THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2014 To: 05/31/2015	Run Date: 09/21/2015 Run Time: 10:21 Version: 2015.03 (09/17/2015)

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

WORKSHEET S
PARTS I, II & III

PART I - COST REPORT STATUS

Provider use only	1. [X] Electronically filed cost report Date: 09/21/2015 Time: 10:21 2. [ ] Manually submitted cost report 3. [ ] If this is an amended report enter the number of times the provider resubmitted the cost report 4. [F] Medicare Utilization. Enter 'F' for full or 'L' for low.		
Contractor use only	5. [ ] Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. [ ] Initial Report for this Provider CCN 9. [ ] Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ___ 12. [ ] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by THE REHABILITATION INSTITUTE OF ST L (26-3028) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 06/01/2014 and ending 05/31/2015, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

ROB WISNER, SVP- REIMBURSEMENT
Title

09/24/2015
Date

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		25,748			66,028	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		25,748			66,028	200

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

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

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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:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	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 / 2014	To: 05 / 31 / 2015	20
21	Type of control (see instructions)	5		21

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.							24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	5,102	891	1,448	277	930		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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

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

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

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

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

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

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

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

Teaching Hospitals that Claim Residents in Nonprovider Settings

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

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

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

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

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

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

Inpatient Psychiatric Faciltiy PPS		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	N			70
71	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, 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 fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program, enter 6 in column 3. (see instructions)				71

Inpatient Rehabilitation Facility PPS		1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.	Y			75
76	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, 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 fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program, enter 6 in column 3. (see instructions)	Y	N		76

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

TEFRA Providers				
85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no.	N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.			86

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

		Physical	Occupational	Speech	Respiratory	
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.					109
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.				N	110

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, Section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.		N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.		Y		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1		118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	108,241	344,928		118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.		N	N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.		N		121

Transplant Center Information

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

All Providers

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

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

141	Name: HEALTHSOUTH CORPORATION	Contractor's Name: CAHABA GBA	Contractor's Number: 10101		141
142	Street: 3660 GRANDVIEW PKWY, SUITE 200	P.O. Box:			142
143	City: BIRMINGHAM	State: AL	ZIP Code: 35243		143
144	Are provider based physicians' costs included in Worksheet A?			Y	144
145	If costs for renal services are claimed on Worksheet A, line 74 are the 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				
		Part A	Part B	Title V	Title XIX	
		1	2	3	4	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N			156
157	Subprovider - IRF	N	N			157
158	Subprovider - Other					158
159	SNF	N	N			159
160	HHA	N	N			160
161	CMHC		N			161
161.10	CORF					161.10

Multicampus

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

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

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

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	N		167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)			168
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
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no. (see instructions)		N	171

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

COMPLETED BY ALL HOSPITALS

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

		Y/N	Type	Date	
Financial Data and Reports		1	2	3	
4	Column 1: Were the financial statements prepared by a Certified Public Accnountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	Y	A	03/02/2015	4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N			5

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		Y	08/03/2015	16
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	08/03/2015	N		17
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N		18
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19
20	If line 16 or 17 is yes, were adjustments made to PS&R Reoprt data for Other? Describe the other adjustments:SPLIT CHARGES FOR SERVICES UNDER ARR	Y		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

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

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

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

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

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

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

Cost Report Preparer Contact Information				
41	First name: COURTNEY	Last name: CAMERON	Title: REIMBURSEMENT SPECIALIST	41
42	Employer: HEALTHSOUTH CORPORATION			42
43	Phone number: 205-968-7055	E-mail Address: COURTNEY.CAMERON@HEALTHSOUTH.COM		43

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2014 To: 05/31/2015	Run Date: 09/21/2015 Run Time: 10:21 Version: 2015.03 (09/17/2015)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						Inpatient Days / Outpatient Visits / Trips				
	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	96	35,040			11,730	5,102	29,254	1
2	HMO and other (see instructions)						2,219	3,546		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			11,730	5,102	29,254	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			11,730	5,102	29,254	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 (see instructions)									32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2014 To: 05/31/2015	Run Date: 09/21/2015 Run Time: 10:21 Version: 2015.03 (09/17/2015)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		Full Time Equivalents			DISCHARGES				
	Component	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					858	329	2,002	1
2	HMO and other (see instructions)					154	215		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)	5.22	324.47			858	329	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)	5.22	324.47						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

Part II - Wage Data

		Wkst A Line No.	Amount Reported	Reclassif-ication of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)	
		1	2	3	4	5	6	
	SALARIES							
1	Total salaries (see instructions)	200	18,298,788			674,897.60		1
2	Non-physician anesthetist Part A							2
3	Non-physician anesthetest Part B							3
4	Physician-Part A - Administrative							4
4.01	Physician-Part A - Teaching							4.01
5	Physician-Part B							5
6	Non-physician-Part B							6
7	Interns & residents (in an approved program)	21						7
7.01	Contracted interns & residents (in an approved program)							7.01
8	Home office personnel							8
9	SNF	44						9
10	Excluded area salaries (see instructions)			57,058		1,461.66		10
	OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)		450,162			11,285.64		11
12	Contract management and administrative services							12
13	Contract labor: Physician-Part A - Administrative		427,926			3,291.50		13
14	Home office salaries & wage-related costs		1,600,830			20,814.08		14
15	Home office: Physician Part A - Administrative							15
16	Home office & Contract Physicians Part A - Teaching							16
	WAGE-RELATED COSTS							
17	Wage-related costs (core)(see instructions)		3,303,271					17
18	Wage-related costs (other)(see instructions)							18
19	Excluded areas		10,332					19
20	Non-physician anesthetist Part A							20
21	Non-physician anesthetist Part B							21
22	Physician Part A - Administrative							22
22.01	Physician Part A - Teaching							22.01
23	Physician Part B							23
24	Wage-related costs (RHC/FQHC)							24
25	Interns & residents (in an approved program)							25
	OVERHEAD COSTS - DIRECT SALARIES							
26	Employee Benefits Department							26
27	Administrative & General		2,553,831	-57,058		84,899.94		27
28	Administrative & General under contract (see instructions)							28
29	Maintenance & Repairs							29
30	Operation of Plant		304,444			14,206.40		30
31	Laundry & Linen Service							31
32	Housekeeping		352,640			28,600.00		32
33	Housekeeping under contract (see instructions)							33
34	Dietary		576,059			38,022.40		34
35	Dietary under contract (see instructions)							35
36	Cafeteria							36
37	Maintenance of Personnel							37
38	Nursing Administration		601,753			15,932.80		38
39	Central Services and Supply							39
40	Pharmacy							40
41	Medical Records & Medical Records Library		201,354			7,425.60		41
42	Social Service		539,202			19,697.60		42
43	Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)	18,298,788		18,298,788	674,897.60	27.11	1
2	Excluded area salaries (see instructions)		57,058	57,058	1,461.66	39.04	2
3	Subtotal salarles (line 1 minus line 2)	18,298,788	-57,058	18,241,730	673,435.94	27.09	3
4	Subtotal other wages & related costs (see instructions)	2,478,918		2,478,918	35,391.22	70.04	4
5	Subtotal wage-related costs (see instructions)	3,303,271		3,303,271		18.11%	5
6	Total (sum of lines 3 through 5)	24,080,977	-57,058	24,023,919	708,827.16	33.89	6
7	Total overhead cost (see instructions)	5,129,283	-57,058	5,072,225	208,784.74	24.29	7

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2014 To: 05/31/2015	Run Date: 09/21/2015 Run Time: 10:21 Version: 2015.03 (09/17/2015)

