

Health Financial Systems Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2019 To: 05/31/2020	Run Date: 10/29/2020 Run Time: 15:00 Version: 2020.06 (10/28/2020)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY**WORKSHEET S
PARTS I, II & III****PART I - COST REPORT STATUS**

Provider use only	1. ☒ Electronically prepared cost report Date: 10/29/2020 Time: 15:00 2. ☐ Manually prepared 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 06/01/2019 and ending 05/31/2020, 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) ROB WISNER
Chief Financial Officer or Administrator of Provider(s)

SVP - REIMBURSEMENT
Title

10/29/2020 15:00
Date

PART III - SETTLEMENT SUMMARY

		TITLE XVIII					
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		-190,465			538,684	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		-190,465			538,684	200

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2 PART I

Hospital and Hospital Health Care Complex Address:

1	Street: 4455 DUNCAN AVE.	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 / 2019	To: 05 / 31 / 2020	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.	6,104	868	604	246	1,117		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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2 PART I

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(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	
	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

	Teaching Hospitals	1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter 'Y' for yes or 'N' for no in column 2.	Y	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	NAHE MA Y/N 2	3	
60	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter 'Y' for yes or 'N' for no in column 2.	N			60
		1	Worksheet A Line # 2	Pass-Through Qualification Criteria Code 3	
		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
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WORKSHEET S-2 PART I

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

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WORKSHEET S-2 PART I

	V	XIX	
Title V and XIX Services	1	2	
90 Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90
91 Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	N	91
92 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92
93 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94 Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95 If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96 Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97 If line 96 is 'Y', enter the reduction percentage in the applicable column.			97
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.	N	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.	N	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.	N	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.	N	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.	N	Y	98.06

Rural Providers	1	2	
105 Does this hospital qualify as a CAH?	N		105
106 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106
107 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes or 'N' for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter 'Y' for yes or 'N' for no in column 2. (see instructions)			107
108 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108
	Physical	Occupational	Speech
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.			Respiratory

	1	2	
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.	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.	N		111
	1	2	3
112 Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112

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. 15-1, chapter 22, section 2208.1.	N			115
116 Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	N			116
117 Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.	Y			117
118 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118
	Premiums	Paid Losses	Self Insurance	
118.01 List amounts of malpractice premiums and paid losses:	64,118	154,987		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

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

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	HB1911	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				
		Part A	Part B	Title V	Title XIX	
		1	2	3	4	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N			156
157	Subprovider - IRF	N	N			157
158	Subprovider - Other					158
159	SNF	N	N			159
160	HHA	N	N			160
161	CMHC		N			161
161.10	CORF					161.10

Multicampus

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

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

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

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

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

COMPLETED BY ALL HOSPITALS

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

		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		Y	08/04/2020	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	08/04/2020	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

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

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

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

Capital Related Cost		
22	Have assets been 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
42	Employer: ENCOMPASS HEALTH		
43	Phone number: 2059698265	E-mail Address: JAMES.WYATT@ENCOMPASSHEALTH.COM	

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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	Hospital 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	47,946			13,076	6,276	35,538	1
2	HMO and other (see instructions)						4,956	2,663		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	47,946			13,076	6,276	35,538	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	47,946			13,076	6,276	35,538	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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3 PART I

	Component	Full Time Equivalents			DISCHARGES				
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					967	405	2,438	1
2	HMO and other (see instructions)					341	136		2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider								4
5	Hospital Adults & Peds. Swing Bed SNF								5
6	Hospital Adults & Peds. Swing Bed NF								6
7	Total Adults & Peds. (exclude observation beds) (see instructions)								7
8	Intensive Care Unit								8
9	Coronary Care Unit								9
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
12	Other Special Care (specify)								12
13	Nursery								13
14	Total (see instructions)	4.69	326.35			967	405	2,438	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency								22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	Total (sum of lines 14-26)	4.69	326.35						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

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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3 PARTS II-III

Part II - Wage Data

	Wkst A Line No.	Amount Reported	Reclassif- ication of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)	
	1	2	3	4	5	6	
SALARIES							
1 Total salaries (see instructions)	200	23,413,635			678,849.60		1
2 Non-physician anesthetist Part A							2
3 Non-physician anesthetist 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)			268,713		6,165.39		10
OTHER WAGES & RELATED COSTS							
11 Contract labor (see instructions)		155,925			3,389.20		11
12 Contract management and administrative services							12
13 Contract labor: Physician-Part A - Administrative		620,024			2,325.00		13
14 Home office salaries & wage-related costs							14
14.01 Home office salaries		1,474,354			21,553.77		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
16.01 Home office Physicians Part A - Teaching							16.01
16.02 Home office contract Physicians Part A - Teaching							16.02
WAGE-RELATED COSTS							
17 Wage-related costs (core)(see instructions)		4,123,013					17
18 Wage-related costs (other)(see instructions)							18
19 Excluded areas		47,868					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		688,837					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: Physicians Part A - Teaching - wage-related (core)							25.53
OVERHEAD COSTS - DIRECT SALARIES							
26 Employee Benefits Department							26
27 Administrative & General		3,715,675	-268,713		87,476.21		27
28 Administrative & General under contract (see instructions)		151,004			2,826.73		28
29 Maintenance & Repairs							29
30 Operation of Plant		289,802			9,422.40		30
31 Laundry & Linen Service							31
32 Housekeeping		343,365			22,484.80		32
33 Housekeeping under contract (see instructions)							33
34 Dietary							34
35 Dietary under contract (see instructions)		50,974			1,657.69		35
36 Cafeteria							36
37 Maintenance of Personnel							37
38 Nursing Administration		1,263,811			27,435.20		38
39 Central Services and Supply							39
40 Pharmacy							40
41 Medical Records & Medical Records Library		277,360			12,230.40		41
42 Social Service		758,331			24,897.60		42
43 Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		23,615,613		23,615,613	683,334.02	34.56	1
2	Excluded area salaries (see instructions)			268,713	268,713	6,165.39	43.58	2
3	Subtotal salaries (line 1 minus line 2)		23,615,613	-268,713	23,346,900	677,168.63	34.48	3
4	Subtotal other wages & related costs (see instructions)		2,250,303		2,250,303	27,267.97	82.53	4
5	Subtotal wage-related costs (see instructions)		4,811,850		4,811,850		20.61%	5
6	Total (sum of lines 3 through 5)		30,677,766	-268,713	30,409,053	704,436.60	43.17	6
7	Total overhead cost (see instructions)		6,850,322	-268,713	6,581,609	188,431.03	34.93	7

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

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions	344,709	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)	2,712,769	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)	36,785	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	144,557	15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-Employers Portion Only	1,668,776	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance		19
20	State or Federal Unemployment Taxes	96,751	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	-833,467	22
23	Tuition Reimbursement		23
24	Total Wage Related cost (Sum of lines 1-23)	4,170,880	24

Part B - Other Than Core Related Cost

25	Other Wage Related Costs (SPECIFY)		25
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HOSPITAL CONTRACT LABOR AND BENEFIT COST**WORKSHEET S-3
PART V****Part V - Contract Labor and Benefit Cost****Hospital and Hospital-Based Component Identification:**

	Component	Contract Labor	Benefit Cost	
	0	1	2	
1	Total facility contract labor and benefit cost	775,949	4,170,881	1
2	Hospital	775,949	4,123,013	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		47,868	18

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HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

WORKSHEET S-5

RENAL DIALYSIS STATISTICS

	DESCRIPTION	Outpatient		Training		Home		
		Regular	High Flux	Hemo-dialysis	CAPD CCPD	Hemo-dialysis	CAPD CCPD	
		1	2	3	4	5	6	
1	Number of patients in program at end of cost reporting period							1
2	Number of times per week patient receives dialysis							2
3	Average patient dialysis time including setup							3
4	CAPD exchanges per day							4
5	Number of days in year dialysis furnished							5
6	Number of stations							6
7	Treatment capacity per day per station							7
8	Utilization (see instructions)							8
9	Average times dialyzers re-used							9
10	Percentage of patients re-using dialyzers							10

ESRD PPS

		1	2	
10.01	Is the dialysis facility approved as a low-volume facility for this cost reporting period? Enter 'Y' for yes or 'N' for no. (see instructions)			10.01
10.02	Did your facility elect 100% PPS effective January 1, 2011? Enter 'Y' for yes or 'N' for no. (see instructions for 'new' providers)			10.02
10.03	If you responded 'N' to line 10.02, enter in column 1 the year of transition for periods prior to January 1 and enter in column 2 the year of transition for periods after December 31. (see instructions)		4	10.03

TRANSPLANT INFORMATION

11	Number of patients on transplant list		11
12	Number of patients transplanted during the cost reporting period		12

EPOETIN

13	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider		13
14	Epoetin amount from Worksheet A for home dialysis program		14
15	Number of EPO units furnished relating to the renal dialysis department		15
16	Number of EPO units furnished relating to the home dialysis department		16

ARANESP

17	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider		17
18	ARANESP amount from Worksheet A for home dialysis program		18
19	Number of ARANESP units furnished relating to the renal dialysis department		19
20	Number of ARANESP units furnished relating to the home dialysis department		20

PHYSICIAN PAYMENT METHOD (Enter 'X' for applicable method(s))

21	MCP	INITIAL METHOD	
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Erythropoiesis-Stimulating Agents (ESA) Statistics:		ESA Description	Net Cost of ESAs for Renal Patients	Net Cost of ESAs for Home Patients	Number of ESA Units - Renal Dialysis Dept.	Number of ESA Units - Home Dialysis Dept.	
		1	2	3	4	5	
22	Enter in column 1 the ESA description. Enter in column 2 the net costs of ESAs furnished to all renal dialysis patients. Enter in column 3 the net cost of ESAs furnished to all home dialysis program patients. Enter in column 4 the number of ESA units furnished to patients in the renal dialysis department. Enter in column 5 the number of units furnished to patients in the home dialysis program. (see instructions)						22

