THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2017 To: 05/31/2018	Run Date: 09/26/2018 Run Time: 16:30 Version: 2018.04 (08/06/2018)

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

WORKSHEET S
PARTS I, II & III

PART I - COST REPORT STATUS

Provider use only	1. [X] Electronically filed cost report Date: 09/26/2018 Time: 16:30 2. [ ] Manually submitted cost report 3. [ ] If this is an amended report enter the number of times the provider resubmitted the cost report 4. [F] Medicare Utilization. Enter 'F' for full or 'L' for low.		
Contractor use only	5. [ ] Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. [ ] Initial Report for this Provider CCN 9. [ ] Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ___ 12. [ ] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by THE REHABILITATION INSTITUTE OF ST L (26-3028) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 06/01/2017 and ending 05/31/2018, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

[_] I have read and agree with the above certification statement. I certify that I intend my electronic signature on this cerficication statement to be the legally binding equivalent of my original signature.

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

SVP - REIMBURSEMENT
Title

_____
Date

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		-168,510			274,169	1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		-168,510			274,169	200

The above amounts represent 'due to' or 'due from' the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to resopnd to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send appilcations, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any corresponence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:

1	Street: 4455 DUNCAN AVE.	P.O. Box:			1
2	City: ST. LOUIS	State: MO	ZIP Code: 63110	County: ST. LOUIS	2

Hospital and Hospital-Based Component Identification:

							Payment System (P, T, O, or N)			
	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	THE REHABILITATION INSTITUTE OF ST L	26-3028	41180	5	04 / 02 / 2001	N	P	O	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF									7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC									15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 06 / 01 / 2017	To: 05 / 31 / 2018	20
21	Type of control (see instructions)	5		21

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.							24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	5,367	338	1,021	467	1,441		25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	1		26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.			35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.			37
37.01	Is this hospital a former MDH that is eilgible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)	N		37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

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

Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services ad defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
		NAHE 413.85 Y/N 1	Worksheet A Line # 2	Pass-Through Qualification Criteria Code 3	
60	Are you claiming nursing and allied health education (NAHE) costs for any program(s) that meet the criteria under 42 CFR 413.85? (see instructions)	N			60
		Y/N 1	IME 4	Direct GME 5	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.)(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathci FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1	2	3	4	

Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the IME FTE unweighted count. Enter in column 4 direct the GME FTE unweighted count.

ACA Provisions Affecting the Health Resources and Services Administration (HRSA)

62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital reseived HRSA PCRE funding (see instructions)				62
62.01	Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost reporting period of HRSA THC program. (see instructions)				62.01

Teaching Hospitals that Claim Residents in Nonprovider Settings

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

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

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

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

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

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

Inpatient Psychiatric Faciltiy PPS		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	N			70
71	If line 70 is yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				71

Inpatient Rehabilitation Facility PPS		1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.	Y			75
76	If line 75 is yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	Y	N		76

Long Term Care Hospital PPS				
80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.	N		80
81	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no.	N		81

TEFRA Providers				
85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no.	N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.			86
87	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter 'Y' for yes and 'N' for no.	N		87

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XIX	
Title V and XIX Services		1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92
93	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97
98	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06

Rural Providers				1	2	
105	Does this hospital qualify as a CAH?			N		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elinination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.					107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.			N		108
		Physical	Occupational	Speech	Respiratory	
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.					109

		1	
110	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? If yes, compolete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110
		1	2	
111	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for additional beds; and/or 'C' for tele-healsh services.			111

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.		N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.		Y		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1		118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	64,959	128,263		118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.		N	N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.		N		121
122	Does the cost report contain state health care related taxes as defined in §1983(w)(3) of the Act? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.		Y	5.00	122

Transplant Center Information

125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.	N		125
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date in column 2.			126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date in column 2.			127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date in column 2.			128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date in column 2.			129
130	If this is a Medicare cetfified pancreas transplant center enter the certification date in column 1 and termination date in column 2.			130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date in column 2.			131
132	If this is a Medicare cetfified islet transplant center enter the certification date in column 1 and termination date in column 2.			132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date in column 2.			133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.			134

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

All Providers

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

If this facility is part of a chain organization, enter the name of the home office, the home office contractor name, and home office contractor number on line 141. Enter the address of the home office on lines 142 and 143.

141	Name: ENCOMPASS HEALTH (FORMERLY HEA	Contractor's Name: CAHABA GBA		Contractor's Number: 10101	141
142	Street: 9001 LIBERTY PARKWAY	P.O. Box:			142
143	City: BIRMINGHAM	State: AL	ZIP Code: 35242		143

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

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

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

Multicampus

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

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

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

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	N		167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)			168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)			168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. (see instructions)			169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no in column 1. If column 1 is 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

COMPLETED BY ALL HOSPITALS

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

		Y/N	Type	Date	
Financial Data and Reports		1	2	3	
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	Y	A	02/28/2018	4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N			5

		Y/N	Y/N	
Approved Educational Activities		1	2	
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N		6
7	Are costs claimed for allied health programs? If yes, see instructions.	N		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N		8
9	Are costs claimed for Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	N		9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructinos.	N		10
11	Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N		16
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	08/01/2018	N		17
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N		18
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19
20	If line 16 or 17 is yes, were adjustments made to PS&R Reoprt data for Other? Describe the other adjustments:SUBSCRIPT	Y		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

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

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

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

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

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

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

Cost Report Preparer Contact Information				
41	First name: JIM	Last name: WYATT	Title: SENIOR REIMBURSEMENT SPECI	41
42	Employer: ENCOMPASS HEALTH			42
43	Phone number: 2059698265	E-mail Address: COURTNEY.CAMERON@HEALTHSOUTH.COM		43

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2017 To: 05/31/2018	Run Date: 09/26/2018 Run Time: 16:30 Version: 2018.04 (08/06/2018)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						Inpatient Days / Outpatient Visits / Trips				
	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	131	46,905			12,584	5,367	33,066	1
2	HMO and other (see instructions)						3,615	3,267		2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF									5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		131	46,905			12,584	5,367	33,066	7
8	Intensive Care Unit	31								8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	Other Special Care (specify)	35								12
13	Nursery	43								13
14	Total (see instructions)		131	46,905			12,584	5,367	33,066	14
15	CAH Visits									15
16	Subprovider - IPF	40								16
17	Subprovider - IRF	41								17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44								19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101								22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116								24
24.10	Hospice (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	Total (sum of lines 14-26)		131							27
28	Observation Bed Days									28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)									32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33
33.01	LTCH site neutral days and discharges									33.01

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2017 To: 05/31/2018	Run Date: 09/26/2018 Run Time: 16:30 Version: 2018.04 (08/06/2018)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		Full Time Equivalents			DISCHARGES				
	Component	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					963	369	2,401	1
2	HMO and other (see instructions)					263	223		2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider								4
5	Hospital Adults & Peds. Swing Bed SNF								5
6	Hospital Adults & Peds. Swing Bed NF								6
7	Total Adults & Peds. (exclude observation beds) (see instructions)								7
8	Intensive Care Unit								8
9	Coronary Care Unit								9
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
12	Other Special Care (specify)								12
13	Nursery								13
14	Total (see instructions)		335.24			963	369	2,401	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency								22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	Total (sum of lines 14-26)		335.24						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32.01
33	LTCH non-covered days								33
33.01	LTCH site neutral days and discharges								33.01

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2017 To: 05/31/2018	Run Date: 09/26/2018 Run Time: 16:30 Version: 2018.04 (08/06/2018)

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

Part II - Wage Data

		Wkst A Line No.	Amount Reported	Reclassif-ication of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)	
		1	2	3	4	5	6	
	SALARIES							
1	Total salaries (see instructions)	200	21,921,160					1
2	Non-physician anesthetist Part A							2
3	Non-physician anesthetest Part B							3
4	Physician-Part A - Administrative							4
4.01	Physician-Part A - Teaching							4.01
5	Physician-Part B							5
6	Non-physician-Part B							6
7	Interns & residents (in an approved program)	21						7
7.01	Contracted interns & residents (in an approved program)							7.01
8	Home office and/or related organization personnel							8
9	SNF	44						9
10	Excluded area salaries (see instructions)			198,849				10
	OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)							11
12	Contract management and administrative services							12
13	Contract labor: Physician-Part A - Administrative							13
14	Home office salaries & wage-related costs							14
14.01	Home office salaries							14.01
14.02	Related organization salaries							14.02
15	Home office: Physician Part A - Administrative							15
16	Home office & Contract Physicians Part A - Teaching							16
	WAGE-RELATED COSTS							
17	Wage-related costs (core)(see instructions)							17
18	Wage-related costs (other)(see instructions)							18
19	Excluded areas							19
20	Non-physician anesthetist Part A							20
21	Non-physician anesthetist Part B							21
22	Physician Part A - Administrative							22
22.01	Physician Part A - Teaching							22.01
23	Physician Part B							23
24	Wage-related costs (RHC/FQHC)							24
25	Interns & residents (in an approved program)							25
25.50	Home office wage-related							25.50
25.51	Related organization wage-related							25.51
25.52	Home office: Physician Part A - Administrative - wage-related							25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related							25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26	Employee Benefits Department							26
27	Administrative & General		3,322,008	-198,849				27
28	Administrative & General under contract (see instructions)							28
29	Maintenance & Repairs							29
30	Operation of Plant		270,538					30
31	Laundry & Linen Service		280					31
32	Housekeeping		278,944					32
33	Housekeeping under contract (see instructions)							33
34	Dietary							34
35	Dietary under contract (see instructions)							35
36	Cafeteria							36
37	Maintenance of Personnel							37
38	Nursing Administration		1,128,579					38
39	Central Services and Supply							39
40	Pharmacy							40
41	Medical Records & Medical Records Library		268,495					41
42	Social Service		791,498					42
43	Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		21,921,160		21,921,160			1
2	Excluded area salaries (see instructions)			198,849	198,849			2
3	Subtotal salarles (line 1 minus line 2)		21,921,160	-198,849	21,722,311			3
4	Subtotal other wages & related costs (see instructions)							4
5	Subtotal wage-related costs (see instructions)							5
6	Total (sum of lines 3 through 5)		21,921,160	-198,849	21,722,311			6
7	Total overhead cost (see instructions)		6,060,342	-198,849	5,861,493			7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

