

INSTRUCTIONS FOR COST REPORT FILING

TO: Ms. Christina Bare
Richland Memorial Hospital
800 East Locust Street
Olney, IL 62450

PROVIDER NO. 14-0147
PERIOD ENDED 09/30/2017

THE ENCLOSED FORMS SHOULD BE CAREFULLY REVIEWED BEFORE FILING.

FORMS: TITLE XVIII - MEDICARE

- HOSPITAL
- FILE (1) MEDICARE CD WHICH INCLUDES: ECR & PI FILES, ANNUAL AUDIT REPORT, CMS 2552-10 MEDICARE COST ANALYSIS, AND SUPPORTING WORKPAPERS.
- FILE (1) COPY OF SIGNED SIGNATURE PAGE FROM CMS 2552-10 (WORKSHEET S)
- EMAIL PASSWORD PROTECTED DETAILED BAD DEBT LOGS TO: J6_Cost_Report_Filing@anthem.com
- SUBMIT A **COPY** OF THE CHECK WITH THE COST REPORT

DUE DATE: TO BE FILED ON OR BEFORE February 28, 2018

SIGNATURE: THE BOTTOM OF PAGE 1 SHOULD BE SIGNED BY AN OFFICER OR ADMINISTRATOR OF THE HEALTH CARE INSTITUTION.

MAILING: 1 COPY SHOULD BE MAILED TO:

US Postal Service:

National Government Services, Inc.
Cost Report Processing Unit
PO Box 9731
Portland, ME 04104

DATE MAILED _____

Courier:

National Government Services, Inc.
Cost Report Processing Unit
2 Gannett Drive
South Portland, ME 04106

DATE MAILED _____

Mail Check to:

National Government Services
P.O. Box 809199
Chicago, IL 60680-9199

DATE MAILED _____

RICHLAND MEMORIAL HOSPITAL
OLNEY, ILLINOIS
MEDICARE COST REPORT
YEAR ENDED SEPTEMBER 30, 2017

February 22, 2018

National Government Services
P.O. Box 9731
Portland, ME 04104

Dear Sir or Madam:

We are submitting this cost report on behalf of Richland Memorial Hospital for the fiscal year ended September 30, 2017, which includes six Level 2000 Errors. The 200500 errors and the explanation for these errors is as follows:

- If Worksheet S-2, columns 2 and 5, line 14 are present, then there must be an entry on Worksheet O, column 7, line 3.
- If Worksheet S-2, columns 2 and 5, line 14 are present, then there must be an entry on Worksheet O, column 7, line 5.
- If Worksheet S-2, columns 2 and 5, line 14 are present, then there must be an entry on Worksheet O, column 7, line 13.
- If Worksheet S-2, columns 2 and 5, line 14 are present, then there must be an entry on Worksheet O, column 7, line 14.
- If Worksheet S-2, columns 2 and 5, line 14 are present, then there must be an entry on Worksheet O, column 7, line 38.
- If Worksheet S-2, columns 2 and 5, line 14 are present, then there must be an entry on Worksheet O, column 7, line 41.

All of these errors are due to an error in the cost report (Win-LASH) software, and are not indicative of an actual error in the cost report.

Sincerely,

Kerber, Eck & Braeckel LLP

National Government Services, Inc.
P.O. Box 9731
Portland, ME 04104

Re: Provider: Richland Memorial Hospital
Provider Numbers: 14-0147, 14-S147, 14-U147, 14-5580, 14-7187, 14-1542, 14-8548
Period ended: 09/30/2017
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 \$78,000.

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 total amount protested on worksheet E, Part A is \$78,000.

Sincerely,

Richland Memorial Hospital

Richland Memorial Hospital
Hospital Specific Rate Recalculation
September 30, 2017

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
2016 Update Factor	1.0110
2017 Update Factor	1.0098
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
2016 Budget Neutrality	0.998404
2017 Budget Neutrality	0.999078
2012 Rural Floor Add-on	1.009
2014 Document & Coding	0.948
2015 Medicare Part A Offset	0.998
2016 Policy on Admission Floor	<u>1.006</u>
2012 difference	117.22
DRG weight	<u>889.13</u>
	104,228
MDH payment factor	<u>0.75</u>
	<u><u>78,171</u></u>
Rounded	<u><u>78,000</u></u>

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/22/2018 Run Time: 15:19 Version: 2018.01 (02/20/2018)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

WORKSHEET S
PARTS I, II & III

PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report Date: 02/22/2018 Time: 15:19	
	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 (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN
		10. NPR Date: _____ 11. Contractor's Vendor Code: ____ 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by RICHLAND MEMORIAL HOSPITAL (14-0147) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 10/01/2016 and ending 09/30/2017, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

ECR Encryption: 02/22/2018 15:19
ovq3aQU9WzqaHVmN0T.km2k:rcPC0
gmYZ60jfMW0wJwBl2O6cMb3sHSdlnC
28XA16DQoM0xaaAl

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

Title

PI Encryption: 02/22/2018 15:19
aFRavptgRzS:s5qfwNIYOgo0dlqCk0
XOnpr0eQz5qehfUuGrQc5Nq3altRE6
oFYc0wwJq60ELFNh

Date

PART III - SETTLEMENT SUMMARY

		TITLE XVIII			HIT	TITLE XIX	
		TITLE V	PART A	PART B			
		1	2	3	4	5	
1	HOSPITAL		-147,944	-16,611			1
2	SUBPROVIDER - IPF		7,487				2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF		1,257				5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC			160,680			10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		-139,200	144,069			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.

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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 / 2016	To: 09 / 30 / 2017	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.	457	94			105	198	24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.							25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	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
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with the FY 2016 OPSS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)	N					37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning: 10 / 01 / 2016		Ending: 09 / 30 / 2017			38

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

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

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

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

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

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

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

Teaching Hospitals that Claim Residents in Nonprovider Settings

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

WORKSHEET S-2
PART I

Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all 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 is yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			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 is yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)						76
Long Term Care Hospital PPS							
80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.				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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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Title V and XIX Services		V	XIX	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92
93	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97
98	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.06

Rural Providers

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

		1	2	
110	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.		N	110
111	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for additional beds; and/or 'C' for tele-health services.			111

Miscellaneous Cost Reporting Information

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	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.	724,815		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
122	Does the cost report contain state health care related taxes as defined in §1983(w)(3) of the Act? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.	N		122

Transplant Center Information

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

All Providers

		1	2	
140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)	N		140

If this facility is part of a chain organization, enter the name of the home office, the home office contractor name, and home office contractor number on line 141. Enter the address of the home office on lines 142 and 143.

141	Name:	Contractor's Name:	Contractor's Number:	141
142	Street:	P.O. Box:		142
143	City:	State:	ZIP Code:	143
144	Are provider based physicians' costs included in Worksheet A?		Y	144
145	If costs for renal services are claimed on Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.		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.	N			167	
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)				168	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)				168.01	
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. (see instructions)				169	
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)				170	
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no in column 1. If column 1 is 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions)			N	0	171

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

COMPLETED BY ALL HOSPITALS

Provider Organization and Operation		Y/N	Date		
		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

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

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

Bad Debts		Y/N	
		1	2
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12
13	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14

Bed Complement		Y/N	
		1	2
15	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15

		Part A		Part B	
		Y/N	Date	Y/N	Date
		1	2	3	4
PS&R Report Data					
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	11/26/2017	Y	11/26/2017
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			2,171	540	3,304	1
2	HMO and other (see instructions)						214	105		2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF						218		218	5
6	Hospital Adults & Peds. Swing Bed NF									4
7	Total Adults & Peds. (exclude observation beds) (see instructions)		39	14,235			2,389	540	3,526	7
8	Intensive Care Unit	31	8	2,920			687	11	753	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						198	406	13
14	Total (see instructions)		47	17,155			3,076	749	4,685	14
15	CAH Visits									15
16	Subprovider - IPF	40	10	3,650			268	669	1,187	16
17	Subprovider - IRF	41								17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44	34	12,410			2,704		9,589	19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101					8,600		10,132	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					3,065		8,373	26
27	Total (sum of lines 14-26)		92							27
28	Observation Bed Days							186	1,100	28
29	Ambulance Trips						969			29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)									32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33
33.01	LTCH site neutral days and discharges									33.01

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	Component	Full Time Equivalents			DISCHARGES				
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					740	235	1,258	1
2	HMO and other (see instructions)					52			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)		376.54			740	235	1,258	14
15	CAH Visits								15
16	Subprovider - IPF		12.71			42	163	271	16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility		30.38						19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency		13.36						22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)		4.29						24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC		16.28						26
27	Total (sum of lines 14-26)		453.56						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32.01
33	LTCH non-covered days								33
33.01	LTCH site neutral days and discharges								33.01

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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

Part II - Wage Data

		Wkst A Line No.	Amount Reported	Reclassif- ication of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)	
		1	2	3	4	5	6	
SALARIES								
1	Total salaries (see instructions)	200	24,519,332		24,519,332	943,407.00	25.99	1
2	Non-physician anesthetist Part A							2
3	Non-physician anesthetest Part B		842,775		842,775	8,000.00	105.35	3
4	Physician-Part A - Administrative							4
4.01	Physician-Part A - Teaching							4.01
5	Physician-Part B		336,604		336,604	2,080.00	161.83	5
6	Non-physician-Part B		647,915		647,915	31,447.00	20.60	6
7	Interns & residents (in an approved program)	21						7
7.01	Contracted interns & residents (in an approved program)							7.01
8	Home office and/or related organization personnel							8
9	SNF	44	1,240,030		1,240,030	63,190.00	19.62	9
10	Excluded area salaries (see instructions)		6,520,109		6,520,109	200,135.00	32.58	10
OTHER WAGES & RELATED COSTS								
11	Contract labor (see instructions)		255,057		255,057	4,008.00	63.64	11
12	Contract management and administrative services							12
13	Contract labor: Physician-Part A - Administrative							13
14	Home office salaries & wage-related costs							14
14.01	Home office salaries							14.01
14.02	Related organization salaries							14.02
15	Home office: Physician Part A - Administrative							15
16	Home office & Contract Physicians Part A - Teaching							16
WAGE-RELATED COSTS								
17	Wage-related costs (core)(see instructions)		6,597,868		6,597,868			17
18	Wage-related costs (other)(see instructions)		227,598		227,598			18
19	Excluded areas		2,531,010		2,531,010			19
20	Non-physician anesthetist Part A							20
21	Non-physician anesthetist Part B		160,028		160,028			21
22	Physician Part A - Administrative							22
22.01	Physician Part A - Teaching							22.01
23	Physician Part B		14,640		14,640			23
24	Wage-related costs (RHC/FQHC)		86,333		86,333			24
25	Interns & residents (in an approved program)							25
25.50	Home office wage-related							25.50
25.51	Related organization wage-related							25.51
25.52	Home office: Physician Part A - Administrative - wage-related							25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related							25.53
OVERHEAD COSTS - DIRECT SALARIES								
26	Employee Benefits Department		243,551		243,551	5,586.00	43.60	26
27	Administrative & General		2,098,153		2,098,153	98,704.00	21.26	27
28	Administrative & General under contract (see instructions)		36,000		36,000	425.00	84.71	28
29	Maintenance & Repairs		536,047		536,047	24,811.00	21.61	29
30	Operation of Plant							30
31	Laundry & Linen Service		241,873		241,873	17,389.00	13.91	31
32	Housekeeping		353,045		353,045	31,577.00	11.18	32
33	Housekeeping under contract (see instructions)							33
34	Dietary		545,966	-428,851	117,115	11,793.00	9.93	34
35	Dietary under contract (see instructions)							35
36	Cafeteria			428,851	428,851	37,675.00	11.38	36
37	Maintenance of Personnel							37
38	Nursing Administration		1,404,775		1,404,775	43,956.00	31.96	38
39	Central Services and Supply		73,775		73,775	5,876.00	12.56	39
40	Pharmacy		498,609		498,609	13,629.00	36.58	40
41	Medical Records & Medical Records Library		522,868		522,868	25,342.00	20.63	41
42	Social Service							42
43	Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		22,728,038		22,728,038	902,305.00	25.19	1
2	Excluded area salaries (see instructions)		7,760,139		7,760,139	263,325.00	29.47	2
3	Subtotal salaries (line 1 minus line 2)		14,967,899		14,967,899	638,980.00	23.42	3
4	Subtotal other wages & related costs (see instructions)		255,057		255,057	4,008.00	63.64	4
5	Subtotal wage-related costs (see instructions)		6,825,466		6,825,466		45.60%	5
6	Total (sum of lines 3 through 5)		22,048,422		22,048,422	642,988.00	34.29	6
7	Total overhead cost (see instructions)		6,554,662		6,554,662	316,763.00	20.69	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	767,637	1
2		2
3		3
4		4
PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5		5
6		6
7		7
HEALTH AND INSURANCE COST		
8		8
8.01	6,715,347	8.01
8.02		8.02
8.03		8.03
9		9
10		10
11		11
12		12
13		13
14		14
15	66,077	15
16		16
TAXES		
17	1,337,859	17
18	312,886	18
19	22,264	19
20		20
OTHER		
21		21
22		22
23	83,225	23
24	9,305,295	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)	227,598	25
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HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

Part V - Contract Labor and Benefit Cost

Hospital and Hospital-Based Component Identification:

	Component	Contract Labor	Benefit Cost	
	0	1	2	
1	Total facility contract labor and benefit cost	498,696		1
2	Hospital	304,175		2
3	Subprovider - IPF	152,533		3
4	Subprovider - IRF			4
5	Subprovider - (OTHER)			5
6	Swing Beds - SNF			6
7	Swing Beds - NF			7
8	Hospital-Based SNF	28,268		8
9	Hospital-Based NF			9
10	Hospital-Based OLTC			10
11	Hospital-Based HHA			11
12	Separately Certified ASC			12
13	Hospital-Based Hospice	13,720		13
14	Hospital-Based Health Clinic - RHC			14
15	Hospital-Based Health Clinic - FQHC			15
16	Hospital-Based - CMHC			16
17	Renal Dialysis			17
18	Other			18

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HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA

HHA CCN: 14-7187

WORKSHEET S-4

HOME HEALTH AGENCY STATISTICAL DATA

County:

	Description	Title V 1	Title XVIII 2	Title XIX 3	Other 4	Total 5	
1	Home Health Aide Hours		5,789		325	6,114	1
2	Unduplicated Census Count (see instructions)		314.00	34.00	46.00	394.00	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)		2.18		2.18
5	Other Administrative Personnel		1.79		1.79
6	Direct Nursing Service		9.08		9.08
7	Nursing Supervisor		1.07		1.07
8	Physical Therapy Service				8
9	Physical Therapy Supervisor				9
10	Occupational Therapy Service				10
11	Occupational Therapy Supervisor				11
12	Speech Pathology Service				12
13	Speech Pathology Supervisor				13
14	Medical Social Service		0.06		0.06
15	Medical Social Service Supervisor				15
16	Home Health Aide		2.94		2.94
17	Home Health Aide Supervisor				17
18	Other (specify)				18

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				Total (columns 1 through 4)	
		Without Outliers 1	With Outliers 2	LUPA Episodes 3	PEP only Episodes 4		
21	Skilled Nursing Visits	2,912	1,020	88	25	4,045	21
22	Skilled Nursing Visit Charges	780,788	272,141	23,556	6,725	1,083,210	22
23	Physical Therapy Visits	1,717	196	14	18	1,945	23
24	Physical Therapy Visit Charges	461,983	52,692	3,765	4,857	523,297	24
25	Occupational Therapy Visits	330	106	2	1	439	25
26	Occupational Therapy Visit Charges	88,549	28,410	538	269	117,766	26
27	Speech Pathology Visits	91	67	5		163	27
28	Speech Pathology Visit Charges	24,478	17,894	1,345		43,717	28
29	Medical Social Service Visits	17	3	1	1	22	29
30	Medical Social Service Visit Charges	6,335	1,121	374	374	8,204	30
31	Home Health Aide Visits	631	190	4		825	31
32	Home Health Aide Visit Charges	98,389	29,582	626		128,597	32
33	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	5,698	1,582	114	45	7,439	33
34	Other Charges						34
35	Total Charges (sum of lines 22, 24, 26, 28, 30, 32 and 34)	1,460,522	401,840	30,204	12,225	1,904,791	35
36	Total Number of Episodes (standard/non-outlier)	435		37	5	477	36
37	Total Number of Outlier Episodes		33		1	34	37
38	Total Non-Routine Medical Supply Charges	42,227	29,028	3,625	281	75,161	38

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PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

WORKSHEET S-7

		Y/N	DATE	
		1	2	
1	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter 'Y' for yes 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				6
7	RHX				7
8	RHL				8
9	RMX	14		14	9
10	RML	14		14	10
11	RLX				11
12	RUC	48		48	12
13	RUB	56		56	13
14	RUA	143		143	14
15	RVC	302		302	15
16	RVB	324		324	16
17	RVA	953		953	17
18	RHC	201	16	217	18
19	RHB	92	10	102	19
20	RHA	273	51	324	20
21	RMC	38		38	21
22	RMB	41	6	47	22
23	RMA	66	40	106	23
24	RLB				24
25	RLA				25
26	ES3				26
27	ES2				27
28	ES1		8	8	28
29	HE2				29
30	HE1		8	8	30
31	HD2				31
32	HD1		11	11	32
33	HC2				33
34	HC1	10	6	16	34
35	HB2				35
36	HB1	4	13	17	36
37	LE2				37
38	LE1		1	1	38
39	LD2				39
40	LD1	46	4	50	40
41	LC2				41
42	LC1				42
43	LB2				43
44	LB1				44
45	CE2				45
46	CE1				46
47	CD2				47
48	CD1	10	18	28	48
49	CC2				49
50	CC1	11		11	50
51	CB2				51
52	CB1	4	10	14	52
53	CA2				53
54	CA1	26	16	42	54
55	SE3				55
56	SE2				56
57	SE1				57
58	SSC				58
59	SSB				59
60	SSA				60
61	IB2				61
62	IB1				62
63	IA1				63
64	IA2				64
65	BB2				65
66	BB1				66
67	BA2				67
68	BA1				68
69	PE2				69
70	PE1				70
71	PD2				71

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PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

WORKSHEET S-7

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	2	3	4	
72	PD1	11		11	72
73	PC2				73
74	PC1	2		2	74
75	PB2				75
76	PB1	9		9	76
77	PA2				77
78	PA1	6		6	78
199	AAA				199
200	TOTAL	2,704	218	2,922	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	1,761,400	64.95%	Y	202
203	Recruitment				203
204	Retention of employees				204
205	Training	11,088	0.41%	Y	205
206	Other (specify)				206
207	Total SNF Revenue (Worksheet G-2, Part I, line 7, column 3)	2,711,824			207

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HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

COMPONENT CCN: 14-8548

WORKSHEET S-8

Check applicable box: Hospital-Based RHC Hospital-Based FQHC

Clinic Address and Identification:

1	Street: 100 SOUTH MAIN	1
2	City: WEST SALEM State: IL ZIP Code: 62476 County:	2
3	HOSPITAL-BASED 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 a hospital-based 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	from	to	
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
11 Clinic			0800	1700	0800	1700	0800	1700	0800	1700	0800	1700			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.	N		13
14	RHC/FQHC 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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HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

HOSPICE CCN: 14-1542

WORKSHEET S-9
PARTS I THROUGH IV

PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015

		Unduplicated Days					Total (sum of cols. 1, 2, & 5)	
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other		
		1	2	3	4	5	6	
1	Continuous Home Care							1
2	Routine Home Care							2
3	Inpatient Respite Care							3
4	General Inpatient Care							4
5	Total Hospice Days							5

