This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 14-0147 Worksheet S Peri od: From 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/31/2024 10:42 am PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 5/31/2024 Time: 10:42 am ] Manually prepared cost report use only If this is an amended report enter the number of times the provider resubmitted this cost report Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled with Audit 9. [N] Final Report for this Provider CCN (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

(5) Amended

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 submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by RICHLAND MEMORIAL HOSPITAL (14-0147) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 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.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SIGNATURE STATEMENT	
1	Der	nis Hesch	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Denni s Hesch			2
3	Signatory Title	EXECUTIVE VICE PRESIDENT			3
4	Date	(Dated when report is electronica			4

			Title	XVIII			
		Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	-252, 379	45, 371	0	0	1.00
2.00	SUBPROVI DER - I PF	0	0	0		0	2.00
3.00	SUBPROVI DER - I RF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	12, 822	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
7. 00	SKILLED NURSING FACILITY	0	0	0		0	7.00
9. 00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		72, 610		0	10.00
10. 01	RURAL HEALTH CLINIC II	0		235, 440		0	10. 01
200.00	TOTAL	0	-239, 557	353, 421	0	0	200.00

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 number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 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 the 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.

Health Financial Systems RICHLAND MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10
HOSPITAL AND HOSPITAL HEALTH CAPE COMPLEX LIPENTIFICATION DATA Provider CCN: 14-0147 Period: Worksheet S-2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-0147 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/31/2024 10: 42 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 800 EAST LOCUST 1.00 PO Box: 1.00 Zip Code: 62450-2958 County: RICHLAND 2.00 City: OLNEY State: IL 2.00 Provi der Component Name CCN CBSA Date Payment System (P, T, 0, or N) Туре Certi fi ed Number Number XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal RICHLAND MEMORIAL 140147 99914 07/01/1966 Ν 3.00 HOSPI TAI Subprovi der - IPF 4.00 4.00 5.00 Subprovi der - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF RICHIAND MEMORIAL 1411147 99914 Р N 11/13/2003 7.00 Ν 7 00 HOSPITAL SWING BED 8.00 Swing Beds - NF 8.00 9.00 Hospital -Based SNF RICHLAND MEMORIAL 145580 99914 11/05/1987 Р 9.00 HOSPITAL SNF 10.00 Hospital -Based NF 10.00 11.00 Hospi tal -Based OLTC 11.00 Hospi tal -Based HHA 12.00 12.00 Separately Certified ASC 13.00 13 00 14.00 Hospi tal -Based Hospi ce 14.00 15.00 Hospital -Based Health Clinic - RHC RICHLAND MEMORIAL 148548 99914 12/04/2015 0 Ν 15.00 HOSPITAL WEST SALE Hospital-Based Health Clinic - RHC RICHLAND MEMORIAL 138584 99914 03/15/2018 0 N 15.01 15.01 Ν HOSPITAL FAM PRAC 15.02 15.02 Hospital-Based Health Clinic - RHC  $\Pi\Pi$ Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 Hospital -Based (CORF) I 17.10 17.10 17. 20 Hospital -Based (OPT) I 17.20 Hospital -Based (00T) I 17.30 17.30 17. 40 Hospi tal -Based (OSP) I 17 40 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2 00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2023 12/31/2023 20.00 21.00 Type of Control (see instructions) 21.00 2. 00 1. 00 3.00 Inpatient PPS Information N 22.00 Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, 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 Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no Ν 22.01 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) 22.02 Is this a newly merged hospital that requires a final UCP to be Ν Ν 22.02 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. 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas N Ν 22.03 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.

	MEMORI AL	HOSPI TAL			In Lie	eu of Form CM:	S-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provi der CC	CN: 14-0147		/01/2023 /31/2023		repared:
			1. 00		2. 00	3. 00	
22.04 Did this hospital receive a geographic reclassification rural as a result of the revised OMB delineations for adopted by CMS in FY 2021? Enter in column 1, "Y" for for the portion of the cost reporting period prior to in column 2, "Y" for yes or "N" for no for the portion reporting period occurring on or after October 1. (see Does this hospital contain at least 100 but not more counted in accordance with 42 CFR 412.105)? Enter in yes or "N" for no.	statistic yes or "N October 1 on of the c ee instruct than 499 k I column 3,	cal areas V" for no I. Enter cost tions) peds (as "Y" for	1.00			3.00	22. 04
23.00 Which method is used to determine Medicaid days on libelow? In column 1, enter 1 if date of admission, 2 i if date of discharge. Is the method of identifying the reporting period different from the method used in the reporting period? In column 2, enter "Y" for yes or	f census one days in the prior control of the prior control of the prior control of the prior of	days, or 3 this cost ost o.	0	3	N N	Other	23.00
	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	<b>;</b>	lays Medicai days	d
24.00   If this provider is an IPPS hospital, enter the	1. 00 141	2.00	3.00	4. 00	5.0		26 24.00
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.  25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the 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.	0				0	0	25. 00
					/Rurai S 1.00	Date of Geographics 2.00	gr
26.00 Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or	rural. ige) status	s at the en	d of the co		:	2	26. 00 27. 00
enter the effective date of the geographic reclassifi 35.00 If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			SCH status i	n		1	35.00
					nni ng: 1. 00	Endi ng: 2. 00	
36.00 Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date 37.00 If this is a Medicare dependent hospital (MDH), enter	es.	•		ber 01/0	01/2023	12/31/2023	36.00
is in effect in the cost reporting period.  37.01 Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo	ne MDH trar	nsitional p	payment in				37. 01
instructions) 38.00   If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.							38. 00
enter subsequent dutes.					Y/N	Y/N	
39.00 Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet t accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions)	, (ii), or the mileage	r (iii)? En e requireme	nter in colu ents in	ume mn	1. 00 Y	2. 00 Y	39.00
40.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	er 1. Ente	er "Y" for			N	N	40. 00

alth Financial Systems RICHLAND OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DAT		AL HOSPITAL Provider Co	CN: 14-0147	<u> </u>	пыес		m CMS-25 eet S-2	352
STITAL AND HOSTITAL HEALTH CARL COMMERN TENTH TO DATE	IA	Trovider of		From 01/01	/2023 /2023	Part I Date/Ti	me Prepa 024 10:42	
					V	XVIII	XI X	:2 0
Prospective Payment System (PPS)-Capital					1.00	2.00	3.00	
i.00 Does this facility qualify and receive Capital payment	t for o	di sproporti ona	ite share in a	ccordance	N	N	N	45
with 42 CFR Section §412.320? (see instructions) .00 Is this facility eligible for additional payment except pursuant to 42 CFR §412.348(f)? If yes, complete Wkst.					N	N	N	46
Pt. III.  .00   Is this a new hospital under 42 CFR §412.300(b) PPS ca				· ·	N	N	N I	47
.00 Is the facility electing full federal capital payment? Teaching Hospitals					N	N	N	48
ON Is this a hospital involved in training residents in a periods beginning prior to December 27, 2020, enter "Vecost reporting periods beginning on or after December the instructions. For column 2, if the response to colinvolved in training residents in approved GME program and are you are impacted by CR 11642 (or applicable CF	Y" for 27, 20 lumn 1 ms in	yes or "N" fo 020, under 42 is "Y", or if the prior year	or no in colum CFR 413.78(b) this hospita or penultima	n 1. For (2), see I was ite year,	N			56
"Y" for yes; otherwise, enter "N" for no in column 2. For cost reporting periods beginning prior to December is this the first cost reporting period during which rat this facility? Enter "Y" for yes or "N" for no in residents start training in the first month of this com "N" for no in column 2. If column 2 is "Y", complete complete Wkst. D, Parts III & IV and D-2, Pt. II, if a beginning on or after December 27, 2020, under 42 CFR which month(s) of the cost report the residents were complete.	reside columi ost rej Worksl applica 413.7 on duty	nts in approven 1. If column corting perioc neet E-4. If cable. For cost 7(e)(1)(iv) ay, if the resp	ed GME program  1 1 is "Y", di  17: Enter "Y"  column 2 is "N  reporting pe  and (v), regar  conse to line	s trained d for yes or ", eriods dless of 56 is "Y"	-			57
for yes, enter "Y" for yes in column 1, do not complet 00 If line 56 is yes, did this facility elect cost reimbu defined in CMS Pub. 15-1, chapter 21, §2148? If yes, o	urseme	nt for physici			N			58
00 A 1: 100 W 100 W								
OU Are costs claimed on line 100 of worksheet A? If yes,	, comp	lete Wkst. D-2		Workshe	N Act A	Pass_TI		59
OU Are costs claimed on line 100 of worksheet A? If yes,	, comp	lete Wkst. D-2	2, Pt. I. NAHE 413.85 Y/N	Workshe Li ne	et A	Pass-TI Qualifi Crite	cation rion	59
			NAHE 413. 85 Y/N		eet A #	Qualifi Crite	nrough cation rion de	
	(NAHE) 85? (; umn 1. R) NAHI	costs for see If column 1	NAHE 413. 85 Y/N	Li ne	eet A #	Qualifi Crite Coo	nrough cation rion de	
OO Are you claiming nursing and allied health education (any programs that meet the criteria under 42 CFR 413.8 instructions) Enter "Y" for yes or "N" for no in coluis "Y", are you impacted by CR 11642 (or subsequent CF	(NAHE) 85? (; umn 1. R) NAHI	costs for see If column 1	NAHE 413. 85 Y/N	Li ne	eet A #	Qualifi Crite Coo	nrough cation rion de 00	60
OO Are you claiming nursing and allied health education (any programs that meet the criteria under 42 CFR 413.8 instructions) Enter "Y" for yes or "N" for no in coluis "Y", are you impacted by CR 11642 (or subsequent CF adjustment? Enter "Y" for yes or "N" for no in column	(NAHE) 85? (sumn 1. R) NAHI n 2.	costs for see If column 1 E MA payment	NAHE 413. 85 Y/N 1. 00 N	2. 0	0	Qualifi Crite Coo 3.0	nrough cation erion de DO	
OO Are you claiming nursing and allied health education (any programs that meet the criteria under 42 CFR 413.8 instructions) Enter "Y" for yes or "N" for no in coluis "Y", are you impacted by CR 11642 (or subsequent CF adjustment? Enter "Y" for yes or "N" for no in column	(NAHE) 85? (: umn 1. R) NAHI n 2. Y/N	costs for see If column 1 E MA payment IME	NAHE 413.85 Y/N  1.00 N  Direct GME	2. 0	0	Qualifi Crite Coo 3.0	nrough cation erion de DO	60
OO Are you claiming nursing and allied health education (any programs that meet the criteria under 42 CFR 413.8 instructions) Enter "Y" for yes or "N" for no in coluis "Y", are you impacted by CR 11642 (or subsequent CF adjustment? Enter "Y" for yes or "N" for no in column  OO Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)  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)	(NAHE) 85? (sumn 1. R) NAHI n 2. Y/N	costs for see If column 1 E MA payment IME	NAHE 413.85 Y/N  1.00 N  Direct GME	2. 0	0 0	Qualifi Crite Coo 3.0	t GME	6.6
Are you claiming nursing and allied health education (any programs that meet the criteria under 42 CFR 413.8 instructions) Enter "Y" for yes or "N" for no in coluis "Y", are you impacted by CR 11642 (or subsequent CR adjustment? Enter "Y" for yes or "N" for no in column of the colu	(NAHE) 85? (sumn 1. R) NAHI n 2. Y/N	costs for see If column 1 E MA payment IME	NAHE 413.85 Y/N  1.00 N  Direct GME	2. 0	0 0	Qualifi Crite Coo 3.0	t GME	6.6
OO Are you claiming nursing and allied health education (any programs that meet the criteria under 42 CFR 413.8 instructions) Enter "Y" for yes or "N" for no in coluis "Y", are you impacted by CR 11642 (or subsequent CF adjustment? Enter "Y" for yes or "N" for no in column of the c	(NAHE) 85? (sumn 1. R) NAHI n 2. Y/N	costs for see If column 1 E MA payment IME	NAHE 413.85 Y/N  1.00 N  Direct GME	2. 0	0 0	Qualifi Crite Coo 3.0	t GME	60
OO Are you claiming nursing and allied health education (any programs that meet the criteria under 42 CFR 413.8 instructions) Enter "Y" for yes or "N" for no in coluis "Y", are you impacted by CR 11642 (or subsequent CF adjustment? Enter "Y" for yes or "N" for no in column 1. (see instructions)  OI 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)  OI 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)  OI Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)  OI Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the	(NAHE) 85? (sumn 1. R) NAHI n 2. Y/N	costs for see If column 1 E MA payment IME	NAHE 413.85 Y/N  1.00 N  Direct GME	2. 0	0 0	Qualifi Crite Coo 3.0	t GME 00 0.00	61 61 61
any programs that meet the criteria under 42 CFR 413.8 instructions) Enter "Y" for yes or "N" for no in coluis "Y", are you impacted by CR 11642 (or subsequent CF adjustment? Enter "Y" for yes or "N" for no in column adjustment? Enter "Y" for yes or "N" for no in column 1. (see instructions)  O1 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)  O2 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)  O3 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)  O4 Enter the number of unweighted primary care/or	(NAHE) 85? (sumn 1. R) NAHI n 2. Y/N	costs for see If column 1 E MA payment IME	NAHE 413.85 Y/N  1.00 N  Direct GME	2. 0	0 0	Qualifi Crite Coo 3.0	t GME	61 61

Health Financial Systems RICHLAND MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-0147 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/31/2024 10:42 am Unwei ghted Program Name Unwei ghted Program Code IME FTE Count Direct GME FTE Count 2.00 3. 00 1.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0.00 0.00 61.10 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. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 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, the direct GME FTE unweighted count. 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62 00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) 62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter N 63.00 'Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ (col. 1 + col. 2)) FTEs FTEs in Nonprovi der Hospi tal Si te 1. 00 2.00 3. 00 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. 0.000000 64.00 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents 0 00 0 00 n 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) Program Name Program Code Unwei ghted Unwei ghted Ratio (col. FTEs 3/ (col. 3 + FTEs in Nonprovi der Hospi tal col. 4)) Si te 1.00 2.00 3.00 4. 00 5.00 0. 00 0.000000 65.00 65.00 Enter in column 1, if line 63 0.00 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. 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)

Health Financial Systems RICHLAND MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-0147 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/31/2024 10:42 am Unwei ghted Unwei ghted Ratio (col. FTEs FTEs in 1/ (col. 1 + Nonprovi der Hospi tal col. 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 66.00 Enter in column 1 the number of unweighted non-primary care resident 0.00 0.00 0.000000 66.00 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) Program Name Unwei ghted Unwei ghted Program Code Ratio (col. FTEs in **FTEs** 3/(col. 3 +Nonprovi der Hospi tal col. 4)) Si te 1.00 2.00 3.00 4.00 5.00 67.00 Enter in column 1, the program 0.00 0.00 0.000000 67.00 name associated with each of your primary care programs in which you trained residents. 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) 1.00 Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022) For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your 68.00 MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)? 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS 70 00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? N 70 00 Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most Ν Ν 0 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) 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 or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF 75 00 subprovider? Enter "Y" for yes and "N" for no.

If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 0 76.00 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 or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) 1.00 Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 80.00 N 81.00 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 81.00 TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 85.00 Ν Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 86.00 §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 87.00 Is this hospital an extended neoplastic disease care hospital classified under section 87.00 N 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.

Heal th	Financial Systems RICHLAND MEMORIAL HOSPITAL		In Lie	u of Form CMS-	2552-10
			Period: From 01/01/2023	Worksheet S-2	
			To 12/31/2023		epared:
		,	Approved for Permanent	Number of	
			Adjustment	Approved Permanent	
			(Y/N) 1.00	Adjustments 2.00	_
88. 00	Column 1: Is this hospital approved for a permanent adjustment to the T		N		88.00
	amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete 89. (see instructions)	col. 2 and lin	е		
	Column 2: Enter the number of approved permanent adjustments.		566 11		
		Wkst. A Line No.	e Effective Date	Approved Permanent	
				Adjustment Amount Per	
				Di scharge	
89. 00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number	1.00	2. 00	3.00	89.00
07.00	on which the per discharge permanent adjustment approval was based.	0.0		`	3 67.00
	Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount				
	per di scharge.				
	Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.				
			1. 00	XI X 2. 00	-
	Title V and XIX Services				
90. 00	Does this facility have title V and/or XIX inpatient hospital services? yes or "N" for no in the applicable column.	Enter "Y" for	Y	Υ	90.00
91. 00	is this hospital reimbursed for title V and/or XIX through the cost rep		N	N	91.00
92. 00	full or in part? Enter "Y" for yes or "N" for no in the applicable colu Are title XIX NF patients occupying title XVIII SNF beds (dual certific			N	92.00
93. 00	instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V	and XLX2 Enter	N	N	93.00
	"Y" for yes or "N" for no in the applicable column.				
94. 00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for applicable column.	no in the	N	N	94.00
	If line 94 is "Y", enter the reduction percentage in the applicable col Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for		0. 00 N	0. 00 N	95. 00 96. 00
90.00	applicable column.		IN IN	IN IN	
97. 00 98. 00	If line 96 is "Y", enter the reduction percentage in the applicable col Does title V or XIX follow Medicare (title XVIII) for the interns and r		0. 00 N	0. 00 N	97. 00 98. 00
70.00	stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "				70.00
98. 01	column 1 for title V, and in column 2 for title XIX.  Does title V or XIX follow Medicare (title XVIII) for the reporting of	charges on Wkst	. N	N	98. 01
	C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and title XIX.	in column 2 for			
98. 02	Does title V or XIX follow Medicare (title XVIII) for the calculation o		N	N	98. 02
	bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for n for title V, and in column 2 for title XIX.	o in column 1			
98. 03	Does title V or XIX follow Medicare (title XVIII) for a critical access			N	98. 03
	reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for title V, and in column 2 for title XIX.	r no in column	1		
98. 04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed outpatient services cost? Enter "Y" for yes or "N" for no in column 1 f	101% of	N	N	98. 04
	in column 2 for title XIX.				
98. 05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for			N	98. 05
98. 06	column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) when cost reimbursed	for Wkst D	N	N	98. 06
90.00	Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for titl		IN IN	IN IN	90.00
	column 2 for title XIX. Rural Providers				
	Does this hospital qualify as a CAH?		. N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive m for outpatient services? (see instructions)	etnod of paymen	τ		106. 00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimburs training programs? Enter "Y" for yes or "N" for no in column 1. (see i				107. 00
	Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I	&Rs in an			
	approved medical education program in the CAH's excluded IPF and/or IR Enter "Y" for yes or "N" for no in column 2. (see instructions)	F unit(s)?			
107. 01	If this facility is a REH (line 3, column 4, is "12"), is it eligible f				107. 01
	reimbursement for I&R training programs? Enter "Y" for yes or "N" for n instructions) $$	,			
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee sc CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	hedul e? See 42	N		108.00
	1-1.1. 2221. 31. 31.12. 1.13(3). 2.11(3) 1 101 you of 14 101 110.		T	1	1