LOW VOLUME		CCN	Treatments			
		1	2			
23	If line 10.01 is yes, enter in column 1 the CCN for each renal dialysis facility listed on Worksheet S-2, Part I, line 18 and its subscripts. Enter in column 2, the total treatments for each CCN. (see instructions)					23

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt		3,567,614	3,567,614	142,760	3,710,374	-377,469	3,332,905	1
2	00200	Cap Rel Costs-Mvble Equip		1,303,742	1,303,742	43,386	1,347,128	-29,244	1,317,884	2
3	00300	Other Cap Rel Costs		170,129	170,129	-170,129			-0-	3
4	00400	Employee Benefits Department		4,383,812	4,383,812		4,383,812	-240,559	4,143,253	4
5	00500	Administrative & General	3,715,675	7,512,742	11,228,417	-894,583	10,333,834	-1,642,777	8,691,057	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	289,802	773,467	1,063,269	-15,164	1,048,105	-39,777	1,008,328	7
8	00800	Laundry & Linen Service		303,187	303,187		303,187		303,187	8
9	00900	Housekeeping	343,365	79,761	423,126		423,126		423,126	9
10	01000	Dietary		1,581,308	1,581,308	-28	1,581,280	-244,170	1,337,110	10
11	01100	Cafeteria								11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	1,263,811	13,794	1,277,605		1,277,605	-108	1,277,497	13
14	01400	Central Services & Supply								14
15	01500	Pharmacy								15
16	01600	Medical Records & Library	277,360	8,790	286,150		286,150	-320	285,830	16
17	01700	Social Service	758,331	14,441	772,772		772,772	-2,410	770,362	17
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd				118,750	118,750		118,750	22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	9,524,562	200,377	9,724,939	581,810	10,306,749	-324,430	9,982,319	30
		ANCILLARY SERVICE COST CENTERS								
54	05400	Radiology-Diagnostic		220,214	220,214	-172,796	47,418		47,418	54
54.01	05401	RADIOLOGY-SUA				172,796	172,796	-110,020	62,776	54.01
60	06000	Laboratory	10,320	801,863	812,183		812,183		812,183	60
60.01	06001	LABORATORY-SUA								60.01
65	06500	Respiratory Therapy	610,038	1,257	611,295		611,295	-105	611,190	65
66	06600	Physical Therapy	2,470,450	157,400	2,627,850	-193,493	2,434,357	-43,347	2,391,010	66
67	06700	Occupational Therapy	1,907,932	35,825	1,943,757	132,904	2,076,661	-20,059	2,056,602	67
68	06800	Speech Pathology	958,803	25,070	983,873	60,589	1,044,462		1,044,462	68
71	07100	Medical Supplies Charged to Patients	192,629	785,625	978,254	15,283	993,537	-861	992,676	71
73	07300	Drugs Charged to Patients	992,174	1,295,474	2,287,648		2,287,648		2,287,648	73
76	03550	PSYCHOLOGY	98,383	1,725	100,108	-100,108				76
76.01	03951	SPECIAL PROCEDURES								76.01
		OUTPATIENT SERVICE COST CENTERS								
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
113	11300	Interest Expense		7,414	7,414		7,414	-7,414		113
118		SUBTOTALS (sum of lines 1-117)	23,413,635	23,245,031	46,658,666	-278,023	46,380,643	-3,083,070	43,297,573	118
		NONREIMBURSABLE COST CENTERS								
192	19200	Physicians' Private Offices								192
194	07950	MARKETING NRCC				275,772	275,772		275,772	194
194.01	07951	GUEST MEALS								194.01
194.02	07952	CLINICAL PSYCHOLOGY				2,251	2,251		2,251	194.02
200		TOTAL (sum of lines 118-199)	23,413,635	23,245,031	46,658,666		46,658,666	-3,083,070	43,575,596	200

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RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				
			COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	INSURANCE	A	Cap Rel Costs-Bldg & Fixt	1		12,283	1
2	INSURANCE	A	Cap Rel Costs-Mvble Equip	2		3,734	2
3	INSURANCE	A					3
500	Total reclassifications					16,017	500
	Code Letter - A						
1	MARKETING	B	MARKETING NRCC	194	268,713	7,059	1
2	MARKETING	B					2
3	MARKETING	B					3
500	Total reclassifications				268,713	7,059	500
	Code Letter - B						
1	PHYSICIANS	C	Adults & Pediatrics	30		480,280	1
2	PHYSICIANS	C					2
500	Total reclassifications					480,280	500
	Code Letter - C						
1	MISC RECLASS	D	Adults & Pediatrics	30	98,383	3,147	1
2	MISC RECLASS	D					2
3	MISC RECLASS	D					3
500	Total reclassifications				98,383	3,147	500
	Code Letter - D						
1	SERVICE UNDER ARRANGEMENT	E	RADIOLOGY-SUA	54.01		172,796	1
2	SERVICE UNDER ARRANGEMENT	E					2
500	Total reclassifications					172,796	500
	Code Letter - E						
1	INTERNS & RESIDENTS	F	I&R Services-Other Prgm Costs	22		118,750	1
2	INTERNS & RESIDENTS	F					2
500	Total reclassifications					118,750	500
	Code Letter - F						
1	REBATE RECLASS	G	Occupational Therapy	67	132,372	532	1
2	REBATE RECLASS	G	Speech Pathology	68	60,346	243	2
3	REBATE RECLASS	G					3
500	Total reclassifications				192,718	775	500
	Code Letter - G						
1	OXYGEN RECLASS	H	Medical Supplies Charged to P	71		15,283	1
2	OXYGEN RECLASS	H					2
3	OXYGEN RECLASS	H					3
500	Total reclassifications					15,283	500
	Code Letter - H						
1	CONTRACT SERVICES	I	CLINICAL PSYCHOLOGY	194.02		2,251	1
2	CONTRACT SERVICES	I					2
500	Total reclassifications					2,251	500
	Code Letter - I						
	GRAND TOTAL (Increases)				559,814	816,358	

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

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RECLASSIFICATIONS

WORKSHEET A-6

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	INSURANCE	A					12	1
2	INSURANCE	A					12	2
3	INSURANCE	A	Administrative & General	5		16,017		3
500	Total reclassifications					16,017		500
	Code letter - A							
1	MARKETING	B						1
2	MARKETING	B	Administrative & General	5	268,713	7,031		2
3	MARKETING	B	Dietary	10		28		3
500	Total reclassifications				268,713	7,059		500
	Code letter - B							
1	PHYSICIANS	C						1
2	PHYSICIANS	C	Administrative & General	5		480,280		2
500	Total reclassifications					480,280		500
	Code letter - C							
1	MISC RECLASS	D						1
2	MISC RECLASS	D	Administrative & General	5		1,422		2
3	MISC RECLASS	D	PSYCHOLOGY	76	98,383	1,725		3
500	Total reclassifications				98,383	3,147		500
	Code letter - D							
1	SERVICE UNDER ARRANGEMENT	E						1
2	SERVICE UNDER ARRANGEMENT	E	Radiology-Diagnostic	54		172,796		2
500	Total reclassifications					172,796		500
	Code letter - E							
1	INTERNS & RESIDENTS	F						1
2	INTERNS & RESIDENTS	F	Administrative & General	5		118,750		2
500	Total reclassifications					118,750		500
	Code letter - F							
1	REBATE RECLASS	G						1
2	REBATE RECLASS	G						2
3	REBATE RECLASS	G	Physical Therapy	66	192,718	775		3
500	Total reclassifications				192,718	775		500
	Code letter - G							
1	OXYGEN RECLASS	H						1
2	OXYGEN RECLASS	H	Administrative & General	5		119		2
3	OXYGEN RECLASS	H	Operation of Plant	7		15,164		3
500	Total reclassifications					15,283		500
	Code letter - H							
1	CONTRACT SERVICES	I						1
2	CONTRACT SERVICES	I	Administrative & General	5		2,251		2
500	Total reclassifications					2,251		500
	Code letter - I							
	GRAND TOTAL (Decreases)				559,814	816,358		

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

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RECONCILIATION OF CAPITAL COST CENTERS**WORKSHEET A-7
PARTS I, II & III****PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES**

		Acquisitions							
	Description	Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		1	2	3	4	5	6	7	
1	Land								1
2	Land Improvements	20,740					20,740		2
3	Buildings and Fixtures	17,932,733				273,201	17,659,532		3
4	Building Improvements	11,544,909	1,677,109		1,677,109	122,561	13,099,457		4
5	Fixed Equipment								5
6	Movable Equipment	8,908,143	447,921		447,921	2,193	9,353,871		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	38,406,525	2,125,030		2,125,030	397,955	40,133,600		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	38,406,525	2,125,030		2,125,030	397,955	40,133,600		10

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

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	1,671,240	1,896,374					3,567,614	1
2	Cap Rel Costs-Mvble Equip	920,229	383,513					1,303,742	2
3	Total (sum of lines 1-2)	2,591,469	2,279,887					4,871,356	3

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

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	30,779,729		30,779,729	0.766932		130,477		130,477	1
2	Cap Rel Costs-Mvble Equip	9,353,871		9,353,871	0.233068		39,652		39,652	2
3	Total (sum of lines 1-2)	40,133,600		40,133,600	1.000000		170,129		170,129	3

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	1,845,869	1,125,886	218,390	12,283	130,477		3,332,905	1
2	Cap Rel Costs-Mvble Equip	890,985	383,513		3,734	39,652		1,317,884	2
3	Total (sum of lines 1-2)	2,736,854	1,509,399	218,390	16,017	170,129		4,650,789	3

