
8	00800	Laundry & Linen Service		36,562	36,562	19,024	55,586	-24,876	30,710	8
9	00900	Housekeeping	308,922	98,875	407,797	-19,024	388,773	-3,270	385,503	9
10	01000	Dietary	300,649	531,065	831,714	-149	831,565	-151,153	680,412	10
11	01100	Cafeteria								11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	459,614	24,121	483,735		483,735	-73	483,662	13
14	01400	Central Services & Supply								14
15	01500	Pharmacy								15
16	01600	Medical Records & Library	140,773	82,831	223,604		223,604	-50	223,554	16
17	01700	Social Service	592,037	22,519	614,556		614,556	-260	614,296	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	4,508,676	248,165	4,756,841	25,765	4,782,606	-50,030	4,732,576	30
		ANCILLARY SERVICE COST CENTERS								
54	05400	Radiology-Diagnostic		182,935	182,935	-29,533	153,402	-2,639	150,763	54
54.01	05401	RADIOLOGY-SUA				38,607	38,607	-26,299	12,308	54.01
60	06000	Laboratory		436,516	436,516	306,721	743,237	-337,488	405,749	60
60.01	06001	LAB - SUA								60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	375,259	14,705	389,964		389,964	-2,601	387,363	65
66	06600	Physical Therapy	1,426,652	35,598	1,462,250	-68,766	1,393,484	-274	1,393,210	66
67	06700	Occupational Therapy	1,378,068	12,805	1,390,873	46,552	1,437,425		1,437,425	67
68	06800	Speech Pathology	630,960	7,101	638,061	22,214	660,275		660,275	68
71	07100	Medical Supplies Charged to Patients	69,162	318,638	387,800		387,800	-21,440	366,360	71
73	07300	Drugs Charged to Patients	484,522	743,000	1,227,522		1,227,522	-742	1,226,780	73
76	03550	PSYCHOLOGY								76
76.01	03951	SPECIAL PROCEDURES		498,462	498,462	-358,816	139,646	-16,765	122,881	76.01
76.02	03950	SPECIAL PROCEDURES SUA				43,021	43,021	-28,301	14,720	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		4,868	4,868		4,868	-4,868		113
118		SUBTOTALS (sum of lines 1-117)	13,032,450	13,164,321	26,196,771	-223,665	25,973,106	-994,534	24,978,572	118
		NONREIMBURSABLE COST CENTERS								
192	19200	Physicians' Private Offices		489	489		489		489	192
194	07950	NRCC MARKETING				223,665	223,665		223,665	194
194.01	07951	GUEST MEALS								194.01
200		TOTAL (sum of lines 118-199)	13,032,450	13,164,810	26,197,260		26,197,260	-994,534	25,202,726	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		23,684	1
2	INSURANCE	A	Cap Rel Costs-Mvble Equip	2		17,141	2
3	INSURANCE	A					3
500	Total reclassifications					40,825	500
	Code Letter - A						
1	MARKETING	B	NRCC MARKETING	194	204,683	18,982	1
2	MARKETING	B					2
3	MARKETING	B					3
500	Total reclassifications				204,683	18,982	500
	Code Letter - B						
1	PHYSICIANS	C	Adults & Pediatrics	30		25,765	1
2	PHYSICIANS	C					2
500	Total reclassifications					25,765	500
	Code Letter - C						
1	DEPT 283	D	Occupational Therapy	67	45,464		1
2	DEPT 283	D	Speech Pathology	68	20,787		2
3	DEPT 283	D					3
500	Total reclassifications				66,251		500
	Code Letter - D						
1	SERVICE UNDER ARRANGEMENT	E	RADIOLOGY-SUA	54.01		38,607	1
2	SERVICE UNDER ARRANGEMENT	E	SPECIAL PROCEDURES SUA	76.02		43,021	2
3	SERVICE UNDER ARRANGEMENT	E					3
4	SERVICE UNDER ARRANGEMENT	E					4
500	Total reclassifications					81,628	500
	Code Letter - E						
1	DAY TREATMENT	F	Occupational Therapy	67		1,088	1
2	DAY TREATMENT	F	Speech Pathology	68		1,427	2
3	DAY TREATMENT	F					3
500	Total reclassifications					2,515	500
	Code Letter - F						
1	LAUNDRY	G	Laundry & Linen Service	8	19,024		1
2	LAUNDRY	G					2
500	Total reclassifications				19,024		500
	Code Letter - G						
1	SPECIAL PROCEDURES	H	Radiology-Diagnostic	54		9,074	1
2	SPECIAL PROCEDURES	H	Laboratory	60		306,721	2
3	SPECIAL PROCEDURES	H					3
500	Total reclassifications					315,795	500
	Code Letter - H						
	GRAND TOTAL (Increases)				289,958	485,510	

(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		40,825		3
500	Total reclassifications					40,825		500
	Code letter - A							
1	MARKETING	B						1
2	MARKETING	B	Administrative & General	5	204,683	18,833		2
3	MARKETING	B	Dietary	10		149		3
500	Total reclassifications				204,683	18,982		500
	Code letter - B							
1	PHYSICIANS	C						1
2	PHYSICIANS	C	Administrative & General	5		25,765		2
500	Total reclassifications					25,765		500
	Code letter - C							
1	DEPT 283	D						1
2	DEPT 283	D						2
3	DEPT 283	D	Physical Therapy	66	66,251			3
500	Total reclassifications				66,251			500
	Code letter - D							
1	SERVICE UNDER ARRANGEMENT	E						1
2	SERVICE UNDER ARRANGEMENT	E						2
3	SERVICE UNDER ARRANGEMENT	E	Radiology-Diagnostic	54		38,607		3
4	SERVICE UNDER ARRANGEMENT	E	SPECIAL PROCEDURES	76.01		43,021		4
500	Total reclassifications					81,628		500
	Code letter - E							
1	DAY TREATMENT	F						1
2	DAY TREATMENT	F						2
3	DAY TREATMENT	F	Physical Therapy	66		2,515		3
500	Total reclassifications					2,515		500
	Code letter - F							
1	LAUNDRY	G						1
2	LAUNDRY	G	Housekeeping	9	19,024			2
500	Total reclassifications				19,024			500
	Code letter - G							
1	SPECIAL PROCEDURES	H						1
2	SPECIAL PROCEDURES	H						2
3	SPECIAL PROCEDURES	H	SPECIAL PROCEDURES	76.01		315,795		3
500	Total reclassifications					315,795		500
	Code letter - H							
	GRAND TOTAL (Decreases)				289,958	485,510		