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der (		eriod: rom 01/01/2023	Worksheet S   Part	S-2
			o 12/31/2023	B Date/Time I	
	Physi cal	Occupati onal	Speech	S/31/2024 Respi rator	
	1. 00	2.00	3. 00	4.00	
19.00 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 no for each therapy.		N	N	N	109
				1. 00	
0.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	Y" for yes o	or "N" for no. I	f yes,	N	110
			1.00	2. 00	
1.00 If this facility qualifies as a CAH, did it participate in t Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ad for tele-health services.	ost reporting Diumn 1 is Y, Ticipating i	period? Enter enter the n column 2.	N		111
		1.00	2. 00	3. 00	
2.00 Did this hospital participate in the Pennsylvania Rural Heal (PARHM) demonstration for any portion of the current cost re period? Enter "Y" for yes or "N" for no in column 1. If co "Y", enter in column 2, the date the hospital began particip demonstration. In column 3, enter the date the hospital cea participation in the demonstration, if applicable.	eporting Diumn 1 is Dating in the	N			112
Miscellaneous Cost Reporting Information 5.00 Is this an all-inclusive rate provider? Enter "Y" for yes or	"N" for no	N			011
in column 1. If column 1 is yes, enter the method used (A, B in column 2. If column 2 is "E", enter in column 3 either "9 for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub. 15-1, chapter 22, §2208.1.	3, or E only) 93" percent (includes				
6.00 Is this facility classified as a referral center? Enter "Y" "N" for no.	for yes or	N			110
7.00 s this facility legally-required to carry malpractice insur "Y" for yes or "N" for no.	ance? Enter	Y			117
3.00 Is the malpractice insurance a claims-made or occurrence polif the policy is claim-made. Enter 2 if the policy is occurr			2		118
		Premi ums	Losses	Insurance	
		1.00	2. 00	3.00	_
3.01 List amounts of malpractice premiums and paid losses:		181, 204		0	0118
			1.00		
3.02 Are malpractice premiums and paid losses reported in a cost	center other	than the	1. 00 N	2. 00	118
Administrative and General? If yes, submit supporting sched and amounts contained therein.					111
					1
0.00 DO NOT USE THIS LINE 10.00 Is this a SCH or EACH that qualifies for the Outpatient Hold S3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmen	n column 1, " ualifies for	Y" for yes or the Outpatient	N	N	120
0.00 DO NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no.	n column 1, " ualifies for nts? (see ins	Y" for yes or the Outpatient structions)	N Y	N	
0.00 DO NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no. 0.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.	n column 1, " ualifies for nts? (see ins ntable devic	Y" for yes or the Outpatient structions) ces charged to 03(w)(3) of the		N	12
0.00 DO NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain healthcare related taxes as deformed Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. 3.00 Did the facility and/or its subproviders (if applicable) pur services, e.g., legal, accounting, tax preparation, bookkeep management/consulting services, from an unrelated organizatifor yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., professional services expenses, for services purchased from located in a CBSA outside of the main hospital CBSA? In column	n column 1, " Halifies for Hali	Y" for yes or the Outpatient structions)  des charged to 03(w)(3) of the ter in column 2 csional and/or an 1, enter "Y" can 50% of total aganizations	Y	N	12° 12° 12°
<ul> <li>0.00 DO NOT USE THIS LINE</li> <li>0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with &lt; 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no.</li> <li>0.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.</li> <li>0.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.</li> <li>0.00 Did the facility and/or its subproviders (if applicable) pur services, e.g., legal, accounting, tax preparation, bookkeep management/consulting services, from an unrelated organizati for yes or "N" for no.</li> <li>If column 1 is "Y", were the majority of the expenses, i.e., professional services expenses, for services purchased from</li> </ul>	n column 1, " Halifies for Hali	Y" for yes or the Outpatient structions)  des charged to 03(w)(3) of the ter in column 2 csional and/or an 1, enter "Y" can 50% of total aganizations	Y N	N	12 <sup>2</sup>
2.00 DO NOT USE THIS LINE 2.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. 3.00 Did the facility and/or its subproviders (if applicable) pur services, e.g., legal, accounting, tax preparation, bookkeep management/consulting services, from an unrelated organizati for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., professional services expenses, for services purchased from located in a CBSA outside of the main hospital CBSA? In colu "N" for no. Certified Transplant Center Information 5.00 Does this facility operate a Medicare-certified transplant of	n column 1, " Halifies for hali	Y" for yes or the Outpatient structions) sees charged to O3(w)(3) of the ter in column 2 ossional, and/or on 1, enter "Y" on 50% of total organizations "Y" for yes or	Y N	N	12 <sup>2</sup>
2.00 DO NOT USE THIS LINE 2.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain healthcare related taxes as deformed Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. 3.00 Did the facility and/or its subproviders (if applicable) purservices, e.g., legal, accounting, tax preparation, bookkeep management/consulting services, from an unrelated organizatifor yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., professional services expenses, for services purchased from located in a CBSA outside of the main hospital CBSA? In column "N" for no. Certified Transplant Center Information 5.00 Does this facility operate a Medicare-certified transplant cand "N" for no. If yes, enter certification date(s) (mm/dd/y 5.00 of this is a Medicare-certified kidney transplant program, e	n column 1, " Halifies for Hali	Y" for yes or the Outpatient structions)  des charged to 03(w)(3) of the ter in column 2 csional and/or in 1, enter "Y" on 50% of total reganizations "Y" for yes or	Y N N	N	123
0.00 DO NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies provision in ACA §3121 and applicable amendments. 1.00 Did this facility incur and report costs for high cost implations patients? Enter "Y" for yes or "N" for no. 1.00 Does the cost report contain healthcare related taxes as defact? Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. 1.00 Did the facility and/or its subproviders (if applicable) purservices, e.g., legal, accounting, tax preparation, bookkeep management/consulting services, from an unrelated organizati for yes or "N" for no. 1 If column 1 is "Y", were the majority of the expenses, i.e., professional services expenses, for services purchased from located in a CBSA outside of the main hospital CBSA? In column "N" for no. 1 Certified Transplant Center Information 1 Column Tolum (my/d/y) for no. If yes, enter certification date(s) (mm/dd/y)	n column 1, " Halifies for Hali	Y" for yes or the Outpatient structions)  ces charged to  O3(w)(3) of the cer in column 2  osional  , and/or  on 1, enter "Y"  on 50% of total  reganizations  "Y" for yes or  other in the certain of the certain column 2  osional  , and/or  on 1, enter "Y"  on 50% of total  reganizations  "Y" for yes or  other in the certain of the certain column 2  other in the certain	Y N N	N	12 12 12

alth Financial Systems OSPITAL AND HOSPITAL HEALTH CARE COMPLE	EX IDENTIFICATION DATA	Provi der CC	CN: 14-0147	Peri od	:	Worksheet S	-2
				From O	1/01/2023 2/31/2023	Part I Date/Time P 5/31/2024 1	repare
		<u> </u>			1 00		
28.00  f this is a Medicare-certified	iver transplant program, e	nter the certi	fication dat	e	1. 00	2. 00	128.
in column 1 and termination date,	if applicable, in column	2.					400
9.00 If this is a Medicare-certified I in column 1 and termination date,			ication date				129.
0.00  f this is a Medicare-certified p	ancreas transplant program	, enter the ce	rti fi cati on				130.
date in column 1 and termination 1.00 If this is a Medicare-certified i			certi fi cati d	on			131.
date in column 1 and termination	date, if applicable, in co	lumn 2.					100
2.00 If this is a Medicare-certified i in column 1 and termination date,			fication dat	e			132.
3.00 Removed and reserved							133.
4.00  f this is a hospital-based organ  in column 1 and termination date,			he OPO numbe	er			134
All Providers							
0.00 Are there any related organization chapter 10? Enter "Y" for yes or					Υ		140
are claimed, enter in column 2 th				.5			
1.00 If this facility is part of a cha	2.0		ugh 142 +ba	nomo o	3.00	of the home	
office and enter the home office	contractor name and contra	ictor number.	ough 143 the	name ar	iu auui ess	or the nome	
1.00 Name:	Contractor's Name: PO Box:		Contract	tor's Nu	umber:		141 142
2. 00 Street: 3. 00 Ci ty:	State:		Zi p Code	e:			143
						1.00	
1.00 Are provider based physicians' co	sts included in Worksheet	A?				1. 00 Y	144
	laimed on Wkst. A, line 74				1.00	2. 00	145
inpatient services only? Enter "Y no, does the dialysis facility in period? Enter "Y" for yes or "N" 5.00 Has the cost allocation methodolo	laimed on Wkst. A, line 74 " for yes or "N" for no in clude Medicare utilization for no in column 2. gy changed from the previo	column 1. If for this cost usly filed cos	column 1 is reporting t report?	f	1. 00 N	2.00	
inpatient services only? Enter "Y no, does the dialysis facility in period? Enter "Y" for yes or "N"	laimed on Wkst. A, line 74 ' for yes or "N" for no in clude Medicare utilization for no in column 2. gy changed from the previon column 1. (See CMS Pub.	column 1. If for this cost usly filed cos	column 1 is reporting t report?	f		2.00	
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inpatient services only? Enter "Y no, does the dialysis facility in period? Enter "Y" for yes or "N" 5.00 Has the cost allocation methodolo Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/	laimed on Wkst. A, line 74  " for yes or "N" for no in clude Medicare utilization for no in column 2.  gy changed from the previon column 1. (See CMS Pub. dd/yyyy) in column 2.  [cal basis? Enter "Y" for fallocation? Enter "Y" for	column 1. If for this cost usly filed cos 15-2, chapter  yes or "N" for r yes or "N" f	column 1 is reporting t report? 40, §4020) I			1. 00 N N	146 147 148
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Health Financial Systems	RICHLAND MEMORIA	L HOSPITAL	In Lie	u of Form CM	S-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDEN	ITIFICATION DATA	Provider CCN: 14-0147	Peri od: From 01/01/2023 To 12/31/2023		Prepared:
				1. 00	
Health Information Technology (HIT) inc			ent Act		
167.00 Is this provider a meaningful user under				Y	167. 00
168.00   If this provider is a CAH (line 105 is reasonable cost incurred for the HIT as:			), enter the		168. 00
168.01 If this provider is a CAH and is not a	r a hardship		168. 01		
exception under §413.70(a)(6)(ii)? Ente	r "Y" for yes or "N" f	for no. (see instructions	)	İ	
169.00 If this provider is a meaningful user (transition factor. (see instructions)	ine 167 is "Y") and i	s not a CAH (line 105 is	"N"), enter the	9.	99169.00
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginn period respectively (mm/dd/yyyy)	ng date and ending da	te for the reporting			170. 00
			1. 00	2. 00	
171.00 ffline 167 is "Y", does this provider section 1876 Medicare cost plans reporte "Y" for yes and "N" for no in column 1. 1876 Medicare days in column 2. (see in:	ed on Wkst. S-3, Pt. I If column 1 is yes, e	, line 2, col. 6? Enter	N on		0 171. 00

Heal th	Financial Systems RICHLAND MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 14-0147	Peri od:	Worksheet S-2	
				From 01/01/2023 To 12/31/2023		epared:
				V /N	5/31/2024 10:	42 am
				Y/N 1. 00	<u>Date</u> 2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE	MENT QUESTION	NAI RE	1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N	for all NO r	esponses. Ent	er all dates in	the	
	mm/dd/yyyy format.  COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the			N		1.00
	reporting period? If yes, enter the date of the change in c	column 2. (see	instructions Y/N	Date	V/I	
			1.00	2. 00	3.00	
2. 00	Has the provider terminated participation in the Medicare F	Program? If	N	2.00	0.00	2.00
	yes, enter in column 2 the date of termination and in colum	nn 3, "V" for				
3. 00	voluntary or "I" for involuntary. Is the provider involved in business transactions, including	na managamant	l N			3.00
3.00	contracts, with individuals or entities (e.g., chain home of		IN IN			3.00
	or medical supply companies) that are related to the provide	ler or its				
	officers, medical staff, management personnel, or members of					
	of directors through ownership, control, or family and other lationships? (see instructions)	er similar				
	Trenditionships: (See Fristi detrons)		Y/N	Type	Date	
			1.00	2. 00	3. 00	
4 66	Financial Data and Reports					,
4. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f		N			4.00
	or "R" for Reviewed. Submit complete copy or enter date ava					
	column 3. (see instructions) If no, see instructions.					
5.00	Are the cost report total expenses and total revenues diffe		N			5.00
	those on the filed financial statements? If yes, submit rec	conciliation.		Y/N	Legal Oper.	
				1.00	2. 00	
	Approved Educational Activities					
6.00	Column 1: Are costs claimed for a nursing program? Column	2: If yes, i	s the provide	er N		6.00
7. 00	the legal operator of the program?  Are costs claimed for Allied Health Programs? If "Y" see in	etructione		N		7.00
8. 00	Were nursing programs and/or allied health programs approve		wed durina th			8.00
	cost reporting period? If yes, see instructions.		3			
9. 00	Are costs claimed for Interns and Residents in an approved		cal educatior	n N		9. 00
10. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated of		the current	N		10.00
10.00	cost reporting period? If yes, see instructions.	7 Tenewed Til	the current			10.00
11.00	Are GME cost directly assigned to cost centers other than I	& R in an Ap	proved	N		11.00
	Teaching Program on Worksheet A? If yes, see instructions.				\/ /N	
					1. 00	
	Bad Debts				1.00	
	Is the provider seeking reimbursement for bad debts? If yes	•			Y	12.00
13. 00	If line 12 is yes, did the provider's bad debt collection p	oolicy change	during this d	cost reporting	N	13.00
14 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsura	nce amounts w	aived? If ves	3 500	N	14.00
14.00	instructions.	ince amounts w	arvea: ir yes	3, 300	.,	14.00
	Bed Complement					
15. 00	Did total beds available change from the prior cost reporti				<u>N</u> -t B	15. 00
		Y/N	t A Date	Y/N	тв Date	
		1. 00	2.00	3. 00	4. 00	
	PS&R Data					
16. 00		Υ	04/18/2024	Y	04/18/2024	16.00
	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)					
17. 00	Was the cost report prepared using the PS&R Report for	N		N		17. 00
	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)					1
18. 00	1	N		N		18.00
	Report data for additional claims that have been billed					
	but are not included on the PS&R Report used to file this					
19. 00	cost report? If yes, see instructions.  If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19.00
17.00	Report data for corrections of other PS&R Report	14		IN		19.00
	information? If yes, see instructions.					
	· ·					

21. 00 Was rec  COM Cap 22. 00 Hav 1 rep	Fline 16 or 17 is yes, were adjustments made to PS&R eport data for Other? Describe the other adjustments:	(	ption	From 01/01/2023 To 12/31/2023		repared:		
21. 00 Was rec  COM Cap 22. 00 Hav 1 rep	port data for Other? Describe the other adjustments:	(	ipti on	V /NI	5/31/2024			
21. 00 Was rec  COM Cap 22. 00 Hav 1 rep	port data for Other? Describe the other adjustments:	(	ptron		Y/N	U. 42 all		
21. 00 Was rec  COM Cap 22. 00 Hav 1 rep	port data for Other? Describe the other adjustments:		)	1.00	3. 00			
21. 00 Was rec  COM Cap 22. 00 Hav 23. 00 Hav			<u> </u>	N	N	20.00		
22. 00 Have rep								
22. 00 Have rep	. It is a set to be a set of the	Y/N 1.00	2.00	Y/N 3. 00	Date 4.00			
22. 00 Have rep	s the cost report prepared only using the provider's	N 1.00	2.00	3.00 N	4.00	21.00		
Cap 22. 00 Hav 23. 00 Hav rep	cords? If yes, see instructions.							
Cap 22. 00 Hav 23. 00 Hav rep					4 00			
Cap 22. 00 Hav 23. 00 Hav rep	MPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EDT CHILDDENS I	LO INT IDSUL		1. 00			
22.00 Hav 23.00 Hav	pital Related Cost	LFT CHILDRENS I	103FT TALS)					
rep	ve assets been relifed for Medicare purposes? If yes, see	e instructions				22. 0		
	ve changes occurred in the Medicare depreciation expense	due to apprais	sals made du	ring the cost		23. 0		
24. UU TWAT	porting period? If yes, see instructions.					04.0		
	ere new leases and/or amendments to existing leases entere Tyes, see instructions	ea into auring	this cost r	eporting period?		24.0		
1	ve there been new capitalized leases entered into during	the cost repo	rting period	? If yes, see		25. 0		
i ns	structions.	·	0.					
	ere assets subject to Sec. 2314 of DEFRA acquired during the estructions.	he cost reporti	ing period?	If yes, see		26. 0		
	istructions. Is the provider's capitalization policy changed during the	e cost reporti	na period? L	f ves. submit		27. 0		
	ру.		<u> </u>	3				
	terest Expense							
	ere new loans, mortgage agreements or letters of credit en eriod? If yes, see instructions.	ntered into du	ring the cos	t reporting		28. 0		
	d the provider have a funded depreciation account and/or	bond funds (De	ebt Service	Reserve Fund)		29. 0		
	eated as a funded depreciation account? If yes, see instr			,				
	s existing debt been replaced prior to its scheduled matu	urity with new	debt? If ye	s, see		30.0		
	nstructions. Is debt been recalled before scheduled maturity without is	ssuance of new	deht2 If ve	002 20		31.0		
i ns	structions.	ssuance of new	debt: 11 ye	3, 300		31.0		
	rchased Services							
	we changes or new agreements occurred in patient care ser		ed through c	ontractual		32.0		
	rangements with suppliers of services? If yes, see instru Tline 32 is yes, were the requirements of Sec. 2135.2 app		na to compet	itive bidding? If	,	33. 0		
	o, see instructions.	p od po. ta	g to compor			00.0		
	ovi der-Based Physi ci ans							
	ere services furnished at the provider facility under an a	arrangement wi	th provider-	based physicians?		34.0		
35. 00   I f	`yes, see instructions. `line 34 is yes, were there new agreements or amended exi	isting agreeme	nts with the	provider-based		35.0		
phy	ysicians during the cost reporting period? If yes, see in	nstructi ons.		p. ov. do. based		00.0		
				Y/N	Date			
Нов	ma Offica Casts			1.00	2. 00			
	me Office Costs ere home office costs claimed on the cost report?					36.00		
	Fline 36 is yes, has a home office cost statement been pr	repared by the	home office	?		37.00		
	yes, see instructions.			_				
	fline 36 is yes , was the fiscal year end of the home off me provider? If yes, enter in column 2 the fiscal year end			f		38.0		
1	fline 36 is yes, did the provider render services to othe			s.		39.0		
	e instructions.					37.0		
	Time 36 is yes, did the provider render services to the	home office?	If yes, see			40.00		
i ns	i nstructi ons.							
		1.	00	2. (	00			
Cos	Cost Report Preparer Contact Information							
		KYLE		LEE		41.00		
	eld by the cost report preparer in columns 1, 2, and 3,							
	spectively. Iter the employer/company name of the cost report	   CARLE HEALTH S	YSTEM			42.00		
	reparer.					.2.0		
13. 00 Ent	uter the telephone number and email address of the cost port preparer in columns 1 and 2, respectively.	417-268-5953		KYLE. LEE2@CARLI	E. COM	43.00		

Health Financial Systems	RICHLAND MEMOR	RIAL HOSPITA	AL	In Lieu of Form CMS-2552-1			
HOSPITAL AND HOSPITAL HEALTH CARE	REI MBURSEMENT	QUESTI ONNAI RE	Provi de	er CCN: 14-0147	riod: om 01/01/2023 12/31/2023	Worksheet S-2 Part II Date/Time Pre 5/31/2024 10:	epared:
				3. 00			
Cost Report Preparer Contac	t Information		•				
41.00 Enter the first name, last	name and the ti	tle/position	DI RECTOR-F	I NANCE			41.00
held by the cost report pre	parer in colum	ns 1, 2, and 3,					
respecti vel y.							1
42.00 Enter the employer/company	name of the cos	st report					42.00
preparer.							1
43.00 Enter the telephone number							43.00
report preparer in columns	1 and 2, respec	cti vel y.	1				

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: | Part | P 
 Heal th Fi nancial
 Systems
 RICHLAND

 HOSPITAL
 AND
 HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provi der CCN: 14-0147

						o 12/31/2023	Date/lime Prep   5/31/2024 10:4	
							1/P Days /	72 diii
							0/P Visits /	
							Tri ps	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH/REH Hours	Title V	
		Li ne No.			Avai I abl e			
		1. 00		2. 00	3. 00	4. 00	5. 00	
	PART I - STATISTICAL DATA				1	1		
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		39	14, 235	0.00	0	1.00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
2. 00	for the portion of LDP room available beds) HMO and other (see instructions)							2. 00
3. 00	HMO IPF Subprovider							3. 00
4. 00	HMO IRF Subprovider							4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF						ol	6.00
7. 00	Total Adults and Peds. (exclude observation			39	14, 235	0.00	0	7.00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT	31. 00		8	2, 920	0. 00	0	8.00
9. 00	CORONARY CARE UNIT							9.00
10.00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						_	12.00
13.00	NURSERY	43. 00			47.455		0	13.00
14.00	Total (see instructions)			47	17, 155	0.00		14.00
15. 00 15. 10	CAH visits					0.00	0	15. 00 15. 10
16. 00	REH hours and visits SUBPROVIDER - IPF	40.00		0		0.00	0	16. 00
17. 00	SUBPROVIDER - I RF	40.00		Ü				17. 00
18. 00	SUBPROVI DER							18. 00
19. 00	SKILLED NURSING FACILITY	44. 00		0			0	19. 00
20. 00	NURSING FACILITY			· ·	١		Ĭ	20.00
21. 00	OTHER LONG TERM CARE							21.00
22. 00	HOME HEALTH AGENCY	101.00					o	22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)							23.00
24.00	HOSPI CE	116. 00		1	365	i		24.00
24. 10	HOSPICE (non-distinct part)	30.00						24. 10
25. 00	CMHC - CMHC							25.00
25. 10	CMHC - CORF	99. 10					0	25. 10
25. 20	CMHC - OUTPATIENT PHYSICAL THERAPY	99. 20					0	25. 20
25. 30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	99. 30					0	25. 30
25. 40	CMHC - OUTPATIENT SPEECH PATHOLOGY	99. 40					0	25. 40
26. 00 26. 01	RURAL HEALTH CLINIC RURAL HEALTH CLINIC II	88. 00 88. 01					0	26. 00 26. 01
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27. 00	Total (sum of lines 14-26)	07.00		48				27. 00
28. 00	Observation Bed Days			40			0	28. 00
29. 00	Ambulance Trips						Ĭ	29. 00
30.00	Employee discount days (see instruction)							30.00
31.00	Employee discount days - IRF							31.00
32.00	Labor & delivery days (see instructions)			0	l c			32.00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33.00	LTCH non-covered days							33.00
33. 01	LTCH site neutral days and discharges	20.00		^			ا ا	33. 01
34. UU	Temporary Expansion COVID-19 PHE Acute Care	30.00	l	0	0	'I	0	34.00

