

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

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. ☒ Electronically filed cost report Date: 10/01/2019 Time: 09:46 2. ☐ Manually submitted cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted the cost report 4. ☒ Medicare Utilization. Enter 'F' for full or 'L' for low.	
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ____ 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by THE REHABILITATION INSTITUTE OF ST. (26-3028) (Provider Name(s) and Number(s)) for the cost reporting period beginning 06/01/2018 and ending 05/31/2019, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

SVP - REIMBURSEMENT
Title

Date

PART III - SETTLEMENT SUMMARY

		TITLE XVIII					
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		-112,179			918,723	1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		-112,179			918,723	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.

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

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

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	THE REHABILITATION INSTITUTE OF ST.	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 / 2018	To: 05 / 31 / 2019		20
21	Type of control (see instructions)	5			21

Inpatient PPS Information

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.							24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	5,938	932	746	191	1,900		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)			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

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**WORKSHEET S-2
PART I**

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40
		V	XVIII	XIX
	Prospective Payment System (PPS)-Capital	1	2	3
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	N	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

		1	2	3	
56	Teaching Hospitals 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
		NAHE 413.85 Y/N 1	Worksheet A Line # 2	Pass-Through Qualification Criteria Code 3	
60	Are you claiming nursing and allied health education (NAHE) costs for any program(s) that meet the criteria under 42 CFR 413.85? (see instructions)	N			60
		Y/N 1	IME 4	Direct GME 5	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or 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. Enter in column 4, the direct GME FTE unweighted count.

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

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

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

62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital 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 through 67. (see instructions)	N			63
----	--	---	--	--	----

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**WORKSHEET S-2
PART I**

Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						64
Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)							
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
65							65
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						66
Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)							
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
67							67

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

Inpatient Rehabilitation Facility PPS

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

Long Term Care Hospital PPS

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

TEFRA Providers

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

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**WORKSHEET S-2
PART I**

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

Rural Providers

Rural Providers				1	2	
105	Does this hospital qualify as a CAH?			N		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME 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
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.	Physical	Occupational	Speech	Respiratory	109
110	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			1		
				N		110
				1	2	
111	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for additional beds; and/or 'C' for tele-health services.					111

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-L, 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
118.01	List amounts of malpractice premiums and paid losses:	Premiums	Paid Losses	Self Insurance	
		65,692	173,490		118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.	N	N		120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.	N			121
122	Does the cost report contain state health care related taxes as defined in §1903(w)(3) of the Act? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00		122

Transplant Center Information

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

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**WORKSHEET S-2
PART I**

All Providers

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

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

141	Name: ENCOMPASS HEALTH	Contractor's Name: PALMETTO GBA	Contractor's Number: 10111	141
142	Street: 9001 LIBERTY PARKWAY	P.O. Box:		142
143	City: BIRMINGHAM	State: AL	ZIP Code: 35242	143
144	Are provider based physicians' costs included in Worksheet A?	Y		144
145	If costs for renal services are claimed on Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.	N	N	145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, chapter 40, §4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N		147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N		148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	N		149

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

		Title XVIII		Title V	Title XIX	
		Part A	Part B	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. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE**WORKSHEET S-2
PART II**

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

COMPLETED BY ALL HOSPITALS

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

		Y/N	Type	Date	
Financial Data and Reports		1	2	3	
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	Y	A	02/27/2019	4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N			5

		Y/N	Y/N	
Approved Educational Activities		1	2	
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N		6
7	Are costs claimed for allied health programs? If yes, see instructions.	N		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N		8
9	Are costs claimed for Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	N		9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see 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	
Bad Debts		Y	
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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N		16
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	08/01/2019	N		17
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N		18
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19
20	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE**WORKSHEET S-2
PART II**

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

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

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

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

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

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

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

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

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA**WORKSHEET S-3
PART I**

		Inpatient Days / Outpatient Visits / Trips								
	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	131	47,815			14,530	6,109	36,102	1
2	HMO and other (see instructions)						4,350	3,598		2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF									5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		131	47,815			14,530	6,109	36,102	7
8	Intensive Care Unit	31								8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	Other Special Care (specify)	35								12
13	Nursery	43								13
14	Total (see instructions)		131	47,815			14,530	6,109	36,102	14
15	CAH Visits									15
16	Subprovider - IPF	40								16
17	Subprovider - IRF	41								17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44								19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101								22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116								24
24.10	Hospice (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	Total (sum of lines 14-26)		131							27
28	Observation Bed Days									28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)									32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33
33.01	LTCH site neutral days and discharges									33.01

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

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)					1,059	434	2,487	1
2	HMO and other (see instructions)					298	176		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)		344.85			1,059	434	2,487	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)		344.85						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32.01
33	LTCH non-covered days								33
33.01	LTCH site neutral days and discharges								33.01

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

HOSPITAL WAGE INDEX INFORMATION**WORKSHEET S-3
PARTS II-III****Part II - Wage Data**

		Wkst A Line No.	Amount Reported	Reclassif- ication of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)	
		1	2	3	4	5	6	
	SALARIES							
1	Total salaries (see instructions)	200	23,872,821					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)			245,386				10
	OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)							11
12	Contract management and administrative services							12
13	Contract labor: Physician-Part A - Administrative							13
14	Home office salaries & wage-related costs							14
14.01	Home office salaries							14.01
14.02	Related organization salaries							14.02
15	Home office: Physician Part A - Administrative							15
16	Home office & Contract Physicians Part A - Teaching							16
	WAGE-RELATED COSTS							
17	Wage-related costs (core)(see instructions)							17
18	Wage-related costs (other)(see instructions)							18
19	Excluded areas							19
20	Non-physician anesthetist Part A							20
21	Non-physician anesthetist Part B							21
22	Physician Part A - Administrative							22
22.01	Physician Part A - Teaching							22.01
23	Physician Part B							23
24	Wage-related costs (RHC/FQHC)							24
25	Interns & residents (in an approved program)							25
25.50	Home office wage-related							25.50
25.51	Related organization wage-related							25.51
25.52	Home office: Physician Part A - Administrative - wage-related							25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related							25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26	Employee Benefits Department							26
27	Administrative & General		3,470,592	-245,386				27
28	Administrative & General under contract (see instructions)							28
29	Maintenance & Repairs							29
30	Operation of Plant		249,832					30
31	Laundry & Linen Service							31
32	Housekeeping		274,414					32
33	Housekeeping under contract (see instructions)							33
34	Dietary							34
35	Dietary under contract (see instructions)							35
36	Cafeteria							36
37	Maintenance of Personnel							37
38	Nursing Administration		1,156,491					38
39	Central Services and Supply							39
40	Pharmacy							40
41	Medical Records & Medical Records Library		307,595					41
42	Social Service		802,535					42
43	Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		23,872,821		23,872,821		1
2	Excluded area salaries (see instructions)			245,386	245,386		2
3	Subtotal salaries (line 1 minus line 2)		23,872,821	-245,386	23,627,435		3
4	Subtotal other wages & related costs (see instructions)						4
5	Subtotal wage-related costs (see instructions)						5
6	Total (sum of lines 3 through 5)		23,872,821	-245,386	23,627,435		6
7	Total overhead cost (see instructions)		6,261,459	-245,386	6,016,073		7

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

HOSPITAL WAGE RELATED COSTS**WORKSHEET S-3****Part IV - Wage Related Cost****PART IV****Part A - Core List**

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

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)		25
----	------------------------------------	--	----

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

HOSPITAL CONTRACT LABOR AND BENEFIT COST**WORKSHEET S-3****Part V - Contract Labor and Benefit Cost****PART V****Hospital and Hospital-Based Component Identification:**

	Component	Contract Labor	Benefit Cost	
	0	1	2	
1	Total facility contract labor and benefit cost	1,177,859	4,741,967	1
2	Hospital	1,177,859	4,693,225	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		48,742	18

