

National Government Services, Inc.
3200 Pleasant Run, Suite B
Springfield, IL 62711

Re: Provider: Richland Memorial Hospital

Provider Numbers: 14-0147, 14-S147, 14-U147, 14-5580, 14-7187, 14-1542

Period ended: 09/30/2014

Protested amounts claimed on submitted cost report.

Dear Sir or Madam:

The Provider contends that its base-year hospital-specific rate, applied to calculate the payments to the Provider during this cost reporting period, is artificially low because of the application of a cumulative budget neutrality factor that encompasses all budget neutrality adjustments made prior to the base year. As reflected in the attached calculation, the Provider estimates that the reimbursement impact of this issue for this cost reporting period is \$97,000.

The Provider currently has an appeal of the determination of its base-year hospital specific rate pending before the Provider Reimbursement Review Board. As explained in that appeal, the Provider contends that applying a cumulative budget neutrality adjustment to the base year hospital-specific rate is fatally flawed for at least the following reasons:

- It is contrary to the statutory mandate to use "100 percent of the hospital's target amount." See, e.g., Soc. Sec. Act § 1886(d) (5) (D) (i).
- It is duplicative and removes twice the effect of recalibrating DRGs: once when the hospital-specific rate is divided by the hospital's case mix index and again when the budget neutrality factor is directly applied to the hospital-specific rate.

Richland Memorial Hospital
Hospital Specific Rate Recalculation
September 30, 2014

The hospital specific calculation without the cumulative
budget neutrality factor would be:

HSP difference for September 30, 2010	109.74
2011 Update Factor	1.0235
2012 Update Factor	1.0190
2013 Update Factor	1.0180
2014 Update Factor	1.0170
2011 Budget Neutrality	0.996731
2012 Budget Neutrality	0.997903
2013 Budget Neutrality	0.998431
2014 Budget Neutrality	0.997989
2012 Rural Floor Add-on	1.009
2014 Document & Coding	0.948
2014 Medicare Part A Offset	0.998
	<hr/>
2012 difference	112.11
DRG weight	1,157.94
	<hr/>
	129,814
MDH payment factor	0.75
	<hr/>
	97,361
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Rounded	97,000
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RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/07/2015 Run Time: 12:29 Version: 2014.10
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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. <input checked="" type="checkbox"/> ELECTRONICALLY FILED COST REPORT	DATE: 02/07/2015	TIME: 12:29
	2. <input type="checkbox"/> MANUALLY SUBMITTED COST REPORT		
	3. <input type="checkbox"/> IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THE COST REPORT		
	4. <input type="checkbox"/> MEDICARE UTILIZATION. ENTER 'F' FOR FULL OR 'L' FOR LOW.		
CONTRACTOR USE ONLY	5. <input type="checkbox"/> COST REPORT STATUS	6. DATE RECEIVED: _____	10. NPR DATE: _____
	1 -AS SUBMITTED	7. CONTRACTOR NO: _____	11. CONTRACTOR'S VENDOR CODE: _____
	2 -SETTLED WITHOUT AUDIT	8. <input type="checkbox"/> INITIAL REPORT FOR THIS PROVIDER CCN	12. <input type="checkbox"/> IF LINE 5, COLUMN 1 IS 4: ENTER NUMBER OF TIMES REOPENED = 0-9.
	3 -SETTLED WITH AUDIT	9. <input type="checkbox"/> FINAL REPORT FOR THIS PROVIDER CCN	
	4 -REOPENED		
	5 -AMENDED		

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 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE 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 RICHLAND MEMORIAL HOSPITAL (14-0147) ((PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 10/01/2013 AND ENDING 09/30/2014, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT 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.

ECR Encryption: 02/07/2015 12:29
Vg8FvOB.WxwVScV8Tq8rgepcC:CoS0
PzZXf0iKD49jcoeqguTym54wy40RWq
dbY:15P7lz0Wz.7t

(SIGNED) _____
OFFICER OR ADMINISTRATOR OF PROVIDER(S)

TITLE

DATE

PI Encryption: 02/07/2015 12:29
WVyYVVUN8OtuHDyciHIVU:T0B08sR0
nRvuR0FqM0iYPDIMITGuHe6p5J6vv3
62sB0rYsox0epklk

PART III - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII		HIT	TITLE XIX	
		1	PART A 2	PART B 3	4	5	
1	HOSPITAL		-214,056	39,606	1,740		1
2	SUBPROVIDER - IPF		8,614				2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF		2,780				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		-202,662	39,606	1,740		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.

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RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 01/22/2015 Run Time: 14:57 Version: 2014.10
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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: 800 EAST LOCUST	P.O. Box:								1	
2	City: OLNEY	State: IL	ZIP Code: 62450-2958	County: RICHLAND				2			
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	RICHLAND MEMORIAL HOSPITAL	14-0147	99914	1	07/01/1966	N	P	P	3	
4	Subprovider - IPF	RICHLAND MEMORIAL HOSPITAL PSYCH	14-S147	99914	4	07/01/1966	N	P	P	4	
5	Subprovider - IRF									5	
6	Subprovider - (OTHER)									6	
7	Swing Beds - SNF	RICHLAND MEMORIAL HOSPITAL SWING BED	14-U147	99914		11/13/2003	N	P	N	7	
8	Swing Beds - NF									8	
9	Hospital-Based SNF	RICHLAND MEMORIAL HOSPITAL SNF	14-5580	99914		11/05/1987	N	P	N	9	
10	Hospital-Based NF									10	
11	Hospital-Based OLTC									11	
12	Hospital-Based HHA	RICHLAND MEMORIAL HOSPITAL HHA	14-7187	99914		05/01/1980	N	P	N	12	
13	Separately Certified ASC									13	
14	Hospital-Based Hospice	RICHLAND MEMORIAL HOSPITAL HOSPICE	14-1542	99914		04/23/1991				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: 10 / 01 / 2013	To: 09 / 30 / 2014				20				
21	Type of control (see instructions)	2		21							
Inpatient PPS Information										1	2
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.								Y	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	Y	22.01
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter 'Y' for yes or 'N' for no.								3	N	23
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days				
		1	2	3	4	5	6				
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	831	53			131	407		24		
25	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.								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.				2					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.				2					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 in effect in the cost reporting period.				1					37	
38	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				Beginning: 10 / 01 / 2013	Ending: 09 / 30 / 2014				38	
										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)(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)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)								Y	Y	39

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XVIII	XIX	
		1	2	3	
Prospective Payment System (PPS)-Capital		N	N	N	45
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	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 Worksheet L, Part III and L-1, Parts I through III.	N	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	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N	48
Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	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 Worksheet E-4. If column 2 is 'N', complete Worksheet D, Part III & IV and D-2, Part 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, section 2148? If yes, complete Worksheet D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	N			60
		Y/N	IME	Direct GME	
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 and enter in column 4 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 and enter in column 4 direct 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 Non-Provider Settings					
63	Has your facility trained residents in non-provider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64-67. (see instructions)	N			63

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings-This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	RATIO (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider 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					
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider 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					
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	1	2	3	70
71	If line 70 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, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5.	N	N		71
Inpatient Rehabilitation Facility PPS					
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.	1	2	3	75
76	If line 75 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, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5.				76
Long Term Care Hospital PPS					
80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.		N		80
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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Title V and XIX Services		V	XIX			
		1	2			
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90		
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	N	91		
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92		
93	Does this facility operate an ICF/MR 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		
Rural Providers		1	2			
105	Does this hospital qualify as a Critical Access Hospital (CAH)?	N		105		
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106		
107	Column 1: If 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. If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes, complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter 'Y' for yes or 'N' for no in column 2.			107		
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108		
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.	Physical	Occupational	Speech	Respiratory	109
		N	N	N	N	
Miscellaneous Cost Reporting Information						
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If 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'	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.	2			118	
		Premiums	Paid Losses	Self Insurance		
118.01	List amounts of malpractice premiums and paid losses:	634,242			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.	Y			121	
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, if applicable in column 2.				126	
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				127	
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				128	
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				129	
130	If this is a Medicare certified pancreas transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				130	
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				131	
132	If this is a Medicare certified islet transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				132	
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date, if applicable 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)	N			140
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
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 Worksheet A, line 74 are they costs for inpatient services only? Enter 'Y' for yes, or 'N' for no.	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, section 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	1	3
155	Hospital	N	N	N	N
156	Subprovider - IPF	N	N	N	N
157	Subprovider - IRF	N	N		
158	Subprovider - Other				
159	SNF	N	N	N	N
160	HHA	N	N	N	N
161	CMHC		N		
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.				166
	Name	County	State	ZIP Code	CBSA
	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.	Y			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
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transitional factor. (see instructions)	0.50			169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			10/01/2013	09/30/2014

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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	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 'T' FOR INVOLUNTARY.	N			2
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (e.g., chain home offices, drug or medical supply companies) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (see instructions)	N			3
FINANCIAL DATA AND REPORTS					
		Y/N	TYPE	DATE	
		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 ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N			5
APPROVED EDUCATIONAL ACTIVITIES					
		Y/N	Y/N		
		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 INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N			9
10	WAS AN INTERN-RESIDENT 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
BAD DEBTS					
				Y/N	
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.			Y	12
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.			N	13
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			N	14
BED COMPLEMENT					
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N	15
PART A					
		Y/N	DATE	Y/N	DATE
		1	2	3	4
PS&R REPORT DATA					
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (see instructions)	Y	11/14/2014	Y	11/14/2014
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (see instructions)	N		N	
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	
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	
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART IIGENERAL 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 COSTS			
22	HAVE ASSETS BEEN RELIEF 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 CAPITALIZED 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
HOME OFFICE COSTS		Y/N	DATE
36	WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT?	1	2
37	IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.		
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.		
39	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO OTHER CHAIN COMPONENTS? IF YES, SEE INSTRUCTIONS.		
40	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.		
COST REORT PREPARER INFORMATION			
41	FIRST NAME: DAVID	LAST NAME: SCHNAKE	TITLE: PARTNER
42	EMPLOYER: KERBER, ECK & BRAECKEL, LLP		
43	PHONE NUMBER: 618-529-1040	E-MAIL ADDRESS: DAVIDS@KEBCPA.COM	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	COMPONENT	WKST A LINE NO.	NO. OF BEDS	BED DAYS AVAILABLE	CAH HOURS	INPATIENT DAYS/OUTPATIENT VISITS/TRIPS				
						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	39	14,235			2,865	873	4,685	1
2	HMO AND OTHER (see instructions)						111	131		2
3	HMO IPF SUBPROVIDER									3
4	HMO IRF SUBPROVIDER									4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF						372			372
6	HOSPITAL ADULTS & PEDS. SWING BED NF									31
7	TOTAL ADULTS & PEDS. (exclude observation beds)(see instructions)		39	14,235			3,237	873		5,088
8	INTENSIVE CARE UNIT	31	8	2,920			878	11		939
9	CORONARY CARE UNIT	32								
10	BURN INTENSIVE CARE UNIT	33								
11	SURGICAL INTENSIVE CARE UNIT	34								
12	OTHER SPECIAL CARE (SPECIFY)	35								
13	NURSERY	43						407		611
14	TOTAL (see instructions)		47	17,155			4,115	1,291		6,638
15	CAH VISITS									
16	SUBPROVIDER - IPF	40	10	3,650			501	913		2,073
17	SUBPROVIDER - IRF	41								
18	SUBPROVIDER I	42								
19	SKILLED NURSING FACILITY	44	34	12,410			2,941			10,067
20	NURSING FACILITY	45								
21	OTHER LONG TERM CARE	46								
22	HOME HEALTH AGENCY	101					11,798			14,019
23	ASC (Distinct Part)	115								
24	HOSPICE (Distinct Part)	116	1	365						
24.10	HOSPICE (non-distinct part)	30								
25	CMHC	99								
26	RHC	88								
27	TOTAL (sum of lines 14-26)		92							
28	OBSERVATION BED DAYS							182		910
29	AMBULANCE TRIPS						1,047			
30	EMPLOYEE DISCOUNT DAYS (see instructions)									
31	EMPLOYEE DISCOUNT DAYS-IRF									
32	LABOR & DELIVERY DAYS (see instructions)									
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)									32.01
33	LTCH NON-COVERED DAYS									33

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	COMPONENT	FULL TIME EQUIVALENTS			DISCHARGES			TOTAL ALL PATIENTS	
		TOTAL INTERNS & RESIDENTS	EMPLOYEES ON PAYROLL	NONPAID WORKERS	TITLE V	TITLE XVIII	TITLE XIX		
		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)					892	191	1,345	1
2	HMO AND OTHER (see instructions)					32			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)		380.01			892	191	1,345	14
15	CAH VISITS								15
16	SUBPROVIDER - IPF		15.55			107	209	489	16
17	SUBPROVIDER - IRF								17
18	SUBPROVIDER I								18
19	SKILLED NURSING FACILITY		28.50						19
20	NURSING FACILITY								20
21	OTHER LONG TERM CARE								21
22	HOME HEALTH AGENCY		15.31						22
23	ASC (Distinct Part)								23
24	HOSPICE (Distinct Part)		4.33						24
24.10	HOSPICE (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	TOTAL (sum of lines 14-26)		443.70						27
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)								32

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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	200	21,336,727		21,336,727	922,898.00	23.12	1
2							2
3		782,901		782,901	7,854.00	99.68	3
4							4
4.01							4.01
5							5
6							6
7	21						7
7.01							7.01
8							8
9	44	1,025,533		1,025,533	59,282.00	17.30	9
10		5,222,351		5,222,351	177,772.00	29.38	10
OTHER WAGES & RELATED COSTS							
11		260,463		260,463	4,160.00	62.61	11
12							12
13							13
14							14
15							15
16							16
WAGE-RELATED COSTS							
17		4,535,670		4,535,670			17
18		150,457		150,457			18
19		1,512,347		1,512,347			19
20							20
21		146,510		146,510			21
22							22
22.01							22.01
23							23
24							24
25							25
OVERHEAD COSTS - DIRECT SALARIES							
26		225,141		225,141	8,525.00	26.41	26
27		2,017,575		2,017,575	102,560.00	19.67	27
28		32,000		32,000	375.00	85.33	28
29		527,109		527,109	26,226.00	20.10	29
30							30
31		238,762		238,762	18,872.00	12.65	31
32		365,050		365,050	33,950.00	10.75	32
33							33
34		541,327	-393,700	147,627	14,441.00	10.22	34
35							35
36			393,700	393,700	38,515.00	10.22	36
37							37
38		1,200,448		1,200,448	40,304.00	29.78	38
39		69,309		69,309	6,063.00	11.43	39
40		417,183		417,183	13,527.00	30.84	40
41		540,620		540,620	30,185.00	17.91	41
42							42
43							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (see instructions)	20,585,826		20,585,826	915,419.00	22.49	1
2	EXCLUDED AREA SALARIES (see instructions)	6,247,884		6,247,884	237,054.00	26.36	2
3	SUBTOTAL SALARIES (line 1 minus line 2)	14,337,942		14,337,942	678,365.00	21.14	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (see instructions)	260,463		260,463	4,160.00	62.61	4
5	SUBTOTAL WAGE-RELATED COSTS (see instructions)	4,686,127		4,686,127		32.68%	5
6	TOTAL (sum of lines 3 through 5)	19,284,532		19,284,532	682,525.00	28.25	6
7	TOTAL OVERHEAD COST (see instructions)	6,174,524		6,174,524	333,543.00	18.51	7

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HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3

PART IV - WAGE RELATED COST

PART IV

PART A - CORE LIST

		AMOUNT REPORTED	
	RETIREMENT COST		
1	401K EMPLOYER CONTRIBUTIONS	616,120	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)	3,634,664	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN		10
11	LIFE INSURANCE (If employee is owner or beneficiary)		11
12	ACCIDENTAL INSURANCE (If employee is owner or beneficiary)		12
13	DISABILITY INSURANCE (If employee is owner or beneficiary)		13
14	LONG-TERM CARE INSURANCE (If employee is owner or beneficiary)		14
15	WORKERS' COMPENSATION INSURANCE	296,313	15
16	RETIREMENT HEALTH CARE COST (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-EMPLOYERS PORTION ONLY	1,180,005	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY	275,969	18
19	UNEMPLOYMENT INSURANCE	25,586	19
20	STATE OR FEDERAL UNEMPLOYMENT TAXES		20
	OTHER		
21	EXECUTIVE DEFERRED COMPENSATION (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	DAY CARE COSTS AND ALLOWANCES		22
23	TUITION REIMBURSEMENT	95,192	23
24	TOTAL WAGE RELATED COST (Sum of lines 1-23)	6,123,849	24

PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE REL	221,135	25
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WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3, Part IV, Line 4)

EXHIBIT 3

STEP 2: DETERMINE THE 3-YEAR AVERAGING PERIOD			
1	WAGE INDEX FISCAL YEAR ENDING DATE		1
2	PROVIDER'S COST REPORTING PERIOD USED FOR WAGE INDEX YEAR ON LINE 1 (FYB in Col. 1, FYE in Col. 2)		2
3	MIDPOINT OF PROVIDER'S COST REPORTING PERIOD SHOWN ON LINE 2, ADJUSTED TO FIRST OF MONTH		3
4	DATE BEGINNING THE 3-YEAR AVERAGING PERIOD (subtract 18 months from midpoint shown on Line 3)		4
5	DATE ENDING THE 3-YEAR AVERAGING PERIOD (add 18 months to midpoint shown on Line 3)		5
STEP 2 (OPTIONAL): ADJUST AVERAGING PERIOD FOR A NEW PLAN (see instructions)			
6	EFFECTIVE DATE OF PENSION PLAN		6
7	FIRST DAY OF THE PROVIDER COST REPORTING PERIOD CONTAINING THE PENSION PLAN EFFECTIVE DATE		7
8	STARTING DATE OF THE ADJUSTED AVERAGING PERIOD (date on Line 7, adjusted to first of month)		8

IF THIS DATE OCCURS AFTER THE PERIOD SHOWN ON LINE 2, STOP HERE AND SEE INSTRUCTIONS

STEP 3: AVERAGE PENSION CONTRIBUTIONS DURING THE AVERAGING PERIOD			
9	BEGINNING DATE OF AVERAGING PERIOD FROM LINE 4 OR LINE 8, AS APPLICABLE		9
10	ENDING DATE OF AVERAGING PERIOD FROM LINE 5		10
11	ENTER PROVIDER CONTRIBUTIONS MADE DURING AVERAGING PERIOD ON LINES 9 & 10	DEPOSIT DATE(S)	CONTRIBUTION(S)
12	TOTAL CALENDAR MONTHS INCLUDED IN AVERAGING PERIOD (36 unless Step 2 completed)		12
13	TOTAL CONTRIBUTIONS MADE DURING AVERAGING PERIOD		13
14	AVERAGE MONTHLY CONTRIBUTION (Line 13 divided by Line 12)		14
15	NUMBER OF MONTHS IN PROVIDER COST REPORTING PERIOD ON LINE 2		15
16	AVERAGE PENSION CONTRIBUTIONS (Line 14 times Line 15)		16
STEP 4: TOTAL PENSION COST FOR WAGE INDEX			
17	ANNUAL PREFUNDING INSTALLMENT (see instructions)		17
18	REPORTABLE PREFUNDING INSTALLMENT ((Line 17 times Line 15) divided by 12)		18
19	TOTAL PENSION COST FOR WAGE INDEX (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)		19

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HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT	CONTRACT LABOR	BENEFIT COST	
	0	1	2	
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST	473,999		1
2	HOSPITAL	260,463		2
3	SUBPROVIDER - IPF	173,450		3
4	SUBPROVIDER - IRF			4
5	SUBPROVIDER - (OTHER)			5
6	SWING BEDS - SNF			6
7	SWING BEDS - NF			7
8	HOSPITAL-BASED SNF	30,000		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	10,086		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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HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA

HHA CCN: 14-7187

WORKSHEET S-4

HOME HEALTH AGENCY STATISTICAL DATA

COUNTY:

	DESCRIPTION	TITLE V 1	TITLE XVIII 2	TITLE XIX 3	OTHER 4	TOTAL 5	
1	HOME HEALTH AIDE HOURS		5,649		142	5,791	1
2	UNDULICATED CENSUS COUNT (see instructions)		346.00	57.00	55.00	458.00	2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

	ENTER THE NUMBER OF HOURS IN YOUR NORMAL WORK WEEK 40.00	NUMBER OF EMPLOYEES (Full Time Equivalent)			
		STAFF	CONTRACT	TOTAL	
		1	2	3	
3	ADMINISTRATOR AND ASSISTANT ADMINISTRATOR(S)				3
4	DIRECTOR(S) AND ASSISTANT DIRECTOR(S)		1.00		1.00 4
5	OTHER ADMINISTRATIVE PERSONNEL		1.40		1.40 5
6	DIRECT NURSING SERVICE		12.10		12.10 6
7	NURSING SUPERVISOR		1.90		1.90 7
8	PHYSICAL THERAPY SERVICE				8
9	PHYSICAL THERAPY SUPERVISOR				9
10	OCCUPATIONAL THERAPY SERVICE				10
11	OCCUPATIONAL THERAPY SUPERVISOR				11
12	SPEECH PATHOLOGY SERVICE				12
13	SPEECH PATHOLOGY SUPERVISOR				13
14	MEDICAL SOCIAL SERVICE		0.10		0.10 14
15	MEDICAL SOCIAL SERVICE SUPERVISOR				15
16	HOME HEALTH AIDE		2.80		2.80 16
17	HOME HEALTH AIDE SUPERVISOR				17
18	OTHER (SPECIFY)				18

HOME HEALTH AGENCY - CBSA CODES

19	ENTER IN COLUMN 1 THE NUMBER OF CBSAs WHERE YOU PROVIDED SERVICES DURING THE COST REPORTING PERIOD.		1	19
20	LIST THOSE CBSA CODE(S) IN COLUMN 1 SERVICED DURING THIS COST REPORTING PERIOD (line 20 contains the first code).		99914	20

PPS ACTIVITY

		FULL EPISODES				TOTAL (columns 1 through 4)	
		WITHOUT OUTLIERS	WITH OUTLIERS	LUPA EPISODES	PEP ONLY EPISODES		
		1	2	3	4		
21	SKILLED NURSING VISITS	4,890	1,192	209	53	6,344	21
22	SKILLED NURSING VISIT CHARGES	1,044,444	267,315	34,123	10,921	1,356,803	22
23	PHYSICAL THERAPY VISITS	2,646	91	28	20	2,785	23
24	PHYSICAL THERAPY VISIT CHARGES	600,283	20,839	5,128	4,662	630,912	24
25	OCCUPATIONAL THERAPY VISITS	567	45	5	3	620	25
26	OCCUPATIONAL THERAPY VISIT CHARGES	129,524	10,456	930	697	141,607	26
27	SPEECH PATHOLOGY VISITS	102	18	1		121	27
28	SPEECH PATHOLOGY VISIT CHARGES	22,866	4,183	232		27,281	28
29	MEDICAL SOCIAL SERVICE VISITS	47	4	1		52	29
30	MEDICAL SOCIAL SERVICE VISIT CHARGES	15,155	1,291	323		16,769	30
31	HOME HEALTH AIDE VISITS	1,584	287	1	4	1,876	31
32	HOME HEALTH AIDE VISIT CHARGES	208,133	38,556	135	541	247,365	32
33	TOTAL VISITS (sum of lines 21, 23, 25, 27, 29, and 31)	9,836	1,637	245	80	11,798	33
34	OTHER CHARGES						34
35	TOTAL CHARGES (sum of lines 22, 24, 26, 28, 30, 32 and 34)	2,020,405	342,640	40,871	16,821	2,420,737	35
36	TOTAL NUMBER OF EPISODES (standard/non-outlier)	474		69	5	548	36
37	TOTAL NUMBER OF OUTLIER EPISODES		36		1	37	37
38	TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	56,360	23,635	3,297	95	83,387	38

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PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

WORKSHEET S-7

		Y/N	DATE	
		1	2	
1	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, WERE ALL PATIENTS UNDER MANAGED CARE OR WAS THERE NO MEDICARE UTILIZATION? ENTER 'Y' FOR YES IN COLUMN 1 AND DO NOT COMPLETE THE REST OF THIS WORKSHEET.	N		1
2	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE AGREEMENT DATE (mm/dd/yyyy) IN COLUMN 2.	Y	11/12/2003	2

	GROUP	SNF DAYS	SWING BED SNF DAYS	TOTAL (sum of col. 2 + 3)	
	1	2	3	4	
3	RUX				3
4	RUL				4
5	RVX	12		12	5
6	RVL				6
7	RHX	9		9	7
8	RHL				8
9	RMX	19		19	9
10	RML		8	8	10
11	RLX				11
12	RUC	106		106	12
13	RUB	22		22	13
14	RUA	115		115	14
15	RVC	547		547	15
16	RVB	105		105	16
17	RVA	748		748	17
18	RHC	358	20	378	18
19	RHB	42		42	19
20	RHA	453	21	474	20
21	RMC	24	28	52	21
22	RMB	8	18	26	22
23	RMA	96	38	134	23
24	RLB				24
25	RLA				25
26	ES3				26
27	ES2				27
28	ES1	39	42	81	28
29	HE2				29
30	HE1	1	18	19	30
31	HD2				31
32	HD1	11	23	34	32
33	HC2				33
34	HC1	16	2	18	34
35	HB2	4	9	13	35
36	HB1	40	52	92	36
37	LE2				37
38	LE1				38
39	LD2				39
40	LD1	11		11	40
41	LC2				41
42	LC1				42
43	LB2				43
44	LB1				44
45	CE2				45
46	CE1		5	5	46
47	CD2				47
48	CD1	16	7	23	48
49	CC2				49
50	CC1	14	13	27	50
51	CB2				51
52	CB1	38	39	77	52
53	CA2		3	3	53
54	CA1	59	23	82	54
55	SE3				55
56	SE2				56
57	SE1				57
58	SSC				58
59	SSB				59
60	SSA				60
61	IB2				61
62	IB1				62
63	IA1				63
64	IA2				64
65	BB2				65
66	BB1				66
67	BA2				67
68	BA1				68
69	PE2				69
70	PE1				70

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PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

WORKSHEET S-7

	GROUP	SNF DAYS	SWING BED SNF DAYS	TOTAL (sum of col. 2 + 3)	
	1	2	3	4	
71	PD2				71
72	PD1	3	2	5	72
73	PC2				73
74	PC1				74
75	PB2				75
76	PB1	10	1	11	76
77	PA2				77
78	PA1	14		14	78
199	AAA	1		1	199
200	TOTAL	2,941	372	3,313	200

SNF SERVICES

		CBSA AT BEGINNING OF COST REPORTING PERIOD	CBSA ON/AFTER OCTOBER 1 OF THE COST REPORTING PERIOD (if applicable)	
		1	2	
201	ENTER IN COLUMN 1 THE SNF CBSA CODE, OR 5 CHARACTER NON-CBSA CODE IF A RURAL FACILITY, IN EFFECT AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER IN COLUMN 2 THE CODE IN EFFECT ON OR AFTER OCTOBER 1 OF THE COST REPORTING PERIOD (if applicable).	00014	00014	201

A NOTICE PUBLISHED IN THE FEDERAL REGISTER VOLUME 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. FOR LINES 202 THROUGH 207: ENTER IN COLUMN 1 THE AMOUNT OF THE EXPENSE FOR EACH CATEGORY. ENTER IN COLUMN 2 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 7, COLUMN 3. IN COLUMN 3, ENTER 'Y' OR 'N' FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (see instructions)

		EXPENSES	PERCENTAGE	ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES?	
		1	2	3	
202	STAFFING	1,372,193	58.71%	Y	202
203	RECRUITMENT				203
204	RETENTION OF EMPLOYEES				204
205	TRAINING	5,911	0.25%	Y	205
206	OTHER (SPECIFY)				206
207	TOTAL SNF REVENUE (Worksheet G-2, Part I, line 7, column 3)	2,337,229			207

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HOSPICE IDENTIFICATION DATA

HOSPICE CCN: 14-1542

WORKSHEET S-9
PARTS I & II

PART I - ENROLLMENT DAYS

		UNDUPLICATED DAYS						
		TITLE XVIII	TITLE XIX	TITLE XVIII SKILLED NURSING FACILITY	TITLE XIX NURSING FACILITY	ALL OTHER	TOTAL (sum of cols. 1, 2, & 5)	
		1	2	3	4	5	6	
1	CONTINUOUS HOME CARE							1
2	ROUTINE HOME CARE	3,143	98			246	3,487	2
3	INPATIENT RESPITE CARE							3
4	GENERAL INPATIENT CARE							4
5	TOTAL HOSPICE DAYS	3,143	98			246	3,487	5

PART II - CENSUS DATA

		TITLE XVIII	TITLE XIX	TITLE XVIII SKILLED NURSING FACILITY	TITLE XIX NURSING FACILITY	ALL OTHER	TOTAL (sum of cols. 1, 2, & 5)	
		1	2	3	4	5	6	
6	NUMBER OF PATIENTS RECEIVING HOSPICE CARE	83	7			5	95	6
7	TOTAL NUMBER OF UNDUPLICATED CONTINUOUS C							7
8	AVERAGE LENGTH OF STAY (line 5/line 6)	37.87	14.00			49.20	36.71	8
9	UNDUPLICATED CENSUS COUNT							9

NOTE: Parts I & II, columns 1 and 2 also include the days reported in column 3 and 4.

