

RICHLAND MEMORIAL HOSPITAL

OLNEY, ILLINOIS

MEDICARE COST REPORT

YEAR ENDED SEPTEMBER 30, 2015

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: 09/30/2015
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 \$80,000.

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.

The Provider is appealing its Hospital Acquired Condition (HAC) penalty. The provider believes there is a flaw in the calculation formula; specifically, when the number of cases in the infection domain does not meet the threshold, that domain is not used. This results in 100% of our HAC score coming from the PSI domain, which for all other hospitals, only accounts for 35% of their total HAC score. This unfairly distorts our overall HAC score.

The Provider estimates, based on their CMS Provider Statistical Report (PSR), the reimbursement impact of this issue for this cost reporting period is \$58,000.

The total amount protested on worksheet E, Part A is $\$80,000 + \$58,000 = \$138,000$.

Sincerely,

Richland Memorial Hospital

Richland Memorial Hospital
Hospital Specific Rate Recalculation
September 30, 2015

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
2015 Update Factor	1.0220
2011 Budget Neutrality	0.996731
2012 Budget Neutrality	0.997903
2013 Budget Neutrality	0.998431
2014 Budget Neutrality	0.997989
2015 Budget Neutrality	0.998761
2012 Rural Floor Add-on	1.009
2014 Document & Coding	0.948
2015 Medicare Part A Offset	0.998
	<hr/>
2012 difference	114.43
DRG weight	929.04
	<hr/>
	106,312
MDH payment factor	0.75
	<hr/>
	79,734
	<hr/> <hr/>
Rounded	80,000
	<hr/> <hr/>

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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: 02/20/2016 Time: 08:49	
		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 checked="" 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:
	(3) Settled with audit	9. <input type="checkbox"/> Final Report for this Provider CCN	Enter number of times reopened = 0-9.
	(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 certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by

ECR Encryption: 02/20/2016 08:49
7JCov83L1BDA1i3Z7UdtPa1hT.1Xf0
SwdwL05vva1eisoQ6OPwbVaGulq8rs
3Tgv1:XyA101.H7t

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

Title

Date

PI Encryption: 02/20/2016 08:49
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:hpmq0MMv9n:BwvvBI0rfq12Wy/MmNO
YD.i0d6:yu0zeJeu

PART III - SETTLEMENT SUMMARY

	TITLE V	TITLE XVIII		HIT	TITLE XIX	
		PART A	PART B			
	1	2	3	4	5	
1 HOSPITAL						
2 SUBPROVIDER - IPF		-30,831	17,052	349,953		1
3 SUBPROVIDER - IRF		6,947				2
4 SUBPROVIDER (OTHER)						3
5 SWING BED - SNF						4
6 SWING BED - NF		10,240				5
7 SKILLED NURSING FACILITY						6
8 NURSING FACILITY						7
9 HOME HEALTH AGENCY						8
10 HEALTH CLINIC - RHC			52			9
11 HEALTH CLINIC - FQHC						10
12 OUTPATIENT REHABILITATION PROVIDER						11
200 TOTAL		-13,644	17,104	349,953		12
						200

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:

1	Street: 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:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	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	RICHLAND MEMORIAL HOSPITAL WEST SALE	14-8548	99914		12 / 04 / 2015	N	O	N	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 / 2014	To: 09 / 30 / 2015	20
21	Type of control (see instructions)	2		21

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

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days		
	1	2	3	4	5	6		
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	708	40			139	318	24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.							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 is in effect in the cost reporting period.	1					37

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning: 10 / 01 / 2014	Ending: 09 / 30 / 2015	38
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WORKSHEET S-2
PART I

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)	V	XVIII	XIX	
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	I	2	3	
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 Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. 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 Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
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
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.(see instructions)	Y/N	IME	Direct GME	
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 Nonprovider Settings

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

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

Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)					
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))
	1	2	3	4	5
65					65

Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				66
Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)					
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))
	1	2	3	4	5
67					67

Inpatient Psychiatric Facility PPS		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	Y			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, indicate which program year began during this cost reporting period. (see instructions)	N	N		71

Inpatient Rehabilitation Facility PPS		1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.	N			75
76	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				76

Long Term Care Hospital PPS					
80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.		N		80
81	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no.		N		81

TEFRA Providers					
85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA? Enter 'Y' for yes or 'N' for no.		N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.				86
87	Is this hospital a 'subclause (II)' LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter 'Y' for yes and 'N' for no.		N		87

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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/IID facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97

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	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.			107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108
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
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.		N	110

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1.	N		115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.	Y		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2		118
118.01	List amounts of malpractice premiums and paid losses:	Premiums 635,648	Paid Losses Self Insurance	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 Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.	N	N	145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, chapter 40, §4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N		147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N		148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	N		149

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

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

Multicampus

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

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

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	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
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)					168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. (see instructions)	0.25				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 / 2014	09 / 30 / 2015			170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no. (see instructions)		N			171

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

COMPLETED BY ALL HOSPITALS

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

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

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

		Y/N
Bad Debts		Y/N
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y
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
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N

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

		Part A		Part B	
		Y/N	Date	Y/N	Date
PS&R Report Data		1	2	3	4
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	11/12/2015	Y	11/12/2015
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 II

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

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

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

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

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

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

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

Cost Report Preparer Contact Information				
41	First name: MARK	Last name: DALLAS	Title: PARTNER	41
42	Employer: KERBER, ECK & BRAECKEL, LLP			42
43	Phone number: 618-529-1040	E-mail Address: MARKD@KEBCPA.COM		43

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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			Total All Patients	
						Title V	Title XVIII	Title XIX		
		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			2,272	720	3,795	1
2	HMO and other (see instructions)						145	139		2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF						317			5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		39	14,235			2,589	720	4,121	7
8	Intensive Care Unit	31	8	2,920			757	28	822	8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	Other Special Care (specify)	35								12
13	Nursery	43						318	580	13
14	Total (see instructions)		47	17,155			3,346	1,066	5,523	14
15	CAH Visits									15
16	Subprovider - IPF	40	10	3,650			584	1,176	2,288	16
17	Subprovider - IRF	41								17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44	34	12,410			2,981		10,077	19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101					9,250		11,249	22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116	1	365						24
24.10	Hospice (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88							877	26
27	Total (sum of lines 14-26)		92							27
28	Observation Bed Days							205	983	28
29	Ambulance Trips						1,004			29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)									32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	Component	Full Time Equivalents			DISCHARGES				
		Total Interns & Residents 9	Employees On Payroll 10	Nonpaid Workers 11	Title V 12	Title XVIII 13	Title XIX 14	Total All Patients 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)					762	312	1,434	1
2	HMO and other (see instructions)					40			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)		398.85			762	312	1,434	14
15	CAH Visits								15
16	Subprovider - IPF		17.37			116	321	565	16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility		30.52						19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency		14.86						22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)		4.74						24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC		1.79						26
27	Total (sum of lines 14-26)		468.13						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	Reclassification 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	22,289,627		22,289,627	969,993.00	22.98	1
2							2
3		962,282		962,282	9,560.00	100.66	3
4							4
4.01							4.01
5							5
6							6
7	21						7
7.01							7.01
8							8
9	44	1,084,416		1,084,416	63,478.00	17.08	9
10		5,813,492	-53,428	5,760,064	201,480.00	28.59	10
OTHER WAGES & RELATED COSTS							
11		266,819		266,819	4,072.00	65.53	11
12							12
13							13
14							14
15							15
16							16
WAGE-RELATED COSTS							
17		5,827,653		5,827,653			17
18		160,567		160,567			18
19		2,184,634		2,184,634			19
20							20
21		204,978		204,978			21
22							22
22.01							22.01
23							23
24							24
25							25
OVERHEAD COSTS - DIRECT SALARIES							
26		229,370		229,370	8,678.00	26.43	26
27		2,082,819		2,082,819	105,151.00	19.81	27
28		36,000		36,000	425.00	84.71	28
29		528,747		528,747	26,544.00	19.92	29
30							30
31		257,425		257,425	20,276.00	12.70	31
32		344,110		344,110	35,041.00	9.82	32
33							33
34		537,634	-395,323	142,311	14,465.00	9.84	34
35							35
36			395,323	395,323	40,180.00	9.84	36
37							37
38		1,214,701		1,214,701	41,173.00	29.50	38
39		71,421		71,421	6,402.00	11.16	39
40		464,842		464,842	14,915.00	31.17	40
41		542,062		542,062	32,043.00	16.92	41
42							42
43							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)	21,363,345		21,363,345	960,858.00	22.23	1
2	Excluded area salaries (see instructions)	6,897,908	-53,428	6,844,480	264,958.00	25.83	2
3	Subtotal salaries (line 1 minus line 2)	14,465,437	53,428	14,518,865	695,900.00	20.86	3
4	Subtotal other wages & related costs (see instructions)	266,819		266,819	4,072.00	65.53	4
5	Subtotal wage-related costs (see instructions)	5,988,220		5,988,220		41.24%	5
6	Total (sum of lines 3 through 5)	20,720,476	53,428	20,773,904	699,972.00	29.68	6
7	Total overhead cost (see instructions)	6,309,131		6,309,131	345,293.00	18.27	7

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HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

Part IV - Wage Related Cost

Part A - Core List

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions	658,676	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)	5,606,091	8
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan		10
11	Life Insurance (If employee is owner or beneficiary)		11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)		13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	261,669	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	1,228,740	17
18	Medicare Taxes - Employers Portion Only	287,366	18
19	Unemployment Insurance	1,200	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	82,958	23
24	Total Wage Related cost (Sum of lines 1-23)	8,126,700	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)	251,132	25
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WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3, Part IV, Line 4)

EXHIBIT 3

STEP 1: 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) 11
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	495,997		1
2	Hospital	272,498		2
3	Subprovider - IPF	180,749		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	12,750		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		4,926		306	5,232	1
2	Unduplicated Census Count (see instructions)		319.00	48.00	53.00	420.00	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 1	Contract 2	Total 3	
3	Administrator and Assistant Administrator(s)				3
4	Director(s) and Assistant Director(s)		1.00		1.00
5	Other Administrative Personnel		0.90		0.90
6	Direct Nursing Service		11.83		11.83
7	Nursing Supervisor		1.48		1.48
8	Physical Therapy Service				
9	Physical Therapy Supervisor				
10	Occupational Therapy Service				
11	Occupational Therapy Supervisor				
12	Speech Pathology Service				
13	Speech Pathology Supervisor				
14	Medical Social Service		0.08		0.08
15	Medical Social Service Supervisor				
16	Home Health Aide		2.52		2.52
17	Home Health Aide Supervisor				
18	Other (specify)				

HOME HEALTH AGENCY CBSA CODES

19	Enter the number of CBSAs where you provided services during the cost reporting period.		1	19
20	List those CBSA code(s) serviced during this cost reporting period (line 20 contains the first code).		99914	20

PPS ACTIVITY

		Full Episodes		LUPA Episodes	PEP only Episodes	Total (columns 1 through 4)	
		Without Outliers	With Outliers				
		1	2	3	4	5	
21	Skilled Nursing Visits	4,098	1,214	130	41	5,483	21
22	Skilled Nursing Visit Charges	996,925	294,902	31,671	10,003	1,333,501	22
23	Physical Therapy Visits	1,982	106	18	29	2,135	23
24	Physical Therapy Visit Charges	483,529	25,673	4,405	7,097	520,704	24
25	Occupational Therapy Visits	261	24		2	287	25
26	Occupational Therapy Visit Charges	63,237	5,646		488	69,371	26
27	Speech Pathology Visits	57		4		61	27
28	Speech Pathology Visit Charges	13,872		976		14,848	28
29	Medical Social Service Visits	34	8		2	44	29
30	Medical Social Service Visit Charges	11,443	2,647		678	14,768	30
31	Home Health Aide Visits	1,118	107		15	1,240	31
32	Home Health Aide Visit Charges	157,983	14,969		2,131	175,083	32
33	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	7,550	1,459	152	89	9,250	33
34	Other Charges						34
35	Total Charges (sum of lines 22, 24, 26, 28, 30, 32 and 34)	1,726,989	343,837	37,052	20,397	2,128,275	35
36	Total Number of Episodes (standard/non-outlier)	437		52	7	496	36
37	Total Number of Ourlier Episodes		33			33	37
38	Total Non-Routine Medical Supply Charges	73,239	36,567	4,340	226	114,372	38

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HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

WORKSHEET S-5

RENAL DIALYSIS STATISTICS

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

ESRD PPS

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

TRANSPLANT INFORMATION

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

EPOETIN

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

ARANESP

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

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

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

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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 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				5
6	RVL	27		27	6
7	RHX				7
8	RHL		7	7	8
9	RMX				9
10	RML	43		43	10
11	RLX				11
12	RUC	55		55	12
13	RUB	112		112	13
14	RUA	72		72	14
15	RVC	576		576	15
16	RVB	259		259	16
17	RVA	929	11	940	17
18	RHC	168	17	185	18
19	RHB				19
20	RHA	263	41	304	20
21	RMC	100	5	105	21
22	RMB	47	6	53	22
23	RMA	25	43	68	23
24	RLB				24
25	RLA				25
26	ES3				26
27	ES2				27
28	ES1		42	42	28
29	HE2				29
30	HE1	35	9	44	30
31	HD2				31
32	HD1		15	15	32
33	HC2				33
34	HC1	42	1	43	34
35	HB2				35
36	HB1	14	7	21	36
37	LE2				37
38	LE1	30		30	38
39	LD2				39
40	LD1	40	3	43	40
41	LC2				41
42	LC1				42
43	LB2				43
44	LB1		2	2	44
45	CE2				45
46	CE1	21	4	25	46
47	CD2				47
48	CD1	34	10	44	48
49	CC2				49
50	CC1	6	9	15	50
51	CB2				51
52	CB1	28	21	49	52
53	CA2				53
54	CA1	2	57	59	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	12	2	14	66
67	BA2				67
68	BA1				68
69	PE2				69
70	PE1	14		14	70
71	PD2				71

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PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

WORKSHEET S-7

	Group	SNF Days 2	Swing Bed SNF Days 3	Total (sum of col. 2 + 3) 4	
	1				
72	PD1				72
73	PC2				73
74	PC1				74
75	PB2				75
76	PB1	11		11	76
77	PA2				77
78	PA1	11	5	16	78
199	AAA	5		5	199
200	TOTAL	2,981	317	3,298	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	1,537,894	61.48%	Y	202
203	Recruitment				203
204	Retention of employees				204
205	Training	5,403	0.22%	Y	205
206	Other (specify)				206
207	Total SNF Revenue (Worksheet G-2, Part I, line 7, column 3)	2,501,330			207

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HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER
STATISTICAL DATA

COMPONENT CCN: 14-8548

WORKSHEET S-8

Check applicable box: RHC FQHC

Clinic Address and Identification:

1	Street: 100 SOUTH MAIN	1
2	City: WEST SALEM State: IL ZIP Code: 62476 County:	2
3	FQHCs ONLY: Designation - Enter 'R' for rural or 'U' for urban	3

Source of Federal Funds:

		Grant Award	Date	
		1	2	
4	Community Health Center (Section 330(d), PHS Act)			4
5	Migrant Health Center (Section 329(d), PHS Act)			5
6	Health Services for the Homeless (Section 340(d), PHS)			6
7	Appalachian Regional Commission			7
8	Look-alikes			8
9	Other (specify)			9

10	Does this facility operate as other than an RHC or FQHC? Enter 'Y' for yes or 'N' for no in column 1. If yes, indicate the number of other operations in column 2.	1 N	2 10
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Facility hours of operations (1)

	Type Operation	Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		
		from	to	from	to	from	to	from	to	from	to	from	to			
11	Clinic	0														11

(1) Enter clinic hours of operation on line 11 and other type operations on subscripts of line 11 (both type and hours of operation). List hours of operation based on a 24 hour clock. For example: 8:00am is 0800, 6:30pm is 1830, and midnight is 2400.

12	Have you received an approval for an exception to the productivity standard?	1 N	2 12
13	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter in column 2 the number of providers included in this cost report. List the names of all providers and numbers below.	1 N	2 13
14	Provider name: _____ CCN number: _____		14

		Y/N	V	XVIII	XIX	Total Visits	
		1	2	3	4	5	
15	Have you provided all or substantially all GME cost? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter in columns 2, 3, and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15

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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	3,858	22			241	4,121	2
3	Inpatient Respite Care					7	7	3
4	General Inpatient Care							4
5	Total Hospice Days	3,858	22			248	4,128	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	92	3			12	107	6
7	Total Number of Unduplicated Continuous Care Hours Billable to Medicare							7
8	Average Length of Stay (line 5/line 6)	41.93	7.33			20.67	38.58	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)	0.239983	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid	2,460,428	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	34,761,450	6
7	Medicaid cost (line 1 times line 6)	8,342,157	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.	5,881,729	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 care (see instructions for each line)

17	Private grants, donations, or endowment income restricted to fundng 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)	5,881,729	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	1,096,725	416,952	1,513,677	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	263,195	100,061	363,256	21
22	Partial payment by patients approved for charity care	7,582	24,719	32,301	22
23	Cost of charity care (line 21 minus line 22)	255,613	75,342	330,955	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)		26	
27	Medicare bad debts for the entire hospital complex (see instructions)		281,079	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		-281,079	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		-67,454	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)		263,501	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		6,145,230	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		552,429	552,429	363,830	916,259	-278,954	637,305	1
2	00200	Cap Rel Costs-Mvble Equip		1,299,230	1,299,230	20,223	1,319,453		1,319,453	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	229,370	8,485,653	8,715,023		8,715,023	-232,007	8,483,016	4
5	00500	Administrative & General	2,082,819	4,227,522	6,310,341	-73,683	6,236,658	-2,265,056	3,971,602	5
6	00600	Maintenance & Repairs	528,747	384,666	913,413		913,413		913,413	6
7	00700	Operation of Plant		466,034	466,034		466,034		466,034	7
8	00800	Laundry & Linen Service	257,425	98,769	356,194		356,194	-192,457	163,737	8
9	00900	Housekeeping	344,110	172,667	516,777		516,777		516,777	9
10	01000	Dietary	537,634	823,111	1,360,745	-997,988	362,757		362,757	10
11	01100	Cafeteria				997,988	997,988	-283,894	714,094	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	1,214,701	166,010	1,380,711		1,380,711		1,380,711	13
14	01400	Central Services & Supply	71,421	14,944	86,365		86,365	-9,662	76,703	14
15	01500	Pharmacy	464,842	1,895,291	2,360,133		2,360,133	-93	2,360,040	15
16	01600	Medical Records & Library	542,062	190,183	732,245		732,245	-1,088	731,157	16
17	01700	Social Service								17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	Paramed Ed Prgm-(specify)								23
INPATIENT ROUTINE SERVICE COST CENTERS										
30	03000	Adults & Pediatrics	1,824,546	123,214	1,947,760		1,947,760	-105	1,947,655	30
31	03100	Intensive Care Unit	655,754	33,750	689,504		689,504		689,504	31
40	04000	Subprovider - IPF	684,579	209,004	893,583		893,583	-124,965	768,618	40
43	04300	Nursery	236,049	13,910	249,959		249,959		249,959	43
44	04400	Skilled Nursing Facility	1,084,416	115,087	1,199,503		1,199,503		1,199,503	44
ANCILLARY SERVICE COST CENTERS										
50	05000	Operating Room	710,497	345,511	1,056,008		1,056,008		1,056,008	50
53	05300	Anesthesiology	962,282	28,017	990,299		990,299	-971,202	19,097	53
54	05400	Radiology-Diagnostic	666,759	253,197	919,956		919,956		919,956	54
56	05600	Radioisotope	81,462	44,947	126,409		126,409		126,409	56
57	05700	CT Scan	106,861	160,243	267,104		267,104		267,104	57
58	05800	MRI		306,225	306,225		306,225		306,225	58
60	06000	Laboratory	1,097,616	1,394,817	2,492,433		2,492,433	-19,458	2,472,975	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	06400	Intravenous Therapy		39,834	39,834		39,834		39,834	64
65	06500	Respiratory Therapy	371,515	11,702	383,217		383,217		383,217	65
66	06600	Physical Therapy	1,520,713	63,172	1,583,885		1,583,885		1,583,885	66
68	06800	Speech Pathology	157,556	6,089	163,645		163,645		163,645	68
69	06900	Electrocardiology		159,550	159,550		159,550		159,550	69
71	07100	Medical Supplies Charged to Patients		1,845,298	1,845,298	-269,296	1,576,002		1,576,002	71
72	07200	Impl. Dev. Charged to Patients				269,296	269,296		269,296	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										
88	08800	Rural Health Clinic				58,734	58,734		58,734	88
91	09100	Emergency	726,978	941,618	1,668,596		1,668,596	-438,235	1,230,361	91
92	09200	Observation Beds (Non-Distinct Part)								92
OTHER REIMBURSABLE COST CENTERS										
95	09500	Ambulance Services	506,520	145,423	651,943		651,943		651,943	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	699,668	147,924	847,592		847,592		847,592	101
SPECIAL PURPOSE COST CENTERS										
113	11300	Interest Expense		310,370	310,370	-310,370				113
116	11600	Hospice	201,625	142,113	343,738		343,738		343,738	116
118		SUBTOTALS (sum of lines 1-117)	18,568,527	25,617,524	44,186,051	58,734	44,244,785	-4,817,176	39,427,609	118
NONREIMBURSABLE COST CENTERS										
192	19200	Physicians' Private Offices	3,699,264	532,450	4,231,714	-58,734	4,172,980		4,172,980	192
194	07950	OTHER NONREIMBURSABLE								194
194.01	07952	MEMORY DISORDER	21,836	715	22,551		22,551		22,551	194.01
194.02	07953	ASSISTED LIVING								194.02
200		TOTAL (sum of lines 118-199)	22,289,627	26,150,689	48,440,316		48,440,316	-4,817,176	43,623,140	200

