

Health Financial Systems Compu-Max 2552-10

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY**WORKSHEET S
PARTS I, II & III****PART I - COST REPORT STATUS**

Provider use only		1. ☐ Electronically prepared cost report 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: 11/16/2020	Time: 13:50
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 SSM SELECT REHAB ST LOUIS, LLC (26-3031) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 07/01/2019 and ending 06/30/2020, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) SCOTT A. ROMBERGER
Chief Financial Officer or Administrator of Provider(s)

VICE PRESIDENT
Title

11/16/2020 13:50
Date

PART III - SETTLEMENT SUMMARY

		TITLE XVIII					
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		-1,128,151	13		495,889	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		-1,128,151	13		495,889	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: 1027 BELLEVUE AVENUE	P.O. Box:		1
2	City: RICHMOND HEIGHTS	State: MO	ZIP Code: 63117	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	SSM SELECT REHAB ST LOUIS, LLC	26-3031	41180	5	12 / 08 / 2009	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: 07 / 01 / 2019	To: 06 / 30 / 2020	20
21	Type of control (see instructions)	4		21

Inpatient PPS Information

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.							24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	4,306	488	296	199	918		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

		1	2	3	
	Teaching Hospitals				
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.	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 osteopathci FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the IME FTE unweighted count. 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)	N	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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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2 PART I

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

Rural Providers				1	2		
105	Does this hospital qualify as a CAH?			N		105	
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106	
107	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes or 'N' for no in column 1. (see instructions)					107	
	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)						
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.			N		108	
			Physical	Occupational	Speech	Respiratory	
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.			N	Y	Y	109

		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:	562,877			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.	N			122

Health Financial Systems Compu-Max 2552-10

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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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	HB0312	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: SELECT MEDICAL	Contractor's Name: NOVITAS SOLUTIONS INC	Contractor's Number: 12001	141
142	Street: 4714 GETTYSBURG ROAD	P.O. Box:		142
143	City: MECHANICSBURG	State: PA	ZIP Code: 17055	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.	Y	N	145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, chapter 40, §4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N		147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N		148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	N		149

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

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

Multicampus

165	Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter 'Y' for yes or 'N' for no.	Y					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	
	SSM RICHMOND HEIGHTS	ST LOUIS	MO	63117	41180	185.17	
	SSM BRIDGETON	ST LOUIS	MO	63044	41180	203.19	
	SSM LAKE ST. LOUIS	ST CHARLES	MO	63367	41180	81.82	

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)	N			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.	N			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

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)	Y	10/29/2020	Y	10/29/2020	16
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		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

Health Financial Systems Compu-Max 2552-10

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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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	
	1	2	
Home Office Costs			
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: TOM	Last name: RIVES	Title: SENIOR REIMBURSEMENT ANALY
42	Employer: SELECT MEDICAL		
43	Phone number: 717-972-8110	E-mail Address: TRIVES@SELECTMEDICAL.COM	

Health Financial Systems Compu-Max 2552-10

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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	125	45,750			16,039	4,306	36,859	1
2	HMO and other (see instructions)						7,897	918		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)		125	45,750			16,039	4,306	36,859	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)		125	45,750			16,039	4,306	36,859	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)		125							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

Health Financial Systems Compu-Max 2552-10

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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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)					1,348	311	2,888	1
2	HMO and other (see instructions)					591	69		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)		470.18			1,348	311	2,888	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)		470.18						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

Health Financial Systems Compu-Max 2552-10

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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	33,364,240			977,980.00		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)			123,451		3,973.00		10
OTHER WAGES & RELATED COSTS							
11 Contract labor (see instructions)							11
12 Contract management and administrative services							12
13 Contract labor: Physician-Part A - Administrative		193,050			1,287.00		13
14 Home office salaries & wage-related costs							14
14.01 Home office salaries							14.01
14.02 Related organization salaries							14.02
15 Home office: Physician Part A - Administrative							15
16 Home office & Contract Physicians Part A - Teaching							16
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)							17
18 Wage-related costs (other)(see instructions)							18
19 Excluded areas							19
20 Non-physician anesthetist Part A							20
21 Non-physician anesthetist Part B							21
22 Physician Part A - Administrative							22
22.01 Physician Part A - Teaching							22.01
23 Physician Part B							23
24 Wage-related costs (RHC/FOHC)							24
25 Interns & residents (in an approved program)							25
25.50 Home office wage-related							25.50
25.51 Related organization wage-related							25.51
25.52 Home office: Physician Part A - Administrative - wage-related							25.52
25.53 Home office: Physicians Part A - Teaching - wage-related (core)							25.53
OVERHEAD COSTS - DIRECT SALARIES							
26 Employee Benefits Department		379,295			13,059.00		26
27 Administrative & General		4,737,804	-123,451		106,739.00		27
28 Administrative & General under contract (see instructions)							28
29 Maintenance & Repairs							29
30 Operation of Plant		232,127			8,122.00		30
31 Laundry & Linen Service							31
32 Housekeeping		482,077			32,557.00		32
33 Housekeeping under contract (see instructions)							33
34 Dietary		555,860			30,191.00		34
35 Dietary under contract (see instructions)							35
36 Cafeteria							36
37 Maintenance of Personnel							37
38 Nursing Administration		640,307			11,991.00		38
39 Central Services and Supply							39
40 Pharmacy							40
41 Medical Records & Medical Records Library		175,329			9,905.00		41
42 Social Service							42
43 Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		33,364,240		33,364,240	977,980.00	34.12	1
2	Excluded area salaries (see instructions)			123,451	123,451	3,973.00	31.07	2
3	Subtotal salaries (line 1 minus line 2)		33,364,240	-123,451	33,240,789	974,007.00	34.13	3
4	Subtotal other wages & related costs (see instructions)		193,050		193,050	1,287.00	150.00	4
5	Subtotal wage-related costs (see instructions)							5
6	Total (sum of lines 3 through 5)		33,557,290	-123,451	33,433,839	975,294.00	34.28	6
7	Total overhead cost (see instructions)		7,202,799	-123,451	7,079,348	212,564.00	33.30	7

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

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

Part B - Other Than Core Related Cost

25	Other Wage Related Costs (SPECIFY)		25
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Health Financial Systems Compu-Max 2552-10

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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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			1
2	Hospital			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			18

