Exhibit A

CORPORATE INTEGRITY AGREEMENT
BETWEEN THE
OFFICE OF INSPECTOR GENERAL
OF THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
AND
HEALTHSOUTH CORPORATION

I. PREAMBLE

WHEREAS, HealthSouth Corporation, ("HealthSouth") a publicly traded corporation with its principal offices in Birmingham, Alabama, owns and manages, among other things, inpatient rehabilitation hospitals and outpatient rehabilitation clinics that receive payment from the Federal health care programs;

WHEREAS, HealthSouth represents that, in early 1997, HealthSouth contracted with a consultant to formalize its compliance program within the framework of the U.S. Sentencing Guidelines. As part of this process, HealthSouth formalized its Standards of Business Conduct, designated a compliance officer, established an employee compliance training program, established a compliance hotline, and developed a process for screening all employees through the Office of Inspector General ("OIG") sanctions listings and state and regulatory databases (the "HealthSouth Compliance Program"). On October 15, 1997, the HealthSouth Board of Directors adopted and approved its Standards of Business Conduct (the "Standards") under the HealthSouth Compliance Program. The Standards were last amended March 13, 1999;

WHEREAS, the OIG of the United States Department of Health and Human Services ("HHS") and HealthSouth (sometimes collectively referred to as the "Parties") recognize that changes have been proposed to the Medicare reimbursement system for inpatient rehabilitation hospitals;

WHEREAS, substantial uncertainty exists regarding the date that the new reimbursement system will be implemented;

WHEREAS, HealthSouth seeks to reasonably ensure that its billings by inpatient rehabilitation hospitals to the Federal health care programs under the new and the previous reimbursement systems are accurate and have mutually agreed to the Review Procedures set forth below;

WHEREAS, the Review Procedures are necessarily unique and reflect contingencies involved with implementation of the new reimbursement system;

WHEREAS, the OIG intends to recognize improvements in HealthSouth's internal audits and controls by reducing the scope of external reviews as appropriate under the Review Procedures;

WHEREAS, contemporaneously with this CIA, HealthSouth is entering into a Settlement Agreement with the United States, and this CIA is incorporated by reference into the Settlement Agreement;

NOW THEREFORE, HealthSouth (as that term is defined herein) hereby enters into this Corporate Integrity Agreement ("CIA") with the OIG that, along with HealthSouth's existing compliance program, seeks to promote compliance by all Covered Persons and Relevant Covered Persons (as these terms are defined herein) with the statutes, regulations and written directives of Medicare, Medicaid, TRICARE and all other Federal health care programs (as defined in 42 U.S.C. § 1320a-7b(f)) ("Federal health care program requirements").

II. TERM AND SCOPE OF THE CIA

A. The period of the compliance obligations assumed by HealthSouth under this CIA shall be five (5) years from the effective date of this CIA (unless otherwise specified). The effective date of this CIA shall be the date on which the final signatory of this CIA executes this CIA.

B. Sections VII, VIII, IX, X and XI shall remain in effect until within one hundred twenty (120) days of OIG's receipt of HealthSouth's final annual report or one hundred twenty (120) days of OIG's receipt of any additional materials submitted by HealthSouth pursuant to OIG's request, whichever is later.

C. The scope of this CIA shall be governed by the following definitions:

1. HealthSouth includes any corporation, limited liability company, partnership or any other legal entity or organization in which HealthSouth directly or indirectly owns greater than fifty percent (50%) of the voting equity and has the ability to control the day-to-day operations of the entity.

2. Covered Persons includes all officers, directors and employees (including employed physicians) of HealthSouth and its subsidiaries, physicians serving as medical directors, or third parties responsible for the preparation or submission of reimbursement claims, or the supervision thereof, and all other individuals responsible for the provision, marketing or documentation of items or services reimbursable by Federal health care programs, or in the preparation of claims, reports or other requests for reimbursement for such items or services. Notwithstanding the above, part-time and pool agents or employees who work less than one hundred sixty (160) hours per year are not Covered Persons.

3. Relevant Covered Persons includes those HealthSouth officers and employees whose job functions are related to the Policies and Procedures described in, and required by, Section III.B.2.

III. CORPORATE INTEGRITY OBLIGATIONS

The HealthSouth Compliance Program includes, or shall be amended within ninety (90) days of the effective date of this CIA to include, the following elements:

A. Compliance Officer and Committee

1. *Compliance Officer*. HealthSouth has appointed an individual to serve as its Compliance Officer, and shall formally maintain the appointment of an individual to serve as the Compliance Officer. The Compliance Officer is independent of Company executive officers, and can bring issues directly to the Board of Directors. The Compliance Officer reports to the Board of Directors at regularly scheduled Board meetings (at least quarterly) and shall continue to do so. The Compliance Officer is an officer of HealthSouth and shall make periodic (at least quarterly) reports regarding compliance matters relating to the CIA directly to the Board of Directors of HealthSouth, and shall be authorized to report on such matters to the Board of Directors at any time. The Compliance Officer shall be responsible for monitoring the day-to-day compliance activities engaged in by HealthSouth as well as for any reporting obligations created under this CIA.

Any changes in the identity or position description of the Compliance Officer, or any actions or changes that would reasonably be expected to substantially affect the Compliance Officer's ability to perform the duties necessary to meet the obligations in this CIA, must be reported to OIG, in writing, within fifteen (15) days of such a change.

2. *Compliance Office.* Under the direction of the Compliance Officer, HealthSouth represents that it established a Compliance Office that conducts and/or coordinates routine audits of selected sites and divisions based upon OIG's annual work plan, investigates issues through the Company's Hotline, and reviews facilities' compliance with the Company's training standards. The Compliance Office shall be responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with Federal health care program requirements and the requirements set forth in this CIA, along with its reporting responsibilities under the HealthSouth Compliance Program.

3. *Compliance Committee.* HealthSouth has represented to HHS that it has a Compliance Committee. The Compliance Committee includes three outside members of the Board of Directors who are not officers or employees of HealthSouth. HealthSouth agrees that its Compliance Committee will be comprised of at least four individuals, one of which shall be a member of HealthSouth's senior management. The Compliance Officer attends and participates in Compliance Committee meetings, and the Compliance Committee supports the Compliance Officer in fulfilling his/her responsibilities under the CIA.

Any changes in the composition of the Compliance Committee, or any actions or changes that would affect the Compliance Committee's ability to perform the duties necessary to meet the obligations in this CIA, must be reported to the OIG, in writing, within fifteen (15) days of such a change.

B. Written Standards

1. *Code of Conduct.* HealthSouth has represented to HHS-OIG that, pursuant to the HealthSouth Compliance Program, it has adopted and distributed a Code of Conduct to all Covered Persons. HealthSouth will make the promotion of, and adherence to, the Code of Conduct an element in evaluating the performance of all employees. New Covered Persons shall receive the Code of Conduct within two (2) weeks after becoming a Covered Person. The Code of Conduct shall continue to

maintain the following elements:

a. HealthSouth's commitment to full compliance with applicable Federal health care program requirements;

b. HealthSouth's requirement that all of its Covered Persons shall be expected to comply with applicable Federal health care program requirements and with HealthSouth's own Policies and Procedures, including the requirements of this CIA;

c. the requirement that all of HealthSouth's Covered Persons shall be expected to report to the Compliance Officer or other individual designated by the HealthSouth suspected violations of any Federal health care program requirements or of HealthSouth's own Policies and Procedures;

d. the possible consequences to both HealthSouth and Covered Persons of failure to comply with applicable Federal health care program requirements and with HealthSouth's own Policies and Procedures or of failure to report such non-compliance; and

e. the right of all Covered Persons to use the HealthSouth Disclosure Program (described in Section III.E.), and HealthSouth's commitment to maintain confidentiality, as appropriate, and non-retaliation with respect to disclosures.

Within one hundred twenty (120) days of the effective date of the CIA, to the extent not already achieved as part of HealthSouth's Compliance Program, each Covered Person shall certify, in writing, that he or she has received, read, understood, and will abide by HealthSouth's Code of Conduct. New Covered Persons shall receive the Code of Conduct and shall complete the required certification within two weeks after becoming a Covered Person or within ninety (90) days of the effective date of the CIA, whichever is later.

HealthSouth shall annually review the Code of Conduct to determine if revisions are appropriate and shall make any necessary revisions based on such a review. Any such revised Code of Conduct shall be distributed to Covered Persons within thirty (30) days of finalizing such changes. Covered Persons shall certify that they have received, read, understood, and will abide by the revised Code of Conduct within sixty (60) days of the distribution of such revisions. HealthSouth may distribute such revisions in the form

of a separate addendum to the Code of Conduct.

2. *Policies and Procedures.* To the extent not already implemented, within ninety (90) days of the effective date of this CIA, HealthSouth shall implement written Policies and Procedures which, at a minimum, shall address:

a. the reimbursement standards and prohibitions of the applicable Federal health care programs regarding related party transactions;

b. the reimbursement standards and prohibitions of the applicable Federal health care programs regarding sale-leaseback arrangements; and

c. reimbursement standards and prohibitions of the applicable Federal health care programs regarding costs reporting, as applicable and appropriate.

Within ninety (90) days of the effective date of the CIA, the relevant portions of the Policies and Procedures shall be distributed to all Relevant Covered Persons. Appropriate and knowledgeable staff should be available to explain the Policies and Procedures.

At least annually (and more frequently if appropriate), HealthSouth shall assess and update as necessary the Policies and Procedures required by this section. Within thirty (30) days of the effective date of any revisions, the relevant portions of any such revised Policies and Procedures shall be distributed to all Relevant Covered Persons.

C. Training and Education

1. *HealthSouth Compliance Training.* HealthSouth represents that it has an established compliance training program. HealthSouth tracks and monitors its employee training from its Corporate Office through its Compliance Office. HealthSouth agrees to maintain or provide at a substantially similar level the following training requirements:

a. Compliance Orientation Training. HealthSouth has and will continue to distribute a detailed Trainer's Manual to facilities for use in preparing and conducting the Compliance Orientation. HealthSouth agrees to continue to provide its Compliance Orientation Training to its employees within ten (10) business days of their respective hire date. HealthSouth agrees that its Compliance Orientation has and will

consist of a live two-hour session in which a brief introductory video explains the nature and purpose of the Company's Compliance Program. Through the use of slides and/or employee handouts, the moderator has and will discuss key aspects of the Standards and the importance of maintaining compliance with applicable laws and regulations. Employees have been and will be asked to review a number of case studies to identify the relevant compliance issues and determine the ideal resolution process. HealthSouth may make non-material changes to the specific approach to its Compliance Orientation Training, provided that the length of the training session remains no less than two (2) hours. Beginning no more than thirty (30) days after the effective date of this CIA, the Compliance Orientation Training will cover the requirements of this CIA.

