

**KPMG LLP Compu-Max 2552-10**

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 06/01/2016 To: 05/31/2017	Run Date: 09/26/2017 Run Time: 13:40 Version: 2017.01 (08/09/2017)
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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY**

**WORKSHEET S  
PARTS I, II & III**

**PART I - COST REPORT STATUS**

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted the cost report 4. <input checked="" type="checkbox"/> Medicare Utilization. Enter 'F' for full or 'L' for low.		Date: 09/26/2017 Time: 13:40
Contractor use only	5. <input type="checkbox"/> 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. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ____ 12. <input type="checkbox"/> 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 06/01/2016 and ending 05/31/2017, 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

09/27/2017  
Date

**PART III - SETTLEMENT SUMMARY**

		TITLE XVIII					
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		51,857				1
2	SUBPROVIDER - IPF					523,138	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		51,857			523,138	200

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence 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	
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 / 2016	To: 05 / 31 / 2017	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.	4,364	809	497	465	1,758		25

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

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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
Prospective Payment System (PPS)-Capital		V	XVIII	XIX
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	1	2	3
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	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	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	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 as defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	N			60
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

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

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

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

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

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

**Teaching Hospitals that Claim Residents in 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
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**WORKSHEET S-2  
PART I**

Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all 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)						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))		
65	1	2	3	4	5		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))		
67	1	2	3	4	5		67

**Inpatient Psychiatric Facility PPS**

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

**Inpatient Rehabilitation Facility PPS**

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

**Long Term Care Hospital PPS**

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

**TEFRA Providers**

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

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**WORKSHEET S-2  
PART I**

		V	XIX	
Title V and XIX Services		1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92
93	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97

**Rural Providers**

		1	2		
105	Does this hospital qualify as a critical access hospital (CAH)?	N		105	
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106	
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.			107	
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108	
		Physical	Occupational	Speech	Respiratory
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.				109
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.			N	110

**Miscellaneous Cost Reporting Information**

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	N			116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.	Y			117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	87,617	503,795		118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.	N		N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.	N			121
122	Does the cost report contain state health or similar taxes? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.	Y		5.00	122

**Transplant Center Information**

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

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**WORKSHEET S-2  
PART I**

All Providers

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

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

141	Name: HEALTHSOUTH CORPORATION	Contractor's Name: CAHABA GBA	Contractor's Number: 10101	141
142	Street: 3660 GRANDVIEW PARKWAY, SUITE	P.O. Box:		142
143	City: BIRMINGHAM	State: AL	ZIP Code: 35243	143
144	Are provider based physicians' costs included in Worksheet A?	Y		144
145	If costs for renal services are claimed on Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.	N	N	145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, chapter 40, §4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N		147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N		148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	N		149

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

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

Multicampus

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

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

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

**KPMG LLP Compu-Max 2552-10**

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 06/01/2016 To: 05/31/2017	Run Date: 09/26/2017 Run Time: 13:40 Version: 2017.01 (08/09/2017)
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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE**

**WORKSHEET S-2  
PART II**

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

**COMPLETED BY ALL HOSPITALS**

		Y/N	Date		
<b>Provider Organization and Operation</b>					
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	
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	
<b>Financial Data and Reports</b>					
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	Y	A	02/22/2017	4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N			5

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

		Y/N	
<b>Bad Debts</b>			
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

<b>Bed Complement</b>			
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
<b>PS&amp;R Report Data</b>					
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	08/01/2017	N	
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N	
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	
20	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	

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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE**

**WORKSHEET S-2  
PART II**

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

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

Capital Related Cost		
22	Have assets been relieved 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

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

Cost Report Preparer Contact Information			
41	First name: COURTNEY	Last name: CAMERON	Title: REIMBURSEMENT SPECIALIST
42	Employer: HEALTHSOUTH CORPORATION		
43	Phone number: 2059687055	E-mail Address: COURTNEY.CAMERON@HEALTHSOUTH.COM	

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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA**

**WORKSHEET S-3  
PART I**

	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Inpatient Days / Outpatient Visits / Trips			Total All Patients	
						Title V	Title XVIII	Title XIX		
		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			10,047	4,454	28,284	1
2	HMO and other (see instructions)						2,914	3,439		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			10,047	4,454	28,284	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			10,047	4,454	28,284	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

**KPMG LLP Compu-Max 2552-10**

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 06/01/2016 To: 05/31/2017	Run Date: 09/26/2017 Run Time: 13:40 Version: 2017.01 (08/09/2017)
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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA**

**WORKSHEET S-3  
PART I**

	Component	Full Time Equivalents			DISCHARGES				
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					745	373	1,943	1
2	HMO and other (see instructions)					207	137		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)	4.93	293.29			745	373	1,943	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)	4.93	293.29						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

**KPMG LLP Compu-Max 2552-10**

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 06/01/2016 To: 05/31/2017	Run Date: 09/26/2017 Run Time: 13:40 Version: 2017.01 (08/09/2017)
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**HOSPITAL WAGE INDEX INFORMATION**

**WORKSHEET S-3  
PARTS II-III**

**Part II - Wage Data**

	Wkst A Line No.	Amount Reported	Reclassif- ication of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)	
	1	2	3	4	5	6	
<b>SALARIES</b>							
1	Total salaries (see instructions)	200	17,745,301		610,043.20		1
2	Non-physician anesthetist Part A						2
3	Non-physician anesthetest Part B						3
4	Physician-Part A - Administrative						4
4.01	Physician-Part A - Teaching						4.01
5	Physician-Part B						5
6	Non-physician-Part B						6
7	Interns & residents (in an approved program)	21					7
7.01	Contracted interns & residents (in an approved program)						7.01
8	Home office and/or related organization personnel						8
9	SNF	44					9
10	Excluded area salaries (see instructions)			122,725	3,078.40		10
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11	Contract labor (see instructions)		546,129		15,656.59		11
12	Contract management and administrative services						12
13	Contract labor: Physician-Part A - Administrative		406,134		2,471.00		13
14	Home office salaries & wage-related costs						14
14.01	Home office salaries		941,930		16,121.26		14.01
14.02	Related organization salaries						14.02
15	Home office: Physician Part A - Administrative						15
16	Home office & Contract Physicians Part A - Teaching						16
<b>WAGE-RELATED COSTS</b>							
17	Wage-related costs (core)(see instructions)		3,555,484				17
18	Wage-related costs (other)(see instructions)						18
19	Excluded areas		24,761				19
20	Non-physician anesthetist Part A						20
21	Non-physician anesthetist Part B						21
22	Physician Part A - Administrative						22
22.01	Physician Part A - Teaching						22.01
23	Physician Part B						23
24	Wage-related costs (RHC/FQHC)						24
25	Interns & residents (in an approved program)						25
25.50	Home office wage-related		376,042				25.50
25.51	Related organization wage-related						25.51
25.52	Home office: Physician Part A - Administrative - wage-related						25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related						25.53
<b>OVERHEAD COSTS - DIRECT SALARIES</b>							
26	Employee Benefits Department						26
27	Administrative & General		2,646,102	-122,725	81,889.60		27
28	Administrative & General under contract (see instructions)						28
29	Maintenance & Repairs						29
30	Operation of Plant		273,498		9,859.20		30
31	Laundry & Linen Service						31
32	Housekeeping		283,860		24,419.20		32
33	Housekeeping under contract (see instructions)						33
34	Dietary						34
35	Dietary under contract (see instructions)						35
36	Cafeteria						36
37	Maintenance of Personnel						37
38	Nursing Administration		558,332		15,184.00		38
39	Central Services and Supply						39
40	Pharmacy						40
41	Medical Records & Medical Records Library		212,919		7,862.40		41
42	Social Service		617,946		21,361.60		42
43	Other General Service						43

**Part III - Hospital Wage Index Summary**

1	Net salaries (see instructions)		17,745,301		17,745,301	610,043.20	29.09	1
2	Excluded area salaries (see instructions)			122,725	122,725	3,078.40	39.87	2
3	Subtotal salaries (line 1 minus line 2)		17,745,301	-122,725	17,622,576	606,964.80	29.03	3
4	Subtotal other wages & related costs (see instructions)		1,894,193		1,894,193	34,248.85	55.31	4
5	Subtotal wage-related costs (see instructions)		3,931,526		3,931,526		22.31%	5
6	Total (sum of lines 3 through 5)		23,571,020	-122,725	23,448,295	641,213.65	36.57	6
7	Total overhead cost (see instructions)		4,592,657	-122,725	4,469,932	160,576.00	27.84	7

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**HOSPITAL WAGE RELATED COSTS**

**WORKSHEET S-3  
PART IV**

**Part IV - Wage Related Cost**

**Part A - Core List**

		Amount Reported	
	<b>RETIREMENT COST</b>		
1	401K Employer Contributions	255,901	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
	<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization):</b>		
5	401k/TSA Plan Administration Fees		5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees		7
	<b>HEALTH AND INSURANCE COST</b>		
8	Health Insurance (Purchased or Self Funded)		8
8.01	Health Insurance (Self Funded without a Third Party Administrator)		8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	2,480,121	8.02
8.03	Health Insurance (Purchased)		8.03
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan		10
11	Life Insurance (If employee is owner or beneficiary)	37,235	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	160,901	15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	<b>TAXES</b>		
17	FICA-Employers Portion Only	1,297,339	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance		19
20	State or Federal Unemployment Taxes	52,809	20
	<b>OTHER</b>		
21	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	Day Care Costs and Allowances	-704,062	22
23	Tuition Reimbursement		23
24	Total Wage Related cost (Sum of lines 1-23)	3,580,244	24