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HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

WORKSHEET S-10

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)	0.255092	1
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MEDICAID (see instructions for each line)

2	NET REVENUE FROM MEDICAID	1,108,090	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	Y	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	Y	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID		5
6	MEDICAID CHARGES	29,942,631	6
7	MEDICAID COST (line 1 times line 6)	7,638,126	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (line 7 minus the sum of lines 2 and 5) IF LINE 7 IS LESS THAN THE SUM OF LINES 2 AND 5, THEN ENTER ZERO.	6,530,036	8

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(see instructions for each line)

9	NET REVENUE FROM STAND-ALONE SCHIP		9
10	STAND-ALONE SCHIP CHARGES		10
11	STAND-ALONE SCHIP COST (line 1 times line 10)		11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (line 11 minus line 9) IF LINE 11 IS LESS THAN LINE 9, THEN ENTER ZERO.		12

OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (see instructions for each line)

13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (not included on lines 2, 5, or 9)		13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (not included in lines 6 or 10)		14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (line 1 times line 14)		15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (line 15 minus line 13) IF LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERO.		16

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE			17	
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS			18	
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (sum of lines 8, 12 and 16)	6,530,036		19	
		UNINSURED PATIENTS	INSURED PATIENTS	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (at full charges excluding non-reimbursable cost centers) FOR THE ENTIRE FACILITY	1,721,279	595,365	2,316,644	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (line 1 times line 20)	439,085	151,873	590,958	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	5,636	25,948	31,584	22
23	COST OF CHARITY CARE (line 21 minus line 22)	433,449	125,925	559,374	23

24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM?	N	24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (see instructions)		25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	3,344,611	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	317,828	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 26 minus line 27)	3,026,783	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 1 times line 28)	772,108	29
30	COST OF UNCOMPENSATED CARE (line 23, column 3 plus line 29)	1,331,482	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (line 19 plus line 30)	7,861,518	31

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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		544,999	544,999	348,699	893,698	-89,712	803,986	1
2	00200	CAP REL COSTS-MVBLE EQUIP		1,197,429	1,197,429	20,223	1,217,652		1,217,652	2
3	00300	OTHER CAP REL COSTS							-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	225,141	6,456,008	6,681,149		6,681,149	-167,148	6,514,001	4
5	00500	ADMINISTRATIVE & GENERAL	2,017,575	4,121,719	6,139,294	-73,683	6,065,611	-2,284,800	3,780,811	5
6	00600	MAINTENANCE & REPAIRS	527,109	303,542	830,651		830,651		830,651	6
7	00700	OPERATION OF PLANT		490,828	490,828		490,828		490,828	7
8	00800	LAUNDRY & LINEN SERVICE	238,762	102,063	340,825		340,825	-170,457	170,368	8
9	00900	HOUSEKEEPING	365,050	147,566	512,616		512,616		512,616	9
10	01000	DIETARY	541,327	803,652	1,344,979	-978,186	366,793		366,793	10
11	01100	CAFETERIA				978,186	978,186	-270,716	707,470	11
12	01200	MAINTENANCE OF PERSONNEL								12
13	01300	NURSING ADMINISTRATION	1,200,448	134,127	1,334,575		1,334,575		1,334,575	13
14	01400	CENTRAL SERVICES & SUPPLY	69,309	-10,123	59,186		59,186	-8,747	50,439	14
15	01500	PHARMACY	417,183	1,762,665	2,179,848		2,179,848	-794	2,179,054	15
16	01600	MEDICAL RECORDS & LIBRARY	540,620	201,695	742,315		742,315	-3,556	738,759	16
17	01700	SOCIAL SERVICE								17
19	01900	NONPHYSICIAN ANESTHETISTS								19
20	02000	NURSING SCHOOL								20
21	02100	I&R SERVICES-SALARY & FRINGES APPRVD								21
22	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD								22
23	02300	PARAMED ED PRGM-(SPECIFY)								23
		INPATIENT ROUTINE SERV COST CENTERS								
30	03000	ADULTS & PEDIATRICS	1,951,054	175,633	2,126,687		2,126,687	-19	2,126,668	30
31	03100	INTENSIVE CARE UNIT	658,873	49,023	707,896		707,896		707,896	31
40	04000	SUBPROVIDER - IPF	644,177	206,302	850,479		850,479	-134,307	716,172	40
43	04300	NURSERY	216,803	17,257	234,060		234,060		234,060	43
44	04400	SKILLED NURSING FACILITY	1,025,533	109,632	1,135,165		1,135,165		1,135,165	44
		ANCILLARY SERVICE COST CENTERS								
50	05000	OPERATING ROOM	720,580	368,344	1,088,924		1,088,924		1,088,924	50
53	05300	ANESTHESIOLOGY	782,901	134,276	917,177		917,177	-899,516	17,661	53
54	05400	RADIOLOGY-DIAGNOSTIC	646,240	253,452	899,692		899,692		899,692	54
56	05600	RADIOISOTOPE	72,338	116,001	188,339		188,339		188,339	56
57	05700	CT SCAN	106,377	130,583	236,960		236,960		236,960	57
58	05800	MRI		239,385	239,385		239,385		239,385	58
60	06000	LABORATORY	1,055,631	1,409,842	2,465,473		2,465,473	-19,551	2,445,922	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	06400	INTRAVENOUS THERAPY		27,188	27,188		27,188		27,188	64
65	06500	RESPIRATORY THERAPY	383,976	12,223	396,199		396,199		396,199	65
66	06600	PHYSICAL THERAPY	1,469,602	58,581	1,528,183		1,528,183		1,528,183	66
68	06800	SPEECH PATHOLOGY	175,416	7,144	182,560		182,560		182,560	68
69	06900	ELECTROCARDIOLOGY		190,499	190,499		190,499		190,499	69
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		1,976,944	1,976,944	-363,105	1,613,839		1,613,839	71
72	07200	IMPL. DEV. CHARGED TO PATIENTS				363,105	363,105		363,105	72
73	07300	DRUGS CHARGED TO PATIENTS								73
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								
91	09100	EMERGENCY	706,528	888,878	1,595,406		1,595,406	-774,952	820,454	91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)								92
		OTHER REIMBURSABLE COST CENTERS								
95	09500	AMBULANCE SERVICES	505,309	146,415	651,724		651,724		651,724	95
99.10	09910	CORF								99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY								99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY								99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY								99.40
101	10100	HOME HEALTH AGENCY	719,652	158,530	878,182		878,182		878,182	101
		SPECIAL PURPOSE COST CENTERS								
113	11300	INTEREST EXPENSE		295,239	295,239	-295,239				113
116	11600	HOSPICE	192,020	154,716	346,736		346,736		346,736	116
118		SUBTOTALS (sum of lines 1-117)	18,175,534	23,382,257	41,557,791		41,557,791	-4,824,275	36,733,516	118
		NONREIMBURSABLE COST CENTERS								
192	19200	PHYSICIANS' PRIVATE OFFICES	3,139,890	794,633	3,934,523		3,934,523		3,934,523	192
194	07950	OTHER NONREIMBURSABLE								194
194.01	07952	MEMORY DISORDER	21,303	835	22,138		22,138		22,138	194.01
194.02	07953	ASSISTED LIVING								194.02
200		TOTAL (sum of lines 118-199)	21,336,727	24,177,725	45,514,452		45,514,452	-4,824,275	40,690,177	200

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RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION(S)		CODE (1)	INCREASES				
			COST CENTER	LINE #	SALARY	OTHER	
1		1	2	3	4	5	
1	RECLASS CAFETERIA	A	CAFETERIA	11	393,700	584,486	1
500	TOTAL RECLASSIFICATIONS				393,700	584,486	500
	CODE LETTER - A						
1	INTEREST EXPENSE	B	CAP REL COSTS-BLDG & FIXT	1		295,239	1
500	TOTAL RECLASSIFICATIONS					295,239	500
	CODE LETTER - B						
1	OTHER CAPITAL RELATED	C	CAP REL COSTS-BLDG & FIXT	1		53,460	1
2			CAP REL COSTS-MVBLE EQUIP	2		20,223	2
500	TOTAL RECLASSIFICATIONS					73,683	500
	CODE LETTER - C						
1	RECLASS MEDICAL SUPPLIES	D	IMPL. DEV. CHARGED TO PATIENT	72		363,105	1
500	TOTAL RECLASSIFICATIONS					363,105	500
	CODE LETTER - D						
	GRAND TOTAL (INCREASES)				393,700	1,316,513	

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

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RECLASSIFICATIONS

WORKSHEET A-6

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	RECLASS CAFETERIA	A	DIETARY	10	393,700	584,486		
500	TOTAL RECLASSIFICATIONS				393,700	584,486	1	
	CODE LETTER - A						500	
1	INTEREST EXPENSE	B	INTEREST EXPENSE	113		295,239		
500	TOTAL RECLASSIFICATIONS					295,239	11	
	CODE LETTER - B						500	
1	OTHER CAPITAL RELATED	C	ADMINISTRATIVE & GENERAL	5		73,683		
2							12	
500	TOTAL RECLASSIFICATIONS					73,683	12	
	CODE LETTER - C						2	
1	RECLASS MEDICAL SUPPLIES	D	MEDICAL SUPPLIES CHARGED TO P	71		363,105		
500	TOTAL RECLASSIFICATIONS					363,105	1	
	CODE LETTER - D						500	
	GRAND TOTAL (DECREASES)				393,700	1,316,513		

(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	39,983					39,983		1
2	LAND IMPROVEMENTS	510,497					510,497		2
3	BUILDINGS AND FIXTURES	14,620,639	95,164		95,164		14,715,803		3
4	BUILDING IMPROVEMENTS	9,603,972					9,603,972		4
5	FIXED EQUIPMENT	2,456,266				29,000	2,427,266		5
6	MOVABLE EQUIPMENT	16,130,201	1,014,387		1,014,387	358,840	16,785,748		6
7	HIT DESIGNATED ASSETS	733,370	37,500		37,500		770,870		7
8	SUBTOTAL (sum of lines 1-7)	44,094,928	1,147,051		1,147,051	387,840	44,854,139		8
9	RECONCILING ITEMS								9
10	TOTAL (line 7 minus line 9)	44,094,928	1,147,051		1,147,051	387,840	44,854,139		10

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

	DESCRIPTION	SUMMARY OF CAPITAL							
		DEPRECIATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)	TOTAL(1) (Sum of (cols. 9 through 14))	
*		9	10	11	12	13	14	15	
1	CAP REL COSTS-BLDG & FIXT	544,999						544,999	1
2	CAP REL COSTS-MVBLE EQUIP	1,197,429						1,197,429	2
3	TOTAL (sum of lines 1-2)	1,742,428						1,742,428	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 instr.)	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL (sum of (cols. 5 through 7))	
*		9	10	11	12	13	14	15	16	
1	CAP REL COSTS-BLDG & FI	27,297,521		27,297,521	0.608584					1
2	CAP REL COSTS-MVBLE EQU	17,556,618		17,556,618	0.391416					2
3	TOTAL (sum of lines 1-2)	44,854,139		44,854,139	1.000000					3

	DESCRIPTION	SUMMARY OF CAPITAL							
		DEPRECIATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)	TOTAL(2) (sum of (cols. 9 through 14))	
*		9	10	11	12	13	14	15	
1	CAP REL COSTS-BLDG & FIXT	544,999		205,527	53,460			803,986	1
2	CAP REL COSTS-MVBLE EQUIP	1,197,429			20,223			1,217,652	2
3	TOTAL (sum of lines 1-2)	1,742,428		205,527	73,683			2,021,638	3

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

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF.
				COST CENTER	LINE#	
		1	2	3	4	5
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (chapter 2)	B	-89,712	CAP REL COSTS-BLDG & FIXT	1	11
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)	B	-4,703	ADMINISTRATIVE & GENERAL	5	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)	A	-23,576	ADMINISTRATIVE & GENERAL	5	7
8	TELEVISION AND RADIO SERVICE (chapter 21)					8
9	PARKING LOT (chapter 21)					9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-928,810			10
11	SALE OF SCRAP, WASTE, ETC. (chapter 23)					11
12	RELATED ORGANIZATION TRANSACTIONS (chapter 10)	WKST A-8-1				12
13	LAUNDRY AND LINEN SERVICE	B	-170,457	LAUNDRY & LINEN SERVICE	8	13
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-217,530	CAFETERIA	11	14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS	B	-8,747	CENTRAL SERVICES & SUPPLY	14	16
17	SALE OF DRUGS TO OTHER THAN PATIENTS	B	-794	PHARMACY	15	17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-3,556	MEDICAL RECORDS & LIBRARY	16	18
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)					19
20	VENDING MACHINES	B	-13,880	CAFETERIA	11	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 AND					32
33	SPECIAL FUNCTIONS	B	-39,306	CAFETERIA	11	33
34	GUEST ROOM	B	-19	ADULTS & PEDIATRICS	30	34
35	MISC INCOME	B	-5,572	ADMINISTRATIVE & GENERAL	5	35
36	RETURNED CHECKS	B	-317	ADMINISTRATIVE & GENERAL	5	36
37	DIETARY CONSULTATION	B	-132	ADMINISTRATIVE & GENERAL	5	37
38	PHYSICIAN RECRUITMENT	A	-177,811	ADMINISTRATIVE & GENERAL	5	38
39	CRNA SALARIES	A	-782,901	ANESTHESIOLOGY	53	39
40	CRNA CONTRACT SERVICES	A	-116,615	ANESTHESIOLOGY	53	40
41	CRNA BENEFITS	A	-146,510	EMPLOYEE BENEFITS DEPARTMENT	4	41
42	LOBBYING DUES	A	-21,577	ADMINISTRATIVE & GENERAL	5	42
43	FOUNDATION SALARIES	A	-69,393	ADMINISTRATIVE & GENERAL	5	43
44	FOUNDATION BENEFITS	A	-20,638	EMPLOYEE BENEFITS DEPARTMENT	4	44
45	FOUNDATION OTHER	A	-6,572	ADMINISTRATIVE & GENERAL	5	45
46	ADVERTISING	A	-255,808	ADMINISTRATIVE & GENERAL	5	46
47	PROVIDER TAX ASSESSMENT	A	-1,537,022	ADMINISTRATIVE & GENERAL	5	47
48	RENTAL INCOME	A	-5,800	ADMINISTRATIVE & GENERAL	5	48
49	HHA VEHICLE REIMBURSEMENT	B	-2,475	ADMINISTRATIVE & GENERAL	5	49
49.01	MISC PATIENT REVENUE	B	-41,419	ADMINISTRATIVE & GENERAL	5	49.01
49.03	INTEREST RECEIPTS	B	-132,623	ADMINISTRATIVE & GENERAL	5	49.03
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-4,824,275			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	
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							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			
				NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS	
	1	2	3	4	5	6	
6							6
7							7
8							8
9							9
10							10

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

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

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN- ERATION	PROFESS- IONAL COMPON- ENT	PROVIDER COMPON- ENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPON- ENT HOURS	UNADJ- USTED RCE LIMIT	5 PERCENT OF UNADJ- USTED RCE LIMIT	
	1	2	3	4	5	6	7	8	9	
1	40	SUBPROVIDER - IPF AGGREGATE	173,450	85,450	88,000	138,700	587	39,143	1,957	1
2	60	LABORATORY AGGREGATE	97,755	19,551	78,204	208,000	1,248	124,800	6,240	2
3	91	EMERGENCY AGGREGATE	774,952	774,952		159,800				3
4	44	SKILLED NURSING FACI AGGREGATE	30,000		30,000	159,800	416	31,960	1,598	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	1,076,157	879,953	196,204		2,251	195,903	9,795	200

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	10 WKST A LINE #	11 COST CENTER/ PHYSICIAN IDENTIFIER	12 COST OF MEMBER- SHIPS & CONTIN- UING EDUCATION	13 PROVIDER COMPON- ENT SHARE OF COL. 12	14 PHYSICIAN COST OF MALPRACT- ICE INSURANCE	15 PROVIDER COMPON- ENT SHARE OF COL. 14	16 ADJUSTED RCE LIMIT	17 RCE DISALLOW- ANCE	18 ADJUST- MENT	
	10	11	12	13	14	15	16	17	18	
1	40	SUBPROVIDER - IPF AGGREGATE					39,143	48,857	134,307	1
2	60	LABORATORY AGGREGATE					124,800		19,551	2
3	91	EMERGENCY AGGREGATE							774,952	3
4	44	SKILLED NURSING FACI AGGREGATE					31,960			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					195,903	48,857	928,810	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)	NEW CAP RE L COSTS-BL DG & FIXT	NEW CAP RE L COSTS-MV BLE EQUIP	EMPLOYEE B ENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINISTRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	803,986	803,986					1
2	CAP REL COSTS-MVBLE EQUIP	1,217,652		1,217,652				2
4	EMPLOYEE BENEFITS DEPARTMENT	6,514,001	2,591	314	6,516,906			4
5	ADMINISTRATIVE & GENERAL	3,780,811	78,586	276,343	622,293	4,758,033	4,758,033	5
6	MAINTENANCE & REPAIRS	830,651	10,722	59,950	169,684	1,071,007	141,820	6
7	OPERATION OF PLANT	490,828	37,291			528,119	69,932	7
8	LAUNDRY & LINEN SERVICE	170,368	15,378	20,067	76,861	282,674	37,431	8
9	HOUSEKEEPING	512,616	1,749	487	117,515	632,367	83,736	9
10	DIETARY	366,793	32,262	3,101	47,523	449,679	59,545	10
11	CAPETERIA	707,470	9,153	8,385	126,738	851,746	112,786	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	1,334,575	31,999	117,474	386,442	1,870,490	247,685	13
14	CENTRAL SERVICES & SUPPLY	50,439	22,667	19,405	22,312	114,823	15,205	14
15	PHARMACY	2,179,054	12,259	93,804	134,297	2,419,414	320,372	15
16	MEDICAL RECORDS & LIBRARY	738,759	9,525	4,574	174,034	926,892	122,736	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	2,126,668	127,971	79,633	628,074	2,962,346	392,265	30
31	INTENSIVE CARE UNIT	707,896	29,827	34,889	212,101	984,713	130,393	31
40	SUBPROVIDER - IPF	716,172	35,110	540	207,370	959,192	127,013	40
43	NURSERY	234,060	4,215	824	69,792	308,891	40,902	43
44	SKILLED NURSING FACILITY	1,135,165	42,965	5,419	330,134	1,513,683	200,437	44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	1,088,924	49,706	92,452	231,966	1,463,048	193,732	50
53	ANESTHESIOLOGY	17,661	295	29,498		47,454	6,284	53
54	RADIOLOGY-DIAGNOSTIC	899,692	35,934	159,206	208,034	1,302,866	172,522	54
56	RADIOISOTOPE	188,339	3,198	16,036	23,287	230,860	30,570	56
57	CT SCAN	236,960	3,189	22,423	34,244	296,816	39,303	57
58	MRI	239,385				239,385	31,699	58
60	LABORATORY	2,445,922	33,582	16,462	339,823	2,835,789	375,507	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY	27,188				27,188	3,600	64
65	RESPIRATORY THERAPY	396,199	3,865	3,972	123,608	527,644	69,869	65
66	PHYSICAL THERAPY	1,528,183	24,540	11,583	473,087	2,037,393	269,785	66
68	SPEECH PATHOLOGY	182,560	953		56,469	239,982	31,778	68
69	ELECTROCARDIOLOGY	190,499	1,657	4,523		196,679	26,044	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,613,839				1,613,839	213,700	71
72	IMPL. DEV. CHARGED TO PATIENTS	363,105				363,105	48,081	72
73	DRUGS CHARGED TO PATIENTS							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	820,454	15,701	80,945	227,442	1,144,542	151,557	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES	651,724	22,778	46,787	162,667	883,956	117,051	95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY	878,182	6,134	264	231,667	1,116,247	147,810	101
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
116	HOSPICE	346,736	6,134	44	61,814	414,728	54,917	116
118	SUBTOTALS (sum of lines 1-117)	36,733,516	711,936	1,209,404	5,499,278	35,615,590	4,086,067	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES	3,934,523	91,369	8,190	1,010,770	5,044,852	668,029	192
194	OTHER NONREIMBURSABLE							194
194.01	MEMORY DISORDER	22,138	681	58	6,858	29,735	3,937	194.01
194.02	ASSISTED LIVING							194.02
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	40,690,177	803,986	1,217,652	6,516,906	40,690,177	4,758,033	202

Optimizer Systems, Inc.

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Micro System

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	MAINTENANCE & REPAIRS 6	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSEKEEPING 9	DIETARY 10	CAFETERIA 11	
GENERAL SERVICE COST CENTERS								
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS	1,212,827						6
7	OPERATION OF PLANT	63,514	661,565					7
8	LAUNDRY & LINEN SERVICE	26,193	15,077	361,375				8
9	HOUSEKEEPING	2,978	1,714	24,227	745,022			9
10	DIETARY	54,948	31,629	1,534		597,335		10
11	CAFETERIA	15,589	8,973	4,147			993,241	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	54,501	31,372		4,004			13
14	CENTRAL SERVICES & SUPPLY	38,607	22,223	5,299	5,300			14
15	PHARMACY	20,879	12,018		1,178			15
16	MEDICAL RECORDS & LIBRARY	16,223	9,338		707			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	217,967	125,465	107,524	220,819	181,291	113,788	30
31	INTENSIVE CARE UNIT	50,802	29,242	31,043	41,691	29,869	31,184	31
40	SUBPROVIDER - IPF	59,799	34,422	10,033	59,946	65,941	33,506	40
43	NURSERY	7,179	4,132	5,681	17,901		2,654	43
44	SKILLED NURSING FACILITY	73,178	42,122	97,882	104,817	320,234	41,136	44
ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	84,659	48,731	33,489	83,147		57,723	50
53	ANESTHESIOLOGY	502	289		2,827		3,981	53
54	RADIOLOGY-DIAGNOSTIC	61,202	35,229	6,629	31,798		39,809	54
56	RADIOISOTOPE	5,447	3,135	758	5,653		3,981	56
57	CT SCAN	5,431	3,126		10,953		7,962	57
58	MRI							58
60	LABORATORY	57,197	32,924	1,138	20,257		49,098	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY							64
65	RESPIRATORY THERAPY	6,583	3,790		1,178		32,179	65
66	PHYSICAL THERAPY	41,797	24,059	5,867	43,458		58,055	66
68	SPEECH PATHOLOGY	1,622	934				7,298	68
69	ELECTROCARDIOLOGY	2,821	1,624		1,295			69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
91	EMERGENCY	26,741	15,393	23,481	41,809		28,862	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
OTHER REIMBURSABLE COST CENTERS								
95	AMBULANCE SERVICES	38,795	22,331	2,268	1,413		57,723	95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY	10,447	6,014		10,953		31,516	101
SPECIAL PURPOSE COST CENTERS								
113	INTEREST EXPENSE							113
116	HOSPICE	10,447	6,014		10,953		15,592	116
118	SUBTOTALS (sum of lines 1-117)	1,056,048	571,320	361,000	722,057	597,335	942,816	118
NONREIMBURSABLE COST CENTERS								
192	PHYSICIANS' PRIVATE OFFICES	155,619	89,577	375	22,965		50,425	192
194	OTHER NONREIMBURSABLE							194
194.01	MEMORY DISORDER	1,160	668					194.01
194.02	ASSISTED LIVING							194.02
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	1,212,827	661,565	361,375	745,022	597,335	993,241	202

Optimizer Systems, Inc.

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Micro System

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	NURSING AD MINISTRATI ON 13	CENTRAL SE RVICES & S UPPLY 14	PHARMACY 15	MEDICAL RE CORDS & LI BRARY 16	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	2,374,258						13
14	CENTRAL SERVICES & SUPPLY		224,347					14
15	PHARMACY			2,804,381				15
16	MEDICAL RECORDS & LIBRARY				1,183,049			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	724,090		1,749	463,511	5,510,815		30
31	INTENSIVE CARE UNIT	196,682		180	98,948	1,624,747		31
40	SUBPROVIDER - IPF	243,805		27	13,774	1,607,458		40
43	NURSERY	66,724			6,887	460,951		43
44	SKILLED NURSING FACILITY	446,750		239	20,099	2,860,577		44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	200,533		1,984	75,336	2,242,382		50
53	ANESTHESIOLOGY	59,188		45,397		165,922		53
54	RADIOLOGY-DIAGNOSTIC			307	365	1,650,727		54
56	RADIOISOTOPE			50		280,454		56
57	CT SCAN				410	364,001		57
58	MRI				67	271,151		58
60	LABORATORY			195	843	3,372,948		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY			52,479		83,267		64
65	RESPIRATORY THERAPY			58,452		699,695		65
66	PHYSICAL THERAPY			405	141	2,480,960		66
68	SPEECH PATHOLOGY					281,614		68
69	ELECTROCARDIOLOGY					228,463		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		183,965			2,011,504		71
72	IMPL. DEV. CHARGED TO PATIENTS		40,382			451,568		72
73	DRUGS CHARGED TO PATIENTS			2,603,125		2,603,125		73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	213,533		687	146,595	1,793,200		91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES	222,953		5,401	843	1,352,734		95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY			203		1,323,190		101
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
116	HOSPICE			6	422	513,079		116
118	SUBTOTALS (sum of lines 1-117)	2,374,258	224,347	2,770,886	828,241	34,234,532		118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES			33,495	354,808	6,420,145		192
194	OTHER NONREIMBURSABLE							194
194.01	MEMORY DISORDER					35,500		194.01
194.02	ASSISTED LIVING							194.02
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	2,374,258	224,347	2,804,381	1,183,049	40,690,177		202

Optimizer Systems, Inc.

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	TOTAL				
		26				
	GENERAL SERVICE COST CENTERS					
1	CAP REL COSTS-BLDG & FIXT					1
2	CAP REL COSTS-MVBLE EQUIP					2
4	EMPLOYEE BENEFITS DEPARTMENT					4
5	ADMINISTRATIVE & GENERAL					5
6	MAINTENANCE & REPAIRS					6
7	OPERATION OF PLANT					7
8	LAUNDRY & LINEN SERVICE					8
9	HOUSEKEEPING					9
10	DIETARY					10
11	CAFETERIA					11
12	MAINTENANCE OF PERSONNEL					12
13	NURSING ADMINISTRATION					13
14	CENTRAL SERVICES & SUPPLY					14
15	PHARMACY					15
16	MEDICAL RECORDS & LIBRARY					16
17	SOCIAL SERVICE					17
19	NONPHYSICIAN ANESTHETISTS					19
20	NURSING SCHOOL					20
21	I&R SERVICES-SALARY & FRINGES APPRVD					21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD					22
23	PARAMED ED PRGM-(SPECIFY)					23
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS	5,510,815				30
31	INTENSIVE CARE UNIT	1,624,747				31
40	SUBPROVIDER - IPF	1,607,458				40
43	NURSERY	460,951				43
44	SKILLED NURSING FACILITY	2,860,577				44
	ANCILLARY SERVICE COST CENTERS					
50	OPERATING ROOM	2,242,382				50
53	ANESTHESIOLOGY	165,922				53
54	RADIOLOGY-DIAGNOSTIC	1,650,727				54
56	RADIOISOTOPE	280,454				56
57	CT SCAN	364,001				57
58	MRI	271,151				58
60	LABORATORY	3,372,948				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
64	INTRAVENOUS THERAPY	83,267				64
65	RESPIRATORY THERAPY	699,695				65
66	PHYSICAL THERAPY	2,480,960				66
68	SPEECH PATHOLOGY	281,614				68
69	ELECTROCARDIOLOGY	228,463				69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,011,504				71
72	IMPL. DEV. CHARGED TO PATIENTS	451,568				72
73	DRUGS CHARGED TO PATIENTS	2,603,125				73
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
91	EMERGENCY	1,793,200				91
92	OBSERVATION BEDS (NON-DISTINCT PART)					92
	OTHER REIMBURSABLE COST CENTERS					
95	AMBULANCE SERVICES	1,352,734				95
99.10	CORF					99.10
99.20	OUTPATIENT PHYSICAL THERAPY					99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40	OUTPATIENT SPEECH PATHOLOGY					99.40
101	HOME HEALTH AGENCY	1,323,190				101
	SPECIAL PURPOSE COST CENTERS					
113	INTEREST EXPENSE					113
116	HOSPICE	513,079				116
118	SUBTOTALS (sum of lines 1-117)	34,234,532				118
	NONREIMBURSABLE COST CENTERS					
192	PHYSICIANS' PRIVATE OFFICES	6,420,145				192
194	OTHER NONREIMBURSABLE					194
194.01	MEMORY DISORDER	35,500				194.01
194.02	ASSISTED LIVING					194.02
200	CROSS FOOT ADJUSTMENTS					200
201	NEGATIVE COST CENTER					201
202	TOTAL (sum of lines 118-201)	40,690,177				202

Optimizer Systems, Inc.

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	NEW CAP RE L COSTS-BL DG & FIXT	NEW CAP RE L COSTS-MV BLE EQUIP	SUBTOTAL	EMPLOYEE B ENEFITS DEPARTMENT	ADMINISTRA TIVE & GEN ERAL	
		0	1	2	2A	4	5	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT		2,591	314	2,905	2,905		4
5	ADMINISTRATIVE & GENERAL	4,248	78,586	276,343	359,177	276	359,453	5
6	MAINTENANCE & REPAIRS		10,722	59,950	70,672	75	10,714	6
7	OPERATION OF PLANT		37,291		37,291		5,283	7
8	LAUNDRY & LINEN SERVICE		15,378	20,067	35,445	34	2,828	8
9	HOUSEKEEPING		1,749	487	2,236	52	6,326	9
10	DIETARY		32,262	3,101	35,363	21	4,499	10
11	CAFETERIA		9,153	8,385	17,538	56	8,521	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		31,999	117,474	149,473	172	18,712	13
14	CENTRAL SERVICES & SUPPLY		22,667	19,405	42,072	10	1,149	14
15	PHARMACY		12,259	93,804	106,063	60	24,204	15
16	MEDICAL RECORDS & LIBRARY		9,525	4,574	14,099	77	9,273	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	9,291	127,971	79,633	216,895	279	29,635	30
31	INTENSIVE CARE UNIT	1,189	29,827	34,889	65,905	94	9,851	31
40	SUBPROVIDER - IPF		35,110	540	35,650	92	9,596	40
43	NURSERY		4,215	824	5,039	31	3,090	43
44	SKILLED NURSING FACILITY	3,338	42,965	5,419	51,722	147	15,143	44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	177,962	49,706	92,452	320,120	103	14,636	50
53	ANESTHESIOLOGY		295	29,498	29,793		475	53
54	RADIOLOGY-DIAGNOSTIC		35,934	159,206	195,140	92	13,034	54
56	RADIOISOTOPE		3,198	16,036	19,234	10	2,310	56
57	CT SCAN		3,189	22,423	25,612	15	2,969	57
58	MRI						2,395	58
60	LABORATORY	44,708	33,582	16,462	94,752	151	28,369	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY						272	64
65	RESPIRATORY THERAPY	6,050	3,865	3,972	13,887	55	5,279	65
66	PHYSICAL THERAPY		24,540	11,583	36,123	210	20,382	66
68	SPEECH PATHOLOGY		953		953	25	2,401	68
69	ELECTROCARDIOLOGY		1,657	4,523	6,180		1,968	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						16,145	71
72	IMPL. DEV. CHARGED TO PATIENTS						3,633	72
73	DRUGS CHARGED TO PATIENTS							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY		15,701	80,945	96,646	101	11,450	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES	205	22,778	46,787	69,770	72	8,843	95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY	23,650	6,134	264	30,048	103	11,167	101
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
116	HOSPICE	45,978	6,134	44	52,156	27	4,149	116
118	SUBTOTALS (sum of lines 1-117)	316,619	711,936	1,209,404	2,237,959	2,440	308,701	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES		91,369	8,190	99,559	462	50,455	192
194	OTHER NONREIMBURSABLE							194
194.01	MEMORY DISORDER		681	58	739	3	297	194.01
194.02	ASSISTED LIVING							194.02
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	316,619	803,986	1,217,652	2,338,257	2,905	359,453	202

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	MAINTENANCE & REPAIRS 6	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSEKEEPING 9	DIETARY 10	CAFETERIA 11	
GENERAL SERVICE COST CENTERS								
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS	81,461						6
7	OPERATION OF PLANT	4,266	46,840					7
8	LAUNDRY & LINEN SERVICE	1,759	1,067	41,133				8
9	HOUSEKEEPING	200	121	2,758	11,693			9
10	DIETARY	3,691	2,239	175		45,988		10
11	CAFETERIA	1,047	635	472			28,269	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	3,661	2,221			63	4,729	13
14	CENTRAL SERVICES & SUPPLY	2,593	1,573	603	83		651	14
15	PHARMACY	1,402	851		18		869	15
16	MEDICAL RECORDS & LIBRARY	1,090	661		11		3,050	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	14,639	8,888	12,238	3,468	13,957	3,239	30
31	INTENSIVE CARE UNIT	3,412	2,070	3,533	654	2,300	888	31
40	SUBPROVIDER - IPF	4,016	2,437	1,142	941	5,077	954	40
43	NURSERY	482	293	647	281		76	43
44	SKILLED NURSING FACILITY	4,915	2,982	11,141	1,645	24,654	1,171	44
ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	5,686	3,450	3,812	1,305		1,643	50
53	ANESTHESIOLOGY	34	20		44		113	53
54	RADIOLOGY-DIAGNOSTIC	4,111	2,494	755	499		1,133	54
56	RADIOISOTOPE	366	222	86	89		113	56
57	CT SCAN	365	221		172		227	57
58	MRI							58
60	LABORATORY	3,842	2,331	129	318		1,397	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY							64
65	RESPIRATORY THERAPY	442	268		18		916	65
66	PHYSICAL THERAPY	2,807	1,703	668	682		1,652	66
68	SPEECH PATHOLOGY	109	66				208	68
69	ELECTROCARDIOLOGY	190	115		20			69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
91	EMERGENCY	1,796	1,090	2,673	656		821	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
OTHER REIMBURSABLE COST CENTERS								
95	AMBULANCE SERVICES	2,606	1,581	258	22		1,643	95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY	702	426		172		897	101
SPECIAL PURPOSE COST CENTERS								
113	INTEREST EXPENSE							113
116	HOSPICE	702	426		172		444	116
118	SUBTOTALS (sum of lines 1-117)	70,931	40,451	41,090	11,333	45,988	26,834	118
NONREIMBURSABLE COST CENTERS								
192	PHYSICIANS' PRIVATE OFFICES	10,452	6,342	43	360		1,435	192
194	OTHER NONREIMBURSABLE							194
194.01	MEMORY DISORDER	78	47					194.01
194.02	ASSISTED LIVING							194.02
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	81,461	46,840	41,133	11,693	45,988	28,269	202

Optimizer Systems, Inc.

WinLASH

Micro System

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	NURSING AD	CENTRAL SE	PHARMACY	MEDICAL RE	SUBTOTAL	I&R COST &
		MINISTRATI	RVICES & S		CORDS & LI		POST STEP-
		ON	UPPLY		BRARY		DOWN ADJS
		13	14	15	16	24	25
GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	179,031					13
14	CENTRAL SERVICES & SUPPLY		48,734				14
15	PHARMACY			133,467			15
16	MEDICAL RECORDS & LIBRARY				28,261		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	54,601		83	11,071	368,993	30
31	INTENSIVE CARE UNIT	14,831		9	2,364	105,911	31
40	SUBPROVIDER - IPF	18,384		1	329	78,619	40
43	NURSERY	5,031			165	15,135	43
44	SKILLED NURSING FACILITY	33,687		11	480	147,698	44
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	15,121		94	1,800	367,770	50
53	ANESTHESIOLOGY	4,463		2,161		37,103	53
54	RADIOLOGY-DIAGNOSTIC			15	9	217,282	54
56	RADIOISOTOPE			2		22,432	56
57	CT SCAN				10	29,591	57
58	MRI				2	2,397	58
60	LABORATORY			9	20	131,318	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	INTRAVENOUS THERAPY			2,498		2,770	64
65	RESPIRATORY THERAPY			2,782		23,647	65
66	PHYSICAL THERAPY			19	3	64,249	66
68	SPEECH PATHOLOGY					3,762	68
69	ELECTROCARDIOLOGY					8,473	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		39,962			56,107	71
72	IMPL. DEV. CHARGED TO PATIENTS		8,772			12,405	72
73	DRUGS CHARGED TO PATIENTS			123,889		123,889	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	16,101		33	3,502	134,869	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES	16,812		257	20	101,884	95
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
101	HOME HEALTH AGENCY			10		43,525	101
SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE						113
116	HOSPICE				10	58,086	116
118	SUBTOTALS (sum of lines 1-117)	179,031	48,734	131,873	19,785	2,157,915	118
NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES			1,594	8,476	179,178	192
194	OTHER NONREIMBURSABLE						194
194.01	MEMORY DISORDER					1,164	194.01
194.02	ASSISTED LIVING						194.02
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (sum of lines 118-201)	179,031	48,734	133,467	28,261	2,338,257	202

Optimizer Systems, Inc.