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RECLASSIFICATIONS

WORKSHEET A-6

		INCREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	RECLASS CAFETERIA	A	Cafeteria	11	395,323	602,665	1
500	Total reclassifications				395,323	602,665	500
	Code Letter - A						
1	INTEREST EXPENSE	B	Cap Rel Costs-Bldg & Fixt	1		310,370	1
500	Total reclassifications					310,370	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		269,296	1
500	Total reclassifications					269,296	500
	Code Letter - D						
1	RECLASS RHC EXPENSES	E	Rural Health Clinic	88	53,428	5,306	1
500	Total reclassifications				53,428	5,306	500
	Code Letter - E						
	GRAND TOTAL (Increases)				448,751	1,261,320	

(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	395,323	602,665	1	
500	Total reclassifications				395,323	602,665	500	
	Code letter - A							
1	INTEREST EXPENSE	B	Interest Expense	113		310,370	11	
500	Total reclassifications					310,370	500	
	Code letter - B							
1	OTHER CAPITAL RELATED	C	Administrative & General	5		73,683	12	
2							12	
500	Total reclassifications					73,683	500	
	Code letter - C							
1	RECLASS MEDICAL SUPPLIES	D	Medical Supplies Charged to P	71		269,296	1	
500	Total reclassifications					269,296	500	
	Code letter - D							
1	RECLASS RHC EXPENSES	E	Physicians' Private Offices	192	53,428	5,306	1	
500	Total reclassifications				53,428	5,306	500	
	Code letter - E							
	GRAND TOTAL (Decreases)				448,751	1,261,320		

(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				125,475	385,022	2
3	Buildings and Fixtures	14,715,803	794,842		794,842	58,969	15,451,676	3
4	Building Improvements	9,603,972				45,716	9,558,256	4
5	Fixed Equipment	2,427,266				72,093	2,355,173	5
6	Movable Equipment	16,785,748	1,717,307		1,717,307	2,374,339	16,128,716	6
7	HIT-designated Assets	770,870	124,799		124,799		895,669	7
8	Subtotal (sum of lines 1-7)	44,854,139	2,636,948		2,636,948	2,676,592	44,814,495	8
9	Reconciling Items							9
10	Total (line 7 minus line 9)	44,854,139	2,636,948		2,636,948	2,676,592	44,814,495	10

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

	Description	SUMMARY OF CAPITAL							Total (1) (sum of cols. 9 through 14)
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)		
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	552,429						552,429	1
2	Cap Rel Costs-Mvble Equip	1,299,230						1,299,230	2
3	Total (sum of lines 1-2)	1,851,659						1,851,659	3

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

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL			
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)
*		1	2	3	4	5	6	7	8
1	Cap Rel Costs-Bldg & Fi	27,790,110		27,790,110	0.620114				1
2	Cap Rel Costs-Mvble Equip	17,024,385		17,024,385	0.379886				2
3	Total (sum of lines 1-2)	44,814,495		44,814,495	1.000000				3

	Description	SUMMARY OF CAPITAL							Total (2) (sum of cols. 9 through 14)
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)		
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	552,429		31,416	53,460			637,305	1
2	Cap Rel Costs-Mvble Equip	1,299,230			20,223			1,319,453	2
3	Total (sum of lines 1-2)	1,851,659		31,416	73,683			1,956,758	3

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

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.
		1	2	3	4	5
1	Investment income-buildings & fixtures (chapter 2)	B	-278,954	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	-5,246	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	-18,605	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	-582,658			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	-192,457	Laundry & Linen Service	8	13
14	Cafeteria - employees and guests	B	-236,656	Cafeteria	11	14
15	Rental of quarters to employees & others					15
16	Sale of medical and surgical supplies to other than patients	B	-9,662	Central Services & Supply	14	16
17	Sale of drugs to other than patients	B	-93	Pharmacy	15	17
18	Sale of medical records and abstracts	B	-1,088	Medical Records & Library	16	18
19	Nursing school (tuition, fees, books, etc.)					19
20	Vending machines	B	-13,190	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					32
33	SPECIAL FUNCTIONS	B	-34,048	Cafeteria	11	33
34	GUEST ROOM	B	-105	Adults & Pediatrics	30	34
35	MISC INCOME	B	-441	Administrative & General	5	35
36	RETURNED CHECKS	B	277	Administrative & General	5	36
37	DIETARY CONSULTATION	B	1	Administrative & General	5	37
38	PHYSICIAN RECRUITMENT	A	-146,972	Administrative & General	5	38
39	CRNA SALARIES	A	-962,282	Anesthesiology	53	39
40	CRNA CONTRACT SERVICES	A	-8,920	Anesthesiology	53	40
41	CRNA BENEFITS	A	-204,978	Employee Benefits Department	4	41
42	LOBBYING DUES	A	-21,130	Administrative & General	5	42
43	FOUNDATION SALARIES	A	-71,130	Administrative & General	5	43
44	FOUNDATION BENEFITS	A	-27,029	Employee Benefits Department	4	44
45	FOUNDATION OTHER	A	-7,932	Administrative & General	5	45
46	ADVERTISING	A	-311,960	Administrative & General	5	46
47	PROVIDER TAX ASSESSMENT	A	-1,592,595	Administrative & General	5	47
48	RENTAL INCOME	A	-4,000	Administrative & General	5	48
49	HHA VEHICLE REIMBURSEMENT	B	-1,500	Administrative & General	5	49
49.01	MISC PATIENT REVENUE	B	-43,873	Administrative & General	5	49.01
49.03	INTEREST RECEIPTS	B	-39,950	Administrative & General	5	49.03
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-4,817,176			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	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	40	Subprovider - IPF AGGREGATE	180,750	84,750	96,000	181,300	640	55,785	2,789	1
2	60	Laboratory AGGREGATE	97,290	19,458	77,832	260,300	1,248	156,180	7,809	2
3	91	Emergency AGGREGATE	438,235	438,235		211,500				3
4	44	Skilled Nursing Faci AGGREGATE				211,500				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	716,275	542,443	173,832		1,888	211,965	10,598	200

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	40	Subprovider - IPF	AGGREGATE				55,785	40,215	124,965	1
2	60	Laboratory	AGGREGATE				156,180		19,458	2
3	91	Emergency	AGGREGATE						438,235	3
4	44	Skilled Nursing Faci	AGGREGATE							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					211,965	40,215	582,658	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 BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINISTRATIVE & GENERAL	
		0	1	2	4	4A	5	
GENERAL SERVICE COST CENTERS								
1	Cap Rel Costs-Bldg & Fixt	637,305	637,305					1
2	Cap Rel Costs-Mvble Equip	1,319,453		1,319,453				2
4	Employee Benefits Department	8,483,016	2,031	158	8,485,205			4
5	Administrative & General	3,971,602	61,593	290,368	807,127	5,130,690	5,130,690	5
6	Maintenance & Repairs	913,413	8,403	96,753	213,501	1,232,070	164,224	6
7	Operation of Plant	466,034	29,228			495,262	66,014	7
8	Laundry & Linen Service	163,737	12,053	20,024	103,945	299,759	39,955	8
9	Housekeeping	516,777	1,371	537	138,947	657,632	87,656	9
10	Dietary	362,757	25,286	3,141	57,463	448,647	59,801	10
11	Cafeteria	714,094	7,173	8,942	159,626	889,835	118,607	11
12	Maintenance of Personnel							12
13	Nursing Administration	1,380,711	25,080	117,691	490,480	2,013,962	268,443	13
14	Central Services & Supply	76,703	17,766	23,969	28,839	147,277	19,631	14
15	Pharmacy	2,360,040	9,608	93,605	187,697	2,650,950	353,348	15
16	Medical Records & Library	731,157	7,466	5,413	218,878	962,914	128,348	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
INPATIENT ROUTINE SERV COST CENTERS								
30	Adults & Pediatrics	1,947,655	100,299	67,364	736,728	2,852,046	380,152	30
31	Intensive Care Unit	689,504	23,378	20,554	264,785	998,221	133,054	31
40	Subprovider - IPF	768,618	27,518	453	276,424	1,073,013	143,023	40
43	Nursery	249,959	3,304	2,965	95,314	351,542	46,857	43
44	Skilled Nursing Facility	1,199,503	33,675	6,225	437,873	1,677,276	223,566	44
ANCILLARY SERVICE COST CENTERS								
50	Operating Room	1,056,008	38,958	89,881	286,889	1,471,736	196,169	50
53	Anesthesiology	19,097	231	18,523	37,851	37,851	5,045	53
54	Radiology-Diagnostic	919,956	28,164	233,351	269,229	1,450,700	193,365	54
56	Radioisotope	126,409	2,507	23,587	32,893	185,396	24,712	56
57	CT Scan	267,104	2,499	22,375	43,149	335,127	44,669	57
58	MRI	306,225				306,225	40,817	58
60	Laboratory	2,472,975	26,321	25,730	443,203	2,968,229	395,638	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy	39,834				39,834	5,310	64
65	Respiratory Therapy	383,217	3,030	5,249	150,013	541,509	72,178	65
66	Physical Therapy	1,583,885	19,234	9,440	614,044	2,226,603	296,786	66
68	Speech Pathology	163,645	747	272	63,619	228,283	30,428	68
69	Electrocardiology	159,550	1,298	1,529		162,377	21,643	69
71	Medical Supplies Charged to Patients	1,576,002				1,576,002	210,067	71
72	Impl. Dev. Charged to Patients	269,296				269,296	35,895	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								
88	Rural Health Clinic	58,734	822	711	21,574	81,841	10,909	88
91	Emergency	1,230,361	12,306	74,682	293,544	1,610,893	214,718	91
92	Observation Beds (Non-Distinct Part)							92
OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	651,943	17,853	47,672	204,526	921,994	122,894	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	847,592	4,808	92	282,517	1,135,009	151,286	101
SPECIAL PURPOSE COST CENTERS								
113	Interest Expense							113
116	Hospice	343,738	4,808	558	81,414	430,518	57,384	116
118	SUBTOTALS (sum of lines 1-117)	39,427,609	558,818	1,311,814	7,004,241	37,860,519	4,362,592	118
NONREIMBURSABLE COST CENTERS								
192	Physicians' Private Offices	4,172,980	77,953	7,581	1,472,147	5,730,661	763,838	192
194	OTHER NONREIMBURSABLE							194
194.01	MEMORY DISORDER	22,551	534	58	8,817	31,960	4,260	194.01
194.02	ASSISTED LIVING							194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	43,623,140	637,305	1,319,453	8,485,205	43,623,140	5,130,690	202

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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	1,396,294						6
7	Operation of Plant	72,196	633,472					7
8	Laundry & Linen Service	29,773	14,244	383,731				8
9	Housekeeping	3,385	1,620	24,560	774,853			9
10	Dietary	62,458	29,881	1,497		602,284		10
11	Cafeteria	17,719	8,477	4,259			1,038,897	11
12	Maintenance of Personnel							12
13	Nursing Administration	61,951	29,638		13,508		185,425	13
14	Central Services & Supply	43,884	20,995	5,368	9,166		24,797	14
15	Pharmacy	23,733	11,354		3,136		37,011	15
16	Medical Records & Library	18,441	8,822				44,413	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	247,759	118,533	99,034	205,673	158,281	127,318	30
31	Intensive Care Unit	57,746	27,627	34,117	31,438	27,677	34,420	31
40	Subprovider - IPF	67,973	32,519	11,023	55,318	77,034	38,861	40
43	Nursery	8,160	3,904	23,410	15,196		2,221	43
44	Skilled Nursing Facility	83,180	39,795	103,195	107,178	339,292	47,374	44
ANCILLARY SERVICE COST CENTERS								
50	Operating Room	96,231	46,039	36,206	70,675		60,698	50
53	Anesthesiology	570	273				4,811	53
54	Radiology-Diagnostic	69,567	33,282	6,714	32,242		44,043	54
56	Radioisotope	6,191	2,962	768	5,146		7,032	56
57	CT Scan	6,174	2,954		9,970		9,993	57
58	MRI							58
60	Laboratory	65,015	31,104	1,155	22,111		57,367	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy							64
65	Respiratory Therapy	7,483	3,580		2,895		37,381	65
66	Physical Therapy	47,510	22,729	5,948	71,962		66,990	66
68	Speech Pathology	1,844	882				9,993	68
69	Electrocardiology	3,207	1,534		4,503			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								
88	Rural Health Clinic	2,031	972	379				88
91	Emergency	30,396	14,542	23,797	40,041		38,491	91
92	Observation Beds (Non-Distinct Part)							92
OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	44,098	21,097	2,301	11,015		58,477	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	11,875	5,681		14,714		36,641	101
SPECIAL PURPOSE COST CENTERS								
113	Interest Expense							113
116	Hospice	11,875	5,681		14,634		19,246	116
118	SUBTOTALS (sum of lines 1-117)	1,202,425	540,721	383,731	740,521	602,284	993,003	118
NONREIMBURSABLE COST CENTERS								
192	Physicians' Private Offices	192,551	92,120		34,332		45,894	192
194	OTHER NONREIMBURSABLE							194
194.01	MEMORY DISORDER	1,318	631					194.01
194.02	ASSISTED LIVING							194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,396,294	633,472	383,731	774,853	602,284	1,038,897	202

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	NURSING ADMINISTRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 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	2,572,927						13
14	Central Services & Supply		271,118					14
15	Pharmacy			3,079,532				15
16	Medical Records & Library				1,162,938			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	716,502		1,240	365,746	5,272,284		30
31	Intensive Care Unit	212,246		75	21,727	1,578,348		31
40	Subprovider - IPF	286,117		27	39,316	1,824,224		40
43	Nursery	77,070			16,037	544,397		43
44	Skilled Nursing Facility	502,648		143	29,487	3,153,134		44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	217,876		1,662	38,282	2,235,574		50
53	Anesthesiology	75,700		29,256		153,506		53
54	Radiology-Diagnostic			387		1,830,300		54
56	Radioisotope			99		232,306		56
57	CT Scan					408,887		57
58	MRI					347,042		58
60	Laboratory			201	5,173	3,545,993		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy			77,059		122,203		64
65	Respiratory Therapy			80,501		745,527		65
66	Physical Therapy			1,298		2,739,826		66
68	Speech Pathology					271,430		68
69	Electrocardiology					193,264		69
71	Medical Supplies Charged to Patients		222,317			2,008,386		71
72	Impl. Dev. Charged to Patients		48,801			353,992		72
73	Drugs Charged to Patients			2,835,802		2,835,802		73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic			621		96,753		88
91	Emergency	240,856		1,826	76,046	2,291,606		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	243,912		8,407	517	1,434,712		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			350		1,355,556		101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice					539,338		116
118	SUBTOTALS (sum of lines 1-117)	2,572,927	271,118	3,038,954	592,331	36,114,390		118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices			40,578	570,607	7,470,581		192
194	OTHER NONREIMBURSABLE							194
194.01	MEMORY DISORDER					38,169		194.01
194.02	ASSISTED LIVING							194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	2,572,927	271,118	3,079,532	1,162,938	43,623,140		202

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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	5,272,284					30
31	Intensive Care Unit	1,578,348					31
40	Subprovider - IPF	1,824,224					40
43	Nursery	544,397					43
44	Skilled Nursing Facility	3,153,134					44
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	2,235,574					50
53	Anesthesiology	153,506					53
54	Radiology-Diagnostic	1,830,300					54
56	Radioisotope	232,306					56
57	CT Scan	408,887					57
58	MRI	347,042					58
60	Laboratory	3,545,993					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	Intravenous Therapy	122,203					64
65	Respiratory Therapy	745,527					65
66	Physical Therapy	2,739,826					66
68	Speech Pathology	271,430					68
69	Electrocardiology	193,264					69
71	Medical Supplies Charged to Patients	2,008,386					71
72	Impl. Dev. Charged to Patients	353,992					72
73	Drugs Charged to Patients	2,835,802					73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	96,753					88
91	Emergency	2,291,606					91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services	1,434,712					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	1,355,556					101
	SPECIAL PURPOSE COST CENTERS						
113	Interest Expense						113
116	Hospice	539,338					116
118	SUBTOTALS (sum of lines 1-117)	36,114,390					118
	NONREIMBURSABLE COST CENTERS						
192	Physicians' Private Offices	7,470,581					192
194	OTHER NONREIMBURSABLE						194
194.01	MEMORY DISORDER	38,169					194.01
194.02	ASSISTED LIVING						194.02
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	43,623,140					202

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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		2,031	158	2,189	2,189		4
5	Administrative & General	5,004	61,593	290,368	356,965	208	357,173	5
6	Maintenance & Repairs		8,403	96,753	105,156	55	11,432	6
7	Operation of Plant		29,228		29,228		4,596	7
8	Laundry & Linen Service		12,053	20,024	32,077	27	2,781	8
9	Housekeeping		1,371	537	1,908	36	6,102	9
10	Dietary		25,286	3,141	28,427	15	4,163	10
11	Cafeteria		7,173	8,942	16,115	41	8,257	11
12	Maintenance of Personnel							12
13	Nursing Administration		25,080	117,691	142,771	126	18,688	13
14	Central Services & Supply		17,766	23,969	41,735	7	1,367	14
15	Pharmacy		9,608	93,605	103,213	48	24,598	15
16	Medical Records & Library		7,466	5,413	12,879	56	8,935	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	2,195	100,299	67,364	169,858	190	26,464	30
31	Intensive Care Unit	529	23,378	20,554	44,461	68	9,262	31
40	Subprovider - IPF		27,518	453	27,971	71	9,956	40
43	Nursery		3,304	2,965	6,269	25	3,262	43
44	Skilled Nursing Facility	7,702	33,675	6,225	47,602	113	15,563	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	166,122	38,958	89,881	294,961	74	13,656	50
53	Anesthesiology		231	18,523	18,754		351	53
54	Radiology-Diagnostic		28,164	233,351	261,515	69	13,461	54
56	Radioisotope		2,507	23,587	26,094	8	1,720	56
57	CT Scan		2,499	22,375	24,874	11	3,110	57
58	MRI						2,841	58
60	Laboratory	32,518	26,321	25,730	84,569	114	27,542	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy						370	64
65	Respiratory Therapy	6,000	3,030	5,249	14,279	39	5,025	65
66	Physical Therapy		19,234	9,440	28,674	158	20,661	66
68	Speech Pathology		747	272	1,019	16	2,118	68
69	Electrocardiology		1,298	1,529	2,827		1,507	69
71	Medical Supplies Charged to Patients						14,624	71
72	Impl. Dev. Charged to Patients						2,499	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							
88	Rural Health Clinic		822	711	1,533	6	759	88
91	Emergency		12,306	74,682	86,988	76	14,947	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	2,270	17,853	47,672	67,795	53	8,555	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	28,102	4,808	92	33,002	73	10,532	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice	41,190	4,808	558	46,556	21	3,995	116
118	SUBTOTALS (sum of lines 1-117)	291,632	558,818	1,311,814	2,162,264	1,804	303,699	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		77,953	7,581	85,534	383	53,177	192
194	OTHER NONREIMBURSABLE							194
194.01	MEMORY DISORDER		534	58	592	2	297	194.01
194.02	ASSISTED LIVING							194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	291,632	637,305	1,319,453	2,248,390	2,189	357,173	202