**Part B - Other Than Core Related Cost**

25	OTHER WAGE RELATED COSTs (SPECIFY)		25
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**HOSPITAL CONTRACT LABOR AND BENEFIT COST**

**WORKSHEET S-3  
PART V**

**Part V - Contract Labor and Benefit Cost**

**Hospital and Hospital-Based Component Identification:**

	Component	Contract Labor	Benefit Cost	
	0	1	2	
1	Total facility contract labor and benefit cost	546,129	3,580,245	1
2	Hospital	546,129	3,555,484	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		24,761	18

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

**WORKSHEET A**

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		<b>GENERAL SERVICE COST CENTERS</b>								
1	00100	Cap Rel Costs-Bldg & Fixt		1,429,307	1,429,307	128,335	1,557,642	27,655	1,585,297	1
2	00200	Cap Rel Costs-Mvble Equip		802,871	802,871	36,801	839,672	-2,298	837,374	2
3	00300	Other Cap Rel Costs		132,958	132,958	-132,958			-0-	3
4	00400	Employee Benefits Department		3,867,528	3,867,528		3,867,528	-380,877	3,486,651	4
5	00500	Administrative & General	2,646,102	6,910,432	9,556,534	-715,137	8,841,397	-1,255,751	7,585,646	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	273,498	772,333	1,045,831	-17,052	1,028,779	-44,071	984,708	7
8	00800	Laundry & Linen Service		209,429	209,429		209,429		209,429	8
9	00900	Housekeeping	283,860	86,958	370,818		370,818		370,818	9
10	01000	Dietary		1,298,305	1,298,305	-13	1,298,292		1,298,292	10
11	01100	Cafeteria								11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	558,332	10,809	569,141		569,141	-570	568,571	13
14	01400	Central Services & Supply								14
15	01500	Pharmacy								15
16	01600	Medical Records & Library	212,919	21,882	234,801		234,801		234,801	16
17	01700	Social Service	617,946	15,990	633,936		633,936	-201	633,735	17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd				165,000	165,000		165,000	22
23	02300	Paramed Ed Prgm-(specify)								23
		<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30	03000	Adults & Pediatrics	6,392,441	517,876	6,910,317	361,300	7,271,617	-129,256	7,142,361	30
		<b>ANCILLARY SERVICE COST CENTERS</b>								
54	05400	Radiology-Diagnostic		177,209	177,209	-129,890	47,319	-1	47,318	54
54.01	05401	RADIOLOGY				129,890	129,890	-54,650	75,240	54.01
60	06000	Laboratory		546,295	546,295		546,295		546,295	60
62.30	06250	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>								62.30
65	06500	Respiratory Therapy	387,662	6,505	394,167	17,903	412,070	-145	411,925	65
66	06600	Physical Therapy	2,913,757	124,736	3,038,493		3,038,493	-12,500	3,025,993	66
67	06700	Occupational Therapy	1,768,370	199,135	1,967,505		1,967,505	-12,500	1,955,005	67
68	06800	Speech Pathology	1,003,806	12,066	1,015,872		1,015,872		1,015,872	68
71	07100	Medical Supplies Charged to Patients	142,724	580,323	723,047		723,047	-28	723,019	71
73	07300	Drugs Charged to Patients	496,025	1,004,899	1,500,924		1,500,924	-9,362	1,491,562	73
76	03550	PSYCHOLOGY	47,859	560	48,419	-48,419				76
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		<b>OUTPATIENT SERVICE COST CENTERS</b>								
92	09200	Observation Beds (Non-Distinct Part)								92
		<b>OTHER REIMBURSABLE COST CENTERS</b>								
		<b>SPECIAL PURPOSE COST CENTERS</b>								
113	11300	Interest Expense		8,056	8,056		8,056	-8,056		113
118		SUBTOTALS (sum of lines 1-117)	17,745,301	18,736,462	36,481,763	-204,240	36,277,523	-1,882,611	34,394,912	118
		<b>NONREIMBURSABLE COST CENTERS</b>								
192	19200	Physicians' Private Offices								192
194	07950	MARKETING				126,398	126,398		126,398	194
194.01	07951	GUEST MEALS								194.01
194.02	07952	CLINICAL PSYCH				77,842	77,842		77,842	194.02
200		TOTAL (sum of lines 118-199)	17,745,301	18,736,462	36,481,763		36,481,763	-1,882,611	34,599,152	200

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**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		25,007	1
2	INSURANCE	A	Cap Rel Costs-Mvble Equip	2		7,171	2
3	INSURANCE	A					3
500	Total reclassifications					32,178	500
	Code Letter - A						
1	MARKETING	B	MARKETING	194	122,725	3,673	1
2	MARKETING	B					2
3	MARKETING	B					3
500	Total reclassifications				122,725	3,673	500
	Code Letter - B						
1	PHYSICIANS	C	Adults & Pediatrics	30		312,573	1
2	PHYSICIANS	C					2
500	Total reclassifications					312,573	500
	Code Letter - C						
1	PROFESSIONAL FEES	D	I&R Services-Other Prgm Costs	22		165,000	1
2	PROFESSIONAL FEES	D					2
500	Total reclassifications					165,000	500
	Code Letter - D						
1	CLINICAL PSYCHOLOGY	E	CLINICAL PSYCH	194.02		36,000	1
2	CLINICAL PSYCHOLOGY	E					2
500	Total reclassifications					36,000	500
	Code Letter - E						
1	MISC RECLASS	F	Adults & Pediatrics	30	47,859	868	1
2	MISC RECLASS	F					2
3	MISC RECLASS	F					3
500	Total reclassifications				47,859	868	500
	Code Letter - F						
1	SERVICE UNDER ARRANGEMENT	G	RADIOLOGY	54.01		129,890	1
2	SERVICE UNDER ARRANGEMENT	G					2
500	Total reclassifications					129,890	500
	Code Letter - G						
1	CONTRACT SERVICES	H	CLINICAL PSYCH	194.02		41,842	1
2	CONTRACT SERVICES	H					2
500	Total reclassifications					41,842	500
	Code Letter - H						
1	REBATE RECLASS	I	Respiratory Therapy	65		17,903	1
2	REBATE RECLASS	I					2
3	REBATE RECLASS	I					3
500	Total reclassifications					17,903	500
	Code Letter - I						
	GRAND TOTAL (Increases)				170,584	739,927	

(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.

**KPMG LLP Compu-Max 2552-10**

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**RECLASSIFICATIONS**

**WORKSHEET A-6**

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	INSURANCE	A					12	1
2	INSURANCE	A					12	2
3	INSURANCE	A	Administrative & General	5		32,178		3
500	Total reclassifications					32,178		500
	Code letter - A							
1	MARKETING	B						1
2	MARKETING	B	Administrative & General	5	122,725	3,660		2
3	MARKETING	B	Dietary	10		13		3
500	Total reclassifications				122,725	3,673		500
	Code letter - B							
1	PHYSICIANS	C						1
2	PHYSICIANS	C	Administrative & General	5		312,573		2
500	Total reclassifications					312,573		500
	Code letter - C							
1	PROFESSIONAL FEES	D						1
2	PROFESSIONAL FEES	D	Administrative & General	5		165,000		2
500	Total reclassifications					165,000		500
	Code letter - D							
1	CLINICAL PSYCHOLOGY	E						1
2	CLINICAL PSYCHOLOGY	E	Administrative & General	5		36,000		2
500	Total reclassifications					36,000		500
	Code letter - E							
1	MISC RECLASS	F						1
2	MISC RECLASS	F	Administrative & General	5		308		2
3	MISC RECLASS	F	PSYCHOLOGY	76	47,859	560		3
500	Total reclassifications				47,859	868		500
	Code letter - F							
1	SERVICE UNDER ARRANGEMENT	G						1
2	SERVICE UNDER ARRANGEMENT	G	Radiology-Diagnostic	54		129,890		2
500	Total reclassifications					129,890		500
	Code letter - G							
1	CONTRACT SERVICES	H						1
2	CONTRACT SERVICES	H	Administrative & General	5		41,842		2
500	Total reclassifications					41,842		500
	Code letter - H							
1	REBATE RECLASS	I						1
2	REBATE RECLASS	I	Administrative & General	5		851		2
3	REBATE RECLASS	I	Operation of Plant	7		17,052		3
500	Total reclassifications					17,903		500
	Code letter - I							
	GRAND TOTAL (Decreases)				170,584	739,927		

(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.

