

KPMG LLP Compu-Max 2552-10

RML HEALTH PROVIDERS, L.P. Provider CCN: 14-2010	In Lieu of Form CMS-2552-10	Period : From: 06/01/2017 To: 05/31/2018	Run Date: 10/29/2018 Run Time: 08:58 Version: 2018.04 (09/26/2018)
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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 filed cost report Date: 10/29/2018 Time: 08:58 2. ☐ Manually submitted cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted the cost report 4. ☒ Medicare Utilization. Enter 'F' for full or 'L' for low.	
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ____ 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by RML HEALTH PROVIDERS, L.P. (14-2010) {(Provider Name(s) and Number(s))} for the cost reporting period beginning 06/01/2017 and ending 05/31/2018, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

Title

Date

PART III - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII		HIT	TITLE XIX	
		1	PART A 2	PART B 3	4	5	
1	HOSPITAL		-43,652				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		-43,652				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: 5601 SOUTH COUNTY LINE ROAD	P.O. Box:		1
2	City: HINSDALE	State: IL	ZIP Code: 60521	County: COOK

Hospital and Hospital-Based Component Identification:

								Payment System (P, T, O, or N)		
Component		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	V	XVIII	XIX	
0		1	2	3	4	5	6	7	8	
3	Hospital	RML HEALTH PROVIDERS, L.P.	14-2010	16974	2	06 / 01 / 1997	N	P	N	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF									7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC									15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 06 / 01 / 2017	To: 05 / 31 / 2018		20
21	Type of control (see instructions)	2			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.	2	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.							25

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

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

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40
		V	XVIII	XIX
	Prospective Payment System (PPS)-Capital	1	2	3
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	N	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	48

		1	2	3	
56	Teaching Hospitals Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
		NAHE 413.85 Y/N 1	Worksheet A Line # 2	Pass-Through Qualification Criteria Code 3	
60	Are you claiming nursing and allied health education (NAHE) costs for any program(s) that meet the criteria under 42 CFR 413.85? (see instructions)	N			60
		Y/N 1	IME 4	Direct GME 5	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

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

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

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

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

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

Teaching Hospitals that Claim Residents in Nonprovider Settings

63	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64 through 67. (see instructions)	N			63
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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.	N			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)				76

Long Term Care Hospital PPS

80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.	Y		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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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	N	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.	N	N	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	N	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

Rural Providers				1	2	
105	Does this hospital qualify as a CAH?			N		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.					107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.			N		108
		Physical	Occupational	Speech	Respiratory	
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.					109
1						
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.					111

Miscellaneous Cost Reporting Information

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:	619,640	480,000		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 §1983(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

Transplant Center Information

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

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

All Providers

		1	2	
140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)	Y		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:	Contractor's Name:	Contractor's Number:	141
142	Street:	P.O. Box:		142
143	City:	State:	ZIP Code:	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.	N				165
166	If line 165 is yes, for each campus, enter the name in column 0, county in column 1, state in column 2, ZIP in column 3, CBSA in column 4, FTE/campus in column 5. (see instructions)					166
	Name	County	State	ZIP Code	CBSA	FTE/Campus
	0	1	2	3	4	5

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

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

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

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

COMPLETED BY ALL HOSPITALS

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

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

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

		Y/N	
Bad Debts		Y	
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12
13	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N		16
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	09/04/2018	Y	09/04/2018	17
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N		18
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19
20	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

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

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

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

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

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

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

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

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

Cost Report Preparer Contact Information			
41	First name: THOMAS	Last name: STITT	Title: VICE PRESIDENT OF FINANCE
42	Employer: HEALTH DIMENSIONS GROUP		
43	Phone number: 763-225-8639	E-mail Address: TOM@HDG11.COM	

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

		Inpatient Days / Outpatient Visits / Trips								
	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	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	168	61,320			16,660	15,587	49,201	1
2	HMO and other (see instructions)									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)		168	61,320			16,660	15,587	49,201	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)		168	61,320			16,660	15,587	49,201	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)		168							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						2,485			33
33.01	LTCH site neutral days and discharges						1,218			33.01

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

	Component	Full Time Equivalents			DISCHARGES				
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					418	460	1,333	1
2	HMO and other (see instructions)								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)		680.11			418	460	1,333	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)		680.11						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32.01
33	LTCH non-covered days					64			33
33.01	LTCH site neutral days and discharges					31			33.01

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

		Wkst A Line No.	Amount Reported	Reclassif- ication of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)	
		1	2	3	4	5	6	
	SALARIES							
1	Total salaries (see instructions)	200	46,401,778			1,414,629.41		1
2	Non-physician anesthetist Part A							2
3	Non-physician anesthetest Part B							3
4	Physician-Part A - Administrative		26,753			178.35		4
4.01	Physician-Part A - Teaching							4.01
5	Physician-Part B		814,912			13,059.49		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)		276,645	-7,775		5,166.86		10
	OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)		263,849			4,107.58		11
12	Contract management and administrative services							12
13	Contract labor: Physician-Part A - Administrative		230,623			1,083.73		13
14	Home office salaries & wage-related costs							14
14.01	Home office salaries							14.01
14.02	Related organization salaries							14.02
15	Home office: Physician Part A - Administrative							15
16	Home office & Contract Physicians Part A - Teaching							16
	WAGE-RELATED COSTS							
17	Wage-related costs (core)(see instructions)		10,473,967					17
18	Wage-related costs (other)(see instructions)							18
19	Excluded areas		62,178					19
20	Non-physician anesthetist Part A							20
21	Non-physician anesthetist Part B							21
22	Physician Part A - Administrative		6,187					22
22.01	Physician Part A - Teaching							22.01
23	Physician Part B		188,455					23
24	Wage-related costs (RHC/FQHC)							24
25	Interns & residents (in an approved program)							25
25.50	Home office wage-related							25.50
25.51	Related organization wage-related							25.51
25.52	Home office: Physician Part A - Administrative - wage-related							25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related							25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26	Employee Benefits Department		517,995	15,530		11,609.47		26
27	Administrative & General		9,408,345	-681,066		182,941.38		27
28	Administrative & General under contract (see instructions)		35,040			287.00		28
29	Maintenance & Repairs		165,976	7,455		4,331.60		29
30	Operation of Plant		1,714,414	34,699		56,624.75		30
31	Laundry & Linen Service							31
32	Housekeeping		1,097,440	30,040		70,846.74		32
33	Housekeeping under contract (see instructions)							33
34	Dietary		651,187	-239,364		20,000.35		34
35	Dietary under contract (see instructions)							35
36	Cafeteria			173,255		8,414.36		36
37	Maintenance of Personnel							37
38	Nursing Administration		878,201	53,958		21,492.14		38
39	Central Services and Supply							39
40	Pharmacy							40
41	Medical Records & Medical Records Library		317,668	12,074		11,755.50		41
42	Social Service		1,260,061	31,497		36,726.63		42
43	Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		45,621,906		45,621,906	1,401,856.92	32.54	1
2	Excluded area salaries (see instructions)		276,645	-7,775	268,870	5,166.86	52.04	2
3	Subtotal salaries (line 1 minus line 2)		45,345,261	7,775	45,353,036	1,396,690.06	32.47	3
4	Subtotal other wages & related costs (see instructions)		494,472		494,472	5,191.31	95.25	4
5	Subtotal wage-related costs (see instructions)		10,480,154		10,480,154		23.11%	5
6	Total (sum of lines 3 through 5)		56,319,887	7,775	56,327,662	1,401,881.37	40.18	6
7	Total overhead cost (see instructions)		16,046,327	-561,922	15,484,405	425,029.92	36.43	7

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

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions	1,767,056	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)	4,785,717	8.02
8.03	Health Insurance (Purchased)		8.03
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan	165,569	10
11	Life Insurance (If employee is owner or beneficiary)	63,236	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	92,339	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)	1,309	14
15	Workers' Compensation Insurance	437,569	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	3,281,132	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance		19
20	State or Federal Unemployment Taxes	64,188	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	72,674	23
24	Total Wage Related cost (Sum of lines 1-23)	10,730,789	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)		25
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HOSPITAL CONTRACT LABOR AND BENEFIT COST**WORKSHEET S-3****Part V - Contract Labor and Benefit Cost****PART V****Hospital and Hospital-Based Component Identification:**