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

Part IV - Wage Related Cost

Part A - Core List

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions	254,383	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)	2,103,981	8
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan		10
11	Life Insurance (If employee is owner or beneficiary)	39,587	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)		13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	171,463	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	1,331,535	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance		19
20	State or Federal Unemployment Taxes	109,443	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	-696,789	22
23	Tuition Reimbursement		23
24	Total Wage Related cost (Sum of lines 1-23)	3,313,603	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)		25

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	Supporting Exhibit for Form **CMS-2552-10**	Period : From: 06/01/2014 To: 05/31/2015	Run Date: 09/21/2015 Run Time: 10:21 Version: 2015.03 (09/17/2015)

WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3, Part IV, Line 4) **EXHIBIT 3**

	STEP 1: DETERMINE THE 3-YEAR AVERAGING PERIOD			
1	Wage Index Fiscal Year Ending Date			1
2	Provider's Cost Reporting Period Used for Wage Index Year on Line 1 (FYB in Col. 1, FYE in Col. 2)			2
3	Midpoint of Provider's Cost Reporting Period Shown on Line 2, Adjusted to First of Month			3
4	Date Beginning the 3-Year Averaging Period (subtract 18 months from midpoint shown on Line 3)			4
5	Date Ending the 3-Year Averaging Period (add 18 months to midpoint shown on Line 3)			5
	STEP 2 (OPTIONAL): ADJUST AVERAGING PERIOD FOR A NEW PLAN (see instructions)			
6	Effective Date of Pension Plan			6
7	First Day of the Provider Cost Reporting Period Containing the Pension Plan Effective Date			7
8	Starting Date of the Adjusted Averaging Period (date on Line 7, adjusted to first of month)			8

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

	STEP 3: AVERAGE PENSION CONTRIBUTIONS DURING THE AVERAGING PERIOD			
9	Beginning Date of Averaging Period from Line 4 or Line 8, as Applicable			9
10	Ending Date of Averaging Period from Line 5			10
11	Enter Provider Contributions Made During Averaging Period on Lines 9 & 10	**DEPOSIT DATE(S)**	**CONTRIB-UTION(S)**	11
12	Total Calendar Months Included in Averaging Period (36 unless Step 2 completed)			12
13	Total Contributions Made During Averaging Period			13
14	Average Monthly Contribution (Line 13 divided by Line 12)			14
15	Number of MOnths in Provider Cost Reporting Period on Line 2			15
16	Average Pension Contributions (Line 14 times Line 15)			16
	STEP 4: TOTAL PENSION COST FOR WAGE INDEX			
17	Annual Prefunding Installment (see instructions)			17
18	Reportable Prefunding Installment ((Line 17 times Line 15) divided by 12)			18
19	Total Pension Cost for Wage Index (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)			19

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2014 To: 05/31/2015	Run Date: 09/21/2015 Run Time: 10:21 Version: 2015.03 (09/17/2015)

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	450,162	3,313,603	1
2	Hospital	450,162	3,303,271	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		10,332	18

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

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt		1,441,842	1,441,842	111,479	1,553,321	69,217	1,622,538	1
2	00200	Cap Rel Costs-Mvble Equip		774,516	774,516	31,428	805,944	-6,345	799,599	2
3	00300	Other Cap Rel Costs		110,222	110,222	-110,222			-0-	3
4	00400	Employee Benefits Department		3,730,961	3,730,961		3,730,961	-372,867	3,358,094	4
5	00500	Administrative & General	2,553,831	6,908,119	9,461,950	-885,343	8,576,607	-1,694,924	6,881,683	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	304,444	787,044	1,091,488	210,763	1,302,251	-259,889	1,042,362	7
8	00800	Laundry & Linen Service		211,858	211,858		211,858		211,858	8
9	00900	Housekeeping	352,640	93,858	446,498		446,498		446,498	9
10	01000	Dietary	576,059	581,935	1,157,994	-86	1,157,908	-77,230	1,080,678	10
11	01100	Cafeteria								11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	601,753	10,835	612,588		612,588	-226	612,362	13
14	01400	Central Services & Supply								14
15	01500	Pharmacy								15
16	01600	Medical Records & Library	201,354	40,318	241,672		241,672	-190	241,482	16
17	01700	Social Service	539,202	23,976	563,178		563,178	-71	563,107	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				169,250	169,250		169,250	22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	6,315,583	380,568	6,696,151	391,195	7,087,346	-118,956	6,968,390	30
		ANCILLARY SERVICE COST CENTERS								
54	05400	Radiology-Diagnostic		245,511	245,511	-154,316	91,195		91,195	54
54.01	05401	RADIOLOGY-SUA				157,143	157,143	-71,480	85,663	54.01
60	06000	Laboratory		543,654	543,654		543,654		543,654	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	341,212	1,666	342,878	16,025	358,903	-231	358,672	65
66	06600	Physical Therapy	2,836,319	145,364	2,981,683		2,981,683	1,269	2,982,952	66
67	06700	Occupational Therapy	2,094,898	203,043	2,297,941		2,297,941		2,297,941	67
68	06800	Speech Pathology	978,946	7,134	986,080		986,080	-242	985,838	68
71	07100	Medical Supplies Charged to Patients	84,363	653,855	738,218	-2,827	735,391	-319	735,072	71
73	07300	Drugs Charged to Patients	464,809	1,070,355	1,535,164		1,535,164	-3,835	1,531,329	73
76	03550	PSYCHOLOGY	53,375	104	53,479	-53,479				76
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
113	11300	Interest Expense		16,397	16,397		16,397	-16,397		113
118		SUBTOTALS (sum of lines 1-117)	18,298,788	17,983,135	36,281,923	-118,990	36,162,933	-2,552,716	33,610,217	118
		NONREIMBURSABLE COST CENTERS								
192	19200	Physicians' Private Offices								192
194	07950	MARKETING				59,222	59,222		59,222	194
194.01	07952	GUEST MEALS								194.01
194.02	07951	CLINICAL PSYCH				59,768	59,768		59,768	194.02
200		TOTAL (sum of lines 118-199)	18,298,788	17,983,135	36,281,923		36,281,923	-2,552,716	33,729,207	200

RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	INSURANCE	A	Cap Rel Costs-Bldg & Fixt	1		25,498	1
2	INSURANCE	A	Cap Rel Costs-Mvble Equip	2		7,187	2
3	INSURANCE	A					3
500	Total reclassifications					32,685	500
	Code Letter - A						
1	MARKETING	B	MARKETING	194	57,058	2,164	1
2	MARKETING	B					2
3	MARKETING	B					3
500	Total reclassifications				57,058	2,164	500
	Code Letter - B						
1	PHYSICIANS	C	Adults & Pediatrics	30		337,716	1
2	PHYSICIANS	C					2
500	Total reclassifications					337,716	500
	Code Letter - C						
1	PROFESSIONAL FEES	D	I&R Services-Other Prgm Costs	22		169,250	1
2	PROFESSIONAL FEES	D					2
500	Total reclassifications					169,250	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	53,375	104	1
2	MISC RECLASS	F					2
500	Total reclassifications				53,375	104	500
	Code Letter - F						
1	SERVICE UNDER ARRANGEMENT	G	RADIOLOGY-SUA	54.01		157,143	1
2	SERVICE UNDER ARRANGEMENT	G					2
500	Total reclassifications					157,143	500
	Code Letter - G						
1	CONTRACTED SERVICES	H	Radiology-Diagnostic	54		2,827	1
2	CONTRACTED SERVICES	H	CLINICAL PSYCH	194.02		23,768	2
3	CONTRACTED SERVICES	H					3
4	CONTRACTED SERVICES	H					4
500	Total reclassifications					26,595	500
	Code Letter - H						
1	OXYGEN RECLASS	I	Respiratory Therapy	65		16,025	1
2	OXYGEN RECLASS	I					2
500	Total reclassifications					16,025	500
	Code Letter - I						
1	RELATED PARTY RECLASS	J	Operation of Plant	7		226,788	1
2	RELATED PARTY RECLASS	J					2
500	Total reclassifications					226,788	500
	Code Letter - J						
	GRAND TOTAL (Increases)				110,433	1,004,470	