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SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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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				3,944,667	3,944,667		3,944,667	1
2	00200	Cap Rel Costs-Mvble Equip		20,783,948	20,783,948	-14,042,857	6,741,091	-4,718,679	2,022,412	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	379,295	134,384	513,679	79,718	593,397	-494	592,903	4
5	00500	Administrative & General	4,737,804	745,073	5,482,877	9,842,547	15,325,424	1,789,049	17,114,473	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	232,127	234,381	466,508		466,508		466,508	7
8	00800	Laundry & Linen Service		278,829	278,829		278,829	-2,997	275,832	8
9	00900	Housekeeping	482,077	348,226	830,303		830,303	-26	830,277	9
10	01000	Dietary	555,860	1,314,721	1,870,581	-278,147	1,592,434	-3,597	1,588,837	10
11	01100	Cafeteria				278,147	278,147	-58,469	219,678	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	640,307	141,758	782,065		782,065		782,065	13
14	01400	Central Services & Supply								14
15	01500	Pharmacy								15
16	01600	Medical Records & Library	175,329	34,519	209,848		209,848	-6,940	202,908	16
17	01700	Social Service								17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	10,847,978	2,516,870	13,364,848		13,364,848	580,161	13,945,009	30
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room		94,851	94,851		94,851	-25,304	69,547	50
54	05400	Radiology-Diagnostic		235,947	235,947		235,947	-86,303	149,644	54
60	06000	Laboratory		734,476	734,476		734,476	-384,482	349,994	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	160,785	49,098	209,883		209,883	-319	209,564	65
66	06600	Physical Therapy	7,844,405	1,518,465	9,362,870		9,362,870	-5,249,145	4,113,725	66
67	06700	Occupational Therapy	4,139,696	718,224	4,857,920		4,857,920	-2,150,318	2,707,602	67
68	06800	Speech Pathology	1,782,197	333,906	2,116,103		2,116,103	-659,659	1,456,444	68
69	06900	Electrocardiology		197,345	197,345		197,345	-87,165	110,180	69
71	07100	Medical Supplies Charged to Patients	227,220	1,288,610	1,515,830		1,515,830		1,515,830	71
73	07300	Drugs Charged to Patients	1,159,160	1,123,436	2,282,596		2,282,596		2,282,596	73
74	07400	Renal Dialysis		487,142	487,142		487,142		487,142	74
75.01	07502	SSM OP CLINICS						31,134,729	31,134,729	75.01
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								
118		SUBTOTALS (sum of lines 1-117)	33,364,240	33,314,209	66,678,449	-175,925	66,502,524	20,070,042	86,572,566	118
		NONREIMBURSABLE COST CENTERS								
194	07950	PROVIDER RELATIONS				175,925	175,925		175,925	194
200		TOTAL (sum of lines 118-199)	33,364,240	33,314,209	66,678,449		66,678,449	20,070,042	86,748,491	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	FACILITY RENT	A	Cap Rel Costs-Bldg & Fixt	1		3,944,667	1
500	Total reclassifications					3,944,667	500
	Code Letter - A						
1	EMPLOYEE BENEFITS	B	Employee Benefits Department	4		79,718	1
500	Total reclassifications					79,718	500
	Code Letter - B						
1	CAPITAL RECONCILIATION RECLASS	C	Administrative & General	5		10,088,292	1
500	Total reclassifications					10,088,292	500
	Code Letter - C						
1	OPERATING PORTION OF INTEREST EXPEN	D	Administrative & General	5		9,898	1
500	Total reclassifications					9,898	500
	Code Letter - D						
1	PROVIDER RELATIONS	E	PROVIDER RELATIONS	194	123,451	52,474	1
500	Total reclassifications				123,451	52,474	500
	Code Letter - E						
1	DIETARY RECLASS	F	Cafeteria	11		278,147	1
500	Total reclassifications					278,147	500
	Code Letter - F						
	GRAND TOTAL (Increases)				123,451	14,453,196	

(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	FACILITY RENT	A	Cap Rel Costs-Mvble Equip	2		3,944,667	10	1
500	Total reclassifications					3,944,667		500
	Code letter - A							
1	EMPLOYEE BENEFITS	B	Administrative & General	5		79,718		1
500	Total reclassifications					79,718		500
	Code letter - B							
1	CAPITAL RECONCILIATION RECLASS	C	Cap Rel Costs-Mvble Equip	2		10,088,292	12	1
500	Total reclassifications					10,088,292		500
	Code letter - C							
1	OPERATING PORTION OF INTEREST EXPEN	D	Cap Rel Costs-Mvble Equip	2		9,898	11	1
500	Total reclassifications					9,898		500
	Code letter - D							
1	PROVIDER RELATIONS	E	Administrative & General	5	123,451	52,474		1
500	Total reclassifications				123,451	52,474		500
	Code letter - E							
1	DIETARY RECLASS	F	Dietary	10		278,147		1
500	Total reclassifications					278,147		500
	Code letter - F							
	GRAND TOTAL (Decreases)				123,451	14,453,196		

(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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SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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RECONCILIATION OF CAPITAL COST CENTERS**WORKSHEET A-7
PARTS I, II & III****PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES**

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
			Purchases	Donation	Total				
		1	2	3	4	5	6	7	
1	Land								1
2	Land Improvements								2
3	Buildings and Fixtures								3
4	Building Improvements	18,305,887	1,625,739		1,625,739		19,931,626		4
5	Fixed Equipment								5
6	Movable Equipment	13,596,582	1,253,553		1,253,553		14,850,135		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	31,902,469	2,879,292		2,879,292		34,781,761		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	31,902,469	2,879,292		2,879,292		34,781,761		10

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

	Description	SUMMARY OF CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt								1
2	Cap Rel Costs-Mvble Equip	1,743,270	3,944,864	5,018,752	662,184	4,767,216	4,647,662	20,783,948	2
3	Total (sum of lines 1-2)	1,743,270	3,944,864	5,018,752	662,184	4,767,216	4,647,662	20,783,948	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 line numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	19,931,626		19,931,626	0.573048					1
2	Cap Rel Costs-Mvble Equip	14,850,135		14,850,135	0.426952					2
3	Total (sum of lines 1-2)	34,781,761		34,781,761	1.000000					3

	Description	SUMMARY OF CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt		3,944,667					3,944,667	1
2	Cap Rel Costs-Mvble Equip	1,939,572	197	93,873	-9,426,108	4,767,216	4,647,662	2,022,412	2
3	Total (sum of lines 1-2)	1,939,572	3,944,864	93,873	-9,426,108	4,767,216	4,647,662	5,967,079	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	-630,310				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1	596,580				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	OP SATELLITE CLINICS EXPENSE	A	32,811,821	SSM OP CLINICS	75.01		33
34							34
35	PHYSICIAN SERVICES EXPENSE	A	862,419	Adults & Pediatrics	30		35
36	REVERSE BAD DEBT GL CREDIT BALANCE	A	15,000	Administrative & General	5		36
37							37
37.01	CHARITABLE CONTRIBUTIONS	A	-946	Administrative & General	5		37.01
38	GIFTS	A					38
39							39
40	MEDICAL RECORDS INCOME	B	-6,940	Medical Records & Library	16		40
41	CAFETERIA INCOME	B	-58,469	Cafeteria	11		41
41.01	MINORITY INTEREST	A	-4,995,397	Cap Rel Costs-Mvble Equip	2	11	41.01
41.02	MINORITY INTEREST	A	-2,766,257	SSM OP CLINICS	75.01		41.02
41.03	MINORITY INTEREST	A	303,838	Adults & Pediatrics	30		41.03
41.04	OTHER PERSONNEL EXPENSE	A	-75,532	Administrative & General	5		41.04
41.05	OTHER PERSONNEL EXPENSE	A	-80,665	SSM OP CLINICS	75.01		41.05
41.06	OTHER PERSONNEL EXPENSE	A	-775	Adults & Pediatrics	30		41.06
42							42
42.05	MARKETING	A	-52,353	SSM OP CLINICS	75.01		42.05
42.06	GIFTS	A	-535	SSM OP CLINICS	75.01		42.06
42.08	LEASED THERAPIST EXPENSE	A	80,416	Cap Rel Costs-Mvble Equip	2	11	42.08
42.09	LEASED THERAPIST EXPENSE	A	-494	Employee Benefits Department	4		42.09
42.10	LEASED THERAPIST EXPENSE	A	-671,357	Administrative & General	5		42.10
42.12	LEASED THERAPIST EXPENSE	A	-5,249,145	Physical Therapy	66		42.12
42.13	LEASED THERAPIST EXPENSE	A	-2,150,318	Occupational Therapy	67		42.13
42.14	LEASED THERAPISTS EXPENSE	A	-659,659	Speech Pathology	68		42.14
43							43
44							44
45							45
46	COVID 19 GRANT	A	2,799,120	Administrative & General	5		46
47							47
48							48
49							49