	Component	Contract Labor	Benefit Cost	
	0	1	2	
1	Total facility contract labor and benefit cost			1
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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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		1,937,511	1,937,511	1,012,562	2,950,073	-970,953	1,979,120	1
2	00200	Cap Rel Costs-Mvble Equip		3,964,050	3,964,050	-868,048	3,096,002		3,096,002	2
3	00300	Other Cap Rel Costs		144,514	144,514	-144,514			-0-	3
4	00400	Employee Benefits Department	517,995	7,751,969	8,269,964	15,530	8,285,494	-145,331	8,140,163	4
5.01	00560	PURCHASING	409,155	122,620	531,775	13,345	545,120		545,120	5.01
5.02	00570	ADMITTING	1,600,543	191,595	1,792,138	11,472	1,803,610	-12,890	1,790,720	5.02
5.03	00580	PATIENT ACCOUNTS	459,566	100,873	560,439	14,463	574,902	-67	574,835	5.03
5.04	00590	OTHER A&G	6,939,081	13,255,006	20,194,087	-734,355	19,459,732	-8,521,065	10,938,667	5.04
6	00600	Maintenance & Repairs	165,976	234,460	400,436	7,455	407,891		407,891	6
7	00700	Operation of Plant	1,714,414	1,739,689	3,454,103	34,699	3,488,802	-572	3,488,230	7
8	00800	Laundry & Linen Service		176,300	176,300		176,300		176,300	8
9	00900	Housekeeping	1,097,440	514,884	1,612,324	30,040	1,642,364		1,642,364	9
10	01000	Dietary	651,187	369,910	1,021,097	-363,110	657,987	-10,774	647,213	10
11	01100	Cafeteria				276,818	276,818	-137,344	139,474	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	878,201	68,247	946,448	53,958	1,000,406		1,000,406	13
14	01400	Central Services & Supply								14
15	01500	Pharmacy								15
16	01600	Medical Records & Library	317,668	67,134	384,802	12,074	396,876	-1,759	395,117	16
17	01700	Social Service	1,260,061	205,931	1,465,992	31,497	1,497,489		1,497,489	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	17,631,776	6,693,632	24,325,408	-1,617,211	22,708,197	-1,433,750	21,274,447	30
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	416,156	485,524	901,680	-217,740	683,940	-21	683,919	50
54	05400	Radiology-Diagnostic	682,926	269,187	952,113	14,491	966,604	-970	965,634	54
56	05600	Radioisotope		28,694	28,694		28,694		28,694	56
60	06000	Laboratory	119,204	1,140,091	1,259,295	2,623	1,261,918	-30,000	1,231,918	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	7,582,056	1,792,622	9,374,678	-928,955	8,445,723	-1,034,380	7,411,343	65
66	06600	Physical Therapy	1,101,251	107,283	1,208,534	-1,447	1,207,087	-17	1,207,070	66
67	06700	Occupational Therapy	644,749	53,239	697,988	2,133	700,121		700,121	67
68	06800	Speech Pathology	416,695	33,511	450,206	4,941	455,147		455,147	68
68.01	03550	PSYCHOLOGY								68.01
71	07100	Medical Supplies Charged to Patients				3,135,660	3,135,660		3,135,660	71
73	07300	Drugs Charged to Patients	1,442,094	3,376,275	4,818,369	212,017	5,030,386	-452	5,029,934	73
74	07400	Renal Dialysis		1,876,230	1,876,230	-674	1,875,556		1,875,556	74
75.01	03630	ULTRASOUND	76,939	17,826	94,765	767	95,532		95,532	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
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	46,125,133	46,718,807	92,843,940	10,491	92,854,431	-12,300,345	80,554,086	118
		NONREIMBURSABLE COST CENTERS								
190.01	19002	IDLE SPACE								190.01
194	07950	PSYCHOLOGY	276,645	20,903	297,548	-10,491	287,057		287,057	194
200		TOTAL (sum of lines 118-199)	46,401,778	46,739,710	93,141,488		93,141,488	-12,300,345	80,841,143	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	RECLASS CAFETERIA COST FROM DIETARY	A	Cafeteria	11	166,988	103,563	1
500	Total reclassifications				166,988	103,563	500
	Code Letter - A						
1	MEDICAL SUPPLIES	B	Medical Supplies Charged to P	71		3,135,660	1
2							2
3							3
4							4
5							5
500	Total reclassifications					3,135,660	500
	Code Letter - B						
1	DRUGS	C	Drugs Charged to Patients	73		174,760	1
2							2
3							3
4							4
5							5
6							6
500	Total reclassifications					174,760	500
	Code Letter - C						
1	SALARY RECLASS	D	Employee Benefits Department	4	15,530		1
2			PURCHASING	5.01	13,345		2
3			ADMITTING	5.02	11,472		3
4			PATIENT ACCOUNTS	5.03	14,463		4
5			Maintenance & Repairs	6	7,455		5
6			Operation of Plant	7	34,699		6
7			Housekeeping	9	30,040		7
8			Dietary	10	14,900		8
9			Cafeteria	11	6,267		9
10			Nursing Administration	13	53,958		10
11			Medical Records & Library	16	12,074		11
12			Social Service	17	31,497		12
13			Adults & Pediatrics	30	279,492		13
14			Operating Room	50	4,377		14
15			Radiology-Diagnostic	54	14,491		15
16			Laboratory	60	2,623		16
17			Respiratory Therapy	65	107,457		17
18			Physical Therapy	66	23,594		18
19			Occupational Therapy	67	7,422		19
20			Speech Pathology	68	4,941		20
21			PSYCHOLOGY	194	6,427		21
22			Drugs Charged to Patients	73	37,257		22
23			ULTRASOUND	75.01	767		23
500	Total reclassifications				734,548		500
	Code Letter - D						
1	BUILDING INTEREST EXPENSE	E	Cap Rel Costs-Bldg & Fixt	1		924,434	1
500	Total reclassifications					924,434	500
	Code Letter - E						
1	DIETICIAN SALARIES	F	Adults & Pediatrics	30	87,276	20,183	1
500	Total reclassifications				87,276	20,183	500
	Code Letter - F						
1	PSYCHOLOGY ADMIN	H	OTHER A&G	5.04	14,202	2,716	1
500	Total reclassifications				14,202	2,716	500
	Code Letter - H						
	GRAND TOTAL (Increases)				1,003,014	4,361,316	

(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	RECLASS CAFETERIA COST FROM DIETARY	A	Dietary	10	166,988	103,563		1
500	Total reclassifications				166,988	103,563		500
	Code letter - A							
1	MEDICAL SUPPLIES	B	Adults & Pediatrics	30		1,849,755		1
2			Operating Room	50		220,143		2
3			Respiratory Therapy	65		1,035,432		3
4			Physical Therapy	66		25,041		4
5			Occupational Therapy	67		5,289		5
500	Total reclassifications					3,135,660		500
	Code letter - B							
1	DRUGS	C	OTHER A&G	5.04		16,725		1
2			Adults & Pediatrics	30		154,407		2
3			Operating Room	50		1,974		3
4								4
5			Respiratory Therapy	65		980		5
6			Renal Dialysis	74		674		6
500	Total reclassifications					174,760		500
	Code letter - C							
1	SALARY RECLASS	D	OTHER A&G	5.04	734,548			1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
500	Total reclassifications				734,548			500
	Code letter - D							
1	BUILDING INTEREST EXPENSE	E	Cap Rel Costs-Mvble Equip	2		924,434	11	1
500	Total reclassifications					924,434		500
	Code letter - E							
1	DIETICIAN SALARIES	F	Dietary	10	87,276	20,183		1
500	Total reclassifications				87,276	20,183		500
	Code letter - F							
1	PSYCHOLOGY ADMIN	H	PSYCHOLOGY	194	14,202	2,716		1
500	Total reclassifications				14,202	2,716		500
	Code letter - H							
	GRAND TOTAL (Decreases)				1,003,014	4,361,316		