**KPMG LLP Compu-Max 2552-10**

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**RECONCILIATION OF CAPITAL COST CENTERS**

**WORKSHEET A-7  
PARTS I, II & III**

**PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES**

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
			Purchases	Donation	Total				
		1	2	3	4	5	6	7	
1	Land								1
2	Land Improvements	20,740					20,740		2
3	Buildings and Fixtures	18,219,367				105,020	18,114,347		3
4	Building Improvements	3,254,676	548,606		548,606		3,803,282		4
5	Fixed Equipment								5
6	Movable Equipment	6,187,702	202,050		202,050	98,862	6,290,890		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	27,682,485	750,656		750,656	203,882	28,229,259		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	27,682,485	750,656		750,656	203,882	28,229,259		10

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

	Description	SUMMARY OF CAPITAL							Total (1) (sum of cols. 9 through 14)	
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt	825,744	603,563					1,429,307	1	
2	Cap Rel Costs-Mvble Equip	493,654	309,217					802,871	2	
3	Total (sum of lines 1-2)	1,319,398	912,780					2,232,178	3	

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

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

**PART III - RECONCILIATION OF CAPITAL COST CENTERS**

	Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		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	21,938,369		21,938,369	0.777150		103,328		103,328	1
2	Cap Rel Costs-Mvble Equip	6,290,890		6,290,890	0.222850		29,630		29,630	2
3	Total (sum of lines 1-2)	28,229,259		28,229,259	1.000000		132,958		132,958	3

	Description	SUMMARY OF CAPITAL							Total (2) (sum of cols. 9 through 14)	
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt	946,499	62,641	447,822	25,007	103,328		1,585,297	1	
2	Cap Rel Costs-Mvble Equip	491,356	309,217		7,171	29,630		837,374	2	
3	Total (sum of lines 1-2)	1,437,855	371,858	447,822	32,178	132,958		2,422,671	3	

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

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**ADJUSTMENTS TO EXPENSES**

**WORKSHEET A-8**

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		
				COST CENTER	LINE#	Wkst. A-7 Ref.
		1	2	3	4	5
1	Investment income-buildings & fixtures (chapter 2)			Cap Rel Costs-Bldg & Fixt	1	1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2	2
3	Investment income-other (chapter 2)					3
4	Trade, quantity, and time discounts (chapter 8)					4
5	Refunds and rebates of expenses (chapter 8)					5
6	Rental of provider space by suppliers (chapter 8)					6
7	Telephone services (pay stations excl) (chapter 21)					7
8	Television and radio service (chapter 21)					8
9	Parking lot (chapter 21)					9
10	Provider-based physician adjustment	Wkst A-8-2	-125,273			10
11	Sale of scrap, waste, etc. (chapter 23)					11
12	Related organization transactions (chapter 10)	Wkst A-8-1	1,843,179			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	-8,056	Interest Expense	113	37
37.02	DEPRECIATION	A	3	Cap Rel Costs-Mvble Equip	2	37.02
37.03	INSURANCE	A	-373,260	Employee Benefits Department	4	37.03
37.04	INSURANCE	A	-135,915	Administrative & General	5	37.04
37.05	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-650,314	Administrative & General	5	37.05
37.06	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-102	Operation of Plant	7	37.06
37.07	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-140	Social Service	17	37.07
37.08	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-3,983	Adults & Pediatrics	30	37.08
37.09	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-145	Respiratory Therapy	65	37.09
37.10	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-12,500	Physical Therapy	66	37.10
37.11	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-12,500	Occupational Therapy	67	37.11
37.12	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-28	Medical Supplies Charged to Patients	71	37.12
37.13	PATIENT TELEPHONE	A	-541	Cap Rel Costs-Mvble Equip	2	37.13
37.14	PATIENT TELEPHONE	A	-5,488	Employee Benefits Department	4	37.14
37.15	PATIENT TELEPHONE	A	-31,377	Administrative & General	5	37.15
37.16	PATIENT TELEPHONE	A	-1,302	Operation of Plant	7	37.16
37.17	PATIENT TELEVISION	A	-1,760	Cap Rel Costs-Mvble Equip	2	37.17
37.18	PATIENT TELEVISION	A	-12,542	Operation of Plant	7	37.18
37.19	PRINTING	A	-14,637	Administrative & General	5	37.19
37.20	PRINTING	A	-5	Operation of Plant	7	37.20
37.21	PRINTING	A	-90	Nursing Administration	13	37.21
37.22	LOBBYING EXPENSE	A	-351	Employee Benefits Department	4	37.22
37.23	LOBBYING EXPENSE	A	-2,334	Administrative & General	5	37.23
37.24	LEGAL FEES	A	-4,624	Operation of Plant	7	37.24
37.25	MISCELLANEOUS INCOME	B	-19,798	Cap Rel Costs-Bldg & Fixt	1	37.25
37.26	MISCELLANEOUS INCOME	B	-47	Administrative & General	5	37.26
37.27	MISCELLANEOUS INCOME	B	-61	Social Service	17	37.27
37.28	MISCELLANEOUS INCOME	B	-5,692	Drugs Charged to Patients	73	37.28
37.29	PATIENT TRANSPORTATION	A	-1,778	Employee Benefits Department	4	37.29

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**ADJUSTMENTS TO EXPENSES**

**WORKSHEET A-8**

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			Wkst. A-7 Ref.
				COST CENTER	LINE#		
		1	2	3	4	5	
37.30	PATIENT TRANSPORTATION	A	-77,376	Administrative & General	5		37.30
37.31	PATIENT TRANSPORTATION	A	-11,561	Operation of Plant	7		37.31
37.32	MISC. TAX	A	-1,828,051	Administrative & General	5		37.32
37.33	PROFESSIONAL FEES	A	-205,225	Administrative & General	5		37.33
37.34	CONTRACT SERVICES	A	-1,941	Administrative & General	5		37.34
37.35	HBP	A	-176,996	Administrative & General	5		37.35
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)		-1,882,611				50

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

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

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

WORKSHEET A-8-1

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

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1	5	Administrative & General	TO OFFSET MANAGEMENT FEES		858,881	-858,881		1
2	1	Cap Rel Costs-Bldg & Fixt	TO INCLUDE ALLOWABLE HOME OFFICE COS	120,755		120,755	9	2
3	1	Cap Rel Costs-Bldg & Fixt	TO INCLUDE ALLOWABLE HOME OFFICE COS	467,620		467,620	11	3
3.01	5	Administrative & General	TO INCLUDE ALLOWABLE HOME OFFICE COS	2,389,623		2,389,623		3.01
3.02	5	Administrative & General	TO INCLUDE ALLOWABLE HOME OFFICE COS	496,105		496,105		3.02
3.03	2	Cap Rel Costs-Mvble Equip	INTERCOMPANY WAGE AND EXPENSE TRANSF	5,431	5,431		10	3.03
3.04	3	Other Cap Rel Costs	INTERCOMPANY WAGE AND EXPENSE TRANSF	32	32			3.04
3.05	4	Employee Benefits Department	INTERCOMPANY WAGE AND EXPENSE TRANSF	2,838,169	2,838,169			3.05
3.06	5	Administrative & General	INTERCOMPANY WAGE AND EXPENSE TRANSF	2,094,169	2,094,169			3.06
3.07	7	Operation of Plant	INTERCOMPANY WAGE AND EXPENSE TRANSF	5,562	5,562			3.07
3.08	9	Housekeeping	INTERCOMPANY WAGE AND EXPENSE TRANSF	131	131			3.08
3.09	10	Dietary	INTERCOMPANY WAGE AND EXPENSE TRANSF	-14,547	-14,547			3.09
3.10	13	Nursing Administration	INTERCOMPANY WAGE AND EXPENSE TRANSF	1	1			3.10
3.11	16	Medical Records & Library	INTERCOMPANY WAGE AND EXPENSE TRANSF	15,118	15,118			3.11
3.12	17	Social Service	INTERCOMPANY WAGE AND EXPENSE TRANSF	626	626			3.12
3.13	30	Adults & Pediatrics	INTERCOMPANY WAGE AND EXPENSE TRANSF	5,700	5,700			3.13
3.14	54	Radiology-Diagnostic	INTERCOMPANY WAGE AND EXPENSE TRANSF	-67	-66	-1		3.14
3.15	65	Respiratory Therapy	INTERCOMPANY WAGE AND EXPENSE TRANSF	210	210			3.15
3.16	66	Physical Therapy	INTERCOMPANY WAGE AND EXPENSE TRANSF	343	343			3.16
3.17	67	Occupational Therapy	INTERCOMPANY WAGE AND EXPENSE TRANSF	-12,290	-12,290			3.17
3.18	68	Speech Pathology	INTERCOMPANY WAGE AND EXPENSE TRANSF	-50	-50			3.18
3.19	71	Medical Supplies Charged to Patients	INTERCOMPANY WAGE AND EXPENSE TRANSF	-30,879	-30,879			3.19
3.20	73	Drugs Charged to Patients	INTERCOMPANY WAGE AND EXPENSE TRANSF	-233	-233			3.20
3.21	113	Interest Expense	INTERCOMPANY WAGE AND EXPENSE TRANSF	8,056	8,056			3.21
3.22	5	Administrative & General	RELATED PARTY - BJCH	67,392	225,777	-158,385		3.22
3.23	7	Operation of Plant	RELATED PARTY - BJCH	5,930	19,865	-13,935		3.23
3.24	13	Nursing Administration	RELATED PARTY - BJCH	204	684	-480		3.24
3.25	54.01	RADIOLOGY	RELATED PARTY - BJCH	55,449	110,099	-54,650		3.25
3.26	60	Laboratory	RELATED PARTY - BJCH	326,962	326,962			3.26
3.27	73	Drugs Charged to Patients	RELATED PARTY - BJCH	2,900	6,570	-3,670		3.27
3.28	1	Cap Rel Costs-Bldg & Fixt	RELATED PARTY RENT		540,922	-540,922	10	3.28
4								4
5		TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12		8,848,422	7,005,243	1,843,179		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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**KPMG LLP Compu-Max 2552-10**