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt		3,480,732	3,480,732	169,574	3,650,306	-153,535	3,496,771	1
2	00200	Cap Rel Costs-Mvble Equip		1,322,946	1,322,946	51,208	1,374,154	-32,544	1,341,610	2
3	00300	Other Cap Rel Costs		205,039	205,039	-205,039			-0-	3
4	00400	Employee Benefits Department		4,695,644	4,695,644		4,695,644	40,020	4,735,664	4
5	00500	Administrative & General	3,470,592	7,112,347	10,582,939	-857,032	9,725,907	-871,412	8,854,495	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	249,832	801,098	1,050,930	-9,922	1,041,008	-42,616	998,392	7
8	00800	Laundry & Linen Service		255,353	255,353		255,353	-17	255,336	8
9	00900	Housekeeping	274,414	97,229	371,643		371,643		371,643	9
10	01000	Dietary		1,607,144	1,607,144	-130	1,607,014	-162,088	1,444,926	10
11	01100	Cafeteria								11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	1,156,491	17,810	1,174,301		1,174,301		1,174,301	13
14	01400	Central Services & Supply								14
15	01500	Pharmacy								15
16	01600	Medical Records & Library	307,595	4,221	311,816		311,816	-110	311,706	16
17	01700	Social Service	802,535	11,689	814,224		814,224	-2,422	811,802	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				-41,250	-41,250		-41,250	22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	9,195,418	537,656	9,733,074	723,582	10,456,656	-463,597	9,993,059	30
		ANCILLARY SERVICE COST CENTERS								
54	05400	Radiology-Diagnostic		255,789	255,789	-254,736	1,053		1,053	54
54.01	05401	RADIOLOGY-SUA				254,736	254,736	-43,120	211,616	54.01
60	06000	Laboratory		747,253	747,253		747,253		747,253	60
60.01	03952	LAB - SUA								60.01
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	680,625	17,529	698,154		698,154		698,154	65
66	06600	Physical Therapy	3,168,983	93,726	3,262,709		3,262,709	-8,333	3,254,376	66
67	06700	Occupational Therapy	2,163,997	119,509	2,283,506		2,283,506	-20,833	2,262,673	67
68	06800	Speech Pathology	1,190,134	13,649	1,203,783		1,203,783		1,203,783	68
71	07100	Medical Supplies Charged to Patients	181,795	678,944	860,739	9,926	870,665		870,665	71
73	07300	Drugs Charged to Patients	920,080	1,488,915	2,408,995		2,408,995	-26,758	2,382,237	73
76	03550	PSYCHOLOGY	110,330	394	110,724	-110,724				76
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
92	09200	Observation Beds (Non-Distinct Part)								92
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM								93.99
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
113	11300	Interest Expense		7,748	7,748		7,748	-7,748		113
118		SUBTOTALS (sum of lines 1-117)	23,872,821	23,572,364	47,445,185	-269,807	47,175,378	-1,795,113	45,380,265	118
		NONREIMBURSABLE COST CENTERS								
192	19200	Physicians' Private Offices								192
194	07950	MARKETING NRCC				253,049	253,049		253,049	194
194.01	07951	GUEST MEALS								194.01
194.02	07952	CLINICAL PSYCHOLOGY				16,758	16,758		16,758	194.02
200		TOTAL (sum of lines 118-199)	23,872,821	23,572,364	47,445,185		47,445,185	-1,795,113	45,650,072	200

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

RECLASSIFICATIONS**WORKSHEET A-6**

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				
			COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	INSURANCE	A	Cap Rel Costs-Bldg & Fixt	1		12,092	1
2	INSURANCE	A	Cap Rel Costs-Mvble Equip	2		3,651	2
3	INSURANCE	A					3
500	Total reclassifications					15,743	500
	Code Letter - A						
1	MARKETING	B	MARKETING NRCC	194	245,386	7,663	1
2	MARKETING	B					2
3	MARKETING	B					3
500	Total reclassifications				245,386	7,663	500
	Code Letter - B						
1	PHYSICIANS	C	Adults & Pediatrics	30		611,580	1
2	PHYSICIANS	C					2
500	Total reclassifications					611,580	500
	Code Letter - C						
1	PROFESSIONAL FEES	D					1
2	PROFESSIONAL FEES	D	Administrative & General	5		41,250	2
500	Total reclassifications					41,250	500
	Code Letter - D						
1	HHA RECLASS	E	Adults & Pediatrics	30	110,330	1,672	1
2	HHA RECLASS	E					2
3	HHA RECLASS	E					3
500	Total reclassifications				110,330	1,672	500
	Code Letter - E						
1	SERVICE UNDER ARRANGEMENT	F	RADIOLOGY-SUA	54.01		254,736	1
2	SERVICE UNDER ARRANGEMENT	F					2
500	Total reclassifications					254,736	500
	Code Letter - F						
1	CONTRACT SERVICES	G	CLINICAL PSYCHOLOGY	194.02		16,758	1
2	CONTRACT SERVICES	G					2
500	Total reclassifications					16,758	500
	Code Letter - G						
1	OXYGEN RECLASS	H	Medical Supplies Charged to P	71		9,926	1
2	OXYGEN RECLASS	H					2
3	OXYGEN RECLASS	H					3
500	Total reclassifications					9,926	500
	Code Letter - H						
	GRAND TOTAL (Increases)				355,716	959,328	

(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

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

RECLASSIFICATIONS
WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	DECREASES				Wkst A-7 Ref.	
			COST CENTER	LINE #	SALARY	OTHER		
		1	6	7	8	9	10	
1	INSURANCE	A					12	1
2	INSURANCE	A					12	2
3	INSURANCE	A	Administrative & General	5		15,743		3
500	Total reclassifications					15,743		500
	Code letter - A							
1	MARKETING	B						1
2	MARKETING	B	Administrative & General	5	245,386	7,533		2
3	MARKETING	B	Dietary	10		130		3
500	Total reclassifications				245,386	7,663		500
	Code letter - B							
1	PHYSICIANS	C						1
2	PHYSICIANS	C	Administrative & General	5		611,580		2
500	Total reclassifications					611,580		500
	Code letter - C							
1	PROFESSIONAL FEES	D	I&R Services-Other Prgm Costs	22		41,250		1
2	PROFESSIONAL FEES	D						2
500	Total reclassifications					41,250		500
	Code letter - D							
1	HHA RECLASS	E						1
2	HHA RECLASS	E	Administrative & General	5		1,278		2
3	HHA RECLASS	E	PSYCHOLOGY	76	110,330	394		3
500	Total reclassifications				110,330	1,672		500
	Code letter - E							
1	SERVICE UNDER ARRANGEMENT	F						1
2	SERVICE UNDER ARRANGEMENT	F	Radiology-Diagnostic	54		254,736		2
500	Total reclassifications					254,736		500
	Code letter - F							
1	CONTRACT SERVICES	G						1
2	CONTRACT SERVICES	G	Administrative & General	5		16,758		2
500	Total reclassifications					16,758		500
	Code letter - G							
1	OXYGEN RECLASS	H						1
2	OXYGEN RECLASS	H	Administrative & General	5		4		2
3	OXYGEN RECLASS	H	Operation of Plant	7		9,922		3
500	Total reclassifications					9,926		500
	Code letter - H							
	GRAND TOTAL (Decreases)				355,716	959,328		

(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

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

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	18,065,336				132,603	17,932,733		3
4	Building Improvements	11,162,892	382,017		382,017		11,544,909		4
5	Fixed Equipment								5
6	Movable Equipment	8,853,581	516,668		516,668	462,106	8,908,143		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	38,102,549	898,685		898,685	594,709	38,406,525		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	38,102,549	898,685		898,685	594,709	38,406,525		10

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

	Description	SUMMARY OF CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		9	10	11	12	13	14	15	
*									
1	Cap Rel Costs-Bldg & Fixt	1,592,496	1,888,236					3,480,732	1
2	Cap Rel Costs-Mvble Equip	903,128	419,818					1,322,946	2
3	Total (sum of lines 1-2)	2,495,624	2,308,054					4,803,678	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	29,498,382		29,498,382	0.768057		157,482		157,482	1
2	Cap Rel Costs-Mvble Equip	8,908,143		8,908,143	0.231943		47,557		47,557	2
3	Total (sum of lines 1-2)	38,406,525		38,406,525	1.000000		205,039		205,039	3

	Description	SUMMARY OF CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		9	10	11	12	13	14	15	
*									
1	Cap Rel Costs-Bldg & Fixt	1,781,005	1,167,181	379,011	12,092	157,482		3,496,771	1
2	Cap Rel Costs-Mvble Equip	870,584	419,818		3,651	47,557		1,341,610	2
3	Total (sum of lines 1-2)	2,651,589	1,586,999	379,011	15,743	205,039		4,838,381	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.)