Upon completion of the training session, HealthSouth agrees that the following documentation will be completed by the respective new employees or orientation training instructor, as appropriate:

(i) Evidence of Completion form, documenting employee's attendance and receipt of the Standards; such documentation will be filed in the employee's personnel file;

(ii) Classroom Roster, including a listing of attendees; such documentation will be forwarded to the Corporate Office for entry into the HealthSouth tracking system; and

(iii) Participant Evaluation; such documentation, including significant comments will be forwarded to the Corporate Office for review, evaluation and retention.

b. Refresher Training. HealthSouth represents that, as part of its Compliance Program, all employees who would have been Covered Persons had this CIA been in effect have participated in refresher training within two (2) years from the completion of their original training ("Refresher Training"). HealthSouth represents that its Compliance Office has distributed a Moderator's Guide to its facilities to assist in administering the Refresher Training. The Refresher Training requires the employee to review the basic elements of the Compliance Program (including the Standards) and complete a number of exercises. Upon completion of the Refresher Training, the following documentation has been and, during the term of this CIA, will be prepared:

(i) Evidence of Completion Form, including an Employee

acknowledgment that he/she has completed the refresher workbook and possesses a copy of the Standards and Moderator's certification attesting to the employee's completion of the refresher workbook; such documentation will be filed in the employee's personnel file.

(ii) Employee Contact Page, providing contact information for key personnel to guide employees in resolving conflicts.

(iii) Refresher Training Summary Report, completed by each facility and forwarded to HealthSouth's Compliance Office for entry into the training tracking system.

HealthSouth agrees that, as of the Effective Date of this CIA, at a minimum, each Covered Person will be required to complete the Refresher Training each year during the five (5) year period of this CIA. The current training materials have been made available to OIG, and HealthSouth agrees that future training materials will be made available to OIG upon request. Beginning no more than thirty (30) days after the effective date of this CIA, the Refresher Training will cover the requirements of this CIA.

2. *Specific Training*. HealthSouth represents that it has provided specific training in the last twelve (12) months to Covered Persons who are involved in the delivery of patient care items or services and/or in the preparation or submission of claims for reimbursement from any Federal health care program. To the extent the specific training provided in the last twelve (12) months to Covered Persons under the HealthSouth Compliance Program did not include the following subjects, within one hundred twenty (120) days of the effective date of the CIA, HealthSouth agrees to furnish to Covered Persons and Relevant Covered Persons the following additional training related to:

a. the submission of accurate bills for services rendered to Federal health care program beneficiaries;

b. policies, procedures and other requirements applicable to the documentation of medical records;

c. the personal obligation of each individual involved in the billing process to ensure that such billings are accurate;

d. applicable reimbursement statutes, regulations, and program requirements and directives, including but not limited to (if applicable to the particular Covered Person's job function) the requirements related to cost reporting, related party transactions, and sale-leaseback arrangements;

e. the legal sanctions for improper billings; and

f. examples of proper and improper billing practices.

Persons providing the training must be knowledgeable about the subject area.

Relevant Covered Persons shall receive this specific training within thirty (30) days of the beginning of their employment or becoming Relevant Covered Persons or within one hundred twenty (120) days of the effective date of this CIA, whichever is later. A HealthSouth Covered Person or Relevant Covered Person who has completed the specific training shall review a new Covered Person and/or new Relevant Covered Person's work, to the extent that the work relates to the delivery of patient care items or services and/or in the preparation or submission of claims for reimbursement from any Federal health care program, until such time as the new Covered Person and/or new Relevant Covered Person completes the specific training relevant to his/her duties.

HealthSouth shall continue to provide specific training for Relevant Covered Persons. During the term of this CIA, every Relevant Covered Person shall receive at least two (2) hours of specific training annually.

3. *Employee Attestations.* HealthSouth shall maintain documents that reflect attendance at general and specific training sessions for all Covered Persons and Relevant Covered Persons. At a minimum, the documents shall include dated sheets with a heading or description of the type of training and the attendees' signatures attesting to their attendance at the training sessions. The Compliance Officer (or his or her designee) shall retain these documents, along with all course materials. These shall be made available to OIG, upon request.

D. Review Procedures

HealthSouth represents that, as part of its compliance program, it conducts periodic internal audits and compliance reviews. To supplement such periodic audits and reviews, HealthSouth agrees to conduct the following review procedures:

1. *General Description.*

a. Retention of Independent Review Organization. Within 90 days of the effective date of this CIA, HealthSouth shall retain an entity (or entities), such as an accounting, auditing or consulting firm (hereinafter "Independent Review Organization" or "IRO"), to perform review engagements to assist HealthSouth in assessing and evaluating its billing, coding and cost reporting practices with respect to its inpatient rehabilitation facilities ("IRFs"), and its compliance obligations pursuant to this CIA and the Settlement Agreement. Each Independent Review Organization retained by HealthSouth shall have expertise in the billing, coding, reporting and other Medicare program requirements applicable to IRFs and in the general requirements of the Federal health care program(s) from which HealthSouth seeks reimbursement. Each IRO shall assess, along with HealthSouth, whether it can perform the IRO engagements in a professionally independent fashion taking into account any other business relationships or other engagements that may exist.

b. Types of Engagements. The IRO(s) shall conduct three separate engagements. One engagement shall address HealthSouth's cost reporting to the Medicare program with respect to its cost-based reimbursement of IRFs for cost-report years ending in 2000 and 2001, and for any subsequent cost-report years during the term of this CIA in which any HealthSouth IRF is not 100% reimbursed under the Medicare per discharge prospective payment system ("PPS") to be implemented for IRFs sometime after April 1, 2001 ("Cost Reporting Engagement"). The second engagement shall address HealthSouth's compliance with the obligations assumed under this CIA and the Settlement Agreement ("Compliance Engagement"). The third engagement shall address HealthSouth's billing and coding to the Medicare program with respect to its IRFs under the Medicare PPS ("Billing Engagement").

c. Frequency of IRO Engagements. The Cost Reporting Engagement shall be performed during at least the first two years of this CIA's term (or later as applicable pursuant to Section III.D.1.b) and shall cover the selected IRF's most recently filed cost reports. The Compliance Engagement shall be performed by the IRO for the first year of this CIA's term. The Billing Engagement shall be performed for the second year of this CIA's term for Medicare payments received during that second year; the extent of the Billing Engagement in subsequent periods during the term of this CIA for Medicare payments received during those periods shall depend upon the conditions set forth in Section III.D.5 below.

d. Retention of Records. The IRO and HealthSouth shall retain and make available to the OIG, upon request, all work papers, supporting documentation, correspondence, and draft reports (those exchanged between the IRO and HealthSouth) related to the engagements.

2. *Cost Reporting Engagement.* The Cost Reporting Engagement shall consist of the following:

a. Cost Report Systems Review. The IRO shall review HealthSouth's cost report preparation process for all IRF's for which cost reports are submitted for cost-based reimbursement by HealthSouth to the Medicare program ("Cost Report Systems Review"). The Cost Report Systems Review shall consist of a thorough review of HealthSouth's cost report, home office cost statement, information statement and payment request preparation process relating to any and all costs submitted by IRFs for the applicable cost report periods to the Medicare program (including, but not limited to, the steps HealthSouth takes to ensure that the proper information is being recorded on such submissions to the Medicare program and safeguards to ensure that only proper costs and dollar amounts are being submitted for reimbursement to such program).

b. Cost Report Review. The IRO shall perform a review of a random selection of all cost reports filed by HealthSouth in the period being audited (the "Cost Report Review"). The Cost Report Review will be performed in accordance with the procedures outlined in Appendix A to this CIA, which is incorporated by reference. The number of cost reports to be reviewed in each period will be determined as follows:

(i) If the IRO determines, based upon its Cost Report Systems Review as described in Section III.D.2.a, that HealthSouth's cost report preparation process is functioning appropriately, and that HealthSouth has established appropriate internal control and other operating procedures to ensure that the proper information is being recorded in HealthSouth's cost report submissions, then the IRO will perform a review of the HealthSouth Home Office Cost report and a random selection of ten percent (10%) of all cost reports filed in the period being audited by HealthSouth IRFs which were not 100% reimbursed under the PPS for the entire period being audited.

(ii) If the IRO determines , based upon its Cost Report Systems Review as described in Section III.D.2.a, that HealthSouth's cost report preparation process is not functioning appropriately, or that HealthSouth has not

established appropriate internal control and other operating procedures to ensure that the proper information is being recorded in HealthSouth's cost report submissions, then the IRO will perform a review of the HealthSouth Home Office Cost report and a random selection of twenty-five percent (25%) of all cost reports filed in the period being audited by HealthSouth IRFs which were not 100% reimbursed under the PPS for the entire period being audited.

c. Cost Reporting Engagement Report. The IRO shall prepare a report based upon the Cost Reporting Engagement and as contemplated by the AICPA's Statement of Position 99-1, *Guidance to Practitioners in Conducting and Reporting on an Agreed-Upon Procedures Engagement to Assist Management in Evaluating the Effectiveness of Its Corporate Compliance Program*, and consulting standards, as appropriate. The Report shall include the IRO's findings and supporting rationale regarding (i) the strengths and weaknesses in HealthSouth's cost report, home office cost statement, information statement and payment request preparation process relating to any and all costs submitted to the Medicare program covered by the Cost Report Systems Review set out in section III.D.2.a of this CIA in the period being audited; (ii) any recommendations the IRO may have to improve any of these systems, operations, and processes; and (iii) a summary of the conclusions from the Cost Report Review.

3. *Compliance Engagement.*

a. Compliance Review. The IRO shall conduct a review of HealthSouth's compliance activities ("Compliance Review"). Specifically, the Compliance Review shall consist of a review of HealthSouth's adherence to the obligations set forth in sections I through VIII of this CIA, and a review of HealthSouth's compliance with certain provisions of the Settlement Agreement.

i. CIA Obligations Review. The IRO shall assess and evaluate HealthSouth's compliance with the obligations set forth in sections I through VIII of this CIA.

ii. Unallowable Costs Review. The IRO shall determine whether HealthSouth has complied with its obligation not to charge to, or otherwise seek payment from, Federal or State payers for the "unallowable costs" described in Section III.12 of the Settlement Agreement, and its obligation to identify to applicable Federal or State payers any such "unallowable costs" included in payments previously sought from the United States, or any State Medicaid program. This "unallowable cost" analysis shall

include, but not be limited to, payments sought in any cost reports, cost statements, information reports, or payment requests already submitted by HealthSouth or any of its subsidiaries. HealthSouth agrees and shall request that such cost reports, cost statements, information reports or payment requests, even if already settled, be adjusted to account for the effect of the inclusion of the "unallowable costs." In making this determination, the IRO may need to review cost reports and/or financial statements from the year in which of the Settlement Agreement was executed, as well as from previous years.

b. Compliance Review Report. The IRO shall prepare a report (the "Compliance Review Report") based upon the Compliance Review and as contemplated by the AICPA's Statement of Position 99-1, *Guidance to Practitioners in Conducting and Reporting on an Agreed-Upon Procedures Engagement to Assist Management in Evaluating the Effectiveness of Its Corporate Compliance Program*, and consulting standards, as appropriate. The Compliance Review Report shall include the IRO's findings and supporting rationale and a summary of such findings and rationale with respect to:

i. HealthSouth's compliance with the terms of sections I through VIII of the CIA, as applicable; and

ii. HealthSouth's compliance with its obligation not to charge to, or otherwise seek payment from, Federal or State payers for the "unallowable costs" described in the Settlement Agreement, and its obligation to identify to applicable Federal or State payers any such "unallowable costs" included in payments previously sought from such payer.