(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	5,365,427					5,365,427		4
5	Fixed Equipment								5
6	Movable Equipment	3,978,992					3,978,992		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	9,344,419					9,344,419		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	9,344,419					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	451,755	1,140,804					1,592,559	1
2	Cap Rel Costs-Mvble Equip	462,213	262,824					725,037	2
3	Total (sum of lines 1-2)	913,968	1,403,628					2,317,596	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		112,145		112,145	1
2	Cap Rel Costs-Mvble Equ	3,978,992		3,978,992	0.425815		83,167		83,167	2
3	Total (sum of lines 1-2)	9,344,419		9,344,419	1.000000		195,312		195,312	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	532,534	1,140,804	172,114	23,684	112,457		1,981,593	1
2	Cap Rel Costs-Mvble Equip	450,482	250,525		17,141	83,393		801,541	2
3	Total (sum of lines 1-2)	983,016	1,391,329	172,114	40,825	195,850		2,783,134	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	-5,733				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1	-765,986				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	-4,868	Interest Expense	113	11	37
37.01	DEPRECIATION	A	321	Cap Rel Costs-Bldg & Fixt	1	9	37.01
37.03	INSURANCE	A	344,315	Employee Benefits Department	4		37.03
37.04	INSURANCE	A	-231,579	Administrative & General	5		37.04
37.05	PROPERTY TAX	A	312	Cap Rel Costs-Bldg & Fixt	1	13	37.05
37.06	PROPERTY TAX	A	226	Cap Rel Costs-Mvble Equip	2	13	37.06
37.07	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-135,950	Administrative & General	5		37.07
37.09	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	6	Housekeeping	9		37.09
37.10	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-48	Nursing Administration	13		37.10
37.11	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-260	Social Service	17		37.11
37.13	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-3,668	Medical Supplies Charged to Patients	71		37.13
37.14	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-26	Drugs Charged to Patients	73		37.14
37.15	PATIENT TELEPHONE	A	-4,500	Cap Rel Costs-Mvble Equip	2	9	37.15
37.16	PATIENT TELEPHONE	A	-13,993	Employee Benefits Department	4		37.16
37.17	PATIENT TELEPHONE	A	-24,755	Administrative & General	5		37.17
37.18	PATIENT TELEVISION	A	-7,231	Cap Rel Costs-Mvble Equip	2	9	37.18
37.19	PATIENT TELEVISION	A	-1,073	Operation of Plant	7		37.19
37.20	PRINTING	A	-5,944	Administrative & General	5		37.20
37.22	LOBBYING EXPENSE	A	-266	Administrative & General	5		37.22
37.23	LOBBYING EXPENSE	A	-25	Nursing Administration	13		37.23
37.24	LEGAL FEES	A	-7,000	Administrative & General	5		37.24
37.25	MISCELLANEOUS INCOME	B	-1,547	Cap Rel Costs-Bldg & Fixt	1	11	37.25
37.26	MISCELLANEOUS INCOME	B	-2,601	Administrative & General	5		37.26
37.27	MISCELLANEOUS INCOME	B	-18,430	Dietary	10		37.27
37.28	MISCELLANEOUS INCOME	B	-50	Medical Records & Library	16		37.28
37.29	PATIENT TRANSPORTATION	A	-9,562	Employee Benefits Department	4		37.29
37.30	PATIENT TRANSPORTATION	A	-41,427	Operation of Plant	7		37.30
37.31	PATIENT TRANSPORTATION	A	-44,297	Adults & Pediatrics	30		37.31
37.32	PROFESSIONAL FEES	A	-8,895	Administrative & General	5		37.32

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/04/2017 Run Time: 09:36 Version: 2017.01 (04/10/2017)