Part IV - Wage Related Cost

Part A - Core List

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions		1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Nonqualified Defined Benefit Plan Cost (see instructions)		3
4	Qualified Defined Benefit Plan Cost (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA Plan Administration Fees		5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees		7
	HEALTH AND INSURANCE COST		
8	Health Insurance (Purchased or Self Funded)		8
8.01	Health Insurance (Self Funded without a Third Party Administrator)		8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		8.02
8.03	Health Insurance (Purchased)		8.03
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan		10
11	Life Insurance (If employee is owner or beneficiary)		11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)		13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance		15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-Employers Portion Only		17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance		19
20	State or Federal Unemployment Taxes		20
	OTHER		
21	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	Day Care Costs and Allowances		22
23	Tuition Reimbursement		23
24	Total Wage Related cost (Sum of lines 1-23)		24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)		25

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2017 To: 05/31/2018	Run Date: 09/26/2018 Run Time: 16:30 Version: 2018.04 (08/06/2018)

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

Part V - Contract Labor and Benefit Cost

Hospital and Hospital-Based Component Identification:

	Component	Contract Labor	Benefit Cost	
	0	1	2	
1	Total facility contract labor and benefit cost	909,735	4,108,626	1
2	Hospital	909,735	4,071,356	2
3	Subprovider - IPF			3
4	Subprovider - IRF			4
5	Subprovider - (OTHER)			5
6	Swing Beds - SNF			6
7	Swing Beds - NF			7
8	Hospital-Based SNF			8
9	Hospital-Based NF			9
10	Hospital-Based OLTC			10
11	Hospital-Based HHA			11
12	Separately Certified ASC			12
13	Hospital-Based Hospice			13
14	Hospital-Based Health Clinic - RHC			14
15	Hospital-Based Health Clinic - FQHC			15
16	Hospital-Based - CMHC			16
17	Renal Dialysis			17
18	Other		37,270	18

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES **WORKSHEET A**

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt		3,368,656	3,368,656	94,653	3,463,309	22,553	3,485,862	1
2	00200	Cap Rel Costs-Mvble Equip		1,196,329	1,196,329	28,651	1,224,980	-25,526	1,199,454	2
3	00300	Other Cap Rel Costs		113,540	113,540	-113,540			-0-	3
4	00400	Employee Benefits Department		4,590,813	4,590,813		4,590,813	-502,118	4,088,695	4
5	00500	Administrative & General	3,322,008	7,247,630	10,569,638	-768,167	9,801,471	-1,606,396	8,195,075	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	270,538	808,219	1,078,757	-10,473	1,068,284	-43,955	1,024,329	7
8	00800	Laundry & Linen Service	280	229,495	229,775		229,775	-24	229,751	8
9	00900	Housekeeping	278,944	94,164	373,108		373,108		373,108	9
10	01000	Dietary		1,464,582	1,464,582	-56	1,464,526	-110,612	1,353,914	10
11	01100	Cafeteria								11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	1,128,579	22,998	1,151,577		1,151,577	-85	1,151,492	13
14	01400	Central Services & Supply								14
15	01500	Pharmacy								15
16	01600	Medical Records & Library	268,495	32,005	300,500		300,500	-193	300,307	16
17	01700	Social Service	791,498	18,413	809,911		809,911	-1,276	808,635	17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd				165,000	165,000		165,000	22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	8,215,941	973,014	9,188,955	402,581	9,591,536	-326,971	9,264,565	30
		ANCILLARY SERVICE COST CENTERS								
54	05400	Radiology-Diagnostic		208,428	208,428	-208,428				54
54.01	05401	RADIOLOGY-SUA				208,588	208,588	-91,896	116,692	54.01
60	06000	Laboratory		815,648	815,648	-427,929	387,719		387,719	60
60.01	06001	LAB - SUA				427,929	427,929		427,929	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	630,423	18,082	648,505	10,863	659,368	-348	659,020	65
66	06600	Physical Therapy	3,124,722	134,902	3,259,624		3,259,624	-279	3,259,345	66
67	06700	Occupational Therapy	1,718,285	103,108	1,821,393		1,821,393		1,821,393	67
68	06800	Speech Pathology	1,065,222	27,853	1,093,075		1,093,075	-320	1,092,755	68
71	07100	Medical Supplies Charged to Patients	167,317	700,355	867,672		867,672	-1,692	865,980	71
73	07300	Drugs Charged to Patients	864,204	1,254,629	2,118,833		2,118,833	-11,581	2,107,252	73
76	03550	PSYCHOLOGY	74,704	731	75,435	-75,437	-2		-2	76
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
92	09200	Observation Beds (Non-Distinct Part)								92
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM								93.99
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
113	11300	Interest Expense		7,770	7,770		7,770	-7,770		113
118		SUBTOTALS (sum of lines 1-117)	21,921,160	23,431,364	45,352,524	-265,765	45,086,759	-2,708,489	42,378,270	118
		NONREIMBURSABLE COST CENTERS								
192	19200	Physicians' Private Offices								192
194	07950	MARKETING				206,793	206,793		206,793	194
194.02	07951	CLINICAL PSYCHOLOGY				58,972	58,972		58,972	194.02
200		TOTAL (sum of lines 118-199)	21,921,160	23,431,364	45,352,524		45,352,524	-2,708,489	42,644,035	200

RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	INSURANCE	A	Cap Rel Costs-Bldg & Fixt	1		7,495	1
2	INSURANCE	A	Cap Rel Costs-Mvble Equip	2		2,269	2
3	INSURANCE	A					3
500	Total reclassifications					9,764	500
	Code Letter - A						
1	MARKETING	B	MARKETING	194	198,849	7,944	1
2	MARKETING	B					2
3	MARKETING	B					3
500	Total reclassifications				198,849	7,944	500
	Code Letter - B						
1	PHYSICIANS	C	Adults & Pediatrics	30		325,538	1
2	PHYSICIANS	C					2
500	Total reclassifications					325,538	500
	Code Letter - C						
1	PROFESSIONAL FEES	D	I&R Services-Other Prgm Costs	22		165,000	1
2	PROFESSIONAL FEES	D					2
500	Total reclassifications					165,000	500
	Code Letter - D						
1	COUNSELORS NOT PSYCHOLOGISTS	E	Adults & Pediatrics	30	74,705	2,338	1
2	COUNSELORS NOT PSYCHOLOGISTS	E					2
3	COUNSELORS NOT PSYCHOLOGISTS	E					3
500	Total reclassifications				74,705	2,338	500
	Code Letter - E						
1	SERVICE UNDER ARRANGEMENT	F	RADIOLOGY-SUA	54.01		208,428	1
2	SERVICE UNDER ARRANGEMENT	F	LAB - SUA	60.01		427,929	2
3	SERVICE UNDER ARRANGEMENT	F					3
4	SERVICE UNDER ARRANGEMENT	F					4
500	Total reclassifications					636,357	500
	Code Letter - F						
1	CONTRACT SERVICES	G	RADIOLOGY-SUA	54.01		160	1
2	CONTRACT SERVICES	G	CLINICAL PSYCHOLOGY	194.02		58,972	2
3	CONTRACT SERVICES	G					3
500	Total reclassifications					59,132	500
	Code Letter - G						
1	REBATE RECLASS	H	Respiratory Therapy	65		10,863	1
2	REBATE RECLASS	H					2
3	REBATE RECLASS	H					3
500	Total reclassifications					10,863	500
	Code Letter - H						
	GRAND TOTAL (Increases)				273,554	1,216,936	