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	MAINTENANC E & REPAIR S	OPERATION OF PLANT	LAUNDRY & LINEN SERV ICE	HOUSEKEEPI NG	DIETARY	CAFETERIA	
		6	7	8	9	10	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	116,643						6
7	Operation of Plant	6,031	39,855					7
8	Laundry & Linen Service	2,487	896	38,268				8
9	Housekeeping	283	102	2,449	10,880			9
10	Dietary	5,218	1,880	149		39,852		10
11	Cafeteria	1,480	533	425			26,851	11
12	Maintenance of Personnel							12
13	Nursing Administration	5,175	1,865		190		4,794	13
14	Central Services & Supply	3,666	1,321	535	129		641	14
15	Pharmacy	1,983	714		44		957	15
16	Medical Records & Library	1,541	555				1,148	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	20,696	7,457	9,876	2,889	10,473	3,291	30
31	Intensive Care Unit	4,824	1,738	3,402	441	1,831	890	31
40	Subprovider - IPF	5,678	2,046	1,099	777	5,097	1,004	40
43	Nursery	682	246	2,335	213		57	43
44	Skilled Nursing Facility	6,949	2,504	10,291	1,505	22,451	1,224	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	8,039	2,897	3,611	992		1,569	50
53	Anesthesiology	48	17				124	53
54	Radiology-Diagnostic	5,811	2,094	670	453		1,138	54
56	Radioisotope	517	186	77	72		182	56
57	CT Scan	516	186		140		258	57
58	MRI							58
60	Laboratory	5,431	1,957	115	310		1,483	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy							64
65	Respiratory Therapy	625	225		41		966	65
66	Physical Therapy	3,969	1,430	593	1,010		1,731	66
68	Speech Pathology	154	56				258	68
69	Electrocardiology	268	97		63			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							
88	Rural Health Clinic	170	61	38				88
91	Emergency	2,539	915	2,373	562		995	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	3,684	1,327	230	155		1,511	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	992	357		207		947	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice	992	357		205		497	116
118	SUBTOTALS (sum of lines 1-117)	100,448	34,019	38,268	10,398	39,852	25,665	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	16,085	5,796		482		1,186	192
194	OTHER NONREIMBURSABLE							194
194.01	MEMORY DISORDER	110	40					194.01
194.02	ASSISTED LIVING							194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	116,643	39,855	38,268	10,880	39,852	26,851	202

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	NURSING ADMINISTRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 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	173,609						13
14	Central Services & Supply		49,401					14
15	Pharmacy			131,557				15
16	Medical Records & Library				25,114			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	48,347		53	7,898	307,492		30
31	Intensive Care Unit	14,321		3	469	81,710		31
40	Subprovider - IPF	19,306		1	849	73,855		40
43	Nursery	5,200			346	18,635		43
44	Skilled Nursing Facility	33,916		6	637	142,761		44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	14,701		71	827	341,398		50
53	Anesthesiology	5,108		1,250		25,652		53
54	Radiology-Diagnostic			17		285,228		54
56	Radioisotope			4		28,860		56
57	CT Scan					29,095		57
58	MRI					2,841		58
60	Laboratory			9	112	121,642		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy			3,292		3,662		64
65	Respiratory Therapy			3,439		24,639		65
66	Physical Therapy			55		58,281		66
68	Speech Pathology					3,621		68
69	Electrocardiology					4,762		69
71	Medical Supplies Charged to Patients		40,509			55,133		71
72	Impl. Dev. Charged to Patients		8,892			11,391		72
73	Drugs Charged to Patients			121,145		121,145		73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic			27		2,594		88
91	Emergency	16,252		78	1,642	127,367		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	16,458		359	11	100,138		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			15		46,125		101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice					52,623		116
118	SUBTOTALS (sum of lines 1-117)	173,609	49,401	129,824	12,791	2,070,650		118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices			1,733	12,323	176,699		192
194	OTHER NONREIMBURSABLE							194
194.01	MEMORY DISORDER					1,041		194.01
194.02	ASSISTED LIVING							194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	173,609	49,401	131,557	25,114	2,248,390		202

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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	307,492				30
31	Intensive Care Unit	81,710				31
40	Subprovider - IPF	73,855				40
43	Nursery	18,635				43
44	Skilled Nursing Facility	142,761				44
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room	341,398				50
53	Anesthesiology	25,652				53
54	Radiology-Diagnostic	285,228				54
56	Radioisotope	28,860				56
57	CT Scan	29,095				57
58	MRI	2,841				58
60	Laboratory	121,642				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
64	Intravenous Therapy	3,662				64
65	Respiratory Therapy	24,639				65
66	Physical Therapy	58,281				66
68	Speech Pathology	3,621				68
69	Electrocardiology	4,762				69
71	Medical Supplies Charged to Patients	55,133				71
72	Impl. Dev. Charged to Patients	11,391				72
73	Drugs Charged to Patients	121,145				73
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
88	Rural Health Clinic	2,594				88
91	Emergency	127,367				91
92	Observation Beds (Non-Distinct Part)					92
	OTHER REIMBURSABLE COST CENTERS					
95	Ambulance Services	100,138				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	46,125				101
	SPECIAL PURPOSE COST CENTERS					
113	Interest Expense					113
116	Hospice	52,623				116
118	SUBTOTALS (sum of lines 1-117)	2,070,650				118
	NONREIMBURSABLE COST CENTERS					
192	Physicians' Private Offices	176,699				192
194	OTHER NONREIMBURSABLE					194
194.01	MEMORY DISORDER	1,041				194.01
194.02	ASSISTED LIVING					194.02
200	Cross Foot Adjustments					200
201	Negative Cost Centers					201
202	TOTAL (sum of lines 118-201)	2,248,390				202

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	NEW CAP RE	NEW CAP RE	EMPLOYEE B	RECON-	ADMINISTRA	MAINTENANC	
		L COSTS-BL	L COSTS-MV	ENEFFITS		TIVE & GEN	E & REPAIR	
		DG & FIXT	BLE EQUIP	DEPARTMENT	CILATION	ERAL	S	
		SQUARE	DOLLAR	GROSS		ACCUM	SQUARE	
		FEET	VALUE -NEW	SALARIES		COST	FEET	
		1	2	4	5A	5	6	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	176,706						1
2	Cap Rel Costs-Mvble Equip		1,299,222					2
4	Employee Benefits Department	563	156	21,014,049				4
5	Administrative & General	17,078	285,915	1,998,892	-5,130,690	38,492,450		5
6	Maintenance & Repairs	2,330	95,269	528,747		1,232,070	156,735	6
7	Operation of Plant	8,104				495,262	8,104	7
8	Laundry & Linen Service	3,342	19,717	257,425		299,759	3,342	8
9	Housekeeping	380	529	344,110		657,632	380	9
10	Dietary	7,011	3,093	142,311		448,647	7,011	10
11	Cafeteria	1,989	8,805	395,323		889,835	1,989	11
12	Maintenance of Personnel							12
13	Nursing Administration	6,954	115,886	1,214,701		2,013,962	6,954	13
14	Central Services & Supply	4,926	23,601	71,421		147,277	4,926	14
15	Pharmacy	2,664	92,170	464,842		2,650,950	2,664	15
16	Medical Records & Library	2,070	5,330	542,062		962,914	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	66,331	1,824,546		2,852,046	27,811	30
31	Intensive Care Unit	6,482	20,239	655,754		998,221	6,482	31
40	Subprovider - IPF	7,630	446	684,579		1,073,013	7,630	40
43	Nursery	916	2,920	236,049		351,542	916	43
44	Skilled Nursing Facility	9,337	6,130	1,084,416		1,677,276	9,337	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	10,802	88,503	710,497		1,471,736	10,802	50
53	Anesthesiology	64	18,239			37,851	64	53
54	Radiology-Diagnostic	7,809	229,773	666,759		1,450,700	7,809	54
56	Radioisotope	695	23,225	81,462		185,396	695	56
57	CT Scan	693	22,032	106,861		335,127	693	57
58	MRI					306,225		58
60	Laboratory	7,298	25,335	1,097,616		2,968,229	7,298	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy					39,834		64
65	Respiratory Therapy	840	5,169	371,515		541,509	840	65
66	Physical Therapy	5,333	9,295	1,520,713		2,226,603	5,333	66
68	Speech Pathology	207	268	157,556		228,283	207	68
69	Electrocardiology	360	1,506			162,377	360	69
71	Medical Supplies Charged to Patients					1,576,002		71
72	Impl. Dev. Charged to Patients					269,296		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							
88	Rural Health Clinic	228	700	53,428		81,841	228	88
91	Emergency	3,412	73,537	726,978		1,610,893	3,412	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	4,950	46,941	506,520		921,994	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	91	699,668		1,135,009	1,333	101
	SPECIAL PURPOSE COST CENTERS							
116	Hospice	1,333	549	201,625		430,518	1,333	116
118	SUBTOTALS (sum of lines 1-117)	154,944	1,291,700	17,346,376	-5,130,690	32,729,829	134,973	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	21,614	7,465	3,645,837		5,730,661	21,614	192
194	OTHER NONREIMBURSABLE							194
194.01	MEMORY DISORDER	148	57	21,836		31,960	148	194.01
194.02	ASSISTED LIVING							194.02
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	637,305	1,319,453	8,485,205		5,130,690	1,396,294	202
203	Unit Cost Multiplier (Wkst. B, Part I)	3.606584	1.015572	0.403787		0.133291	8.908629	203
204	Cost to be allocated (Per Wkst. B, Part II)			2,189		357,173	116,643	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000104		0.009279	0.744205	205

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		SQUARE FEET	LAUNDRY POUNDS	HOURS OF SERVICE	DIETARY MEALS SERV	CAFE MEALS SERV	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	148,631						7
8	Laundry & Linen Service	3,342	495,392					8
9	Housekeeping	380	31,707	9,637				9
10	Dietary	7,011	1,932		86,784			10
11	Cafeteria	1,989	5,498			2,807		11
12	Maintenance of Personnel							12
13	Nursing Administration	6,954		168		501	324,928	13
14	Central Services & Supply	4,926	6,930	114		67		14
15	Pharmacy	2,664		39		100		15
16	Medical Records & Library	2,070				120		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	127,852	2,558	22,807	344	90,485	30
31	Intensive Care Unit	6,482	44,045	391	3,988	93	26,804	31
40	Subprovider - IPF	7,630	14,231	688	11,100	105	36,133	40
43	Nursery	916	30,222	189		6	9,733	43
44	Skilled Nursing Facility	9,337	133,222	1,333	48,889	128	63,478	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	10,802	46,741	879		164	27,515	50
53	Anesthesiology	64				13	9,560	53
54	Radiology-Diagnostic	7,809	8,668	401		119		54
56	Radioisotope	695	992	64		19		56
57	CT Scan	693		124		27		57
58	MRI							58
60	Laboratory	7,298	1,491	275		155		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy							64
65	Respiratory Therapy	840		36		101		65
66	Physical Therapy	5,333	7,679	895		181		66
68	Speech Pathology	207				27		68
69	Electrocardiology	360		56				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							
88	Rural Health Clinic	228	489					88
91	Emergency	3,412	30,722	498		104	30,417	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	4,950	2,971	137		158	30,803	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		183		99		101
	SPECIAL PURPOSE COST CENTERS							
116	Hospice	1,333		182		52		116
118	SUBTOTALS (sum of lines 1-117)	126,869	495,392	9,210	86,784	2,683	324,928	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	21,614		427		124		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 centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	633,472	383,731	774,853	602,284	1,038,897	2,572,927	202
203	Unit Cost Multiplier (Wkst. B, Part I)	4.262045	0.774601	80.403964	6.940035	370.109369	7.918453	203
204	Cost to be allocated (Per Wkst. B, Part II)	39,855	38,268	10,880	39,852	26,851	173,609	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.268147	0.077248	1.128982	0.459209	9.565729	0.534300	205

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY CS COSTED REQUIS 14	PHARMACY PHARM COSTED REQ 15	MEDICAL RECORDS & LIBRARY TIME SPENT 16				
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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 & Linsen 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		1,591,894					15
16	Medical Records & Library			2,248				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		641	707				30
31	Intensive Care Unit		39	42				31
40	Subprovider - IPF		14	76				40
43	Nursery			31				43
44	Skilled Nursing Facility		74	57				44
ANCILLARY SERVICE COST CENTERS								
50	Operating Room		859	74				50
53	Anesthesiology		15,123					53
54	Radiology-Diagnostic		200					54
56	Radioisotope		51					56
57	CT Scan							57
58	MRI							58
60	Laboratory		104	10				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy		39,834					64
65	Respiratory Therapy		41,613					65
66	Physical Therapy		671					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		1,465,903					73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic		321					88
91	Emergency		944	147				91
92	Observation Beds (Non-Distinct Part)							92
OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services		4,346	1				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		181					101
SPECIAL PURPOSE COST CENTERS								
116	Hospice							116
118	SUBTOTALS (sum of lines 1-117)	100	1,570,918	1,145				118
NONREIMBURSABLE COST CENTERS								
192	Physicians' Private Offices		20,976	1,103				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 centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	271,118	3,079,532	1,162,938				202
203	Unit Cost Multiplier (Wkst. B, Part I)	2,711.180000	1,934,508	517,321,174				203
204	Cost to be allocated (Per Wkst. B, Part II)	49,401	131,557	25,114				204

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY CS COSTED REQUIS	PHARMACY PHARM COSTED REQ	MEDICAL RECORDS & LIBRARY TIME SPENT				
		14	15	16				
205	Unit Cost Multiplier (Wkst. B, Part II)	494.010000	0.082642	11.171708				205

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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	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	COSTS			
				Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	5,272,284		5,272,284		5,272,284	30
31	Intensive Care Unit	1,578,348		1,578,348		1,578,348	31
40	Subprovider - IPF	1,824,224		1,824,224	40,215	1,864,439	40
43	Nursery	544,397		544,397		544,397	43
44	Skilled Nursing Facility	3,153,134		3,153,134		3,153,134	44
ANCILLARY SERVICE COST CENTERS							
50	Operating Room	2,235,574		2,235,574		2,235,574	50
53	Anesthesiology	153,506		153,506		153,506	53
54	Radiology-Diagnostic	1,830,300		1,830,300		1,830,300	54
56	Radioisotope	232,306		232,306		232,306	56
57	CT Scan	408,887		408,887		408,887	57
58	MRI	347,042		347,042		347,042	58
60	Laboratory	3,545,993		3,545,993		3,545,993	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	Intravenous Therapy	122,203		122,203		122,203	64
65	Respiratory Therapy	745,527		745,527		745,527	65
66	Physical Therapy	2,739,826		2,739,826		2,739,826	66
68	Speech Pathology	271,430		271,430		271,430	68
69	Electrocardiology	193,264		193,264		193,264	69
71	Medical Supplies Charged to Patients	2,008,386		2,008,386		2,008,386	71
72	Impl. Dev. Charged to Patients	353,992		353,992		353,992	72
73	Drugs Charged to Patients	2,835,802		2,835,802		2,835,802	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	96,753		96,753		96,753	88
91	Emergency	2,291,606		2,291,606		2,291,606	91
92	Observation Beds (Non-Distinct Part)	1,070,988		1,070,988		1,070,988	92
OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	1,434,712		1,434,712		1,434,712	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	1,355,556		1,355,556		1,355,556	101
113	Interest Expense						113
116	Hospice	539,338		539,338		539,338	116
200	Subtotal (sum of lines 30 thru 199)	37,185,378		37,185,378	40,215	37,225,593	200
201	Less Observation Beds	1,070,988		1,070,988		1,070,988	201
202	Total (line 200 minus line 201)	36,114,390		36,114,390		36,154,605	202

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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 SERVICE COST CENTERS							
30	Adults & Pediatrics	4,681,910		4,681,910				30
31	Intensive Care Unit	1,556,033		1,556,033				31
40	Subprovider - IPF	2,763,564		2,763,564				40
43	Nursery	591,487		591,487				43
44	Skilled Nursing Facility	2,501,330		2,501,330				44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	3,853,443	11,800,390	15,653,833	0.142813	0.142813	0.142813	50
53	Anesthesiology	1,137,985	10,628,079	11,766,064	0.013047	0.013047	0.013047	53
54	Radiology-Diagnostic	1,191,409	9,879,451	11,070,860	0.165326	0.165326	0.165326	54
56	Radioisotope	159,342	2,814,792	2,974,134	0.078109	0.078109	0.078109	56
57	CT Scan	1,466,960	12,417,589	13,884,549	0.029449	0.029449	0.029449	57
58	MRI	86,016	2,560,460	2,646,476	0.131134	0.131134	0.131134	58
60	Laboratory	3,676,051	21,979,000	25,655,051	0.138218	0.138218	0.138218	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy	791,210	263,793	1,055,003	0.115832	0.115832	0.115832	64
65	Respiratory Therapy	2,360,252	1,140,552	3,500,804	0.212959	0.212959	0.212959	65
66	Physical Therapy	3,282,872	6,831,163	10,114,035	0.270893	0.270893	0.270893	66
68	Speech Pathology	147,021	571,532	718,553	0.377745	0.377745	0.377745	68
69	Electrocardiology	307,737	2,376,839	2,684,576	0.071991	0.071991	0.071991	69
71	Medical Supplies Charged to Patients	2,257,829	2,951,148	5,208,977	0.385562	0.385562	0.385562	71
72	Impl. Dev. Charged to Patients	173,154	500,084	673,238	0.525805	0.525805	0.525805	72
73	Drugs Charged to Patients	4,692,795	7,173,128	11,865,923	0.238987	0.238987	0.238987	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		98,407	98,407				88
91	Emergency	1,421,112	8,597,312	10,018,424	0.228739	0.228739	0.228739	91
92	Observation Beds (Non-Distinct Part)	545,688	1,839,821	2,385,509	0.448956	0.448956	0.448956	92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	45,710	2,169,075	2,214,785	0.647788	0.647788	0.647788	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		2,886,396	2,886,396				101
113	Interest Expense							113
116	Hospice		1,317,549	1,317,549				116
200	Subtotal (sum of lines 30 thru 199)	39,690,910	110,796,560	150,487,470				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	39,690,910	110,796,560	150,487,470				202

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

	(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 SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	307,492	3,885	303,607	4,778	63.54	2,272	144,363	30
31	Intensive Care Unit	81,710		81,710	822	99.40	757	75,246	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	73,855		73,855	2,288	32.28	584	18,852	40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery	18,635		18,635	580	32.13			43
44	Skilled Nursing Facility	142,761		142,761	10,077	14.17	2,981	42,241	44
45	Nursing Facility								45
200	Total (lines 30-199)	624,453		620,568	18,545		6,594	280,702	200