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	
38							38
39							39
40							40
41							41
42							42
43							43
44							44
45							45
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-994,534				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	TO OFFSET MANAGEMENT FEES		2,326,069	-2,326,069		1
2	1	Cap Rel Costs-Bldg & Fixt	TO INCLUDE ALLOWABLE HOME OFFICE COS	80,458		80,458	9	2
3	1	Cap Rel Costs-Bldg & Fixt	TO INCLUDE ALLOWABLE HOME OFFICE COS	173,661		173,661	11	3
3.01	5	Administrative & General	TO INCLUDE ALLOWABLE HOME OFFICE COS	1,592,963		1,592,963		3.01
3.02	5	Administrative & General	TO INCLUDE ALLOWABLE HOME OFFICE COS	332,132		332,132		3.02
3.03	2	Cap Rel Costs-Mvble Equip	INTERCOMPANY WAGE AND EXPENSE TRANSF	15,794	15,794		10	3.03
3.04	4	Employee Benefits Department	INTERCOMPANY WAGE AND EXPENSE TRANSF	2,415,414	2,415,414			3.04
3.05	5	Administrative & General	INTERCOMPANY WAGE AND EXPENSE TRANSF	3,012,486	3,012,486			3.05
3.06	7	Operation of Plant	INTERCOMPANY WAGE AND EXPENSE TRANSF	23,418	23,418			3.06
3.07	9	Housekeeping	INTERCOMPANY WAGE AND EXPENSE TRANSF	3,920	3,920			3.07
3.08	10	Dietary	INTERCOMPANY WAGE AND EXPENSE TRANSF	-6,860	-6,860			3.08
3.09	13	Nursing Administration	INTERCOMPANY WAGE AND EXPENSE TRANSF	1,139	1,139			3.09
3.10	16	Medical Records & Library	INTERCOMPANY WAGE AND EXPENSE TRANSF	106	106			3.10
3.11	17	Social Service	INTERCOMPANY WAGE AND EXPENSE TRANSF	2,369	2,369			3.11
3.12	30	Adults & Pediatrics	INTERCOMPANY WAGE AND EXPENSE TRANSF	8,586	8,586			3.12
3.13	65	Respiratory Therapy	INTERCOMPANY WAGE AND EXPENSE TRANSF	421	421			3.13
3.14	66	Physical Therapy	INTERCOMPANY WAGE AND EXPENSE TRANSF	-9,733	-9,733			3.14
3.15	67	Occupational Therapy	INTERCOMPANY WAGE AND EXPENSE TRANSF	-1,539	-1,539			3.15
3.16	68	Speech Pathology	INTERCOMPANY WAGE AND EXPENSE TRANSF	2,178	2,178			3.16
3.17	71	Medical Supplies Charged to Patients	INTERCOMPANY WAGE AND EXPENSE TRANSF	-6,624	-6,624			3.17
3.18	73	Drugs Charged to Patients	INTERCOMPANY WAGE AND EXPENSE TRANSF	720,740	720,740			3.18
3.19	113	Interest Expense	INTERCOMPANY WAGE AND EXPENSE TRANSF	4,868	4,868		11	3.19
3.20	192	Physicians' Private Offices	INTERCOMPANY WAGE AND EXPENSE TRANSF	80	80			3.20
3.21	1	Cap Rel Costs-Bldg & Fixt	DEACONESS	397,032	397,032		10	3.21
3.22	2	Cap Rel Costs-Mvble Equip	DEACONESS	4,081	16,380	-12,299	10	3.22
3.23	5	Administrative & General	DEACONESS	4,348	17,450	-13,102		3.23
3.24	7	Operation of Plant	DEACONESS	23,403	23,403			3.24
3.25	8	Laundry & Linen Service	DEACONESS	6,639	31,515	-24,876		3.25
3.26	9	Housekeeping	DEACONESS	1,087	4,363	-3,276		3.26
3.27	10	Dietary	DEACONESS	38,637	171,360	-132,723		3.27
3.28	54	Radiology-Diagnostic	DEACONESS	1,235	3,874	-2,639		3.28
3.29	54.01	RADIOLOGY-SUA	DEACONESS	12,308	38,607	-26,299		3.29
3.30	60	Laboratory	DEACONESS	99,000	436,488	-337,488		3.30
3.31	65	Respiratory Therapy	DEACONESS	673	3,274	-2,601		3.31
3.32	66	Physical Therapy	DEACONESS	703	977	-274		3.32
3.33	71	Medical Supplies Charged to Patients	DEACONESS	17,378	35,150	-17,772		3.33
3.34	73	Drugs Charged to Patients	DEACONESS	248	964	-716		3.34
3.35	76.01	SPECIAL PROCEDURES	DEACONESS	8,719	25,484	-16,765		3.35
3.36	76.02	SPECIAL PROCEDURES SUA	DEACONESS	14,720	43,021	-28,301		3.36
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12			8,996,188	9,762,174	-765,986		5

* The amounts on lines 1 through 4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which have not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

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

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

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to

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	

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		72.50	HEALTHSOUTH CORPORATION		HEALTHCARE	6
7	B		27.50	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 Provider CCN: 15-3025	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/04/2017 Run Time: 09:36 Version: 2017.01 (04/10/2017)

PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun-eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	30	Adults & Pediatrics AGGREGATE	25,765		25,765	211,500	197	20,032	1,002	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	25,765		25,765		197	20,032	1,002	200

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/04/2017 Run Time: 09:36 Version: 2017.01 (04/10/2017)

PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	30	Adults & Pediatrics AGGREGATE					20,032	5,733	5,733	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					20,032	5,733	5,733	200

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	1,981,593	1,981,593					1
2	Cap Rel Costs-Mvble Equip	801,541		801,541				2
4	Employee Benefits Department	3,334,847	9,886	3,999	3,348,732			4
5	Administrative & General	4,670,388	347,428	140,532	481,786	5,640,134	5,640,134	5
6	Maintenance & Repairs							6
7	Operation of Plant	861,656	70,158	28,379	71,298	1,031,491	297,803	7
8	Laundry & Linen Service	30,710	15,016	6,074	4,888	56,688	16,366	8
9	Housekeeping	385,503	11,465	4,637	74,490	476,095	137,454	9
10	Dietary	680,412	107,543	43,500	77,253	908,708	262,354	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	483,662	13,251	5,360	118,099	620,372	179,108	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	223,554	11,402	4,612	36,172	275,740	79,609	16
17	Social Service	614,296	24,362	9,854	152,126	800,638	231,153	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	4,732,576	871,251	352,416	1,158,524	7,114,767	2,054,114	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	150,763	13,064	5,284		169,111	48,824	54
54.01	RADIOLOGY-SUA	12,308				12,308		54.01
60	Laboratory	405,749	1,246	504		407,499	117,649	60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	387,363	4,652	1,882	96,424	490,321	141,561	65
66	Physical Therapy	1,393,210	151,200	61,159	349,559	1,955,128	564,467	66
67	Occupational Therapy	1,437,425	124,823	50,490	365,781	1,978,519	571,220	67
68	Speech Pathology	660,275	49,597	20,062	167,468	897,402	259,090	68
71	Medical Supplies Charged to Patients	366,360	34,518	13,962	17,771	432,611	124,900	71
73	Drugs Charged to Patients	1,226,780	10,592	4,285	124,499	1,366,156	394,424	73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES	122,881				122,881	35,477	76.01
76.02	SPECIAL PROCEDURES SUA	14,720				14,720		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)	24,978,572	1,871,454	756,991	3,296,138	24,771,289	5,515,573	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	489	104,677	42,341		147,507	42,587	192
194	NRCC MARKETING	223,665	5,462	2,209	52,594	283,930	81,974	194
194.01	GUEST MEALS							194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	25,202,726	1,981,593	801,541	3,348,732	25,202,726	5,640,134	202