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

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

		EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		LINE#	Wkst. A-7 Ref.	
DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER			
	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	-311,487				10
11 Sale of scrap, waste, etc. (chapter 23)						11
12 Related organization transactions (chapter 10)	Wkst A-8-1	1,357,996				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	-7,414	Interest Expense	113	11	37
37.01 DEPRECIATION	A	-917	Cap Rel Costs-Bldg & Fixt	1	9	37.01
37.02 DEPRECIATION	A	-3	Cap Rel Costs-Mvble Equip	2	9	37.02
37.03 INSURANCE	A	-235,001	Employee Benefits Department	4		37.03
37.04 INSURANCE	A	-455,397	Administrative & General	5		37.04
37.05 NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-406,742	Administrative & General	5		37.05
37.06 NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-3,458	Operation of Plant	7		37.06
37.07 NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-192	Medical Records & Library	16		37.07
37.08 NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-2,410	Social Service	17		37.08
37.09 NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-12,943	Adults & Pediatrics	30		37.09
37.10 NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-105	Respiratory Therapy	65		37.10
37.11 NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-40,667	Physical Therapy	66		37.11
37.12 NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-16,667	Occupational Therapy	67		37.12
37.13 NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-100	Medical Supplies Charged to Patients	71		37.13
37.14 PATIENT TELEPHONE	A	-4,000	Cap Rel Costs-Mvble Equip	2	9	37.14
37.15 PATIENT TELEPHONE	A	-4,540	Employee Benefits Department	4		37.15
37.16 PATIENT TELEPHONE	A	-30,259	Administrative & General	5		37.16
37.17 PATIENT TELEVISION	A	-16,092	Cap Rel Costs-Mvble Equip	2	9	37.17
37.18 PATIENT TELEVISION	A	-19,110	Administrative & General	5		37.18
37.19 PRINTING	A	-5,458	Administrative & General	5		37.19
37.21 LOBBYING EXPENSE	A	-86	Employee Benefits Department	4		37.21
37.22 LOBBYING EXPENSE	A	-1,746	Administrative & General	5		37.22
37.23 LEGAL FEES	A	-2,045	Administrative & General	5		37.23
37.24 MISCELLANEOUS INCOME	B	-5,985	Administrative & General	5		37.24
37.25 MISCELLANEOUS INCOME	B	-109	Dietary	10		37.25
37.26 MISCELLANEOUS INCOME	B	-128	Medical Records & Library	16		37.26
37.27 PATIENT TRANSPORTATION	A	-9,149	Cap Rel Costs-Mvble Equip	2	9	37.27
37.28 PATIENT TRANSPORTATION	A	-746	Employee Benefits Department	4		37.28
37.29 PATIENT TRANSPORTATION	A	-49,634	Administrative & General	5		37.29

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
37.30	PATIENT TRANSPORTATION	A	-10,205	Operation of Plant	7		37.30
37.31	PROVIDER TAX	A	-2,195,726	Administrative & General	5		37.31
37.32	PROFESSIONAL FEES	A	-477,745	Administrative & General	5		37.32
37.33	CLINICAL PSYCHOLOGY	A	-36,000	Administrative & General	5		37.33
37.34	INTERNS & RESIDENTS	A	-2,583	Physical Therapy	66		37.34
37.35	INTERNS & RESIDENTS	A	-3,326	Occupational Therapy	67		37.35
37.36	COMMUNITY EVENTS	A	-186	Employee Benefits Department	4		37.36
37.37	COMMUNITY EVENTS	A	-482	Administrative & General	5		37.37
37.38	COMMUNITY EVENTS	A	-108	Nursing Administration	13		37.38
37.39	COMMUNITY EVENTS	A	-97	Physical Therapy	66		37.39
37.40	COMMUNITY EVENTS	A	-66	Occupational Therapy	67		37.40
37.41	PHYSICIANS	A	-71,952	Administrative & General	5		37.41
38							38
39							39
40							40
41							41
42							42
43							43
44							44
45							45
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-3,083,070				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 subscripits thereof.

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

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

WORKSHEET A-8-1

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

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1	5	Administrative & General	TO OFFSET MANAGEMENT FEES		1,281,568	-1,281,568		1
2	1	Cap Rel Costs-Bldg & Fixt	TO INCLUDE ALLOWABLE HOME OFFICE COS	175,546		175,546	9	2
3	1	Cap Rel Costs-Bldg & Fixt	TO INCLUDE ALLOWABLE HOME OFFICE COS	216,330		216,330	11	3
3.01	5	Administrative & General	TO INCLUDE ALLOWABLE HOME OFFICE COS	3,194,612		3,194,612		3.01
3.02	5	Administrative & General	TO INCLUDE ALLOWABLE HOME OFFICE COS	368,024		368,024		3.02
3.03	5	Administrative & General	TO INCLUDE ALLOWABLE HOME OFFICE COS	-11,815		-11,815		3.03
3.04	1	Cap Rel Costs-Bldg & Fixt	TO INCLUDE ALLOWABLE HOME OFFICE COS	2,060		2,060	11	3.04
3.05	2	Cap Rel Costs-Mvble Equip	INTERCOMPANY WAGE AND EXPENSE TRANSF	4,853	4,853		9	3.05
3.06	3	Other Cap Rel Costs	INTERCOMPANY WAGE AND EXPENSE TRANSF	4	4			3.06
3.07	4	Employee Benefits Department	INTERCOMPANY WAGE AND EXPENSE TRANSF	3,074,735	3,074,735			3.07
3.08	5	Administrative & General	INTERCOMPANY WAGE AND EXPENSE TRANSF	2,603,599	2,603,599			3.08
3.09	7	Operation of Plant	INTERCOMPANY WAGE AND EXPENSE TRANSF	1,631	1,631			3.09
3.10	9	Housekeeping	INTERCOMPANY WAGE AND EXPENSE TRANSF	75	75			3.10
3.11	10	Dietary	INTERCOMPANY WAGE AND EXPENSE TRANSF	-14,326	-14,326			3.11
3.12	13	Nursing Administration	INTERCOMPANY WAGE AND EXPENSE TRANSF	678	678			3.12
3.13	16	Medical Records & Library	INTERCOMPANY WAGE AND EXPENSE TRANSF	-2,325	-2,325			3.13
3.14	17	Social Service	INTERCOMPANY WAGE AND EXPENSE TRANSF	2,907	2,907			3.14
3.15	30	Adults & Pediatrics	INTERCOMPANY WAGE AND EXPENSE TRANSF	15,072	15,072			3.15
3.16	54	Radiology-Diagnostic	INTERCOMPANY WAGE AND EXPENSE TRANSF	-2,234	-2,234			3.16
3.17	60	Laboratory	INTERCOMPANY WAGE AND EXPENSE TRANSF	-103	-103			3.17
3.18	66	Physical Therapy	INTERCOMPANY WAGE AND EXPENSE TRANSF	2,486	2,486			3.18
3.19	67	Occupational Therapy	INTERCOMPANY WAGE AND EXPENSE TRANSF	-463	-463			3.19
3.20	68	Speech Pathology	INTERCOMPANY WAGE AND EXPENSE TRANSF	153	153			3.20
3.21	71	Medical Supplies Charged to Patients	INTERCOMPANY WAGE AND EXPENSE TRANSF	36,524	36,524			3.21
3.22	73	Drugs Charged to Patients	INTERCOMPANY WAGE AND EXPENSE TRANSF	-1,460,616	-1,460,616			3.22
3.23	76	PSYCHOLOGY	INTERCOMPANY WAGE AND EXPENSE TRANSF	-1,382	-1,382			3.23
3.24	113	Interest Expense	INTERCOMPANY WAGE AND EXPENSE TRANSF	7,414	7,414		11	3.24
3.25	5	Administrative & General	RELATED PARTY	67,760	221,509	-153,749		3.25
3.26	7	Operation of Plant	RELATED PARTY	10,559	36,673	-26,114		3.26
3.27	10	Dietary	RELATED PARTY	98,679	342,740	-244,061		3.27
3.28	30	Adults & Pediatrics	RELATED PARTY	425	425			3.28
3.29	54.01	RADIOLOGY-SUA	RELATED PARTY	102,792	212,812	-110,020		3.29
3.30	60	Laboratory	RELATED PARTY	414,056	414,056			3.30
3.31	71	Medical Supplies Charged to Patients	RELATED PARTY	639	1,400	-761		3.31
3.32	1	Cap Rel Costs-Bldg & Fixt	RELATED PARTY	-38,900	580,988	-619,888	10	3.32
3.33	1	Cap Rel Costs-Bldg & Fixt	RELATED PARTY	1,164,787	1,315,387	-150,600	10	3.33
4								4
5		TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12		10,034,236	8,676,240	1,357,996		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

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STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS**WORKSHEET A-8-1****B. INTERRELATIONSHIP OF RELATED ORGANIZATION(S) AND/OR HOME OFFICE:**

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

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

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

section 1861 of the Social Security Act. If you do not provide all or any part of the requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

				Related Organization(s) and/or Home Office			
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
6	B		50.00	ENCOMPASS HEALTH CORPORATION		HEALTHCARE	6
7	B		50.00	BJC HEALTHCARE		HEALTHCARE	7
8	G	ENCOMPASS HEALTH CORPORATION				HEALTHCARE	8
9							9
9.01	G	BARNES JEWISH CHRISTIAN HOSPIT				HEALTHCARE	9.01
9.02	G	BARNES JEWISH ST. PETERS HOSPI				HEALTHCARE	9.02
10							10

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

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

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun- eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	30	Adults & Pediatrics AGGREGATE	480,280		480,280	211,500	1,660	168,793	8,440	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	480,280		480,280		1,660	168,793	8,440	200

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	30	Adults & Pediatrics AGGREGATE					168,793	311,487	311,487	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					168,793	311,487	311,487	200