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

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

	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	39,390,234					39,390,234		3
4	Building Improvements	1,462,671	1,478,655		1,478,655		2,941,326		4
5	Fixed Equipment								5
6	Movable Equipment	25,647,349	1,437,063		1,437,063		27,084,412		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	66,500,254	2,915,718		2,915,718		69,415,972		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	66,500,254	2,915,718		2,915,718		69,415,972		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	1,678,764	258,747					1,937,511	1
2	Cap Rel Costs-Mvble Equip	1,579,311		2,384,739				3,964,050	2
3	Total (sum of lines 1-2)	3,258,075	258,747	2,384,739				5,901,561	3

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

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
		1	2	3	4	5	6	7	8	
*										
1	Cap Rel Costs-Bldg & Fi	42,331,560		42,331,560	0.609824	88,128			88,128	1
2	Cap Rel Costs-Mvble Equip	27,084,412		27,084,412	0.390176	56,386			56,386	2
3	Total (sum of lines 1-2)	69,415,972		69,415,972	1.000000	144,514			144,514	3

	Description	SUMMARY OF CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		9	10	11	12	13	14	15	
*									
1	Cap Rel Costs-Bldg & Fixt	1,678,764	-712,206	924,434	88,128			1,979,120	1
2	Cap Rel Costs-Mvble Equip	1,579,311		1,460,305	56,386			3,096,002	2
3	Total (sum of lines 1-2)	3,258,075	-712,206	2,384,739	144,514			5,075,122	3

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

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ADJUSTMENTS TO EXPENSES**WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
1	Investment income-buildings & fixtures (chapter 2)			Cap Rel Costs-Bldg & Fixt	1		1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)						7
8	Television and radio service (chapter 21)						8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-1,932,673				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1	-970,953				12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-137,344	Cafeteria	11		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	B	-1,759	Medical Records & Library	16		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	MARKETING	A	-52,616	OTHER A&G	5.04		33
33.05	RESEARCH AND DEVELOPMENT	A	-89,672	OTHER A&G	5.04		33.05
33.06	MARKETING	A	-12,890	ADMITTING	5.02		33.06
33.07	PULMONARY EXPENSE	A	-1,034,380	Respiratory Therapy	65		33.07
33.10	OTHER REVENUE - NURSING	B	-86	Adults & Pediatrics	30		33.10
33.11	OTHER REVENUE - FACILITY OPERAT	B	-572	Operation of Plant	7		33.11
33.13	OTHER REVENUE - PHARMACY	B	-452	Drugs Charged to Patients	73		33.13
33.16	OTHER REVENUE - DIETARY	B	-10,774	Dietary	10		33.16
33.17	OTHER REVENUE - RADIOLOGY	B	-970	Radiology-Diagnostic	54		33.17
33.19	DONATIONS	A	-34,605	OTHER A&G	5.04		33.19
33.22	ENTERTAINMENT EXPENSE	A	-13,008	OTHER A&G	5.04		33.22
33.23	MEMBERSHIP DUES	A	-64,058	OTHER A&G	5.04		33.23
33.24	UNFUNDED SELF INSURANCE	A	-69,946	OTHER A&G	5.04		33.24
33.31	OTHER REVENUE-PATIENTS ACCOUNTS	A	-67	PATIENT ACCOUNTS	5.03		33.31
33.32	OTHER REVENUE - HUMAN RESOURCES	B	-20	Employee Benefits Department	4		33.32
33.34	OTHER REVENUE - PHYCICAL THERAP	B	-17	Physical Therapy	66		33.34
34							34
35	PROVIDER RELATIONS MARKETING	A	-46,891	OTHER A&G	5.04		35
36							36
37	OTHER REVENUE - ACCOUNTING	B	-7,904	OTHER A&G	5.04		37
38	MEDICAID PROVIDER TAX - SUPPLEM	A	-7,672,267	OTHER A&G	5.04		38
39	PULMONARY PHYSICIAN BENEFITS	A	-145,311	Employee Benefits Department	4		39
40							40
41	OTHER REVENUE - A&G	B	-1,226	OTHER A&G	5.04		41
42							42
43							43
44							44
45							45
46	OTHER REVENUE - OPERATING ROOM	B	-21	Operating Room	50		46
47	BAD DEBTS	A	137	OTHER A&G	5.04		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)		-12,300,345				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	1	Cap Rel Costs-Bldg & Fixt	ADVOCATE BUILDING COST	685,188	1,656,141	-970,953	10	1
2								2
3								3
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12			685,188	1,656,141	-970,953		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.

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office			
	1	2	3	Name	Percentage of Ownership	Type of Business	
6	B		49.50	LOYOLA UNIVERSITY MEDICAL CENT		HOSPITAL	6
7	B		49.50	ADVOCATE HEALTH AND HOSPITALS		HOSPITAL	7
8	B		1.00	RMLHP CORPORATION		CORPORATION	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:

KPMG LLP Compu-Max 2552-10

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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	5.04	OTHER A&G AGGREGATE	597,333	339,357	257,376	211,500	1,262	128,324	6,416	1
2	30	Adults & Pediatrics AGGREGATE	1,433,664	1,433,664		179,000				2
3										3
4	60	Laboratory AGGREGATE	30,000	30,000						4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	2,060,997	1,803,021	257,376		1,262	128,324	6,416	200

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	5.04	OTHER A&G AGGREGATE					128,324	129,052	469,009	1
2	30	Adults & Pediatrics AGGREGATE							1,433,664	2
3										3
4	60	Laboratory AGGREGATE							30,000	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL					128,324	129,052	1,932,673	200

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

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	PURCHASING	ADMITTING	
		0	1	2	4	5.01	5.02	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	1,979,120	1,979,120					1
2	Cap Rel Costs-Mvble Equip	3,096,002		3,096,002				2
4	Employee Benefits Department	8,140,163	48,255	64	8,188,482			4
5.01	PURCHASING	545,120	53,788	18,456	72,070	689,434		5.01
5.02	ADMITTING	1,790,720	23,772	8,348	283,838		2,106,678	5.02
5.03	PATIENT ACCOUNTS	574,835	12,873	1,582	81,589			5.03
5.04	OTHER A&G	10,938,667	588,085	967,681	1,032,817	25,489		5.04
6	Maintenance & Repairs	407,891	36,290	724	30,134	10,898		6
7	Operation of Plant	3,488,230	152,813	225,623	307,586	10,114		7
8	Laundry & Linen Service	176,300	32,208	1,056		478		8
9	Housekeeping	1,642,364	30,235	14,354	207,222	2,226		9
10	Dietary	647,213	110,854	80,985	68,405	6,034		10
11	Cafeteria	139,474	49,226	340,358	39,509	2,563		11
12	Maintenance of Personnel							12
13	Nursing Administration	1,000,406	13,865		166,851			13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	395,117	25,130	2,380	58,093	3,299		16
17	Social Service	1,497,489	18,270	1,903	263,608	4,642		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	21,274,447	427,245	954,973	3,212,199	44,068	859,572	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	683,919	27,124	2,641	71,160	1,186	17,045	50
54	Radiology-Diagnostic	965,634	53,130	167,534	133,892	1,546	34,790	54
56	Radioisotope	28,694	1,159			2,352	101	56
60	Laboratory	1,231,918		5,209	21,197	39,556	67,312	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	7,411,343	35,612	153,191	1,406,441	8,770	454,264	65
66	Physical Therapy	1,207,070	17,780	15,004	211,086	105	33,268	66
67	Occupational Therapy	700,121	11,714		117,745		29,359	67
68	Speech Pathology	455,147	10,430		77,859	72	20,187	68
68.01	PSYCHOLOGY							68.01
71	Medical Supplies Charged to Patients	3,135,660				257,002	195,358	71
73	Drugs Charged to Patients	5,029,934	47,117	133,936	264,118	268,061	329,554	73
74	Renal Dialysis	1,875,556	3,236			973	59,838	74
75.01	ULTRASOUND	95,532	3,007		13,727		6,030	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
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	80,554,086	1,833,218	3,096,002	8,141,146	689,434	2,106,678	118
	NONREIMBURSABLE COST CENTERS							
190.01	IDLE SPACE		141,287					190.01
194	PSYCHOLOGY	287,057	4,615		47,336			194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	80,841,143	1,979,120	3,096,002	8,188,482	689,434	2,106,678	202

