



COMPU-MAX

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2013 To: 05/31/2014	Run Date: 10/24/2014 Run Time: 09:15 Version: 2014.03
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

WORKSHEET S
PARTS I, II & III

PART I - COST REPORT STATUS

PROVIDER USE ONLY	1. <input checked="" type="checkbox"/> ELECTRONICALLY FILED COST REPORT		DATE: 10/24/2014	TIME: 09:15
	2. <input type="checkbox"/> MANUALLY SUBMITTED COST REPORT			
	3. <input type="checkbox"/> IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THE COST REPORT			
	4. <input checked="" type="checkbox"/> MEDICARE UTILIZATION. ENTER 'F' FOR FULL OR 'L' FOR LOW.			
CONTRACTOR USE ONLY	5. <input type="checkbox"/> COST REPORT STATUS	6. DATE RECEIVED: _____	10. NPR DATE: _____	
	1 -AS SUBMITTED	7. CONTRACTOR NO: _____	11. CONTRACTOR'S VENDOR CODE: _____	
	2 -SETTLED WITHOUT AUDIT	8. <input type="checkbox"/> INITIAL REPORT FOR THIS PROVIDER CCN	12. <input type="checkbox"/> IF LINE 5, COLUMN 1 IS 4: ENTER NUMBER OF TIMES REOPENED = 0-9.	
	3 -SETTLED WITH AUDIT	9. <input type="checkbox"/> FINAL REPORT FOR THIS PROVIDER CCN		
	4 -REOPENED			
	5 -AMENDED			

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE 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 06/01/2013 AND ENDING 05/31/2014, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

(SIGNED) _____
OFFICER OR ADMINISTRATOR OF PROVIDER(S)

TITLE

DATE

PART III - SETTLEMENT SUMMARY

		TITLE XVIII			HIT	TITLE XIX	
		TITLE V	PART A	PART B			
		1	2	3	4	5	
1	HOSPITAL		-151,060			-42,757	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		-151,060			-42,757	200

THE ABOVE AMOUNTS REPRESENT 'DUE TO' OR 'DUE FROM' THE APPLICABLE PROGRAM FOR THE ELEMENT OF THE ABOVE COMPLEX INDICATED.

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A VALID OMB CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED 673 HOURS PER RESPONSE, INCLUDING THE TIME TO REVIEW INSTRUCTIONS, SEARCH EXISTING RESOURCES, GATHER THE DATA NEEDED, AND COMPLETE AND REVIEW THE INFORMATION COLLECTION. IF YOU HAVE ANY COMMENTS CONCERNING THE ACCURACY OF THE TIME ESTIMATE(S) OR SUGGESTIONS FOR IMPROVING THIS FORM, PLEASE WRITE TO: CMS, 7500 SECURITY BOULEVARD, ATTN: PRA REPORT CLEARANCE OFFICER, MAIL STOP C4-26-05, BALTIMORE, MARYLAND 21244-1850.



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:														
1	Street: 4455 DUNCAN AVENUE	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 / 2013	To: 05 / 31 / 2014							20				
21	Type of control (see instructions)	5								21				
Inpatient PPS Information														
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				
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 col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.									24				
25	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.							4,572	624	1,172	504	615		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 in effect in the cost reporting period.									37				
38	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				Beginning:		Ending:			38				
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)							N	N	39				



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		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 Worksheet L, Part III and L-1, Parts I through 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 Worksheet E-4. If column 2 is 'N', complete Worksheet D, Part III & IV and D-2, Part II, if applicable.	N	N		57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub 15-1, section 2148? If yes, complete Worksheet D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	N			60
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06
Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.					
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count
		1	2	3	4
Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.					
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					
62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				62
62.01	Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost reporting period of HRSA THC program. (see instructions)				62.01
Teaching Hospitals that Claim Residents in Non-Provider Settings					
63	Has your facility trained residents in non-provider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64-67. (see instructions)	N			63



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WORKSHEET S-2
PART I

Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings-This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	RATIO (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						64
Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)							
	Program Name	Program Code		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4)	
	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 non-provider 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 Facility PPS				1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.			N			70
71	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5.						71
Inpatient Rehabilitation Facility PPS				1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.			Y			75
76	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5.			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
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



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WORKSHEET S-2
PART I

		V	XIX	
Title V and XIX Services		1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92
93	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97
Rural Providers		1	2	
105	Does this hospital qualify as a Critical Access Hospital (CAH)?	N		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106
107	Column 1: 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. If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes, complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter 'Y' for yes or 'N' for no in column 2.			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
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.	N	Physical Occupational Speech Respiratory	109
Miscellaneous Cost Reporting Information				
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If 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'	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:	111,325	185,185	118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.	N	N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.	N		121
Transplant Center Information				
125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.	N		125
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			129
130	If this is a Medicare certified pancreas transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			131
132	If this is a Medicare certified islet transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.			134



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WORKSHEET S-2
PART I

All Providers						
		1	2			
140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)	Y	019005		140	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.						
141	Name: HEALTHSOUTH CORPORATION	Contractor's Name: CAHABA GBA		Contractor's Number: 10101		
142	Street: 3660 GRANDVIEW PKWY, SUITE 200	P.O. Box:				
143	City: BIRMINGHAM	State: AL	ZIP Code: 35243			
144	Are provider based physicians' costs included in Worksheet A?	Y			144	
145	If costs for renal services are claimed on Worksheet A, line 74 are they costs for inpatient services only? Enter 'Y' for yes, or 'N' for no.	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, section 4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.	N			146	
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N			147	
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N			148	
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	N			149	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter 'Y' for yes or 'N' for no for each component for Part A and Part B. See 42 CFR §413.13)						
		Title XVIII		Title V	Title XIX	
		Part A	Part B	2	3	
155	Hospital	N	N		N	
156	Subprovider - IPF	N	N			
157	Subprovider - IRF	N	N			
158	Surpvodier - Other					
159	SNF	N	N			
160	HHA	N	N			
161	CMHC		N			
161.10	CORF					
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.				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	
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transitional 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	



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

GENERAL INSTRUCTION: ENTER Y FOR ALL YES RESPONSES. ENTER N FOR ALL NO RESPONSES.
ENTER ALL DATES IN THE MM/DD/YYYY FORMAT.

COMPLETED BY ALL HOSPITALS

		Y/N	DATE		
PROVIDER ORGANIZATION AND OPERATION		1	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
FINANCIAL DATA AND REPORTS		Y/N	TYPE	DATE	
		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	02/20/2014	4
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N			5
APPROVED EDUCATIONAL ACTIVITIES		Y/N	Y/N		
		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 INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N			9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N			10
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N			11
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
		1	2	3	4
PS&R REPORT DATA					
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (see instructions)	N		Y	08/15/2014
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	08/15/2014	N	
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N	
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N	
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS: SPLIT CHARGES FOR SERVICES UNDER ARR	Y		N	
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

GENERAL INSTRUCTION: ENTER Y FOR ALL YES RESPONSES. ENTER N FOR ALL NO RESPONSES.
ENTER ALL DATES IN THE MM/DD/YYYY FORMAT.

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

CAPITAL RELATED COSTS			
22	HAVE ASSETS BEEN RELIEFED 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 CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		27
INTEREST EXPENSE			
28	WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		28
29	DID THE PROVIDER HAVE A FUNDED DEPRECIATION ACCOUNT AND/OR BOND FUNDS (debt service reserve fund) TREATED AS A FUNDED DEPRECIATION ACCOUNT? IF YES, SEE INSTRUCTIONS.		29
30	HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS.		30
31	HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS.		31
PURCHASED SERVICES			
32	HAVE CHANGES OR NEW AGREEMENTS OCCURRED IN PATIENT CARE SERVICES FURNISHED THROUGH CONTRACTUAL ARRANGEMENTS WITH SUPPLIERS OF SERVICES? IF YES, SEE INSTRUCTIONS.		32
33	IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS.		33
PROVIDER-BASED PHYSICIANS			
34	ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIANS? IF YES, SEE INSTRUCTIONS.		34
35	IF LINE 34 IS YES, WERE THERE NEW AGREEMENTS OR AMENDED EXISTING AGREEMENTS WITH THE PROVIDER-BASED PHYSICIANS DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		35
HOME OFFICE COSTS		Y/N	DATE
36	WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT?	1	2
37	IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.		
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.		
39	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO OTHER CHAIN COMPONENTS? IF YES, SEE INSTRUCTIONS.		
40	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.		
COST REORT PREPARER INFORMATION			
41	FIRST NAME: JIM	LAST NAME: WYATT	TITLE: SR REIMBURSEMENT SPECIALIS
42	EMPLOYER: HEALTHSOUTH CORPORATION		
43	PHONE NUMBER: 205-969-8265	E-MAIL ADDRESS: JAMES.WYATT@HEALTHSOUTH.COM	



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	COMPONENT	WKST A LINE NO.	NO. OF BEDS	BED DAYS AVAILABLE	CAH HOURS	INPATIENT DAYS/OUTPATIENT VISITS/TRIPS				
						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	96	35,040			11,983	4,797	28,860	1
2	HMO AND OTHER (see instructions)						1,712	2,690		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)		96	35,040			11,983	4,797	28,860	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)		96	35,040			11,983	4,797	28,860	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)		96							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 DAYS (see instructions)									32
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)									32.01
33	LTCH NON-COVERED DAYS									33



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	COMPONENT	FULL TIME EQUIVALENTS			DISCHARGES				
		TOTAL INTERNS & RESIDENTS	EMPLOYEES ON PAYROLL	NONPAID WORKERS	TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		9	10	11	12	13	14	15	
1	HOSPITAL ADULTS & PEDS. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					924	323	2,002	1
2	HMO AND OTHER (see instructions)					129			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)	5.79	330.15			924	323	2,002	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)	5.79	330.15						27
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)								32



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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

PART II - WAGE DATA

	WKST A LINE NO.	AMOUNT REPORTED	RECLASSIF- ICATION OF SALARIES (from Worksheet A-6)	ADJUSTED SALARIES (column 2 ± column 3)	PAID HOURS RELATED TO SALARIES IN COLUMN 4	AVERAGE HOURLY WAGE (column 4 ± column 5)	
	1	2	3	4	5	6	
SALARIES							
1	200	17,975,524			686,712.00		1
2							2
3							3
4							4
4.01							4.01
5							5
6							6
7	21						7
7.01							7.01
8							8
9	44						9
10			6,489		166.40		10
OTHER WAGES & RELATED COSTS							
11		264,513			5,898.00		11
12							12
13		389,012			3,149.00		13
14		1,736,360			20,608.45		14
15							15
16							16
WAGE-RELATED COSTS							
17		3,195,743					17
18							18
19		1,154					19
20							20
21							21
22							22
22.01							22.01
23							23
24							24
25							25
OVERHEAD COSTS - DIRECT SALARIES							
26							26
27		2,690,512	-6,489		91,915.20		27
28							28
29							29
30		280,112			13,062.40		30
31							31
32		334,628			27,331.20		32
33							33
34		545,860			38,272.00		34
35							35
36							36
37							37
38		625,987			18,948.80		38
39							39
40							40
41		261,990			11,876.80		41
42		527,495			20,280.00		42
43							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (see instructions)		17,975,524		17,975,524	686,712.00	26.18	1
2	EXCLUDED AREA SALARIES (see instructions)			6,489	6,489	166.40	39.00	2
3	SUBTOTAL SALARIES (line 1 minus line 2)		17,975,524	-6,489	17,969,035	686,545.60	26.17	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (see instructions)		2,389,885		2,389,885	29,655.45	80.59	4
5	SUBTOTAL WAGE-RELATED COSTS (see instructions)		3,195,743		3,195,743		17.78%	5
6	TOTAL (sum of lines 3 through 5)		23,561,152	-6,489	23,554,663	716,201.05	32.89	6
7	TOTAL OVERHEAD COST (see instructions)		5,266,584	-6,489	5,260,095	221,686.40	23.73	7