Health Financial Systems Compu-Max 2552-10

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B PART I

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS- TRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	3,332,905	3,332,905					1
2	Cap Rel Costs-Mvble Equip	1,317,884		1,317,884				2
4	Employee Benefits Department	4,143,253			4,143,253			4
5	Administrative & General	8,691,057	223,894	88,531	609,971	9,613,453	9,613,453	5
6	Maintenance & Repairs							6
7	Operation of Plant	1,008,328	9,997	3,953	51,283	1,073,561	304,449	7
8	Laundry & Linen Service	303,187	27,344	10,812		341,343	96,801	8
9	Housekeeping	423,126	13,454	5,320	60,762	502,662	142,549	9
10	Dietary	1,337,110	177,614	70,231		1,584,955	449,474	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	1,277,497	13,174	5,209	223,643	1,519,523	430,918	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	285,830	20,617	8,152	49,081	363,680	103,135	16
17	Social Service	770,362	13,392	5,295	134,193	923,242	261,820	17
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd	118,750				118,750	33,676	22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	9,982,319	1,919,406	758,965	1,702,867	14,363,557	4,073,334	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	47,418				47,418	13,447	54
54.01	RADIOLOGY-SUA	62,776				62,776		54.01
60	Laboratory	812,183	16,880	6,675	1,826	837,564	237,523	60
60.01	LABORATORY-SUA							60.01
65	Respiratory Therapy	611,190	12,240	4,840	107,952	736,222	208,784	65
66	Physical Therapy	2,391,010	401,103	158,603	403,065	3,353,781	951,092	66
67	Occupational Therapy	2,056,602	215,298	85,132	361,050	2,718,082	770,815	67
68	Speech Pathology	1,044,462	104,083	41,156	180,348	1,370,049	388,529	68
71	Medical Supplies Charged to Patients	992,676	69,700	27,561	34,087	1,124,024	318,760	71
73	Drugs Charged to Patients	2,287,648	40,051	15,837	175,574	2,519,110	714,389	73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES							76.01
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	43,297,573	3,278,247	1,296,272	4,095,702	43,173,752	9,499,495	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		51,668	20,430		72,098	20,446	192
194	MARKETING NRCC	275,772	2,990	1,182	47,551	327,495	92,874	194
194.01	GUEST MEALS							194.01
194.02	CLINICAL PSYCHOLOGY	2,251				2,251	638	194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	43,575,596	3,332,905	1,317,884	4,143,253	43,575,596	9,613,453	202

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B PART I

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	NURSING ADMINIS- TRATION	MEDICAL RECORDS & LIBRARY	
		7	8	9	10	13	16	
	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	1,378,010						7
8	Laundry & Linen Service	12,159	450,303					8
9	Housekeeping	5,983		651,194				9
10	Dietary	78,978		37,820	2,151,227			10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	5,858		2,805		1,959,104		13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	9,168		4,390			480,373	16
17	Social Service	5,955		2,852				17
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	853,483	450,303	408,704	2,151,227	1,959,104	237,178	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic						1,558	54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory	7,506		3,594			13,837	60
60.01	LABORATORY-SUA							60.01
65	Respiratory Therapy	5,442		2,606			8,535	65
66	Physical Therapy	178,355		85,408			58,144	66
67	Occupational Therapy	95,735		45,844			58,412	67
68	Speech Pathology	46,282		22,163			26,548	68
71	Medical Supplies Charged to Patients	30,993		14,841			2,814	71
73	Drugs Charged to Patients	17,809		8,528			73,347	73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES							76.01
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	1,353,706	450,303	639,555	2,151,227	1,959,104	480,373	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	22,975		11,002				192
194	MARKETING NRCC	1,329		637				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)	1,378,010	450,303	651,194	2,151,227	1,959,104	480,373	202

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B PART I

	COST CENTER DESCRIPTIONS	SOCIAL SERVICE	I&R PROGRAM COSTS	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL		
		17	22	24	25	26		
	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	1,193,869						17
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd		152,426					22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,193,869	152,426	25,843,185	-152,426	25,690,759		30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic			62,423		62,423		54
54.01	RADIOLOGY-SUA			62,776		62,776		54.01
60	Laboratory			1,100,024		1,100,024		60
60.01	LABORATORY-SUA							60.01
65	Respiratory Therapy			961,589		961,589		65
66	Physical Therapy			4,626,780		4,626,780		66
67	Occupational Therapy			3,688,888		3,688,888		67
68	Speech Pathology			1,853,571		1,853,571		68
71	Medical Supplies Charged to Patients			1,491,432		1,491,432		71
73	Drugs Charged to Patients			3,333,183		3,333,183		73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES							76.01
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	1,193,869	152,426	43,023,851	-152,426	42,871,425		118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices			126,521		126,521		192
194	MARKETING NRCC			422,335		422,335		194
194.01	GUEST MEALS							194.01
194.02	CLINICAL PSYCHOLOGY			2,889		2,889		194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,193,869	152,426	43,575,596	-152,426	43,423,170		202

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	ADMINIS- TRATIVE & GENERAL	OPERATION OF PLANT	
		0	1	2	2A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General		223,894	88,531	312,425	312,425		5
6	Maintenance & Repairs							6
7	Operation of Plant		9,997	3,953	13,950	9,894	23,844	7
8	Laundry & Linen Service		27,344	10,812	38,156	3,146	210	8
9	Housekeeping		13,454	5,320	18,774	4,633	104	9
10	Dietary		177,614	70,231	247,845	14,607	1,367	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration		13,174	5,209	18,383	14,004	101	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		20,617	8,152	28,769	3,352	159	16
17	Social Service		13,392	5,295	18,687	8,509	103	17
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd					1,094		22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		1,919,406	758,965	2,678,371	132,383	14,767	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic					437		54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory		16,880	6,675	23,555	7,719	130	60
60.01	LABORATORY-SUA							60.01
65	Respiratory Therapy		12,240	4,840	17,080	6,785	94	65
66	Physical Therapy		401,103	158,603	559,706	30,908	3,086	66
67	Occupational Therapy		215,298	85,132	300,430	25,050	1,657	67
68	Speech Pathology		104,083	41,156	145,239	12,626	801	68
71	Medical Supplies Charged to Patients		69,700	27,561	97,261	10,359	536	71
73	Drugs Charged to Patients		40,051	15,837	55,888	23,216	308	73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES							76.01
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)		3,278,247	1,296,272	4,574,519	308,722	23,423	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		51,668	20,430	72,098	664	398	192
194	MARKETING NRCC		2,990	1,182	4,172	3,018	23	194
194.01	GUEST MEALS							194.01
194.02	CLINICAL PSYCHOLOGY					21		194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		3,332,905	1,317,884	4,650,789	312,425	23,844	202

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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	41,512						8
9	Housekeeping		23,511					9
10	Dietary		1,365	265,184				10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration		101		32,589			13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		159			32,439		16
17	Social Service		103				27,402	17
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	41,512	14,756	265,184	32,589	16,014	27,402	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic					105		54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory		130			935		60
60.01	LABORATORY-SUA							60.01
65	Respiratory Therapy		94			576		65
66	Physical Therapy		3,084			3,927		66
67	Occupational Therapy		1,655			3,945		67
68	Speech Pathology		800			1,793		68
71	Medical Supplies Charged to Patients		536			190		71
73	Drugs Charged to Patients		308			4,954		73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES							76.01
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	41,512	23,091	265,184	32,589	32,439	27,402	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		397					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)	41,512	23,511	265,184	32,589	32,439	27,402	202

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B PART II

	COST CENTER DESCRIPTIONS	I&R PROGRAM COSTS	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL			
		22	24	25	26			
	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
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd	1,094						22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		3,222,978		3,222,978			30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic		542		542			54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory		32,469		32,469			60
60.01	LABORATORY-SUA							60.01
65	Respiratory Therapy		24,629		24,629			65
66	Physical Therapy		600,711		600,711			66
67	Occupational Therapy		332,737		332,737			67
68	Speech Pathology		161,259		161,259			68
71	Medical Supplies Charged to Patients		108,882		108,882			71
73	Drugs Charged to Patients		84,674		84,674			73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES							76.01
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)		4,568,881		4,568,881			118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		73,557		73,557			192
194	MARKETING NRCC		7,236		7,236			194
194.01	GUEST MEALS							194.01
194.02	CLINICAL PSYCHOLOGY		21		21			194.02
200	Cross Foot Adjustments	1,094	1,094		1,094			200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,094	4,650,789		4,650,789			202

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	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	107,016						1
2	Cap Rel Costs-Mvble Equip		107,016					2
4	Employee Benefits Department			23,413,635				4
5	Administrative & General	7,189	7,189	3,446,962	-9,613,453	33,899,367		5
6	Maintenance & Repairs							6
7	Operation of Plant	321	321	289,802		1,073,561	99,506	7
8	Laundry & Linen Service	878	878			341,343	878	8
9	Housekeeping	432	432	343,365		502,662	432	9
10	Dietary	5,703	5,703			1,584,955	5,703	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	423	423	1,263,811		1,519,523	423	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	662	662	277,360		363,680	662	16
17	Social Service	430	430	758,331		923,242	430	17
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd					118,750		22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	61,630	61,630	9,622,945		14,363,557	61,630	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic					47,418		54
54.01	RADIOLOGY-SUA				-62,776			54.01
60	Laboratory	542	542	10,320		837,564	542	60
60.01	LABORATORY-SUA							60.01
65	Respiratory Therapy	393	393	610,038		736,222	393	65
66	Physical Therapy	12,879	12,879	2,277,732		3,353,781	12,879	66
67	Occupational Therapy	6,913	6,913	2,040,304		2,718,082	6,913	67
68	Speech Pathology	3,342	3,342	1,019,149		1,370,049	3,342	68
71	Medical Supplies Charged to Patients	2,238	2,238	192,629		1,124,024	2,238	71
73	Drugs Charged to Patients	1,286	1,286	992,174		2,519,110	1,286	73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES							76.01
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	105,261	105,261	23,144,922	-9,676,229	33,497,523	97,751	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	1,659	1,659			72,098	1,659	192
194	MARKETING NRCC	96	96	268,713		327,495	96	194
194.01	GUEST MEALS							194.01
194.02	CLINICAL PSYCHOLOGY					2,251		194.02
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	3,332,905	1,317,884	4,143,253		9,613,453	1,378,010	202
203	Unit Cost Multiplier (Wkst. B, Part I)	31.143988	12.314831	0.176959		0.283588	13.848512	203
204	Cost to be allocated (Per Wkst. B, Part II)					312,425	23,844	204
205	Unit Cost Multiplier (Wkst. B, Part II)					0.009216	0.239624	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

