

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: 06/01/2020 To: 05/31/2021	Run Date: 09/23/2021 Run Time: 12:06 Version: 2020.06 (08/18/2021)
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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 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.			Date: 09/23/2021 Time: 12:06
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 06/01/2020 and ending 05/31/2021, 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

09/23/2021 12:06
Date

PART III - SETTLEMENT SUMMARY

		TITLE XVIII					
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		-185,579			530,086	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		-185,579			530,086	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 / 2020	To: 05 / 31 / 2021	20
21	Type of control (see instructions)	5		21

Inpatient PPS Information

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.							24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	5,317	912	375	331	2,069		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

		1	2	
Rural Providers		N		
105	Does this hospital qualify as a CAH?			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	3	
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:	64,306	155,529		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	02/26/2021	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	08/04/2021	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	08/04/2021	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: MARLENE	Last name: SILWAL	Title: REIMBURSEMENT ACCOUNTANT
42	Employer: ENCOMPASS HEALTH		
43	Phone number: 2059694969	E-mail Address: MARLENE.SILWAL@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	47,815			12,971	5,442	37,250	1
2	HMO and other (see instructions)						7,242	3,562		2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF									5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		131	47,815			12,971	5,442	37,250	7
8	Intensive Care Unit	31								8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	Other Special Care (specify)	35								12
13	Nursery	43								13
14	Total (see instructions)		131	47,815			12,971	5,442	37,250	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)					980	349	2,614	1
2	HMO and other (see instructions)					484	233		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)	4.18	330.21			980	349	2,614	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)	4.18	330.21						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	24,842,396			686,857.60		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)			217,118		4,631.32		10
OTHER WAGES & RELATED COSTS							
11 Contract labor (see instructions)		328,251			6,619.38		11
12 Contract management and administrative services							12
13 Contract labor: Physician-Part A - Administrative		435,822			2,087.00		13
14 Home office salaries & wage-related costs							14
14.01 Home office salaries			1,423,949		21,162.78		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)		4,687,156					17
18 Wage-related costs (other)(see instructions)							18
19 Excluded areas		41,331					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		641,614					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		3,345,394	-539,403		79,047.08		27
28 Administrative & General under contract (see instructions)		104,062			542.64		28
29 Maintenance & Repairs							29
30 Operation of Plant		308,342			10,587.20		30
31 Laundry & Linen Service							31
32 Housekeeping		382,584			24,377.60		32
33 Housekeeping under contract (see instructions)							33
34 Dietary							34
35 Dietary under contract (see instructions)		64,135			2,085.70		35
36 Cafeteria							36
37 Maintenance of Personnel							37
38 Nursing Administration		1,354,822			28,787.20		38
39 Central Services and Supply							39
40 Pharmacy							40
41 Medical Records & Medical Records Library		303,024			13,332.80		41
42 Social Service		847,003			26,811.20		42
43 Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		25,010,593		25,010,593	689,485.94	36.27	1
2	Excluded area salaries (see instructions)			217,118	217,118	4,631.32	46.88	2
3	Subtotal salaries (line 1 minus line 2)		25,010,593	-217,118	24,793,475	684,854.62	36.20	3
4	Subtotal other wages & related costs (see instructions)		764,073	1,423,949	2,188,022	29,869.16	73.25	4
5	Subtotal wage-related costs (see instructions)		5,328,770		5,328,770		21.49%	5
6	Total (sum of lines 3 through 5)		31,103,436	1,206,831	32,310,267	714,723.78	45.21	6
7	Total overhead cost (see instructions)		6,709,366	-539,403	6,169,963	185,571.42	33.25	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	372,789	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)	3,093,378	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)	26,738	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	166,472	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	1,803,104	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance		19
20	State or Federal Unemployment Taxes	127,104	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	-861,098	22
23	Tuition Reimbursement		23
24	Total Wage Related cost (Sum of lines 1-23)	4,728,487	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	764,073	4,728,487	1
2	Hospital	764,073	4,687,156	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		41,331	18

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: 06/01/2020 To: 05/31/2021	Run Date: 09/23/2021 Run Time: 12:06 Version: 2020.06 (08/18/2021)
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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

Health Financial Systems Compu-Max 2552-10

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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		3,579,031	3,579,031	144,882	3,723,913	-273,806	3,450,107	1
2	00200	Cap Rel Costs-Mvble Equip		1,075,510	1,075,510	42,768	1,118,278	-27,769	1,090,509	2
3	00300	Other Cap Rel Costs		172,662	172,662	-172,662			-0-	3
4	00400	Employee Benefits Department		4,621,841	4,621,841		4,621,841	71,064	4,692,905	4
5	00500	Administrative & General	3,345,394	7,711,847	11,057,241	-742,424	10,314,817	-1,974,539	8,340,278	5
7	00700	Operation of Plant	308,342	790,349	1,098,691	-15,002	1,083,689	-31,952	1,051,737	7
8	00800	Laundry & Linen Service		425,399	425,399		425,399		425,399	8
9	00900	Housekeeping	382,584	72,907	455,491		455,491		455,491	9
10	01000	Dietary		1,648,256	1,648,256		1,648,256	-265,627	1,382,629	10
13	01300	Nursing Administration	1,354,822	15,380	1,370,202		1,370,202		1,370,202	13
16	01600	Medical Records & Library	303,024	5,044	308,068		308,068	-115	307,953	16
17	01700	Social Service	847,003	16,914	863,917		863,917		863,917	17
22	02200	I&R Services-Other Prgm Costs Apprvd				183,750	183,750		183,750	22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	10,499,955	321,493	10,821,448	1,262,929	12,084,377	-181,909	11,902,468	30
		ANCILLARY SERVICE COST CENTERS								
54	05400	Radiology-Diagnostic		278,378	278,378	-201,913	76,465	-24,974	51,491	54
54.01	05401	RADIOLOGY-SUA				192,261	192,261	-61,156	131,105	54.01
60	06000	Laboratory	31,356	1,222,062	1,253,418	9,652	1,263,070		1,263,070	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	650,933	3,529	654,462		654,462		654,462	65
66	06600	Physical Therapy	2,531,587	188,783	2,720,370	-161,766	2,558,604	-26,501	2,532,103	66
67	06700	Occupational Therapy	2,178,018	69,894	2,247,912	113,236	2,361,148	-53,595	2,307,553	67
68	06800	Speech Pathology	1,007,122	15,213	1,022,335	48,530	1,070,865	-2	1,070,863	68
71	07100	Medical Supplies Charged to Patients	192,062	1,036,601	1,228,663	-791,894	436,769	-258	436,511	71
73	07300	Drugs Charged to Patients	1,078,883	1,092,481	2,171,364		2,171,364		2,171,364	73
76	03550	PSYCHOLOGY	131,311	1,190	132,501	-132,501				76
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
92	09200	Observation Beds (Non-Distinct Part)								92
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM								93.99
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
113	11300	Interest Expense		7,032	7,032		7,032	-7,032		113
118		SUBTOTALS (sum of lines 1-117)	24,842,396	24,371,796	49,214,192	-220,154	48,994,038	-2,858,171	46,135,867	118
		NONREIMBURSABLE COST CENTERS								
192	19200	Physicians' Private Offices								192
194	07951	MARKETING NRCC				220,154	220,154		220,154	194
194.10	07960	OTHER NRCC								194.10
200		TOTAL (sum of lines 118-199)	24,842,396	24,371,796	49,214,192		49,214,192	-2,858,171	46,356,021	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		11,572	1
2	INSURANCE	A	Cap Rel Costs-Mvble Equip	2		3,416	2
3	INSURANCE	A					3
500	Total reclassifications					14,988	500
	Code Letter - A						
1	MARKETING	B	MARKETING NRCC	194	217,118	3,036	1
2	MARKETING	B					2
500	Total reclassifications				217,118	3,036	500
	Code Letter - B						
1	PHYSICIANS	C	Adults & Pediatrics	30	322,285		1
2	PHYSICIANS	C					2
500	Total reclassifications				322,285		500
	Code Letter - C						
1	COMS RECLASS (MEDICAL SUPPLIES)	D	Adults & Pediatrics	30		806,896	1
2	COMS RECLASS (MEDICAL SUPPLIES)	D					2
500	Total reclassifications					806,896	500
	Code Letter - D						
1	SERVICE UNDER ARRANGEMENT	E	RADIOLOGY-SUA	54.01		192,261	1
2	SERVICE UNDER ARRANGEMENT	E					2
500	Total reclassifications					192,261	500
	Code Letter - E						
1	INTERNS & RESIDENTS	F	I&R Services-Other Prgm Costs	22		183,750	1
2	INTERNS & RESIDENTS	F					2
500	Total reclassifications					183,750	500
	Code Letter - F						
1	CONTRACT SERVICES	G	Laboratory	60		9,652	1
2	CONTRACT SERVICES	G					2
500	Total reclassifications					9,652	500
	Code Letter - G						
1	REHAB TECH RECLASS	H	Occupational Therapy	67	112,225	1,011	1
2	REHAB TECH RECLASS	H	Speech Pathology	68	48,097	433	2
3	REHAB TECH RECLASS	H					3
500	Total reclassifications				160,322	1,444	500
	Code Letter - H						
1	DEPT 295 MISC RECLASS	I	Adults & Pediatrics	30	131,311	2,437	1
2	DEPT 295 MISC RECLASS	I					2
3	DEPT 295 MISC RECLASS	I					3
500	Total reclassifications				131,311	2,437	500
	Code Letter - I						
1	OXYGEN RECLASS	J	Medical Supplies Charged to P	71		15,002	1
2	OXYGEN RECLASS	J					2
500	Total reclassifications					15,002	500
	Code Letter - J						
	GRAND TOTAL (Increases)				831,036	1,229,466	