4. *Internal Billing Review*. For each annual period during the term of this CIA in which the PPS is in effect for at least ninety (90) days, HealthSouth, through appropriate internal audit personnel, shall conduct a review of its own billings to the Medicare program for services rendered in HealthSouth's IRFs under the PPS (the "Internal Billing Review"); provided, however, that no Internal Billing Review will be required for the second annual period, when the IRO will perform its Billing Engagement pursuant to Section III.D.5. The Internal Billing Review shall be composed of two separate reviews, a "Claims Review" and a "Billings Systems Review."

a. Billing Systems Review. HealthSouth shall review its IRF billing and coding systems and/or operations (the "Billing Systems Review"). The Billing Systems Review shall consist of a thorough review of the following:

i. HealthSouth's billing systems and/or operations relating to claims submitted by HealthSouth's IRFs to the Medicare program (including, but not limited to, the operation of the billing system, safeguards to ensure proper claim submission and billing, procedures to correct inaccurate billing, but excluding the cost report preparation process that is the subject of the Cost Reporting Engagement); and

ii. HealthSouth's coding systems and/or operations relating to claims submitted by HealthSouth's IRFs to the Medicare program (including, but not limited to, the process by which claims are coded, safeguards to ensure proper coding, and procedures to correct inaccurate coding).

b. Billing Systems Review Report. HealthSouth shall prepare a report based upon each Billing Systems Review performed ("Billing Systems Review Report"). The Billing Systems Review Report shall include HealthSouth's findings and supporting rationale regarding:

i. the strengths and weaknesses in HealthSouth's billing systems and/or operations for its IRFs; and

ii. the strengths and weaknesses in HealthSouth's coding systems and/or operations for its IRFs; and

iii. any recommendations HealthSouth's audit personnel may have to improve any of these systems, operations, and processes.

c. Claims Review. HealthSouth shall perform a Claims Review to identify any overpayments through an appraisal of Paid Claims submitted by HealthSouth to the Medicare program. The Claims Review shall be performed in accordance with, as appropriate, either Section III.D.4.c.i below, or the procedures set forth in Appendix B to this CIA, which is incorporated by reference. The claims to be reviewed by HealthSouth will be randomly selected from a population consisting of all Paid Claims received by all of HealthSouth's IRFs during the period under review. The number of claims reviewed by HealthSouth for each period will be determined as follows:

(i) If the results of the Billing Systems Review conducted by HealthSouth as described in Section III.D.4.a, above, indicate that such Systems are

functioning appropriately (thereby indicating that HealthSouth has established appropriate internal controls and other operating procedures to ensure that appropriate claims are being submitted to the Medicare program by HealthSouth IRF(s)), then the number of Paid Claims to be selected for the period under review will total one hundred twenty (120). The one hundred twenty (120) Paid Claims will be selected from a random sample of at least ten percent (10%) but no less than four (4) of HealthSouth's IRFs that submitted claims to the Medicare program under the PPS for at least ninety (90) days during the period under review. The one hundred twenty (120) claims shall be evenly selected from among the randomly selected IRFs. For example, if a total of one hundred twenty (120) of HealthSouth's IRFs submitted claims to Medicare under the PPS for at least ninety (90) days during the period under review, then the sample shall consist of ten (10) Paid Claims randomly selected from each of twelve (12) IRFs that were also selected at random. If a total of forty (40) of HealthSouth's IRFs submitted claims to the Medicare program under the PPS for at least ninety (90) days during the period under review, then the sample shall consist of thirty (30) Paid Claims randomly selected from each of four (4) IRFs that were selected at random. IRFs that are randomly selected during one year's review shall be removed from the pool of IRFs to be sampled during the subsequent year's review only, then shall be added back to the pool for purposes of later reviews.

(ii) The sample of one hundred twenty (120) Paid Claims shall be used to calculate the total dollar amount of Overpayments (as that term is defined in Appendix B). For any review conducted in accordance with this Section only, the Precision Requirements of Appendix B shall not apply at the ninety percent (90%) Confidence Level, and it is agreed that, for purposes of assessing HealthSouth's claims submission compliance under this CIA, the total dollar amount of Overpayments shall be calculated based upon the midpoint of the confidence interval (the point estimate).

(iii) In the event that the total dollar amount of Overpayments exceeds five percent (5%) of gross Medicare payments received by the selected IRFs under the PPS, HealthSouth shall conduct a second Claims Review for the same period in accordance with the terms of Appendix B. In addition, if the results of the Billing Systems Review conducted by HealthSouth as described in Section III.D.4.a, above, indicate that such systems are not functioning appropriately (and therefore do not provide a reasonable level of assurance that HealthSouth has established appropriate internal control and other operating procedures to ensure that appropriate claims are being submitted to the Medicare program by HealthSouth IRFs), then the Claims Review will be conducted pursuant to Appendix B.

d. Claims Review Report. HealthSouth shall prepare a report based upon each Claims Review performed ("Claims Review Report"). The Claims Review Report shall be created in accordance with the procedures set forth in Section B of Appendix B to this CIA (except that if the selection of Paid Claims reviewed occurs pursuant to Sections III.D.4.c.i, then the Report may be modified as appropriate).

5. *IRO Billing Engagement*. For the second year of this CIA, HealthSouth shall engage its IRO to perform the Billing Engagement in accordance with the following provisions:

a. IRO Claims and Billing Systems Reviews. The IRO shall perform a Claims Review in accordance with the procedures set forth in Appendix B to this CIA to identify any overpayments through an appraisal of Paid Claims received by HealthSouth IRFs from the Medicare program under the PPS during the second year of this CIA, and a Billing Systems Review in the manner described in Section III.D.4a.

b. IRO Claims Review and Systems Review Reports. The IRO shall prepare reports based upon the IRO's Claims Review and Billing Systems Review and as contemplated by the AICPA's Statement of Position 99-1, *Guidance to Practitioners in Conducting and Reporting on an Agreed-Upon Procedures Engagement to Assist Management in Evaluating the Effectiveness of Its Corporate Compliance Program*, and consulting standards, as applicable.

c. IRO Validation Review. Concurrently with its year two Claims Review and Systems Review, the IRO shall perform a validation review of the Billing Systems and Claims Reviews performed by HealthSouth in year one of this CIA pursuant to Sections III.D.4.a and III.D.4.c (the "IRO Validation Review"). The IRO Validation Review shall be performed in accordance with the procedures set forth in Appendix C to this CIA, which is incorporated by reference. Additional reviews, including additional Validation Reviews, may be performed as set forth in Section III.D.5.e, below.

d. IRO Validation Review Report. The IRO shall prepare a report, as contemplated by the AICPA's Statement of Position 99-1, *Guidance to Practitioners in Conducting and Reporting on an Agreed-Upon Procedures Engagement to Assist Management in Evaluating the Effectiveness of Its Corporate Compliance Program*, and consulting standards, as applicable.

e. Additional Claims and Validation Reviews. In the event that the IRO Validation Review reflects that HealthSouth's Billing Systems and Claims Reviews for the period reviewed are substantially accurate, then the IRO shall not perform any Billing Engagement for those periods. In the event that the IRO Validation Review reflects that either HealthSouth's Billing Systems Review or its Claims Review for year one is not substantially accurate, then the IRO shall: (i) perform its own Claims Review (in accordance with Section III.D.5.a) and issue its own Claims Review Report (in accordance with Section III.D.5.b) for the period(s) in question; (ii) issue a report recommending appropriate changes to HealthSouth's Billing Systems and Claims review procedures; and (iii) perform another Validation Review following the third and fourth year of this CIA of the Billing Systems Reviews and Claims Reviews performed by HealthSouth for the third and fourth periods reviewed. For purposes of this paragraph, a HealthSouth Claims Review will be deemed "substantially accurate" if the amount of the Overpayment identified in such Claims Review differs by no more than two percent (2%) from the amount of Overpayment identified in the IRO Validation Review (such amount being adjusted appropriately to account for the smaller sample size used for the Validation Review).

f. Additional IRO Systems Reviews. In the event that any Internal Billing Review conducted by HealthSouth or the IRO's Claims Review shows an error rate of greater than or equal to five percent (5%) for claims reimbursed under the PPS, in the following year, the IRO shall perform an additional Systems Review of systems related to the systems implicated by the respective Internal Billing Review or the IRO's Claims Review. The results of this additional Systems Review shall be reported to the OIG in HealthSouth's Annual Report, and shall include: (i) the IRO's recommendations for improving any of the systems implicated; and (ii) an evaluation of whether previous recommendations by HealthSouth's Internal Audit Department related to such systems were not, or could not, be implemented.

6. *Validation Review.* In the event the OIG has reason to believe that: (a) HealthSouth's Cost Reporting Engagement, Compliance Engagement or Billing Engagement fails to conform to the requirements of this CIA; or (b) the findings or Cost Report Review results are inaccurate, the OIG may, at its sole discretion, conduct its own review to determine whether the Cost Reporting, Compliance, and/or Billing Engagements comply with the requirements of the CIA and/or the Cost Report Review, Claims Review, IRO Claims Review or Validation Review results are inaccurate. HealthSouth agrees to pay for the reasonable cost of any such review performed by the OIG or any of its designated agents so long as it is initiated before one year after the

HealthSouth's final submission (as described in section II) is received by the OIG. Prior to initiating such a review, OIG shall notify HealthSouth of the specific failure to conform or inaccuracy that prompted the additional review.

7. *Independence Certification.* Within one hundred twenty (120) days from the effective date of this CIA, the IRO shall provide to HealthSouth a certification or sworn affidavit that it has evaluated its professional independence with regard to the Cost Reporting, Compliance, and Billing Engagements, and that it has concluded that it is, in fact, independent. Such certification shall be included in HealthSouth's Implementation Report submission.

E. Disclosure Program

The HealthSouth Compliance Program includes a Disclosure Program, which includes a toll free "Hotline" to enable individuals to disclose, to the Compliance Officer or some other person who is not in the disclosing individual's chain of command, any identified issues or questions associated with HealthSouth's policies, conduct, practices, or procedures with respect to a Federal health care program, believed by the individual to be a potential violation of criminal, civil or administrative law. HealthSouth shall continue to publicize the existence of the Hotline (e.g., via periodic e-mails or newsletters to employees, or by posting the information in prominent common areas).