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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	
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		20,070,042				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	2	Cap Rel Costs-Mvble Equip	HOME OFFICE CAPITAL	196,302		196,302	9	1
2	5	Administrative & General	HOME OFFICE ADMIN	4,372,254	4,647,662	-275,408		2
3	30	Adults & Pediatrics	HOME OFFICE A&P	83,218	38,229	44,989		3
3.01	75.01	SSM OP CLINICS	HOME OFFICE OP	3,981,009	2,758,291	1,222,718		3.01
3.02	5	Administrative & General	ADMIN	4,327	6,155	-1,828		3.02
3.03	8	Laundry & Linen Service	LAUNDRY	44,904	47,901	-2,997		3.03
3.04	9	Housekeeping	HOUSEKEEPING	215	241	-26		3.04
3.05	10	Dietary	DIETARY	251,112	254,709	-3,597		3.05
3.06	50	Operating Room	OR	28,081	53,385	-25,304		3.06
3.07	54	Radiology-Diagnostic	RADIOLOGY	131,857	218,160	-86,303		3.07
3.08	60	Laboratory	LAB	313,693	698,175	-384,482		3.08
3.09	65	Respiratory Therapy	RT	11,621	11,940	-319		3.09
3.10	66	Physical Therapy	PT	55	55			3.10
3.11	67	Occupational Therapy	OT	90	90			3.11
3.13	69	Electrocardiology	EKG	36,450	123,615	-87,165		3.13
3.14	73	Drugs Charged to Patients	PHARMACY	24,712	24,712			3.14
3.15	74	Renal Dialysis	DIALYSIS	1,389	1,389			3.15
3.16	71	Medical Supplies Charged to Patients	CENTRAL SUPPLIES	5,625	5,625			3.16
4								4
5		TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12		9,486,914	8,890,334	596,580		5

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

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

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

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

				Related Organization(s) and/or Home Office			
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
6	B			SELECT PHYSICAL THERAPY OF ST	51.00	HEALTHCARE	6
7	B			SSM HEALTH CARE ST LOUIS	49.00	HEALTHCARE	7
8							8
9							9
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:

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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 A	185,590	119,139	66,451	211,500	745	75,754	3,788	1
2	30	Adults & Pediatrics B	34,790	20,120	14,670	211,500	240	24,404	1,220	2
3	30	Adults & Pediatrics C	427,419	271,846	155,573	211,500	757	76,974	3,849	3
4	30	Adults & Pediatrics D	90,925	51,791	39,134	211,500	740	75,245	3,762	4
5	30	Adults & Pediatrics E	20,285	19,842	443	211,500	8	813	41	5
6	30	Adults & Pediatrics F	4,972	2,467	2,505	211,500	34	3,457	173	6
7	30	Adults & Pediatrics G	96,128	66,506	29,622	211,500	555	56,434	2,822	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	860,109	551,711	308,398		3,079	313,081	15,655	200

Health Financial Systems Compu-Max 2552-10

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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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 A					75,754		119,139	1
2	30	Adults & Pediatrics B					24,404		20,120	2
3	30	Adults & Pediatrics C					76,974	78,599	350,445	3
4	30	Adults & Pediatrics D					75,245		51,791	4
5	30	Adults & Pediatrics E					813		19,842	5
6	30	Adults & Pediatrics F					3,457		2,467	6
7	30	Adults & Pediatrics G					56,434		66,506	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					313,081	78,599	630,310	200

Health Financial Systems Compu-Max 2552-10

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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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	3,944,667	3,944,667					1
2	Cap Rel Costs-Mvble Equip	2,022,412		2,022,412				2
4	Employee Benefits Department	592,903	3,696	1,895	598,494			4
5	Administrative & General	17,114,473	1,594,182	817,331	83,723	19,609,709	19,609,709	5
6	Maintenance & Repairs							6
7	Operation of Plant	466,508	92,841	47,599	4,212	611,160	332,870	7
8	Laundry & Linen Service	275,832	55,577	28,494		359,903	196,022	8
9	Housekeeping	830,277	12,164	6,236	8,747	857,424	466,999	9
10	Dietary	1,588,837	73,251	37,555	10,086	1,709,729	931,209	10
11	Cafeteria	219,678	78,258	40,122		338,058	184,124	11
12	Maintenance of Personnel							12
13	Nursing Administration	782,065	66,296	33,989	11,618	893,968	486,902	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	202,908	15,793	8,097	3,181	229,979	125,259	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	13,945,009	1,399,396	717,464	196,839	16,258,708	8,855,348	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	69,547				69,547	37,879	50
54	Radiology-Diagnostic	149,644	18,078	9,268		176,990	96,398	54
60	Laboratory	349,994	4,637	2,377		357,008	194,445	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	209,564			2,917	212,481	115,728	65
66	Physical Therapy	4,113,725	209,773	107,550	142,329	4,573,377	2,490,904	66
67	Occupational Therapy	2,707,602	166,562	85,396	75,111	3,034,671	1,652,843	67
68	Speech Pathology	1,456,444	15,994	8,200	32,336	1,512,974	824,046	68
69	Electrocardiology	110,180				110,180	60,010	69
71	Medical Supplies Charged to Patients	1,515,830	80,106	41,070	4,123	1,641,129	893,846	71
73	Drugs Charged to Patients	2,282,596	54,367	27,874	21,032	2,385,869	1,299,471	73
74	Renal Dialysis	487,142				487,142	265,323	74
75.01	SSM OP CLINICS	31,134,729				31,134,729		75.01
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)	86,572,566	3,940,971	2,020,517	596,254	86,564,735	19,509,626	118
	NONREIMBURSABLE COST CENTERS							
194	PROVIDER RELATIONS	175,925	3,696	1,895	2,240	183,756	100,083	194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	86,748,491	3,944,667	2,022,412	598,494	86,748,491	19,609,709	202

Health Financial Systems Compu-Max 2552-10

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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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	CAFETERIA	NURSING ADMINIS- TRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	944,030						7
8	Laundry & Linen Service	23,277	579,202					8
9	Housekeeping	5,095		1,329,518				9
10	Dietary	30,680		44,547	2,716,165			10
11	Cafeteria	32,777		47,592		602,551		11
12	Maintenance of Personnel							12
13	Nursing Administration	27,767		40,317		11,289	1,460,243	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	6,615		9,604		11,391		16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	586,115	579,202	851,027	2,716,165	342,121	1,460,243	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
54	Radiology-Diagnostic	7,571		10,994				54
60	Laboratory	1,942		2,820				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy					10,160		65
66	Physical Therapy	87,860		127,571		94,484		66
67	Occupational Therapy	69,762		101,293		58,189		67
68	Speech Pathology	6,699		9,727		32,669		68
69	Electrocardiology							69
71	Medical Supplies Charged to Patients	33,551		48,715		8,997		71
73	Drugs Charged to Patients	22,771		33,063		29,146		73
74	Renal Dialysis							74
75.01	SSM OP CLINICS							75.01
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)	942,482	579,202	1,327,270	2,716,165	598,446	1,460,243	118
	NONREIMBURSABLE COST CENTERS							
194	PROVIDER RELATIONS	1,548		2,248		4,105		194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	944,030	579,202	1,329,518	2,716,165	602,551	1,460,243	202