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

RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	INSURANCE	A					12	1
2	INSURANCE	A					12	2
3	INSURANCE	A	Administrative & General	5		32,685		3
500	Total reclassifications					32,685		500
	Code letter - A							
1	MARKETING	B						1
2	MARKETING	B	Administrative & General	5	57,058	2,078		2
3	MARKETING	B	Dietary	10		86		3
500	Total reclassifications				57,058	2,164		500
	Code letter - B							
1	PHYSICIANS	C						1
2	PHYSICIANS	C	Administrative & General	5		337,716		2
500	Total reclassifications					337,716		500
	Code letter - C							
1	PROFESSIONAL FEES	D						1
2	PROFESSIONAL FEES	D	Administrative & General	5		169,250		2
500	Total reclassifications					169,250		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	PSYCHOLOGY	76	53,375	104		2
500	Total reclassifications				53,375	104		500
	Code letter - F							
1	SERVICE UNDER ARRANGEMENT	G						1
2	SERVICE UNDER ARRANGEMENT	G	Radiology-Diagnostic	54		157,143		2
500	Total reclassifications					157,143		500
	Code letter - G							
1	CONTRACTED SERVICES	H						1
2	CONTRACTED SERVICES	H						2
3	CONTRACTED SERVICES	H	Administrative & General	5		23,768		3
4	CONTRACTED SERVICES	H	Medical Supplies Charged to P	71		2,827		4
500	Total reclassifications					26,595		500
	Code letter - H							
1	OXYGEN RECLASS	I						1
2	OXYGEN RECLASS	I	Operation of Plant	7		16,025		2
500	Total reclassifications					16,025		500
	Code letter - I							
1	RELATED PARTY RECLASS	J						1
2	RELATED PARTY RECLASS	J	Administrative & General	5		226,788		2
500	Total reclassifications					226,788		500
	Code letter - J							
	GRAND TOTAL (Decreases)				110,433	1,004,470		

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

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

			Acquisitions						
	Description	Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		1	2	3	4	5	6	7	
1	Land								1
2	Land Improvements								2
3	Buildings and Fixtures	18,332,294					18,332,294		3
4	Building Improvements	2,998,223	18,826		18,826		3,017,049		4
5	Fixed Equipment								5
6	Movable Equipment	5,840,458	643,905		643,905	465,257	6,019,106		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	27,170,975	662,731		662,731	465,257	27,368,449		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	27,170,975	662,731		662,731	465,257	27,368,449		10

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

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	788,181	653,661					1,441,842	1
2	Cap Rel Costs-Mvble Equip	493,157	281,359					774,516	2
3	Total (sum of lines 1-2)	1,281,338	935,020					2,216,358	3

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

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	21,349,343		21,349,343	0.780071		85,981		85,981	1
2	Cap Rel Costs-Mvble Equ	6,019,106		6,019,106	0.219929		24,241		24,241	2
3	Total (sum of lines 1-2)	27,368,449		27,368,449	1.000000		110,222		110,222	3

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	1,058,768	159,505	291,525	25,498	87,242		1,622,538	1
2	Cap Rel Costs-Mvble Equip	486,456	281,359		7,187	24,597		799,599	2
3	Total (sum of lines 1-2)	1,545,224	440,864	291,525	32,685	111,839		2,422,137	3

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

ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
1	Investment income-buildings & fixtures (chapter 2)			Cap Rel Costs-Bldg & Fixt	1		1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)						3
4	Trace, 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	-117,863				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1	1,934,632				12
13	Laundry and linen service						13
14	Cafeteria - employees and guests						14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients						16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts						18
19	Nursing school (tuition,fees,books,etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation						32
33							33
34							34
35							35
36							36
37	INTEREST	A	-11,737	Interest Expense	113	11	37
37.01	DEPRECIATION	A	-1	Cap Rel Costs-Bldg & Fixt	1	9	37.01
37.02	DEPRECIATION	A	-1	Cap Rel Costs-Mvble Equip	2	9	37.02
37.03	INSURANCE	A	-355,743	Employee Benefits Department	4		37.03
37.04	INSURANCE	A	-364,996	Administrative & General	5		37.04
37.05	PROPERTY TAX	A	1,261	Cap Rel Costs-Bldg & Fixt	1	13	37.05
37.06	PROPERTY TAX	A	356	Cap Rel Costs-Mvble Equip	2	13	37.06
37.07	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-704,175	Administrative & General	5		37.07
37.08	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-131	Operation of Plant	7		37.08
37.09	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-6	Nursing Administration	13		37.09
37.10	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-71	Social Service	17		37.10
37.11	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-1,093	Adults & Pediatrics	30		37.11
37.12	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-231	Respiratory Therapy	65		37.12
37.13	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	1,489	Physical Therapy	66		37.13
37.15	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-242	Speech Pathology	68		37.15
37.16	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-319	Medical Supplies Charged to Patients	71		37.16
37.17	PATIENT TELEPHONE	A	-59	Cap Rel Costs-Mvble Equip	2	9	37.17
37.18	PATIENT TELEPHONE	A	-5,783	Employee Benefits Department	4		37.18
37.19	PATIENT TELEPHONE	A	-36,512	Administrative & General	5		37.19
37.20	PATIENT TELEPHONE	A	-320	Operation of Plant	7		37.20
37.21	PATIENT TELEVISION	A	-6,641	Cap Rel Costs-Mvble Equip	2	9	37.21
37.22	PATIENT TELEVISION	A	-8,601	Administrative & General	5		37.22
37.23	PATIENT TELEVISION	A	-2,892	Operation of Plant	7		37.23
37.24	PRINTING	A	-8,397	Administrative & General	5		37.24
37.25	PRINTING	A	-27	Operation of Plant	7		37.25
37.26	LOBBYING EXPENSE	A	-315	Employee Benefits Department	4		37.26
37.27	LOBBYING EXPENSE	A	-3,157	Administrative & General	5		37.27
37.28	FRANCHISE TAX ADJUSTMENT	A	-25,501	Administrative & General	5		37.28
37.29	MISCELLANEOUS INCOME	B	-24,618	Cap Rel Costs-Bldg & Fixt	1	11	37.29

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ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
37.30	MISCELLANEOUS INCOME	B	-9,930	Administrative & General	5		37.30
37.31	MISCELLANEOUS INCOME	B	-77,230	Dietary	10		37.31
37.32	MISCELLANEOUS INCOME	B	-190	Medical Records & Library	16		37.32
37.33	MISCELLANEOUS INCOME	B	-220	Physical Therapy	66		37.33
37.34	MISCELLANEOUS INCOME	B	-2,183	Drugs Charged to Patients	73		37.34
37.35	PATIENT TRANSPORTATION	A	-11,026	Employee Benefits Department	4		37.35
37.36	PATIENT TRANSPORTATION	A	-39,096	Administrative & General	5		37.36
37.37	PATIENT TRANSPORTATION	A	-63,522	Operation of Plant	7		37.37
37.38	MISC. TAX	A	-2,331,054	Administrative & General	5		37.38
37.39	PROFESSIONAL FEES	A	-178,489	Administrative & General	5		37.39
37.40	PHYSICIANS	A	-98,082	Administrative & General	5		37.40
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)		-2,552,716				50