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HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3

PART IV - WAGE RELATED COST

PART IV

PART A - CORE LIST

		AMOUNT REPORTED	
	RETIREMENT COST		
1	401K EMPLOYER CONTRIBUTIONS	249,645	1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3	NONQUALIFIED DEFINED BENEFIT PLAN COST (see instructions)		3
4	QUALIFIED DEFINED BENEFIT PLAN COST (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA PLAN ADMINISTRATION FEES		5
6	LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7	EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
	HEALTH AND INSURANCE COST		
8	HEALTH INSURANCE (Purchased or Self Funded)	1,906,776	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN		10
11	LIFE INSURANCE (If employee is owner or beneficiary)	39,659	11
12	ACCIDENTAL 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	128,958	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	1,308,578	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE		19
20	STATE OR FEDERAL UNEMPLOYMENT TAXES	242,620	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	-679,339	22
23	TUITION REIMBURSEMENT		23
24	TOTAL WAGE RELATED COST (Sum of lines 1-23)	3,196,897	24

PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE REL		25
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WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3, Part IV, Line 4)

EXHIBIT 3

STEP 2: DETERMINE THE 3-YEAR AVERAGING PERIOD			
1	WAGE INDEX FISCAL YEAR ENDING DATE		1
2	PROVIDER'S COST REPORTING PERIOD USED FOR WAGE INDEX YEAR ON LINE 1 (FYB in Col. 1, FYE in Col. 2)		2
3	MIDPOINT OF PROVIDER'S COST REPORTING PERIOD SHOWN ON LINE 2, ADJUSTED TO FIRST OF MONTH		3
4	DATE BEGINNING THE 3-YEAR AVERAGING PERIOD (subtract 18 months from midpoint shown on Line 3)		4
5	DATE ENDING THE 3-YEAR AVERAGING PERIOD (add 18 months to midpoint shown on Line 3)		5
STEP 2 (OPTIONAL): ADJUST AVERAGING PERIOD FOR A NEW PLAN (see instructions)			
6	EFFECTIVE DATE OF PENSION PLAN		6
7	FIRST DAY OF THE PROVIDER COST REPORTING PERIOD CONTAINING THE PENSION PLAN EFFECTIVE DATE		7
8	STARTING DATE OF THE ADJUSTED AVERAGING PERIOD (date on Line 7, adjusted to first of month)		8

IF THIS DATE OCCURS AFTER THE PERIOD SHOWN ON LINE 2, STOP HERE AND SEE INSTRUCTIONS

STEP 3: AVERAGE PENSION CONTRIBUTIONS DURING THE AVERAGING PERIOD			
9	BEGINNING DATE OF AVERAGING PERIOD FROM LINE 4 OR LINE 8, AS APPLICABLE		9
10	ENDING DATE OF AVERAGING PERIOD FROM LINE 5		10
11	ENTER PROVIDER CONTRIBUTIONS MADE DURING AVERAGING PERIOD ON LINES 9 & 10	DEPOSIT DATE(S)	CONTRIBUTION(S) 11
12	TOTAL CALENDAR MONTHS INCLUDED IN AVERAGING PERIOD (36 unless Step 2 completed)		12
13	TOTAL CONTRIBUTIONS MADE DURING AVERAGING PERIOD		13
14	AVERAGE MONTHLY CONTRIBUTION (Line 13 divided by Line 12)		14
15	NUMBER OF MONTHS IN PROVIDER COST REPORTING PERIOD ON LINE 2		15
16	AVERAGE PENSION CONTRIBUTIONS (Line 14 times Line 15)		16
STEP 4: TOTAL PENSION COST FOR WAGE INDEX			
17	ANNUAL PREFUNDING INSTALLMENT (see instructions)		17
18	REPORTABLE PREFUNDING INSTALLMENT ((Line 17 times Line 15) divided by 12)		18
19	TOTAL PENSION COST FOR WAGE INDEX (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)		19



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HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT	CONTRACT LABOR	BENEFIT COST	
	0	1	2	
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST	264,513	3,196,897	1
2	HOSPITAL	264,513	3,195,743	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		1,154	18



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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	CAP REL COSTS-BLDG & FIXT		1,425,751	1,425,751	116,155	1,541,906	92,649	1,634,555	1
2	00200	CAP REL COSTS-MVBLE EQUIP		638,247	638,247	31,585	669,832	-9,081	660,751	2
3	00300	OTHER CAP REL COSTS		113,035	113,035	-113,035			-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT		3,742,721	3,742,721		3,742,721	-573,889	3,168,832	4
5	00500	ADMINISTRATIVE & GENERAL	2,690,512	7,608,747	10,299,259	-774,677	9,524,582	-2,484,113	7,040,469	5
6	00600	MAINTENANCE & REPAIRS								6
7	00700	OPERATION OF PLANT	280,112	755,692	1,035,804	170,360	1,206,164	-189,311	1,016,853	7
8	00800	LAUNDRY & LINEN SERVICE		198,904	198,904		198,904		198,904	8
9	00900	HOUSEKEEPING	334,628	86,231	420,859		420,859		420,859	9
10	01000	DIETARY	545,860	593,625	1,139,485	-30	1,139,455	-154	1,139,301	10
11	01100	CAFETERIA						-77,890	-77,890	11
12	01200	MAINTENANCE OF PERSONNEL								12
13	01300	NURSING ADMINISTRATION	625,987	4,976	630,963		630,963	-310	630,653	13
14	01400	CENTRAL SERVICES & SUPPLY								14
15	01500	PHARMACY								15
16	01600	MEDICAL RECORDS & LIBRARY	261,990	77,069	339,059		339,059	-65	338,994	16
17	01700	SOCIAL SERVICE	527,495	13,943	541,438		541,438	-215	541,223	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 SERV COST CENTERS								
30	03000	ADULTS & PEDIATRICS	6,076,624	251,249	6,327,873	344,150	6,672,023	-98,366	6,573,657	30
		ANCILLARY SERVICE COST CENTERS								
54	05400	RADIOLOGY-DIAGNOSTIC		158,510	158,510	-93,793	64,717		64,717	54
54.01	05401	RADIOLOGY-SUA				93,793	93,793	-16,562	77,231	54.01
60	06000	LABORATORY		484,387	484,387	-1,692	482,695		482,695	60
60.01	06001	LAB - SUA				1,692	1,692		1,692	60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	RESPIRATORY THERAPY	323,872	717	324,589	-92,954	231,635	-181	231,454	65
66	06600	PHYSICAL THERAPY	2,787,405	148,666	2,936,071	89,957	3,026,028	-12,482	3,013,546	66
67	06700	OCCUPATIONAL THERAPY	2,093,082	162,282	2,255,364	19,101	2,274,465	-8,333	2,266,132	67
68	06800	SPEECH PATHOLOGY	903,418	6,192	909,610		909,610		909,610	68
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	82,115	658,066	740,181	364	740,545	-296	740,249	71
73	07300	DRUGS CHARGED TO PATIENTS	403,544	997,885	1,401,429	-261	1,401,168	-4,845	1,396,323	73
76	03550	PSYCHOLOGY	38,880	216	39,096	-39,096				76
76.01	03951	SPECIAL PROCEDURES								76.01
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
113	11300	INTEREST EXPENSE		73,725	73,725		73,725	-73,725		113
118		SUBTOTALS (sum of lines 1-117)	17,975,524	18,200,836	36,176,360	-83,381	36,092,979	-3,457,169	32,635,810	118
		NONREIMBURSABLE COST CENTERS								
192	19200	PHYSICIANS' PRIVATE OFFICES								192
194	07950	MARKETING				6,610	6,610		6,610	194
194.01	07951	GUEST MEALS								194.01
194.02	07952	CLINICAL PSYCH				76,771	76,771		76,771	194.02
200		TOTAL (sum of lines 118-199)	17,975,524	18,200,836	36,176,360		36,176,360	-3,457,169	32,719,191	200



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RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				
			COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	INSURANCE	A	CAP REL COSTS-BLDG & FIXT	1		27,417	1
2	INSURANCE	A	CAP REL COSTS-MVBLE EQUIP	2		7,288	2
3	INSURANCE	A					3
500	TOTAL RECLASSIFICATIONS					34,705	500
	CODE LETTER - A						
1	MARKETING	B	MARKETING	194	6,489	121	1
2	MARKETING	B					2
3	MARKETING	B					3
500	TOTAL RECLASSIFICATIONS				6,489	121	500
	CODE LETTER - B						
1	PHYSICIANS	C	ADULTS & PEDIATRICS	30		305,054	1
2	PHYSICIANS	C					2
500	TOTAL RECLASSIFICATIONS					305,054	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	CLINICAL PSYCHOLOGY	E	CLINICAL PSYCH	194.02		36,000	1
2	CLINICAL PSYCHOLOGY	E					2
500	TOTAL RECLASSIFICATIONS					36,000	500
	CODE LETTER - E						
1	MISC RECLASS	F	ADULTS & PEDIATRICS	30	38,880	216	1
2	MISC RECLASS	F	PHYSICAL THERAPY	66	101,939	54	2
3	MISC RECLASS	F	OCCUPATIONAL THERAPY	67	7,028	37	3
4	MISC RECLASS	F					4
5	MISC RECLASS	F					5
500	TOTAL RECLASSIFICATIONS				147,847	307	500
	CODE LETTER - F						
1	SERVICE UNDER ARRANGEMENT	G	RADIOLOGY-SUA	54.01		93,793	1
2	SERVICE UNDER ARRANGEMENT	G	LAB - SUA	60.01		1,692	2
3	SERVICE UNDER ARRANGEMENT	G					3
4	SERVICE UNDER ARRANGEMENT	G					4
500	TOTAL RECLASSIFICATIONS					95,485	500
	CODE LETTER - G						
1	CONTRACT SERVICES	H	OCCUPATIONAL THERAPY	67		12,036	1
2	CONTRACT SERVICES	H	CLINICAL PSYCH	194.02		40,771	2
3	CONTRACT SERVICES	H					3
4	CONTRACT SERVICES	H					4
500	TOTAL RECLASSIFICATIONS					52,807	500
	CODE LETTER - H						
1	OXYGEN	I	RESPIRATORY THERAPY	65		16,104	1
2	OXYGEN	I					2
3	OXYGEN	I					3
500	TOTAL RECLASSIFICATIONS					16,104	500
	CODE LETTER - I						
1	RELATED PARTY MISCODING	J	OPERATION OF PLANT	7		186,203	1
2	RELATED PARTY MISCODING	J	MEDICAL SUPPLIES CHARGED TO P	71		364	2
3	RELATED PARTY MISCODING	J					3
500	TOTAL RECLASSIFICATIONS					186,567	500
	CODE LETTER - J						
	GRAND TOTAL (INCREASES)					154,336	892,150