Health Financial Systems Compu-Max 2552-10

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B PART I

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL		
		16	24	25	26		
	GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5	Administrative & General						5
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library	382,848					16
17	Social Service						17
19	Nonphysician Anesthetists						19
20	Nursing School						20
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
23	Paramed Ed Prgm-(specify)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	Adults & Pediatrics	99,411	31,748,340		31,748,340		30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	372	107,798		107,798		50
54	Radiology-Diagnostic	3,879	295,832		295,832		54
60	Laboratory	10,595	566,810		566,810		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	2,928	341,297		341,297		65
66	Physical Therapy	24,068	7,398,264		7,398,264		66
67	Occupational Therapy	21,013	4,937,771		4,937,771		67
68	Speech Pathology	24,378	2,410,493		2,410,493		68
69	Electrocardiology	1,628	171,818		171,818		69
71	Medical Supplies Charged to Patients	5,319	2,631,557		2,631,557		71
73	Drugs Charged to Patients	12,770	3,783,090		3,783,090		73
74	Renal Dialysis	1,262	753,727		753,727		74
75.01	SSM OP CLINICS	175,225	31,309,954		31,309,954		75.01
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)	382,848	86,456,751		86,456,751		118
	NONREIMBURSABLE COST CENTERS						
194	PROVIDER RELATIONS		291,740		291,740		194
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	382,848	86,748,491		86,748,491		202

Health Financial Systems Compu-Max 2552-10

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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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	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS- TRATIVE + GENERAL	
		0	1	2	2A	4	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department		3,696	1,895	5,591	5,591		4
5	Administrative & General		1,594,182	817,331	2,411,513	784	2,412,297	5
6	Maintenance & Repairs							6
7	Operation of Plant		92,841	47,599	140,440	39	40,948	7
8	Laundry & Linen Service		55,577	28,494	84,071		24,114	8
9	Housekeeping		12,164	6,236	18,400	82	57,448	9
10	Dietary		73,251	37,555	110,806	94	114,554	10
11	Cafeteria		78,258	40,122	118,380		22,650	11
12	Maintenance of Personnel							12
13	Nursing Administration		66,296	33,989	100,285	109	59,897	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		15,793	8,097	23,890	30	15,409	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		1,399,396	717,464	2,116,860	1,828	1,089,338	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room						4,660	50
54	Radiology-Diagnostic		18,078	9,268	27,346		11,859	54
60	Laboratory		4,637	2,377	7,014		23,920	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	4,263			4,263	27	14,236	65
66	Physical Therapy		209,773	107,550	317,323	1,334	306,421	66
67	Occupational Therapy		166,562	85,396	251,958	704	203,326	67
68	Speech Pathology		15,994	8,200	24,194	303	101,371	68
69	Electrocardiology						7,382	69
71	Medical Supplies Charged to Patients	48,174	80,106	41,070	169,350	39	109,957	71
73	Drugs Charged to Patients		54,367	27,874	82,241	197	159,856	73
74	Renal Dialysis						32,639	74
75.01	SSM OP CLINICS	13,687			13,687			75.01
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)	66,124	3,940,971	2,020,517	6,027,612	5,570	2,399,985	118
	NONREIMBURSABLE COST CENTERS							
194	PROVIDER RELATIONS		3,696	1,895	5,591	21	12,312	194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	66,124	3,944,667	2,022,412	6,033,203	5,591	2,412,297	202

Health Financial Systems Compu-Max 2552-10

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B PART II

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	181,427						7
8	Laundry & Linen Service	4,474	112,659					8
9	Housekeeping	979		76,909				9
10	Dietary	5,896		2,577	233,927			10
11	Cafeteria	6,299		2,753		150,082		11
12	Maintenance of Personnel							12
13	Nursing Administration	5,336		2,332		2,812	170,771	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	1,271		556		2,837		16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	112,643	112,659	49,228	233,927	85,214	170,771	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
54	Radiology-Diagnostic	1,455		636				54
60	Laboratory	373		163				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy					2,531		65
66	Physical Therapy	16,885		7,380		23,534		66
67	Occupational Therapy	13,407		5,860		14,494		67
68	Speech Pathology	1,287		563		8,137		68
69	Electrocardiology							69
71	Medical Supplies Charged to Patients	6,448		2,818		2,241		71
73	Drugs Charged to Patients	4,376		1,913		7,260		73
74	Renal Dialysis							74
75.01	SSM OP CLINICS							75.01
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)	181,129	112,659	76,779	233,927	149,060	170,771	118
	NONREIMBURSABLE COST CENTERS							
194	PROVIDER RELATIONS	298		130		1,022		194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	181,427	112,659	76,909	233,927	150,082	170,771	202

Health Financial Systems Compu-Max 2552-10

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B PART II

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL		
		16	24	25	26		
	GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5	Administrative & General						5
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library	43,993					16
17	Social Service						17
19	Nonphysician Anesthetists						19
20	Nursing School						20
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
23	Paramed Ed Prgm-(specify)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	Adults & Pediatrics	11,400	3,983,868		3,983,868		30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	43	4,703		4,703		50
54	Radiology-Diagnostic	445	41,741		41,741		54
60	Laboratory	1,215	32,685		32,685		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	336	21,393		21,393		65
66	Physical Therapy	2,760	675,637		675,637		66
67	Occupational Therapy	2,410	492,159		492,159		67
68	Speech Pathology	2,796	138,651		138,651		68
69	Electrocardiology	187	7,569		7,569		69
71	Medical Supplies Charged to Patients	610	291,463		291,463		71
73	Drugs Charged to Patients	1,465	257,308		257,308		73
74	Renal Dialysis	145	32,784		32,784		74
75.01	SSM OP CLINICS	20,181	33,868		33,868		75.01
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)	43,993	6,013,829		6,013,829		118
	NONREIMBURSABLE COST CENTERS						
194	PROVIDER RELATIONS		19,374		19,374		194
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	43,993	6,033,203		6,033,203		202

Health Financial Systems Compu-Max 2552-10

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS + FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE + GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	117,396						1
2	Cap Rel Costs-Mvble Equip		117,396					2
4	Employee Benefits Department	110	110	32,984,945				4
5	Administrative & General	47,444	47,444	4,614,353	-19,609,709	36,004,053		5
6	Maintenance & Repairs							6
7	Operation of Plant	2,763	2,763	232,127		611,160	67,079	7
8	Laundry & Linen Service	1,654	1,654			359,903	1,654	8
9	Housekeeping	362	362	482,077		857,424	362	9
10	Dietary	2,180	2,180	555,860		1,709,729	2,180	10
11	Cafeteria	2,329	2,329			338,058	2,329	11
12	Maintenance of Personnel							12
13	Nursing Administration	1,973	1,973	640,307		893,968	1,973	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	470	470	175,329		229,979	470	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	41,647	41,647	10,847,978		16,258,708	41,647	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room					69,547		50
54	Radiology-Diagnostic	538	538			176,990	538	54
60	Laboratory	138	138			357,008	138	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			160,785		212,481		65
66	Physical Therapy	6,243	6,243	7,844,405		4,573,377	6,243	66
67	Occupational Therapy	4,957	4,957	4,139,696		3,034,671	4,957	67
68	Speech Pathology	476	476	1,782,197		1,512,974	476	68
69	Electrocardiology					110,180		69
71	Medical Supplies Charged to Patients	2,384	2,384	227,220		1,641,129	2,384	71
73	Drugs Charged to Patients	1,618	1,618	1,159,160		2,385,869	1,618	73
74	Renal Dialysis					487,142		74
75.01	SSM OP CLINICS				-31,134,729			75.01
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)	117,286	117,286	32,861,494	-50,744,438	35,820,297	66,969	118
	NONREIMBURSABLE COST CENTERS							
194	PROVIDER RELATIONS	110	110	123,451		183,756	110	194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	3,944,667	2,022,412	598,494		19,609,709	944,030	202
203	Unit Cost Multiplier (Wkst. B, Part I)	33.601375	17.227265	0.018144		0.544653	14.073406	203
204	Cost to be allocated (Per Wkst. B, Part II)			5,591		2,412,297	181,427	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000170		0.067001	2.704677	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