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

	COST CENTER DESCRIPTIONS	PATIENT ACCOUNTS	SUBTOTAL (cols.0-4)	OTHER A+G	MAIN- TENANCE + REPAIRS	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	
		5.03	4A	5.04	6	7	8	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	PURCHASING							5.01
5.02	ADMITTING							5.02
5.03	PATIENT ACCOUNTS	670,879						5.03
5.04	OTHER A&G		13,552,739	13,552,739				5.04
6	Maintenance & Repairs		485,937	97,874	583,811			6
7	Operation of Plant		4,184,366	842,786		5,027,152		7
8	Laundry & Linen Service		210,042	42,305		152,284	404,631	8
9	Housekeeping		1,896,401	381,960		142,955		9
10	Dietary		913,491	183,989		524,134		10
11	Cafeteria		571,130	115,033		232,745		11
12	Maintenance of Personnel							12
13	Nursing Administration		1,181,122	237,893		65,554		13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		484,019	97,488		118,816		16
17	Social Service		1,785,912	359,706		86,385		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	273,775	27,046,279	5,447,452	484,894	2,020,074	233,472	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	5,427	808,502	162,843		128,244		50
54	Radiology-Diagnostic	11,078	1,367,604	275,453	4,056	251,207		54
56	Radioisotope	32	32,338	6,513		5,479		56
60	Laboratory	21,433	1,386,625	279,284				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	144,647	9,614,268	1,936,439	92,608	168,376	171,159	65
66	Physical Therapy	10,593	1,494,906	301,094	2,253	84,065		66
67	Occupational Therapy	9,349	868,288	174,884		55,385		67
68	Speech Pathology	6,428	570,123	114,830		49,313		68
68.01	PSYCHOLOGY							68.01
71	Medical Supplies Charged to Patients	62,206	3,650,226	735,203				71
73	Drugs Charged to Patients	104,937	6,177,657	1,244,260		222,774		73
74	Renal Dialysis	19,054	1,958,657	394,499		15,302		74
75.01	ULTRASOUND	1,920	120,216	24,213		14,216		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
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	670,879	80,360,848	13,456,001	583,811	4,337,308	404,631	118
	NONREIMBURSABLE COST CENTERS							
190.01	IDLE SPACE		141,287	28,457		668,026		190.01
194	PSYCHOLOGY		339,008	68,281		21,818		194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	670,879	80,841,143	13,552,739	583,811	5,027,152	404,631	202

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

	COST CENTER DESCRIPTIONS	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	
		9	10	11	13	16	17	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	PURCHASING							5.01
5.02	ADMITTING							5.02
5.03	PATIENT ACCOUNTS							5.03
5.04	OTHER A&G							5.04
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping	2,421,316						9
10	Dietary	268,199	1,889,813					10
11	Cafeteria	119,096		1,038,004				11
12	Maintenance of Personnel							12
13	Nursing Administration	33,544		21,044	1,539,157			13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	60,798		11,510		772,631		16
17	Social Service	44,203		35,976			2,312,182	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	1,033,669	1,889,813	627,661	1,515,886	315,241	2,312,182	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	65,623		9,636	23,271	6,251		50
54	Radiology-Diagnostic	128,542		17,377		12,760		54
56	Radioisotope	2,804				37		56
60	Laboratory			5,745		24,687		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	86,158		209,011		166,606		65
66	Physical Therapy	43,016		33,246		12,201		66
67	Occupational Therapy	28,340		15,788		10,768		67
68	Speech Pathology	25,234		11,225		7,404		68
68.01	PSYCHOLOGY							68.01
71	Medical Supplies Charged to Patients					71,650		71
73	Drugs Charged to Patients	113,993		33,246		120,868		73
74	Renal Dialysis	7,830				21,946		74
75.01	ULTRASOUND	7,275		1,487		2,212		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
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	2,068,324	1,889,813	1,032,952	1,539,157	772,631	2,312,182	118
	NONREIMBURSABLE COST CENTERS							
190.01	IDLE SPACE	341,828						190.01
194	PSYCHOLOGY	11,164		5,052				194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	2,421,316	1,889,813	1,038,004	1,539,157	772,631	2,312,182	202

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

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL			
		24	25	26			
	GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5.01	PURCHASING						5.01
5.02	ADMITTING						5.02
5.03	PATIENT ACCOUNTS						5.03
5.04	OTHER A&G						5.04
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	42,926,623		42,926,623			30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,204,370		1,204,370			50
54	Radiology-Diagnostic	2,056,999		2,056,999			54
56	Radioisotope	47,171		47,171			56
60	Laboratory	1,696,341		1,696,341			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	12,444,625		12,444,625			65
66	Physical Therapy	1,970,781		1,970,781			66
67	Occupational Therapy	1,153,453		1,153,453			67
68	Speech Pathology	778,129		778,129			68
68.01	PSYCHOLOGY						68.01
71	Medical Supplies Charged to Patients	4,457,079		4,457,079			71
73	Drugs Charged to Patients	7,912,798		7,912,798			73
74	Renal Dialysis	2,398,234		2,398,234			74
75.01	ULTRASOUND	169,619		169,619			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
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)	79,216,222		79,216,222			118
	NONREIMBURSABLE COST CENTERS						
190.01	IDLE SPACE	1,179,598		1,179,598			190.01
194	PSYCHOLOGY	445,323		445,323			194
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	80,841,143		80,841,143			202

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RML HEALTH PROVIDERS, L.P. Provider CCN: 14-2010	In Lieu of Form CMS-2552-10	Period : From: 06/01/2017 To: 05/31/2018	Run Date: 10/29/2018 Run Time: 08:58 Version: 2018.04 (09/26/2018)
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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	PURCHASING	
		0	1	2	2A	4	5.01	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department		48,255	64	48,319	48,319		4
5.01	PURCHASING		53,788	18,456	72,244	425	72,669	5.01
5.02	ADMITTING	1,530	23,772	8,348	33,650	1,675		5.02
5.03	PATIENT ACCOUNTS		12,873	1,582	14,455	481		5.03
5.04	OTHER A&G		588,085	967,681	1,555,766	6,094	2,687	5.04
6	Maintenance & Repairs		36,290	724	37,014	178	1,149	6
7	Operation of Plant		152,813	225,623	378,436	1,815	1,066	7
8	Laundry & Linen Service		32,208	1,056	33,264		50	8
9	Housekeeping		30,235	14,354	44,589	1,223	235	9
10	Dietary	348	110,854	80,985	192,187	404	636	10
11	Cafeteria	146	49,226	340,358	389,730	233	270	11
12	Maintenance of Personnel							12
13	Nursing Administration		13,865		13,865	984		13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		25,130	2,380	27,510	343	348	16
17	Social Service		18,270	1,903	20,173	1,555	489	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	1,126,562	427,245	954,973	2,508,780	18,959	4,645	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		27,124	2,641	29,765	420	125	50
54	Radiology-Diagnostic		53,130	167,534	220,664	790	163	54
56	Radioisotope		1,159		1,159		248	56
60	Laboratory			5,209	5,209	125	4,169	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	13,581	35,612	153,191	202,384	8,298	924	65
66	Physical Therapy		17,780	15,004	32,784	1,245	11	66
67	Occupational Therapy		11,714		11,714	695		67
68	Speech Pathology		10,430		10,430	459	8	68
68.01	PSYCHOLOGY							68.01
71	Medical Supplies Charged to Patients						27,089	71
73	Drugs Charged to Patients		47,117	133,936	181,053	1,558	28,254	73
74	Renal Dialysis		3,236		3,236		103	74
75.01	ULTRASOUND		3,007		3,007	81		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
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,142,167	1,833,218	3,096,002	6,071,387	48,040	72,669	118
	NONREIMBURSABLE COST CENTERS							
190.01	IDLE SPACE		141,287		141,287			190.01
194	PSYCHOLOGY		4,615		4,615	279		194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,142,167	1,979,120	3,096,002	6,217,289	48,319	72,669	202