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



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RECLASSIFICATIONS

WORKSHEET A-6

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	INSURANCE	A					12	1
2	INSURANCE	A					12	2
3	INSURANCE	A	ADMINISTRATIVE & GENERAL	5		34,705		3
500	TOTAL RECLASSIFICATIONS					34,705		500
	CODE LETTER - A							
1	MARKETING	B						1
2	MARKETING	B	ADMINISTRATIVE & GENERAL	5	6,489	91		2
3	MARKETING	B	DIETARY	10		30		3
500	TOTAL RECLASSIFICATIONS				6,489	121		500
	CODE LETTER - B							
1	PHYSICIANS	C						1
2	PHYSICIANS	C	ADMINISTRATIVE & GENERAL	5		305,054		2
500	TOTAL RECLASSIFICATIONS					305,054		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	CLINICAL PSYCHOLOGY	E						1
2	CLINICAL PSYCHOLOGY	E	ADMINISTRATIVE & GENERAL	5		36,000		2
500	TOTAL RECLASSIFICATIONS					36,000		500
	CODE LETTER - E							
1	MISC RECLASS	F						1
2	MISC RECLASS	F						2
3	MISC RECLASS	F						3
4	MISC RECLASS	F	RESPIRATORY THERAPY	65	108,967	91		4
5	MISC RECLASS	F	PSYCHOLOGY	76	38,880	216		5
500	TOTAL RECLASSIFICATIONS				147,847	307		500
	CODE LETTER - F							
1	SERVICE UNDER ARRANGEMENT	G						1
2	SERVICE UNDER ARRANGEMENT	G						2
3	SERVICE UNDER ARRANGEMENT	G	RADIOLOGY-DIAGNOSTIC	54		93,793		3
4	SERVICE UNDER ARRANGEMENT	G	LABORATORY	60		1,692		4
500	TOTAL RECLASSIFICATIONS					95,485		500
	CODE LETTER - G							
1	CONTRACT SERVICES	H						1
2	CONTRACT SERVICES	H						2
3	CONTRACT SERVICES	H	ADMINISTRATIVE & GENERAL	5		40,771		3
4	CONTRACT SERVICES	H	PHYSICAL THERAPY	66		12,036		4
500	TOTAL RECLASSIFICATIONS					52,807		500
	CODE LETTER - H							
1	OXYGEN	I						1
2	OXYGEN	I	OPERATION OF PLANT	7		15,843		2
3	OXYGEN	I	DRUGS CHARGED TO PATIENTS	73		261		3
500	TOTAL RECLASSIFICATIONS					16,104		500
	CODE LETTER - I							
1	RELATED PARTY MISCODING	J						1
2	RELATED PARTY MISCODING	J						2
3	RELATED PARTY MISCODING	J	ADMINISTRATIVE & GENERAL	5		186,567		3
500	TOTAL RECLASSIFICATIONS					186,567		500
	CODE LETTER - J							
	GRAND TOTAL (DECREASES)				154,336	892,150		

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



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RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

	DESCRIPTION	BEGINNING BALANCES	ACQUISITIONS			DISPOSALS AND RETIRE- MENTS	ENDING BALANCE	FULLY DEPREC- IATED ASSETS	
			PURCHASES	DONATION	TOTAL				
		1	2	3	4	5	6	7	
1	LAND								1
2	LAND IMPROVEMENTS								2
3	BUILDINGS AND FIXTURES	18,337,718				5,424	18,332,294		3
4	BUILDING IMPROVEMENTS	2,861,239	136,984		136,984		2,998,223		4
5	FIXED EQUIPMENT								5
6	MOVABLE EQUIPMENT	4,149,228	1,702,141		1,702,141	10,911	5,840,458		6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (sum of lines 1-7)	25,348,185	1,839,125		1,839,125	16,335	27,170,975		8
9	RECONCILING ITEMS								9
10	TOTAL (line 7 minus line 9)	25,348,185	1,839,125		1,839,125	16,335	27,170,975		10

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

	DESCRIPTION	SUMMARY OF CAPITAL							TOTAL(1) (Sum of cols. 9 through 14)	
		DEPREC- IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL- RELATED COSTS (see instr.)			
*		9	10	11	12	13	14	15		
1	CAP REL COSTS-BLDG & FIXT	774,138	651,613						1,425,751	1
2	CAP REL COSTS-MVBLE EQUIP	299,643	338,604						638,247	2
3	TOTAL (sum of lines 1-2)	1,073,781	990,217						2,063,998	3

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

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	DESCRIPTION	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				TOTAL (sum of cols. 5 through 7)	
		GROSS ASSETS	CAPITAL- IZED LEASES	GROSS ASSETS FOR RATIO (col. 1 - col. 2)	RATIO (see instr.)	INSURANCE	TAXES	OTHER CAPITAL- RELATED COSTS			
*		9	10	11	12	13	14	15	16		
1	CAP REL COSTS-BLDG & FI	21,330,517		21,330,517	0.785048		88,738			88,738	1
2	CAP REL COSTS-MVBLE EQU	5,840,458		5,840,458	0.214952		24,297			24,297	2
3	TOTAL (sum of lines 1-2)	27,170,975		27,170,975	1.000000		113,035			113,035	3

	DESCRIPTION	SUMMARY OF CAPITAL							TOTAL(2) (sum of cols. 9 through 14)	
		DEPREC- IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL- RELATED COSTS (see instr.)			
*		9	10	11	12	13	14	15		
1	CAP REL COSTS-BLDG & FIXT	1,039,283	169,541	309,548	27,417	88,766			1,634,555	1
2	CAP REL COSTS-MVBLE EQUIP	290,554	338,604		7,288	24,305			660,751	2
3	TOTAL (sum of lines 1-2)	1,329,837	508,145	309,548	34,705	113,071			2,295,306	3

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



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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		
				COST CENTER	LINE#	WKST A-7 REF.
		1	2	3	4	5
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (chapter 2)			CAP REL COSTS-BLDG & FIXT	1	1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (chapter 2)			CAP REL COSTS-MVBLE EQUIP	2	2
3	INVESTMENT INCOME-OTHER (chapter 2)					3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (chapter 8)					4
5	REFUNDS AND REBATES OF EXPENSES (chapter 8)					5
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (chapter 8)					6
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (chapter 21)					7
8	TELEVISION AND RADIO SERVICE (chapter 21)					8
9	PARKING LOT (chapter 21)					9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-98,220			10
11	SALE OF SCRAP, WASTE, ETC. (chapter 23)					11
12	RELATED ORGANIZATION TRANSACTIONS (chapter 10)	WKST A-8-1	1,789,050			12
13	LAUNDRY AND LINEN SERVICE					13
14	CAFETERIA - EMPLOYEES AND GUESTS					14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					16
17	SALE OF DRUGS TO OTHER THAN PATIENTS					17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS					18
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)					19
20	VENDING MACHINES					20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (chapter 21)					21
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENTS					22
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		RESPIRATORY THERAPY	65	23
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		PHYSICAL THERAPY	66	24
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (chapter 21)			UTILIZATION REVIEW-SNF	114	25
26	DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1	26
27	DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2	27
28	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	28
29	PHYSICIANS' ASSISTANT					29
30	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67	30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		SPEECH PATHOLOGY	68	31
32	CAH HIT ADJ FOR DEPRECIATION AND					32
33						33
34						34
35						35
36						36
37	INTEREST	A	-15,112	INTEREST EXPENSE	113	37
37.02	DEPRECIATION	A	-1	CAP REL COSTS-MVBLE EQUIP	2	37.02
37.03	INSURANCE	A	-562,125	EMPLOYEE BENEFITS DEPARTMENT	4	37.03
37.04	INSURANCE	A	-553,985	ADMINISTRATIVE & GENERAL	5	37.04
37.05	PROPERTY TAX	A	28	CAP REL COSTS-BLDG & FIXT	1	37.05
37.06	PROPERTY TAX	A	8	CAP REL COSTS-MVBLE EQUIP	2	37.06
37.07	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-627,642	ADMINISTRATIVE & GENERAL	5	37.07
37.08	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-406	OPERATION OF PLANT	7	37.08
37.09	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-154	DIETARY	10	37.09
37.10	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-215	SOCIAL SERVICE	17	37.10
37.11	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-146	ADULTS & PEDIATRICS	30	37.11
37.12	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-181	RESPIRATORY THERAPY	65	37.12
37.13	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-9,842	PHYSICAL THERAPY	66	37.13
37.14	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-8,333	OCCUPATIONAL THERAPY	67	37.14
37.15	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-89	MEDICAL SUPPLIES CHARGED TO PATIENTS	71	37.15
37.16	PATIENT TELEPHONE	A	-60	CAP REL COSTS-MVBLE EQUIP	2	37.16
37.17	PATIENT TELEPHONE	A	-5,614	EMPLOYEE BENEFITS DEPARTMENT	4	37.17
37.18	PATIENT TELEPHONE	A	-36,591	ADMINISTRATIVE & GENERAL	5	37.18
37.19	PATIENT TELEPHONE	A	-420	OPERATION OF PLANT	7	37.19
37.20	PATIENT TELEVISION	A	-9,028	CAP REL COSTS-MVBLE EQUIP	2	37.20
37.21	PATIENT TELEVISION	A	-10,228	OPERATION OF PLANT	7	37.21
37.22	PRINTING	A	-10,231	ADMINISTRATIVE & GENERAL	5	37.22
37.23	PRINTING	A	-29	OPERATION OF PLANT	7	37.23
37.24	PRINTING	A	-2	DRUGS CHARGED TO PATIENTS	73	37.24
37.25	LOBBYING EXPENSE	A	-39	EMPLOYEE BENEFITS DEPARTMENT	4	37.25
37.26	LOBBYING EXPENSE	A	-204	ADMINISTRATIVE & GENERAL	5	37.26
37.27	MISCELLANEOUS INCOME	B	-82,127	CAP REL COSTS-BLDG & FIXT	1	37.27