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE PATIENT DAYS	HOUSE- KEEPING SQUARE FEET	DIETARY MEALS SERVED	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	35,538						8
9	Housekeeping		98,196					9
10	Dietary		5,703	106,614				10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration		423		35,538			13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		662			73,905,660		16
17	Social Service		430				35,538	17
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	35,538	61,630	106,614	35,538	36,490,888	35,538	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic					239,711		54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory		542			2,128,831		60
60.01	LABORATORY-SUA							60.01
65	Respiratory Therapy		393			1,313,117		65
66	Physical Therapy		12,879			8,945,205		66
67	Occupational Therapy		6,913			8,986,480		67
68	Speech Pathology		3,342			4,084,262		68
71	Medical Supplies Charged to Patients		2,238			432,970		71
73	Drugs Charged to Patients		1,286			11,284,196		73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES							76.01
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	35,538	96,441	106,614	35,538	73,905,660	35,538	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		1,659					192
194	MARKETING NRCC		96					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)	450,303	651,194	2,151,227	1,959,104	480,373	1,193,869	202
203	Unit Cost Multiplier (Wkst. B, Part I)	12.671028	6.631574	20.177716	55.127019	0.006500	33.594153	203
204	Cost to be allocated (Per Wkst. B, Part II)	41,512	23,511	265,184	32,589	32,439	27,402	204
205	Unit Cost Multiplier (Wkst. B, Part II)	1.168102	0.239429	2.487328	0.917018	0.000439	0.771062	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

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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
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	LABORATORY-SUA							60.01
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients							73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES							76.01
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	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)	152,426						202
203	Unit Cost Multiplier (Wkst. B, Part I)	1,524.260000						203
204	Cost to be allocated (Per Wkst. B, Part II)	1,094						204
205	Unit Cost Multiplier (Wkst. B, Part II)	10.940000						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

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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

		WORKSHEET			
	DESCRIPTION	CODE	LINE NO.	AMOUNT	
	1	2	3	4	

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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	25,690,759		25,690,759	311,487	26,002,246	30
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	62,423		62,423		62,423	54
54.01	RADIOLOGY-SUA	62,776		62,776		62,776	54.01
60	Laboratory	1,100,024		1,100,024		1,100,024	60
60.01	LABORATORY-SUA						60.01
65	Respiratory Therapy	961,589		961,589		961,589	65
66	Physical Therapy	4,626,780		4,626,780		4,626,780	66
67	Occupational Therapy	3,688,888		3,688,888		3,688,888	67
68	Speech Pathology	1,853,571		1,853,571		1,853,571	68
71	Medical Supplies Charged to Patients	1,491,432		1,491,432		1,491,432	71
73	Drugs Charged to Patients	3,333,183		3,333,183		3,333,183	73
76	PSYCHOLOGY						76
76.01	SPECIAL PROCEDURES						76.01
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	42,871,425		42,871,425	311,487	43,182,912	200
201	Less Observation Beds						201
202	Total (line 200 minus line 201)	42,871,425		42,871,425		43,182,912	202

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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	36,490,888		36,490,888				30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	239,484	765	240,249	0.259826	0.259826	0.259826	54
54.01	RADIOLOGY-SUA	438,717		438,717	0.143090	0.143090	0.143090	54.01
60	Laboratory	2,128,831		2,128,831	0.516727	0.516727	0.516727	60
60.01	LABORATORY-SUA							60.01
65	Respiratory Therapy	1,313,117		1,313,117	0.732295	0.732295	0.732295	65
66	Physical Therapy	8,687,005	258,200	8,945,205	0.517236	0.517236	0.517236	66
67	Occupational Therapy	8,858,283	128,197	8,986,480	0.410493	0.410493	0.410493	67
68	Speech Pathology	3,976,151	108,111	4,084,262	0.453833	0.453833	0.453833	68
71	Medical Supplies Charged to Patients	432,865	105	432,970	3.444654	3.444654	3.444654	71
73	Drugs Charged to Patients	11,283,658		11,283,658	0.295399	0.295399	0.295399	73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES							76.01
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	73,848,999	495,378	74,344,377				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	73,848,999	495,378	74,344,377				202

Health Financial Systems Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2019 To: 05/31/2020	Run Date: 10/29/2020 Run Time: 15:00 Version: 2020.06 (10/28/2020)
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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	25,690,759		25,690,759	311,487	26,002,246	30
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	62,423		62,423		62,423	54
54.01	RADIOLOGY-SUA	62,776		62,776		62,776	54.01
60	Laboratory	1,100,024		1,100,024		1,100,024	60
60.01	LABORATORY-SUA						60.01
65	Respiratory Therapy	961,589		961,589		961,589	65
66	Physical Therapy	4,626,780		4,626,780		4,626,780	66
67	Occupational Therapy	3,688,888		3,688,888		3,688,888	67
68	Speech Pathology	1,853,571		1,853,571		1,853,571	68
71	Medical Supplies Charged to Patients	1,491,432		1,491,432		1,491,432	71
73	Drugs Charged to Patients	3,333,183		3,333,183		3,333,183	73
76	PSYCHOLOGY						76
76.01	SPECIAL PROCEDURES						76.01
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	42,871,425		42,871,425	311,487	43,182,912	200
201	Less Observation Beds						201
202	Total (line 200 minus line 201)	42,871,425		42,871,425	311,487	43,182,912	202

Health Financial Systems Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2019 To: 05/31/2020	Run Date: 10/29/2020 Run Time: 15:00 Version: 2020.06 (10/28/2020)
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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	36,490,888		36,490,888				30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	239,484	765	240,249	0.259826	0.259826	0.259826	54
54.01	RADIOLOGY-SUA	438,717		438,717	0.143090	0.143090	0.143090	54.01
60	Laboratory	2,128,831		2,128,831	0.516727	0.516727	0.516727	60
60.01	LABORATORY-SUA							60.01
65	Respiratory Therapy	1,313,117		1,313,117	0.732295	0.732295	0.732295	65
66	Physical Therapy	8,687,005	258,200	8,945,205	0.517236	0.517236	0.517236	66
67	Occupational Therapy	8,858,283	128,197	8,986,480	0.410493	0.410493	0.410493	67
68	Speech Pathology	3,976,151	108,111	4,084,262	0.453833	0.453833	0.453833	68
71	Medical Supplies Charged to Patients	432,865	105	432,970	3.444654	3.444654	3.444654	71
73	Drugs Charged to Patients	11,283,658		11,283,658	0.295399	0.295399	0.295399	73
76	PSYCHOLOGY							76
76.01	SPECIAL PROCEDURES							76.01
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	73,848,999	495,378	74,344,377				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	73,848,999	495,378	74,344,377				202

Health Financial Systems Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2019 To: 05/31/2020	Run Date: 10/29/2020 Run Time: 15:00 Version: 2020.06 (10/28/2020)
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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	62,423	542	61,881		54
54.01	RADIOLOGY-SUA	62,776		62,776		54.01
60	Laboratory	1,100,024	32,469	1,067,555		60
60.01	LABORATORY-SUA					60.01
65	Respiratory Therapy	961,589	24,629	936,960		65
66	Physical Therapy	4,626,780	600,711	4,026,069		66
67	Occupational Therapy	3,688,888	332,737	3,356,151		67
68	Speech Pathology	1,853,571	161,259	1,692,312		68
71	Medical Supplies Charged to Patients	1,491,432	108,882	1,382,550		71
73	Drugs Charged to Patients	3,333,183	84,674	3,248,509		73
76	PSYCHOLOGY					76
76.01	SPECIAL PROCEDURES					76.01
	OUTPATIENT SERVICE COST CENTERS					
92	Observation Beds (Non-Distinct Part)					92
	OTHER REIMBURSABLE COST CENTERS					
113	Interest Expense					113
200	Subtotal	17,180,666	1,345,903	15,834,763		200
201	Less Observation Beds					201
202	Total	17,180,666	1,345,903	15,834,763		202

Health Financial Systems Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2019 To: 05/31/2020	Run Date: 10/29/2020 Run Time: 15:00 Version: 2020.06 (10/28/2020)
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CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