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	INSURANCE	A					12	1
2	INSURANCE	A					12	2
3	INSURANCE	A	Administrative & General	5		9,764		3
500	Total reclassifications					9,764		500
	Code letter - A							
1	MARKETING	B						1
2	MARKETING	B	Administrative & General	5	198,849	7,888		2
3	MARKETING	B	Dietary	10		56		3
500	Total reclassifications				198,849	7,944		500
	Code letter - B							
1	PHYSICIANS	C						1
2	PHYSICIANS	C	Administrative & General	5		325,538		2
500	Total reclassifications					325,538		500
	Code letter - C							
1	PROFESSIONAL FEES	D						1
2	PROFESSIONAL FEES	D	Administrative & General	5		165,000		2
500	Total reclassifications					165,000		500
	Code letter - D							
1	COUNSELORS NOT PSYCHOLOGISTS	E						1
2	COUNSELORS NOT PSYCHOLOGISTS	E	Administrative & General	5		1,606		2
3	COUNSELORS NOT PSYCHOLOGISTS	E	PSYCHOLOGY	76	74,705	732		3
500	Total reclassifications				74,705	2,338		500
	Code letter - E							
1	SERVICE UNDER ARRANGEMENT	F						1
2	SERVICE UNDER ARRANGEMENT	F						2
3	SERVICE UNDER ARRANGEMENT	F	Radiology-Diagnostic	54		208,428		3
4	SERVICE UNDER ARRANGEMENT	F	Laboratory	60		427,929		4
500	Total reclassifications					636,357		500
	Code letter - F							
1	CONTRACT SERVICES	G						1
2	CONTRACT SERVICES	G						2
3	CONTRACT SERVICES	G	Administrative & General	5		59,132		3
500	Total reclassifications					59,132		500
	Code letter - G							
1	REBATE RECLASS	H						1
2	REBATE RECLASS	H	Administrative & General	5		390		2
3	REBATE RECLASS	H	Operation of Plant	7		10,473		3
500	Total reclassifications					10,863		500
	Code letter - H							
	GRAND TOTAL (Decreases)				273,554	1,216,936		

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

			Acquisitions						
	Description	Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		1	2	3	4	5	6	7	
1	Land								1
2	Land Improvements	20,740					20,740		2
3	Buildings and Fixtures	18,114,347				49,011	18,065,336		3
4	Building Improvements	3,803,282	14,151,438		14,151,438	6,791,828	11,162,892		4
5	Fixed Equipment								5
6	Movable Equipment	6,290,890	2,695,599		2,695,599	132,908	8,853,581		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	28,229,259	16,847,037		16,847,037	6,973,747	38,102,549		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	28,229,259	16,847,037		16,847,037	6,973,747	38,102,549		10

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 AND 2

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	1,525,444	1,843,212					3,368,656	1
2	Cap Rel Costs-Mvble Equip	799,957	396,372					1,196,329	2
3	Total (sum of lines 1-2)	2,325,401	2,239,584					4,564,985	3

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

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	29,248,968		29,248,968	0.767638		87,158		87,158	1
2	Cap Rel Costs-Mvble Equ	8,853,581		8,853,581	0.232362		26,382		26,382	2
3	Total (sum of lines 1-2)	38,102,549		38,102,549	1.000000		113,540		113,540	3

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	1,667,226	1,274,962	449,021	7,495	87,158		3,485,862	1
2	Cap Rel Costs-Mvble Equip	781,986	388,817		2,269	26,382		1,199,454	2
3	Total (sum of lines 1-2)	2,449,212	1,663,779	449,021	9,764	113,540		4,685,316	3

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

ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
1	Investment income-buildings & fixtures (chapter 2)			Cap Rel Costs-Bldg & Fixt	1		1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)						7
8	Television and radio service (chapter 21)						8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-309,537				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1	2,156,194				12
13	Laundry and linen service						13
14	Cafeteria - employees and guests						14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients						16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts						18
19	Nursing and allied health education (tuition, fees, books, etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation						32
33							33
34							34
35							35
36							36
37	INTEREST	A	-7,770	Interest Expense	113	11	37
37.02	DEPRECIATION	A	-3	Cap Rel Costs-Mvble Equip	2	9	37.02
37.03	INSURANCE	A	-496,857	Employee Benefits Department	4		37.03
37.04	INSURANCE	A	-490,433	Administrative & General	5		37.04
37.05	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-704,063	Administrative & General	5		37.05
37.06	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-1,671	Operation of Plant	7		37.06
37.07	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-85	Nursing Administration	13		37.07
37.08	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-18	Medical Records & Library	16		37.08
37.09	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-1,238	Social Service	17		37.09
37.10	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-17,434	Adults & Pediatrics	30		37.10
37.11	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-348	Respiratory Therapy	65		37.11
37.12	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-201	Physical Therapy	66		37.12
37.14	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-320	Speech Pathology	68		37.14
37.15	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-1,096	Medical Supplies Charged to Patients	71		37.15
37.16	PATIENT TELEPHONE	A	-4,112	Cap Rel Costs-Mvble Equip	2	9	37.16
37.17	PATIENT TELEPHONE	A	-4,521	Employee Benefits Department	4		37.17
37.18	PATIENT TELEPHONE	A	-28,442	Administrative & General	5		37.18
37.19	PATIENT TELEVISION	A	-13,856	Cap Rel Costs-Mvble Equip	2	9	37.19
37.20	PATIENT TELEVISION	A	-10,269	Administrative & General	5		37.20
37.21	PRINTING	A	-5,907	Administrative & General	5		37.21
37.22	PRINTING	A	-6	Operation of Plant	7		37.22
37.23	LOBBYING EXPENSE	A	-66	Employee Benefits Department	4		37.23
37.24	LOBBYING EXPENSE	A	-766	Administrative & General	5		37.24
37.25	LOBBYING EXPENSE	A	-34	Operation of Plant	7		37.25
37.26	LOBBYING EXPENSE	A	-38	Social Service	17		37.26
37.27	MISCELLANEOUS INCOME	B	-65,349	Administrative & General	5		37.27
37.28	MISCELLANEOUS INCOME	B	-175	Medical Records & Library	16		37.28
37.29	MISCELLANEOUS INCOME	B	-10,256	Drugs Charged to Patients	73		37.29
37.30	PATIENT TRANSPORTATION	A	-7,555	Cap Rel Costs-Mvble Equip	2	10	37.30

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2017 To: 05/31/2018	Run Date: 09/26/2018 Run Time: 16:30 Version: 2018.04 (08/06/2018)

ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
37.31	PATIENT TRANSPORTATION	A	-674	Employee Benefits Department	4		37.31
37.32	PATIENT TRANSPORTATION	A	-71,466	Administrative & General	5		37.32
37.33	PATIENT TRANSPORTATION	A	-9,695	Operation of Plant	7		37.33
37.34	PATIENT TRANSPORTATION	A	-24	Laundry & Linen Service	8		37.34
37.36	PROFESSIONAL FEES	A	-367,056	Administrative & General	5		37.36
37.37	CLINICAL PSYCHOLOGY	A	-36,000	Administrative & General	5		37.37
37.38	CONTRACT SERVICES	A	-3,747	Administrative & General	5		37.38
37.39	PHYSICAN	A	-150,977	Administrative & General	5		37.39
38	MISC. TAX	A	-2,042,618	Administrative & General	5		38
39							39
40							40
41							41
42							42
43							43
44							44
45							45
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-2,708,489				50

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1
(2) Basis for adjustment (see instructions)
A. Costs - if cost, including applicable overhead, can be determined
B. Amount Received - if cost cannot be determined
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

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

A: COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1	5	Administrative & General	TO OFFSET MANAGEMENT FEES		804,181	-804,181		1
2	1	Cap Rel Costs-Bldg & Fixt	TO INCLUDE ALLOWABLE HOME OFFICE COS	141,782		141,782	9	2
3	1	Cap Rel Costs-Bldg & Fixt	TO INCLUDE ALLOWABLE HOME OFFICE COS	449,021		449,021	11	3
3.01	5	Administrative & General	TO INCLUDE ALLOWABLE HOME OFFICE COS	2,866,829		2,866,829		3.01
3.02	5	Administrative & General	TO INCLUDE ALLOWABLE HOME OFFICE COS	461,511		461,511		3.02
3.03	2	Cap Rel Costs-Mvble Equip	INTERCOMPANY WAGE AND EXPENSE TRANSF	4,899	4,899		9	3.03
3.04	4	Employee Benefits Department	INTERCOMPANY WAGE AND EXPENSE TRANSF	3,387,213	3,387,213			3.04
3.05	5	Administrative & General	INTERCOMPANY WAGE AND EXPENSE TRANSF	2,031,726	2,031,726			3.05
3.06	7	Operation of Plant	INTERCOMPANY WAGE AND EXPENSE TRANSF	6,845	6,845			3.06
3.07	9	Housekeeping	INTERCOMPANY WAGE AND EXPENSE TRANSF	555	555			3.07
3.08	10	Dietary	INTERCOMPANY WAGE AND EXPENSE TRANSF	-3,802	-3,802			3.08
3.09	13	Nursing Administration	INTERCOMPANY WAGE AND EXPENSE TRANSF	1,165	1,165			3.09
3.10	16	Medical Records & Library	INTERCOMPANY WAGE AND EXPENSE TRANSF	5,053	5,053			3.10
3.11	17	Social Service	INTERCOMPANY WAGE AND EXPENSE TRANSF	3,724	3,724			3.11
3.12	30	Adults & Pediatrics	INTERCOMPANY WAGE AND EXPENSE TRANSF	18,183	18,183			3.12
3.13	54	Radiology-Diagnostic	INTERCOMPANY WAGE AND EXPENSE TRANSF	-6,469	-6,469			3.13
3.14	60	Laboratory	INTERCOMPANY WAGE AND EXPENSE TRANSF	5,669	5,669			3.14
3.15	65	Respiratory Therapy	INTERCOMPANY WAGE AND EXPENSE TRANSF	369	369			3.15
3.16	66	Physical Therapy	INTERCOMPANY WAGE AND EXPENSE TRANSF	5,086	5,086			3.16
3.17	67	Occupational Therapy	INTERCOMPANY WAGE AND EXPENSE TRANSF	-2,834	-2,834			3.17
3.18	68	Speech Pathology	INTERCOMPANY WAGE AND EXPENSE TRANSF	-2,482	-2,482			3.18
3.19	71	Medical Supplies Charged to Patients	INTERCOMPANY WAGE AND EXPENSE TRANSF	-33,952	-33,952			3.19
3.20	73	Drugs Charged to Patients	INTERCOMPANY WAGE AND EXPENSE TRANSF	41,786	41,786			3.20
3.21	113	Interest Expense	INTERCOMPANY WAGE AND EXPENSE TRANSF	7,770	7,770		11	3.21
3.22	5	Administrative & General	RELATED PARTY - BJC	60,772	214,234	-153,462		3.22
3.23	7	Operation of Plant	RELATED PARTY - BJC	12,804	45,353	-32,549		3.23
3.24	10	Dietary	RELATED PARTY - BJC	43,512	154,124	-110,612		3.24
3.25	54.01	RADIOLOGY-SUA	RELATED PARTY - BJC	84,322	176,218	-91,896		3.25
3.26	60.01	LAB - SUA	RELATED PARTY - BJC	427,929	427,929			3.26
3.27	66	Physical Therapy	RELATED PARTY - BJC	73	151	-78		3.27
3.28	71	Medical Supplies Charged to Patients	RELATED PARTY - BJC	500	1,096	-596		3.28
3.29	73	Drugs Charged to Patients	RELATED PARTY - BJC	925	2,250	-1,325		3.29
3.30	1	Cap Rel Costs-Bldg & Fixt	RELATED PARTY - RENT	-8,376	559,874	-568,250	10	3.30
3.31	1	Cap Rel Costs-Bldg & Fixt	RELATED PARTY - RENT ST. PETERS	1,280,599	1,280,599		10	3.31
3.32	5	Administrative & General	RELATED PARTY - RENT ST. PETERS	2,250	2,250			3.32
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12			11,294,957	9,138,763	2,156,194		5