 
 Health Financial Systems
 RICHLAND

 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provider CCN: 14-0147 

Component					'	0 12/31/2023	5/31/2024 10:	
PART   - STATISTICAL DATA			I/P Davs	/ O/P Visits	/ Trips	Full Time I		12 (3
Patt I - STATISTICAL DATA				. , ., ., ., .,				
Patt I - STATISTICAL DATA								
PART I - STATISTICAL DATA   1,00   8,00   9,00   10,00		Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
PART I - STATISTICAL DATA		·			Pati ents	& Residents	Payrol I	
1.00   Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Saing Bed, Observation Bed and Hospice days) (see Instructions for col. 2 for the portion of LDP room avail able beds)   2.00   HWO and other (see Instructions)   0   624   2.00   0   3.30   0   0   1   1   1   1   1   1   1			6. 00	7. 00	8. 00	9. 00	10.00	
B exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LIDP room available beds)		PART I - STATISTICAL DATA	,		•			
Hospice days) (See Instructions for col. 2   For the portion of LDP room available beds)   2.00   HMD and other (See Instructions)   0   624   2.00   3.00   4.00	1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 651	158	3, 222			1.00
For the portion of LDP room available beds) 2. 00 HW0 and other (see Instructions) 3. 00 HW0 IPF Subprovider 0 0 0 3. 00 HW0 IPF Subprovider 0 0 0 4. 00 HW0 IPF Subprovider 0 0 0 5. 00 Hospital Adults & Peds. Swing Bed SNF 5. 00 6. 00 Hospital Adults & Peds. Swing Bed NF 7. 00 Total Adults and Peds. (exclude observation beds) (see Instructions) 8. 00 INTENSIVE CARE UNIT 1 176 17 352 8. 00 10. 00 BURN INTENSIVE CARE UNIT 1 10. 00 SUBGRAVE CARE UNI		8 exclude Swing Bed, Observation Bed and						
2.00   MMO and other (see instructions)   0   624   3.00   4.00		Hospice days) (see instructions for col. 2						
3. 00         HMO IPF Subprovider         0         0         0         4. 00         5. 00         4. 00         5. 00         4. 00         5. 00         4. 00         5. 00         4. 00         5. 00         4. 00         5. 00         4. 00         5. 00         6. 00         6. 00         6. 00         6. 00         6. 00         6. 00         6. 00         6. 00         6. 00         6. 00         6. 00         6. 00         6. 00         6. 00         7. 00         7. 00         7. 00         7. 00         6. 00         6. 00         6. 00         7. 00         8. 00         7. 00         8. 00         7. 00         8. 00         7. 00         9. 00         1. 10         8. 00         9. 00         1. 10         9. 00         1. 10         9. 00         1. 10         9. 00         1. 10         9. 00         1. 10         9. 00         1. 10		for the portion of LDP room available beds)						
4.00	2.00	HMO and other (see instructions)	0	624				2.00
5.00 Hospit al Adults & Peds. Swing Bed SNF	3.00	HMO IPF Subprovider	0	0				3.00
Hospi tal Adults & Peds. Swing Bed NF	4.00		0	0				4.00
Total Adults and Peds. (exclude observation beds) (see instructions)   R. 00   Bods) (see instructions)   R. 00   R.	5.00	Hospital Adults & Peds. Swing Bed SNF	1, 069	345	1, 414			5.00
bods  (see   instructions)					•			
8.00   OCCOMPANY CARE UNIT   176   17   352   8.00   9.00   0.0	7.00		2, 720	560	4, 693			7.00
0.00   CORONARY CARE UNIT   10.00   11.00								
10. 00   BURN INTENSIVE CARE UNIT   10. 00			176	17	352			
11.00   SURGICAL INTENSIVE CARE UNIT								
12. 00   OTHER SPECIAL CARE (SPECIFY)   15   312   313   00   00   00   00   00   00   0								
13. 00   NURSERY								
14. 00   Total (see instructions)   2,896   592   5,357   0.00   316.85   14.00   15.00   CAH visits   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
15.00								
15.10   REH hours and visits   0   0   0   0   0   0   0   0   0			2, 896			0.00	316.85	
16. 00 SUBPROVI DER - IPF			0					
17.00   SUBPROVI DER - IRF   18.00   SUBPROVI DER   19.00   SKILLED NURSING FACILITY   0   0   0   0   0   0   0   0   0			-	-		0.00	0.00	
18. 00   SUBPROVI DER			U	Ü	0	0.00	0.00	
19. 00   SKILLED NURSING FACILITY   0   0   0   0   0   0   0   0   0								1
20.00   NURSING FACILITY   21.00   OTHER LONG TERM CARE   22.00   HOME HEALTH AGENCY   O   O   O   O   O   O   O   O   O			0	0		0.00	0.00	1
21.00   OTHER LONG TERM CARE   22.00   HOME HEALTH AGENCY   0   0   0   0   0   0   0   0   0			U	Ü	0	0.00	0.00	
22. 00 HOME HEALTH AGENCY								
23. 00   AMBULATORY SURGICAL CENTER (D.P.)   23. 00   24. 00   HOSPICE   0   0   0   0   0   0   0   0   0			0	0	_	0.00	0.00	1
24. 00 HOSPICE			U	0	0	0.00	0.00	
24. 10		` ′	0	0	_	0.00	0.00	
25. 00 CMHC - CMHC 25. 10 CMHC - CORF 25. 10 CMHC - CORF 25. 20 CMHC - OUTPATIENT PHYSICAL THERAPY 25. 20 CMHC - OUTPATIENT OCCUPATIONAL THERAPY 25. 20 CMHC - OUTPATIENT OCCUPATIONAL THERAPY 26. 30 CMHC - OUTPATIENT SPEECH PATHOLOGY 27. 20 CMHC - OUTPATIENT SPEECH PATHOLOGY 28. 40 CMHC - OUTPATIENT SPEECH PATHOLOGY 38. 40 CMHC - OUTPATIENT SPEECH PATHOLOGY 39. 40 CMHC - OUTPATIENT SPEECH PATHOLOGY 40 CMHC - OUTPATIENT SP			o o	O	_	0.00	0.00	
25. 10 CMHC - CORF 25. 20 CMHC - OUTPATIENT PHYSICAL THERAPY 25. 20 CMHC - OUTPATIENT OCCUPATIONAL THERAPY 25. 30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY 26. 40 CMHC - OUTPATIENT SPEECH PATHOLOGY 26. 00 RURAL HEALTH CLINIC 26. 01 RURAL HEALTH CLINIC II 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 33. 01 LTCH site neutral days and discharges  0 0 0 0 0 0.00 0.00 0.00 0.00 0.00 0.					Ĭ			
25. 20 CMHC - OUTPATIENT PHYSICAL THERAPY 0 0 0 0 0 0 0 0 0 0 0 0 25. 20 25. 30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY 0 0 0 0 0 0 0 0 0 0 0 0 0 25. 30 25. 40 CMHC - OUTPATIENT SPECH PATHOLOGY 0 0 0 0 0 0 0 0 0 0 0 25. 30 25. 40 CMHC - OUTPATIENT SPECH PATHOLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	0	0.00	0.00	
25. 30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY 25. 40 CMHC - OUTPATIENT SPEECH PATHOLOGY 26. 00 RURAL HEALTH CLINIC 26. 01 RURAL HEALTH CLINIC II 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 33. 01 LTCH site neutral days and discharges			0	-				
25. 40 CMHC - OUTPATIENT SPEECH PATHOLOGY 26. 00 RURAL HEALTH CLINIC 26. 01 RURAL HEALTH CLINIC II 26. 25 REDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 29. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 33. 01 LTCH site neutral days and discharges			0	0	0			
26. 00 RURAL HEALTH CLINIC 1,770 0 5,291 0.00 9.69 26.00 26.01 RURAL HEALTH CLINIC II 3,710 0 29,101 0.00 41.09 26.01 26.25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.00 0.00 26.25 27.00 Total (sum of lines 14-26) 0.00 29,00 367.63 27.00 29.00 Ambul ance Trips 0 1,031 0 Employee discount days (see instruction) 29.00 Employee discount days (see instructions) 20.00 Employee discount days (see instructions) 20.00 Labor & delivery days (see instructions) 20.00 Labor & delivery days (see instructions) 33.00 LTCH non-covered days 0 0 33.01 LTCH site neutral days and discharges 0 0 0 0 0 0.00 29,101 0.00 29,101 0.00 0.00 26.25 0.00 0.00 0.00 0.00 26.25 0.00 0.00 0.00 0.00 0.00 26.25 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0			0	0	0	0.00		
26. 01 RURAL HEALTH CLINIC II 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observati on Bed Days 29. 00 Ambul ance Trips 29. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 31. 00 LTCH site neutral days and discharges 33. 01 LTCH site neutral days and discharges			1, 770	0	5, 291			
26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0.00 0.00 26. 25 27. 00 Total (sum of lines 14-26) 0.00 367. 63 27. 00 28. 00 Observation Bed Days 0 1,031 28. 00 29. 00 Ambul ance Trips 0 29. 00 Employee discount days (see instruction) 0 29. 00	26. 01	RURAL HEALTH CLINIC II	3, 710	0	29, 101			26. 01
28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges  0 1,031 0 29.00 0 30.00 0 30.00 0 31.00 0 31.00 0 32.01 0 32.01 0 33.00 0 33.01			1	0		0.00	0.00	26. 25
29. 00 Ambul ance Trips	27.00	Total (sum of lines 14-26)				0.00	367. 63	27.00
29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges  0 29.00 30.00 31.00 31.00 32.01 33.00 33.01	28.00	Observation Bed Days		0	1, 031			28. 00
31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges  31.00 32.00 32.00 32.01 0 33.00 33.01	29.00		0					29. 00
32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges  32.00 26 58 0 32.00 32.01 0 33.01	30.00	Employee discount days (see instruction)			0			30.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)  33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges  0 32.01	31.00	Employee discount days - IRF			0			31.00
outpati ent days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 0 33.01	32.00	Labor & delivery days (see instructions)	o	26	58			32.00
33.00 LTCH non-covered days 0 33.00 33.01 LTCH site neutral days and discharges 0 33.01	32. 01				0			32. 01
33.01 LTCH site neutral days and discharges 0 33.01								
			0					
			١	_				
34.00   Temporary Expansion COVID-19 PHE Acute Care   0 0 0 0 34.00	34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	1 0		l	34.00

Provider CCN: 14-0147 

				To	12/31/2023	Date/Time Pre 5/31/2024 10:	
		Full Time		Di sch	arges	37 3 17 2024 10.	72 dili
		Equi val ents			ŭ		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
	DADT I CTATICTICAL DATA	11. 00	12. 00	13. 00	14. 00	15. 00	
1. 00	PART I - STATISTICAL DATA		0	591	1	1, 282	1. 00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and		Ü	591	'	1, 282	1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			0	1		2.00
3.00	HMO IPF Subprovider				o		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6. 00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
8. 00	beds) (see instructions)   INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	591	1	1, 282	14.00
15.00	CAH visits						15.00
15. 10	REH hours and visits						15. 10
16.00	SUBPROVI DER - I PF	0.00	0	0	0	0	16.00
17. 00	SUBPROVIDER - I RF						17.00
18. 00 19. 00	SUBPROVIDER  SKILLED NURSING FACILITY	0.00		•			18. 00 19. 00
20.00	NURSING FACILITY	0.00					20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY	0.00					22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE	0.00					24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC						25. 00
25. 10	CMHC - CORF	0.00					25. 10
25. 20 25. 30	CMHC - OUTPATIENT PHYSICAL THERAPY	0.00					25. 20
25. 30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY CMHC - OUTPATIENT SPEECH PATHOLOGY	0. 00 0. 00					25. 30 25. 40
26. 00	RURAL HEALTH CLINIC	0.00					26. 00
26. 01	RURAL HEALTH CLINIC II	0.00					26. 01
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27.00	Total (sum of lines 14-26)	0.00					27. 00
28.00	Observation Bed Days						28. 00
29. 00	Ambul ance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32. 00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)						32. 01
33. 00	LTCH non-covered days			o			33. 00
33. 01	LTCH site neutral days and discharges						33. 01
	Temporary Expansion COVID-19 PHE Acute Care				ļ		34.00
- · · · <del>-</del>	1 1 3 12 2 2	'		1	ļ	ļ	

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part | I | To 12/31/2023 | Date/Time Prepared: | Part Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 14-0147

A 3.00 Non-physic B 4.00 Physician-Administra 4.01 Physicians 5.00 Physicians 6.00 Non-physician-Physicians 6.00 Non-physicians 7.00 Interns & approved programs 8.00 Home officiorganizati 9.00 SNF 10.00 Excluded a instructic OTHER WAGE 11.00 Contract I Care 12.00 Contract I management	aries (see ons) cian anesthetist Part cian A - citive s - Part A - Teaching and Non -Part B cian-Part B for cased RHC and FOHC  residents (in an corogram) d interns and (in an approved ce and/or related con personnel area salaries (see		Amount Reported  2.00  35,340,431  0  257,931  0  8,176,206  1,837,385  0  0  7,015,097	Reclassificat i on of Salaries (from Wkst. A-6) 3.00  -6,552,767  0 0 0 0 0 0 0 0 0	0 257, 931 0 0 8, 176, 206 1, 837, 385 0	0. 00 3, 046. 00 0. 00 0. 00 31, 126. 00	5/31/2024 10:   Average   Hourl y Wage (col . 4 + col . 5)	1. 000 2. 000 3. 000 4. 000 5. 000 7. 000 7. 001
SALARIES  1.00 Total sala instruction A  3.00 Non-physical A  4.00 Physician-Administral Administral Administration Administra	aries (see ons) cian anesthetist Part cian A - tive cian Part A - Teaching and Non cian Part B cian Part B cian Part B cian Part B cian FOHC cresidents (in an corogram) dinterns and (in an approved ce and/or related on personnel carea salaries (see cons) S & RELATED COSTS	200.00	2. 00 35, 340, 431 0 257, 931 0 8, 176, 206 1, 837, 385 0 0	Sal ari es (from Wkst. A-6) 3.00 -6,552,767 0 0 0	(col . 2 ± col . 3)  4. 00  28, 787, 664  0  257, 931  0  8, 176, 206  1, 837, 385  0  0	5. 00  764, 668. 00  0. 00  3, 046. 00  0. 00  31, 126. 00  16, 214. 00  0. 00  0. 00	(col · 4 ÷ col · 5)  6.00  37.65  0.00  84.68  0.00  262.68  113.32  0.00  0.00	2. 00 3. 00 4. 00 4. 01 5. 00 6. 00 7. 00
SALARIES  1.00 Total sala instruction A  3.00 Non-physical A  4.00 Physician-Administral Administral Administration Administra	aries (see ons) cian anesthetist Part cian A - tive cian Part A - Teaching and Non cian Part B cian Part B cian Part B cian Part B cian FOHC cresidents (in an corogram) dinterns and (in an approved ce and/or related on personnel carea salaries (see cons) S & RELATED COSTS	200.00	35, 340, 431 0 257, 931 0 0 8, 176, 206 1, 837, 385 0 0	(from Wkst. A-6) 3.00  -6,552,767  0 0 0 0 0 0 0	3) 4.00 28,787,664 0 257,931 0 8,176,206 1,837,385 0	764, 668. 00 0. 00 3, 046. 00 0. 00 31, 126. 00 16, 214. 00 0. 00 0. 00	6. 00 37. 65 0. 00 84. 68 0. 00 262. 68 113. 32 0. 00 0. 00	2. 00 3. 00 4. 00 4. 01 5. 00 6. 00 7. 00
SALARIES  1.00 Total sala instruction A  3.00 Non-physical A  4.00 Physician-Administral Administral Administration Administra	aries (see ons) cian anesthetist Part cian A - tive cian Part A - Teaching and Non cian Part B cian Part B cian Part B cian Part B cian FOHC cresidents (in an corogram) dinterns and (in an approved ce and/or related on personnel carea salaries (see cons) S & RELATED COSTS	200.00	35, 340, 431 0 257, 931 0 0 8, 176, 206 1, 837, 385 0 0	A-6) 3.00  -6,552,767  0  0  0  0  0  0  0	4.00 28,787,664 0 257,931 0 8,176,206 1,837,385	5. 00 764, 668. 00 0. 00 3, 046. 00 0. 00 31, 126. 00 16, 214. 00 0. 00 0. 00	6. 00 37. 65 0. 00 84. 68 0. 00 262. 68 113. 32 0. 00 0. 00	2. 00 3. 00 4. 00 4. 01 5. 00 6. 00 7. 00
SALARIES  1.00 Total sala instruction A  3.00 Non-physical A  4.00 Physician-Administral Administral Administration Administra	aries (see ons) cian anesthetist Part cian A - tive cian Part A - Teaching and Non cian Part B cian Part B cian Part B cian Part B cian FOHC cresidents (in an corogram) dinterns and (in an approved ce and/or related on personnel carea salaries (see cons) S & RELATED COSTS	200.00	35, 340, 431 0 257, 931 0 0 8, 176, 206 1, 837, 385 0 0	-6, 552, 767 0 0 0 0 0 0	28, 787, 664 0 257, 931 0 0 8, 176, 206 1, 837, 385 0	764, 668. 00 0. 00 3, 046. 00 0. 00 0. 00 31, 126. 00 16, 214. 00 0. 00 0. 00	37. 65 0. 00 84. 68 0. 00 0. 00 262. 68 113. 32 0. 00 0. 00	2. 00 3. 00 4. 00 4. 01 5. 00 6. 00 7. 00
SALARIES  1.00 Total sala instruction A  3.00 Non-physical A  4.00 Physician-Administral Administral Administration Administra	aries (see ons) cian anesthetist Part cian A - tive cian Part A - Teaching and Non cian Part B cian Part B cian Part B cian Part B cian FOHC cresidents (in an corogram) dinterns and (in an approved ce and/or related on personnel carea salaries (see cons) S & RELATED COSTS	21. 00	0 257, 931 0 0 8, 176, 206 1, 837, 385 0 0	0 0 0 0 0	0 257, 931 0 0 8, 176, 206 1, 837, 385 0	0. 00 3, 046. 00 0. 00 0. 00 31, 126. 00 16, 214. 00 0. 00 0. 00	0. 00 84. 68 0. 00 0. 00 262. 68 113. 32 0. 00 0. 00	2. 00 3. 00 4. 00 4. 01 5. 00 6. 00 7. 00
1.00 Total sala instruction of the contract I care 12.00 Total sala instruction of the contract I care 12.00 Total sala instruction of the contract I care 12.00 Total sala instruction of the contract I care 12.00 Total sala instruction of the contract I care 12.00 Total sala instruction of the contract I care 12.00 Total sala instruction of the contract I care 12.00 Total sala instruction of the contract I care 12.00 Total sala instruction of the contract I care 12.00 Total sala instruction of the contract I care 12.00 Total sala instruction of the care 12.00 Tota	cian anesthetist Part cian and Non cian and Non cian anesthetist cian and FOHC cresidents (in an crogram) dinterns and (in an approved ce and/or related on personnel crea salaries (see cons) S & RELATED COSTS	21. 00	0 257, 931 0 0 8, 176, 206 1, 837, 385 0 0	0 0 0 0 0	0 257, 931 0 0 8, 176, 206 1, 837, 385 0	0. 00 3, 046. 00 0. 00 0. 00 31, 126. 00 16, 214. 00 0. 00 0. 00	0. 00 84. 68 0. 00 0. 00 262. 68 113. 32 0. 00 0. 00	2. 00 3. 00 4. 00 4. 01 5. 00 6. 00 7. 00
instruction Non-physical Non-physical Non-physical B A.00 Physician-Administra Administra Administra Physicians Physician- Physician- Non-physical Non-physical Services T.00 Interns & approved presidents programs Non-physical Services T.01 Contracted residents programs Non-physical Services T.00 Interns & approved presidents programs Non-physical Services Toolory in the services Toolory	cian anesthetist Part cian and Non cian and Non cian anesthetist cian and FOHC cresidents (in an crogram) dinterns and (in an approved ce and/or related on personnel crea salaries (see cons) S & RELATED COSTS	21. 00	0 257, 931 0 0 8, 176, 206 1, 837, 385 0 0	0 0 0 0 0	0 257, 931 0 0 8, 176, 206 1, 837, 385 0	0. 00 3, 046. 00 0. 00 0. 00 31, 126. 00 16, 214. 00 0. 00 0. 00	0. 00 84. 68 0. 00 0. 00 262. 68 113. 32 0. 00 0. 00	2. 00 3. 00 4. 00 4. 01 5. 00 6. 00 7. 00
A 3.00 Non-physic B 4.00 Physician-Administra 4.01 Physicians 5.00 Physician-Physician	cian anesthetist Part  Part A -  Itive S - Part A - Teaching and Non  Part B  cian-Part B for based RHC and FOHC  residents (in an  brogram) I interns and (in an approved  ce and/or related on personnel  area salaries (see  cons)  S & RELATED COSTS	21. 00	257, 931 0 0 8, 176, 206 1, 837, 385 0 0	0 0 0 0	257, 931 0 0 8, 176, 206 1, 837, 385 0	3, 046. 00 0. 00 0. 00 31, 126. 00 16, 214. 00 0. 00 0. 00	84. 68 0. 00 0. 00 262. 68 113. 32 0. 00 0. 00	3. 00 4. 00 4. 01 5. 00 6. 00 7. 00 7. 01
3.00 Non-physic B 4.00 Physician-Administra 4.01 Physicians 5.00 Physicians 6.00 Non-physician-Physician-Non-physic 1.00 Non-physican-Non-physican-Non-physican-Non-physican-Non-physican-Non-Physicians 6.00 Non-physican-Non-Physicians 6.00 Non-physican-Non-Physician-Non-Physician-Non-Physican-Physican-Non-Physican-Non-Physican-Physican-Non-Physican-Physican-Non-Physican-Physican-Physican-Physican-Physican-Physican-Physican-Physican-Physican-Physican-Physican-Physican-Physican-Physician-Physican-Physican-Physican-Physican-Physician	Part A - utive s - Part A - Teaching and Non Part B cian-Part B for cased RHC and FOHC residents (in an orogram) d interns and (in an approved ce and/or related on personnel area salaries (see cons) S & RELATED COSTS	21. 00	0 0 8, 176, 206 1, 837, 385 0 0 0	0 0 0	0 8, 176, 206 1, 837, 385 0 0	0. 00 0. 00 31, 126. 00 16, 214. 00 0. 00	0. 00 0. 00 262. 68 113. 32 0. 00 0. 00	4. 00 4. 01 5. 00 6. 00 7. 00 7. 01
B 4.00 Physician-Administra 4.01 Physicians 5.00 Physician Physician-Physician-Physician-Physician-Physician-Physician-Physician-Physician-Physican	Part A - utive s - Part A - Teaching and Non Part B cian-Part B for cased RHC and FOHC residents (in an orogram) d interns and (in an approved ce and/or related on personnel area salaries (see cons) S & RELATED COSTS	21. 00	0 0 8, 176, 206 1, 837, 385 0 0 0	0 0 0	0 8, 176, 206 1, 837, 385 0 0	0. 00 0. 00 31, 126. 00 16, 214. 00 0. 00	0. 00 0. 00 262. 68 113. 32 0. 00 0. 00	4. 00 4. 01 5. 00 6. 00 7. 00 7. 01
Administra 4.01 Physicians 5.00 Physicians Physician 6.00 Non-physician- hospital-b services 7.00 Interns & approved presidents programs) 8.00 Home officiorganizati 9.00 SNF 10.00 Excluded a instructic OTHER WAGE 11.00 Contract I Care 12.00 Contract I management	ative  5 - Part A - Teaching and Non Part B cian-Part B for based RHC and FOHC  residents (in an program) d interns and (in an approved  the and/or related on personnel area salaries (see cons)  S & RELATED COSTS	21. 00	0 8, 176, 206 1, 837, 385 0 0	0 0	0 8, 176, 206 1, 837, 385 0 0	0. 00 31, 126. 00 16, 214. 00 0. 00 0. 00	0. 00 262. 68 113. 32 0. 00 0. 00	4. 01 5. 00 6. 00 7. 00 7. 01
4.01 Physicians 5.00 Physician Physician Physician Contracted Physician Physician Physician Physician Physician Physician Non-physic Services Physician Physician Physician Physician Physician Services Physician Physician Services Physician Services Physician Services Physician Services Physician Services Physician Physicians Services Physicians Services Physicians Services Physicians Physicians Services Physicians Services Physicians Services Physicians Services Physicians Physicians Physicians Services Physicians Physician	s - Part A - Teaching and Non Part B cian-Part B for based RHC and FOHC  residents (in an brogram) d interns and (in an approved  ce and/or related on personnel area salaries (see bns) S & RELATED COSTS	21. 00	1, 837, 385 0 0 0	0	8, 176, 206 1, 837, 385 0 0	31, 126. 00 16, 214. 00 0. 00 0. 00	262. 68 113. 32 0. 00 0. 00	5. 00 6. 00 7. 00 7. 01
5.00 Physician Physician-Physician-Non-Physician-Non-Physician-Non-Physician-Non-Physician Physician Physi	and Non Part B cian-Part B for cased RHC and FOHC  residents (in an program) d interns and (in an approved  ce and/or related on personnel  area salaries (see cons) S & RELATED COSTS	21. 00	1, 837, 385 0 0 0	0	8, 176, 206 1, 837, 385 0 0	31, 126. 00 16, 214. 00 0. 00 0. 00	262. 68 113. 32 0. 00 0. 00	5. 00 6. 00 7. 00 7. 01
Physician- Non-physic hospital - be services 7.00 Interns & approved programs) 8.00 Home officior organizati 9.00 SNF 10.00 Excluded a instructior OTHER WAGE 11.00 Contract I Care 12.00 Contract I management	Part B sian-Part B for based RHC and FOHC residents (in an brogram) d interns and (in an approved se and/or related on personnel area salaries (see bns) S & RELATED COSTS		1, 837, 385 0 0 0	0	1, 837, 385 0	16, 214. 00 0. 00 0. 00	113. 32 0. 00 0. 00	6. 00 7. 00 7. 01
hospital -b services 7.00 Interns & approved p Contracted residents programs) 8.00 Home offic organizati 9.00 SNF 10.00 Excluded a instruction OTHER WAGE 11.00 Contract I Care 12.00 Contract I management	residents (in an program) In interns and (in an approved ce and/or related on personnel area salaries (see ans) S & RELATED COSTS		0 0	0	0	0. 00 0. 00	0. 00 0. 00	7. 00 7. 01
services 7.00 Interns & approved p 7.01 Contracted residents programs) 8.00 Home office organizati 9.00 SNF 10.00 Excluded a instruction OTHER WAGE 11.00 Contract I Care 12.00 Contract I management	residents (in an program) dinterns and (in an approved ce and/or related on personnel area salaries (see ons) S & RELATED COSTS		0	0	0	0. 00	0. 00	7. 01
7.00 Interns & approved properties approved programs) 8.00 Home office organizati 9.00 SNF 10.00 Excluded a instruction of the WAGE 11.00 Contract I Care 12.00 Contract I management	orogram) I interns and (in an approved  ce and/or related on personnel  area salaries (see ons) S & RELATED COSTS		0	0	0	0. 00	0. 00	7. 01
approved procession approv	orogram) I interns and (in an approved  ce and/or related on personnel  area salaries (see ons) S & RELATED COSTS		0	_		0. 00	0. 00	7. 01
residents programs)  8.00 Home offic organizati  9.00 SNF  10.00 Excluded a instructic OTHER WAGE  11.00 Contract I Care  12.00 Contract I management	(in an approved te and/or related on personnel trea salaries (see ons) S & RELATED COSTS	44. 00	0	_				
9.00 Home office organizati 9.00 SNF 10.00 Excluded a instructic OTHER WAGE 11.00 Contract I Care 12.00 Contract I management	ce and/or related on personnel area salaries (see ons) S & RELATED COSTS	44. 00	0	0	0	0. 00	0. 00	
8.00 Home office organizati 9.00 SNF 10.00 Excluded a instruction OTHER WAGE 11.00 Contract I Care 12.00 Contract I management	on personnel area salaries (see ons) S & RELATED COSTS	44. 00	0	0	0	0. 00	0. 00	1
9.00 SNF 10.00 Excluded a instructic OTHER WAGE 11.00 Contract I Care 12.00 Contract I management	area salaries (see ons) S & RELATED COSTS	44. 00	0 7, 015, 097	0				8.00
10.00 Excluded a instruction OTHER WAGE 11.00 Contract I Care 12.00 Contract I management	ons) S & RELATED COSTS	44.00	0 7, 015, 097	0		l e		1
instruction OTHER WAGE 11.00 Contract I Care 12.00 Contract I management	ons) S & RELATED COSTS		7,015,097	4 100 177	0 2, 886, 920	0. 00 59, 599. 00	0. 00 48. 44	
11.00 Contract I Care 12.00 Contract I management	S & RELATED COSTS			-4, 128, 177	2, 880, 920	59, 599. 00	48. 44	10.00
12.00 Care Contract I management	abor: Direct Patient							l
12.00 Contract I management			0	0	0	0. 00	0. 00	11. 00
management	abor: Top Level		0	0	0	0. 00	0.00	12.00
managaman+	and other		Ĭ	O		0.00	0.00	12.00
	and administrative							ł
services	aban. Dhuai ai an Dant			0	0	0.00	0.00	12 00
13.00   Contract I A - Admini	abor: Physician-Part strative		0	U	٥	0. 00	0. 00	13.00
	ce and/or related		О	0	0	0. 00	0. 00	14.00
	on salaries and							1
wage-relat	ted costs ce salaries		2	0	2	1. 00	2 00	14. 01
	ganization salaries		ō	0		0. 00	0. 00	
	ce: Physician Part A		0	0	0	0. 00	0. 00	15. 00
- Administ	rative ce and Contract		0	0	0	0.00	0. 00	16. 00
	s Part A - Teaching		o o	0		0.00	0.00	10.00
16.01 Home office	ce Physicians Part A		0	0	0	0. 00	0. 00	16. 01
- Teaching			0	0	0	0.00	0.00	14 03
	ce contract S Part A - Teaching		U	U	٥	0.00	0.00	16. 02
WAGE-RELAT								l
	ed costs (core) (see		4, 875, 311	0	4, 875, 311			17.00
i nstructi c 18.00 Wage-relat	ons) ced costs (other)							18. 00
(see instr								
19. 00 Excluded a			1, 261, 842	0	1, 261, 842			19.00
20. 00 Non-physi α	ian anesthetist Part		0	0	0			20.00
21. 00 Non-physi c	ian anesthetist Part		73, 209	0	73, 209			21.00
В								ł
22.00 Physician Administra			0	0	0			22.00
	Part A - Teaching		o	0	o			22. 01
23. 00 Physi ci an			263, 473	0	263, 473			23.00
	red costs (RHC/FQHC)		140, 374	0	140, 374			24.00
25.00 Interns & approved p	residents (in an		0	0	0			25.00
	ce wage-related		1	0	1			25. 50
(core)	, and the second							
	gani zati on		0	0	0			25. 51
wage-relat 25.52 Home office	cec (core) ce: Physician Part A		n	Ω	n			25. 52
- Administ	rative -		Ĭ	0				
wage-rel at	ted (core)							ļ