WORKSHEET C PART II

[] Title V

[XX] Title XIX

	COST CENTER DESCRIPTIONS	Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Wkst C, Part I, col. 8)	Outpatient Cost to Charge Ratio(col. 6 ÷ col. 7)	
		5	6	7	8	
	ANCILLARY SERVICE COST CENTERS					
54	Radiology-Diagnostic		62,423	240,249	0.259826	54
54.01	RADIOLOGY-SUA		62,776	438,717	0.143090	54.01
60	Laboratory		1,100,024	2,128,831	0.516727	60
60.01	LABORATORY-SUA					60.01
65	Respiratory Therapy		961,589	1,313,117	0.732295	65
66	Physical Therapy		4,626,780	8,945,205	0.517236	66
67	Occupational Therapy		3,688,888	8,986,480	0.410493	67
68	Speech Pathology		1,853,571	4,084,262	0.453833	68
71	Medical Supplies Charged to Patients		1,491,432	432,970	3.444654	71
73	Drugs Charged to Patients		3,333,183	11,283,658	0.295399	73
76	PSYCHOLOGY					76
76.01	SPECIAL PROCEDURES					76.01
	OUTPATIENT SERVICE COST CENTERS					
92	Observation Beds (Non-Distinct Part)					92
	OTHER REIMBURSABLE COST CENTERS					
113	Interest Expense					113
200	Subtotal		17,180,666	37,853,489		200
201	Less Observation Beds					201
202	Total		17,180,666	37,853,489		202

Health Financial Systems Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2019 To: 05/31/2020	Run Date: 10/29/2020 Run Time: 15:00 Version: 2020.06 (10/28/2020)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D PART I

Check ☐ Title V ☒ Hospital ☒ PPS
 Applicable ☒ Title XVIII, Part A ☐ PARHM Demonstration ☐ 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)	3,222,978		3,222,978	35,538	90.69	13,076	1,185,862	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)	3,222,978		3,222,978	35,538		13,076	1,185,862	200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2019 To: 05/31/2020	Run Date: 10/29/2020 Run Time: 15:00 Version: 2020.06 (10/28/2020)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 26-3028

WORKSHEET D
PART II

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

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	542	240,249	0.002256	43,276	98	54
54.01	RADIOLOGY-SUA		438,717		157,708		54.01
60	Laboratory	32,469	2,128,831	0.015252	856,376	13,061	60
60.01	LABORATORY-SUA						60.01
65	Respiratory Therapy	24,629	1,313,117	0.018756	558,145	10,469	65
66	Physical Therapy	600,711	8,945,205	0.067155	3,285,827	220,660	66
67	Occupational Therapy	332,737	8,986,480	0.037026	3,333,606	123,430	67
68	Speech Pathology	161,259	4,084,262	0.039483	1,351,462	53,360	68
71	Medical Supplies Charged to Pat	108,882	432,970	0.251477	187,018	47,031	71
73	Drugs Charged to Patients	84,674	11,283,658	0.007504	4,352,493	32,661	73
76	PSYCHOLOGY						76
76.01	SPECIAL PROCEDURES						76.01
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct						92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,345,903	37,853,489		14,125,911	500,770	200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2019 To: 05/31/2020	Run Date: 10/29/2020 Run Time: 15:00 Version: 2020.06 (10/28/2020)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

☐ Title V

☒ Title XVIII, Part A

☐ Title XIX

☒ Hospital

☐ PARHM Demonstration

☒ PPS

☐ TEFRA

		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

Health Financial Systems Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2019 To: 05/31/2020	Run Date: 10/29/2020 Run Time: 15:00 Version: 2020.06 (10/28/2020)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

☐ Title V

☒ Title XVIII, Part A

☐ Title XIX

☒ Hospital

☐ PARHM Demonstration

☒ PPS

☐ TEFRA

		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)	35,538		13,076		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)	35,538		13,076		200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2019 To: 05/31/2020	Run Date: 10/29/2020 Run Time: 15:00 Version: 2020.06 (10/28/2020)
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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	LABORATORY-SUA									60.01
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
76.01	SPECIAL PROCEDURES									76.01
	OUTPATIENT SERVICE COST CENTERS									
92	Observation Beds (Non-Distinct									92
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2019 To: 05/31/2020	Run Date: 10/29/2020 Run Time: 15:00 Version: 2020.06 (10/28/2020)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 26-3028

WORKSHEET D
PART IV

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

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	240,249			43,276		765		54
54.01	RADIOLOGY-SUA	438,717			157,708				54.01
60	Laboratory	2,128,831			856,376				60
60.01	LABORATORY-SUA								60.01
65	Respiratory Therapy	1,313,117			558,145				65
66	Physical Therapy	8,945,205			3,285,827				66
67	Occupational Therapy	8,986,480			3,333,606				67
68	Speech Pathology	4,084,262			1,351,462				68
71	Medical Supplies Charged to Pat	432,970			187,018				71
73	Drugs Charged to Patients	11,283,658			4,352,493				73
76	PSYCHOLOGY								76
76.01	SPECIAL PROCEDURES								76.01
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct								92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	37,853,489			14,125,911		765		200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2019 To: 05/31/2020	Run Date: 10/29/2020 Run Time: 15:00 Version: 2020.06 (10/28/2020)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 26-3028

WORKSHEET D
PART V

Check ☐ Title V - O/P
 Applicable ☒ Title XVIII, Part B
 Boxes: ☐ Title XIX - O/P

☒ Hospital
☐ IPF
☐ IRF
☐ SUB
 (Other)

☐ SNF
☐ NF
☐ Swing Bed SNF
☐ Swing Bed NF

☐ ICF/IID
☐ PARHM Demonstration
☐ PARHM CAH Swing Bed SNF

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	0.259826	765			199			54
54.01	RADIOLOGY-SUA	0.143090							54.01
60	Laboratory	0.516727							60
60.01	LABORATORY-SUA								60.01
65	Respiratory Therapy	0.732295							65
66	Physical Therapy	0.517236							66
67	Occupational Therapy	0.410493							67
68	Speech Pathology	0.453833							68
71	Medical Supplies Charged to Pat	3.444654							71
73	Drugs Charged to Patients	0.295399							73
76	PSYCHOLOGY								76
76.01	SPECIAL PROCEDURES								76.01
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct								92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		765			199			200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		765			199			202

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2019 To: 05/31/2020	Run Date: 10/29/2020 Run Time: 15:00 Version: 2020.06 (10/28/2020)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check
Applicable
Boxes:

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

☒ Hospital
☐ PARHM Demonstration

		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)	3,222,978		3,222,978	35,538	90.69	6,276	569,170	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)	3,222,978		3,222,978	35,538		6,276	569,170	200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2019 To: 05/31/2020	Run Date: 10/29/2020 Run Time: 15:00 Version: 2020.06 (10/28/2020)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 26-3028

WORKSHEET D
PART II

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

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	542	240,249	0.002256	17,562	40	54
54.01	RADIOLOGY-SUA		438,717		63,997		54.01
60	Laboratory	32,469	2,128,831	0.015252	281,360	4,291	60
60.01	LABORATORY-SUA						60.01
65	Respiratory Therapy	24,629	1,313,117	0.018756	261,650	4,908	65
66	Physical Therapy	600,711	8,945,205	0.067155	1,510,909	101,465	66
67	Occupational Therapy	332,737	8,986,480	0.037026	1,541,616	57,080	67
68	Speech Pathology	161,259	4,084,262	0.039483	725,064	28,628	68
71	Medical Supplies Charged to Pat	108,882	432,970	0.251477	77,877	19,584	71
73	Drugs Charged to Patients	84,674	11,283,658	0.007504	1,858,218	13,944	73
76	PSYCHOLOGY						76
76.01	SPECIAL PROCEDURES						76.01
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct						92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,345,903	37,853,489		6,338,253	229,940	200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2019 To: 05/31/2020	Run Date: 10/29/2020 Run Time: 15:00 Version: 2020.06 (10/28/2020)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D PART III

Check ☐ Title V ☒ Hospital
Applicable ☐ Title XVIII, Part A ☐ PARHM Demonstration
Boxes: ☒ Title XIX

		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

Health Financial Systems Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2019 To: 05/31/2020	Run Date: 10/29/2020 Run Time: 15:00 Version: 2020.06 (10/28/2020)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D PART III

Check ☐ Title V ☒ Hospital
Applicable ☐ Title XVIII, Part A ☐ PARHM Demonstration
Boxes: ☒ Title XIX

		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)	35,538		6,276		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)	35,538		6,276		200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2019 To: 05/31/2020	Run Date: 10/29/2020 Run Time: 15:00 Version: 2020.06 (10/28/2020)
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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	LABORATORY-SUA									60.01
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
76.01	SPECIAL PROCEDURES									76.01
	OUTPATIENT SERVICE COST CENTERS									
92	Observation Beds (Non-Distinct									92
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2019 To: 05/31/2020	Run Date: 10/29/2020 Run Time: 15:00 Version: 2020.06 (10/28/2020)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 26-3028

WORKSHEET D
PART IV

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

		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	240,249			17,562				54
54.01	RADIOLOGY-SUA	438,717			63,997				54.01
60	Laboratory	2,128,831			281,360				60
60.01	LABORATORY-SUA								60.01
65	Respiratory Therapy	1,313,117			261,650				65
66	Physical Therapy	8,945,205			1,510,909				66
67	Occupational Therapy	8,986,480			1,541,616				67
68	Speech Pathology	4,084,262			725,064				68
71	Medical Supplies Charged to Pat	432,970			77,877				71
73	Drugs Charged to Patients	11,283,658			1,858,218				73
76	PSYCHOLOGY								76
76.01	SPECIAL PROCEDURES								76.01
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct								92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	37,853,489			6,338,253				200

(A) Worksheet A line numbers

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2019 To: 05/31/2020	Run Date: 10/29/2020 Run Time: 15:00 Version: 2020.06 (10/28/2020)
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WORKSHEET D
PART V

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[ ] ICF/IID
[ ] PARHM Demonstration
[ ] PARHM CAH Swing Bed SNF
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(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2019 To: 05/31/2020	Run Date: 10/29/2020 Run Time: 15:00 Version: 2020.06 (10/28/2020)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 26-3028****WORKSHEET D-1
PART I**