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

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

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

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

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

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

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

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

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

				Related Organization(s) and/or Home Office			
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
6	B		50.00	ENCOMPASS HEATLH			6
7	B		50.00	BJC HEALTHCARE			7
8	G	ENCOMPASS HEALTH				HEALTHCARE INTERCOMPANY	8
9	G	BARNES JEWISH CRISTIAN HOSPITA				HEALTHCARE	9
9.01	G	BARNES JEWISH ST. PETERS HOSPI				HEALTHCARE	9.01
10							10

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

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

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2017 To: 05/31/2018	Run Date: 09/26/2018 Run Time: 16:30 Version: 2018.04 (08/06/2018)

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

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun-eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	30	Adults & Pediatrics DR. A	72,000		72,000	211,500	517	52,570	2,629	1
2	30	Adults & Pediatrics DR. B	274,000		274,000	211,500	629	63,958	3,198	2
3	30	Adults & Pediatrics DR. C	76,546		76,546	211,500	30	3,050	153	3
4	30	Adults & Pediatrics DR. D	10,331		10,331	211,500	37	3,762	188	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	432,877		432,877		1,213	123,340	6,168	200

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

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	30	Adults & Pediatrics DR. A					52,570	19,430	19,430	1
2	30	Adults & Pediatrics DR. B					63,958	210,042	210,042	2
3	30	Adults & Pediatrics DR. C					3,050	73,496	73,496	3
4	30	Adults & Pediatrics DR. D					3,762	6,569	6,569	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL					123,340	309,537	309,537	200

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2017 To: 05/31/2018	Run Date: 09/26/2018 Run Time: 16:30 Version: 2018.04 (08/06/2018)

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS-TRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	3,485,862	3,485,862					1
2	Cap Rel Costs-Mvble Equip	1,199,454		1,199,454				2
4	Employee Benefits Department	4,088,695			4,088,695			4
5	Administrative & General	8,195,075	232,929	80,149	582,525	9,090,678	9,090,678	5
6	Maintenance & Repairs							6
7	Operation of Plant	1,024,329	10,299	3,544	50,460	1,088,632	299,811	7
8	Laundry & Linen Service	229,751	26,691	9,184	52	265,678	73,168	8
9	Housekeeping	373,108	14,140	4,865	52,028	444,141	122,317	9
10	Dietary	1,353,914	188,854	64,983		1,607,751	442,778	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	1,151,492	13,610	4,683	210,500	1,380,285	380,133	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	300,307	21,558	7,418	50,079	379,362	104,477	16
17	Social Service	808,635	13,743	4,729	147,629	974,736	268,444	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd	165,000				165,000	45,441	22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	9,264,565	2,008,047	690,950	1,546,359	13,509,921	3,720,666	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic							54
54.01	RADIOLOGY-SUA	116,692				116,692		54.01
60	Laboratory	387,719	17,087	5,880		410,686	113,104	60
60.01	LAB - SUA	427,929				427,929		60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	659,020	12,749	4,387	117,585	793,741	218,598	65
66	Physical Therapy	3,259,345	438,142	150,761	582,817	4,431,065	1,220,324	66
67	Occupational Therapy	1,821,393	216,571	74,520	320,491	2,432,975	670,046	67
68	Speech Pathology	1,092,755	100,636	34,628	198,683	1,426,702	392,917	68
71	Medical Supplies Charged to Patients	865,980	72,521	24,954	31,208	994,663	273,932	71
73	Drugs Charged to Patients	2,107,252	40,864	14,061	161,190	2,323,367	639,860	73
76	PSYCHOLOGY	-2				-2		76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	42,378,270	3,428,441	1,179,696	4,051,606	42,264,002	8,986,016	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		54,937	18,903		73,840	20,336	192
194	MARKETING	206,793	2,484	855	37,089	247,221	68,085	194
194.02	CLINICAL PSYCHOLOGY	58,972				58,972	16,241	194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	42,644,035	3,485,862	1,199,454	4,088,695	42,644,035	9,090,678	202

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

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE-KEEPING	DIETARY	NURSING ADMINIS-TRATION	MEDICAL RECORDS + LIBRARY	
		7	8	9	10	13	16	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	1,388,443						7
8	Laundry & Linen Service	11,428	350,274					8
9	Housekeeping	6,055		572,513				9
10	Dietary	80,864		33,769	2,165,162			10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	5,828		2,434		1,768,680		13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	9,231		3,855			496,925	16
17	Social Service	5,884		2,457				17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	859,815	350,274	359,057	2,165,162	1,768,680	221,266	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic							54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory	7,316		3,055			6,919	60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	5,459		2,280			5,419	65
66	Physical Therapy	187,605		78,344			87,206	66
67	Occupational Therapy	92,732		38,725			69,750	67
68	Speech Pathology	43,091		17,995			35,137	68
71	Medical Supplies Charged to Patients	31,052		12,968			3,747	71
73	Drugs Charged to Patients	17,497		7,307			67,481	73
76	PSYCHOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	1,363,857	350,274	562,246	2,165,162	1,768,680	496,925	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	23,523		9,823				192
194	MARKETING	1,063		444				194
194.02	CLINICAL PSYCHOLOGY							194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,388,443	350,274	572,513	2,165,162	1,768,680	496,925	202

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2017 To: 05/31/2018	Run Date: 09/26/2018 Run Time: 16:30 Version: 2018.04 (08/06/2018)

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

	COST CENTER DESCRIPTIONS	SOCIAL SERVICE	I&R PROGRAM COSTS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		17	22	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service	1,251,521						17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd		210,441					22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,251,521	210,441	24,416,803		24,416,803		30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic							54
54.01	RADIOLOGY-SUA			116,692		116,692		54.01
60	Laboratory			541,080		541,080		60
60.01	LAB - SUA			427,929		427,929		60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			1,025,497		1,025,497		65
66	Physical Therapy			6,004,544		6,004,544		66
67	Occupational Therapy			3,304,228		3,304,228		67
68	Speech Pathology			1,915,842		1,915,842		68
71	Medical Supplies Charged to Patients			1,316,362		1,316,362		71
73	Drugs Charged to Patients			3,055,512		3,055,512		73
76	PSYCHOLOGY			-2		-2		76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	1,251,521	210,441	42,124,487		42,124,487		118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices			127,522		127,522		192
194	MARKETING			316,813		316,813		194
194.02	CLINICAL PSYCHOLOGY			75,213		75,213		194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,251,521	210,441	42,644,035		42,644,035		202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	ADMINIS-TRATIVE & GENERAL	OPERATION OF PLANT	
		0	1	2	2A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General		232,929	80,149	313,078	313,078		5
6	Maintenance & Repairs							6
7	Operation of Plant		10,299	3,544	13,843	10,326	24,169	7
8	Laundry & Linen Service		26,691	9,184	35,875	2,520	199	8
9	Housekeeping		14,140	4,865	19,005	4,213	105	9
10	Dietary		188,854	64,983	253,837	15,250	1,408	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration		13,610	4,683	18,293	13,092	101	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		21,558	7,418	28,976	3,598	161	16
17	Social Service		13,743	4,729	18,472	9,245	102	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd					1,565		22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		2,008,047	690,950	2,698,997	128,132	14,967	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic							54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory		17,087	5,880	22,967	3,895	127	60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		12,749	4,387	17,136	7,529	95	65
66	Physical Therapy		438,142	150,761	588,903	42,029	3,266	66
67	Occupational Therapy		216,571	74,520	291,091	23,077	1,614	67
68	Speech Pathology		100,636	34,628	135,264	13,532	750	68
71	Medical Supplies Charged to Patients		72,521	24,954	97,475	9,434	541	71
73	Drugs Charged to Patients		40,864	14,061	54,925	22,037	305	73
76	PSYCHOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)		3,428,441	1,179,696	4,608,137	309,474	23,741	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		54,937	18,903	73,840	700	409	192
194	MARKETING		2,484	855	3,339	2,345	19	194
194.02	CLINICAL PSYCHOLOGY					559		194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		3,485,862	1,199,454	4,685,316	313,078	24,169	202