The Disclosure Program shall continue to emphasize a non-retribution, non-retaliation policy, and shall continue to include a reporting mechanism for anonymous, confidential communications. Upon receipt of a disclosure, the Compliance Officer (or designee) shall continue to gather all relevant information from the disclosing individual. The Compliance Officer (or designee) shall continue to make a preliminary, good faith inquiry into the allegations set forth in every disclosure to ensure that he or she has obtained all of the information necessary to determine whether a further review should be conducted. For any disclosure that is sufficiently specific so that the Compliance Officer (or appropriate designee) determines it reasonably: (1) permits a determination of the appropriateness of the alleged improper practice; and (2) provides an opportunity for taking corrective action, the Compliance Officer shall conduct an internal review of the allegations set forth in such a disclosure and ensure that proper follow-up is conducted.

The Compliance Officer (or his or her designee) shall continue to maintain a disclosure log, which shall include a record and summary of each disclosure received (whether anonymous or not), the status of the respective internal reviews, and any

corrective action taken in response to the internal reviews. The disclosure log shall be available to OIG, upon request.

F. Ineligible Persons

1. *Definition.* For purposes of this CIA, an "Ineligible Person" shall be any individual or entity who: (a) is currently excluded, debarred or otherwise ineligible to participate in the Federal health care programs or in Federal procurement or non-procurement programs; or (b) has been convicted of a criminal offense related to the provision of health care items or services, but has not yet been excluded, debarred or otherwise declared ineligible.

2. *Screening Requirements.* It shall be HealthSouth's policy not to hire as employees or engage as contractors any Ineligible Person. To prevent hiring or contracting with any Ineligible Person, HealthSouth shall screen all prospective employees and prospective contractors prior to engaging their services by requiring applicants to disclose whether they are Ineligible Persons. In addition, HealthSouth shall check all newly engaged contractors and newly hired employees against the General Services Administration's List of Parties Excluded from Federal Programs (available through the Internet at http://epls.arnet.gov) and the HHS/OIG List of Excluded Individuals/Entities (available through the Internet at http://www.hhs.gov/oig) (these lists will hereinafter be referred to as the "Exclusion Lists"). In the event that HealthSouth screens a newly engaged contractor after the engagement has begun, and HealthSouth learns that such newly engaged contractor has been excluded from participation in the Federal health care programs, HealthSouth shall take all appropriate steps to ensure that it does not charge the Federal health care programs for any items or services provided by the excluded entity.

3. *Review and Removal Requirement.* Within ninety (90) days of the effective date of this CIA, to the extent not performed within the six (6) months preceding such effective date, HealthSouth shall review its list of employees and contractors against the Exclusion Lists. Thereafter, HealthSouth shall review the Exclusion Lists annually. HealthSouth shall also continue to require its employees and contractors to disclose immediately any debarment, exclusion or other event that makes the employee an Ineligible Person.

If HealthSouth has credible notice that an employee or contractor has become an Ineligible Person, HealthSouth shall remove such person from responsibility for, or

involvement with, HealthSouth's business operations related to the Federal health care programs and shall remove such person from any position for which the person's salary or the items or services rendered, ordered, or prescribed by the person are paid in whole or part, directly or indirectly, by Federal health care programs or otherwise with Federal funds at least until such time as the person is reinstated into participation in the Federal health care programs.

4. *Pending Charges and Proposed Exclusions*. If HealthSouth has credible notice that an employee or contractor is charged with a criminal offense related to any Federal health care program, or is proposed for exclusion during his or her employment or contract, the HealthSouth shall take all appropriate actions to ensure that the responsibilities of that employee or contractor have not and shall not adversely affect the quality of care rendered to any beneficiary, patient or resident, or the accuracy of any claims submitted to any Federal health care program.

G. Notification of Government Investigation or Legal Proceedings

Within thirty (30) days of credible notice, HealthSouth shall notify OIG, in writing, of any ongoing investigation or legal proceeding conducted or brought by a governmental entity or its agents involving an allegation that HealthSouth has committed a crime or has engaged in fraudulent activities. This notification shall include a description of the allegation, the identity of the investigating or prosecuting agency, and the status of such investigation or legal proceeding. HealthSouth shall also provide written notice to OIG within thirty (30) days of the resolution of the matter, and shall provide OIG with a description of the findings and/or results of the proceedings, if any.

H. Reporting

1. *Overpayments*

a. Definition of Overpayments. For purposes of this CIA, an "Overpayment" shall mean the amount of money HealthSouth has received in excess of the amount due and payable under any Federal health care program requirements. HealthSouth may not subtract any underpayments for purposes of determining the amount of relevant "Overpayments" for CIA reports.

b. Reporting of Overpayments. If, at any time, HealthSouth identifies or learns of any Overpayments, HealthSouth shall notify the payor (e.g.,

Medicare fiscal intermediary or carrier) within thirty (30) days of identification of the Overpayment and take remedial steps within sixty (60) days of discovery (or such additional time as may be agreed to by the payor) to correct the problem, including preventing the underlying problem and the Overpayments from recurring. Also, within thirty (30) days of identification of the Overpayment, HealthSouth shall repay the Overpayment to the appropriate payor to the extent such Overpayment has been quantified. If not yet quantified, within thirty (30) days of identification, HealthSouth shall notify the payor of its efforts to quantify the Overpayment amount along with a schedule of when such work is expected to be completed. Notification and repayment to the contractor should be done in accordance with the contractor policies, and for Medicare contractors, must include the information, as applicable, contained on the Overpayment Refund Form, provided as Appendix D to this CIA. Notwithstanding the above, notification and repayment of any overpayment amount that routinely is reconciled or adjusted pursuant to policies and procedures established by the payor should be handled in accordance with such policies and procedures.

2. *Material Deficiencies.*

a. Definition of Material Deficiency. For purposes of this CIA, a "Material Deficiency" means anything that involves:

(1) a substantial Overpayment relating to any Federal health care program; or

(2) a matter that a reasonable person would consider a potential violation of criminal, civil or administrative laws applicable to any Federal health care program for which penalties or exclusion may be authorized.

A Material Deficiency may be the result of an isolated event or a series of occurrences.

b. *Reporting of Material Deficiencies.* If HealthSouth determines through any means, to include HealthSouth's Audit Programs, and after reasonable investigation that there is a Material Deficiency, the Compliance Officer shall notify OIG, in writing, within thirty (30) days of making the determination that the Material Deficiency exists. The report to the OIG shall include the following information:

(1) If the Material Deficiency results in an Overpayment, the report to the OIG shall be made at the same time as the notification to the payor required in Section III.H.1., and shall include all of the information on the Overpayment Refund Form, as well as:

(a) the payor's name, address, and contact person to whom the Overpayment was sent; and

(b) the date of the check and identification number (or electronic transaction number) on which the Overpayment was repaid/refunded;

(2) a complete description of the Material Deficiency, including the relevant facts, persons involved, and legal and Federal health care program authorities implicated;

(3) a description of HealthSouth's actions taken to correct the Material Deficiency; and

(4) any further steps HealthSouth plans to take to address the Material Deficiency and prevent it from recurring.

IV. NEW BUSINESS UNITS OR LOCATIONS

In the event that, after the effective date of this CIA, the HealthSouth corporate office changes locations or purchases or establishes new business units furnishing inpatient rehabilitation items or services or general acute care hospital services that may be reimbursed by Federal health care programs, HealthSouth shall notify OIG of this fact as soon as possible, but no later than within thirty (30) days of the date of change of location, purchase or establishment. This notification shall include the location, and Medicare provider number(s) (if any) of each new operation. All Covered Persons and/or Relevant Covered Persons at such new inpatient facility locations shall be subject to the applicable requirements in this CIA.

V. IMPLEMENTATION AND ANNUAL REPORTS

A. Implementation Report. Within one hundred twenty (120) days after the effective date of this CIA, HealthSouth shall submit a written report to OIG summarizing the status of its implementation of the requirements of this CIA. This Implementation

Report shall, to the extent not already provided to the OIG, or if modified, include:

1. the name, address, phone number, position description, and summary of other non-compliance job responsibilities of the Compliance Officer required by Section III.A.;

2. the names and positions of the members of the Compliance Committee required by Section III.A.;

3. a copy of HealthSouth's Code of Conduct required by Section III.B.1.;

4. a summary of the other Policies and Procedures required by Section III.B.2.;

5. a description of the training program required by Section III.C., including a description of the targeted audiences, length of sessions, and a schedule of when the training sessions were held (in addition, HealthSouth shall make all training materials available to OIG upon request);

6. a certification by the Compliance Officer that, to the best of the Compliance Officer's knowledge:

a. the Policies and Procedures required by Section III.B.2. have been developed, are being implemented, and have been distributed to all appropriate Relevant Covered Persons;

b. all Covered Persons have received the Code of Conduct required by Section III.B.1.; and

c. all Covered Persons have completed the applicable training required by Section III.C.;

Any documentation supporting this certification shall be available to OIG, upon request.

7. a description of any changes in the Disclosure Program described in Section III.E.;

8. the identity of the IRO(s), a summary/description of all engagements between HealthSouth and the IRO, including, but not limited to, any outside financial audits, compliance program engagements, or reimbursement consulting, and the proposed start and completion dates of the IRO reviews described in Section III.D;

9. a certification from the IRO regarding its professional independence from HealthSouth;

10. a summary of personnel actions (other than hiring) taken pursuant to Section III.F.;

11. a list of all HealthSouth's locations (including locations and mailing addresses) in existence as of the date that is thirty (30) days before the due date of the Implementation Report, the corresponding name under which each location is doing business, the corresponding phone numbers and fax numbers, and each location's Medicare provider identification number(s);

12. a description of HealthSouth's corporate structure, including identification of any parent and sister companies, subsidiaries and their respective lines of business; and

13. the certification required by Section V.C.

B. Annual Reports. HealthSouth shall submit to OIG Annual Reports with respect to the status of, and findings regarding, HealthSouth's compliance activities for each of the five (5) one-year periods beginning on the effective date of the CIA. (The one-year period covered by each Annual Report shall be referred to as "the Reporting Period").

Each Annual Report shall include:

1. any change in the identity, position description, or other non-compliance job responsibilities of the Compliance Officer and any change in the membership of the Compliance Committee described in Section III.A.;

2. a certification by the Compliance Officer that, to the best of the Compliance Officer's knowledge:

a. all Covered Persons have received and reviewed any Code of Conduct required by Section III.B.1.;

b. all Covered Persons have completed the applicable training and completed any attestation required by Section III.C.; and

c. HealthSouth has complied with its obligations under the Settlement Agreement: (i) not to resubmit to any Federal health care program payors any previously denied claims related to the Covered Conduct addressed in the Settlement Agreement, and not to appeal any such denials of claims; (ii) not to charge to or otherwise seek payment from Federal or State payors for "unallowable costs" (as defined in the Settlement Agreement); and (iii) to identify and adjust any past charges or claims for such unallowable costs;

Any documentation supporting this certification shall be available to OIG, upon request.