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/04/2017 Run Time: 09:36 Version: 2017.01 (04/10/2017)

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	1,329,294						7
8	Laundry & Linen Service	12,844	85,898					8
9	Housekeeping	9,806		623,355				9
10	Dietary	91,985		43,883	1,306,930			10
11	Cafeteria				123,754	123,754		11
12	Maintenance of Personnel							12
13	Nursing Administration	11,334		5,407		5,538	821,759	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	9,753		4,653		1,696		16
17	Social Service	20,838		9,941		7,134		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	745,209	85,898	355,515	1,139,785	54,326	821,759	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	11,174		5,331				54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory	1,066		508				60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	3,979		1,898		4,522		65
66	Physical Therapy	129,327		61,697		16,393		66
67	Occupational Therapy	106,766		50,934		17,154		67
68	Speech Pathology	42,422		20,238		7,854		68
71	Medical Supplies Charged to Patients	29,525		14,085		833		71
73	Drugs Charged to Patients	9,060		4,322		5,838		73
76	PSYCHOLOGY							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)	1,235,088	85,898	578,412	1,263,539	121,288	821,759	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	89,534		42,714				192
194	NRCC MARKETING	4,672		2,229		2,466		194
194.01	GUEST MEALS				43,391			194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,329,294	85,898	623,355	1,306,930	123,754	821,759	202

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	371,451						16
17	Social Service		1,069,704					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	147,904	1,069,704	13,588,981		13,588,981		30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	2,002		236,442		236,442		54
54.01	RADIOLOGY-SUA			12,308		12,308		54.01
60	Laboratory	14,190		540,912		540,912		60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	30,837		673,118		673,118		65
66	Physical Therapy	48,436		2,775,448		2,775,448		66
67	Occupational Therapy	47,663		2,772,256		2,772,256		67
68	Speech Pathology	21,792		1,248,798		1,248,798		68
71	Medical Supplies Charged to Patients	8,217		610,171		610,171		71
73	Drugs Charged to Patients	48,370		1,828,170		1,828,170		73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES	2,040		160,398		160,398		76.01
76.02	SPECIAL PROCEDURES SUA			14,720		14,720		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)	371,451	1,069,704	24,461,722		24,461,722		118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices			322,342		322,342		192
194	NRCC MARKETING			375,271		375,271		194
194.01	GUEST MEALS			43,391		43,391		194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	371,451	1,069,704	25,202,726		25,202,726		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		9,886	3,999	13,885	13,885		4
5	Administrative & General		347,428	140,532	487,960	1,997	489,957	5
6	Maintenance & Repairs							6
7	Operation of Plant		70,158	28,379	98,537	296	25,870	7
8	Laundry & Linen Service		15,016	6,074	21,090	20	1,422	8
9	Housekeeping		11,465	4,637	16,102	309	11,940	9
10	Dietary		107,543	43,500	151,043	320	22,790	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration		13,251	5,360	18,611	489	15,559	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		11,402	4,612	16,014	150	6,916	16
17	Social Service		24,362	9,854	34,216	631	20,080	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		871,251	352,416	1,223,667	4,806	178,444	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic		13,064	5,284	18,348		4,241	54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory		1,246	504	1,750		10,220	60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		4,652	1,882	6,534	400	12,297	65
66	Physical Therapy		151,200	61,159	212,359	1,449	49,035	66
67	Occupational Therapy		124,823	50,490	175,313	1,516	49,621	67
68	Speech Pathology		49,597	20,062	69,659	694	22,507	68
71	Medical Supplies Charged to Patients		34,518	13,962	48,480	74	10,850	71
73	Drugs Charged to Patients		10,592	4,285	14,877	516	34,263	73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES						3,082	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)		1,871,454	756,991	2,628,445	13,667	479,137	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		104,677	42,341	147,018		3,699	192
194	NRCC MARKETING		5,462	2,209	7,671	218	7,121	194
194.01	GUEST MEALS							194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		1,981,593	801,541	2,783,134	13,885	489,957	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	124,703						7
8	Laundry & Linen Service	1,205	23,737					8
9	Housekeeping	920		29,271				9
10	Dietary	8,629		2,061	184,843			10
11	Cafeteria				17,503	17,503		11
12	Maintenance of Personnel							12
13	Nursing Administration	1,063		254		783	36,759	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	915		218		240		16
17	Social Service	1,955		467		1,009		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	69,910	23,737	16,694	161,203	7,684	36,759	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	1,048		250				54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory	100		24				60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	373		89		639		65
66	Physical Therapy	12,132		2,897		2,318		66
67	Occupational Therapy	10,016		2,392		2,426		67
68	Speech Pathology	3,980		950		1,111		68
71	Medical Supplies Charged to Patients	2,770		661		118		71
73	Drugs Charged to Patients	850		203		826		73
76	PSYCHOLOGY							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)	115,866	23,737	27,160	178,706	17,154	36,759	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	8,399		2,006				192
194	NRCC MARKETING	438		105		349		194
194.01	GUEST MEALS				6,137			194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	124,703	23,737	29,271	184,843	17,503	36,759	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	24,453						16
17	Social Service		58,358					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	9,730	58,358	1,790,992		1,790,992		30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	132		24,019		24,019		54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory	935		13,029		13,029		60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,031		22,363		22,363		65
66	Physical Therapy	3,190		283,380		283,380		66
67	Occupational Therapy	3,139		244,423		244,423		67
68	Speech Pathology	1,435		100,336		100,336		68
71	Medical Supplies Charged to Patients	541		63,494		63,494		71
73	Drugs Charged to Patients	3,186		54,721		54,721		73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES	134		3,216		3,216		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)	24,453	58,358	2,599,973		2,599,973		118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices			161,122		161,122		192
194	NRCC MARKETING			15,902		15,902		194
194.01	GUEST MEALS			6,137		6,137		194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	24,453	58,358	2,783,134		2,783,134		202