PART II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015

		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							6
7	Total Number of Unduplicated Continuous Care Hours Billable to Medicare							7
8	Average Length of Stay (line 5/line 6)							8
9	Unduplicated Census Count							9

PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015

		Unduplicated Days			Total (sum of cols. 1 through 3)	
		Title XVIII	Title XIX	Other		
		1	2	3	4	
10	Hospice Continuous Home Care					10
11	Hospice Routine Home Care	5,089	170	434	5,693	11
12	Hospice Inpatient Respite Care	9			9	12
13	Hospice General Inpatient Care					13
14	Total Hospice Days	5,098	170	434	5,702	14

PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1	2	3	4	
15	Hospice Inpatient Respite Care					15
16	Hospice General Inpatient Care					16

NOTE: Parts I and 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)	0.254317	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid	3,053,000	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 and/or supplemental payments from Medicaid?	Y	4
5	If line 4 is no, enter DSH and/or supplemental payments from Medicaid		5
6	Medicaid charges	34,479,872	6
7	Medicaid cost (line 1 times line 6)	8,768,818	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.	5,715,818	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

Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent programs (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)	5,715,818	19

Uncompensated care (see instructions for each line)

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,535,370	777,752	2,313,122	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	390,471	777,752	1,168,223	21
22	Payments received from patients for amounts previously written off as charity care	9,624	51,506	61,130	22
23	Cost of charity care (line 21 minus line 22)	380,847	726,246	1,107,093	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, charges for patient days beyond the indigent care program's length of stay limit		25
26	Total bad debt expense for the entire hospital complex (see instructions)	2,125,130	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	245,240	27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	377,293	27.01
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27.01)	1,747,837	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	576,558	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	1,683,651	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	7,399,469	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		603,019	603,019	340,724	943,743	-79,461	864,282	1
2	00200	Cap Rel Costs-Mvble Equip		1,591,995	1,591,995	26,417	1,618,412		1,618,412	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	243,551	9,631,808	9,875,359		9,875,359	-189,195	9,686,164	4
5	00500	Administrative & General	2,098,153	4,791,877	6,890,030	-103,823	6,786,207	-2,391,221	4,394,986	5
6	00600	Maintenance & Repairs	536,047	471,428	1,007,475		1,007,475		1,007,475	6
7	00700	Operation of Plant		530,488	530,488		530,488		530,488	7
8	00800	Laundry & Linen Service	241,873	92,561	334,434		334,434	-201,529	132,905	8
9	00900	Housekeeping	353,045	122,643	475,688		475,688		475,688	9
10	01000	Dietary	545,966	818,605	1,364,571	-1,071,857	292,714		292,714	10
11	01100	Cafeteria				1,071,857	1,071,857	-302,028	769,829	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	1,404,775	197,217	1,601,992		1,601,992		1,601,992	13
14	01400	Central Services & Supply	73,775	45,553	119,328		119,328	-3,873	115,455	14
15	01500	Pharmacy	498,609	1,778,135	2,276,744		2,276,744		2,276,744	15
16	01600	Medical Records & Library	522,868	103,857	626,725		626,725	-1,331	625,394	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	1,707,999	116,195	1,824,194		1,824,194	-184	1,824,010	30
31	03100	Intensive Care Unit	652,713	43,790	696,503		696,503		696,503	31
40	04000	Subprovider - IPF	546,805	172,899	719,704		719,704	-106,077	613,627	40
43	04300	Nursery	246,112	11,707	257,819		257,819		257,819	43
44	04400	Skilled Nursing Facility	1,240,030	137,687	1,377,717		1,377,717		1,377,717	44
ANCILLARY SERVICE COST CENTERS										
50	05000	Operating Room	655,082	297,744	952,826		952,826		952,826	50
53	05300	Anesthesiology	842,775	20,930	863,705		863,705	-842,775	20,930	53
54	05400	Radiology-Diagnostic	678,076	273,765	951,841		951,841		951,841	54
56	05600	Radioisotope	86,237	42,012	128,249		128,249		128,249	56
57	05700	CT Scan	102,676	201,457	304,133		304,133		304,133	57
58	05800	MRI	83,557	103,429	186,986		186,986		186,986	58
60	06000	Laboratory	1,026,029	1,421,427	2,447,456		2,447,456	-19,607	2,427,849	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	06400	Intravenous Therapy		26,032	26,032		26,032		26,032	64
65	06500	Respiratory Therapy	426,300	8,465	434,765		434,765		434,765	65
66	06600	Physical Therapy	1,745,294	68,693	1,813,987		1,813,987		1,813,987	66
68	06800	Speech Pathology	232,856	13,150	246,006		246,006		246,006	68
69	06900	Electrocardiology		163,994	163,994		163,994		163,994	69
71	07100	Medical Supplies Charged to Patients		1,775,647	1,775,647	-370,193	1,405,454		1,405,454	71
72	07200	Impl. Dev. Charged to Patients				370,193	370,193		370,193	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	984,519	126,445	1,110,964		1,110,964		1,110,964	88
91	09100	Emergency	770,306	1,037,104	1,807,410		1,807,410	-934,715	872,695	91
92	09200	Observation Beds (Non-Distinct Part)								92
OTHER REIMBURSABLE COST CENTERS										
95	09500	Ambulance Services	706,400	146,145	852,545		852,545		852,545	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	679,290	133,028	812,318		812,318		812,318	101
SPECIAL PURPOSE COST CENTERS										
113	11300	Interest Expense		263,318	263,318	-263,318				113
116	11600	Hospice	221,543	180,791	402,334		402,334		402,334	116
118		SUBTOTALS (sum of lines 1-117)	20,153,261	27,565,040	47,718,301		47,718,301	-5,071,996	42,646,305	118
NONREIMBURSABLE COST CENTERS										
192	19200	Physicians' Private Offices	4,341,691	815,164	5,156,855		5,156,855	-140,944	5,015,911	192
194	07950	OTHER NONREIMBURSABLE								194
194.01	07952	MEMORY DISORDER	24,380	180	24,560		24,560		24,560	194.01
194.02	07953	ASSISTED LIVING								194.02
200		TOTAL (sum of lines 118-199)	24,519,332	28,380,384	52,899,716		52,899,716	-5,212,940	47,686,776	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	428,851	643,006	1
500	Total reclassifications				428,851	643,006	500
	Code Letter - A						
1	INTEREST EXPENSE	B	Cap Rel Costs-Bldg & Fixt	1		263,318	1
500	Total reclassifications					263,318	500
	Code Letter - B						
1	OTHER CAPITAL RELATED	C	Cap Rel Costs-Bldg & Fixt	1		77,406	1
2			Cap Rel Costs-Mvble Equip	2		26,417	2
500	Total reclassifications					103,823	500
	Code Letter - C						
1	RECLASS MEDICAL SUPPLIES	D	Impl. Dev. Charged to Patient	72		370,193	1
500	Total reclassifications					370,193	500
	Code Letter - D						
	GRAND TOTAL (Increases)				428,851	1,380,340	

(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	428,851	643,006	1	
500	Total reclassifications				428,851	643,006	500	
	Code letter - A							
1	INTEREST EXPENSE	B	Interest Expense	113		263,318	11	
500	Total reclassifications					263,318	500	
	Code letter - B							
1	OTHER CAPITAL RELATED	C	Administrative & General	5		103,823	12	
2							12	
500	Total reclassifications					103,823	500	
	Code letter - C							
1	RECLASS MEDICAL SUPPLIES	D	Medical Supplies Charged to P	71		370,193	1	
500	Total reclassifications					370,193	500	
	Code letter - D							
	GRAND TOTAL (Decreases)				428,851	1,380,340		

(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	131,315	5		5		131,320	1
2	Land Improvements	385,022	102,098		102,098		487,120	2
3	Buildings and Fixtures	15,987,226	130,291		130,291		16,117,517	3
4	Building Improvements	9,558,256					9,558,256	4
5	Fixed Equipment	2,355,173					2,355,173	5
6	Movable Equipment	18,203,360	1,939,487		1,939,487		20,142,847	6
7	HIT-designated Assets	966,548					966,548	7
8	Subtotal (sum of lines 1-7)	47,586,900	2,171,881		2,171,881		49,758,781	8
9	Reconciling Items							9
10	Total (line 7 minus line 9)	47,586,900	2,171,881		2,171,881		49,758,781	10

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

	Description	SUMMARY OF CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	603,019						603,019	1
2	Cap Rel Costs-Mvble Equip	1,591,995						1,591,995	2
3	Total (sum of lines 1-2)	2,195,014						2,195,014	3

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

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL			
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)
*		1	2	3	4	5	6	7	8
1	Cap Rel Costs-Bldg & Fi	28,706,381		28,706,381	0.576251				1
2	Cap Rel Costs-Mvble Equip	21,109,395		21,109,395	0.423749				2
3	Total (sum of lines 1-2)	49,815,776		49,815,776	1.000000				3

	Description	SUMMARY OF CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	603,019		183,857	77,406			864,282	1
2	Cap Rel Costs-Mvble Equip	1,591,995			26,417			1,618,412	2
3	Total (sum of lines 1-2)	2,195,014		183,857	103,823			2,482,694	3

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

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			Wkst. A-7 Ref.
				COST CENTER	LINE#		
		1	2	3	4	5	
1	Investment income-buildings & fixtures (chapter 2)	B	-79,461	Cap Rel Costs-Bldg & Fixt	1	11	1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)	B	-8,834	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	-18,373	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	-1,060,399				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	-201,529	Laundry & Linen Service	8		13
14	Cafeteria - employees and guests	B	-257,394	Cafeteria	11		14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients	B	-3,873	Central Services & Supply	14		16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts	B	-1,331	Medical Records & Library	16		18
19	Nursing and allied health education (tuition, fees, books, etc.)						19
20	Vending machines	B	-8,891	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	-35,743	Cafeteria	11		33
34	GUEST ROOM	B	-184	Adults & Pediatrics	30		34
35	MISC INCOME	B	-16,426	Administrative & General	5		35
36	RETURNED CHECKS	B	30	Administrative & General	5		36
37							37
38	PHYSICIAN RECRUITMENT	A	-55,022	Administrative & General	5		38
39	CRNA SALARIES	A	-842,775	Anesthesiology	53		39
40							40
41	CRNA BENEFITS	A	-160,028	Employee Benefits Department	4		41
42	LOBBYING DUES	A	-17,442	Administrative & General	5		42
43	FOUNDATION SALARIES	A	-74,787	Administrative & General	5		43
44	FOUNDATION BENEFITS	A	-29,167	Employee Benefits Department	4		44
45	FOUNDATION OTHER	A	-6,794	Administrative & General	5		45
46	ADVERTISING	A	-325,975	Administrative & General	5		46
47	PROVIDER TAX ASSESSMENT	A	-1,802,205	Administrative & General	5		47
48							48
49	HHA VEHICLE REIMBURSEMENT	B	-2,175	Administrative & General	5		49
49.01	MISC PATIENT REVENUE	B	-550	Administrative & General	5		49.01
49.02	MISC REVENUE	B	-3,886	Administrative & General	5		49.02
49.03	INTEREST RECEIPTS	B	-58,782	Administrative & General	5		49.03
49.04	HOSPITALIST	B	-140,944	Physicians' Private Offices	192		49.04
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-5,212,940				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 Remuneration	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	152,535	72,535	80,000	181,300	533	46,458	2,323	1
2	60	Laboratory AGGREGATE	98,034	19,607	78,427	260,300	1,248	156,180	7,809	2
3	91	Emergency AGGREGATE	934,715	934,715		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	1,185,284	1,026,857	158,427		1,781	202,638	10,132	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					46,458	33,542	106,077	1
2	60	Laboratory AGGREGATE					156,180		19,607	2
3	91	Emergency AGGREGATE							934,715	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					202,638	33,542	1,060,399	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	864,282	864,282					1
2	Cap Rel Costs-Mvble Equip	1,618,412		1,618,412				2
4	Employee Benefits Department	9,686,164	2,711	43	9,688,918			4
5	Administrative & General	4,394,986	82,240	261,894	833,793	5,572,913	5,572,913	5
6	Maintenance & Repairs	1,007,475	11,220	154,624	222,488	1,395,807	184,707	6
7	Operation of Plant	530,488	39,025			569,513	75,364	7
8	Laundry & Linen Service	132,905	16,094	15,115	100,390	264,504	35,002	8
9	Housekeeping	475,688	1,830	1,955	146,533	626,006	82,839	9
10	Dietary	292,714	33,762	2,728	48,609	377,813	49,996	10
11	Cafeteria	769,829	9,578	10,262	177,996	967,665	128,051	11
12	Maintenance of Personnel							12
13	Nursing Administration	1,601,992	33,487	118,001	583,057	2,336,537	309,194	13
14	Central Services & Supply	115,455	23,721	18,934	30,621	188,731	24,975	14
15	Pharmacy	2,276,744	12,829	93,910	206,950	2,590,433	342,792	15
16	Medical Records & Library	625,394	9,968	6,233	217,018	858,613	113,620	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	1,824,010	133,923	59,567	708,912	2,726,412	360,786	30
31	Intensive Care Unit	696,503	31,214	12,537	270,911	1,011,165	133,807	31
40	Subprovider - IPF	613,627	36,743	307	226,954	877,631	116,137	40
43	Nursery	257,819	4,411	2,694	102,150	367,074	48,575	43
44	Skilled Nursing Facility	1,377,717	44,963	10,712	514,679	1,948,071	257,788	44
ANCILLARY SERVICE COST CENTERS								
50	Operating Room	952,826	52,017	88,227	271,894	1,364,964	180,626	50
53	Anesthesiology	20,930	308	37,491		58,729	7,772	53
54	Radiology-Diagnostic	951,841	37,604	154,259	281,438	1,425,142	188,589	54
56	Radioisotope	128,249	3,347	22,683	35,793	190,072	25,152	56
57	CT Scan	304,133	3,337	22,305	42,616	372,391	49,279	57
58	MRI	186,986		245,361	34,681	467,028	61,802	58
60	Laboratory	2,427,849	35,144	77,270	425,857	2,966,120	392,507	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy	26,032				26,032	3,445	64
65	Respiratory Therapy	434,765	4,045	11,248	176,938	626,996	82,970	65
66	Physical Therapy	1,813,987	25,681	21,650	724,391	2,585,709	342,167	66
68	Speech Pathology	246,006	997	1,880	96,648	345,531	45,724	68
69	Electrocardiology	163,994	1,734	7,728		173,456	22,953	69
71	Medical Supplies Charged to Patients	1,405,454				1,405,454	185,984	71
72	Impl. Dev. Charged to Patients	370,193				370,193	48,988	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	1,110,964	14,447	14,249	408,629	1,548,289	204,885	88
91	Emergency	872,695	16,431	68,557	319,719	1,277,402	169,039	91
92	Observation Beds (Non-Distinct Part)							92
OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	852,545	23,837	58,355	293,194	1,227,931	162,492	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	812,318	6,419	71	281,942	1,100,750	145,662	101
SPECIAL PURPOSE COST CENTERS								
113	Interest Expense							113
116	Hospice	402,334	6,419	812	91,952	501,517	66,366	116
118	SUBTOTALS (sum of lines 1-117)	42,646,305	759,486	1,601,662	7,876,753	40,712,594	4,650,035	118
NONREIMBURSABLE COST CENTERS								
192	Physicians' Private Offices	5,015,911	104,083	16,750	1,802,046	6,938,790	918,195	192
194	OTHER NONREIMBURSABLE							194
194.01	MEMORY DISORDER	24,560	713		10,119	35,392	4,683	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)	47,686,776	864,282	1,618,412	9,688,918	47,686,776	5,572,913	202

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	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	1,580,514						6
7	Operation of Plant	80,300	725,177					7
8	Laundry & Linen Service	33,115	16,007	348,628				8
9	Housekeeping	3,765	1,820	22,307	736,737			9
10	Dietary	69,470	33,581	1,098		531,958		10
11	Cafeteria	19,708	9,527	4,131			1,129,082	11
12	Maintenance of Personnel							12
13	Nursing Administration	68,905	33,308		15,026		142,492	13
14	Central Services & Supply	48,810	23,594	4,877	9,334		25,885	14
15	Pharmacy	26,397	12,760		4,098		32,788	15
16	Medical Records & Library	20,511	9,915				79,627	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	275,577	133,205	89,955	178,950	135,287	106,499	30
31	Intensive Care Unit	64,228	31,047	30,995	30,621	25,907	34,020	31
40	Subprovider - IPF	75,604	36,546	9,993	42,802	40,839	46,100	40
43	Nursery	9,076	4,387	21,262	19,124			43
44	Skilled Nursing Facility	92,518	44,722	93,727	58,283	329,925	94,912	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	107,034	51,738	32,883	43,712		97,624	50
53	Anesthesiology	634	307				5,177	53
54	Radiology-Diagnostic	77,377	37,403	6,201	30,052		45,114	54
56	Radioisotope	6,887	3,329	695	7,172		3,698	56
57	CT Scan	6,867	3,319		7,513		10,847	57
58	MRI							58
60	Laboratory	72,314	34,955	1,049	19,124		40,430	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy							64
65	Respiratory Therapy	8,323	4,023		2,732		64,589	65
66	Physical Therapy	52,843	25,544	5,408	80,481		100,829	66
68	Speech Pathology	2,051	991		9,562		4,684	68
69	Electrocardiology	3,567	1,724		10,245			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	29,726	14,369	346	26,523			88
91	Emergency	33,809	16,343	21,610	66,935		19,475	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	49,048	23,709	2,091	1,708		64,589	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	13,208	6,385		17,758		14,298	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice	13,208	6,385		17,758		11,833	116
118	SUBTOTALS (sum of lines 1-117)	1,364,880	620,943	348,628	699,513	531,958	1,045,510	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	214,168	103,525		37,224		83,572	192
194	OTHER NONREIMBURSABLE							194
194.01	MEMORY DISORDER	1,466	709					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)	1,580,514	725,177	348,628	736,737	531,958	1,129,082	202

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	
		13	14	15	16	24	25	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	2,905,462						13
14	Central Services & Supply		326,206					14
15	Pharmacy			3,009,268				15
16	Medical Records & Library				1,082,286			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	730,384		578	280,543	5,018,176		30
31	Intensive Care Unit	229,264		59	22,308	1,613,421		31
40	Subprovider - IPF	261,740		26	35,828	1,543,246		40
43	Nursery	87,333			16,900	573,731		43
44	Skilled Nursing Facility	625,472		18	35,152	3,580,588		44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	228,324		423	223,758	2,331,086		50
53	Anesthesiology	79,186		19,097		170,902		53
54	Radiology-Diagnostic			120	676	1,810,674		54
56	Radioisotope			41		237,046		56
57	CT Scan				1,352	451,568		57
58	MRI					528,830		58
60	Laboratory			73	2,704	3,529,276		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy			52,982		82,459		64
65	Respiratory Therapy			7,207		796,840		65
66	Physical Therapy			110		3,193,091		66
68	Speech Pathology					408,543		68
69	Electrocardiology					211,945		69
71	Medical Supplies Charged to Patients		260,965			1,852,403		71
72	Impl. Dev. Charged to Patients		65,241			484,422		72
73	Drugs Charged to Patients			2,844,989		2,844,989		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			36,433		1,860,571		88
91	Emergency	295,850		629	173,058	2,074,150		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	367,909		10,618		1,910,095		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			122		1,298,183		101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice			116		617,183		116
118	SUBTOTALS (sum of lines 1-117)	2,905,462	326,206	2,973,641	792,279	39,023,418		118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices			35,627	290,007	8,621,108		192
194	OTHER NONREIMBURSABLE							194
194.01	MEMORY DISORDER					42,250		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)	2,905,462	326,206	3,009,268	1,082,286	47,686,776		202