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

	COST CENTER DESCRIPTIONS	ADMITTING	PATIENT ACCOUNTS	OTHER A+G	MAIN- TENANCE + REPAIRS	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	
		5.02	5.03	5.04	6	7	8	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	PURCHASING							5.01
5.02	ADMITTING	35,325						5.02
5.03	PATIENT ACCOUNTS		14,936					5.03
5.04	OTHER A&G			1,564,547				5.04
6	Maintenance & Repairs			11,299	49,640			6
7	Operation of Plant			97,291		478,608		7
8	Laundry & Linen Service			4,884		14,498	52,696	8
9	Housekeeping			44,093		13,610		9
10	Dietary			21,240		49,900		10
11	Cafeteria			13,279		22,158		11
12	Maintenance of Personnel							12
13	Nursing Administration			27,462		6,241		13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library			11,254		11,312		16
17	Social Service			41,524		8,224		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	14,368	6,090	628,878	41,229	192,322	30,406	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	286	121	18,798		12,209		50
54	Radiology-Diagnostic	585	247	31,798	345	23,916		54
56	Radioisotope	2	1	752		522		56
60	Laboratory	1,131	477	32,240				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	7,634	3,222	223,541	7,874	16,030	22,290	65
66	Physical Therapy	559	236	34,758	192	8,003		66
67	Occupational Therapy	493	208	20,189		5,273		67
68	Speech Pathology	339	143	13,256		4,695		68
68.01	PSYCHOLOGY							68.01
71	Medical Supplies Charged to Patients	3,283	1,386	84,871				71
73	Drugs Charged to Patients	5,538	2,338	143,637		21,209		73
74	Renal Dialysis	1,006	424	45,541		1,457		74
75.01	ULTRASOUND	101	43	2,795		1,353		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
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	35,325	14,936	1,553,380	49,640	412,932	52,696	118
	NONREIMBURSABLE COST CENTERS							
190.01	IDLE SPACE			3,285		63,599		190.01
194	PSYCHOLOGY			7,882		2,077		194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	35,325	14,936	1,564,547	49,640	478,608	52,696	202

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

	COST CENTER DESCRIPTIONS	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	
		9	10	11	13	16	17	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	PURCHASING							5.01
5.02	ADMITTING							5.02
5.03	PATIENT ACCOUNTS							5.03
5.04	OTHER A&G							5.04
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping	103,750						9
10	Dietary	11,492	275,859					10
11	Cafeteria	5,103		430,773				11
12	Maintenance of Personnel							12
13	Nursing Administration	1,437		8,733	58,722			13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	2,605		4,777		58,149		16
17	Social Service	1,894		14,930			88,789	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	44,292	275,859	260,481	57,834	23,721	88,789	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	2,812		3,999	888	471		50
54	Radiology-Diagnostic	5,508		7,211		960		54
56	Radioisotope	120				3		56
60	Laboratory			2,384		1,858		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	3,692		86,740		12,541		65
66	Physical Therapy	1,843		13,797		918		66
67	Occupational Therapy	1,214		6,552		811		67
68	Speech Pathology	1,081		4,658		557		68
68.01	PSYCHOLOGY							68.01
71	Medical Supplies Charged to Patients					5,393		71
73	Drugs Charged to Patients	4,884		13,797		9,098		73
74	Renal Dialysis	336				1,652		74
75.01	ULTRASOUND	312		617		166		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
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	88,625	275,859	428,676	58,722	58,149	88,789	118
	NONREIMBURSABLE COST CENTERS							
190.01	IDLE SPACE	14,647						190.01
194	PSYCHOLOGY	478		2,097				194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	103,750	275,859	430,773	58,722	58,149	88,789	202

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RML HEALTH PROVIDERS, L.P. Provider CCN: 14-2010	In Lieu of Form CMS-2552-10	Period : From: 06/01/2017 To: 05/31/2018	Run Date: 10/29/2018 Run Time: 08:58 Version: 2018.04 (09/26/2018)
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ALLOCATION OF CAPITAL-RELATED COSTS
**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL				
		24	25	26				
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	PURCHASING							5.01
5.02	ADMITTING							5.02
5.03	PATIENT ACCOUNTS							5.03
5.04	OTHER A&G							5.04
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	4,196,653		4,196,653				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	69,894		69,894				50
54	Radiology-Diagnostic	292,187		292,187				54
56	Radioisotope	2,807		2,807				56
60	Laboratory	47,593		47,593				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	595,170		595,170				65
66	Physical Therapy	94,346		94,346				66
67	Occupational Therapy	47,149		47,149				67
68	Speech Pathology	35,626		35,626				68
68.01	PSYCHOLOGY							68.01
71	Medical Supplies Charged to Patients	122,022		122,022				71
73	Drugs Charged to Patients	411,366		411,366				73
74	Renal Dialysis	53,755		53,755				74
75.01	ULTRASOUND	8,475		8,475				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
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	5,977,043		5,977,043				118
	NONREIMBURSABLE COST CENTERS							
190.01	IDLE SPACE	222,818		222,818				190.01
194	PSYCHOLOGY	17,428		17,428				194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	6,217,289		6,217,289				202

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RML HEALTH PROVIDERS, L.P. Provider CCN: 14-2010	In Lieu of Form CMS-2552-10	Period : From: 06/01/2017 To: 05/31/2018	Run Date: 10/29/2018 Run Time: 08:58 Version: 2018.04 (09/26/2018)
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COST ALLOCATION - STATISTICAL BASIS**WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	PURCHASING SUPPLIES EXPENSE	ADMITTING GROSS REVENUE	PATIENT ACCOUNTS GROSS REVENUE	
		1	2	4	5.01	5.02	5.03	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	189,567						1
2	Cap Rel Costs-Mvble Equip		6,568,284					2
4	Employee Benefits Department	4,622	135	45,751,719				4
5.01	PURCHASING	5,152	39,156	402,681	8,411,767			5.01
5.02	ADMITTING	2,277	17,710	1,585,902		229,878,626		5.02
5.03	PATIENT ACCOUNTS	1,233	3,357	455,867			229,878,626	5.03
5.04	OTHER A&G	56,329	2,052,968	5,770,701	310,986			5.04
6	Maintenance & Repairs	3,476	1,537	168,370	132,970			6
7	Operation of Plant	14,637	478,668	1,718,589	123,401			7
8	Laundry & Linen Service	3,085	2,240		5,836			8
9	Housekeeping	2,896	30,452	1,157,820	27,159			9
10	Dietary	10,618	171,813	382,202	73,622			10
11	Cafeteria	4,715	722,083	220,753	31,273			11
12	Maintenance of Personnel							12
13	Nursing Administration	1,328		932,252				13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	2,407	5,050	324,585	40,256			16
17	Social Service	1,750	4,038	1,472,870	56,637			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	40,923	2,026,012	17,947,518	537,667	93,791,101	93,791,101	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	2,598	5,602	397,595	14,465	1,859,946	1,859,946	50
54	Radiology-Diagnostic	5,089	355,429	748,101	18,857	3,796,349	3,796,349	54
56	Radioisotope	111			28,694	11,057	11,057	56
60	Laboratory		11,052	118,436	482,625	7,345,221	7,345,221	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	3,411	325,000	7,858,264	107,004	49,570,501	49,570,501	65
66	Physical Therapy	1,703	31,831	1,179,407	1,283	3,630,314	3,630,314	66
67	Occupational Therapy	1,122		657,884		3,203,744	3,203,744	67
68	Speech Pathology	999		435,027	877	2,202,834	2,202,834	68
68.01	PSYCHOLOGY							68.01
71	Medical Supplies Charged to Patients				3,135,660	21,318,012	21,318,012	71
73	Drugs Charged to Patients	4,513	284,151	1,475,717	3,270,628	35,961,806	35,961,806	73
74	Renal Dialysis	310			11,867	6,529,681	6,529,681	74
75.01	ULTRASOUND	288		76,698		658,060	658,060	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
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	175,592	6,568,284	45,487,239	8,411,767	229,878,626	229,878,626	118
	NONREIMBURSABLE COST CENTERS							
190.01	IDLE SPACE	13,533						190.01
194	PSYCHOLOGY	442		264,480				194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,979,120	3,096,002	8,188,482	689,434	2,106,678	670,879	202
203	Unit Cost Multiplier (Wkst. B, Part I)	10.440214	0.471356	0.178976	0.081961	0.009164	0.002918	203
204	Cost to be allocated (Per Wkst. B, Part II)			48,319	72,669	35,325	14,936	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.001056	0.008639	0.000154	0.000065	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	RECON- CILIATION	OTHER A+G ACCUM COST	MAIN- TENANCE + REPAIRS WORK ORDERS	OPERATION OF PLANT SQUARE FEET	LAUNDRY + LINEN SERVICE POUNDS OF LAUNDRY	HOUSE- KEEPING SQUARE FEET	
		5A.04	5.04	6	7	8	9	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	PURCHASING							5.01
5.02	ADMITTING							5.02
5.03	PATIENT ACCOUNTS							5.03
5.04	OTHER A&G	-13,552,739	67,288,404					5.04
6	Maintenance & Repairs		485,937	2,591				6
7	Operation of Plant		4,184,366		101,841			7
8	Laundry & Linen Service		210,042		3,085	606,911		8
9	Housekeeping		1,896,401		2,896		95,860	9
10	Dietary		913,491		10,618		10,618	10
11	Cafeteria		571,130		4,715		4,715	11
12	Maintenance of Personnel							12
13	Nursing Administration		1,181,122		1,328		1,328	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		484,019		2,407		2,407	16
17	Social Service		1,785,912		1,750		1,750	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		27,046,279	2,152	40,923	350,188	40,923	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		808,502		2,598		2,598	50
54	Radiology-Diagnostic		1,367,604	18	5,089		5,089	54
56	Radioisotope		32,338		111		111	56
60	Laboratory		1,386,625					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		9,614,268	411	3,411	256,723	3,411	65
66	Physical Therapy		1,494,906	10	1,703		1,703	66
67	Occupational Therapy		868,288		1,122		1,122	67
68	Speech Pathology		570,123		999		999	68
68.01	PSYCHOLOGY							68.01
71	Medical Supplies Charged to Patients		3,650,226					71
73	Drugs Charged to Patients		6,177,657		4,513		4,513	73
74	Renal Dialysis		1,958,657		310		310	74
75.01	ULTRASOUND		120,216		288		288	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
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	-13,552,739	66,808,109	2,591	87,866	606,911	81,885	118
	NONREIMBURSABLE COST CENTERS							
190.01	IDLE SPACE		141,287		13,533		13,533	190.01
194	PSYCHOLOGY		339,008		442		442	194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)		13,552,739	583,811	5,027,152	404,631	2,421,316	202
203	Unit Cost Multiplier (Wkst. B, Part I)		0.201413	225.322655	49.362752	0.666706	25.258878	203
204	Cost to be allocated (Per Wkst. B, Part II)		1,564,547	49,640	478,608	52,696	103,750	204
205	Unit Cost Multiplier (Wkst. B, Part II)		0.023251	19.158626	4.699561	0.086827	1.082308	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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