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

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

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

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

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1	5	Administrative & General	TO OFFSET MANAGEMENT FEES		862,277	-862,277		1
2	1	Cap Rel Costs-Bldg & Fixt	TO INCLUDE ALLOWABLE HOME OFFICE COS	270,588		270,588	9	2
3	1	Cap Rel Costs-Bldg & Fixt	TO INCLUDE ALLOWABLE HOME OFFICE COS	316,143		316,143	11	3
3.01	5	Administrative & General	TO INCLUDE ALLOWABLE HOME OFFICE COS	2,531,556		2,531,556		3.01
3.02	5	Administrative & General	TO INCLUDE ALLOWABLE HOME OFFICE COS	454,740		454,740		3.02
3.03	2	Cap Rel Costs-Mvble Equip	INTERCOMPANY WAGE AND EXPENSE TRANSF	-20,484	-20,484		10	3.03
3.04	4	Employee Benefits Department	INTERCOMPANY WAGE AND EXPENSE TRANSF	2,593,813	2,593,813			3.04
3.05	5	Administrative & General	INTERCOMPANY WAGE AND EXPENSE TRANSF	2,157,581	2,157,581			3.05
3.06	7	Operation of Plant	INTERCOMPANY WAGE AND EXPENSE TRANSF	25,809	25,809			3.06
3.07	9	Housekeeping	INTERCOMPANY WAGE AND EXPENSE TRANSF	65	65			3.07
3.08	10	Dietary	INTERCOMPANY WAGE AND EXPENSE TRANSF	-17,594	-17,594			3.08
3.09	13	Nursing Administration	INTERCOMPANY WAGE AND EXPENSE TRANSF	343	343			3.09
3.10	16	Medical Records & Library	INTERCOMPANY WAGE AND EXPENSE TRANSF	23,031	23,031			3.10
3.11	17	Social Service	INTERCOMPANY WAGE AND EXPENSE TRANSF	-1,885	-1,885			3.11
3.12	30	Adults & Pediatrics	INTERCOMPANY WAGE AND EXPENSE TRANSF	-26,976	-26,976			3.12
3.13	54	Radiology-Diagnostic	INTERCOMPANY WAGE AND EXPENSE TRANSF	-390	-390			3.13
3.14	60	Laboratory	INTERCOMPANY WAGE AND EXPENSE TRANSF	-179	-179			3.14
3.15	66	Physical Therapy	INTERCOMPANY WAGE AND EXPENSE TRANSF	1,105	1,105			3.15
3.16	67	Occupational Therapy	INTERCOMPANY WAGE AND EXPENSE TRANSF	-10,797	-10,797			3.16
3.17	68	Speech Pathology	INTERCOMPANY WAGE AND EXPENSE TRANSF	946	946			3.17
3.18	71	Medical Supplies Charged to Patients	INTERCOMPANY WAGE AND EXPENSE TRANSF	-14,992	-14,992			3.18
3.19	73	Drugs Charged to Patients	INTERCOMPANY WAGE AND EXPENSE TRANSF	-393	-393			3.19
3.20	113	Interest Expense	INTERCOMPANY WAGE AND EXPENSE TRANSF	16,087	16,087		11	3.20
3.21	2	Cap Rel Costs-Mvble Equip	RELATED PARTY - MOTORIKA	14,231	14,231		9	3.21
3.22	5	Administrative & General	RELATED PARTY - MOTORIKA	875	875			3.22
3.23	113	Interest Expense	INTERCOMPANY INTEREST		4,660	-4,660	11	3.23
3.24	5	Administrative & General	RELATED PARTY - BJH	4,774	15,727	-10,953		3.24
3.25	7	Operation of Plant	RELATED PARTY - BJH	84,123	277,120	-192,997		3.25
3.26	13	Nursing Administration	RELATED PARTY - BJH	96	316	-220		3.26
3.27	54.01	RADIOLOGY-SUA	RELATED PARTY - BJH	85,663	157,143	-71,480		3.27
3.28	60	Laboratory	RELATED PARTY - BJH	301,176	301,176			3.28
3.29	73	Drugs Charged to Patients	RELATED PARTY - BJH	932	2,584	-1,652		3.29
3.30	1	Cap Rel Costs-Bldg & Fixt	RELATED PARTY - RENT		494,156	-494,156	10	3.30
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12			8,789,987	6,855,355	1,934,632		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.

				Related Organization(s) and/or Home Office	

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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.

				Related Organization(s) and/or Home Office			
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
6	B		50.00	HEALTHSOUTH			6
7	B		50.00	BJC HEALTHCARE			7
8	G	HEALTHSOUTH				HEALTHCARE	8
9	G	BARNES JEWISH CHRISTIAN HOSPIT				HEALTHCARE	9
9.01	G	MOTORIKA					9.01
10							10

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

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

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2014 To: 05/31/2015	Run Date: 09/21/2015 Run Time: 10:21 Version: 2015.03 (09/17/2015)

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

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun-eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	30	Adults & Pediatrics AGGREGATE	337,716		337,716	171,400	2,668	219,853	10,993	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	337,716		337,716		2,668	219,853	10,993	200

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2014 To: 05/31/2015	Run Date: 09/21/2015 Run Time: 10:21 Version: 2015.03 (09/17/2015)

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

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	30	Adults & Pediatrics AGGREGATE					219,853	117,863	117,863	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL					219,853	117,863	117,863	200

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2014 To: 05/31/2015	Run Date: 09/21/2015 Run Time: 10:21 Version: 2015.03 (09/17/2015)

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	1,622,538	1,622,538					1
2	Cap Rel Costs-Mvble Equip	799,599		799,599				2
4	Employee Benefits Department	3,358,094			3,358,094			4
5	Administrative & General	6,881,683	92,021	45,349	458,195	7,477,248	7,477,248	5
6	Maintenance & Repairs							6
7	Operation of Plant	1,042,362	3,605	1,776	55,870	1,103,613	315,367	7
8	Laundry & Linen Service	211,858				211,858	60,540	8
9	Housekeeping	446,498	6,672	3,288	64,715	521,173	148,930	9
10	Dietary	1,080,678	102,280	50,404	105,715	1,339,077	382,653	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	612,362	5,309	2,616	110,431	730,718	208,809	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	241,482	9,541	4,702	36,951	292,676	83,635	16
17	Social Service	563,107	4,448	2,192	98,952	668,699	191,087	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	169,250				169,250	48,365	22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	6,968,390	889,004	438,109	1,168,792	9,464,295	2,704,501	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	91,195				91,195	26,060	54
54.01	RADIOLOGY-SUA	85,663				85,663		54.01
60	Laboratory	543,654	2,511	1,237		547,402	156,425	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	358,672	4,448	2,192	62,618	427,930	122,285	65
66	Physical Therapy	2,982,952	176,402	86,932	520,507	3,766,793	1,076,395	66
67	Occupational Therapy	2,297,941	172,259	84,891	384,445	2,939,536	839,999	67
68	Speech Pathology	985,838	39,240	19,338	179,651	1,224,067	349,788	68
71	Medical Supplies Charged to Patients	735,072	73,011	35,980	15,482	859,545	245,623	71
73	Drugs Charged to Patients	1,531,329	11,747	5,789	85,299	1,634,164	466,977	73
76	PSYCHOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	33,610,217	1,592,498	784,795	3,347,623	33,554,902	7,427,439	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		29,753	14,663		44,416	12,692	192
194	MARKETING	59,222	287	141	10,471	70,121	20,038	194
194.01	GUEST MEALS							194.01
194.02	CLINICAL PSYCH	59,768				59,768	17,079	194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	33,729,207	1,622,538	799,599	3,358,094	33,729,207	7,477,248	202

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2014 To: 05/31/2015	Run Date: 09/21/2015 Run Time: 10:21 Version: 2015.03 (09/17/2015)