3. a summary of any significant changes or amendments to the Policies and Procedures required by Section III.B.2. and the reasons for such changes;

4. a description of training programs required by Section III.C. (to the extent it has not already been provided as part of the Implementation Report), including a description of the targeted audiences, length of sessions, percentage of attendance, and a schedule of when the training sessions were held (as stated above, HealthSouth shall make all training materials available to OIG upon request);

5. a complete copy of all final reports for the applicable Reporting Period pursuant to Section III.D, including a copy of the methodology used, along with (where applicable) a copy of the IRO's engagement letter;

6. HealthSouth's response and corrective action plan(s) related to any issues raised by the IRO(s);

7. a revised summary/description of all engagements between HealthSouth and the IRO, including, but not limited to, any outside financial audits,

compliance program engagements, or reimbursement consulting, if different from what was submitted as part of the Implementation Report;

8. a summary of Material Deficiencies (as defined in III.H) identified by HealthSouth or its IRO(s) during the Reporting Period and the status of any corrective and preventative action relating to all such Material Deficiencies;

9. a report of the aggregate Overpayments that have been returned to the Federal health care programs during the applicable Reporting Period. Overpayment amounts should be broken down into the following categories: inpatient Medicare, outpatient Medicare, Medicaid (report each applicable state separately), TRICARE, and other Federal health care programs;

10. a summary of the disclosures in the disclosure log required by Section III.E. that relate to alleged violations of Federal health care program requirements;

11. a description of any personnel actions (other than hiring) taken by HealthSouth as a result of the obligations in Section III.F., and the name, title, and responsibilities of any person that falls within the ambit of Section III.F.4., and the actions taken in response to the obligations set forth in that Section;

12. a summary describing any ongoing investigation or legal proceeding required to have been reported pursuant to Section III.G. The summary shall include a description of the allegation, the identity of the investigating or prosecuting agency, and the status of such investigation or legal proceeding;

13. a description of all changes, as of the date that is thirty (30) days prior to the date of the applicable Annual Report, to the most recently provided list (as updated) of HealthSouth's locations (including locations and mailing addresses) as required by Section V.A.10., the corresponding name under which each location is doing business, the corresponding phone numbers and fax numbers, each location's Federal health care program provider identification number(s), and the contractor name and address that issued each provider identification number; and

14. the certification required by Section V.C.

The first Annual Report shall be received by the OIG no later than ninety (90)

days after the end of the first Reporting Period. Subsequent Annual Reports shall be received by OIG no later than the anniversary date of the due date of the first Annual Report.

C. Certifications. The Implementation Report and Annual Reports shall include a certification by the Compliance Officer that: (1) except as otherwise described in the applicable report, HealthSouth is in compliance with all of the requirements of this CIA, to the best of his or her knowledge; and (2) the Compliance Officer has reviewed the Report and has made reasonable inquiry regarding its content and believes that the information is accurate and truthful.

D. Designation of Information. HealthSouth shall clearly identify any portions of its submissions that it believes are trade secrets, or information that is commercial or financial and privileged or confidential, and therefore potentially exempt from disclosure under the Freedom of Information Act ("FOIA"), 5 U.S.C. § 552. HealthSouth shall refrain from identifying any information as exempt from disclosure if HealthSouth is aware that the information does not meet the criteria for exemption from disclosure under FOIA.

VI. NOTIFICATIONS AND SUBMISSION OF REPORTS

Unless otherwise stated in writing after the effective date of this CIA, all notifications and reports required under this CIA shall be submitted to the following entities:

OIG:

Civil Recoveries Branch - Compliance Unit
Office of Counsel to the Inspector General
Office of Inspector General
U.S. Department of Health and Human Services
Cohen Building, Room 5527
330 Independence Avenue, SW
Washington, DC 20201
Telephone: (202) 619-2078
Facsimile: (202) 205-0604

HealthSouth:

Brandon O. Hale
Senior Vice President - Administration
HealthSouth Corporation
One HealthSouth Parkway
Birmingham, AL 35243
Telephone: (205) 969-4704
Facsimile: (205) 969-4750

Unless otherwise specified, all notifications and reports required by this CIA may be made by certified mail, overnight mail, hand delivery or other means, provided that there is proof that such notification was received. For purposes of this requirement, internal facsimile confirmation sheets do not constitute proof of receipt.

VII. OIG INSPECTION, AUDIT AND REVIEW RIGHTS

In addition to any other rights OIG may have by statute, regulation, or contract, OIG or its duly authorized representative(s) may, upon reasonable notice to HealthSouth, examine or request copies of HealthSouth's books, records, and other documents and supporting materials and/or conduct on-site reviews of any of HealthSouth's locations for the purpose of verifying and evaluating: (a) HealthSouth's compliance with the terms of this CIA; and (b) HealthSouth's compliance with the requirements of the Federal health care programs in which it participates. The documentation described above shall be made available by HealthSouth to OIG or its duly authorized representative(s) at all reasonable times after reasonable notice to HealthSouth for inspection, audit or reproduction. Furthermore, for purposes of this provision, OIG or its duly authorized representative(s) may interview any of HealthSouth's employees, contractors, or agents who consent to be interviewed at the individual's place of business during normal business hours or at such other place and time as may be mutually agreed upon between the individual and OIG. HealthSouth agrees to assist OIG or its duly authorized representative(s) in contacting and arranging interviews with such individuals upon OIG's request. HealthSouth's employees may elect to be interviewed with or without a representative of HealthSouth (including counsel) present. However, if an employee, consistent with the rights and privileges of such individual, refuses to be interviewed based upon an individual decision and/or advice of counsel, HealthSouth will not be in breach of this Section if the interview does not occur.

VIII. DOCUMENT AND RECORD RETENTION

HealthSouth shall maintain for inspection all documents and records relating to reimbursement from the Federal health care programs, or to compliance with this CIA, for six years (or longer if otherwise required by law).

IX. DISCLOSURES

The OIG will protect the records submitted by HealthSouth under this CIA to the maximum extent permitted by law. Consistent with HHS's FOIA procedures, set forth in 45 C.F.R. Part 5, the OIG shall make a reasonable effort to notify HealthSouth prior to any release by OIG of information submitted by HealthSouth pursuant to its obligations under this CIA and identified upon submission by HealthSouth as trade secrets, or information that is commercial or financial and privileged or confidential, under the FOIA rules. With respect to such releases, HealthSouth shall have the rights set forth at 45 C.F.R. § 5.65(d). HealthSouth shall refrain from identifying any information as exempt from release if HealthSouth does not reasonably believe that such information does not meet the criteria for exemption from disclosure under FOIA.

HealthSouth asserts that nothing in this CIA, or any communication or report made pursuant to this CIA, shall in and of itself constitute or be construed as a waiver by HealthSouth of its attorney-client, work product, peer review, or other applicable privileges, including the protections contained in 42 C.F.R. § 483.75(o) (related to quality assurance). Notwithstanding that fact, the existence of any such privilege does not affect HealthSouth's obligations to comply with the provisions of this CIA, including any reporting requirements.

X. BREACH AND DEFAULT PROVISIONS

HealthSouth is expected to fully and timely comply with all of its CIA obligations.

A. Stipulated Penalties for Failure to Comply with Certain Obligations. As a contractual remedy, HealthSouth and OIG hereby agree that failure to comply with certain obligations set forth in this CIA may lead to the imposition of the following monetary penalties (hereinafter referred to as "Stipulated Penalties") in accordance with the following provisions.

1. A Stipulated Penalty of $2,500 (which shall begin to accrue on the day after the date the obligation became due) for each day HealthSouth fails to have in

place any of the following obligations described in Section III:

a. a Compliance Officer;

b. a Compliance Committee;

c. a written Code of Conduct;

d. written Policies and Procedures;

e. a requirement that Covered Persons and/or Relevant Covered Persons be trained; and

f. a Disclosure Program.

2. A Stipulated Penalty of $2,500 (which shall begin to accrue on the day after the date the obligation became due) for each day HealthSouth fails to retain an IRO, as required in section III.D.

3. A Stipulated Penalty of $2,500 (which shall begin to accrue on the day after the date the obligation became due) for each day HealthSouth fails to meet any of the deadlines (or any extensions granted by the OIG) for the submission of the Implementation Report or the Annual Reports to OIG.

4. A Stipulated Penalty of $2,000 (which shall begin to accrue on the date the failure to comply began) for each day HealthSouth employs or contracts with an Ineligible Person, and that person: (i) has responsibility for, or involvement with, HealthSouth's business operations related to the Federal health care programs; or (ii) is in a position for which the person's salary or the items or services rendered, ordered, or prescribed by the person are paid in whole or part, directly or indirectly, by Federal health care programs or otherwise with Federal funds (the Stipulated Penalty described in this paragraph shall not be demanded for any time period during which HealthSouth can demonstrate that it did not discover the person's exclusion or other ineligibility after making a reasonable inquiry (as described in Section III.F.) as to the status of the person).

5. A Stipulated Penalty of $1,500 for each day HealthSouth fails to grant access to the information or documentation as required in Section VII. of this CIA. (This Stipulated Penalty shall begin to accrue on the date HealthSouth fails to grant access.)

6. A Stipulated Penalty of $1,000 for each day HealthSouth fails to comply fully and adequately with any obligation of this CIA. In its notice to HealthSouth, OIG shall state the specific grounds for its determination that HealthSouth has failed to comply fully and adequately with the CIA obligation(s) at issue and steps the HealthSouth must take to comply with the CIA. (This Stipulated Penalty shall begin to accrue ten (10) days after the date that OIG provides notice to HealthSouth of the failure to comply, but only if the failure to comply has not been cured by that date). A Stipulated Penalty as described in this paragraph shall not be demanded for any violation for which the OIG has sought a Stipulated Penalty under paragraphs 1-5 of this Section.

With respect to any Stipulated Penalty in Section V.6 of this CIA, the OIG may choose not to seek a Stipulated Penalty if HealthSouth demonstrates to the OIG's satisfaction that the alleged failure to comply could not be cured within the ten (10) day period, but that (i) HealthSouth has begun to cure to take action the failure to comply; (ii) HealthSouth is pursuing such action with due diligence, and (iii) HealthSouth has provided the OIG a reasonable timetable for curing the failure to comply.

B. Timely Written Requests for Extensions. The OIG will consider and HealthSouth may, in advance of the due date, submit a timely written request for an extension of time to perform any act or file any notification or report required by this CIA. Notwithstanding any other provision in this Section, if OIG grants the timely written request with respect to an act, notification, or report, Stipulated Penalties for failure to perform the act or file the notification or report shall not begin to accrue until one day after HealthSouth fails to meet the revised deadline set by OIG. Notwithstanding any other provision in this Section, if OIG denies such a timely written request, Stipulated Penalties for failure to perform the act or file the notification or report shall not begin to accrue until three business days after HealthSouth receives OIG's written denial of such request or the original due date, whichever is later. A timely written request is defined as a request in writing received by OIG at least five business days prior to the date by which any act is due to be performed or any notification or report is due to be filed.