(A) Worksheet A line numbers

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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	341,398	15,653,833	0.021809	1,130,263	24,650	50
53	Anesthesiology	25,652	11,766,064	0.002180	310,671	677	53
54	Radiology-Diagnostic	285,228	11,070,860	0.025764	1,080,208	27,830	54
56	Radioisotope	28,860	2,974,134	0.009704	104,280	1,012	56
57	CT Scan	29,095	13,884,549	0.002095	1,364,361	2,858	57
58	MRI	2,841	2,646,476	0.001074	45,809	49	58
60	Laboratory	121,642	25,655,051	0.004741	3,118,516	14,785	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	Intravenous Therapy	3,662	1,055,003	0.003471	296,374	1,029	64
65	Respiratory Therapy	24,639	3,500,804	0.007038	1,379,346	9,708	65
66	Physical Therapy	58,281	10,114,035	0.005762	462,935	2,667	66
68	Speech Pathology	3,621	718,553	0.005039	48,722	246	68
69	Electrocardiology	4,762	2,684,576	0.001774	290,385	515	69
71	Medical Supplies Charged to Pat	55,133	5,208,977	0.010584	871,489	9,224	71
72	Impl. Dev. Charged to Patients	11,391	673,238	0.016920	131,829	2,231	72
73	Drugs Charged to Patients	121,145	11,865,923	0.010209	2,289,600	23,375	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	2,594	98,407	0.026360			88
91	Emergency	127,367	10,018,424	0.012713	966,354	12,285	91
92	Observation Beds (Non-Distinct	63,262	2,385,509	0.026519	203,641	5,400	92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services						95
200	Total (sum of lines 50-199)	1,310,573	131,974,416		14,094,783	138,541	200

(A) Worksheet A line numbers

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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 Other

		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.)	
(A)	Cost Center Description	1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics General Routine Care)						30
31	Intensive Care Unit						31
32	Coronary Care Unit						32
33	Burn Intensive Care Unit						33
34	Surgical Intensive Care Unit						34
35	Other Special Care (specify)						35
40	Subprovider - IPF						40
41	Subprovider - IRF						41
42	Subprovider I						42
43	Nursery						43
44	Skilled Nursing Facility						44
45	Nursing Facility						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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 [] Other

	Cost Center Description	Total Patient Days	Per Diem (col. 5+ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)		6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	4,778		2,272		30
31	Intensive Care Unit	822		757		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	2,288		584		40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery	580				43
44	Skilled Nursing Facility	10,077		2,981		44
45	Nursing Facility					45
200	Total (lines 30-199)	18,545		6,594		200

(A) Worksheet A line numbers

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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/IID [XX] PPS
 Applicable [XX] Title XVIII, Part A [] IPF [] SNF [] TEFRA
 Boxes: [] Title XIX [] IRF [] NF [] Other

(A)	Cost Center Description	1	2	3	4	5	6	
		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)	
	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 Pat							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							
88	Rural Health Clinic							88
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services							95
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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/IID [XX] PPS
 Applicable [XX] Title XVIII, Part A [] IPF [] SNF [] TEFRA
 Boxes: [] Title XIX [] IRF [] NF [] Other

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5+ col. 7)	Outpatient Ratio of Cost to Charges (col. 6+ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	15,653,833			1,130,263		3,560,977		50
53	Anesthesiology	11,766,064			310,671		716,839		53
54	Radiology-Diagnostic	11,070,860			1,080,208		3,276,383		54
56	Radioisotope	2,974,134			104,280		1,418,143		56
57	CT Scan	13,884,549			1,364,361		4,175,112		57
58	MRI	2,646,476			45,809		763,927		58
60	Laboratory	25,655,051			3,118,516		3,281,809		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	1,055,003			296,374		201,577		64
65	Respiratory Therapy	3,500,804			1,379,346		655,327		65
66	Physical Therapy	10,114,035			462,935		7,356		66
68	Speech Pathology	718,553			48,722		30,620		68
69	Electrocardiology	2,684,576			290,385		966,405		69
71	Medical Supplies Charged to Pat	5,208,977			871,489		1,039,801		71
72	Impl. Dev. Charged to Patients	673,238			131,829		188,342		72
73	Drugs Charged to Patients	11,865,923			2,289,600		3,395,807		73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic	98,407							88
91	Emergency	10,018,424			966,354		2,249,654		91
92	Observation Beds (Non-Distinct	2,385,509			203,641		527,384		92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services								95
200	Total (sum of lines 50-199)	131,974,416			14,094,783		26,455,463		200

(A) Worksheet A line numbers

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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 [XX] Title XVIII, Part B [] IPF [] SNF [] Swing Bed NF
 Boxes: [] Title XIX - O/P [] IRF [] NF [] ICF/IID

(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	0.142813	3,560,977			508,554			50
53	Anesthesiology	0.013047	716,839			9,353			53
54	Radiology-Diagnostic	0.165326	3,276,383	38,100		541,671	6,299		54
56	Radioisotope	0.078109	1,418,143			110,770			56
57	CT Scan	0.029449	4,175,112			122,953			57
58	MRI	0.131134	763,927			100,177			58
60	Laboratory	0.138218	3,281,809	1,509		453,605	209		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	0.115832	201,577			23,349			64
65	Respiratory Therapy	0.212959	655,327			139,558			65
66	Physical Therapy	0.270893	7,356			1,993			66
68	Speech Pathology	0.377745	30,620			11,567			68
69	Electrocardiology	0.071991	966,405			69,572			69
71	Medical Supplies Charged to Pat	0.385562	1,039,801			400,908			71
72	Impl. Dev. Charged to Patients	0.525805	188,342			99,031			72
73	Drugs Charged to Patients	0.238987	3,395,807		34,662	811,554		8,284	73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
91	Emergency	0.228739	2,249,654			514,584			91
92	Observation Beds (Non-Distinct	0.448956	527,384			236,772			92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	0.647788							95
200	Subtotal (see instructions)		26,455,463	39,609	34,662	4,155,971	6,508	8,284	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		26,455,463	39,609	34,662	4,155,971	6,508	8,284	202

(A) Worksheet A line numbers

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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	341,398	15,653,833	0.021809			50
53	Anesthesiology	25,652	11,766,064	0.002180			53
54	Radiology-Diagnostic	285,228	11,070,860	0.025764	2,052	53	54
56	Radioisotope	28,860	2,974,134	0.009704			56
57	CT Scan	29,095	13,884,549	0.002095	17,621	37	57
58	MRI	2,841	2,646,476	0.001074	3,860	4	58
60	Laboratory	121,642	25,655,051	0.004741	95,198	451	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	Intravenous Therapy	3,662	1,055,003	0.003471	478	2	64
65	Respiratory Therapy	24,639	3,500,804	0.007038	15,526	109	65
66	Physical Therapy	58,281	10,114,035	0.005762	925	5	66
68	Speech Pathology	3,621	718,553	0.005039	2,693	14	68
69	Electrocardiology	4,762	2,684,576	0.001774	3,337	6	69
71	Medical Supplies Charged to Pat	55,133	5,208,977	0.010584	3,867	41	71
72	Impl. Dev. Charged to Patients	11,391	673,238	0.016920			72
73	Drugs Charged to Patients	121,145	11,865,923	0.010209	156,498	1,598	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	2,594	98,407	0.026360			88
91	Emergency	127,367	10,018,424	0.012713	57,671	733	91
92	Observation Beds (Non-Distinct		2,385,509				92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services						95
200	Total (sum of lines 50-199)	1,247,311	131,974,416		359,726	3,053	200

(A) Worksheet A line numbers

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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/IID [XX] PPS
 Applicable [XX] Title XVIII, Part A [XX] IPF [] SNF [] TEFRA
 Boxes: [] Title XIX [] IRF [] NF [] Other

(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 Pat							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							
88	Rural Health Clinic							88
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services							95
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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/IID [XX] PPS
 Applicable [XX] Title XVIII, Part A [XX] IPF [] SNF [] TEFRA
 Boxes: [] Title XIX [] IRF [] NF [] Other

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5+ col. 7)	Outpatient Ratio of Cost to Charges (col. 6+ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	15,653,833							50
53	Anesthesiology	11,766,064							53
54	Radiology-Diagnostic	11,070,860			2,052				54
56	Radioisotope	2,974,134							56
57	CT Scan	13,884,549			17,621				57
58	MRI	2,646,476			3,860				58
60	Laboratory	25,655,051			95,198				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	1,055,003			478				64
65	Respiratory Therapy	3,500,804			15,526				65
66	Physical Therapy	10,114,035			925				66
68	Speech Pathology	718,553			2,693				68
69	Electrocardiology	2,684,576			3,337				69
71	Medical Supplies Charged to Pat	5,208,977			3,867				71
72	Impl. Dev. Charged to Patients	673,238							72
73	Drugs Charged to Patients	11,865,923			156,498				73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic	98,407							88
91	Emergency	10,018,424			57,671				91
92	Observation Beds (Non-Distinct	2,385,509							92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services								95
200	Total (sum of lines 50-199)	131,974,416			359,726				200

(A) Worksheet A line numbers

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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/IID

(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	0.142813							50
53	Anesthesiology	0.013047							53
54	Radiology-Diagnostic	0.165326							54
56	Radioisotope	0.078109							56
57	CT Scan	0.029449							57
58	MRI	0.131134							58
60	Laboratory	0.138218							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	0.115832							64
65	Respiratory Therapy	0.212959							65
66	Physical Therapy	0.270893							66
68	Speech Pathology	0.377745							68
69	Electrocardiology	0.071991							69
71	Medical Supplies Charged to Pat	0.385562							71
72	Impl. Dev. Charged to Patients	0.525805							72
73	Drugs Charged to Patients	0.238987							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
91	Emergency	0.228739							91
92	Observation Beds (Non-Distinct	0.448956							92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	0.647788							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

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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/IID

(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	0.142813							50
53	Anesthesiology	0.013047							53
54	Radiology-Diagnostic	0.165326							54
56	Radioisotope	0.078109							56
57	CT Scan	0.029449							57
58	MRI	0.131134							58
60	Laboratory	0.138218							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	0.115832							64
65	Respiratory Therapy	0.212959							65
66	Physical Therapy	0.270893							66
68	Speech Pathology	0.377745							68
69	Electrocardiology	0.071991							69
71	Medical Supplies Charged to Pat	0.385562							71
72	Impl. Dev. Charged to Patients	0.525805							72
73	Drugs Charged to Patients	0.238987							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
91	Emergency	0.228739							91
92	Observation Beds (Non-Distinct	0.448956							92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	0.647788							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

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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/IID [XX] PPS
 Applicable [XX] Title XVIII, Part A [] IPF [XX] SNF [] TEFRA
 Boxes: [] Title XIX [] IRF [] NF [] Other

(A)	Cost Center Description	1	2	3	4	5	6	
		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)	
	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 Pat							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							
88	Rural Health Clinic							88
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services							95
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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/IID [XX] PPS
 Applicable [XX] Title XVIII, Part A [] IPF [XX] SNF [] TEFRA
 Boxes: [] Title XIX [] IRF [] NF [] Other

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5+ col. 7)	Outpatient Ratio of Cost to Charges (col. 6+ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	15,653,833							50
53	Anesthesiology	11,766,064							53
54	Radiology-Diagnostic	11,070,860			92,730				54
56	Radioisotope	2,974,134			7,561				56
57	CT Scan	13,884,549			61,143				57
58	MRI	2,646,476			2,843				58
60	Laboratory	25,655,051			298,090				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	1,055,003			44,763				64
65	Respiratory Therapy	3,500,804			618,981				65
66	Physical Therapy	10,114,035			2,262,887				66
68	Speech Pathology	718,553			82,806				68
69	Electrocardiology	2,684,576			5,612				69
71	Medical Supplies Charged to Pat	5,208,977			127,320				71
72	Impl. Dev. Charged to Patients	673,238							72
73	Drugs Charged to Patients	11,865,923			960,706				73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic	98,407							88
91	Emergency	10,018,424							91
92	Observation Beds (Non-Distinct	2,385,509			3,114				92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services								95
200	Total (sum of lines 50-199)	131,974,416			4,568,556				200

(A) Worksheet A line numbers

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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/IID

(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	0.142813							50
53	Anesthesiology	0.013047							53
54	Radiology-Diagnostic	0.165326							54
56	Radioisotope	0.078109							56
57	CT Scan	0.029449							57
58	MRI	0.131134							58
60	Laboratory	0.138218							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	0.115832							64
65	Respiratory Therapy	0.212959							65
66	Physical Therapy	0.270893							66
68	Speech Pathology	0.377745							68
69	Electrocardiology	0.071991							69
71	Medical Supplies Charged to Pat	0.385562							71
72	Impl. Dev. Charged to Patients	0.525805							72
73	Drugs Charged to Patients	0.238987							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
91	Emergency	0.228739							91
92	Observation Beds (Non-Distinct	0.448956							92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	0.647788							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

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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

	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)		
(A)	1	2	3	4	5	6	7		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	307,492	3,885	303,607	4,778	63.54	720	45,749	30
31	Intensive Care Unit	81,710		81,710	822	99.40	28	2,783	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	73,855		73,855	2,288	32.28	1,176	37,961	40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery	18,635		18,635	580	32.13	318	10,217	43
44	Skilled Nursing Facility	142,761		142,761	10,077	14.17			44
45	Nursing Facility								45
200	Total (lines 30-199)	624,453		620,568	18,545		2,242	96,710	200

(A) Worksheet A line numbers

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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 [] Title XVIII, Part A [] IPF [] TEFRA
 Boxes: [XX] Title XIX [] IRF

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room	341,398	15,653,833	0.021809		50
53	Anesthesiology	25,652	11,766,064	0.002180		53
54	Radiology-Diagnostic	285,228	11,070,860	0.025764		54
56	Radioisotope	28,860	2,974,134	0.009704		56
57	CT Scan	29,095	13,884,549	0.002095		57
58	MRI	2,841	2,646,476	0.001074		58
60	Laboratory	121,642	25,655,051	0.004741		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
64	Intravenous Therapy	3,662	1,055,003	0.003471		64
65	Respiratory Therapy	24,639	3,500,804	0.007038		65
66	Physical Therapy	58,281	10,114,035	0.005762		66
68	Speech Pathology	3,621	718,553	0.005039		68
69	Electrocardiology	4,762	2,684,576	0.001774		69
71	Medical Supplies Charged to Pat	55,133	5,208,977	0.010584		71
72	Impl. Dev. Charged to Patients	11,391	673,238	0.016920		72
73	Drugs Charged to Patients	121,145	11,865,923	0.010209		73
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
88	Rural Health Clinic	2,594	98,407	0.026360		88
91	Emergency	127,367	10,018,424	0.012713		91
92	Observation Beds (Non-Distinct	63,262	2,385,509	0.026519		92
	OTHER REIMBURSABLE COST CENTERS					
95	Ambulance Services					95
200	Total (sum of lines 50-199)	1,310,573	131,974,416			200

(A) Worksheet A line numbers

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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 Other

	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.)	
(A)		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics General Routine Care)						30
31	Intensive Care Unit						31
32	Coronary Care Unit						32
33	Burn Intensive Care Unit						33
34	Surgical Intensive Care Unit						34
35	Other Special Care (specify)						35
40	Subprovider - IPF						40
41	Subprovider - IRF						41
42	Subprovider I						42
43	Nursery						43
44	Skilled Nursing Facility						44
45	Nursing Facility						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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 Other

	Cost Center Description	Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)		6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	4,778		720		30
31	Intensive Care Unit	822		28		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	2,288		1,176		40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery	580		318		43
44	Skilled Nursing Facility	10,077				44
45	Nursing Facility					45
200	Total (lines 30-199)	18,545		2,242		200

(A) Worksheet A line numbers

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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/IID [XX] PPS
 Applicable [] Title XVIII, Part A [] IPF [] SNF [] TEFRA
 Boxes: [XX] Title XIX [] IRF [] NF [] Other

(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 Pat						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						
88	Rural Health Clinic						88
91	Emergency						91
92	Observation Beds (Non-Distinct						92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services						95
200	Total (sum of lines 50-199)						200

(A) Worksheet A line numbers

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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/IID [XX] PPS
 Applicable [] Title XVIII, Part A [] IPF [] SNF [] TEFRA
 Boxes: [XX] Title XIX [] IRF [] NF [] Other

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5+ col. 7)	Outpatient Ratio of Cost to Charges (col. 6+ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	15,653,833							50
53	Anesthesiology	11,766,064							53
54	Radiology-Diagnostic	11,070,860							54
56	Radioisotope	2,974,134							56
57	CT Scan	13,884,549							57
58	MRI	2,646,476							58
60	Laboratory	25,655,051							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	1,055,003							64
65	Respiratory Therapy	3,500,804							65
66	Physical Therapy	10,114,035							66
68	Speech Pathology	718,553							68
69	Electrocardiology	2,684,576							69
71	Medical Supplies Charged to Pat	5,208,977							71
72	Impl. Dev. Charged to Patients	673,238							72
73	Drugs Charged to Patients	11,865,923							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic	98,407							88
91	Emergency	10,018,424							91
92	Observation Beds (Non-Distinct	2,385,509							92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services								95
200	Total (sum of lines 50-199)	131,974,416							200

(A) Worksheet A line numbers

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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/IID

(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.)	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.142813							50
53	Anesthesiology	0.013047							53
54	Radiology-Diagnostic	0.165326							54
56	Radioisotope	0.078109							56
57	CT Scan	0.029449							57
58	MRI	0.131134							58
60	Laboratory	0.138218							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	0.115832							64
65	Respiratory Therapy	0.212959							65
66	Physical Therapy	0.270893							66
68	Speech Pathology	0.377745							68
69	Electrocardiology	0.071991							69
71	Medical Supplies Charged to Pat	0.385562							71
72	Impl. Dev. Charged to Patients	0.525805							72
73	Drugs Charged to Patients	0.238987							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
91	Emergency	0.228739							91
92	Observation Beds (Non-Distinct	0.448956							92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	0.647788							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

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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

	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room	341,398	15,653,833	0.021809		50
53	Anesthesiology	25,652	11,766,064	0.002180		53
54	Radiology-Diagnostic	285,228	11,070,860	0.025764		54
56	Radioisotope	28,860	2,974,134	0.009704		56
57	CT Scan	29,095	13,884,549	0.002095		57
58	MRI	2,841	2,646,476	0.001074		58
60	Laboratory	121,642	25,655,051	0.004741		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
64	Intravenous Therapy	3,662	1,055,003	0.003471		64
65	Respiratory Therapy	24,639	3,500,804	0.007038		65
66	Physical Therapy	58,281	10,114,035	0.005762		66
68	Speech Pathology	3,621	718,553	0.005039		68
69	Electrocardiology	4,762	2,684,576	0.001774		69
71	Medical Supplies Charged to Pat	55,133	5,208,977	0.010584		71
72	Impl. Dev. Charged to Patients	11,391	673,238	0.016920		72
73	Drugs Charged to Patients	121,145	11,865,923	0.010209		73
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
88	Rural Health Clinic	2,594	98,407	0.026360		88
91	Emergency	127,367	10,018,424	0.012713		91
92	Observation Beds (Non-Distinct		2,385,509			92
	OTHER REIMBURSABLE COST CENTERS					
95	Ambulance Services					95
200	Total (sum of lines 50-199)	1,247,311	131,974,416			200

(A) Worksheet A line numbers

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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/IID [XX] PPS
 Applicable [] Title XVIII, Part A [XX] IPF [] SNF [] TEFRA
 Boxes: [XX] Title XIX [] IRF [] NF [] Other

(A)	Cost Center Description	1	2	3	4	5	6	
		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)	
	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 Pat							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							
88	Rural Health Clinic							88
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services							95
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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/IID [XX] PPS
 Applicable [] Title XVIII, Part A [XX] IPF [] SNF [] TEFRA
 Boxes: [XX] Title XIX [] IRF [] NF [] Other