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

**WORKSHEET A-8-1**

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

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

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

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

Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business
1	2	3	4	5	6
6	B	50.00	HEALTHSOUTH		6
7	B	50.00	BJC HEALTHCARE		7
8	G		HEALTHSOUTH		HEALTHCARE
9	G		BARNES JEWISH CHRISTIAN HOSPIT		HEALTHCARE
10					10

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

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

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**PROVIDER-BASED PHYSICIANS ADJUSTMENTS**

**WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun- eration	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	312,573		312,573	211,500	1,842	187,300	9,365	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	312,573		312,573		1,842	187,300	9,365	200

**KPMG LLP Compu-Max 2552-10**

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 06/01/2016 To: 05/31/2017	Run Date: 09/26/2017 Run Time: 13:40 Version: 2017.01 (08/09/2017)
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**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					187,300	125,273	125,273	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					187,300	125,273	125,273	200

**KPMG LLP Compu-Max 2552-10**

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 06/01/2016 To: 05/31/2017	Run Date: 09/26/2017 Run Time: 13:40 Version: 2017.01 (08/09/2017)
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**COST ALLOCATION - GENERAL SERVICE COSTS**

**WORKSHEET B  
PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINISTRATIVE & GENERAL	
		0	1	2	4	4A	5	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt	1,585,297	1,585,297					1
2	Cap Rel Costs-Mvble Equip	837,374		837,374				2
4	Employee Benefits Department	3,486,651			3,486,651			4
5	Administrative & General	7,585,646	92,434	48,825	495,801	8,222,706	8,222,706	5
6	Maintenance & Repairs							6
7	Operation of Plant	984,708	3,632	1,918	53,738	1,043,996	326,391	7
8	Laundry & Linen Service	209,429				209,429	65,475	8
9	Housekeeping	370,818	6,721	3,550	55,774	436,863	136,579	9
10	Dietary	1,298,292	103,040	54,427		1,455,759	455,123	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	568,571	5,041	2,663	109,703	685,978	214,461	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	234,801	9,612	5,077	41,835	291,325	91,079	16
17	Social Service	633,735	4,481	2,367	121,416	761,999	238,228	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd	165,000				165,000	51,585	22
23	Paramed Ed Prgm-(specify)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	7,142,361	895,617	473,075	1,265,409	9,776,462	3,056,476	30
	<b>ANCILLARY SERVICE COST CENTERS</b>							
54	Radiology-Diagnostic	47,318				47,318	14,793	54
54.01	RADIOLOGY	75,240				75,240		54.01
60	Laboratory	546,295	3,975	2,100		552,370	172,691	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	411,925	5,312	2,806	76,169	496,212	155,134	65
66	Physical Therapy	3,025,993	186,152	98,328	572,504	3,882,977	1,213,958	66
67	Occupational Therapy	1,955,005	132,689	70,088	347,455	2,505,237	783,227	67
68	Speech Pathology	1,015,872	47,879	25,291	197,231	1,286,273	402,135	68
71	Medical Supplies Charged to Patients	723,019	46,344	24,479	28,043	821,885	256,951	71
73	Drugs Charged to Patients	1,491,562	11,834	6,251	97,460	1,607,107	502,440	73
76	PSYCHOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
	<b>SPECIAL PURPOSE COST CENTERS</b>							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	34,394,912	1,554,763	821,245	3,462,538	34,324,136	8,136,726	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
192	Physicians' Private Offices		29,974	15,833		45,807	14,321	192
194	MARKETING	126,398	560	296	24,113	151,367	47,323	194
194.01	GUEST MEALS							194.01
194.02	CLINICAL PSYCH	77,842				77,842	24,336	194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	34,599,152	1,585,297	837,374	3,486,651	34,599,152	8,222,706	202

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**COST ALLOCATION - GENERAL SERVICE COSTS**

**WORKSHEET B  
PART I**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	NURSING ADMINIS- TRATION	MEDICAL RECORDS & LIBRARY	
		7	8	9	10	13	16	
	<b>GENERAL SERVICE COST CENTERS</b>							
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	1,370,387						7
8	Laundry & Linen Service		274,904					8
9	Housekeeping	6,185		579,627				9
10	Dietary	94,817		40,286	2,045,985			10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	4,639		1,971		907,049		13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	8,845		3,758			395,007	16
17	Social Service	4,123		1,752				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
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	824,145	274,904	350,166	2,042,615	907,049	161,137	30
	<b>ANCILLARY SERVICE COST CENTERS</b>							
54	Radiology-Diagnostic						1,268	54
54.01	RADIOLOGY							54.01
60	Laboratory	3,658		1,554			7,834	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	4,888		2,077			4,836	65
66	Physical Therapy	171,296		72,781			71,505	66
67	Occupational Therapy	122,100		51,878			59,538	67
68	Speech Pathology	44,059		18,720			29,907	68
71	Medical Supplies Charged to Patients	42,645		18,119			5,462	71
73	Drugs Charged to Patients	10,890		4,627			53,520	73
76	PSYCHOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
	<b>SPECIAL PURPOSE COST CENTERS</b>							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	1,342,290	274,904	567,689	2,042,615	907,049	395,007	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
192	Physicians' Private Offices	27,582		11,719				192
194	MARKETING	515		219				194
194.01	GUEST MEALS				3,370			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)	1,370,387	274,904	579,627	2,045,985	907,049	395,007	202

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THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 06/01/2016 To: 05/31/2017	Run Date: 09/26/2017 Run Time: 13:40 Version: 2017.01 (08/09/2017)
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**COST ALLOCATION - GENERAL SERVICE COSTS**

**WORKSHEET B  
PART I**

	COST CENTER DESCRIPTIONS	SOCIAL SERVICE	I&R PROGRAM COSTS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		17	22	24	25	26	
	<b>GENERAL SERVICE COST CENTERS</b>						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5	Administrative & General						5
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library						16
17	Social Service	1,006,102					17
19	Nonphysician Anesthetists						19
20	Nursing School						20
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd		216,585				22
23	Paramed Ed Prgm-(specify)						23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>						
30	Adults & Pediatrics	1,006,102	216,585	18,615,641		18,615,641	30
	<b>ANCILLARY SERVICE COST CENTERS</b>						
54	Radiology-Diagnostic			63,379		63,379	54
54.01	RADIOLOGY			75,240		75,240	54.01
60	Laboratory			738,107		738,107	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy			663,147		663,147	65
66	Physical Therapy			5,412,517		5,412,517	66
67	Occupational Therapy			3,521,980		3,521,980	67
68	Speech Pathology			1,781,094		1,781,094	68
71	Medical Supplies Charged to Patients			1,145,062		1,145,062	71
73	Drugs Charged to Patients			2,178,584		2,178,584	73
76	PSYCHOLOGY						76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
92	Observation Beds (Non-Distinct Part)						92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
	<b>SPECIAL PURPOSE COST CENTERS</b>						
113	Interest Expense						113
118	SUBTOTALS (sum of lines 1-117)	1,006,102	216,585	34,194,751		34,194,751	118
	<b>NONREIMBURSABLE COST CENTERS</b>						
192	Physicians' Private Offices			99,429		99,429	192
194	MARKETING			199,424		199,424	194
194.01	GUEST MEALS			3,370		3,370	194.01
194.02	CLINICAL PSYCH			102,178		102,178	194.02
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	1,006,102	216,585	34,599,152		34,599,152	202

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**ALLOCATION OF CAPITAL-RELATED COSTS**

**WORKSHEET B  
PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	ADMINIS- TRATIVE & GENERAL	OPERATION OF PLANT	
		0	1	2	2A	5	7	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General		92,434	48,825	141,259	141,259		5
6	Maintenance & Repairs							6
7	Operation of Plant		3,632	1,918	5,550	5,607	11,157	7
8	Laundry & Linen Service					1,125		8
9	Housekeeping		6,721	3,550	10,271	2,346	50	9
10	Dietary		103,040	54,427	157,467	7,819	772	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration		5,041	2,663	7,704	3,684	38	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		9,612	5,077	14,689	1,565	72	16
17	Social Service		4,481	2,367	6,848	4,093	34	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					886		22
23	Paramed Ed Prgm-(specify)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics		895,617	473,075	1,368,692	52,505	6,708	30
	<b>ANCILLARY SERVICE COST CENTERS</b>							
54	Radiology-Diagnostic					254		54
54.01	RADIOLOGY							54.01
60	Laboratory		3,975	2,100	6,075	2,967	30	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		5,312	2,806	8,118	2,665	40	65
66	Physical Therapy		186,152	98,328	284,480	20,855	1,395	66
67	Occupational Therapy		132,689	70,088	202,777	13,456	994	67
68	Speech Pathology		47,879	25,291	73,170	6,909	359	68
71	Medical Supplies Charged to Patients		46,344	24,479	70,823	4,414	347	71
73	Drugs Charged to Patients		11,834	6,251	18,085	8,632	89	73
76	PSYCHOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
	<b>SPECIAL PURPOSE COST CENTERS</b>							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)		1,554,763	821,245	2,376,008	139,782	10,928	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
192	Physicians' Private Offices		29,974	15,833	45,807	246	225	192
194	MARKETING		560	296	856	813	4	194
194.01	GUEST MEALS							194.01
194.02	CLINICAL PSYCH					418		194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		1,585,297	837,374	2,422,671	141,259	11,157	202