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

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	
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	-446,514				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1	2,574,614				12
13	Laundry and linen service						13
14	Cafeteria - employees and guests						14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients						16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts						18
19	Nursing and allied health education (tuition, fees, books, etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation						32
33							33
34							34
35							35
36							36
37	INTEREST	A	-7,748	Interest Expense	113	11	37
37.01	DEPRECIATION	A	-762	Cap Rel Costs-Bldg & Fixt	1	9	37.01
37.03	INSURANCE	A	46,332	Employee Benefits Department	4		37.03
37.04	INSURANCE	A	-467,689	Administrative & General	5		37.04
37.05	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-714,482	Administrative & General	5		37.05
37.06	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-1,265	Operation of Plant	7		37.06
37.07	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-2,422	Social Service	17		37.07
37.08	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-17,083	Adults & Pediatrics	30		37.08
37.09	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-8,333	Physical Therapy	66		37.09
37.10	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-20,833	Occupational Therapy	67		37.10
37.11	PATIENT TELEPHONE	A	-4,041	Cap Rel Costs-Mvble Equip	2	9	37.11
37.12	PATIENT TELEPHONE	A	-4,902	Employee Benefits Department	4		37.12
37.13	PATIENT TELEPHONE	A	-28,421	Administrative & General	5		37.13
37.14	PATIENT TELEVISION	A	-16,970	Cap Rel Costs-Mvble Equip	2	9	37.14
37.15	PATIENT TELEVISION	A	-2,684	Administrative & General	5		37.15
37.16	PRINTING	A	-5,870	Administrative & General	5		37.16
37.17	PRINTING	A	-21	Operation of Plant	7		37.17
37.18	LOBBYING EXPENSE	A	-273	Employee Benefits Department	4		37.18
37.19	LOBBYING EXPENSE	A	-2,217	Administrative & General	5		37.19
37.20	MISCELLANEOUS INCOME	B	-24,621	Administrative & General	5		37.20
37.21	MISCELLANEOUS INCOME	B	-36	Dietary	10		37.21
37.22	MISCELLANEOUS INCOME	B	-110	Medical Records & Library	16		37.22
37.23	MISCELLANEOUS INCOME	B	-5,218	Drugs Charged to Patients	73		37.23
37.24	PATIENT TRANSPORTATION	A	-11,533	Cap Rel Costs-Mvble Equip	2	9	37.24
37.25	PATIENT TRANSPORTATION	A	-1,137	Employee Benefits Department	4		37.25
37.26	PATIENT TRANSPORTATION	A	-99,993	Administrative & General	5		37.26
37.27	PATIENT TRANSPORTATION	A	-15,745	Operation of Plant	7		37.27
37.28	PATIENT TRANSPORTATION	A	-17	Laundry & Linen Service	8		37.28
37.29	MISC. TAX	A	-2,081,513	Administrative & General	5		37.29

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.
		1	2	3	4	5
37.30	PROFESSIONAL FEES	A	-254,332	Administrative & General	5	37.30
37.31	CLINICAL PSYCHOLOGY	A	-36,000	Administrative & General	5	37.31
37.32	INTERNS & RESIDENTS	A	-1,715	Administrative & General	5	37.32
37.33	PHYSICIANS	A	-131,559	Administrative & General	5	37.33
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)		-1,795,113			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.

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

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		847,557	-847,557		1
2	1	Cap Rel Costs-Bldg & Fixt	TO INCLUDE ALLOWABLE HOME OFFICE COS	189,271		189,271	9	2
3	1	Cap Rel Costs-Bldg & Fixt	TO INCLUDE ALLOWABLE HOME OFFICE COS	379,011		379,011	11	3
3.01	5	Administrative & General	TO INCLUDE ALLOWABLE HOME OFFICE COS	3,449,326		3,449,326		3.01
3.02	5	Administrative & General	TO INCLUDE ALLOWABLE HOME OFFICE COS	631,375		631,375		3.02
3.03	5	Administrative & General	TO INCLUDE ALLOWABLE HOME OFFICE COS	-82,611		-82,611		3.03
3.04	2	Cap Rel Costs-Mvble Equip	INTERCOMPANY WAGE AND EXPENSE TRANSF	4,720	4,720		9	3.04
3.05	3	Other Cap Rel Costs	INTERCOMPANY WAGE AND EXPENSE TRANSF	2	2			3.05
3.06	4	Employee Benefits Department	INTERCOMPANY WAGE AND EXPENSE TRANSF	3,342,617	3,342,617			3.06
3.07	5	Administrative & General	INTERCOMPANY WAGE AND EXPENSE TRANSF	2,206,846	2,206,846			3.07
3.08	7	Operation of Plant	INTERCOMPANY WAGE AND EXPENSE TRANSF	5,547	5,547			3.08
3.09	8	Laundry & Linen Service	INTERCOMPANY WAGE AND EXPENSE TRANSF	-41	-41			3.09
3.10	9	Housekeeping	INTERCOMPANY WAGE AND EXPENSE TRANSF	75	75			3.10
3.11	10	Dietary	INTERCOMPANY WAGE AND EXPENSE TRANSF	-8,916	-8,916			3.11
3.12	13	Nursing Administration	INTERCOMPANY WAGE AND EXPENSE TRANSF	481	481			3.12
3.13	16	Medical Records & Library	INTERCOMPANY WAGE AND EXPENSE TRANSF	1,413	1,413			3.13
3.14	17	Social Service	INTERCOMPANY WAGE AND EXPENSE TRANSF	-18	-18			3.14
3.15	30	Adults & Pediatrics	INTERCOMPANY WAGE AND EXPENSE TRANSF	12,125	12,125			3.15
3.16	54	Radiology-Diagnostic	INTERCOMPANY WAGE AND EXPENSE TRANSF	-324	-324			3.16
3.17	60	Laboratory	INTERCOMPANY WAGE AND EXPENSE TRANSF	-334	-334			3.17
3.18	66	Physical Therapy	INTERCOMPANY WAGE AND EXPENSE TRANSF	3,389	3,389			3.18
3.19	67	Occupational Therapy	INTERCOMPANY WAGE AND EXPENSE TRANSF	4,273	4,273			3.19
3.20	68	Speech Pathology	INTERCOMPANY WAGE AND EXPENSE TRANSF	434	434			3.20
3.21	71	Medical Supplies Charged to Patients	INTERCOMPANY WAGE AND EXPENSE TRANSF	-25,141	-25,141			3.21
3.22	73	Drugs Charged to Patients	INTERCOMPANY WAGE AND EXPENSE TRANSF	38,897	38,897			3.22
3.23	113	Interest Expense	INTERCOMPANY WAGE AND EXPENSE TRANSF	7,748	7,748		11	3.23
3.24	5	Administrative & General	RELATED PARTY	69,273	238,872	-169,599		3.24
3.25	7	Operation of Plant	RELATED PARTY	10,450	36,035	-25,585		3.25
3.26	10	Dietary	RELATED PARTY	66,190	228,242	-162,052		3.26
3.27	54.01	RADIOLOGY-SUA	RELATED PARTY	39,803	82,923	-43,120		3.27
3.28	60.01	LAB - SUA	RELATED PARTY	386,900	386,900			3.28
3.29	73	Drugs Charged to Patients	RELATED PARTY	14,968	36,508	-21,540		3.29
3.30	1	Cap Rel Costs-Bldg & Fixt	RELATED PARTY		572,281	-572,281	10	3.30
3.31	1	Cap Rel Costs-Bldg & Fixt	RELATED PARTY	1,164,786	1,313,560	-148,774	10	3.31
3.32	5	Administrative & General	RELATED PARTY		1,250	-1,250		3.32
4								4
5		TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12		11,912,535	9,337,921	2,574,614		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

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	--------------------------------	--	--

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

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

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

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

acceptable for purposes of claiming reimbursement under title XVIII.

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

- (1) Use the following symbols to indicate the interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.