Health Financial Systems Compu-Max 2552-10

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE PATIENT DAYS	HOUSE- KEEPING SQUARE FEET	DIETARY PATIENT DAYS	CAFETERIA MEALS SERVED	NURSING ADMINIS- TRATION DIRECT NRSING HRS	MEDICAL RECORDS & LIBRARY GROSS REVENUE	
		8	9	10	11	13	16	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	36,859						8
9	Housekeeping		65,063					9
10	Dietary		2,180	36,859				10
11	Cafeteria		2,329		17,614			11
12	Maintenance of Personnel							12
13	Nursing Administration		1,973		330	172		13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		470		333		250,910,589	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	36,859	41,647	36,859	10,001	172	65,144,699	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room						243,760	50
54	Radiology-Diagnostic		538				2,541,944	54
60	Laboratory		138				6,942,887	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy				297		1,918,755	65
66	Physical Therapy		6,243		2,762		15,772,229	66
67	Occupational Therapy		4,957		1,701		13,770,048	67
68	Speech Pathology		476		955		15,975,143	68
69	Electrocardiology						1,066,857	69
71	Medical Supplies Charged to Patients		2,384		263		3,485,447	71
73	Drugs Charged to Patients		1,618		852		8,368,593	73
74	Renal Dialysis						827,046	74
75.01	SSM OP CLINICS						114,853,181	75.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	36,859	64,953	36,859	17,494	172	250,910,589	118
	NONREIMBURSABLE COST CENTERS							
194	PROVIDER RELATIONS		110		120			194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	579,202	1,329,518	2,716,165	602,551	1,460,243	382,848	202
203	Unit Cost Multiplier (Wkst. B, Part I)	15.713991	20.434318	73.690686	34.208641	8,489.784884	0.001526	203
204	Cost to be allocated (Per Wkst. B, Part II)	112,659	76,909	233,927	150,082	170,771	43,993	204
205	Unit Cost Multiplier (Wkst. B, Part II)	3.056486	1.182070	6.346537	8.520609	992.854651	0.000175	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

Health Financial Systems Compu-Max 2552-10

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS							

	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics							30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
54	Radiology-Diagnostic							54
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
69	Electrocardiology							69
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
75.01	SSM OP CLINICS							75.01
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)							118
	NONREIMBURSABLE COST CENTERS							
194	PROVIDER RELATIONS							194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)							202
203	Unit Cost Multiplier (Wkst. B, Part I)							203
204	Cost to be allocated (Per Wkst. B, Part II)							204
205	Unit Cost Multiplier (Wkst. B, Part II)							205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

Health Financial Systems Compu-Max 2552-10

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET			
		CODE	LINE NO.	AMOUNT	
	1	2	3	4	

Health Financial Systems Compu-Max 2552-10

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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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	31,748,340		31,748,340	78,599	31,826,939	30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	107,798		107,798		107,798	50
54	Radiology-Diagnostic	295,832		295,832		295,832	54
60	Laboratory	566,810		566,810		566,810	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	341,297		341,297		341,297	65
66	Physical Therapy	7,398,264		7,398,264		7,398,264	66
67	Occupational Therapy	4,937,771		4,937,771		4,937,771	67
68	Speech Pathology	2,410,493		2,410,493		2,410,493	68
69	Electrocardiology	171,818		171,818		171,818	69
71	Medical Supplies Charged to Patients	2,631,557		2,631,557		2,631,557	71
73	Drugs Charged to Patients	3,783,090		3,783,090		3,783,090	73
74	Renal Dialysis	753,727		753,727		753,727	74
75.01	SSM OP CLINICS	31,309,954		31,309,954		31,309,954	75.01
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	Subtotal (sum of lines 30 thru 199)	86,456,751		86,456,751	78,599	86,535,350	200
201	Less Observation Beds						201
202	Total (line 200 minus line 201)	86,456,751		86,456,751		86,535,350	202

Health Financial Systems Compu-Max 2552-10

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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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	65,144,699		65,144,699				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	243,760		243,760	0.442230	0.442230	0.442230	50
54	Radiology-Diagnostic	2,541,944		2,541,944	0.116380	0.116380	0.116380	54
60	Laboratory	6,942,887		6,942,887	0.081639	0.081639	0.081639	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,918,755		1,918,755	0.177874	0.177874	0.177874	65
66	Physical Therapy	14,598,223	1,174,006	15,772,229	0.469069	0.469069	0.469069	66
67	Occupational Therapy	12,606,425	1,163,623	13,770,048	0.358588	0.358588	0.358588	67
68	Speech Pathology	15,090,500	884,643	15,975,143	0.150890	0.150890	0.150890	68
69	Electrocardiology	1,066,857		1,066,857	0.161051	0.161051	0.161051	69
71	Medical Supplies Charged to Patients	3,485,447		3,485,447	0.755013	0.755013	0.755013	71
73	Drugs Charged to Patients	8,368,593		8,368,593	0.452058	0.452058	0.452058	73
74	Renal Dialysis	827,046		827,046	0.911348	0.911348	0.911348	74
75.01	SSM OP CLINICS		114,853,181	114,853,181	0.272609	0.272609	0.272609	75.01
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	Subtotal (sum of lines 30 thru 199)	132,835,136	118,075,453	250,910,589				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	132,835,136	118,075,453	250,910,589				202

Health Financial Systems Compu-Max 2552-10

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE V (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)

WORKSHEET C PART I

	COST CENTER DESCRIPTIONS	COSTS					
		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics						30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room						50
54	Radiology-Diagnostic						54
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
69	Electrocardiology						69
71	Medical Supplies Charged to Patients						71
73	Drugs Charged to Patients						73
74	Renal Dialysis						74
75.01	SSM OP CLINICS						75.01
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	Subtotal (sum of lines 30 thru 199)						200
201	Less Observation Beds						201
202	Total (line 200 minus line 201)						202

Health Financial Systems Compu-Max 2552-10

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE V (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)

WORKSHEET C PART I

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	65,144,699		65,144,699				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	243,760		243,760				50
54	Radiology-Diagnostic	2,541,944		2,541,944				54
60	Laboratory	6,942,887		6,942,887				60
62,30	BLOOD CLOTTING FOR HEMOPHILIACS							62,30
65	Respiratory Therapy	1,918,755		1,918,755				65
66	Physical Therapy	14,598,223	1,174,006	15,772,229				66
67	Occupational Therapy	12,606,425	1,163,623	13,770,048				67
68	Speech Pathology	15,090,500	884,643	15,975,143				68
69	Electrocardiology	1,066,857		1,066,857				69
71	Medical Supplies Charged to Patients	3,485,447		3,485,447				71
73	Drugs Charged to Patients	8,368,593		8,368,593				73
74	Renal Dialysis	827,046		827,046				74
75,01	SSM OP CLINICS		114,853,181	114,853,181				75,01
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	Subtotal (sum of lines 30 thru 199)	132,835,136	118,075,453	250,910,589				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	132,835,136	118,075,453	250,910,589				202

Health Financial Systems Compu-Max 2552-10

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)