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

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	35,538	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	35,538	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.	979	3
4	Semi-private room days (excluding swing-bed private room days)	34,559	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)	13,076	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)	26,002,246	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)	26,002,246	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)	36,490,888	28
29	Private room charges (excluding swing-bed charges)	1,021,102	29
30	Semi-private room charges (excluding swing-bed charges)	35,469,786	30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.712568	31
32	Average private room per diem charge (line 29 ÷ line 3)	1,043.01	32
33	Average semi-private room per diem charge (line 30 ÷ line 4)	1,026.35	33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)	16.66	34
35	Average per diem private room cost differential (line 34 x line 31)	11.87	35
36	Private room cost differential adjustment (line 3 x line 35)	11,621	36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	25,990,625	37

Health Financial Systems Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2019 To: 05/31/2020	Run Date: 10/29/2020 Run Time: 15:00 Version: 2020.06 (10/28/2020)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 26-3028

WORKSHEET D-1 PART II

Check ☐ Title V - I/P ☒ Hospital ☐ SUB (Other) ☒ PPS
Applicable ☒ Title XVIII, Part A ☐ IPF ☐ PARHM Demo ☐ 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)						731.67 38
39	Program general inpatient routine service cost (line 9 x line 38)						9,567,317 39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)						9,567,317 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)						6,496,292 48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						16,063,609 49
PASS THROUGH COST ADJUSTMENTS							
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						1,185,862 50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						500,770 51
52	Total Program excludable cost (sum of lines 50 and 51)						1,686,632 52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						14,376,977 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

Health Financial Systems Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2019 To: 05/31/2020	Run Date: 10/29/2020 Run Time: 15:00 Version: 2020.06 (10/28/2020)
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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

PARHM Demo

☒ 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)					731.67	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

Health Financial Systems Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2019 To: 05/31/2020	Run Date: 10/29/2020 Run Time: 15:00 Version: 2020.06 (10/28/2020)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 26-3028****WORKSHEET D-1
PART I**

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

PART I - ALL PROVIDER COMPONENTS**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	35,538	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	35,538	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.	979	3
4	Semi-private room days (excluding swing-bed private room days)	34,559	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)	6,276	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)	25,690,759	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)	25,690,759	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)	36,490,888	28
29	Private room charges (excluding swing-bed charges)	1,021,102	29
30	Semi-private room charges (excluding swing-bed charges)	35,469,786	30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.704032	31
32	Average private room per diem charge (line 29 ÷ line 3)	1,043.01	32
33	Average semi-private room per diem charge (line 30 ÷ line 4)	1,026.35	33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)	16.66	34
35	Average per diem private room cost differential (line 34 x line 31)	11.73	35
36	Private room cost differential adjustment (line 3 x line 35)	11,484	36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	25,679,275	37

Health Financial Systems Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2019 To: 05/31/2020	Run Date: 10/29/2020 Run Time: 15:00 Version: 2020.06 (10/28/2020)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 26-3028****WORKSHEET D-1
PART II**

Check ☐ **Title V - I/P** ☒ **Hospital** ☐ **SUB (Other)** ☐ **PPS**
Applicable ☐ **Title XVIII, Part A** ☐ **IPF** ☐ **PARHM Demo** ☐ **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)						722.59 38
39	Program general inpatient routine service cost (line 9 x line 38)						4,534,975 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)						4,534,975 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)					2,911,264	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					7,446,239	49
PASS THROUGH COST ADJUSTMENTS							
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					569,170	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					229,940	51
52	Total Program excludable cost (sum of lines 50 and 51)					799,110	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

Health Financial Systems Compu-Max 2552-10

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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

PARHM Demo

☐ 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

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 26-3028

WORKSHEET D-3

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

		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		13,411,005		30
	ANCILLARY SERVICE COST CENTERS				
54	Radiology-Diagnostic	0.259826	43,276	11,244	54
54.01	RADIOLOGY-SUA	0.143090	157,708	22,566	54.01
60	Laboratory	0.516727	856,376	442,513	60
60.01	LABORATORY-SUA				60.01
65	Respiratory Therapy	0.732295	558,145	408,727	65
66	Physical Therapy	0.517236	3,285,827	1,699,548	66
67	Occupational Therapy	0.410493	3,333,606	1,368,422	67
68	Speech Pathology	0.453833	1,351,462	613,338	68
71	Medical Supplies Charged to Patients	3.444654	187,018	644,212	71
73	Drugs Charged to Patients	0.295399	4,352,493	1,285,722	73
76	PSYCHOLOGY				76
76.01	SPECIAL PROCEDURES				76.01
	OUTPATIENT SERVICE COST CENTERS				
92	Observation Beds (Non-Distinct Part)				92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		14,125,911	6,496,292	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		14,125,911		202

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2019 To: 05/31/2020	Run Date: 10/29/2020 Run Time: 15:00 Version: 2020.06 (10/28/2020)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 26-3028

WORKSHEET D-3

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

		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		6,441,664		30
	ANCILLARY SERVICE COST CENTERS				
54	Radiology-Diagnostic	0.259826	17,562	4,563	54
54.01	RADIOLOGY-SUA	0.143090	63,997	9,157	54.01
60	Laboratory	0.516727	281,360	145,386	60
60.01	LABORATORY-SUA				60.01
65	Respiratory Therapy	0.732295	261,650	191,605	65
66	Physical Therapy	0.517236	1,510,909	781,497	66
67	Occupational Therapy	0.410493	1,541,616	632,823	67
68	Speech Pathology	0.453833	725,064	329,058	68
71	Medical Supplies Charged to Patients	3.444654	77,877	268,259	71
73	Drugs Charged to Patients	0.295399	1,858,218	548,916	73
76	PSYCHOLOGY				76
76.01	SPECIAL PROCEDURES				76.01
	OUTPATIENT SERVICE COST CENTERS				
92	Observation Beds (Non-Distinct Part)				92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		6,338,253	2,911,264	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		6,338,253		202

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2019 To: 05/31/2020	Run Date: 10/29/2020 Run Time: 15:00 Version: 2020.06 (10/28/2020)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 26-3028

WORKSHEET E PART B

Check applicable box: ☒ Hospital ☐ IPF ☐ IRF ☐ SUB (Other) ☐ SNF ☐ PARHM Demonstration

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)	199			2
3	OPPS payments	107			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)	107			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	21			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)	86			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)	86			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	86			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)	86			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)	86			40
40.01	Sequestration adjustment (see instructions)	2			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
40.03	Sequestration adjustment - PARHM pass-throughs				40.03
41	Interim payments	84			41
41.01	Interim payments - PARHM				41.01
42	Tentative settlement (for contractors use only)				42
42.01	Tentative settlement - PARHM (for contractor use only)				42.01
43	Balance due provider/program (see instructions)				43
43.01	Balance due provider/program - PARHM (see instructions)				43.01
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

Health Financial Systems Compu-Max 2552-10

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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 26-3028

WORKSHEET E-1
PART I

Check ☒ Hospital ☐ SUB (Other) ☐ PARHM Demonstration
Applicable ☐ IPF ☐ SNF ☐ PARHM CAH Swing Bed-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			21,592,137		84
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					3.01
	amount based on subsequent revision of the interim					3.02
	rate for the cost reporting period. Also show date of	Program				3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to				3.04
		Provider				3.05
						3.06
						3.07
						3.08
						3.09
						3.10
						3.50
						3.51
		Provider	12/03/2019	28,542		3.52
		to				3.53
		Program				3.54
						3.55
						3.56
						3.57
						3.58
						3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			-28,542		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)			21,563,595		84
TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment					5.01
	after desk review. Also show date of each payment.					5.02
	If none, write 'NONE' or enter a zero. (1)	Program				5.03
		to				5.04
		Provider				5.05
						5.06
						5.07
						5.08
						5.09
						5.10
						5.50
						5.51
		Provider				5.52
		to				5.53
		Program				5.54
						5.55
						5.56
						5.57
						5.58
						5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)					5.99
6	Determined net settlement amount (balance due)					6.01
	based on the cost report (1)					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.

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 26-3028

WORKSHEET E-3
PART III

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

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

		1	1.01	
1	Net Federal PPS payment (see instructions)	19,449,275		1
2	Medicare SSI ratio (IRF PPS only) (see instructions)	0.053900		2
3	Inpatient Rehabilitation LIP payments (see instructions)	1,719,316		3
4	Outlier payments	57,676		4
5	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	4.37		5
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) OR (2)			5.01
6	New teaching program adjustment (see instructions)			6
7	Current year unweighted FTE count of I&R excludnig FTEs in the new program growth period of a 'new teaching program' (see instructions)	5.11		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)	97,098361		10
11	Teaching Adjustment Factor (see instructions)	0.045756		11
12	Teaching Adjustment (see instructions)	889,921		12
13	Total PPS Payment (see instructions)	22,116,188		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)	22,116,188		17
18	Primary payer payments	3,200		18
19	Subtotal (line 17 less line 18)	22,112,988		19
20	Deductibles	216,040		20
21	Subtotal (line 19 minus line 20)	21,896,948		21
22	Coinsurance	224,961		22
23	Subtotal (line 21 minus line 22)	21,671,987		23
24	Allowable bad debts (exclude bad debts for professional services) (see instructions)	153,172		24
25	Adjusted reimbursable bad debts (see instructions)	99,562		25
26	Allowable bad debts for dual eligible beneficiaries (see instructions)	103,561		26
27	Subtotal (sum of lines 23 and 25)	21,771,549		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)	21,771,549		32
32.01	Sequestration adjustment (see instructions)	398,419		32.01
32.02	Demonstration payment adjustment amount after sequestration			32.02
33	Interim payments	21,563,595		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)	-190,465		35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	588,678		36