E. Individual is director, officer, administrator, or key person of provider and related organization.

F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

G. Other (financial Or non-financial) specify:

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

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

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun- eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	30	Adults & Pediatrics AGGREGATE	611,850		611,850	211,500	1,626	165,336	8,267	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	611,850		611,850		1,626	165,336	8,267	200

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	--------------------------------	--	--

PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	30	Adults & Pediatrics AGGREGATE					165,336	446,514	446,514	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					165,336	446,514	446,514	200

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

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

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS- TRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	3,496,771	3,496,771					1
2	Cap Rel Costs-Mvble Equip	1,341,610		1,341,610				2
4	Employee Benefits Department	4,735,664			4,735,664			4
5	Administrative & General	8,854,495	234,965	90,149	639,787	9,819,396	9,819,396	5
6	Maintenance & Repairs							6
7	Operation of Plant	998,392	10,489	4,024	49,559	1,062,464	292,559	7
8	Laundry & Linen Service	255,336	28,689	11,007		295,032	81,240	8
9	Housekeeping	371,643	14,116	5,416	54,436	445,611	122,703	9
10	Dietary	1,444,926	186,345	71,495		1,702,766	468,872	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	1,174,301	13,821	5,303	229,414	1,422,839	391,792	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	311,706	21,631	8,299	61,018	402,654	110,874	16
17	Social Service	811,802	14,050	5,391	159,200	990,443	272,727	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	-41,250				-41,250		22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	9,993,059	2,013,755	772,619	1,845,981	14,625,414	4,027,248	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	1,053				1,053	290	54
54.01	RADIOLOGY-SUA	211,616				211,616		54.01
60	Laboratory	747,253	17,710	6,795		771,758	212,511	60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	698,154	12,841	4,927	135,016	850,938	234,313	65
66	Physical Therapy	3,254,376	425,950	163,425	628,634	4,472,385	1,231,511	66
67	Occupational Therapy	2,262,673	223,758	85,849	429,274	3,001,554	826,505	67
68	Speech Pathology	1,203,783	105,899	40,631	236,088	1,586,401	436,830	68
71	Medical Supplies Charged to Patients	870,665	73,453	28,182	36,063	1,008,363	277,662	71
73	Drugs Charged to Patients	2,382,237	42,020	16,122	182,517	2,622,896	722,238	73
76	PSYCHOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	45,380,265	3,439,492	1,319,634	4,686,987	45,252,333	9,709,875	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		54,208	20,798		75,006	20,654	192
194	MARKETING NRCC	253,049	3,071	1,178	48,677	305,975	84,253	194
194.01	GUEST MEALS							194.01
194.02	CLINICAL PSYCHOLOGY	16,758				16,758	4,614	194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	45,650,072	3,496,771	1,341,610	4,735,664	45,650,072	9,819,396	202

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

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

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	NURSING ADMINIS- TRATION	MEDICAL RECORDS & LIBRARY	
		7	8	9	10	13	16	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	1,355,023						7
8	Laundry & Linen Service	11,956	388,228					8
9	Housekeeping	5,883		574,197				9
10	Dietary	77,661		33,348	2,282,647			10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	5,760		2,474		1,822,865		13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	9,015		3,871			526,414	16
17	Social Service	5,856		2,514				17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	839,254	388,228	360,383	2,282,647	1,822,865	234,714	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic						2,434	54
54.01	RADIOLOGY-SUA						4,648	54.01
60	Laboratory	7,381		3,169			13,380	60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	5,352		2,298			6,033	65
66	Physical Therapy	177,520		76,228			79,861	66
67	Occupational Therapy	93,254		40,044			72,637	67
68	Speech Pathology	44,135		18,952			35,321	68
71	Medical Supplies Charged to Patients	30,612		13,145			3,202	71
73	Drugs Charged to Patients	17,512		7,520			74,184	73
76	PSYCHOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	1,331,151	388,228	563,946	2,282,647	1,822,865	526,414	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	22,592		9,701				192
194	MARKETING NRCC	1,280		550				194
194.01	GUEST MEALS							194.01
194.02	CLINICAL PSYCHOLOGY							194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,355,023	388,228	574,197	2,282,647	1,822,865	526,414	202

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

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

	COST CENTER DESCRIPTIONS	SOCIAL SERVICE	I&R PROGRAM COSTS	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL		
		17	22	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service	1,271,540						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		-41,250					22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,271,540		25,852,293		25,852,293		30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic			3,777		3,777		54
54.01	RADIOLOGY-SUA			216,264		216,264		54.01
60	Laboratory			1,008,199		1,008,199		60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			1,098,934		1,098,934		65
66	Physical Therapy			6,037,505		6,037,505		66
67	Occupational Therapy			4,033,994		4,033,994		67
68	Speech Pathology			2,121,639		2,121,639		68
71	Medical Supplies Charged to Patients			1,332,984		1,332,984		71
73	Drugs Charged to Patients			3,444,350		3,444,350		73
76	PSYCHOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	1,271,540		45,149,939		45,149,939		118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices			127,953		127,953		192
194	MARKETING NRCC			392,058		392,058		194
194.01	GUEST MEALS							194.01
194.02	CLINICAL PSYCHOLOGY			21,372		21,372		194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers		-41,250	-41,250		-41,250		201
202	TOTAL (sum of lines 118-201)	1,271,540	-41,250	45,650,072		45,650,072		202

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

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

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	ADMINIS- TRATIVE & GENERAL	OPERATION OF PLANT	
		0	1	2	2A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General		234,965	90,149	325,114	325,114		5
6	Maintenance & Repairs							6
7	Operation of Plant		10,489	4,024	14,513	9,686	24,199	7
8	Laundry & Linen Service		28,689	11,007	39,696	2,690	214	8
9	Housekeeping		14,116	5,416	19,532	4,063	105	9
10	Dietary		186,345	71,495	257,840	15,524	1,387	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration		13,821	5,303	19,124	12,972	103	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		21,631	8,299	29,930	3,671	161	16
17	Social Service		14,050	5,391	19,441	9,030	105	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		2,013,755	772,619	2,786,374	133,338	14,987	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic					10		54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory		17,710	6,795	24,505	7,036	132	60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		12,841	4,927	17,768	7,758	96	65
66	Physical Therapy		425,950	163,425	589,375	40,775	3,170	66
67	Occupational Therapy		223,758	85,849	309,607	27,365	1,665	67
68	Speech Pathology		105,899	40,631	146,530	14,463	788	68
71	Medical Supplies Charged to Patients		73,453	28,182	101,635	9,193	547	71
73	Drugs Charged to Patients		42,020	16,122	58,142	23,913	313	73
76	PSYCHOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)		3,439,492	1,319,634	4,759,126	321,487	23,773	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		54,208	20,798	75,006	684	403	192
194	MARKETING NRCC		3,071	1,178	4,249	2,790	23	194
194.01	GUEST MEALS							194.01
194.02	CLINICAL PSYCHOLOGY					153		194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		3,496,771	1,341,610	4,838,381	325,114	24,199	202

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

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

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	NURSING ADMINIS- TRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		8	9	10	13	16	17	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	42,600						8
9	Housekeeping		23,700					9
10	Dietary		1,376	276,127				10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration		102		32,301			13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		160			33,922		16
17	Social Service		104				28,680	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	42,600	14,875	276,127	32,301	15,145	28,680	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic					157		54
54.01	RADIOLOGY-SUA					299		54.01
60	Laboratory		131			861		60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		95			388		65
66	Physical Therapy		3,146			5,141		66
67	Occupational Therapy		1,653			4,676		67
68	Speech Pathology		782			2,274		68
71	Medical Supplies Charged to Patients		543			206		71
73	Drugs Charged to Patients		310			4,775		73
76	PSYCHOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	42,600	23,277	276,127	32,301	33,922	28,680	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		400					192
194	MARKETING NRCC		23					194
194.01	GUEST MEALS							194.01
194.02	CLINICAL PSYCHOLOGY							194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	42,600	23,700	276,127	32,301	33,922	28,680	202