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	1,418,980						7
8	Laundry & Linen Service		272,398					8
9	Housekeeping	6,200		676,303				9
10	Dietary	95,050		45,501	1,862,281			10
11	Cafeteria				475,325	475,325		11
12	Maintenance of Personnel							12
13	Nursing Administration	4,933		2,362		19,633	966,455	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	8,867		4,244		6,569		16
17	Social Service	4,133		1,979		17,592		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	826,164	272,398	395,487	1,320,110	207,795	966,455	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic							54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory	2,333		1,117				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	4,133		1,979		11,132		65
66	Physical Therapy	163,933		78,475		92,538		66
67	Occupational Therapy	160,083		76,632		68,348		67
68	Speech Pathology	36,467		17,457		31,939		68
71	Medical Supplies Charged to Patients	67,850		32,480		2,752		71
73	Drugs Charged to Patients	10,917		5,226		15,165		73
76	PSYCHOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	1,391,063	272,398	662,939	1,795,435	473,463	966,455	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	27,650		13,236				192
194	MARKETING	267		128		1,862		194
194.01	GUEST MEALS				66,846			194.01
194.02	CLINICAL PSYCH							194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,418,980	272,398	676,303	1,862,281	475,325	966,455	202

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2014 To: 05/31/2015	Run Date: 09/21/2015 Run Time: 10:21 Version: 2015.03 (09/17/2015)

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	395,991						16
17	Social Service		883,490					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			217,615				22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	152,925	883,490	217,615	17,411,235		17,411,235	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	1,828			119,083		119,083	54
54.01	RADIOLOGY-SUA				85,663		85,663	54.01
60	Laboratory	7,779			715,056		715,056	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	3,678			571,137		571,137	65
66	Physical Therapy	72,128			5,250,262		5,250,262	66
67	Occupational Therapy	66,072			4,150,670		4,150,670	67
68	Speech Pathology	30,493			1,690,211		1,690,211	68
71	Medical Supplies Charged to Patients	8,855			1,217,105		1,217,105	71
73	Drugs Charged to Patients	52,233			2,184,682		2,184,682	73
76	PSYCHOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	395,991	883,490	217,615	33,395,104		33,395,104	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices				97,994		97,994	192
194	MARKETING				92,416		92,416	194
194.01	GUEST MEALS				66,846		66,846	194.01
194.02	CLINICAL PSYCH				76,847		76,847	194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	395,991	883,490	217,615	33,729,207		33,729,207	202

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

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	ADMINIS-TRATIVE & GENERAL	OPERATION OF PLANT	
		0	1	2	2A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General		92,021	45,349	137,370	137,370		5
6	Maintenance & Repairs							6
7	Operation of Plant		3,605	1,776	5,381	5,794	11,175	7
8	Laundry & Linen Service					1,112		8
9	Housekeeping		6,672	3,288	9,960	2,736	49	9
10	Dietary		102,280	50,404	152,684	7,030	749	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration		5,309	2,616	7,925	3,836	39	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		9,541	4,702	14,243	1,537	70	16
17	Social Service		4,448	2,192	6,640	3,511	33	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					889		22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		889,004	438,109	1,327,113	49,683	6,505	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic					479		54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory		2,511	1,237	3,748	2,874	18	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		4,448	2,192	6,640	2,247	33	65
66	Physical Therapy		176,402	86,932	263,334	19,776	1,291	66
67	Occupational Therapy		172,259	84,891	257,150	15,433	1,261	67
68	Speech Pathology		39,240	19,338	58,578	6,426	287	68
71	Medical Supplies Charged to Patients		73,011	35,980	108,991	4,513	534	71
73	Drugs Charged to Patients		11,747	5,789	17,536	8,579	86	73
76	PSYCHOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)		1,592,498	784,795	2,377,293	136,455	10,955	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		29,753	14,663	44,416	233	218	192
194	MARKETING		287	141	428	368	2	194
194.01	GUEST MEALS							194.01
194.02	CLINICAL PSYCH					314		194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		1,622,538	799,599	2,422,137	137,370	11,175	202

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2014 To: 05/31/2015	Run Date: 09/21/2015 Run Time: 10:21 Version: 2015.03 (09/17/2015)

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	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	1,112						8
9	Housekeeping		12,745					9
10	Dietary		857	161,320				10
11	Cafeteria			41,175	41,175			11
12	Maintenance of Personnel							12
13	Nursing Administration		45		1,701	13,546		13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		80		569		16,499	16
17	Social Service		37		1,524			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	1,112	7,455	114,354	18,002	13,546	6,356	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic						76	54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory		21				325	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		37		964		153	65
66	Physical Therapy		1,479		8,015		3,010	66
67	Occupational Therapy		1,444		5,920		2,757	67
68	Speech Pathology		329		2,767		1,272	68
71	Medical Supplies Charged to Patients		612		238		370	71
73	Drugs Charged to Patients		98		1,314		2,180	73
76	PSYCHOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	1,112	12,494	155,529	41,014	13,546	16,499	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		249					192
194	MARKETING		2		161			194
194.01	GUEST MEALS			5,791				194.01
194.02	CLINICAL PSYCH							194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,112	12,745	161,320	41,175	13,546	16,499	202

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	11,745						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		889					22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	11,745		1,555,871		1,555,871		30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic			555		555		54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory			6,986		6,986		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			10,074		10,074		65
66	Physical Therapy			296,905		296,905		66
67	Occupational Therapy			283,965		283,965		67
68	Speech Pathology			69,659		69,659		68
71	Medical Supplies Charged to Patients			115,258		115,258		71
73	Drugs Charged to Patients			29,793		29,793		73
76	PSYCHOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	11,745		2,369,066		2,369,066		118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices			45,116		45,116		192
194	MARKETING			961		961		194
194.01	GUEST MEALS			5,791		5,791		194.01
194.02	CLINICAL PSYCH			314		314		194.02
200	Cross Foot Adjustments		889	889		889		200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	11,745	889	2,422,137		2,422,137		202

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

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	90,471						1
2	Cap Rel Costs-Mvble Equip		90,471					2
4	Employee Benefits Department			18,298,788				4
5	Administrative & General	5,131	5,131	2,496,773	-7,477,248	26,166,296		5
6	Maintenance & Repairs							6
7	Operation of Plant	201	201	304,444		1,103,613	85,139	7
8	Laundry & Linen Service					211,858		8
9	Housekeeping	372	372	352,640		521,173	372	9
10	Dietary	5,703	5,703	576,059		1,339,077	5,703	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	296	296	601,753		730,718	296	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	532	532	201,354		292,676	532	16
17	Social Service	248	248	539,202		668,699	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					169,250		22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	49,570	49,570	6,368,958		9,464,295	49,570	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic					91,195		54
54.01	RADIOLOGY-SUA				-85,663			54.01
60	Laboratory	140	140			547,402	140	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	248	248	341,212		427,930	248	65
66	Physical Therapy	9,836	9,836	2,836,319		3,766,793	9,836	66
67	Occupational Therapy	9,605	9,605	2,094,898		2,939,536	9,605	67
68	Speech Pathology	2,188	2,188	978,946		1,224,067	2,188	68
71	Medical Supplies Charged to Patients	4,071	4,071	84,363		859,545	4,071	71
73	Drugs Charged to Patients	655	655	464,809		1,634,164	655	73
76	PSYCHOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	88,796	88,796	18,241,730	-7,562,911	25,991,991	83,464	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	1,659	1,659			44,416	1,659	192
194	MARKETING	16	16	57,058		70,121	16	194
194.01	GUEST MEALS							194.01
194.02	CLINICAL PSYCH					59,768		194.02
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,622,538	799,599	3,358,094		7,477,248	1,418,980	202
203	Unit Cost Multiplier (Wkst. B, Part I)	17.934344	8.838180	0.183515		0.285759	16.666628	203
204	Cost to be allocated (Per Wkst. B, Part II)					137,370	11,175	204
205	Unit Cost Multiplier (Wkst. B, Part II)					0.005250	0.131256	205