(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

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	DECREASES				Wkst A-7 Ref.	
			COST CENTER	LINE #	SALARY	OTHER		
		1	6	7	8	9	10	
1	INSURANCE	A					12	1
2	INSURANCE	A					12	2
3	INSURANCE	A	Administrative & General	5		14,988		3
500	Total reclassifications					14,988		500
	Code letter - A							
1	MARKETING	B						1
2	MARKETING	B	Administrative & General	5	217,118	3,036		2
500	Total reclassifications				217,118	3,036		500
	Code letter - B							
1	PHYSICIANS	C						1
2	PHYSICIANS	C	Administrative & General	5	322,285			2
500	Total reclassifications				322,285			500
	Code letter - C							
1	COMS RECLASS (MEDICAL SUPPLIES)	D						1
2	COMS RECLASS (MEDICAL SUPPLIES)	D	Medical Supplies Charged to P	71		806,896		2
500	Total reclassifications					806,896		500
	Code letter - D							
1	SERVICE UNDER ARRANGEMENT	E						1
2	SERVICE UNDER ARRANGEMENT	E	Radiology-Diagnostic	54		192,261		2
500	Total reclassifications					192,261		500
	Code letter - E							
1	INTERNS & RESIDENTS	F						1
2	INTERNS & RESIDENTS	F	Administrative & General	5		183,750		2
500	Total reclassifications					183,750		500
	Code letter - F							
1	CONTRACT SERVICES	G						1
2	CONTRACT SERVICES	G	Radiology-Diagnostic	54		9,652		2
500	Total reclassifications					9,652		500
	Code letter - G							
1	REHAB TECH RECLASS	H						1
2	REHAB TECH RECLASS	H						2
3	REHAB TECH RECLASS	H	Physical Therapy	66	160,322	1,444		3
500	Total reclassifications				160,322	1,444		500
	Code letter - H							
1	DEPT 295 MISC RECLASS	I						1
2	DEPT 295 MISC RECLASS	I	Administrative & General	5		1,247		2
3	DEPT 295 MISC RECLASS	I	PSYCHOLOGY	76	131,311	1,190		3
500	Total reclassifications				131,311	2,437		500
	Code letter - I							
1	OXYGEN RECLASS	J						1
2	OXYGEN RECLASS	J	Operation of Plant	7		15,002		2
500	Total reclassifications					15,002		500
	Code letter - J							
	GRAND TOTAL (Decreases)				831,036	1,229,466		

(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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THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2020 To: 05/31/2021	Run Date: 09/23/2021 Run Time: 12:06 Version: 2020.06 (08/18/2021)
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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	17,659,532				2,439	17,657,093		3
4	Building Improvements	13,099,457	693,959		693,959	308,090	13,485,326		4
5	Fixed Equipment								5
6	Movable Equipment	9,353,871	1,142,772		1,142,772	1,297,468	9,199,175		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	40,133,600	1,836,731		1,836,731	1,607,997	40,362,334		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	40,133,600	1,836,731		1,836,731	1,607,997	40,362,334		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	1,666,987	1,912,044					3,579,031	1
2	Cap Rel Costs-Mvble Equip	687,015	388,495					1,075,510	2
3	Total (sum of lines 1-2)	2,354,002	2,300,539					4,654,541	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	31,163,159		31,163,159	0.772085		133,310		133,310	1
2	Cap Rel Costs-Mvble Equip	9,199,175		9,199,175	0.227915		39,352		39,352	2
3	Total (sum of lines 1-2)	40,362,334		40,362,334	1.000000		172,662		172,662	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	1,843,648	1,139,554	322,023	11,572	133,310		3,450,107	1
2	Cap Rel Costs-Mvble Equip	659,246	388,495		3,416	39,352		1,090,509	2
3	Total (sum of lines 1-2)	2,502,894	1,528,049	322,023	14,988	172,662		4,540,616	3

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

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		Wkst. A-7 Ref.	
				COST CENTER	LINE#		
		1	2	3	4	5	
1	Investment income-buildings & fixtures (chapter 2)			Cap Rel Costs-Bldg & Fixt	1		1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)						7
8	Television and radio service (chapter 21)						8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-171,388				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1	1,567,632				12
13	Laundry and linen service						13
14	Cafeteria - employees and guests						14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients						16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts						18
19	Nursing 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	-7,032	Interest Expense	113	11	37
37.01	DEPRECIATION	A	-917	Cap Rel Costs-Bldg & Fixt	1	9	37.01
37.02	DEPRECIATION	A	5	Cap Rel Costs-Mvble Equip	2	9	37.02
37.03	INSURANCE	A	95,553	Employee Benefits Department	4		37.03
37.04	INSURANCE	A	-432,800	Administrative & General	5		37.04
37.05	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-267,517	Administrative & General	5		37.05
37.06	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	44	Operation of Plant	7		37.06
37.07	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-12,710	Dietary	10		37.07
37.08	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-10,521	Adults & Pediatrics	30		37.08
37.09	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-26,501	Physical Therapy	66		37.09
37.10	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-50,000	Occupational Therapy	67		37.10
37.11	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-256	Medical Supplies Charged to Patients	71		37.11
37.12	PATIENT TELEPHONE	A	-14,196	Cap Rel Costs-Mvble Equip	2	9	37.12
37.13	PATIENT TELEPHONE	A	-5,629	Employee Benefits Department	4		37.13
37.14	PATIENT TELEPHONE	A	-36,646	Administrative & General	5		37.14
37.15	PATIENT TELEVISION	A	-4,505	Cap Rel Costs-Mvble Equip	2	9	37.15
37.16	PATIENT TELEVISION	A	-19,773	Administrative & General	5		37.16
37.17	PRINTING	A	-6,973	Administrative & General	5	9	37.17
37.18	LOBBYING EXPENSE	A	-66	Employee Benefits Department	4		37.18
37.19	LOBBYING EXPENSE	A	-2,314	Administrative & General	5		37.19
37.20	LOBBYING EXPENSE	A	4	Operation of Plant	7		37.20
37.21	LOBBYING EXPENSE	A	-4	Medical Records & Library	16		37.21
37.22	LOBBYING EXPENSE	A	-3	Occupational Therapy	67		37.22
37.23	LOBBYING EXPENSE	A	-2	Speech Pathology	68		37.23
37.24	LOBBYING EXPENSE	A	-2	Medical Supplies Charged to Patients	71		37.24
37.25	LEGAL FEES	A	-50,583	Administrative & General	5		37.25
37.26	MISCELLANEOUS INCOME	B	-12,661	Administrative & General	5		37.26
37.27	MISCELLANEOUS INCOME	B	-625	Dietary	10		37.27
37.28	MISCELLANEOUS INCOME	B	-111	Medical Records & Library	16		37.28