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

	COST CENTER DESCRIPTIONS	LAUNDRY + LINEN SERVICE	HOUSE-KEEPING	DIETARY	NURSING ADMINIS-TRATION	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	
		8	9	10	13	16	17	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	38,594						8
9	Housekeeping		23,323					9
10	Dietary		1,376	271,871				10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration		99		31,585			13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		157			32,892		16
17	Social Service		100				27,919	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	38,594	14,627	271,871	31,585	14,665	27,919	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic							54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory		124			457		60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		93			358		65
66	Physical Therapy		3,192			5,767		66
67	Occupational Therapy		1,578			4,612		67
68	Speech Pathology		733			2,323		68
71	Medical Supplies Charged to Patients		528			248		71
73	Drugs Charged to Patients		298			4,462		73
76	PSYCHOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	38,594	22,905	271,871	31,585	32,892	27,919	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		400					192
194	MARKETING		18					194
194.02	CLINICAL PSYCHOLOGY							194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	38,594	23,323	271,871	31,585	32,892	27,919	202

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2017 To: 05/31/2018	Run Date: 09/26/2018 Run Time: 16:30 Version: 2018.04 (08/06/2018)

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	I&R PROGRAM COSTS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL			
		22	24	25	26			
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd	1,565						22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		3,241,357		3,241,357			30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic							54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory		27,570		27,570			60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		25,211		25,211			65
66	Physical Therapy		643,157		643,157			66
67	Occupational Therapy		321,972		321,972			67
68	Speech Pathology		152,602		152,602			68
71	Medical Supplies Charged to Patients		108,226		108,226			71
73	Drugs Charged to Patients		82,027		82,027			73
76	PSYCHOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)		4,602,122		4,602,122			118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		75,349		75,349			192
194	MARKETING		5,721		5,721			194
194.02	CLINICAL PSYCHOLOGY		559		559			194.02
200	Cross Foot Adjustments	1,565	1,565		1,565			200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,565	4,685,316		4,685,316			202

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

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	105,266						1
2	Cap Rel Costs-Mvble Equip		105,266					2
4	Employee Benefits Department			21,921,161				4
5	Administrative & General	7,034	7,034	3,123,159	-9,090,678	33,008,738		5
6	Maintenance & Repairs							6
7	Operation of Plant	311	311	270,538		1,088,632	97,921	7
8	Laundry & Linen Service	806	806	280		265,678	806	8
9	Housekeeping	427	427	278,944		444,141	427	9
10	Dietary	5,703	5,703			1,607,751	5,703	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	411	411	1,128,579		1,380,285	411	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	651	651	268,495		379,362	651	16
17	Social Service	415	415	791,498		974,736	415	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd					165,000		22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	60,639	60,639	8,290,646		13,509,921	60,639	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic							54
54.01	RADIOLOGY-SUA				-116,692			54.01
60	Laboratory	516	516			410,686	516	60
60.01	LAB - SUA				-427,929			60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	385	385	630,423		793,741	385	65
66	Physical Therapy	13,231	13,231	3,124,722		4,431,065	13,231	66
67	Occupational Therapy	6,540	6,540	1,718,285		2,432,975	6,540	67
68	Speech Pathology	3,039	3,039	1,065,222		1,426,702	3,039	68
71	Medical Supplies Charged to Patients	2,190	2,190	167,317		994,663	2,190	71
73	Drugs Charged to Patients	1,234	1,234	864,204		2,323,367	1,234	73
76	PSYCHOLOGY				2			76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	103,532	103,532	21,722,312	-9,635,297	32,628,705	96,187	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	1,659	1,659			73,840	1,659	192
194	MARKETING	75	75	198,849		247,221	75	194
194.02	CLINICAL PSYCHOLOGY					58,972		194.02
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	3,485,862	1,199,454	4,088,695		9,090,678	1,388,443	202
203	Unit Cost Multiplier (Wkst. B, Part I)	33.114795	11.394505	0.186518		0.275402	14.179216	203
204	Cost to be allocated (Per Wkst. B, Part II)					313,078	24,169	204
205	Unit Cost Multiplier (Wkst. B, Part II)					0.009485	0.246821	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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

	COST CENTER DESCRIPTIONS	LAUNDRY + LINEN SERVICE PATIENT DAYS	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	NURSING ADMINIS-TRATION PATIENT DAYS	MEDICAL RECORDS + LIBRARY GROSS REVENUE	SOCIAL SERVICE PATIENT DAYS	
		8	9	10	13	16	17	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	33,066						8
9	Housekeeping		96,688					9
10	Dietary		5,703	99,198				10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration		411		33,066			13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		651			72,060,716		16
17	Social Service		415				33,066	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	33,066	60,639	99,198	33,066	32,086,804	33,066	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic							54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory		516			1,003,287		60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		385			785,888		65
66	Physical Therapy		13,231			12,645,917		66
67	Occupational Therapy		6,540			10,114,590		67
68	Speech Pathology		3,039			5,095,244		68
71	Medical Supplies Charged to Patients		2,190			543,403		71
73	Drugs Charged to Patients		1,234			9,785,583		73
76	PSYCHOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	33,066	94,954	99,198	33,066	72,060,716	33,066	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		1,659					192
194	MARKETING		75					194
194.02	CLINICAL PSYCHOLOGY							194.02
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	350,274	572,513	2,165,162	1,768,680	496,925	1,251,521	202
203	Unit Cost Multiplier (Wkst. B, Part I)	10.593177	5.921242	21.826670	53.489385	0.006896	37.849180	203
204	Cost to be allocated (Per Wkst. B, Part II)	38,594	23,323	271,871	31,585	32,892	27,919	204
205	Unit Cost Multiplier (Wkst. B, Part II)	1.167181	0.241219	2.740690	0.955211	0.000456	0.844342	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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

	COST CENTER DESCRIPTIONS	I&R PROGRAM COSTS ASSIGNED TIME						
		22						
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd	100						22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	100						30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic							54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory							60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients							73
76	PSYCHOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	100						118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices							192
194	MARKETING							194
194.02	CLINICAL PSYCHOLOGY							194.02
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	210,441						202
203	Unit Cost Multiplier (Wkst. B, Part I)	2,104.410000						203
204	Cost to be allocated (Per Wkst. B, Part II)	1,565						204
205	Unit Cost Multiplier (Wkst. B, Part II)	15.650000						205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2017 To: 05/31/2018	Run Date: 09/26/2018 Run Time: 16:30 Version: 2018.04 (08/06/2018)

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	CODE	LINE NO.	AMOUNT	
	1	2	3	4	

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2017 To: 05/31/2018	Run Date: 09/26/2018 Run Time: 16:30 Version: 2018.04 (08/06/2018)

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	24,416,803		24,416,803	309,537	24,726,340	30
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic						54
54.01	RADIOLOGY-SUA	116,692		116,692		116,692	54.01
60	Laboratory	541,080		541,080		541,080	60
60.01	LAB - SUA	427,929		427,929		427,929	60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	1,025,497		1,025,497		1,025,497	65
66	Physical Therapy	6,004,544		6,004,544		6,004,544	66
67	Occupational Therapy	3,304,228		3,304,228		3,304,228	67
68	Speech Pathology	1,915,842		1,915,842		1,915,842	68
71	Medical Supplies Charged to Patients	1,316,362		1,316,362		1,316,362	71
73	Drugs Charged to Patients	3,055,512		3,055,512		3,055,512	73
76	PSYCHOLOGY						76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct Part)						92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	42,124,489		42,124,489	309,537	42,434,026	200
201	Less Observation Beds						201
202	Total (line 200 minus line 201)	42,124,489		42,124,489		42,434,026	202

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2017 To: 05/31/2018	Run Date: 09/26/2018 Run Time: 16:30 Version: 2018.04 (08/06/2018)

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	32,086,804		32,086,804				30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic							54
54.01	RADIOLOGY-SUA	1,069,959	1,296	1,071,255	0.108930	0.108930	0.108930	54.01
60	Laboratory	1,003,287		1,003,287	0.539307	0.539307	0.539307	60
60.01	LAB - SUA	1,107,337		1,107,337	0.386449	0.386449	0.386449	60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	785,888		785,888	1.304890	1.304890	1.304890	65
66	Physical Therapy	7,902,265	4,743,652	12,645,917	0.474821	0.474821	0.474821	66
67	Occupational Therapy	8,131,097	1,983,494	10,114,591	0.326679	0.326679	0.326679	67
68	Speech Pathology	3,442,176	1,653,068	5,095,244	0.376006	0.376006	0.376006	68
71	Medical Supplies Charged to Patients	529,799	13,603	543,402	2.422446	2.422446	2.422446	71
73	Drugs Charged to Patients	9,785,583		9,785,583	0.312246	0.312246	0.312246	73
76	PSYCHOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	65,844,195	8,395,113	74,239,308				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	65,844,195	8,395,113	74,239,308				202