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**ALLOCATION OF CAPITAL-RELATED COSTS**

**WORKSHEET B  
PART II**

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		8	9	10	13	16	17	
	<b>GENERAL SERVICE COST CENTERS</b>							
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	1,125						8
9	Housekeeping		12,667					9
10	Dietary		880	166,938				10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration		43		11,469			13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		82			16,408		16
17	Social Service		38				11,013	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
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	1,125	7,653	166,663	11,469	6,711	11,013	30
	<b>ANCILLARY SERVICE COST CENTERS</b>							
54	Radiology-Diagnostic					53		54
54.01	RADIOLOGY							54.01
60	Laboratory		34			325		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		45			201		65
66	Physical Therapy		1,591			2,965		66
67	Occupational Therapy		1,134			2,468		67
68	Speech Pathology		409			1,240		68
71	Medical Supplies Charged to Patients		396			226		71
73	Drugs Charged to Patients		101			2,219		73
76	PSYCHOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
	<b>SPECIAL PURPOSE COST CENTERS</b>							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	1,125	12,406	166,663	11,469	16,408	11,013	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
192	Physicians' Private Offices		256					192
194	MARKETING		5					194
194.01	GUEST MEALS			275				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)	1,125	12,667	166,938	11,469	16,408	11,013	202

**KPMG LLP Compu-Max 2552-10**

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**ALLOCATION OF CAPITAL-RELATED COSTS**

**WORKSHEET B  
PART II**

	COST CENTER DESCRIPTIONS	I&R PROGRAM COSTS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		22	24	25	26		
	<b>GENERAL SERVICE COST CENTERS</b>						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5	Administrative & General						5
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library						16
17	Social Service						17
19	Nonphysician Anesthetists						19
20	Nursing School						20
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd	886					22
23	Paramed Ed Prgm-(specify)						23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>						
30	Adults & Pediatrics		1,632,539		1,632,539		30
	<b>ANCILLARY SERVICE COST CENTERS</b>						
54	Radiology-Diagnostic		307		307		54
54.01	RADIOLOGY						54.01
60	Laboratory		9,431		9,431		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy		11,069		11,069		65
66	Physical Therapy		311,286		311,286		66
67	Occupational Therapy		220,829		220,829		67
68	Speech Pathology		82,087		82,087		68
71	Medical Supplies Charged to Patients		76,206		76,206		71
73	Drugs Charged to Patients		29,126		29,126		73
76	PSYCHOLOGY						76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
92	Observation Beds (Non-Distinct Part)						92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
	<b>SPECIAL PURPOSE COST CENTERS</b>						
113	Interest Expense						113
118	SUBTOTALS (sum of lines 1-117)		2,372,880		2,372,880		118
	<b>NONREIMBURSABLE COST CENTERS</b>						
192	Physicians' Private Offices		46,534		46,534		192
194	MARKETING		1,678		1,678		194
194.01	GUEST MEALS		275		275		194.01
194.02	CLINICAL PSYCH		418		418		194.02
200	Cross Foot Adjustments	886	886		886		200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	886	2,422,671		2,422,671		202

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**COST ALLOCATION - STATISTICAL BASIS**

**WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECONCILIATION	ADMINISTRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt	87,742						1
2	Cap Rel Costs-Mvble Equip		87,742					2
4	Employee Benefits Department			17,745,301				4
5	Administrative & General	5,116	5,116	2,523,377	-8,222,706	26,301,206		5
6	Maintenance & Repairs							6
7	Operation of Plant	201	201	273,498		1,043,996	82,425	7
8	Laundry & Linen Service					209,429		8
9	Housekeeping	372	372	283,860		436,863	372	9
10	Dietary	5,703	5,703			1,455,759	5,703	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	279	279	558,332		685,978	279	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	532	532	212,919		291,325	532	16
17	Social Service	248	248	617,946		761,999	248	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd					165,000		22
23	Paramed Ed Prgm-(specify)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	49,570	49,570	6,440,300		9,776,462	49,570	30
	<b>ANCILLARY SERVICE COST CENTERS</b>							
54	Radiology-Diagnostic					47,318		54
54.01	RADIOLOGY				-75,240			54.01
60	Laboratory	220	220			552,370	220	60
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>							62.30
65	Respiratory Therapy	294	294	387,662		496,212	294	65
66	Physical Therapy	10,303	10,303	2,913,757		3,882,977	10,303	66
67	Occupational Therapy	7,344	7,344	1,768,370		2,505,237	7,344	67
68	Speech Pathology	2,650	2,650	1,003,806		1,286,273	2,650	68
71	Medical Supplies Charged to Patients	2,565	2,565	142,724		821,885	2,565	71
73	Drugs Charged to Patients	655	655	496,025		1,607,107	655	73
76	PSYCHOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	86,052	86,052	17,622,576	-8,297,946	26,026,190	80,735	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
192	Physicians' Private Offices	1,659	1,659			45,807	1,659	192
194	MARKETING	31	31	122,725		151,367	31	194
194.01	GUEST MEALS							194.01
194.02	CLINICAL PSYCH					77,842		194.02
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,585,297	837,374	3,486,651		8,222,706	1,370,387	202
203	Unit Cost Multiplier (Wkst. B, Part I)	18.067710	9.543594	0.196483		0.312636	16.625866	203
204	Cost to be allocated (Per Wkst. B, Part II)					141,259	11,157	204
205	Unit Cost Multiplier (Wkst. B, Part II)					0.005371	0.135359	205

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**COST ALLOCATION - STATISTICAL BASIS**

**WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE PATIENT DAYS	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA GROSS SALARIES	NURSING ADMINISTRATION PATIENT DAYS	MEDICAL RECORDS & LIBRARY GROSS REVENUE	
		8	9	10	11	13	16	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	28,284						8
9	Housekeeping		82,053					9
10	Dietary		5,703	85,004				10
11	Cafeteria				14,664,566			11
12	Maintenance of Personnel							12
13	Nursing Administration		279		558,332	28,284		13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		532		212,919		64,985,540	16
17	Social Service		248		617,946			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
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	28,284	49,570	84,864	6,440,300	28,284	26,507,602	30
	<b>ANCILLARY SERVICE COST CENTERS</b>							
54	Radiology-Diagnostic						208,618	54
54.01	RADIOLOGY							54.01
60	Laboratory		220				1,288,965	60
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>							62.30
65	Respiratory Therapy		294		387,662		795,652	65
66	Physical Therapy		10,303		2,913,757		11,764,484	66
67	Occupational Therapy		7,344		1,768,370		9,795,591	67
68	Speech Pathology		2,650		1,003,806		4,920,466	68
71	Medical Supplies Charged to Patients		2,565		142,724		898,707	71
73	Drugs Charged to Patients		655		496,025		8,805,455	73
76	PSYCHOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	28,284	80,363	84,864	14,541,841	28,284	64,985,540	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
192	Physicians' Private Offices		1,659					192
194	MARKETING		31		122,725			194
194.01	GUEST MEALS			140				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)	274,904	579,627	2,045,985		907,049	395,007	202
203	Unit Cost Multiplier (Wkst. B, Part I)	9.719417	7.064056	24.069279		32.069332	0.006078	203
204	Cost to be allocated (Per Wkst. B, Part II)	1,125	12,667	166,938		11,469	16,408	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.039775	0.154376	1.963884		0.405494	0.000252	205

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**COST ALLOCATION - STATISTICAL BASIS**

**WORKSHEET B-1**

COST CENTER DESCRIPTIONS	SOCIAL SERVICE	I&R PROGRAM COSTS ASSIGNED TIME
	PATIENT DAYS	
	17	22

GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt					1
2	Cap Rel Costs-Mvble Equip					2
4	Employee Benefits Department					4
5	Administrative & General					5
6	Maintenance & Repairs					6
7	Operation of Plant					7
8	Laundry & Linen Service					8
9	Housekeeping					9
10	Dietary					10
11	Cafeteria					11
12	Maintenance of Personnel					12
13	Nursing Administration					13
14	Central Services & Supply					14
15	Pharmacy					15
16	Medical Records & Library					16
17	Social Service	28,284				17
19	Nonphysician Anesthetists					19
20	Nursing School					20
21	I&R Services-Salary & Fringes Apprvd					21
22	I&R Services-Other Prgm Costs Apprvd		100			22
23	Paramed Ed Prgm-(specify)					23
INPATIENT ROUTINE SERV COST CENTERS						
30	Adults & Pediatrics	28,284	100			30
ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic					54
54.01	RADIOLOGY					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)	28,284	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)	1,006,102	216,585			202
203	Unit Cost Multiplier (Wkst. B, Part I)	35.571418	2,165.850000			203
204	Cost to be allocated (Per Wkst. B, Part II)	11,013	886			204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.389372	8.860000			205

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**POST STEPDOWN ADJUSTMENTS**