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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	
37.29	PATIENT TRANSPORTATION	A	-9,073	Cap Rel Costs-Mvble Equip	2	9	37.29
37.30	PATIENT TRANSPORTATION	A	-18,794	Employee Benefits Department	4		37.30
37.31	PATIENT TRANSPORTATION	A	-60,856	Administrative & General	5		37.31
37.32	PATIENT TRANSPORTATION	A	-26,360	Operation of Plant	7		37.32
37.33	MISC. TAX	A	-2,618,675	Administrative & General	5		37.33
37.34	PROFESSIONAL FEES	A	-10,161	Administrative & General	5		37.34
37.35	CLINICAL PSYCHOLOGY	A	-39,000	Administrative & General	5		37.35
37.36	CONTRACT SERVICES WU	A	-2,567	Administrative & General	5		37.36
37.37	CONTRACT SERVICES WU	A	-3,450	Radiology-Diagnostic	54		37.37
37.38	CONTRACT SERVICES WU	A	-3,592	Occupational Therapy	67		37.38
37.39	PHYSICIANS	A	-595,146	Administrative & General	5		37.39
38							38
39							39
40							40
41							41
42							42
43							43
44							44
45							45
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-2,858,171				50

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1

(2) Basis for adjustment (see instructions)

A. Costs - if cost, including applicable overhead, can be determined

B. Amount Received - if cost cannot be determined

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

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

WORKSHEET A-8-1

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

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1	5	Administrative & General	TO OFFSET MANAGEMENT FEES		1,146,335	-1,146,335		1
2	1	Cap Rel Costs-Bldg & Fixt	TO INCLUDE ALLOWABLE HOME OFFICE COS	177,578		177,578	9	2
3	1	Cap Rel Costs-Bldg & Fixt	TO INCLUDE ALLOWABLE HOME OFFICE COS	322,023		322,023	11	3
3.01	5	Administrative & General	TO INCLUDE ALLOWABLE HOME OFFICE COS	3,120,922		3,120,922		3.01
3.02	5	Administrative & General	TO INCLUDE ALLOWABLE HOME OFFICE COS	394,970		394,970		3.02
3.03	2	Cap Rel Costs-Mvble Equip	INTERCOMPANY WAGE AND EXPENSE TRANSF	4,865	4,865		10	3.03
3.04	3	Other Cap Rel Costs	INTERCOMPANY WAGE AND EXPENSE TRANSF	4	4			3.04
3.05	4	Employee Benefits Department	INTERCOMPANY WAGE AND EXPENSE TRANSF	3,144,922	3,144,922			3.05
3.06	5	Administrative & General	INTERCOMPANY WAGE AND EXPENSE TRANSF	2,282,328	2,282,328			3.06
3.07	7	Operation of Plant	INTERCOMPANY WAGE AND EXPENSE TRANSF	11,980	11,980			3.07
3.08	8	Laundry & Linen Service	INTERCOMPANY WAGE AND EXPENSE TRANSF	-660	-660			3.08
3.09	9	Housekeeping	INTERCOMPANY WAGE AND EXPENSE TRANSF	89	89			3.09
3.10	10	Dietary	INTERCOMPANY WAGE AND EXPENSE TRANSF	-19,050	-19,050			3.10
3.11	13	Nursing Administration	INTERCOMPANY WAGE AND EXPENSE TRANSF	339	339			3.11
3.12	16	Medical Records & Library	INTERCOMPANY WAGE AND EXPENSE TRANSF	-303	-303			3.12
3.13	30	Adults & Pediatrics	INTERCOMPANY WAGE AND EXPENSE TRANSF	11,876	11,876			3.13
3.14	54	Radiology-Diagnostic	INTERCOMPANY WAGE AND EXPENSE TRANSF	-2,701	-2,701			3.14
3.15	60	Laboratory	INTERCOMPANY WAGE AND EXPENSE TRANSF	-1,225	-1,225			3.15
3.16	66	Physical Therapy	INTERCOMPANY WAGE AND EXPENSE TRANSF	-159	-159			3.16
3.17	67	Occupational Therapy	INTERCOMPANY WAGE AND EXPENSE TRANSF	448	448			3.17
3.18	68	Speech Pathology	INTERCOMPANY WAGE AND EXPENSE TRANSF	53	53			3.18
3.19	71	Medical Supplies Charged to Patients	INTERCOMPANY WAGE AND EXPENSE TRANSF	176,976	176,976			3.19
3.20	73	Drugs Charged to Patients	INTERCOMPANY WAGE AND EXPENSE TRANSF	44,324	44,324			3.20
3.21	113	Interest Expense	INTERCOMPANY WAGE AND EXPENSE TRANSF	7,032	7,032		11	3.21
3.22	5	Administrative & General	RELATED PARTY - BJC	73,583	262,007	-188,424		3.22
3.23	7	Operation of Plant	RELATED PARTY - BJC	2,135	7,775	-5,640		3.23
3.24	10	Dietary	RELATED PARTY - BJC	95,512	347,804	-252,292		3.24
3.25	30	Adults & Pediatrics	RELATED PARTY - BJC	355	355			3.25
3.26	54	Radiology-Diagnostic	RELATED PARTY - BJC	24,839	46,363	-21,524		3.26
3.27	54.01	RADIOLOGY-SUA	RELATED PARTY - BJC	55,443	116,599	-61,156		3.27
3.28	60	Laboratory	RELATED PARTY - BJC	544,938	544,938			3.28
3.29	71	Medical Supplies Charged to Patients	RELATED PARTY - BJC	-1,400	-1,400			3.29
3.30	1	Cap Rel Costs-Bldg & Fixt	RELATED PARTY - RENT		539,355	-539,355	10	3.30
3.31	1	Cap Rel Costs-Bldg & Fixt	RELATED PARTY - LEASE BJC ST PT	1,139,553	1,372,688	-233,135	10	3.31
4								4
5		TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12		11,611,589	10,043,957	1,567,632		5

* The amounts on lines 1 through 4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which have not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

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

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

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

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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	

				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		HEALTH CARE	6
7	B		50.00	BJC HEALTH CARE		HEALTH CARE	7
8	G	ENCOMPASS HEALTH CORPORATION				HEALTH CARE	8
9	G	BARNES JEWISH CHRISTIAN HOSPIT				HEALTH CARE	9
9.01	G	BARNES JEWISH ST PETERS HOSPIT				HEALTH CARE	9.01
10							10