WORKSHEET C PART I

	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	COSTS			
				Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	31,748,340		31,748,340	78,599	31,826,939	30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	107,798		107,798		107,798	50
54	Radiology-Diagnostic	295,832		295,832		295,832	54
60	Laboratory	566,810		566,810		566,810	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	341,297		341,297		341,297	65
66	Physical Therapy	7,398,264		7,398,264		7,398,264	66
67	Occupational Therapy	4,937,771		4,937,771		4,937,771	67
68	Speech Pathology	2,410,493		2,410,493		2,410,493	68
69	Electrocardiology	171,818		171,818		171,818	69
71	Medical Supplies Charged to Patients	2,631,557		2,631,557		2,631,557	71
73	Drugs Charged to Patients	3,783,090		3,783,090		3,783,090	73
74	Renal Dialysis	753,727		753,727		753,727	74
75.01	SSM OP CLINICS	31,309,954		31,309,954		31,309,954	75.01
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	Subtotal (sum of lines 30 thru 199)	86,456,751		86,456,751	78,599	86,535,350	200
201	Less Observation Beds						201
202	Total (line 200 minus line 201)	86,456,751		86,456,751	78,599	86,535,350	202

Health Financial Systems Compu-Max 2552-10

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)

WORKSHEET C PART I

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	65,144,699		65,144,699				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	243,760		243,760	0.442230	0.442230	0.442230	50
54	Radiology-Diagnostic	2,541,944		2,541,944	0.116380	0.116380	0.116380	54
60	Laboratory	6,942,887		6,942,887	0.081639	0.081639	0.081639	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,918,755		1,918,755	0.177874	0.177874	0.177874	65
66	Physical Therapy	14,598,223	1,174,006	15,772,229	0.469069	0.469069	0.469069	66
67	Occupational Therapy	12,606,425	1,163,623	13,770,048	0.358588	0.358588	0.358588	67
68	Speech Pathology	15,090,500	884,643	15,975,143	0.150890	0.150890	0.150890	68
69	Electrocardiology	1,066,857		1,066,857	0.161051	0.161051	0.161051	69
71	Medical Supplies Charged to Patients	3,485,447		3,485,447	0.755013	0.755013	0.755013	71
73	Drugs Charged to Patients	8,368,593		8,368,593	0.452058	0.452058	0.452058	73
74	Renal Dialysis	827,046		827,046	0.911348	0.911348	0.911348	74
75.01	SSM OP CLINICS		114,853,181	114,853,181	0.272609	0.272609	0.272609	75.01
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	Subtotal (sum of lines 30 thru 199)	132,835,136	118,075,453	250,910,589				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	132,835,136	118,075,453	250,910,589				202

Health Financial Systems Compu-Max 2552-10

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

WORKSHEET C PART II

[] Title V

[XX] Title XIX

	COST CENTER DESCRIPTIONS	Total Cost (Wkst B, Part I, col. 26)	Capital Cost (Wkst B, Part II, col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	
		1	2	3	4	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room	107,798	4,703	103,095		50
54	Radiology-Diagnostic	295,832	41,741	254,091		54
60	Laboratory	566,810	32,685	534,125		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy	341,297	21,393	319,904		65
66	Physical Therapy	7,398,264	675,637	6,722,627		66
67	Occupational Therapy	4,937,771	492,159	4,445,612		67
68	Speech Pathology	2,410,493	138,651	2,271,842		68
69	Electrocardiology	171,818	7,569	164,249		69
71	Medical Supplies Charged to Patients	2,631,557	291,463	2,340,094		71
73	Drugs Charged to Patients	3,783,090	257,308	3,525,782		73
74	Renal Dialysis	753,727	32,784	720,943		74
75.01	SSM OP CLINICS	31,309,954	33,868	31,276,086		75.01
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	Subtotal	54,708,411	2,029,961	52,678,450		200
201	Less Observation Beds					201
202	Total	54,708,411	2,029,961	52,678,450		202

Health Financial Systems Compu-Max 2552-10

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

WORKSHEET C PART II

[] Title V

[XX] Title XIX

	COST CENTER DESCRIPTIONS	Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Wkst C, Part I, col. 8)	Outpatient Cost to Charge Ratio(col. 6 ÷ col. 7)	
		5	6	7	8	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room		107,798	243,760	0.442230	50
54	Radiology-Diagnostic		295,832	2,541,944	0.116380	54
60	Laboratory		566,810	6,942,887	0.081639	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy		341,297	1,918,755	0.177874	65
66	Physical Therapy		7,398,264	15,772,229	0.469069	66
67	Occupational Therapy		4,937,771	13,770,048	0.358588	67
68	Speech Pathology		2,410,493	15,975,143	0.150890	68
69	Electrocardiology		171,818	1,066,857	0.161051	69
71	Medical Supplies Charged to Patients		2,631,557	3,485,447	0.755013	71
73	Drugs Charged to Patients		3,783,090	8,368,593	0.452058	73
74	Renal Dialysis		753,727	827,046	0.911348	74
75.01	SSM OP CLINICS		31,309,954	114,853,181	0.272609	75.01
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	Subtotal		54,708,411	185,765,890		200
201	Less Observation Beds					201
202	Total		54,708,411	185,765,890		202

Health Financial Systems Compu-Max 2552-10

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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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)	3,983,868		3,983,868	36,859	108.08	16,039	1,733,495	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)	3,983,868		3,983,868	36,859		16,039	1,733,495	200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 26-3031

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						
50	Operating Room	4,703	243,760	0.019294	85,692	1,653	50
54	Radiology-Diagnostic	41,741	2,541,944	0.016421	1,114,574	18,302	54
60	Laboratory	32,685	6,942,887	0.004708	3,327,649	15,667	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	21,393	1,918,755	0.011149	776,784	8,660	65
66	Physical Therapy	675,637	15,772,229	0.042837	6,399,530	274,137	66
67	Occupational Therapy	492,159	13,770,048	0.035741	5,537,931	197,931	67
68	Speech Pathology	138,651	15,975,143	0.008679	5,413,209	46,981	68
69	Electrocardiology	7,569	1,066,857	0.007095	505,511	3,587	69
71	Medical Supplies Charged to Pat	291,463	3,485,447	0.083623	1,456,520	121,799	71
73	Drugs Charged to Patients	257,308	8,368,593	0.030747	3,759,099	115,581	73
74	Renal Dialysis	32,784	827,046	0.039640	546,555	21,665	74
75.01	SSM OP CLINICS	33,868	114,853,181	0.000295			75.01
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)	2,029,961	185,765,890		28,923,054	825,963	200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D PART III

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

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D PART III

Check ☐ Title V
 Applicable ☒ Title XVIII, Part A
 Boxes: ☐ 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)	36,859		16,039		30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	36,859		16,039		200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 26-3031

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									
50	Operating Room									50
54	Radiology-Diagnostic									54
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
69	Electrocardiology									69
71	Medical Supplies Charged to Pat									71
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
75.01	SSM OP CLINICS									75.01
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

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 26-3031

WORKSHEET D PART IV

Check [] Title V [XX] Hospital [] SUB (Other) [] ICF/IID [XX] PPS
Applicable [XX] 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								
50	Operating Room	243,760			85,692				50
54	Radiology-Diagnostic	2,541,944			1,114,574				54
60	Laboratory	6,942,887			3,327,649				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	1,918,755			776,784				65
66	Physical Therapy	15,772,229			6,399,530				66
67	Occupational Therapy	13,770,048			5,537,931				67
68	Speech Pathology	15,975,143			5,413,209				68
69	Electrocardiology	1,066,857			505,511				69
71	Medical Supplies Charged to Pat	3,485,447			1,456,520				71
73	Drugs Charged to Patients	8,368,593			3,759,099				73
74	Renal Dialysis	827,046			546,555				74
75.01	SSM OP CLINICS	114,853,181					12,125		75.01
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)	185,765,890			28,923,054		12,125		200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 26-3031