	COST CENTER DESCRIPTIONS	DIETARY MEALS SERVED	CAFETERIA FTES	NURSING ADMINIS- TRATION FTES	MEDICAL RECORDS + LIBRARY GROSS REVENUE	SOCIAL SERVICE PATIENT DAYS		
		10	11	13	16	17		

	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	PURCHASING							5.01
5.02	ADMITTING							5.02
5.03	PATIENT ACCOUNTS							5.03
5.04	OTHER A&G							5.04
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary	70,446						10
11	Cafeteria		50,954					11
12	Maintenance of Personnel							12
13	Nursing Administration		1,033	31,284				13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		565		229,878,626			16
17	Social Service		1,766			49,201		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	70,446	30,811	30,811	93,791,101	49,201		30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		473	473	1,859,946			50
54	Radiology-Diagnostic		853		3,796,349			54
56	Radioisotope				11,057			56
60	Laboratory		282		7,345,221			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		10,260		49,570,501			65
66	Physical Therapy		1,632		3,630,314			66
67	Occupational Therapy		775		3,203,744			67
68	Speech Pathology		551		2,202,834			68
68.01	PSYCHOLOGY							68.01
71	Medical Supplies Charged to Patients				21,318,012			71
73	Drugs Charged to Patients		1,632		35,961,806			73
74	Renal Dialysis				6,529,681			74
75.01	ULTRASOUND		73		658,060			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
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	70,446	50,706	31,284	229,878,626	49,201		118
	NONREIMBURSABLE COST CENTERS							
190.01	IDLE SPACE							190.01
194	PSYCHOLOGY		248					194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,889,813	1,038,004	1,539,157	772,631	2,312,182		202
203	Unit Cost Multiplier (Wkst. B, Part I)	26.826406	20.371394	49.199495	0.003361	46.994614		203
204	Cost to be allocated (Per Wkst. B, Part II)	275,859	430,773	58,722	58,149	88,789		204
205	Unit Cost Multiplier (Wkst. B, Part II)	3.915893	8.454155	1.877062	0.000253	1.804618		205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

KPMG LLP Compu-Max 2552-10

RML HEALTH PROVIDERS, L.P. Provider CCN: 14-2010	In Lieu of Form CMS-2552-10	Period : From: 06/01/2017 To: 05/31/2018	Run Date: 10/29/2018 Run Time: 08:58 Version: 2018.04 (09/26/2018)
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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		AMOUNT	
		CODE	LINE NO.		
	1	2	3	4	

KPMG LLP Compu-Max 2552-10

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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	42,926,623		42,926,623		42,926,623	30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,204,370		1,204,370		1,204,370	50
54	Radiology-Diagnostic	2,056,999		2,056,999		2,056,999	54
56	Radioisotope	47,171		47,171		47,171	56
60	Laboratory	1,696,341		1,696,341		1,696,341	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	12,444,625		12,444,625		12,444,625	65
66	Physical Therapy	1,970,781		1,970,781		1,970,781	66
67	Occupational Therapy	1,153,453		1,153,453		1,153,453	67
68	Speech Pathology	778,129		778,129		778,129	68
68.01	PSYCHOLOGY						68.01
71	Medical Supplies Charged to Patients	4,457,079		4,457,079		4,457,079	71
73	Drugs Charged to Patients	7,912,798		7,912,798		7,912,798	73
74	Renal Dialysis	2,398,234		2,398,234		2,398,234	74
75.01	ULTRASOUND	169,619		169,619		169,619	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
	OTHER REIMBURSABLE COST CENTERS						
200	Subtotal (sum of lines 30 thru 199)	79,216,222		79,216,222		79,216,222	200
201	Less Observation Beds						201
202	Total (line 200 minus line 201)	79,216,222		79,216,222		79,216,222	202

KPMG LLP Compu-Max 2552-10

RML HEALTH PROVIDERS, L.P. Provider CCN: 14-2010	In Lieu of Form CMS-2552-10	Period : From: 06/01/2017 To: 05/31/2018	Run Date: 10/29/2018 Run Time: 08:58 Version: 2018.04 (09/26/2018)
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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	93,791,101		93,791,101				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,790,721	69,225	1,859,946	0.647530	0.647530	0.647530	50
54	Radiology-Diagnostic	3,632,814	163,535	3,796,349	0.541836	0.541836	0.541836	54
56	Radioisotope	11,057		11,057	4.266166	4.266166	4.266166	56
60	Laboratory	7,209,147	136,074	7,345,221	0.230945	0.230945	0.230945	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	48,725,003	845,498	49,570,501	0.251049	0.251049	0.251049	65
66	Physical Therapy	3,624,618	5,696	3,630,314	0.542868	0.542868	0.542868	66
67	Occupational Therapy	3,199,953	3,791	3,203,744	0.360033	0.360033	0.360033	67
68	Speech Pathology	2,200,641	2,193	2,202,834	0.353240	0.353240	0.353240	68
68.01	PSYCHOLOGY							68.01
71	Medical Supplies Charged to Patients	21,318,012		21,318,012	0.209076	0.209076	0.209076	71
73	Drugs Charged to Patients	35,961,806		35,961,806	0.220033	0.220033	0.220033	73
74	Renal Dialysis	5,799,546	730,135	6,529,681	0.367282	0.367282	0.367282	74
75.01	ULTRASOUND	640,061	17,999	658,060	0.257756	0.257756	0.257756	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
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (sum of lines 30 thru 199)	227,904,480	1,974,146	229,878,626				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	227,904,480	1,974,146	229,878,626				202

KPMG LLP Compu-Max 2552-10

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust- ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	4,196,653		4,196,653	49,201	85.30	16,660	1,421,098	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)	4,196,653		4,196,653	49,201		16,660	1,421,098	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

RML HEALTH PROVIDERS, L.P. Provider CCN: 14-2010	In Lieu of Form CMS-2552-10	Period : From: 06/01/2017 To: 05/31/2018	Run Date: 10/29/2018 Run Time: 08:58 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-2010