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2017 To: 05/31/2018	Run Date: 09/26/2018 Run Time: 16:30 Version: 2018.04 (08/06/2018)

COMPUTATION OF RATIO OF COST TO CHARGES - TITLE V (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET) **WORKSHEET C PART I**

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (B Part I col 26 plus sum of cols 21 & 22)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics						30
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic						54
54.01	RADIOLOGY-SUA						54.01
60	Laboratory						60
60.01	LAB - SUA						60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy						65
66	Physical Therapy						66
67	Occupational Therapy						67
68	Speech Pathology						68
71	Medical Supplies Charged to Patients						71
73	Drugs Charged to Patients						73
76	PSYCHOLOGY						76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct Part)						92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)						200
201	Less Observation Beds						201
202	Total (line 200 minus line 201)						202

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2017 To: 05/31/2018	Run Date: 09/26/2018 Run Time: 16:30 Version: 2018.04 (08/06/2018)

COMPUTATION OF RATIO OF COST TO CHARGES - TITLE V (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET) **WORKSHEET C PART I**

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	32,086,804		32,086,804				30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic							54
54.01	RADIOLOGY-SUA	1,069,959	1,296	1,071,255				54.01
60	Laboratory	1,003,287		1,003,287				60
60.01	LAB - SUA	1,107,337		1,107,337				60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	785,888		785,888				65
66	Physical Therapy	7,902,265	4,743,652	12,645,917				66
67	Occupational Therapy	8,131,097	1,983,494	10,114,591				67
68	Speech Pathology	3,442,176	1,653,068	5,095,244				68
71	Medical Supplies Charged to Patients	529,799	13,603	543,402				71
73	Drugs Charged to Patients	9,785,583		9,785,583				73
76	PSYCHOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	65,844,195	8,395,113	74,239,308				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	65,844,195	8,395,113	74,239,308				202

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2017 To: 05/31/2018	Run Date: 09/26/2018 Run Time: 16:30 Version: 2018.04 (08/06/2018)

COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET) **WORKSHEET C PART I**

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (B Part I col 26 plus sum of cols 21 & 22)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	24,416,803		24,416,803	309,537	24,726,340	30
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic						54
54.01	RADIOLOGY-SUA	116,692		116,692		116,692	54.01
60	Laboratory	541,080		541,080		541,080	60
60.01	LAB - SUA	427,929		427,929		427,929	60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	1,025,497		1,025,497		1,025,497	65
66	Physical Therapy	6,004,544		6,004,544		6,004,544	66
67	Occupational Therapy	3,304,228		3,304,228		3,304,228	67
68	Speech Pathology	1,915,842		1,915,842		1,915,842	68
71	Medical Supplies Charged to Patients	1,316,362		1,316,362		1,316,362	71
73	Drugs Charged to Patients	3,055,512		3,055,512		3,055,512	73
76	PSYCHOLOGY						76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct Part)						92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	42,124,489		42,124,489	309,537	42,434,026	200
201	Less Observation Beds						201
202	Total (line 200 minus line 201)	42,124,489		42,124,489	309,537	42,434,026	202

COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET) **WORKSHEET C PART I**

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	32,086,804		32,086,804				30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic							54
54.01	RADIOLOGY-SUA	1,069,959	1,296	1,071,255	0.108930	0.108930	0.108930	54.01
60	Laboratory	1,003,287		1,003,287	0.539307	0.539307	0.539307	60
60.01	LAB - SUA	1,107,337		1,107,337	0.386449	0.386449	0.386449	60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	785,888		785,888	1.304890	1.304890	1.304890	65
66	Physical Therapy	7,902,265	4,743,652	12,645,917	0.474821	0.474821	0.474821	66
67	Occupational Therapy	8,131,097	1,983,494	10,114,591	0.326679	0.326679	0.326679	67
68	Speech Pathology	3,442,176	1,653,068	5,095,244	0.376006	0.376006	0.376006	68
71	Medical Supplies Charged to Patients	529,799	13,603	543,402	2.422446	2.422446	2.422446	71
73	Drugs Charged to Patients	9,785,583		9,785,583	0.312246	0.312246	0.312246	73
76	PSYCHOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	65,844,195	8,395,113	74,239,308				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	65,844,195	8,395,113	74,239,308				202

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2017 To: 05/31/2018	Run Date: 09/26/2018 Run Time: 16:30 Version: 2018.04 (08/06/2018)

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

WORKSHEET C
PART II

[ ] Title V **[XX] Title XIX**

	COST CENTER DESCRIPTIONS	Total Cost (Wkst B, Part I, col. 26)	Capital Cost (Wkst B, Part II, col. 26	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	
		1	2	3	4	
	ANCILLARY SERVICE COST CENTERS					
54	Radiology-Diagnostic					54
54.01	RADIOLOGY-SUA	116,692		116,692		54.01
60	Laboratory	541,080	27,570	513,510		60
60.01	LAB - SUA	427,929		427,929		60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy	1,025,497	25,211	1,000,286		65
66	Physical Therapy	6,004,544	643,157	5,361,387		66
67	Occupational Therapy	3,304,228	321,972	2,982,256		67
68	Speech Pathology	1,915,842	152,602	1,763,240		68
71	Medical Supplies Charged to Patients	1,316,362	108,226	1,208,136		71
73	Drugs Charged to Patients	3,055,512	82,027	2,973,485		73
76	PSYCHOLOGY					76
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
92	Observation Beds (Non-Distinct Part)					92
93.99	PARTIAL HOSPITALIZATION PROGRAM					93.99
	OTHER REIMBURSABLE COST CENTERS					
113	Interest Expense					113
200	Subtotal	17,707,686	1,360,765	16,346,921		200
201	Less Observation Beds					201
202	Total	17,707,686	1,360,765	16,346,921		202

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2017 To: 05/31/2018	Run Date: 09/26/2018 Run Time: 16:30 Version: 2018.04 (08/06/2018)

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY **WORKSHEET C PART II**

[ ] Title V **[XX] Title XIX**

	COST CENTER DESCRIPTIONS	Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Wkst C, Part I, col. 8)	Outpatient Cost to Charge Ratio(col. 6 ÷ col. 7)	
		5	6	7	8	
	ANCILLARY SERVICE COST CENTERS					
54	Radiology-Diagnostic					54
54.01	RADIOLOGY-SUA		116,692	1,071,255	0.108930	54.01
60	Laboratory		541,080	1,003,287	0.539307	60
60.01	LAB - SUA		427,929	1,107,337	0.386449	60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy		1,025,497	785,888	1.304890	65
66	Physical Therapy		6,004,544	12,645,917	0.474821	66
67	Occupational Therapy		3,304,228	10,114,591	0.326679	67
68	Speech Pathology		1,915,842	5,095,244	0.376006	68
71	Medical Supplies Charged to Patients		1,316,362	543,402	2.422446	71
73	Drugs Charged to Patients		3,055,512	9,785,583	0.312246	73
76	PSYCHOLOGY					76
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
92	Observation Beds (Non-Distinct Part)					92
93.99	PARTIAL HOSPITALIZATION PROGRAM					93.99
	OTHER REIMBURSABLE COST CENTERS					
113	Interest Expense					113
200	Subtotal		17,707,686	42,152,504		200
201	Less Observation Beds					201
202	Total		17,707,686	42,152,504		202

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2017 To: 05/31/2018	Run Date: 09/26/2018 Run Time: 16:30 Version: 2018.04 (08/06/2018)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	3,241,357		3,241,357	33,066	98.03	12,584	1,233,610	30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	3,241,357		3,241,357	33,066		12,584	1,233,610	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 26-3028** **WORKSHEET D PART II**

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

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic						54
54.01	RADIOLOGY-SUA		1,071,255		371,576		54.01
60	Laboratory	27,570	1,003,287	0.027480	645,133	17,728	60
60.01	LAB - SUA		1,107,337		427,929		60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	25,211	785,888	0.032080	237,062	7,605	65
66	Physical Therapy	643,157	12,645,917	0.050859	3,040,356	154,629	66
67	Occupational Therapy	321,972	10,114,591	0.031832	3,175,449	101,081	67
68	Speech Pathology	152,602	5,095,244	0.029950	1,262,662	37,817	68
71	Medical Supplies Charged to Pat	108,226	543,402	0.199164	208,143	41,455	71
73	Drugs Charged to Patients	82,027	9,785,583	0.008382	3,759,523	31,512	73
76	PSYCHOLOGY						76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct						92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,360,765	42,152,504		13,127,833	391,827	200

(A) Worksheet A line numbers

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2017 To: 05/31/2018	Run Date: 09/26/2018 Run Time: 16:30 Version: 2018.04 (08/06/2018)