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/04/2017 Run Time: 09:36 Version: 2017.01 (04/10/2017)

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	95,410						1
2	Cap Rel Costs-Mvble Equip		95,410					2
4	Employee Benefits Department	476	476	13,032,450				4
5	Administrative & General	16,728	16,728	1,874,998	-5,640,134	19,535,564		5
6	Maintenance & Repairs							6
7	Operation of Plant	3,378	3,378	277,475		1,031,491	74,828	7
8	Laundry & Linen Service	723	723	19,024		56,688	723	8
9	Housekeeping	552	552	289,898		476,095	552	9
10	Dietary	5,178	5,178	300,649		908,708	5,178	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	638	638	459,614		620,372	638	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	549	549	140,773		275,740	549	16
17	Social Service	1,173	1,173	592,037		800,638	1,173	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	41,949	41,949	4,508,676		7,114,767	41,949	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	629	629			169,111	629	54
54.01	RADIOLOGY-SUA				-12,308			54.01
60	Laboratory	60	60			407,499	60	60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	224	224	375,259		490,321	224	65
66	Physical Therapy	7,280	7,280	1,360,401		1,955,128	7,280	66
67	Occupational Therapy	6,010	6,010	1,423,532		1,978,519	6,010	67
68	Speech Pathology	2,388	2,388	651,747		897,402	2,388	68
71	Medical Supplies Charged to Patients	1,662	1,662	69,162		432,611	1,662	71
73	Drugs Charged to Patients	510	510	484,522		1,366,156	510	73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES					122,881		76.01
76.02	SPECIAL PROCEDURES SUA				-14,720			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)	90,107	90,107	12,827,767	-5,667,162	19,104,127	69,525	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	5,040	5,040			147,507	5,040	192
194	NRCC MARKETING	263	263	204,683		283,930	263	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)	1,981,593	801,541	3,348,732		5,640,134	1,329,294	202
203	Unit Cost Multiplier (Wkst. B, Part I)	20.769238	8.401017	0.256953		0.288711	17.764660	203
204	Cost to be allocated (Per Wkst. B, Part II)			13,885		489,957	124,703	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.001065		0.025080	1.666529	205

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/04/2017 Run Time: 09:36 Version: 2017.01 (04/10/2017)

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	28,711						8
9	Housekeeping		73,553					9
10	Dietary		5,178	98,764				10
11	Cafeteria			9,352	10,270,406			11
12	Maintenance of Personnel							12
13	Nursing Administration		638		459,614	28,711		13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		549		140,773		64,045,260	16
17	Social Service		1,173		592,037			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	28,711	41,949	86,133	4,508,676	28,711	25,502,834	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic		629				345,221	54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory		60				2,446,477	60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		224		375,259		5,316,688	65
66	Physical Therapy		7,280		1,360,401		8,350,970	66
67	Occupational Therapy		6,010		1,423,532		8,217,694	67
68	Speech Pathology		2,388		651,747		3,757,216	68
71	Medical Supplies Charged to Patients		1,662		69,162		1,416,753	71
73	Drugs Charged to Patients		510		484,522		8,339,648	73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES						351,759	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)	28,711	68,250	95,485	10,065,723	28,711	64,045,260	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		5,040					192
194	NRCC MARKETING		263		204,683			194
194.01	GUEST MEALS			3,279				194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	85,898	623,355	1,306,930	123,754	821,759	371,451	202
203	Unit Cost Multiplier (Wkst. B, Part I)	2.991815	8.474909	13.232858	0.012050	28.621748	0.005800	203
204	Cost to be allocated (Per Wkst. B, Part II)	23,737	29,271	184,843	17,503	36,759	24,453	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.826756	0.397958	1.871563	0.001704	1.280311	0.000382	205

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/04/2017 Run Time: 09:36 Version: 2017.01 (04/10/2017)

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

	COST CENTER DESCRIPTIONS	SOCIAL SERVICE PATIENT DAYS						
		17						
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service	28,711						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	28,711						30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic							54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory							60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients							73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES							76.01
76.02	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)	28,711						118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices							192
194	NRCC 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)	1,069,704						202
203	Unit Cost Multiplier (Wkst. B, Part I)	37.257636						203
204	Cost to be allocated (Per Wkst. B, Part II)	58,358						204
205	Unit Cost Multiplier (Wkst. B, Part II)	2.032601						205

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/04/2017 Run Time: 09:36 Version: 2017.01 (04/10/2017)

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/04/2017 Run Time: 09:36 Version: 2017.01 (04/10/2017)

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	13,588,981		13,588,981	5,733	13,594,714	30
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	236,442		236,442		236,442	54
54.01	RADIOLOGY-SUA	12,308		12,308		12,308	54.01
60	Laboratory	540,912		540,912		540,912	60
60.01	LAB - SUA						60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	673,118		673,118		673,118	65
66	Physical Therapy	2,775,448		2,775,448		2,775,448	66
67	Occupational Therapy	2,772,256		2,772,256		2,772,256	67
68	Speech Pathology	1,248,798		1,248,798		1,248,798	68
71	Medical Supplies Charged to Patients	610,171		610,171		610,171	71
73	Drugs Charged to Patients	1,828,170		1,828,170		1,828,170	73
76	PSYCHOLOGY						76
76.01	SPECIAL PROCEDURES	160,398		160,398		160,398	76.01
76.02	SPECIAL PROCEDURES SUA	14,720		14,720		14,720	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)	24,461,722		24,461,722	5,733	24,467,455	200
201	Less Observation Beds						201
202	Total (line 200 minus line 201)	24,461,722		24,461,722		24,467,455	202

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/04/2017 Run Time: 09:36 Version: 2017.01 (04/10/2017)