TO BE COMPLETED BY CONTRACTOR

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

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 26-3028

WORKSHEET E-3
PART VII

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

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	7,446,239		1
2	Medical and other services		8,373	2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	7,446,239	8,373	4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	7,446,239	8,373	7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges	6,441,664		8
9	Ancillary service charges	6,338,253	16,849	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)	12,779,917	16,849	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)	12,779,917	16,849	16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	5,333,678	8,476	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)	7,446,239	8,373	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)	7,446,239	8,373	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)	7,446,239	8,373	31
32	Deductibles			32
33	Coinsurance	33,875	279	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)	7,412,364	8,094	36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	7,412,364	8,094	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)	7,412,364	8,094	40
41	Interim payments	6,874,763	7,011	41
42	Balance due provider/program (line 40 minus line 41)	537,601	1,083	42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

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DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

WORKSHEET E-4

Check ☐ Title V
 Applicable ☒ Title XVIII
 Box: ☐ Title XIX

☒ Hospital
☐ PARHM Demonstration
☐ CAH-based IPF
☐ CAH-based IRF

COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996				1
2	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e) (see instructions)				2
3	Amount of reduction to Direct GME cap under §422 of MMA				3
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)				3.01
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and §413.79(f))				4
4.01	ACA §5503 increase to the direct GME FTE cap (see instructions for cost reporting periods straddling 7/1/2011)				4.01
4.02	ACA §5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)				4.02
5	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)				5
6	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)				6
7	Enter the lesser of line 5 or line 6				7
		Primary Care 1	Other 2	Total 3	
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	0.00	0.00	0.00	8
9	If line 6 is less than line 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6	0.00	0.00	0.00	9
10	Weighted dental and podiatric resident FTE count for the current year		0.00		10
10.01	Unweighted dental and podiatric resident FTE count for the current year				10.01
11	Total weighted FTE count	0.00	0.00		11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00		12
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00		13
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	0.00	0.00		14
15	Adjustment for residents in initial years of new programs	0.00	0.00		15
15.01	Unweighted adjustment for residents in initial years of new programs				15.01
16	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16
16.01	Unweighted adjustment for residents displaced by program or hospital closure				16.01
17	Adjusted rolling average FTE count	0.00	0.00		17
18	Per resident amount	0.00	0.00		18
19	Approved amount for resident costs				19
20	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 §413.79(c)(4)				20
21	Direct GME FTE unweighted resident count over cap (see instructions)				21
22	Allowable additional direct GME FTE resident count (see instructions)				22
23	Enter the locality adjustment national average per resident amount (see instructions)				23
24	Multiply line 22 times line 23				24
25	Total direct GME amount (sum of lines 19 and 24)				25
		Inpatient Part A 1	Managed Care Prior to 1/1 2	Managed Care On or After 1/1 2.01	3
26	Inpatient days (see instructions)	13,076	4,956		26
27	Total inpatient days (see instructions)	35,538	35,538		27
28	Ratio of inpatient days to total inpatient days	0.367944	0.139456	0.000000	28
29	Program direct GME amount				29
29.01	Percent reduction for MA DGME				29.01
30	Reduction for direct GME payments for Medicare Advantage				30
31	Net Program direct GME amount				31
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)					
32	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)				32
33	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)				33
34	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)				34
35	Medicare outpatient ESRD charges (see instructions)				35
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)				36
APPORTIONMENT OF MEDICARE REASONABLE COST OF GME					
Part A Reasonable Cost					
37	Reasonable cost (see instructions)			16,063,609	37
38	Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69)				38
39	Cost of physicians' services in a teaching hospital (see instructions)				39
40	Primary payer payments (see instructions)			3,200	40
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			16,060,409	41
Part B Reasonable Cost					
42	Reasonable cost (see instructions)			199	42
43	Primary payer payments (see instructions)				43
44	Total Part B reasonable cost (line 42 minus line 43)			199	44
45	Total reasonable cost (sum of lines 41 and 44)			16,060,608	45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.999988	46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.000012	47
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48	Total program GME payment (line 31)				48
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)				49
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)				50

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WORKSHEET E-4

	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996				1
2	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e) (see instructions)				2
3	Amount of reduction to Direct GME cap under §422 of MMA				3
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)				3.01
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and §413.79(f))				4
4.01	ACA §5503 increase to the direct GME FTE cap (see instructions for cost reporting periods straddling 7/1/2011)				4.01
4.02	ACA §5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)				4.02
5	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)				5
6	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)				6
7	Enter the lesser of line 5 or line 6				7
		Primary Care 1	Other 2	Total 3	
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	0.00	0.00	0.00	8
9	If line 6 is less than line 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6	0.00	0.00	0.00	9
10	Weighted dental and podiatric resident FTE count for the current year		0.00		10
10.01	Unweighted dental and podiatric resident FTE count for the current year				10.01
11	Total weighted FTE count	0.00	0.00		11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00		12
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00		13
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	0.00	0.00		14
15	Adjustment for residents in initial years of new programs	0.00	0.00		15
15.01	Unweighted adjustment for residents in initial years of new programs				15.01
16	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16
16.01	Unweighted adjustment for residents displaced by program or hospital closure				16.01
17	Adjusted rolling average FTE count	0.00	0.00		17
18	Per resident amount	0.00	0.00		18
19	Approved amount for resident costs				19
20	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 §413.79(c)(4)				20
21	Direct GME FTE unweighted resident count over cap (see instructions)				21
22	Allowable additional direct GME FTE resident count (see instructions)				22
23	Enter the locality adjustment national average per resident amount (see instructions)				23
24	Multiply line 22 times line 23				24
25	Total direct GME amount (sum of lines 19 and 24)				25
		Inpatient Part A 1	Managed Care Prior to 1/1 2	Managed Care On or After 1/1 2.01	3
	COMPUTATION OF PROGRAM PATIENT LOAD				
26	Inpatient days (see instructions)	6,276	2,663		26
27	Total inpatient days (see instructions)	35,538	35,538		27
28	Ratio of inpatient days to total inpatient days	0.176600	0.074934	0.000000	28
29	Program direct GME amount				29
29.01	Percent reduction for MA DGME				29.01
30	Reduction for direct GME payments for Medicare Advantage				30
31	Net Program direct GME amount				31
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)				32
33	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)				33
34	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)				34
35	Medicare outpatient ESRD charges (see instructions)				35
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)				36
	APPORTIONMENT OF MEDICARE REASONABLE COST OF GME				
	Part A Reasonable Cost				
37	Reasonable cost (see instructions)				37
38	Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69)				38
39	Cost of physicians' services in a teaching hospital (see instructions)				39
40	Primary payer payments (see instructions)				40
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)				41
	Part B Reasonable Cost				
42	Reasonable cost (see instructions)				42
43	Primary payer payments (see instructions)				43
44	Total Part B reasonable cost (line 42 minus line 43)				44
45	Total reasonable cost (sum of lines 41 and 44)				45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)				46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)				47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	Total program GME payment (line 31)				48
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)				49
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)				50

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BALANCE SHEET

WORKSHEET G

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

	Assets (Omit Cents)	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1	2	3	4	
CURRENT ASSETS						
1	Cash on hand and in banks	4,396,347				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	11,582,481				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-3,957,537				6
7	Inventory	336,134				7
8	Prepaid expenses	94,252				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	12,451,677				11
FIXED ASSETS						
12	Land					12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings	23,972,520				15
16	Accumulated depreciation	-14,192,231				16
17	Leasehold improvements	6,807,208				17
18	Accumulated depreciation	-2,039,202				18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	9,454,064				23
24	Accumulated depreciation	-7,004,109				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)	16,998,250				30
OTHER ASSETS						
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	8,956,531				34
35	Total other assets (sum of lines 31-34)	8,956,531				35
36	Total assets (sum of lines 11, 30 and 35)	38,406,458				36
	Liabilities and Fund Balances (Omit Cents)	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1	2	3	4	
CURRENT LIABILITIES						
37	Accounts payable	1,199,763				37
38	Salaries, wages and fees payable	2,161,985				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	835,809				44
45	Total current liabilities (sum of lines 37 thru 44)	4,197,557				45
LONG TERM LIABILITIES						
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	22,448,678				49
50	Total long term liabilities (sum of lines 46 thru 49)	22,448,678				50
51	Total liabilities (sum of lines 45 and 50)	26,646,235				51
CAPITAL ACCOUNTS						
52	General fund balance	11,760,223				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)	11,760,223				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	38,406,458				60

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

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	Fund balances at beginning of period		12,467,826			1
2	Net income (loss) (from Worksheet G-3, line 29)		1,970,234			2
3	Total (sum of line 1 and line 2)		14,438,060			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)		14,438,060			11
12	Deductions (debit adjustments) (specify)					12
13	2020 EQUITY DISTN	2,677,837				13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)		2,677,837			18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		11,760,223			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	2020 EQUITY DISTN					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

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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

**WORKSHEET G-2
PARTS I & II****PART I - PATIENT REVENUES**

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	36,610,209		36,610,209	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)	36,610,209		36,610,209	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)	36,610,209		36,610,209	17
18	Ancillary services	37,239,553	494,613	37,734,166	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)	73,849,762	494,613	74,344,375	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		46,658,666	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)		46,658,666	43

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	74,344,375	1
2	Less contractual allowances and discounts on patients' accounts	28,574,107	2
3	Net patient revenues (line 1 minus line 2)	45,770,268	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	46,658,666	4
5	Net income from service to patients (line 3 minus line 4)	-888,398	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments	72,719	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts	41	10
11	Rebates and refunds of expenses		11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests	1,020	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts		18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines	109	21
22	Rental of hosptial space	233,506	22
23	Governmental appropriations		23
24	Other (MISC INC)	2,551,237	24
24.50	COVID-19 PHE FUNDING		24.50
25	Total other income (sum of lines 6-24)	2,858,632	25
26	Total (line 5 plus line 25)	1,970,234	26
29	Net income (or loss) for the period (line 26 minus line 28)	1,970,234	29