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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	5,018,176					30
31	Intensive Care Unit	1,613,421					31
40	Subprovider - IPF	1,543,246					40
43	Nursery	573,731					43
44	Skilled Nursing Facility	3,580,588					44
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	2,331,086					50
53	Anesthesiology	170,902					53
54	Radiology-Diagnostic	1,810,674					54
56	Radioisotope	237,046					56
57	CT Scan	451,568					57
58	MRI	528,830					58
60	Laboratory	3,529,276					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	Intravenous Therapy	82,459					64
65	Respiratory Therapy	796,840					65
66	Physical Therapy	3,193,091					66
68	Speech Pathology	408,543					68
69	Electrocardiology	211,945					69
71	Medical Supplies Charged to Patients	1,852,403					71
72	Impl. Dev. Charged to Patients	484,422					72
73	Drugs Charged to Patients	2,844,989					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	1,860,571					88
91	Emergency	2,074,150					91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services	1,910,095					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	1,298,183					101
	SPECIAL PURPOSE COST CENTERS						
113	Interest Expense						113
116	Hospice	617,183					116
118	SUBTOTALS (sum of lines 1-117)	39,023,418					118
	NONREIMBURSABLE COST CENTERS						
192	Physicians' Private Offices	8,621,108					192
194	OTHER NONREIMBURSABLE						194
194.01	MEMORY DISORDER	42,250					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)	47,686,776					202

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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		2,711	43	2,754	2,754		4
5	Administrative & General	5,004	82,240	261,894	349,138	237	349,375	5
6	Maintenance & Repairs		11,220	154,624	165,844	63	11,580	6
7	Operation of Plant		39,025		39,025		4,725	7
8	Laundry & Linen Service		16,094	15,115	31,209	29	2,194	8
9	Housekeeping		1,830	1,955	3,785	42	5,193	9
10	Dietary		33,762	2,728	36,490	14	3,134	10
11	Cafeteria		9,578	10,262	19,840	51	8,028	11
12	Maintenance of Personnel							12
13	Nursing Administration		33,487	118,001	151,488	166	19,384	13
14	Central Services & Supply		23,721	18,934	42,655	9	1,566	14
15	Pharmacy		12,829	93,910	106,739	59	21,490	15
16	Medical Records & Library		9,968	6,233	16,201	62	7,123	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	3,691	133,923	59,567	197,181	202	22,618	30
31	Intensive Care Unit	116	31,214	12,537	43,867	77	8,389	31
40	Subprovider - IPF		36,743	307	37,050	65	7,281	40
43	Nursery		4,411	2,694	7,105	29	3,045	43
44	Skilled Nursing Facility	5,831	44,963	10,712	61,506	146	16,161	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	161,273	52,017	88,227	301,517	77	11,324	50
53	Anesthesiology		308	37,491	37,799		487	53
54	Radiology-Diagnostic		37,604	154,259	191,863	80	11,823	54
56	Radioisotope		3,347	22,683	26,030	10	1,577	56
57	CT Scan		3,337	22,305	25,642	12	3,089	57
58	MRI			245,361	245,361	10	3,874	58
60	Laboratory	4,409	35,144	77,270	116,823	121	24,607	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy						216	64
65	Respiratory Therapy	2,000	4,045	11,248	17,293	50	5,202	65
66	Physical Therapy		25,681	21,650	47,331	206	21,451	66
68	Speech Pathology		997	1,880	2,877	27	2,867	68
69	Electrocardiology		1,734	7,728	9,462		1,439	69
71	Medical Supplies Charged to Patients						11,660	71
72	Impl. Dev. Charged to Patients						3,071	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		14,447	14,249	28,696	116	12,845	88
91	Emergency		16,431	68,557	84,988	91	10,597	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	1,775	23,837	58,355	83,967	83	10,187	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	26,231	6,419	71	32,721	80	9,132	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice	50,323	6,419	812	57,554	26	4,161	116
118	SUBTOTALS (sum of lines 1-117)	260,653	759,486	1,601,662	2,621,801	2,240	291,520	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		104,083	16,750	120,833	511	57,561	192
194	OTHER NONREIMBURSABLE							194
194.01	MEMORY DISORDER		713		713	3	294	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)	260,653	864,282	1,618,412	2,743,347	2,754	349,375	202

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	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	177,487						6
7	Operation of Plant	9,017	52,767					7
8	Laundry & Linen Service	3,719	1,165	38,316				8
9	Housekeeping	423	132	2,452	12,027			9
10	Dietary	7,801	2,443	121		50,003		10
11	Cafeteria	2,213	693	454			31,279	11
12	Maintenance of Personnel							12
13	Nursing Administration	7,738	2,424		245		3,951	13
14	Central Services & Supply	5,481	1,717	536	152		717	14
15	Pharmacy	2,964	928		67		908	15
16	Medical Records & Library	2,303	721				2,206	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	30,948	9,693	9,887	2,920	12,717	2,950	30
31	Intensive Care Unit	7,213	2,259	3,407	500	2,435	942	31
40	Subprovider - IPF	8,490	2,659	1,098	699	3,839	1,277	40
43	Nursery	1,019	319	2,337	312			43
44	Skilled Nursing Facility	10,389	3,254	10,300	951	31,012	2,629	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	12,020	3,765	3,614	714		2,704	50
53	Anesthesiology	71	22				143	53
54	Radiology-Diagnostic	8,689	2,722	682	491		1,250	54
56	Radioisotope	773	242	76	117		102	56
57	CT Scan	771	242		123		300	57
58	MRI							58
60	Laboratory	8,121	2,543	115	312		1,120	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy							64
65	Respiratory Therapy	935	293		45		1,789	65
66	Physical Therapy	5,934	1,859	594	1,314		2,793	66
68	Speech Pathology	230	72		156		130	68
69	Electrocardiology	401	125		167			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	3,338	1,046	38	433			88
91	Emergency	3,797	1,189	2,375	1,093		540	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	5,508	1,725	230	28		1,789	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	1,483	465		290		396	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice	1,483	465		290		328	116
118	SUBTOTALS (sum of lines 1-117)	153,272	45,182	38,316	11,419	50,003	28,964	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	24,050	7,533		608		2,315	192
194	OTHER NONREIMBURSABLE							194
194.01	MEMORY DISORDER	165	52					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)	177,487	52,767	38,316	12,027	50,003	31,279	202

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	NURSING AD MINISTRATI ON	CENTRAL SE RVICES & S UPPLY	PHARMACY	MEDICAL RE CORDS & LI BRARY	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	
		13	14	15	16	24	25	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	185,396						13
14	Central Services & Supply		52,833					14
15	Pharmacy			133,155				15
16	Medical Records & Library				28,616			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	46,605		26	7,418	343,165		30
31	Intensive Care Unit	14,629		3	590	84,311		31
40	Subprovider - IPF	16,702		1	947	80,108		40
43	Nursery	5,573			447	20,186		43
44	Skilled Nursing Facility	39,911		1	929	177,189		44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	14,569		19	5,916	356,239		50
53	Anesthesiology	5,053		845		44,420		53
54	Radiology-Diagnostic			5	18	217,623		54
56	Radioisotope			2		28,929		56
57	CT Scan				36	30,215		57
58	MRI					249,245		58
60	Laboratory			3	71	153,836		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy			2,344		2,560		64
65	Respiratory Therapy			319		25,926		65
66	Physical Therapy			5		81,487		66
68	Speech Pathology					6,359		68
69	Electrocardiology					11,594		69
71	Medical Supplies Charged to Patients		42,266			53,926		71
72	Impl. Dev. Charged to Patients		10,567			13,638		72
73	Drugs Charged to Patients			125,886		125,886		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			1,612		48,124		88
91	Emergency	18,878		28	4,576	128,152		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	23,476		470		127,463		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			5		44,572		101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
116	Hospice			5		64,312		116
118	SUBTOTALS (sum of lines 1-117)	185,396	52,833	131,579	20,948	2,519,465		118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices			1,576	7,668	222,655		192
194	OTHER NONREIMBURSABLE							194
194.01	MEMORY DISORDER					1,227		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)	185,396	52,833	133,155	28,616	2,743,347		202

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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	343,165					30
31	Intensive Care Unit	84,311					31
40	Subprovider - IPF	80,108					40
43	Nursery	20,186					43
44	Skilled Nursing Facility	177,189					44
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	356,239					50
53	Anesthesiology	44,420					53
54	Radiology-Diagnostic	217,623					54
56	Radioisotope	28,929					56
57	CT Scan	30,215					57
58	MRI	249,245					58
60	Laboratory	153,836					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	Intravenous Therapy	2,560					64
65	Respiratory Therapy	25,926					65
66	Physical Therapy	81,487					66
68	Speech Pathology	6,359					68
69	Electrocardiology	11,594					69
71	Medical Supplies Charged to Patients	53,926					71
72	Impl. Dev. Charged to Patients	13,638					72
73	Drugs Charged to Patients	125,886					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	48,124					88
91	Emergency	128,152					91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services	127,463					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	44,572					101
	SPECIAL PURPOSE COST CENTERS						
113	Interest Expense						113
116	Hospice	64,312					116
118	SUBTOTALS (sum of lines 1-117)	2,519,465					118
	NONREIMBURSABLE COST CENTERS						
192	Physicians' Private Offices	222,655					192
194	OTHER NONREIMBURSABLE						194
194.01	MEMORY DISORDER	1,227					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)	2,743,347					202

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	NEW CAP RE L COSTS-BL DG & FIXT SQUARE FEET	NEW CAP RE L COSTS-MV BLE EQUIP DOLLAR VALUE -NEW	EMPLOYEE B ENEFITS DEPARTMENT GROSS SALARIES	RECON- CILIATION	ADMINISTRA TIVE & GEN ERAL ACCUM COST	MAINTENANC E & REPAIR S SQUARE FEET	
		1	2	4	5A	5	6	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	179,478						1
2	Cap Rel Costs-Mvble Equip		1,598,250					2
4	Employee Benefits Department	563	42	23,343,732				4
5	Administrative & General	17,078	258,633	2,008,879	-5,572,913	42,113,863		5
6	Maintenance & Repairs	2,330	152,698	536,047		1,395,807	159,507	6
7	Operation of Plant	8,104				569,513	8,104	7
8	Laundry & Linen Service	3,342	14,927	241,873		264,504	3,342	8
9	Housekeeping	380	1,931	353,045		626,006	380	9
10	Dietary	7,011	2,694	117,115		377,813	7,011	10
11	Cafeteria	1,989	10,134	428,851		967,665	1,989	11
12	Maintenance of Personnel							12
13	Nursing Administration	6,954	116,531	1,404,775		2,336,537	6,954	13
14	Central Services & Supply	4,926	18,698	73,775		188,731	4,926	14
15	Pharmacy	2,664	92,740	498,609		2,590,433	2,664	15
16	Medical Records & Library	2,070	6,155	522,868		858,613	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	58,825	1,707,999		2,726,412	27,811	30
31	Intensive Care Unit	6,482	12,381	652,713		1,011,165	6,482	31
40	Subprovider - IPF	7,630	303	546,805		877,631	7,630	40
43	Nursery	916	2,660	246,112		367,074	916	43
44	Skilled Nursing Facility	9,337	10,579	1,240,030		1,948,071	9,337	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	10,802	87,128	655,082		1,364,964	10,802	50
53	Anesthesiology	64	37,024			58,729	64	53
54	Radiology-Diagnostic	7,809	152,337	678,076		1,425,142	7,809	54
56	Radioisotope	695	22,400	86,237		190,072	695	56
57	CT Scan	693	22,027	102,676		372,391	693	57
58	MRI		242,304	83,557		467,028		58
60	Laboratory	7,298	76,307	1,026,029		2,966,120	7,298	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy					26,032		64
65	Respiratory Therapy	840	11,108	426,300		626,996	840	65
66	Physical Therapy	5,333	21,380	1,745,294		2,585,709	5,333	66
68	Speech Pathology	207	1,857	232,856		345,531	207	68
69	Electrocardiology	360	7,632			173,456	360	69
71	Medical Supplies Charged to Patients					1,405,454		71
72	Impl. Dev. Charged to Patients					370,193		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	3,000	14,071	984,519		1,548,289	3,000	88
91	Emergency	3,412	67,703	770,306		1,277,402	3,412	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	4,950	57,628	706,400		1,227,931	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	70	679,290		1,100,750	1,333	101
	SPECIAL PURPOSE COST CENTERS							
116	Hospice	1,333	802	221,543		501,517	1,333	116
118	SUBTOTALS (sum of lines 1-117)	157,716	1,581,709	18,977,661	-5,572,913	35,139,681	137,745	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	21,614	16,541	4,341,691		6,938,790	21,614	192
194	OTHER NONREIMBURSABLE							194
194.01	MEMORY DISORDER	148		24,380		35,392	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)	864,282	1,618,412	9,688,918		5,572,913	1,580,514	202
203	Unit Cost Multiplier (Wkst. B, Part I)	4.815532	1.012615	0.415054		0.132330	9.908744	203
204	Cost to be allocated (Per Wkst. B, Part II)			2,754		349,375	177,487	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000118		0.008296	1.112722	205

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERV ICE LAUNDRY POUNDS	HOUSEKEEPING HOURS OF SERVICE	DIETARY DIETARY MEALS SERV	CAFETERIA CAFE MEALS SERV	NURSING ADMINISTRATION ON 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	151,403						7
8	Laundry & Linen Service	3,342	477,758					8
9	Housekeeping	380		6,472				9
10	Dietary	7,011	1,505		78,480			10
11	Cafeteria	1,989	5,661			4,580		11
12	Maintenance of Personnel							12
13	Nursing Administration	6,954		132		578	293,532	13
14	Central Services & Supply	4,926	6,684	82		105		14
15	Pharmacy	2,664		36		133		15
16	Medical Records & Library	2,070				323		16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
INPATIENT ROUTINE SERV COST CENTERS								
30	Adults & Pediatrics	27,811	123,274	1,572	19,959	432	73,789	30
31	Intensive Care Unit	6,482	42,476	269	3,822	138	23,162	31
40	Subprovider - IPF	7,630	13,694	376	6,025	187	26,443	40
43	Nursery	916	29,138	168			8,823	43
44	Skilled Nursing Facility	9,337	128,441	512	48,674	385	63,190	44
ANCILLARY SERVICE COST CENTERS								
50	Operating Room	10,802	45,062	384		396	23,067	50
53	Anesthesiology	64				21	8,000	53
54	Radiology-Diagnostic	7,809	8,498	264		183		54
56	Radioisotope	695	952	63		15		56
57	CT Scan	693		66		44		57
58	MRI							58
60	Laboratory	7,298	1,438	168		164		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy							64
65	Respiratory Therapy	840		24		262		65
66	Physical Therapy	5,333	7,411	707		409		66
68	Speech Pathology	207		84		19		68
69	Electrocardiology	360		90				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	3,000	474	233				88
91	Emergency	3,412	29,614	588		79	29,889	91
92	Observation Beds (Non-Distinct Part)							92
OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	4,950	2,866	15		262	37,169	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		156		58		101
SPECIAL PURPOSE COST CENTERS								
116	Hospice	1,333		156		48		116
118	SUBTOTALS (sum of lines 1-117)	129,641	477,758	6,145	78,480	4,241	293,532	118
NONREIMBURSABLE COST CENTERS								
192	Physicians' Private Offices	21,614		327		339		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)	725,177	348,628	736,737	531,958	1,129,082	2,905,462	202
203	Unit Cost Multiplier (Wkst. B, Part I)	4.789714	0.729717	113.834518	6.778262	246.524454	9.898280	203
204	Cost to be allocated (Per Wkst. B, Part II)	52,767	38,316	12,027	50,003	31,279	185,396	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.348520	0.080200	1.858313	0.637143	6.829476	0.631604	205

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

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

GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5	Administrative & General						5
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply	100					14
15	Pharmacy		1,478,575				15
16	Medical Records & Library			1,601			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		284	415			30
31	Intensive Care Unit		29	33			31
40	Subprovider - IPF		13	53			40
43	Nursery			25			43
44	Skilled Nursing Facility		9	52			44
ANCILLARY SERVICE COST CENTERS							
50	Operating Room		208	331			50
53	Anesthesiology		9,383				53
54	Radiology-Diagnostic		59	1			54
56	Radioisotope		20				56
57	CT Scan			2			57
58	MRI						58
60	Laboratory		36	4			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	Intravenous Therapy		26,032				64
65	Respiratory Therapy		3,541				65
66	Physical Therapy		54				66
68	Speech Pathology						68
69	Electrocardiology						69
71	Medical Supplies Charged to Patients	80					71
72	Impl. Dev. Charged to Patients	20					72
73	Drugs Charged to Patients		1,397,858				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		17,901				88
91	Emergency		309	256			91
92	Observation Beds (Non-Distinct Part)						92
OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services		5,217				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		60				101
SPECIAL PURPOSE COST CENTERS							
116	Hospice		57				116
118	SUBTOTALS (sum of lines 1-117)	100	1,461,070	1,172			118
NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		17,505	429			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)	326,206	3,009,268	1,082,286			202
203	Unit Cost Multiplier (Wkst. B, Part I)	3,262.060000	2.035249	676.006246			203
204	Cost to be allocated (Per Wkst. B, Part II)	52,833	133,155	28,616			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)	528.330000	0.090056	17.873829				205

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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