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

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

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL				
		24	25	26				
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	3,344,427		3,344,427				30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	167		167				54
54.01	RADIOLOGY-SUA	299		299				54.01
60	Laboratory	32,665		32,665				60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	26,105		26,105				65
66	Physical Therapy	641,607		641,607				66
67	Occupational Therapy	344,966		344,966				67
68	Speech Pathology	164,837		164,837				68
71	Medical Supplies Charged to Patients	112,124		112,124				71
73	Drugs Charged to Patients	87,453		87,453				73
76	PSYCHOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	4,754,650		4,754,650				118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	76,493		76,493				192
194	MARKETING NRCC	7,085		7,085				194
194.01	GUEST MEALS							194.01
194.02	CLINICAL PSYCHOLOGY	153		153				194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	4,838,381		4,838,381				202

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

COST ALLOCATION - STATISTICAL BASIS
WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	107,017						1
2	Cap Rel Costs-Mvble Equip		107,017					2
4	Employee Benefits Department			23,872,821				4
5	Administrative & General	7,191	7,191	3,225,206	-9,819,396	35,660,310		5
6	Maintenance & Repairs							6
7	Operation of Plant	321	321	249,832		1,062,464	99,505	7
8	Laundry & Linen Service	878	878			295,032	878	8
9	Housekeeping	432	432	274,414		445,611	432	9
10	Dietary	5,703	5,703			1,702,766	5,703	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	423	423	1,156,491		1,422,839	423	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	662	662	307,595		402,654	662	16
17	Social Service	430	430	802,535		990,443	430	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				41,250			22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	61,630	61,630	9,305,748		14,625,414	61,630	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic					1,053		54
54.01	RADIOLOGY-SUA				-211,616			54.01
60	Laboratory	542	542			771,758	542	60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	393	393	680,625		850,938	393	65
66	Physical Therapy	13,036	13,036	3,168,983		4,472,385	13,036	66
67	Occupational Therapy	6,848	6,848	2,163,997		3,001,554	6,848	67
68	Speech Pathology	3,241	3,241	1,190,134		1,586,401	3,241	68
71	Medical Supplies Charged to Patients	2,248	2,248	181,795		1,008,363	2,248	71
73	Drugs Charged to Patients	1,286	1,286	920,080		2,622,896	1,286	73
76	PSYCHOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	105,264	105,264	23,627,435	-9,989,762	35,262,571	97,752	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	1,659	1,659			75,006	1,659	192
194	MARKETING NRCC	94	94	245,386		305,975	94	194
194.01	GUEST MEALS							194.01
194.02	CLINICAL PSYCHOLOGY					16,758		194.02
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	3,496,771	1,341,610	4,735,664		9,819,396	1,355,023	202
203	Unit Cost Multiplier (Wkst. B, Part I)	32.674911	12.536419	0.198371		0.275359	13.617637	203
204	Cost to be allocated (Per Wkst. B, Part II)					325,114	24,199	204
205	Unit Cost Multiplier (Wkst. B, Part II)					0.009117	0.243194	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

COST ALLOCATION - STATISTICAL BASIS
WORKSHEET B-1

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE PATIENT DAYS	HOUSE- KEEPING SQUARE FEET	DIETARY MEALS SERVED	NURSING ADMINIS- TRATION PATIENT DAYS	MEDICAL RECORDS & LIBRARY GROSS REVENUE	SOCIAL SERVICE PATIENT DAYS	
		8	9	10	13	16	17	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	36,102						8
9	Housekeeping		98,195					9
10	Dietary		5,703	108,306				10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration		423		36,102			13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		662			80,873,353		16
17	Social Service		430				36,102	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							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	36,102	61,630	108,306	36,102	36,058,478	36,102	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic					373,979		54
54.01	RADIOLOGY-SUA					714,080		54.01
60	Laboratory		542			2,055,614		60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		393			926,880		65
66	Physical Therapy		13,036			12,269,307		66
67	Occupational Therapy		6,848			11,159,449		67
68	Speech Pathology		3,241			5,426,468		68
71	Medical Supplies Charged to Patients		2,248			491,989		71
73	Drugs Charged to Patients		1,286			11,397,109		73
76	PSYCHOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	36,102	96,442	108,306	36,102	80,873,353	36,102	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		1,659					192
194	MARKETING NRCC		94					194
194.01	GUEST MEALS							194.01
194.02	CLINICAL PSYCHOLOGY							194.02
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	388,228	574,197	2,282,647	1,822,865	526,414	1,271,540	202
203	Unit Cost Multiplier (Wkst. B, Part I)	10.753642	5.847518	21.075905	50.492078	0.006509	35.220763	203
204	Cost to be allocated (Per Wkst. B, Part II)	42,600	23,700	276,127	32,301	33,922	28,680	204
205	Unit Cost Multiplier (Wkst. B, Part II)	1.179990	0.241356	2.549508	0.894715	0.000419	0.794416	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

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

	COST CENTER DESCRIPTIONS	I&R PROGRAM COSTS ASSIGNED TIME						
		22						

	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd	100						22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	100						30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic							54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory							60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients							73
76	PSYCHOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	100						118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices							192
194	MARKETING NRCC							194
194.01	GUEST MEALS							194.01
194.02	CLINICAL PSYCHOLOGY							194.02
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)							202
203	Unit Cost Multiplier (Wkst. B, Part I)							203
204	Cost to be allocated (Per Wkst. B, Part II)							204
205	Unit Cost Multiplier (Wkst. B, Part II)							205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	--------------------------------	--	--

POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		AMOUNT	
		CODE	LINE NO.		
	1	2	3	4	

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

COMPUTATION OF RATIO OF COST TO CHARGES
**WORKSHEET C
PART I**

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	25,852,293		25,852,293	446,514	26,298,807	30
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	3,777		3,777		3,777	54
54.01	RADIOLOGY-SUA	216,264		216,264		216,264	54.01
60	Laboratory	1,008,199		1,008,199		1,008,199	60
60.01	LAB - SUA						60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	1,098,934		1,098,934		1,098,934	65
66	Physical Therapy	6,037,505		6,037,505		6,037,505	66
67	Occupational Therapy	4,033,994		4,033,994		4,033,994	67
68	Speech Pathology	2,121,639		2,121,639		2,121,639	68
71	Medical Supplies Charged to Patients	1,332,984		1,332,984		1,332,984	71
73	Drugs Charged to Patients	3,444,350		3,444,350		3,444,350	73
76	PSYCHOLOGY						76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct Part)						92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	45,149,939		45,149,939	446,514	45,596,453	200
201	Less Observation Beds						201
202	Total (line 200 minus line 201)	45,149,939		45,149,939		45,596,453	202

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

COMPUTATION OF RATIO OF COST TO CHARGES
**WORKSHEET C
PART I**

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	36,058,478		36,058,478				30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	373,979		373,979	0.010099	0.010099	0.010099	54
54.01	RADIOLOGY-SUA	714,080		714,080	0.302857	0.302857	0.302857	54.01
60	Laboratory	2,055,614		2,055,614	0.490461	0.490461	0.490461	60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	926,880		926,880	1.185627	1.185627	1.185627	65
66	Physical Therapy	8,229,296	4,040,011	12,269,307	0.492082	0.492082	0.492082	66
67	Occupational Therapy	9,235,830	1,923,619	11,159,449	0.361487	0.361487	0.361487	67
68	Speech Pathology	3,830,408	1,596,060	5,426,468	0.390980	0.390980	0.390980	68
71	Medical Supplies Charged to Patients	484,560	7,429	491,989	2.709378	2.709378	2.709378	71
73	Drugs Charged to Patients	11,397,109		11,397,109	0.302213	0.302213	0.302213	73
76	PSYCHOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	73,306,234	7,567,119	80,873,353				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	73,306,234	7,567,119	80,873,353				202

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

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

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

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

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

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	36,058,478		36,058,478				30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	373,979		373,979				54
54.01	RADIOLOGY-SUA	714,080		714,080				54.01
60	Laboratory	2,055,614		2,055,614				60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	926,880		926,880				65
66	Physical Therapy	8,229,296	4,040,011	12,269,307				66
67	Occupational Therapy	9,235,830	1,923,619	11,159,449				67
68	Speech Pathology	3,830,408	1,596,060	5,426,468				68
71	Medical Supplies Charged to Patients	484,560	7,429	491,989				71
73	Drugs Charged to Patients	11,397,109		11,397,109				73
76	PSYCHOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	73,306,234	7,567,119	80,873,353				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	73,306,234	7,567,119	80,873,353				202