**WORKSHEET B-2**

	WORKSHEET			
DESCRIPTION	PART	LINE NO.	AMOUNT	
1	2	3	4	

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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
PART I

	COST CENTER DESCRIPTIONS	COSTS					
		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30	Adults & Pediatrics	18,615,641		18,615,641	125,273	18,740,914	30
	<b>ANCILLARY SERVICE COST CENTERS</b>						
54	Radiology-Diagnostic	63,379		63,379		63,379	54
54.01	RADIOLOGY	75,240		75,240		75,240	54.01
60	Laboratory	738,107		738,107		738,107	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	663,147		663,147		663,147	65
66	Physical Therapy	5,412,517		5,412,517		5,412,517	66
67	Occupational Therapy	3,521,980		3,521,980		3,521,980	67
68	Speech Pathology	1,781,094		1,781,094		1,781,094	68
71	Medical Supplies Charged to Patients	1,145,062		1,145,062		1,145,062	71
73	Drugs Charged to Patients	2,178,584		2,178,584		2,178,584	73
76	PSYCHOLOGY						76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
92	Observation Beds (Non-Distinct Part)						92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	34,194,751		34,194,751	125,273	34,320,024	200
201	Less Observation Beds						201
202	Total (line 200 minus line 201)	34,194,751		34,194,751		34,320,024	202

**KPMG LLP Compu-Max 2552-10**

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 06/01/2016 To: 05/31/2017	Run Date: 09/26/2017 Run Time: 13:40 Version: 2017.01 (08/09/2017)
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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
PART I

	COST CENTER DESCRIPTIONS	CHARGES			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		Inpatient	Outpatient	Total (column 6 + column 7)				
		6	7	8	9	10	11	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30	Adults & Pediatrics	26,507,602		26,507,602				30
	<b>ANCILLARY SERVICE COST CENTERS</b>							
54	Radiology-Diagnostic	208,618		208,618	0.303804	0.303804	0.303804	54
54.01	RADIOLOGY	644,981		644,981	0.116655	0.116655	0.116655	54.01
60	Laboratory	1,288,965		1,288,965	0.572635	0.572635	0.572635	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	795,652		795,652	0.833464	0.833464	0.833464	65
66	Physical Therapy	6,703,874	5,060,610	11,764,484	0.460073	0.460073	0.460073	66
67	Occupational Therapy	6,886,693	2,908,898	9,795,591	0.359547	0.359547	0.359547	67
68	Speech Pathology	3,039,676	1,880,790	4,920,466	0.361977	0.361977	0.361977	68
71	Medical Supplies Charged to Patients	438,636	460,071	898,707	1.274122	1.274122	1.274122	71
73	Drugs Charged to Patients	8,805,455		8,805,455	0.247413	0.247413	0.247413	73
76	PSYCHOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	55,320,152	10,310,369	65,630,521				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	55,320,152	10,310,369	65,630,521				202

**KPMG LLP Compu-Max 2552-10**

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 06/01/2016 To: 05/31/2017	Run Date: 09/26/2017 Run Time: 13:40 Version: 2017.01 (08/09/2017)
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**APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS**

**WORKSHEET D  
PART I**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, (col. 26))	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		1	2	3	4	5	6	7	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30	Adults & Pediatrics General Routine Care)	1,632,539		1,632,539	28,284	57.72	10,047	579,913	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)	1,632,539		1,632,539	28,284		10,047	579,913	200

(A) Worksheet A line numbers



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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D  
PART III**

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

(A)	Cost Center Description	1 Nursing School	2 Allied Health Cost	3 All Other Medical Education Cost	4 Swing-Bed Adjustment Amount (see instructions)	5 Total Costs (sum of cols. 1 through 3 minus col 4.)	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
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

**KPMG LLP Compu-Max 2552-10**

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 06/01/2016 To: 05/31/2017	Run Date: 09/26/2017 Run Time: 13:40 Version: 2017.01 (08/09/2017)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D  
PART III**

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

(A)	Cost Center Description	Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
6	7	8	9			
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30	Adults & Pediatrics (General Routine Care)	28,284		10,047		30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	28,284		10,047		200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 06/01/2016 To: 05/31/2017	Run Date: 09/26/2017 Run Time: 13:40 Version: 2017.01 (08/09/2017)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 26-3028**

**WORKSHEET D  
PART IV**

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

(A)	Cost Center Description	1 Non Physician Anesth- etist Cost	2 Nursing School	3 Allied Health	4 All Other Medical Education Cost	5 Total Cost (sum of col. 1 through col. 4)	6 Total Outpatient Cost (sum of col. 2, 3, and 4)	
	<b>ANCILLARY SERVICE COST CENTERS</b>							
54	Radiology-Diagnostic							54
54.01	RADIOLOGY							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 Pat							71
73	Drugs Charged to Patients							73
76	PSYCHOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
92	Observation Beds (Non-Distinct							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 06/01/2016 To: 05/31/2017	Run Date: 09/26/2017 Run Time: 13:40 Version: 2017.01 (08/09/2017)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 26-3028**

**WORKSHEET D  
PART IV**

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

(A)	Cost Center Description	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)	
7	8	9	10	11	12	13			
	<b>ANCILLARY SERVICE COST CENTERS</b>								
54	Radiology-Diagnostic	208,618			100,510				54
54.01	RADIOLOGY	644,981			197,676				54.01
60	Laboratory	1,288,965			574,515				60
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>								62.30
65	Respiratory Therapy	795,652			188,710				65
66	Physical Therapy	11,764,484			2,407,909				66
67	Occupational Therapy	9,795,591			2,521,915				67
68	Speech Pathology	4,920,466			998,045				68
71	Medical Supplies Charged to Pat	898,707			161,093				71
73	Drugs Charged to Patients	8,805,455			3,229,030				73
76	PSYCHOLOGY								76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
92	Observation Beds (Non-Distinct								92
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	Total (sum of lines 50-199)	39,122,919			10,379,403				200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 06/01/2016 To: 05/31/2017	Run Date: 09/26/2017 Run Time: 13:40 Version: 2017.01 (08/09/2017)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 26-3028

WORKSHEET D  
PART V

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

(A)	Cost Center Description	Program Charges				Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
		1	2	3	4	5	6	7	
	<b>ANCILLARY SERVICE COST CENTERS</b>								
54	Radiology-Diagnostic	0.303804							54
54.01	RADIOLOGY	0.116655							54.01
60	Laboratory	0.572635							60
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>								62.30
65	Respiratory Therapy	0.833464							65
66	Physical Therapy	0.460073							66
67	Occupational Therapy	0.359547							67
68	Speech Pathology	0.361977							68
71	Medical Supplies Charged to Pat	1.274122							71
73	Drugs Charged to Patients	0.247413							73
76	PSYCHOLOGY								76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
92	Observation Beds (Non-Distinct								92
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
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

**KPMG LLP Compu-Max 2552-10**

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 06/01/2016 To: 05/31/2017	Run Date: 09/26/2017 Run Time: 13:40 Version: 2017.01 (08/09/2017)
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**APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS**

**WORKSHEET D  
PART I**

Check  Title V  
 Applicable  Title XVIII, Part A  
 Boxes:  Title XIX

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, (col. 26))	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		1	2	3	4	5	6	7	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30	Adults & Pediatrics General Routine Care)	1,632,539		1,632,539	28,284	57.72	4,454	257,085	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)	1,632,539		1,632,539	28,284		4,454	257,085	200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 06/01/2016 To: 05/31/2017	Run Date: 09/26/2017 Run Time: 13:40 Version: 2017.01 (08/09/2017)
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**APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS**

**COMPONENT CCN: 26-3028**

**WORKSHEET D  
PART II**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	<b>ANCILLARY SERVICE COST CENTERS</b>						
54	Radiology-Diagnostic	307	208,618	0.001472	18,574	27	54
54.01	RADIOLOGY		644,981		115,273		54.01
60	Laboratory	9,431	1,288,965	0.007317	165,115	1,208	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	11,069	795,652	0.013912	210,397	2,927	65
66	Physical Therapy	311,286	11,764,484	0.026460	1,040,548	27,533	66
67	Occupational Therapy	220,829	9,795,591	0.022544	1,059,070	23,876	67
68	Speech Pathology	82,087	4,920,466	0.016683	454,512	7,583	68
71	Medical Supplies Charged to Pat	76,206	898,707	0.084795	65,166	5,526	71
73	Drugs Charged to Patients	29,126	8,805,455	0.003308	1,496,813	4,951	73
76	PSYCHOLOGY						76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
92	Observation Beds (Non-Distinct)						92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
200	Total (sum of lines 50-199)	740,341	39,122,919		4,625,468	73,631	200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 06/01/2016 To: 05/31/2017	Run Date: 09/26/2017 Run Time: 13:40 Version: 2017.01 (08/09/2017)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D  
PART III**

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

(A)	Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
		1	2	3	4	5	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
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



**KPMG LLP Compu-Max 2552-10**

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 06/01/2016 To: 05/31/2017	Run Date: 09/26/2017 Run Time: 13:40 Version: 2017.01 (08/09/2017)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 26-3028**