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

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

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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	322,285		322,285	211,500	1,484	150,897	7,545	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	322,285		322,285		1,484	150,897	7,545	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					150,897	171,388	171,388	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					150,897	171,388	171,388	200

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B PART I

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS- TRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	3,450,107	3,450,107					1
2	Cap Rel Costs-Mvble Equip	1,090,509		1,090,509				2
4	Employee Benefits Department	4,692,905			4,692,905			4
5	Administrative & General	8,340,278	239,611	75,736	530,071	9,185,696	9,185,696	5
7	Operation of Plant	1,051,737	10,779	3,407	58,248	1,124,171	278,793	7
8	Laundry & Linen Service	425,399	29,470	9,315		464,184	115,117	8
9	Housekeeping	455,491	14,496	4,582	72,273	546,842	135,616	9
10	Dietary	1,382,629	191,450	60,513		1,634,592	405,377	10
13	Nursing Administration	1,370,202	14,204	4,490	255,935	1,644,831	407,916	13
16	Medical Records & Library	307,953	22,222	7,024	57,243	394,442	97,821	16
17	Social Service	863,917	14,443	4,565	160,005	1,042,930	258,646	17
22	I&R Services-Other Prgm Costs Apprvd	183,750				183,750	45,570	22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	11,902,468	2,068,859	653,924	2,069,205	16,694,456	4,140,215	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	51,491				51,491	12,770	54
54.01	RADIOLOGY-SUA	131,105				131,105		54.01
60	Laboratory	1,263,070	18,187	5,748	5,923	1,292,928	320,645	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	654,462	13,195	4,171	122,966	794,794	197,108	65
66	Physical Therapy	2,532,103	201,645	63,736	447,949	3,245,433	804,864	66
67	Occupational Therapy	2,307,553	117,536	37,151	432,643	2,894,883	717,928	67
68	Speech Pathology	1,070,863	15,585	4,926	199,338	1,290,712	320,095	68
71	Medical Supplies Charged to Patients	436,511	75,029	23,715	36,282	571,537	141,741	71
73	Drugs Charged to Patients	2,171,364	43,170	13,645	203,809	2,431,988	603,131	73
76	PSYCHOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	46,135,867	3,089,881	976,648	4,651,890	45,620,765	9,003,353	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		357,412	112,971		470,383	116,655	192
194	MARKETING NRCC	220,154	2,814	890	41,015	264,873	65,688	194
194.10	OTHER NRCC							194.10
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	46,356,021	3,450,107	1,090,509	4,692,905	46,356,021	9,185,696	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
7	Operation of Plant	1,402,964						7
8	Laundry & Linen Service	12,922	592,223					8
9	Housekeeping	6,356		688,814				9
10	Dietary	83,944		41,788	2,165,701			10
13	Nursing Administration	6,228		3,100		2,062,075		13
16	Medical Records & Library	9,744		4,850			506,857	16
17	Social Service	6,333		3,153				17
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	907,122	592,223	451,575	2,165,701	2,062,075	249,149	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic						571	54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory	7,974		3,970			18,291	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	5,786		2,880			7,934	65
66	Physical Therapy	88,414		44,014			60,974	66
67	Occupational Therapy	51,535		25,655			62,299	67
68	Speech Pathology	6,833		3,402			26,193	68
71	Medical Supplies Charged to Patients	32,898		16,377			4,673	71
73	Drugs Charged to Patients	18,928		9,423			76,773	73
76	PSYCHOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	1,245,017	592,223	610,187	2,165,701	2,062,075	506,857	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	156,713		78,013				192
194	MARKETING NRCC	1,234		614				194
194.10	OTHER NRCC							194.10
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,402,964	592,223	688,814	2,165,701	2,062,075	506,857	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
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
13	Nursing Administration							13
16	Medical Records & Library							16
17	Social Service	1,311,062						17
22	I&R Services-Other Prgm Costs Apprvd		229,320					22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,311,062	229,320	28,802,898	-229,320	28,573,578		30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic			64,832		64,832		54
54.01	RADIOLOGY-SUA			131,105		131,105		54.01
60	Laboratory			1,643,808		1,643,808		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			1,008,502		1,008,502		65
66	Physical Therapy			4,243,699		4,243,699		66
67	Occupational Therapy			3,752,300		3,752,300		67
68	Speech Pathology			1,647,235		1,647,235		68
71	Medical Supplies Charged to Patients			767,226		767,226		71
73	Drugs Charged to Patients			3,140,243		3,140,243		73
76	PSYCHOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	1,311,062	229,320	45,201,848	-229,320	44,972,528		118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices			821,764		821,764		192
194	MARKETING NRCC			332,409		332,409		194
194.10	OTHER NRCC							194.10
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,311,062	229,320	46,356,021	-229,320	46,126,701		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		239,611	75,736	315,347	315,347		5
7	Operation of Plant		10,779	3,407	14,186	9,571	23,757	7
8	Laundry & Linen Service		29,470	9,315	38,785	3,952	219	8
9	Housekeeping		14,496	4,582	19,078	4,656	108	9
10	Dietary		191,450	60,513	251,963	13,917	1,421	10
13	Nursing Administration		14,204	4,490	18,694	14,004	105	13
16	Medical Records & Library		22,222	7,024	29,246	3,358	165	16
17	Social Service		14,443	4,565	19,008	8,880	107	17
22	I&R Services-Other Prgm Costs Apprvd					1,564		22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		2,068,859	653,924	2,722,783	142,132	15,360	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic					438		54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory		18,187	5,748	23,935	11,008	135	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		13,195	4,171	17,366	6,767	98	65
66	Physical Therapy		201,645	63,736	265,381	27,632	1,497	66
67	Occupational Therapy		117,536	37,151	154,687	24,647	873	67
68	Speech Pathology		15,585	4,926	20,511	10,989	116	68
71	Medical Supplies Charged to Patients		75,029	23,715	98,744	4,866	557	71
73	Drugs Charged to Patients		43,170	13,645	56,815	20,706	321	73
76	PSYCHOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)		3,089,881	976,648	4,066,529	309,087	21,082	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		357,412	112,971	470,383	4,005	2,654	192
194	MARKETING NRCC		2,814	890	3,704	2,255	21	194
194.10	OTHER NRCC							194.10
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		3,450,107	1,090,509	4,540,616	315,347	23,757	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
7	Operation of Plant							7
8	Laundry & Linen Service	42,956						8
9	Housekeeping		23,842					9
10	Dietary		1,446	268,747				10
13	Nursing Administration		107		32,910			13
16	Medical Records & Library		168			32,937		16
17	Social Service		109				28,104	17
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	42,956	15,632	268,747	32,910	16,183	28,104	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic					37		54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory		137			1,189		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		100			516		65
66	Physical Therapy		1,523			3,964		66
67	Occupational Therapy		888			4,050		67
68	Speech Pathology		118			1,703		68
71	Medical Supplies Charged to Patients		567			304		71
73	Drugs Charged to Patients		326			4,991		73
76	PSYCHOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	42,956	21,121	268,747	32,910	32,937	28,104	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		2,700					192
194	MARKETING NRCC		21					194
194.10	OTHER NRCC							194.10
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	42,956	23,842	268,747	32,910	32,937	28,104	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
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
13	Nursing Administration							13
16	Medical Records & Library							16
17	Social Service							17
22	I&R Services-Other Prgm Costs Apprvd	1,564						22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		3,284,807		3,284,807			30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic		475		475			54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory		36,404		36,404			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		24,847		24,847			65
66	Physical Therapy		299,997		299,997			66
67	Occupational Therapy		185,145		185,145			67
68	Speech Pathology		33,437		33,437			68
71	Medical Supplies Charged to Patients		105,038		105,038			71
73	Drugs Charged to Patients		83,159		83,159			73
76	PSYCHOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)		4,053,309		4,053,309			118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		479,742		479,742			192
194	MARKETING NRCC		6,001		6,001			194
194.10	OTHER NRCC							194.10
200	Cross Foot Adjustments	1,564	1,564		1,564			200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,564	4,540,616		4,540,616			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 & Fxt	129,949						1
2	Cap Rel Costs-Mvble Equip		129,949					2
4	Employee Benefits Department			24,842,396				4
5	Administrative & General	9,025	9,025	2,805,991	-9,185,696	37,039,220		5
7	Operation of Plant	406	406	308,342		1,124,171	120,518	7
8	Laundry & Linen Service	1,110	1,110			464,184	1,110	8
9	Housekeeping	546	546	382,584		546,842	546	9
10	Dietary	7,211	7,211			1,634,592	7,211	10
13	Nursing Administration	535	535	1,354,822		1,644,831	535	13
16	Medical Records & Library	837	837	303,024		394,442	837	16
17	Social Service	544	544	847,003		1,042,930	544	17
22	I&R Services-Other Prgm Costs Apprvd					183,750		22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	77,924	77,924	10,953,551		16,694,456	77,924	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic					51,491		54
54.01	RADIOLOGY-SUA				-131,105			54.01