WinLASH

Micro System

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	TOTAL					
		26					
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY						16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	368,993					30
31	INTENSIVE CARE UNIT	105,911					31
40	SUBPROVIDER - IPF	78,619					40
43	NURSERY	15,135					43
44	SKILLED NURSING FACILITY	147,698					44
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	367,770					50
53	ANESTHESIOLOGY	37,103					53
54	RADIOLOGY-DIAGNOSTIC	217,282					54
56	RADIOISOTOPE	22,432					56
57	CT SCAN	29,591					57
58	MRI	2,397					58
60	LABORATORY	131,318					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	INTRAVENOUS THERAPY	2,770					64
65	RESPIRATORY THERAPY	23,647					65
66	PHYSICAL THERAPY	64,249					66
68	SPEECH PATHOLOGY	3,762					68
69	ELECTROCARDIOLOGY	8,473					69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	56,107					71
72	IMPL. DEV. CHARGED TO PATIENTS	12,405					72
73	DRUGS CHARGED TO PATIENTS	123,889					73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	134,869					91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES	101,884					95
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
101	HOME HEALTH AGENCY	43,525					101
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
116	HOSPICE	58,086					116
118	SUBTOTALS (sum of lines 1-117)	2,157,915					118
	NONREIMBURSABLE COST CENTERS						
192	PHYSICIANS' PRIVATE OFFICES	179,178					192
194	OTHER NONREIMBURSABLE						194
194.01	MEMORY DISORDER	1,164					194.01
194.02	ASSISTED LIVING						194.02
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (sum of lines 118-201)	2,338,257					202

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	NEW CAP RE L COSTS-BL DG & FIXT SQUARE FEET	NEW CAP RE L COSTS-MV BLE EQUIP DOLLAR VALUE -NEW	EMPLOYEE B ENEFITS DEPARTMENT GROSS SALARIES	RECON- CILIATION	ADMINISTRA TIVE & GEN ERAL ACCUM COST	MAINTENANC E & REPAIR S SQUARE FEET	
		1	2	4	5A	5	6	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	174,720						1
2	CAP REL COSTS-MVBLE EQUIP		1,196,443					2
4	EMPLOYEE BENEFITS DEPARTMENT	563	309	20,244,207				4
5	ADMINISTRATIVE & GENERAL	17,078	271,530	1,933,097	-4,758,033	35,932,144		5
6	MAINTENANCE & REPAIRS	2,330	58,906	527,109		1,071,007	154,749	6
7	OPERATION OF PLANT	8,104				528,119	8,104	7
8	LAUNDRY & LINEN SERVICE	3,342	19,717	238,762		282,674	3,342	8
9	HOUSEKEEPING	380	479	365,050		632,367	380	9
10	DIETARY	7,011	3,047	147,627		449,679	7,011	10
11	CAFETERIA	1,989	8,239	393,700		851,746	1,989	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	6,954	115,428	1,200,448		1,870,490	6,954	13
14	CENTRAL SERVICES & SUPPLY	4,926	19,067	69,309		114,823	4,926	14
15	PHARMACY	2,664	92,170	417,183		2,419,414	2,664	15
16	MEDICAL RECORDS & LIBRARY	2,070	4,494	540,620		926,892	2,070	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	27,811	78,246	1,951,054		2,962,346	27,811	30
31	INTENSIVE CARE UNIT	6,482	34,281	658,873		984,713	6,482	31
40	SUBPROVIDER - IPF	7,630	531	644,177		959,192	7,630	40
43	NURSERY	916	810	216,803		308,891	916	43
44	SKILLED NURSING FACILITY	9,337	5,325	1,025,533		1,513,683	9,337	44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	10,802	90,842	720,580		1,463,048	10,802	50
53	ANESTHESIOLOGY	64	28,984			47,454	64	53
54	RADIOLOGY-DIAGNOSTIC	7,809	156,433	646,240		1,302,866	7,809	54
56	RADIOISOTOPE	695	15,757	72,338		230,860	695	56
57	CT SCAN	693	22,032	106,377		296,816	693	57
58	MRI					239,385		58
60	LABORATORY	7,298	16,175	1,055,631		2,835,789	7,298	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY					27,188		64
65	RESPIRATORY THERAPY	840	3,903	383,976		527,644	840	65
66	PHYSICAL THERAPY	5,333	11,381	1,469,602		2,037,393	5,333	66
68	SPEECH PATHOLOGY	207		175,416		239,982	207	68
69	ELECTROCARDIOLOGY	360	4,444			196,679	360	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS					1,613,839		71
72	IMPL. DEV. CHARGED TO PATIENTS					363,105		72
73	DRUGS CHARGED TO PATIENTS							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	3,412	79,535	706,528		1,144,542	3,412	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES	4,950	45,972	505,309		883,956	4,950	95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY	1,333	259	719,652		1,116,247	1,333	101
	SPECIAL PURPOSE COST CENTERS							
116	HOSPICE	1,333	43	192,020		414,728	1,333	116
118	SUBTOTALS (sum of lines 1-117)	154,716	1,188,339	17,083,014	-4,758,033	30,857,557	134,745	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES	19,856	8,047	3,139,890		5,044,852	19,856	192
194	OTHER NONREIMBURSABLE							194
194.01	MEMORY DISORDER	148	57	21,303		29,735	148	194.01
194.02	ASSISTED LIVING							194.02
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	803,986	1,217,652	6,516,906		4,758,033	1,212,827	202
203	UNIT COST MULT-WS B PT I	4.601568	1.017727	0.321915		0.132417	7.837382	203
204	COST TO BE ALLOC PER B PT II			2,905		359,453	81,461	204
205	UNIT COST MULT-WS B PT II			0.000143		0.010004	0.526407	205

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE LAUNDRY POUNDS	HOUSEKEEPING HOURS OF SERVICE	DIETARY DIETARY MEALS SERV	CAFETERIA CAFE MEALS SERV	NURSING ADMINISTRATION DIRECT NURSING HO	
		7	8	9	10	11	13	
GENERAL SERVICE COST CENTERS								
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	146,645						7
8	LAUNDRY & LINEN SERVICE	3,342	492,393					8
9	HOUSEKEEPING	380	33,010	6,326				9
10	DIETARY	7,011	2,090		89,753			10
11	CAFETERIA	1,989	5,650			2,994		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	6,954		34		501	315,055	13
14	CENTRAL SERVICES & SUPPLY	4,926	7,220	45		69		14
15	PHARMACY	2,664		10		92		15
16	MEDICAL RECORDS & LIBRARY	2,070		6		323		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	27,811	146,510	1,875	27,240	343	96,084	30
31	INTENSIVE CARE UNIT	6,482	42,298	354	4,488	94	26,099	31
40	SUBPROVIDER - IPF	7,630	13,670	509	9,908	101	32,352	40
43	NURSERY	916	7,740	152		8	8,854	43
44	SKILLED NURSING FACILITY	9,337	133,370	890	48,117	124	59,282	44
ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	10,802	45,630	706		174	26,610	50
53	ANESTHESIOLOGY	64		24		12	7,854	53
54	RADIOLOGY-DIAGNOSTIC	7,809	9,033	270		120		54
56	RADIOISOTOPE	695	1,033	48		12		56
57	CT SCAN	693		93		24		57
58	MRI							58
60	LABORATORY	7,298	1,550	172		148		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY							64
65	RESPIRATORY THERAPY	840		10		97		65
66	PHYSICAL THERAPY	5,333	7,994	369		175		66
68	SPEECH PATHOLOGY	207				22		68
69	ELECTROCARDIOLOGY	360		11				69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
91	EMERGENCY	3,412	31,994	355		87	28,335	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
OTHER REIMBURSABLE COST CENTERS								
95	AMBULANCE SERVICES	4,950	3,090	12		174	29,585	95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY	1,333		93		95		101
SPECIAL PURPOSE COST CENTERS								
116	HOSPICE	1,333		93		47		116
118	SUBTOTALS (sum of lines 1-117)	126,641	491,882	6,131	89,753	2,842	315,055	118
NONREIMBURSABLE COST CENTERS								
192	PHYSICIANS' PRIVATE OFFICES	19,856	511	195		152		192
194	OTHER NONREIMBURSABLE							194
194.01	MEMORY DISORDER	148						194.01
194.02	ASSISTED LIVING							194.02
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	661,565	361,375	745,022	597,335	993,241	2,374,258	202
203	UNIT COST MULT-WS B PT I	4.511337	0.733916	117.771420	6.655321	331.743821	7.536011	203
204	COST TO BE ALLOC PER B PT II	46,840	41,133	11,693	45,988	28,269	179,031	204
205	UNIT COST MULT-WS B PT II	0.319411	0.083537	1.848403	0.512384	9.441884	0.568253	205

Optimizer Systems, Inc.

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY COSTED REQUIS	PHARMACY PHARM COSTED REQ	MEDICAL RECORDS & LIBRARY TIME SPENT				
	14	15	16				

GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY	100					14
15	PHARMACY		1,452,865				15
16	MEDICAL RECORDS & LIBRARY			210,430			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		906	82,445			30
31	INTENSIVE CARE UNIT		93	17,600			31
40	SUBPROVIDER - IPF		14	2,450			40
43	NURSERY			1,225			43
44	SKILLED NURSING FACILITY		124	3,575			44
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM		1,028	13,400			50
53	ANESTHESIOLOGY		23,519				53
54	RADIOLOGY-DIAGNOSTIC		159	65			54
56	RADIOISOTOPE		26				56
57	CT SCAN			73			57
58	MRI			12			58
60	LABORATORY		101	150			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	INTRAVENOUS THERAPY		27,188				64
65	RESPIRATORY THERAPY		30,282				65
66	PHYSICAL THERAPY		210	25			66
68	SPEECH PATHOLOGY						68
69	ELECTROCARDIOLOGY						69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	82					71
72	IMPL. DEV. CHARGED TO PATIENTS	18					72
73	DRUGS CHARGED TO PATIENTS		1,348,600				73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY		356	26,075			91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES		2,798	150			95
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
101	HOME HEALTH AGENCY		105				101
	SPECIAL PURPOSE COST CENTERS						
116	HOSPICE		3	75			116
118	SUBTOTALS (sum of lines 1-117)	100	1,435,512	147,320			118
	NONREIMBURSABLE COST CENTERS						
192	PHYSICIANS' PRIVATE OFFICES		17,353	63,110			192
194	OTHER NONREIMBURSABLE						194
194.01	MEMORY DISORDER						194.01
194.02	ASSISTED LIVING						194.02
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	224,347	2,804,381	1,183,049			202
203	UNIT COST MULT-WS B PT I	2,243.470000	1.930242	5.622055			203
204	COST TO BE ALLOC PER B PT II	48,734	133,467	28,261			204
205	UNIT COST MULT-WS B PT II	487.340000	0.091865	0.134301			205

Optimizer Systems, Inc.

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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		
		PART	LINE NO.	AMOUNT
	1	2	3	4

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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	COSTS					
		TOTAL COST (from Wkst. B, Part I, col. 26)	THERAPY LIMIT ADJ.	TOTAL COSTS	RCE DISALLOW- ANCE	TOTAL COSTS	
		1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	5,510,815		5,510,815		5,510,815	30
31	INTENSIVE CARE UNIT	1,624,747		1,624,747		1,624,747	31
40	SUBPROVIDER - IPF	1,607,458		1,607,458	48,857	1,656,315	40
43	NURSERY	460,951		460,951		460,951	43
44	SKILLED NURSING FACILITY	2,860,577		2,860,577		2,860,577	44
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	2,242,382		2,242,382		2,242,382	50
53	ANESTHESIOLOGY	165,922		165,922		165,922	53
54	RADIOLOGY-DIAGNOSTIC	1,650,727		1,650,727		1,650,727	54
56	RADIOISOTOPE	280,454		280,454		280,454	56
57	CT SCAN	364,001		364,001		364,001	57
58	MRI	271,151		271,151		271,151	58
60	LABORATORY	3,372,948		3,372,948		3,372,948	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	INTRAVENOUS THERAPY	83,267		83,267		83,267	64
65	RESPIRATORY THERAPY	699,695		699,695		699,695	65
66	PHYSICAL THERAPY	2,480,960		2,480,960		2,480,960	66
68	SPEECH PATHOLOGY	281,614		281,614		281,614	68
69	ELECTROCARDIOLOGY	228,463		228,463		228,463	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,011,504		2,011,504		2,011,504	71
72	IMPL. DEV. CHARGED TO PATIENTS	451,568		451,568		451,568	72
73	DRUGS CHARGED TO PATIENTS	2,603,125		2,603,125		2,603,125	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	1,793,200		1,793,200		1,793,200	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	883,519		883,519		883,519	92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES	1,352,734		1,352,734		1,352,734	95
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
101	HOME HEALTH AGENCY	1,323,190		1,323,190		1,323,190	101
113	INTEREST EXPENSE						113
116	HOSPICE	513,079		513,079		513,079	116
200	SUBTOTAL (SEE INSTRUCTIONS)	35,118,051		35,118,051	48,857	35,166,908	200
201	LESS OBSERVATION BEDS	883,519		883,519		883,519	201
202	TOTAL (SEE INSTRUCTIONS)	34,234,532		34,234,532		34,283,389	202

Optimizer Systems, Inc.

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Micro System

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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	CHARGES			COST OR OTHER RATIO	TEFRA INPATIENT RATIO	PPS INPATIENT RATIO	
		INPATIENT	OUTPATIENT	TOTAL (column 6 + column 7)				
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	5,253,946		5,253,946				30
31	INTENSIVE CARE UNIT	1,552,147		1,552,147				31
40	SUBPROVIDER - IPF	2,340,046		2,340,046				40
43	NURSERY	631,941		631,941				43
44	SKILLED NURSING FACILITY	2,337,229		2,337,229				44
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	4,557,086	10,922,125	15,479,211	0.144864	0.144864	0.144864	50
53	ANESTHESIOLOGY	2,757,501	3,136,134	5,893,635	0.028153	0.028153	0.028153	53
54	RADIOLOGY-DIAGNOSTIC	1,481,815	8,464,272	9,946,087	0.165967	0.165967	0.165967	54
56	RADIOISOTOPE	183,787	2,221,964	2,405,751	0.116576	0.116576	0.116576	56
57	CT SCAN	1,783,544	9,524,455	11,307,999	0.032190	0.032190	0.032190	57
58	MRI	89,547	1,841,207	1,930,754	0.140438	0.140438	0.140438	58
60	LABORATORY	4,804,780	19,083,525	23,888,305	0.141197	0.141197	0.141197	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY	814,492	223,695	1,038,187	0.080204	0.080204	0.080204	64
65	RESPIRATORY THERAPY	2,576,766	837,566	3,414,332	0.204929	0.204929	0.204929	65
66	PHYSICAL THERAPY	3,014,289	5,868,025	8,882,314	0.279315	0.279315	0.279315	66
68	SPEECH PATHOLOGY	207,386	552,025	759,411	0.370832	0.370832	0.370832	68
69	ELECTROCARDIOLOGY	354,262	2,181,484	2,535,746	0.090097	0.090097	0.090097	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,720,278	2,766,873	5,487,151	0.366584	0.366584	0.366584	71
72	IMPL. DEV. CHARGED TO PATIENTS	441,565	466,197	907,762	0.497452	0.497452	0.497452	72
73	DRUGS CHARGED TO PATIENTS	5,560,280	5,630,710	11,190,990	0.232609	0.232609	0.232609	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	1,334,577	7,217,560	8,552,137	0.209679	0.209679	0.209679	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	501,851	1,625,828	2,127,679	0.415250	0.415250	0.415250	92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES	42,744	2,042,723	2,085,467	0.648648	0.648648	0.648648	95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY		3,187,940	3,187,940				101
113	INTEREST EXPENSE							113
116	HOSPICE		1,068,440	1,068,440				116
200	SUBTOTAL (SEE INSTRUCTIONS)	45,341,859	88,862,748	134,204,607				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	45,341,859	88,862,748	134,204,607				202

Optimizer Systems, Inc.

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

CHECK TITLE V PPS
 APPLICABLE TITLE XVIII, PART A TEFRA
 BOXES: TITLE XIX

(A)	COST CENTER DESCRIPTION	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)	
		1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	368,993	5,264	363,729	5,595	65.01	2,865	186,254	30
31	INTENSIVE CARE UNIT	105,911		105,911	939	112.79	878	99,030	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	78,619		78,619	2,073	37.93	501	19,003	40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY	15,135		15,135	611	24.77			43
44	SKILLED NURSING FACILITY	147,698		147,698	10,067	14.67	2,941	43,144	44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	716,356		711,092	19,285		7,185	347,431	200

(A) Worksheet A line numbers

Optimizer Systems, Inc.

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Micro System

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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0147

WORKSHEET D
PART II

CHECK [] TITLE V [XX] HOSPITAL [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [] IPF [] TEFRA
 BOXES: [] TITLE XIX [] IRF

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26))	TOTAL CHARGES (from Wkst. C, Part I, (col. 8))	RATIO OF COST TO CHARGES (col. 1 + col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	367,770	15,479,211	0.023759	1,582,541	37,600	50
53	ANESTHESIOLOGY	37,103	5,893,635	0.006295	426,103	2,682	53
54	RADIOLOGY-DIAGNOSTIC	217,282	9,946,087	0.021846	1,247,953	27,263	54
56	RADIOISOTOPE	22,432	2,405,751	0.009324	154,142	1,437	56
57	CT SCAN	29,591	11,307,999	0.002617	1,521,057	3,981	57
58	MRI	2,397	1,930,754	0.001241	53,451	66	58
60	LABORATORY	131,318	23,888,305	0.005497	3,570,914	19,629	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	INTRAVENOUS THERAPY	2,770	1,038,187	0.002668	335,646	896	64
65	RESPIRATORY THERAPY	23,647	3,414,332	0.006926	1,656,011	11,470	65
66	PHYSICAL THERAPY	64,249	8,882,314	0.007233	581,997	4,210	66
68	SPEECH PATHOLOGY	3,762	759,411	0.004954	60,477	300	68
69	ELECTROCARDIOLOGY	8,473	2,535,746	0.003341	284,625	951	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	56,107	5,487,151	0.010225	1,138,288	11,639	71
72	IMPL. DEV. CHARGED TO PATIENTS	12,405	907,762	0.013665	311,059	4,251	72
73	DRUGS CHARGED TO PATIENTS	123,889	11,190,990	0.011070	3,123,289	34,575	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	134,869	8,552,137	0.015770	1,075,120	16,955	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	60,015	2,127,679	0.028207	251,865	7,104	92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES						95
200	TOTAL (sum of lines 50-199)	1,298,079	115,747,451		17,374,538	185,009	200

(A) Worksheet A line numbers

Optimizer Systems, Inc.

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Micro System

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK [] TITLE V [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [] TEFRA
 BOXES: [] TITLE XIX

(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
		NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUSTMENT AMOUNT (see instructions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)	
	INPATIENT ROUTINE SERV 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

Optimizer Systems, Inc.

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Micro System

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

CHECK TITLE V PPS
 APPLICABLE TITLE XVIII, PART A TEFRA
 BOXES: TITLE XIX

		TOTAL PATIENT DAYS	PER DIEM (col. 5+ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	5,595		2,865		30
31	INTENSIVE CARE UNIT	939		878		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	2,073		501		40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY	611				43
44	SKILLED NURSING FACILITY	10,067		2,941		44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	19,285		7,185		200

(A) Worksheet A line numbers

Optimizer Systems, Inc.

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Micro System

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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0147

WORKSHEET D
PART IV

CHECK TITLE V HOSPITAL SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII, PART A IPF SNF TEFRA
 BOXES: TITLE XIX IRF NF

(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
		NON PHYSICIAN ANESTH- ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT- IENT COST (sum of col. 2, 3, and 4)	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
56	RADIOISOTOPE							56
57	CT SCAN							57
58	MRI							58
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY							64
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES							95
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 01/22/2015 Run Time: 14:57 Version: 2014.10
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0147

WORKSHEET D
PART IV

CHECK [] TITLE V [XX] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [] IPF [] SNF [] TEFRA
 BOXES: [] TITLE XIX [] IRF [] NF

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5+ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6+ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)
7	8	9	10	11	12	13		
ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	15,479,211			1,582,541		3,511,231	50
53	ANESTHESIOLOGY	5,893,635			426,103		691,843	53
54	RADIOLOGY-DIAGNOSTIC	9,946,087			1,247,953		2,852,728	54
56	RADIOISOTOPE	2,405,751			154,142		1,062,467	56
57	CT SCAN	11,307,999			1,521,057		3,370,247	57
58	MRI	1,930,754			53,451		528,520	58
60	LABORATORY	23,888,305			3,570,914		2,166,008	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY	1,038,187			335,646		155,869	64
65	RESPIRATORY THERAPY	3,414,332			1,656,011		478,735	65
66	PHYSICAL THERAPY	8,882,314			581,997			66
68	SPEECH PATHOLOGY	759,411			60,477		25,763	68
69	ELECTROCARDIOLOGY	2,535,746			284,625		924,181	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,487,151			1,138,288		959,529	71
72	IMPL. DEV. CHARGED TO PATIENTS	907,762			311,059		191,315	72
73	DRUGS CHARGED TO PATIENTS	11,190,990			3,123,289		2,444,128	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
91	EMERGENCY	8,552,137			1,075,120		1,733,622	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	2,127,679			251,865		374,632	92
OTHER REIMBURSABLE COST CENTERS								
95	AMBULANCE SERVICES							95
200	TOTAL (sum of lines 50-199)	115,747,451			17,374,538		21,470,818	200

(A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 01/22/2015 Run Time: 14:57 Version: 2014.10
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0147

WORKSHEET D
PART V

CHECK TITLE V - O/P HOSPITAL SUB (OTHER) SWING BED SNF
 APPLICABLE TITLE XVIII, PART B IPF SNF SWING BED NF
 BOXES: TITLE XIX - O/P IRF NF ICF/MR

(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.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.144864	3,511,231			508,651			50
53	ANESTHESIOLOGY	0.028153	691,843			19,477			53
54	RADIOLOGY-DIAGNOSTIC	0.165967	2,852,728			473,459			54
56	RADIOISOTOPE	0.116576	1,062,467			123,858			56
57	CT SCAN	0.032190	3,370,247			108,488			57
58	MRI	0.140438	528,520			74,224			58
60	LABORATORY	0.141197	2,166,008			305,834			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	INTRAVENOUS THERAPY	0.080204	155,869			12,501			64
65	RESPIRATORY THERAPY	0.204929	478,735			98,107			65
66	PHYSICAL THERAPY	0.279315							66
68	SPEECH PATHOLOGY	0.370832	25,763			9,554			68
69	ELECTROCARDIOLOGY	0.090097	924,181			83,266			69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.366584	959,529			351,748			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.497452	191,315			95,170			72
73	DRUGS CHARGED TO PATIENTS	0.232609	2,444,128		19,659	568,526		4,573	73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	EMERGENCY	0.209679	1,733,622			363,504			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.415250	374,632			155,566			92
	OTHER REIMBURSABLE COST CENTERS								
95	AMBULANCE SERVICES	0.648648							95
200	SUBTOTAL (see instructions)		21,470,818		19,659	3,351,933		4,573	200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)		21,470,818		19,659	3,351,933		4,573	202

(A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 01/22/2015 Run Time: 14:57 Version: 2014.10
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-S147

WORKSHEET D
PART II

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [XX] IPF [] TEFRA
 BOXES: [] TITLE XIX [] IRF

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26))	TOTAL CHARGES (from Wkst. C, Part I, (col. 8))	RATIO OF COST TO CHARGES (col. 1 + col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	367,770	15,479,211	0.023759			50
53	ANESTHESIOLOGY	37,103	5,893,635	0.006295			53
54	RADIOLOGY-DIAGNOSTIC	217,282	9,946,087	0.021846	7,647	167	54
56	RADIOISOTOPE	22,432	2,405,751	0.009324			56
57	CT SCAN	29,591	11,307,999	0.002617	28,882	76	57
58	MRI	2,397	1,930,754	0.001241			58
60	LABORATORY	131,318	23,888,305	0.005497	104,307	573	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	INTRAVENOUS THERAPY	2,770	1,038,187	0.002668	869	2	64
65	RESPIRATORY THERAPY	23,647	3,414,332	0.006926	3,934	27	65
66	PHYSICAL THERAPY	64,249	8,882,314	0.007233	827	6	66
68	SPEECH PATHOLOGY	3,762	759,411	0.004954			68
69	ELECTROCARDIOLOGY	8,473	2,535,746	0.003341	6,560	22	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	56,107	5,487,151	0.010225	5,316	54	71
72	IMPL. DEV. CHARGED TO PATIENTS	12,405	907,762	0.013665			72
73	DRUGS CHARGED TO PATIENTS	123,889	11,190,990	0.011070	165,618	1,833	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	134,869	8,552,137	0.015770	64,853	1,023	91
92	OBSERVATION BEDS (NON-DISTINCT PART)		2,127,679				92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES						95
200	TOTAL (sum of lines 50-199)	1,238,064	115,747,451		388,813	3,783	200

(A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 01/22/2015 Run Time: 14:57 Version: 2014.10
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-S147

WORKSHEET D
PART IV

CHECK TITLE V HOSPITAL SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII, PART A IPF SNF TEFRA
 BOXES: TITLE XIX IRF NF

(A)	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST	NURSING SCHOOL	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)	
		1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
56	RADIOISOTOPE							56
57	CT SCAN							57
58	MRI							58
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY							64
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES							95
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 01/22/2015 Run Time: 14:57 Version: 2014.10
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-S147

WORKSHEET D
PART IV

CHECK TITLE V HOSPITAL SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII, PART A IPF SNF TEFRA
 BOXES: TITLE XIX IRF NF

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5+ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6+ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)
7	8	9	10	11	12	13		
ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	15,479,211						50
53	ANESTHESIOLOGY	5,893,635						53
54	RADIOLOGY-DIAGNOSTIC	9,946,087			7,647			54
56	RADIOISOTOPE	2,405,751						56
57	CT SCAN	11,307,999			28,882			57
58	MRI	1,930,754						58
60	LABORATORY	23,888,305			104,307			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY	1,038,187			869			64
65	RESPIRATORY THERAPY	3,414,332			3,934			65
66	PHYSICAL THERAPY	8,882,314			827			66
68	SPEECH PATHOLOGY	759,411						68
69	ELECTROCARDIOLOGY	2,535,746			6,560			69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,487,151			5,316			71
72	IMPL. DEV. CHARGED TO PATIENTS	907,762						72
73	DRUGS CHARGED TO PATIENTS	11,190,990			165,618			73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
91	EMERGENCY	8,552,137			64,853			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	2,127,679						92
OTHER REIMBURSABLE COST CENTERS								
95	AMBULANCE SERVICES							95
200	TOTAL (sum of lines 50-199)	115,747,451			388,813			200

(A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 01/22/2015 Run Time: 14:57 Version: 2014.10
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-S147

WORKSHEET D
PART V

CHECK [] TITLE V - O/P [] HOSPITAL [] SUB (OTHER) [] SWING BED SNF
 APPLICABLE [XX] TITLE XVIII, PART B [XX] IPF [] SNF [] SWING BED NF
 BOXES: [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

(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.)
		1	2	3	4	5	6	7
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	0.144864						50
53	ANESTHESIOLOGY	0.028153						53
54	RADIOLOGY-DIAGNOSTIC	0.165967						54
56	RADIOISOTOPE	0.116576						56
57	CT SCAN	0.032190						57
58	MRI	0.140438						58
60	LABORATORY	0.141197						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY	0.080204						64
65	RESPIRATORY THERAPY	0.204929						65
66	PHYSICAL THERAPY	0.279315						66
68	SPEECH PATHOLOGY	0.370832						68
69	ELECTROCARDIOLOGY	0.090097						69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.366584						71
72	IMPL. DEV. CHARGED TO PATIENTS	0.497452						72
73	DRUGS CHARGED TO PATIENTS	0.232609						73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	0.209679						91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.415250						92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES	0.648648						95
200	SUBTOTAL (see instructions)							200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES							201
202	NET CHARGES (line 200 - line 201)							202

(A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 01/22/2015 Run Time: 14:57 Version: 2014.10
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-U147

WORKSHEET D
PART V

CHECK [] TITLE V - O/P [] HOSPITAL [] SUB (OTHER) [XX] SWING BED SNF
 APPLICABLE [XX] TITLE XVIII, PART B [] IPF [] SNF [] SWING BED NF
 BOXES: [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

(A)	COST CENTER DESCRIPTION	COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PROGRAM CHARGES			PROGRAM COST		
			PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)
		1	2	3	4	5	6	7
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	0.144864						50
53	ANESTHESIOLOGY	0.028153						53
54	RADIOLOGY-DIAGNOSTIC	0.165967						54
56	RADIOISOTOPE	0.116576						56
57	CT SCAN	0.032190						57
58	MRI	0.140438						58
60	LABORATORY	0.141197						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY	0.080204						64
65	RESPIRATORY THERAPY	0.204929						65
66	PHYSICAL THERAPY	0.279315						66
68	SPEECH PATHOLOGY	0.370832						68
69	ELECTROCARDIOLOGY	0.090097						69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.366584						71
72	IMPL. DEV. CHARGED TO PATIENTS	0.497452						72
73	DRUGS CHARGED TO PATIENTS	0.232609						73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	0.209679						91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.415250						92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES	0.648648						95
200	SUBTOTAL (see instructions)							200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES							201
202	NET CHARGES (line 200 - line 201)							202

(A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 01/22/2015 Run Time: 14:57 Version: 2014.10
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-5580

WORKSHEET D
PART IV

CHECK TITLE V HOSPITAL SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII, PART A IPF SNF TEFRA
 BOXES: TITLE XIX IRF NF

(A)	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTH- ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT- IENT COST (sum of col. 2, 3, and 4)	
		1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
56	RADIOISOTOPE							56
57	CT SCAN							57
58	MRI							58
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY							64
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES							95
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 01/22/2015 Run Time: 14:57 Version: 2014.10
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-5580

WORKSHEET D
PART IV

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [] IPF [XX] SNF [] TEFRA
 BOXES: [] TITLE XIX [] IRF [] NF

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5+ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6+ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)
7	8	9	10	11	12	13		
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	15,479,211						50
53	ANESTHESIOLOGY	5,893,635						53
54	RADIOLOGY-DIAGNOSTIC	9,946,087			81,946			54
56	RADIOISOTOPE	2,405,751						56
57	CT SCAN	11,307,999			56,130			57
58	MRI	1,930,754			9,092			58
60	LABORATORY	23,888,305			309,002			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY	1,038,187			44,274			64
65	RESPIRATORY THERAPY	3,414,332			541,605			65
66	PHYSICAL THERAPY	8,882,314			1,956,141			66
68	SPEECH PATHOLOGY	759,411			92,001			68
69	ELECTROCARDIOLOGY	2,535,746			3,751			69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,487,151			133,167			71
72	IMPL. DEV. CHARGED TO PATIENTS	907,762						72
73	DRUGS CHARGED TO PATIENTS	11,190,990			926,628			73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	8,552,137						91
92	OBSERVATION BEDS (NON-DISTINCT PART)	2,127,679			9,970			92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES							95
200	TOTAL (sum of lines 50-199)	115,747,451			4,163,707			200

(A) Worksheet A line numbers

Optimizer Systems, Inc.