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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		Wkst A-7 REF.
				COST CENTER	LINE#	
		1	2	3	4	5
37.28	MISCELLANEOUS INCOME	B	-6,326	ADMINISTRATIVE & GENERAL	5	37.28
37.29	MISCELLANEOUS INCOME	B	-77,890	CAFETERIA	11	37.29
37.30	MISCELLANEOUS INCOME	B	-65	MEDICAL RECORDS & LIBRARY	16	37.30
37.31	MISCELLANEOUS INCOME	B	-2,640	PHYSICAL THERAPY	66	37.31
37.32	MISCELLANEOUS INCOME	B	-4,673	DRUGS CHARGED TO PATIENTS	73	37.32
37.33	PATIENT TRANSPORTATION	A	-6,111	EMPLOYEE BENEFITS DEPARTMENT	4	37.33
37.34	PATIENT TRANSPORTATION	A	-96,401	ADMINISTRATIVE & GENERAL	5	37.34
37.35	PATIENT TRANSPORTATION	A	-40,502	OPERATION OF PLANT	7	37.35
37.36	PROFESSIONAL FEES	A	-169,431	ADMINISTRATIVE & GENERAL	5	37.36
37.37	MISC ADJUSTMENT	A	-2,963	ADMINISTRATIVE & GENERAL	5	37.37
37.38	CONTRACT SERVICES	A	-76,426	ADMINISTRATIVE & GENERAL	5	37.38
37.39	COMMUNITY EVENTS	A	-500	ADMINISTRATIVE & GENERAL	5	37.39
37.40	PHYSICIAN ADJUSTMENT	A	-101,306	ADMINISTRATIVE & GENERAL	5	37.40
37.41	PROVIDER TAX	A	-2,629,997	ADMINISTRATIVE & GENERAL	5	37.41
38						38
39						39
40						40
41						41
42						42
43						43
44						44
45						45
46						46
47						47
48						48
49						49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-3,457,169			50

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

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



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STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

WORKSHEET A-8-1

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

	LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT INCLUDED IN WKST. A COLUMN 5	NET ADJUSTMENTS (col. 4 minus col. 5)*	WKST. A-7 REF.	
	1	2	3	4	5	6	7	
1	5	ADMINISTRATIVE & GENERAL	TO OFFSET MANAGEMENT FEES		1,032,884	-1,032,884		1
2	1	CAP REL COSTS-BLDG & FIXT	TO INCLUDE ALLOWABLE HOME OFFICE COS	265,145		265,145	9	2
3	1	CAP REL COSTS-BLDG & FIXT	TO INCLUDE ALLOWABLE HOME OFFICE COS	391,675		391,675	11	3
3.01	5	ADMINISTRATIVE & GENERAL	TO INCLUDE ALLOWABLE HOME OFFICE COS	2,426,623		2,426,623		3.01
3.02	5	ADMINISTRATIVE & GENERAL	TO INCLUDE ALLOWABLE HOME OFFICE COS	442,389		442,389		3.02
3.03	2	CAP REL COSTS-MVBLE EQUIP	INTERCOMPANY WAGE AND EXPENSE TRANSF	6,546	6,546		10	3.03
3.04	4	EMPLOYEE BENEFITS DEPARTMENT	INTERCOMPANY WAGE AND EXPENSE TRANSF	2,624,826	2,624,826			3.04
3.05	5	ADMINISTRATIVE & GENERAL	INTERCOMPANY WAGE AND EXPENSE TRANSF	2,442,029	2,442,029			3.05
3.06	7	OPERATION OF PLANT	INTERCOMPANY WAGE AND EXPENSE TRANSF	5,705	5,705			3.06
3.07	9	HOUSEKEEPING	INTERCOMPANY WAGE AND EXPENSE TRANSF	19	19			3.07
3.08	10	DIETARY	INTERCOMPANY WAGE AND EXPENSE TRANSF	8,042	8,042			3.08
3.09	13	NURSING ADMINISTRATION	INTERCOMPANY WAGE AND EXPENSE TRANSF	90	90			3.09
3.10	16	MEDICAL RECORDS & LIBRARY	INTERCOMPANY WAGE AND EXPENSE TRANSF	25,534	25,534			3.10
3.11	17	SOCIAL SERVICE	INTERCOMPANY WAGE AND EXPENSE TRANSF	3,430	3,430			3.11
3.12	30	ADULTS & PEDIATRICS	INTERCOMPANY WAGE AND EXPENSE TRANSF	-5,168	-5,168			3.12
3.13	54	RADIOLOGY-DIAGNOSTIC	INTERCOMPANY WAGE AND EXPENSE TRANSF	-824	-824			3.13
3.14	60	LABORATORY	INTERCOMPANY WAGE AND EXPENSE TRANSF	-23	-23			3.14
3.15	66	PHYSICAL THERAPY	INTERCOMPANY WAGE AND EXPENSE TRANSF	898	898			3.15
3.16	67	OCCUPATIONAL THERAPY	INTERCOMPANY WAGE AND EXPENSE TRANSF	-4,259	-4,259			3.16
3.17	68	SPEECH PATHOLOGY	INTERCOMPANY WAGE AND EXPENSE TRANSF	2,384	2,384			3.17
3.18	71	MEDICAL SUPPLIES CHARGED TO PATIENTS	INTERCOMPANY WAGE AND EXPENSE TRANSF	-12,730	-12,730			3.18
3.19	73	DRUGS CHARGED TO PATIENTS	INTERCOMPANY WAGE AND EXPENSE TRANSF	-2,062	-2,062			3.19
3.20	113	INTEREST EXPENSE	INTERCOMPANY WAGE AND EXPENSE TRANSF	72,857	72,857		11	3.20
3.21	2	CAP REL COSTS-MVBLE EQUIP	RELATED PARTY - MOTORIKA	25,866	25,866		9	3.21
3.22	5	ADMINISTRATIVE & GENERAL	RELATED PARTY - MOTORIKA	1,605	1,605			3.22
3.23	113	INTEREST EXPENSE	INTEREST INTERCOMPANY		58,613	-58,613	11	3.23
3.24	5	ADMINISTRATIVE & GENERAL	RELATED PARTY - BJH	3,732	11,970	-8,238		3.24
3.25	7	OPERATION OF PLANT	RELATED PARTY - BJH	62,399	200,125	-137,726		3.25
3.26	13	NURSING ADMINISTRATION	RELATED PARTY - BJH	141	451	-310		3.26
3.27	54.01	RADIOLOGY-SUA	RELATED PARTY - BJH	63,261	79,823	-16,562		3.27
3.28	60.01	LAB - SUA	RELATED PARTY - BJH	298,471	298,471			3.28
3.29	71	MEDICAL SUPPLIES CHARGED TO PATIENTS	RELATED PARTY - BJH	157	364	-207		3.29
3.30	73	DRUGS CHARGED TO PATIENTS	RELATED PARTY - BJH	100	270	-170		3.30
3.31	1	CAP REL COSTS-BLDG & FIXT	RELATED PARTY - RENT		482,072	-482,072	10	3.31
4								4
5		TOTALS (SUM OF LINES 1-4) TRANSFER COLUMN 6, LINE 5 TO WORKSHEET A-8, COLUMN 2, LINE 12		9,148,858	7,359,808	1,789,050		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.



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STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

WORKSHEET A-8-1

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

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

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

SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	RELATED ORGANIZATION(S) AND/OR HOME OFFICE		
			NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS
1	2	3	4	5	6

SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	RELATED ORGANIZATION(S) AND/OR HOME OFFICE		
			NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS
1	2	3	4	5	6
6	B	50.00	HEALTHSOUTH		6
7	B	50.00	BJC HEALTHCARE		7
8	G		HEALTHSOUTH		HEALTHCARE
9	G		BARNES JEWISH CHRISTIAN HOSPIT		HEALTHCARE
9.01	G		MOTORIKA		EQUIPMENT SUPPLIER
10					10

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

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



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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN- ERATION	PROFESS- IONAL COMPON- ENT	PROVIDER COMPON- ENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPON- ENT HOURS	UNADJ- USTED RCE LIMIT	5 PERCENT OF UNADJ- USTED RCE LIMIT	
	1	2	3	4	5	6	7	8	9	
1	30	ADULTS & PEDIATRICS AGGREGATE	305,054		305,054	171,400	2,510	206,834	10,342	1
200		TOTAL	305,054		305,054		2,510	206,834	10,342	200



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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBER- SHIPS & CONTIN- UING EDUCATION	PROVIDER COMPON- ENT SHARE OF COL. 12	PHYSICIAN COST OF MALPRACT- ICE INSURANCE	PROVIDER COMPON- ENT SHARE OF COL. 14	ADJUSTED RCE LIMIT	RCE DISALLOW- ANCE	ADJUST- MENT	
	10	11	12	13	14	15	16	17	18	
1	30	ADULTS & PEDIATRICS AGGREGATE					206,834	98,220	98,220	1
200		TOTAL					206,834	98,220	98,220	200



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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS- TRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	1,634,555	1,634,555					1
2	CAP REL COSTS-MVBLE EQUIP	660,751		660,751				2
4	EMPLOYEE BENEFITS DEPARTMENT	3,168,832			3,168,832			4
5	ADMINISTRATIVE & GENERAL	7,040,469	92,956	37,576	473,156	7,644,157	7,644,157	5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	1,016,853	3,632	1,468	49,380	1,071,333	333,047	7
8	LAUNDRY & LINEN SERVICE	198,904				198,904	61,834	8
9	HOUSEKEEPING	420,859	6,721	2,717	58,990	489,287	152,106	9
10	DIETARY	1,139,301	103,037	41,652	96,227	1,380,217	429,071	10
11	CAFETERIA	-77,890				-77,890		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	630,653	5,348	2,162	110,353	748,516	232,693	13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY	338,994	9,612	3,885	46,185	398,676	123,937	16
17	SOCIAL SERVICE	541,223	4,481	1,811	92,990	640,505	199,115	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	51,294	22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	6,573,657	895,589	362,032	1,078,076	8,909,354	2,769,663	30
	ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC	64,717				64,717	20,119	54
54.01	RADIOLOGY-SUA	77,231				77,231		54.01
60	LABORATORY	482,695	2,547	1,030		486,272		60
60.01	LAB - SUA	1,692				1,692	526	60.01
62.30	BLOOD CLOTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	231,454	4,517	1,826	37,885	275,682	85,702	65
66	PHYSICAL THERAPY	3,013,546	218,577	88,357	509,351	3,829,831	1,190,587	66
67	OCCUPATIONAL THERAPY	2,266,132	148,313	59,954	370,220	2,844,619	884,312	67
68	SPEECH PATHOLOGY	909,610	47,860	19,347	159,260	1,136,077	353,175	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	740,249	49,522	20,019	14,476	824,266	256,241	71
73	DRUGS CHARGED TO PATIENTS	1,396,323	11,834	4,784	71,139	1,484,080	461,359	73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	32,635,810	1,604,546	648,620	3,167,688	32,592,526	7,604,781	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES		29,973	12,116		42,089	13,084	192
194	MARKETING	6,610	36	15	1,144	7,805	2,426	194
194.01	GUEST MEALS							194.01
194.02	CLINICAL PSYCH	76,771				76,771	23,866	194.02
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	32,719,191	1,634,555	660,751	3,168,832	32,719,191	7,644,157	202