C. Payment of Stipulated Penalties

1. *Demand Letter*. Upon a finding that HealthSouth has failed to comply with any of the obligations described in Section X.A. and after determining that Stipulated Penalties are appropriate, OIG shall notify HealthSouth of: (a) HealthSouth's failure to comply; and (b) the OIG's exercise of its contractual right to demand payment of the Stipulated Penalties (this notification is hereinafter referred to as the "Demand

Letter").

2. *Response to Demand Letter.* Within ten (10) days of the receipt of the Demand Letter, HealthSouth shall either: (a) cure the breach to OIG's satisfaction and pay the applicable Stipulated Penalties; or (b) request a hearing before an HHS administrative law judge ("ALJ") to dispute OIG's determination of noncompliance, pursuant to the agreed upon provisions set forth below in Section X.E. In the event HealthSouth elects to request an ALJ hearing, the Stipulated Penalties shall continue to accrue until HealthSouth cures, to OIG's satisfaction, the alleged breach in dispute; however, the payment of such accrued Stipulated Penalties shall remain pending until the ALJ determination. Failure to respond to the Demand Letter in one of these two manners within the allowed time period shall be considered a Material Breach (as defined herein) of this CIA and shall be grounds for exclusion under Section X.D.

3. *Form of Payment.* Payment of the Stipulated Penalties shall be made by certified or cashier's check, payable to: "Secretary of the Department of Health and Human Services," and submitted to OIG at the address set forth in Section VI.

4. *Independence from Material Breach Determination.* Except as set forth in Section X.D.1.c., these provisions for payment of Stipulated Penalties shall not affect or otherwise set a standard for OIG's decision that HealthSouth has materially breached this CIA, which decision shall be made at OIG's discretion and shall be governed by the provisions in Section X.D., below.

D. Exclusion for Material Breach of this CIA

1. *Definition of Material Breach.* A Material Breach of this CIA means:

a. a failure by HealthSouth to report a Material Deficiency, take corrective action and make the appropriate refunds, as required in Section III.H.;

b. a repeated or flagrant violation of the obligations under this CIA, including, but not limited to, the obligations addressed in Section X.A.;

c. a failure to respond to a Demand Letter concerning the payment of Stipulated Penalties in accordance with Section X.C.; or

d. a failure to retain and use an Independent Review

Organization in accordance with section III.D.

2. *Notice of Material Breach and Intent to Exclude*. The parties agree that a Material Breach of this CIA by HealthSouth constitutes an independent basis for HealthSouth's exclusion from participation in the Federal health care programs (as defined in 42 U.S.C. § 1320a-7b(f)). Upon a determination by OIG that HealthSouth has materially breached this CIA and that exclusion should be imposed, OIG shall notify HealthSouth of: (a) HealthSouth's Material Breach; and (b) OIG's intent to exercise its contractual right to impose exclusion (this notification is hereinafter referred to as the "Notice of Material Breach and Intent to Exclude").

3. *Opportunity to Cure*. HealthSouth shall have thirty (30) days from the date of receipt of the Notice of Material Breach and Intent to Exclude to demonstrate to OIG's satisfaction that:

a. HealthSouth is in compliance with the obligations of the CIA cited by the OIG as being the basis for the Material Breach;

b. the alleged Material Breach has been cured; or

c. the alleged Material Breach cannot be cured within the thirty (30)-day period, but that: (i) HealthSouth has begun to take action to cure the Material Breach; (ii) HealthSouth is pursuing such action with due diligence; and (iii) HealthSouth has provided to OIG a reasonable timetable for curing the Material Breach.

4. *Exclusion Letter*. If at the conclusion of the thirty (30)-day period, HealthSouth fails to satisfy the requirements of Section X.D.3., OIG may exclude HealthSouth from participation in the Federal health care programs, subject to the Dispute Resolution Provisions in Section X.E. OIG will notify HealthSouth in writing of its determination to exclude HealthSouth (this letter shall be referred to hereinafter as the "Exclusion Letter"). Subject to the Dispute Resolution provisions in Section X.E., below, the exclusion shall go into effect thirty (30) days after the date of the Exclusion Letter. The exclusion shall have national effect and shall also apply to all other Federal procurement and non-procurement programs. Reinstatement to program participation is not automatic. If at the end of the period of exclusion, HealthSouth wishes to apply for reinstatement, HealthSouth must submit a written request for reinstatement in accordance with the provisions at 42 C.F.R. §§ 1001.3001-.3004.

E. Dispute Resolution

1. *Review Rights*. Upon OIG's delivery to HealthSouth of its Demand Letter or of its Exclusion Letter, and as an agreed-upon contractual remedy for the resolution of disputes arising under this CIA, HealthSouth shall be afforded certain review rights comparable to the ones that are provided in 42 U.S.C. § 1320a-7(f) and 42 C.F.R. Part 1005 as if they applied to the Stipulated Penalties or exclusion sought pursuant to this CIA. Specifically, OIG's determination to demand payment of Stipulated Penalties or to seek exclusion shall be subject to review by an HHS ALJ and, in the event of an appeal, the HHS Departmental Appeals Board ("DAB"), in a manner consistent with the provisions in 42 C.F.R. §§ 1005.2-1005.21. Notwithstanding the language in 42 C.F.R. § 1005.2(c), the request for a hearing involving Stipulated Penalties shall be made within ten (10) days of the receipt of the Demand Letter and the request for a hearing involving exclusion shall be made within twenty-five (25) days of receipt of the Exclusion Letter.

2. *Stipulated Penalties Review*. Notwithstanding any provision of Title 42 of the United States Code or Chapter 42 of the Code of Federal Regulations, the only issues in a proceeding for Stipulated Penalties under this CIA shall be: (a) whether HealthSouth was in full and timely compliance with the obligations of this CIA for which the OIG demands payment; and (b) the period of noncompliance. HealthSouth shall have the burden of proving its full and timely compliance and the steps taken to cure the noncompliance, if any. If the ALJ agrees with OIG with regard to a finding of a breach of this CIA and orders HealthSouth to pay Stipulated Penalties, such Stipulated Penalties shall become due and payable twenty (20) days after the ALJ issues such a decision unless HealthSouth requests review of the ALJ decision by the DAB. If the ALJ decision is properly appealed to the DAB and the DAB upholds the determination of OIG, the Stipulated Penalties shall become due and payable twenty (20) days after the DAB issues its decision.

3. *Exclusion Review*. Notwithstanding any provision of Title 42 of the United States Code or Chapter 42 of the Code of Federal Regulations, the only issues in a proceeding for exclusion based on a Material Breach of this CIA shall be:

a. whether HealthSouth was in Material Breach of this CIA;

b. whether such breach was continuing on the date of the Exclusion Letter; and

c. whether the alleged Material Breach could not have been cured within the thirty (30) day period, but that:

(1) HealthSouth had begun to take action to cure the Material Breach within that period;

(2) HealthSouth has pursued and is pursuing such action with due diligence; and

(3) HealthSouth provided to OIG within that period a reasonable timetable for curing the Material Breach and HealthSouth has followed the timetable.

For purposes of the exclusion herein, exclusion shall take effect only after an ALJ decision favorable to OIG, or, if the ALJ rules for the HealthSouth, only after a DAB decision in favor of OIG. HealthSouth's election of its contractual right to appeal to the DAB shall not abrogate the OIG's authority to exclude HealthSouth upon the issuance of an ALJ's decision in favor of the OIG. If the ALJ sustains the determination of the OIG and determines that exclusion is authorized, such exclusion shall take effect twenty (20) days after the ALJ issues such a decision, notwithstanding that HealthSouth may request review of the ALJ decision by the DAB. If the DAB finds in favor of OIG after an ALJ decision adverse to OIG, the exclusion shall take effect twenty (20) days after the DAB decision. HealthSouth agrees to waive its/his/her right to any notice of such an exclusion if a decision upholding the exclusion is rendered by the ALJ or DAB.

4. *Finality of Decision.* The review by an ALJ or DAB provided for above shall not be considered to be an appeal right arising under any statutes or regulations. Consequently, the parties to this CIA agree that the DAB's decision (or the ALJ's decision if not appealed) shall be considered final for all purposes under this CIA.

XI. EFFECTIVE AND BINDING AGREEMENT

Consistent with the provisions in the Settlement Agreement pursuant to which this CIA is entered, and into which this CIA is incorporated, HealthSouth and OIG agree as follows:

A. This CIA shall be binding on the successors, assigns, and transferees of HealthSouth, except that the obligations of this CIA shall not apply to facilities, business units or locations that HealthSouth or a HealthSouth successor no longer operates, or transfers to an unrelated third party as part of an asset sale, if the OIG determines that such asset sale is not a *de facto* merger;

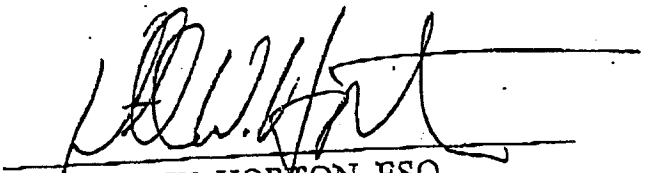
B. This CIA shall become final and binding on the date the final signature is obtained on the CIA;

C. Any modifications to this CIA shall be made with the prior written consent of the parties to this CIA;

D. OIG may agree to a suspension of HealthSouth's obligations under the CIA in the event of HealthSouth's cessation of participation in Federal health care programs. If HealthSouth withdraws from participation in Federal health care programs and is relieved from its CIA obligations by the OIG, HealthSouth agrees to notify OIG thirty (30) days in advance of HealthSouth's intent to reapply as a participating provider or supplier with the Federal health care programs. Upon receipt of such notification, OIG will evaluate whether the CIA should be reactivated or modified.

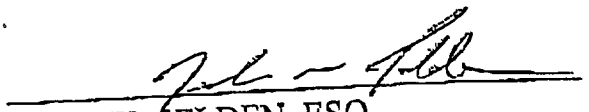
E. The undersigned HealthSouth signatories represent and warrant that they are authorized to execute this CIA. The undersigned OIG signatory represents that he is signing this CIA in his official capacity and that he is authorized to execute this CIA.

ON BEHALF OF HEALTHSOUTH



WILLIAM W. HORTON, ESQ.
Executive Vice President and Corporate Counsel

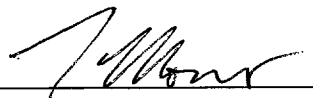
5/17/01
DATE



JACK W. SELDEN, ESQ.
Counsel for HealthSouth Corporation

5-17/01
DATE

ON BEHALF OF THE OFFICE OF INSPECTOR GENERAL OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES



LEWIS MORRIS
Assistant Inspector General for Legal Affairs
Office of Inspector General
U. S. Department of Health and Human Services

5/17/07
DATE

APPENDIX A

Cost Reporting Engagement Review Procedures

The following procedures represent the general expectations for performance by the IRO in meeting the objectives of Section D.2, *Cost Reporting Engagement*, and reporting thereon as described in Section D.2.c.