		WORKSHEET		
DESCRIPTION		CODE	LINE NO.	AMOUNT
1		2	3	4

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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	COSTS					
		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	5,018,176		5,018,176		5,018,176	30
31	Intensive Care Unit	1,613,421		1,613,421		1,613,421	31
40	Subprovider - IPF	1,543,246		1,543,246	33,542	1,576,788	40
43	Nursery	573,731		573,731		573,731	43
44	Skilled Nursing Facility	3,580,588		3,580,588		3,580,588	44
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	2,331,086		2,331,086		2,331,086	50
53	Anesthesiology	170,902		170,902		170,902	53
54	Radiology-Diagnostic	1,810,674		1,810,674		1,810,674	54
56	Radioisotope	237,046		237,046		237,046	56
57	CT Scan	451,568		451,568		451,568	57
58	MRI	528,830		528,830		528,830	58
60	Laboratory	3,529,276		3,529,276		3,529,276	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	Intravenous Therapy	82,459		82,459		82,459	64
65	Respiratory Therapy	796,840		796,840		796,840	65
66	Physical Therapy	3,193,091		3,193,091		3,193,091	66
68	Speech Pathology	408,543		408,543		408,543	68
69	Electrocardiology	211,945		211,945		211,945	69
71	Medical Supplies Charged to Patients	1,852,403		1,852,403		1,852,403	71
72	Impl. Dev. Charged to Patients	484,422		484,422		484,422	72
73	Drugs Charged to Patients	2,844,989		2,844,989		2,844,989	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	1,860,571		1,860,571		1,860,571	88
91	Emergency	2,074,150		2,074,150		2,074,150	91
92	Observation Beds (Non-Distinct Part)	1,241,416		1,241,416		1,241,416	92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services	1,910,095		1,910,095		1,910,095	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	1,298,183		1,298,183		1,298,183	101
113	Interest Expense						113
116	Hospice	617,183		617,183		617,183	116
200	Subtotal (sum of lines 30 thru 199)	40,264,834		40,264,834	33,542	40,298,376	200
201	Less Observation Beds	1,241,416		1,241,416		1,241,416	201
202	Total (line 200 minus line 201)	39,023,418		39,023,418		39,056,960	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	4,497,331		4,497,331				30
31	Intensive Care Unit	1,776,696		1,776,696				31
40	Subprovider - IPF	1,594,558		1,594,558				40
43	Nursery	470,805		470,805				43
44	Skilled Nursing Facility	2,711,824		2,711,824				44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	3,000,831	12,311,709	15,312,540	0.152234	0.152234	0.152234	50
53	Anesthesiology	730,686	3,632,235	4,362,921	0.039171	0.039171	0.039171	53
54	Radiology-Diagnostic	1,335,896	10,529,565	11,865,461	0.152600	0.152600	0.152600	54
56	Radioisotope	157,397	3,129,430	3,286,827	0.072120	0.072120	0.072120	56
57	CT Scan	1,686,657	14,974,221	16,660,878	0.027103	0.027103	0.027103	57
58	MRI	119,889	3,252,196	3,372,085	0.156826	0.156826	0.156826	58
60	Laboratory	3,710,931	24,794,246	28,505,177	0.123812	0.123812	0.123812	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy	877,181	366,009	1,243,190	0.066329	0.066329	0.066329	64
65	Respiratory Therapy	2,586,679	1,563,243	4,149,922	0.192013	0.192013	0.192013	65
66	Physical Therapy	3,746,438	7,436,459	11,182,897	0.285533	0.285533	0.285533	66
68	Speech Pathology	187,737	812,969	1,000,706	0.408255	0.408255	0.408255	68
69	Electrocardiology	328,028	2,782,545	3,110,573	0.068137	0.068137	0.068137	69
71	Medical Supplies Charged to Patients	2,071,638	3,334,749	5,406,387	0.342632	0.342632	0.342632	71
72	Impl. Dev. Charged to Patients	346,777	578,068	924,845	0.523787	0.523787	0.523787	72
73	Drugs Charged to Patients	3,983,892	6,815,580	10,799,472	0.263438	0.263438	0.263438	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		1,299,711	1,299,711				88
91	Emergency	1,562,033	9,063,171	10,625,204	0.195210	0.195210	0.195210	91
92	Observation Beds (Non-Distinct Part)	579,819	2,566,400	3,146,219	0.394574	0.394574	0.394574	92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	28,168	2,123,256	2,151,424	0.887828	0.887828	0.887828	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		2,602,524	2,602,524				101
113	Interest Expense							113
116	Hospice		1,383,658	1,383,658				116
200	Subtotal (sum of lines 30 thru 199)	38,091,891	115,351,944	153,443,835				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	38,091,891	115,351,944	153,443,835				202

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	343,165	3,281	339,884	4,404	77.18	2,171	167,558	30
31	Intensive Care Unit	84,311		84,311	753	111.97	687	76,923	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	80,108		80,108	1,187	67.49	268	18,087	40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery	20,186		20,186	406	49.72			43
44	Skilled Nursing Facility	177,189		177,189	9,589	18.48	2,704	49,970	44
45	Nursing Facility								45
200	Total (lines 30-199)	704,959		701,678	16,339		5,830	312,538	200

(A) Worksheet A line numbers

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0147

WORKSHEET D
PART II

Check Title V Hospital SUB (Other) PPS
 Applicable Title XVIII, Part A IPF TEFRA
 Boxes: Title XIX IRF

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part 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	356,239	15,312,540	0.023265	1,064,837	24,773	50
53	Anesthesiology	44,420	4,362,921	0.010181	217,806	2,217	53
54	Radiology-Diagnostic	217,623	11,865,461	0.018341	1,260,378	23,117	54
56	Radioisotope	28,929	3,286,827	0.008801	95,462	840	56
57	CT Scan	30,215	16,660,878	0.001814	1,638,513	2,972	57
58	MRI	249,245	3,372,085	0.073914	85,143	6,293	58
60	Laboratory	153,836	28,505,177	0.005397	3,390,691	18,300	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	Intravenous Therapy	2,560	1,243,190	0.002059	457,766	943	64
65	Respiratory Therapy	25,926	4,149,922	0.006247	1,594,562	9,961	65
66	Physical Therapy	81,487	11,182,897	0.007287	593,124	4,322	66
68	Speech Pathology	6,359	1,000,706	0.006355	66,803	425	68
69	Electrocardiology	11,594	3,110,573	0.003727	318,661	1,188	69
71	Medical Supplies Charged to Pat	53,926	5,406,387	0.009974	894,161	8,918	71
72	Impl. Dev. Charged to Patients	13,638	924,845	0.014746	174,813	2,578	72
73	Drugs Charged to Patients	125,886	10,799,472	0.011657	2,184,306	25,462	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	48,124	1,299,711	0.037027			88
91	Emergency	128,152	10,625,204	0.012061	1,205,588	14,541	91
92	Observation Beds (Non-Distinct	84,893	3,146,219	0.026983	268,344	7,241	92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services						95
200	Total (sum of lines 50-199)	1,663,052	136,255,015		15,510,958	154,091	200

(A) Worksheet A line numbers

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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 Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	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)	1A	1	2A	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics General Routine Care)							30
31	Intensive Care Unit							31
32	Coronary Care Unit							32
33	Burn Intensive Care Unit							33
34	Surgical Intensive Care Unit							34
35	Other Special Care (specify)							35
40	Subprovider - IPF							40
41	Subprovider - IRF							41
42	Subprovider I							42
43	Nursery							43
44	Skilled Nursing Facility							44
45	Nursing Facility							45
200	TOTAL (lines 30-199)							200

(A) Worksheet A line numbers

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)
(A)	Cost Center Description	6	7	8	9
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics (General Routine Care)	4,404		2,171	30
31	Intensive Care Unit	753		687	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	1,187		268	40
41	Subprovider - IRF				41
42	Subprovider I				42
43	Nursery	406			43
44	Skilled Nursing Facility	9,589		2,704	44
45	Nursing Facility				45
200	Total (lines 30-199)	16,339		5,830	200

(A) Worksheet A line numbers

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0147

WORKSHEET D
PART IV

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

(A)	Cost Center Description	1	2A	2	3A	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: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0147

WORKSHEET D
PART IV

Check Title V Hospital SUB (Other) ICF/IID PPS
 Applicable 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)	
		7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	15,312,540			1,064,837		3,842,845		50
53	Anesthesiology	4,362,921			217,806		797,680		53
54	Radiology-Diagnostic	11,865,461			1,260,378		3,564,265		54
56	Radioisotope	3,286,827			95,462		1,434,243		56
57	CT Scan	16,660,878			1,638,513		4,951,284		57
58	MRI	3,372,085			85,143		983,548		58
60	Laboratory	28,505,177			3,390,691		3,541,008		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	1,243,190			457,766		344,254		64
65	Respiratory Therapy	4,149,922			1,594,562		537,336		65
66	Physical Therapy	11,182,897			593,124		30,552		66
68	Speech Pathology	1,000,706			66,803		32,213		68
69	Electrocardiology	3,110,573			318,661		1,090,999		69
71	Medical Supplies Charged to Pat	5,406,387			894,161		1,153,646		71
72	Impl. Dev. Charged to Patients	924,845			174,813		243,950		72
73	Drugs Charged to Patients	10,799,472			2,184,306		2,714,269		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	1,299,711							88
91	Emergency	10,625,204			1,205,588		2,416,514		91
92	Observation Beds (Non-Distinct)	3,146,219			268,344		599,387		92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services								95
200	Total (sum of lines 50-199)	136,255,015			15,510,958		28,277,993		200

(A) Worksheet A line numbers

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0147

WORKSHEET D
PART V

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

(A)	Cost Center Description	Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	
		1	2	3	4	5	6	7
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	0.152234	3,842,845			585,012		50
53	Anesthesiology	0.039171	797,680			31,246		53
54	Radiology-Diagnostic	0.152600	3,564,265			543,907		54
56	Radioisotope	0.072120	1,434,243			103,438		56
57	CT Scan	0.027103	4,951,284			134,195		57
58	MRI	0.156826	983,548			154,246		58
60	Laboratory	0.123812	3,541,008			438,419		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy	0.066329	344,254			22,834		64
65	Respiratory Therapy	0.192013	537,336			103,175		65
66	Physical Therapy	0.285533	30,552			8,724		66
68	Speech Pathology	0.408255	32,213			13,151		68
69	Electrocardiology	0.068137	1,090,999			74,337		69
71	Medical Supplies Charged to Pat	0.342632	1,153,646			395,276		71
72	Impl. Dev. Charged to Patients	0.523787	243,950			127,778		72
73	Drugs Charged to Patients	0.263438	2,714,269		9,995	715,042	2,633	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	0.195210	2,416,514			471,728		91
92	Observation Beds (Non-Distinct)	0.394574	599,387			236,503		92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	0.887828						95
200	Subtotal (see instructions)		28,277,993		9,995	4,159,011	2,633	200
201	Less PBP Clinic Lab. Services-Program Only Charges							201
202	Net Charges (line 200 - line 201)		28,277,993		9,995	4,159,011	2,633	202

(A) Worksheet A line numbers

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-S147

WORKSHEET D
PART II

Check Title V Hospital SUB (Other) PPS
 Applicable Title XVIII, Part A IPF TEFRA
 Boxes: Title XIX IRF

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	356,239	15,312,540	0.023265			50
53	Anesthesiology	44,420	4,362,921	0.010181			53
54	Radiology-Diagnostic	217,623	11,865,461	0.018341	1,116	20	54
56	Radioisotope	28,929	3,286,827	0.008801			56
57	CT Scan	30,215	16,660,878	0.001814	4,000	7	57
58	MRI	249,245	3,372,085	0.073914			58
60	Laboratory	153,836	28,505,177	0.005397	64,882	350	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	Intravenous Therapy	2,560	1,243,190	0.002059	1,631	3	64
65	Respiratory Therapy	25,926	4,149,922	0.006247			65
66	Physical Therapy	81,487	11,182,897	0.007287	379	3	66
68	Speech Pathology	6,359	1,000,706	0.006355			68
69	Electrocardiology	11,594	3,110,573	0.003727	1,673	6	69
71	Medical Supplies Charged to Pat	53,926	5,406,387	0.009974	2,813	28	71
72	Impl. Dev. Charged to Patients	13,638	924,845	0.014746			72
73	Drugs Charged to Patients	125,886	10,799,472	0.011657	89,213	1,040	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	48,124	1,299,711	0.037027			88
91	Emergency	128,152	10,625,204	0.012061	30,978	374	91
92	Observation Beds (Non-Distinct)		3,146,219				92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services						95
200	Total (sum of lines 50-199)	1,578,159	136,255,015		196,685	1,831	200

(A) Worksheet A line numbers

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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 PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX IRF NF Other

(A)	Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)
		1	2A	2	3A	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: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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 PPS
 Applicable 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)	
		7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	15,312,540							50
53	Anesthesiology	4,362,921							53
54	Radiology-Diagnostic	11,865,461			1,116				54
56	Radioisotope	3,286,827							56
57	CT Scan	16,660,878			4,000				57
58	MRI	3,372,085							58
60	Laboratory	28,505,177			64,882				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	1,243,190			1,631				64
65	Respiratory Therapy	4,149,922							65
66	Physical Therapy	11,182,897			379				66
68	Speech Pathology	1,000,706							68
69	Electrocardiology	3,110,573			1,673				69
71	Medical Supplies Charged to Pat	5,406,387			2,813				71
72	Impl. Dev. Charged to Patients	924,845							72
73	Drugs Charged to Patients	10,799,472			89,213				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	1,299,711							88
91	Emergency	10,625,204			30,978				91
92	Observation Beds (Non-Distinct)	3,146,219							92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services								95
200	Total (sum of lines 50-199)	136,255,015			196,685				200

(A) Worksheet A line numbers

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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 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	0.152234							50
53	Anesthesiology	0.039171							53
54	Radiology-Diagnostic	0.152600							54
56	Radioisotope	0.072120							56
57	CT Scan	0.027103							57
58	MRI	0.156826							58
60	Laboratory	0.123812							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	0.066329							64
65	Respiratory Therapy	0.192013							65
66	Physical Therapy	0.285533							66
68	Speech Pathology	0.408255							68
69	Electrocardiology	0.068137							69
71	Medical Supplies Charged to Pat	0.342632							71
72	Impl. Dev. Charged to Patients	0.523787							72
73	Drugs Charged to Patients	0.263438							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	0.195210							91
92	Observation Beds (Non-Distinct)	0.394574							92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	0.887828							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: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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) Swing Bed SNF
 Applicable 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	0.152234							50
53	Anesthesiology	0.039171							53
54	Radiology-Diagnostic	0.152600							54
56	Radioisotope	0.072120							56
57	CT Scan	0.027103							57
58	MRI	0.156826							58
60	Laboratory	0.123812							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	0.066329							64
65	Respiratory Therapy	0.192013							65
66	Physical Therapy	0.285533							66
68	Speech Pathology	0.408255							68
69	Electrocardiology	0.068137							69
71	Medical Supplies Charged to Pat	0.342632							71
72	Impl. Dev. Charged to Patients	0.523787							72
73	Drugs Charged to Patients	0.263438							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	0.195210							91
92	Observation Beds (Non-Distinct)	0.394574							92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	0.887828							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: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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 PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX IRF NF Other

(A)	Cost Center Description	1	2A	2	3A	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: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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 PPS
 Applicable 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)	
		7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	15,312,540							50
53	Anesthesiology	4,362,921							53
54	Radiology-Diagnostic	11,865,461			65,754				54
56	Radioisotope	3,286,827							56
57	CT Scan	16,660,878			30,141				57
58	MRI	3,372,085			9,664				58
60	Laboratory	28,505,177			220,186				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	1,243,190			51,515				64
65	Respiratory Therapy	4,149,922			550,406				65
66	Physical Therapy	11,182,897			2,395,409				66
68	Speech Pathology	1,000,706			95,896				68
69	Electrocardiology	3,110,573			7,025				69
71	Medical Supplies Charged to Pat	5,406,387			163,916				71
72	Impl. Dev. Charged to Patients	924,845							72
73	Drugs Charged to Patients	10,799,472			611,339				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	1,299,711							88
91	Emergency	10,625,204							91
92	Observation Beds (Non-Distinct)	3,146,219			10,110				92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services								95
200	Total (sum of lines 50-199)	136,255,015			4,211,361				200

(A) Worksheet A line numbers

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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 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	0.152234							50
53	Anesthesiology	0.039171							53
54	Radiology-Diagnostic	0.152600							54
56	Radioisotope	0.072120							56
57	CT Scan	0.027103							57
58	MRI	0.156826							58
60	Laboratory	0.123812							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	0.066329							64
65	Respiratory Therapy	0.192013							65
66	Physical Therapy	0.285533							66
68	Speech Pathology	0.408255							68
69	Electrocardiology	0.068137							69
71	Medical Supplies Charged to Pat	0.342632							71
72	Impl. Dev. Charged to Patients	0.523787							72
73	Drugs Charged to Patients	0.263438							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	0.195210							91
92	Observation Beds (Non-Distinct)	0.394574							92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	0.887828							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: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	343,165	3,281	339,884	4,404	77.18	540	41,677	30
31	Intensive Care Unit	84,311		84,311	753	111.97	11	1,232	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	80,108		80,108	1,187	67.49	669	45,151	40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery	20,186		20,186	406	49.72	198	9,845	43
44	Skilled Nursing Facility	177,189		177,189	9,589	18.48			44
45	Nursing Facility								45
200	Total (lines 30-199)	704,959		701,678	16,339		1,418	97,905	200

(A) Worksheet A line numbers

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0147

WORKSHEET D
PART II

Check Title V Hospital SUB (Other) PPS
 Applicable Title XVIII, Part A IPF TEFRA
 Boxes: Title XIX IRF

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part 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	356,239	15,312,540	0.023265		50
53	Anesthesiology	44,420	4,362,921	0.010181		53
54	Radiology-Diagnostic	217,623	11,865,461	0.018341		54
56	Radioisotope	28,929	3,286,827	0.008801		56
57	CT Scan	30,215	16,660,878	0.001814		57
58	MRI	249,245	3,372,085	0.073914		58
60	Laboratory	153,836	28,505,177	0.005397		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
64	Intravenous Therapy	2,560	1,243,190	0.002059		64
65	Respiratory Therapy	25,926	4,149,922	0.006247		65
66	Physical Therapy	81,487	11,182,897	0.007287		66
68	Speech Pathology	6,359	1,000,706	0.006355		68
69	Electrocardiology	11,594	3,110,573	0.003727		69
71	Medical Supplies Charged to Pat	53,926	5,406,387	0.009974		71
72	Impl. Dev. Charged to Patients	13,638	924,845	0.014746		72
73	Drugs Charged to Patients	125,886	10,799,472	0.011657		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	48,124	1,299,711	0.037027		88
91	Emergency	128,152	10,625,204	0.012061		91
92	Observation Beds (Non-Distinct	84,893	3,146,219	0.026983		92
	OTHER REIMBURSABLE COST CENTERS					
95	Ambulance Services					95
200	Total (sum of lines 50-199)	1,663,052	136,255,015			200

(A) Worksheet A line numbers

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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 TEERA
 Boxes: Title XIX Other

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

(A) Worksheet A line numbers

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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

(A)	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)
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics (General Routine Care)	4,404		540	30
31	Intensive Care Unit	753		11	31
32	Coronary Care Unit				32
33	Burn Intensive Care Unit				33
34	Surgical Intensive Care Unit				34
35	Other Special Care (specify)				35
40	Subprovider - IPF	1,187		669	40
41	Subprovider - IRF				41
42	Subprovider I				42
43	Nursery	406		198	43
44	Skilled Nursing Facility	9,589			44
45	Nursing Facility				45
200	Total (lines 30-199)	16,339		1,418	200

(A) Worksheet A line numbers

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0147

WORKSHEET D
PART IV

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

(A)	Cost Center Description	1	2A	2	3A	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: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0147

WORKSHEET D
PART IV

Check Title V Hospital SUB (Other) ICF/IID PPS
 Applicable 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)	
		7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	15,312,540							50
53	Anesthesiology	4,362,921							53
54	Radiology-Diagnostic	11,865,461							54
56	Radioisotope	3,286,827							56
57	CT Scan	16,660,878							57
58	MRI	3,372,085							58
60	Laboratory	28,505,177							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	1,243,190							64
65	Respiratory Therapy	4,149,922							65
66	Physical Therapy	11,182,897							66
68	Speech Pathology	1,000,706							68
69	Electrocardiology	3,110,573							69
71	Medical Supplies Charged to Pat	5,406,387							71
72	Impl. Dev. Charged to Patients	924,845							72
73	Drugs Charged to Patients	10,799,472							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	1,299,711							88
91	Emergency	10,625,204							91
92	Observation Beds (Non-Distinct)	3,146,219							92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services								95
200	Total (sum of lines 50-199)	136,255,015							200