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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	1,404,380						7
8	LAUNDRY & LINEN SERVICE		260,738					8
9	HOUSEKEEPING	6,137		647,530				9
10	DIETARY	94,087		43,572	1,946,947			10
11	CAFETERIA				522,593	444,703		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	4,883		2,261		19,700	1,008,053	13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY	8,777		4,065		8,245		16
17	SOCIAL SERVICE	4,091		1,895		16,600		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	817,800	260,738	378,726	1,354,801	192,458	1,008,053	30
	ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC							54
54.01	RADIOLOGY-SUA							54.01
60	LABORATORY	2,326		1,077				60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	4,124		1,910		6,763		65
66	PHYSICAL THERAPY	199,591		92,431		90,928		66
67	OCCUPATIONAL THERAPY	135,431		62,718		66,090		67
68	SPEECH PATHOLOGY	43,703		20,239		28,431		68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	45,221		20,942		2,584		71
73	DRUGS CHARGED TO PATIENTS	10,806		5,004		12,700		73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	1,376,977	260,738	634,840	1,877,394	444,499	1,008,053	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES	27,370		12,675				192
194	MARKETING	33		15		204		194
194.01	GUEST MEALS				69,553			194.01
194.02	CLINICAL PSYCH							194.02
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	1,404,380	260,738	647,530	1,946,947	444,703	1,008,053	202



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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	I&R PROGRAM COSTS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		16	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	543,700						16
17	SOCIAL SERVICE		862,206					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			216,294				22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	215,757	862,206	216,294	16,985,850		16,985,850	30
	ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC	2,757			87,593		87,593	54
54.01	RADIOLOGY-SUA				77,231		77,231	54.01
60	LABORATORY	11,175			500,850		500,850	60
60.01	LAB - SUA				2,218		2,218	60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	5,291			379,472		379,472	65
66	PHYSICAL THERAPY	108,227			5,511,595		5,511,595	66
67	OCCUPATIONAL THERAPY	93,415			4,086,585		4,086,585	67
68	SPEECH PATHOLOGY	37,712			1,619,337		1,619,337	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,440			1,161,694		1,161,694	71
73	DRUGS CHARGED TO PATIENTS	56,926			2,030,875		2,030,875	73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	543,700	862,206	216,294	32,443,300		32,443,300	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES				95,218		95,218	192
194	MARKETING				10,483		10,483	194
194.01	GUEST MEALS				69,553		69,553	194.01
194.02	CLINICAL PSYCH				100,637		100,637	194.02
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	543,700	862,206	216,294	32,719,191		32,719,191	202



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	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		92,956	37,576	130,532	130,532		5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT		3,632	1,468	5,100	5,687	10,787	7
8	LAUNDRY & LINEN SERVICE					1,056		8
9	HOUSEKEEPING		6,721	2,717	9,438	2,597	47	9
10	DIETARY		103,037	41,652	144,689	7,326	723	10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		5,348	2,162	7,510	3,973	38	13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY		9,612	3,885	13,497	2,116	67	16
17	SOCIAL SERVICE		4,481	1,811	6,292	3,400	31	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					876		22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		895,589	362,032	1,257,621	47,303	6,282	30
	ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC					344		54
54.01	RADIOLOGY-SUA							54.01
60	LABORATORY		2,547	1,030	3,577		18	60
60.01	LAB - SUA					9		60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		4,517	1,826	6,343	1,463	32	65
66	PHYSICAL THERAPY		218,577	88,357	306,934	20,329	1,533	66
67	OCCUPATIONAL THERAPY		148,313	59,954	208,267	15,099	1,040	67
68	SPEECH PATHOLOGY		47,860	19,347	67,207	6,030	336	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		49,522	20,019	69,541	4,375	347	71
73	DRUGS CHARGED TO PATIENTS		11,834	4,784	16,618	7,877	83	73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)		1,604,546	648,620	2,253,166	129,860	10,577	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES		29,973	12,116	42,089	223	210	192
194	MARKETING		36	15	51	41		194
194.01	GUEST MEALS							194.01
194.02	CLINICAL PSYCH					408		194.02
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)		1,634,555	660,751	2,295,306	130,532	10,787	202



COMPU-MAX

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
		8	9	10	11	13	16	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE	1,056						8
9	HOUSEKEEPING		12,082					9
10	DIETARY		813	153,551				10
11	CAFETERIA			41,216	35,073			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		42		1,554	13,117		13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY		76		650		16,406	16
17	SOCIAL SERVICE		35		1,309			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	1,056	7,067	106,850	15,180	13,117	6,503	30
	ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC						83	54
54.01	RADIOLOGY-SUA							54.01
60	LABORATORY		20				337	60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		36		533		160	65
66	PHYSICAL THERAPY		1,725		7,171		3,268	66
67	OCCUPATIONAL THERAPY		1,170		5,212		2,821	67
68	SPEECH PATHOLOGY		378		2,242		1,139	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		391		204		376	71
73	DRUGS CHARGED TO PATIENTS		93		1,002		1,719	73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	1,056	11,846	148,066	35,057	13,117	16,406	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES		236					192
194	MARKETING				16			194
194.01	GUEST MEALS			5,485				194.01
194.02	CLINICAL PSYCH							194.02
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER				6,143			201
202	TOTAL (sum of lines 118-201)	1,056	12,082	153,551	41,216	13,117	16,406	202



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	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	11,067					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		876				22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	11,067		1,472,046		1,472,046	30
	ANCLLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC			427		427	54
54.01	RADIOLOGY-SUA						54.01
60	LABORATORY			3,952		3,952	60
60.01	LAB - SUA			9		9	60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY			8,567		8,567	65
66	PHYSICAL THERAPY			340,960		340,960	66
67	OCCUPATIONAL THERAPY			233,609		233,609	67
68	SPEECH PATHOLOGY			77,332		77,332	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS			75,234		75,234	71
73	DRUGS CHARGED TO PATIENTS			27,392		27,392	73
76	PSYCHOLOGY						76
76.01	SPECIAL PROCEDURES						76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (sum of lines 1-117)	11,067		2,239,528		2,239,528	118
	NONREIMBURSABLE COST CENTERS						
192	PHYSICIANS' PRIVATE OFFICES			42,758		42,758	192
194	MARKETING			108		108	194
194.01	GUEST MEALS			5,485		5,485	194.01
194.02	CLINICAL PSYCH			408		408	194.02
200	CROSS FOOT ADJUSTMENTS		876	876		876	200
201	NEGATIVE COST CENTER			6,143		6,143	201
202	TOTAL (sum of lines 118-201)	11,067	876	2,295,306		2,295,306	202



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECONCILIATION	ADMINISTRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	90,471						1
2	CAP REL COSTS-MVBLE EQUIP		90,471					2
4	EMPLOYEE BENEFITS DEPARTMENT			17,975,524				4
5	ADMINISTRATIVE & GENERAL	5,145	5,145	2,684,023	-7,644,157	24,589,421		5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	201	201	280,112		1,071,333	85,125	7
8	LAUNDRY & LINEN SERVICE					198,904		8
9	HOUSEKEEPING	372	372	334,628		489,287	372	9
10	DIETARY	5,703	5,703	545,860		1,380,217	5,703	10
11	CAFETERIA				77,890			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	296	296	625,987		748,516	296	13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY	532	532	261,990		398,676	532	16
17	SOCIAL SERVICE	248	248	527,495		640,505	248	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	49,570	49,570	6,115,504		8,909,354	49,570	30
	ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC					64,717		54
54.01	RADIOLOGY-SUA				-77,231			54.01
60	LABORATORY	141	141		-486,272		141	60
60.01	LAB - SUA					1,692		60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	250	250	214,905		275,682	250	65
66	PHYSICAL THERAPY	12,098	12,098	2,889,344		3,829,831	12,098	66
67	OCCUPATIONAL THERAPY	8,209	8,209	2,100,110		2,844,619	8,209	67
68	SPEECH PATHOLOGY	2,649	2,649	903,418		1,136,077	2,649	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,741	2,741	82,115		824,266	2,741	71
73	DRUGS CHARGED TO PATIENTS	655	655	403,544		1,484,080	655	73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	88,810	88,810	17,969,035	-8,129,770	24,462,756	83,464	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES	1,659	1,659			42,089	1,659	192
194	MARKETING	2	2	6,489		7,805	2	194
194.01	GUEST MEALS							194.01
194.02	CLINICAL PSYCH					76,771		194.02
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	1,634,555	660,751	3,168,832		7,644,157	1,404,380	202
203	UNIT COST MULT-WS B PT I	18.067171	7.303456	0.176286		0.310872	16.497856	203
204	COST TO BE ALLOC PER B PT II					130,532	10,787	204
205	UNIT COST MULT-WS B PT II					0.005308	0.126720	205



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE PATIENT DAYS	HOUSE- KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA GROSS SALARIES	NURSING ADMINIS- TRATION PATIENT DAYS	MEDICAL RECORDS & LIBRARY GROSS REVENUE	
		8	9	10	11	13	16	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE	28,860						8
9	HOUSEKEEPING		84,753					9
10	DIETARY		5,703	124,426				10
11	CAFETERIA			33,398	14,130,901			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		296		625,987	28,860		13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY		532		261,990		62,194,665	16
17	SOCIAL SERVICE		248		527,495			17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	28,860	49,570	86,583	6,115,504	28,860	24,681,012	30
	ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC						315,390	54
54.01	RADIOLOGY-SUA							54.01
60	LABORATORY		141				1,278,330	60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		250		214,905		605,250	65
66	PHYSICAL THERAPY		12,098		2,889,344		12,380,125	66
67	OCCUPATIONAL THERAPY		8,209		2,100,110		10,685,758	67
68	SPEECH PATHOLOGY		2,649		903,418		4,313,902	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		2,741		82,115		1,423,067	71
73	DRUGS CHARGED TO PATIENTS		655		403,544		6,511,831	73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	28,860	83,092	119,981	14,124,412	28,860	62,194,665	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES		1,659					192
194	MARKETING		2		6,489			194
194.01	GUEST MEALS			4,445				194.01
194.02	CLINICAL PSYCH							194.02
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	260,738	647,530	1,946,947	444,703	1,008,053	543,700	202
203	UNIT COST MULT-WS B PT I	9.034581	7.640202	15.647429	0.031470	34.929071	0.008742	203
204	COST TO BE ALLOC PER B PT II	1,056	12,082	153,551	35,073	13,117	16,406	204
205	UNIT COST MULT-WS B PT II	0.036590	0.142555	1.234075	0.002482	0.454505	0.000264	205