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

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

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	25,852,293		25,852,293	446,514	26,298,807	30
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	3,777		3,777		3,777	54
54.01	RADIOLOGY-SUA	216,264		216,264		216,264	54.01
60	Laboratory	1,008,199		1,008,199		1,008,199	60
60.01	LAB - SUA						60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	1,098,934		1,098,934		1,098,934	65
66	Physical Therapy	6,037,505		6,037,505		6,037,505	66
67	Occupational Therapy	4,033,994		4,033,994		4,033,994	67
68	Speech Pathology	2,121,639		2,121,639		2,121,639	68
71	Medical Supplies Charged to Patients	1,332,984		1,332,984		1,332,984	71
73	Drugs Charged to Patients	3,444,350		3,444,350		3,444,350	73
76	PSYCHOLOGY						76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct Part)						92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	45,149,939		45,149,939	446,514	45,596,453	200
201	Less Observation Beds						201
202	Total (line 200 minus line 201)	45,149,939		45,149,939	446,514	45,596,453	202

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

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

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	36,058,478		36,058,478				30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	373,979		373,979	0.010099	0.010099	0.010099	54
54.01	RADIOLOGY-SUA	714,080		714,080	0.302857	0.302857	0.302857	54.01
60	Laboratory	2,055,614		2,055,614	0.490461	0.490461	0.490461	60
60.01	LAB - SUA							60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	926,880		926,880	1.185627	1.185627	1.185627	65
66	Physical Therapy	8,229,296	4,040,011	12,269,307	0.492082	0.492082	0.492082	66
67	Occupational Therapy	9,235,830	1,923,619	11,159,449	0.361487	0.361487	0.361487	67
68	Speech Pathology	3,830,408	1,596,060	5,426,468	0.390980	0.390980	0.390980	68
71	Medical Supplies Charged to Patients	484,560	7,429	491,989	2.709378	2.709378	2.709378	71
73	Drugs Charged to Patients	11,397,109		11,397,109	0.302213	0.302213	0.302213	73
76	PSYCHOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	73,306,234	7,567,119	80,873,353				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	73,306,234	7,567,119	80,873,353				202

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY
**WORKSHEET C
PART II**
[] Title V
[XX] Title XIX

	COST CENTER DESCRIPTIONS	Total Cost (Wkst B, Part I, col. 26)	Capital Cost (Wkst B, Part II, col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	
		1	2	3	4	
	ANCILLARY SERVICE COST CENTERS					
54	Radiology-Diagnostic	3,777	167	3,610		54
54.01	RADIOLOGY-SUA	216,264	299	215,965		54.01
60	Laboratory	1,008,199	32,665	975,534		60
60.01	LAB - SUA					60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy	1,098,934	26,105	1,072,829		65
66	Physical Therapy	6,037,505	641,607	5,395,898		66
67	Occupational Therapy	4,033,994	344,966	3,689,028		67
68	Speech Pathology	2,121,639	164,837	1,956,802		68
71	Medical Supplies Charged to Patients	1,332,984	112,124	1,220,860		71
73	Drugs Charged to Patients	3,444,350	87,453	3,356,897		73
76	PSYCHOLOGY					76
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
92	Observation Beds (Non-Distinct Part)					92
93.99	PARTIAL HOSPITALIZATION PROGRAM					93.99
	OTHER REIMBURSABLE COST CENTERS					
113	Interest Expense					113
200	Subtotal	19,297,646	1,410,223	17,887,423		200
201	Less Observation Beds					201
202	Total	19,297,646	1,410,223	17,887,423		202

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

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

☒ Title XIX

	COST CENTER DESCRIPTIONS	Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Wkst C, Part I, col. 8)	Outpatient Cost to Charge Ratio(col. 6 ÷ col. 7)	
		5	6	7	8	
	ANCILLARY SERVICE COST CENTERS					
54	Radiology-Diagnostic		3,777	373,979	0.010099	54
54.01	RADIOLOGY-SUA		216,264	714,080	0.302857	54.01
60	Laboratory		1,008,199	2,055,614	0.490461	60
60.01	LAB - SUA					60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy		1,098,934	926,880	1.185627	65
66	Physical Therapy		6,037,505	12,269,307	0.492082	66
67	Occupational Therapy		4,033,994	11,159,449	0.361487	67
68	Speech Pathology		2,121,639	5,426,468	0.390980	68
71	Medical Supplies Charged to Patients		1,332,984	491,989	2.709378	71
73	Drugs Charged to Patients		3,444,350	11,397,109	0.302213	73
76	PSYCHOLOGY					76
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
92	Observation Beds (Non-Distinct Part)					92
93.99	PARTIAL HOSPITALIZATION PROGRAM					93.99
	OTHER REIMBURSABLE COST CENTERS					
113	Interest Expense					113
200	Subtotal		19,297,646	44,814,875		200
201	Less Observation Beds					201
202	Total		19,297,646	44,814,875		202

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust- ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	3,344,427		3,344,427	36,102	92.64	14,530	1,346,059	30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	3,344,427		3,344,427	36,102		14,530	1,346,059	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 26-3028

WORKSHEET D
PART II

Check
Applicable
Boxes:

☐ Title V

☒ Title XVIII, Part A

☐ Title XIX

☒ Hospital

☐ IPF

☐ IRF

☐ SUB (Other)

☒ PPS

☐ TEFRA

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	167	373,979	0.000447	125,791	56	54
54.01	RADIOLOGY-SUA	299	714,080	0.000419	239,880	101	54.01
60	Laboratory	32,665	2,055,614	0.015891	1,034,875	16,445	60
60.01	LAB - SUA						60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	26,105	926,880	0.028164	361,122	10,171	65
66	Physical Therapy	641,607	12,269,307	0.052294	3,394,567	177,515	66
67	Occupational Therapy	344,966	11,159,449	0.030912	3,905,210	120,718	67
68	Speech Pathology	164,837	5,426,468	0.030376	1,375,744	41,790	68
71	Medical Supplies Charged to Pat	112,124	491,989	0.227899	213,384	48,630	71
73	Drugs Charged to Patients	87,453	11,397,109	0.007673	5,004,299	38,398	73
76	PSYCHOLOGY						76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct						92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,410,223	44,814,875		15,654,872	453,824	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

☐ Title V
☒ Title XVIII, Part A
☐ Title XIX

☒ PPS
☐ TEFRA
☐ Other

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

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	--------------------------------	--	--

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

☐ Title V
☒ Title XVIII, Part A
☐ Title XIX

☒ PPS
☐ TEFRA
☐ Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass- Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	36,102		14,530		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)	36,102		14,530		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

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

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

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

**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

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass- Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass- Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	373,979			125,791				54
54.01	RADIOLOGY-SUA	714,080			239,880				54.01
60	Laboratory	2,055,614			1,034,875				60
60.01	LAB - SUA								60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	926,880			361,122				65
66	Physical Therapy	12,269,307			3,394,567				66
67	Occupational Therapy	11,159,449			3,905,210				67
68	Speech Pathology	5,426,468			1,375,744				68
71	Medical Supplies Charged to Pat	491,989			213,384				71
73	Drugs Charged to Patients	11,397,109			5,004,299				73
76	PSYCHOLOGY								76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	44,814,875			15,654,872				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

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	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost			
			PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
	ANCILLARY SERVICE COST CENTERS	1	2	3	4	5	6	7	
54	Radiology-Diagnostic	0.010099							54
54.01	RADIOLOGY-SUA	0.302857							54.01
60	Laboratory	0.490461							60
60.01	LAB - SUA								60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	1.185627							65
66	Physical Therapy	0.492082							66
67	Occupational Therapy	0.361487							67
68	Speech Pathology	0.390980							68
71	Medical Supplies Charged to Pat	2.709378							71
73	Drugs Charged to Patients	0.302213							73
76	PSYCHOLOGY								76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust- ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	3,344,427		3,344,427	36,102	92.64	6,109	565,938	30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	3,344,427		3,344,427	36,102		6,109	565,938	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 26-3028