HOSPITAL WAGE INDEX INFORMATION Provider CCN: 14-0147 Worksheet S-3 From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/31/2024 10:42 am Wkst. A Line Amount Recl assi fi cat Adj usted Paid Hours Average Hourly Wage (col. 4 ÷ col. 5) Number Sal ari es Related to Reported ion of Sal ari es (col. 2 ± col. Salaries in (from Wkst. 3) col. 4 A-6) 1.00 2.00 3.00 4.00 5.00 6.00 25.53 Home office: Physicians Part A 0 25. 53 - Teaching - wage-related (core) OVERHEAD COSTS - DIRECT SALARIES 26.00 Employee Benefits Department 4.00 0.00 0. 00 26.00 27.00 Administrative & General 5.00 1, 143, 885 0 1, 143, 885 67, 342. 00 16. 99 27.00 28. 00 Administrative & General under 2.00 28.00 0 1.00 contract (see inst.) 29.00 29.00 Maintenance & Repairs 6.00 761, 307 0 761, 307 22, 635. 00 33. 63 30.00 Operation of Plant 7.00 0 0.00 0.00 30.00 262, 084 31.00 Laundry & Linen Service 8.00 9, 384. 00 27. 93 31.00 0 262, 084 32.00 33, 965. 00 21. 04 Housekeepi ng 9.00 714, 628 C 714, 628 32.00 33.00 Housekeeping under contract 0.00 0.00 33.00 (see instructions) 34.00 Dietary 10.00 1, 098, 564 -741, 530 357, 034 15, 506. 00 23. 03 34.00 Dietary under contract (see 35.00  $\cap$ 0.00 0.00 35.00 instructions) 36.00 Cafeteri a 11.00 0 741, 530 741, 530 32, 205. 00 23. 03 36.00 0.00 37.00 Maintenance of Personnel 12.00 0.00 37.00 0 Nursing Administration 38.00 1, 552, 471 28, 136. 00 55. 18 38.00 13.00 Ω 1, 552, 471 39.00 Central Services and Supply 14.00 102, 313 0 102, 313 5, 073. 00 20. 17 39.00 933, 088 933, 088 15, 500. 00 40.00 Pharmacy 15.00 0 60. 20 40.00

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41.00

0.00 42.00

0.00 43.00

16.00

17.00

18.00

Medical Records & Medical Records Library

Social Service

43.00 Other General Service

41.00

42.00

Health Financial Systems	RICHLAND MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE INDEX INFORMATION	Provider CCN: 14-0147	Peri od: Worksheet S-3

						rom 01/01/2023 o 12/31/2023	Part III Date/Time Prep 5/31/2024 10:4	
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Pai d Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		25, 068, 911	-6, 552, 767	18, 516, 144	714, 283. 00	25. 92	1.00
	instructions)							
2.00	Excluded area salaries (see		7, 015, 097	-4, 128, 177	2, 886, 920	59, 599. 00	48. 44	2.00
	instructions)							
3.00	Subtotal salaries (line 1		18, 053, 814	-2, 424, 590	15, 629, 224	654, 684. 00	23. 87	3.00
	minus line 2)							
4.00	Subtotal other wages & related		2	0	2	1.00	2. 00	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		4, 875, 312	0	4, 875, 312	0.00	31. 19	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		22, 929, 128	-2, 424, 590	20, 504, 538	654, 685. 00	31. 32	6.00
7.00	Total overhead cost (see		6, 568, 342	0	6, 568, 342	229, 747. 00	28. 59	7.00
	instructions)							
					-	•		

Health Financial Systems	RICHLAND MEMORIAL HOSPITAL	In Lieu	ı of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS		Peri od: From 01/01/2023	Worksheet S-3 Part IV
			Date/Time Prepared:

	10 12/31/202	5/31/2024 10:	
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS	•	
	Part A - Core List		1
	RETI REMENT COST		1
1.00	401K Employer Contributions	522, 812	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		1
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	3, 488, 930	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	0	8. 02
8.03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	37, 630	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	95, 389	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	154, 326	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
	Noncumulative portion)		l
	TAXES		
17.00	FICA-Employers Portion Only	2, 282, 019	
18. 00	Medicare Taxes - Employers Portion Only	0	18. 00
19. 00	Unempl oyment Insurance	-2, 182	19. 00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (se	e <b>e</b> 0	21.00
	instructions))		1
22.00	Day Care Cost and Allowances	0	22. 00
23.00	Tuition Reimbursement	46, 285	
24.00	Total Wage Related cost (Sum of lines 1 -23)	6, 625, 209	24.00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00

Health Financial Systems	RICHLAND MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 14-014	Peri od:	Worksheet S-3

1103111	AL CONTRACT LABOR AND DENETTT COST	110VI del CCN. 14-0147		rom 01/01/2023	Part V	
			T			pared:
					5/31/2024 10:	
	Cost Center Description			Contract	Benefit Cost	
				Labor		
				1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost					
	Hospital and Hospital-Based Component Identification:					
1.00	Total facility's contract labor and benefit cost			0	0	1.00
2.00	Hospi tal			0	0	2.00
3.00	SUBPROVI DER - I PF			0	0	3.00
4.00	SUBPROVI DER - I RF					4.00
5.00	Subprovi der - (Other)			0	0	5.00
6.00	Swing Beds - SNF			0	0	6.00
7.00	Swing Beds - NF			0	0	7.00
8.00	SKILLED NURSING FACILITY			0	0	8.00
9.00	NURSING FACILITY					9.00
10.00	OTHER LONG TERM CARE I					10.00
11. 00	Hospi tal -Based HHA			0	0	11.00
12.00	AMBULATORY SURGICAL CENTER (D. P. ) I					12.00
13.00	Hospi tal -Based Hospi ce			0	0	13.00
14.00	Hospital-Based Health Clinic RHC			0	0	14.00
14. 01	Hospital-Based Health Clinic RHC 1			0	0	14.01
14. 02	Hospital-Based Health Clinic RHC 2			0	0	14.02
15.00	Hospital-Based Health Clinic FQHC					15.00
16.00	Hospi tal -Based-CMHC					16.00
16. 10	Hospi tal -Based-CMHC 10			0	0	16. 10
16. 20	Hospi tal -Based-CMHC 20			0	0	16. 20
16. 30	Hospi tal -Based-CMHC 30			0	0	16.30
16. 40	Hospi tal -Based-CMHC 40			0	0	16. 40
17.00	RENAL DIALYSIS I					17.00
18.00	Other			0	0	18.00
	•			•		

Health Financial Systems	RICHLAND MEMOR	TAL HOSPITAL		In Li	eu of Form CMS	S-2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-0147	Peri od:	Worksheet S	
			CON 14 OF 40	From 01/01/2023		
		Component	CCN: 14-8548	To 12/31/2023	3 Date/Time Pr 5/31/2024 10	
				RHC I	Cost	
		-				
				1	. 00	
Clinic Address and Identification						
1.00 Street		0:	4	100 SOUTH MAI		1.00
		Ci 1.		State 2.00	ZIP Code 3.00	
2.00 City, State, ZIP Code, County		WEST SALEM	00	I LLI NOI :		2.00
2.00   orty, state, 211 code, codinty		WEST SALEW		TEETNOT	502470	2.00
					1.00	
3.00 HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for rur	al or "U" for o	urban			0 3.00
				nt Award	Date	
				1. 00	2. 00	
Source of Federal Funds	A . 1 >				T	
4.00 Community Health Center (Section 330(d), PHS						4.00
5.00 Migrant Health Center (Section 329(d), PHS Ac 6.00 Health Services for the Homeless (Section 340						5. 00 6. 00
7.00 Appal achi an Regional Commission	J(u), FIIS ACT)					7.00
8. 00 Look-Alikes						8. 00
9. 00 OTHER (SPECIFY)						9. 00
				1. 00	2.00	
10.00 Does this facility operate as other than a ho						0 10.00
yes or "N" for no in column 1. If yes, indica						
2. (Enter in subscripts of line 11 the type of hours.)	r other operat	ion(s) and the	operating			
[TIOUI S. ]	Sun	day	l N	londay	Tuesday	
(nours.)		day to		londay	Tuesday	
(nour s. )	Sun from 1.00	to 2.00	from 3.00	londay to 4.00	Tuesday from 5.00	
Facility hours of operations (1)	from	to	from	to	from	
	from	to 2.00	from	to	from	11.00
Facility hours of operations (1)	from	to 2.00	from 3.00	to 4. 00	from 5. 00	11.00
Facility hours of operations (1) 11.00 CLINIC	from 1.00	to 2.00	from 3.00	to 4.00	from 5.00	
Facility hours of operations (1)  11.00 CLINIC  12.00 Have you received an approval for an exception	from 1.00  on to the prod	to 2.00	from 3.00 08:00	to 4.00	from 5. 00	12.00
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Facility hours of operations (1)  11.00 CLINIC  12.00 Have you received an approval for an exception and the second secon	from 1.00  on to the prodd in CMS Pub. umn 1. If yes,	to 2.00  uctivity standa 100-04, chapter	from 3.00  08:00  ard? - 9, section mn 2 the	to 4.00	from 5. 00	12.00
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Facility hours of operations (1)  11.00 CLINIC  12.00 Have you received an approval for an exception and the second is this a consolidated cost report as defined and another and the second in the se	from 1.00  on to the prod d in CMS Pub. umn 1. If yes, List the name ng multiple c )? Enter "Y" dated RHC grou RHC grouping.	to 2.00  uctivity standa 100-04, chapter enter in colur s of all provious consolidated RH for yes or "N" pings and compi Consolidated	from 3.00  08:00  ard? 9, section nn 2 the ders and  Cs (as define for no. If ete a RHC grouping	to 4.00 17:00 1.00 N	from 5. 00	12.00
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Facility hours of operations (1)  11.00 CLINIC  12.00 Have you received an approval for an exception 13.00 Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columnumber of providers included in this report. numbers below.  13.01 If line 13, column 1, is "Y", are you reporting in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consolidated	from 1.00  on to the prod d in CMS Pub. umn 1. If yes, List the name ng multiple c )? Enter "Y" dated RHC grou RHC grouping. onsolidated RH	to 2.00  uctivity standa 100-04, chapter enter in colur s of all provious consolidated RH for yes or "N" pings and compings and comping	from 3.00  08:00  ard? r 9, section nn 2 the ders and  Cs (as definition of the context of the c	to 4.00  17:00  1.00  N  ed N	from 5.00	12.00
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Facility hours of operations (1)  11.00 CLINIC  12.00 Have you received an approval for an exception of the state of the s	from 1.00  on to the prod d in CMS Pub. umn 1. If yes, List the name ng multiple c )? Enter "Y" dated RHC grouping. onsolidated RHCs in the grou	to 2.00  uctivity stand. 100-04, chapter enter in colur s of all provious consolidated RH for yes or "N" pings and compings and compings and comping.	from 3.00  08:00  ard? 9, section nn 2 the ders and  Cs (as define for no. If ete a RHC grouping oing or  Prov	to 4.00  17:00  1.00  N  ed N  gs ider name 1.00  XIX	From 5.00  08:00  2.00  CCN 2.00  Total Visits	0 13.00 0 13.00
Facility hours of operations (1)  11.00 CLINIC  12.00 Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columnumber of providers included in this report. In numbers below.  13.01 If line 13, column 1, is "Y", are you reporting in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consolid separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered consolidated are comprised exclusively of new consolidated RHC  14.00 RHC/FOHC name, CCN	from 1.00  on to the prod d in CMS Pub. umn 1. If yes, List the name ng multiple c )? Enter "Y" dated RHC grouping. onsolidated RHCs in the grou	to 2.00  uctivity stand. 100-04, chapter enter in colur s of all provious consolidated RH for yes or "N" pings and compings and compings and comping.	from 3.00  08:00  ard? 9, section nn 2 the ders and  Cs (as define for no. If ete a RHC grouping oing or  Prov	to 4.00  17:00  1.00  N  ed N  gs ider name 1.00  XIX	From 5.00  08:00  2.00  CCN 2.00  Total Visits	12.00 0 13.00 0 13.01
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Facility hours of operations (1)  11.00 CLINIC  12.00 Have you received an approval for an exception 13.00 Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colon number of providers included in this report. In the number of providers included in this report. In CMS Pub. 100-02, chapter 13, section 80.2; yes, enter in column 2 the number of consolidated are comprised exclusively of grandfathered comprised exclusively of grandfathered comprised exclusively of new consolidated RHC  14.00 RHC/FQHC name, CCN  15.00 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	from 1.00  on to the prod d in CMS Pub. umn 1. If yes, List the name ng multiple c )? Enter "Y" dated RHC grouping. onsolidated RHCs in the grou	to 2.00  uctivity stand. 100-04, chapter enter in colur s of all provious consolidated RH for yes or "N" pings and compings and compings and comping.	from 3.00  08:00  ard? 9, section nn 2 the ders and  Cs (as define for no. If ete a RHC grouping oing or  Prov	to 4.00  17:00  1.00  N  ed N  gs ider name 1.00  XIX	From 5.00  08:00  2.00  CCN 2.00  Total Visits	12.00 0 13.00 0 13.01
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Health Financial Systems	RI CHLAND MEMOR	RIAL HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-0147	Peri od:	Worksheet S-8	3
		Component	CCN: 14-8548	From 01/01/2023 To 12/31/2023		epared: 42 am
				RHC I	Cost	
		Cou	ınty			
		4.	00			
2.00 City, State, ZIP Code, County						2.00
	Tuesday	Wedn	esday	Thur	sday	
	to	from	to	from	to	
	6. 00	7. 00	8. 00	9. 00	10.00	
Facility hours of operations (1)						
11. 00 CLINIC	17: 00	08: 00	17: 00	08: 00	17: 00	11.00
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13.00	14.00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	17: 00				11. 00