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTIONS	SOCIAL SERVICE	I&R PROGRAM COSTS ASSIGNED TIME
	PATIENT DAYS	
	17	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	28,860			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	28,860	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
76.01	SPECIAL PROCEDURES				76.01
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS					
92	OBSERVATION BEDS (NON-DISTINCT PART)				92
OTHER REIMBURSABLE COST CENTERS					
SPECIAL PURPOSE COST CENTERS					
118	SUBTOTALS (sum of lines 1-117)	28,860	100		118
NONREIMBURSABLE COST CENTERS					
192	PHYSICIANS' PRIVATE OFFICES				192
194	MARKETING				194
194.01	GUEST MEALS				194.01
194.02	CLINICAL PSYCH				194.02
200	CROSS FOOT ADJUSTMENTS				200
201	NEGATIVE COST CENTER				201
202	COST TO BE ALLOC PER B PT I	862,206	216,294		202
203	UNIT COST MULT-WS B PT I	29,875,468	2,162,940,000		203
204	COST TO BE ALLOC PER B PT II	11,067	876		204
205	UNIT COST MULT-WS B PT II	0.383472	8.760000		205



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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		
		PART	LINE NO.	AMOUNT
	1	2	3	4



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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	COSTS					
		TOTAL COST (from Wkst. B, Part I, col. 26)	THERAPY LIMIT ADJ.	TOTAL COSTS	RCE DISALLOW- ANCE	TOTAL COSTS	
		1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	16,985,850		16,985,850	98,220	17,084,070	30
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC	87,593		87,593		87,593	54
54.01	RADIOLOGY-SUA	77,231		77,231		77,231	54.01
60	LABORATORY	500,850		500,850		500,850	60
60.01	LAB - SUA	2,218		2,218		2,218	60.01
62.30	BLOOD CLOTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	379,472		379,472		379,472	65
66	PHYSICAL THERAPY	5,511,595		5,511,595		5,511,595	66
67	OCCUPATIONAL THERAPY	4,086,585		4,086,585		4,086,585	67
68	SPEECH PATHOLOGY	1,619,337		1,619,337		1,619,337	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,161,694		1,161,694		1,161,694	71
73	DRUGS CHARGED TO PATIENTS	2,030,875		2,030,875		2,030,875	73
76	PSYCHOLOGY						76
76.01	SPECIAL PROCEDURES						76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
113	INTEREST EXPENSE						113
200	SUBTOTAL (SEE INSTRUCTIONS)	32,443,300		32,443,300	98,220	32,541,520	200
201	LESS OBSERVATION BEDS						201
202	TOTAL (SEE INSTRUCTIONS)	32,443,300		32,443,300		32,541,520	202



COMPU-MAX

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2013 To: 05/31/2014	Run Date: 10/24/2014 Run Time: 09:15 Version: 2014.03
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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	CHARGES			COST OR OTHER RATIO	TEFRA INPATIENT RATIO	PPS INPATIENT RATIO	
		INPATIENT	OUTPATIENT	TOTAL (column 6 + column 7)				
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	24,681,012		24,681,012				30
	ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC	94,915		94,915	0.922857	0.922857	0.922857	54
54.01	RADIOLOGY-SUA	317,443		317,443	0.243291	0.243291	0.243291	54.01
60	LABORATORY	1,276,239	435	1,276,674	0.392308	0.392308	0.392308	60
60.01	LAB - SUA	3,382		3,382	0.655825	0.655825	0.655825	60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	604,023	1,227	605,250	0.626967	0.626967	0.626967	65
66	PHYSICAL THERAPY	6,921,872	5,458,253	12,380,125	0.445197	0.445197	0.445197	66
67	OCCUPATIONAL THERAPY	6,936,158	3,749,600	10,685,758	0.382433	0.382433	0.382433	67
68	SPEECH PATHOLOGY	2,855,416	1,458,486	4,313,902	0.375376	0.375376	0.375376	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	431,250	991,817	1,423,067	0.816331	0.816331	0.816331	71
73	DRUGS CHARGED TO PATIENTS	6,511,831		6,511,831	0.311875	0.311875	0.311875	73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
113	INTEREST EXPENSE							113
200	SUBTOTAL (SEE INSTRUCTIONS)	50,633,541	11,659,818	62,293,359				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	50,633,541	11,659,818	62,293,359				202



COMPU-MAX

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2013 To: 05/31/2014	Run Date: 10/24/2014 Run Time: 09:15 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

CHECK TITLE V PPS
 APPLICABLE TITLE XVIII, PART A TEFRA
 BOXES: TITLE XIX

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26))	SWING BED ADJUSTMENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
	INPATIENT ROUTINE SERV COST CENTERS	1	2	3	4	5	6	7	
30	ADULTS & PEDIATRICS (General Routine Care)	1,472,046		1,472,046	28,860	51.01	11,983	611,253	30
31	INTENSIVE CARE UNIT								31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT								34
35	OTHER SPECIAL CARE (SPECIFY)								35
40	SUBPROVIDER - IPF								40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY								43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	1,472,046		1,472,046	28,860		11,983	611,253	200

(A) Worksheet A line numbers



COMPU-MAX

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2013 To: 05/31/2014	Run Date: 10/24/2014 Run Time: 09:15 Version: 2014.03
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 26-3028

WORKSHEET D
PART II

CHECK TITLE V HOSPITAL SUB (OTHER) PPS
 APPLICABLE TITLE XVIII, PART A IPF TEFRA
 BOXES: TITLE XIX IRF

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26))	TOTAL CHARGES (from Wkst. C, Part I, (col. 8))	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC	427	94,915	0.004499	42,169	190	54
54.01	RADIOLOGY-SUA		317,443		172,304		54.01
60	LABORATORY	3,952	1,276,674	0.003096	610,116	1,889	60
60.01	LAB - SUA	9	3,382	0.002661	633	2	60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	8,567	605,250	0.014154	203,075	2,874	65
66	PHYSICAL THERAPY	340,960	12,380,125	0.027541	2,921,866	80,471	66
67	OCCUPATIONAL THERAPY	233,609	10,685,758	0.021862	2,945,240	64,389	67
68	SPEECH PATHOLOGY	77,332	4,313,902	0.017926	1,069,315	19,169	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	75,234	1,423,067	0.052868	224,683	11,879	71
73	DRUGS CHARGED TO PATIENTS	27,392	6,511,831	0.004206	2,801,414	11,783	73
76	PSYCHOLOGY						76
76.01	SPECIAL PROCEDURES						76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	767,482	37,612,347		10,990,815	192,646	200

(A) Worksheet A line numbers



COMPU-MAX

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2013 To: 05/31/2014	Run Date: 10/24/2014 Run Time: 09:15 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK TITLE V PPS
 APPLICABLE TITLE XVIII, PART A TEFRA
 BOXES: TITLE XIX

(A)	COST CENTER DESCRIPTION	NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUSTMENT AMOUNT (see instructions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)	
		1	2	3	4	5	
	INPATIENT ROUTINE SERV 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



COMPU-MAX

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2013 To: 05/31/2014	Run Date: 10/24/2014 Run Time: 09:15 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK TITLE V PPS
 APPLICABLE TITLE XVIII, PART A TEFRA
 BOXES: TITLE XIX

(A)	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS	PER DIEM (col. 5 ÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
6		7		8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	28,860		11,983		30
31	INTENSIVE CARE UNIT					31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF					40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY					43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	28,860		11,983		200

(A) Worksheet A line numbers



COMPU-MAX

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2013 To: 05/31/2014	Run Date: 10/24/2014 Run Time: 09:15 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 26-3028

WORKSHEET D
PART IV

CHECK TITLE V HOSPITAL SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII, PART A IPF SNF TEFRA
 BOXES: TITLE XIX IRF NF

(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC							54
54.01	RADIOLOGY-SUA							54.01
60	LABORATORY							60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
73	DRUGS CHARGED TO PATIENTS							73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers



COMPU-MAX

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2013 To: 05/31/2014	Run Date: 10/24/2014 Run Time: 09:15 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 26-3028

WORKSHEET D
PART IV

CHECK TITLE V HOSPITAL SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII, PART A IPF SNF TEFRA
 BOXES: TITLE XIX IRF NF

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5 ÷ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6 ÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)	
7		8		9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
54	RADIOLOGY-DIAGNOSTIC	94,915			42,169				54
54.01	RADIOLOGY-SUA	317,443			172,304				54.01
60	LABORATORY	1,276,674			610,116				60
60.01	LAB - SUA	3,382			633				60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	605,250			203,075				65
66	PHYSICAL THERAPY	12,380,125			2,921,866		110		66
67	OCCUPATIONAL THERAPY	10,685,758			2,945,240				67
68	SPEECH PATHOLOGY	4,313,902			1,069,315				68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,423,067			224,683				71
73	DRUGS CHARGED TO PATIENTS	6,511,831			2,801,414				73
76	PSYCHOLOGY								76
76.01	SPECIAL PROCEDURES								76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	OBSERVATION BEDS (NON-DISTINCT PART)								92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	37,612,347			10,990,815		110		200

(A) Worksheet A line numbers



COMPU-MAX

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2013 To: 05/31/2014	Run Date: 10/24/2014 Run Time: 09:15 Version: 2014.03
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 26-3028

WORKSHEET D
PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL [] SUB (OTHER) [] SWING BED SNF
 APPLICABLE [XX] TITLE XVIII, PART B [] IPF [] SNF [] SWING BED NF
 BOXES: [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

(A)	COST CENTER DESCRIPTION	COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PROGRAM CHARGES			PROGRAM COST		
			PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)
		1	2	3	4	5	6	7
	ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC	0.922857						54
54.01	RADIOLOGY-SUA	0.243291						54.01
60	LABORATORY	0.392308						60
60.01	LAB - SUA	0.655825						60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	0.626967						65
66	PHYSICAL THERAPY	0.445197	110			49		66
67	OCCUPATIONAL THERAPY	0.382433						67
68	SPEECH PATHOLOGY	0.375376						68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.816331						71
73	DRUGS CHARGED TO PATIENTS	0.311875						73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	SUBTOTAL (see instructions)		110			49		200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES							201
202	NET CHARGES (line 200 - line 201)		110			49		202

(A) Worksheet A line numbers



COMPU-MAX

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2013 To: 05/31/2014	Run Date: 10/24/2014 Run Time: 09:15 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

CHECK TITLE V
 APPLICABLE TITLE XVIII, PART A
 BOXES: TITLE XIX

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26))	SWING BED ADJUSTMENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
	INPATIENT ROUTINE SERV COST CENTERS	1	2	3	4	5	6	7	
30	ADULTS & PEDIATRICS (General Routine Care)	1,472,046		1,472,046	28,860	51.01	4,797	244,695	30
31	INTENSIVE CARE UNIT								31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT								34
35	OTHER SPECIAL CARE (SPECIFY)								35
40	SUBPROVIDER - IPF								40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY								43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	1,472,046		1,472,046	28,860		4,797	244,695	200

(A) Worksheet A line numbers



COMPU-MAX

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2013 To: 05/31/2014	Run Date: 10/24/2014 Run Time: 09:15 Version: 2014.03
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 26-3028