WORKSHEET D
PART II

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☒ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	167	373,979	0.000447	52,331	23	54
54.01	RADIOLOGY-SUA	299	714,080	0.000419	99,795	42	54.01
60	Laboratory	32,665	2,055,614	0.015891	274,924	4,369	60
60.01	LAB - SUA						60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	26,105	926,880	0.028164	226,700	6,385	65
66	Physical Therapy	641,607	12,269,307	0.052294	1,365,481	71,406	66
67	Occupational Therapy	344,966	11,159,449	0.030912	1,501,408	46,412	67
68	Speech Pathology	164,837	5,426,468	0.030376	659,553	20,035	68
71	Medical Supplies Charged to Pat	112,124	491,989	0.227899	94,234	21,476	71
73	Drugs Charged to Patients	87,453	11,397,109	0.007673	2,359,707	18,106	73
76	PSYCHOLOGY						76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct						92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,410,223	44,814,875		6,634,133	188,254	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☐ PPS
☐ TEFRA
☒ Other

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

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	--------------------------------	--	--

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☐ PPS
☐ TEFRA
☒ Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass- Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	36,102		6,109		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)	36,102		6,109		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 26-3028

WORKSHEET D
PART IV

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☒ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☐ PPS
☐ TEFRA
☒ Other

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

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 26-3028

WORKSHEET D
PART IV

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☒ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☐ PPS
☐ TEFRA
☒ Other

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass- Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass- Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	373,979			52,331				54
54.01	RADIOLOGY-SUA	714,080			99,795				54.01
60	Laboratory	2,055,614			274,924				60
60.01	LAB - SUA								60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	926,880			226,700				65
66	Physical Therapy	12,269,307			1,365,481				66
67	Occupational Therapy	11,159,449			1,501,408				67
68	Speech Pathology	5,426,468			659,553				68
71	Medical Supplies Charged to Pat	491,989			94,234				71
73	Drugs Charged to Patients	11,397,109			2,359,707				73
76	PSYCHOLOGY								76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	44,814,875			6,634,133				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

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	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost			
			PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
	ANCILLARY SERVICE COST CENTERS	1	2	3	4	5	6	7	
54	Radiology-Diagnostic	0.010099							54
54.01	RADIOLOGY-SUA	0.302857							54.01
60	Laboratory	0.490461							60
60.01	LAB - SUA								60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	1.185627							65
66	Physical Therapy	0.492082		135,568			66,711		66
67	Occupational Therapy	0.361487		23,844			8,619		67
68	Speech Pathology	0.390980		28,466			11,130		68
71	Medical Supplies Charged to Pat	2.709378		487			1,319		71
73	Drugs Charged to Patients	0.302213							73
76	PSYCHOLOGY								76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			188,365			87,779		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			188,365			87,779		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

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)	36,102	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	36,102	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.	761	3
4	Semi-private room days (excluding swing-bed private room days)	35,341	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)	14,530	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)	26,298,807	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)	26,298,807	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)	36,058,478	28
29	Private room charges (excluding swing-bed charges)	849,264	29
30	Semi-private room charges (excluding swing-bed charges)	35,209,214	30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.729338	31
32	Average private room per diem charge (line 29 ÷ line 3)	1,115.98	32
33	Average semi-private room per diem charge (line 30 ÷ line 4)	996.27	33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)	119.71	34
35	Average per diem private room cost differential (line 34 x line 31)	87.31	35
36	Private room cost differential adjustment (line 3 x line 35)	66,443	36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	26,232,364	37

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

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							1	
38	Adjusted general inpatient routine service cost per diem (see instructions)						728.46	38
39	Program general inpatient routine service cost (line 9 x line 38)						10,584,524	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)						10,584,524	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1	2	3	4	5		
42	Nursery (Titles V and XIX only)							42
	Intensive Care Type Inpatient Hospital Units							
43	Intensive Care Unit							43
44	Coronary Care Unit							44
45	Burn Intensive Care Unit							45
46	Surgical Intensive Care Unit							46
47	Other Special Care (specify)							47
							1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						6,720,119	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						17,304,643	49
PASS THROUGH COST ADJUSTMENTS								
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						1,346,059	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						453,824	51
52	Total Program excludable cost (sum of lines 50 and 51)						1,799,883	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						15,504,760	53
TARGET AMOUNT AND LIMIT COMPUTATION								
54	Program discharges							54
55	Target amount per discharge							55
56	Target amount (line 54 x line 55)							56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)							57
58	Bonus payment (see instructions)							58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.							59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.							60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)							61
62	Relief payment (see instructions)							62
63	Allowable Inpatient cost plus incentive payment (see instructions)							63
PROGRAM INPATIENT ROUTINE SWING BED COST								
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)							64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)							65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)							66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)							67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)							68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)							69

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 26-3028

WORKSHEET D-1
PARTS III & IV

Check
Applicable
Boxes:

☐ Title V - I/P

☒ Title XVIII, Part A

☐ Title XIX - I/P

☒ Hospital

☐ IPF

☐ IRF

☐ SUB (Other)

☐ SNF

☐ NF

☐ ICF/IID

☒ PPS

☐ TEFRA

☐ Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)						87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					728.46	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. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

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)	36,102	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	36,102	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.	761	3
4	Semi-private room days (excluding swing-bed private room days)	35,341	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)	6,109	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)	25,852,293	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)	25,852,293	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)	36,058,478	28
29	Private room charges (excluding swing-bed charges)	849,264	29
30	Semi-private room charges (excluding swing-bed charges)	35,209,214	30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.716955	31
32	Average private room per diem charge (line 29 ÷ line 3)	1,115.98	32
33	Average semi-private room per diem charge (line 30 ÷ line 4)	996.27	33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)	119.71	34
35	Average per diem private room cost differential (line 34 x line 31)	85.83	35
36	Private room cost differential adjustment (line 3 x line 35)	65,317	36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	25,786,976	37

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

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							1	
38	Adjusted general inpatient routine service cost per diem (see instructions)						714.28	38
39	Program general inpatient routine service cost (line 9 x line 38)						4,363,537	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)						4,363,537	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1	2	3	4	5		
42	Nursery (Titles V and XIX only)							42
	Intensive Care Type Inpatient Hospital Units							
43	Intensive Care Unit							43
44	Coronary Care Unit							44
45	Burn Intensive Care Unit							45
46	Surgical Intensive Care Unit							46
47	Other Special Care (specify)							47
							1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						2,875,363	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						7,238,900	49
PASS THROUGH COST ADJUSTMENTS								
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						565,938	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						188,254	51
52	Total Program excludable cost (sum of lines 50 and 51)						754,192	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)							53
TARGET AMOUNT AND LIMIT COMPUTATION								
54	Program discharges							54
55	Target amount per discharge							55
56	Target amount (line 54 x line 55)							56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)							57
58	Bonus payment (see instructions)							58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.							59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.							60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)							61
62	Relief payment (see instructions)							62
63	Allowable Inpatient cost plus incentive payment (see instructions)							63
PROGRAM INPATIENT ROUTINE SWING BED COST								
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)							64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)							65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)							66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)							67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)							68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)							69

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 26-3028

WORKSHEET D-1
PARTS III & IV

Check
Applicable
Boxes:

☐ Title V - I/P

☐ Title XVIII, Part A

☒ Title XIX - I/P

☒ Hospital

☐ IPF

☐ IRF

☐ SUB (Other)