**WORKSHEET D  
PART IV**

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

(A)	Cost Center Description	1 Non Physician Anesth- etist Cost	2 Nursing School	3 Allied Health	4 All Other Medical Education Cost	5 Total Cost (sum of col. 1 through col. 4)	6 Total Outpatient Cost (sum of col. 2, 3, and 4)	
	<b>ANCILLARY SERVICE COST CENTERS</b>							
54	Radiology-Diagnostic							54
54.01	RADIOLOGY							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 Pat							71
73	Drugs Charged to Patients							73
76	PSYCHOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
92	Observation Beds (Non-Distinct							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 06/01/2016 To: 05/31/2017	Run Date: 09/26/2017 Run Time: 13:40 Version: 2017.01 (08/09/2017)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 26-3028**

**WORKSHEET D  
PART IV**

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

(A)	Cost Center Description	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)	
7	8	9	10	11	12	13			
	<b>ANCILLARY SERVICE COST CENTERS</b>								
54	Radiology-Diagnostic	208,618			18,574				54
54.01	RADIOLOGY	644,981			115,273				54.01
60	Laboratory	1,288,965			165,115				60
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>								62.30
65	Respiratory Therapy	795,652			210,397				65
66	Physical Therapy	11,764,484			1,040,548				66
67	Occupational Therapy	9,795,591			1,059,070				67
68	Speech Pathology	4,920,466			454,512				68
71	Medical Supplies Charged to Pat	898,707			65,166				71
73	Drugs Charged to Patients	8,805,455			1,496,813				73
76	PSYCHOLOGY								76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
92	Observation Beds (Non-Distinct)								92
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	Total (sum of lines 50-199)	39,122,919			4,625,468				200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 06/01/2016 To: 05/31/2017	Run Date: 09/26/2017 Run Time: 13:40 Version: 2017.01 (08/09/2017)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 26-3028

WORKSHEET D  
PART V

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

(A)	Cost Center Description	Program Charges				Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
		1	2	3	4	5	6	7	
	<b>ANCILLARY SERVICE COST CENTERS</b>								
54	Radiology-Diagnostic	0.303804							54
54.01	RADIOLOGY	0.116655							54.01
60	Laboratory	0.572635							60
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>								62.30
65	Respiratory Therapy	0.833464							65
66	Physical Therapy	0.460073		34,374			15,815		66
67	Occupational Therapy	0.359547		15,335			5,514		67
68	Speech Pathology	0.361977		12,182			4,410		68
71	Medical Supplies Charged to Pat	1.274122		5,707			7,271		71
73	Drugs Charged to Patients	0.247413							73
76	PSYCHOLOGY								76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
92	Observation Beds (Non-Distinct								92
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	Subtotal (see instructions)			67,598			33,010		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			67,598			33,010		202

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 06/01/2016 To: 05/31/2017	Run Date: 09/26/2017 Run Time: 13:40 Version: 2017.01 (08/09/2017)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 26-3028

WORKSHEET D-1  
PART I

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

PART I - ALL PROVIDER COMPONENTS

**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	28,284	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	28,284	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.	294	3
4	Semi-private room days (excluding swing-bed private room days)	27,990	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)	10,047	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)	18,740,914	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)	18,740,914	27

**PRIVATE ROOM DIFFERENTIAL ADJUSTMENT**

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)	26,507,602	28
29	Private room charges (excluding swing-bed charges)	309,410	29
30	Semi-private room charges (excluding swing-bed charges)	26,198,192	30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.707001	31
32	Average private room per diem charge (line 29 ÷ line 3)	1,052.41	32
33	Average semi-private room per diem charge (line 30 ÷ line 4)	935.98	33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)	116.43	34
35	Average per diem private room cost differential (line 34 x line 31)	82.32	35
36	Private room cost differential adjustment (line 3 x line 35)	24,202	36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	18,716,712	37

**KPMG LLP Compu-Max 2552-10**

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 26-3028

WORKSHEET D-1  
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

**PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS**

							1	
38	Adjusted general inpatient routine service cost per diem (see instructions)						662.60	38
39	Program general inpatient routine service cost (line 9 x line 38)						6,657,142	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)						6,657,142	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
	<b>Intensive Care Type Inpatient Hospital Units</b>							
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)						3,919,851	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						10,576,993	49
	<b>PASS THROUGH COST ADJUSTMENTS</b>							
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						579,913	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						168,536	51
52	Total Program excludable cost (sum of lines 50 and 51)						748,449	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						9,828,544	53
	<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
54	Program discharges							54
55	Target amount per discharge							55
56	Target amount (line 54 x line 55)							56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)							57
58	Bonus payment (see instructions)							58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.							59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.							60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)							61
62	Relief payment (see instructions)							62
63	Allowable Inpatient cost plus incentive payment (see instructions)							63
	<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)							64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)							65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)							66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)							67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)							68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)							69

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THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 06/01/2016 To: 05/31/2017	Run Date: 09/26/2017 Run Time: 13:40 Version: 2017.01 (08/09/2017)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 26-3028

WORKSHEET D-1  
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)							87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						662.60	88
89	Observation bed cost (line 87 x line 88) (see instructions)							89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)		
		1	2	3	4	5		
90	Capital-related cost							90
91	Nursing School							91
92	Allied Health							92
93	Other Medical Education							93

**KPMG LLP Compu-Max 2552-10**

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 06/01/2016 To: 05/31/2017	Run Date: 09/26/2017 Run Time: 13:40 Version: 2017.01 (08/09/2017)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 26-3028

WORKSHEET D-1  
PART I

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

PART I - ALL PROVIDER COMPONENTS

**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	28,284	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	28,284	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.	294	3
4	Semi-private room days (excluding swing-bed private room days)	27,990	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)	4,454	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)	18,615,641	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)	18,615,641	27

**PRIVATE ROOM DIFFERENTIAL ADJUSTMENT**

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)	26,507,602	28
29	Private room charges (excluding swing-bed charges)	309,410	29
30	Semi-private room charges (excluding swing-bed charges)	26,198,192	30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.702276	31
32	Average private room per diem charge (line 29 ÷ line 3)	1,052.41	32
33	Average semi-private room per diem charge (line 30 ÷ line 4)	935.98	33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)	116.43	34
35	Average per diem private room cost differential (line 34 x line 31)	81.77	35
36	Private room cost differential adjustment (line 3 x line 35)	24,040	36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	18,591,601	37

**KPMG LLP Compu-Max 2552-10**

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 26-3028

WORKSHEET D-1  
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

**PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS**

38	Adjusted general inpatient routine service cost per diem (see instructions)					657.32	38
39	Program general inpatient routine service cost (line 9 x line 38)					2,927,703	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)					2,927,703	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
	<b>Intensive Care Type Inpatient Hospital Units</b>						
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)					1,766,395	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					4,694,098	49
	<b>PASS THROUGH COST ADJUSTMENTS</b>						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					257,085	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					73,631	51
52	Total Program excludable cost (sum of lines 50 and 51)					330,716	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						53
	<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>						
54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63
	<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>						
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

**KPMG LLP Compu-Max 2552-10**

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 06/01/2016 To: 05/31/2017	Run Date: 09/26/2017 Run Time: 13:40 Version: 2017.01 (08/09/2017)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 26-3028

WORKSHEET D-1  
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

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

**KPMG LLP Compu-Max 2552-10**

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 06/01/2016 To: 05/31/2017	Run Date: 09/26/2017 Run Time: 13:40 Version: 2017.01 (08/09/2017)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 26-3028

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30	Adults & Pediatrics		9,409,635		30
	<b>ANCILLARY SERVICE COST CENTERS</b>				
54	Radiology-Diagnostic	0.303804	100,510	30,535	54
54.01	RADIOLOGY	0.116655	197,676	23,060	54.01
60	Laboratory	0.572635	574,515	328,987	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.833464	188,710	157,283	65
66	Physical Therapy	0.460073	2,407,909	1,107,814	66
67	Occupational Therapy	0.359547	2,521,915	906,747	67
68	Speech Pathology	0.361977	998,045	361,269	68
71	Medical Supplies Charged to Patients	1.274122	161,093	205,252	71
73	Drugs Charged to Patients	0.247413	3,229,030	798,904	73
76	PSYCHOLOGY				76
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>				
92	Observation Beds (Non-Distinct Part)				92
	<b>OTHER REIMBURSABLE COST CENTERS</b>				
200	Total (sum of lines 50-94, and 96-98)		10,379,403	3,919,851	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		10,379,403		202

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 06/01/2016 To: 05/31/2017	Run Date: 09/26/2017 Run Time: 13:40 Version: 2017.01 (08/09/2017)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 26-3028

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30	Adults & Pediatrics		4,168,314		30
	<b>ANCILLARY SERVICE COST CENTERS</b>				
54	Radiology-Diagnostic	0.303804	18,574	5,643	54
54.01	RADIOLOGY	0.116655	115,273	13,447	54.01
60	Laboratory	0.572635	165,115	94,551	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.833464	210,397	175,358	65
66	Physical Therapy	0.460073	1,040,548	478,728	66
67	Occupational Therapy	0.359547	1,059,070	380,785	67
68	Speech Pathology	0.361977	454,512	164,523	68
71	Medical Supplies Charged to Patients	1.274122	65,166	83,029	71
73	Drugs Charged to Patients	0.247413	1,496,813	370,331	73
76	PSYCHOLOGY				76
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>				
92	Observation Beds (Non-Distinct Part)				92
	<b>OTHER REIMBURSABLE COST CENTERS</b>				
200	Total (sum of lines 50-94, and 96-98)		4,625,468	1,766,395	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		4,625,468		202