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5+ col. 7)	Outpatient Ratio of Cost to Charges (col. 6+ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	15,653,833							50
53	Anesthesiology	11,766,064							53
54	Radiology-Diagnostic	11,070,860							54
56	Radioisotope	2,974,134							56
57	CT Scan	13,884,549							57
58	MRI	2,646,476							58
60	Laboratory	25,655,051							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	1,055,003							64
65	Respiratory Therapy	3,500,804							65
66	Physical Therapy	10,114,035							66
68	Speech Pathology	718,553							68
69	Electrocardiology	2,684,576							69
71	Medical Supplies Charged to Pat	5,208,977							71
72	Impl. Dev. Charged to Patients	673,238							72
73	Drugs Charged to Patients	11,865,923							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic	98,407							88
91	Emergency	10,018,424							91
92	Observation Beds (Non-Distinct	2,385,509							92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services								95
200	Total (sum of lines 50-199)	131,974,416							200

(A) Worksheet A line numbers

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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/IID

(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	0.142813							50
53	Anesthesiology	0.013047							53
54	Radiology-Diagnostic	0.165326							54
56	Radioisotope	0.078109							56
57	CT Scan	0.029449							57
58	MRI	0.131134							58
60	Laboratory	0.138218							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	0.115832							64
65	Respiratory Therapy	0.212959							65
66	Physical Therapy	0.270893							66
68	Speech Pathology	0.377745							68
69	Electrocardiology	0.071991							69
71	Medical Supplies Charged to Pat	0.385562							71
72	Impl. Dev. Charged to Patients	0.525805							72
73	Drugs Charged to Patients	0.238987							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
91	Emergency	0.228739							91
92	Observation Beds (Non-Distinct)	0.448956							92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	0.647788							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

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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/IID [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)	5,104	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,778	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)	3,795	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	79	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)	238	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	2	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)	7	8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,272	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)	79	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)	238	11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	202.51	17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	207.37	18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	137.24	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	139.98	20
21	Total general inpatient routine service cost (see instructions)	5,272,284	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	15,998	22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	49,354	23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	274	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	980	25
26	Total swing-bed cost (see instructions)	66,606	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,205,678	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,205,678	37

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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)					1,089.51	38
39	Program general inpatient routine service cost (line 9 x line 38)					2,475,367	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)					2,475,367	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	1,578,348	822	1,920.13	757	1,453,538	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 (Wkst. D-3, col. 3, line 200)					2,587,193	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					6,516,098	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					219,609	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					138,541	51
52	Total Program excludable cost (sum of lines 50 and 51)					358,150	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					6,157,948	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)					15,998	64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)					49,354	65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)					65,352	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

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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/IID 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)					983	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,089.51	88
89	Observation bed cost (line 87 x line 88) (see instructions)					1,070,988	89
		Cost	Routine Cost (from line 27)	col. 1+col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	307,492	5,205,678	0.059069	1,070,988	63,262	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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/IID [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)	2,288	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,288	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.	917	3
4	Semi-private room days (excluding swing-bed private room days)	1,371	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	584	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	1,864,439	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,864,439	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)	2,763,564	28
29	Private room charges (excluding swing-bed charges)	1,033,459	29
30	Semi-private room charges (excluding swing-bed charges)	1,730,105	30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.674650	31
32	Average private room per diem charge (line 29 ÷ line 3)	1,127.00	32
33	Average semi-private room per diem charge (line 30 ÷ line 4)	1,261.93	33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,864,439	37

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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 [XX] Title XVIII, Part A [XX] 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)	814.88	38
39	Program general inpatient routine service cost (line 9 x line 38)	475,890	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)	475,890	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	71,475	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	547,365	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	18,852	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	3,053	51
52	Total Program excludable cost (sum of lines 50 and 51)	21,905	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	525,460	53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	If line 53 + 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-5580

WORKSHEET D-1
PART I

Check [] Title V - I/P [] Hospital [] SUB (Other) [] ICF/IID [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)	10,077	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	10,077	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)	10,077	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,981	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	3,153,134	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,153,134	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,153,134	37

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX - I/P IRF NF Other

PART III - SNF, NF, AND ICF/IID ONLY

70	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	3,153,134	70
71	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	312.90	71
72	Program routine service cost (line 9 x line 71)	932,755	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)	932,755	74
75	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26)		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)	932,755	83
84	Program inpatient ancillary services (see instructions)	1,121,068	84
85	Utilization review - physician compensation (see instructions)		85
86	Total Program inpatient operating costs (sum of lines 83 through 85)	2,053,823	86

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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/IID [XX] PPS
 Applicable [] Title XVIII, Part A [] 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)	5,104	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,778	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)	3,795	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	79	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)	238	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	2	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)	7	8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	720	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)	580	15
16	Nursery days (title V or XIX only)	318	16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	202.51	17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	207.37	18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	137.24	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	139.98	20
21	Total general inpatient routine service cost (see instructions)	5,272,284	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	15,998	22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	49,354	23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	274	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	980	25
26	Total swing-bed cost (see instructions)	66,606	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,205,678	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,205,678	37

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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

38	Adjusted general inpatient routine service cost per diem (see instructions)					1,089.51	38
39	Program general inpatient routine service cost (line 9 x line 38)					784,447	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)					784,447	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)	544,397	580	938.62	318	298,481	42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	1,578,348	822	1,920.13	28	53,764	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 (Wkst. D-3, col. 3, line 200)						48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					1,136,692	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					58,749	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51
52	Total Program excludable cost (sum of lines 50 and 51)					58,749	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					1,077,943	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

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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/IID 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)	983	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)	col. 1+col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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/IID [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)	2,288	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,288	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.	917	3
4	Semi-private room days (excluding swing-bed private room days)	1,371	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,176	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	1,864,439	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,864,439	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)	2,763,564	28
29	Private room charges (excluding swing-bed charges)	1,033,459	29
30	Semi-private room charges (excluding swing-bed charges)	1,730,105	30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.674650	31
32	Average private room per diem charge (line 29 ÷ line 3)	1,127.00	32
33	Average semi-private room per diem charge (line 30 ÷ line 4)	1,261.93	33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,864,439	37

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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 [] 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)	814.88	38
39	Program general inpatient routine service cost (line 9 x line 38)	958,299	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)	958,299	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	958,299	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	37,961	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51
52	Total Program excludable cost (sum of lines 50 and 51)	37,961	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	920,338	53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0147

WORKSHEET D-3

Check [] Title V [XX] Hospital [] SUB (Other) [] Swing Bed SNF [XX] PPS
 Applicable [XX] Title XVIII, Part A [] IPF [] SNF [] Swing Bed NF [] TEFRA
 Boxes: [] Title XIX [] IRF [] NF [] ICF/IID [] 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		2,108,444		30
31	Intensive Care Unit		1,051,575		31
40	Subprovider - IPF				40
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.142813	1,130,263	161,416	50
53	Anesthesiology	0.013047	310,671	4,053	53
54	Radiology-Diagnostic	0.165326	1,080,208	178,586	54
56	Radioisotope	0.078109	104,280	8,145	56
57	CT Scan	0.029449	1,364,361	40,179	57
58	MRI	0.131134	45,809	6,007	58
60	Laboratory	0.138218	3,118,516	431,035	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	Intravenous Therapy	0.115832	296,374	34,330	64
65	Respiratory Therapy	0.212959	1,379,346	293,744	65
66	Physical Therapy	0.270893	462,935	125,406	66
68	Speech Pathology	0.377745	48,722	18,404	68
69	Electrocardiology	0.071991	290,385	20,905	69
71	Medical Supplies Charged to Patients	0.385562	871,489	336,013	71
72	Impl. Dev. Charged to Patients	0.525805	131,829	69,316	72
73	Drugs Charged to Patients	0.238987	2,289,600	547,185	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
91	Emergency	0.228739	966,354	221,043	91
92	Observation Beds (Non-Distinct Part)	0.448956	203,641	91,426	92
	OTHER REIMBURSABLE COST CENTERS				
95	Ambulance Services				95
200	Total (sum of lines 50-94, and 96-98)		14,094,783	2,587,193	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		14,094,783		202

(A) Worksheet A line numbers

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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 [XX] PPS
 Applicable [XX] Title XVIII, Part A [XX] IPF [] SNF [] Swing Bed NF [] TEFRA
 Boxes: [] Title XIX [] IRF [] NF [] ICF/IID [] 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		657,630		40
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.142813			50
53	Anesthesiology	0.013047			53
54	Radiology-Diagnostic	0.165326	2,052	339	54
56	Radioisotope	0.078109			56
57	CT Scan	0.029449	17,621	519	57
58	MRI	0.131134	3,860	506	58
60	Laboratory	0.138218	95,198	13,158	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	Intravenous Therapy	0.115832	478	55	64
65	Respiratory Therapy	0.212959	15,526	3,306	65
66	Physical Therapy	0.270893	925	251	66
68	Speech Pathology	0.377745	2,693	1,017	68
69	Electrocardiology	0.071991	3,337	240	69
71	Medical Supplies Charged to Patients	0.385562	3,867	1,491	71
72	Impl. Dev. Charged to Patients	0.525805			72
73	Drugs Charged to Patients	0.238987	156,498	37,401	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
91	Emergency	0.228739	57,671	13,192	91
92	Observation Beds (Non-Distinct Part)	0.448956			92
	OTHER REIMBURSABLE COST CENTERS				
95	Ambulance Services				95
200	Total (sum of lines 50-94, and 96-98)		359,726	71,475	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		359,726		202

(A) Worksheet A line numbers

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-U147

WORKSHEET D-3

Check [] Title V [] Hospital [] SUB (Other) [XX] Swing Bed SNF [XX] PPS
 Applicable [XX] Title XVIII, Part A [] IPF [] SNF [] Swing Bed NF [] TEFRA
 Boxes: [] Title XIX [] IRF [] NF [] ICF/IID [] 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	0.142813			50
53	Anesthesiology	0.013047			53
54	Radiology-Diagnostic	0.165326	12,490	2,065	54
56	Radioisotope	0.078109			56
57	CT Scan	0.029449	10,648	314	57
58	MRI	0.131134			58
60	Laboratory	0.138218	41,859	5,786	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	Intravenous Therapy	0.115832	8,640	1,001	64
65	Respiratory Therapy	0.212959	110,472	23,526	65
66	Physical Therapy	0.270893	121,078	32,799	66
68	Speech Pathology	0.377745	8,959	3,384	68
69	Electrocardiology	0.071991	5,371	387	69
71	Medical Supplies Charged to Patients	0.385562	17,878	6,893	71
72	Impl. Dev. Charged to Patients	0.525805			72
73	Drugs Charged to Patients	0.238987	131,429	31,410	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
91	Emergency	0.228739			91
92	Observation Beds (Non-Distinct Part)	0.448956	411	185	92
	OTHER REIMBURSABLE COST CENTERS				
95	Ambulance Services				95
200	Total (sum of lines 50-94, and 96-98)		469,235	107,750	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		469,235		202

(A) Worksheet A line numbers

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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/IID 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	0.142813			50
53	Anesthesiology	0.013047			53
54	Radiology-Diagnostic	0.165326	92,730	15,331	54
56	Radioisotope	0.078109	7,561	591	56
57	CT Scan	0.029449	61,143	1,801	57
58	MRI	0.131134	2,843	373	58
60	Laboratory	0.138218	298,090	41,201	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	Intravenous Therapy	0.115832	44,763	5,185	64
65	Respiratory Therapy	0.212959	618,981	131,818	65
66	Physical Therapy	0.270893	2,262,887	613,000	66
68	Speech Pathology	0.377745	82,806	31,280	68
69	Electrocardiology	0.071991	5,612	404	69
71	Medical Supplies Charged to Patients	0.385562	127,320	49,090	71
72	Impl. Dev. Charged to Patients	0.525805			72
73	Drugs Charged to Patients	0.238987	960,706	229,596	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS					
88	Rural Health Clinic				88
91	Emergency	0.228739			91
92	Observation Beds (Non-Distinct Part)	0.448956	3,114	1,398	92
OTHER REIMBURSABLE COST CENTERS					
95	Ambulance Services				95
200	Total (sum of lines 50-94, and 96-98)		4,568,556	1,121,068	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		4,568,556		202

(A) Worksheet A line numbers

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0147

WORKSHEET D-3

Check [] Title V [XX] Hospital [] SUB (Other) [] Swing Bed SNF [XX] PPS
 Applicable [] Title XVIII, Part A [] IPF [] SNF [] Swing Bed NF [] TEFRA
 Boxes: [XX] Title XIX [] IRF [] NF [] ICF/IID [] 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
43	Nursery				43
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.142813			50
53	Anesthesiology	0.013047			53
54	Radiology-Diagnostic	0.165326			54
56	Radioisotope	0.078109			56
57	CT Scan	0.029449			57
58	MRI	0.131134			58
60	Laboratory	0.138218			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	Intravenous Therapy	0.115832			64
65	Respiratory Therapy	0.212959			65
66	Physical Therapy	0.270893			66
68	Speech Pathology	0.377745			68
69	Electrocardiology	0.071991			69
71	Medical Supplies Charged to Patients	0.385562			71
72	Impl. Dev. Charged to Patients	0.525805			72
73	Drugs Charged to Patients	0.238987			73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
91	Emergency	0.228739			91
92	Observation Beds (Non-Distinct Part)	0.448956			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

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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 [XX] PPS
 Applicable [] Title XVIII, Part A [XX] IPF [] SNF [] Swing Bed NF [] TEFRA
 Boxes: [XX] Title XIX [] IRF [] NF [] ICF/IID [] 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	0.142813			50
53	Anesthesiology	0.013047			53
54	Radiology-Diagnostic	0.165326			54
56	Radioisotope	0.078109			56
57	CT Scan	0.029449			57
58	MRI	0.131134			58
60	Laboratory	0.138218			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	Intravenous Therapy	0.115832			64
65	Respiratory Therapy	0.212959			65
66	Physical Therapy	0.270893			66
68	Speech Pathology	0.377745			68
69	Electrocardiology	0.071991			69
71	Medical Supplies Charged to Patients	0.385562			71
72	Impl. Dev. Charged to Patients	0.525805			72
73	Drugs Charged to Patients	0.238987			73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
91	Emergency	0.228739			91
92	Observation Beds (Non-Distinct Part)	0.448956			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

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
1	DRG amounts other than outlier payments				1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)				1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	4,335,975			1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)				1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)				1.04
2	Outlier payments for discharges (see instructions)	1,765			2
2.01	Outlier reconciliation amount				2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)				2.02
3	Managed care simulated payments				3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	43.41			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) 64 FR 26340 (May 12, 1998), and 67 FR 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 line 8 plus lines (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 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
22.01	IME payment adjustment - Managed Care (see instructions)				22.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA					
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 factor (see instructions)				27
28	IME add-on adjustment amount (see instructions)				28
28.01	IME add-on adjustment amount - Managed Care (see instructions)				28.01
29	Total IME payment (sum of lines 22 and 28)				29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)				29.01
Disproportionate Share Adjustment					
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.0461			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.2319			31
32	Sum of lines 30 and 31	0.2780			32
33	Allowable disproportionate share percentage (see instructions)	0.1102			33
34	Disproportionate share adjustment (see instructions)	119,456			34
Uncompensated Care Adjustment					
		Prior to	On or after		
		October 1	October 1		
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)		347,538		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		347,538		35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	347,538			36
Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)					
40	Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				40
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)				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

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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
47	Subtotal (see instructions)	4,804,734			47
48	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see instructions)	5,040,838			48
49	Total payment for inpatient operating costs (see instructions)	4,981,812			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	341,404			50
51	Exception payment for inpatient program capital (Wkst. L, Pt. 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 Pt. III, col. I, line 69)				55
56	Cost of physicians' services in a teaching hospital (see instructions)				56
57	Routine service other pass through costs (from Wkst. D, Pt. III, col. 9, lines 30 through 35).				57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)				58
59	Total (sum of amounts on lines 49 through 58)	5,323,216			59
60	Primary payer payments				60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	5,323,216			61
62	Deductibles billed to program beneficiaries	675,896			62
63	Coinurance billed to program beneficiaries	4,604			63
64	Allowable bad debts (see instructions)	222,225			64
65	Adjusted reimbursable bad debts (see instructions)	144,446			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	189,546			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	4,787,162			67
68	Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions)				68
69	Outlier payments reconciliation (sum of lines 93, 95 and 96) (for SCH see instructions)				69
70	Other adjustments (specify) (see instructions)				70
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	516			70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	-3,913			70.91
70.93	HVBP payment adjustment amount (see instructions)	12,637			70.93
70.94	HRR adjustment amount (see instructions)	-95,681			70.94
70.96	Low volume adjustment for federal fiscal year (2014)				70.96
70.97	Low volume adjustment for federal fiscal year (2015)	518,061			70.97
70.99	HAC adjustment amount (see instructions)	57,548			70.99
71	Amount due provider (see instructions)	5,161,234			71
71.01	Sequestration adjustment (see instructions)	103,225			71.01
72	Interim payments	5,088,840			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	-30,831			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	138,000			75

TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)

90	Operating outlier amount from Wkst. E, Pt. A line 2 (see instructions)				90
91	Capital outlier from Wkst. L, Pt. 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

HSP Bonus Payment Amount

		Prior to 10/1	On or After 10/1	
100	HSP bonus amount (see instructions)		177,078	100

HVBP Adjustment for HSP Bonus Payment

		Prior to 10/1	On or After 10/1	
101	HVBP adjustment factor (see instructions)	0.0000000000	1.0029145283	101
102	HVBP adjustment amount for HSP bonus payment (see instructions)		516	102

HRR Adjustment for HSP Bonus Payment

		Prior to 10/1	On or After 10/1	
103	HRR adjustment factor (see instructions)	0.0000	0.9779	103
104	HRR adjustment amount for HSP bonus payment (see instructions)		-3,913	104

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

EXHIBIT 4

	(Amt. from Wkst. E, Pt. A or L Pt. I)	Pre/Post Entitlement	NOT APPLICABLE	3.01	4	4.01	Total (col. 2 through 4)	
	1	2	3	3.01	4	4.01	5	
1	DRG Amounts Other Than Outlier Payments							1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1							1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	4,335,975			4,335,975		4,335,975	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1							1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1							1.04
2	Outlier payments for discharges	1,765			1,765		1,765	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
6.01	IME payment adjustment for managed care							6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7	IME payment adjustment factor							7
8	IME add-on adjustment amount							8
8.01	IME payment adjustment add-on for managed care							8.01
9	Total IME payment (sum of lines 6 and 8)							9
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)							9.01
	Disproportionate Share Adjustment							
10	Allowable disproportionate share percentage	0.1102	0.1102	0.1102	0.1102	0.1102	0.1102	10
11	Disproportionate share adjustment	119,456			119,456		119,456	11
11.01	Uncompensated care payments	347,538			347,538		347,538	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12	Total ESRD additional payment							12
13	Subtotal	4,804,734			4,804,734		4,804,734	13
14	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.)	5,040,838			5,040,838		5,040,838	14
15	Total payment for inpatient operating costs SCH and MDH only	4,981,812			4,981,812		4,981,812	15
16	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	341,404			341,404		341,404	16
17	Special add-on payments for new technologies							17
17.01	Net organ acquisition cost (Wkst. D-4 Pt. III, col 1, line 69)							17.01
17.02	Credits received from manufacturers for replaced devices applicable to MS-DRG							17.02
18	Capital outlier reconciliation adjustment amount							18
19	SUBTOTAL				5,323,216		5,323,216	19
20	Capital DRG other than outlier	341,312			341,312		341,312	20
20.01	Model 4 BPCI Capital DRG other than outlier							20.01
21	Capital DRG outlier payments	92			92		92	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	341,404			341,404		341,404	26
27	Low volume adjustment factor			0.109286	0.097321			27
28	Low volume adjustment (transfer amount to Worksheet E, Part A, line 70.96)(prior to 10/1)							28
29	Low Volume Adjustment (transfer amount to Worksheet E, Part A, line 70.97)(on/after 10/1)				518,061		518,061	29