WORKSHEET D PART II

Check ☐ Title V ☒ Hospital ☐ SUB (Other) ☒ PPS
Applicable ☒ Title XVIII, Part A ☐ IPF ☐ 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	69,894	1,859,946	0.037579	574,993	21,608	50
54	Radiology-Diagnostic	292,187	3,796,349	0.076965	1,473,209	113,386	54
56	Radioisotope	2,807	11,057	0.253866	3,362	853	56
60	Laboratory	47,593	7,345,221	0.006479	2,788,917	18,069	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	595,170	49,570,501	0.012007	20,130,598	241,708	65
66	Physical Therapy	94,346	3,630,314	0.025988	1,206,231	31,348	66
67	Occupational Therapy	47,149	3,203,744	0.014717	1,052,786	15,494	67
68	Speech Pathology	35,626	2,202,834	0.016173	839,702	13,581	68
68.01	PSYCHOLOGY						68.01
71	Medical Supplies Charged to Pat	122,022	21,318,012	0.005724	7,153,788	40,948	71
73	Drugs Charged to Patients	411,366	35,961,806	0.011439	11,214,041	128,277	73
74	Renal Dialysis	53,755	6,529,681	0.008232	2,336,850	19,237	74
75.01	ULTRASOUND	8,475	658,060	0.012879	136,254	1,755	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
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,780,390	136,087,525		48,910,731	646,264	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

RML HEALTH PROVIDERS, L.P. Provider CCN: 14-2010	In Lieu of Form CMS-2552-10	Period : From: 06/01/2017 To: 05/31/2018	Run Date: 10/29/2018 Run Time: 08:58 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

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

☒ PPS
☐ TEFRA
☐ Other

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

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

RML HEALTH PROVIDERS, L.P. Provider CCN: 14-2010	In Lieu of Form CMS-2552-10	Period : From: 06/01/2017 To: 05/31/2018	Run Date: 10/29/2018 Run Time: 08:58 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

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

☒ PPS
☐ TEFRA
☐ Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass- Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	49,201		16,660		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)	49,201		16,660		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

RML HEALTH PROVIDERS, L.P. Provider CCN: 14-2010	In Lieu of Form CMS-2552-10	Period : From: 06/01/2017 To: 05/31/2018	Run Date: 10/29/2018 Run Time: 08:58 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-2010

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
56	Radioisotope									56
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
68.01	PSYCHOLOGY									68.01
71	Medical Supplies Charged to Pat									71
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
75.01	ULTRASOUND									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
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

RML HEALTH PROVIDERS, L.P. Provider CCN: 14-2010	In Lieu of Form CMS-2552-10	Period : From: 06/01/2017 To: 05/31/2018	Run Date: 10/29/2018 Run Time: 08:58 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-2010

WORKSHEET D
PART IV

Check
Applicable
Boxes:

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

☒ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☒ PPS
☐ TEFRA
☐ Other

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass- Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass- Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	1,859,946			574,993		69,225		50
54	Radiology-Diagnostic	3,796,349			1,473,209		163,535		54
56	Radioisotope	11,057			3,362				56
60	Laboratory	7,345,221			2,788,917		136,074		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	49,570,501			20,130,598		845,498		65
66	Physical Therapy	3,630,314			1,206,231		5,696		66
67	Occupational Therapy	3,203,744			1,052,786		3,791		67
68	Speech Pathology	2,202,834			839,702		2,193		68
68.01	PSYCHOLOGY								68.01
71	Medical Supplies Charged to Pat	21,318,012			7,153,788				71
73	Drugs Charged to Patients	35,961,806			11,214,041				73
74	Renal Dialysis	6,529,681			2,336,850		730,135		74
75.01	ULTRASOUND	658,060			136,254		17,999		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
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	136,087,525			48,910,731		1,974,146		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

RML HEALTH PROVIDERS, L.P. Provider CCN: 14-2010	In Lieu of Form CMS-2552-10	Period : From: 06/01/2017 To: 05/31/2018	Run Date: 10/29/2018 Run Time: 08:58 Version: 2018.04 (09/26/2018)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-2010

WORKSHEET D
PART V

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

(A)	Cost Center Description	Program Charges				Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.647530	69,225			44,825			50
54	Radiology-Diagnostic	0.541836	163,535			88,609			54
56	Radioisotope	4.266166							56
60	Laboratory	0.230945	136,074			31,426			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.251049	845,498			212,261			65
66	Physical Therapy	0.542868	5,696			3,092			66
67	Occupational Therapy	0.360033	3,791			1,365			67
68	Speech Pathology	0.353240	2,193			775			68
68.01	PSYCHOLOGY								68.01
71	Medical Supplies Charged to Pat	0.209076							71
73	Drugs Charged to Patients	0.220033							73
74	Renal Dialysis	0.367282	730,135			268,165			74
75.01	ULTRASOUND	0.257756	17,999			4,639			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
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		1,974,146			655,157			200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		1,974,146			655,157			202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

RML HEALTH PROVIDERS, L.P. Provider CCN: 14-2010	In Lieu of Form CMS-2552-10	Period : From: 06/01/2017 To: 05/31/2018	Run Date: 10/29/2018 Run Time: 08:58 Version: 2018.04 (09/26/2018)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-2010****WORKSHEET D-1
PART I**

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

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

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	49,201	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	49,201	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)	49,201	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)	16,660	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)	42,926,623	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)	42,926,623	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)	42,926,623	37

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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-2010****WORKSHEET D-1
PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS							1	
38	Adjusted general inpatient routine service cost per diem (see instructions)						872.47	38
39	Program general inpatient routine service cost (line 9 x line 38)						14,535,350	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)						14,535,350	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)						13,069,783	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						27,605,133	49
PASS THROUGH COST ADJUSTMENTS								
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						1,421,098	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						646,264	51
52	Total Program excludable cost (sum of lines 50 and 51)						2,067,362	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						25,537,771	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

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-2010

WORKSHEET D-1
PARTS III & IV

Check
Applicable
Boxes:

☐ Title V - I/P

☒ Title XVIII, Part A

☐ Title XIX - I/P

☒ Hospital

☐ IPF

☐ IRF

☐ SUB (Other)

☐ SNF

☐ NF

☐ ICF/IID

☒ PPS

☐ TEFRA

☐ Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)						87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					872.47	88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-2010

WORKSHEET D-3

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		32,560,713		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.647530	574,993	372,325	50
54	Radiology-Diagnostic	0.541836	1,473,209	798,238	54
56	Radioisotope	4.266166	3,362	14,343	56
60	Laboratory	0.230945	2,788,917	644,086	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.251049	20,130,598	5,053,766	65
66	Physical Therapy	0.542868	1,206,231	654,824	66
67	Occupational Therapy	0.360033	1,052,786	379,038	67
68	Speech Pathology	0.353240	839,702	296,616	68
68.01	PSYCHOLOGY				68.01
71	Medical Supplies Charged to Patients	0.209076	7,153,788	1,495,685	71
73	Drugs Charged to Patients	0.220033	11,214,041	2,467,459	73
74	Renal Dialysis	0.367282	2,336,850	858,283	74
75.01	ULTRASOUND	0.257756	136,254	35,120	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
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		48,910,731	13,069,783	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		48,910,731		202

(A) Worksheet A line numbers

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CALCULATION OF REIMBURSEMENT SETTLEMENT**COMPONENT CCN: 14-2010****WORKSHEET E
PART B**Check applicable box: ☒ **Hospital** ☐ **IPF** ☐ **IRF** ☐ **SUB (Other)** ☐ **SNF****PART B - MEDICAL AND OTHER HEALTH SERVICES**

		1	1.01	1.02	
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under OPPS (see instructions)	655,157			2
3	OPPS payments	669,586			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)	0.939			5
6	Line 2 times line 5	615,192			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)	669,586			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	133,919			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)	535,667			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)	535,667			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	535,667			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)	535,667			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)	535,667			40
40.01	Sequestration adjustment (see instructions)	10,713			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	524,954			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)				43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (see instructions)				91
92	The rate used to calculate the Time Value of Money				92
93	Time Value of Money (see instructions)				93
94	Total (sum of lines 91 and 93)				94