60	Laboratory	685	685	31,356		1,292,928	685	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	497	497	650,933		794,794	497	65
66	Physical Therapy	7,595	7,595	2,371,265		3,245,433	7,595	66
67	Occupational Therapy	4,427	4,427	2,290,243		2,894,883	4,427	67
68	Speech Pathology	587	587	1,055,219		1,290,712	587	68
71	Medical Supplies Charged to Patients	2,826	2,826	192,062		571,537	2,826	71
73	Drugs Charged to Patients	1,626	1,626	1,078,883		2,431,988	1,626	73
76	PSYCHOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	116,381	116,381	24,625,278	-9,316,801	36,303,964	106,950	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	13,462	13,462			470,383	13,462	192
194	MARKETING NRCC	106	106	217,118		264,873	106	194
194.10	OTHER NRCC							194.10
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	3,450,107	1,090,509	4,692,905		9,185,696	1,402,964	202
203	Unit Cost Multiplier (Wkst. B, Part I)	26.549700	8.391823	0.188907		0.247999	11.641116	203
204	Cost to be allocated (Per Wkst. B, Part II)					315,347	23,757	204
205	Unit Cost Multiplier (Wkst. B, Part II)					0.008514	0.197124	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
7	Operation of Plant							7
8	Laundry & Linen Service	37,250						8
9	Housekeeping		118,862					9
10	Dietary		7,211	111,750				10
13	Nursing Administration		535		37,250			13
16	Medical Records & Library		837			80,176,607		16
17	Social Service		544				37,250	17
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	37,250	77,924	111,750	37,250	39,413,164	37,250	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic					90,322		54
54.01	RADIOLOGY-SUA							54.01
60	Laboratory		685			2,893,151		60
62.30	BLOOD CLOTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		497			1,254,947		65
66	Physical Therapy		7,595			9,644,670		66
67	Occupational Therapy		4,427			9,854,252		67
68	Speech Pathology		587			4,143,153		68
71	Medical Supplies Charged to Patients		2,826			739,110		71
73	Drugs Charged to Patients		1,626			12,143,838		73
76	PSYCHOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	37,250	105,294	111,750	37,250	80,176,607	37,250	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		13,462					192
194	MARKETING NRCC		106					194
194.10	OTHER NRCC							194.10
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	592,223	688,814	2,165,701	2,062,075	506,857	1,311,062	202
203	Unit Cost Multiplier (Wkst. B, Part I)	15.898604	5.795073	19.379875	55.357718	0.006322	35.196295	203
204	Cost to be allocated (Per Wkst. B, Part II)	42,956	23,842	268,747	32,910	32,937	28,104	204
205	Unit Cost Multiplier (Wkst. B, Part II)	1.153181	0.200586	2.404895	0.883490	0.000411	0.754470	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
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
13	Nursing Administration							13
16	Medical Records & Library							16
17	Social Service							17
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
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients							73
76	PSYCHOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	100						118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices							192
194	MARKETING NRCC							194
194.10	OTHER NRCC							194.10
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	229,320						202
203	Unit Cost Multiplier (Wkst. B, Part I)	2,293.200000						203
204	Cost to be allocated (Per Wkst. B, Part II)	1,564						204
205	Unit Cost Multiplier (Wkst. B, Part II)	15.640000						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	28,573,578		28,573,578	171,388	28,744,966	30
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	64,832		64,832		64,832	54
54.01	RADIOLOGY-SUA	131,105		131,105		131,105	54.01
60	Laboratory	1,643,808		1,643,808		1,643,808	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	1,008,502		1,008,502		1,008,502	65
66	Physical Therapy	4,243,699		4,243,699		4,243,699	66
67	Occupational Therapy	3,752,300		3,752,300		3,752,300	67
68	Speech Pathology	1,647,235		1,647,235		1,647,235	68
71	Medical Supplies Charged to Patients	767,226		767,226		767,226	71
73	Drugs Charged to Patients	3,140,243		3,140,243		3,140,243	73
76	PSYCHOLOGY						76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct Part)						92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	44,972,528		44,972,528	171,388	45,143,916	200
201	Less Observation Beds						201
202	Total (line 200 minus line 201)	44,972,528		44,972,528		45,143,916	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	39,413,164		39,413,164				30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	89,812	510	90,322	0.717787	0.717787	0.717787	54
54.01	RADIOLOGY-SUA	227,106		227,106	0.577285	0.577285	0.577285	54.01
60	Laboratory	2,893,151		2,893,151	0.568172	0.568172	0.568172	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,254,947		1,254,947	0.803621	0.803621	0.803621	65
66	Physical Therapy	9,644,670		9,644,670	0.440005	0.440005	0.440005	66
67	Occupational Therapy	9,854,252		9,854,252	0.380780	0.380780	0.380780	67
68	Speech Pathology	4,143,153		4,143,153	0.397580	0.397580	0.397580	68
71	Medical Supplies Charged to Patients	739,110		739,110	1.038040	1.038040	1.038040	71
73	Drugs Charged to Patients	12,143,838		12,143,838	0.258587	0.258587	0.258587	73
76	PSYCHOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	80,403,203	510	80,403,713				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	80,403,203	510	80,403,713				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: 06/01/2020 To: 05/31/2021	Run Date: 09/23/2021 Run Time: 12:06 Version: 2020.06 (08/18/2021)
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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	28,573,578		28,573,578	171,388	28,744,966	30
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	64,832		64,832		64,832	54
54.01	RADIOLOGY-SUA	131,105		131,105		131,105	54.01
60	Laboratory	1,643,808		1,643,808		1,643,808	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	1,008,502		1,008,502		1,008,502	65
66	Physical Therapy	4,243,699		4,243,699		4,243,699	66
67	Occupational Therapy	3,752,300		3,752,300		3,752,300	67
68	Speech Pathology	1,647,235		1,647,235		1,647,235	68
71	Medical Supplies Charged to Patients	767,226		767,226		767,226	71
73	Drugs Charged to Patients	3,140,243		3,140,243		3,140,243	73
76	PSYCHOLOGY						76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct Part)						92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	44,972,528		44,972,528	171,388	45,143,916	200
201	Less Observation Beds						201
202	Total (line 200 minus line 201)	44,972,528		44,972,528	171,388	45,143,916	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: 06/01/2020 To: 05/31/2021	Run Date: 09/23/2021 Run Time: 12:06 Version: 2020.06 (08/18/2021)
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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	39,413,164		39,413,164				30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	89,812	510	90,322	0.717787	0.717787	0.717787	54
54.01	RADIOLOGY-SUA	227,106		227,106	0.577285	0.577285	0.577285	54.01
60	Laboratory	2,893,151		2,893,151	0.568172	0.568172	0.568172	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,254,947		1,254,947	0.803621	0.803621	0.803621	65
66	Physical Therapy	9,644,670		9,644,670	0.440005	0.440005	0.440005	66
67	Occupational Therapy	9,854,252		9,854,252	0.380780	0.380780	0.380780	67
68	Speech Pathology	4,143,153		4,143,153	0.397580	0.397580	0.397580	68
71	Medical Supplies Charged to Patients	739,110		739,110	1.038040	1.038040	1.038040	71
73	Drugs Charged to Patients	12,143,838		12,143,838	0.258587	0.258587	0.258587	73
76	PSYCHOLOGY							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	80,403,203	510	80,403,713				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	80,403,203	510	80,403,713				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: 06/01/2020 To: 05/31/2021	Run Date: 09/23/2021 Run Time: 12:06 Version: 2020.06 (08/18/2021)
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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	64,832	475	64,357		54
54.01	RADIOLOGY-SUA	131,105		131,105		54.01
60	Laboratory	1,643,808	36,404	1,607,404		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy	1,008,502	24,847	983,655		65
66	Physical Therapy	4,243,699	299,997	3,943,702		66
67	Occupational Therapy	3,752,300	185,145	3,567,155		67
68	Speech Pathology	1,647,235	33,437	1,613,798		68
71	Medical Supplies Charged to Patients	767,226	105,038	662,188		71
73	Drugs Charged to Patients	3,140,243	83,159	3,057,084		73
76	PSYCHOLOGY					76
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
92	Observation Beds (Non-Distinct Part)					92
93.99	PARTIAL HOSPITALIZATION PROGRAM					93.99
	OTHER REIMBURSABLE COST CENTERS					
113	Interest Expense					113
200	Subtotal	16,398,950	768,502	15,630,448		200
201	Less Observation Beds					201
202	Total	16,398,950	768,502	15,630,448		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: 06/01/2020 To: 05/31/2021	Run Date: 09/23/2021 Run Time: 12:06 Version: 2020.06 (08/18/2021)
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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		64,832	90,322	0.717787	54
54.01	RADIOLOGY-SUA		131,105	227,106	0.577285	54.01
60	Laboratory		1,643,808	2,893,151	0.568172	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy		1,008,502	1,254,947	0.803621	65
66	Physical Therapy		4,243,699	9,644,670	0.440005	66
67	Occupational Therapy		3,752,300	9,854,252	0.380780	67
68	Speech Pathology		1,647,235	4,143,153	0.397580	68
71	Medical Supplies Charged to Patients		767,226	739,110	1.038040	71
73	Drugs Charged to Patients		3,140,243	12,143,838	0.258587	73
76	PSYCHOLOGY					76
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
92	Observation Beds (Non-Distinct Part)					92
93.99	PARTIAL HOSPITALIZATION PROGRAM					93.99
	OTHER REIMBURSABLE COST CENTERS					
113	Interest Expense					113
200	Subtotal		16,398,950	40,990,549		200
201	Less Observation Beds					201
202	Total		16,398,950	40,990,549		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: 06/01/2020 To: 05/31/2021	Run Date: 09/23/2021 Run Time: 12:06 Version: 2020.06 (08/18/2021)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D PART I