(A) Worksheet A line numbers

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.152234							50
53	Anesthesiology	0.039171							53
54	Radiology-Diagnostic	0.152600							54
56	Radioisotope	0.072120							56
57	CT Scan	0.027103							57
58	MRI	0.156826							58
60	Laboratory	0.123812							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	0.066329							64
65	Respiratory Therapy	0.192013							65
66	Physical Therapy	0.285533							66
68	Speech Pathology	0.408255							68
69	Electrocardiology	0.068137							69
71	Medical Supplies Charged to Pat	0.342632							71
72	Impl. Dev. Charged to Patients	0.523787							72
73	Drugs Charged to Patients	0.263438							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	0.195210							91
92	Observation Beds (Non-Distinct)	0.394574							92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	0.887828							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: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-S147

WORKSHEET D
PART II

Check Title V Hospital SUB (Other) PPS
 Applicable Title XVIII, Part A IPF TEFRA
 Boxes: Title XIX IRF

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)
		1	2	3	4	5
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room	356,239	15,312,540	0.023265		50
53	Anesthesiology	44,420	4,362,921	0.010181		53
54	Radiology-Diagnostic	217,623	11,865,461	0.018341		54
56	Radioisotope	28,929	3,286,827	0.008801		56
57	CT Scan	30,215	16,660,878	0.001814		57
58	MRI	249,245	3,372,085	0.073914		58
60	Laboratory	153,836	28,505,177	0.005397		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
64	Intravenous Therapy	2,560	1,243,190	0.002059		64
65	Respiratory Therapy	25,926	4,149,922	0.006247		65
66	Physical Therapy	81,487	11,182,897	0.007287		66
68	Speech Pathology	6,359	1,000,706	0.006355		68
69	Electrocardiology	11,594	3,110,573	0.003727		69
71	Medical Supplies Charged to Pat	53,926	5,406,387	0.009974		71
72	Impl. Dev. Charged to Patients	13,638	924,845	0.014746		72
73	Drugs Charged to Patients	125,886	10,799,472	0.011657		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	48,124	1,299,711	0.037027		88
91	Emergency	128,152	10,625,204	0.012061		91
92	Observation Beds (Non-Distinct)		3,146,219			92
	OTHER REIMBURSABLE COST CENTERS					
95	Ambulance Services					95
200	Total (sum of lines 50-199)	1,578,159	136,255,015			200

(A) Worksheet A line numbers

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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 PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX IRF NF Other

(A)	Cost Center Description	1	2A	2	3A	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: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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 PPS
 Applicable 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)	
		7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	15,312,540							50
53	Anesthesiology	4,362,921							53
54	Radiology-Diagnostic	11,865,461							54
56	Radioisotope	3,286,827							56
57	CT Scan	16,660,878							57
58	MRI	3,372,085							58
60	Laboratory	28,505,177							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	1,243,190							64
65	Respiratory Therapy	4,149,922							65
66	Physical Therapy	11,182,897							66
68	Speech Pathology	1,000,706							68
69	Electrocardiology	3,110,573							69
71	Medical Supplies Charged to Pat	5,406,387							71
72	Impl. Dev. Charged to Patients	924,845							72
73	Drugs Charged to Patients	10,799,472							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	1,299,711							88
91	Emergency	10,625,204							91
92	Observation Beds (Non-Distinct)	3,146,219							92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services								95
200	Total (sum of lines 50-199)	136,255,015							200

(A) Worksheet A line numbers

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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	0.152234							50
53	Anesthesiology	0.039171							53
54	Radiology-Diagnostic	0.152600							54
56	Radioisotope	0.072120							56
57	CT Scan	0.027103							57
58	MRI	0.156826							58
60	Laboratory	0.123812							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	0.066329							64
65	Respiratory Therapy	0.192013							65
66	Physical Therapy	0.285533							66
68	Speech Pathology	0.408255							68
69	Electrocardiology	0.068137							69
71	Medical Supplies Charged to Pat	0.342632							71
72	Impl. Dev. Charged to Patients	0.523787							72
73	Drugs Charged to Patients	0.263438							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	0.195210							91
92	Observation Beds (Non-Distinct)	0.394574							92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	0.887828							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: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0147

WORKSHEET D-1
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,626	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,404	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)	3,304	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	54	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)	164	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	1	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)	3	8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,171	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)	54	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)	164	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	212.56	17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	218.85	18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	147.50	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	155.41	20
21	Total general inpatient routine service cost (see instructions)	5,018,176	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	11,478	22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	35,891	23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	148	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	466	25
26	Total swing-bed cost (see instructions)	47,983	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,970,193	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)	4,970,193	37

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0147

WORKSHEET D-1
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

1

38	Adjusted general inpatient routine service cost per diem (see instructions)					1,128.56	38
39	Program general inpatient routine service cost (line 9 x line 38)					2,450,104	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)					2,450,104	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	1,613,421	753	2,142.66	687	1,472,007	43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47

1

48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					2,716,894	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					6,639,005	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					244,481	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					154,091	51
52	Total Program excludable cost (sum of lines 50 and 51)					398,572	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					6,240,433	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)					11,478	64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)					35,891	65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)					47,369	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: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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)					1,100	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,128.56	88
89	Observation bed cost (line 87 x line 88) (see instructions)					1,241,416	89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	343,165	5,018,176	0.068384	1,241,416	84,893	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: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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 PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX - I/P IRF NF Other

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,187	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,187	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.	1,131	3
4	Semi-private room days (excluding swing-bed private room days)	56	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)	268	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)	1,576,788	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)	1,576,788	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)	1,594,128	28
29	Private room charges (excluding swing-bed charges)	1,518,378	29
30	Semi-private room charges (excluding swing-bed charges)	75,750	30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.989123	31
32	Average private room per diem charge (line 29 ÷ line 3)	1,342.51	32
33	Average semi-private room per diem charge (line 30 ÷ line 4)	1,352.68	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)	1,576,788	37

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-S147

WORKSHEET D-1
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

1

38	Adjusted general inpatient routine service cost per diem (see instructions)	1,328.38	38
39	Program general inpatient routine service cost (line 9 x line 38)	356,006	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)	356,006	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	39,154	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	395,160	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	18,087	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,831	51
52	Total Program excludable cost (sum of lines 50 and 51)	19,918	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	375,242	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 PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX - I/P IRF NF Other

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	9,589	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	9,589	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)	9,589	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)	2,704	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)	3,580,588	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)	3,580,588	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)	3,580,588	37

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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)	3,580,588	70
71	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	373.41	71
72	Program routine service cost (line 9 x line 71)	1,009,701	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)	1,009,701	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)	1,009,701	83
84	Program inpatient ancillary services (see instructions)	1,093,530	84
85	Utilization review - physician compensation (see instructions)		85
86	Total Program inpatient operating costs (sum of lines 83 through 85)	2,103,231	86

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0147

WORKSHEET D-1
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,626	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,404	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)	3,304	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	54	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)	164	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	1	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)	3	8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	540	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)	406	15
16	Nursery days (title V or XIX only)	198	16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	212.56	17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	218.85	18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	147.50	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	155.41	20
21	Total general inpatient routine service cost (see instructions)	5,018,176	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	11,478	22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	35,891	23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	148	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	466	25
26	Total swing-bed cost (see instructions)	47,983	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,970,193	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)	4,970,193	37

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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

		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	
38	Adjusted general inpatient routine service cost per diem (see instructions)					1,128.56	38
39	Program general inpatient routine service cost (line 9 x line 38)					609,422	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)					609,422	41
42	Nursery (Titles V and XIX only)	573,731	406	1,413.13	198	279,800	42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	1,613,421	753	2,142.66	11	23,569	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)					912,791	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					52,754	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)					52,754	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					860,037	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: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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)					1,100	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 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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 PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX - I/P IRF NF Other

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,187	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,187	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.	1,131	3
4	Semi-private room days (excluding swing-bed private room days)	56	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)	669	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)	1,576,788	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)	1,576,788	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)	1,594,128	28
29	Private room charges (excluding swing-bed charges)	1,518,378	29
30	Semi-private room charges (excluding swing-bed charges)	75,750	30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.989123	31
32	Average private room per diem charge (line 29 ÷ line 3)	1,342.51	32
33	Average semi-private room per diem charge (line 30 ÷ line 4)	1,352.68	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)	1,576,788	37

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-S147

WORKSHEET D-1
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

1

38	Adjusted general inpatient routine service cost per diem (see instructions)	1,328.38	38
39	Program general inpatient routine service cost (line 9 x line 38)	888,686	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)	888,686	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)	888,686	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	45,151	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)	45,151	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	843,535	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: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0147

WORKSHEET D-3

Check Title V Hospital SUB (Other) Swing Bed SNF PPS
 Applicable Title XVIII, Part A IPF SNF Swing Bed NF TEFRA
 Boxes: Title XIX IRF NF ICF/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		2,215,071		30
31	Intensive Care Unit		1,017,837		31
40	Subprovider - IPF				40
ANCILLARY SERVICE COST CENTERS					
50	Operating Room	0.152234	1,064,837	162,104	50
53	Anesthesiology	0.039171	217,806	8,532	53
54	Radiology-Diagnostic	0.152600	1,260,378	192,334	54
56	Radioisotope	0.072120	95,462	6,885	56
57	CT Scan	0.027103	1,638,513	44,409	57
58	MRI	0.156826	85,143	13,353	58
60	Laboratory	0.123812	3,390,691	419,808	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	Intravenous Therapy	0.066329	457,766	30,363	64
65	Respiratory Therapy	0.192013	1,594,562	306,177	65
66	Physical Therapy	0.285533	593,124	169,356	66
68	Speech Pathology	0.408255	66,803	27,273	68
69	Electrocardiology	0.068137	318,661	21,713	69
71	Medical Supplies Charged to Patients	0.342632	894,161	306,368	71
72	Impl. Dev. Charged to Patients	0.523787	174,813	91,565	72
73	Drugs Charged to Patients	0.263438	2,184,306	575,429	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	0.195210	1,205,588	235,343	91
92	Observation Beds (Non-Distinct Part)	0.394574	268,344	105,882	92
OTHER REIMBURSABLE COST CENTERS					
95	Ambulance Services				95
200	Total (sum of lines 50-94, and 96-98)		15,510,958	2,716,894	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		15,510,958		202

(A) Worksheet A line numbers

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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 PFS
 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		319,335		40
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.152234			50
53	Anesthesiology	0.039171			53
54	Radiology-Diagnostic	0.152600	1,116	170	54
56	Radioisotope	0.072120			56
57	CT Scan	0.027103	4,000	108	57
58	MRI	0.156826			58
60	Laboratory	0.123812	64,882	8,033	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	Intravenous Therapy	0.066329	1,631	108	64
65	Respiratory Therapy	0.192013			65
66	Physical Therapy	0.285533	379	108	66
68	Speech Pathology	0.408255			68
69	Electrocardiology	0.068137	1,673	114	69
71	Medical Supplies Charged to Patients	0.342632	2,813	964	71
72	Impl. Dev. Charged to Patients	0.523787			72
73	Drugs Charged to Patients	0.263438	89,213	23,502	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	0.195210	30,978	6,047	91
92	Observation Beds (Non-Distinct Part)	0.394574			92
	OTHER REIMBURSABLE COST CENTERS				
95	Ambulance Services				95
200	Total (sum of lines 50-94, and 96-98)		196,685	39,154	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		196,685		202

(A) Worksheet A line numbers

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-U147

WORKSHEET D-3

Check Title V Hospital SUB (Other) Swing Bed SNF PPS
 Applicable Title XVIII, Part A IPF SNF Swing Bed NF TEFRA
 Boxes: Title XIX IRF NF ICF/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	0.152234			50
53	Anesthesiology	0.039171			53
54	Radiology-Diagnostic	0.152600	8,648	1,320	54
56	Radioisotope	0.072120			56
57	CT Scan	0.027103	14,003	380	57
58	MRI	0.156826			58
60	Laboratory	0.123812	35,172	4,355	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	Intravenous Therapy	0.066329	12,212	810	64
65	Respiratory Therapy	0.192013	75,711	14,537	65
66	Physical Therapy	0.285533	103,501	29,553	66
68	Speech Pathology	0.408255	2,030	829	68
69	Electrocardiology	0.068137	669	46	69
71	Medical Supplies Charged to Patients	0.342632	16,991	5,822	71
72	Impl. Dev. Charged to Patients	0.523787			72
73	Drugs Charged to Patients	0.263438	81,963	21,592	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	0.195210			91
92	Observation Beds (Non-Distinct Part)	0.394574	151	60	92
OTHER REIMBURSABLE COST CENTERS					
95	Ambulance Services				95
200	Total (sum of lines 50-94, and 96-98)		351,051	79,304	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		351,051		202

(A) Worksheet A line numbers

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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	0.152234			50
53	Anesthesiology	0.039171			53
54	Radiology-Diagnostic	0.152600	65,754	10,034	54
56	Radioisotope	0.072120			56
57	CT Scan	0.027103	30,141	817	57
58	MRI	0.156826	9,664	1,516	58
60	Laboratory	0.123812	220,186	27,262	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	Intravenous Therapy	0.066329	51,515	3,417	64
65	Respiratory Therapy	0.192013	550,406	105,685	65
66	Physical Therapy	0.285533	2,395,409	683,968	66
68	Speech Pathology	0.408255	95,896	39,150	68
69	Electrocardiology	0.068137	7,025	479	69
71	Medical Supplies Charged to Patients	0.342632	163,916	56,163	71
72	Impl. Dev. Charged to Patients	0.523787			72
73	Drugs Charged to Patients	0.263438	611,339	161,050	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	0.195210			91
92	Observation Beds (Non-Distinct Part)	0.394574	10,110	3,989	92
	OTHER REIMBURSABLE COST CENTERS				
95	Ambulance Services				95
200	Total (sum of lines 50-94, and 96-98)		4,211,361	1,093,530	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		4,211,361		202

(A) Worksheet A line numbers

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0147

WORKSHEET D-3

Check Title V Hospital SUB (Other) Swing Bed SNF PPS
 Applicable Title XVIII, Part A IPF SNF Swing Bed NF TEFRA
 Boxes: Title XIX IRF NF ICF/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	0.152234		50
53	Anesthesiology	0.039171		53
54	Radiology-Diagnostic	0.152600		54
56	Radioisotope	0.072120		56
57	CT Scan	0.027103		57
58	MRI	0.156826		58
60	Laboratory	0.123812		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS			62.30
64	Intravenous Therapy	0.066329		64
65	Respiratory Therapy	0.192013		65
66	Physical Therapy	0.285533		66
68	Speech Pathology	0.408255		68
69	Electrocardiology	0.068137		69
71	Medical Supplies Charged to Patients	0.342632		71
72	Impl. Dev. Charged to Patients	0.523787		72
73	Drugs Charged to Patients	0.263438		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	0.195210		91
92	Observation Beds (Non-Distinct Part)	0.394574		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: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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 PFS
 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	0.152234			50
53	Anesthesiology	0.039171			53
54	Radiology-Diagnostic	0.152600			54
56	Radioisotope	0.072120			56
57	CT Scan	0.027103			57
58	MRI	0.156826			58
60	Laboratory	0.123812			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	Intravenous Therapy	0.066329			64
65	Respiratory Therapy	0.192013			65
66	Physical Therapy	0.285533			66
68	Speech Pathology	0.408255			68
69	Electrocardiology	0.068137			69
71	Medical Supplies Charged to Patients	0.342632			71
72	Impl. Dev. Charged to Patients	0.523787			72
73	Drugs Charged to Patients	0.263438			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	0.195210			91
92	Observation Beds (Non-Distinct Part)	0.394574			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: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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)	4,248,797			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)	20,809			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)	43.38			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)	0.0492			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.1914			31
32	Sum of lines 30 and 31	0.2406			32
33	Allowable disproportionate share percentage (see instructions)	0.0804			33
34	Disproportionate share adjustment (see instructions)	85,401			34
		Prior to		On or after	
		October 1 (1.00)	(1.01)	October 1 (2.00)	
Uncompensated Care Adjustment					
35	Total uncompensated care amount (see instructions)				35
35.01	Factor 3 (see instructions)				35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)			280,302	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)			280,302	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	280,302			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)	4,635,309			47
48	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see instructions)	4,942,041			48
49	Total payment for inpatient operating costs (see instructions)	4,865,358			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	340,084			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. 1, 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)	5,205,442			59
60	Primary payer payments				60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	5,205,442			61
62	Deductibles billed to program beneficiaries	681,212			62
63	Coinsurance billed to program beneficiaries				63
64	Allowable bad debts (see instructions)	201,666			64
65	Adjusted reimbursable bad debts (see instructions)	131,083			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	175,620			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	4,655,313			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)	-141			70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	-6,901			70.91
70.93	HVBP payment adjustment amount (see instructions)	-2,597			70.93
70.94	HRR adjustment amount (see instructions)	-127,464			70.94
70.97	Low volume adjustment for federal fiscal year (2017)	729,694			70.97
70.99	HAC adjustment amount (see instructions)	57,980			70.99
71	Amount due provider (see instructions)	5,189,924			71
71.01	Sequestration adjustment (see instructions)	103,798			71.01
71.02	Demonstration payment adjustment amount after sequestration				71.02
72	Interim payments	5,234,070			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	-147,944			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	78,000			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)		230,049		100
HVBP Adjustment for HSP Bonus Payment		Prior to 10/1	On or After 10/1		
101	HVBP adjustment factor (see instructions)	0.0000000000	0.9993887940		101
102	HVBP adjustment amount for HSP bonus payment (see instructions)		-141		102
HRR Adjustment for HSP Bonus Payment		Prior to 10/1	On or After 10/1		
103	HRR adjustment factor (see instructions)	0.0000	0.9700		103
104	HRR adjustment amount for HSP bonus payment (see instructions)		-6,901		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. 1)	Pre/Post Entitlement					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	4,248,797			4,248,797		4,248,797	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	20,809			20,809		20,809	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	0.0804	0.0804	0.0804	0.0804	0.0804	0.0804	10
11	Disproportionate share adjustment	85,401			85,401		85,401	11
11.01	Uncompensated care payments	280,302			280,302		280,302	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12	Total ESRD additional payment							12
13	Subtotal	4,635,309			4,635,309		4,635,309	13
14	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.)	4,942,041			4,942,041		4,942,041	14
15	Total payment for inpatient operating costs SCH and MDH only	4,865,358			4,865,358		4,865,358	15
16	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	340,084			340,084		340,084	16
17	Special add-on payments for new technologies							17
17.01	DO NOT USE THIS LINE							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				5,205,442		5,205,442	19
20	Capital DRG other than outlier	339,240			339,240		339,240	20
20.01	Model 4 BPCI Capital DRG other than outlier							20.01
21	Capital DRG outlier payments	844			844		844	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	340,084			340,084		340,084	26
27	Low volume adjustment factor				0.140179			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)				729,694		729,694	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	4,248,797		4,248,797		4,248,797	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	20,809		20,809		20,809	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	0.0804	0.0804	0.0804	0.0804	0.0804	10
11	Disproportionate share adjustment	85,401		85,401		85,401	11
11.01	Uncompensated care payments	280,302		280,302		280,302	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12	Total ESRD additional payment						12
13	Subtotal	4,635,309		4,635,309		4,635,309	13
14	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.)	4,942,041		4,942,041		4,942,041	14
15	Total payment for inpatient operating costs SCH and MDH only	4,865,358		4,865,358		4,865,358	15
16	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	340,084		340,084		340,084	16
17	Special add-on payments for new technologies						17
17.01	DO NOT USE THIS LINE						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			5,205,442		5,205,442	19
20	Capital DRG other than outlier	339,240		339,240		339,240	20
20.01	Model 4 BPCI Capital DRG other than outlier						20.01
21	Capital DRG outlier payments	844		844		844	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	340,084		340,084		340,084	26
27							27
28	Low volume adjustment prior to October 1						28
29	Low volume adjustment on or after October 1	729,694		729,694		729,694	29
30	HVBP payment adjustment	-2,597		-2,597		-2,597	30
30.01	HVBP payment adjustment for HSP bonus payment	-141		-141		-141	30.01
31	HRR adjustment	-127,464		-127,464		-127,464	31
31.01	HRR adjustment for HSP bonus payment	-6,901		-6,901		-6,901	31.01
32	HAC Reduction Program adjustment			57,980		57,980	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) SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	2,633			1
2	Medical and other services reimbursed under OPPS (see instructions)	4,159,011			2
3	OPPS payments	3,589,147			3
4	Outlier payment (see instructions)	4,304			4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)	0.810			5
6	Line 2 times line 5	3,368,799			6
7	Sum of lines 3, 4, and 4.01, divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	2,633			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	9,995			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)	9,995			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)	9,995			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions))	7,362			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) (see instructions)	2,633			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	3,593,451			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	760,269			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)	2,835,815			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)	2,835,815			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	2,835,815			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)	161,913			34
35	Adjusted reimbursable bad debts (see instructions)	105,243			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	156,800			36
37	Subtotal (see instructions)	2,941,058			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)	2,941,058			40
40.01	Sequestration adjustment (see instructions)	58,821			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	2,898,848			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-16,611			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	OPPS payments				3
4	Outlier payment (see instructions)				4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (see instructions)				21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)				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
40.02	Demonstration payment adjustment amount after sequestration				40.02
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: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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	OPPS payments				3
4	Outlier payment (see instructions)				4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (see instructions)				21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)				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
40.02	Demonstration payment adjustment amount after sequestration				40.02
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: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-0147