	Financial Systems	RICHLAND MEMORIA				eu of Form CM		552-10
HOSPI 1	AL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-0147	Peri od: From 01/01/2023	Worksheet S	-8	
			Component	CCN: 13-8584	To 12/31/2023	B Date/Time P		
					RHC II	5/31/2024 1 Cost		2 am
					RHC II	COS		
					1	. 00		
	Clinic Address and Identification						4	
1. 00	Street		Ci	ty	800 LOCUST ST State	ZIP Code	$\dashv$	1. 0
				00	2. 00	3. 00	+	
2. 00	City, State, ZIP Code, County	OL	_NEY			62450	T	2.00
							$\perp$	
3. 00	HOSPITAL-BASED FOHCS ONLY: Designation - Ent	or "D" for rural	or "II" for	urban		1.00	0	3. 0
3.00	HOSPITAL-BASED FUNCS UNLT. Designation - Ent	ei k ioi iuiai	01 0 101		nt Award	Date	4	3.0
					1. 00	2.00		
	Source of Federal Funds							
4.00	Community Health Center (Section 330(d), PHS							4. 00 5. 00
5. 00 6. 00	Migrant Health Center (Section 329(d), PHS A Health Services for the Homeless (Section 34							6.00
7. 00	Appal achi an Regional Commission	ro(d), This Acti						7. 00
8.00	Look-Alikes							8.00
9. 00	OTHER (SPECIFY)						$\dashv$	9. 0
					1.00	2.00	+	
10. 00	Does this facility operate as other than a h	nospi tal -based RH	IC or FQHC? E	nter "Y" for		2.00	0	10. 0
	yes or "N" for no in column 1. If yes, indic							
	2. (Enter in subscripts of line 11 the type of	of other operatio	n(s) and the	operati ng				
	hours.)	Sunda	21/	I N	Monday	Tuesday	$\dashv$	
		from	to	from	to	from	+	
		1. 00	2.00	3. 00	4. 00	5. 00		
	Facility hours of operations (1)							
11. 00	CLINIC						$\dashv$	11. 00
					1. 00	2.00	+	
12. 00	Have you received an approval for an excepti	on to the produc	tivity stand	ard?	1.00	2.00	$\top$	12.00
13.00	Is this a consolidated cost report as define	1 1 0110 5 1 40	∩_04 chante	r 9, section	N		0	13.00
	30.8? Enter "Y" for yes or "N" for no in col	umn 1. If yes, e	enter in colu					
	number of providers included in this report.	umn 1. If yes, e	enter in colu					
13. 01		umn 1. If yes, e List the names	enter in colu of all provi	ders and	ed N		0	13. 0°
	number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2	umn 1. If yes, e List the names ing multiple con 2)? Enter "Y" fo	enter in colu of all provi asolidated RH or yes or "N"	ders and Cs (as defind for no. If			0	13. 01
	number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoli	umn 1. If yes, e List the names ing multiple con ?)? Enter "Y" fo dated RHC groupi	enter in colum of all provious asolidated RHor yes or "N" ngs and comp	ders and Cs (as defind for no. If Lete a			0	13. 0¹
	number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoli separate Worksheet S-8 for each consolidated	umn 1. If yes, e List the names ing multiple con 2)? Enter "Y" fo dated RHC groupi I RHC grouping.	enter in colum of all provious asolidated RHor yes or "N" ngs and comp Consolidated	ders and Cs (as defind for no. If lete a RHC grouping			0	13. 01
	number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoli	umn 1. If yes, e List the names ing multiple con 2)? Enter "Y" fo dated RHC groupi I RHC grouping. consolidated RHCs	enter in column of all provinces of all provinces or "N" ngs and comp Consolidated in the group	ders and Cs (as defind for no. If lete a RHC grouping			0	13. 0°
	number of providers included in this report. numbers below.  If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered of	umn 1. If yes, e List the names ing multiple con 2)? Enter "Y" fo dated RHC groupi I RHC grouping. consolidated RHCs	enter in column of all provinces of all provinces or "N" ngs and comp Consolidated in the group	ders and  Cs (as define for no. If lete a RHC groupine ping or		CCN	0	13. 0
13. 01	number of providers included in this report. numbers below.  If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoli separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RH	umn 1. If yes, e List the names ing multiple con 2)? Enter "Y" fo dated RHC groupi I RHC grouping. consolidated RHCs	enter in column of all provinces of all provinces or "N" ngs and comp Consolidated in the group	ders and  Cs (as define for no. If lete a RHC groupine ping or  Provi	gs	CCN 2. 00		
13. 01	number of providers included in this report. numbers below.  If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered of	umn 1. If yes, e List the names ing multiple con 2)? Enter "Y" fo dated RHC groupi I RHC grouping. consolidated RHCs ICs in the groupi	enter in column of all provinces of all provinces of "N" ngs and comp Consolidated in the groung.	ders and  Cs (as define for no. If lete a RHC groupine ping or  Provi	gs ider name 1.00	2. 00		13. 01
13. 01	number of providers included in this report. numbers below.  If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoli separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RH	umn 1. If yes, e List the names ling multiple con 2)? Enter "Y" fo dated RHC groupi I RHC grouping. consolidated RHCs ICs in the groupi Y/N	enter in column of all provings of all provings and computer of the grounds.	ders and  Cs (as define for no. If lete a RHC groupine ping or  Provi	ider name 1.00	2.00 Total Visit		
13. 01	number of providers included in this report. numbers below.  If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoli separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RH	umn 1. If yes, e List the names ing multiple con 2)? Enter "Y" fo dated RHC groupi I RHC grouping. consolidated RHCs ICs in the groupi	enter in column of all provinces of all provinces of "N" ngs and comp Consolidated in the groung.	ders and  Cs (as define for no. If lete a RHC groupine ping or  Provi	gs ider name 1.00	2. 00	S	
13. 01	number of providers included in this report. numbers below.  If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoli separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered c comprised exclusively of new consolidated RH  RHC/FQHC name, CCN  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in	umn 1. If yes, e List the names ing multiple con 2)? Enter "Y" fo dated RHC groupi I RHC grouping. consolidated RHCs ICs in the groupi  Y/N 1.00	enter in column of all provings of all provings and computer of the ground of the grou	ders and  Cs (as define for no. If lete a RHC groupine ping or  Provi	ider name 1.00	2.00 Total Visit	S	14.00
13. 01	number of providers included in this report. numbers below.  If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoli separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RH  RHC/FOHC name, CCN  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	umn 1. If yes, e List the names ing multiple con 2)? Enter "Y" fo dated RHC groupi I RHC grouping. consolidated RHCs ICs in the groupi  Y/N 1.00	enter in column of all provings of all provings and computer of the ground of the grou	ders and  Cs (as define for no. If lete a RHC groupine ping or  Provi	ider name 1.00	2.00 Total Visit	S	14.0
13. 01	number of providers included in this report. numbers below.  If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoli separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered of comprised exclusively of new consolidated RH  RHC/FQHC name, CCN  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	umn 1. If yes, e List the names ing multiple con 2)? Enter "Y" fo dated RHC groupi I RHC grouping. consolidated RHCs ICs in the groupi  Y/N 1.00	enter in column of all provings of all provings and computer of the ground of the grou	ders and  Cs (as define for no. If lete a RHC groupine ping or  Provi	ider name 1.00	2.00 Total Visit	S	14. 00
13. 01	number of providers included in this report. numbers below.  If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoli separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered of comprised exclusively of new consolidated RH  RHC/FOHC name, CCN  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	umn 1. If yes, e List the names ing multiple con 2)? Enter "Y" fo dated RHC groupi I RHC grouping. consolidated RHCs ICs in the groupi  Y/N 1.00	enter in column of all provings of all provings and computer of the ground of the grou	ders and  Cs (as define for no. If lete a RHC groupine ping or  Provi	ider name 1.00	2.00 Total Visit	S	14. 0
13. 01	number of providers included in this report. numbers below.  If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoli separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered of comprised exclusively of new consolidated RH  RHC/FQHC name, CCN  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	umn 1. If yes, e List the names ing multiple con 2)? Enter "Y" fo dated RHC groupi I RHC grouping. consolidated RHCs ICs in the groupi  Y/N 1.00	enter in column of all provings of all provings and computer of the ground of the grou	ders and  Cs (as define for no. If lete a RHC groupine ping or  Provi	ider name 1.00	2.00 Total Visit	S	14.0

Health Financial Systems	RI CHLAND MEMOR	IAL HOSPITAL		In Lieu of Form CMS-2552-10			
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der CO	CN: 14-0147	Peri od:	Worksheet S-8	Worksheet S-8	
		Component (	CCN: 13-8584	From 01/01/2023 To 12/31/2023	Date/Time Pre	narod:	
		Component	JCN. 13-0304	10 12/31/2023	5/31/2024 10:	42 am	
				RHC II	Cost		
		Cou	nty				
		4.	00				
2.00 City, State, ZIP Code, County		RI CHLAND					
	Tuesday	Wednesday		Thur	sday		
	to	from	to	from	to		
	6. 00	7. 00	8. 00	9. 00	10.00		
Facility hours of operations (1)							
11. 00   CLI NI C						11.00	
	Fri	day	Sa	turday			
	from	to	from	to			
	11. 00	12. 00	13.00	14. 00			
Facility hours of operations (1)							
11. 00 CLINIC						11.00	

	Financial Systems RICHLAND MEMORIAL I				u of Form CMS-2				
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der CCI	N: 14-0147	Peri od: From 01/01/2023 To 12/31/2023		pared:			
					1. 00				
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA				1.00				
	Uncompensated and Indigent Care Cost-to-Charge Ratio					1			
1.00	Cost to charge ratio (see instructions)				0. 244961	1.00			
	Medicaid (see instructions for each line)								
2. 00	Net revenue from Medicaid				10, 499, 367	2.00			
3.00	Did you receive DSH or supplemental payments from Medicaid?					3.00			
4. 00 5. 00	If line 3 is yes, does line 2 include all DSH and/or supplement If line 4 is no, then enter DSH and/or supplemental payments fr			ai d?	0	4. 00 5. 00			
6. 00	Medicaid charges	on wearcard	J		53, 434, 492				
7. 00	Medicaid cost (line 1 times line 6)				13, 089, 367				
8. 00	Difference between net revenue and costs for Medicaid program (	see instru	ctions)		2, 590, 000				
	Children's Health Insurance Program (CHIP) (see instructions for				=/ 0.17/ 000	1			
9.00	Net revenue from stand-alone CHIP	0	9.00						
10.00	Stand-alone CHIP charges	0							
11. 00	Stand-alone CHIP cost (line 1 times line 10)	0							
12. 00	Difference between net revenue and costs for stand-alone CHIP (	0	12.00						
12 00	Other state or local government indigent care program (see inst				0	12.00			
13. 00 14. 00	Net revenue from state or local indigent care program (Not incl Charges for patients covered under state or local indigent care	0	13.00						
14.00	10)	e program (i	vot inciuded	III IIIles o or	U	14.00			
15. 00	State or local indigent care program cost (line 1 times line 14	0	15.00						
	Difference between net revenue and costs for state or local inc	0							
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see								
	instructions for each line)				0	17.00			
17.00									
18. 00 19. 00	Government grants, appropriations or transfers for support of h			o (oum of lines	2 500 000				
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16)	That gent (	Jare program	s (suii oi iiiles	2, 590, 000	19.00			
			Uni nsured	Insured	Total (col. 1				
			pati ents	pati ents	+ col. 2)				
			1. 00	2. 00	3. 00				
20. 00	Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions)	T	1, 434, 80	9 690, 563	2, 125, 372	20.00			
21. 00	Cost of patients approved for charity care and uninsured discou		351, 4	· ·	2, 125, 372 860, 885				
21.00	instructions)	1113 (300	331, 4	307, 413	000, 003	21.00			
22.00	Payments received from patients for amounts previously written	off as		0 0	0	22. 00			
	charity care								
23. 00	Cost of charity care (see instructions)		351, 47	72 509, 413	860, 885	23. 00			
					1 00				
24. 00	Does the amount on line 20 col. 2, include charges for patient	days hoyon	d a Longth o	f ctay limit	1. 00 N	24. 00			
24.00	imposed on patients covered by Medicaid or other indigent care		a a rengtii c	ı Stay ilmit	įΝ	24.00			
25. 00									
	stay limit		0	25. 00					
25. 01	Charges for insured patients' liability (see instructions)				239, 921	25. 01			
	Bad debt amount (see instructions)				3, 828, 352				
27. 00	Medicare reimbursable bad debts (see instructions)				248, 588				
27. 01	Medicare allowable bad debts (see instructions)				382, 444				
28. 00	Non-Medicare bad debt amount (see instructions)			`	3, 445, 908				
	Cost of non-Medicare and non-reimbursable Medicare bad debt amo	ounts (see i	nstructions	)	977, 969				
		ne 30)							
	0 Cost of uncompensated care (line 23, col. 3, plus line 29) 1,838,854 30.0 Total unreimbursed and uncompensated care cost (line 19 plus line 30) 4,428,854 31.0								

HOSPI 7	Financial Systems RICHLAND MEMORIAL TAL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der CCN: 1	4-0147	Peri od:	u of Form CMS-2 Worksheet S-1				
				From 01/01/2023 To 12/31/2023	Parts I & II	epared:			
					1.00				
	PART II - HOSPITAL DATA				11.00				
	Uncompensated and Indigent Care Cost-to-Charge Ratio								
1.00	Cost to charge ratio (see instructions)				0. 201299	1.00			
	Medicaid (see instructions for each line)				ı				
2.00	Net revenue from Medicaid					2.00			
3. 00 4. 00	Did you receive DSH or supplemental payments from Medicaid? If line 3 is yes, does line 2 include all DSH and/or supplement	stal paymonts f	rom Modic	ai d2		3. 00 4. 00			
4. 00 5. 00	If line 4 is no, then enter DSH and/or supplemental payments f		rolli wearc	ai u r		5.00			
6. 00	Medicaid charges	Tom Wear cara				6.00			
7. 00	Medicaid cost (line 1 times line 6)					7.00			
8.00	Difference between net revenue and costs for Medicaid program		8.00						
	Children's Health Insurance Program (CHIP) (see instructions f	for each line)	•			Ī			
9. 00	Net revenue from stand-alone CHIP					9.00			
10.00	Stand-alone CHIP charges		10.00						
11.00	Stand-alone CHIP cost (line 1 times line 10)		11.00						
12.00	O Difference between net revenue and costs for stand-alone CHIP (see instructions)  Other state or local government indigent care program (see instructions for each line)								
13. 00						13.00			
14. 00									
14.00	10)	e program (Not	The dued	TH THIES O OF		14.00			
15. 00	State or local indigent care program cost (line 1 times line 1		15.00						
16. 00	Difference between net revenue and costs for state or local in		16.00						
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see								
	instructions for each line)				Г				
17. 00 18. 00	Private grants, donations, or endowment income restricted to 1		17.00						
19.00	Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and local			c (sum of lines		19.00			
19.00	8, 12 and 16)	ii iliui gelit cai	e program	s (sum of filles		19.00			
		U	ni nsured	Insured	Total (col. 1				
		r	oati ents	pati ents	+ col . 2)				
			1. 00	2. 00	3. 00				
20. 00	Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions	.)		ol o	0	20.00			
21. 00	Cost of patients approved for charity care and uninsured disco	′			0				
21.00	instructions)	Junta (See				21.00			
22. 00	Payments received from patients for amounts previously writter	n off as		0 0	0	22.00			
	charity care								
23. 00	Cost of charity care (see instructions)			0 0	0	23.00			
					1.00				
24. 00	Does the amount on line 20 col. 2, include charges for patient	t days bayand a	Longth o	Fotov limit	1. 00 N	24.00			
24.00	imposed on patients covered by Medicaid or other indigent care		rength o	Stay IIIII t	IN IN	24.00			
25. 00	If line 24 is yes, enter the charges for patient days beyond to		re progra	m's Lenath of	0	25. 00			
_5. 50	stay limit		p. ogi di		[	20.00			
25. 01	Charges for insured patients' liability (see instructions)				0	25. 01			
	Bad debt amount (see instructions)				3, 828, 252				
27. 00	Medicare reimbursable bad debts (see instructions)				248, 587				
27 01	Medicare allowable bad debts (see instructions)				382, 442				
27. 01	Non-Medicare bad debt amount (see instructions)				3, 445, 810				
28. 00									
28. 00 29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt am								
28. 00 29. 00 30. 00		•	tructi ons	)	827, 493 827, 493 827, 493	30.00			