Win LASH

Micro System

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 01/22/2015 Run Time: 14:57 Version: 2014.10
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-5580

WORKSHEET D
PART V

CHECK [] TITLE V - O/P [] HOSPITAL [] SUB (OTHER) [] SWING BED SNF
 APPLICABLE [XX] TITLE XVIII, PART B [] IPF [XX] SNF [] SWING BED NF
 BOXES: [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

(A)	COST CENTER DESCRIPTION	COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PROGRAM CHARGES			PROGRAM COST		
			PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)
1	2	3	4	5	6	7		
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	0.144864					50	
53	ANESTHESIOLOGY	0.028153					53	
54	RADIOLOGY-DIAGNOSTIC	0.165967					54	
56	RADIOISOTOPE	0.116576					56	
57	CT SCAN	0.032190					57	
58	MRI	0.140438					58	
60	LABORATORY	0.141197					60	
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30	
64	INTRAVENOUS THERAPY	0.080204					64	
65	RESPIRATORY THERAPY	0.204929					65	
66	PHYSICAL THERAPY	0.279315					66	
68	SPEECH PATHOLOGY	0.370832					68	
69	ELECTROCARDIOLOGY	0.090097					69	
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.366584					71	
72	IMPL. DEV. CHARGED TO PATIENTS	0.497452					72	
73	DRUGS CHARGED TO PATIENTS	0.232609					73	
76.97	CARDIAC REHABILITATION						76.97	
76.98	HYPERBARIC OXYGEN THERAPY						76.98	
76.99	LITHOTRIPSY						76.99	
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	0.209679					91	
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.415250					92	
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES	0.648648					95	
200	SUBTOTAL (see instructions)						200	
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES						201	
202	NET CHARGES (line 200 - line 201)						202	

(A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 01/22/2015 Run Time: 14:57 Version: 2014.10
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

CHECK TITLE V PPS
 APPLICABLE TITLE XVIII, PART A TEFRA
 BOXES: TITLE XIX

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26))	SWING BED ADJUSTMENT	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)	
		1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	368,993	5,264	363,729	5,595	65.01	873	56,754	30
31	INTENSIVE CARE UNIT	105,911		105,911	939	112.79	11	1,241	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	78,619		78,619	2,073	37.93	913	34,630	40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY	15,135		15,135	611	24.77	407	10,081	43
44	SKILLED NURSING FACILITY	147,698		147,698	10,067	14.67			44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	716,356		711,092	19,285		2,204	102,706	200

(A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 01/22/2015 Run Time: 14:57 Version: 2014.10
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0147

WORKSHEET D
PART II

CHECK TITLE V HOSPITAL SUB (OTHER) PPS
 APPLICABLE TITLE XVIII, PART A IPF TEFRA
 BOXES: TITLE XIX IRF

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part I, 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)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	367,770	15,479,211	0.023759	1,909,566	45,369	50
53	ANESTHESIOLOGY	37,103	5,893,635	0.006295	285,768	1,799	53
54	RADIOLOGY-DIAGNOSTIC	217,282	9,946,087	0.021846	110,277	2,409	54
56	RADIOISOTOPE	22,432	2,405,751	0.009324	14,824	138	56
57	CT SCAN	29,591	11,307,999	0.002617	143,758	376	57
58	MRI	2,397	1,930,754	0.001241	5,249	7	58
60	LABORATORY	131,318	23,888,305	0.005497	710,693	3,907	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	INTRAVENOUS THERAPY	2,770	1,038,187	0.002668	569	2	64
65	RESPIRATORY THERAPY	23,647	3,414,332	0.006926	81,577	565	65
66	PHYSICAL THERAPY	64,249	8,882,314	0.007233	12,794	93	66
68	SPEECH PATHOLOGY	3,762	759,411	0.004954	47,619	236	68
69	ELECTROCARDIOLOGY	8,473	2,535,746	0.003341	46,949	157	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	56,107	5,487,151	0.010225	649,608	6,642	71
72	IMPL. DEV. CHARGED TO PATIENTS	12,405	907,762	0.013665	32,062	438	72
73	DRUGS CHARGED TO PATIENTS	123,889	11,190,990	0.011070	725,759	8,034	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	134,869	8,552,137	0.015770	179,595	2,832	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	60,015	2,127,679	0.028207	37,588	1,060	92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES						95
200	TOTAL (sum of lines 50-199)	1,298,079	115,747,451		4,994,255	74,064	200

(A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 01/22/2015 Run Time: 14:57 Version: 2014.10
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK [] TITLE V [XX] PPS
 APPLICABLE [] TITLE XVIII, PART A [] TEFRA
 BOXES: [XX] TITLE XIX

(A)	COST CENTER DESCRIPTION	NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUSTMENT AMOUNT (see instructions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)
		1	2	3	4	5
	INPATIENT ROUTINE SERV 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

Optimizer Systems, Inc.

WinLASH

Micro System

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 01/22/2015 Run Time: 14:57 Version: 2014.10
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK TITLE V PPS
 APPLICABLE TITLE XVIII, PART A TEFRA
 BOXES: TITLE XIX

		TOTAL PATIENT DAYS	PER DIEM (col. 5+ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	5,595		873		30
31	INTENSIVE CARE UNIT	939		11		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	2,073		913		40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY	611		407		43
44	SKILLED NURSING FACILITY	10,067				44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	19,285		2,204		200

(A) Worksheet A line numbers

Optimizer Systems, Inc.

Win LASH

Micro System

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 01/22/2015 Run Time: 14:57 Version: 2014.10
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0147

WORKSHEET D
PART IV

CHECK TITLE V HOSPITAL SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII, PART A IPF SNF TEFRA
 BOXES: TITLE XIX IRF NF

(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM						50
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC						54
56	RADIOISOTOPE						56
57	CT SCAN						57
58	MRI						58
60	LABORATORY						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	INTRAVENOUS THERAPY						64
65	RESPIRATORY THERAPY						65
66	PHYSICAL THERAPY						66
68	SPEECH PATHOLOGY						68
69	ELECTROCARDIOLOGY						69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						71
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS						73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY						91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES						95
200	TOTAL (sum of lines 50-199)						200

(A) Worksheet A line numbers

Optimizer Systems, Inc.

Win LASH

Micro System

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 01/22/2015 Run Time: 14:57 Version: 2014.10
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0147

WORKSHEET D
PART IV

CHECK [] TITLE V [XX] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [] TITLE XVIII, PART A [] IPF [] SNF [] TEFRA
 BOXES: [XX] TITLE XIX [] IRF [] NF

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5+ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6+ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)
7	8	9	10	11	12	13		
ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	15,479,211			1,909,566			50
53	ANESTHESIOLOGY	5,893,635			285,768			53
54	RADIOLOGY-DIAGNOSTIC	9,946,087			110,277			54
56	RADIOISOTOPE	2,405,751			14,824			56
57	CT SCAN	11,307,999			143,758			57
58	MRI	1,930,754			5,249			58
60	LABORATORY	23,888,305			710,693			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY	1,038,187			569			64
65	RESPIRATORY THERAPY	3,414,332			81,577			65
66	PHYSICAL THERAPY	8,882,314			12,794			66
68	SPEECH PATHOLOGY	759,411			47,619			68
69	ELECTROCARDIOLOGY	2,535,746			46,949			69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,487,151			649,608			71
72	IMPL. DEV. CHARGED TO PATIENTS	907,762			32,062			72
73	DRUGS CHARGED TO PATIENTS	11,190,990			725,759			73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
91	EMERGENCY	8,552,137			179,595			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	2,127,679			37,588			92
OTHER REIMBURSABLE COST CENTERS								
95	AMBULANCE SERVICES							95
200	TOTAL (sum of lines 50-199)	115,747,451			4,994,255			200

(A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 01/22/2015 Run Time: 14:57 Version: 2014.10
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0147

WORKSHEET D
PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL [] SUB (OTHER) [] SWING BED SNF
 APPLICABLE [] TITLE XVIII, PART B [] IPF [] SNF [] SWING BED NF
 BOXES: [XX] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

(A)	COST CENTER DESCRIPTION	COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PROGRAM CHARGES			PROGRAM COST			
			PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.144864							50
53	ANESTHESIOLOGY	0.028153							53
54	RADIOLOGY-DIAGNOSTIC	0.165967							54
56	RADIOISOTOPE	0.116576							56
57	CT SCAN	0.032190							57
58	MRI	0.140438							58
60	LABORATORY	0.141197							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	INTRAVENOUS THERAPY	0.080204							64
65	RESPIRATORY THERAPY	0.204929							65
66	PHYSICAL THERAPY	0.279315							66
68	SPEECH PATHOLOGY	0.370832							68
69	ELECTROCARDIOLOGY	0.090097							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.366584							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.497452							72
73	DRUGS CHARGED TO PATIENTS	0.232609							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	EMERGENCY	0.209679							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.415250							92
	OTHER REIMBURSABLE COST CENTERS								
95	AMBULANCE SERVICES	0.648648							95
200	SUBTOTAL (see instructions)								200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)								202

(A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 01/22/2015 Run Time: 14:57 Version: 2014.10
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-S147

WORKSHEET D
PART II

CHECK TITLE V HOSPITAL SUB (OTHER) PPS
 APPLICABLE TITLE XVIII, PART A IPF TEFRA
 BOXES: TITLE XIX IRF

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26))	TOTAL CHARGES (from Wkst. C, Part I, (col. 8))	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)
		1	2	3	4	5
	ANCILLARY SERVICE COST CENTERS					
50	OPERATING ROOM	367,770	15,479,211	0.023759		50
53	ANESTHESIOLOGY	37,103	5,893,635	0.006295		53
54	RADIOLOGY-DIAGNOSTIC	217,282	9,946,087	0.021846		54
56	RADIOISOTOPE	22,432	2,405,751	0.009324		56
57	CT SCAN	29,591	11,307,999	0.002617		57
58	MRI	2,397	1,930,754	0.001241		58
60	LABORATORY	131,318	23,888,305	0.005497		60
62.30	BLOOD CLOTING FOR HEMOPHILIACS					62.30
64	INTRAVENOUS THERAPY	2,770	1,038,187	0.002668		64
65	RESPIRATORY THERAPY	23,647	3,414,332	0.006926		65
66	PHYSICAL THERAPY	64,249	8,882,314	0.007233		66
68	SPEECH PATHOLOGY	3,762	759,411	0.004954		68
69	ELECTROCARDIOLOGY	8,473	2,535,746	0.003341		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	56,107	5,487,151	0.010225		71
72	IMPL. DEV. CHARGED TO PATIENTS	12,405	907,762	0.013665		72
73	DRUGS CHARGED TO PATIENTS	123,889	11,190,990	0.011070		73
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
91	EMERGENCY	134,869	8,552,137	0.015770		91
92	OBSERVATION BEDS (NON-DISTINCT PART)		2,127,679			92
	OTHER REIMBURSABLE COST CENTERS					
95	AMBULANCE SERVICES					95
200	TOTAL (sum of lines 50-199)	1,238,064	115,747,451			200

(A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 01/22/2015 Run Time: 14:57 Version: 2014.10
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-S147

WORKSHEET D
PART IV

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [] TITLE XVIII, PART A [XX] IPF [] SNF [] TEFRA
 BOXES: [XX] TITLE XIX [] IRF [] NF

(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
		NON PHYSICIAN ANESTH- ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT- IENT COST (sum of col. 2, 3, and 4)	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
56	RADIOISOTOPE							56
57	CT SCAN							57
58	MRI							58
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY							64
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES							95
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers

Optimizer Systems, Inc.

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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-S147

WORKSHEET D
PART IV

CHECK TITLE V HOSPITAL SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII, PART A IPF SNF TEFRA
 BOXES: TITLE XIX IRF NF

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5+ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6+ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)
7	8	9	10	11	12	13		
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	15,479,211						50
53	ANESTHESIOLOGY	5,893,635						53
54	RADIOLOGY-DIAGNOSTIC	9,946,087						54
56	RADIOISOTOPE	2,405,751						56
57	CT SCAN	11,307,999						57
58	MRI	1,930,754						58
60	LABORATORY	23,888,305						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY	1,038,187						64
65	RESPIRATORY THERAPY	3,414,332						65
66	PHYSICAL THERAPY	8,882,314						66
68	SPEECH PATHOLOGY	759,411						68
69	ELECTROCARDIOLOGY	2,535,746						69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,487,151						71
72	IMPL. DEV. CHARGED TO PATIENTS	907,762						72
73	DRUGS CHARGED TO PATIENTS	11,190,990						73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	8,552,137						91
92	OBSERVATION BEDS (NON-DISTINCT PART)	2,127,679						92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES							95
200	TOTAL (sum of lines 50-199)	115,747,451						200

(A) Worksheet A line numbers

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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-S147

WORKSHEET D
PART V

CHECK [] TITLE V - O/P [] HOSPITAL [] SUB (OTHER) [] SWING BED SNF
 APPLICABLE [] TITLE XVIII, PART B [XX] IPF [] SNF [] SWING BED NF
 BOXES: [XX] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

(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.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.144864							50
53	ANESTHESIOLOGY	0.028153							53
54	RADIOLOGY-DIAGNOSTIC	0.165967							54
56	RADIOISOTOPE	0.116576							56
57	CT SCAN	0.032190							57
58	MRI	0.140438							58
60	LABORATORY	0.141197							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	INTRAVENOUS THERAPY	0.080204							64
65	RESPIRATORY THERAPY	0.204929							65
66	PHYSICAL THERAPY	0.279315							66
68	SPEECH PATHOLOGY	0.370832							68
69	ELECTROCARDIOLOGY	0.090097							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.366584							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.497452							72
73	DRUGS CHARGED TO PATIENTS	0.232609							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	EMERGENCY	0.209679							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.415250							92
	OTHER REIMBURSABLE COST CENTERS								
95	AMBULANCE SERVICES	0.648648							95
200	SUBTOTAL (see instructions)								200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)								202

(A) Worksheet A line numbers

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Micro System

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 01/22/2015 Run Time: 14:57 Version: 2014.10
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0147

WORKSHEET D-1
PART I

CHECK [] TITLE V - I/P [XX] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] 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)	5,998	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	5,595	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)	4,685	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	93	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)	279	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	8	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)	23	8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	2,865	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)	93	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)	279	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 Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title 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	197.90	17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	202.51	18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	119.75	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	119.75	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	5,510,815	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17)	18,405	22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 6 x line 18)	56,500	23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 7 x line 19)	958	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)	2,754	25
26	TOTAL SWING-BED COST (see instructions)	78,617	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	5,432,198	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	5,432,198	37

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0147

WORKSHEET D-1
PART II

CHECK [] TITLE V - I/P [XX] HOSPITAL [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] 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

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					970.90	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					2,781,629	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)					2,781,629	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	1,624,747	939	1,730.29	878	1,519,195	43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47

48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)					3,232,462	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					7,533,286	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)					285,284	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)					185,009	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)					470,293	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)					7,062,993	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)					18,405	64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)					56,500	65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)					74,905	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: 14-0147

WORKSHEET D-1
PARTS III & IV

CHECK TITLE V - I/P HOSPITAL SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII, PART A IPF SNF TEFRA
 BOXES: TITLE XIX - I/P IRF NF OTHER

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					910	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 + line 2)					970.90	88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)					883,519	89
		COST	ROUTINE COST (from line 27)	column 1 + column 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	368,993	5,432,198	0.067927	883,519	60,015	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-S147

WORKSHEET D-1
PART I

CHECK [] TITLE V - I/P [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [XX] 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)	2,073	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	2,073	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.	646	3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	1,427	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	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	501	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 Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title 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)	1,656,315	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	1,656,315	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)	2,340,046	28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)	693,158	29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)	1,646,888	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)	0.707813	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)	1,073.00	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)	1,154.09	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 - line 36)	1,656,315	37

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-S147

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)	798.99	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	400,294	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)	400,294	41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)	72,696	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	472,990	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	19,003	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	3,783	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	22,786	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)	450,204	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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Micro System

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-5580

WORKSHEET D-1
PART I

CHECK [] TITLE V - I/P [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [] IPF [XX] 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)	10,067	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	10,067	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)	10,067	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	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	2,941	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 Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title 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)	2,860,577	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	2,860,577	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	2,860,577	37

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-5580

WORKSHEET D-1
PARTS III & IV

CHECK TITLE V - I/P HOSPITAL SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII, PART A IPF SNF TEFRA
 BOXES: TITLE XIX - I/P IRF NF OTHER

PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY

70	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST (line 37)	2,860,577	70
71	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (line 70 ÷ line 2)	284.15	71
72	PROGRAM ROUTINE SERVICE COST (line 9 x line 71)	835,685	72
73	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM (line 14 x line 35)		73
74	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS (line 72 + line 73)	835,685	74
75	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS (from Worksheet B, Part II, column 26, line 45)		75
76	PER DIEM CAPITAL-RELATED COSTS (line 75 ÷ line 2)		76
77	PROGRAM CAPITAL-RELATED COSTS (line 9 x line 76)		77
78	INPATIENT ROUTINE SERVICE COST (line 74 minus line 77)		78
79	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS (from provider records)		79
80	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION (line 78 minus line 79)		80
81	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION		81
82	INPATIENT ROUTINE SERVICE COST LIMITATION (line 9 x line 81)		82
83	REASONABLE INPATIENT ROUTINE SERVICE COSTS (see instructions)	835,685	83
84	PROGRAM INPATIENT ANCILLARY SERVICES (see instructions)	1,024,190	84
85	UTILIZATION REVIEW-PHYSICIAN COMPENSATION (see instructions)		85
86	TOTAL PROGRAM INPATIENT OPERATING COSTS (sum of lines 83 through 85)	1,859,875	86

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0147

WORKSHEET D-1
PART I

CHECK TITLE V - I/P HOSPITAL SUB (OTHER) ICF/MR 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)	5,998	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	5,595	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)	4,685	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	93	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)	279	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	8	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)	23	8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	873	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 Title XIX only)	611	15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)	407	16

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	197.90	17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	202.51	18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	119.75	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	119.75	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	5,510,815	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17)	18,405	22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 6 x line 18)	56,500	23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 7 x line 19)	958	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)	2,754	25
26	TOTAL SWING-BED COST (see instructions)	78,617	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	5,432,198	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	5,432,198	37

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0147

WORKSHEET D-1
PART II

CHECK [] TITLE V - I/P [XX] HOSPITAL [] SUB (OTHER) [XX] PPS
 APPLICABLE [] TITLE XVIII, PART A [] IPF [] TEFRA
 BOXES: [XX] 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)						970.90	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)						847,596	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)						847,596	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)	460,951	611	754.42	407	307,049		42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS							
43	INTENSIVE CARE UNIT	1,624,747	939	1,730.29	11	19,033		43
44	CORONARY CARE UNIT							44
45	BURN INTENSIVE CARE UNIT							45
46	SURGICAL INTENSIVE CARE UNIT							46
47	OTHER SPECIAL CARE (SPECIFY)							47

48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)						928,809	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)						2,102,487	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)						68,076	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)						74,064	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)						142,140	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)						1,960,347	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

Optimizer Systems, Inc.

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0147

WORKSHEET D-1
PARTS III & IV

CHECK TITLE V - I/P HOSPITAL SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII, PART A IPF SNF TEFRA
 BOXES: TITLE XIX - I/P IRF NF OTHER

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					910	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)						88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)						89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 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 COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

Optimizer Systems, Inc.

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Micro System

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-S147

WORKSHEET D-1
PART I

CHECK [] TITLE V - I/P [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [] TITLE XVIII, PART A [XX] IPF [] SNF [] TEFRA
 BOXES: [XX] 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)	2,073	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	2,073	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.	646	3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	1,427	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	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	913	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 Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title 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)	1,656,315	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	1,656,315	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)	2,340,046	28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)	693,158	29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)	1,646,888	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)	0.707813	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)	1,073.00	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)	1,154.09	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 - line 36)	1,656,315	37

Optimizer Systems, Inc.

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Micro System

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 01/22/2015 Run Time: 14:57 Version: 2014.10
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-S147

WORKSHEET D-1
PART II

CHECK [] TITLE V - I/P [] HOSPITAL [] SUB (OTHER) [XX] PPS
 APPLICABLE [] TITLE XVIII, PART A [XX] IPF [] TEFRA
 BOXES: [XX] TITLE XIX - I/P [] TRF [] 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)	798.99	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	729,478	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)	729,478	41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)		48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	729,478	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	34,630	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)		51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	34,630	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)	694,848	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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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0147

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/MR OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		2,532,962		30
31	INTENSIVE CARE UNIT		1,169,468		31
40	SUBPROVIDER - IPF				40
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.144864	1,582,541	229,253	50
53	ANESTHESIOLOGY	0.028153	426,103	11,996	53
54	RADIOLOGY-DIAGNOSTIC	0.165967	1,247,953	207,119	54
56	RADIOISOTOPE	0.116576	154,142	17,969	56
57	CT SCAN	0.032190	1,521,057	48,963	57
58	MRI	0.140438	53,451	7,507	58
60	LABORATORY	0.141197	3,570,914	504,202	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	INTRAVENOUS THERAPY	0.080204	335,646	26,920	64
65	RESPIRATORY THERAPY	0.204929	1,656,011	339,365	65
66	PHYSICAL THERAPY	0.279315	581,997	162,560	66
68	SPEECH PATHOLOGY	0.370832	60,477	22,427	68
69	ELECTROCARDIOLOGY	0.090097	284,625	25,644	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.366584	1,138,288	417,278	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.497452	311,059	154,737	72
73	DRUGS CHARGED TO PATIENTS	0.232609	3,123,289	726,505	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	EMERGENCY	0.209679	1,075,120	225,430	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.415250	251,865	104,587	92
	OTHER REIMBURSABLE COST CENTERS				
95	AMBULANCE SERVICES				95
200	TOTAL (sum of lines 50-94, and 96-98)		17,374,538	3,232,462	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		17,374,538		202

(A) Worksheet A line numbers

Optimizer Systems, Inc.

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Micro System

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 01/22/2015 Run Time: 14:57 Version: 2014.10
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-S147

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/MR OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
40	SUBPROVIDER - IPF		537,146		40
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.144864			50
53	ANESTHESIOLOGY	0.028153			53
54	RADIOLOGY-DIAGNOSTIC	0.165967	7,647	1,269	54
56	RADIOISOTOPE	0.116576			56
57	CT SCAN	0.032190	28,882	930	57
58	MRI	0.140438			58
60	LABORATORY	0.141197	104,307	14,728	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	INTRAVENOUS THERAPY	0.080204	869	70	64
65	RESPIRATORY THERAPY	0.204929	3,934	806	65
66	PHYSICAL THERAPY	0.279315	827	231	66
68	SPEECH PATHOLOGY	0.370832			68
69	ELECTROCARDIOLOGY	0.090097	6,560	591	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.366584	5,316	1,949	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.497452			72
73	DRUGS CHARGED TO PATIENTS	0.232609	165,618	38,524	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	EMERGENCY	0.209679	64,853	13,598	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.415250			92
	OTHER REIMBURSABLE COST CENTERS				
95	AMBULANCE SERVICES				95
200	TOTAL (sum of lines 50-94, and 96-98)		388,813	72,696	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		388,813		202

(A) Worksheet A line numbers

Optimizer Systems, Inc.

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Micro System

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 01/22/2015 Run Time: 14:57 Version: 2014.10
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-U147

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/MR OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
40	SUBPROVIDER - IPF				40
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.144864	2,873	416	50
53	ANESTHESIOLOGY	0.028153			53
54	RADIOLOGY-DIAGNOSTIC	0.165967	25,975	4,311	54
56	RADIOISOTOPE	0.116576	2,095	244	56
57	CT SCAN	0.032190	12,060	388	57
58	MRI	0.140438			58
60	LABORATORY	0.141197	102,540	14,478	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	INTRAVENOUS THERAPY	0.080204	16,678	1,338	64
65	RESPIRATORY THERAPY	0.204929	173,949	35,647	65
66	PHYSICAL THERAPY	0.279315	112,075	31,304	66
68	SPEECH PATHOLOGY	0.370832	7,215	2,676	68
69	ELECTROCARDIOLOGY	0.090097	2,804	253	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.366584	33,093	12,131	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.497452			72
73	DRUGS CHARGED TO PATIENTS	0.232609	241,134	56,090	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	EMERGENCY	0.209679			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.415250			92
	OTHER REIMBURSABLE COST CENTERS				
95	AMBULANCE SERVICES				95
200	TOTAL (sum of lines 50-94, and 96-98)		732,491	159,276	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		732,491		202

(A) Worksheet A line numbers

Optimizer Systems, Inc.

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Micro System

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 01/22/2015 Run Time: 14:57 Version: 2014.10
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-5580

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/MR OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
40	SUBPROVIDER - IPF				40
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.144864			50
53	ANESTHESIOLOGY	0.028153			53
54	RADIOLOGY-DIAGNOSTIC	0.165967	81,946	13,600	54
56	RADIOISOTOPE	0.116576			56
57	CT SCAN	0.032190	56,130	1,807	57
58	MRI	0.140438	9,092	1,277	58
60	LABORATORY	0.141197	309,002	43,630	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	INTRAVENOUS THERAPY	0.080204	44,274	3,551	64
65	RESPIRATORY THERAPY	0.204929	541,605	110,991	65
66	PHYSICAL THERAPY	0.279315	1,956,141	546,380	66
68	SPEECH PATHOLOGY	0.370832	92,001	34,117	68
69	ELECTROCARDIOLOGY	0.090097	3,751	338	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.366584	133,167	48,817	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.497452			72
73	DRUGS CHARGED TO PATIENTS	0.232609	926,628	215,542	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	EMERGENCY	0.209679			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.415250	9,970	4,140	92
	OTHER REIMBURSABLE COST CENTERS				
95	AMBULANCE SERVICES				95
200	TOTAL (sum of lines 50-94, and 96-98)		4,163,707	1,024,190	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		4,163,707		202

(A) Worksheet A line numbers

Optimizer Systems, Inc.

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Micro System

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 01/22/2015 Run Time: 14:57 Version: 2014.10
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0147

WORKSHEET D-3

CHECK TITLE V HOSPITAL SUB (OTHER) SWING BED SNE PPS *Removal charges*
 APPLICABLE TITLE XVIII, PART A IPF SNF SWING BED NF TEFRA *M*
 BOXES: TITLE XIX IRF NF ICF/MR OTHER *System*

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		746,978		30
31	INTENSIVE CARE UNIT		20,280		31
40	SUBPROVIDER - IPF				40
43	NURSERY		255,797		43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.144864	1,909,566	276,627	50
53	ANESTHESIOLOGY	0.028153	285,768	8,045	53
54	RADIOLOGY-DIAGNOSTIC	0.165967	110,277	18,302	54
56	RADIOISOTOPE	0.116576	14,824	1,728	56
57	CT SCAN	0.032190	143,758	4,628	57
58	MRI	0.140438	5,249	737	58
60	LABORATORY	0.141197	710,693	100,348	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	INTRAVENOUS THERAPY	0.080204	569	46	64
65	RESPIRATORY THERAPY	0.204929	81,577	16,717	65
66	PHYSICAL THERAPY	0.279315	12,794	3,574	66
68	SPEECH PATHOLOGY	0.370832	47,619	17,659	68
69	ELECTROCARDIOLOGY	0.090097	46,949	4,230	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.366584	649,608	238,136	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.497452	32,062	15,949	72
73	DRUGS CHARGED TO PATIENTS	0.232609	725,759	168,818	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	EMERGENCY	0.209679	179,595	37,657	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.415250	37,588	15,608	92
	OTHER REIMBURSABLE COST CENTERS				
95	AMBULANCE SERVICES				95
200	TOTAL (sum of lines 50-94, and 96-98)		4,994,255	928,809	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		4,994,255		202

(A) Worksheet A line numbers

Optimizer Systems, Inc.

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Micro System

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-S147

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/MR OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
40	SUBPROVIDER - IPF				40
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.144864			50
53	ANESTHESIOLOGY	0.028153			53
54	RADIOLOGY-DIAGNOSTIC	0.165967			54
56	RADIOISOTOPE	0.116576			56
57	CT SCAN	0.032190			57
58	MRI	0.140438			58
60	LABORATORY	0.141197			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	INTRAVENOUS THERAPY	0.080204			64
65	RESPIRATORY THERAPY	0.204929			65
66	PHYSICAL THERAPY	0.279315			66
68	SPEECH PATHOLOGY	0.370832			68
69	ELECTROCARDIOLOGY	0.090097			69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.366584			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.497452			72
73	DRUGS CHARGED TO PATIENTS	0.232609			73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	EMERGENCY	0.209679			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.415250			92
	OTHER REIMBURSABLE COST CENTERS				
95	AMBULANCE SERVICES				95
200	TOTAL (sum of lines 50-94, and 96-98)				200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)				202

(A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 01/22/2015 Run Time: 14:57 Version: 2014.10
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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK [XX] HOSPITAL
APPLICABLE BOX:

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS	5,404,395			1
1.01	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING PRIOR TO OCTOBER 1, 2013 (see instructions)				1.01
1.02	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2013 (see instructions)				1.02
1.03	DRG FOR FEDERAL SPECIFIC OPERATING PAYMENT FOR MODEL 4 BPCI (see instructions)				1.03
2	OUTLIER PAYMENTS FOR DISCHARGES (see instructions)	45,406			2
2.01	OUTLIER RECONCILIATION AMOUNT				2.01
2.02	OUTLIER PAYMENT FOR MODEL 4 BPCI (see instructions)				
3	MANAGED CARE SIMULATED PAYMENTS				3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)	43.40			4
INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS					
5	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996 (see instructions)				5
6	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.79(e)				6
7	MMA SECTION 422 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105(f)(1)(iv)(B)(1)				7
7.01	ACA SECTION 5503 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105(f)(1)(iv)(B)(2). IF THE COST REPORT STRADDLES JULY 1, 2011 THEN SEE INSTRUCTIONS				7.01
8	ADJUSTMENT (INCREASE OR DECREASE) TO THE FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR §413.75(b), §413.79(c)(2)(iv) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 50069, AUGUST 1, 2002				8
8.01	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS UNDER SECTION 5503 OF THE ACA. IF THE COST REPORT STRADDLES JULY 1, 2011, SEE INSTRUCTIONS				8.01
8.02	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS FROM A CLOSED TEACHING HOSPITAL UNDER SECTION 5506 OF ACA. (see instructions)				8.02
9	SUM OF LINES 5 PLUS 6 MINUS LINES (7 AND 7.01) PLUS/MINUS LINES (8, 8.01 AND 8.02) (see instructions)				9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS				10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS				11
12	CURRENT YEAR ALLOWABLE FTE (see instructions)				12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR				13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO				14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3				15
16	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF THE PROGRAM				16
17	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE				17
18	ADJUSTED ROLLING AVERAGE FTE COUNT				18
19	CURRENT YEAR RESIDENT TO BED RATIO (line 18 divided by line 4)				19
20	PRIOR YEAR RESIDENT TO BED RATIO (see instructions)				20
21	ENTER THE LESSER OF LINES 19 OR 20 (see instructions)				21
22	IME PAYMENT ADJUSTMENT (see instructions)				22
INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON					
23	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42 SEC. 412.105(f)(1)(iv)(C)				23
24	IME FTE RESIDENT COUNT OVER CAP (see instructions)				24
25	IF THE AMOUNT ON LINE 24 IS GREATER THAN -0-, THEN ENTER THE LOWER OF LINE 23 OR LINE 24 (see instructions)				25
26	RESIDENT TO BED RATIO (divide line 25 by line 4)				26
27	IME PAYMENTS ADJUSTMENT (see instructions)				27
28	IME ADJUSTMENT (see instructions)				28
29	TOTAL IME PAYMENT (sum of lines 22 and 28)				29
DISPROPORTIONATE SHARE ADJUSTMENT					
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (see instructions)	0.0377			30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL (see instructions)	0.2281			31
32	SUM OF LINES 30 AND 31	0.2658			32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.1114			33
34	DISPROPORTIONATE SHARE ADJUSTMENT (see instructions)	150,512			34
		PRIOR TO	ON OR AFTER		
		OCTOBER 1	OCTOBER 1		
UNCOMPENSATED CARE ADJUSTMENT					
35	TOTAL UNCOMPENSATED CARE AMOUNT (see instructions)				35
35.01	FACTOR 3 (see instructions)				35.01
35.02	HOSPITAL UNCOMPENSATED CARE PAYMENT (if line 34 is zero, enter zero on this line) (see instructions)		463,869		35.02
35.03	PRO RATA SHARE OF THE HOSPITAL UNCOMPENSATED CARE PAYMENT AMOUNT (see instructions)		463,869		35.03
36	TOTAL UNCOMPENSATED CARE (sum of columns 1 and 2 on line 35.03)	463,869			36
ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES					
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I EXCLUDING DISCHARGES FOR MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				40

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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK [XX] HOSPITAL
APPLICABLE BOX:

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
41	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				41
41.01	TOTAL ESRD MEDICARE COVERED AND PAID DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				41.01
42	DIVIDE LINE 41 BY LINE 40 (if less than 10%, you do not qualify for adjustment)		SEH		42
43	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				43
44	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK (line 43 divided by line 41.01 divided by 7 days)				44
45	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS (see instructions)				45
46	TOTAL ADDITIONAL PAYMENT (line 45 times line 44 times line 41.01)				46
47	SUBTOTAL (see instructions)	6,064,182			47
48	HOSPITAL SPECIFIC PAYMENTS (to be completed by SCH and MDH, small rural hospitals only (see instructions)	6,155,214			48
49	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (see instructions)	6,132,456	6,116,912		49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (from Wkst L, Parts I, II, as applicable)	428,728			50
51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (Wkst L, Part III) (see instructions)				51
52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (from Wkst E-4, line 49) (see instructions)				52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT				53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES				54
55	NET ORGAN ACQUISITION COST (Wkst D-4, Part III, col. 1, line 69)				55
56	COST OF TEACHING PHYSICIANS (Wkst D-5, Part II, col. 3, line 20)				56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS				57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (Wkst D, Part IV, col. 11, line 200)				58
59	TOTAL (sum of amounts on lines 49 through 58)	6,561,184			59
60	PRIMARY PAYER PAYMENTS				60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (line 59 minus line 60)	6,561,184			61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	723,112			62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	4,440			63
64	ALLOWABLE BAD DEBTS (see instructions)	293,841			64
65	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	190,997			65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	259,578			66
67	SUBTOTAL (line 61 plus line 65 minus lines 62 and 63)	6,024,629			67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (see instructions)				68
69	OUTLIER PAYMENTS RECONCILIATION				69
70	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				70
70.93	HVPB PAYMENT ADJUSTMENT (see instructions)	16,513			70.93
70.94	HOSPITAL READMISSIONS REDUCTION ADJUSTMENT (see instructions)	-40,533			70.94
70.97	LOW VOLUME ADJUSTMENT FOR FEDERAL FISCAL YEAR (2014)	717,046			70.97
71	AMOUNT DUE PROVIDER (see instructions)	6,717,655			71
71.01	SEQUESTRATION ADJUSTMENT (see instructions)	134,353			71.01
72	INTERIM PAYMENTS	6,797,358			72
73	TENTATIVE SETTLEMENT (for contractor use only)				73
74	BALANCE DUE PROVIDER/PROGRAM (line 71 minus lines 71.01, 72 and 73)	-214,056			74
75	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2	97,360			75