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	25,502,834		25,502,834				30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	344,720	501	345,221	0.684900	0.684900	0.684900	54
54.01	RADIOLOGY-SUA	118,777		118,777	0.103623	0.103623	0.103623	54.01
60	Laboratory	2,446,477		2,446,477	0.221098	0.221098	0.221098	60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	5,316,688		5,316,688	0.126605	0.126605	0.126605	65
66	Physical Therapy	6,806,156	1,544,814	8,350,970	0.332350	0.332350	0.332350	66
67	Occupational Therapy	7,371,983	845,711	8,217,694	0.337352	0.337352	0.337352	67
68	Speech Pathology	2,647,805	1,109,411	3,757,216	0.332373	0.332373	0.332373	68
71	Medical Supplies Charged to Patients	1,403,942	12,811	1,416,753	0.430683	0.430683	0.430683	71
73	Drugs Charged to Patients	8,339,648		8,339,648	0.219214	0.219214	0.219214	73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES	351,759		351,759	0.455988	0.455988	0.455988	76.01
76.02	SPECIAL PROCEDURES SUA	129,627		129,627	0.113557	0.113557	0.113557	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)	60,780,416	3,513,248	64,293,664				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	60,780,416	3,513,248	64,293,664				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)	1,790,992		1,790,992	28,711	62.38	19,199	1,197,634	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)	1,790,992		1,790,992	28,711		19,199	1,197,634	200

(A) Worksheet A line numbers

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/04/2017 Run Time: 09:36 Version: 2017.01 (04/10/2017)

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	24,019	345,221	0.069576	223,296	15,536	54
54.01	RADIOLOGY-SUA		118,777		107,548		54.01
60	Laboratory	13,029	2,446,477	0.005326	1,724,071	9,182	60
60.01	LAB - SUA						60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	22,363	5,316,688	0.004206	3,781,412	15,905	65
66	Physical Therapy	283,380	8,350,970	0.033934	4,546,091	154,267	66
67	Occupational Therapy	244,423	8,217,694	0.029744	4,958,578	147,488	67
68	Speech Pathology	100,336	3,757,216	0.026705	1,729,589	46,189	68
71	Medical Supplies Charged to Pat	63,494	1,416,753	0.044817	955,219	42,810	71
73	Drugs Charged to Patients	54,721	8,339,648	0.006562	5,426,708	35,610	73
76	PSYCHOLOGY						76
76.01	SPECIAL PROCEDURES	3,216	351,759	0.009143	232,332	2,124	76.01
76.02	SPECIAL PROCEDURES SUA		129,627		120,053		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)	808,981	38,790,830		23,804,897	469,111	200

(A) Worksheet A line numbers

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/04/2017 Run Time: 09:36 Version: 2017.01 (04/10/2017)

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

		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 Provider CCN: 15-3025	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/04/2017 Run Time: 09:36 Version: 2017.01 (04/10/2017)

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)	28,711		19,199		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)	28,711		19,199		200

(A) Worksheet A line numbers

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/04/2017 Run Time: 09:36 Version: 2017.01 (04/10/2017)

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**	**[XX] PPS**	
	[XX] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**	
	[ ] Title XIX	**[ ] IRF**	**[ ] NF**		**[ ] 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
60.01	LAB - SUA							60.01
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	PSYCHOLOGY							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	345,221			223,296		501		54
54.01	RADIOLOGY-SUA	118,777			107,548				54.01
60	Laboratory	2,446,477			1,724,071				60
60.01	LAB - SUA								60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	5,316,688			3,781,412				65
66	Physical Therapy	8,350,970			4,546,091				66
67	Occupational Therapy	8,217,694			4,958,578				67
68	Speech Pathology	3,757,216			1,729,589				68
71	Medical Supplies Charged to Pat	1,416,753			955,219		45		71
73	Drugs Charged to Patients	8,339,648			5,426,708				73
76	PSYCHOLOGY								76
76.01	SPECIAL PROCEDURES	351,759			232,332				76.01
76.02	SPECIAL PROCEDURES SUA	129,627			120,053				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)	38,790,830			23,804,897		546		200

(A) Worksheet A line numbers

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/04/2017 Run Time: 09:36 Version: 2017.01 (04/10/2017)

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	0.684900	501			343			54
54.01	RADIOLOGY-SUA	0.103623							54.01
60	Laboratory	0.221098							60
60.01	LAB - SUA								60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.126605							65
66	Physical Therapy	0.332350							66
67	Occupational Therapy	0.337352							67
68	Speech Pathology	0.332373							68
71	Medical Supplies Charged to Pat	0.430683	45			19			71
73	Drugs Charged to Patients	0.219214							73
76	PSYCHOLOGY								76
76.01	SPECIAL PROCEDURES	0.455988							76.01
76.02	SPECIAL PROCEDURES SUA	0.113557							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)		546			362			200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		546			362			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)	1,790,992		1,790,992	28,711	62.38	293	18,277	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)	1,790,992		1,790,992	28,711		293	18,277	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] Hospital [ ] SUB (Other)
[ ] Title XVIII, Part A [ ] IPF
[XX] Title XIX [ ] IRF

		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	24,019	345,221	0.069576	311	22	54
54.01	RADIOLOGY-SUA		118,777		5,445		54.01
60	Laboratory	13,029	2,446,477	0.005326	16,689	89	60
60.01	LAB - SUA						60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	22,363	5,316,688	0.004206	57,928	244	65
66	Physical Therapy	283,380	8,350,970	0.033934	64,069	2,174	66
67	Occupational Therapy	244,423	8,217,694	0.029744	68,241	2,030	67
68	Speech Pathology	100,336	3,757,216	0.026705	38,088	1,017	68
71	Medical Supplies Charged to Pat	63,494	1,416,753	0.044817	18,740	840	71
73	Drugs Charged to Patients	54,721	8,339,648	0.006562	104,350	685	73
76	PSYCHOLOGY						76
76.01	SPECIAL PROCEDURES	3,216	351,759	0.009143	389	4	76.01
76.02	SPECIAL PROCEDURES SUA		129,627		4,875		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)	808,981	38,790,830		379,125	7,105	200

(A) Worksheet A line numbers

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/04/2017 Run Time: 09:36 Version: 2017.01 (04/10/2017)