WORKSHEET E-1
PART I

Check Hospital SUB (Other)
 Applicable IPF SNF
 Boxes: IRF Swing Bed SNF

	DESCRIPTION	INPATIENT PART A		PART B		
		mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4	
1	Total interim payments paid to provider		5,234,070		2,898,848	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
		.03				3.03
		.04				3.04
		.05				3.05
		.06				3.06
		.07				3.07
		.08				3.08
		.09				3.09
		.10				3.10
		.50				3.50
		.51				3.51
		.52				3.52
		.53				3.53
		.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)		5,234,070		2,898,848	4
TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
		.01				5.01
		.02				5.02
		.03				5.03
		.04				5.04
		.05				5.05
		.06				5.06
		.07				5.07
		.08				5.08
		.09				5.09
		.10				5.10
		.50				5.50
		.51				5.51
		.52				5.52
		.53				5.53
		.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)		-147,944		-16,611	6.02
8	Name of Contractor		5,086,126		2,882,237	7
						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: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4
1	Total interim payments paid to provider		201,047		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)		201,047		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	7,487		6.01
		.02			6.02
7	Total Medicare program liability (see instructions)		208,534		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: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4
1	Total interim payments paid to provider		63,097		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)		63,097		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	1,257		6.01
		.02			6.02
7	Total Medicare program liability (see instructions)		64,354		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: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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		917,235		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)		917,235		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)		917,235		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: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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)	70,247	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	218	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)	70,247	8
9	Primary payer payments (see instructions)		9
10	Subtotal (line 8 minus line 9)	70,247	10
11	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		11
12	Subtotal (line 10 minus line 11)	70,247	12
13	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	5,863	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)	64,384	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)	1,974	17
17.01	Adjusted reimbursable bad debts (see instructions)	1,283	17.01
18	Allowable bad debts for dual eligible beneficiaries (see instructions)		18
19	Total (see instructions)	65,667	19
19.01	Sequestration adjustment (see instructions)	1,313	19.01
19.02	Demonstration payment adjustment amount after sequestration		19.02
20	Interim payments	63,097	20
21	Tentative settlement (for contractor use only)		21
22	Balance due provider/program (line 19 minus lines 19.01, 19.02, 20 and 21)	1,257	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: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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)	237,452	1
2	Net IPF PPS Outlier payment	6,910	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)	3.252055	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)	244,362	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)	244,362	16
17	Primary payer payments		17
18	Subtotal (line 16 less line 17)	244,362	18
19	Deductibles	39,203	19
20	Subtotal (line 18 minus line 19)	205,159	20
21	Coinsurance		21
22	Subtotal (line 20 minus line 21)	205,159	22
23	Allowable bad debts (exclude bad debts for professional services) (see instructions)	11,740	23
24	Adjusted reimbursable bad debts (see instructions)	7,631	24
25	Allowable bad debts for dual eligible beneficiaries (see instructions)		25
26	Subtotal (sum of lines 22 and 24)	212,790	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)	212,790	31
31.01	Sequestration adjustment (see instructions)	4,256	31.01
31.02	Demonstration payment adjustment amount after sequestration		31.02
32	Interim payments	201,047	32
33	Tentative settlement (for contractor use only)		33
34	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	7,487	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: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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	1,124,226	1
2	Routine service other pass through costs		2
3	Ancillary service other pass through costs		3
4	Subtotal (sum of lines 1-3)	1,124,226	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	188,272	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)	935,954	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)	935,954	15
15.01	Sequestration adjustment (see instructions)	18,719	15.01
15.02	Demonstration payment adjustment amount after sequestration		15.02
16	Interim payments	917,235	16
17	Tentative settlement (for contractor use only)		17
18	Balance due provider/program (line 15 minus lines 15.01, 15.02, 16 and 17)		18
19	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		19

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-0147

WORKSHEET E-3
PART VII

Check Title V Hospital NF PPS
 Applicable Title XIX SUB (Other) ICF/IID TEFRA
 Boxes: SNF Other

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services			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 cahrgre 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 PPS
 Applicable Title XIX 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 cahrgre 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

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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	738,348				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	8,317,430				4
5	Other receivables	230,222				5
6	Allowances for uncollectible notes and accounts receivable					6
7	Inventory	768,037				7
8	Prepaid expenses	548,563				8
9	Other current assets	2,045,312				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	12,647,912				11
FIXED ASSETS						
12	Land	188,315				12
13	Land improvements	487,119				13
14	Accumulated depreciation	-370,319				14
15	Buildings	25,675,773				15
16	Accumulated depreciation	-18,441,794				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment	2,355,173				19
20	Accumulated depreciation	-2,294,408				20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	21,109,394				23
24	Accumulated depreciation	-14,447,774				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	14,261,479				30
OTHER ASSETS						
31	Investments	11,767,837				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	320,094				34
35	Total other assets (sum of lines 31-34)	12,087,931				35
36	Total assets (sum of lines 11, 30 and 35)	38,997,322				36
Liabilities and Fund Balances						
Liabilities and Fund Balances (Omit Cents)		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1	2	3	4	
CURRENT LIABILITIES						
37	Accounts payable	1,921,804				37
38	Salaries, wages and fees payable	2,083,514				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	312,865				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	1,287,699				44
45	Total current liabilities (sum of lines 37 thru 44)	5,605,882				45
LONG TERM LIABILITIES						
46	Mortgage payable					46
47	Notes payable	5,876,218				47
48	Unsecured loans					48
49	Other long term liabilities					49
50	Total long term liabilities (sum of lines 46 thru 49)	5,876,218				50
51	Total liabilities (sum of lines 45 and 50)	11,482,100				51
CAPITAL ACCOUNTS						
52	General fund balance	27,515,222				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)	27,515,222				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	38,997,322				60

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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		26,613,563		1
2	Net income (loss) (from Worksheet G-3, line 29)		901,659		2
3	Total (sum of line 1 and line 2)		27,515,222		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)		27,515,222		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)		27,515,222		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: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	5,058,510		5,058,510	1
2	Subprovider IPF	1,594,128		1,594,128	2
3	Subprovider IRF				3
5	Swing Bed - SNF	107,630		107,630	5
6	Swing Bed - NF				6
7	Skilled nursing facility	2,711,824		2,711,824	7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	9,472,092		9,472,092	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	1,630,720		1,630,720	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)	1,630,720		1,630,720	16
17	Total inpatient routine care services (sum of lines 10 and 16)	11,102,812		11,102,812	17
18	Ancillary services	25,861,365	112,594,221	138,455,586	18
19	Outpatient services		9,752,597	9,752,597	19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency		3,982,447	3,982,447	22
23	Ambulance	28,168	2,123,256	2,151,424	23
25	ASC				25
26	Hospice				26
27	OTHER	1,302,408	1,309,320	2,611,728	27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	38,294,753	129,761,841	168,056,594	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		52,899,716	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)		52,899,716	43

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	168,056,594	1
2	Less contractual allowances and discounts on patients' accounts	116,536,190	2
3	Net patient revenues (line 1 minus line 2)	51,520,404	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	52,899,716	4
5	Net income from service to patients (line 3 minus line 4)	-1,379,312	5

OTHER INCOME

6	Contributions, donations, bequests, etc.	124,992	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	8,834	10
11	Rebates and refunds of expenses		11
12	Parking lot receipts		12
13	Revenue from laundry and linen service	201,529	13
14	Revenue from meals sold to employees and guests	293,139	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients	3,873	16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts	1,331	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	8,891	21
22	Rental of hosptial space		22
23	Governmental appropriations		23
24	Other (PROPERTY TAX REVENUE)	430,327	24
24.01	Other (EHR MEANINGFUL USE)	21,560	24.01
24.02	Other (GRANTS)	27,096	24.02
24.03	Other (OTHER)	242,771	24.03
24.04	Other (NET ASSETS RELEASED BY FOUNDATION)	16,233	24.04
24.05	Other (INVESTMENT INCOME)	900,395	24.05
25	Total other income (sum of lines 6-24)	2,280,971	25
26	Total (line 5 plus line 25)	901,659	26
27.01	Other expenses (NET ASSETS RELEASED BY FOUNDATION)		27.01
29	Net income (or loss) for the period (line 26 minus line 28)	901,659	29

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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	50,556		722		91,891	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	556,178		18,280			6
7	Physical Therapy			10,271			7
8	Occupational Therapy			4,637			8
9	Speech Pathology			1,934			9
10	Medical Social Services	3,472		16			10
11	Home Health Aide	68,885		5,476			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)	679,091		41,336		91,891	24

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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	143,169		143,169		143,169	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	574,458		574,458		574,458	6
7	Physical Therapy	10,271		10,271		10,271	7
8	Occupational Therapy	4,637		4,637		4,637	8
9	Speech Pathology	1,934		1,934		1,934	9
10	Medical Social Services	3,488		3,488		3,488	10
11	Home Health Aide	74,361		74,361		74,361	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)	812,318		812,318		812,318	24

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

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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	143,169				5
HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	574,458				6
7	Physical Therapy	10,271				7
8	Occupational Therapy	4,637				8
9	Speech Pathology	1,934				9
10	Medical Social Services	3,488				10
11	Home Health Aide	74,361				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)	812,318				24

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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		143,169	143,169		5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care		574,458	122,909	697,367	6
7	Physical Therapy		10,271	2,198	12,469	7
8	Occupational Therapy		4,637	992	5,629	8
9	Speech Pathology		1,934	414	2,348	9
10	Medical Social Services		3,488	746	4,234	10
11	Home Health Aide		74,361	15,910	90,271	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)		812,318		812,318	24

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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						
2	Capital Related-Movable Equipment						
3	Plant Operation & Maintenance						
4	Transportation (see instructions)						
5	Administrative and General					-143,169	669,149
HHA REIMBURSABLE SERVICES							
6	Skilled Nursing Care						574,458
7	Physical Therapy						10,271
8	Occupational Therapy						4,637
9	Speech Pathology						1,934
10	Medical Social Services						3,488
11	Home Health Aide						74,361
12	Supplies (see instructions)						
13	Drugs						
14	DME						
HHA NONREIMBURSABLE SERVICES							
15	Home Dialysis Aide Services						
16	Respiratory Therapy						
17	Private Duty Nursing						
18	Clinic						
19	Health Promotion Activities						
20	Day Care Program						
21	Home Delivered Means Program						
22	Homemaker Service						
23	All Others						
23.50	Telemedicine						
24	Totals (sum of lines 1-23)					-143,169	669,149
25	Cost To Be Allocated (per Worksheet H-1, Part I)						143,169
26	Unit Cost Multiplier						0.213957

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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7187

WORKSHEET H-2
PART I

	HHA COST CENTER (omit cents)	HHA TRIAL BALANCE(1)	NEW CAP RE L COSTS-BL DG & FIXT	NEW CAP RE L COSTS-MV BLE EQUIP	EMPLOYEE B ENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINISTRA TIVE & GEN ERAL	
		0	1	2	4	4A	5	
1	Administrative and General		6,419	71	20,983	27,473	3,636	1
2	Skilled Nursing Care	697,367			230,927	928,294	122,840	2
3	Physical Therapy	12,469				12,469	1,650	3
4	Occupational Therapy	5,629				5,629	745	4
5	Speech Pathology	2,348				2,348	311	5
6	Medical Social Services	4,234			1,441	5,675	751	6
7	Home Health Aide	90,271			28,591	118,862	15,729	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)	812,318	6,419	71	281,942	1,100,750	145,662	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: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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	13,208	6,385		17,758		14,298	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)	13,208	6,385		17,758		14,298	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: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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				122			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)				122			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: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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						82,880	1
2	Skilled Nursing Care						1,051,134	2
3	Physical Therapy						14,119	3
4	Occupational Therapy						6,374	4
5	Speech Pathology						2,659	5
6	Medical Social Services						6,426	6
7	Home Health Aide						134,591	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)						1,298,183	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: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7187

WORKSHEET H-2
PART I

	HHA COST CENTER (omit cents)	I&R COST & POST STEP- DOWN ADJS	SUBTOTAL (cols 23 +/- 24)	ALLOCATED HHA A&G (see PtII)	TOTAL HHA COSTS		
		25	26	27	28		
1	Administrative and General		82,880				1
2	Skilled Nursing Care		1,051,134	71,684	1,122,818		2
3	Physical Therapy		14,119	963	15,082		3
4	Occupational Therapy		6,374	435	6,809		4
5	Speech Pathology		2,659	181	2,840		5
6	Medical Social Services		6,426	438	6,864		6
7	Home Health Aide		134,591	9,179	143,770		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)		1,298,183	82,880	1,298,183		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.			0.068197			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.

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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- 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	70	50,556		27,473	1,333	1
2	Skilled Nursing Care			556,377		928,294		2
3	Physical Therapy					12,469		3
4	Occupational Therapy					5,629		4
5	Speech Pathology					2,348		5
6	Medical Social Services			3,472		5,675		6
7	Home Health Aide			68,885		118,862		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	70	679,290		1,100,750	1,333	20
21	Total cost to be allocated	6,419	71	281,942		145,662	13,208	21
22	Unit Cost Multiplier	4.815454		0.415054		0.132330		22
22	Unit Cost Multiplier		1.014286				9.908477	22

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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 14-7187

WORKSHEET H-2
PART II

	HHA COST CENTER	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE ICE LAUNDRY POUNDS	HOUSEKEEPING HOURS OF SERVICE	DIETARY DIETARY MEALS SERV	CAFETERIA CAFE MEALS SERV	MAINTENANCE OF PERSONNEL NUMBER HOUSED	
		7	8	9	10	11	12	
1	Administrative and General	1,333		156		58		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		156		58		20
21	Total cost to be allocated	6,385		17,758		14,298		21
22	Unit Cost Multiplier	4.789947		113.833333		246.517241		22
22	Unit Cost Multiplier							22

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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 14-7187

WORKSHEET H-2
PART II

	HHA COST CENTER	NURSING AD MINISTRATI ON DIRECT NURSING HO	CENTRAL SE RVICES & S UPPLY CS COSTED REQUIS	PHARMACY PHARM COSTED REQ	MEDICAL RE CORDS & LI BRARY TIME SPENT	SOCIAL SERVICE TIME SPENT	NONPHYSIC. ANESTHET. ASSIGNED TIME	
		13	14	15	16	17	19	
1	Administrative and General			60				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)			60				20
21	Total cost to be allocated			122				21
22	Unit Cost Multiplier			2.033333				22
22	Unit Cost Multiplier							22

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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: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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								
	Patient Services	From Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA COSTS (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		1	2	3	4	5		
1	Skilled Nursing Care	2	1,122,818		1,122,818	5,574	201.44	1
2	Physical Therapy	3	15,082	255,249	270,331	2,734	98.88	2
3	Occupational Therapy	4	6,809		6,809	590	11.54	3
4	Speech Pathology	5	2,840	25,368	28,208	267	105.65	4
5	Medical Social Services	6	6,864		6,864	45	152.53	5
6	Home Health Aide	7	143,770		143,770	922	155.93	6
7	Total (sum of lines 1-6)		1,298,183	280,617	1,578,800	10,132		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		4,045		8
9	Physical Therapy	99914		1,945		9
10	Occupational Therapy	99914		439		10
11	Speech Pathology	99914		163		11
12	Medical Social Services	99914		22		12
13	Home Health Aide	99914		825		13
14	Total (sum of lines 8-13)			7,439		14

Supplies and Drugs Cost Computations							
	Other Patient Services	From Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)
		1	2	3	4	5	
15	Cost of Medical Supplies	8		30,340	30,340	88,550	0.342631
16	Cost of Drugs	9					

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

		From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charges (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated
		1	2	3	4	
1	Physical Therapy	66	0.285533	893,940	255,249	col. 2, line 2
2	Occupational Therapy	67				col. 2, line 3
3	Speech Pathology	68	0.408255	62,137	25,368	col. 2, line 4
4	Medical Supplies Charged to Pat	71	0.342632	88,550	30,340	col. 2, line 15
5	Drugs Charged to Patients	73	0.263438			col. 2, line 16

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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APPORTIONMENT OF PATIENT SERVICE COSTS

HHA CCN: 14-7187

WORKSHEET H-3
PARTS I & II

Check applicable box: Title V Title XVIII Title XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

Cost Per Visit Computation		Program Visits			Cost of Services				
		Part B			Part B				
	Patient Services	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Total Program Cost (sum of cols 9-10)	
		6	7	8	9	10	11	12	
1	Skilled Nursing Care		4,045			814,825		814,825	1
2	Physical Therapy		1,945			192,322		192,322	2
3	Occupational Therapy		439			5,066		5,066	3
4	Speech Pathology		163			17,221		17,221	4
5	Medical Social Services		22			3,356		3,356	5
6	Home Health Aide		825			128,642		128,642	6
7	Total (sum of lines 1-6)		7,439			1,161,432		1,161,432	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: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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 B		
		Part A	Not Subject to Deductibles & Coinsurance	
		1	2	3
	Reasonable Cost of Part A & Part B Services			
1	Reasonable cost of services (see instructions)			1
2	Total charges			2
	Customary Charges			
3	Amount actually collected from patients liable for payment for services on a charge basis (from your records)			3
4	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)			4
5	Ratio of line 3 to line 4 (not to exceed 1.000000)			5
6	Total customary charges (see instructions)			6
7	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)			7
8	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)			8
9	Primary payer 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		864,949	11
12	Total PPS Reimbursement - Full Episodes with Outliers		101,003	12
13	Total PPS Reimbursement - LUPA Episodes		16,187	13
14	Total PPS Reimbursement - PEP Episodes		2,860	14
15	Total PPS Outlier Reimbursement - Full Episodes with Outliers		35,574	15
16	Total PPS Outlier Reimbursement - PSP Episodes		2,670	16
17	Total Other Payments		630	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)		1,023,873	22
23	Excess reasonable cost (from line 8)			23
24	Subtotal (line 22 minus line 23)		1,023,873	24
25	Coinsurance billed to program patients (from your records)			25
26	Net cost (line 24 minus line 25)		1,023,873	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)		1,023,873	29
30	Other adjustments (see instructions) (specify)		-2,863	30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			30.50
31	Subtotal (see instructions)		1,021,010	31
31.01	Sequestration adjustment (see instructions)		20,420	31.01
31.02	Demonstration payment adjustment amount after sequestration			31.02
32	Interim payments (see instructions)		1,000,590	32
33	Tentative settlement (for contractor use only)			33
34	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115-2			35

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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				1,000,590	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)				1,000,590	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)				1,000,590	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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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	339,240	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	844	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)	11.12	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)	340,084	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: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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

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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)	RECLASS- IFICATIONS	RECLASS- IFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	Physician	350,473		350,473		350,473		350,473	1
2	Physician Assistant								2
3	Nurse Practitioner	189,554		189,554		189,554		189,554	3
4	Visiting Nurse								4
5	Other Nurse	178,225		178,225		178,225		178,225	5
6	Clinical Psychologist								6
7	Clinical Social Worker								7
8	Laboratory Technician	44,922		44,922		44,922		44,922	8
9	Other Facility Health Care Staff Costs								9
10	Subtotal (sum of lines 1 through 9)	763,174		763,174		763,174		763,174	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		47,388	47,388		47,388		47,388	15
16	Transportation (Health Care Staff)		12,526	12,526		12,526		12,526	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)		59,914	59,914		59,914		59,914	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	763,174	59,914	823,088		823,088		823,088	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
25.01	Telehealth								25.01
25.02	Chronic Care Management								25.02
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		20,335	20,335		20,335		20,335	29
30	Administrative Costs	221,345	46,196	267,541		267,541		267,541	30
31	Total Facility Overhead (sum of lines 29 and 30)	221,345	66,531	287,876		287,876		287,876	31
32	Total facility costs (sum of lines 22, 28 and 31)	984,519	126,445	1,110,964		1,110,964		1,110,964	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.