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	29,254						8
9	Housekeeping		84,767					9
10	Dietary		5,703	123,806				10
11	Cafeteria			31,600	14,568,872			11
12	Maintenance of Personnel							12
13	Nursing Administration		296		601,753	29,254		13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		532		201,354		66,899,401	16
17	Social Service		248		539,202			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	29,254	49,570	87,762	6,368,958	29,254	25,834,022	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic						308,857	54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory		140				1,314,247	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		248		341,212		621,387	65
66	Physical Therapy		9,836		2,836,319		12,185,851	66
67	Occupational Therapy		9,605		2,094,898		11,162,673	67
68	Speech Pathology		2,188		978,946		5,151,731	68
71	Medical Supplies Charged to Patients		4,071		84,363		1,495,974	71
73	Drugs Charged to Patients		655		464,809		8,824,659	73
76	PSYCHOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	29,254	83,092	119,362	14,511,814	29,254	66,899,401	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		1,659					192
194	MARKETING		16		57,058			194
194.01	GUEST MEALS			4,444				194.01
194.02	CLINICAL PSYCH							194.02
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	272,398	676,303	1,862,281	475,325	966,455	395,991	202
203	Unit Cost Multiplier (Wkst. B, Part I)	9.311479	7.978376	15.041929	0.032626	33.036679	0.005919	203
204	Cost to be allocated (Per Wkst. B, Part II)	1,112	12,745	161,320	41,175	13,546	16,499	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.038012	0.150353	1.303006	0.002826	0.463048	0.000247	205

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2014 To: 05/31/2015	Run Date: 09/21/2015 Run Time: 10:21 Version: 2015.03 (09/17/2015)

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

	COST CENTER DESCRIPTIONS	SOCIAL SERVICE PATIENT DAYS	I&R PROGRAM COSTS ASSIGNED TIME					
		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	29,254						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	29,254	100					30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic							54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients							73
76	PSYCHOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	29,254	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 centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	883,490	217,615					202
203	Unit Cost Multiplier (Wkst. B, Part I)	30.200656	2,176.150000					203
204	Cost to be allocated (Per Wkst. B, Part II)	11,745	889					204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.401484	8.890000					205

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2014 To: 05/31/2015	Run Date: 09/21/2015 Run Time: 10:21 Version: 2015.03 (09/17/2015)

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2014 To: 05/31/2015	Run Date: 09/21/2015 Run Time: 10:21 Version: 2015.03 (09/17/2015)

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	17,411,235		17,411,235	117,863	17,529,098	30
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	119,083		119,083		119,083	54
54.01	RADIOLOGY-SUA	85,663		85,663		85,663	54.01
60	Laboratory	715,056		715,056		715,056	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	571,137		571,137		571,137	65
66	Physical Therapy	5,250,262		5,250,262		5,250,262	66
67	Occupational Therapy	4,150,670		4,150,670		4,150,670	67
68	Speech Pathology	1,690,211		1,690,211		1,690,211	68
71	Medical Supplies Charged to Patients	1,217,105		1,217,105		1,217,105	71
73	Drugs Charged to Patients	2,184,682		2,184,682		2,184,682	73
76	PSYCHOLOGY						76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	33,395,104		33,395,104	117,863	33,512,967	200
201	Less Observation Beds						201
202	Total (line 200 minus line 201)	33,395,104		33,395,104		33,512,967	202

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2014 To: 05/31/2015	Run Date: 09/21/2015 Run Time: 10:21 Version: 2015.03 (09/17/2015)

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	25,834,022		25,834,022				30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	308,857		308,857	0.385560	0.385560	0.385560	54
54.01	RADIOLOGY-SUA	305,509		305,509	0.280394	0.280394	0.280394	54.01
60	Laboratory	1,314,247		1,314,247	0.544080	0.544080	0.544080	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	621,147	240	621,387	0.919133	0.919133	0.919133	65
66	Physical Therapy	6,902,475	5,283,376	12,185,851	0.430849	0.430849	0.430849	66
67	Occupational Therapy	6,995,997	4,166,676	11,162,673	0.371835	0.371835	0.371835	67
68	Speech Pathology	3,321,707	1,830,024	5,151,731	0.328086	0.328086	0.328086	68
71	Medical Supplies Charged to Patients	356,179	1,139,795	1,495,974	0.813587	0.813587	0.813587	71
73	Drugs Charged to Patients	8,824,659		8,824,659	0.247566	0.247566	0.247566	73
76	PSYCHOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	54,784,799	12,420,111	67,204,910				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	54,784,799	12,420,111	67,204,910				202

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2014 To: 05/31/2015	Run Date: 09/21/2015 Run Time: 10:21 Version: 2015.03 (09/17/2015)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	1,555,871		1,555,871	29,254	53.18	11,730	623,801	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)	1,555,871		1,555,871	29,254		11,730	623,801	200

(A) Worksheet A line numbers

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

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

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	555	308,857	0.001797	70,450	127	54
54.01	RADIOLOGY-SUA		305,509		37,608		54.01
60	Laboratory	6,986	1,314,247	0.005316	661,143	3,515	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	10,074	621,387	0.016212	202,071	3,276	65
66	Physical Therapy	296,905	12,185,851	0.024365	2,786,829	67,901	66
67	Occupational Therapy	283,965	11,162,673	0.025439	2,819,312	71,720	67
68	Speech Pathology	69,659	5,151,731	0.013521	1,318,375	17,826	68
71	Medical Supplies Charged to Patients	115,258	1,495,974	0.077045	142,272	10,961	71
73	Drugs Charged to Patients	29,793	8,824,659	0.003376	3,785,402	12,780	73
76	PSYCHOLOGY						76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	813,195	41,370,888		11,823,462	188,106	200

(A) Worksheet A line numbers

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2014 To: 05/31/2015	Run Date: 09/21/2015 Run Time: 10:21 Version: 2015.03 (09/17/2015)

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

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

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

(A) Worksheet A line numbers

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2014 To: 05/31/2015	Run Date: 09/21/2015 Run Time: 10:21 Version: 2015.03 (09/17/2015)

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

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

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	29,254		11,730		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)	29,254		11,730		200

(A) Worksheet A line numbers

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

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

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

(A) Worksheet A line numbers

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2014 To: 05/31/2015	Run Date: 09/21/2015 Run Time: 10:21 Version: 2015.03 (09/17/2015)

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

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

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	308,857			70,450				54
54.01	RADIOLOGY-SUA	305,509			37,608				54.01
60	Laboratory	1,314,247			661,143				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	621,387			202,071				65
66	Physical Therapy	12,185,851			2,786,829				66
67	Occupational Therapy	11,162,673			2,819,312				67
68	Speech Pathology	5,151,731			1,318,375				68
71	Medical Supplies Charged to Patients	1,495,974			142,272				71
73	Drugs Charged to Patients	8,824,659			3,785,402				73
76	PSYCHOLOGY								76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct Part)								92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	41,370,888			11,823,462				200

(A) Worksheet A line numbers

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2014 To: 05/31/2015	Run Date: 09/21/2015 Run Time: 10:21 Version: 2015.03 (09/17/2015)

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

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	0.385560							54
54.01	RADIOLOGY-SUA	0.280394							54.01
60	Laboratory	0.544080							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.919133							65
66	Physical Therapy	0.430849							66
67	Occupational Therapy	0.371835							67
68	Speech Pathology	0.328086							68
71	Medical Supplies Charged to Patients	0.813587							71
73	Drugs Charged to Patients	0.247566							73
76	PSYCHOLOGY								76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct Part)								92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2014 To: 05/31/2015	Run Date: 09/21/2015 Run Time: 10:21 Version: 2015.03 (09/17/2015)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	1,555,871		1,555,871	29,254	53.18	5,102	271,324	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)	1,555,871		1,555,871	29,254		5,102	271,324	200