☐ SNF

☐ NF

☐ ICF/IID

☐ PPS

☐ TEFRA

☒ Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)						87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						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. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		14,511,990		30
	ANCILLARY SERVICE COST CENTERS				
54	Radiology-Diagnostic	0.010099	125,791	1,270	54
54.01	RADIOLOGY-SUA	0.302857	239,880	72,649	54.01
60	Laboratory	0.490461	1,034,875	507,566	60
60.01	LAB - SUA				60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	1.185627	361,122	428,156	65
66	Physical Therapy	0.492082	3,394,567	1,670,405	66
67	Occupational Therapy	0.361487	3,905,210	1,411,683	67
68	Speech Pathology	0.390980	1,375,744	537,888	68
71	Medical Supplies Charged to Patients	2.709378	213,384	578,138	71
73	Drugs Charged to Patients	0.302213	5,004,299	1,512,364	73
76	PSYCHOLOGY				76
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
92	Observation Beds (Non-Distinct Part)				92
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		15,654,872	6,720,119	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		15,654,872		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		6,112,102		30
	ANCILLARY SERVICE COST CENTERS				
54	Radiology-Diagnostic	0.010099	52,331	528	54
54.01	RADIOLOGY-SUA	0.302857	99,795	30,224	54.01
60	Laboratory	0.490461	274,924	134,839	60
60.01	LAB - SUA				60.01
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	1.185627	226,700	268,782	65
66	Physical Therapy	0.492082	1,365,481	671,929	66
67	Occupational Therapy	0.361487	1,501,408	542,739	67
68	Speech Pathology	0.390980	659,553	257,872	68
71	Medical Supplies Charged to Patients	2.709378	94,234	255,316	71
73	Drugs Charged to Patients	0.302213	2,359,707	713,134	73
76	PSYCHOLOGY				76
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
92	Observation Beds (Non-Distinct Part)				92
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		6,634,133	2,875,363	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		6,634,133		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

CALCULATION OF REIMBURSEMENT SETTLEMENT**COMPONENT CCN: 26-3028****WORKSHEET E
PART B**Check applicable box: ☒ Hospital ☐ IPF ☐ IRF ☐ SUB (Other) ☐ SNF**PART B - MEDICAL AND OTHER HEALTH SERVICES**

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

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (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. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

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

			INPATIENT PART A		PART B	
DESCRIPTION			mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4
1	Total interim payments paid to provider			22,908,368		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	09/21/2018	30,393		3.02
		.03				3.03
		.04				3.04
		.05				3.05
		.06				3.06
		.07				3.07
		.08				3.08
		.09				3.09
		.10				3.10
		.50				3.50
		.51	11/21/2018	81,351		3.51
		.52				3.52
		.53				3.53
		.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		-50,958		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)			22,857,410		4
TO BE COMPLETED BY CONTRACTOR						
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
		.03				5.03
		.04				5.04
		.05				5.05
		.06				5.06
		.07				5.07
		.08				5.08
		.09				5.09
		.10				5.10
		.50				5.50
		.51				5.51
		.52				5.52
		.53				5.53
		.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				6.01
		.02				6.02
7	Total Medicare program liability (see instructions)					7
8	Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)	

(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. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

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

Check ☒ 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)	20,617,959		1
2	Medicare SSI ratio (IRF PPS only) (see instructions)	0.075900		2
3	Inpatient Rehabilitation LIP payments (see instructions)	2,034,993		3
4	Outlier payments	57,062		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)	5.52		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)	98.909589		10
11	Teaching Adjustment Factor (see instructions)	0.044918		11
12	Teaching Adjustment (see instructions)	926,117		12
13	Total PPS Payment (see instructions)	23,636,131		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)	23,636,131		17
18	Primary payer payments	3,926		18
19	Subtotal (line 17 less line 18)	23,632,205		19
20	Deductibles	263,028		20
21	Subtotal (line 19 minus line 20)	23,369,177		21
22	Coinsurance	246,984		22
23	Subtotal (line 21 minus line 22)	23,122,193		23
24	Allowable bad debts (exclude bad debts for professional services) (see instructions)	134,194		24
25	Adjusted reimbursable bad debts (see instructions)	87,226		25
26	Allowable bad debts for dual eligible beneficiaries (see instructions)	107,121		26
27	Subtotal (sum of lines 23 and 25)	23,209,419		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)	23,209,419		32
32.01	Sequestration adjustment (see instructions)	464,188		32.01
32.02	Demonstration payment adjustment amount after sequestration			32.02
33	Interim payments	22,857,410		33
34	Tentative settlement (for contractor use only)			34
35	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33 and 34)	-112,179		35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	670,424		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

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

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	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	7,238,900		1
2	Medical and other services		87,779	2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	7,238,900	87,779	4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	7,238,900	87,779	7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges	6,112,102		8
9	Ancillary service charges	6,634,133	188,365	9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)	12,746,235	188,365	12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahрге basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)	12,746,235	188,365	16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	5,507,335	100,586	17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)	7,238,900	87,779	21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)	7,238,900	87,779	29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)			30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	7,238,900	87,779	31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)	7,238,900	87,779	36
37	OTHER ADJUSTMENTS (RD PARTY PAYMENTS)	22,508	725	37
38	Subtotal (line 36 ± line 37)	7,261,408	88,504	38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)	7,261,408	88,504	40
41	Interim payments	6,365,207	65,982	41
42	Balance due provider/program (line 40 minus line 41)	896,201	22,522	42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

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	
	Assets (Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	4,983,728				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	11,957,213				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-4,434,093				6
7	Inventory	351,871				7
8	Prepaid expenses	125,540				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	12,984,259				11
	FIXED ASSETS					
12	Land					12
13	Land improvements	20,740				13
14	Accumulated depreciation	-7,615				14
15	Buildings	22,670,433				15
16	Accumulated depreciation	-13,260,277				16
17	Leasehold improvements	6,807,208				17
18	Accumulated depreciation	-1,351,401				18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	8,908,143				23
24	Accumulated depreciation	-6,095,945				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)	17,691,286				30
	OTHER ASSETS					
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	9,742,696				34
35	Total other assets (sum of lines 31-34)	9,742,696				35
36	Total assets (sum of lines 11, 30 and 35)	40,418,241				36
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	Liabilities and Fund Balances (Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable	1,605,828				37
38	Salaries, wages and fees payable	1,850,047				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	851,067				44
45	Total current liabilities (sum of lines 37 thru 44)	4,306,942				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	23,643,472				49
50	Total long term liabilities (sum of lines 46 thru 49)	23,643,472				50
51	Total liabilities (sum of lines 45 and 50)	27,950,414				51
	CAPITAL ACCOUNTS					
52	General fund balance	12,467,827				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	12,467,827				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	40,418,241				60

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

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		13,270,827		1
2	Net income (loss) (from Worksheet G-3, line 29)		817,757		2
3	Total (sum of line 1 and line 2)		14,088,584		3
4	Additions (credit adjustments) (specify)				4
5					5
6					6
7					7
8					8
9					9
10	Total additions (sum of lines 4-9)				10
11	Subtotal (line 3 plus line 10)		14,088,584		11
12	Deductions (debit adjustments) (specify)				12
13	2019 EQUITY DISTRIBUTION	1,620,758			13
14					14
15					15
16					16
17					17
18	Total deductions (sum of lines 12-17)		1,620,758		18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		12,467,826		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	2019 EQUITY DISTRIBUTION				13
14					14
15					15
16					16
17					17
18	Total deductions (sum of lines 12-17)				18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)				19

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES**WORKSHEET G-2
PARTS I & II****PART I - PATIENT REVENUES**

	REVENUE CENTER	INPATIENT	OUTPATIENT	TOTAL	
		1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	36,058,478		36,058,478	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)	36,058,478		36,058,478	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit				11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)				16
17	Total inpatient routine care services (sum of lines 10 and 16)	36,058,478		36,058,478	17
18	Ancillary services	37,247,755	7,567,120	44,814,875	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)	73,306,233	7,567,120	80,873,353	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		47,445,185	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)		47,445,185	43

KPMG LLP Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2018 To: 05/31/2019	Run Date: 10/01/2019 Run Time: 09:46 Version: 2018.12 (08/29/2019)
--	---------------------------------------	--	--

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	80,873,353	1
2	Less contractual allowances and discounts on patients' accounts	34,725,963	2
3	Net patient revenues (line 1 minus line 2)	46,147,390	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	47,445,185	4
5	Net income from service to patients (line 3 minus line 4)	-1,297,795	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments	61,602	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts	20	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	756	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	5,218	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	36	21
22	Rental of hosptial space	43,380	22
23	Governmental appropriations		23
24	Other (specify)	2,004,540	24
25	Total other income (sum of lines 6-24)	2,115,552	25
26	Total (line 5 plus line 25)	817,757	26
29	Net income (or loss) for the period (line 26 minus line 28)	817,757	29