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

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

		Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjust-ment Amount (see instruct-ions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	Cost Center Description	1A	1	2A	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)								30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	TOTAL (lines 30-199)								200

(A) Worksheet A line numbers

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2017 To: 05/31/2018	Run Date: 09/26/2018 Run Time: 16:30 Version: 2018.04 (08/06/2018)

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

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

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	33,066		12,584		30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	33,066		12,584		200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 26-3028** | **WORKSHEET D PART IV**

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

		Non Physician Anesth-etist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
54	Radiology-Diagnostic									54
54.01	RADIOLOGY-SUA									54.01
60	Laboratory									60
60.01	LAB - SUA									60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
71	Medical Supplies Charged to Pat									71
73	Drugs Charged to Patients									73
76	PSYCHOLOGY									76
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
92	Observation Beds (Non-Distinct									92
93.99	PARTIAL HOSPITALIZATION PROGRAM									93.99
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 26-3028** | **WORKSHEET D PART IV**

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

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic								54
54.01	RADIOLOGY-SUA	1,071,255			371,576				54.01
60	Laboratory	1,003,287			645,133				60
60.01	LAB - SUA	1,107,337			427,929				60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	785,888			237,062				65
66	Physical Therapy	12,645,917			3,040,356				66
67	Occupational Therapy	10,114,591			3,175,449				67
68	Speech Pathology	5,095,244			1,262,662				68
71	Medical Supplies Charged to Pat	543,402			208,143				71
73	Drugs Charged to Patients	9,785,583			3,759,523				73
76	PSYCHOLOGY								76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	42,152,504			13,127,833				200

(A) Worksheet A line numbers

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2017 To: 05/31/2018	Run Date: 09/26/2018 Run Time: 16:30 Version: 2018.04 (08/06/2018)

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 26-3028** **WORKSHEET D PART V**

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic								54
54.01	RADIOLOGY-SUA	0.108930							54.01
60	Laboratory	0.539307							60
60.01	LAB - SUA	0.386449							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	1.304890							65
66	Physical Therapy	0.474821							66
67	Occupational Therapy	0.326679							67
68	Speech Pathology	0.376006							68
71	Medical Supplies Charged to Pat	2.422446							71
73	Drugs Charged to Patients	0.312246							73
76	PSYCHOLOGY								76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	3,241,357		3,241,357	33,066	98.03	5,367	526,127	30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	3,241,357		3,241,357	33,066		5,367	526,127	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 26-3028** **WORKSHEET D PART II**

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

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic						54
54.01	RADIOLOGY-SUA		1,071,255		138,266		54.01
60	Laboratory	27,570	1,003,287	0.027480	105,282	2,893	60
60.01	LAB - SUA		1,107,337		168,542		60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	25,211	785,888	0.032080	185,427	5,948	65
66	Physical Therapy	643,157	12,645,917	0.050859	1,244,676	63,303	66
67	Occupational Therapy	321,972	10,114,591	0.031832	1,263,350	40,215	67
68	Speech Pathology	152,602	5,095,244	0.029950	551,006	16,503	68
71	Medical Supplies Charged to Pat	108,226	543,402	0.199164	73,363	14,611	71
73	Drugs Charged to Patients	82,027	9,785,583	0.008382	1,574,462	13,197	73
76	PSYCHOLOGY						76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct						92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,360,765	42,152,504		5,304,374	156,670	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

		Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjust-ment Amount (see instruct-ions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	Cost Center Description	1A	1	2A	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)								30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	TOTAL (lines 30-199)								200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	33,066		5,367		30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	33,066		5,367		200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 26-3028** | **WORKSHEET D PART IV**

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

		Non Physician Anesth-etist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
54	Radiology-Diagnostic									54
54.01	RADIOLOGY-SUA									54.01
60	Laboratory									60
60.01	LAB - SUA									60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
71	Medical Supplies Charged to Pat									71
73	Drugs Charged to Patients									73
76	PSYCHOLOGY									76
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
92	Observation Beds (Non-Distinct									92
93.99	PARTIAL HOSPITALIZATION PROGRAM									93.99
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 26-3028** | **WORKSHEET D PART IV**

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

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic								54
54.01	RADIOLOGY-SUA	1,071,255			138,266				54.01
60	Laboratory	1,003,287			105,282				60
60.01	LAB - SUA	1,107,337			168,542				60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	785,888			185,427				65
66	Physical Therapy	12,645,917			1,244,676				66
67	Occupational Therapy	10,114,591			1,263,350				67
68	Speech Pathology	5,095,244			551,006				68
71	Medical Supplies Charged to Pat	543,402			73,363				71
73	Drugs Charged to Patients	9,785,583			1,574,462				73
76	PSYCHOLOGY								76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	42,152,504			5,304,374				200

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 26-3028** **WORKSHEET D PART V**

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic								54
54.01	RADIOLOGY-SUA	0.108930							54.01
60	Laboratory	0.539307							60
60.01	LAB - SUA	0.386449							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	1.304890							65
66	Physical Therapy	0.474821		55,767			26,479		66
67	Occupational Therapy	0.326679		16,828			5,497		67
68	Speech Pathology	0.376006		9,784			3,679		68
71	Medical Supplies Charged to Pat	2.422446		358			867		71
73	Drugs Charged to Patients	0.312246							73
76	PSYCHOLOGY								76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			82,737			36,522		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			82,737			36,522		202

(A) Worksheet A line numbers

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2017 To: 05/31/2018	Run Date: 09/26/2018 Run Time: 16:30 Version: 2018.04 (08/06/2018)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 26-3028** **WORKSHEET D-1**
PART I

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	33,066	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	33,066	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.	1,272	3
4	Semi-private room days (excluding swing-bed private room days)	31,794	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	12,584	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	24,726,340	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	24,726,340	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)	32,086,804	28
29	Private room charges (excluding swing-bed charges)	1,360,934	29
30	Semi-private room charges (excluding swing-bed charges)	30,725,870	30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.770608	31
32	Average private room per diem charge (line 29 ÷ line 3)	1,069.92	32
33	Average semi-private room per diem charge (line 30 ÷ line 4)	966.40	33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)	103.52	34
35	Average per diem private room cost differential (line 34 x line 31)	79.77	35
36	Private room cost differential adjustment (line 3 x line 35)	101,467	36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	24,624,873	37

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2017 To: 05/31/2018	Run Date: 09/26/2018 Run Time: 16:30 Version: 2018.04 (08/06/2018)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 26-3028** **WORKSHEET D-1 PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS					1	
38	Adjusted general inpatient routine service cost per diem (see instructions)					747.79	38
39	Program general inpatient routine service cost (line 9 x line 38)					9,410,189	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)					9,410,189	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
						1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					5,496,971	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					14,907,160	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,233,610	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					391,827	51
52	Total Program excludable cost (sum of lines 50 and 51)					1,625,437	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					13,281,723	53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)						87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					747.79	88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2017 To: 05/31/2018	Run Date: 09/26/2018 Run Time: 16:30 Version: 2018.04 (08/06/2018)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 26-3028** **WORKSHEET D-1**
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	33,066	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	33,066	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.	1,272	3
4	Semi-private room days (excluding swing-bed private room days)	31,794	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	5,367	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	24,416,803	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	24,416,803	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)	32,086,804	28
29	Private room charges (excluding swing-bed charges)	1,360,934	29
30	Semi-private room charges (excluding swing-bed charges)	30,725,870	30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.760961	31
32	Average private room per diem charge (line 29 ÷ line 3)	1,069.92	32
33	Average semi-private room per diem charge (line 30 ÷ line 4)	966.40	33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)	103.52	34
35	Average per diem private room cost differential (line 34 x line 31)	78.77	35
36	Private room cost differential adjustment (line 3 x line 35)	100,195	36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	24,316,608	37

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2017 To: 05/31/2018	Run Date: 09/26/2018 Run Time: 16:30 Version: 2018.04 (08/06/2018)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 26-3028** **WORKSHEET D-1 PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS					1	
38	Adjusted general inpatient routine service cost per diem (see instructions)					735.40	38
39	Program general inpatient routine service cost (line 9 x line 38)					3,946,892	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)					3,946,892	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
						1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					2,259,162	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					6,206,054	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					526,127	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					156,670	51
52	Total Program excludable cost (sum of lines 50 and 51)					682,797	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 26-3028** **WORKSHEET D-1**
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)						87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 26-3028** **WORKSHEET D-3**

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		12,230,367		30
	ANCILLARY SERVICE COST CENTERS				
54	Radiology-Diagnostic				54
54.01	RADIOLOGY-SUA	0.108930	371,576	40,476	54.01
60	Laboratory	0.539307	645,133	347,925	60
60.01	LAB - SUA	0.386449	427,929	165,373	60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	1.304890	237,062	309,340	65
66	Physical Therapy	0.474821	3,040,356	1,443,625	66
67	Occupational Therapy	0.326679	3,175,449	1,037,353	67
68	Speech Pathology	0.376006	1,262,662	474,768	68
71	Medical Supplies Charged to Patients	2.422446	208,143	504,215	71
73	Drugs Charged to Patients	0.312246	3,759,523	1,173,896	73
76	PSYCHOLOGY				76
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
92	Observation Beds (Non-Distinct Part)				92
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		13,127,833	5,496,971	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		13,127,833		202