TO BE COMPLETED BY CONTRACTOR

90	OPERATING OUTLIER AMOUNT FROM WORKSHEET E, PART A, LINE 2				90
91	CAPITAL OUTLIER FROM WORKSHEET L, PART I, LINE 2				91
92	OPERATING OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)				92
93	CAPITAL OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)				93
94	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (see instructions)				94
95	TIME VALUE OF MONEY FOR OPERATING EXPENSES (see instructions)				95
96	TIME VALUE OF MONEY FOR CAPITAL RELATED EXPENSES (see instructions)				96

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LOW VOLUME ADJUSTMENT CALCULATION SCHEDULE (For Worksheet E Part A, Lines 70.96 and 70.97)

EXHIBIT 4

		AMOUNTS FROM E PART A	PRIOR TO 10/1/2010 OR AFTER 3/31/2015 PRE/POST-ENTITLEMENT	NOT APPLICABLE		10/01/2013 through 09/30/2014		(COLUMNS 2 THROUGH 4) TOTAL	
		1	2	3	3.01	4	4.01	5	
1	DRG Amounts Other Than Outlier Payments	5,404,395				5,404,395		5,404,395	1
1.01	DRG Amounts Other Than Outlier Payments for Discharges prior to 10/1/2013								1.01
1.02	DRG Amounts Other Than Outlier Payments for Discharges on/after 10/1/2013								1.02
1.03	DRG for Federal Specific Operating Payment for Model 4 BPCI								1.03
2	Outlier Payments for Discharges	45,406				45,406		45,406	2
2.01	Outlier Payment for Discharges for Model 4 BPCI								2.01
3	Operating Outlier Reconciliation								3
4	Managed Care Simulated Payments								4
INDIRECT MEDICAL EDUCATION ADJUSTMENT									
5	Amount from Worksheet E Part A, Line 21								5
6	IME Payment Adjustment								6
INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON FOR MME SECTION 422									
7	Amount from Worksheet E Part A, Line 27								7
8	IME Add-on Adjustment								8
9	Total IME Payment								9
DISPROPORTIONATE SHARE ADJUSTMENT									
10	Allowable Disproportionate Share Percentage	0.1114	0.1114	0.1114	0.1114	0.1114	0.1114		10
11	Disproportionate Share Adjustment	150,513				150,513		150,513	11
11.01	Uncompensated Care Payments	463,869				463,869		463,869	11.01
ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES									
12	Total ESRD Additional Payment								12
13	Subtotal	6,064,183				6,064,183		6,064,183	13
14	Hospital Specific Payments	6,155,214				6,155,214		6,155,214	14
15	Total Payment for Inpatient Operating Costs - E Part A Line 49	6,132,456				6,132,456		6,132,456	15
16	Payment for Inpatient Program Capital	428,728				428,728		428,728	16
17	Special Add-on Payments for New Technologies								17
18	Capital Outlier Reconciliation Adjustment Amount								18
19	Subtotal					6,561,184		6,561,184	19
CAPITAL PAYMENTS									
20	Capital DRG Other Than Outlier	425,554				425,554		425,554	20
20.01	Model 4 BPCI Capital DRG Other Than Outlier								20.01
21	Capital DRG Outlier Payments	3,174				3,174		3,174	21
21.01	Model 4 BPCI Capital DRG Outlier Payments								21.01
22	Indirect Medical Education Percentage								22
23	Indirect Medical Education Adjustment								23
24	Allowable Disproportionate Share Percentage								24
25	Disproportionate Share Adjustment								25
26	Total Prospective Capital Payments	428,728				428,728		428,728	26
LOW VOLUME ADJUSTMENT									
27	Low Volume Adjustment Factor					0.109286			27
28	Low Volume Adjustment								28
29	Low Volume Adjustment					717,046		717,046	29

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-0147

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)	4,573	1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (see instructions)	3,351,933	2
3	PPS PAYMENTS	3,176,912	3
4	OUTLIER PAYMENT (see instructions)	907	4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)	0.810	5
6	LINE 2 TIMES LINE 5	2,715,066	6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6		7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)		8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200		9
10	ORGAN ACQUISITION		10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)	4,573	11
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
12	ANCILLARY SERVICE CHARGES	19,659	12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)		13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)	19,659	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)	19,659	18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions))	15,086	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 (line 11 minus line 20) (for CAH, see instructions)	4,573	21
22	INTERNS AND RESIDENTS (see instructions)		22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)		23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)	3,177,819	24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25	DEDUCTIBLES AND COINSURANCE (see instructions)		25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)	756,077	26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	2,426,315	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)	2,426,315	30
31	PRIMARY PAYER PAYMENTS		31
32	SUBTOTAL (line 30 minus line 31)	2,426,315	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)	177,294	34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	115,241	35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	151,439	36
37	SUBTOTAL (see instructions)	2,541,556	37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R		38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)		39
40	SUBTOTAL (see instructions)	2,541,556	40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	50,831	40.01
41	INTERIM PAYMENTS	2,451,119	41
42	TENTATIVE SETTLEMENT (for contractor use only)		42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	39,606	43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 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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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-S147

WORKSHEET E
PART B

CHECK APPLICABLE BOX: [] HOSPITAL [XX] 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 OPPTS (see instructions)				2
3	PPS PAYMENTS				3
4	OUTLIER PAYMENT (see instructions)				4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)				5
6	LINE 2 TIMES LINE 5				6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6				7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART 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, line 69, col. 4)				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 (line 11 minus line 20) (for CAH, see instructions)				21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)				25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)				26
27	SUBTOTAL ((lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23) (see instructions)				27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Wkst E-4, line 50)				28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (from Wkst E-4, line 36)				29
30	SUBTOTAL (sum of lines 27 through 29)				30
31	PRIMARY PAYER PAYMENTS				31
32	SUBTOTAL (line 30 minus line 31)				32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	COMPOSITE RATE ESRD (from Wkst I-5, line 11)				33
34	ALLOWABLE BAD DEBTS (see instructions)				34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)				35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)				36
37	SUBTOTAL (see instructions)				37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)				40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)				40.01
41	INTERIM PAYMENTS				41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)				43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 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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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-5580

WORKSHEET E
PART B

CHECK APPLICABLE BOX: [] HOSPITAL [] IPF [] IRF [] SUB (OTHER) [XX] 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 OPPTS (see instructions)				2
3	PPS PAYMENTS				3
4	OUTLIER PAYMENT (see instructions)				4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)				5
6	LINE 2 TIMES LINE 5				6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6				7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART 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, line 69, col. 4)				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 (line 11 minus line 20) (for CAH, see instructions)				21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)				25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)				26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)				27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Wkst E-4, line 50)				28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (from Wkst E-4, line 36)				29
30	SUBTOTAL (sum of lines 27 through 29)				30
31	PRIMARY PAYER PAYMENTS				31
32	SUBTOTAL (line 30 minus line 31)				32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	COMPOSITE RATE ESRD (from Wkst I-5, line 11)				33
34	ALLOWABLE BAD DEBTS (see instructions)				34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)				35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)				36
37	SUBTOTAL (see instructions)				37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)				40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)				40.01
41	INTERIM PAYMENTS				41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)				43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 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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RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 01/22/2015 Run Time: 14:57 Version: 2014.10
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-0147

WORKSHEET E-1
PART I

CHECK HOSPITAL SUB (OTHER)
 APPLICABLE IPF SNF
 BOXES: IRF SWING BED SNF

	DESCRIPTION	INPATIENT PART A		PART B		
		mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER		6,638,715		2,470,713	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	05/02/2014	158,643		3.01
		.02				3.02
		.03	PROGRAM			3.03
		.04	TO			3.04
		.05	PROVIDER			3.05
		.06				3.06
		.07				3.07
		.08				3.08
		.09				3.09
		.10				3.10
		.50				3.50
		.51			05/05/2014	3.51
		.52	PROVIDER		19,594	3.52
		.53	TO			3.53
		.54	PROGRAM			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		158,643	-19,594	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)			6,797,358	2,451,119	4
TO BE COMPLETED BY CONTRACTOR						
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)					
		.01				5.01
		.02				5.02
		.03	PROGRAM			5.03
		.04	TO			5.04
		.05	PROVIDER			5.05
		.06				5.06
		.07				5.07
		.08				5.08
		.09				5.09
		.10				5.10
		.50				5.50
		.51				5.51
		.52	PROVIDER			5.52
		.53	TO			5.53
		.54	PROGRAM			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			90,437	6.01
		.02		-79,703		6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)			6,717,655	2,541,556	7
8	NAME OF CONTRACTOR		CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)	8

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

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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-S147

WORKSHEET E-1
PART I

CHECK [] HOSPITAL [] SUB (OTHER)
 APPLICABLE [XX] IPF [] SNF
 BOXES: [] IRF [] SWING BED SNF

	DESCRIPTION	INPATIENT PART A		PART B		
		mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER		325,541			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					3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM					3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM	.03			3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO	.04			3.04
		PROVIDER	.05			3.05
			.06			3.06
			.07			3.07
			.08			3.08
			.09			3.09
			.10			3.10
			.50			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			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)			325,541		4
TO BE COMPLETED BY CONTRACTOR						
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT		.01			5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.		.02			5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	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)		.01	15,433		6.01
	BASED ON THE COST REPORT (1)		.02			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)			340,974		7
8	NAME OF CONTRACTOR	CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)		8

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

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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-U147

WORKSHEET E-1
PART I

CHECK [] HOSPITAL [] SUB (OTHER)
 APPLICABLE [] IPF [] SNF
 BOXES: [] IRF [XX] SWING BED SNF

	DESCRIPTION	INPATIENT PART A		PART B	
		mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER		106,769		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				3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM				3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM	.03		3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO	.04		3.04
		PROVIDER	.05		3.05
			.06		3.06
			.07		3.07
			.08		3.08
			.09		3.09
			.10		3.10
			.50		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		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)		106,769		4
TO BE COMPLETED BY CONTRACTOR					
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT		.01		5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.		.02		5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	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	5,016	6.01
			.02		6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)			111,785	7
8	NAME OF CONTRACTOR		CONTRACTOR NUMBER	NPR DATE (Month/Day/Year)	8

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

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Micro System

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 01/22/2015 Run Time: 14:57 Version: 2014.10
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-5580

WORKSHEET E-1
PART I

CHECK [] HOSPITAL [] SUB (OTHER)
 APPLICABLE [] IPF [XX] SNF
 BOXES: [] IRF [] SWING BED SNF

	DESCRIPTION	INPATIENT PART A		PART B		
		mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
		1	2	3	4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER		981,267			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					3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM					3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM				3.03
		TO				3.04
		PROVIDER				3.05
						3.06
						3.07
						3.08
						3.09
						3.10
						3.50
						3.51
		PROVIDER				3.52
		TO				3.53
		PROGRAM				3.54
						3.55
						3.56
						3.57
						3.58
						3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)					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)		981,267			4
TO BE COMPLETED BY CONTRACTOR						
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT					5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.					5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM				5.03
		TO				5.04
		PROVIDER				5.05
						5.06
						5.07
						5.08
						5.09
						5.10
						5.50
						5.51
		PROVIDER				5.52
		TO				5.53
		PROGRAM				5.54
						5.55
						5.56
						5.57
						5.58
						5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)					5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due) BASED ON THE COST REPORT (1)		20,026			6.01
						6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)		1,001,293			7
8	NAME OF CONTRACTOR	CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)		8

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

Optimizer Systems, Inc.

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Micro System

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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK [XX] HOSPITAL [] CAH
APPLICABLE BOX:

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	1,345	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	3,743	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	111	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	5,624	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	134,204,607	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	2,316,644	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (see instructions)	710,967	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (see instructions)	14,219	9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (see instructions)	696,748	10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)	695,008	30
31	OTHER ADJUSTMENTS ()		31
32	BALANCE DUE PROVIDER (line 8 (or line 10) minus line 30 and line 31) (see instructions)	1,740	32

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CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

COMPONENT CCN: 14-U147

WORKSHEET E-2

CHECK TITLE V SWING BED - SNF
 APPLICABLE TITLE XVIII SWING BED - NF
 BOXES: TITLE XIX

COMPUTATION OF NET COSTS OF COVERED SERVICES

	PART A	PART B	
	1	2	
1 INPATIENT ROUTINE SERVICES - SWING BED-SNF (see instructions)	115,916		1
2 INPATIENT ROUTINE SERVICES - SWING BED-NF (see instructions)			2
3 ANCILLARY SERVICES (from Wkst D-3, col. 3, line 200 for Part A, and sum of Wkst D, Part V, cols. 5 and 7, line 202 for Part B) (for CAH, see instructions)			3
4 PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (see instructions)			4
5 PROGRAM DAYS	372		5
6 INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (see instructions)			6
7 UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY			7
8 SUBTOTAL (sum of lines 1-3 plus lines 6 and 7)	115,916		8
9 PRIMARY PAYER PAYMENTS (see instructions)			9
10 SUBTOTAL (line 8 minus line 9)	115,916		10
11 DEDUCTIBLES BILLED TO PROGRAM PATIENTS (exclude amounts applicable to physician professional services)			11
12 SUBTOTAL (line 10 minus line 11)	115,916		12
13 COINSURANCE BILLED TO PROGRAM PATIENTS (exclude coinsurance for physician professional services)	6,968		13
14 80% OF PART B COSTS (line 12 x 80%)			14
15 SUBTOTAL (enter the lesser of line 12 minus line 13, or line 14)	108,948		15
16 OTHER ADJUSTMENTS (SPECIFY) (see instructions)			16
17 ALLOWABLE BAD DEBTS (see instructions)	4,364		17
17.01 ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	2,837		17.01
18 ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)			18
19 TOTAL (see instructions)	111,785		19
19.01 SEQUESTRATION ADJUSTMENT (see instructions)	2,236		19.01
20 INTERIM PAYMENTS	106,769		20
21 TENTATIVE SETTLEMENT (for contractor use only)			21
22 BALANCE DUE PROVIDER/PROGRAM (line 19 minus lines 19.01, 20 and 21)	2,780		22
23 PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			23

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-S147

WORKSHEET E-3
PART II

CHECK [] HOSPITAL
 APPLICABLE [XX] SUBPROVIDER IPF
 BOX:

PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS

1	NET FEDERAL IPF PPS PAYMENT (excluding outlier, ECT, and medical education payments)	427,904	1
2	NET IPF PPS OUTLIER PAYMENT		2
3	NET IPF PPS ECT PAYMENT		3
4	UNWEIGHTED INTERN AND RESIDENT FTE COUNT IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004		4
4.01	CAP INCREASES FOR THE UNWEIGHTED INTERN AND RESIDENT FTE COUNT FOR RESIDENTS THAT WERE DISPLACED BY PROGRAM OR HOSPITAL CLOSURE, THAT WOULD NOT BE COUNTED WITHOUT A TEMPORARY CAP ADJUSTMENT UNDER §412.424(d)(1)(iii)(F)(1) OR (2) (see instructions)	4.01	4.01
5	NEW TEACHING PROGRAM ADJUSTMENT (see instructions)		5
6	CURRENT YEAR UNWEIGHTED FTE COUNT OF I&R EXCLUDING FTEs IN THE NEW PROGRAM GROWTH PERIOD OF A NEW TEACHING PROGRAM (see instructions)		6
7	CURRENT YEAR UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE NEW PROGRAM GROWTH PERIOD OF A NEW TEACHING PROGRAM (see instructions)		7
8	INTERN AND RESIDENT COUNT FOR IPF PPS MEDICAL EDUCATION ADJUSTMENT (see instructions)		8
9	AVERAGE DAILY CENSUS (see instructions)	5.679452	9
10	TEACHING ADJUSTMENT FACTOR $\{(1 + (\text{line } 8/\text{line } 9)) \text{ raised to the power of } .5150 - 1\}$		10
11	TEACHING ADJUSTMENT (line 1 multiplied by line 10)		11
12	ADJUSTED NET IPF PPS PAYMENTS (sum of lines 1, 2, 3 and 11)	427,904	12
13	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (see instructions)		13
14	ORGAN ACQUISITION		14
15	COST OF TEACHING PHYSICIANS (from Worksheet D-5, Part II, col. 3, line 20) (see instructions)		15
16	SUBTOTAL (see instructions)	427,904	16
17	PRIMARY PAYER PAYMENTS		17
18	SUBTOTAL (line 16 less line 17)	427,904	18
19	DEDUCTIBLES	92,979	19
20	SUBTOTAL (line 18 minus line 19)	334,925	20
21	COINSURANCE	2,704	21
22	SUBTOTAL (line 20 minus line 21)	332,221	22
23	ALLOWABLE BAD DEBTS (exclude bad debts for professional services) (see instructions)	13,466	23
24	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	8,753	24
25	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)		25
26	SUBTOTAL (sum of lines 22 and 24)	340,974	26
27	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4, line 49) (for freestanding IPF only)		27
28	OTHER PASS THROUGH COSTS (see instructions)		28
29	OUTLIER PAYMENTS RECONCILIATION		29
30	OTHER ADJUSTMENTS (SPECIFY) (see instructions)		30
31	TOTAL AMOUNT PAYABLE TO THE PROVIDER (see instructions)	340,974	31
31.01	SEQUESTRATION ADJUSTMENT (see instructions)	6,819	31.01
32	INTERIM PAYMENTS	325,541	32
33	TENTATIVE SETTLEMENT (for contractor use only)		33
34	BALANCE DUE PROVIDER/PROGRAM (line 31 minus lines 31.01, 32 and 33)	8,614	34
35	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		35

TO BE COMPLETED BY CONTRACTOR

50	ORIGINAL OUTLIER AMOUNT FROM WORKSHEET E-3, PART II, 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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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART VI

PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES

PROSPECTIVE PAYMENT AMOUNT (see instructions)		
1	RESOURCE UTILIZATION GROUP (RUGS) PAYMENT	1,139,025 1
2	ROUTINE SERVICE OTHER PASS THROUGH COSTS	2
3	ANCILLARY SERVICE OTHER PASS THROUGH COSTS	3
4	SUBTOTAL (sum of lines 1-3)	1,139,025 4
COMPUTATION OF NET COST OF COVERED SERVICES		
5	DO NOT USE THIS LINE	5
6	DEDUCTIBLES	6
7	COINSURANCE	137,732 7
8	ALLOWABLE BAD DEBTS (see instructions)	8
9	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	9
10	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	10
11	UTILIZATION REVIEW	11
12	SUBTOTAL (sum of lines 4 and 5 minus 6 & 7 plus 10 and 11) (see instructions)	1,001,293 12
13	INPATIENT PRIMARY PAYER PAYMENTS	13
14	OTHER ADJUSTMENTS (SPECIFY) (see instructions)	14
15	SUBTOTAL (line 12 minus 13 ± line 14)	1,001,293 15
15.01	SEQUESTRATION ADJUSTMENT (see instructions)	20,026 15.01
16	INTERIM PAYMENTS	981,267 16
17	TENTATIVE SETTLEMENT (for contractor use only)	17
18	BALANCE DUE PROVIDER/PROGRAM (line 15 minus 15.01, 16 and 17)	18
19	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	19

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-0147

WORKSHEET E-3
PART VII

CHECK [] TITLE V [XX] HOSPITAL [] NF [XX] PPS
 APPLICABLE [XX] TITLE XIX [] SUB (OTHER) [] ICF/MR [] TEFRA
 BOXES: [] SNF [] OTHER

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
COMPUTATION OF NET COST OF COVERED SERVICES				
1	INPATIENT HOSPITAL SNF/NF SERVICES			1
2	MEDICAL AND OTHER SERVICES			2
3	ORGAN ACQUISITION (certified transplant centers only)			3
4	SUBTOTAL (sum of lines 1, 2 and 3)			4
5	INPATIENT PRIMARY PAYER PAYMENTS			5
6	OUTPATIENT PRIMARY PAYER PAYMENTS			6
7	SUBTOTAL (line 4 less sum of lines 5 and 6)			7
COMPUTATION OF LESSER OF COST OR CHARGES				
REASONABLE CHARGES				
8	ROUTINE SERVICE CHARGES			8
9	ANCILLARY SERVICE CHARGES	4,994,255		9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE			10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION			11
12	TOTAL REASONABLE CHARGES (sum of lines 8-11)	4,994,255		12
CUSTOMARY CHARGES				
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)			14
15	RATIO OF LINE 13 TO LINE 14 (not to exceed 1.000000)	1	1	15
16	TOTAL CUSTOMARY CHARGES (see instructions)	4,994,255		16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 16 exceeds line 4) (see instructions)	4,994,255		17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 4 exceeds line 16) (see instructions)			18
19	INTERNS AND RESIDENTS (see instructions)			19
20	COST OF TEACHING PHYSICIANS (see instructions)			20
21	COST OF COVERED SERVICES (lesser of line 4 or line 16) (for CAH, see instructions)			21
PROSPECTIVE PAYMENT AMOUNT				
22	OTHER THAN OUTLIER PAYMENTS			22
23	OUTLIER PAYMENTS			23
24	PROGRAM CAPITAL PAYMENTS			24
25	CAPITAL EXCEPTION PAYMENTS (see instructions)			25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS			26
27	SUBTOTAL (sum of lines 22 through 26)			27
28	CUSTOMARY CHARGES (Titles V or XIX PPS covered services only)			28
29	SUM OF LINES 27 AND 21			29
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30	EXCESS OF REASONABLE COST (from line 18)			30
31	SUBTOTAL (sum of lines 19 and 20 plus 29 minus lines 5 and 6)			31
32	DEDUCTIBLES			32
33	COINSURANCE			33
34	ALLOWABLE BAD DEBTS (see instructions)			34
35	UTILIZATION REVIEW			35
36	SUBTOTAL (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	SUBTOTAL (line 36 ± line 37)			38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4)			39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (sum of lines 38 and 39)			40
41	INTERIM PAYMENTS			41
42	BALANCE DUE PROVIDER/PROGRAM (line 40 minus 41)			42
43	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			43

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BALANCE SHEET

WORKSHEET G

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

ASSETS (Omit Cents)		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
CURRENT ASSETS		1	2	3	4	
1	CASH ON HAND AND IN BANKS	2,509,666				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	5,932,251				4
5	OTHER RECEIVABLES	1,022,111				5
6	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE					6
7	INVENTORY	795,065				7
8	PREPAID EXPENSES	360,476				8
9	OTHER CURRENT ASSETS	1,159,756				9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	11,779,325				11
FIXED ASSETS						
12	LAND	39,983				12
13	LAND IMPROVEMENTS	510,497				13
14	ACCUMULATED DEPRECIATION	-472,447				14
15	BUILDINGS	24,319,775				15
16	ACCUMULATED DEPRECIATION	-16,952,289				16
17	LEASEHOLD IMPROVEMENTS					17
18	ACCUMULATED AMORTIZATION					18
19	FIXED EQUIPMENT	2,427,266				19
20	ACCUMULATED DEPRECIATION	-2,239,109				20
21	AUTOMOBILES AND TRUCKS					21
22	ACCUMULATED DEPRECIATION					22
23	MAJOR MOVABLE EQUIPMENT	17,556,619				23
24	ACCUMULATED DEPRECIATION	-12,411,910				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)	12,778,385				30
OTHER ASSETS						
31	INVESTMENTS	10,370,010				31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	330,945				34
35	TOTAL OTHER ASSETS (sum of lines 31-34)	10,700,955				35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	35,258,665				36
LIABILITIES AND FUND BALANCES (Omit Cents)		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
CURRENT LIABILITIES		1	2	3	4	
37	ACCOUNTS PAYABLE	1,430,575				37
38	SALARIES, WAGES & FEES PAYABLE	2,588,334				38
39	PAYROLL TAXES PAYABLE					39
40	NOTES & LOANS PAYABLE (short term)	277,405				40
41	DEFERRED INCOME					41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS					43
44	OTHER CURRENT LIABILITIES	1,534,829				44
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	5,831,143				45
LONG TERM LIABILITIES						
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE	6,776,740				47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES					49
50	TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49)	6,776,740				50
51	TOTAL LIABILITIES (sum of lines 45 and 50)	12,607,883				51
CAPITAL ACCOUNTS						
52	GENERAL FUND BALANCE	22,650,782				52
53	SPECIFIC PURPOSE FUND BALANCE					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 52-58)	22,650,782				59
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)	35,258,665				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		21,083,391			1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		1,567,391			2
3	TOTAL (sum of line 1 and line 2)		22,650,782			3
4	ADDITIONS (credit adjustments)					4
5						5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)		22,650,782			11
12	DEDUCTIONS (debit adjustments)					12
13						13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)		22,650,782			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)					4
5						5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)					11
12	DEDUCTIONS (debit adjustments)					12
13						13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)					19

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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	HOSPITAL	5,964,240		5,964,240	1
2	SUBPROVIDER IPF	2,340,046		2,340,046	2
3	SUBPROVIDER IRF				3
5	SWING BED - SNF	170,245		170,245	5
6	SWING BED - NF				6
7	SKILLED NURSING FACILITY	2,337,229		2,337,229	7
8	NURSING FACILITY				8
9	OTHER LONG TERM CARE				9
10	TOTAL GENERAL INPATIENT CARE SERVICES (sum of lines 1-9)	10,811,760		10,811,760	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT	1,573,238		1,573,238	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)	1,573,238		1,573,238	16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (sum of lines 10 and 16)	12,384,998		12,384,998	17
18	ANCILLARY SERVICES	30,555,656	87,212,595	117,768,251	18
19	OUTPATIENT SERVICES		6,460,407	6,460,407	19
20	RHC				20
21	FQHC				21
22	HOME HEALTH AGENCY		4,256,380	4,256,380	22
23	AMBULANCE	42,744	2,042,723	2,085,467	23
25	ASC				25
26	HOSPICE				26
27	OTHER	1,429,166	984,775	2,413,941	27
28	TOTAL PATIENT REVENUES (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	44,412,564	100,956,880	145,369,444	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		45,514,452	29
30	ADD (SPECIFY)			30
31				31
32				32
33				33
34				34
35				35
36	TOTAL ADDITIONS (sum of lines 30-35)			36
37	BAD DEBT EXP. DEDUCTED FROM REVENUE			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)		45,514,452	43

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STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (from Worksheet G-2, Part I, column 3, line 28)	145,369,444	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	100,974,215	2
3	NET PATIENT REVENUES (line 1 minus line 2)	44,395,229	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	45,514,452	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	-1,119,223	5

OTHER INCOME

6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	161,797	6
7	INCOME FROM INVESTMENTS	311,546	7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS	4,703	10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE	170,457	13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	256,968	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS	8,747	16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS	794	17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	3,556	18
19	TUITION (fees, sale of textbooks, uniforms, etc.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES	13,880	21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (PROPERTY TAX REVENUE)	440,502	24
24.01	OTHER (EHR MEANINGFUL USE)	922,368	24.01
24.02	OTHER (GRANTS)	39,666	24.02
24.03	OTHER (OTHER)	275,088	24.03
24.04	OTHER (NET ASSETS RELEASED BY FOUNDATION)	76,542	24.04
25	TOTAL OTHER INCOME (sum of lines 6-24)	2,686,614	25
26	TOTAL (line 5 plus line 25)	1,567,391	26
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	1,567,391	29

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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 14-7187

WORKSHEET H

	COST CENTER DESCRIPTIONS (omit cents)	SALARIES	EMPLOYEE BENEFITS	TRANSPOR- TATION (see ins- tructions)	CONTRACTED/ PURCHASED SERVICES	OTHER COSTS	
		1	2	3	4	5	
	GENERAL SERVICE COST CENTER						
1	CAPITAL RELATED-BLDGS & FIXTURES						1
2	CAPITAL RELATED-MOVABLE EQUIPMENT						2
3	PLANT OPERATION & MAINTENANCE						3
4	TRANSPORTATION (see instructions)						4
5	ADMINISTRATIVE AND GENERAL	109,319		4,343		83,472	5
	HHA REIMBURSABLE SERVICES						
6	SKILLED NURSING CARE	526,777		25,953			6
7	PHYSICAL THERAPY			20,511			7
8	OCCUPATIONAL THERAPY			7,516			8
9	SPEECH PATHOLOGY			1,332			9
10	MEDICAL SOCIAL SERVICES	4,913					10
11	HOME HEALTH AIDE	78,643		15,403			11
12	SUPPLIES (see instructions)						12
13	DRUGS						13
14	DME						14
	HHA NONREIMBURSABLE SERVICES						
15	HOME DIALYSIS AIDE SERVICES						15
16	RESPIRATORY THERAPY						16
17	PRIVATE DUTY NURSING						17
18	CLINIC						18
19	HEALTH PROMOTION ACTIVITIES						19
20	DAY CARE PROGRAM						20
21	HOME DELIVERED MEALS PROGRAM						21
22	HOMEMAKER SERVICE						22
23	ALL OTHERS						23
23.50	TELEMEDICINE						23.50
24	TOTAL (sum of lines 1-23)	719,652		75,058		83,472	24

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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 14-7187

WORKSHEET H

	COST CENTER DESCRIPTIONS (omit cents)	TOTAL (sum of cols. 1 thru 5)	RECLASS- IFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 6 + col. 7)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 8 + col. 9)	
		6	7	8	9	10	
	GENERAL SERVICE COST CENTER						
1	CAPITAL RELATED-BLDGS & FIXTURES						1
2	CAPITAL RELATED-MOVABLE EQUIPMENT						2
3	PLANT OPERATION & MAINTENANCE						3
4	TRANSPORTATION (see instructions)						4
5	ADMINISTRATIVE AND GENERAL	197,134		197,134		197,134	5
	HHA REIMBURSABLE SERVICES						
6	SKILLED NURSING CARE	552,730		552,730		552,730	6
7	PHYSICAL THERAPY	20,511		20,511		20,511	7
8	OCCUPATIONAL THERAPY	7,516		7,516		7,516	8
9	SPEECH PATHOLOGY	1,332		1,332		1,332	9
10	MEDICAL SOCIAL SERVICES	4,913		4,913		4,913	10
11	HOME HEALTH AIDE	94,046		94,046		94,046	11
12	SUPPLIES (see instructions)						12
13	DRUGS						13
14	DME						14
	HHA NONREIMBURSABLE SERVICES						
15	HOME DIALYSIS AIDE SERVICES						15
16	RESPIRATORY THERAPY						16
17	PRIVATE DUTY NURSING						17
18	CLINIC						18
19	HEALTH PROMOTION ACTIVITIES						19
20	DAY CARE PROGRAM						20
21	HOME DELIVERED MEALS PROGRAM						21
22	HOMEMAKER SERVICE						22
23	ALL OTHERS						23
23.50	TELEMEDICINE						23.50
24	TOTAL (sum of lines 1-23)	878,182		878,182		878,182	24

Column 6, line 24 should agree with Worksheet A, column 3, line 101, or subscript as applicable.

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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 14-7187

WORKSHEET H-1
PART I

		NET EXPENSES FOR COST ALLOCATION (from Wkst. H, col. 10)	CAPITAL RELATED COSTS			
			BLDGS. & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINTENANCE	
		0	1	2	3	
GENERAL SERVICE COST CENTER						
1	CAPITAL RELATED-BLDGS & FIXTURES					1
2	CAPITAL RELATED-MOVABLE EQUIPMENT					2
3	PLANT OPERATION & MAINTENANCE					3
4	TRANSPORTATION (see instructions)					4
5	ADMINISTRATIVE AND GENERAL	197,134				5
HHA REIMBURSABLE SERVICES						
6	SKILLED NURSING CARE	552,730				6
7	PHYSICAL THERAPY	20,511				7
8	OCCUPATIONAL THERAPY	7,516				8
9	SPEECH PATHOLOGY	1,332				9
10	MEDICAL SOCIAL SERVICES	4,913				10
11	HOME HEALTH AIDE	94,046				11
12	SUPPLIES (see instructions)					12
13	DRUGS					13
14	DME					14
HHA NONREIMBURSABLE SERVICES						
15	HOME DIALYSIS AIDE SERVICES					15
16	RESPIRATORY THERAPY					16
17	PRIVATE DUTY NURSING					17
18	CLINIC					18
19	HEALTH PROMOTION ACTIVITIES					19
20	DAY CARE PROGRAM					20
21	HOME DELIVERED MEALS PROGRAM					21
22	HOMEMAKER SERVICE					22
23	ALL OTHERS					23
23.50	TELEMEDICINE					23.50
24	TOTAL (sum of lines 1-23)	878,182				24

Optimizer Systems, Inc.