	FINANCIAL SYSTEMS SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	RICHLAND MEMORIA		CN: 14 0147 [		Workshoot A	2332-10
RECLA	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	JF EXPENSES	Provi der C		Period: From 01/01/2023	Worksheet A	
					To 12/31/2023		
	01.01	6.1	0.11	T. I. I. () 4	D I	5/31/2024 10:	42 am
	Cost Center Description	Sal ari es	0ther		Reclassificat	Reclassified	
				+ col . 2)	i ons (See A-6)	Trial Balance (col. 3 +-	
					A-0)		
		1. 00	2. 00	3. 00	4. 00	col . 4) 5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
1. 00	00100 CAP REL COSTS-BLDG & FLXT		833, 040	833, 040	208, 140	1, 041, 180	1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP		055, 040	033, 040	200, 140	1, 041, 100	1
3. 00	00300 OTHER CAP REL COSTS		0			0	
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT		163, 012	163. 012		163, 012	
5. 00	00500 ADMINISTRATIVE & GENERAL	1, 143, 885	17, 305, 204			18, 261, 915	•
6. 00	00600 MAI NTENANCE & REPAI RS	761, 307	830, 280			1, 591, 587	•
7. 00	00700 OPERATION OF PLANT	701, 307	678, 562			678, 562	
8. 00	00800 LAUNDRY & LINEN SERVICE	262, 084	206, 583			468, 667	
9. 00	00900 HOUSEKEEPI NG	714, 628	352, 287			1, 066, 915	
10.00	01000 DI ETARY	1, 098, 564	789, 014			613, 464	1
11. 00	01100 CAFETERI A	1,070,001	707,011	1,007,070	1, 274, 114	1, 274, 114	1
12. 00	01200 MAINTENANCE OF PERSONNEL		0		0	0	
13. 00	01300 NURSI NG ADMI NI STRATI ON	1, 552, 471	457, 308	2, 009, 779	0	2, 009, 779	
14. 00	01400 CENTRAL SERVICES & SUPPLY	102, 313	203, 985			306, 298	1
15. 00	01500 PHARMACY	933, 088	2, 365, 671				
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	960			960	
17. 00	01700 SOCIAL SERVICE	ol	0		0	0	
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	ol	0		0	0	
20. 00	02000 NURSI NG PROGRAM	ol	0		0	0	
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV		0			0	
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	ol	0		0	0	
23. 00	02300 PARAMED ED PRGM-(SPECIFY)		0			0	
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>			,		20.00
30.00	03000 ADULTS & PEDIATRICS	3, 104, 091	1, 177, 119	4, 281, 210	-408, 867	3, 872, 343	30.00
31.00	03100 INTENSIVE CARE UNIT	361, 628	210, 518		•	570, 314	
40.00	04000 SUBPROVI DER – I PF	0	0	),		0	
43. 00	04300 NURSERY	312, 452	116, 447	428, 899	0	428, 899	
44. 00	04400 SKILLED NURSING FACILITY	0 12, 102	,	) .23,37		0	
00	ANCILLARY SERVICE COST CENTERS	<u> </u>			,		1
50.00	05000 OPERATING ROOM	694, 330	2, 206, 436	2, 900, 766	-303, 051	2, 597, 715	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	) _,,		395, 051	1
53. 00	05300 ANESTHESI OLOGY	1, 535, 236	368, 471	1, 903, 70		1, 898, 543	
54.00	05400 RADI OLOGY-DI AGNOSTI C	934, 950	284, 724			1, 202, 851	
56. 00	05600 RADI OI SOTOPE	169, 580	295, 832			465, 412	1
57. 00	05700 CT SCAN	436, 104	165, 400			600, 834	
58. 00	05800 MRI	119, 866	159, 804			279, 554	
60.00	06000 LABORATORY	1, 375, 201	2, 005, 806			3, 380, 841	
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	o	0		0	0	1
64.00	06400 I NTRAVENOUS THERAPY	o	0		0	0	1
65.00	06500 RESPI RATORY THERAPY	804, 957	383, 187	1, 188, 144	-192	1, 187, 952	65.00
66.00	06600 PHYSI CAL THERAPY	1, 889, 365	511, 380	2, 400, 745	-263	2, 400, 482	
68.00	06800 SPEECH PATHOLOGY	216, 569	249, 493	466, 062	-182, 759	283, 303	68.00
69.00	06900 ELECTROCARDI OLOGY	2, 767	40, 936	43, 703	0	43, 703	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	)	394, 921	394, 921	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	) (	82, 009	82, 009	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	) (	796, 879	796, 879	73.00
73. 01	07301 I NJECTABLE DRUGS	0	0	) (	1, 336, 216	1, 336, 216	73.01
76. 97	07697 CARDIAC REHABILITATION	0	0	) (	0	0	76. 97
76. 98	07698 HYPERBARIC OXYGEN THERAPY	0	0	) (	0	0	
76. 99	07699 LI THOTRI PSY	0	0	) (	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						1
88. 00	08800 RURAL HEALTH CLINIC	997, 695	288, 814			1, 388, 910	
88. 01	08801 RURAL HEALTH CLINIC II	4, 393, 280	1, 478, 538	5, 871, 818	584, 998	6, 456, 816	1
88. 02	08802 RURAL HEALTH CLINIC III	0	0	) (	0	0	
90.00	09000 CLI NI C	227, 756	161, 763	389, 519	9 0	389, 519	90.00
91.00	09100 EMERGENCY	4, 181, 167	1, 154, 144	5, 335, 311	-9, 775	5, 325, 536	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART			1			92.00
93. 99	09399 PARTI AL HOSPI TALI ZATI ON PROGRAM	0	0	) (	0	0	93. 99
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	0		0	0	
99. 10	09910 CORF	0	0		0	0	
99. 20	09920 OUTPATIENT PHYSICAL THERAPY	0	0		0	0	
99. 30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0		0	0	
	09940 OUTPATIENT SPEECH PATHOLOGY	0	0		0	0	
101.00	10100 HOME HEALTH AGENCY	0	0	)  (	0	0	101.00
	SPECIAL PURPOSE COST CENTERS			1			
	11600 H0SPI CE	0	0		1		116.00
118. 00	, , ,	28, 325, 334	35, 444, 718	63, 770, 052	708, 365	64, 478, 417	J118. 00
46-	NONREI MBURSABLE COST CENTERS						
	19200 PHYSI CI ANS' PRI VATE OFFI CES	5, 544, 318	1, 270, 498			6, 127, 417	
194.00	07950 OTHER NONREI MBURSABLE	0	0	)  (	0  ر	0	194. 00

Health Financial Systems	RICHLAND MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (	OF EXPENSES	Provider CO		Peri od:	Worksheet A	
				From 01/01/2023		
				To 12/31/2023	Date/Time Pre 5/31/2024 10:	42 am_
Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
			+ col. 2)	ions (See	Trial Balance	
				A-6)	(col. 3 +-	
					col. 4)	
	1. 00	2.00	3. 00	4. 00	5. 00	
194. 01 07952 MEMORY DI SORDER	0	0	(	0	0	194. 01
194.02 07953 ASSISTED LIVING	1, 305, 061	353, 795	1, 658, 856	0	1, 658, 856	194. 02
194. 03 07951 CONTRACTED RETAIL RX	165, 718	2, 370, 860	2, 536, 578	-20, 966	2, 515, 612	194. 03
200.00   TOTAL (SUM OF LINES 118 through 199)	35, 340, 431	39, 439, 871	74, 780, 302	2 0	74, 780, 302	200. 00

Health FinancialSystemsRICHLAND MERECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provi der CCN: 14-0147

2. 00   00200   CAP REL COSTS -MVBLE EQUIP   0   0   0   0   0   0   0   0   0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 19. 00 21. 00 22. 00 23. 00
CENERAL SERVICE COST CENTERS   COUNTY   COUNTY	2. 00 3. 00 4. 00 5. 00 7. 00 8. 00 9. 00 0. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 19. 00 22. 00 23. 00 21. 00 22. 00 23. 00 20. 00 21. 00 22. 00 23. 00 20. 00
GENERAL SERVICE COST CENTERS	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 19. 00 22. 00 23. 00 21. 00 22. 00 23. 00 20. 00 21. 00 22. 00 23. 00 20. 00
CENERAL SERVICE COST CENTERS	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 19. 00 22. 00 23. 00 21. 00 22. 00 23. 00 20. 00 21. 00 22. 00 23. 00 20. 00
2. 00   00200   CAP REL COSTS-MVBLE EQUIP   0   0   0   0   0   0   0   0   0	2. 00 3. 00 4. 00 5. 00 7. 00 8. 00 9. 00 0. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 19. 00 22. 00 23. 00 21. 00 22. 00 23. 00 20. 00 21. 00 22. 00 23. 00 20. 00
3. 00 0300 OTHER CAP REL COSTS 0 0 0 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 1, 062, 815 1, 225, 827 5. 00 00500 ADMINISTRATIVE & GENERAL -6, 483, 737 11, 778, 178 6. 00 00600 MAINTENANCE & REPAIRS 0 1, 591, 587 7. 00 00700 OPERATION OF PLANT 1, 335, 473 2, 014, 035 8. 00 00800 LAUNDRY & LINEN SERVICE -14, 033 454, 634 9. 00 00900 HOUSEKEEPING 0 1, 066, 915 10. 00 01000 DI ETARY 0 0 613, 464 11. 00 01100 CAFETERIA -242, 483 1, 031, 631 12. 00 01200 MAINTENANCE OF PERSONNEL 0 0 0 13. 00 01300 NURSIN GADMIN STRATION 1, 119, 799 3, 129, 578 14. 00 01400 CENTRAL SERVICES & SUPPLY 503, 701 809, 999 15. 00 01500 PHARMACY 14, 287 1, 237, 648 17. 00 01500 PHARMACY 14, 287 1, 237, 648 17. 00 01700 SOCI AL SERVICE 0 0 0 17. 00 01700 SOCI AL SERVICE 0 0 0 17. 00 01700 NONPHYSI CI AN ANESTHETISTS 0 0 0 17. 00 01700 NONPHYSI CI AN ANESTHETISTS 0 0 0 17. 00 01700 NONPHYSI CI AN ANESTHETISTS 0 0 0 17. 00 01700 NONPHYSI CI AN ANESTHETISTS 0 0 0 17. 00 01700 NONPHYSI CI AN ANESTHETISTS 0 0 0 17. 00 01700 NONPHYSI CI AN ANESTHETISTS 0 0 0 17. 00 01700 NONPHYSI CI AN ANESTHETISTS 0 0 0 17. 00 01700 NONPHYSI CI AN ANESTHETISTS 0 0 0 17. 00 01700 NONPHYSI CI AN ANESTHETISTS 0 0 0 17. 00 01700 NONPHYSI CI AN ANESTHETISTS 0 0 0 17. 00 01700 NONPHYSI CI AN ANESTHETISTS 0 0 0 0 17. 00 01700 NONPHYSI CI AN ANESTHETISTS 0 0 0 0 17. 00 01700 NONPHYSI CI AN ANESTHETISTS 0 0 0 0 18. SERVICES-SALARY & FRINGES APPRV 0 0 0 19. 00 02000 NURSIN NO PROGRAM 0 0 0 22. 00 02000 NURSIN NO PROGRAM 0 0 0 0 23. 00 03000 ADULTS & PEDI ATRIC S -109, 448 3, 762, 895 31. 00 03100 INTENSI VE CARE UNIT 0 570, 314 40. 00 04400 SKILLED NURSI NG FACILITY 0 0 750, 314 40. 00 04400 SKILLED NURSI NG FACILITY 0 0 428, 899	3. 00 4. 00 5. 00 6. 00 8. 00 9. 00 10. 00 11. 00 12. 00 15. 00 16. 00 17. 00 19. 00 20. 00 21. 00 22. 00 23. 00 30. 00 31. 00 40. 00 31. 00 40.
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 4. 00 15. 00 17. 00 19. 00 20. 00 21. 00 22. 00 23. 00 33. 00 44. 00 15. 00 16. 00 17. 00 18. 00 19. 0
5. 00   00500   ADMI NI STRATI VE & GENERAL   -6, 483, 737   11, 778, 178   6. 00   00600   MAI NITENANCE & REPAI RS   0   1, 591, 587   587   587   7. 00   00700   OPERATI ON OF PLANT   1, 335, 473   2, 014, 035   7. 00   00800   LAUNDRY & LI NEN SERVI CE   -14, 033   454, 634   7. 00   00900   HOUSEKEEPI NG   0   1, 066, 915   7. 00   00900   HOUSEKEEPI NG   0   613, 464   1. 0. 01100   CAFETERI A   -242, 483   1, 031, 631   1. 0. 01100   CAFETERI A   -242, 483   1, 031, 631   1. 0. 01300   NURSING ADMI NI STRATI ON   1, 119, 799   3, 129, 578   1. 0. 01400   CENTRAL SERVI CES & SUPPLY   503, 701   809, 999   1. 01400   CENTRAL SERVI CES & SUPPLY   503, 701   809, 999   1. 01500   PHARMACY   14, 287   1, 237, 648   1. 0. 01400   MEDI CAL RECORDS & LI BRARY   847, 170   848, 130   1. 0. 01700   SOCI AL SERVI CE   0   0   0   0   0   0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0.	5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 4. 00 15. 00 17. 00 19. 00 20. 00 21. 00 22. 00 23. 00
6. 00	6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 20. 00 21. 00 22. 00 23. 00 33. 00 44. 00 55. 00 66. 00 17. 00 20. 00 21. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 20. 00 20
8. 00	8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 19. 00 20. 00 21. 00 22. 00 23. 00 30. 00 31. 00 31. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 37. 00 38. 00 39. 00 30. 00
9. 00	9. 00 10. 00 11. 00 2. 00 13. 00 14. 00 15. 00 17. 00 19. 00 20. 00 21. 00 22. 00 23. 00 30. 00 31. 00
10.00	10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 19.00 20.00 21.00 22.00 23.00 30.00 31.00 30.00
11. 00	11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 19. 00 20. 00 21. 00 22. 00 23. 00 80. 00 81. 00 80. 00
12. 00	22. 00 13. 00 14. 00 15. 00 16. 00 17. 00 19. 00 20. 00 21. 00 22. 00 23. 00 31. 00 31. 00 40. 00
13. 00	33. 00 14. 00 15. 00 16. 00 17. 00 19. 00 20. 00 21. 00 22. 00 23. 00 31. 00 40. 00
14. 00	15. 00 16. 00 17. 00 19. 00 20. 00 21. 00 22. 00 23. 00 30. 00 31. 00 40. 00
16. 00	16. 00 17. 00 19. 00 20. 00 21. 00 22. 00 23. 00 80. 00 81. 00
17. 00 01700 SOCI AL SERVI CE 0 0 0 1900 NONPHYSI CI AN ANESTHETI STS 0 0 0 120. 00 02000 NURSI NG PROGRAM 0 0 0 220. 00 02100 I &R SERVI CES-SALARY & FRI NGES APPRV 0 0 0 0 0 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV 0 0 0 0 0 02300 PARAMED ED PRGM-(SPECI FY) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	17. 00 19. 00 20. 00 21. 00 22. 00 23. 00 30. 00 31. 00
19. 00	19. 00 20. 00 21. 00 22. 00 23. 00 30. 00 31. 00
20. 00   02000   NURSI NG PROGRAM   0 0 0 0   0   2   2   2   1   00   0   0   0   0   0   0   0	20. 00 21. 00 22. 00 23. 00 30. 00 31. 00
21. 00   02100   1&R SERVI CES-SALARY & FRINGES APPRV   0   0   0   0   22. 00   02200   1&R SERVI CES-OTHER PRGM COSTS APPRV   0   0   0   0   0   23. 00   02300   PARAMED ED PRGM-(SPECI FY)   0   0   0   0   0   0   0   0   0	21. 00 22. 00 23. 00 30. 00 31. 00
23. 00   02300   PARAMED ED PRGM-(SPECIFY)   0   0   0       INPATIENT ROUTINE SERVICE COST CENTERS  30. 00   03000   ADULTS & PEDIATRICS   -109, 448   3,762,895   3   31. 00   03100   INTENSIVE CARE UNIT   0   570,314   3   40. 00   04000   SUBPROVIDER - IPF   0   0   0     43. 00   04300   NURSERY   0   428,899   4   44. 00   04400   SKILLED NURSING FACILITY   0   0   0   4	23. 00 80. 00 81. 00 40. 00
INPATIENT ROUTINE SERVICE COST CENTERS	30. 00 31. 00 40. 00
30. 00   03000   ADULTS & PEDIATRICS   -109, 448   3,762, 895   3   31. 00   03100   INTENSI VE CARE UNIT   0   570, 314   3   40. 00   04000   SUBPROVI DER - I PF   0   0   0   4   43. 00   04300   NURSERY   0   428, 899   4   44. 00   04400   SKI LLED NURSI NG FACILITY   0   0   0   4	31. 00 40. 00
31.00   03100   INTENSIVE CARE UNIT   0   570, 314   3   40.00   04000   SUBPROVI DER - I PF   0   0   0   428, 899   44.00   04400   SKILLED NURSING FACILITY   0   0   0   0   0   4	31. 00 40. 00
40. 00       04000       SUBPROVI DER - I PF       0       0       0       4         43. 00       04300       NURSERY       0       428, 899       4         44. 00       04400       SKI LLED NURSI NG FACI LI TY       0       0       0	10.00
43. 00   04300   NURSERY   0   428, 899   44. 00   04400   SKI LLED   NURSI NG   FACI LI TY   0   0   0   428, 899   44. 00   0   0   0   0   0   0   0   0   0	3 00
	5.50
	14.00
ANCILLARY SERVICE COST CENTERS	
	50. 00 52. 00
	3.00
	4. 00
	6.00
	7. 00
	8.00
	60. 00 62. 30
	64.00
	5.00
	6.00
	8.00
	9.00
	71.00
	72.00 73.00
	73. 01
	76. 97
	76. 98
	76. 99
OUTPATI ENT SERVI CE COST CENTERS           88. 00         08800 RURAL HEALTH CLINIC         36,384         1,425,294         8	38. 00
	38. 01
	38. 02
	90.00
	91.00
	92.00
93. 99 O9399 PARTIAL HOSPITALIZATION PROGRAM O O O OTHER REIMBURSABLE COST CENTERS	93. 99
	95. 00
	99. 10
99. 20   09920   OUTPATI ENT PHYSI CAL THERAPY   0   0   9	9. 20
	99. 30
	9.40
	01.00
SPECIAL PURPOSE COST CENTERS         0         0         116.00         110.00	6. 00
	8. 00
NONREI MBURSABLE COST CENTERS	
	2.00
	11 00
174. 01 07732  MEMORT DISORDER   U  U  U	94. 00 94. 01

Health Financial Systems	RI CHLAND MEMOR	IAL HOSPITAL	1	n Lieu of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL I	BALANCE OF EXPENSES	Provi der CCN: 1	From 01/01	/2023   Worksheet A   /2023   Date/Time Prepared: 5/31/2024 10:42 am
Cost Center Description	Adjustments (See A-8)	Net Expenses		

			5/31/2024 TO: 42 alli
Cost Center Description	Adjustments	Net Expenses	
	(See A-8)	For	
		Allocation	
	6. 00	7. 00	
194. 02 07953 ASSISTED LIVING	-39, 820	1, 619, 036	194. 02
194. 03 07951 CONTRACTED RETAIL RX	0	2, 515, 612	194. 03
200.00 TOTAL (SUM OF LINES 118 through 199)	-11, 079, 988	63, 700, 314	200.00

Heal th Financial Systems RICHLAND MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10
RECLASSIFICATIONS Provider CCN: 14-0147 Period: From 01/01/2023 To 12/31/2023 Date/Time Prepared:

					То	12/31/2023	3   Date/Time Prepa   5/31/2024 10:42	
		Increases					3/31/2024 10. 42	<u>z</u> aiii
	Cost Center	Li ne #	Sal ary	0ther				
	2. 00	3. 00	4. 00	5. 00				
	A - RECLASS CAFETERIA							
1.00	CAFETERI A	<u>11.</u> 00	74 <u>1, 5</u> 30	53 <u>2, 5</u> 84				1.00
	TOTALS		741, 530	532, 584				
	B - INTEREST EXPENSE							
1.00	CAP REL COSTS-BLDG & FLXT	1.00	0	18 <u>7, 1</u> 74				1.00
	TOTALS		0	187, 174				
	C - OTHER CAPITAL RELATED							
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	20, 966				1.00
2.00		0.00	0	0				2.00
	TOTALS		0	20, 966				
	D - HOSPITALIST SALARY							
1.00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	3, 671, 209				1.00
2.00	ANESTHESI OLOGY	53. 00	0	202, 617				2.00
3.00	EMERGENCY	<u>91.</u> 00	0	<u>2, 678, 9</u> 41				3.00
	TOTALS		0	6, 552, 767				
	E - RECLASS MEDICAL SUPPLIES							
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	394, 921				1.00
	PATI ENT							
2.00	I MPL. DEV. CHARGED TO	72. 00	0	82, 009				2.00
	PATI ENTS							
3.00		0.00	•	0				3.00
	TOTALS		0	476, 930				
	F - RECLASS DRUGS		_1					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	796, 879				1.00
2.00	I NJECTABLE DRUGS	73. 01	0	1, 336, 216				2.00
3. 00		0. 00	0	0				3. 00
4. 00		0. 00	0	0				4.00
5. 00		0.00	0	0				5.00
6.00		0. 00	0	0				6. 00
7. 00		0.00	0	0				7.00
8.00		0. 00	0	0				8. 00
9. 00		0. 00	0	0				9. 00
10.00		0. 00	0	0				10.00
11.00		0. 00	0	0			•	11.00
12.00		0.00	•	0				12.00
	TOTALS		0	2, 133, 095				
	G - LABOR AND DELIVERY							
1.00	DELIVERY ROOM & LABOR ROOM	<u>52.</u> 00	31 <u>1, 8</u> 58	8 <u>3, 1</u> 93				1.00
	TOTALS		311, 858	83, 193				
	I - PHYSICIAN PRACTICE MANAGEM							
1.00	RURAL HEALTH CLINIC	88. 00	71, 439	30, 962				1.00
2. 00	RURAL HEALTH CLINIC I	<u>88.</u> 01	385, 529	<u>199, 4</u> 69				2.00
	TOTALS		456, 968	230, 431				
	Grand Total: Increases		1, 510, 356	10, 217, 140			150	00.00

							3/31/2024 10:42 am
		Decreases		•			
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
	A - RECLASS CAFETERIA						
1.00	DI ETARY	10. 00	74 <u>1, 5</u> 30	<u>532, 5</u> 84			1.00
	TOTALS		741, 530	532, 584	1		
	B - INTEREST EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	187, 174	1 11		1.00
	TOTALS		0	187, 174	1		
	C - OTHER CAPITAL RELATED						
1.00	CONTRACTED RETAIL RX	194. 03	0	20, 966	5 12		1.00
2.00		0.00	o	(	13		2.00
	TOTALS	$   \top$	0	20, 966	5		
	D - HOSPITALIST SALARY						
1.00	PHYSICIANS' PRIVATE OFFICES	192. 00	3, 671, 209	(	0		1.00
2.00	ANESTHESI OLOGY	53.00	202, 617	(	0		2.00
3.00	EMERGENCY	91.00	2, 678, 941	(	0		3.00
	TOTALS		6, 552, 767				
	E - RECLASS MEDICAL SUPPLIES	•					
1.00	OPERATI NG ROOM	50.00	0	293, 911	1 0		1.00
2. 00	RADI OLOGY-DI AGNOSTI C	54.00	o	260			2.00
3.00	SPEECH PATHOLOGY	68. 00	o	182, 759		•	3.00
	TOTALS			476, 930			
	F - RECLASS DRUGS		-				
1.00	PHARMACY	15. 00	0	2, 075, 398	3 0		1.00
2.00	ADULTS & PEDIATRICS	30.00	O	13, 816	5		2.00
3.00	INTENSIVE CARE UNIT	31.00	O	1, 832	2 0		3.00
4.00	OPERATI NG ROOM	50.00	ol	9, 140	0		4.00
5.00	ANESTHESI OLOGY	53.00	ol	5, 164			5.00
6.00	RADI OLOGY-DI AGNOSTI C	54.00	o	16, 563			6.00
7. 00	CT SCAN	57.00	o	670			7.00
8. 00	MRI	58. 00	o	116			8.00
9. 00	LABORATORY	60, 00	o	166			9.00
10.00	RESPIRATORY THERAPY	65.00	o	192	0		10.00
11. 00	PHYSI CAL THERAPY	66.00	ol	263			11.00
12. 00	EMERGENCY	91. 00	o	9. 775		1	12.00
	TOTALS	— — <del>///</del> —		2, 133, 095	<del> </del>		12.00
	G - LABOR AND DELIVERY				<u>-11</u>		
1.00	ADULTS & PEDIATRICS	30, 00	311, 858	83, 193	3 0		1, 00
	TOTALS		311, 858	83, 193			
	I - PHYSICIAN PRACTICE MANAGE	MENT	311, 230	33, 170	-1		
1. 00	PHYSI CLANS' PRI VATE OFFI CES	192. 00	456, 968	230, 431	1 0		1.00
2. 00		0.00	430, 700	230, 431			2.00
00	TOTALS — — — — —	— — <del>"</del> "	456, 968	230, 431		†	2.00
500 00	Grand Total: Decreases		8, 063, 123	3, 664, 373		1	500.00
300. 00			3, 000, 120	0,001,070	1	I	1 330. 00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147