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 Provider CCN: 15-3025	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/04/2017 Run Time: 09:36 Version: 2017.01 (04/10/2017)

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)	28,711		293		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)	28,711		293		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
60.01	LAB - SUA							60.01
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	PSYCHOLOGY							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	345,221			311				54
54.01	RADIOLOGY-SUA	118,777			5,445				54.01
60	Laboratory	2,446,477			16,689				60
60.01	LAB - SUA								60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	5,316,688			57,928				65
66	Physical Therapy	8,350,970			64,069				66
67	Occupational Therapy	8,217,694			68,241				67
68	Speech Pathology	3,757,216			38,088				68
71	Medical Supplies Charged to Pat	1,416,753			18,740				71
73	Drugs Charged to Patients	8,339,648			104,350				73
76	PSYCHOLOGY								76
76.01	SPECIAL PROCEDURES	351,759			389				76.01
76.02	SPECIAL PROCEDURES SUA	129,627			4,875				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)	38,790,830			379,125				200

(A) Worksheet A line numbers

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/04/2017 Run Time: 09:36 Version: 2017.01 (04/10/2017)

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	0.684900							54
54.01	RADIOLOGY-SUA	0.103623							54.01
60	Laboratory	0.221098							60
60.01	LAB - SUA								60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.126605							65
66	Physical Therapy	0.332350		42,123			14,000		66
67	Occupational Therapy	0.337352		28,014			9,451		67
68	Speech Pathology	0.332373		32,869			10,925		68
71	Medical Supplies Charged to Pat	0.430683		118			51		71
73	Drugs Charged to Patients	0.219214							73
76	PSYCHOLOGY								76
76.01	SPECIAL PROCEDURES	0.455988							76.01
76.02	SPECIAL PROCEDURES SUA	0.113557							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)			103,124			34,427		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			103,124			34,427		202

(A) Worksheet A line numbers

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/04/2017 Run Time: 09:36 Version: 2017.01 (04/10/2017)

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)	28,711	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	28,711	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.	1,675	3
4	Semi-private room days (excluding swing-bed private room days)	27,036	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)	19,199	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)	941	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)	13,594,714	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)	13,594,714	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)	25,377,182	28
29	Private room charges (excluding swing-bed charges)	1,517,186	29
30	Semi-private room charges (excluding swing-bed charges)	23,859,996	30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.535706	31
32	Average private room per diem charge (line 29 ÷ line 3)	905.78	32
33	Average semi-private room per diem charge (line 30 ÷ line 4)	882.53	33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)	23.25	34
35	Average per diem private room cost differential (line 34 x line 31)	12.46	35
36	Private room cost differential adjustment (line 3 x line 35)	20,871	36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	13,573,843	37

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/04/2017 Run Time: 09:36 Version: 2017.01 (04/10/2017)

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)					473.50	38
39	Program general inpatient routine service cost (line 9 x line 38)					9,090,727	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)					9,090,727	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)					6,503,143	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					15,593,870	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,197,634	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					469,111	51
52	Total Program excludable cost (sum of lines 50 and 51)					1,666,745	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					13,927,125	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)					473.50	88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/04/2017 Run Time: 09:36 Version: 2017.01 (04/10/2017)

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)	28,711	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	28,711	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.	1,675	3
4	Semi-private room days (excluding swing-bed private room days)	27,036	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)	293	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)	13,588,981	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)	13,588,981	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)	25,377,182	28
29	Private room charges (excluding swing-bed charges)	1,517,186	29
30	Semi-private room charges (excluding swing-bed charges)	23,859,996	30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.535480	31
32	Average private room per diem charge (line 29 ÷ line 3)	905.78	32
33	Average semi-private room per diem charge (line 30 ÷ line 4)	882.53	33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)	23.25	34
35	Average per diem private room cost differential (line 34 x line 31)	12.45	35
36	Private room cost differential adjustment (line 3 x line 35)	20,854	36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	13,568,127	37

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/04/2017 Run Time: 09:36 Version: 2017.01 (04/10/2017)

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)	472.58	38
39	Program general inpatient routine service cost (line 9 x line 38)	138,466	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)	138,466	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)	100,451	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	238,917	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	18,277	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	7,105	51
52	Total Program excludable cost (sum of lines 50 and 51)	25,382	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

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 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/04/2017 Run Time: 09:36 Version: 2017.01 (04/10/2017)

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 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		16,955,745		30
	ANCILLARY SERVICE COST CENTERS				
54	Radiology-Diagnostic	0.684900	223,296	152,935	54
54.01	RADIOLOGY-SUA	0.103623	107,548	11,144	54.01
60	Laboratory	0.221098	1,724,071	381,189	60
60.01	LAB - SUA				60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.126605	3,781,412	478,746	65
66	Physical Therapy	0.332350	4,546,091	1,510,893	66
67	Occupational Therapy	0.337352	4,958,578	1,672,786	67
68	Speech Pathology	0.332373	1,729,589	574,869	68
71	Medical Supplies Charged to Patients	0.430683	955,219	411,397	71
73	Drugs Charged to Patients	0.219214	5,426,708	1,189,610	73
76	PSYCHOLOGY				76
76.01	SPECIAL PROCEDURES	0.455988	232,332	105,941	76.01
76.02	SPECIAL PROCEDURES SUA	0.113557	120,053	13,633	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)		23,804,897	6,503,143	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		23,804,897		202

(A) Worksheet A line numbers

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/04/2017 Run Time: 09:36 Version: 2017.01 (04/10/2017)