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HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION

EXHIBIT 5

	(Amt. from Wkst. E, Pt. A or L Pt. I)	Prior to 10/1	(2.01)	On or after 10/1	(3.01)	Total (cols. 2 and 3)	
	(1)	(2)	(2.01)	(3)	(3.01)	(4)	
1	DRG Amounts Other Than Outlier Payments						1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1						1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	4,335,975		4,335,975		4,335,975	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1						1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1						1.04
2	Outlier payments for discharges	1,765		1,765		1,765	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
6.01	IME payment adjustment for managed care						6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7	IME payment adjustment factor						7
8	IME add-on adjustment amount						8
8.01	IME payment adjustment add-on for managed care						8.01
9	Total IME payment (sum of lines 6 and 8)						9
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)						9.01
	Disproportionate Share Adjustment						
10	Allowable disproportionate share percentage	0.1102	0.1102	0.1102	0.1102	0.1102	10
11	Disproportionate share adjustment	119,456		119,456		119,456	11
11.01	Uncompensated care payments	347,538		347,538		347,538	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12	Total ESRD additional payment						12
13	Subtotal	4,804,734		4,804,734		4,804,734	13
14	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.)	5,040,838		5,040,838		5,040,838	14
15	Total payment for inpatient operating costs SCH and MDH only	4,981,812		4,981,812		4,981,812	15
16	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	341,404		341,404		341,404	16
17	Special add-on payments for new technologies						17
17.01	Net organ acquisition cost (Wkst. D-4 Pt. III, col 1, line 69)						17.01
17.02	Credits received from manufacturers for replaced devices applicable to MS-DRG						17.02
18	Capital outlier reconciliation adjustment amount						18
19	SUBTOTAL			5,323,216		5,323,216	19
20	Capital DRG other than outlier	341,312		341,312		341,312	20
20.01	Model 4 BPCI Capital DRG other than outlier						20.01
21	Capital DRG outlier payments	92		92		92	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	341,404		341,404		341,404	26
27							27
28	Low volume adjustment prior to October 1						28
29	Low volume adjustment on or after October 1	518,061		518,061		518,061	29
30	HVBP payment adjustment	12,637		12,637		12,637	30
30.01	HVBP payment adjustment for HSP bonus payment	516		516		516	30.01
31	HRR adjustment	-95,681		-95,681		-95,681	31
31.01	HRR adjustment for HSP bonus payment	-3,913		-3,913		-3,913	31.01
32	HAC Reduction Program adjustment			57,548		57,548	32

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-0147

WORKSHEET E
PART B

Check applicable box: Hospital IPF IRF SUB (Other) SNE

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	14,792			1
2	Medical and other services reimbursed under OPPS (see instructions)	4,155,971			2
3	PPS payments	3,672,908			3
4	Outlier payment (see instructions)	1,350			4
5	Enter the hospital specific payment to cost ratio (see instructions)	0.810			5
6	Line 2 times line 5	3,366,337			6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	14,792			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	74,271			12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)	74,271			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)	74,271			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions))	59,479			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)	14,792			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)	3,674,258			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	835,213			26
27	Subtotal ((lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23) (see instructions)	2,853,837			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)	2,853,837			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	2,853,837			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)	183,264			34
35	Adjusted reimbursable bad debts (see instructions)	119,122			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	147,699			36
37	Subtotal (see instructions)	2,972,959			37
38	MSP-LCC reconciliation amount from PS&R	572			38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	2,972,387			40
40.01	Sequestration adjustment (see instructions)	59,448			40.01
41	Interim payments	2,895,887			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	17,052			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-S147

WORKSHEET E
PART B

Check applicable box: Hospital IPF IRF SUB (Other) SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

	1	1.01	1.02	
1	Medical and other services (see instructions)			1
2	Medical and other services reimbursed under OPPS (see instructions)			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 and line 4 divided by line 6			7
8	Transitional corridor payment (see instructions)			8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			9
10	Organ acquisition			10
11	Total cost (sum of lines 1 and 10) (see instructions)			11
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
12	Ancillary service charges			12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)			13
14	Total reasonable charges (sum of lines 12 and 13)			14
	CUSTOMARY CHARGES			
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis			15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000		17
18	Total customary charges (see instructions)			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)			19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)			20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)			21
22	Interns and residents (see instructions)			22
23	Cost of physicians' services in a teaching hospital (see instructions)			23
24	Total prospective payment (sum of lines 3, 4, 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 minus 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
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
40	Subtotal (see instructions)			40
40.01	Sequestration adjustment (see instructions)			40.01
41	Interim payments			41
42	Tentative settlement (for contractors use only)			42
43	Balance due provider/program (see instructions)			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			44

TO BE COMPLETED BY CONTRACTOR

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

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-5580

WORKSHEET E
PART B

Check applicable box: Hospital IPF IRF SUB (Other) SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under OPPS (see instructions)				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 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)				21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 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 minus 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
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)				40
40.01	Sequestration adjustment (see instructions)				40.01
41	Interim payments				41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)				43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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	AMOUNT	mm/dd/yyyy	AMOUNT		
	1	2	3	4		
1 Total interim payments paid to provider		5,050,868		2,876,320	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	04/29/2015	37,972	04/29/2015	19,567	3.01
	.02					3.02
	Program					3.03
	to					3.04
	Provider					3.05
	.06					3.06
	.07					3.07
	.08					3.08
	.09					3.09
	.10					3.10
	.50					3.50
	.51					3.51
	Provider					3.52
	to					3.53
	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		37,972		19,567	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)			5,088,840		2,895,887	4
TO BE COMPLETED BY CONTRACTOR						
5 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)						
	.01					5.01
	.02					5.02
	Program					5.03
	to					5.04
	Provider					5.05
	.06					5.06
	.07					5.07
	.08					5.08
	.09					5.09
	.10					5.10
	.50					5.50
	.51					5.51
	Provider					5.52
	to					5.53
	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				17,052	6.01
	.02		-30,831			6.02
7 Total Medicare program liability (see instructions)			5,058,009		2,912,939	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.

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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 IPF 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		385,675			1
2 Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero					2
3 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
		.01			3.01
		.02			3.02
	Program	.03			3.03
	to	.04			3.04
	Provider	.05			3.05
		.06			3.06
		.07			3.07
		.08			3.08
		.09			3.09
		.10			3.10
		.50			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)			385,675		4
TO BE COMPLETED BY CONTRACTOR					
5 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
		.01			5.01
		.02			5.02
	Program	.03			5.03
	to	.04			5.04
	Provider	.05			5.05
		.06			5.06
		.07			5.07
		.08			5.08
		.09			5.09
		.10			5.10
		.50			5.50
		.51			5.51
	Provider	.52			5.52
	to	.53			5.53
	Program	.54			5.54
		.55			5.55
		.56			5.56
		.57			5.57
		.58			5.58
		.59			5.59
Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99			5.99
6 Determined net settlement amount (balance due) based on the cost report (1)		.01	6,947		6.01
		.02			6.02
7 Total Medicare program liability (see instructions)			392,622		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.

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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 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		80,609			1
2 Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero					2
3 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
	.01				3.01
	.02				3.02
	Program	.03			3.03
	to	.04			3.04
	Provider	.05			3.05
		.06			3.06
		.07			3.07
		.08			3.08
		.09			3.09
		.10			3.10
		.50			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)		80,609			4
TO BE COMPLETED BY CONTRACTOR					
5 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
	.01				5.01
	.02				5.02
	Program	.03			5.03
	to	.04			5.04
	Provider	.05			5.05
		.06			5.06
		.07			5.07
		.08			5.08
		.09			5.09
		.10			5.10
		.50			5.50
		.51			5.51
	Provider	.52			5.52
	to	.53			5.53
	Program	.54			5.54
		.55			5.55
		.56			5.56
		.57			5.57
		.58			5.58
		.59			5.59
Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				5.99
6 Determined net settlement amount (balance due) based on the cost report (1)	.01		10,240		6.01
	.02				6.02
7 Total Medicare program liability (see instructions)			90,849		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.

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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 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		980,387		1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero				2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)				
		.01			3.01
		.02			3.02
	Program	.03			3.03
	to	.04			3.04
	Provider	.05			3.05
		.06			3.06
		.07			3.07
		.08			3.08
		.09			3.09
		.10			3.10
		.50			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)		980,387		4
TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)				
		.01			5.01
		.02			5.02
	Program	.03			5.03
	to	.04			5.04
	Provider	.05			5.05
		.06			5.06
		.07			5.07
		.08			5.08
		.09			5.09
		.10			5.10
		.50			5.50
		.51			5.51
	Provider	.52			5.52
	to	.53			5.53
	Program	.54			5.54
		.55			5.55
		.56			5.56
		.57			5.57
		.58			5.58
		.59			5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99			5.99
6	Determined net settlement amount (balance due) based on the cost report (1)	.01			6.01
		.02			6.02
7	Total Medicare program liability (see instructions)		980,387		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.

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

Check 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 (Wkst. S-3, Pt. I, col. 15, line 14)	1,434	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	3,029	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	145	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	4,617	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	150,487,470	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	1,513,677	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)		7
8	Calculation of the HIT incentive payment (see instructions)	357,095	8
9	Sequestration adjustment amount (see instructions)	7,142	9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	349,953	10

INPATIENT HOSPITAL SERVICES UNDER THE IPSS & CAH

30	Initial/interim HIT payment(s)		30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)	349,953	32

(*) This worksheet is completed by the contractor for standard and non-standard cost reporting periods at cost report settlement. Providers may complete this worksheet for a standard cost reporting period.

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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)	97,336		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, Pt. V, cols. 6 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	317		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 through 3 plus lines 6 and 7)	97,336		8
9	Primary payer payments (see instructions)			9
10	Subtotal (line 8 minus line 9)	97,336		10
11	Deductibles billed to program patients (exclude amounts applicable to physician professional services)			11
12	Subtotal (line 10 minus line 11)	97,336		12
13	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	15,082		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)	82,254		15
16	Other Adjustments (specify) (see instructions)			16
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
17	Allowable bad debts (see instructions)	16,075		17
17.01	Adjusted reimbursable bad debts (see instructions)	10,449		17.01
18	Allowable bad debts for dual eligible beneficiaries (see instructions)			18
19	Total (see instructions)	92,703		19
19.01	Sequestration adjustment (see instructions)	1,854		19.01
20	Interim payments	80,609		20
21	Tentative settlement (for contractor use only)			21
22	Balance due provider/program (line 19 minus lines 19.01, 20 and 21)	10,240		22
23	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			23

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-S147

WORKSHEET E-3
PART II

Check Hospital
Applicable 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)	510,397	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 (see instructions)		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 42 CFR §412.424(d)(1)(iii)(F)(1) OR (2) (see instructions)		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)	6,268,493	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)	510,397	12
13	Nursing and allied health managed care payment (see instructions)		13
14	Organ acquisition DO NOT USE THIS LINE		14
15	Cost of physicians' services in a teaching hospital (see instructions)		15
16	Subtotal (see instructions)	510,397	16
17	Primary payer payments		17
18	Subtotal (line 16 less line 17)	510,397	18
19	Deductibles	114,934	19
20	Subtotal (line 18 minus line 19)	395,463	20
21	Coinsurance	1,890	21
22	Subtotal (line 20 minus line 21)	393,573	22
23	Allowable bad debts (exclude bad debts for professional services) (see instructions)	10,864	23
24	Adjusted reimbursable bad debts (see instructions)	7,062	24
25	Allowable bad debts for dual eligible beneficiaries (see instructions)		25
26	Subtotal (sum of lines 22 and 24)	400,635	26
27	Direct graduate medical education payments (from Wkst. 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
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		30.50
31	Total amount payable to the provider (see instructions)	400,635	31
31.01	Sequestration adjustment (see instructions)	8,013	31.01
32	Interim payments	385,675	32
33	Tentative settlement (for contractor use only)		33
34	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)	6,947	34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §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

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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	1,200,391	1
2	Routine service other pass through costs		2
3	Ancillary service other pass through costs		3
4	Subtotal (sum of lines 1-3)	1,200,391	4
COMPUTATION OF NET COST OF COVERED SERVICES			
5	Medical and other services. Do not use this line. (see instructions)		5
6	Deductibles		6
7	Coinsurance	199,996	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 lines 6 and 7, plus lines 10 and 11) (see instructions)	1,000,395	12
13	Inpatient primary payer payments		13
14	Other adjustments (specify) (see instructions)		14
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		14.50
15	Subtotal (see instructions)	1,000,395	15
15.01	Sequestration adjustment (see instructions)	20,008	15.01
16	Interim payments	980,387	16
17	Tentative settlement (for contractor use only)		17
18	Balance due provider/program (line 15 minus lines 15.01, 16 and 17)		18
19	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §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/IID [] TEFRA
 Boxes: [] SNF [] Other

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
COMPUTATION OF NET COST OF COVERED SERVICES				
1	Inpatient hospital/SNF/NF services			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			9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)			12
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)	1.000000	1.000000	15
16	Total customary charges (see instructions)			16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)			21
PROSPECTIVE PAYMENT AMOUNT				
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)			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 Wkst. 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 line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-S147

WORKSHEET E-3
PART VII

Check [] Title V [] Hospital [] NF [XX] PPS
 Applicable [XX] Title XIX [XX] Subprovider IPF [] ICF/IID [] TEFRA
 Boxes: [] SNF [] Other

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
COMPUTATION OF NET COST OF COVERED SERVICES				
1	Inpatient hospital/SNF/NF services			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			9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)			12
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)	1.000000	1.000000	15
16	Total customary charges (see instructions)			16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)			21
PROSPECTIVE PAYMENT AMOUNT				
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)			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 Wkst. 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 line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §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)

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
Assets (Omit Cents)		1	2	3	4	
CURRENT ASSETS						
1	Cash on hand and in banks	3,987,416				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	5,934,066				4
5	Other receivables	715,922				5
6	Allowances for uncollectible notes and accounts receivable					6
7	Inventory	821,516				7
8	Prepaid expenses	956,055				8
9	Other current assets	1,766,244				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	14,181,219				11
FIXED ASSETS						
12	Land	39,983				12
13	Land improvements	385,022				13
14	Accumulated depreciation	-353,886				14
15	Buildings	25,009,931				15
16	Accumulated depreciation	-17,348,574				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment	2,355,173				19
20	Accumulated depreciation	-2,211,565				20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	17,024,386				23
24	Accumulated depreciation	-11,338,352				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)	13,562,118				30
OTHER ASSETS						
31	Investments	11,090,181				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	254,428				34
35	Total other assets (sum of lines 31-34)	11,344,609				35
36	Total assets (sum of lines 11, 30 and 35)	39,087,946				36
Liabilities and Fund Balances						
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
(Omit Cents)		1	2	3	4	
CURRENT LIABILITIES						
37	Accounts payable	1,843,474				37
38	Salaries, wages and fees payable	2,817,794				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	288,128				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	1,686,343				44
45	Total current liabilities (sum of lines 37 thru 44)	6,635,739				45
LONG TERM LIABILITIES						
46	Mortgage payable					46
47	Notes payable	6,488,574				47
48	Unsecured loans					48
49	Other long term liabilities					49
50	Total long term liabilities (sum of lines 46 thru 49)	6,488,574				50
51	Total liabilities (sum of lines 45 and 50)	13,124,313				51
CAPITAL ACCOUNTS						
52	General fund balance	25,963,633				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	25,963,633				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	39,087,946				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		22,650,782		1
2	Net income (loss) (from Worksheet G-3, line 29)		3,312,851		2
3	Total (sum of line 1 and line 2)		25,963,633		3
4	Additions (credit adjustments) (specify)				4
5					5
6					6
7					7
8					8
9					9
10	Total additions (sum of lines 4-9)				10
11	Subtotal (line 3 plus line 10)		25,963,633		11
12	Deductions (debit adjustments) (specify)				12
13					13
14					14
15					15
16					16
17					17
18	Total deductions (sum of lines 12-17)				18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		25,963,633		19

		ENDOWMENT FUND		PLANT FUND	
		5	6	7	8
1	Fund balances at beginning of period				1
2	Net income (loss) (from Worksheet G-3, line 29)				2
3	Total (sum of line 1 and line 2)				3
4	Additions (credit adjustments) (specify)				4
5					5
6					6
7					7
8					8
9					9
10	Total additions (sum of lines 4-9)				10
11	Subtotal (line 3 plus line 10)				11
12	Deductions (debit adjustments) (specify)				12
13					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

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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	5,277,966		5,277,966	1
2	Subprovider IPF	2,763,564		2,763,564	2
3	Subprovider IRF				3
5	Swing Bed - SNF	153,550		153,550	5
6	Swing Bed - NF				6
7	Skilled nursing facility	2,501,330		2,501,330	7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	10,696,410		10,696,410	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	1,526,456		1,526,456	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)	1,526,456		1,526,456	16
17	Total inpatient routine care services (sum of lines 10 and 16)	12,222,866		12,222,866	17
18	Ancillary services	27,345,627	100,767,882	128,113,509	18
19	Outpatient services		8,713,420	8,713,420	19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency		4,202,364	4,202,364	22
23	Ambulance	45,710	2,169,075	2,214,785	23
25	ASC				25
26	Hospice				26
27	OTHER	1,252,032	1,113,110	2,365,142	27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	40,866,235	116,965,851	157,832,086	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		48,440,316	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)		48,440,316	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)	157,832,086	1
2	Less contractual allowances and discounts on patients' accounts	109,413,873	2
3	Net patient revenues (line 1 minus line 2)	48,418,213	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	48,440,316	4
5	Net income from service to patients (line 3 minus line 4)	-22,103	5

OTHER INCOME

6	Contributions, donations, bequests, etc.	1,801,956	6
7	Income from investments		7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts	5,246	10
11	Rebates and refunds of expenses		11
12	Parking lot receipts		12
13	Revenue from laundry and linen service	192,457	13
14	Revenue from meals sold to employees and guests	271,094	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients	9,662	16
17	Revenue from sale of drugs to other than patients	93	17
18	Revenue from sale of medical records and abstracts	1,088	18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines	13,190	21
22	Rental of hosptial space		22
23	Governmental appropriations		23
24	Other (PROPERTY TAX REVENUE)	399,996	24
24.01	Other (EHR MEANINGFUL USE)	648,122	24.01
24.02	Other (GRANTS)	35,000	24.02
24.03	Other (OTHER)	184,601	24.03
24.04	Other (NET ASSETS RELEASED BY FOUNDATION)		24.04
25	Total other income (sum of lines 6-24)	3,562,505	25
26	Total (line 5 plus line 25)	3,540,402	26
27	Other expenses (INVESTMENT INCOME)	151,034	27
27.01	Other expenses (NET ASSETS RELEASED BY FOUNDATION)	76,517	27.01
28	Total other expenses (sum of line 27 and subscripts)	227,551	28
29	Net income (or loss) for the period (line 26 minus line 28)	3,312,851	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 CENTERS						
1	Capital Related-Bldgs and Fixtures						1
2	Capital Related-Movable Equipment						2
3	Plant Operation & Maintenance						3
4	Transportation (see instructions)						4
5	Administrative and General	99,807		959		98,078	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	523,885		20,124			6
7	Physical Therapy			13,151			7
8	Occupational Therapy			3,993			8
9	Speech Pathology			631			9
10	Medical Social Services	3,959					10
11	Home Health Aide	72,017		10,988			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)	699,668		49,846		98,078	24

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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 CENTERS						
1	Capital Related-Bldgs and Fixtures						1
2	Capital Related-Movable Equipment						2
3	Plant Operation & Maintenance						3
4	Transportation (see instructions)						4
5	Administrative and General	198,844		198,844		198,844	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	544,009		544,009		544,009	6
7	Physical Therapy	13,151		13,151		13,151	7
8	Occupational Therapy	3,993		3,993		3,993	8
9	Speech Pathology	631		631		631	9
10	Medical Social Services	3,959		3,959		3,959	10
11	Home Health Aide	83,005		83,005		83,005	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)	847,592		847,592		847,592	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 CENTERS						
1	Capital Related-Bldgs. and Fixtures					1
2	Capital Related-Movable Equipment					2
3	Plant Operation & Maintenance					3
4	Transportation (see instructions)					4
5	Administrative and General	198,844				5
HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	544,009				6
7	Physical Therapy	13,151				7
8	Occupational Therapy	3,993				8
9	Speech Pathology	631				9
10	Medical Social Services	3,959				10
11	Home Health Aide	83,005				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 Means Program					21
22	Homemaker Service					22
23	All Others					23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)	847,592				24

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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 CENTERS					
1	Capital Related-Bldgs. and Fixtures					1
2	Capital Related-Movable Equipment					2
3	Plant Operation & Maintenance					3
4	Transportation (see instructions)					4
5	Administrative and General		198,844	198,844		5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care		544,009	166,742	710,751	6
7	Physical Therapy		13,151	4,031	17,182	7
8	Occupational Therapy		3,993	1,224	5,217	8
9	Speech Pathology		631	193	824	9
10	Medical Social Services		3,959	1,213	5,172	10
11	Home Health Aide		83,005	25,441	108,446	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 Means Program					21
22	Homemaker Service					22
23	All Others					23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)		847,592		847,592	24

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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 CENTERS								
1	Capital Related-Bldgs. and Fixtures							1
2	Capital Related-Movable Equipment							2
3	Plant Operation & Maintenance							3
4	Transportation (see instructions)							4
5	Administrative and General					-198,844	648,748	5
HHA REIMBURSABLE SERVICES								
6	Skilled Nursing Care						544,009	6
7	Physical Therapy						13,151	7
8	Occupational Therapy						3,993	8
9	Speech Pathology						631	9
10	Medical Social Services						3,959	10
11	Home Health Aide						83,005	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 Means Program							21
22	Homemaker Service							22
23	All Others							23
23.50	Telemedicine							23.50
24	Totals (sum of lines 1-23)					-198,844	648,748	24
25	Cost To Be Allocated (per Worksheet H-1, Part I)						198,844	25
26	Unit Cost Multiplier						0.306504	26

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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		4,808	92	40,301	45,201	6,025	1
2	Skilled Nursing Care	710,751			211,537	922,288	122,932	2
3	Physical Therapy	17,182				17,182	2,290	3
4	Occupational Therapy	5,217				5,217	695	4
5	Speech Pathology	824				824	110	5
6	Medical Social Services	5,172			1,599	6,771	903	6
7	Home Health Aide	108,446			29,080	137,526	18,331	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)	847,592	4,808	92	282,517	1,135,009	151,286	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.