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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	1.00	3,840	4,200	4,200		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	2.00	4,533	2,100	4,200		3
4	Subtotal (sum of lines 1 through 3)	3.00	8,373		8,400	8,400	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)	3.00	8,373			8,400	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)					823,088	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)					823,088	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)					287,876	14
15	Parent provider overhead allocated to facility (see instructions)					749,607	15
16	Total overhead (sum of lines 14 and 15)					1,037,483	16
17	Allowable Direct GME overhead (see instructions)						17
18	Subtotal (see instructions)					1,037,483	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)					1,037,483	19
20	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					1,860,571	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 Title V Title XIX
 FQHC Title XVIII

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	Total allowable cost of RHC/FQHC services (from Wkst. M-2, line 20)	1,860,571	1
2	Cost of vaccines and their administration (from Wkst. M-4, line 15)	1,330	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	1,859,241	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	8,400	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	8,400	6
7	Adjusted cost per visit (line 3 divided by line 6)	221.34	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)	221.34	221.34	221.34	9
CALCULATION OF SETTLEMENT					
10	Program covered visits excluding mental health services (from contractor records)		3,066		10
11	Program cost excluding costs for mental health services (line 9 x line 10)		678,628		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)		678,628		16
16.01	Total program charges (see instructions)(from contractor's records)		415,121		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		1,197		16.02
16.03	Total program preventive costs (see instructions)		1,956		16.03
16.04	Total program non-preventive costs (see instructions)		510,010		16.04
16.05	Total program cost (see instructions)		511,966		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		39,160		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		75,194		19
20	Net Medicare cost excluding vaccines (see instructions)		511,966		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,331		21
22	Total reimbursable Program cost (line 20 plus line 21)		513,297		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)		513,297		26
26.01	Sequestration adjustment (see instructions)		10,266		26.01
26.02	Demonstration payment adjustment amount after sequestration				26.02
27	Interim payments		342,351		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		160,680		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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CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

COMPONENT CCN: 14-8548

WORKSHEET M-4

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

		PNEUMO- COCCAL	INFLUENZA	
		1	2	
1	Health care staff cost (from Wkst. M-1, col. 7, line 10)	763,174	763,174	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000081	0.000580	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	62	443	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	72	11	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	134	454	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	823,088	823,088	6
7	Total overhead (from Wkst. M-2, line 16)	1,037,483	1,037,483	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000163	0.000552	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	169	573	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	303	1,027	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	31	222	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	9.77	4.63	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	31	222	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	303	1,028	14
15	Total cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		1,330	15
16	Total Program cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		1,331	16

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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		244,550	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	05/11/2017	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	97,801	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)		342,351	
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		6.01
		.02		6.02
7	Total Medicare program liability (see instructions)		503,031	
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.

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ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

HOSPICE CCN: 14-1542

WORKSHEET O

	SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	SUBTOTAL	ADJUST- MENTS	TOTAL (col. 5 + col. 6)	
	1	2	3	4	5	6	7	
GENERAL SERVICE COST CENTERS								
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
3	Employee Benefits Department							3
4	Administrative & General	16,038	99,803	115,841	115,841		115,841	4
5	Plant Operation & Maintenance							5
6	Laundry & Linen Service							6
7	Housekeeping							7
8	Dietary		1,244	1,244	1,244		1,244	8
9	Nursing Administration							9
10	Routine Medical Supplies		54,893	54,893	54,893		54,893	10
11	Medical Records							11
12	Staff Transportation		24,851	24,851	24,851		24,851	12
13	Volunteer Service Coordination							13
14	Pharmacy							14
15	Physician Administrative Services							15
16	Other General Service							16
17	Patient/Residential Care Services							17
DIRECT PATIENT CARE SERVICE COST CENTERS								
25	Inpatient Care - Contracted							25
26	Physician Services							26
27	Nurse Practitioner							27
28	Registered Nurse	129,829		129,829	129,829		129,829	28
29	LPN/LVN							29
30	Physical Therapy							30
31	Occupational Therapy							31
32	Speech/Language Pathology							32
33	Medical Social Services	50,614		50,614	50,614		50,614	33
34	Spiritual Counseling							34
35	Dietary Counseling							35
36	Counseling - Other							36
37	Hospice Aide and Homemaker Services	25,062		25,062	25,062		25,062	37
38	Durable Medical Equipment - Oxygen							38
39	Patient Transportation							39
40	Imaging Services							40
41	Labs and Diagnostics							41
42	Medical Supplies - Non-routine							42
43	Outpatient Services							43
44	Palliative Radiation Therapy							44
45	Palliative Chemotherapy							45
46	Other Patient Care Services							46
NONREIMBURSABLE COST CENTERS								
60	Bereavement Program							60
61	Volunteer Program							61
62	Fundraising							62
63	Hospice/Palliative Medicine Fellows							63
64	Palliative care Program							64
65	Other Physician Services							65
66	Residential Care							66
67	Advertising							67
68	Telehealth / Telemonitoring							68
69	Thrift Store							69
70	Nursing Facility Room & Board							70
71	Other Nonreimbursable							71
100	TOTAL	221,543	180,791	402,334	402,334		402,334	100

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS
 HOSPICE CONTINUOUS HOME CARE

HOSPICE CCN: 14-1542

WORKSHEET O-1

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	SUBTOTAL	ADJUST- MENTS	TOTAL (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	DIRECT PATIENT CARE SERVICE COST CENTERS								
25	Inpatient Care - Contracted								25
26	Physician Services								26
27	Nurse Practitioner								27
28	Registered Nurse								28
29	LPN/LVN								29
30	Physical Therapy								30
31	Occupational Therapy								31
32	Speech/Language Pathology								32
33	Medical Social Services								33
34	Spiritual Counseling								34
35	Dietary Counseling								35
36	Counseling - Other								36
37	Hospice Aide and Homemaker Services								37
38	Durable Medical Equipment - Oxygen								38
39	Patient Transportation								39
40	Imaging Services								40
41	Labs and Diagnostics								41
42	Medical Supplies - Non-routine								42
43	Outpatient Services								43
44	Palliative Radiation Therapy								44
45	Palliative Chemotherapy								45
46	Other Patient Care Services								46
100	TOTAL								100

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS
HOSPICE ROUTINE HOME CARE

HOSPICE CCN: 14-1542

WORKSHEET O-2

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	SUBTOTAL	ADJUST- MENTS	TOTAL (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	DIRECT PATIENT CARE SERVICE COST CENTERS								
25	Inpatient Care - Contracted								25
26	Physician Services								26
27	Nurse Practitioner								27
28	Registered Nurse	129,828		129,828		129,828		129,828	28
29	LPN/LVN								29
30	Physical Therapy								30
31	Occupational Therapy								31
32	Speech/Language Pathology								32
33	Medical Social Services	50,614		50,614		50,614		50,614	33
34	Spiritual Counseling								34
35	Dietary Counseling								35
36	Counseling - Other								36
37	Hospice Aide and Homemaker Services	25,062		25,062		25,062		25,062	37
38	Durable Medical Equipment - Oxygen								38
39	Patient Transportation								39
40	Imaging Services								40
41	Labs and Diagnostics								41
42	Medical Supplies - Non-routine								42
43	Outpatient Services								43
44	Palliative Radiation Therapy								44
45	Palliative Chemotherapy								45
46	Other Patient Care Services								46
100	TOTAL	205,504		205,504		205,504		205,504	100

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS
HOSPICE INPATIENT RESPITE CARE

HOSPICE CCN: 14-1542

WORKSHEET O-3

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	SUBTOTAL	ADJUST- MENTS	TOTAL (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	DIRECT PATIENT CARE SERVICE COST CENTERS								
25	Inpatient Care - Contracted								25
26	Physician Services								26
27	Nurse Practitioner								27
28	Registered Nurse	1		1		1		1	28
29	LPN/LVN								29
30	Physical Therapy								30
31	Occupational Therapy								31
32	Speech/Language Pathology								32
33	Medical Social Services								33
34	Spiritual Counseling								34
35	Dietary Counseling								35
36	Counseling - Other								36
37	Hospice Aide and Homemaker Services								37
38	Durable Medical Equipment - Oxygen								38
39	Patient Transportation								39
40	Imaging Services								40
41	Labs and Diagnostics								41
42	Medical Supplies - Non-routine								42
43	Outpatient Services								43
44	Palliative Radiation Therapy								44
45	Palliative Chemotherapy								45
46	Other Patient Care Services								46
100	TOTAL	1		1		1		1	100

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS
 HOSPICE GENERAL INPATIENT CARE

HOSPICE CCN: 14-1542

WORKSHEET O-4

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	SUBTOTAL	ADJUST- MENTS	TOTAL (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	DIRECT PATIENT CARE SERVICE COST CENTERS								
25	Inpatient Care - Contracted								25
26	Physician Services								26
27	Nurse Practitioner								27
28	Registered Nurse								28
29	LPN/LVN								29
30	Physical Therapy								30
31	Occupational Therapy								31
32	Speech/Language Pathology								32
33	Medical Social Services								33
34	Spiritual Counseling								34
35	Dietary Counseling								35
36	Counseling - Other								36
37	Hospice Aide and Homemaker Services								37
38	Durable Medical Equipment - Oxygen								38
39	Patient Transportation								39
40	Imaging Services								40
41	Labs and Diagnostics								41
42	Medical Supplies - Non-routine								42
43	Outpatient Services								43
44	Palliative Radiation Therapy								44
45	Palliative Chemotherapy								45
46	Other Patient Care Services								46
100	TOTAL								100

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET EXPENSES FOR ALLOCATION

HOSPICE CCN: 14-1542

WORKSHEET O-5

	Descriptions	HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols 1+2)	
		1	2	3	
	GENERAL SERVICE COST CENTERS				
1	Cap Rel Costs-Bldg & Fixt		6,419	6,419	1
2	Cap Rel Costs-Mvble Equip		812	812	2
3	Employee Benefits Department		91,952	91,952	3
4	Administrative & General	115,841	78,199	194,040	4
5	Plant Operation & Maintenance		19,593	19,593	5
6	Laundry & Linen Service				6
7	Housekeeping		17,758	17,758	7
8	Dietary	1,244		1,244	8
9	Nursing Administration				9
10	Routine Medical Supplies	54,893		54,893	10
11	Medical Records				11
12	Staff Transportation	24,851		24,851	12
13	Volunteer Service Coordination				13
14	Pharmacy		116	116	14
15	Physician Administrative Services				15
16	Other General Service				16
17	Patient/Residential Care Services				17
	LEVEL OF CARE				
50	Hospice Continuous Home Care				50
51	Hospice Routine Home Care	205,504		205,504	51
52	Hospice Inpatient Respite Care	1		1	52
53	Hospice General Inpatient Care				53
	NONREIMBURSABLE COST CENTERS				
60	Bereavement Program				60
61	Volunteer Program				61
62	Fundraising				62
63	Hospice/Palliative Medicine Fellows				63
64	Palliative care Program				64
65	Other Physician Services				65
66	Residential Care				66
67	Advertising				67
68	Telehealth / Telemonitoring				68
69	Thrift Store				69
70	Nursing Facility Room & Board				70
71	Other Nonreimbursable				71
99	Negative Cost Center				99
100	TOTAL	402,334	214,849	617,183	100

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

HOSPICE CCN: 14-1542

WORKSHEET O-6
PART I

	Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	ADMINISTRATIVE & GENERAL	PLANT OP & MAINT	
		0	1	2	3	3A	4	5	
GENERAL SERVICE COST CENTERS									
1	Cap Rel Costs-Bldg & Fixt	6,419	6,419						1
2	Cap Rel Costs-Mvble Equip	812		812					2
3	Employee Benefits Department	91,952			91,952				3
4	Administrative & General	194,040		812	13,935	208,787	208,787		4
5	Plant Operation & Maintenance	19,593				19,593	10,017	29,610	5
6	Laundry & Linen Service								6
7	Housekeeping	17,758				17,758	9,079		7
8	Dietary	1,244				1,244	636		8
9	Nursing Administration								9
10	Routine Medical Supplies	54,893				54,893	28,063		10
11	Medical Records								11
12	Staff Transportation	24,851				24,851	12,705		12
13	Volunteer Service Coordination								13
14	Pharmacy	116				116	59		14
15	Physician Administrative Services								15
16	Other General Service		6,419			6,419	3,282	29,610	16
17	Patient/Residential Care Services								17
LEVEL OF CARE									
50	Hospice Continuous Home Care				16	16	8		50
51	Hospice Routine Home Care	205,504			78,001	283,505	144,937		51
52	Hospice Inpatient Respite Care	1				1	1		52
53	Hospice General Inpatient Care								53
NONREIMBURSABLE COST CENTERS									
60	Bereavement Program								60
61	Volunteer Program								61
62	Fundraising								62
63	Hospice/Palliative Medicine Fellows								63
64	Palliative care Program								64
65	Other Physician Services								65
66	Residential Care								66
67	Advertising								67
68	Telehealth / Telemonitoring								68
69	Thrift Store								69
70	Nursing Facility Room & Board								70
71	Other Nonreimbursable								71
99	Negative Cost Center								99
100	TOTAL	617,183	6,419	812	91,952	617,183	208,787	29,610	100

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

HOSPICE CCN: 14-1542

WORKSHEET O-6
PART I

	Descriptions	LAUNDRY & LINEN	HOUSE-KEEPING	DIETARY	NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	
		6	7	8	9	10	11	12	
	GENERAL SERVICE COST CENTERS								
1	Cap Rel Costs-Bldg & Fixt								1
2	Cap Rel Costs-Mvble Equip								2
3	Employee Benefits Department								3
4	Administrative & General								4
5	Plant Operation & Maintenance								5
6	Laundry & Linen Service								6
7	Housekeeping		26,837						7
8	Dietary			1,880					8
9	Nursing Administration								9
10	Routine Medical Supplies					82,956			10
11	Medical Records								11
12	Staff Transportation							37,556	12
13	Volunteer Service Coordination								13
14	Pharmacy								14
15	Physician Administrative Services								15
16	Other General Service		26,837						16
17	Patient/Residential Care Services								17
	LEVEL OF CARE								
50	Hospice Continuous Home Care								50
51	Hospice Routine Home Care					82,825		37,556	51
52	Hospice Inpatient Respite Care			264		131			52
53	Hospice General Inpatient Care								53
	NONREIMBURSABLE COST CENTERS								
60	Bereavement Program								60
61	Volunteer Program								61
62	Fundraising								62
63	Hospice/Palliative Medicine Fellows								63
64	Palliative care Program								64
65	Other Physician Services								65
66	Residential Care								66
67	Advertising								67
68	Telehealth / Telemonitoring								68
69	Thrift Store								69
70	Nursing Facility Room & Board								70
71	Other Nonreimbursable			1,616					71
99	Negative Cost Center								99
100	TOTAL		26,837	1,880		82,956		37,556	100

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

HOSPICE CCN: 14-1542

WORKSHEET O-6
PART I

	Descriptions	VOLUNTEER SVC COOR- DINATION	PHARMACY	PHYSICIAN ADMIN SERVICES	OTHER GENERAL SERVICE	PATIENT/ RES CARE SVCS	TOTAL	
		13	14	15	16	17	18	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
3	Employee Benefits Department							3
4	Administrative & General							4
5	Plant Operation & Maintenance							5
6	Laundry & Linen Service							6
7	Housekeeping							7
8	Dietary							8
9	Nursing Administration							9
10	Routine Medical Supplies							10
11	Medical Records							11
12	Staff Transportation							12
13	Volunteer Service Coordination							13
14	Pharmacy		175					14
15	Physician Administrative Services							15
16	Other General Service				66,148			16
17	Patient/Residential Care Services							17
	LEVEL OF CARE							
50	Hospice Continuous Home Care				14		38	50
51	Hospice Routine Home Care		175		66,134		615,132	51
52	Hospice Inpatient Respite Care						397	52
53	Hospice General Inpatient Care							53
	NONREIMBURSABLE COST CENTERS							
60	Bereavement Program							60
61	Volunteer Program							61
62	Fundraising							62
63	Hospice/Palliative Medicine Fellows							63
64	Palliative care Program							64
65	Other Physician Services							65
66	Residential Care							66
67	Advertising							67
68	Telehealth / Telemonitoring							68
69	Thrift Store							69
70	Nursing Facility Room & Board							70
71	Other Nonreimbursable						1,616	71
99	Negative Cost Center							99
100	TOTAL		175		66,148		617,183	100

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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COST ALLOCATION - HOSPITAL-BASED HOSPICE COSTS STATISTICAL BASIS