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 06/01/2016 To: 05/31/2017	Run Date: 09/26/2017 Run Time: 13:40 Version: 2017.01 (08/09/2017)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 26-3028

WORKSHEET E  
PART B

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

**PART B - MEDICAL AND OTHER HEALTH SERVICES**

		1	1.01	1.02	
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under OPPTS (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
	<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
	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
	<b>CUSTOMARY CHARGES</b>				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)				21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)				24
	<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
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
	<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
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 (see instructions)				91
92	The rate used to calculate the Time Value of Money				92
93	Time Value of Money (see instructions)				93
94	Total (sum of lines 91 and 93)				94

**KPMG LLP Compu-Max 2552-10**

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 06/01/2016 To: 05/31/2017	Run Date: 09/26/2017 Run Time: 13:40 Version: 2017.01 (08/09/2017)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 26-3028

WORKSHEET E-1  
PART I

Check  Hospital  SUB (Other)  
Applicable  IPF  SNF  
Boxes:  IRF  Swing Bed SNF

	DESCRIPTION	INPATIENT PART A		PART B	
		mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4
1	Total interim payments paid to provider		16,416,191		1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero				2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)				
		.01			3.01
		.02			3.02
	Program	.03			3.03
	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)		16,416,191		4
<b>TO BE COMPLETED BY CONTRACTOR</b>					
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)				
		.01			5.01
		.02			5.02
	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) based on the cost report (1)	.01	51,857		6.01
		.02			6.02
7	Total Medicare program liability (see instructions)		16,468,048		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.

**KPMG LLP Compu-Max 2552-10**

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 06/01/2016 To: 05/31/2017	Run Date: 09/26/2017 Run Time: 13:40 Version: 2017.01 (08/09/2017)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 26-3028

WORKSHEET E-3  
PART III

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

**PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS**

		1	1.01	
1	Net Federal PPS payment (see instructions)	14,755,265		1
2	Medicare SSI ratio (IRF PPS only) (see instructions)	0.081000		2
3	Inpatient Rehabilitation LIP payments (see instructions)	1,513,890		3
4	Outlier payments	30,873		4
5	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	4.37		5
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) OR (2)			5.01
6	New teaching program adjustment (see instructions)			6
7	Current year unweighted FTE count of I&R excluding FTEs in the new program growth period of a 'new teaching program' (see instructions)	4.93		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)	77,490,411		10
11	Teaching Adjustment Factor (see instructions)	0.057339		11
12	Teaching Adjustment (see instructions)	846,052		12
13	Total PPS Payment (see instructions)	17,146,080		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)	17,146,080		17
18	Primary payer payments	24,722		18
19	Subtotal (line 17 less line 18)	17,121,358		19
20	Deductibles	210,616		20
21	Subtotal (line 19 minus line 20)	16,910,742		21
22	Coinsurance	193,683		22
23	Subtotal (line 21 minus line 22)	16,717,059		23
24	Allowable bad debts (exclude bad debts for professional services) (see instructions)	133,957		24
25	Adjusted reimbursable bad debts (see instructions)	87,072		25
26	Allowable bad debts for dual eligible beneficiaries (see instructions)	86,912		26
27	Subtotal (sum of lines 23 and 25)	16,804,131		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)	16,804,131		32
32.01	Sequestration adjustment (see instructions)	336,083		32.01
33	Interim payments	16,416,191		33
34	Tentative settlement (for contractor use only)			34
35	Balance due provider/program (line 32 minus lines 32.01, 33 and 34)	51,857		35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	435,861		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

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 26-3028

WORKSHEET E-3  
PART VII

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

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

	INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>			
1	4,694,098		1
2		33,010	2
3			3
4	4,694,098	33,010	4
5			5
6			6
7	4,694,098	33,010	7
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>			
<b>REASONABLE CHARGES</b>			
8	4,168,314		8
9	4,625,468	67,598	9
10			10
11			11
12	8,793,782	67,598	12
<b>CUSTOMARY CHARGES</b>			
13			13
14			14
15	1.000000	1.000000	15
16	8,793,782	67,598	16
17	4,099,684	34,588	17
18			18
19			19
20			20
21	4,694,098	33,010	21
<b>PROSPECTIVE PAYMENT AMOUNT</b>			
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29	4,694,098	33,010	29
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>			
30			30
31	4,694,098	33,010	31
32			32
33			33
34			34
35			35
36	4,694,098	33,010	36
37			37
38	4,694,098	33,010	38
39			39
40	4,694,098	33,010	40
41	4,133,462	70,508	41
42	560,636	-37,498	42
43			43

**KPMG LLP Compu-Max 2552-10**

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 06/01/2016 To: 05/31/2017	Run Date: 09/26/2017 Run Time: 13:40 Version: 2017.01 (08/09/2017)
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**BALANCE SHEET**

**WORKSHEET G**

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

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
<b>Assets</b> (Omit Cents)		1	2	3	4	
<b>CURRENT ASSETS</b>						
1	Cash on hand and in banks	2,886,302				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	10,954,345				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-3,832,219				6
7	Inventory	277,681				7
8	Prepaid expenses	161,675				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	10,447,784				11
<b>FIXED ASSETS</b>						
12	Land					12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings	23,387,549				15
16	Accumulated depreciation	-11,492,197				16
17	Leasehold improvements	9,155				17
18	Accumulated depreciation	-9,155				18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	6,406,933				23
24	Accumulated depreciation	-4,862,155				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)	13,440,130				30
<b>OTHER ASSETS</b>						
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	913,599				34
35	Total other assets (sum of lines 31-34)	913,599				35
36	Total assets (sum of lines 11, 30 and 35)	24,801,513				36
<b>Liabilities and Fund Balances</b> (Omit Cents)						
		1	2	3	4	
<b>CURRENT LIABILITIES</b>						
37	Accounts payable	1,120,375				37
38	Salaries, wages and fees payable	1,423,262				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	88,688				44
45	Total current liabilities (sum of lines 37 thru 44)	2,632,325				45
<b>LONG TERM LIABILITIES</b>						
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	11,896,585				49
50	Total long term liabilities (sum of lines 46 thru 49)	11,896,585				50
51	Total liabilities (sum of lines 45 and 50)	14,528,910				51
<b>CAPITAL ACCOUNTS</b>						
52	General fund balance	10,272,603				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)	10,272,603				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	24,801,513				60

**KPMG LLP Compu-Max 2552-10**

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 06/01/2016 To: 05/31/2017	Run Date: 09/26/2017 Run Time: 13:40 Version: 2017.01 (08/09/2017)
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**STATEMENT OF CHANGES IN FUND BALANCES**

**WORKSHEET G-1**

		GENERAL FUND		SPECIFIC PURPOSE FUND	
		1	2	3	4
1	Fund balances at beginning of period		10,124,209		1
2	Net income (loss) (from Worksheet G-3, line 29)		2,784,908		2
3	Total (sum of line 1 and line 2)		12,909,117		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)		12,909,117		11
12	Deductions (debit adjustments) (specify)				12
13	MINORITY INTEREST	1,392,453			13
14	DISTRIBUTIONS	1,244,059			14
15	ROUNDING	2			15
16					16
17					17
18	Total deductions (sum of lines 12-17)		2,636,514		18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		10,272,603		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	ROUNDING				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

**KPMG LLP Compu-Max 2552-10**

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 06/01/2016 To: 05/31/2017	Run Date: 09/26/2017 Run Time: 13:40 Version: 2017.01 (08/09/2017)
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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

**WORKSHEET G-2  
PARTS I & II**

**PART I - PATIENT REVENUES**

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
	<b>GENERAL INPATIENT ROUTINE CARE SERVICES</b>				
1	Hospital	26,507,602		26,507,602	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)	26,507,602		26,507,602	10
	<b>INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES</b>				
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)	26,507,602		26,507,602	17
18	Ancillary services	28,812,548	10,310,367	39,122,915	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)	55,320,150	10,310,367	65,630,517	28

**PART II - OPERATING EXPENSES**

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		36,481,763	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)		36,481,763	43

**KPMG LLP Compu-Max 2552-10**

THE REHABILITATION INSTITUTE OF ST L Provider CCN: 26-3028	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 06/01/2016 To: 05/31/2017	Run Date: 09/26/2017 Run Time: 13:40 Version: 2017.01 (08/09/2017)
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**STATEMENT OF REVENUES AND EXPENSES****WORKSHEET G-3**

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	65,630,517	1
2	Less contractual allowances and discounts on patients' accounts	28,141,624	2
3	Net patient revenues (line 1 minus line 2)	37,488,893	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	36,481,763	4
5	Net income from service to patients (line 3 minus line 4)	1,007,130	5

**OTHER INCOME**

6	Contributions, donations, bequests, etc.		6
7	Income from investments	25,163	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts		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		14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts		18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hospitial space	42,156	22
23	Governmental appropriations		23
24	Other (specify)	1,710,459	24
25	Total other income (sum of lines 6-24)	1,777,778	25
26	Total (line 5 plus line 25)	2,784,908	26
29	Net income (or loss) for the period (line 26 minus line 28)	2,784,908	29