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		259,800		30
	ANCILLARY SERVICE COST CENTERS				
54	Radiology-Diagnostic	0.684900	311	213	54
54.01	RADIOLOGY-SUA	0.103623	5,445	564	54.01
60	Laboratory	0.221098	16,689	3,690	60
60.01	LAB - SUA				60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.126605	57,928	7,334	65
66	Physical Therapy	0.332350	64,069	21,293	66
67	Occupational Therapy	0.337352	68,241	23,021	67
68	Speech Pathology	0.332373	38,088	12,659	68
71	Medical Supplies Charged to Patients	0.430683	18,740	8,071	71
73	Drugs Charged to Patients	0.219214	104,350	22,875	73
76	PSYCHOLOGY				76
76.01	SPECIAL PROCEDURES	0.455988	389	177	76.01
76.02	SPECIAL PROCEDURES SUA	0.113557	4,875	554	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)		379,125	100,451	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		379,125		202

(A) Worksheet A line numbers

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

Check applicable box: [XX] Hospital [ ] IPF [ ] IRF [ ] SUB (Other) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under OPPS (see instructions)	362			2
3	PPS payments	171			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)	171			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	34			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)	137			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)	137			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	137			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)	137			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)	137			40
40.01	Sequestration adjustment (see instructions)	3			40.01
41	Interim payments	134			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 Provider CCN: 15-3025	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/04/2017 Run Time: 09:36 Version: 2017.01 (04/10/2017)

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				26,721,847		134	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)				26,721,847		134	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.

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/04/2017 Run Time: 09:36 Version: 2017.01 (04/10/2017)

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

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)	26,779,893		1
2	Medicare SSI ratio (IRF PPS only) (see instructions)	0.059400		2
3	Inpatient Rehabilitation LIP payments (see instructions)	1,363,097		3
4	Outlier payments	29,442		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)	78.445355		10
11	Teaching Adjustment Factor (see instructions)			11
12	Teaching Adjustment (see instructions)			12
13	Total PPS Payment (see instructions)	28,172,432		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)	28,172,432		17
18	Primary payer payments	13,895		18
19	Subtotal (line 17 less line 18)	28,158,537		19
20	Deductibles	452,770		20
21	Subtotal (line 19 minus line 20)	27,705,767		21
22	Coinsurance	164,486		22
23	Subtotal (line 21 minus line 22)	27,541,281		23
24	Allowable bad debts (exclude bad debts for professional services) (see instructions)	146,113		24
25	Adjusted reimbursable bad debts (see instructions)	94,973		25
26	Allowable bad debts for dual eligible beneficiaries (see instructions)	110,553		26
27	Subtotal (sum of lines 23 and 25)	27,636,254		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)	27,636,254		32
32.01	Sequestration adjustment (see instructions)	552,725		32.01
33	Interim payments	26,721,847		33
34	Tentative settlement (for contractor use only)			34
35	Balance due provider/program (line 32 minus lines 32.01, 33 and 34)	361,682		35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	839,331		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	238,917		1
2	Medical and other services		34,427	2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	238,917	34,427	4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	238,917	34,427	7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges	259,800		8
9	Ancillary service charges	379,125	103,124	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)	638,925	103,124	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)	638,925	103,124	16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	400,008	68,697	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)	238,917	34,427	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)	238,917	34,427	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)	238,917	34,427	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)	238,917	34,427	36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	238,917	34,427	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)	238,917	34,427	40
41	Interim payments	170,293	15,315	41
42	Balance due provider/program (line 40 minus line 41)	68,624	19,112	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	4,668,136				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	10,735,754				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-3,325,831				6
7	Inventory	73,168				7
8	Prepaid expenses	7,880				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	12,159,107				11
	FIXED ASSETS					
12	Land					12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings					15
16	Accumulated depreciation					16
17	Leasehold improvements	5,808,187				17
18	Accumulated depreciation	-2,826,763				18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	4,259,951				23
24	Accumulated depreciation	-2,513,649				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)	4,727,726				30
	OTHER ASSETS					
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	12,307,845				34
35	Total other assets (sum of lines 31-34)	12,307,845				35
36	Total assets (sum of lines 11, 30 and 35)	29,194,678				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	418,740				37
38	Salaries, wages and fees payable	1,125,240				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	3,107,337				44
45	Total current liabilities (sum of lines 37 thru 44)	4,651,317				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	6,936,296				49
50	Total long term liabilities (sum of lines 46 thru 49)	6,936,296				50
51	Total liabilities (sum of lines 45 and 50)	11,587,613				51
	CAPITAL ACCOUNTS					
52	General fund balance	17,607,065				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)	17,607,065				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	29,194,678				60

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/04/2017 Run Time: 09:36 Version: 2017.01 (04/10/2017)

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		17,578,700			1
2	Net income (loss) (from Worksheet G-3, line 29)		12,682,840			2
3	Total (sum of line 1 and line 2)		30,261,540			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)		30,261,540			11
12	Deductions (debit adjustments) (specify)					12
13	MINORITY INTEREST	3,487,781				13
14		9,166,694				14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)		12,654,475			18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		17,607,065			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						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

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	25,502,834		25,502,834	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)	25,502,834		25,502,834	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)	25,502,834		25,502,834	17
18	Ancillary services	35,278,083	3,512,747	38,790,830	18
19	Outpatient services				19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	Other (specify)				27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	60,780,917	3,512,747	64,293,664	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		26,197,260	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)		26,197,260	43

HEALTHSOUTH DEACONESS REHABILITATION Provider CCN: 15-3025	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2016 To: 12/31/2016	Run Date: 05/04/2017 Run Time: 09:36 Version: 2017.01 (04/10/2017)

STATEMENT OF REVENUES AND EXPENSES **WORKSHEET G-3**

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	64,293,664	1
2	Less contractual allowances and discounts on patients' accounts	25,525,843	2
3	Net patient revenues (line 1 minus line 2)	38,767,821	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	26,197,260	4
5	Net income from service to patients (line 3 minus line 4)	12,570,561	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments	8,239	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts	43	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	30,115	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts		18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines	2,468	21
22	Rental of hosptial space	89,019	22
23	Governmental appropriations		23
24	Other (specify)	-17,605	24
25	Total other income (sum of lines 6-24)	112,279	25
26	Total (line 5 plus line 25)	12,682,840	26
29	Net income (or loss) for the period (line 26 minus line 28)	12,682,840	29