				10	12/31/2023	5/31/2024 10:	
				Acqui si ti ons		, .,,	
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1. 00	Land	1, 005, 119	12, 097	0	12, 097	0	1
2.00	Land Improvements	666, 914	21, 416	0	21, 416	0	2.00
3.00	Buildings and Fixtures	23, 904, 319	590, 371	0	590, 371	0	3.00
4.00	Building Improvements	9, 558, 256	0	0	0	0	4.00
5. 00	Fixed Equipment	2, 355, 173	0	0	0	0	5.00
6.00	Movable Equipment	27, 093, 905	1, 238, 207	0	1, 238, 207	0	
7. 00	HIT designated Assets	0	0	0	0	0	7. 00
8. 00	Subtotal (sum of lines 1-7)	64, 583, 686	1, 862, 091	0	1, 862, 091	0	8.00
9.00	Reconciling Items	0	0	0	0	0	,
10.00	Total (line 8 minus line 9)	64, 583, 686	1, 862, 091	0	1, 862, 091	0	10.00
		Endi ng	Ful I y				
		Bal ance	Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE		_				
1.00	Land	1, 017, 216	0				1.00
2. 00	Land Improvements	688, 330	0				2.00
3. 00	Buildings and Fixtures	24, 494, 690	0				3. 00
4. 00	Building Improvements	9, 558, 256	0				4. 00
5. 00	Fixed Equipment	2, 355, 173	0				5. 00
6.00	Movable Equipment	28, 332, 112	0				6. 00
7. 00	HIT designated Assets	0	0				7. 00
8. 00	Subtotal (sum of lines 1-7)	66, 445, 777	0				8. 00
9. 00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	66, 445, 777	0				10.00

Heal th	n Financial Systems	RICHLAND MEMOR	IAL HOSPITAL		In Lieu of Form CMS-2552		
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C	CN: 14-0147	Peri od: From 01/01/2023 To 12/31/2023	Date/Time Pre	pared:
			CI	JMMARY OF CAP	I TAI	5/31/2024 10:	42 am
			30	JIVIIVIARY OF CAP	ITAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
					(see	instructions)	
					instructions)		
		9. 00	10. 00	11. 00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLU	MN 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FIXT	833, 040	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	833, 040	0		0 0	0	3.00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	0ther	Total (1)				
		Capi tal -Rel at	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLU	MN 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	833, 040				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3. 00	Total (sum of lines 1-2)	0	833, 040				3. 00

Health Financial Systems		RICHLAND MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10		
RECONCILIATION OF CAPITAL COSTS CENTERS			Provi der C	CN: 14-0147	Peri od:	Worksheet A-7	
					From 01/01/2023 To 12/31/2023		nared·
						5/31/2024 10:	
		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 -			
				col . 2)			
	DART III DECONCILIATION OF CARLTAL COCTO	1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS C	38, 113, 665		38, 113, 66	5 0. 573606	0	1.00
2. 00	CAP REL COSTS-BLDG & FIXT	28, 332, 112	l .	28, 332, 11		Ŭ	2.00
3.00	Total (sum of lines 1-2)	66, 445, 777		66, 445, 77		- 1	3.00
3.00	S. 60   Total (Sam of Tries 1 2)		ALLOCATION OF OTHER CAPITAL		SUMMARY OF CAPITAL		3.00
	,						
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Rel at				
			ed Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						0	1 00
1. 00 2. 00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	0	0	2	0 833, 040	0	1. 00 2. 00
3. 00	Total (sum of lines 1-2)	0	0		0 833, 040	-	3.00
3.00	Total (suil of fiftes 1-2)	SUMMARY OF CAPITAL					3.00
	Somman, or our like						
	Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)	
			(see	instructions)			
			instructions)		ed Costs (see	9 through 14)	
		11 00	10.00	10.00	instructions)	45.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	11. 00	12. 00	13.00	14. 00	15. 00	
1. 00	CAP REL COSTS-BLDG & FIXT	187, 174	20, 966		0 0	1, 041, 180	1.00
2.00	CAP REL COSTS-BEDG & TTAT	107, 174	20, 900	1		1,041,180	2.00
3.00	Total (sum of lines 1-2)	187, 174	ı	1	o o	_	
		1	,	I .	-1	, ,	

					From 01/01/2023 To 12/31/2023		pared:
				Expense Classification or	n Worksheet A	5/31/2024 10:	42 am
			Т	o/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	·	(2) 1. 00	2. 00	3.00	4.00	Ref. 5. 00	
1. 00	Investment income - CAP REL	1.00		CAP REL COSTS-BLDG & FIXT	4.00	5.00	1.00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		000	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2.00
	COSTS-MVBLE EQUIP (chapter 2)			WILL GOOTS WINDER EGOTT			
3. 00	Investment income - other (chapter 2)		0		0.00	0	3.00
4. 00	Trade, quantity, and time		0		0. 00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		О		0.00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6. 00
	suppliers (chapter 8)					_	
7. 00	Tel ephone services (pay stations excluded) (chapter		0		0. 00	0	7.00
0.00	21)		0		0.00		0.00
8. 00	Television and radio service (chapter 21)		٥		0.00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	-3, 738, 689		0. 00	0	
	adj ustment	N 0 2					
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12. 00	Related organization	A-8-1	1, 869, 300			0	12.00
13. 00	transactions (chapter 10) Laundry and linen service	В	-14, 033 L	AUNDRY & LINEN SERVICE	8. 00	0	13.00
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee	В	-242, 483	CAFETERI A	11. 00 0. 00	0	14. 00 15. 00
	and others		ď				
16. 00	Sale of medical and surgical supplies to other than		0		0. 00	0	16. 00
17.00	patients				0.00		17.00
	Sale of drugs to other than patients		0		0.00	0	17.00
18. 00	Sale of medical records and abstracts		0		0.00	0	18.00
19. 00	Nursing and allied health		0		0. 00	0	19.00
	education (tuition, fees, books, etc.)						
	Vendi ng machi nes		0		0.00	0	
21.00	Income from imposition of interest, finance or penalty		O		0.00	0	21.00
22 00	charges (chapter 21) Interest expense on Medicare		0		0. 00	0	22. 00
22.00	overpayments and borrowings to		Ŭ.		0.00		22.00
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	OF	RESPI RATORY THERAPY	65. 00		23. 00
	therapy costs in excess of						
24. 00	limitation (chapter 14) Adjustment for physical	A-8-3	OF	PHYSICAL THERAPY	66. 00		24.00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review -		0 *	*** Cost Center Deleted ***	114. 00		25. 00
	physicians' compensation (chapter 21)						
26. 00	Depreciation - CAP REL		olo	CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
27. 00			olo	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		Olv	IONPHYSICIAN ANESTHETISTS	19.00		28. 00
29. 00	Physicians' assistant		0		0.00	0	29. 00
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	0 *	*** Cost Center Deleted ***	67. 00		30.00
30 00	limitation (chapter 14)			DILLTS & DEDLATRICS	30.00		20.00
30. 99	Hospice (non-distinct) (see instructions)		O	DULTS & PEDIATRICS	30. 00		30. 99

	Financial Systems		RICHLAND MEMOR			u of Form CMS-2	
ADJUST	MENTS TO EXPENSES				eriod: rom 01/01/2023	Worksheet A-8	
					o 12/31/2023		pared.
						5/31/2024 10:	42 am
				Expense Classification on			
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	, , , , , , , , , , , , , , , , , , ,	(2)				Ref.	
		1. 00	2. 00	3.00	4. 00	5. 00	
31.00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00
	pathology costs in excess of						
	limitation (chapter 14)						
32. 00	CAH HIT Adjustment for		0		0. 00	0	32.00
00.00	Depreciation and Interest				0.00		00.00
33. 00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
34. 00	MISC REVENUE	В	_733	PHYSI CAL THERAPY	66. 00	0	34.00
35. 00	MI SC REVENUE	В		ADMINISTRATIVE & GENERAL	5. 00	l .	35.00
36. 00	MI SC REVENUE	В	1	SPEECH PATHOLOGY	68. 00	l	
37. 00	DONATIONS	A		ADMINISTRATIVE & GENERAL	5. 00	0	37.00
38.00	PHYSICIAN RECRUITMENT	A		ADMINISTRATIVE & GENERAL	5. 00	0	38. 00
39.00	CRNA SALARIES	Α	-1, 276, 646	ANESTHESI OLOGY	53.00	0	39.00
41.00	CRNA BENEFITS	A	-37, 951	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	41.00
42.00	LOBBYING DUES	Α	-1	ADMINISTRATIVE & GENERAL	5. 00	0	42.00
43.00	ADVERTI SI NG	A		ADMINISTRATIVE & GENERAL	5. 00	0	10.00
44.00	ADVERTI SI NG	A	•	RADI OLOGY-DI AGNOSTI C	54. 00	0	1
45. 00	ASBESTOS	A		ADMINISTRATIVE & GENERAL	5. 00		1 .0.00
47.00	PROVI DER TAX ASSESSMENT	Α		ADMINISTRATIVE & GENERAL	5. 00	l e	1
49. 02	PROVI DER TAX ASSESSMENT	A		ASSISTED LIVING	194. 02		1
49. 03	MISC REVENUE	В		EMERGENCY	91. 00		1
49. 04	HOSPITALIST SALARIES	A		PHYSICIANS' PRIVATE OFFICES	192.00		49.04
49. 05	HOSPITALIST BENEFITS	A	•	PHYSICIANS' PRIVATE OFFICES	192. 00	0	49.05
50.00	TOTAL (sum of lines 1 thru 49)		-11, 079, 988	1			50.00

column 6, line 200.) (1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(Transfer to Worksheet A,

<sup>(2)</sup> 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.

OTTICE				To 12/31/2023	Date/Time Pre 5/31/2024 10:		
	Li ne No.	Cost Center	Expense Items	Amount of	Amount		
				Allowable Cost	Included in		
					Wks. A, column		
					5		
	1. 00	2. 00	3. 00	4. 00	5. 00		
	A. COSTS INCURRED AND ADJUSTI	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED	ORGANI ZATI ONS OF	R CLAIMED HOME		
	OFFICE COSTS:						
1. 00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HO ALLOCATION	1, 100, 766	0	1. 00	
2.00	5. 00	ADMINISTRATIVE & GENERAL	HO ALLOCATION	9, 373, 820	12, 658, 453	2.00	
3.00	7. 00	OPERATION OF PLANT	HO ALLOCATION	1, 335, 473	0	3.00	
3. 01	14.00	CENTRAL SERVICES & SUPPLY	HO ALLOCATION	503, 701	0	3. 01	
3.02	16.00	MEDICAL RECORDS & LIBRARY	HO ALLOCATION	847, 170	0	3.02	
4.00	88.00	RURAL HEALTH CLINIC	HO ALLOCATION	36, 384	0	4.00	
4. 01	88. 01	RURAL HEALTH CLINIC II	HO ALLOCATION	196, 353	0	4.01	
4.03	13.00	NURSING ADMINISTRATION	HO ALLOCATION	1, 119, 799	0	4.03	
4.04	15. 00	PHARMACY	HO ALLOCATION	14, 287	0	4.04	
5.00	TOTALS (sum of lines 1-4).			14, 527, 753	12, 658, 453	5.00	
	Transfer column 6, line 5 to						
	Worksheet A-8, column 2,						
	line 12.						

\* The amounts on lines 1-4 (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 has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

			Related Organization(s) and/	or Home Office				
Symbol (1)	Name	Percentage of	Name	Percentage of				
•		Ownershi p		Ownershi p				
1. 00	2. 00	3. 00	4. 00	5. 00				
B. INTERRELATIONSHIP TO 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 request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6. 00	В	THE CARLE FOUND	100.00 SYSTEM	100.00	6.00
7.00			0. 00	0.00	7.00
8.00			0. 00	0.00	8. 00
9.00			0. 00	0.00	9. 00
10.00			0. 00	0.00	10.00
100.00	G. Other (financial or				100.00
	non-financial) specify:				

- (1) Use the following symbols to indicate 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.

Heal th	Financial Syst	ems		RICHLAND MEMORIA	L HOSPITAL		In Lieu	of Form CMS-	2552-10
STATEME OFFI CE		SERVICES FROM	RELATED ORGANI	ZATIONS AND HOME	Provi der (	CCN: 14-0147	Peri od: From 01/01/2023 To 12/31/2023	Worksheet A-B Date/Time Pro 5/31/2024 10	epared:
	Adjustments (col. 4 minus col. 5)*							0,0,,202. 10	, L G
	6. 00	7. 00	MENTS DECILIDED	AS A RESULT OF TR	ANICACTIONIC	WITH DELATED	ODCANI ZATLONG OD	CLAIMED HOME	
	OFFICE COSTS:	KED AND ADJUSTI	WENTS REQUIRED	AS A RESULT OF IR	ANSACTIONS	WITH RELATED	URGANI ZATI UNS UR	CLATWED HOWE	
1.00	1, 100, 766	0							1.00
2.00	-3, 284, 633	0							2.00
3.00	1, 335, 473	0							3.00
3. 01	503, 701	0							3. 01
3. 02	847, 170	0							3. 02
4.00	36, 384	0							4.00
4.01	196, 353	0							4. 01
4.03	1, 119, 799	0							4. 03
4.04	14, 287	0							4. 04

\* The amounts on lines 1-4 (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 has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

5.00

Hus	not been posted to worksheet A,	cordining 1 and/or 2, the amount arrowable should be rhareated in cordinin 4 or this part	•
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6. 00		
	B. INTERRELATIONSHIP TO RELA	TED 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 request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

	HOME OFFICE	6.00
7.00		7.00
7. 00 8. 00		8.00
9.00		9.00
10.00		10.00
9. 00 10. 00 100. 00		100.00

- (1) Use the following symbols to indicate 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.

1, 869, 300

| Peri od: | Worksheet A-8-2 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Provider CCN: 14-0147

					1	To 12/31/2023	3   Date/Time Pro   5/31/2024 10:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
				·	·		Hours	
	1.00	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
1.00		ADMINISTRATIVE & GENERAL	5, 270	5, 270	0	0	0	1.00
2.00	53. 00	ANESTHESI OLOGY	202, 607	202, 607	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	109, 448	109, 448	0	0	0	3.00
4.00	91. 00	EMERGENCY	3, 418, 759	3, 418, 759	0	0	0	4.00
5.00	69. 00	ELECTROCARDI OLOGY	2, 605	2, 605	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6. 00
7.00	0.00		0	0	0	0	0	7. 00
8. 00	0.00		0	0	0	0	0	8. 00
9. 00	0.00		0	0	0	0	0	9. 00
10.00	0.00		0	0	0	0	0	10.00
200.00			3, 738, 689	3, 738, 689	0		0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of		Physician Cost	
		ldentifier	Limit	Unadjusted RCE	Memberships &	Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Education	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13. 00	14. 00	
1. 00		ADMINISTRATIVE & GENERAL	0	· -	_	_		
2.00		ANESTHESI OLOGY	0	· -	0	0	_	
3. 00		ADULTS & PEDIATRICS	0	0	0	0	0	3. 00
4. 00		EMERGENCY	0	0	0	0	0	4.00
5. 00		ELECTROCARDI OLOGY	0	0	0	0	0	5. 00
6. 00	0.00		0	0	0	0	0	6. 00
7. 00	0.00		0	0	0	0	0	
8.00	0.00		0	0	0	0	0	
9.00	0.00		0	0	0	0	0	
10.00	0. 00		0	0	0	0	0	
200.00	W	01.01(Dl11	0	0	RCE	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component	Adjusted RCE Limit	Di sal Lowance	Adjustment		
		rdentiffer	Share of col.	LIIIII (	Di Sai i Owance			
			14					
	1.00	2. 00	15. 00	16. 00	17. 00	18. 00		
1. 00		ADMINISTRATIVE & GENERAL	0					1.00
2. 00		ANESTHESI OLOGY	l o	l o	0	202, 607		2.00
3. 00		ADULTS & PEDIATRICS	l	Ö	0	109, 448		3.00
4.00	91. 00	EMERGENCY	0	0	0	3, 418, 759		4.00
5. 00		ELECTROCARDI OLOGY	0	0	0	2, 605		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7. 00
8.00	0.00		0	0	0	0		8. 00
9. 00	0.00		0	0	0	0		9. 00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	3, 738, 689		200.00

| Peri od: | Worksheet B | From 01/01/2023 | Part | | To | 12/31/2023 | Date/Time Prepared: Provider CCN: 14-0147

			j	o 12/31/2023	Date/Time Pre 5/31/2024 10:	
		CAPI TAL REI	LATED COSTS		5/31/2024 10:	42 alli
Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
	for Cost			BENEFITS DEPARTMENT		
	Allocation (from Wkst A			DEPARTMENT		
	col. 7)	1.00	0.00	4.00	4.0	
GENERAL SERVICE COST CENTERS	0	1. 00	2. 00	4. 00	4A	
1.00 O0100 CAP REL COSTS-BLDG & FLXT	1, 041, 180	1, 041, 180	i			1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0 1, 225, 827	4, 367				2.00 4.00
5. 00   00500   ADMI NI STRATI VE & GENERAL	11, 778, 178	148, 448	1		11, 975, 508	5.00
6. 00 00600 MAI NTENANCE & REPAI RS	1, 591, 587	22, 428	1	,	1, 646, 548	6.00
7. 00   00700   OPERATI ON OF PLANT 8. 00   00800   LAUNDRY & LI NEN SERVI CE	2, 014, 035 454, 634	279 27, 738	1	0 11, 200	2, 014, 314 493, 572	7. 00 8. 00
9. 00   00900   HOUSEKEEPI NG	1, 066, 915	25, 267		30, 538	1, 122, 720	9. 00
10. 00   01000   DI ETARY 11. 00   01100   CAFETERI A	613, 464 1, 031, 631	67, 581 0	(		696, 302 1, 063, 319	10. 00 11. 00
12.00 01200 MAINTENANCE OF PERSONNEL	0	0		0	0	12.00
13.00 O1300 NURSING ADMINISTRATION 14.00 O1400 CENTRAL SERVICES & SUPPLY	3, 129, 578 809, 999	2, 838 34, 385	1	7 00,0.2	3, 198, 758 848, 756	13. 00 14. 00
15. 00   01500   PHARMACY	1, 237, 648	17, 756	1		1, 295, 278	15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	848, 130	10, 184	(	0	858, 314	
17. 00   01700   SOCIAL SERVICE 19. 00   01900   NONPHYSICIAN ANESTHETISTS	0	0			0	17. 00 19. 00
20. 00 02000 NURSI NG PROGRAM	0	0		o	0	20.00
21.00   02100   I&R SERVICES-SALARY & FRINGES APPRV 22.00   02200   I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		1	0	21. 00 22. 00
23. 00 02300 PARAMED ED PRGM-(SPECIFY)	0	0	1	1	0	23. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS  30. 00 03000 ADULTS & PEDI ATRI CS	3, 762, 895	145, 800	(	119, 320	4, 028, 015	30.00
31. 00   03100   NTENSIVE CARE UNIT	570, 314	28, 533	1		614, 300	31.00
40. 00   04000   SUBPROVI DER -   PF	0	0	1	1	0	40.00
43. 00   04300   NURSERY 44. 00   04400   SKILLED   NURSING   FACILITY	428, 899 0	9, 039 0	1	13, 352	451, 290 0	43. 00 44. 00
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM 52.00   05200   DELIVERY ROOM & LABOR ROOM	2, 597, 715 395, 051	50, 140 0	i		2, 677, 526 408, 378	50. 00 52. 00
53. 00   05300   ANESTHESI OLOGY	419, 290	Ö		56, 947	476, 237	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C 56. 00   05600   RADI OI SOTOPE	1, 200, 602 465, 412	22, 673 6, 349	1	39, 953 7, 247	1, 263, 228 479, 008	54. 00 56. 00
57. 00   05700   CT   SCAN	600, 834	5, 371			624, 841	57.00
58. 00   05800   MRI	279, 554	5, 642		1 -7	290, 318	58.00
60. 00   06000   LABORATORY 62. 30   06250   BLOOD   CLOTTING FOR HEMOPHILIACS	3, 380, 841 0	31, 712 0	1	58, 766 0	3, 471, 319 0	60. 00 62. 30
64.00 06400 INTRAVENOUS THERAPY	0	0		0	0	64.00
65. 00   06500   RESPI RATORY   THERAPY 66. 00   06600   PHYSI CAL   THERAPY	1, 187, 952 2, 399, 749	9, 118 8, 996		34, 398 80, 738	1, 231, 468 2, 489, 483	65. 00 66. 00
68.00 06800 SPEECH PATHOLOGY	283, 095	4, 183	1	9, 255	296, 533	
69. 00   06900   ELECTROCARDI OLOGY 71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENT	41, 098 394, 921	0	(	118	41, 216 394, 921	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	82, 009	0			82, 009	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	796, 879	0		0	796, 879	73.00
73. 01   07301   NJECTABLE DRUGS 76. 97   07697   CARDI AC REHABI LI TATI ON	1, 336, 216 0	0			1, 336, 216 0	73. 01 76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	(	0	0	76. 98
76. 99 O7699 LI THOTRI PSY OUTPATI ENT SERVI CE COST CENTERS	0	0	(	)  0	0	76. 99
88. 00 08800 RURAL HEALTH CLINIC	1, 425, 294		1		1, 503, 060	88. 00
88. 01   08801   RURAL HEALTH CLINIC II 88. 02   08802   RURAL HEALTH CLINIC III	6, 653, 169	93, 363	(	204, 223	6, 950, 755 0	88. 01 88. 02
90. 00   09000   CLINIC	389, 519	8, 507		9, 733	407, 759	90.00
91. 00 09100 EMERGENCY	1, 862, 977	29, 511		64, 195	1, 956, 683	91.00
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART 93. 99   09399   PARTIAL HOSPITALIZATION PROGRAM	0	О		o	0	92. 00 93. 99
OTHER REIMBURSABLE COST CENTERS						
95. 00   09500   AMBULANCE SERVI CES 99. 10   09910   CORF	0	0	1	0	0	95. 00 99. 10
99. 20 09920 OUTPATIENT PHYSICAL THERAPY	o o	Ö		o o	0	99. 20
99. 30   O9930   OUTPATI ENT OCCUPATI ONAL THERAPY 99. 40   O9940   OUTPATI ENT SPEECH PATHOLOGY	0	0	(		0	99. 30 99. 40
101.00 10100 HOME HEALTH AGENCY	0	0		´l		101.00
SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE			(			116 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	57, 797, 091	852, 287		1, 106, 827		116. 00 118. 00
, ,			•		•	