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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	11,875	5,681		14,714		36,641	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)	11,875	5,681		14,714		36,641	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.

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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				350			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)				350			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.

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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						120,487	1
2	Skilled Nursing Care						1,045,220	2
3	Physical Therapy						19,472	3
4	Occupational Therapy						5,912	4
5	Speech Pathology						934	5
6	Medical Social Services						7,674	6
7	Home Health Aide						155,857	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)						1,355,556	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.

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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 25	SUBTOTAL (cols 23 +/- 24) 26	ALLOCATED HHA A&G (see PtII) 27	TOTAL HHA COSTS 28		
1	Administrative and General		120,487				1
2	Skilled Nursing Care		1,045,220	101,965	1,147,185		2
3	Physical Therapy		19,472	1,900	21,372		3
4	Occupational Therapy		5,912	577	6,489		4
5	Speech Pathology		934	91	1,025		5
6	Medical Social Services		7,674	749	8,423		6
7	Home Health Aide		155,857	15,205	171,062		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)		1,355,556	120,487	1,355,556		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.			0.097555			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.

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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 & FIXT 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	91	99,807		45,201	1,333	1
2	Skilled Nursing Care			523,885		922,288		2
3	Physical Therapy					17,182		3
4	Occupational Therapy					5,217		4
5	Speech Pathology					824		5
6	Medical Social Services			3,959		6,771		6
7	Home Health Aide			72,017		137,526		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	91	699,668		1,135,009	1,333	20
21	Total cost to be allocated	4,808	92	282,517		151,286	11,875	21
22	Unit Cost Multiplier	3.606902		0.403787		0.133291		22
22	Unit Cost Multiplier		1.010989				8.908477	22

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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 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		183		99		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		183		99		20
21	Total cost to be allocated	5,681		14,714		36,641		21
22	Unit Cost Multiplier	4.261815		80.404372		370.111111		22
22	Unit Cost Multiplier							22

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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 ADMINISTRATION DIRECT NURSING HO	CENTRAL SERVICES & SUPPLY COSTED REQUIS	PHARMACY PHARM COSTED REQ	MEDICAL RECORDS & LIBRARY TIME SPENT	SOCIAL SERVICE TIME SPENT	NONPHYSICIAN ANESTHET. ASSIGNED TIME	
		13	14	15	16	17	19	
1	Administrative and General			181				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)			181				20
21	Total cost to be allocated			350				21
22	Unit Cost Multiplier			1.933702				22
22	Unit Cost Multiplier							22

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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		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)	
Patient Services			1	2	3	4	5	
1	Skilled Nursing Care	2	1,147,185		1,147,185	6,769	169.48	1
2	Physical Therapy	3	21,372	208,810	230,182	2,617	87.96	2
3	Occupational Therapy	4	6,489		6,489	426	15.23	3
4	Speech Pathology	5	1,025	6,636	7,661	73	104.95	4
5	Medical Social Services	6	8,423		8,423	47	179.21	5
6	Home Health Aide	7	171,062		171,062	1,317	129.89	6
7	Total (sum of lines 1-6)		1,355,556	215,446	1,571,002	11,249		7

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		5,483		8
9	Physical Therapy	99914		2,135		9
10	Occupational Therapy	99914		287		10
11	Speech Pathology	99914		61		11
12	Medical Social Services	99914		44		12
13	Home Health Aide	99914		1,240		13
14	Total (sum of lines 8-13)			9,250		14

Supplies and Drugs Cost Computations		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 Records)	Ratio (col. 3 ÷ col. 4)	
Other Patient Services			1	2	3	4	5	
15	Cost of Medical Supplies	8		53,627	53,627	139,089	0.385559	15
16	Cost of Drugs	9						16

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	0.270893	770,822	208,810	col. 2, line 2	1
2	Occupational Therapy	67				col. 2, line 3	2
3	Speech Pathology	68	0.377745	17,567	6,636	col. 2, line 4	3
4	Medical Supplies Charged to Pat	71	0.385562	139,089	53,627	col. 2, line 15	4
5	Drugs Charged to Patients	73	0.238987			col. 2, line 16	5

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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			Total Program Cost (sum of cols 9-10)	
		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		
		6	7	8	9	10	11	12	
1	Skilled Nursing Care		5,483			929,259		929,259	1
2	Physical Therapy		2,135			187,795		187,795	2
3	Occupational Therapy		287			4,371		4,371	3
4	Speech Pathology		61			6,402		6,402	4
5	Medical Social Services		44			7,885		7,885	5
6	Home Health Aide		1,240			161,064		161,064	6
7	Total (sum of lines 1-6)		9,250			1,296,776		1,296,776	7

Supplies and Drugs Cost 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

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

HHA CCN: 14-7187

WORKSHEET H-4
PARTS I & II

Check applicable box: Title V Title XVIII Title XIX

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

	Description	Part A 1	Part B		
			Not Subject to Deductibles & Coinsurance 2	Subject to Deductibles & Coinsurance 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 amounts				9

PART II - 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		1,082,613	11
12	Total PPS Reimbursement - Full Episodes with Outliers		81,226	12
13	Total PPS Reimbursement - LUPA Episodes		19,738	13
14	Total PPS Reimbursement - PEP Episodes		9,121	14
15	Total PPS Outlier Reimbursement - Full Episodes with Outliers		32,497	15
16	Total PPS Outlier Reimbursement - PSP Episodes			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 thru 20 minus line 21)		1,225,195	22
23	Excess reasonable cost (from line 8)			23
24	Subtotal (line 22 minus line 23)		1,225,195	24
25	Coinsurance billed to program patients (from your records)			25
26	Net cost (line 24 minus line 25)		1,225,195	26
27	Reimbursable bad debts (from your records)			27
28	Reimbursable bad debts for dual eligible (see instructions)			28
29	Total costs - current cost reporting period (line 26 plus line 27)		1,225,195	29
30	Other adjustments (see instructions) (specify)			30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			30.50
31	Subtotal (see instructions)		1,225,195	31
31.01	Sequestration adjustment (see instructions)		24,505	31.01
32	Interim payments (see instructions)		1,200,690	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, §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 1	Amount 2	mm/dd/yyyy 3	Amount 4	
1	Total interim payments paid to provider				1,200,690	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero.					2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
		.01				3.01
		.02				3.02
	Program	.03				3.03
	To	.04				3.04
	Provider	.05				3.05
		.06				3.06
		.07				3.07
		.08				3.08
		.09				3.09
		.10				3.10
		.50				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)				1,200,690	4
TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
		.01				5.01
		.02				5.02
	Program	.03				5.03
	To	.04				5.04
	Provider	.05				5.05
		.06				5.06
		.07				5.07
		.08				5.08
		.09				5.09
		.10				5.10
		.50				5.50
		.51				5.51
	Provider	.52				5.52
	To	.53				5.53
	Program	.54				5.54
		.55				5.55
		.56				5.56
		.57				5.57
		.58				5.58
		.59				5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				5.99
6	Determine net settlement amount (balance due) based on the cost report (see instructions)	.01				6.01
		.02				6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				1,200,690	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 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	27,565		674		118,369	6
	INPATIENT CARE SERVICE						
7	Inpatient - General Care						7
8	Inpatient - Respite Care						8
	VISITING SERVICES						
9	Physician Services						9
10	Nursing Care	108,615		17,559			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	45,515					15
16	Spiritual Counseling						16
17	Dietary Counseling						17
18	Counseling - Other						18
19	Home Health Aide and Homemaker	19,930		5,511			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)	201,625		23,744		118,369	39

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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						1
2						2
3						3
4						4
5						5
6	146,608		146,608		146,608	6
INPATIENT CARE SERVICE						
7						7
8						8
VISITING SERVICES						
9						9
10	126,174		126,174		126,174	10
11						11
12						12
13						13
14						14
15	45,515		45,515		45,515	15
16						16
17						17
18						18
19	25,441		25,441		25,441	19
20						20
21						21
OTHER HOSPICE SERVICE COSTS						
22						22
23						23
24						24
25						25
26						26
27						27
28						28
29						29
30						30
31						31
32						32
33						33
34						34
HOSPICE NONREIMBURSABLE SERVICE						
35						35
36						36
37						37
38						38
39	343,738		343,738		343,738	39

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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 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				27,565		6
	INPATIENT CARE SERVICE						
7	Inpatient - General Care						7
8	Inpatient - Respite Care						8
	VISITING SERVICES						
9	Physician Services						9
10	Nursing Care					108,615	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			45,515			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 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)			45,515	27,565	108,615	39

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

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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					1
2					2
3					3
4					4
5					5
6				27,565	6
INPATIENT CARE SERVICE					
7					7
8					8
VISITING SERVICES					
9					9
10				108,615	10
11					11
12					12
13					13
14					14
15				45,515	15
16					16
17					17
18					18
19		19,930		19,930	19
20					20
21					21
OTHER HOSPICE SERVICE COSTS					
22					22
23					23
24					24
25					25
26					26
27					27
28					28
29					29
30					30
31					31
32					32
33					33
34					34
HOSPICE NONREIMBURSABLE SERVICE					
35					35
36					36
37					37
38					38
39		19,930		201,625	39

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

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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 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						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 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)						39

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

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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					1
2					2
3					3
4					4
5					5
6					6
INPATIENT CARE SERVICE					
7					7
8					8
VISITING SERVICES					
9					9
10					10
11					11
12					12
13					13
14					14
15					15
16					16
17					17
18					18
19					19
20					20
21					21
OTHER HOSPICE SERVICE COSTS					
22					22
23					23
24					24
25					25
26					26
27					27
28					28
29					29
30					30
31					31
32					32
33					33
34					34
HOSPICE NONREIMBURSABLE SERVICE					
35					35
36					36
37					37
38					38
39					39

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

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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 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						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 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)						39

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

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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					1
2					2
3					3
4					4
5					5
6					6
INPATIENT CARE SERVICE					
7					7
8					8
VISITING SERVICES					
9					9
10					10
11					11
12					12
13					13
14					14
15					15
16					16
17					17
18					18
19					19
20					20
21					21
OTHER HOSPICE SERVICE COSTS					
22					22
23					23
24					24
25					25
26					26
27					27
28					28
29					29
30					30
31					31
32					32
33					33
34					34
HOSPICE NONREIMBURSABLE SERVICE					
35					35
36					36
37					37
38					38
39					39

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

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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 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	146,608				6
	INPATIENT CARE SERVICE					
7	Inpatient - General Care					7
8	Inpatient - Respite Care					8
	VISITING SERVICES					
9	Physician Services					9
10	Nursing Care	126,174				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	45,515				15
16	Spiritual Counseling					16
17	Dietary Counseling					17
18	Counseling - Other					18
19	Home Health Aide and Homemaker	25,441				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)	343,738				39

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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 Fixt.				1
2	Capital Related Costs-Movable Egiup.				2
3	Plant Operation and Maintenance				3
4	Transportation - Staff				4
5	Volunteer Service Coordination				5
6	Administrative and General		146,608	146,608	6
INPATIENT CARE SERVICE					
7	Inpatient - General Care				7
8	Inpatient - Respite Care				8
VISITING SERVICES					
9	Physician Services				9
10	Nursing Care		126,174	93,837	220,011
11	Nursing Care-Continuous Home Care				11
12	Physical Therapy				12
13	Occupational Therapy				13
14	Speech / Language Pathology				14
15	Medical Social Services		45,515	33,850	79,365
16	Spiritual Counseling				16
17	Dietary Counseling				17
18	Counseling - Other				18
19	Home Health Aide and Homemaker		25,441	18,921	44,362
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)		343,738		343,738

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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COST ALLOCATION - HOSPICE STATISTICAL BASIS

HOSPICE CCN: 14-1542

WORKSHEET K-4
PART II

	COST CENTER DESCRIPTIONS	CAPITAL RELATED COSTS						ADMINIS- TRATIVE & GENERAL (Acc. Cost)	
		BUILDINGS & FIXTURES (Sq. Ft.)	MOVABLE EQUIPMENT (\$ Value)	PLANT OPERATION & MAINT. (Sq. Ft.)	TRANS- PORTATION (Mileage)	VOLUNTEER SERVICES COORDI- NATOR (Hours)	RECONCIL- IATION		
		1	2	3	4	5	6A	6	
	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						-146,608	197,130	6
	INPATIENT CARE SERVICE								
7	Inpatient - General Care								7
8	Inpatient - Respite Care								8
	VISITING SERVICES								
9	Physician Services								9
10	Nursing Care							126,174	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							45,515	15
16	Spiritual Counseling								16
17	Dietary Counseling								17
18	Counseling - Other								18
19	Home Health Aide and Homemaker							25,441	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	Cost to be Allocated (per Wskt K-4, Part I)							146,608	39
40	Unit Cost Multiplier							0.743712	40

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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 ENEFFITS DEPARTMENT	SUBTOTAL 4A	ADMINISTRA TIVE & GEN ERAL	
		0	1	2	4		5	
1	Administrative and General		4,808	558	11,130	16,496	2,199	1
2	Inpatient - General Care							2
3	Inpatient - Respite Care							3
4	Physician Services							4
5	Nursing Care	220,011			43,858	263,869	35,171	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	79,365			18,378	97,743	13,028	10
11	Spiritual Counseling							11
12	Dietary Counseling							12
13	Counseling - Other							13
14	Home Health Aide and Homemaker	44,362			8,048	52,410	6,986	14
15	HH Aide & Homemaker - Cont. Home Care							15
16	Other							16
17	Drugs, Biological and Infusion Therapy							17
18	Analgesics							18
19	Sedatives / Hypnotics							19
20	Other - Specify							20
21	Durable Medical 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/R Dept.)							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)	343,738	4,808	558	81,414	430,518	57,384	34
35	Unit Cost Multiplier (see instructions)							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.

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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	11,875	5,681		14,634		19,246	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 Care							15
16	Other							16
17	Drugs, Biological and Infusion Therapy							17
18	Analgesics							18
19	Sedatives / Hypnotics							19
20	Other - Specify							20
21	Durable Medical 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/R Dept.)							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)	11,875	5,681		14,634		19,246	34
35	Unit Cost Multiplier (see instructions)							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.

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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							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 Care							15
16	Other							16
17	Drugs, Biological and Infusion Therapy							17
18	Analgesics							18
19	Sedatives / Hypnotics							19
20	Other - Specify							20
21	Durable Medical 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/R Dept.)							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)							34
35	Unit Cost Multiplier (see instructions)							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.

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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						70,131	1
2	Inpatient - General Care							2
3	Inpatient - Respite Care							3
4	Physician Services							4
5	Nursing Care						299,040	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						110,771	10
11	Spiritual Counseling							11
12	Dietary Counseling							12
13	Counseling - Other							13
14	Home Health Aide and Homemaker						59,396	14
15	HH Aide & Homemaker - Cont. Home Care							15
16	Other							16
17	Drugs, Biological and Infusion Therapy							17
18	Analgesics							18
19	Sedatives / Hypnotics							19
20	Other - Specify							20
21	Durable Medical 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/R Dept.)							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)						539,338	34
35	Unit Cost Multiplier (see instructions)							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.

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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		70,131				1
2	Inpatient - General Care						2
3	Inpatient - Respite Care						3
4	Physician Services						4
5	Nursing Care		299,040	44,696	343,736		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		110,771	16,557	127,328		10
11	Spiritual Counseling						11
12	Dietary Counseling						12
13	Counseling - Other						13
14	Home Health Aide and Homemaker		59,396	8,878	68,274		14
15	HH Aide & Homemaker - Cont. Home Care						15
16	Other						16
17	Drugs, Biological and Infusion Therapy						17
18	Analgesics						18
19	Sedatives / Hypnotics						19
20	Other - Specify						20
21	Durable Medical 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/R Dept.)						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)		539,338		539,338		34
35	Unit Cost Multiplier (see instructions)			0.149467			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	549	27,565		16,496	1,333	1
2	Inpatient - General Care							2
3	Inpatient - Respite Care							3
4	Physician Services							4
5	Nursing Care			108,615		263,869		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			45,515		97,743		10
11	Spiritual Counseling							11
12	Dietary Counseling							12
13	Counseling - Other							13
14	Home Health Aide and Homemaker			19,930		52,410		14
15	HH Aide & Homemaker - Cont. Home Care							15
16	Other							16
17	Drugs, Biological and Infusion Therapy							17
18	Analgesics							18
19	Sedatives / Hypnotics							19
20	Other - Specify							20
21	Durable Medical 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/R Dept.)							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	549	201,625		430,518	1,333	34
35	Total cost to be allocated	4,808	558	81,414		57,384	11,875	35
36	Unit Cost Multiplier (see instructions)	3.606902		0.403789		0.133291		36
36	Unit Cost Multiplier (see instructions)		1.016393				8.908477	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	LAUNDRY & LINEN SERVICE 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		182		52		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 Care							15
16	Other							16
17	Drugs, Biological and Infusion Therapy							17
18	Analgesics							18
19	Sedatives / Hypnotics							19
20	Other - Specify							20
21	Durable Medical 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/R Dept.)							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		182		52		34
35	Total cost to be allocated	5,681		14,634		19,246		35
36	Unit Cost Multiplier (see instructions)	4.261815		80.406593		370.115385		36
36	Unit Cost Multiplier (see instructions)							36

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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	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							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 Care							15
16	Other							16
17	Drugs, Biological and Infusion Therapy							17
18	Analgesics							18
19	Sedatives / Hypnotics							19
20	Other - Specify							20
21	Durable Medical 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/R Dept.)							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 (see instructions)							36
36	Unit Cost Multiplier (see instructions)							36

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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 Care							15
16	Other							16
17	Drugs, Biological and Infusion Therapy							17
18	Analgesics							18
19	Sedatives / Hypnotics							19
20	Other - Specify							20
21	Durable Medical 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/R Dept.)							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 (see instructions)							36
36	Unit Cost Multiplier (see instructions)							36

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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	0.270893			1
2	Occupational Therapy	67				2
3	Speech / Language Pathology	68	0.377745			3
4	Drugs, Biological and Infusion Therapy	73	0.238987			4
5	Durable Medical Equipment/Oxygen	96				5
6	Labs and Diagnostics	60	0.138218			6
7	Medical Supplies	71	0.385562			7
8	Outpatient Services (including E/R Dept.)	93				8
9	Radiation Therapy	55				9
10	Other	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

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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CALCULATION OF HOSPICE PER DIEM COST

HOSPICE CCN: 14-1542

WORKSHEET K-6

COMPUTATION OF PER DIEM COST		TITLE XVIII	TITLE XIX	OTHER	TOTAL	
		1	2	3	4	
1	Total cost (see instructions)				539,338	1
2	Total unduplicated days (Worksheet S-9, column 6, line 5)				4,128	2
3	Average cost per diem (line 1 divided by line 2)				130.65	3
4	Unduplicated Medicare days (Worksheet S-9, column 1, line 5)	3,858				4
5	Aggregate Medicare cost (line 3 times line 4)	504,048				5
6	Unduplicated Medicaid days (Worksheet S-9, column 2, line 5)		22			6
7	Aggregate Medicaid cost (line 3 times line 6)		2,874			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)			248		12
13	Aggregate cost for other days (line 3 times line 12)			32,401		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.