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

☒ Hospital
☐ PARHM Demonstration

☒ PPS
☐ TEFRA

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust- ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	3,284,807		3,284,807	37,250	88.18	12,971	1,143,783	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)	3,284,807		3,284,807	37,250		12,971	1,143,783	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: 06/01/2020 To: 05/31/2021	Run Date: 09/23/2021 Run Time: 12:06 Version: 2020.06 (08/18/2021)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 26-3028

WORKSHEET D
PART II

Check ☐ Title V ☒ Hospital ☐ SUB (Other) ☒ PPS
Applicable ☒ Title XVIII, Part A ☐ IPF ☐ 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	475	90,322	0.005259	34,810	183	54
54.01	RADIOLOGY-SUA		227,106		87,545		54.01
60	Laboratory	36,404	2,893,151	0.012583	1,007,569	12,678	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	24,847	1,254,947	0.019799	478,759	9,479	65
66	Physical Therapy	299,997	9,644,670	0.031105	3,432,807	106,777	66
67	Occupational Therapy	185,145	9,854,252	0.018788	3,524,820	66,224	67
68	Speech Pathology	33,437	4,143,153	0.008070	1,331,490	10,745	68
71	Medical Supplies Charged to Pat	105,038	739,110	0.142114	252,939	35,946	71
73	Drugs Charged to Patients	83,159	12,143,838	0.006848	4,330,856	29,658	73
76	PSYCHOLOGY						76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct						92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	768,502	40,990,549		14,481,595	271,690	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: 06/01/2020 To: 05/31/2021	Run Date: 09/23/2021 Run Time: 12:06 Version: 2020.06 (08/18/2021)
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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: 06/01/2020 To: 05/31/2021	Run Date: 09/23/2021 Run Time: 12:06 Version: 2020.06 (08/18/2021)
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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)	37,250		12,971		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)	37,250		12,971		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: 06/01/2020 To: 05/31/2021	Run Date: 09/23/2021 Run Time: 12:06 Version: 2020.06 (08/18/2021)
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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
62.30	BLOOD CLOTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
71	Medical Supplies Charged to Pat									71
73	Drugs Charged to Patients									73
76	PSYCHOLOGY									76
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
92	Observation Beds (Non-Distinct									92
93.99	PARTIAL HOSPITALIZATION PROGRAM									93.99
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

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: 06/01/2020 To: 05/31/2021	Run Date: 09/23/2021 Run Time: 12:06 Version: 2020.06 (08/18/2021)
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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

		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	90,322			34,810		510		54
54.01	RADIOLOGY-SUA	227,106			87,545				54.01
60	Laboratory	2,893,151			1,007,569				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	1,254,947			478,759				65
66	Physical Therapy	9,644,670			3,432,807				66
67	Occupational Therapy	9,854,252			3,524,820				67
68	Speech Pathology	4,143,153			1,331,490				68
71	Medical Supplies Charged to Pat	739,110			252,939				71
73	Drugs Charged to Patients	12,143,838			4,330,856				73
76	PSYCHOLOGY								76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	40,990,549			14,481,595		510		200

(A) Worksheet A line numbers

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2020 To: 05/31/2021	Run Date: 09/23/2021 Run Time: 12:06 Version: 2020.06 (08/18/2021)
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WORKSHEET D
PART V

			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	0.717787	510			366			54
54.01	RADIOLOGY-SUA	0.577285							54.01
60	Laboratory	0.568172							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.803621							65
66	Physical Therapy	0.440005							66
67	Occupational Therapy	0.380780							67
68	Speech Pathology	0.397580							68
71	Medical Supplies Charged to Pat	1.038040							71
73	Drugs Charged to Patients	0.258587							73
76	PSYCHOLOGY								76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		510			366			200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		510			366			202