HOSPICE CCN: 14-1542

WORKSHEET O-6
PART II

	Descriptions	CAP REL BLDG & FIX SQUARE FEET	CAP REL MVBLE EQUIP DOLLAR VALUE	EMPLOYEE BENEFITS DEPART- MENT GROSS SALARIES	RECONCIL- IATION	ADMINIS- TRATIVE & GENERAL ACCUM. COST	PLANT OP & MAINT SQUARE FEET	LAUNDRY & LINEN IN-FACIL- ITY DAYS	
		1	2	3	4A	4	5	6	
	GENERAL SERVICE COST CENTERS								
1	Cap Rel Costs-Bldg & Fixt	1,333							1
2	Cap Rel Costs-Mvble Equip		802						2
3	Employee Benefits Department			224,310					3
4	Administrative & General		802	33,994	-208,787	408,396			4
5	Plant Operation & Maintenance					19,593	1,333		5
6	Laundry & Linen Service								6
7	Housekeeping					17,758			7
8	Dietary					1,244			8
9	Nursing Administration								9
10	Routine Medical Supplies					54,893			10
11	Medical Records								11
12	Staff Transportation					24,851			12
13	Volunteer Service Coordination								13
14	Pharmacy					116			14
15	Physician Administrative Services								15
16	Other General Service	1,333				6,419	1,333		16
17	Patient/Residential Care Services								17
	LEVEL OF CARE								
50	Hospice Continuous Home Care			40		16			50
51	Hospice Routine Home Care			190,276		283,505			51
52	Hospice Inpatient Respite Care					1			52
53	Hospice General Inpatient Care								53
	NONREIMBURSABLE COST CENTERS								
60	Bereavement Program								60
61	Volunteer Program								61
62	Fundraising								62
63	Hospice/Palliative Medicine Fellows								63
64	Palliative care Program								64
65	Other Physician Services								65
66	Residential Care								66
67	Advertising								67
68	Telehealth / Telemonitoring								68
69	Thrift Store								69
70	Nursing Facility Room & Board								70
71	Other Nonreimbursable								71
99	Negative Cost Center								99
100	Cost to be allocated (per O-6 Pt 1)	6,419	812	91,952		208,787	29,610		100
101	Unit cost multiplier	4.815454	1.012469	0.409933		0.511237	22.213053		101

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COST ALLOCATION - HOSPITAL-BASED HOSPICE COSTS STATISTICAL BASIS

HOSPICE CCN: 14-1542

WORKSHEET O-6
PART II

	Descriptions	HOUSE-KEEPING SQUARE FEET 7	DIETARY IN-FACILITY DAYS 8	NURSING ADMINISTRATION DIRECT NURS. HRS. 9	ROUTINE MEDICAL SUPPLIES PATIENT DAYS 10	MEDICAL RECORDS PATIENT DAYS 11	STAFF TRANSPORTATION MILEAGE 12	VOLUNTEER SVC COORDINATION HOURS OF SERVICE 13	
	GENERAL SERVICE COST CENTERS								
1	Cap Rel Costs-Bldg & Fixt								1
2	Cap Rel Costs-Mvble Equip								2
3	Employee Benefits Department								3
4	Administrative & General								4
5	Plant Operation & Maintenance								5
6	Laundry & Linen Service								6
7	Housekeeping	1,333							7
8	Dietary		64						8
9	Nursing Administration								9
10	Routine Medical Supplies				5,702				10
11	Medical Records								11
12	Staff Transportation						385		12
13	Volunteer Service Coordination								13
14	Pharmacy								14
15	Physician Administrative Services								15
16	Other General Service	1,333							16
17	Patient/Residential Care Services								17
	LEVEL OF CARE								
50	Hospice Continuous Home Care								50
51	Hospice Routine Home Care				5,693		385		51
52	Hospice Inpatient Respite Care		9		9				52
53	Hospice General Inpatient Care								53
	NONREIMBURSABLE COST CENTERS								
60	Bereavement Program								60
61	Volunteer Program								61
62	Fundraising								62
63	Hospice/Palliative Medicine Fellows								63
64	Palliative care Program								64
65	Other Physician Services								65
66	Residential Care								66
67	Advertising								67
68	Telehealth / Telemonitoring								68
69	Thrift Store								69
70	Nursing Facility Room & Board								70
71	Other Nonreimbursable		55						71
99	Negative Cost Center								99
100	Cost to be allocated (per O-6 Pt I)	26,837	1,880		82,956		37,556		100
101	Unit cost multiplier	20.132783	29.375000		14.548579		97.548052		101

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COST ALLOCATION - HOSPITAL-BASED HOSPICE COSTS STATISTICAL BASIS

HOSPICE CCN: 14-1542

WORKSHEET O-6
PART II

	PHARMACY	PHYSICIAN	OTHER	PATIENT/	
	CHARGES	ADMIN	GENERAL	RESIDENT	
Descriptions	14	SERVICES	SERVICE	CARE SVCS	
		PATIENT	SPECIFY	IN-FACIL-	
		DAYS	BASIS	ITY DAYS	
	14	15	16	17	
GENERAL SERVICE COST CENTERS					
1 Cap Rel Costs-Bldg & Fixt					1
2 Cap Rel Costs-Mvble Equip					2
3 Employee Benefits Department					3
4 Administrative & General					4
5 Plant Operation & Maintenance					5
6 Laundry & Linen Service					6
7 Housekeeping					7
8 Dietary					8
9 Nursing Administration					9
10 Routine Medical Supplies					10
11 Medical Records					11
12 Staff Transportation					12
13 Volunteer Service Coordination					13
14 Pharmacy	175				14
15 Physician Administrative Services					15
16 Other General Service			4,726		16
17 Patient/Residential Care Services					17
LEVEL OF CARE					
50 Hospice Continuous Home Care			1		50
51 Hospice Routine Home Care	175		4,725		51
52 Hospice Inpatient Respite Care					52
53 Hospice General Inpatient Care					53
NONREIMBURSABLE COST CENTERS					
60 Bereavement Program					60
61 Volunteer Program					61
62 Fundraising					62
63 Hospice/Palliative Medicine Fellows					63
64 Palliative care Program					64
65 Other Physician Services					65
66 Residential Care					66
67 Advertising					67
68 Telehealth / Telemonitoring					68
69 Thrift Store					69
70 Nursing Facility Room & Board					70
71 Other Nonreimbursable					71
99 Negative Cost Center					99
100 Cost to be allocated (per O-6 Pt I)	175		66,148		100
101 Unit cost multiplier	1.000000		13.996614		101

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APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE

HOSPICE CCN: 14-1542

WORKSHEET O-7

		Charges by LOC (from Provider Records)					
	Wkst C Pt I, col. 9, line	Cost to Charge Ratio	HCHC	HRHC	HIRC	HGIP	
Cost Center Descriptions	0	1	2	3	4	5	
ANCILLARY SERVICE COST CENTERS							
1 Physical Therapy	66	0.285533					1
2 Occupational Therapy	67						2
3 Speech Language Pathology	68	0.408255					3
4 Drugs, Biological & Infusion Therapy	73	0.263438					4
5 Durable Medical Equipment/Oxygen	96						5
6 Labs and Diagnostics	60	0.123812					6
7 Medical Supplies	71	0.342632					7
8 Outpatient Services (incl E/R)	93						8
9 Radiation Therapy	55						9
10 Other	76						10
11 Totals (sum of lines 1-10)							11

		Shared Service Costs by LOC				
		HCHC (col 1 x col 2)	HRHC (col 1 x col 3)	HIRC (col 1 x col 4)	HGIP (col 1 x col 5)	
Cost Center Descriptions		6	7	8	9	
ANCILLARY SERVICE COST CENTERS						
1 Physical Therapy						1
2 Occupational Therapy						2
3 Speech Language Pathology						3
4 Drugs, Biological & Infusion Therapy						4
5 Durable Medical Equipment/Oxygen						5
6 Labs and Diagnostics						6
7 Medical Supplies						7
8 Outpatient Services (incl E/R)						8
9 Radiation Therapy						9
10 Other						10
11 Totals (sum of lines 1-10)						11

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	In Lieu of Form CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

HOSPICE CCN: 14-1542

WORKSHEET O-8

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1	2	3	
HOSPICE CONTINUOUS HOME CARE					
1	Total cost			38	1
2	Total unduplicated days				2
3	Total average cost per diem				3
4	Unduplicated program days				4
5	Program cost				5
HOSPICE ROUTINE HOME CARE					
6	Total cost			615,132	6
7	Total unduplicated days			5,693	7
8	Total average cost per diem			108.05	8
9	Unduplicated program days	5,089	170		9
10	Program cost	549,866	18,369		10
HOSPICE INPATIENT RESPITE CARE					
11	Total cost			397	11
12	Total unduplicated days			9	12
13	Total average cost per diem			44.11	13
14	Unduplicated program days	9			14
15	Program cost	397			15
HOSPICE GENERAL INPATIENT CARE					
16	Total cost				16
17	Total unduplicated days				17
18	Total average cost per diem				18
19	Unduplicated program days				19
20	Program cost				20
TOTAL HOSPICE CARE					
21	Total cost			615,567	21
22	Total unduplicated days			5,702	22
23	Average cost per diem			107.96	23

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	Non CMS worksheet CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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		
UTILIZATION PERCENTAGES BASED ON DAYS								
30	Adults & Pediatrics	49.30		12.26			61.56	30
31	Intensive Care Unit	91.24		1.46			92.70	31
43	Nursery			48.77			48.77	43
UTILIZATION PERCENTAGES BASED ON CHARGES								
50	Operating Room	6.95	25.10				32.05	50
53	Anesthesiology	4.99	18.28				23.27	53
54	Radiology-Diagnostic	10.62	30.04				40.66	54
56	Radioisotope	2.90	43.64				46.54	56
57	CT Scan	9.83	29.72				39.55	57
58	MRI	2.52	29.17				31.69	58
60	Laboratory	11.90	12.42				24.32	60
64	Intravenous Therapy	36.82	27.69				64.51	64
65	Respiratory Therapy	38.42	12.95				51.37	65
66	Physical Therapy	5.30	0.27				5.57	66
68	Speech Pathology	6.68	3.22				9.90	68
69	Electrocardiology	10.24	35.07				45.31	69
71	Medical Supplies Charged to Pat	16.54	21.34				37.88	71
72	Impl. Dev. Charged to Patients	18.90	26.38				45.28	72
73	Drugs Charged to Patients	20.23	25.23				45.46	73
91	Emergency	11.35	22.74				34.09	91
92	Observation Beds (Non-Distinct	8.53	19.05				27.58	92
200	TOTAL CHARGES	11.21	20.44				31.65	200

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	Non CMS worksheet CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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	22.58		56.36				78.94	40
	UTILIZATION PERCENTAGES BASED ON CHARGES								
54	Radiology-Diagnostic	0.01						0.01	54
57	CT Scan	0.02						0.02	57
60	Laboratory	0.23						0.23	60
64	Intravenous Therapy	0.13						0.13	64
69	Electrocardiology	0.05						0.05	69
71	Medical Supplies Charged to Pat	0.05						0.05	71
73	Drugs Charged to Patients	0.83						0.83	73
91	Emergency	0.29						0.29	91
200	TOTAL CHARGES	0.14						0.14	200

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	Non CMS worksheet CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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		
UTILIZATION PERCENTAGES BASED ON DAYS								
44	Skilled Nursing Facility	28.20					28.20	44
UTILIZATION PERCENTAGES BASED ON CHARGES								
54	Radiology-Diagnostic	0.55					0.55	54
57	CT Scan	0.18					0.18	57
58	MRI	0.29					0.29	58
60	Laboratory	0.77					0.77	60
64	Intravenous Therapy	4.14					4.14	64
65	Respiratory Therapy	13.26					13.26	65
66	Physical Therapy	21.42					21.42	66
68	Speech Pathology	9.58					9.58	68
69	Electrocardiology	0.23					0.23	69
71	Medical Supplies Charged to Pat	3.03					3.03	71
73	Drugs Charged to Patients	5.66					5.66	73
92	Observation Beds (Non-Distinct)	0.32					0.32	92
200	TOTAL CHARGES	3.04					3.04	200

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

	COST CENTERS	TITLE XVIII		TITLE XIX		TITLE V		TOTAL THIRD PARTY UTIL	
		PART A	PART B	INPATIENT	OUTPAT- IENT	INPATIENT	OUTPAT- IENT		
		1	2	3	4	5	6		
	UTILIZATION PERCENTAGES BASED ON CHARGES								
54	Radiology-Diagnostic	0.07						0.07	54
57	CT Scan	0.08						0.08	57
60	Laboratory	0.12						0.12	60
64	Intravenous Therapy	0.98						0.98	64
65	Respiratory Therapy	1.82						1.82	65
66	Physical Therapy	0.93						0.93	66
68	Speech Pathology	0.20						0.20	68
69	Electrocardiology	0.02						0.02	69
71	Medical Supplies Charged to Pat	0.31						0.31	71
73	Drugs Charged to Patients	0.76						0.76	73
200	TOTAL CHARGES	0.25						0.25	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	864,282	1.81	-864,282	-3.54			1
2	Cap Rel Costs-Mvble Equip	1,618,412	3.39	-1,618,412	-6.63			2
3	Other Cap Rel Costs							3
4	Employee Benefits Department	9,686,164	20.31	-9,686,164	-39.71			4
5	Administrative & General	4,394,986	9.22	-4,394,986	-18.02			5
6	Maintenance & Repairs	1,007,475	2.11	-1,007,475	-4.13			6
7	Operation of Plant	530,488	1.11	-530,488	-2.17			7
8	Laundry & Linen Service	132,905	0.28	-132,905	-0.54			8
9	Housekeeping	475,688	1.00	-475,688	-1.95			9
10	Dietary	292,714	0.61	-292,714	-1.20			10
11	Cafeteria	769,829	1.61	-769,829	-3.16			11
12	Maintenance of Personnel							12
13	Nursing Administration	1,601,992	3.36	-1,601,992	-6.57			13
14	Central Services & Supply	115,455	0.24	-115,455	-0.47			14
15	Pharmacy	2,276,744	4.77	-2,276,744	-9.33			15
16	Medical Records & Library	625,394	1.31	-625,394	-2.56			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	1,824,010	3.82	3,194,166	13.09	5,018,176	10.52	30
31	Intensive Care Unit	696,503	1.46	916,918	3.76	1,613,421	3.38	31
40	Subprovider - IPF	613,627	1.29	929,619	3.81	1,543,246	3.24	40
43	Nursery	257,819	0.54	315,912	1.30	573,731	1.20	43
44	Skilled Nursing Facility	1,377,717	2.89	2,202,871	9.03	3,580,588	7.51	44
ANCILLARY SERVICE COST CENTERS								
50	Operating Room	952,826	2.00	1,378,260	5.65	2,331,086	4.89	50
53	Anesthesiology	20,930	0.04	149,972	0.61	170,902	0.36	53
54	Radiology-Diagnostic	951,841	2.00	858,833	3.52	1,810,674	3.80	54
56	Radioisotope	128,249	0.27	108,797	0.45	237,046	0.50	56
57	CT Scan	304,133	0.64	147,435	0.60	451,568	0.95	57
58	MRI	186,986	0.39	341,844	1.40	528,830	1.11	58
60	Laboratory	2,427,849	5.09	1,101,427	4.52	3,529,276	7.40	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy	26,032	0.05	56,427	0.23	82,459	0.17	64
65	Respiratory Therapy	434,765	0.91	362,075	1.48	796,840	1.67	65
66	Physical Therapy	1,813,987	3.80	1,379,104	5.65	3,193,091	6.70	66
68	Speech Pathology	246,006	0.52	162,537	0.67	408,543	0.86	68
69	Electrocardiology	163,994	0.34	47,951	0.20	211,945	0.44	69
71	Medical Supplies Charged to Patients	1,405,454	2.95	446,949	1.83	1,852,403	3.88	71
72	Impl. Dev. Charged to Patients	370,193	0.78	114,229	0.47	484,422	1.02	72
73	Drugs Charged to Patients			2,844,989	11.66	2,844,989	5.97	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	1,110,964	2.33	749,607	3.07	1,860,571	3.90	88
91	Emergency	872,695	1.83	1,201,455	4.93	2,074,150	4.35	91
92	Observation Beds (Non-Distinct Part)							92
OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	852,545	1.79	1,057,550	4.34	1,910,095	4.01	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	812,318	1.70	485,865	1.99	1,298,183	2.72	101
SPECIAL PURPOSE COST CENTERS								
116	Hospice	402,334	0.84	214,849	0.88	617,183	1.29	116
NONREIMBURSABLE COST CENTERS								
192	Physicians' Private Offices	5,015,911	10.52	3,605,197	14.78	8,621,108	18.08	192
194	OTHER NONREIMBURSABLE							194
194.01	MEMORY DISORDER	24,560	0.05	17,690	0.07	42,250	0.09	194.01
194.02	ASSISTED LIVING							194.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL	47,686,776	100.00			47,686,776	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	356,239	15,312,540	0.023265	1,064,837	24,773	50
53	Anesthesiology	44,420	4,362,921	0.010181	217,806	2,217	53
54	Radiology-Diagnostic	217,623	11,865,461	0.018341	1,260,378	23,117	54
56	Radioisotope	28,929	3,286,827	0.008801	95,462	840	56
57	CT Scan	30,215	16,660,878	0.001814	1,638,513	2,972	57
58	MRI	249,245	3,372,085	0.073914	85,143	6,293	58
60	Laboratory	153,836	28,505,177	0.005397	3,390,691	18,300	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	Intravenous Therapy	2,560	1,243,190	0.002059	457,766	943	64
65	Respiratory Therapy	25,926	4,149,922	0.006247	1,594,562	9,961	65
66	Physical Therapy	81,487	11,182,897	0.007287	593,124	4,322	66
68	Speech Pathology	6,359	1,000,706	0.006355	66,803	425	68
69	Electrocardiology	11,594	3,110,573	0.003727	318,661	1,188	69
71	Medical Supplies Charged to Pat	53,926	5,406,387	0.009974	894,161	8,918	71
72	Impl. Dev. Charged to Patients	13,638	924,845	0.014746	174,813	2,578	72
73	Drugs Charged to Patients	125,886	10,799,472	0.011657	2,184,306	25,462	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
88	Rural Health Clinic	48,124	1,299,711	0.037027			88
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	128,152	10,625,204	0.012061	1,205,588	14,541	91
92	Observation Beds (Non-Distinct	84,893	3,146,219	0.026983	268,344	7,241	92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services						95
200	TOTAL	1,663,052	136,255,015		15,510,958	154,091	200

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

	COST CENTER DESCRIPTION	CAPITAL RELATED COSTS	SWING-BED ADJUST-MENT AMOUNT	REDUCED CAPITAL RELATED COST	TOTAL PATIENT DAYS	PER DIEM	INPATIENT PROGRAM DAYS	MEDICARE INPATIENT PPS CAPITAL COSTS	
		1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics	343,165	3,281	339,884	4,404	77.18	2,171	167,558	30
31	Intensive Care Unit	84,311		84,311	753	111.97	687	76,923	31
200	TOTAL	427,476	3,281	424,195	5,157		2,858	244,481	200

MEDICARE INPATIENT ROUTINE SERVICE PPS CAPITAL COSTS	244,481
MEDICARE INPATIENT ANCILLARY SERVICE PPS CAPITAL COSTS	154,091
TOTAL MEDICARE INPATIENT PPS CAPITAL COSTS	398,572
MEDICARE DISCHARGES (Worksheet S-3, Part I, line 14, column 13)	740
MEDICARE PATIENT DAYS (Worksheet S-3, Part I, line 14, column 6 - Worksheet S-3, Part I, line 5, column 6)	2,858
PER DISCHARGE CAPITAL COSTS	538.61

RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147	Non CMS worksheet CMS-2552-10	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/21/2018 Run Time: 10:32 Version: 2018.01 (02/20/2018)
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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)	6,240,433
2. HOSPITAL PART A TITLE XVIII CHARGES (sum of inpatient charges and ancillary charges on Worksheet D-3 for hospital Title XVIII component)	18,743,866
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.333

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))	395,160
2. TOTAL MEDICARE CHARGES (Worksheet D-3, line 40, column 2 plus Worksheet D-3, line 202, column 2) (see CR 5619)	516,020
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.766

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)	398,572
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)	4,137,136
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)	28,215,228
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.147