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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	341,312	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	92	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)	12.65	3
4	Number of interns & residents (see instructions)		4
5	Indirect medical education percentage (see instructions)		5
6	Indirect medical education adjustment (see instructions)		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 (see instructions)		11
12	Total prospective capital payments (see instructions)	341,404	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

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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 (see instructions)	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 (see instructions)	11
12	Total prospective capital payments (see instructions)	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

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDINARY 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 SERVICE 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						
88	Rural Health Clinic						88
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 Centers						201
202	TOTAL (sum of lines 118-201)						202

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ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/
FEDERALLY QUALIFIED HEALTH CENTER COSTS

COMPONENT CCN: 14-8548

WORKSHEET M-1

Check applicable box: RHC I FQHC

		COMPENSATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASSIFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	Physician	23,032		23,032		23,032		23,032	1
2	Physician Assistant								2
3	Nurse Practitioner	7,489		7,489		7,489		7,489	3
4	Visiting Nurse								4
5	Other Nurse	6,660		6,660		6,660		6,660	5
6	Clinical Psychologist								6
7	Clinical Social Worker								7
8	Laboratory Technician	3,734		3,734		3,734		3,734	8
9	Other Facility Health Care Staff Costs								9
10	Subtotal (sum of lines 1 through 9)	40,915		40,915		40,915		40,915	10
	COSTS UNDER AGREEMENT								
11	Physician Services Under Agreement								11
12	Physician Supervision Under Agreement								12
13	Other Costs Under Agreement								13
14	Subtotal (sum of lines 11 through 13)								14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies		2,742	2,742		2,742		2,742	15
16	Transportation (Health Care Staff)		391	391		391		391	16
17	Depreciation-Medical Equipment								17
18	Professional Liability Insurance								18
19	Other Health Care Costs								19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)		3,133	3,133		3,133		3,133	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	40,915	3,133	44,048		44,048		44,048	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
26	All other nonreimbursable costs								26
27	Nonallowable GME costs								27
28	Total Nonreimbursable Costs (sum of lines 23 through 27)								28
	FACILITY OVERHEAD								
29	Facility Costs								29
30	Administrative Costs	12,513	2,173	14,686		14,686		14,686	30
31	Total Facility Overhead (sum of lines 29 and 30)	12,513	2,173	14,686		14,686		14,686	31
32	Total facility costs (sum of lines 22, 28 and 31)	53,428	5,306	58,734		58,734		58,734	32

The net expenses for cost allocation on Worksheet A for the RHC/FQHC cost center line must equal the total facility costs in column 7, line 32 of this worksheet.

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

COMPONENT CCN: 14-8548

WORKSHEET M-2

Check applicable box: RHC I FQHC

VISITS AND PRODUCTIVITY

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	Positions	1	2	3	4	5	
1	Physicians	0.92	475	4,200	3,864		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	0.87	402	2,100	1,827		3
4	Subtotal (sum of lines 1 through 3)	1.79	877		5,691	5,691	4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker						7
7.01	Medical Nutrition Therapist (FQHC only)						7.01
7.02	Diabetes Self Management Training (FQHC only)						7.02
8	Total FTEs and Visits (sum of lines 4 through 7)	1.79	877			5,691	8
9	Physician Services Under Agreements						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					44,048	10
11	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)						11
12	Cost of all services (excluding overhead) (sum of lines 10 and 11)					44,048	12
13	Ratio of RHC/FQHC services (line 10 divided by line 12)					1.000000	13
14	Total facility overhead (from Wkst. M-1, col. 7, line 31)					14,686	14
15	Parent provider overhead allocated to facility (see instructions)					38,019	15
16	Total overhead (sum of lines 14 and 15)					52,705	16
17	Allowable Direct GME overhead (see instructions)						17
18	Subtotal (see instructions)					52,705	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)					52,705	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)					96,753	20

(1) The productivity standard for physicians is 4,200 and 2,100 for physician assistants and nurse practitioners. If an exception to the standard has been granted (Worksheet S-8, line 12 equals 'Y'), column 3, lines 1 thru 3 of this worksheet should contain, at a minimum, one element that is different than the standard.

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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

COMPONENT CCN: 14-8548

WORKSHEET M-3

Check applicable boxes: RHC I FQHC Title V Title XVIII Title XIX

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	Total allowable cost of RHC/FQHC services (from Wkst. M-2, line 20)	96,753	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	53	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	96,700	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	5,691	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	5,691	6
7	Adjusted cost per visit (line 3 divided by line 6)	16.99	7

		Calculation of Limit (1)		
		Prior to January 1	On or after January 1	(See instr.)
		1	2	3
8	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)			8
9	Rate for program covered visits (see instructions)	16.99	16.99	9
CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)			10
11	Program cost excluding costs for mental health services (line 9 x line 10)			11
12	Program covered visits for mental health services (from contractor records)			12
13	Program covered cost from mental health services (line 9 x line 12)			13
14	Limit adjustment for mental health services (see instructions)			14
15	Graduate Medical Education pass-through cost (see instructions)			15
16	Total Program cost (see instructions)			16
16.01	Total program charges (see instructions)(from contractor's records)			16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			16.02
16.03	Total program preventive costs (see instructions)			16.03
16.04	Total program non-preventive costs (see instructions)			16.04
16.05	Total program cost (see instructions)			16.05
17	Primary payer payments			17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)			18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			19
20	Net Medicare cost excluding vaccines (see instructions)			20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		53	21
22	Total reimbursable Program cost (line 20 plus line 21)		53	22
23	Allowable bad debts (see instructions)			23
23.01	Adjusted reimbursable bad debts (see instructions)			23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)			24
25	Other adjustments (specify) (see instructions)			25
26	Net reimbursable amount (see instructions)		53	26
26.01	Sequestration adjustment (see instructions)		1	26.01
27	Interim payments			27
28	Tentative settlement (for contractor use only)			28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		52	29
30	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			30

(1) Lines 8 through 14: Fiscal year providers use columns 1 & 2, calendar year providers use column 2 only.

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ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC
 PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

COMPONENT CCN: 14-8548

WORKSHEET M-5

Check applicable box: RHC I FQHC

		Part B		
DESCRIPTION		mm/dd/yyyy	Amount	
		1	2	
1	Total interim payments paid to provider			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 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 zero (1)			
		.01		3.01
		.02		3.02
	Program	.03		3.03
	to	.04		3.04
	Provider	.05		3.05
		.06		3.06
		.07		3.07
		.08		3.08
		.09		3.09
		.10		3.10
		.50		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. M-3, line 27)			
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 zero (1)			
		.01		5.01
		.02		5.02
	Program	.03		5.03
	to	.04		5.04
	Provider	.05		5.05
		.06		5.06
		.07		5.07
		.08		5.08
		.09		5.09
		.10		5.10
		.50		5.50
		.51		5.51
	Provider	.52		5.52
	to	.53		5.53
	Program	.54		5.54
		.55		5.55
		.56		5.56
		.57		5.57
		.58		5.58
		.59		5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99		5.99
6	Determine net settlement amount (balance due) based on the cost report (1)	.01	52	6.01
		.02		6.02
7	Total Medicare program liability (see instructions)		52	
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 you agree to the amount of repayment, even though the total repayment is not accomplished until a later date.

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	Non CMS worksheet CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/20/2016 Run Time: 08:49 Version: 2015.10 (02/03/2016)
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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	47.55		15.07				62.62	30
31	Intensive Care Unit	92.09		3.41				95.50	31
43	Nursery			54.83				54.83	43
	UTILIZATION PERCENTAGES BASED ON CHARGES								
50	Operating Room	7.22	22.75					29.97	50
53	Anesthesiology	2.64	6.09					8.73	53
54	Radiology-Diagnostic	9.76	29.94					39.70	54
56	Radioisotope	3.51	47.68					51.19	56
57	CT Scan	9.83	30.07					39.90	57
58	MRI	1.73	28.87					30.60	58
60	Laboratory	12.16	12.80					24.96	60
64	Intravenous Therapy	28.09	19.11					47.20	64
65	Respiratory Therapy	39.40	18.72					58.12	65
66	Physical Therapy	4.58	0.07					4.65	66
68	Speech Pathology	6.78	4.26					11.04	68
69	Electrocardiology	10.82	36.00					46.82	69
71	Medical Supplies Charged to Pat	16.73	19.96					36.69	71
72	Impl. Dev. Charged to Patients	19.58	27.98					47.56	72
73	Drugs Charged to Patients	19.30	28.91					48.21	73
91	Emergency	9.65	22.46					32.11	91
92	Observation Beds (Non-Distinct	8.54	22.11					30.65	92
200	TOTAL CHARGES	10.50	19.77					30.27	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	25.52		51.40				76.92	40
UTILIZATION PERCENTAGES BASED ON CHARGES									
54	Radiology-Diagnostic	0.02						0.02	54
57	CT Scan	0.13						0.13	57
58	MRI	0.15						0.15	58
60	Laboratory	0.37						0.37	60
64	Intravenous Therapy	0.05						0.05	64
65	Respiratory Therapy	0.44						0.44	65
66	Physical Therapy	0.01						0.01	66
68	Speech Pathology	0.37						0.37	68
69	Electrocardiology	0.12						0.12	69
71	Medical Supplies Charged to Pat	0.07						0.07	71
73	Drugs Charged to Patients	1.32						1.32	73
91	Emergency	0.58						0.58	91
200	TOTAL CHARGES	0.27						0.27	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	29.58						29.58	44
	UTILIZATION PERCENTAGES BASED ON CHARGES								
54	Radiology-Diagnostic	0.84						0.84	54
56	Radioisotope	0.25						0.25	56
57	CT Scan	0.44						0.44	57
58	MRI	0.11						0.11	58
60	Laboratory	1.16						1.16	60
64	Intravenous Therapy	4.24						4.24	64
65	Respiratory Therapy	17.68						17.68	65
66	Physical Therapy	22.37						22.37	66
68	Speech Pathology	11.52						11.52	68
69	Electrocardiology	0.21						0.21	69
71	Medical Supplies Charged to Pat	2.44						2.44	71
73	Drugs Charged to Patients	8.10						8.10	73
92	Observation Beds (Non-Distinct	0.13						0.13	92
200	TOTAL CHARGES	3.40						3.40	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	7	
	UTILIZATION PERCENTAGES BASED ON CHARGES								
54	Radiology-Diagnostic	0.11						0.11	54
57	CT Scan	0.08						0.08	57
60	Laboratory	0.16						0.16	60
64	Intravenous Therapy	0.82						0.82	64
65	Respiratory Therapy	3.16						3.16	65
66	Physical Therapy	1.20						1.20	66
68	Speech Pathology	1.25						1.25	68
69	Electrocardiology	0.20						0.20	69
71	Medical Supplies Charged to Pat	0.34						0.34	71
73	Drugs Charged to Patients	1.11						1.11	73
92	Observation Beds (Non-Distinct)	0.02						0.02	92
200	TOTAL CHARGES	0.35						0.35	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	637,305	1.46	-637,305	-2.88			1
2	Cap Rel Costs-Mvble Equip	1,319,453	3.02	-1,319,453	-5.97			2
3	Other Cap Rel Costs							3
4	Employee Benefits Department	8,483,016	19.45	-8,483,016	-38.39			4
5	Administrative & General	3,971,602	9.10	-3,971,602	-17.97			5
6	Maintenance & Repairs	913,413	2.09	-913,413	-4.13			6
7	Operation of Plant	466,034	1.07	-466,034	-2.11			7
8	Laundry & Linen Service	163,737	0.38	-163,737	-0.74			8
9	Housekeeping	516,777	1.18	-516,777	-2.34			9
10	Dietary	362,757	0.83	-362,757	-1.64			10
11	Cafeteria	714,094	1.64	-714,094	-3.23			11
12	Maintenance of Personnel							12
13	Nursing Administration	1,380,711	3.17	-1,380,711	-6.25			13
14	Central Services & Supply	76,703	0.18	-76,703	-0.35			14
15	Pharmacy	2,360,040	5.41	-2,360,040	-10.68			15
16	Medical Records & Library	731,157	1.68	-731,157	-3.31			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	1,947,655	4.46	3,324,629	15.05	5,272,284	12.09	30
31	Intensive Care Unit	689,504	1.58	888,844	4.02	1,578,348	3.62	31
40	Subprovider - IPF	768,618	1.76	1,055,606	4.78	1,824,224	4.18	40
43	Nursery	249,959	0.57	294,438	1.33	544,397	1.25	43
44	Skilled Nursing Facility	1,199,503	2.75	1,953,631	8.84	3,153,134	7.23	44
ANCILLARY SERVICE COST CENTERS								
50	Operating Room	1,056,008	2.42	1,179,566	5.34	2,235,574	5.12	50
53	Anesthesiology	19,097	0.04	134,409	0.61	153,506	0.35	53
54	Radiology-Diagnostic	919,956	2.11	910,344	4.12	1,830,300	4.20	54
56	Radioisotope	126,409	0.29	105,897	0.48	232,306	0.53	56
57	CT Scan	267,104	0.61	141,783	0.64	408,887	0.94	57
58	MRI	306,225	0.70	40,817	0.18	347,042	0.80	58
60	Laboratory	2,472,975	5.67	1,073,018	4.86	3,545,993	8.13	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy	39,834	0.09	82,369	0.37	122,203	0.28	64
65	Respiratory Therapy	383,217	0.88	362,310	1.64	745,527	1.71	65
66	Physical Therapy	1,583,885	3.63	1,155,941	5.23	2,739,826	6.28	66
68	Speech Pathology	163,645	0.38	107,785	0.49	271,430	0.62	68
69	Electrocardiology	159,550	0.37	33,714	0.15	193,264	0.44	69
71	Medical Supplies Charged to Patients	1,576,002	3.61	432,384	1.96	2,008,386	4.60	71
72	Impl. Dev. Charged to Patients	269,296	0.62	84,696	0.38	353,992	0.81	72
73	Drugs Charged to Patients			2,835,802	12.83	2,835,802	6.50	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic	58,734	0.13	38,019	0.17	96,753	0.22	88
91	Emergency	1,230,361	2.82	1,061,245	4.80	2,291,606	5.25	91
92	Observation Beds (Non-Distinct Part)							92
OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	651,943	1.49	782,769	3.54	1,434,712	3.29	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	847,592	1.94	507,964	2.30	1,355,556	3.11	101
SPECIAL PURPOSE COST CENTERS								
116	Hospice	343,738	0.79	195,600	0.89	539,338	1.24	116
NONREIMBURSABLE COST CENTERS								
192	Physicians' Private Offices	4,172,980	9.57	3,297,601	14.92	7,470,581	17.13	192
194	OTHER NONREIMBURSABLE							194
194.01	MEMORY DISORDER	22,551	0.05	15,618	0.07	38,169	0.09	194.01
194.02	ASSISTED LIVING							194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL	43,623,140	100.00			43,623,140	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	341,398	15,653,833	0.021809	1,130,263	24,650	50
53	Anesthesiology	25,652	11,766,064	0.002180	310,671	677	53
54	Radiology-Diagnostic	285,228	11,070,860	0.025764	1,080,208	27,830	54
56	Radioisotope	28,860	2,974,134	0.009704	104,280	1,012	56
57	CT Scan	29,095	13,884,549	0.002095	1,364,361	2,858	57
58	MRI	2,841	2,646,476	0.001074	45,809	49	58
60	Laboratory	121,642	25,655,051	0.004741	3,118,516	14,785	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	Intravenous Therapy	3,662	1,055,003	0.003471	296,374	1,029	64
65	Respiratory Therapy	24,639	3,500,804	0.007038	1,379,346	9,708	65
66	Physical Therapy	58,281	10,114,035	0.005762	462,935	2,667	66
68	Speech Pathology	3,621	718,553	0.005039	48,722	246	68
69	Electrocardiology	4,762	2,684,576	0.001774	290,385	515	69
71	Medical Supplies Charged to Pat	55,133	5,208,977	0.010584	871,489	9,224	71
72	Impl. Dev. Charged to Patients	11,391	673,238	0.016920	131,829	2,231	72
73	Drugs Charged to Patients	121,145	11,865,923	0.010209	2,289,600	23,375	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
88	Rural Health Clinic	2,594	98,407	0.026360			88
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	127,367	10,018,424	0.012713	966,354	12,285	91
92	Observation Beds (Non-Distinct	63,262	2,385,509	0.026519	203,641	5,400	92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services						95
200	TOTAL	1,310,573	131,974,416		14,094,783	138,541	200

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

	COST CENTER DESCRIPTION	CAPITAL RELATED COSTS	SWING-BED ADJUSTMENT 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	307,492	3,885	303,607	4,778	63.54	2,272	144,363	30
31	Intensive Care Unit	81,710		81,710	822	99.40	757	75,246	31
200	TOTAL	389,202	3,885	385,317	5,600		3,029	219,609	200

MEDICARE INPATIENT ROUTINE SERVICE PPS CAPITAL COSTS	219,609
MEDICARE INPATIENT ANCILLARY SERVICE PPS CAPITAL COSTS	138,541
TOTAL MEDICARE INPATIENT PPS CAPITAL COSTS	358,150
MEDICARE DISCHARGES (Worksheet S-3, Part I, line 14, column 13)	762
MEDICARE PATIENT DAYS (Worksheet S-3, Part I, line 14, column 6 - Worksheet S-3, Part I, line 5, column 6)	3,029
PER DISCHARGE CAPITAL COSTS	470.01

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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)	6,157,948
2. HOSPITAL PART A TITLE XVIII CHARGES (sum of inpatient charges and ancillary charges on Worksheet D-3 for hospital Title XVIII component)	17,254,802
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.357

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))	547,365
2. TOTAL MEDICARE CHARGES (Worksheet D-3, line 40, column 2 plus Worksheet D-3, line 202, column 2) (see CR 5619)	1,017,356
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.538

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)	358,150
2. RATIO OF COST TO CHARGES (line II-1 / line I-2)	0.021

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)	4,142,411
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)	26,417,487
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.157