WORKSHEET D
PART II

CHECK [] TITLE V [XX] HOSPITAL [] SUB (OTHER)
 APPLICABLE [] TITLE XVIII, PART A [] IPF
 BOXES: [XX] TITLE XIX [] IRF

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26))	TOTAL CHARGES (from Wkst. C, Part I, (col. 8))	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC	427	94,915	0.004499	40,863	184	54
54.01	RADIOLOGY-SUA		317,443		4,753		54.01
60	LABORATORY	3,952	1,276,674	0.003096	137,036	424	60
60.01	LAB - SUA	9	3,382	0.002661	25		60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	8,567	605,250	0.014154	160,240	2,268	65
66	PHYSICAL THERAPY	340,960	12,380,125	0.027541	1,159,105	31,923	66
67	OCCUPATIONAL THERAPY	233,609	10,685,758	0.021862	1,160,720	25,376	67
68	SPEECH PATHOLOGY	77,332	4,313,902	0.017926	460,540	8,256	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	75,234	1,423,067	0.052868	56,394	2,981	71
73	DRUGS CHARGED TO PATIENTS	27,392	6,511,831	0.004206	816,857	3,436	73
76	PSYCHOLOGY						76
76.01	SPECIAL PROCEDURES						76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	767,482	37,612,347		3,996,533	74,848	200

(A) Worksheet A line numbers



COMPU-MAX

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2013 To: 05/31/2014	Run Date: 10/24/2014 Run Time: 09:15 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK TITLE V
 APPLICABLE TITLE XVIII, PART A
 BOXES: TITLE XIX

(A)	COST CENTER DESCRIPTION	NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUSTMENT AMOUNT (see instructions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)	
	INPATIENT ROUTINE SERV COST CENTERS	1	2	3	4	5	
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



COMPU-MAX

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2013 To: 05/31/2014	Run Date: 10/24/2014 Run Time: 09:15 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK TITLE V
 APPLICABLE TITLE XVIII, PART A
 BOXES: TITLE XIX

(A)	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS	PER DIEM (col. 5 ÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
6		7		8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	28,860		4,797		30
31	INTENSIVE CARE UNIT					31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF					40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY					43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	28,860		4,797		200

(A) Worksheet A line numbers



COMPU-MAX

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2013 To: 05/31/2014	Run Date: 10/24/2014 Run Time: 09:15 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 26-3028

WORKSHEET D
PART IV

CHECK TITLE V HOSPITAL SUB (OTHER) ICF/MR
 APPLICABLE TITLE XVIII, PART A IPF SNF
 BOXES: TITLE XIX IRF NF

(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
		NON PHYSICIAN ANESTH- ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT- IENT COST (sum of col. 2, 3, and 4)	
	ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC							54
54.01	RADIOLOGY-SUA							54.01
60	LABORATORY							60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
73	DRUGS CHARGED TO PATIENTS							73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers



COMPU-MAX

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2013 To: 05/31/2014	Run Date: 10/24/2014 Run Time: 09:15 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 26-3028

WORKSHEET D
PART IV

CHECK TITLE V HOSPITAL SUB (OTHER) ICF/MR
 APPLICABLE TITLE XVIII, PART A IPF SNF
 BOXES: TITLE XIX IRF NF

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)
	ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC	94,915			40,863			54
54.01	RADIOLOGY-SUA	317,443			4,753			54.01
60	LABORATORY	1,276,674			137,036			60
60.01	LAB - SUA	3,382			25			60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	605,250			160,240			65
66	PHYSICAL THERAPY	12,380,125			1,159,105			66
67	OCCUPATIONAL THERAPY	10,685,758			1,160,720			67
68	SPEECH PATHOLOGY	4,313,902			460,540			68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,423,067			56,394			71
73	DRUGS CHARGED TO PATIENTS	6,511,831			816,857			73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)	37,612,347			3,996,533			200

(A) Worksheet A line numbers



COMPU-MAX

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2013 To: 05/31/2014	Run Date: 10/24/2014 Run Time: 09:15 Version: 2014.03
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 26-3028

WORKSHEET D
PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL [] SUB (OTHER) [] SWING BED SNF
 APPLICABLE [] TITLE XVIII, PART B [] IPF [] SNF [] SWING BED NF
 BOXES: [XX] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

(A)	COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COST		
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)
		1	2	3	4	5	6	7
	ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC	0.922857						54
54.01	RADIOLOGY-SUA	0.243291						54.01
60	LABORATORY	0.392308						60
60.01	LAB - SUA	0.655825						60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	0.626967		28			18	65
66	PHYSICAL THERAPY	0.445197		27,957			12,446	66
67	OCCUPATIONAL THERAPY	0.382433		18,559			7,098	67
68	SPEECH PATHOLOGY	0.375376		13,202			4,956	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.816331		4,206			3,433	71
73	DRUGS CHARGED TO PATIENTS	0.311875						73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	SUBTOTAL (see instructions)			63,952			27,951	200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES							201
202	NET CHARGES (line 200 - line 201)			63,952			27,951	202

(A) Worksheet A line numbers



COMPU-MAX

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2013 To: 05/31/2014	Run Date: 10/24/2014 Run Time: 09:15 Version: 2014.03
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 26-3028

WORKSHEET D-1
PART I

CHECK TITLE V - I/P HOSPITAL SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII, PART A IPF SNF TEFRA
 BOXES: TITLE XIX - I/P IRF NF OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	28,860	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	28,860	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.	225	3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	28,635	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	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	11,983	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 Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title 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)	17,084,070	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	17,084,070	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)	24,681,859	28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)	215,792	29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)	24,466,067	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)	0.692171	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)	959.08	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)	854.41	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)	104.67	34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)	72.45	35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)	16,301	36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	17,067,769	37



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 26-3028

WORKSHEET D-1
PART II

CHECK [] TITLE V - I/P [XX] HOSPITAL [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [] IPF [] TEFRA
 BOXES: [] TITLE XIX - I/P [] IRF [] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

1

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					591.96	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					7,093,457	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)						40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)					7,093,457	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 (Worksheet D-3, column 3, line 200)					4,333,590	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					11,427,047	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)					611,253	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)					192,646	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)					803,899	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)					10,623,148	53

TARGET AMOUNT AND LIMIT COMPUTATION

54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT (line 54 x line 55)						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)						57
58	BONUS PAYMENT (see instructions)						58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET						59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET						60
61	IF LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)						61
62	RELIEF PAYMENT (see instructions)						62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)						63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)						66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)						67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)						68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)						69



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 26-3028

WORKSHEET D-1
PARTS III & IV

CHECK TITLE V - I/P HOSPITAL SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII, PART A IPF SNF TEFRA
 BOXES: TITLE XIX - I/P IRF NF OTHER

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)						87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)					591.96	88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)						89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 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 COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 26-3028

WORKSHEET D-1
PART I

CHECK TITLE V - I/P HOSPITAL SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII, PART A IPF SNF TEFRA
 BOXES: TITLE XIX - I/P IRF NF OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	28,860	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	28,860	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.	225	3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	28,635	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	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	4,797	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 Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title 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)	16,985,850	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	16,985,850	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)	24,681,859	28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)	215,792	29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)	24,466,067	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)	0.688192	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)	959.08	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)	854.41	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)	104.67	34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)	72.03	35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)	16,207	36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	16,969,643	37



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 26-3028

WORKSHEET D-1
PART II

CHECK [] TITLE V - I/P [XX] HOSPITAL [] SUB (OTHER) [] PPS
 APPLICABLE [] TITLE XVIII, PART A [] IPF [] TEFRA
 BOXES: [XX] TITLE XIX - I/P [] IRF [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)					588.00	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					2,820,636	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)					2,820,636	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 (Worksheet D-3, column 3, line 200)					1,626,705	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					4,447,341	49
	PASS-THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)					244,695	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)					74,848	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)					319,543	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)						53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT (line 54 x line 55)						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)						57
58	BONUS PAYMENT (see instructions)						58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET						59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET						60
61	IF LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)						61
62	RELIEF PAYMENT (see instructions)						62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)						66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)						67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)						68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)						69



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 26-3028

WORKSHEET D-1
PARTS III & IV

CHECK TITLE V - I/P HOSPITAL SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII, PART A IPF SNF TEFRA
 BOXES: TITLE XIX - I/P IRF NF OTHER

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)						87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)						88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)						89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 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 COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93



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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 26-3028

WORKSHEET D-3

CHECK TITLE V HOSPITAL SUB (OTHER) SWING BED SNF PPS
 APPLICABLE TITLE XVIII, PART A IPF SNF SWING BED NF TEFRA
 BOXES: TITLE XIX IRF NF ICF/MR OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		10,229,529		30
	ANCILLARY SERVICE COST CENTERS				
54	RADIOLOGY-DIAGNOSTIC	0.922857	42,169	38,916	54
54.01	RADIOLOGY-SUA	0.243291	172,304	41,920	54.01
60	LABORATORY	0.392308	610,116	239,353	60
60.01	LAB - SUA	0.655825	633	415	60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.626967	203,075	127,321	65
66	PHYSICAL THERAPY	0.445197	2,921,866	1,300,806	66
67	OCCUPATIONAL THERAPY	0.382433	2,945,240	1,126,357	67
68	SPEECH PATHOLOGY	0.375376	1,069,315	401,395	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.816331	224,683	183,416	71
73	DRUGS CHARGED TO PATIENTS	0.311875	2,801,414	873,691	73
76	PSYCHOLOGY				76
76.01	SPECIAL PROCEDURES				76.01
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
92	OBSERVATION BEDS (NON-DISTINCT PART)				92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		10,990,815	4,333,590	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		10,990,815		202

(A) Worksheet A line numbers



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THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2013 To: 05/31/2014	Run Date: 10/24/2014 Run Time: 09:15 Version: 2014.03
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 26-3028

WORKSHEET D-3

CHECK TITLE V HOSPITAL SUB (OTHER) SWING BED SNF PPS
 APPLICABLE TITLE XVIII, PART A IPF SNF SWING BED NF TEFRA
 BOXES: TITLE XIX IRF NF ICF/MR 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		4,100,105		30
	ANCILLARY SERVICE COST CENTERS				
54	RADIOLOGY-DIAGNOSTIC	0.922857	40,863	37,711	54
54.01	RADIOLOGY-SUA	0.243291	4,753	1,156	54.01
60	LABORATORY	0.392308	137,036	53,760	60
60.01	LAB - SUA	0.655825	25	16	60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.626967	160,240	100,465	65
66	PHYSICAL THERAPY	0.445197	1,159,105	516,030	66
67	OCCUPATIONAL THERAPY	0.382433	1,160,720	443,898	67
68	SPEECH PATHOLOGY	0.375376	460,540	172,876	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.816331	56,394	46,036	71
73	DRUGS CHARGED TO PATIENTS	0.311875	816,857	254,757	73
76	PSYCHOLOGY				76
76.01	SPECIAL PROCEDURES				76.01
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
92	OBSERVATION BEDS (NON-DISTINCT PART)				92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		3,996,533	1,626,705	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		3,996,533		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: 06/01/2013 To: 05/31/2014	Run Date: 10/24/2014 Run Time: 09:15 Version: 2014.03
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 26-3028