WORKSHEET D
PART V

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

			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								
50	Operating Room	0.442230							50
54	Radiology-Diagnostic	0.116380							54
60	Laboratory	0.081639							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.177874							65
66	Physical Therapy	0.469069							66
67	Occupational Therapy	0.358588							67
68	Speech Pathology	0.150890							68
69	Electrocardiology	0.161051							69
71	Medical Supplies Charged to Pat	0.755013							71
73	Drugs Charged to Patients	0.452058							73
74	Renal Dialysis	0.911348							74
75.01	SSM OP CLINICS	0.272609	12,125			3,305			75.01
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)		12,125			3,305			200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		12,125			3,305			202

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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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

		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)	3,983,868		3,983,868	36,859	108.08	4,306	465,392	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)	3,983,868		3,983,868	36,859		4,306	465,392	200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 26-3031

WORKSHEET D
PART II

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	4,703	243,760	0.019294	19,862	383	50
54	Radiology-Diagnostic	41,741	2,541,944	0.016421	237,518	3,900	54
60	Laboratory	32,685	6,942,887	0.004708	686,721	3,233	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	21,393	1,918,755	0.011149	260,478	2,904	65
66	Physical Therapy	675,637	15,772,229	0.042837	1,654,279	70,864	66
67	Occupational Therapy	492,159	13,770,048	0.035741	1,434,684	51,277	67
68	Speech Pathology	138,651	15,975,143	0.008679	1,692,062	14,685	68
69	Electrocardiology	7,569	1,066,857	0.007095	124,906	886	69
71	Medical Supplies Charged to Pat	291,463	3,485,447	0.083623	396,933	33,193	71
73	Drugs Charged to Patients	257,308	8,368,593	0.030747	1,012,568	31,133	73
74	Renal Dialysis	32,784	827,046	0.039640	31,711	1,257	74
75.01	SSM OP CLINICS	33,868	114,853,181	0.000295			75.01
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)	2,029,961	185,765,890		7,551,722	213,715	200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D PART III

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

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS**WORKSHEET D
PART III**

Check ☐ Title V
 Applicable ☐ Title XVIII, Part A
 Boxes: ☒ 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)	36,859		4,306		30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	36,859		4,306		200

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 26-3031

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									
50	Operating Room									50
54	Radiology-Diagnostic									54
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
69	Electrocardiology									69
71	Medical Supplies Charged to Pat									71
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
75.01	SSM OP CLINICS									75.01
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

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 26-3031

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								
50	Operating Room	243,760			19,862				50
54	Radiology-Diagnostic	2,541,944			237,518				54
60	Laboratory	6,942,887			686,721				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	1,918,755			260,478				65
66	Physical Therapy	15,772,229			1,654,279				66
67	Occupational Therapy	13,770,048			1,434,684				67
68	Speech Pathology	15,975,143			1,692,062				68
69	Electrocardiology	1,066,857			124,906				69
71	Medical Supplies Charged to Pat	3,485,447			396,933				71
73	Drugs Charged to Patients	8,368,593			1,012,568				73
74	Renal Dialysis	827,046			31,711				74
75.01	SSM OP CLINICS	114,853,181							75.01
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)	185,765,890			7,551,722				200

(A) Worksheet A line numbers

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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WORKSHEET D
PART V

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[ ] ICF/IID
[ ] PARHM Demonstration
[ ] PARHM CAH Swing Bed SNF
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			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								
50	Operating Room	0.442230							50
54	Radiology-Diagnostic	0.116380							54
60	Laboratory	0.081639							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.177874							65
66	Physical Therapy	0.469069							66
67	Occupational Therapy	0.358588							67
68	Speech Pathology	0.150890							68
69	Electrocardiology	0.161051							69
71	Medical Supplies Charged to Pat	0.755013							71
73	Drugs Charged to Patients	0.452058							73
74	Renal Dialysis	0.911348							74
75.01	SSM OP CLINICS	0.272609							75.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 26-3031****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)	36,859	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	36,859	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)	36,859	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)	16,039	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)	31,826,939	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)	31,826,939	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)	31,826,939	37

Health Financial Systems Compu-Max 2552-10

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 26-3031

WORKSHEET D-1 PART II

Check [] Title V - I/P [XX] Hospital [] SUB (Other) [XX] PPS
Applicable [XX] 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)						863.48	38
39	Program general inpatient routine service cost (line 9 x line 38)						13,849,356	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)						13,849,356	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)						9,760,440	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						23,609,796	49
PASS THROUGH COST ADJUSTMENTS								
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						1,733,495	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						825,963	51
52	Total Program excludable cost (sum of lines 50 and 51)						2,559,458	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						21,050,338	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

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 26-3031

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)					863.48	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

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 26-3031

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)	36,859	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	36,859	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)	36,859	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	4,306	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)	31,748,340	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)	31,748,340	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)	31,748,340	37

Health Financial Systems Compu-Max 2552-10

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 26-3031

WORKSHEET D-1 PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS							1	
38	Adjusted general inpatient routine service cost per diem (see instructions)						861.35	38
39	Program general inpatient routine service cost (line 9 x line 38)						3,708,973	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)							40
41	Total Program general inpatient routine service cost (line 39 + line 40)						3,708,973	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)						2,491,012	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						6,199,985	49
PASS THROUGH COST ADJUSTMENTS								
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						465,392	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						213,715	51
52	Total Program excludable cost (sum of lines 50 and 51)						679,107	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

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 26-3031

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)					861.35	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

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 26-3031

WORKSHEET D-3

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		27,081,062		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.442230	85,692	37,896	50
54	Radiology-Diagnostic	0.116380	1,114,574	129,714	54
60	Laboratory	0.081639	3,327,649	271,666	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.177874	776,784	138,170	65
66	Physical Therapy	0.469069	6,399,530	3,001,821	66
67	Occupational Therapy	0.358588	5,537,931	1,985,836	67
68	Speech Pathology	0.150890	5,413,209	816,799	68
69	Electrocardiology	0.161051	505,511	81,413	69
71	Medical Supplies Charged to Patients	0.755013	1,456,520	1,099,692	71
73	Drugs Charged to Patients	0.452058	3,759,099	1,699,331	73
74	Renal Dialysis	0.911348	546,555	498,102	74
75.01	SSM OP CLINICS	0.272609			75.01
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)		28,923,054	9,760,440	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		28,923,054		202

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 26-3031

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
	INPATIENT ROUTINE SERVICE COST CENTERS	1	2	3	
30	Adults & Pediatrics		7,645,453		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.442230	19,862	8,784	50
54	Radiology-Diagnostic	0.116380	237,518	27,642	54
60	Laboratory	0.081639	686,721	56,063	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.177874	260,478	46,332	65
66	Physical Therapy	0.469069	1,654,279	775,971	66
67	Occupational Therapy	0.358588	1,434,684	514,460	67
68	Speech Pathology	0.150890	1,692,062	255,315	68
69	Electrocardiology	0.161051	124,906	20,116	69
71	Medical Supplies Charged to Patients	0.755013	396,933	299,690	71
73	Drugs Charged to Patients	0.452058	1,012,568	457,739	73
74	Renal Dialysis	0.911348	31,711	28,900	74
75.01	SSM OP CLINICS	0.272609			75.01
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)		7,551,722	2,491,012	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		7,551,722		202