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WORKSHEET E-1
PART I

				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				28,484,582		524,954	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)		.01					3.01
			.02					3.02
		Program	.03					3.03
		to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50	05/03/2018	4,309,631			3.50
			.51					3.51
		Provider	.52					3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		-4,309,631			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)				24,174,951		524,954	4
TO BE COMPLETED BY CONTRACTOR								
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)		.01					5.01
			.02					5.02
		Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due) based on the cost report (1)		.01					6.01
			.02		-43,652			6.02
7	Total Medicare program liability (see instructions)				24,131,299		524,954	7
8	Name of Contractor			Contractor Number		NPR Date (Month/Day/Year)		8

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CALCULATION OF REIMBURSEMENT SETTLEMENT**WORKSHEET E-3
PART IV**

Check applicable box: [XX] Hospital

PART IV - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER LTCH PPS

1	Net Federal PPS payment (see instructions)	23,947,384	1
1.01	Full standard payment amount	19,556,734	1.01
1.02	Short stay outlier standard payment amount	4,109,417	1.02
1.03	Site neutral payment amount - Cost	60,834	1.03
1.04	Site neutral payment amount - IPPS comparable	220,399	1.04
2	Outlier payments	3,307,888	2
3	Total PPS payments (sum of lines 1 and 2)	27,255,272	3
4	Nursing and allied health managed care payments (see instructions)		4
5	Organ acquisition DO NOT USE THIS LINE		5
6	Cost of physicians' services in a teaching hospital (see instructions)		6
7	Subtotal (see instructions)	27,255,272	7
8	Primary payer payments		8
9	Subtotal (line 7 less line 8)	27,255,272	9
10	Deductibles	38,404	10
11	Subtotal (line 9 minus line 10)	27,216,868	11
12	Coinsurance	3,528,088	12
13	Subtotal (line 11 minus line 12)	23,688,780	13
14	Allowable bad debts (exclude bad debts for professional services) (see instructions)	1,438,453	14
15	Adjusted reimbursable bad debts (see instructions)	934,994	15
16	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,248,484	16
17	Subtotal (sum of lines 13 and 15)	24,623,774	17
18	Direct graduate medical education payments (from Wkst. E-4, line 49)		18
19	Other pass through costs (see instructions)		19
20	Outlier payments reconciliation		20
21	Other adjustments (specify) (see instructions)		21
21.50	Pioneer ACO demonstration payment adjustment (see instructions)		21.50
22	Total amount payable to the provider (see instructions)	24,623,774	22
22.01	Sequestration adjustment (see instructions)	492,475	22.01
22.02	Demonstration payment adjustment amount after sequestration		22.02
23	Interim payments	24,174,951	23
24	Tentative settlement (for contractor use only)		24
25	Balance due provider/program (line 22 minus lines 22.01, 22.02, 23 and 24)	-43,652	25
26	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		26

TO BE COMPLETED BY CONTRACTOR

50	Original outlier amount from Wkst. E-3 Part IV, line 2 (see instructions)		50
51	Outlier reconciliation adjustment amount (see instructions)		51
52	The rate used to calculate the Time Value of Money (see instructions)		52
53	Time Value of Money (see instructions)		53

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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	5,307,719				1
2	Temporary investments	16,405,955				2
3	Notes receivable					3
4	Accounts receivable	25,308,081				4
5	Other receivables	261,343				5
6	Allowances for uncollectible notes and accounts receivable	-3,705,000				6
7	Inventory	536,971				7
8	Prepaid expenses	1,714,428				8
9	Other current assets	1,373,325				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	47,202,822				11
	FIXED ASSETS					
12	Land					12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings	39,390,234				15
16	Accumulated depreciation	-4,118,122				16
17	Leasehold improvements	2,941,326				17
18	Accumulated depreciation	-312,589				18
19	Fixed equipment	5,219,855				19
20	Accumulated depreciation	-4,267,438				20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	21,864,557				23
24	Accumulated depreciation	-16,894,832				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)	43,822,991				30
	OTHER ASSETS					
31	Investments	25,006,502				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	4,403,525				34
35	Total other assets (sum of lines 31-34)	29,410,027				35
36	Total assets (sum of lines 11, 30 and 35)	120,435,840				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	8,694,273				37
38	Salaries, wages and fees payable	3,513,071				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)					40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds	973,765				43
44	Other current liabilities	6,387,913				44
45	Total current liabilities (sum of lines 37 thru 44)	19,569,022				45
	LONG TERM LIABILITIES					
46	Mortgage payable	35,275,720				46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	6,460,110				49
50	Total long term liabilities (sum of lines 46 thru 49)	41,735,830				50
51	Total liabilities (sum of lines 45 and 50)	61,304,852				51
	CAPITAL ACCOUNTS					
52	General fund balance	59,130,988				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)	59,130,988				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	120,435,840				60

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

		GENERAL FUND		SPECIFIC PURPOSE FUND	
		1	2	3	4
1	Fund balances at beginning of period		51,788,145		1
2	Net income (loss) (from Worksheet G-3, line 29)		13,491,625		2
3	Total (sum of line 1 and line 2)		65,279,770		3
4	Additions (credit adjustments) (specify)				4
5	ADVOCATE CAPITAL CONTRIBUTIONS				5
6	CHANGE IN TEMP RESTRICTED CONTRIBUT				6
7					7
8					8
9					9
10	Total additions (sum of lines 4-9)				10
11	Subtotal (line 3 plus line 10)		65,279,770		11
12	Deductions (debit adjustments) (specify)				12
13	UNREALIZED LOSS ON INVESTMENT	6,148,782			13
14	PARTNERSHIP DISTRIBUTIONS				14
15					15
16					16
17					17
18	Total deductions (sum of lines 12-17)		6,148,782		18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		59,130,988		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	ADVOCATE CAPITAL CONTRIBUTIONS				5
6	CHANGE IN TEMP RESTRICTED CONTRIBUT				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	UNREALIZED LOSS ON INVESTMENT				13
14	PARTNERSHIP DISTRIBUTIONS				14
15					15
16					16
17					17
18	Total deductions (sum of lines 12-17)				18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)				19

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RML HEALTH PROVIDERS, L.P. Provider CCN: 14-2010	In Lieu of Form CMS-2552-10	Period : From: 06/01/2017 To: 05/31/2018	Run Date: 10/29/2018 Run Time: 08:58 Version: 2018.04 (09/26/2018)
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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES**WORKSHEET G-2
PARTS I & II****PART I - PATIENT REVENUES**

	REVENUE CENTER	INPATIENT	OUTPATIENT	TOTAL	
		1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	102,274,967		102,274,967	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)	102,274,967		102,274,967	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)	102,274,967		102,274,967	17
18	Ancillary services	127,603,660		127,603,660	18
19	Outpatient services				19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	PRO FEES		3,164,314	3,164,314	27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	229,878,627	3,164,314	233,042,941	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		93,141,488	29
30	Add (specify)	1		30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)		1	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)		93,141,489	43

KPMG LLP Compu-Max 2552-10

RML HEALTH PROVIDERS, L.P. Provider CCN: 14-2010	In Lieu of Form CMS-2552-10	Period : From: 06/01/2017 To: 05/31/2018	Run Date: 10/29/2018 Run Time: 08:58 Version: 2018.04 (09/26/2018)
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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)	233,042,941	1
2	Less contractual allowances and discounts on patients' accounts	129,275,457	2
3	Net patient revenues (line 1 minus line 2)	103,767,484	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	93,141,489	4
5	Net income from service to patients (line 3 minus line 4)	10,625,995	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		14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts		18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hosptial space		22
23	Governmental appropriations		23
24	Other (OTHER (OTHER REVENUE))	3,164,621	24
24.01	Other (OTHER (GRANT REVENUE))		24.01
24.02	Other (OTHER (GAIN ON SALE OF ASSET))		24.02
24.03	Other (MISC)		24.03
25	Total other income (sum of lines 6-24)	3,164,621	25
26	Total (line 5 plus line 25)	13,790,616	26
27	Other expenses (GAIN ON SALE OF ASSET)	298,991	27
27.01	Other expenses (MISCELLANEOUS)		27.01
28	Total other expenses (sum of line 27 and subscripts)	298,991	28
29	Net income (or loss) for the period (line 26 minus line 28)	13,491,625	29