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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: 06/01/2020 To: 05/31/2021	Run Date: 09/23/2021 Run Time: 12:06 Version: 2020.06 (08/18/2021)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D PART I

Check ☐ Title V ☒ Hospital
Applicable ☐ Title XVIII, Part A ☐ PARHM Demonstration
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)	3,284,807		3,284,807	37,250	88.18	5,442	479,876	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)	3,284,807		3,284,807	37,250		5,442	479,876	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: 06/01/2020 To: 05/31/2021	Run Date: 09/23/2021 Run Time: 12:06 Version: 2020.06 (08/18/2021)
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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	475	90,322	0.005259	10,071	53	54
54.01	RADIOLOGY-SUA		227,106		23,292		54.01
60	Laboratory	36,404	2,893,151	0.012583	291,047	3,662	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	24,847	1,254,947	0.019799	209,056	4,139	65
66	Physical Therapy	299,997	9,644,670	0.031105	1,385,754	43,104	66
67	Occupational Therapy	185,145	9,854,252	0.018788	1,404,990	26,397	67
68	Speech Pathology	33,437	4,143,153	0.008070	589,314	4,756	68
71	Medical Supplies Charged to Pat	105,038	739,110	0.142114	108,767	15,457	71
73	Drugs Charged to Patients	83,159	12,143,838	0.006848	1,814,047	12,423	73
76	PSYCHOLOGY						76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct						92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	768,502	40,990,549		5,836,338	109,991	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: 06/01/2020 To: 05/31/2021	Run Date: 09/23/2021 Run Time: 12:06 Version: 2020.06 (08/18/2021)
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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

		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: 06/01/2020 To: 05/31/2021	Run Date: 09/23/2021 Run Time: 12:06 Version: 2020.06 (08/18/2021)
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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

		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)	37,250		5,442		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)	37,250		5,442		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: 06/01/2020 To: 05/31/2021	Run Date: 09/23/2021 Run Time: 12:06 Version: 2020.06 (08/18/2021)
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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
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
71	Medical Supplies Charged to Pat									71
73	Drugs Charged to Patients									73
76	PSYCHOLOGY									76
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
92	Observation Beds (Non-Distinct									92
93.99	PARTIAL HOSPITALIZATION PROGRAM									93.99
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

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: 06/01/2020 To: 05/31/2021	Run Date: 09/23/2021 Run Time: 12:06 Version: 2020.06 (08/18/2021)
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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	90,322			10,071				54
54.01	RADIOLOGY-SUA	227,106			23,292				54.01
60	Laboratory	2,893,151			291,047				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	1,254,947			209,056				65
66	Physical Therapy	9,644,670			1,385,754				66
67	Occupational Therapy	9,854,252			1,404,990				67
68	Speech Pathology	4,143,153			589,314				68
71	Medical Supplies Charged to Pat	739,110			108,767				71
73	Drugs Charged to Patients	12,143,838			1,814,047				73
76	PSYCHOLOGY								76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	40,990,549			5,836,338				200

(A) Worksheet A line numbers

THE REHABILITATION INSTITUTE OF ST. Provider CCN: 26-3028	In Lieu of Form CMS-2552-10	Period : From: 06/01/2020 To: 05/31/2021	Run Date: 09/23/2021 Run Time: 12:06 Version: 2020.06 (08/18/2021)
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WORKSHEET D
PART V

			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	0.717787							54
54.01	RADIOLOGY-SUA	0.577285							54.01
60	Laboratory	0.568172							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.803621							65
66	Physical Therapy	0.440005							66
67	Occupational Therapy	0.380780							67
68	Speech Pathology	0.397580							68
71	Medical Supplies Charged to Pat	1.038040							71
73	Drugs Charged to Patients	0.258587							73
76	PSYCHOLOGY								76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

Page: 54

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: 06/01/2020 To: 05/31/2021	Run Date: 09/23/2021 Run Time: 12:06 Version: 2020.06 (08/18/2021)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 26-3028

WORKSHEET D-1 PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	37,250	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	37,250	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	37,250	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)	12,971	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)	28,744,966	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)	28,744,966	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 31)		32
33	Average semi-private room per diem charge (line 30 ÷ line 31)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	28,744,966	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: 06/01/2020 To: 05/31/2021	Run Date: 09/23/2021 Run Time: 12:06 Version: 2020.06 (08/18/2021)
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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)						771.68 38
39	Program general inpatient routine service cost (line 9 x line 38)						10,009,461 39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)						10,009,461 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)						5,797,208 48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						15,806,669 49
PASS THROUGH COST ADJUSTMENTS							
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						1,143,783 50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						271,690 51
52	Total Program excludable cost (sum of lines 50 and 51)						1,415,473 52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						14,391,196 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: 06/01/2020 To: 05/31/2021	Run Date: 09/23/2021 Run Time: 12:06 Version: 2020.06 (08/18/2021)
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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)					771.68	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: 06/01/2020 To: 05/31/2021	Run Date: 09/23/2021 Run Time: 12:06 Version: 2020.06 (08/18/2021)
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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 ☒ Other

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	37,250	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	37,250	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	37,250	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	5,442	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)	28,573,578	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)	28,573,578	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	28,573,578	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: 06/01/2020 To: 05/31/2021	Run Date: 09/23/2021 Run Time: 12:06 Version: 2020.06 (08/18/2021)
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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)						767.08 38
39	Program general inpatient routine service cost (line 9 x line 38)						4,174,449 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)						4,174,449 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)					2,315,065	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					6,489,514	49
PASS THROUGH COST ADJUSTMENTS							
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					479,876	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					109,991	51
52	Total Program excludable cost (sum of lines 50 and 51)					589,867	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)					771.68	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: 06/01/2020 To: 05/31/2021	Run Date: 09/23/2021 Run Time: 12:06 Version: 2020.06 (08/18/2021)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 26-3028

WORKSHEET D-3

Check ☐ Title V ☒ Hospital ☐ SNF ☐ ICF/IID ☒ PPS
 Applicable ☒ Title XVIII, Part A ☐ IPF ☐ NF ☐ PARHM Demo ☐ TEFRA
 Boxes: ☐ Title XIX ☐ IRF ☐ Swing Bed SNF ☐ PARHM CAH ☐ 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		13,704,157		30
	ANCILLARY SERVICE COST CENTERS				
54	Radiology-Diagnostic	0.717787	34,810	24,986	54
54.01	RADIOLOGY-SUA	0.577285	87,545	50,538	54.01
60	Laboratory	0.568172	1,007,569	572,472	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.803621	478,759	384,741	65
66	Physical Therapy	0.440005	3,432,807	1,510,452	66
67	Occupational Therapy	0.380780	3,524,820	1,342,181	67
68	Speech Pathology	0.397580	1,331,490	529,374	68
71	Medical Supplies Charged to Patients	1.038040	252,939	262,561	71
73	Drugs Charged to Patients	0.258587	4,330,856	1,119,903	73
76	PSYCHOLOGY				76
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
92	Observation Beds (Non-Distinct Part)				92
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		14,481,595	5,797,208	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		14,481,595		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: 06/01/2020 To: 05/31/2021	Run Date: 09/23/2021 Run Time: 12:06 Version: 2020.06 (08/18/2021)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 26-3028