WORKSHEET E
PART B

CHECK APPLICABLE BOX: HOSPITAL IPF IRF SUB (OTHER) SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	MEDICAL AND OTHER SERVICES (see instructions)				1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (see instructions)	49			2
3	PPS PAYMENTS	78			3
4	OUTLIER PAYMENT (see instructions)				4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)				5
6	LINE 2 TIMES LINE 5				6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6				7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART 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, line 69, col. 4)				13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)				16
17	RATIO OF LINE 15 TO LINE 16 (not to exceed 1.000000)	1.000000			17
18	TOTAL CUSTOMARY CHARGES (see instructions)				18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions))				19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 11 exceeds line 18 (see instructions))				20
21	LESSER OF COST OR CHARGES (line 11 minus line 20) (for CAH, see instructions)				21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)	78			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)				25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)	16			26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	62			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)	62			30
31	PRIMARY PAYER PAYMENTS				31
32	SUBTOTAL (line 30 minus line 31)	62			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)	62			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)	62			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	1			40.01
41	INTERIM PAYMENTS	61			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)				43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2				44

TO BE COMPLETED BY CONTRACTOR

90	ORIGINAL OUTLIER AMOUNT (see instructions)				90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)				91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY				92
93	TIME VALUE OF MONEY (see instructions)				93
94	TOTAL (sum of lines 91 and 93)				94



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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 26-3028

WORKSHEET E-1
PART I

CHECK HOSPITAL SUB (OTHER)
 APPLICABLE IPF SNF
 BOXES: IRF SWING BED SNF

	DESCRIPTION	INPATIENT PART A		PART B	
		mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT
		1	2	3	4
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER		17,991,973		61
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO				2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT	.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)		17,991,973		61
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	213,040		1
	BASED ON THE COST REPORT (1)	.02			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)		18,205,013		62
8	NAME OF CONTRACTOR	CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)	
					8

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



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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 26-3028

WORKSHEET E-3
PART III

CHECK [XX] HOSPITAL
 APPLICABLE [] SUBPROVIDER IRF
 BOX:

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

		1	1.01	
1	NET FEDERAL PPS PAYMENT (see instructions)	5,690,193	10,130,276	1
2	MEDICARE SSI RATIO (see instructions)	0.092300		2
3	INPATIENT REHABILITATION LIP PAYMENTS (see instructions)	848,977	1,018,093	3
4	OUTLIER PAYMENTS	76,192		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 §412.424(d)(1)(iii)(F)(1) OR (2) (SEE INSTRUCTIONS)			5.01
6	NEW TEACHING PROGRAM ADJUSTMENT (see instructions)			6
7	CURRENT YEAR UNWEIGHTED FTE COUNT OF I&R EXCLUDING FTEs IN THE NEW PROGRAM GROWTH PERIOD OF A 'NEW TEACHING PROGRAM' (see instructions)	5.79		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)	79,068,493		10
11	TEACHING ADJUSTMENT FACTOR (see instructions)	0.037683	0.056195	11
12	TEACHING ADJUSTMENT (see instructions)	214,424	569,271	12
13	TOTAL PPS PAYMENT (see instructions)	18,547,426		13
14	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENTS (see instructions)			14
15	ORGAN ACQUISITION			15
16	COST OF TEACHING PHYSICIANS (from Worksheet D-5, Part II, col. 3, line 20) (see instructions)			16
17	SUBTOTAL (see instructions)	18,547,426		17
18	PRIMARY PAYER PAYMENTS	28,694		18
19	SUBTOTAL (line 17 less line 18)	18,518,732		19
20	DEDUCTIBLES	226,601		20
21	SUBTOTAL (line 19 minus line 20)	18,292,131		21
22	COINSURANCE	182,112		22
23	SUBTOTAL (line 21 minus line 22)	18,110,019		23
24	ALLOWABLE BAD DEBTS (exclude bad debts for professional services) (see instructions)	146,145		24
25	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	94,994		25
26	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	110,106		26
27	SUBTOTAL (sum of lines 23 and 25)	18,205,013		27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4, line 49) (for freestanding IRF only)			28
29	OTHER PASS THROUGH COSTS (see instructions)			29
30	OUTLIER PAYMENTS RECONCILIATION			30
31	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			31
32	TOTAL AMOUNT PAYABLE TO THE PROVIDER (see instructions)	18,205,013		32
32.01	SEQUESTRATION ADJUSTMENT (see instructions)	364,100		32.01
33	INTERIM PAYMENTS	17,991,973		33
34	TENTATIVE SETTLEMENT (for contractor use only)			34
35	BALANCE DUE PROVIDER/PROGRAM (line 32 minus lines 32.01, 33 and 34)	-151,060		35
36	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	27,920		36

TO BE COMPLETED BY CONTRACTOR

50	ORIGINAL OUTLIER AMOUNT FROM WORKSHEET E-3, PART 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



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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 26-3028

WORKSHEET E-3
PART VII

CHECK TITLE V HOSPITAL NF PPS
 APPLICABLE TITLE XIX SUB (OTHER) ICF/MR TEFRA
 BOXES: SNF OTHER

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	INPATIENT HOSPITAL SNF/NF SERVICES	4,447,341		1
2	MEDICAL AND OTHER SERVICES		27,951	2
3	ORGAN ACQUISITION (certified transplant centers only)			3
4	SUBTOTAL (sum of lines 1, 2 and 3)	4,447,341	27,951	4
5	INPATIENT PRIMARY PAYER PAYMENTS			5
6	OUTPATIENT PRIMARY PAYER PAYMENTS			6
7	SUBTOTAL (line 4 less sum of lines 5 and 6)	4,447,341	27,951	7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	ROUTINE SERVICE CHARGES	4,100,105		8
9	ANCILLARY SERVICE CHARGES	3,996,533	63,952	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)	8,096,638	63,952	12
	CUSTOMARY CHARGES			
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE 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	1	15
16	TOTAL CUSTOMARY CHARGES (see instructions)	8,096,638	63,952	16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 16 exceeds line 4) (see instructions)	3,649,297	36,001	17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 4 exceeds line 16) (see instructions)			18
19	INTERNS AND RESIDENTS (see instructions)			19
20	COST OF TEACHING PHYSICIANS (see instructions)			20
21	COST OF COVERED SERVICES (lesser of line 4 or line 16) (for CAH, see instructions)	4,447,341	27,951	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	SUM OF LINES 27 AND 21	4,447,341	27,951	29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	EXCESS OF REASONABLE COST (from line 18)			30
31	SUBTOTAL (sum of lines 19 and 20 plus 29 minus lines 5 and 6)	4,447,341	27,951	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)	4,447,341	27,951	36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	SUBTOTAL (line 36 ± line 37)	4,447,341	27,951	38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4)			39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (sum of lines 38 and 39)	4,447,341	27,951	40
41	INTERIM PAYMENTS	4,453,673	64,376	41
42	BALANCE DUE PROVIDER/PROGRAM (line 40 minus 41)	-6,332	-36,425	42
43	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			43



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BALANCE SHEET

WORKSHEET G

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

	ASSETS (Omit Cents)	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
CURRENT ASSETS						
1	CASH ON HAND AND IN BANKS	1,917,333				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	9,159,599				4
5	OTHER RECEIVABLES					5
6	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE	-2,727,685				6
7	INVENTORY	211,007				7
8	PREPAID EXPENSES	160,900				8
9	OTHER CURRENT ASSETS					9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	8,721,154				11
FIXED ASSETS						
12	LAND					12
13	LAND IMPROVEMENTS					13
14	ACCUMULATED DEPRECIATION					14
15	BUILDINGS	21,321,362				15
16	ACCUMULATED DEPRECIATION	-9,090,019				16
17	LEASEHOLD IMPROVEMENTS	9,155				17
18	ACCUMULATED AMORTIZATION	-764				18
19	FIXED EQUIPMENT					19
20	ACCUMULATED DEPRECIATION					20
21	AUTOMOBILES AND TRUCKS					21
22	ACCUMULATED DEPRECIATION					22
23	MAJOR MOVABLE EQUIPMENT	5,843,658				23
24	ACCUMULATED DEPRECIATION	-3,637,957				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)	14,445,435				30
OTHER ASSETS						
31	INVESTMENTS					31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	1,968,759				34
35	TOTAL OTHER ASSETS (sum of lines 31-34)	1,968,759				35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	25,135,348				36
LIABILITIES AND FUND BALANCES						
	(Omit Cents)	1	2	3	4	
CURRENT LIABILITIES						
37	ACCOUNTS PAYABLE	743,908				37
38	SALARIES, WAGES & FEES PAYABLE	1,163,839				38
39	PAYROLL TAXES PAYABLE					39
40	NOTES & LOANS PAYABLE (short term)					40
41	DEFERRED INCOME					41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS					43
44	OTHER CURRENT LIABILITIES	59,990				44
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	1,967,737				45
LONG TERM LIABILITIES						
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE					47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES	12,627,859				49
50	TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49)	12,627,859				50
51	TOTAL LIABILITIES (sum of lines 45 and 50)	14,595,596				51
CAPITAL ACCOUNTS						
52	GENERAL FUND BALANCE	10,539,752				52
53	SPECIFIC PURPOSE FUND BALANCE					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 52-58)	10,539,752				59
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)	25,135,348				60



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STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	FUND BALANCES AT BEGINNING OF PERIOD		10,002,669			1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		4,188,609			2
3	TOTAL (sum of line 1 and line 2)		14,191,278			3
4	ADDITIONS (credit adjustments)					4
5						5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)		14,191,278			11
12	DEDUCTIONS (debit adjustments)					12
13	MINORITY INTEREST	2,094,306				13
14	DISTRIBUTIONS	1,557,220				14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)		3,651,526			18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)		10,539,752			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)					4
5						5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)					11
12	DEDUCTIONS (debit adjustments)					12
13	MINORITY INTEREST					13
14	DISTRIBUTIONS					14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)					19



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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	HOSPITAL	24,681,012		24,681,012	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)	24,681,012		24,681,012	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)	24,681,012		24,681,012	17
18	ANCILLARY SERVICES	25,952,530	11,659,819	37,612,349	18
19	OUTPATIENT SERVICES				19
20	RHC				20
21	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)	50,633,542	11,659,819	62,293,361	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		36,176,360	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)		36,176,360	43



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STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (from Worksheet G-2, Part I, column 3, line 28)	62,293,361	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	25,404,658	2
3	NET PATIENT REVENUES (line 1 minus line 2)	36,888,703	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	36,176,360	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	712,343	5

OTHER INCOME

6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	87,302	7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS	130	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	86,546	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS	4,673	17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (fees, sale of textbooks, uniforms, etc.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES	6,033	21
22	RENTAL OF HOSPITAL SPACE	40,097	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (SPECIFY)	3,251,485	24
25	TOTAL OTHER INCOME (sum of lines 6-24)	3,476,266	25
26	TOTAL (line 5 plus line 25)	4,188,609	26
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	4,188,609	29