(A) Worksheet A line numbers

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2017 To: 05/31/2018	Run Date: 09/26/2018 Run Time: 16:30 Version: 2018.04 (08/06/2018)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 26-3028** **WORKSHEET D-3**

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		5,208,428		30
	ANCILLARY SERVICE COST CENTERS				
54	Radiology-Diagnostic				54
54.01	RADIOLOGY-SUA	0.108930	138,266	15,061	54.01
60	Laboratory	0.539307	105,282	56,779	60
60.01	LAB - SUA	0.386449	168,542	65,133	60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	1.304890	185,427	241,962	65
66	Physical Therapy	0.474821	1,244,676	590,998	66
67	Occupational Therapy	0.326679	1,263,350	412,710	67
68	Speech Pathology	0.376006	551,006	207,182	68
71	Medical Supplies Charged to Patients	2.422446	73,363	177,718	71
73	Drugs Charged to Patients	0.312246	1,574,462	491,619	73
76	PSYCHOLOGY				76
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
92	Observation Beds (Non-Distinct Part)				92
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		5,304,374	2,259,162	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		5,304,374		202

(A) Worksheet A line numbers

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2017 To: 05/31/2018	Run Date: 09/26/2018 Run Time: 16:30 Version: 2018.04 (08/06/2018)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 26-3028** **WORKSHEET E PART B**

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	OPPS payments				3
4	Outlier payment (see instructions)				4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (see instructions)				21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)				26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)				27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)				30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)				32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)				34
35	Adjusted reimbursable bad debts (see instructions)				35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)				36
37	Subtotal (see instructions)				37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)				40
40.01	Sequestration adjustment (see instructions)				40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments				41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)				43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2017 To: 05/31/2018	Run Date: 09/26/2018 Run Time: 16:30 Version: 2018.04 (08/06/2018)

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 26-3028** **WORKSHEET E-1 PART I**

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

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				20,682,044			1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		Provider	.52					3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99					3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				20,682,044			4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due)		.01					6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)							7
8	Name of Contractor			Contractor Number		NPR Date (Month/Day/Year)		8

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

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2017 To: 05/31/2018	Run Date: 09/26/2018 Run Time: 16:30 Version: 2018.04 (08/06/2018)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 26-3028** **WORKSHEET E-3 PART III**

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

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

		1	1.01	
1	Net Federal PPS payment (see instructions)	18,556,086		1
2	Medicare SSI ratio (IRF PPS only) (see instructions)	0.071900		2
3	Inpatient Rehabilitation LIP payments (see instructions)	1,773,962		3
4	Outlier payments	7,141		4
5	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	4.37		5
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) OR (2)			5.01
6	New teaching program adjustment (see instructions)			6
7	Current year unweighted FTE count of I&R excludnig FTEs in the new program growth period of a 'new teaching program' (see instructions)	5.87		7
8	Current year unweighted I&R FTE count for residents within the new program growth period of a 'new teaching program' (see instructions)			8
9	Intern and resident count for IRF PPS medical education adjustment (see instructions)	4.37		9
10	Average daily census (see instructions)	90.591781		10
11	Teaching Adjustment Factor (see instructions)	0.049043		11
12	Teaching Adjustment (see instructions)	910,046		12
13	Total PPS Payment (see instructions)	21,247,235		13
14	Nursing and allied health managed care payments (see instructions)			14
15	Organ acquisition DO NOT USE THIS LINE			15
16	Cost of physicians' services in a teaching hospital (see instructions)			16
17	Subtotal (see instructions)	21,247,235		17
18	Primary payer payments	755		18
19	Subtotal (line 17 less line 18)	21,246,480		19
20	Deductibles	235,405		20
21	Subtotal (line 19 minus line 20)	21,011,075		21
22	Coinsurance	198,223		22
23	Subtotal (line 21 minus line 22)	20,812,852		23
24	Allowable bad debts (exclude bad debts for professional services) (see instructions)	183,579		24
25	Adjusted reimbursable bad debts (see instructions)	119,326		25
26	Allowable bad debts for dual eligible beneficiaries (see instructions)	143,917		26
27	Subtotal (sum of lines 23 and 25)	20,932,178		27
28	Direct graduate medical education payments (from Wkst. E-4, line 49) (For free standing IRF only)			28
29	Other pass through costs (see instructions)			29
30	Outlier payments reconciliation			30
31	Other adjustments (specify) (see instructions)			31
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			31.50
32	Total amount payable to the provider (see instructions)	20,932,178		32
32.01	Sequestration adjustment (see instructions)	418,644		32.01
32.02	Demonstration payment adjustment amount after sequestration			32.02
33	Interim payments	20,682,044		33
34	Tentative settlement (for contractor use only)			34
35	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33 and 34)	-168,510		35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	602,404		36

TO BE COMPLETED BY CONTRACTOR

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

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2017 To: 05/31/2018	Run Date: 09/26/2018 Run Time: 16:30 Version: 2018.04 (08/06/2018)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 26-3028** **WORKSHEET E-3 PART VII**

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

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	6,206,054		1
2	Medical and other services		36,522	2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	6,206,054	36,522	4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	6,206,054	36,522	7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges	5,304,374	82,737	9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)	5,304,374	82,737	12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahrge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)	5,304,374	82,737	16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		46,215	17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	901,680		18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)	5,304,374	36,522	21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)	5,304,374	36,522	29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)	901,680		30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	5,304,374	36,522	31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)	5,304,374	36,522	36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	5,304,374	36,522	38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)	5,304,374	36,522	40
41	Interim payments	4,983,349	83,378	41
42	Balance due provider/program (line 40 minus line 41)	321,025	-46,856	42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

BALANCE SHEET **WORKSHEET G**

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

	Assets	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	4,253,676				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	11,805,955				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-4,103,497				6
7	Inventory	363,693				7
8	Prepaid expenses	7,763				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	12,327,590				11
	FIXED ASSETS					
12	Land					12
13	Land improvements	20,740				13
14	Accumulated depreciation					14
15	Buildings	22,426,833				15
16	Accumulated depreciation	-12,478,603				16
17	Leasehold improvements	6,801,394				17
18	Accumulated depreciation	-663,989				18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	8,853,580				23
24	Accumulated depreciation	-5,534,404				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	19,425,551				30
	OTHER ASSETS					
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	479,632				34
35	Total other assets (sum of lines 31-34)	479,632				35
36	Total assets (sum of lines 11, 30 and 35)	32,232,773				36

	Liabilities and Fund Balances	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable	1,574,486				37
38	Salaries, wages and fees payable	1,730,530				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)					40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	116,024				44
45	Total current liabilities (sum of lines 37 thru 44)	3,421,040				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	15,540,906				49
50	Total long term liabilities (sum of lines 46 thru 49)	15,540,906				50
51	Total liabilities (sum of lines 45 and 50)	18,961,946				51
	CAPITAL ACCOUNTS					
52	General fund balance	13,270,827				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	13,270,827				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	32,232,773				60

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2017 To: 05/31/2018	Run Date: 09/26/2018 Run Time: 16:30 Version: 2018.04 (08/06/2018)

STATEMENT OF CHANGES IN FUND BALANCES **WORKSHEET G-1**

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	Fund balances at beginning of period		10,272,603			1
2	Net income (loss) (from Worksheet G-3, line 29)		-614,961			2
3	Total (sum of line 1 and line 2)		9,657,642			3
4	Additions (credit adjustments) (specify)					4
5						5
6	DISTRIBUTION	3,305,705				6
7	MINORITY INTEREST	307,480				7
8						8
9						9
10	Total additions (sum of lines 4-9)		3,613,185			10
11	Subtotal (line 3 plus line 10)		13,270,827			11
12	Deductions (debit adjustments) (specify)					12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		13,270,827			19

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	32,086,804		32,086,804	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility				7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	32,086,804		32,086,804	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit				11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)				16
17	Total inpatient routine care services (sum of lines 10 and 16)	32,086,804		32,086,804	17
18	Ancillary services	33,757,392	8,395,113	42,152,505	18
19	Outpatient services				19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	Other (specify)				27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	65,844,196	8,395,113	74,239,309	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		45,352,524	29
30	Add (specify)			30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)			37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		45,352,524	43

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	74,239,309	1
2	Less contractual allowances and discounts on patients' accounts	31,436,733	2
3	Net patient revenues (line 1 minus line 2)	42,802,576	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	45,352,524	4
5	Net income from service to patients (line 3 minus line 4)	-2,549,948	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments	79,733	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts	35	10
11	Rebates and refunds of expenses		11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests	1,141	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients	10,256	17
18	Revenue from sale of medical records and abstracts		18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hosptial space	42,975	22
23	Governmental appropriations		23
24	Other (specify)		24
24.01	Other (MISC INCOME)	-2,439	24.01
24.02	Other (PROVIDER TAX)	1,843,993	24.02
24.03	Other (LOSS ON SALE OF ASSET)	-52,895	24.03
24.04	Other (ADDITIONAL RENT)	553	24.04
24.05	Other (PROVIDER TAX)	11,643	24.05
24.06	Other (MISC INCOME)	-8	24.06
25	Total other income (sum of lines 6-24)	1,934,987	25
26	Total (line 5 plus line 25)	-614,961	26
29	Net income (or loss) for the period (line 26 minus line 28)	-614,961	29