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Micro System

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 01/22/2015 Run Time: 14:57 Version: 2014.10
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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 14-7187

WORKSHEET H-1
PART I

		TRANSPORT- ATION	SUBTOTAL (cols. 0-4)	ADMINI- STRATIVE & GENERAL	TOTAL (col. 4A + 5)	
		4	4A	5	6	
	GENERAL SERVICE COST CENTER					
1	CAPITAL RELATED-BLDGS & FIXTURES					1
2	CAPITAL RELATED-MOVABLE EQUIPMENT					2
3	PLANT OPERATION & MAINTENANCE					3
4	TRANSPORTATION (see instructions)					4
5	ADMINISTRATIVE AND GENERAL		197,134	197,134		5
	HHA REIMBURSABLE SERVICES					
6	SKILLED NURSING CARE		552,730	159,991	712,721	6
7	PHYSICAL THERAPY		20,511	5,937	26,448	7
8	OCCUPATIONAL THERAPY		7,516	2,176	9,692	8
9	SPEECH PATHOLOGY		1,332	386	1,718	9
10	MEDICAL SOCIAL SERVICES		4,913	1,422	6,335	10
11	HOME HEALTH AIDE		94,046	27,222	121,268	11
12	SUPPLIES (see instructions)					12
13	DRUGS					13
14	DME					14
	HHA NONREIMBURSABLE SERVICES					
15	HOME DIALYSIS AIDE SERVICES					15
16	RESPIRATORY THERAPY					16
17	PRIVATE DUTY NURSING					17
18	CLINIC					18
19	HEALTH PROMOTION ACTIVITIES					19
20	DAY CARE PROGRAM					20
21	HOME DELIVERED MEALS PROGRAM					21
22	HOMEMAKER SERVICE					22
23	ALL OTHERS					23
23.50	TELEMEDICINE					23.50
24	TOTAL (sum of lines 1-23)		878,182		878,182	24

Optimizer Systems, Inc.

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Micro System

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 01/22/2015 Run Time: 14:57 Version: 2014.10
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COST ALLOCATION - HHA STATISTICAL BASIS

HHA CCN: 14-7187

WORKSHEET H-1
PART II

		CAPITAL RELATED COSTS						
		BLDGS. & FIXTURES (Square Feet)	MOVABLE EQUIPMENT (Dollar Value)	PLANT OPERATION & MAINTENANCE (Square Feet)	TRANSPORTATION (Mileage)	RECONCILIATION	ADMINISTRATIVE & GENERAL (Accum. Cost)	
		1	2	3	4	5A	5	
GENERAL SERVICE COST CENTER								
1	CAPITAL RELATED-BLDGS & FIXTURES							1
2	CAPITAL RELATED-MOVABLE EQUIPMENT							2
3	PLANT OPERATION & MAINTENANCE							3
4	TRANSPORTATION (see instructions)							4
5	ADMINISTRATIVE AND GENERAL					-197,134	681,048	5
HHA REIMBURSABLE SERVICES								
6	SKILLED NURSING CARE						552,730	6
7	PHYSICAL THERAPY						20,511	7
8	OCCUPATIONAL THERAPY						7,516	8
9	SPEECH PATHOLOGY						1,332	9
10	MEDICAL SOCIAL SERVICES						4,913	10
11	HOME HEALTH AIDE						94,046	11
12	SUPPLIES (see instructions)							12
13	DRUGS							13
14	DME							14
HHA NONREIMBURSABLE SERVICES								
15	HOME DIALYSIS AIDE SERVICES							15
16	RESPIRATORY THERAPY							16
17	PRIVATE DUTY NURSING							17
18	CLINIC							18
19	HEALTH PROMOTION ACTIVITIES							19
20	DAY CARE PROGRAM							20
21	HOME DELIVERED MEALS PROGRAM							21
22	HOMEMAKER SERVICE							22
23	ALL OTHERS							23
23.50	TELEMEDICINE							23.50
24	TOTAL (sum of lines 1-23)					-197,134	681,048	24
25	COST TO BE ALLOC (per Worksheet H-1, Part I)						197,134	25
26	UNIT COST MULTIPLIER						0.289457	26

Optimizer Systems, Inc.

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Micro System

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 01/22/2015 Run Time: 14:57 Version: 2014.10
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7187

WORKSHEET H-2
PART I

	HHA COST CENTER (omit cents)	HHA TRIAL BALANCE(1)	NEW CAP RE L COSTS-BL DG & FIXT	NEW CAP RE L COSTS-MV BLE EQUIP	EMPLOYEE B ENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINISTRA TIVE & GEN ERAL	
		0	1	2	4	4A	5	
1	ADMINISTRATIVE AND GENERAL		6,134	264	35,191	41,589	5,507	1
2	SKILLED NURSING CARE	712,721			169,578	882,299	116,833	2
3	PHYSICAL THERAPY	26,448				26,448	3,502	3
4	OCCUPATIONAL THERAPY	9,692				9,692	1,283	4
5	SPEECH PATHOLOGY	1,718				1,718	227	5
6	MEDICAL SOCIAL SERVICES	6,335			1,582	7,917	1,048	6
7	HOME HEALTH AIDE	121,268			25,316	146,584	19,410	7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
20	TOTALS (sum of lines 1-19)(2)	878,182	6,134	264	231,667	1,116,247	147,810	20
21	UNIT COST MULTIPLIER: COLUMN 26, LINE 1 DIVIDED BY THE SUM OF COLUMN 26, LINE 20 MINUS COLUMN 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.							21

- (1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
- (2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Optimizer Systems, Inc.

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Micro System

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 01/22/2015 Run Time: 14:57 Version: 2014.10
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7187

WORKSHEET H-2
PART I

	HHA COST CENTER (omit cents)	MAINTENANC E & REPAIR S	OPERATION OF PLANT	LAUNDRY & LINEN SERV ICE	HOUSEKEEPI NG	DIETARY	CAFETERIA	
		6	7	8	9	10	11	
1	ADMINISTRATIVE AND GENERAL	10,447	6,014		10,953		31,516	1
2	SKILLED NURSING CARE							2
3	PHYSICAL THERAPY							3
4	OCCUPATIONAL THERAPY							4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE							7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
20	TOTALS (sum of lines 1-19)(2)	10,447	6,014		10,953		31,516	20
21	UNIT COST MULTIPLIER: COLUMN 26, LINE 1 DIVIDED BY THE SUM OF COLUMN 26, LINE 20 MINUS COLUMN 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.							21

- (1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
- (2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Optimizer Systems, Inc.

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Micro System

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 01/22/2015 Run Time: 14:57 Version: 2014.10
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7187

WORKSHEET H-2
PART I

	HHA COST CENTER (omit cents)	MAIN- TENANCE OF PERSONNEL	NURSING AD MINISTRATI ON	CENTRAL SE RVICES & S UPPLY	PHARMACY	MEDICAL RE CORDS & LI BRARY	SOCIAL SERVICE	
		12	13	14	15	16	17	
1	ADMINISTRATIVE AND GENERAL				203			1
2	SKILLED NURSING CARE							2
3	PHYSICAL THERAPY							3
4	OCCUPATIONAL THERAPY							4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE							7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
20	TOTALS (sum of lines 1-19)(2)				203			20
21	UNIT COST MULTIPLIER: COLUMN 26, LINE 1 DIVIDED BY THE SUM OF COLUMN 26, LINE 20 MINUS COLUMN 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.							21

- (1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
- (2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Optimizer Systems, Inc.

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Micro System

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 01/22/2015 Run Time: 14:57 Version: 2014.10
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7187

WORKSHEET H-2
PART I

	HHA COST CENTER (omit cents)	NONPHYSIC. ANESTHET.	NURSING SCHOOL	I&R SALARY & FRINGES	I&R PROGRAM COSTS	PARAMED EDUCATION	SUBTOTAL (sum of col.4A-23)	
		19	20	21	22	23	24	
1	ADMINISTRATIVE AND GENERAL						106,229	1
2	SKILLED NURSING CARE						999,132	2
3	PHYSICAL THERAPY						29,950	3
4	OCCUPATIONAL THERAPY						10,975	4
5	SPEECH PATHOLOGY						1,945	5
6	MEDICAL SOCIAL SERVICES						8,965	6
7	HOME HEALTH AIDE						165,994	7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
20	TOTALS (sum of lines 1-19)(2)						1,323,190	20
21	UNIT COST MULTIPLIER: COLUMN 26, LINE 1 DIVIDED BY THE SUM OF COLUMN 26, LINE 20 MINUS COLUMN 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Optimizer Systems, Inc.

WinLASH

Micro System

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 01/22/2015 Run Time: 14:57 Version: 2014.10
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7187

WORKSHEET H-2
PART I

	HHA COST CENTER (omit cents)	I&R COST & POST STEP- DOWN ADJS	SUBTOTAL (sum of col.4A-23)	ALLOCATED HHA A&G (see Pt.2)	TOTAL HHA COSTS		
		25	26	27	28		
1	ADMINISTRATIVE AND GENERAL		106,229				1
2	SKILLED NURSING CARE		999,132	87,214	1,086,346		2
3	PHYSICAL THERAPY		29,950	2,614	32,564		3
4	OCCUPATIONAL THERAPY		10,975	958	11,933		4
5	SPEECH PATHOLOGY		1,945	170	2,115		5
6	MEDICAL SOCIAL SERVICES		8,965	783	9,748		6
7	HOME HEALTH AIDE		165,994	14,490	180,484		7
8	SUPPLIES						8
9	DRUGS						9
10	DME						10
11	HOME DIALYSIS AIDE SERVICES						11
12	RESPIRATORY THERAPY						12
13	PRIVATE DUTY NURSING						13
14	CLINIC						14
15	HEALTH PROMOTION ACTIVITIES						15
16	DAY CARE PROGRAM						16
17	HOME DELIVERED MEALS PROGRAM						17
18	HOMEMAKER SERVICE						18
19	ALL OTHERS						19
20	TOTALS (sum of lines 1-19)(2)		1,323,190	106,229	1,323,190		20
21	UNIT COST MULTIPLIER: COLUMN 26, LINE 1 DIVIDED BY THE SUM OF COLUMN 26, LINE 20 MINUS COLUMN 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.			0.087290			21

- (1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
- (2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Optimizer Systems, Inc.

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Micro System

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 01/22/2015 Run Time: 14:57 Version: 2014.10
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 14-7187

WORKSHEET H-2
PART II

	HHA COST CENTER	NEW CAP RE L COSTS-BL DG & FLXT SQUARE FEET	NEW CAP RE L COSTS-MV BLE EQUIP DOLLAR VALUE -NEW	EMPLOYEE B ENEFITS DEPARTMENT GROSS SALARIES	RECON- CILLATION	ADMINISTRA TIVE & GEN ERAL ACCUM COST	MAINTENANC E & REPAIR S SQUARE FEET	
		1	2	4	4A	5	6	
1	ADMINISTRATIVE AND GENERAL	1,333	259	109,319		41,589	1,333	1
2	SKILLED NURSING CARE			526,777		882,299		2
3	PHYSICAL THERAPY					26,448		3
4	OCCUPATIONAL THERAPY					9,692		4
5	SPEECH PATHOLOGY					1,718		5
6	MEDICAL SOCIAL SERVICES			4,913		7,917		6
7	HOME HEALTH AIDE			78,643		146,584		7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
19.50	TELEMEDICINE							19.50
20	TOTALS (sum of lines 1-19)	1,333	259	719,652		1,116,247	1,333	20
21	TOTAL COST TO BE ALLOCATED	6,134	264	231,667		147,810	10,447	21
22	UNIT COST MULTIPLIER	4.601650		0.321915		0.132417		22
22	UNIT COST MULTIPLIER		1.019305				7.837209	22

Optimizer Systems, Inc.

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Micro System

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 01/22/2015 Run Time: 14:57 Version: 2014.10
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 14-7187

WORKSHEET H-2
PART II

	HHA COST CENTER	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE ICE LAUNDRY POUNDS	HOUSEKEEPING HOURS OF SERVICE	DIETARY DIETARY MEALS SERV	CAFETERIA CAFE MEALS SERV	MAINTENANCE OF PERSONNEL NUMBER HOUSED	
		7	8	9	10	11	12	
1	ADMINISTRATIVE AND GENERAL	1,333		93		95		1
2	SKILLED NURSING CARE							2
3	PHYSICAL THERAPY							3
4	OCCUPATIONAL THERAPY							4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE							7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
19.50	TELEMEDICINE							19.50
20	TOTALS (sum of lines 1-19)	1,333		93		95		20
21	TOTAL COST TO BE ALLOCATED	6,014		10,953		31,516		21
22	UNIT COST MULTIPLIER	4.511628		117.774194		331.747368		22
22	UNIT COST MULTIPLIER							22

Optimizer Systems, Inc.

WinLASH

Micro System

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 01/22/2015 Run Time: 14:57 Version: 2014.10
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 14-7187

WORKSHEET H-2
PART II

	HHA COST CENTER	NURSING AD MINISTRATI ON DIRECT NURSING HO	CENTRAL SE RVICES & S UPPLY CS COSTED REQUIS	PHARMACY PHARM COSTED REQ	MEDICAL RE CORDS & LI BRARY TIME SPENT	SOCIAL SERVICE TIME SPENT	NONPHYSIC. ANESTHET. ASSIGNED TIME	
		13	14	15	16	17	19	
1	ADMINISTRATIVE AND GENERAL			105				1
2	SKILLED NURSING CARE							2
3	PHYSICAL THERAPY							3
4	OCCUPATIONAL THERAPY							4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE							7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
19.50	TELEMEDICINE							19.50
20	TOTALS (sum of lines 1-19)			105				20
21	TOTAL COST TO BE ALLOCATED			203				21
22	UNIT COST MULTIPLIER			1.933333				22
22	UNIT COST MULTIPLIER							22

Optimizer Systems, Inc.

WinLASH

Micro System

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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 14-7187

WORKSHEET H-2
PART II

	HHA COST CENTER	NURSING SCHOOL ASSIGNED TIME	I&R SALARY & FRINGES ASSIGNED TIME	I&R PROGRAM COSTS ASSIGNED TIME	PARAMED EDUCATION ASSIGNED TIME		
		20	21	22	23		
1	ADMINISTRATIVE AND GENERAL						1
2	SKILLED NURSING CARE						2
3	PHYSICAL THERAPY						3
4	OCCUPATIONAL THERAPY						4
5	SPEECH PATHOLOGY						5
6	MEDICAL SOCIAL SERVICES						6
7	HOME HEALTH AIDE						7
8	SUPPLIES						8
9	DRUGS						9
10	DME						10
11	HOME DIALYSIS AIDE SERVICES						11
12	RESPIRATORY THERAPY						12
13	PRIVATE DUTY NURSING						13
14	CLINIC						14
15	HEALTH PROMOTION ACTIVITIES						15
16	DAY CARE PROGRAM						16
17	HOME DELIVERED MEALS PROGRAM						17
18	HOMEMAKER SERVICE						18
19	ALL OTHERS						19
19.50	TELEMEDICINE						19.50
20	TOTALS (sum of lines 1-19)						20
21	TOTAL COST TO BE ALLOCATED						21
22	UNIT COST MULTIPLIER						22
22	UNIT COST MULTIPLIER						22

Optimizer Systems, Inc.

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Micro System

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period: From: 10/01/2013 To: 09/30/2014	Run Date: 01/22/2015 Run Time: 14:57 Version: 2014.10
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APPORTIONMENT OF PATIENT SERVICE COSTS

HHA CCN: 14-7187

WORKSHEET H-3
PARTS I & II

CHECK APPLICABLE BOX: [] TITLE V [XX] TITLE XVIII [] TITLE XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION							
	PATIENT SERVICES	FROM WKST. H-2, PART I, COL. 28, LINE	FACILITY COSTS (from Wkst. H-2, Part I)	SHARED ANCILLARY COSTS (from Part II)	TOTAL HHA COSTS (cols. 1 + 2)	TOTAL VISITS	AVERAGE COST PER VISIT (col. 3 ÷ col. 4)
		1	2	3	4	5	
1	SKILLED NURSING CARE	2	1,086,346		1,086,346	7,969	136.32
2	PHYSICAL THERAPY	3	32,564	269,292	301,856	3,174	95.10
3	OCCUPATIONAL THERAPY	4	11,933		11,933	754	15.83
4	SPEECH PATHOLOGY	5	2,115	10,943	13,058	139	93.94
5	MEDICAL SOCIAL SERVICES	6	9,748		9,748	60	162.47
6	HOME HEALTH AIDE	7	180,484		180,484	1,923	93.86
7	TOTAL (sum of lines 1-6)		1,323,190	280,235	1,603,425	14,019	

LIMITATION COST COMPUTATION				PROGRAM VISITS			
	PATIENT SERVICES	CBSA NO.	PART A	NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE		
		1	2	3	4		
8	SKILLED NURSING CARE	99914	546	5,798		8	
9	PHYSICAL THERAPY	99914	303	2,482		9	
10	OCCUPATIONAL THERAPY	99914	41	579		10	
11	SPEECH PATHOLOGY	99914		121		11	
12	MEDICAL SOCIAL SERVICES	99914	2	50		12	
13	HOME HEALTH AIDE	99914	108	1,768		13	
14	TOTAL (sum of lines 8-13)		1,000	10,798		14	

SUPPLIES AND DRUGS COSTS COMPUTATIONS							
	OTHER PATIENT SERVICES	FROM WKST. H-2, PART I, COL. 28, LINE	FACILITY COSTS (from Wkst. H-2, Part I)	SHARED ANCILLARY COSTS (from Part II)	TOTAL HHA COSTS (cols. 1 + 2)	TOTAL CHARGES (from HHA Record)	RATIO (col. 3 ÷ col. 4)
		1	2	3	4	5	
15	COST OF MEDICAL SUPPLIES	8		36,323	36,323	99,085	0.366584
16	COST OF DRUGS	9					

PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS

		FROM WKST. C, PART I, COL. 9, LINE	COST TO CHARGE RATIO	TOTAL HHA CHARGES (from provider records)	HHA SHARED ANCILLARY COSTS (col. 1 x col. 2)	TRANSFER TO PART I AS INDICATED
		1	2	3	4	
1	PHYSICAL THERAPY	66	0.279315	964,117	269,292	col. 2, line 2
2	OCCUPATIONAL THERAPY	67				col. 2, line 3
3	SPEECH PATHOLOGY	68	0.370832	29,510	10,943	col. 2, line 4
4	MEDICAL SUPPLIES CHARGED TO PAT	71	0.366584	99,085	36,323	col. 2, line 15
5	DRUGS CHARGED TO PATIENTS	73	0.232609			col. 2, line 16

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APPORTIONMENT OF PATIENT SERVICE COSTS

HHA CCN: 14-7187

WORKSHEET H-3
PARTS I & II

CHECK APPLICABLE BOX: TITLE V TITLE XVIII TITLE XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION		PROGRAM VISITS			COST OF SERVICES				
		PART B			PART B				
	PATIENT SERVICES	PART A	NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE	PART A	NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE	TOTAL PROGRAM COST (sum of cols 9-10)	
		6	7	8	9	10	11	12	
1	SKILLED NURSING CARE	546	5,798		74,431	790,383		864,814	1
2	PHYSICAL THERAPY	303	2,482		28,815	236,038		264,853	2
3	OCCUPATIONAL THERAPY	41	579		649	9,166		9,815	3
4	SPEECH PATHOLOGY		121			11,367		11,367	4
5	MEDICAL SOCIAL SERVICES	2	50		325	8,124		8,449	5
6	HOME HEALTH AIDE	108	1,768		10,137	165,944		176,081	6
7	TOTAL (sum of lines 1-6)	1,000	10,798		114,357	1,221,022		1,335,379	7

SUPPLIES AND DRUGS COSTS COMPUTATIONS		PROGRAM COVERED CHARGES			COST OF SERVICES				
		PART B			PART B				
	OTHER PATIENT SERVICES	PART A	NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE	PART A	NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE		
		6	7	8	9	10	11		
15	COST OF MEDICAL SUPPLIES								15
16	COST OF DRUGS								16

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CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

HHA CCN: 14-7187

WORKSHEET H-4
PARTS I & II

CHECK APPLICABLE BOX: [] TITLE V [XX] TITLE XVIII [] TITLE XIX

PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES

	DESCRIPTION	PART B		
		PART A	NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	
	1	2	3	
	REASONABLE COST OF PART A & PART B SERVICES			
1	REASONABLE COST OF SERVICES (see instructions)			1
2	TOTAL CHARGES			2
	CUSTOMARY CHARGES			
3	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS (from your records)			3
4	AMOUNT 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(b)			4
5	RATIO OF LINE 3 TO LINE 4 (not to exceed 1.000000)			5
6	TOTAL CUSTOMARY CHARGES (see instructions)			6
7	EXCESS OF TOTAL CUSTOMARY CHARGES OVER TOTAL REASONABLE COST (complete only if line 6 exceeds line 1)			7
8	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 1 exceeds line 6)			8
9	PRIMARY PAYER PAYMENTS			9

COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

	DESCRIPTION	PART A SERVICES	PART B SERVICES	
		1	2	
10	TOTAL REASONABLE COST (see instructions)			10
11	TOTAL PPS REIMBURSEMENT - FULL EPISODES WITHOUT OUTLIERS	105,855	1,165,559	11
12	TOTAL PPS REIMBURSEMENT - FULL EPISODES WITH OUTLIERS	6,117	79,264	12
13	TOTAL PPS REIMBURSEMENT - LUPA EPISODES		22,399	13
14	TOTAL PPS REIMBURSEMENT - PEP EPISODES		5,235	14
15	TOTAL PPS OUTLIER REIMBURSEMENT - FULL EPISODES WITH OUTLIERS	2,124	24,463	15
16	TOTAL PPS OUTLIER REIMBURSEMENT - PEP EPISODES		127	16
17	TOTAL OTHER PAYMENTS			17
18	DME PAYMENTS			18
19	OXYGEN PAYMENTS			19
20	PROSTHETIC AND ORTHOTIC PAYMENTS			20
21	PART B DEDUCTIBLES BILLED TO MEDICARE PATIENTS (exclude coinsurance)			21
22	SUBTOTAL (sum of lines 10-20 minus line 21)	114,096	1,297,047	22
23	EXCESS REASONABLE COST (from line 8)			23
24	SUBTOTAL (line 22 minus line 23)	114,096	1,297,047	24
25	COINSURANCE BILLED TO PROGRAM PATIENTS (from your records)			25
26	NET COST (line 24 minus line 25)	114,096	1,297,047	26
27	REIMBURSABLE BAD DEBTS (from your records)			27
28	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)			28
29	TOTAL COSTS - CURRENT COST REPORTING PERIOD (line 26 plus line 27)	114,096	1,297,047	29
30	OTHER ADJUSTMENTS (SPECIFY) (see instructions)		-3,932	30
31	SUBTOTAL (line 29 plus/minus line 30)	114,096	1,293,115	31
31.01	SEQUESTRATION ADJUSTMENT (see instructions)	2,282	25,863	31.01
32	INTERIM PAYMENTS (see instructions)	111,814	1,267,252	32
33	TENTATIVE SETTLEMENT (for contractor use only)			33
34	BALANCE DUE PROVIDER/PROGRAM (line 31 minus lines 31.01, 32 and 33)			34
35	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115-2			35

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ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES HHA CCN: 14-7187

WORKSHEET H-5

	DESCRIPTION	PART A		PART B		
		mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
		1	2	3	4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER		111,814		1,267,252	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	.01				3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM	.02				3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM	.03			3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO	.04			3.04
		PROVIDER	.05			3.05
			.06			3.06
			.07			3.07
			.08			3.08
			.09			3.09
			.10			3.10
			.50			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				3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		111,814		1,267,252	4
TO BE COMPLETED BY CONTRACTOR						
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT	.01				5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.	.02				5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	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	2,282		25,863	6.01
		.02				6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)		114,096		1,293,115	7
8	NAME OF CONTRACTOR	CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)		8

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

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RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 01/22/2015 Run Time: 14:57 Version: 2014.10
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ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

HOSPICE CCN: 14-1542

WORKSHEET K

	COST CENTER DESCRIPTIONS	SALARIES (from Wkst. K-1)	EMPLOYEE BENEFITS (from Wkst. K-2)	TRANSPOR- TATION (see inst.)	CONTRACTED SERVICES (from Wkst. K-3)	OTHER	
		1	2	3	4	5	
	GENERAL SERVICE COST CENTER						
1	CAPITAL RELATED COSTS-BLDG AND FIXT.						1
2	CAPITAL RELATED COSTS-MOVABLE EQUIP.						2
3	PLANT OPERATION AND MAINTENANCE						3
4	TRANSPORTATION - STAFF						4
5	VOLUNTEER SERVICE COORDINATION						5
6	ADMINISTRATIVE AND GENERAL	27,152		1,036		140,608	6
	INPATIENT CARE SERVICE						
7	INPATIENT - GENERAL CARE						7
8	INPATIENT - RESPITE CARE						8
	VISITING SERVICES						
9	PHYSICIAN SERVICES						9
10	NURSING CARE	107,288		10,275			10
11	NURSING CARE-CONTINUOUS HOME CARE						11
12	PHYSICAL THERAPY						12
13	OCCUPATIONAL THERAPY						13
14	SPEECH/LANGUAGE PATHOLOGY						14
15	MEDICAL SOCIAL SERVICES	43,523					15
16	SPIRITUAL COUNSELING						16
17	DIETARY COUNSELING						17
18	COUNSELING - OTHER						18
19	HOME HEALTH AIDE AND HOMEMAKER	14,057		2,797			19
20	HH AIDE & HOMEMAKER - CONT. HOME CARE						20
21	OTHER						21
	OTHER HOSPICE SERVICE COSTS						
22	DRUGS, BIOLOGICAL AND INFUSION THERAPY						22
23	ANALGESICS						23
24	SEDATIVES/HYPNOTICS						24
25	OTHER - SPECIFY						25
26	DURABLE MEDICAL EQUIPMENT/OXYGEN						26
27	PATIENT TRANSPORTATION						27
28	IMAGING SERVICES						28
29	LABS AND DIAGNOSTICS						29
30	MEDICAL SUPPLIES						30
31	OUTPATIENT SERVICES (including E/R Dept.)						31
32	RADIATION THERAPY						32
33	CHEMOTHERAPY						33
34	OTHER						34
	HOSPICE NONREIMBURSABLE SERVICE						
35	BEREAVEMENT PROGRAM COSTS						35
36	VOLUNTEER PROGRAM COSTS						36
37	FUNDRAISING						37
38	OTHER PROGRAM COSTS						38
39	TOTAL (sum of lines 1-38)	192,020		14,108		140,608	39

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ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

HOSPICE CCN: 14-1542

WORKSHEET K

		TOTAL (cols. 1-5) 6	RECLASSI- FICATION 7	SUBTOTAL (col. 6 ± col. 7) 8	ADJUST- MENTS 9	TOTAL (col. 8 ± col. 9) 10	
	GENERAL SERVICE COST CENTER						
1	CAPITAL RELATED COSTS-BLDG AND FIXT.						1
2	CAPITAL RELATED COSTS-MOVABLE EQUIP.						2
3	PLANT OPERATION AND MAINTENANCE						3
4	TRANSPORTATION - STAFF						4
5	VOLUNTEER SERVICE COORDINATION						5
6	ADMINISTRATIVE AND GENERAL	168,796		168,796		168,796	6
	INPATIENT CARE SERVICE						
7	INPATIENT - GENERAL CARE						7
8	INPATIENT - RESPITE CARE						8
	VISITING SERVICES						
9	PHYSICIAN SERVICES						9
10	NURSING CARE	117,563		117,563		117,563	10
11	NURSING CARE-CONTINUOUS HOME CARE						11
12	PHYSICAL THERAPY						12
13	OCCUPATIONAL THERAPY						13
14	SPEECH/LANGUAGE PATHOLOGY						14
15	MEDICAL SOCIAL SERVICES	43,523		43,523		43,523	15
16	SPIRITUAL COUNSELING						16
17	DIETARY COUNSELING						17
18	COUNSELING - OTHER						18
19	HOME HEALTH AIDE AND HOME MAKER	16,854		16,854		16,854	19
20	HH AIDE & HOME MAKER - CONT. HOME CARE						20
21	OTHER						21
	OTHER HOSPICE SERVICE COSTS						
22	DRUGS, BIOLOGICAL AND INFUSION THERAPY						22
23	ANALGESICS						23
24	SEDATIVES/HYPNOTICS						24
25	OTHER - SPECIFY						25
26	DURABLE MEDICAL EQUIPMENT/OXYGEN						26
27	PATIENT TRANSPORTATION						27
28	IMAGING SERVICES						28
29	LABS AND DIAGNOSTICS						29
30	MEDICAL SUPPLIES						30
31	OUTPATIENT SERVICES (including E/R Dept.)						31
32	RADIATION THERAPY						32
33	CHEMOTHERAPY						33
34	OTHER						34
	HOSPICE NONREIMBURSABLE SERVICE						
35	BEREAVEMENT PROGRAM COSTS						35
36	VOLUNTEER PROGRAM COSTS						36
37	FUNDRAISING						37
38	OTHER PROGRAM COSTS						38
39	TOTAL (sum of lines 1-38)	346,736		346,736		346,736	39

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HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

HOSPICE CCN: 14-1542

WORKSHEET K-1

	COST CENTER DESCRIPTIONS (omit cents)	ADMINIS- TRATOR	DIRECTOR	MEDICAL SOCIAL WORKERS	SUPERVISORS	NURSES	
		1	2	3	4	5	
	GENERAL SERVICE COST CENTER						
1	CAPITAL RELATED COSTS-BLDG AND FIX						1
2	CAPITAL RELATED COSTS-MOVABLE EQUI						2
3	PLANT OPERATION AND MAINTENANCE						3
4	TRANSPORTATION - STAFF						4
5	VOLUNTEER SERVICE COORDINATION						5
6	ADMINISTRATIVE AND GENERAL				27,152		6
	INPATIENT CARE SERVICE						
7	INPATIENT - GENERAL CARE						7
8	INPATIENT - RESPITE CARE						8
	VISITING SERVICES						
9	PHYSICIAN SERVICES						9
10	NURSING CARE					107,288	10
11	NURSING CARE-CONTINUOUS HOME CARE						11
12	PHYSICAL THERAPY						12
13	OCCUPATIONAL THERAPY						13
14	SPEECH/LANGUAGE PATHOLOGY						14
15	MEDICAL SOCIAL SERVICES			43,523			15
16	SPIRITUAL COUNSELING						16
17	DIETARY COUNSELING						17
18	COUNSELING - OTHER						18
19	HOME HEALTH AIDE AND HOMEMAKER						19
20	HH AIDE & HOMEMAKER - CONT. HOME C						20
21	OTHER						21
	OTHER HOSPICE SERVICE COSTS						
22	DRUGS, BIOLOGICAL AND INFUSION THE						22
23	ANALGESICS						23
24	SEDATIVES/HYPNOTICS						24
25	OTHER - SPECIFY						25
26	DURABLE MEDICAL EQUIPMENT/OXYGEN						26
27	PATIENT TRANSPORTATION						27
28	IMAGING SERVICES						28
29	LABS AND DIAGNOSTICS						29
30	MEDICAL SUPPLIES						30
31	OUTPATIENT SERVICES (including E/R						31
32	RADIATION THERAPY						32
33	CHEMOTHERAPY						33
34	OTHER						34
	HOSPICE NONREIMBURSABLE SERVICE						
35	BEREAVEMENT PROGRAM COSTS						35
36	VOLUNTEER PROGRAM COSTS						36
37	FUNDRAISING						37
38	OTHER PROGRAM COSTS						38
39	TOTAL (sum of lines 1-38)			43,523	27,152	107,288	39

(1) Transfer the amount in column 9 to Wkst. K, column 1.

Optimizer Systems, Inc.

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Micro System

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 01/22/2015 Run Time: 14:57 Version: 2014.10
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HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

HOSPICE CCN: 14-1542

WORKSHEET K-1

	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
	6	7	8	9	
GENERAL SERVICE COST CENTER					
1 CAPITAL RELATED COSTS-BLDG AND FIX					1
2 CAPITAL RELATED COSTS-MOVABLE EQUI					2
3 PLANT OPERATION AND MAINTENANCE					3
4 TRANSPORTATION - STAFF					4
5 VOLUNTEER SERVICE COORDINATION					5
6 ADMINISTRATIVE AND GENERAL				27,152	6
INPATIENT CARE SERVICE					
7 INPATIENT - GENERAL CARE					7
8 INPATIENT - RESPITE CARE					8
VISITING SERVICES					
9 PHYSICIAN SERVICES					9
10 NURSING CARE				107,288	10
11 NURSING CARE-CONTINUOUS HOME CARE					11
12 PHYSICAL THERAPY					12
13 OCCUPATIONAL THERAPY					13
14 SPEECH/LANGUAGE PATHOLOGY					14
15 MEDICAL SOCIAL SERVICES				43,523	15
16 SPIRITUAL COUNSELING					16
17 DIETARY COUNSELING					17
18 COUNSELING - OTHER					18
19 HOME HEALTH AIDE AND HOME MAKER		14,057		14,057	19
20 HH AIDE & HOME MAKER - CONT. HOME C					20
21 OTHER					21
OTHER HOSPICE SERVICE COSTS					
22 DRUGS, BIOLOGICAL AND INFUSION THE					22
23 ANALGESICS					23
24 SEDATIVES/HYPNOTICS					24
25 OTHER - SPECIFY					25
26 DURABLE MEDICAL EQUIPMENT/OXYGEN					26
27 PATIENT TRANSPORTATION					27
28 IMAGING SERVICES					28
29 LABS AND DIAGNOSTICS					29
30 MEDICAL SUPPLIES					30
31 OUTPATIENT SERVICES (including E/R					31
32 RADIATION THERAPY					32
33 CHEMOTHERAPY					33
34 OTHER					34
HOSPICE NONREIMBURSABLE SERVICE					
35 BEREAVEMENT PROGRAM COSTS					35
36 VOLUNTEER PROGRAM COSTS					36
37 FUNDRAISING					37
38 OTHER PROGRAM COSTS					38
39 TOTAL (sum of lines 1-38)		14,057		192,020	39

(1) Transfer the amount in column 9 to Wkst. K, column 1.