1. At a minimum, the IRO should review the "Capital Cost - Building and Fixtures" and "Capital Costs - Movable Equipment" cost centers to determine if capital costs are being claimed for transactions with related parties. As a part of this review, the IRO should perform a test of asset acquisitions, looking for acquisitions from related party organizations. Where acquisitions from related parties occurred, the IRO should ensure that depreciation on those assets has been reduced to the cost of the related organization. In addition, the IRO should review lease expenses for the building, and material equipment leases, to ensure that related party lease expenses, if applicable, have been reduced to the cost of the related organization. The IRO should specifically review the "Capital Costs - Building and Fixtures" cost center for the Great Lakes Hospital to ensure that the lease payments are reduced to allowable ownership costs. Any issues or potential errors identified through performance of the review procedures set forth below shall be evaluated to determine the impact, if any, on the HealthSouth's Home Office Cost Report.

2. Perform analysis through comparison (substantially in the form of Exhibit 1 to this Appendix) of key data from the IRF cost report. Inquire of responsible HealthSouth officials regarding significant variances between the current year and the prior year and capture those explanations as reported findings.

3. Obtain and inspect the Worksheet A series of the selected IRF cost report, and perform the following:

- Agree total expenses per Worksheet A to related compilation workpapers maintained by HealthSouth reimbursement staff.

- Based upon the results of the analysis performed pursuant to Paragraph 2 above, judgmentally select five (5) cost centers that may be more susceptible to abuse or misallocation of costs than other cost centers, in addition to the cost centers identified in Paragraph 1, from the HealthSouth compilation workpapers and trace individual department totals to related general ledger amounts.

- Summarize the information reported on Worksheet A-8-1 with respect to related organization transactions. Inquire of responsible HealthSouth officials regarding the full and complete reporting of applicable transactions. To the extent reported transactions involve (i) equipment, services and/or supplies

purchased from related entities, and/or (ii) lease payments made to related entities, inspect supporting documentation with respect to those transactions and conclude whether HealthSouth has complied with applicable regulatory requirements regarding those transactions.

4. Obtain and inspect the Worksheet B series of the selected IRF cost report, and perform the following:

- Based upon the results of the analysis performed pursuant to Paragraph 2 above, judgmentally select five (5) cost centers that may be more susceptible to abuse or misallocation of costs than other cost centers, in addition to the cost centers identified in Paragraph 1, from the Worksheet B-1 statistical sets and agree individual totals to related HealthSouth compilation workpapers, and agree five individual department totals per cost center to related supporting documentation.

5. Obtain and inspect the Worksheet C series of the selected IRF cost report, and perform the following:

- Agree total charges per Worksheet C to related compilation workpapers maintained by HealthSouth reimbursement staff.

- Based upon the results of the analysis performed pursuant to Paragraph 2 above, judgmentally select five (5) cost centers that may be more susceptible to abuse or misallocation of costs than other cost centers, in addition to the cost centers identified in Paragraph 1, from the HealthSouth compilation workpapers and trace individual department totals to related general ledger amounts.

6. Obtain and inspect the Worksheet D series of the selected IRF cost report, and perform the following:

- Agree total Medicare and Medicaid charges per applicable D-series worksheets to related compilation workpapers maintained by HealthSouth reimbursement staff.

- Based upon the results of the analysis performed pursuant to Paragraph 2 above, judgmentally select five (5) cost centers that may be more susceptible to abuse or misallocation of costs than other cost centers, from the HealthSouth compilation workpapers and trace total charges to related fiscal intermediary reports (e.g., PS&R) and other supporting documentation (e.g., detailed unpaid charges listings).

- Agree the IRF's Medicare TEFRA limit as reported on Worksheet D-1 part II to related supporting fiscal intermediary documentation.

7. Obtain and inspect the Worksheet E series of the selected IRF cost report, and perform the following:

- Trace key settlement amounts from applicable E-series worksheets to appropriate supporting documentation. Key settlement amounts include the following:

  - deductibles and coinsurance;
  - actual payment amounts; and
  - allowable bad debts.

8. Obtain and inspect the most recent fiscal intermediary adjustment report related to the Medicare program's settlement of the IRF cost report.

9. Obtain and inspect the Home Office Cost Report, and perform generally the same procedures as outlined in Paragraph 3 above.

APPENDIX B

A. Claims Review.

1. ***Definitions***. For the purposes of the Claims Review, the following definitions shall be used:

a. Claims Review Sample: A statistically valid, randomly selected, sample of items selected for appraisal in the Claims Review.

b. Item: Any discrete unit that can be sampled (e.g., code, line item, beneficiary, patient encounter, etc.).

c. Overpayment: Consistent with the definition of Overpayment as articulated in section III.H.1.a of the CIA, the amount of money HealthSouth has received in excess of the amount due and payable under any Federal health care program requirements. For the purposes of the Claims Review and all reporting to the OIG under this CIA, HealthSouth shall not subtract or "net out" underpayments when determining the amount of relevant Overpayments.

d. Paid Claim: A code or line item submitted by HealthSouth and for which HealthSouth has received reimbursement from the Medicare program.

e. Population: All Items for which HealthSouth has submitted a code or line item and for which HealthSouth has received reimbursement from the Medicare program (i.e., a Paid Claim) during the 12-month period covered by the Claims Review. To be included in the Population, an Item must have resulted in at least one Paid Claim.

f. Probe Sample: A sample of Items selected through simple random sampling from the Population for the purpose of estimating the mean and standard deviation of Overpayments in the Population. The estimated mean and standard deviation of Overpayments in the Population are to be used to calculate the minimum number of Items that shall be included in the Claims Review Sample in order to achieve the required confidence and precision levels.

g. RAT-STATS: OIG's Office of Audit Services Statistical Sampling Software. RAT-STATS is publicly available to download through the Internet at "www.hhs.gov/oig/oas/ratstat.html".

2. ***Description of Claims Review***. The Claims Review shall consist of an appraisal of a statistically valid sample of Items (the Claims Review Sample) that can be projected to the total Population.

a. Confidence and Precision Requirements. The Claims Review Sample should contain a sufficient number of Items (according to the RAT-STATS calculation) so that if the Overpayments identified in the Claims Review Sample were projected to the Population, the projection would provide a 90% confidence level and a maximum relative precision (i.e., semi-width of the confidence interval) of plus or minus 25% of the point estimate. In other words, if the Claims Review Overpayment results were projected to the Population at a 90% confidence level, the confidence interval (expressed in dollars) should be sufficiently narrow that the upper bound of the confidence interval would not exceed 125% of the midpoint of the confidence interval (the point estimate), and the lower bound of the confidence interval would not be less than 75% of the midpoint of the confidence interval.

b. Use of a Probe Sample to Determine Claims Review Sample Size. To determine how many Items must be included in the Claims Review Sample to meet the 90% confidence level and 25% precision requirements, the mean and the standard deviation of Overpayments in the Population must be estimated. Estimates for each unique Population shall be developed through the use of a single Probe Sample. The Probe Sample shall be used to determine the minimum Claims Review Sample size through one of the two following options:

i. *Probe Sample with a Minimum Size of Thirty Items*. The Probe Sample shall include at least 30 Items, and shall be selected through the use of RAT-STATS' "Random Numbers" function. Once all Paid Claims associated with the Items included in the Probe Sample have been reviewed, the estimated mean and standard deviation of Overpayments in the Population shall be determined. This determination is based on the Overpayment amount received by HealthSouth for each Item in the sample. The "Difference Values

Only" function located under the "Variable Appraisals" component of RAT-STATS shall be used to calculate the estimated mean and standard deviation of Overpayments in the Population. For purposes of estimating the mean and standard deviation of Overpayments in the Population, and entering this information into the "Variable Appraisals", "Difference Values Only" function of RAT-STATS, any underpayment identified for a Paid Claim in the Probe Sample shall be treated as a zero overpayment. If no Overpayments are found in this Probe Sample, then a second Probe Sample, of at least 30 Items, must be selected and reviewed. The estimated mean and standard deviation of Overpayments in the Population (based on the amount of Overpayments received by HealthSouth for each sample Item) shall be determined from this Probe Sample, using RAT-STATS' "Difference Values Only" function located under the "Variable Appraisals" component. If no Overpayments are found in this second Probe Sample, then the Claims Review can be terminated with the results of the second Probe Sample, and the results of the two Probe Samples shall be reported in lieu of the Claims Review when preparing and submitting the Claims Review Report (see section B, below); or

ii. *Probe Sample with a Minimum Size of Fifty Items*. The Probe Sample shall include at least 50 Items, and shall be selected through the use of RAT-STATS' "Random Numbers" function. Once all Paid Claims associated with the Items included in the Probe Sample have been reviewed, the estimated mean and standard deviation of Overpayments in the Population shall be determined. This determination is based on the Overpayment amount received by HealthSouth for each Item in the sample. The "Difference Values Only" function located under the "Variable Appraisals" component of RAT-STATS shall be used to calculate the estimated mean and standard deviation of Overpayments in the Population. For purposes of estimating the mean and standard deviation of Overpayments in the Population, and entering this information into the "Variable Appraisals", "Difference Values Only" function of RAT-STATS, any underpayment identified for a Paid Claim in the Probe Sample shall be treated as a zero overpayment. If no Overpayments are found in this 50 Item Probe Sample, then the Claims Review can be terminated with the review of the Probe Sample and the results of

the Probe Sample shall be reported in lieu of the results of the Claims Review when preparing and submitting the Claims Review Report (see section B, below).

c. Calculation of Claims Review Sample Size and Selection of the Claims Review Sample. The estimates of the mean and the standard deviation of Overpayments in the Population obtained through the review of the Probe Sample shall be used to estimate the minimum size of the Claims Review Sample. In order to estimate the number of Items that must be included in the Claims Review Sample to meet the 90% confidence level and 25% precision requirements, RAT-STATS' "Sample Size Estimators" (located under the "Utility Programs" file) shall be used. Whereas the Claims Review Sample size is estimated from the results of the probe sample, there is a possibility that examining the number of Items identified by RAT-STATS may not achieve the 90% confidence and 25% precision levels. If the reviewer can demonstrate that the review was properly conducted, but the 90% confidence level and 25% precision interval could not be achieved, the reviewer will not be required to examine additional items.

The Claims Review Sample shall be selected by using RAT-STATS' "Random Numbers" function, and shall be selected from the entire Population, with the Population including those Items reviewed as part of the Probe Sample, so that all Items in the Population have an equal chance of inclusion in the Claims Review Sample.

d. Item Appraisal. For each Item appraised (either as part of the Claims Review Sample or of the Probe Sample), only Paid Claims shall be evaluated. Every Paid Claim in the Claims Review Sample shall be evaluated by the IRO to determine whether the claim submitted was correctly coded, submitted, and reimbursed. Each appraisal must be sufficient to provide all information required under the Claims Review Report.

e. Paid Claims without Supporting Documentation. For the purpose of appraising Items included in the Claims Review and/or the Probe Sample, any Paid Claim for which HealthSouth, at the time of the Claims Review, cannot produce documentation sufficient to support the Paid Claim shall be considered an error and the total reimbursement received by HealthSouth for such Paid Claim shall be deemed an Overpayment. Replacement

sampling for Paid Claims with missing documentation is not permitted.

f. Use of First Samples Drawn. For the purposes of all samples (Probe Sample(s) and Claims Review Sample(s)) discussed in this Appendix, the Paid Claims associated with the Items selected in the first sample (or first sample for each strata, if applicable) shall be used. In other words, it is not permissible to generate a number of random samples and then select one for use as the Probe Sample or Claims Review Sample.