(A) Worksheet A line numbers

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

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

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	555	308,857	0.001797	47,843	86	54
54.01	RADIOLOGY-SUA		305,509		21,050		54.01
60	Laboratory	6,986	1,314,247	0.005316	204,349	1,086	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	10,074	621,387	0.016212	117,683	1,908	65
66	Physical Therapy	296,905	12,185,851	0.024365	1,158,521	28,227	66
67	Occupational Therapy	283,965	11,162,673	0.025439	606,287	15,423	67
68	Speech Pathology	69,659	5,151,731	0.013521	1,175,274	15,891	68
71	Medical Supplies Charged to Patients	115,258	1,495,974	0.077045	70,649	5,443	71
73	Drugs Charged to Patients	29,793	8,824,659	0.003376	1,398,398	4,721	73
76	PSYCHOLOGY						76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	813,195	41,370,888		4,800,054	72,785	200

(A) Worksheet A line numbers

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2014 To: 05/31/2015	Run Date: 09/21/2015 Run Time: 10:21 Version: 2015.03 (09/17/2015)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

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

(A) Worksheet A line numbers

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2014 To: 05/31/2015	Run Date: 09/21/2015 Run Time: 10:21 Version: 2015.03 (09/17/2015)

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

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

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	29,254		5,102		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)	29,254		5,102		200

(A) Worksheet A line numbers

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

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

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

(A) Worksheet A line numbers

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2014 To: 05/31/2015	Run Date: 09/21/2015 Run Time: 10:21 Version: 2015.03 (09/17/2015)

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

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

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	308,857			47,843				54
54.01	RADIOLOGY-SUA	305,509			21,050				54.01
60	Laboratory	1,314,247			204,349				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	621,387			117,683				65
66	Physical Therapy	12,185,851			1,158,521				66
67	Occupational Therapy	11,162,673			606,287				67
68	Speech Pathology	5,151,731			1,175,274				68
71	Medical Supplies Charged to Patients	1,495,974			70,649				71
73	Drugs Charged to Patients	8,824,659			1,398,398				73
76	PSYCHOLOGY								76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct Part)								92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	41,370,888			4,800,054				200

(A) Worksheet A line numbers

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2014 To: 05/31/2015	Run Date: 09/21/2015 Run Time: 10:21 Version: 2015.03 (09/17/2015)

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

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	0.385560							54
54.01	RADIOLOGY-SUA	0.280394							54.01
60	Laboratory	0.544080							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.919133							65
66	Physical Therapy	0.430849		22,301			9,608		66
67	Occupational Therapy	0.371835		16,216			6,030		67
68	Speech Pathology	0.328086		5,979			1,962		68
71	Medical Supplies Charged to Patients	0.813587		5,594			4,551		71
73	Drugs Charged to Patients	0.247566							73
76	PSYCHOLOGY								76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct Part)								92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			50,090			22,151		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			50,090			22,151		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: 06/01/2014 To: 05/31/2015	Run Date: 09/21/2015 Run Time: 10:21 Version: 2015.03 (09/17/2015)

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

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	29,254	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	29,254	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.	382	3
4	Semi-private room days (excluding swing-bed private room days)	28,872	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	11,730	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	17,529,098	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	17,529,098	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)	25,834,022	28
29	Private room charges (excluding swing-bed charges)	377,373	29
30	Semi-private room charges (excluding swing-bed charges)	25,456,649	30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.678528	31
32	Average private room per diem charge (line 29 ÷ line 3)	987.89	32
33	Average semi-private room per diem charge (line 30 ÷ line 4)	881.71	33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)	106.18	34
35	Average per diem private room cost differential (line 34 x line 31)	72.05	35
36	Private room cost differential adjustment (line 3 x line 35)	27,523	36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	17,501,575	37

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2014 To: 05/31/2015	Run Date: 09/21/2015 Run Time: 10:21 Version: 2015.03 (09/17/2015)

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

Check Applicable Boxes: [ ] Title V - I/P [XX] Hospital [ ] SUB (Other) [XX] PPS
[XX] Title XVIII, Part A [ ] IPF [ ] TEFRA
[ ] 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)	599.20	38
39	Program general inpatient routine service cost (line 9 x line 38)	7,028,616	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)	7,028,616	41

		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47

		1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	4,317,602	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	11,346,218	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	623,801	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	188,106	51
52	Total Program excludable cost (sum of lines 50 and 51)	811,907	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	10,534,311	53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63

PROGRAM INPATIENT ROUTINE SWING BED COST

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

Check Applicable Boxes:	**[ ] Title V - I/P**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/MR**	**[XX] PPS**
	[XX] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**
	[ ] 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)					599.20	88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 27)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2014 To: 05/31/2015	Run Date: 09/21/2015 Run Time: 10:21 Version: 2015.03 (09/17/2015)

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

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	29,254	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	29,254	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.	382	3
4	Semi-private room days (excluding swing-bed private room days)	28,872	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	5,102	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	17,411,235	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	17,411,235	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)	25,834,022	28
29	Private room charges (excluding swing-bed charges)	377,373	29
30	Semi-private room charges (excluding swing-bed charges)	25,456,649	30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.673965	31
32	Average private room per diem charge (line 29 ÷ line 3)	987.89	32
33	Average semi-private room per diem charge (line 30 ÷ line 4)	881.71	33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)	106.18	34
35	Average per diem private room cost differential (line 34 x line 31)	71.56	35
36	Private room cost differential adjustment (line 3 x line 35)	27,336	36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	17,383,899	37

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2014 To: 05/31/2015	Run Date: 09/21/2015 Run Time: 10:21 Version: 2015.03 (09/17/2015)

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

Check Applicable Boxes: [ ] Title V - I/P [XX] Hospital [ ] SUB (Other) [ ] PPS
[ ] Title XVIII, Part A [ ] IPF [ ] TEFRA
[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)					594.24	38
39	Program general inpatient routine service cost (line 9 x line 38)					3,031,812	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)					3,031,812	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
						1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,757,549	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					4,789,361	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					271,324	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					72,785	51
52	Total Program excludable cost (sum of lines 50 and 51)					344,109	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

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

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

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

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2014 To: 05/31/2015	Run Date: 09/21/2015 Run Time: 10:21 Version: 2015.03 (09/17/2015)

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

Check Applicable Boxes:	**[ ] Title V**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] Swing Bed SNF**	**[XX] PPS**
	[XX] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**	**[ ] Swing Bed NF**	**[ ] TEFRA**
	[ ] Title XIX	**[ ] IRF**	**[ ] NF**	**[ ] ICF/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		10,355,326		30
	ANCILLARY SERVICE COST CENTERS				
54	Radiology-Diagnostic	0.385560	70,450	27,163	54
54.01	RADIOLOGY-SUA	0.280394	37,608	10,545	54.01
60	Laboratory	0.544080	661,143	359,715	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.919133	202,071	185,730	65
66	Physical Therapy	0.430849	2,786,829	1,200,702	66
67	Occupational Therapy	0.371835	2,819,312	1,048,319	67
68	Speech Pathology	0.328086	1,318,375	432,540	68
71	Medical Supplies Charged to Patients	0.813587	142,272	115,751	71
73	Drugs Charged to Patients	0.247566	3,785,402	937,137	73
76	PSYCHOLOGY				76
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
92	Observation Beds (Non-Distinct Part)				92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		11,823,462	4,317,602	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		11,823,462		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: 06/01/2014 To: 05/31/2015	Run Date: 09/21/2015 Run Time: 10:21 Version: 2015.03 (09/17/2015)