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HOSPICE COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PAYROLL RELATED)

HOSPICE CCN: 14-1542

WORKSHEET K-2

	COST CENTER DESCRIPTIONS (omit cents)	ADMINIS- TRATOR	DIRECTOR	MEDICAL SOCIAL WORKERS	SUPERVISORS	NURSES	
		1	2	3	4	5	
	GENERAL SERVICE COST CENTER						
1	CAPITAL RELATED COSTS-BLDG AND FIX						1
2	CAPITAL RELATED COSTS-MOVABLE EQUI						2
3	PLANT OPERATION AND MAINTENANCE						3
4	TRANSPORTATION - STAFF						4
5	VOLUNTEER SERVICE COORDINATION						5
6	ADMINISTRATIVE AND GENERAL						6
	INPATIENT CARE SERVICE						
7	INPATIENT - GENERAL CARE						7
8	INPATIENT - RESPITE CARE						8
	VISITING SERVICES						
9	PHYSICIAN SERVICES						9
10	NURSING CARE						10
11	NURSING CARE-CONTINUOUS HOME CARE						11
12	PHYSICAL THERAPY						12
13	OCCUPATIONAL THERAPY						13
14	SPEECH/LANGUAGE PATHOLOGY						14
15	MEDICAL SOCIAL SERVICES						15
16	SPIRITUAL COUNSELING						16
17	DIETARY COUNSELING						17
18	COUNSELING - OTHER						18
19	HOME HEALTH AIDE AND HOMEMAKER						19
20	HH AIDE & HOMEMAKER - CONT. HOME C						20
21	OTHER						21
	OTHER HOSPICE SERVICE COSTS						
22	DRUGS, BIOLOGICAL AND INFUSION THE						22
23	ANALGESICS						23
24	SEDATIVES/HYPNOTICS						24
25	OTHER - SPECIFY						25
26	DURABLE MEDICAL EQUIPMENT/OXYGEN						26
27	PATIENT TRANSPORTATION						27
28	IMAGING SERVICES						28
29	LABS AND DIAGNOSTICS						29
30	MEDICAL SUPPLIES						30
31	OUTPATIENT SERVICES (including E/R						31
32	RADIATION THERAPY						32
33	CHEMOTHERAPY						33
34	OTHER						34
	HOSPICE NONREIMBURSABLE SERVICE						
35	BEREAVEMENT PROGRAM COSTS						35
36	VOLUNTEER PROGRAM COSTS						36
37	FUNDRAISING						37
38	OTHER PROGRAM COSTS						38
39	TOTAL (sum of lines 1-38)						39

(1) Transfer the amount in column 9 to Wkst. K, column 2.

Optimizer Systems, Inc.

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Micro System

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 01/22/2015 Run Time: 14:57 Version: 2014.10
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HOSPICE COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PAYROLL RELATED)

HOSPICE CCN: 14-1542

WORKSHEET K-2

	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)
	6	7	8	9
GENERAL SERVICE COST CENTER				
1 CAPITAL RELATED COSTS-BLDG AND FIX				1
2 CAPITAL RELATED COSTS-MOVABLE EQUI				2
3 PLANT OPERATION AND MAINTENANCE				3
4 TRANSPORTATION - STAFF				4
5 VOLUNTEER SERVICE COORDINATION				5
6 ADMINISTRATIVE AND GENERAL				6
INPATIENT CARE SERVICE				
7 INPATIENT - GENERAL CARE				7
8 INPATIENT - RESPITE CARE				8
VISITING SERVICES				
9 PHYSICIAN SERVICES				9
10 NURSING CARE				10
11 NURSING CARE-CONTINUOUS HOME CARE				11
12 PHYSICAL THERAPY				12
13 OCCUPATIONAL THERAPY				13
14 SPEECH/LANGUAGE PATHOLOGY				14
15 MEDICAL SOCIAL SERVICES				15
16 SPIRITUAL COUNSELING				16
17 DIETARY COUNSELING				17
18 COUNSELING - OTHER				18
19 HOME HEALTH AIDE AND HOMEMAKER				19
20 HH AIDE & HOMEMAKER - CONT. HOME C				20
21 OTHER				21
OTHER HOSPICE SERVICE COSTS				
22 DRUGS, BIOLOGICAL AND INFUSION THE				22
23 ANALGESICS				23
24 SEDATIVES/HYPNOTICS				24
25 OTHER - SPECIFY				25
26 DURABLE MEDICAL EQUIPMENT/OXYGEN				26
27 PATIENT TRANSPORTATION				27
28 IMAGING SERVICES				28
29 LABS AND DIAGNOSTICS				29
30 MEDICAL SUPPLIES				30
31 OUTPATIENT SERVICES (including E/R				31
32 RADIATION THERAPY				32
33 CHEMOTHERAPY				33
34 OTHER				34
HOSPICE NONREIMBURSABLE SERVICE				
35 BEREAVEMENT PROGRAM COSTS				35
36 VOLUNTEER PROGRAM COSTS				36
37 FUNDRAISING				37
38 OTHER PROGRAM COSTS				38
39 TOTAL (sum of lines 1-38)				39

(1) Transfer the amount in column 9 to Wkst. K, column 2.

Optimizer Systems, Inc.

WinLASH

Micro System

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 01/22/2015 Run Time: 14:57 Version: 2014.10
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HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES

HOSPICE CCN: 14-1542

WORKSHEET K-3

	COST CENTER DESCRIPTIONS (omit cents)	ADMINIS- TRATOR	DIRECTOR	MEDICAL SOCIAL WORKERS	SUPERVISORS	NURSES	
		1	2	3	4	5	
	GENERAL SERVICE COST CENTER						
1	CAPITAL RELATED COSTS-BLDG AND FIX						1
2	CAPITAL RELATED COSTS-MOVABLE EQUI						2
3	PLANT OPERATION AND MAINTENANCE						3
4	TRANSPORTATION - STAFF						4
5	VOLUNTEER SERVICE COORDINATION						5
6	ADMINISTRATIVE AND GENERAL						6
	INPATIENT CARE SERVICE						
7	INPATIENT - GENERAL CARE						7
8	INPATIENT - RESPITE CARE						8
	VISITING SERVICES						
9	PHYSICIAN SERVICES						9
10	NURSING CARE						10
11	NURSING CARE-CONTINUOUS HOME CARE						11
12	PHYSICAL THERAPY						12
13	OCCUPATIONAL THERAPY						13
14	SPEECH/LANGUAGE PATHOLOGY						14
15	MEDICAL SOCIAL SERVICES						15
16	SPIRITUAL COUNSELING						16
17	DIETARY COUNSELING						17
18	COUNSELING - OTHER						18
19	HOME HEALTH AIDE AND HOMEMAKER						19
20	HH AIDE & HOMEMAKER - CONT. HOME C						20
21	OTHER						21
	OTHER HOSPICE SERVICE COSTS						
22	DRUGS, BIOLOGICAL AND INFUSION THE						22
23	ANALGESICS						23
24	SEDATIVES/HYPNOTICS						24
25	OTHER - SPECIFY						25
26	DURABLE MEDICAL EQUIPMENT/OXYGEN						26
27	PATIENT TRANSPORTATION						27
28	IMAGING SERVICES						28
29	LABS AND DIAGNOSTICS						29
30	MEDICAL SUPPLIES						30
31	OUTPATIENT SERVICES (including E/R						31
32	RADIATION THERAPY						32
33	CHEMOTHERAPY						33
34	OTHER						34
	HOSPICE NONREIMBURSABLE SERVICE						
35	BEREAVEMENT PROGRAM COSTS						35
36	VOLUNTEER PROGRAM COSTS						36
37	FUNDRAISING						37
38	OTHER PROGRAM COSTS						38
39	TOTAL (sum of lines 1-38)						39

(1) Transfer the amount in column 9 to Wkst. K, column 4.

Optimizer Systems, Inc.

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Micro System

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 01/22/2015 Run Time: 14:57 Version: 2014.10
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HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES

HOSPICE CCN: 14-1542

WORKSHEET K-3

	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)
	6	7	8	9
GENERAL SERVICE COST CENTER				
1 CAPITAL RELATED COSTS-BLDG AND FIX				1
2 CAPITAL RELATED COSTS-MOVABLE EQUI				2
3 PLANT OPERATION AND MAINTENANCE				3
4 TRANSPORTATION - STAFF				4
5 VOLUNTEER SERVICE COORDINATION				5
6 ADMINISTRATIVE AND GENERAL				6
INPATIENT CARE SERVICE				
7 INPATIENT - GENERAL CARE				7
8 INPATIENT - RESPITE CARE				8
VISITING SERVICES				
9 PHYSICIAN SERVICES				9
10 NURSING CARE				10
11 NURSING CARE-CONTINUOUS HOME CARE				11
12 PHYSICAL THERAPY				12
13 OCCUPATIONAL THERAPY				13
14 SPEECH/LANGUAGE PATHOLOGY				14
15 MEDICAL SOCIAL SERVICES				15
16 SPIRITUAL COUNSELING				16
17 DIETARY COUNSELING				17
18 COUNSELING - OTHER				18
19 HOME HEALTH AIDE AND HOMEMAKER				19
20 HH AIDE & HOMEMAKER - CONT. HOME C				20
21 OTHER				21
OTHER HOSPICE SERVICE COSTS				
22 DRUGS, BIOLOGICAL AND INFUSION THE				22
23 ANALGESICS				23
24 SEDATIVES/HYPNOTICS				24
25 OTHER - SPECIFY				25
26 DURABLE MEDICAL EQUIPMENT/OXYGEN				26
27 PATIENT TRANSPORTATION				27
28 IMAGING SERVICES				28
29 LABS AND DIAGNOSTICS				29
30 MEDICAL SUPPLIES				30
31 OUTPATIENT SERVICES (including E/R				31
32 RADIATION THERAPY				32
33 CHEMOTHERAPY				33
34 OTHER				34
HOSPICE NONREIMBURSABLE SERVICE				
35 BEREAVEMENT PROGRAM COSTS				35
36 VOLUNTEER PROGRAM COSTS				36
37 FUNDRAISING				37
38 OTHER PROGRAM COSTS				38
39 TOTAL (sum of lines 1-38)				39

(1) Transfer the amount in column 9 to Wkst. K, column 4.

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Micro System

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 01/22/2015 Run Time: 14:57 Version: 2014.10
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COST ALLOCATION - HOSPICE GENERAL SERVICE COST

HOSPICE CCN: 14-1542

WORKSHEET K-4
PART I

	COST CENTER DESCRIPTIONS	CAPITAL RELATED COSTS				
		NET EXPENSES FOR COST ALLOCATION	BUILDINGS & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	
		0	1	2	3	4
	GENERAL SERVICE COST CENTER					
1	CAPITAL RELATED COSTS-BLDG AND FIX					1
2	CAPITAL RELATED COSTS-MOVABLE EQUI					2
3	PLANT OPERATION AND MAINTENANCE					3
4	TRANSPORTATION - STAFF					4
5	VOLUNTEER SERVICE COORDINATION					5
6	ADMINISTRATIVE AND GENERAL	168,796				6
	INPATIENT CARE SERVICE					
7	INPATIENT - GENERAL CARE					7
8	INPATIENT - RESPITE CARE					8
	VISITING SERVICES					
9	PHYSICIAN SERVICES					9
10	NURSING CARE	117,563				10
11	NURSING CARE-CONTINUOUS HOME CARE					11
12	PHYSICAL THERAPY					12
13	OCCUPATIONAL THERAPY					13
14	SPEECH/LANGUAGE PATHOLOGY					14
15	MEDICAL SOCIAL SERVICES	43,523				15
16	SPIRITUAL COUNSELING					16
17	DIETARY COUNSELING					17
18	COUNSELING - OTHER					18
19	HOME HEALTH AIDE AND HOMEMAKER	16,854				19
20	HH AIDE & HOMEMAKER - CONT. HOME C					20
21	OTHER					21
	OTHER HOSPICE SERVICE COSTS					
22	DRUGS, BIOLOGICAL AND INFUSION THE					22
23	ANALGESICS					23
24	SEDATIVES/HYPNOTICS					24
25	OTHER - SPECIFY					25
26	DURABLE MEDICAL EQUIPMENT/OXYGEN					26
27	PATIENT TRANSPORTATION					27
28	IMAGING SERVICES					28
29	LABS AND DIAGNOSTICS					29
30	MEDICAL SUPPLIES					30
31	OUTPATIENT SERVICES (including E/R					31
32	RADIATION THERAPY					32
33	CHEMOTHERAPY					33
34	OTHER					34
	HOSPICE NONREIMBURSABLE SERVICE					
35	BEREAVEMENT PROGRAM COSTS					35
36	VOLUNTEER PROGRAM COSTS					36
37	FUNDRAISING					37
38	OTHER PROGRAM COSTS					38
39	TOTAL (sum of lines 1-38)	346,736				39

Optimizer Systems, Inc.

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Micro System

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 01/22/2015 Run Time: 14:57 Version: 2014.10
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COST ALLOCATION - HOSPICE GENERAL SERVICE COST

HOSPICE CCN: 14-1542

WORKSHEET K-4
PART I

	VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (cols. 0 - 5)	ADMINISTRATIVE & GENERAL	TOTAL (col. 5 ± col. 6)	
	5	5A	6	7	
GENERAL SERVICE COST CENTER					
1 CAPITAL RELATED COSTS-BLDG AND FIX					1
2 CAPITAL RELATED COSTS-MOVABLE EQUI					2
3 PLANT OPERATION AND MAINTENANCE					3
4 TRANSPORTATION - STAFF					4
5 VOLUNTEER SERVICE COORDINATION					5
6 ADMINISTRATIVE AND GENERAL		168,796	168,796		6
INPATIENT CARE SERVICE					
7 INPATIENT - GENERAL CARE					7
8 INPATIENT - RESPITE CARE					8
VISITING SERVICES					
9 PHYSICIAN SERVICES					9
10 NURSING CARE		117,563	111,522	229,085	10
11 NURSING CARE-CONTINUOUS HOME CARE					11
12 PHYSICAL THERAPY					12
13 OCCUPATIONAL THERAPY					13
14 SPEECH/LANGUAGE PATHOLOGY					14
15 MEDICAL SOCIAL SERVICES		43,523	41,286	84,809	15
16 SPIRITUAL COUNSELING					16
17 DIETARY COUNSELING					17
18 COUNSELING - OTHER					18
19 HOME HEALTH AIDE AND HOMEMAKER		16,854	15,988	32,842	19
20 HH AIDE & HOMEMAKER - CONT. HOME C					20
21 OTHER					21
OTHER HOSPICE SERVICE COSTS					
22 DRUGS, BIOLOGICAL AND INFUSION THE					22
23 ANALGESICS					23
24 SEDATIVES/HYPNOTICS					24
25 OTHER - SPECIFY					25
26 DURABLE MEDICAL EQUIPMENT/OXYGEN					26
27 PATIENT TRANSPORTATION					27
28 IMAGING SERVICES					28
29 LABS AND DIAGNOSTICS					29
30 MEDICAL SUPPLIES					30
31 OUTPATIENT SERVICES (including E/R					31
32 RADIATION THERAPY					32
33 CHEMOTHERAPY					33
34 OTHER					34
HOSPICE NONREIMBURSABLE SERVICE					
35 BEREAVEMENT PROGRAM COSTS					35
36 VOLUNTEER PROGRAM COSTS					36
37 FUNDRAISING					37
38 OTHER PROGRAM COSTS					38
39 TOTAL (sum of lines 1-38)		346,736		346,736	39

Optimizer Systems, Inc.

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Micro System

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 01/22/2015 Run Time: 14:57 Version: 2014.10
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COST ALLOCATION - HOSPICE STATISTICAL BASIS

HOSPICE CCN: 14-1542

WORKSHEET K-4
PART II

	COST CENTER DESCRIPTIONS	CAPITAL RELATED COSTS					RECONCILIATION	ADMINISTRATIVE & GENERAL (Acc. Cost)	
		BUILDINGS & FIXTURES (Sq. Ft.)	MOVABLE EQUIPMENT (\$ Value)	PLANT OPERATION & MAINT. (Sq. Ft.)	TRANSPORTATION (Mileage)	VOLUNTEER SERVICES COORDINATOR (Hours)			
		1	2	3	4	5	6A	6	
	GENERAL SERVICE COST CENTER								
1	CAPITAL RELATED COSTS-BLDG AND FIX								1
2	CAPITAL RELATED COSTS-MOVABLE EQUI								2
3	PLANT OPERATION AND MAINTENANCE								3
4	TRANSPORTATION - STAFF								4
5	VOLUNTEER SERVICE COORDINATION								5
6	ADMINISTRATIVE AND GENERAL						-168,796	177,940	6
	INPATIENT CARE SERVICE								
7	INPATIENT - GENERAL CARE								7
8	INPATIENT - RESPITE CARE								8
	VISITING SERVICES								
9	PHYSICIAN SERVICES								9
10	NURSING CARE							117,563	10
11	NURSING CARE-CONTINUOUS HOME CARE								11
12	PHYSICAL THERAPY								12
13	OCCUPATIONAL THERAPY								13
14	SPEECH/LANGUAGE PATHOLOGY								14
15	MEDICAL SOCIAL SERVICES							43,523	15
16	SPIRITUAL COUNSELING								16
17	DIETARY COUNSELING								17
18	COUNSELING - OTHER								18
19	HOME HEALTH AIDE AND HOMEMAKER							16,854	19
20	HH AIDE & HOMEMAKER - CONT. HOME C								20
21	OTHER								21
	OTHER HOSPICE SERVICE COSTS								
22	DRUGS, BIOLOGICAL AND INFUSION THE								22
23	ANALGESICS								23
24	SEDATIVES/HYPNOTICS								24
25	OTHER - SPECIFY								25
26	DURABLE MEDICAL EQUIPMENT/OXYGEN								26
27	PATIENT TRANSPORTATION								27
28	IMAGING SERVICES								28
29	LABS AND DIAGNOSTICS								29
30	MEDICAL SUPPLIES								30
31	OUTPATIENT SERVICES (including E/R								31
32	RADIATION THERAPY								32
33	CHEMOTHERAPY								33
34	OTHER								34
	HOSPICE NONREIMBURSABLE SERVICE								
35	BEREAVEMENT PROGRAM COSTS								35
36	VOLUNTEER PROGRAM COSTS								36
37	FUNDRAISING								37
38	OTHER PROGRAM COSTS								38
39	TOTAL (sum of lines 1-38)							168,796	39
40	UNIT COST MULTIPLIER							0.948612	40

Optimizer Systems, Inc.

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Micro System

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 01/22/2015 Run Time: 14:57 Version: 2014.10
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ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

HOSPICE CCN: 14-1542

WORKSHEET K-5
PART I

PART I - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

	HOSPICE COST CENTER (omit cents)	HOSPICE TRIAL BALANCE(1)	NEW CAP RE L COSTS-BL DG & FIXT	NEW CAP RE L COSTS-MV BLE EQUIP	EMPLOYEE B ENEFITS DEPARTMENT	SUBTOTAL	ADMINISTRA TIVE & GEN ERAL	
		0	1	2	4	4A	5	
1	ADMINISTRATIVE AND GENERAL		6,134	44	8,741	14,919	1,976	1
2	INPATIENT - GENERAL CARE							2
3	INPATIENT - RESPITE CARE							3
4	PHYSICIAN SERVICES							4
5	NURSING CARE	229,085			34,537	263,622	34,908	5
6	NURSING CARE-CONTINUOUS HOME CARE							6
7	PHYSICAL THERAPY							7
8	OCCUPATIONAL THERAPY							8
9	SPEECH/LANGUAGE PATHOLOGY							9
10	MEDICAL SOCIAL SERVICES	84,809			4,525	89,334	11,829	10
11	SPIRITUAL COUNSELING							11
12	DIETARY COUNSELING							12
13	COUNSELING - OTHER							13
14	HOME HEALTH AIDE AND HOMEMAKER	32,842			14,011	46,853	6,204	14
15	HH AIDE & HOMEMAKER - CONT. HOME							15
16	OTHER							16
17	DRUGS, BIOLOGICAL AND INFUSION TH							17
18	ANALGESICS							18
19	SEDATIVES / HYPNOTICS							19
20	OTHER - SPECIFY							20
21	DURABLE MED. EQUIPMENT/OXYGEN							21
22	PATIENT TRANSPORTATION							22
23	IMAGING SERVICES							23
24	LABS AND DIAGNOSTICS							24
25	MEDICAL SUPPLIES							25
26	OUTPATIENT SERVICES (including E/							26
27	RADIATION THERAPY							27
28	CHEMOTHERAPY							28
29	OTHER							29
30	BEREAVEMENT PROGRAM COSTS							30
31	VOLUNTEER PROGRAM COSTS							31
32	FUNDRAISING							32
33	OTHER PROGRAM COSTS							33
34	TOTALS (sum of lines 1-33) (2)	346,736	6,134	44	61,814	414,728	54,917	34
35	UNIT COST MULTIPLIER (see instruc							35

(1) Column 0, line 34 must agree with Wkst. A, column 7, line 116.

(2) Columns 0 through 25, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 116.

Optimizer Systems, Inc.

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Micro System

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period: From: 10/01/2013 To: 09/30/2014	Run Date: 01/22/2015 Run Time: 14:57 Version: 2014.10
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ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

HOSPICE CCN: 14-1542

WORKSHEET K-5
PART I

PART I - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

	HOSPICE COST CENTER (omit cents)	MAINTENANC E & REPAIR S	OPERATION OF PLANT	LAUNDRY & LINEN SERV ICE	HOUSEKEEPI NG	DIETARY	CAFETERIA	
		6	7	8	9	10	11	
1	ADMINISTRATIVE AND GENERAL	10,447	6,014		10,953		15,592	1
2	INPATIENT - GENERAL CARE							2
3	INPATIENT - RESPITE CARE							3
4	PHYSICIAN SERVICES							4
5	NURSING CARE							5
6	NURSING CARE-CONTINUOUS HOME CARE							6
7	PHYSICAL THERAPY							7
8	OCCUPATIONAL THERAPY							8
9	SPEECH/LANGUAGE PATHOLOGY							9
10	MEDICAL SOCIAL SERVICES							10
11	SPIRITUAL COUNSELING							11
12	DIETARY COUNSELING							12
13	COUNSELING - OTHER							13
14	HOME HEALTH AIDE AND HOMEMAKER							14
15	HH AIDE & HOMEMAKER - CONT. HOME							15
16	OTHER							16
17	DRUGS, BIOLOGICAL AND INFUSION TH							17
18	ANALGESICS							18
19	SEDATIVES / HYPNOTICS							19
20	OTHER - SPECIFY							20
21	DURABLE MED. EQUIPMENT/OXYGEN							21
22	PATIENT TRANSPORTATION							22
23	IMAGING SERVICES							23
24	LABS AND DIAGNOSTICS							24
25	MEDICAL SUPPLIES							25
26	OUTPATIENT SERVICES (including E/							26
27	RADIATION THERAPY							27
28	CHEMOTHERAPY							28
29	OTHER							29
30	BEREAVEMENT PROGRAM COSTS							30
31	VOLUNTEER PROGRAM COSTS							31
32	FUNDRAISING							32
33	OTHER PROGRAM COSTS							33
34	TOTALS (sum of lines 1-33) (2)	10,447	6,014		10,953		15,592	34
35	UNIT COST MULTIPLIER (see instruc							35

- (1) Column 0, line 34 must agree with Wkst. A, column 7, line 116.
- (2) Columns 0 through 25, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 116.

Optimizer Systems, Inc.

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Micro System

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 01/22/2015 Run Time: 14:57 Version: 2014.10
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ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

HOSPICE CCN: 14-1542

WORKSHEET K-5
PART I

PART I - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

	HOSPICE COST CENTER (omit cents)	MAIN- TENANCE OF PERSONNEL	NURSING AD MINISTRATI ON	CENTRAL SE RVICES & S UPPLY	PHARMACY	MEDICAL RE CORDS & LI BRARY	SOCIAL SERVICE	
		12	13	14	15	16	17	
1	ADMINISTRATIVE AND GENERAL				6	422		1
2	INPATIENT - GENERAL CARE							2
3	INPATIENT - RESPITE CARE							3
4	PHYSICIAN SERVICES							4
5	NURSING CARE							5
6	NURSING CARE-CONTINUOUS HOME CARE							6
7	PHYSICAL THERAPY							7
8	OCCUPATIONAL THERAPY							8
9	SPEECH/LANGUAGE PATHOLOGY							9
10	MEDICAL SOCIAL SERVICES							10
11	SPIRITUAL COUNSELING							11
12	DIETARY COUNSELING							12
13	COUNSELING - OTHER							13
14	HOME HEALTH AIDE AND HOMEMAKER							14
15	HH AIDE & HOMEMAKER - CONT. HOME							15
16	OTHER							16
17	DRUGS, BIOLOGICAL AND INFUSION TH							17
18	ANALGESICS							18
19	SEDATIVES / HYPNOTICS							19
20	OTHER - SPECIFY							20
21	DURABLE MED. EQUIPMENT/OXYGEN							21
22	PATIENT TRANSPORTATION							22
23	IMAGING SERVICES							23
24	LABS AND DIAGNOSTICS							24
25	MEDICAL SUPPLIES							25
26	OUTPATIENT SERVICES (including E/							26
27	RADIATION THERAPY							27
28	CHEMOTHERAPY							28
29	OTHER							29
30	BEREAVEMENT PROGRAM COSTS							30
31	VOLUNTEER PROGRAM COSTS							31
32	FUNDRAISING							32
33	OTHER PROGRAM COSTS							33
34	TOTALS (sum of lines 1-33) (2)				6	422		34
35	UNIT COST MULTIPLIER (see instruc							35

(1) Column 0, line 34 must agree with Wkst. A, column 7, line 116.
 (2) Columns 0 through 25, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 116.

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ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

HOSPICE CCN: 14-1542

WORKSHEET K-5
PART I

PART I - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

	HOSPICE COST CENTER (omit cents)	NONPHYSIC. ANESTHET.	NURSING SCHOOL	I&R SALARY & FRINGES	I&R PROGRAM COSTS	PARAMED EDUCATION	SUBTOTAL (cols. 4A-23)	
		19	20	21	22	23	24	
1	ADMINISTRATIVE AND GENERAL						60,329	1
2	INPATIENT - GENERAL CARE							2
3	INPATIENT - RESPITE CARE							3
4	PHYSICIAN SERVICES							4
5	NURSING CARE						298,530	5
6	NURSING CARE-CONTINUOUS HOME CARE							6
7	PHYSICAL THERAPY							7
8	OCCUPATIONAL THERAPY							8
9	SPEECH/LANGUAGE PATHOLOGY							9
10	MEDICAL SOCIAL SERVICES						101,163	10
11	SPIRITUAL COUNSELING							11
12	DIETARY COUNSELING							12
13	COUNSELING - OTHER							13
14	HOME HEALTH AIDE AND HOMEMAKER						53,057	14
15	HH AIDE & HOMEMAKER - CONT. HOME							15
16	OTHER							16
17	DRUGS, BIOLOGICAL AND INFUSION TH							17
18	ANALGESICS							18
19	SEDATIVES / HYPNOTICS							19
20	OTHER - SPECIFY							20
21	DURABLE MED. EQUIPMENT/OXYGEN							21
22	PATIENT TRANSPORTATION							22
23	IMAGING SERVICES							23
24	LABS AND DIAGNOSTICS							24
25	MEDICAL SUPPLIES							25
26	OUTPATIENT SERVICES (including E/							26
27	RADIATION THERAPY							27
28	CHEMOTHERAPY							28
29	OTHER							29
30	BEREAVEMENT PROGRAM COSTS							30
31	VOLUNTEER PROGRAM COSTS							31
32	FUNDRAISING							32
33	OTHER PROGRAM COSTS							33
34	TOTALS (sum of lines 1-33) (2)						513,079	34
35	UNIT COST MULTIPLIER (see instruc							35

- (1) Column 0, line 34 must agree with Wkst. A, column 7, line 116.
- (2) Columns 0 through 25, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 116.

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ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

HOSPICE CCN: 14-1542

WORKSHEET K-5
PART I

PART I - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

	HOSPICE COST CENTER (omit cents)	I&R COST & POST STEP- DOWN ADJS	SUBTOTAL (cols. 24 ± 25)	ALLOC HOSP A&G (See Part II)	TOTAL HOSP COSTS (col 26 ± 27)		
		25	26	27	28		
1	ADMINISTRATIVE AND GENERAL		60,329				1
2	INPATIENT - GENERAL CARE						2
3	INPATIENT - RESPITE CARE						3
4	PHYSICIAN SERVICES						4
5	NURSING CARE		298,530	39,779	338,309		5
6	NURSING CARE-CONTINUOUS HOME CARE						6
7	PHYSICAL THERAPY						7
8	OCCUPATIONAL THERAPY						8
9	SPEECH/LANGUAGE PATHOLOGY						9
10	MEDICAL SOCIAL SERVICES		101,163	13,480	114,643		10
11	SPIRITUAL COUNSELING						11
12	DIETARY COUNSELING						12
13	COUNSELING - OTHER						13
14	HOME HEALTH AIDE AND HOMEMAKER		53,057	7,070	60,127		14
15	HH AIDE & HOMEMAKER - CONT. HOME						15
16	OTHER						16
17	DRUGS, BIOLOGICAL AND INFUSION TH						17
18	ANALGESICS						18
19	SEDATIVES / HYPNOTICS						19
20	OTHER - SPECIFY						20
21	DURABLE MED. EQUIPMENT/OXYGEN						21
22	PATIENT TRANSPORTATION						22
23	IMAGING SERVICES						23
24	LABS AND DIAGNOSTICS						24
25	MEDICAL SUPPLIES						25
26	OUTPATIENT SERVICES (including E/						26
27	RADIATION THERAPY						27
28	CHEMOTHERAPY						28
29	OTHER						29
30	BEREAVEMENT PROGRAM COSTS						30
31	VOLUNTEER PROGRAM COSTS						31
32	FUNDRAISING						32
33	OTHER PROGRAM COSTS						33
34	TOTALS (sum of lines 1-33) (2)		513,079		513,079		34
35	UNIT COST MULTIPLIER (see instruc			0.133250			35

- (1) Column 0, line 34 must agree with Wkst. A, column 7, line 116.
- (2) Columns 0 through 25, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 116.