WORKSHEET D-3

Check ☐ Title V ☒ Hospital ☐ SNF ☐ ICF/IID ☐ PPS
 Applicable ☐ Title XVIII, Part A ☐ IPF ☐ NF ☐ PARHM Demo ☐ TEFRA
 Boxes: ☒ Title XIX ☐ IRF ☐ Swing Bed SNF ☐ PARHM CAH ☒ 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		5,713,474		30
	ANCILLARY SERVICE COST CENTERS				
54	Radiology-Diagnostic	0.717787	10,071	7,229	54
54.01	RADIOLOGY-SUA	0.577285	23,292	13,446	54.01
60	Laboratory	0.568172	291,047	165,365	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.803621	209,056	168,002	65
66	Physical Therapy	0.440005	1,385,754	609,739	66
67	Occupational Therapy	0.380780	1,404,990	534,992	67
68	Speech Pathology	0.397580	589,314	234,299	68
71	Medical Supplies Charged to Patients	1.038040	108,767	112,904	71
73	Drugs Charged to Patients	0.258587	1,814,047	469,089	73
76	PSYCHOLOGY				76
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
92	Observation Beds (Non-Distinct Part)				92
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		5,836,338	2,315,065	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		5,836,338		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: 06/01/2020 To: 05/31/2021	Run Date: 09/23/2021 Run Time: 12:06 Version: 2020.06 (08/18/2021)
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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)	366			2
3	OPPS payments	154			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)	154			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	31			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)	123			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)	123			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	123			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)	123			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)	123			40
40.01	Sequestration adjustment (see instructions)				40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
40.03	Sequestration adjustment - PARHM pass-throughs				40.03
41	Interim payments	123			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			23,240,246		123
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	10/02/2020	14,375		3.52
		to	01/22/2021	46,701		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)			-61,076		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)			23,179,170		123
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)	8

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

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: 06/01/2020 To: 05/31/2021	Run Date: 09/23/2021 Run Time: 12:06 Version: 2020.06 (08/18/2021)
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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)	20,616,002		1
2	Medicare SSI ratio (IRF PPS only) (see instructions)	0.053900		2
3	Inpatient Rehabilitation LIP payments (see instructions)	1,768,853		3
4	Outlier payments	43,198		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)	4.18		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)	4.18		9
10	Average daily census (see instructions)	102,054795		10
11	Teaching Adjustment Factor (see instructions)	0.041639		11
12	Teaching Adjustment (see instructions)	858,430		12
13	Total PPS Payment (see instructions)	23,286,483		13
14	Nursing and allied health managed care payments (see instructions)			14
15	Organ acquisition DO NOT USE THIS LINE			15
16	Cost of physicians' services in a teaching hospital (see instructions)			16
17	Subtotal (see instructions)	23,286,483		17
18	Primary payer payments			18
19	Subtotal (line 17 less line 18)	23,286,483		19
20	Deductibles	169,716		20
21	Subtotal (line 19 minus line 20)	23,116,767		21
22	Coinsurance	219,575		22
23	Subtotal (line 21 minus line 22)	22,897,192		23
24	Allowable bad debts (exclude bad debts for professional services) (see instructions)	148,306		24
25	Adjusted reimbursable bad debts (see instructions)	96,399		25
26	Allowable bad debts for dual eligible beneficiaries (see instructions)	68,427		26
27	Subtotal (sum of lines 23 and 25)	22,993,591		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)	22,993,591		32
32.01	Sequestration adjustment (see instructions)			32.01
32.02	Demonstration payment adjustment amount after sequestration			32.02
33	Interim payments	23,179,170		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)	-185,579		35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	626,011		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

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: 06/01/2020 To: 05/31/2021	Run Date: 09/23/2021 Run Time: 12:06 Version: 2020.06 (08/18/2021)
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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	6,489,514		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	6,489,514		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	6,489,514		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges	5,713,474		8
9	Ancillary service charges	5,836,338		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)	11,549,812		12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahrge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)	11,549,812		16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	5,060,298		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)	6,489,514		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)	6,489,514		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)	6,489,514		31
32	Deductibles			32
33	Coinsurance	61,797		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)	6,427,717		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	6,427,717		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)	6,427,717		40
41	Interim payments	5,897,631		41
42	Balance due provider/program (line 40 minus line 41)	530,086		42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

Health Financial Systems Compu-Max 2552-10

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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)	12,971	7,242		26
27	Total inpatient days (see instructions)	37,250	37,250		27
28	Ratio of inpatient days to total inpatient days	0.348215	0.194416	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)			15,806,669	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)			15,806,669	41
Part B Reasonable Cost					
42	Reasonable cost (see instructions)			366	42
43	Primary payer payments (see instructions)				43
44	Total Part B reasonable cost (line 42 minus line 43)			366	44
45	Total reasonable cost (sum of lines 41 and 44)			15,807,035	45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.999977	46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.000023	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)	5,442	3,562		26
27	Total inpatient days (see instructions)	37,250	37,250		27
28	Ratio of inpatient days to total inpatient days	0.146094	0.095624	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	5,243,675				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	12,772,509				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-4,542,659				6
7	Inventory	339,843				7
8	Prepaid expenses	269,539				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	14,082,907				11
FIXED ASSETS						
12	Land					12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings	24,351,248				15
16	Accumulated depreciation	-15,134,666				16
17	Leasehold improvements	6,811,910				17
18	Accumulated depreciation	-2,727,774				18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	9,255,707				23
24	Accumulated depreciation	-7,123,959				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)	15,432,466				30
OTHER ASSETS						
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	8,704,059				34
35	Total other assets (sum of lines 31-34)	8,704,059				35
36	Total assets (sum of lines 11, 30 and 35)	38,219,432				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	1,141,358				37
38	Salaries, wages and fees payable	2,753,889				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	872,312				44
45	Total current liabilities (sum of lines 37 thru 44)	4,767,559				45
LONG TERM LIABILITIES						
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	21,849,041				49
50	Total long term liabilities (sum of lines 46 thru 49)	21,849,041				50
51	Total liabilities (sum of lines 45 and 50)	26,616,600				51
CAPITAL ACCOUNTS						
52	General fund balance	11,602,832				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)	11,602,832				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	38,219,432				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		11,760,223		1
2	Net income (loss) (from Worksheet G-3, line 29)		4,642,538		2
3	Total (sum of line 1 and line 2)		16,402,761		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)		16,402,761		11
12	Deductions (debit adjustments) (specify)				12
13	EQUITY DISTRIBUTION	2,478,655			13
14	MINORITY INTEREST	2,321,264			14
15	ROUNDING	10			15
16					16
17					17
18	Total deductions (sum of lines 12-17)		4,799,929		18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		11,602,832		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	EQUITY DISTRIBUTION				13
14	MINORITY INTEREST				14
15	ROUNDING				15
16					16
17					17
18	Total deductions (sum of lines 12-17)				18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)				19

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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	39,413,164		39,413,164	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)	39,413,164		39,413,164	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)	39,413,164		39,413,164	17
18	Ancillary services	40,990,550		40,990,550	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)	80,403,714		80,403,714	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		49,214,192	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)		49,214,192	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)	80,403,714	1
2	Less contractual allowances and discounts on patients' accounts	30,893,354	2
3	Net patient revenues (line 1 minus line 2)	49,510,360	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	49,214,192	4
5	Net income from service to patients (line 3 minus line 4)	296,168	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments	23,387	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts		10
11	Rebates and refunds of expenses		11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests	20	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	605	21
22	Rental of hosptial space	255,467	22
23	Governmental appropriations		23
24	Other (specify)	4,066,891	24
24.50	COVID-19 PHE FUNDING		24.50
25	Total other income (sum of lines 6-24)	4,346,370	25
26	Total (line 5 plus line 25)	4,642,538	26
29	Net income (or loss) for the period (line 26 minus line 28)	4,642,538	29