B. Claims Review Report. The following information shall be included in each Claims Review Report:

1. ***Claims Review Methodology***

a. Claims Review Objective: A clear statement of the objective intended to be achieved by the Claims Review.

b. Sampling Unit: A description of the Item as that term is utilized for the Claims Review. As noted in section A.1.b above, for purposes of this Billing Engagement, the term "Item" may refer to any discrete unit that can be sampled (e.g., claim, line item, beneficiary, patient encounter, etc.).

c. Claims Review Population: A description of the Population subject to the Claims Review.

d. Sampling Frame: A description of the sampling frame, which is the totality of Items from which the Probe and Claims Review Sample have been selected and an explanation of the methodology used to identify the sampling frame. In most circumstances, the sampling frame will be identical to the Population.

e. Sources of Data: A description of the documentation relied upon by the IRO when performing the Claims Review (e.g., medical records, physician orders, certificates of medical necessity, requisition forms, local medical review policies, HCFA program memoranda, Medicare carrier or intermediary manual or bulletins, other policies, regulations, or directives).

f. Review Protocol: A narrative description of how the Claims Review was conducted and what was evaluated.

2. ***Statistical Sampling Documentation***

a. The number of Items appraised in the Probe Sample(s) and in the Claims Review Sample.

b. A copy of the RAT-STATS printout of the random numbers generated by the "Random Numbers" function.

c. A copy of the RAT-STATS printout of the "Sample Size Estimators" results used to calculate the minimum number of Items for inclusion in the Claims Review Sample.

d. A copy of the RAT-STATS printout of the "Variable Appraisals", "Difference Values Only" function results for the Probe Sample, including a copy of the data file.

e. The Sampling Frame used in the Probe Sample(s) and the Claims Review Sample will be available to the OIG upon request.

3. ***Claims Review Results***

a. Total number and percentage of instances in which the IRO determined that the Paid Claims submitted by HealthSouth ("Claim Submitted") differed from what should have been the correct claim ("Correct Claim"), regardless of the effect on the payment.

b. Total number and percentage of instances in which the Claim Submitted differed from the Correct Claim and in which such difference resulted in an Overpayment to HealthSouth.

c. The total dollar amount of all Paid Claims in the Claims Review Sample and the total dollar amount of Overpayments associated with the Paid Claims identified by the Claims Review. (This is the total dollar amount of the Overpayments identified in section B.3.b above.) The IRO may, in its report to HealthSouth, identify underpayments, but any underpayments identified during the Claims Review shall not be offset or "netted out" of the total dollar amount of Paid Claims or of the Overpayments when reporting these amounts in the Claims Review Report to the OIG.

d. The level of precision achieved by the Claims Review at a 90% confidence level.

e. A spreadsheet of the Claims Review results that includes the following information for each Paid Claim appraised: Federal health care program billed, beneficiary health insurance claim number, date of service, procedure code submitted, procedure code reimbursed, allowed amount reimbursed by payer, correct procedure code (as determined by the IRO), correct allowed amount (as determined by the IRO), dollar difference between allowed amount reimbursed by payer and the correct allowed amount. (See Attachment 1 to this Appendix.)

4. ***Credentials.*** The names and credentials of the individuals who: (1) designed the statistical sampling procedures and the review methodology utilized for the Claims Review; and (2) performed the Claims Review.

Attachment 1

Claim Review Results

Federal Health Care Program Billed	Bene HIC #	Date of Service	Procedure Code Submitted	Procedure Code Reimbursed	Allowed Amount Reimbursed	Correct Procedure Code (IRO determined)	Correct Allowed Amt (IRO determined)	Dollar Difference between Amt Reimbursed and Correct Allowed Amt

APPENDIX C

Validation Review Procedures

The purpose of the Validation Review is two-fold: to validate HealthSouth's own evaluation of internal control and other operating procedures resulting from its Internal Billing Systems Review, and to substantiate HealthSouth's methodology and conclusions with respect to its Internal Claims Review. This appendix generally describes the procedures to be performed by the IRO in achieving this two-fold objective.

1. With respect to its review of HealthSouth's Internal Billing Systems Review, the IRO will perform tasks designed to address key risks and controls in the following areas:

- **Patient Registration Admitting**
  - Collection of appropriate MDS-PAC[1] and related assessment information
  - Identification and training of MDS-PAC assessment team members
    - Patient interviews
    - Patient observation
    - Other information, i.e., clinical record
  - Compliance with signature requirements and personnel assignments for specific assessment items (AB/a and AB/b through AB/g)
  - Assessment of schedule requirements and reference data
    - Admission (Days 1 through 3)
    - Days 8 through 10
    - Days 28 through 30
    - Days 58 through 60
    - Discharge/Services Stays
    - Interrupted Stays

- **Medical Records**
  - Correlation of documentation establishing appropriate medical necessity for inpatient services and clinical status reflected in MDS-PAC data
  - Identification of information flow from medical record to MDS-PAC

---

[1]Recognizing that the rules implementing the PPS for IRFs have not been finalized by HCFA at the time this Appendix is being drafted and agreed upon, any reference to MDS-PAC herein will be considered to refer to whatever assessment instrument is ultimately used in the PPS. To the extent the IRO believes that any of these procedures should be reasonably modified to account for the provisions of the final PPS rules, then the IRO will have the reasonable discretion to make such modifications.

assessment
- Medical review verification of MDS-PAC data accuracy and patient medical records
- Retention requirements for completed MDS-PAC assessments
- Quality improvement monitoring and public reporting
- Confidentiality of MDS-PAC data

- **Patient Accounting**
  - Evaluation of the information flow from all points of service and medical record to the Medicare claim
  - Monitoring compliance with assessment reference data requirements and penalty provisions
  - Encoding and editing MDS-PAC data requirements, software application, and deadlines
  - Accurate and timely transmission of data, initial and final validation reports and format specifications
  - Monitoring of rejected assessment records
  - Monitoring compliance with MDS-PAC transmission time frame requirements and penalty provisions
  - Verification of Medicare payment rates, exception reporting, and denial management
  - Monitoring transfer payments, short-stay outliers, interrupted stays, rural locations, DSH, and outlier payments

- **Patient Care Departments**
  - Cross-departmental participation in collection of assessment information
  - Flow of information from patient care departments to MDS-PAC assessment
  - Flow of information from patient care departments to medical record
  - Patient observations and interviews

- **Utilization Review**
  - Monitoring of patient stay, transfer cases, interrupted stays, and short stays
  - Monitoring patient tolerance for intensive rehabilitation services
  - Monitoring outlier stays
  - Assessment of discharge planning implications of PPS and transfer policies (outpatient therapies, home healthcare, day programs SNF care, sub-acute care, etc.)

- **Administrative/Business Strategy**
  - Assessment of the financial performance monitoring tools and decision support capabilities

- Determination of the level and adequacy of PPS educational activities
- Identification of product line profitability
  - Resource utilization (Gross charges)
  - Net revenue benefit
- Assessment of demands on physician relations and defining physician role under PPS model
- Implications on configuration of outpatient service structure
- Determination of adequacy of PIP payment levels under new payment method

2. With respect to its review of HealthSouth's Internal Billing Systems and Claims Reviews, the IRO will perform the following tasks:

   - Review HealthSouth's Internal Billing Systems and Claims Review methodologies for conformity with reasonably expected review procedures and professional independence and objectivity standards (e.g, assess whether HealthSouth's Claims Reviews were performed by personnel with appropriate medical training who did not previously bill or code the claims under review).

   - With respect to an Internal Claims Review conducted by HealthSouth pursuant to Section III.4.a.i. of the CIA, randomly select 50% of the Paid Claims reviewed by HealthSouth; with respect to an Internal Claims Review conducted by HealthSouth pursuant to Section III.4.a.ii. of the CIA, randomly select 25% of the Paid Claims reviewed by HealthSouth.

   - Review each Paid Claim for the following attributes:

     - Documentation of medical necessity

     - Appropriate approvals/sign-offs consistent with HealthSouth internal policy

     - Supporting clinical documentation for documented diagnosis

     - Billing group assignment consistent and appropriate relative to documented diagnosis

OVERPAYMENT REFUND

TO BE COMPLETED BY MEDICARE CONTRACTOR

Date:_____
Contractor Deposit Control #_____ Date of Deposit: _____
Contractor Contact Name:_____Phone #_____
Contractor Address:_____
Contractor Fax:_____

TO BE COMPLETED BY PROVIDER/PHYSICIAN/SUPPLIER

Please complete and forward to Medicare Contractor. This form, or a similar document containing the following information, should accompany every voluntary refund so that receipt of check is properly recorded and applied.

PROVIDER/PHYSICIAN/SUPPLIERNAME_____
ADDRESS_____
PROVIDER/PHYSICIAN/SUPPLIER #_____CHECK NUMBER#_____
CONTACT PERSON:_____PHONE #_____
AMOUNT OF CHECK $_____ CHECK DATE_____

REFUND INFORMATION

For each Claim, provide the following:
Patient Name_____HIC #_____
Medicare Claim Number_____Claim Amount Refunded $_____
Reason Code for Claim Adjustment:_____ (Select reason code from list below. Use one reaso
n per claim)

(Please list all claim numbers involved. Attach separate sheet, if necessary)

*Note: If Specific Patient/HIC/Claim #/Claim Amount data not available for all claims due to Statistical Sampling, please indicate methodology and formula used to determine amount and reason for overpayment:*_____

For Institutional Facilities Only:
Cost Report Year(s) _____
(If multiple cost report years are involved, provide a breakdown by amount and corresponding cost report year.)

For OIG Reporting Requirements:
Do you have a Corporate Integrity Agreement with OIG? Yes No

Reason Codes:

Billing/Clerical Error	MSP/Other Payer Involvement	Miscellaneous
01 - Corrected Date of Service	08 - MSP Group Health Plan Insurance	13 - Insufficient Documentation
02 - Duplicate	09 - MSP No Fault Insurance	14 - Patient Enrolled in an HMO
03 - Corrected CPT Code	10 - MSP Liability Insurance	15 - Services Not Rendered
04 - Not Our Patient(s)	11 - MSP, Workers Comp.(Including Black Lung	16 - Medical Necessity
05 - Modifier Added/Removed	12 - Veterans Administration	17 - Other (Please Specify)
06 - Billed in Error		_____
07 - Corrected CPT Code		