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ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS HOSPICE CCN: 14-1542

WORKSHEET K-5
PART II

PART II - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS

	HOSPICE COST CENTER	NEW CAP RE L COSTS-BL DG & FIXT SQUARE FEET	NEW CAP RE L COSTS-MV BLE EQUIP DOLLAR VALUE-NEW	EMPLOYEE B ENEFITS DEPARTMENT GROSS SALARIES	RECON- CILIATION	ADMINISTRA TIVE & GEN ERAL ACCUM COST	MAINTENANC E & REPAIR S SQUARE FEET	
		1	2	4	4A	5	6	
1	ADMINISTRATIVE AND GENERAL	1,333	43	27,152		14,919	1,333	1
2	INPATIENT - GENERAL CARE							2
3	INPATIENT - RESPITE CARE							3
4	PHYSICIAN SERVICES							4
5	NURSING CARE			107,288		263,622		5
6	NURSING CARE-CONTINUOUS HOME CARE							6
7	PHYSICAL THERAPY							7
8	OCCUPATIONAL THERAPY							8
9	SPEECH/LANGUAGE PATHOLOGY							9
10	MEDICAL SOCIAL SERVICES			14,057		89,334		10
11	SPIRITUAL COUNSELING							11
12	DIETARY COUNSELING							12
13	COUNSELING - OTHER							13
14	HOME HEALTH AIDE AND HOMEMAKER			43,523		46,853		14
15	HH AIDE & HOMEMAKER - CONT. HOME							15
16	OTHER							16
17	DRUGS, BIOLOGICAL AND INFUSION TH							17
18	ANALGESICS							18
19	SEDATIVES / HYPNOTICS							19
20	OTHER - SPECIFY							20
21	DURABLE MED. EQUIPMENT/OXYGEN							21
22	PATIENT TRANSPORTATION							22
23	IMAGING SERVICES							23
24	LABS AND DIAGNOSTICS							24
25	MEDICAL SUPPLIES							25
26	OUTPATIENT SERVICES (including E/							26
27	RADIATION THERAPY							27
28	CHEMOTHERAPY							28
29	OTHER							29
30	BEREAVEMENT PROGRAM COSTS							30
31	VOLUNTEER PROGRAM COSTS							31
32	FUNDRAISING							32
33	OTHER PROGRAM COSTS							33
34	TOTALS (sum of lines 1-33)	1,333	43	192,020		414,728	1,333	34
35	TOTAL COST TO BE ALLOCATED	6,134	44	61,814		54,917	10,447	35
36	UNIT COST MULTIPLIER	4.601650		0.321914		0.132417		36
36	UNIT COST MULTIPLIER		1.023256				7.837209	36

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ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS HOSPICE CCN: 14-1542

WORKSHEET K-5
PART II

PART II - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS

	HOSPICE COST CENTER	OPERATION OF PLANT SQUARE FEET 7	LAUNDRY & LINEN SERVICE ICE LAUNDRY POUNDS 8	HOUSEKEEPING HOURS OF SERVICE 9	DIETARY DIETARY MEALS SERV 10	CAFETERIA CAFE MEALS SERV 11	MAINTENANCE OF PERSONNEL NUMBER HOUSED 12	
1	ADMINISTRATIVE AND GENERAL	1,333		9,300		47		1
2	INPATIENT - GENERAL CARE							2
3	INPATIENT - RESPITE CARE							3
4	PHYSICIAN SERVICES							4
5	NURSING CARE							5
6	NURSING CARE-CONTINUOUS HOME CARE							6
7	PHYSICAL THERAPY							7
8	OCCUPATIONAL THERAPY							8
9	SPEECH/LANGUAGE PATHOLOGY							9
10	MEDICAL SOCIAL SERVICES							10
11	SPIRITUAL COUNSELING							11
12	DIETARY COUNSELING							12
13	COUNSELING - OTHER							13
14	HOME HEALTH AIDE AND HOMEMAKER							14
15	HH AIDE & HOMEMAKER - CONT. HOME							15
16	OTHER							16
17	DRUGS, BIOLOGICAL AND INFUSION TH							17
18	ANALGESICS							18
19	SEDATIVES / HYPNOTICS							19
20	OTHER - SPECIFY							20
21	DURABLE MED. EQUIPMENT/OXYGEN							21
22	PATIENT TRANSPORTATION							22
23	IMAGING SERVICES							23
24	LABS AND DIAGNOSTICS							24
25	MEDICAL SUPPLIES							25
26	OUTPATIENT SERVICES (including E/							26
27	RADIATION THERAPY							27
28	CHEMOTHERAPY							28
29	OTHER							29
30	BEREAVEMENT PROGRAM COSTS							30
31	VOLUNTEER PROGRAM COSTS							31
32	FUNDRAISING							32
33	OTHER PROGRAM COSTS							33
34	TOTALS (sum of lines 1-33)	1,333		9,300		47		34
35	TOTAL COST TO BE ALLOCATED	6,014		10,953		15,592		35
36	UNIT COST MULTIPLIER	4.511628		1.177742		331.744681		36
36	UNIT COST MULTIPLIER							36

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ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS HOSPICE CCN: 14-1542

WORKSHEET K-5
PART II

PART II - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS

	HOSPICE COST CENTER	NURSING AD MINISTRATI ON DIRECT NURSING HO 13	CENTRAL SE RVICES & S UPPLY CS COSTED REQUIS 14	PHARMACY PHARM COSTED REQ 15	MEDICAL RE CORDS & LI BRARY TIME SPENT 16	SOCIAL SERVICE TIME SPENT 17	NONPHYSIC. ANESTHET. ASSIGNED TIME 19	
1	ADMINISTRATIVE AND GENERAL			300	75			1
2	INPATIENT - GENERAL CARE							2
3	INPATIENT - RESPITE CARE							3
4	PHYSICIAN SERVICES							4
5	NURSING CARE							5
6	NURSING CARE-CONTINUOUS HOME CARE							6
7	PHYSICAL THERAPY							7
8	OCCUPATIONAL THERAPY							8
9	SPEECH/LANGUAGE PATHOLOGY							9
10	MEDICAL SOCIAL SERVICES							10
11	SPIRITUAL COUNSELING							11
12	DIETARY COUNSELING							12
13	COUNSELING - OTHER							13
14	HOME HEALTH AIDE AND HOMEMAKER							14
15	HH AIDE & HOMEMAKER - CONT. HOME							15
16	OTHER							16
17	DRUGS, BIOLOGICAL AND INFUSION TH							17
18	ANALGESICS							18
19	SEDATIVES / HYPNOTICS							19
20	OTHER - SPECIFY							20
21	DURABLE MED. EQUIPMENT/OXYGEN							21
22	PATIENT TRANSPORTATION							22
23	IMAGING SERVICES							23
24	LABS AND DIAGNOSTICS							24
25	MEDICAL SUPPLIES							25
26	OUTPATIENT SERVICES (including E/							26
27	RADIATION THERAPY							27
28	CHEMOTHERAPY							28
29	OTHER							29
30	BEREAVEMENT PROGRAM COSTS							30
31	VOLUNTEER PROGRAM COSTS							31
32	FUNDRAISING							32
33	OTHER PROGRAM COSTS							33
34	TOTALS (sum of lines 1-33)			300	75			34
35	TOTAL COST TO BE ALLOCATED			6	422			35
36	UNIT COST MULTIPLIER			0.020000				36
36	UNIT COST MULTIPLIER				5.626667			36

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ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS HOSPICE CCN: 14-1542

WORKSHEET K-5
PART II

PART II - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS

	HOSPICE COST CENTER	NURSING SCHOOL ASSIGNED TIME	I&R SALARY & FRINGES ASSIGNED TIME	I&R PROGRAM COSTS ASSIGNED TIME	PARAMED EDUCATION ASSIGNED TIME			
		20	21	22	23			
1	ADMINISTRATIVE AND GENERAL							1
2	INPATIENT - GENERAL CARE							2
3	INPATIENT - RESPITE CARE							3
4	PHYSICIAN SERVICES							4
5	NURSING CARE							5
6	NURSING CARE-CONTINUOUS HOME CARE							6
7	PHYSICAL THERAPY							7
8	OCCUPATIONAL THERAPY							8
9	SPEECH/LANGUAGE PATHOLOGY							9
10	MEDICAL SOCIAL SERVICES							10
11	SPIRITUAL COUNSELING							11
12	DIETARY COUNSELING							12
13	COUNSELING - OTHER							13
14	HOME HEALTH AIDE AND HOMEMAKER							14
15	HH AIDE & HOMEMAKER - CONT. HOME							15
16	OTHER							16
17	DRUGS, BIOLOGICAL AND INFUSION TH							17
18	ANALGESICS							18
19	SEDATIVES / HYPNOTICS							19
20	OTHER - SPECIFY							20
21	DURABLE MED. EQUIPMENT/OXYGEN							21
22	PATIENT TRANSPORTATION							22
23	IMAGING SERVICES							23
24	LABS AND DIAGNOSTICS							24
25	MEDICAL SUPPLIES							25
26	OUTPATIENT SERVICES (including E/							26
27	RADIATION THERAPY							27
28	CHEMOTHERAPY							28
29	OTHER							29
30	BEREAVEMENT PROGRAM COSTS							30
31	VOLUNTEER PROGRAM COSTS							31
32	FUNDRAISING							32
33	OTHER PROGRAM COSTS							33
34	TOTALS (sum of lines 1-33)							34
35	TOTAL COST TO BE ALLOCATED							35
36	UNIT COST MULTIPLIER							36
36	UNIT COST MULTIPLIER							36

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APPORTIONMENT OF HOSPICE SHARED SERVICES

HOSPICE CCN: 14-1542

WORKSHEET K-5
PART III

PART III - COMPUTATION OF TOTAL HOSPICE SHARED COSTS

	COST CENTER	WKST C, PART I, COL. 9, LINE	COST TO CHARGE RATIO	TOTAL HOSPICE CHARGES (Provider Records)	HOSPICE SHARED ANCILLARY COSTS (cols. 1 x 2)	
		0	1	2	3	
	ANCILLARY SERVICE COST CENTERS					
1	PHYSICAL THERAPY	66	0.279315			1
2	OCCUPATIONAL THERAPY	67				2
3	SPEECH/LANGUAGE PATHOLOGY	68	0.370832			3
4	DRUGS, BIOLOGICAL AND INFUSION THERAPY	73	0.232609			4
5	DURABLE MEDICAL EQUIPMENT/OXYGEN	96				5
6	LABS AND DIAGNOSTICS	60	0.141197			6
7	MEDICAL SUPPLIES	71	0.366584			7
8	OUTPATIENT SERVICES (including E/R Dept.)	93				8
9	RADIATION THERAPY	55				9
10	OTHER ANCILLARY (SPECIFY)	76				10
10.97	CARDIAC REHABILITATION	76.97				10.97
10.98	HYPERBARIC OXYGEN THERAPY	76.98				10.98
10.99	LITHOTRIPSY	76.99				10.99
11	TOTALS (sum of lines 1-10)					11

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CALCULATION OF HOSPICE PER DIEM COST

HOSPICE CCN: 14-1542

WORKSHEET K-6

COMPUTATION OF PER DIEM COSTS		TITLE XVIII	TITLE XIX	OTHER	TOTAL	
		1	2	3	4	
1	TOTAL COST (see instructions)				513,079	1
2	TOTAL UNDUPLICATED DAYS (Worksheet S-9, column 6, line 5)				3,487	2
3	AVERAGE COST PER DIEM (line 1 divided by line 2)				147.14	3
4	UNDUPLICATED MEDICARE DAYS (Worksheet S-9, column 1, line 5)	3,143				4
5	AGGREGATE MEDICARE COST (line 3 times line 4)	462,461				5
6	UNDUPLICATED MEDICAID DAYS (Worksheet S-9, column 2, line 5)		98			6
7	AGGREGATE MEDICAID COST (line 3 times line 6)		14,420			7
8	UNDUPLICATED SNF DAYS (Worksheet S-9, column 3, line 5)					8
9	AGGREGATE SNF COST (line 3 times line 8)					9
10	UNDUPLICATED NF DAYS (Worksheet S-9, column 4, line 5)					10
11	AGGREGATE NF COST (line 3 times line 10)					11
12	OTHER UNDUPLICATED DAYS (Worksheet S-9, column 5, line 5)			246		12
13	AGGREGATE COST FOR OTHER DAYS (line 3 times line 12)			36,196		13

Note: The data for the SNF and NF on lines 8 through 11 are included in the Medicare and Medicaid lines 4 through 7.

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CALCULATION OF CAPITAL PAYMENT

COMPONENT CCN: 14-0147

WORKSHEET L

CHECK [] TITLE V [XX] HOSPITAL [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [] SUB (OTHER) [] COST METHOD
 BOXES: [] TITLE XIX

PART I - FULLY PROSPECTIVE METHOD

CAPITAL FEDERAL AMOUNT			
1	CAPITAL DRG OTHER THAN OUTLIER	425,554	1
1.01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER		1.01
2	CAPITAL DRG OUTLIER PAYMENTS	3,174	2
2.01	MODEL 4 BPCI CAPITAL DRG OUTLIER PAYMENTS		2.01
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)	15.41	3
4	NUMBER OF INTERNS & RESIDENTS (see instructions)		4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (see instructions)		5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (multiply line 5 by the sum of lines 1 and 1.01)		6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (Worksheet E, Part A line 30) (see instructions)		7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (see instructions)		8
9	SUM OF LINES 7 AND 8		9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)		10
11	DISPROPORTIONATE SHARE ADJUSTMENT (line 10 times the sum of lines 1 and 1.01)		11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	428,728	12

PART II - PAYMENT UNDER REASONABLE COST

1	PROGRAM INPATIENT ROUTINE CAPITAL COST (see instructions)		1
2	PROGRAM INPATIENT ANCILLARY CAPITAL COST (see instructions)		2
3	TOTAL INPATIENT PROGRAM CAPITAL COST (line 1 plus line 2)		3
4	CAPITAL COST PAYMENT FACTOR (see instructions)		4
5	TOTAL INPATIENT PROGRAM CAPITAL COST (line 3 times line 4)		5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	PROGRAM INPATIENT CAPITAL COSTS (see instructions)		1
2	PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		2
3	NET PROGRAM INPATIENT CAPITAL COSTS (line 1 minus line 2)		3
4	APPLICABLE EXCEPTION PERCENTAGE (see instructions)		4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS (line 3 x line 4)		5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (line 2 x line 6)		7
8	CAPITAL MINIMUM PAYMENT LEVEL (line 5 plus line 7)		8
9	CURRENT YEAR CAPITAL PAYMENTS (from Part I, line 12 as applicable)		9
10	CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 8 less line 9)		10
11	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT (from prior year Worksheet L, Part III, line 14)		11
12	NET COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 10 plus line 11)		12
13	CURRENT YEAR EXCEPTION PAYMENT (if line 12 is positive, enter the amount on this line)		13
14	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR THE FOLLOWING PERIOD (if line 12 is negative, enter the amount on this line)		14
15	CURRENT YEAR ALLOWABLE OPERATING AND CAPITAL PAYMENT (see instructions)		15
16	CURRENT YEAR OPERATING AND CAPITAL COSTS (see instructions)		16
17	CURRENT YEAR EXCEPTION OFFSET AMOUNT (see instructions)		17

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CALCULATION OF CAPITAL PAYMENT

COMPONENT CCN: 14-0147

WORKSHEET L

CHECK TITLE V HOSPITAL PPS
 APPLICABLE TITLE XVIII, PART A SUB (OTHER) COST METHOD
 BOXES: TITLE XIX

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	CAPITAL DRG OTHER THAN OUTLIER		1
1.01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER		1.01
2	CAPITAL DRG OUTLIER PAYMENTS		2
2.01	MODEL 4 BPCI CAPITAL DRG OUTLIER PAYMENTS		2.01
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)		3
4	NUMBER OF INTERNS & RESIDENTS (see instructions)		4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (see instructions)		5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (multiply line 5 by the sum of lines 1 and 1.01)		6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (Worksheet E, Part A line 30) (see instructions)		7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (see instructions)		8
9	SUM OF LINES 7 AND 8		9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)		10
11	DISPROPORTIONATE SHARE ADJUSTMENT (line 10 times the sum of lines 1 and 1.01)		11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of lines 1, 1.01, 2, 2.01, 6 and 11)		12

PART II - PAYMENT UNDER REASONABLE COST

1	PROGRAM INPATIENT ROUTINE CAPITAL COST (see instructions)		1
2	PROGRAM INPATIENT ANCILLARY CAPITAL COST (see instructions)		2
3	TOTAL INPATIENT PROGRAM CAPITAL COST (line 1 plus line 2)		3
4	CAPITAL COST PAYMENT FACTOR (see instructions)		4
5	TOTAL INPATIENT PROGRAM CAPITAL COST (line 3 times line 4)		5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	PROGRAM INPATIENT CAPITAL COSTS (see instructions)		1
2	PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		2
3	NET PROGRAM INPATIENT CAPITAL COSTS (line 1 minus line 2)		3
4	APPLICABLE EXCEPTION PERCENTAGE (see instructions)		4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS (line 3 x line 4)		5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (line 2 x line 6)		7
8	CAPITAL MINIMUM PAYMENT LEVEL (line 5 plus line 7)		8
9	CURRENT YEAR CAPITAL PAYMENTS (from Part I, line 12 as applicable)		9
10	CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 8 less line 9)		10
11	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT (from prior year Worksheet L, Part III, line 14)		11
12	NET COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 10 plus line 11)		12
13	CURRENT YEAR EXCEPTION PAYMENT (if line 12 is positive, enter the amount on this line)		13
14	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR THE FOLLOWING PERIOD (if line 12 is negative, enter the amount on this line)		14
15	CURRENT YEAR ALLOWABLE OPERATING AND CAPITAL PAYMENT (see instructions)		15
16	CURRENT YEAR OPERATING AND CAPITAL COSTS (see instructions)		16
17	CURRENT YEAR EXCEPTION OFFSET AMOUNT (see instructions)		17

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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL	
		0	2A	24	25	26	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY						16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS						30
31	INTENSIVE CARE UNIT						31
40	SUBPROVIDER - IPF						40
43	NURSERY						43
44	SKILLED NURSING FACILITY						44
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM						50
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC						54
56	RADIOISOTOPE						56
57	CT SCAN						57
58	MRI						58
60	LABORATORY						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	INTRAVENOUS THERAPY						64
65	RESPIRATORY THERAPY						65
66	PHYSICAL THERAPY						66
68	SPEECH PATHOLOGY						68
69	ELECTROCARDIOLOGY						69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						71
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS						73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY						91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES						95
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
101	HOME HEALTH AGENCY						101
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
116	HOSPICE						116
118	SUBTOTALS (sum of lines 1-117)						118
	NONREIMBURSABLE COST CENTERS						
192	PHYSICIANS' PRIVATE OFFICES						192
194	OTHER NONREIMBURSABLE						194
194.01	MEMORY DISORDER						194.01
194.02	ASSISTED LIVING						194.02
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (sum of lines 118-201)						202

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REPORT 97 - UTILIZATION STATISTICS - HOSPITAL

	COST CENTERS	TITLE XVIII		TITLE XIX		TITLE V		TOTAL THIRD PARTY UTIL	
		PART A	PART B	INPATIENT	OUTPAT- IENT	INPATIENT	OUTPAT- IENT		
		1	2	3	4	5	6	7	
	UTILIZATION PERCENTAGES BASED ON DAYS								
30	ADULTS & PEDIATRICS	51.21		15.60				66.81	30
31	INTENSIVE CARE UNIT	93.50		1.17				94.67	31
43	NURSERY			66.61				66.61	43
	UTILIZATION PERCENTAGES BASED ON CHARGES								
50	OPERATING ROOM	10.22	22.68	12.34				45.24	50
53	ANESTHESIOLOGY	7.23	11.74	4.85				23.82	53
54	RADIOLOGY-DIAGNOSTIC	12.55	28.68	1.11				42.34	54
56	RADIOISOTOPE	6.41	44.16	0.62				51.19	56
57	CT SCAN	13.45	29.80	1.27				44.52	57
58	MRI	2.77	27.37	0.27				30.41	58
60	LABORATORY	14.95	9.07	2.98				27.00	60
64	INTRAVENOUS THERAPY	32.33	15.01	0.05				47.39	64
65	RESPIRATORY THERAPY	48.50	14.02	2.39				64.91	65
66	PHYSICAL THERAPY	6.55		0.14				6.69	66
68	SPEECH PATHOLOGY	7.96	3.39	6.27				17.62	68
69	ELECTROCARDIOLOGY	11.22	36.45	1.85				49.52	69
71	MEDICAL SUPPLIES CHARGED TO PAT	20.74	17.49	11.84				50.07	71
72	IMPL. DEV. CHARGED TO PATIENTS	34.27	21.08	3.53				58.88	72
73	DRUGS CHARGED TO PATIENTS	27.91	22.02	6.49				56.42	73
91	EMERGENCY	12.57	20.27	2.10				34.94	91
92	OBSERVATION BEDS (NON-DISTINCT	11.84	17.61	1.77				31.22	92
200	TOTAL CHARGES	14.75	18.24	4.24				37.23	200

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REPORT 97 - UTILIZATION STATISTICS - SUBPROVIDER-IPF

COST CENTERS	TITLE XVIII		TITLE XIX		TITLE V		TOTAL THIRD PARTY UTIL	
	PART A	PART B	INPATIENT	OUTPAT- IENT	INPATIENT	OUTPAT- IENT		
	1	2	3	4	5	6	7	
UTILIZATION PERCENTAGES BASED ON DAYS								
40 SUBPROVIDER - IPF	24.17		44.04				68.21	40
UTILIZATION PERCENTAGES BASED ON CHARGES								
54 RADIOLOGY-DIAGNOSTIC	0.08						0.08	54
57 CT SCAN	0.26						0.26	57
60 LABORATORY	0.44						0.44	60
64 INTRAVENOUS THERAPY	0.08						0.08	64
65 RESPIRATORY THERAPY	0.12						0.12	65
66 PHYSICAL THERAPY	0.01						0.01	66
69 ELECTROCARDIOLOGY	0.26						0.26	69
71 MEDICAL SUPPLIES CHARGED TO PAT	0.10						0.10	71
73 DRUGS CHARGED TO PATIENTS	1.48						1.48	73
91 EMERGENCY	0.76						0.76	91
200 TOTAL CHARGES	0.33						0.33	200

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REPORT 97 - UTILIZATION STATISTICS - SNF / NF

COST CENTERS	TITLE XVIII		TITLE XIX		TITLE V		TOTAL THIRD PARTY UTIL	
	PART A	PART B	INPATIENT	OUTPAT- IENT	INPATIENT	OUTPAT- IENT		
	1	2	3	4	5	6	7	
UTILIZATION PERCENTAGES BASED ON DAYS								
44 SKILLED NURSING FACILITY	29.21						29.21	44
UTILIZATION PERCENTAGES BASED ON CHARGES								
54 RADIOLOGY-DIAGNOSTIC	0.82						0.82	54
57 CT SCAN	0.50						0.50	57
58 MRI	0.47						0.47	58
60 LABORATORY	1.29						1.29	60
64 INTRAVENOUS THERAPY	4.26						4.26	64
65 RESPIRATORY THERAPY	15.86						15.86	65
66 PHYSICAL THERAPY	22.02						22.02	66
68 SPEECH PATHOLOGY	12.11						12.11	68
69 ELECTROCARDIOLOGY	0.15						0.15	69
71 MEDICAL SUPPLIES CHARGED TO PAT	2.43						2.43	71
73 DRUGS CHARGED TO PATIENTS	8.28						8.28	73
92 OBSERVATION BEDS (NON-DISTINCT)	0.47						0.47	92
200 TOTAL CHARGES	3.53						3.53	200

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REPORT 97 - UTILIZATION STATISTICS - SWING-BED SNF / NF

COST CENTERS	TITLE XVIII		TITLE XIX		TITLE V		TOTAL THIRD PARTY UTIL	
	PART A	PART B	INPATIENT	OUTPAT- IENT	INPATIENT	OUTPAT- IENT		
	1	2	3	4	5	6		
UTILIZATION PERCENTAGES BASED ON CHARGES								
50	OPERATING ROOM	0.02					0.02	50
54	RADIOLOGY-DIAGNOSTIC	0.26					0.26	54
56	RADIOISOTOPE	0.09					0.09	56
57	CT SCAN	0.11					0.11	57
60	LABORATORY	0.43					0.43	60
64	INTRAVENOUS THERAPY	1.61					1.61	64
65	RESPIRATORY THERAPY	5.09					5.09	65
66	PHYSICAL THERAPY	1.26					1.26	66
68	SPEECH PATHOLOGY	0.95					0.95	68
69	ELECTROCARDIOLOGY	0.11					0.11	69
71	MEDICAL SUPPLIES CHARGED TO PAT	0.60					0.60	71
73	DRUGS CHARGED TO PATIENTS	2.15					2.15	73
200	TOTAL CHARGES	0.62					0.62	200

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REPORT 98 - COST ALLOCATION SUMMARY

	COST CENTERS	DIRECT COSTS		ALLOCATED OVERHEAD		TOTAL COSTS		
		AMOUNT	%	AMOUNT	%	AMOUNT	%	
		1	2	3	4	5	6	
GENERAL SERVICE COST CENTERS								
1	CAP REL COSTS-BLDG & FIXT	803,986	1.98	-803,986	-4.08			1
2	CAP REL COSTS-MVBLE EQUIP	1,217,652	2.99	-1,217,652	-6.18			2
3	OTHER CAP REL COSTS							3
4	EMPLOYEE BENEFITS DEPARTMENT	6,514,001	16.01	-6,514,001	-33.07			4
5	ADMINISTRATIVE & GENERAL	3,780,811	9.29	-3,780,811	-19.19			5
6	MAINTENANCE & REPAIRS	830,651	2.04	-830,651	-4.22			6
7	OPERATION OF PLANT	490,828	1.21	-490,828	-2.49			7
8	LAUNDRY & LINEN SERVICE	170,368	0.42	-170,368	-0.86			8
9	HOUSEKEEPING	512,616	1.26	-512,616	-2.60			9
10	DIETARY	366,793	0.90	-366,793	-1.86			10
11	CAFETERIA	707,470	1.74	-707,470	-3.59			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	1,334,575	3.28	-1,334,575	-6.78			13
14	CENTRAL SERVICES & SUPPLY	50,439	0.12	-50,439	-0.26			14
15	PHARMACY	2,179,054	5.36	-2,179,054	-11.06			15
16	MEDICAL RECORDS & LIBRARY	738,759	1.82	-738,759	-3.75			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 SERVICE COST CENTERS								
30	ADULTS & PEDIATRICS	2,126,668	5.23	3,384,147	17.18	5,510,815	13.54	30
31	INTENSIVE CARE UNIT	707,896	1.74	916,851	4.65	1,624,747	3.99	31
40	SUBPROVIDER - IPF	716,172	1.76	891,286	4.52	1,607,458	3.95	40
43	NURSERY	234,060	0.58	226,891	1.15	460,951	1.13	43
44	SKILLED NURSING FACILITY	1,135,165	2.79	1,725,412	8.76	2,860,577	7.03	44
ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	1,088,924	2.68	1,153,458	5.86	2,242,382	5.51	50
53	ANESTHESIOLOGY	17,661	0.04	148,261	0.75	165,922	0.41	53
54	RADIOLOGY-DIAGNOSTIC	899,692	2.21	751,035	3.81	1,650,727	4.06	54
56	RADIOISOTOPE	188,339	0.46	92,115	0.47	280,454	0.69	56
57	CT SCAN	236,960	0.58	127,041	0.64	364,001	0.89	57
58	MRI	239,385	0.59	31,766	0.16	271,151	0.67	58
60	LABORATORY	2,445,922	6.01	927,026	4.71	3,372,948	8.29	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY	27,188	0.07	56,079	0.28	83,267	0.20	64
65	RESPIRATORY THERAPY	396,199	0.97	303,496	1.54	699,695	1.72	65
66	PHYSICAL THERAPY	1,528,183	3.76	952,777	4.84	2,480,960	6.10	66
68	SPEECH PATHOLOGY	182,560	0.45	99,054	0.50	281,614	0.69	68
69	ELECTROCARDIOLOGY	190,499	0.47	37,964	0.19	228,463	0.56	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,613,839	3.97	397,665	2.02	2,011,504	4.94	71
72	IMPL. DEV. CHARGED TO PATIENTS	363,105	0.89	88,463	0.45	451,568	1.11	72
73	DRUGS CHARGED TO PATIENTS			2,603,125	13.22	2,603,125	6.40	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
91	EMERGENCY	820,454	2.02	972,746	4.94	1,793,200	4.41	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
OTHER REIMBURSABLE COST CENTERS								
95	AMBULANCE SERVICES	651,724	1.60	701,010	3.56	1,352,734	3.32	95
OUTPATIENT SERVICE COST CENTERS								
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	HOME HEALTH AGENCY	878,182	2.16	445,008	2.26	1,323,190	3.25	101
SPECIAL PURPOSE COST CENTERS								
116	HOSPICE	346,736	0.85	166,343	0.84	513,079	1.26	116
NONREIMBURSABLE COST CENTERS								
192	PHYSICIANS' PRIVATE OFFICES	3,934,523	9.67	2,485,622	12.62	6,420,145	15.78	192
194	OTHER NONREIMBURSABLE							194
194.0	MEMORY DISORDER	22,138	0.05	13,362	0.07	35,500	0.09	194.0
1								1
194.0	ASSISTED LIVING							194.0
2								2
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL	40,690,177	100.00			40,690,177	100.00	202

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REPORT 99 - APPORTIONMENT OF INPATIENT MEDICARE ANCILLARY SERVICE PPS CAPITAL COSTS

	COST CENTER DESCRIPTION	CAPITAL RELATED COSTS	TOTAL CHARGES	RATIO OF CAPITAL COSTS TO CHARGES	INPATIENT PROGRAM CHARGES	MEDICARE INPATIENT PPS CAPITAL COSTS	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	367,770	15,479,211	0.023759	1,582,541	37,600	50
53	ANESTHESIOLOGY	37,103	5,893,635	0.006295	426,103	2,682	53
54	RADIOLOGY-DIAGNOSTIC	217,282	9,946,087	0.021846	1,247,953	27,263	54
56	RADIOISOTOPE	22,432	2,405,751	0.009324	154,142	1,437	56
57	CT SCAN	29,591	11,307,999	0.002617	1,521,057	3,981	57
58	MRI	2,397	1,930,754	0.001241	53,451	66	58
60	LABORATORY	131,318	23,888,305	0.005497	3,570,914	19,629	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	INTRAVENOUS THERAPY	2,770	1,038,187	0.002668	335,646	896	64
65	RESPIRATORY THERAPY	23,647	3,414,332	0.006926	1,656,011	11,470	65
66	PHYSICAL THERAPY	64,249	8,882,314	0.007233	581,997	4,210	66
68	SPEECH PATHOLOGY	3,762	759,411	0.004954	60,477	300	68
69	ELECTROCARDIOLOGY	8,473	2,535,746	0.003341	284,625	951	69
71	MEDICAL SUPPLIES CHARGED TO PAT	56,107	5,487,151	0.010225	1,138,288	11,639	71
72	IMPL. DEV. CHARGED TO PATIENTS	12,405	907,762	0.013665	311,059	4,251	72
73	DRUGS CHARGED TO PATIENTS	123,889	11,190,990	0.011070	3,123,289	34,575	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	134,869	8,552,137	0.015770	1,075,120	16,955	91
92	OBSERVATION BEDS (NON-DISTINCT	60,015	2,127,679	0.028207	251,865	7,104	92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES						95
200	TOTAL	1,298,079	115,747,451		17,374,538	185,009	200

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REPORT 99 - APPORTIONMENT OF INPATIENT MEDICARE ROUTINE SERVICE PPS CAPITAL COSTS

	COST CENTER DESCRIPTION	CAPITAL RELATED COSTS	SWING-BED ADJUST-MENT AMOUNT	REDUCED CAPITAL RELATED COST	TOTAL PATIENT DAYS	PER DIEM	INPATIENT PROGRAM DAYS	MEDICARE INPATIENT PPS CAPITAL COSTS	
		1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	ADULTS & PEDIATRICS	368,993	5,264	363,729	5,595	65.01	2,865	186,254	30
31	INTENSIVE CARE UNIT	105,911		105,911	939	112.79	878	99,030	31
200	TOTAL	474,904	5,264	469,640	6,534		3,743	285,284	200

MEDICARE INPATIENT ROUTINE SERVICE PPS CAPITAL COSTS	285,284
MEDICARE INPATIENT ANCILLARY SERVICE PPS CAPITAL COSTS	185,009
TOTAL MEDICARE INPATIENT PPS CAPITAL COSTS	470,293
MEDICARE DISCHARGES (Worksheet S-3, Part I, line 14, column 13)	892
MEDICARE PATIENT DAYS (Worksheet S-3, Part I, line 14, column 6 - Worksheet S-3, Part I, line 5, column 6)	3,743
PER DISCHARGE CAPITAL COSTS	527.23

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I. COST TO CHARGE RATIO FOR PPS HOSPITALS

1. TOTAL PROGRAM (Title XVIII) INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COST. (Worksheet D-1, Part II, line 53)	7,062,993
2. HOSPITAL PART A TITLE XVIII CHARGES (sum of inpatient charges and ancillary charges on Worksheet D-3 for hospital Title XVIII component)	21,076,968
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.335

COST TO CHARGE RATIO FOR PSYCH SUBPROVIDER

1. TOTAL MEDICARE COSTS (Worksheet D-1, Part II, line 49 - (Worksheet D, Part III, column 9, line 40 + Worksheet D, Part IV, column 11, line 200))	472,990
2. TOTAL MEDICARE CHARGES (Worksheet D-3, line 40, column 2 plus Worksheet D-3, line 202, column 2) (see CR 5619)	925,959
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.511

II. COST TO CHARGE RATIO FOR CAPITAL

1. TOTAL MEDICARE INPATIENT PPS CAPITAL RELATED COSTS (Worksheet D, Part I, lines 30-35, column 7 + Worksheet D, Part II, line 200, column 5)	470,293
2. RATIO OF COST TO CHARGES (line II-1 / line I-2)	0.022

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

1. TOTAL PROGRAM (Title XVIII) OUTPATIENT COST EXCLUDING SERVICES NOT SUBJECT TO OPPTS. (Worksheet D, Part V, columns 2, 2.01, 2.02 x column 1 less lines 61, 66-68, 74, 94, 95 & 96)	3,342,379
2. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPPTS. (Worksheet D, Part V, line 202, columns 2, 2.01, & 2.02 less lines 61, 66-68, 74, 94, 95 & 96)	21,445,055
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.156