(A) Worksheet A line numbers

Health Financial Systems Compu-Max 2552-10

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 26-3031

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)	3,305			2
3	OPPS payments	5,739			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)	5,739			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	1,147			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)	4,592			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)	4,592			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	4,592			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)	4,592			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)	4,592			40
40.01	Sequestration adjustment (see instructions)	77			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
40.03	Sequestration adjustment - PARHM pass-throughs				40.03
41	Interim payments	4,502			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)	13			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

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 26-3031

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			26,687,755		4,502
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		02/26/2020	2,662,600		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
			06/15/2020	302,000		3.50
						3.51
		Provider				3.52
		to				3.53
		Program				3.54
						3.55
						3.56
						3.57
						3.58
						3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			2,360,600		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)			29,048,355		4,502
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)					13
	based on the cost report (1)			-1,128,151		6.01
7	Total Medicare program liability (see instructions)			27,920,204		4,515
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

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 26-3031

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)	26,753,705		1
2	Medicare SSI ratio (IRF PPS only) (see instructions)	0.043800		2
3	Inpatient Rehabilitation LIP payments (see instructions)	1,685,483		3
4	Outlier payments	274,498		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)			5
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) OR (2)			5.01
6	New teaching program adjustment (see instructions)			6
7	Current year unweighted FTE count of I&R excluding FTEs in the new program growth period of a 'new teaching program' (see instructions)			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)			9
10	Average daily census (see instructions)	100.707650		10
11	Teaching Adjustment Factor (see instructions)			11
12	Teaching Adjustment (see instructions)			12
13	Total PPS Payment (see instructions)	28,713,686		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)	28,713,686		17
18	Primary payer payments	4,088		18
19	Subtotal (line 17 less line 18)	28,709,598		19
20	Deductibles	267,608		20
21	Subtotal (line 19 minus line 20)	28,441,990		21
22	Coinurance	138,248		22
23	Subtotal (line 21 minus line 22)	28,303,742		23
24	Allowable bad debts (exclude bad debts for professional services) (see instructions)	139,459		24
25	Adjusted reimbursable bad debts (see instructions)	90,648		25
26	Allowable bad debts for dual eligible beneficiaries (see instructions)	104,656		26
27	Subtotal (sum of lines 23 and 25)	28,394,390		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)	28,394,390		32
32.01	Sequestration adjustment (see instructions)	474,186		32.01
32.02	Demonstration payment adjustment amount after sequestration			32.02
33	Interim payments	29,048,355		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)	-1,128,151		35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			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

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 26-3031

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	6,199,985		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	6,199,985		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	6,199,985		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges	7,645,453		8
9	Ancillary service charges	7,551,722		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)	15,197,175		12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahрге basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)	15,197,175		16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	8,997,190		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)	6,199,985		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)	6,199,985		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)	6,199,985		31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)	6,199,985		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	6,199,985		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)	6,199,985		40
41	Interim payments	5,704,096		41
42	Balance due provider/program (line 40 minus line 41)	495,889		42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

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SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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BALANCE SHEET

WORKSHEET G

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

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	Assets (Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	4,399				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	6,769,663				4
5	Other receivables	71,690				5
6	Allowances for uncollectible notes and accounts receivable					6
7	Inventory					7
8	Prepaid expenses	43,714				8
9	Other current assets	352,241				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	7,241,707				11
	FIXED ASSETS					
12	Land					12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings	19,931,626				15
16	Accumulated depreciation	-11,818,382				16
17	Leasehold improvements	1,239,045				17
18	Accumulated depreciation					18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	14,850,135				23
24	Accumulated depreciation	-9,293,911				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)	14,908,513				30
	OTHER ASSETS					
31	Investments					31
32	Deposits on leases	65,769				32
33	Due from owners/officers	43,253,260				33
34	Other assets	77,666,743				34
35	Total other assets (sum of lines 31-34)	120,985,772				35
36	Total assets (sum of lines 11, 30 and 35)	143,135,992				36
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	Liabilities and Fund Balances (Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable	1,663,657				37
38	Salaries, wages and fees payable	6,840,321				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	5,911,162				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds	10,412,307				43
44	Other current liabilities	10,283				44
45	Total current liabilities (sum of lines 37 thru 44)	24,837,730				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable	28,835,742				47
48	Unsecured loans					48
49	Other long term liabilities	687,463				49
50	Total long term liabilities (sum of lines 46 thru 49)	29,523,205				50
51	Total liabilities (sum of lines 45 and 50)	54,360,935				51
	CAPITAL ACCOUNTS					
52	General fund balance	88,775,057				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)	88,775,057				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	143,135,992				60

Health Financial Systems Compu-Max 2552-10

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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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		91,049,342		1
2	Net income (loss) (from Worksheet G-3, line 29)		17,849,832		2
3	Total (sum of line 1 and line 2)		108,899,174		3
4	Additions (credit adjustments) (specify)				4
5	FUND BALANCE RECON	-20,124,117			5
6					6
7					7
8					8
9					9
10	Total additions (sum of lines 4-9)		-20,124,117		10
11	Subtotal (line 3 plus line 10)		88,775,057		11
12	Deductions (debit adjustments) (specify)				12
13					13
14					14
15					15
16					16
17					17
18	Total deductions (sum of lines 12-17)				18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		88,775,057		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	FUND BALANCE RECON				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					13
14					14
15					15
16					16
17					17
18	Total deductions (sum of lines 12-17)				18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)				19

Health Financial Systems Compu-Max 2552-10

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

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

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	65,144,699		65,144,699	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)	65,144,699		65,144,699	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)	65,144,699		65,144,699	17
18	Ancillary services	67,690,437	114,853,181	182,543,618	18
19	Outpatient services		3,222,272	3,222,272	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)	132,835,136	118,075,453	250,910,589	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		66,678,449	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)		66,678,449	43

Health Financial Systems Compu-Max 2552-10

SSM SELECT REHAB ST LOUIS, LLC Provider CCN: 26-3031	In Lieu of Form CMS-2552-10	Period : From: 07/01/2019 To: 06/30/2020	Run Date: 11/16/2020 Run Time: 13:50 Version: 2020.06 (11/06/2020)
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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)	250,910,589	1
2	Less contractual allowances and discounts on patients' accounts	150,362,905	2
3	Net patient revenues (line 1 minus line 2)	100,547,684	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	66,678,449	4
5	Net income from service to patients (line 3 minus line 4)	33,869,235	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments		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	58,469	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	6,940	18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hosptial space		22
23	Governmental appropriations		23
24	Other (OTHER INCOME)	1,406	24
24.01	Other (ACCUTE THERAPISTS)	5,040,000	24.01
24.02	Other (HOME HEALTH)	3,478,684	24.02
24.03	Other (THERAPISTS TO ST JOES)		24.03
24.04	Other (MARK UP)	199,490	24.04
24.05	Other (SSM PHYSICIAN REVENUE)	546,180	24.05
24.50	COVID-19 PHE FUNDING	2,799,120	24.50
25	Total other income (sum of lines 6-24)	12,130,289	25
26	Total (line 5 plus line 25)	45,999,524	26
27	Other expenses (OP CLINIC EXPENSE)	27,287,273	27
27.01	Other expenses (SSM PHYSICIAN EXPENSE)	862,419	27.01
27.02	Other expenses (INTERCOMPANY INTEREST)		27.02
28	Total other expenses (sum of line 27 and subscripts)	28,149,692	28
29	Net income (or loss) for the period (line 26 minus line 28)	17,849,832	29