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

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		4,463,687		30
	ANCILLARY SERVICE COST CENTERS				
54	Radiology-Diagnostic	0.385560	47,843	18,446	54
54.01	RADIOLOGY-SUA	0.280394	21,050	5,902	54.01
60	Laboratory	0.544080	204,349	111,182	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.919133	117,683	108,166	65
66	Physical Therapy	0.430849	1,158,521	499,148	66
67	Occupational Therapy	0.371835	606,287	225,439	67
68	Speech Pathology	0.328086	1,175,274	385,591	68
71	Medical Supplies Charged to Patients	0.813587	70,649	57,479	71
73	Drugs Charged to Patients	0.247566	1,398,398	346,196	73
76	PSYCHOLOGY				76
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
92	Observation Beds (Non-Distinct Part)				92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		4,800,054	1,757,549	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		4,800,054		202

(A) Worksheet A line numbers

PART B - MEDICAL AND OTHER HEALTH SERVICES

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

TO BE COMPLETED BY CONTRACTOR

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

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2014 To: 05/31/2015	Run Date: 09/21/2015 Run Time: 10:21 Version: 2015.03 (09/17/2015)

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

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

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				17,860,046			1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		Provider	.52					3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99					3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				17,860,046			4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due)		.01		390,764			6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				18,250,810			7
8	Name of Contractor			Contractor Number		NPR Date (Month/Day/Year)		8

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

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

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

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

		1	1.01	
1	Net Federal PPS payment (see instructions)	15,888,999		1
2	Medicare SSI ratio (IRF PPS only) (see instructions)	0.077000		2
3	Inpatient Rehabilitation LIP payments (see instructions)	1,682,645		3
4	Outlier payments	54,434		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)			5.01
6	New teaching program adjustment (see instructions)			6
7	Current year unweighted FTE count of I&R excludnig FTEs in the new program growth period of a 'new teaching program' (see instructions)	5.22		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)	80.147945		10
11	Teaching Adjustment Factor (see instructions)	0.055437		11
12	Teaching Adjustment (see instructions)	880,838		12
13	Total PPS Payment (see instructions)	18,506,916		13
14	Nursing and allied health managed care payments (see instructions)			14
15	Organ acquisition DO NOT USE THIS LINE			15
16	Cost of physicians' services in a teaching hospital (see instructions)			16
17	Subtotal (see instructions)	18,506,916		17
18	Primary payer payments			18
19	Subtotal (line 17 less line 18)	18,506,916		19
20	Deductibles	124,488		20
21	Subtotal (line 19 minus line 20)	18,382,428		21
22	Coinsurance	219,255		22
23	Subtotal (line 21 minus line 22)	18,163,173		23
24	Allowable bad debts (exclude bad debts for professional services) (see instructions)	134,826		24
25	Adjusted reimbursable bad debts (see instructions)	87,637		25
26	Allowable bad debts for dual eligible beneficiaries (see instructions)	82,570		26
27	Subtotal (sum of lines 23 and 25)	18,250,810		27
28	Direct graduate medical education payments (from Wkst. E-4, line 49) (For free standing IRF only)			28
29	Other pass through costs (see instructions)			29
30	Outlier payments reconciliation			30
31	Other adjustments (specify) (see instructions)			31
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			31.50
32	Total amount payable to the provider (see instructions)	18,250,810		32
32.01	Sequestration adjustment (see instructions)	365,016		32.01
33	Interim payments	17,860,046		33
34	Tentative settlement (for contractor use only)			34
35	Balance due provider/program (line 32 minus lines 32.01, 33 and 34)	25,748		35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	28,463		36

TO BE COMPLETED BY CONTRACTOR

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

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

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

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	4,789,361		1
2	Medical and other services		22,151	2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	4,789,361	22,151	4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	4,789,361	22,151	7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges	4,463,687		8
9	Ancillary service charges	4,800,054	50,090	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)	9,263,741	50,090	12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahrge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)	9,263,741	50,090	16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	4,474,380	27,939	17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)	4,789,361	22,151	21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)	4,789,361	22,151	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)	4,789,361	22,151	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)	4,789,361	22,151	36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	4,789,361	22,151	38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)	4,789,361	22,151	40
41	Interim payments	4,695,055	50,429	41
42	Balance due provider/program (line 40 minus line 41)	94,306	-28,278	42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

BALANCE SHEET **WORKSHEET G**

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

	Assets	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	3,310,889				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	9,217,416				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-2,919,404				6
7	Inventory	241,822				7
8	Prepaid expenses	210,641				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	10,061,364				11
	FIXED ASSETS					
12	Land					12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings	21,340,187				15
16	Accumulated depreciation	-9,869,804				16
17	Leasehold improvements	9,155				17
18	Accumulated depreciation	-9,155				18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Audomobiles and trucks	120,296				21
22	Accumulated depreciation	-120,296				22
23	Major movable equipment	5,912,825				23
24	Accumulated depreciation	-3,921,868				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)	13,461,340				30
	OTHER ASSETS					
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	1,593,752				34
35	Total other assets (sum of lines 31-34)	1,593,752				35
36	Total assets (sum of lines 11, 30 and 35)	25,116,456				36

	Liabilities and Fund Balances	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable	915,543				37
38	Salaries, wages and fees payable	1,287,586				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)					40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	49,931				44
45	Total current liabilities (sum of lines 37 thru 44)	2,253,060				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	12,230,136				49
50	Total long term liabilities (sum of lines 46 thru 49)	12,230,136				50
51	Total liabilities (sum of lines 45 and 50)	14,483,196				51
	CAPITAL ACCOUNTS					
52	General fund balance	10,633,260				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	10,633,260				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	25,116,456				60

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2014 To: 05/31/2015	Run Date: 09/21/2015 Run Time: 10:21 Version: 2015.03 (09/17/2015)

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		10,539,752			1
2	Net income (loss) (from Worksheet G-3, line 29)		4,219,032			2
3	Total (sum of line 1 and line 2)		14,758,784			3
4	Additions (credit adjustments) (specify)					4
5						5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)		14,758,784			11
12	Deductions (debit adjustments) (specify)					12
13	MINORITY INTEREST	2,109,516				13
14	DISTRIBUTIONS	2,016,008				14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)		4,125,524			18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		10,633,260			19

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	25,833,932		25,833,932	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility				7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	25,833,932		25,833,932	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit				11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)				16
17	Total inpatient routine care services (sum of lines 10 and 16)	25,833,932		25,833,932	17
18	Ancillary services	28,951,008	12,419,966	41,370,974	18
19	Outpatient services				19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	Other (specify)				27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	54,784,940	12,419,966	67,204,906	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		36,281,923	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)		36,281,923	43

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form **CMS-2552-10**	Period : From: 06/01/2014 To: 05/31/2015	Run Date: 09/21/2015 Run Time: 10:21 Version: 2015.03 (09/17/2015)

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	67,204,906	1
2	Less contractual allowances and discounts on patients' accounts	29,753,231	2
3	Net patient revenues (line 1 minus line 2)	37,451,675	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	36,281,923	4
5	Net income from service to patients (line 3 minus line 4)	1,169,752	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments	30,225	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts	290	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	85,812	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients	2,183	17
18	Revenue from sale of medical records and abstracts		18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines	6,661	21
22	Rental of hosptial space	41,136	22
23	Governmental appropriations		23
24	Other (specify)	2,882,973	24
25	Total other income (sum of lines 6-24)	3,049,280	25
26	Total (line 5 plus line 25)	4,219,032	26
29	Net income (or loss) for the period (line 26 minus line 28)	4,219,032	29