Health Finar	ncial Systems	RI CHLAND MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	TION - GENERAL SERVICE COSTS		Provi der CO		Period: From 01/01/2023 To 12/31/2023		pared:
						5/31/2024 10:	
			CAPI TAL REL	LATED COSTS			
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		0	1.00	2.00	4. 00	4A	
NONRE	IMBURSABLE COST CENTERS						
192. 00 19200	PHYSICIANS' PRIVATE OFFICES	1, 768, 575	129, 661		0 60, 516	1, 958, 752	192.00
194.00 07950	OTHER NONREIMBURSABLE	0	0		0 0	0	194. 00
194. 01 07952	MEMORY DI SORDER	0	0		0 0	0	194. 01
194. 02 07953	ASSISTED LIVING	1, 619, 036	59, 232		0 55, 769	1, 734, 037	194. 02
194. 03 07951	CONTRACTED RETAIL RX	2, 515, 612	0		0 7, 082	2, 522, 694	194. 03
200. 00	Cross Foot Adjustments					0	200. 00
201.00	Negative Cost Centers		0		0 0	0	201.00
202. 00	TOTAL (sum lines 118 through 201)	63, 700, 314	1, 041, 180		0 1, 230, 194	63, 700, 314	202. 00

Provider CCN: 14-0147

Peri od: Worksheet B From 01/01/2023 Part I To 12/31/2023 Date/Ti me Prepared: 5/31/2024 10:42 am

						5/31/2024 10:	
	Cost Center Description	ADMINISTRATIV E & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
		5. 00	6. 00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00
4. 00 5. 00	00500 ADMINISTRATIVE & GENERAL	11, 975, 508					4. 00 5. 00
6. 00	00600 MAINTENANCE & REPAIRS	381, 214	2, 027, 762				6.00
7. 00	00700 OPERATION OF PLANT	466, 360	654	1			7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	114, 273	64, 954		752, 308		8.00
9. 00	00900 HOUSEKEEPI NG	259, 936	59, 167		58, 112	1, 572, 359	1
10.00	01000 DI ETARY	161, 210			13, 619	0	1
11. 00	01100 CAFETERI A	246, 183	0	0	0	0	11. 00
12. 00	01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
	01300 NURSI NG ADMI NI STRATI ON	740, 586	6, 647		0	298, 204	1
14.00	01400 CENTRAL SERVICES & SUPPLY	196, 507	80, 518		12, 713	185, 249	1
15. 00 16. 00	01500   PHARMACY   01600   MEDI CAL RECORDS & LI BRARY	299, 887 198, 719	41, 578 23, 847		0	81, 329 0	15. 00 16. 00
	01700 SOCIAL SERVICE	170, 717	23,647	27, 170	0	0	17.00
	01900 NONPHYSI CI AN ANESTHETI STS	0	0	Ö	0	Ö	
	02000 NURSI NG PROGRAM	0	Ö	ō	0	Ō	20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	О	0	0	21.00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	932, 578			327, 774	216, 877	30.00
31.00	03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	142, 225	66, 816 0	81, 787 0	0	31, 628	1
40. 00 43. 00	04300 NURSERY	104, 484	21, 167	25, 911	13, 166	0	
44. 00	04400 SKILLED NURSING FACILITY	0	21, 107	· ·	13, 100	0	1
44.00	ANCI LLARY SERVI CE COST CENTERS				<u> </u>		1 44.00
50.00	05000 OPERATING ROOM	619, 909	117, 413	143, 722	30, 870	180, 731	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	94, 549	0	0	19, 067	31, 628	52.00
53.00	05300 ANESTHESI OLOGY	110, 260	0	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	292, 466	53, 093		15, 938	11, 296	1
56. 00	05600 RADI OI SOTOPE	110, 901	14, 868		1, 816		1
57. 00	05700 CT SCAN	144, 665	12, 578		0	11, 296	1
58.00	05800 MRI	67, 215	13, 212		2 725	11, 296	1
60. 00 62. 30	06000   LABORATORY   06250   BLOOD   CLOTTING FOR HEMOPHILIACS	803, 690 0	74, 260 0	1	2, 725 0	31, 628 0	1
64. 00	06400 I NTRAVENOUS THERAPY	0	0		0	0	64.00
65. 00	06500 RESPIRATORY THERAPY	285, 113	21, 352	26, 136	14, 073	11, 296	1
66. 00	06600 PHYSI CAL THERAPY	576, 373	21, 065		0	27, 110	1
68.00	06800 SPEECH PATHOLOGY	68, 654	9, 796	11, 991	0	27, 110	68.00
69. 00	06900 ELECTROCARDI OLOGY	9, 542	0	0	0	11, 296	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	91, 433	0	0	0	0	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	18, 987	0	0	0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	184, 496	0	0	0	0	
	07301   I NJECTABLE DRUGS   07697   CARDI AC REHABI LI TATI ON	309, 365 0	0	1	0	0	
76. 97 76. 98	07698 HYPERBARIC OXYGEN THERAPY	0		1	0	0	
76. 99	07699 LI THOTRI PSY	0	0		0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS				<u> </u>		1
88. 00	08800 RURAL HEALTH CLINIC	347, 993	75, 119	91, 951	0	90, 365	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	1, 609, 285			909		
88. 02	08802 RURAL HEALTH CLINIC III	0	0	_	0	0	
90.00	09000 CLI NI C	94, 406	19, 920		18, 160		
	09100 EMERGENCY	453, 017	69, 106	84, 591	56, 296	94, 884	
92. 00 93. 99	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0		92.00
93. 99	09399 PARTIAL HOSPITALIZATION PROGRAM OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	93. 99
95 00	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
99. 10	09910 CORF	0	0	_	0	, o	
	09920 OUTPATIENT PHYSICAL THERAPY	0	Ö	ō	0	Ō	1
	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	О	0	0	99. 30
99. 40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99. 40
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS	I					
	11600 HOSPI CE	0	0		0		116.00
118.00	3 /	10, 536, 481	1, 585, 434	1, 939, 885	585, 238	1, 454, 884	1118.00
102.00	NONREI MBURSABLE COST CENTERS	452 407	202 (25	271 4/0	2	22 501	102.00
	19200 PHYSICIANS' PRIVATE OFFICES  07950 OTHER NONREIMBURSABLE	453, 496 0	303, 625 0		0		192. 00 194. 00
	07952 MEMORY DISORDER	0	0		0		194.00
	07953 ASSISTED LIVING	401, 469	138, 703	169, 783	167, 070		194. 01
	07951 CONTRACTED RETAIL RX	584, 062			0		194. 03
	1					•	

Health Fina	ancial Systems	RICHLAND MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST ALLOC	ATION - GENERAL SERVICE COSTS		Provi der		Peri od:	Worksheet B	
					From 01/01/2023 To 12/31/2023		pared:
						5/31/2024 10:	
	Cost Center Description	ADMI NI STRATI V	MAINTENANCE 8	& OPERATION OF		HOUSEKEEPI NG	
		E & GENERAL	REPAI RS	PLANT	LINEN SERVICE		
		5. 00	6. 00	7.00	8. 00	9. 00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0		0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	11, 975, 508	2, 027, 76	2, 481, 32	752, 308	1, 572, 359	202. 00

Provider CCN: 14-0147

Peri od: Worksheet B From 01/01/2023 Part I To 12/31/2023 Date/Ti me Prepared: 5/31/2024 10:42 am

					0 12/31/2023	5/31/2024 10:	
	Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF PERSONNEL	NURSI NG ADMI NI STRATI O	CENTRAL SERVICES &	
		10.00	11. 00	12.00	N 13. 00	SUPPLY 14. 00	
	GENERAL SERVICE COST CENTERS						
13. 00 14. 00 15. 00 16. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	1, 223, 102 0 0 0 0 0	1, 309, 502 0 72, 846 13, 134 40, 130 0	0 0	4, 325, 177 0 0 0	1, 435, 437 0 0	
19. 00 20. 00 21. 00 22. 00	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING PROGRAM 02100 I&R SERVICES-SALARY & FRINGES APPRV 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS	0 0 0 0 0	0 0 0 0 0	000000000000000000000000000000000000000	0 0 0 0	0 0 0 0 0	19. 00 20. 00 21. 00
40. 00 43. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04300 NURSERY 04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	394, 862 63, 015 0 0	208, 316 22, 134 0 19, 801 0		259, 924 0 242, 220	54, 201 7, 324 0 0 0	40. 00 43. 00
52. 00 53. 00 54. 00 56. 00 57. 00 58. 00 60. 00 62. 30 64. 00 66. 00 68. 00 69. 00 71. 00 73. 00 73. 01 76. 97 76. 98 76. 99 88. 00 88. 01 88. 01 88. 02	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05600 RADI OLOGY-DI AGNOSTI C 05600 RADI OL SOTOPE 05700 CT SCAN 05800 MRI 06000 LABORATORY 06250 BLOOD CLOTTING FOR HEMOPHILIACS 06400 INTRAVENOUS THERAPY 06500 RESPIRATORY THERAPY 06600 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07301 INJECTABLE DRUGS 07697 CARDI AC REHABILITATION 07698 HYPERBARI C OXYGEN THERAPY 07699 LI THOTRI PSY 0UTPATIENT SERVI CE COST CENTERS 08800 RURAL HEALTH CLINI C 08801 RURAL HEALTH CLINI C 110	0 12, 029 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	46, 745 0 28, 182 51, 597 7, 708 26, 323 7, 190 91, 422 0 0 45, 231 122, 545 12, 448 60 0 0 0 0 0 0 0 0	000000000000000000000000000000000000000	0 0 47, 063 5, 701 0 0 0 0 43, 326 0 728 0 0 0 0 0	36, 539 0 4, 709 68 0 2, 678 464 664 0 0 2, 179 0 0 951, 174 327, 848 0 0 0	52. 00 53. 00 54. 00 56. 00 57. 00 58. 00 60. 00 62. 30 64. 00 65. 00 66. 00 68. 00 69. 00 71. 00 72. 00 73. 00 73. 01 76. 98 76. 99 88. 00 88. 01 88. 02
91. 00 92. 00	09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART 09399 PARTIAL HOSPITALIZATION PROGRAM OTHER REIMBURSABLE COST CENTERS	0 0	12, 096 105, 463 0	0	82, 218 615, 810 0	0 39, 078 0	92.00
99. 10 99. 20 99. 30 99. 40	09500 AMBULANCE SERVICES 09910 CORF 09920 OUTPATIENT PHYSICAL THERAPY 09930 OUTPATIENT OCCUPATIONAL THERAPY 09940 OUTPATIENT SPEECH PATHOLOGY 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0 0 0 0 0	0 0 0 0 0	0 0 0 0 0	0 0 0	0 0 0 0 0	99. 10 99. 20 99. 30
116. 00 118. 00	11600 HOSPI CE	0 469, 906	0 1, 206, 812			0 1, 427, 290	116. 00 118. 00
194. 00 194. 01	19200 PHYSICIANS' PRIVATE OFFICES 07950 OTHER NONREIMBURSABLE 07952 MEMORY DISORDER 07953 ASSISTED LIVING	0 0 0 753, 196	0 0 0 102, 690	0	0	0	192. 00 194. 00 194. 01 194. 02

Health Financial Systems	RI CHLAND MEMOR	IAL HOSPITAL		In Lieu	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der Co	CCN: 14-0147	Peri od: From 01/01/2023 To 12/31/2023	Worksheet B Part I Date/Time Pre 5/31/2024 10:	

						5/31/2024 10:	<u>42 am</u>
	Cost Center Description	DI ETARY	CAFETERI A	MAI NTENANCE	NURSI NG	CENTRAL	
				OF PERSONNEL	ADMI NI STRATI O	SERVICES &	
					N	SUPPLY	
		10.00	11. 00	12.00	13.00	14. 00	
194. 03 079	51 CONTRACTED RETAIL RX	0	0	C	0	0	194. 03
200.00	Cross Foot Adjustments						200. 00
201.00	Negati ve Cost Centers	0	0	C	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	1, 223, 102	1, 309, 502		4, 325, 177	1, 435, 437	202.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-0147

				Т	o 12/31/2023	Date/Time Pre 5/31/2024 10:	
	Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	NONPHYSI CI AN ANESTHETI STS	NURSI NG PROGRAM	42 dili
		15. 00	16. 00	17. 00	19. 00	20.00	
14. 00 15. 00 16. 00 17. 00 19. 00 20. 00 21. 00 22. 00	GENERAL SERVICE COST CENTERS  00100 CAP REL COSTS-BLDG & FIXT  00200 CAP REL COSTS-BLDG & FIXT  00400 EMPLOYEE BENEFITS DEPARTMENT  00500 ADMINISTRATIVE & GENERAL  00600 MAINTENANCE & REPAIRS  00700 OPERATION OF PLANT  00800 LAUNDRY & LINEN SERVICE  00900 HOUSEKEEPING  01000 DIETARY  01100 CAFETERIA  01200 MAINTENANCE OF PERSONNEL  01300 NURSING ADMINISTRATION  01400 CENTRAL SERVICES & SUPPLY  01500 PHARMACY  01600 MEDICAL RECORDS & LIBRARY  01700 SOCIAL SERVICE  01900 NONPHYSICIAN ANESTHETISTS  02000 NURSING PROGRAM  02100 I &R SERVICES-SALARY & FRINGES APPRV  02200 I &R SERVICES-OTHER PRGM COSTS APPRV  02300 PARAMED ED PRGM-(SPECIFY)  INPATIENT ROUTINE SERVICE COST CENTERS	1, 809, 097 0 0 0 0 0 0	1, 110, 070 0 0 0 0 0	000000000000000000000000000000000000000	0	0	1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 19. 00 20. 00 21. 00 22. 00 23. 00
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04300 NURSERY 04400 SKILLED NURSING FACILITY	0 0 0 0 0	231, 992 17, 462 0 17, 462 0	0 0 0 0	0 0 0	0 0 0 0	31. 00 40. 00 43. 00
52. 00 53. 00 54. 00 56. 00 57. 00 58. 00 62. 30 64. 00 65. 00 68. 00 69. 00 71. 00 72. 00 73. 01 76. 97 76. 98 76. 99	ANCILLARY SERVICE COST CENTERS  05000 OPERATING ROOM  05200 DELIVERY ROOM & LABOR ROOM  05300 ANESTHESI OLOGY  05400 RADI OLOGY-DI AGNOSTI C  05600 RADI OI SOTOPE  05700 CT SCAN  05800 MRI  06000 LABORATORY  06250 BLOOD CLOTTING FOR HEMOPHILIACS  06400 I NTRAVENOUS THERAPY  06500 RESPIRATORY THERAPY  06500 PHYSI CAL THERAPY  06600 PHYSI CAL THERAPY  06800 SPEECH PATHOLOGY  06900 ELECTROCARDI OLOGY  07100 MEDI CAL SUPPLIES CHARGED TO PATIENT  07200 I MPL. DEV. CHARGED TO PATIENTS  07300 DRUGS CHARGED TO PATIENTS  07301 I NJECTABLE DRUGS  07697 CARDI AC REHABI LI TATI ON  07698 HYPERBARI C OXYGEN THERAPY  07699 LI THOTRI PSY  OUTPATIENT SERVICE COST CENTERS	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	346, 740 7, 484 0 27, 440 0 0 0 54, 880 0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	52. 00 53. 00 54. 00 56. 00 57. 00 58. 00 60. 00 62. 30 64. 00 65. 00 68. 00 69. 00 71. 00 72. 00 73. 01 76. 97 76. 98 76. 99
88. 02 90. 00 91. 00 92. 00	08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC II 08802 RURAL HEALTH CLINIC III 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART 09399 PARTIAL HOSPITALIZATION PROGRAM OTHER REIMBURSABLE COST CENTERS	0 0 0 4, 071 0	0 0 0 0 117, 243	000000000000000000000000000000000000000	0 0 0	0 0 0 0 0	88. 01 88. 02 90. 00 91. 00 92. 00
99. 10 99. 20 99. 30 99. 40 101. 00	09500 AMBULANCE SERVICES 09910 CORF 09920 OUTPATIENT PHYSICAL THERAPY 09930 OUTPATIENT OCCUPATIONAL THERAPY 09940 OUTPATIENT SPEECH PATHOLOGY 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0 0 0 0 0 0	0 0 0 0 0 0	0 0 0 0 0	0 0 0 0 0	0 0 0 0 0 0	99. 10 99. 20 99. 30
116. 00 118. 00		0 1, 809, 097	0 820, 703	C C			116. 00 118. 00
194. 00 194. 01	NONREIMBURSABLE COST CENTERS 19200 PHYSI CI ANS' PRI VATE OFFI CES 07950 OTHER NONREI MBURSABLE 07952 MEMORY DI SORDER 07953 ASSI STED LI VI NG	0 0 0 0	266, 916 0 0 22, 451	0 0 0	0 0 0 0	0	192. 00 194. 00 194. 01 194. 02

Health Financial Systems	RICHLAND MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der C		Peri od:	Worksheet B	
				From 01/01/2023	Part I	
				To 12/31/2023	Date/Time Pre	
					5/31/2024 10:	42 am
Cost Center Description	PHARMACY	MEDI CAL	SOCI AL	NONPHYSI CI AN	NURSI NG	
		RECORDS &	SERVI CE	ANESTHETI STS	PROGRAM	
		LI BRARY				
	15. 00	16. 00	17.00	19.00	20.00	

0

1, 110, 070

1, 809, 097

0

0

0 0 0

194.03 07951 CONTRACTED RETAIL RX
200.00 Cross Foot Adjustments
201.00 Negative Cost Centers
202.00 TOTAL (sum lines 118 through 201)

| Peri od: | Worksheet B | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Provider CCN: 14-0147

				To	12/31/2023	Date/Time Pre 5/31/2024 10:	
		INTERNS &	RESI DENTS			373172024 10.	42 diii
	Cost Center Description	SERVI CES-SALA RY & FRI NGES APPRV	SERVI CES-OTHE R PRGM COSTS APPRV	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	OFNEDAL CEDIMOR OCCUPANTEDO	21. 00	22. 00	23. 00	24. 00	25. 00	
1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 17. 00	GENERAL SERVICE COST CENTERS  00100 CAP REL COSTS-BLDG & FIXT  00200 CAP REL COSTS-WNBLE EQUIP  00400 EMPLOYEE BENEFITS DEPARTMENT  00500 ADMINISTRATIVE & GENERAL  00600 MAINTENANCE & REPAIRS  00700 OPERATION OF PLANT  00800 LAUNDRY & LINEN SERVICE  00900 HOUSEKEEPING  01000 DIETARY  01100 CAFETERIA  01200 MAINTENANCE OF PERSONNEL  01300 NURSING ADMINISTRATION  01400 CENTRAL SERVICES & SUPPLY  01500 PHARMACY  01600 MEDICAL RECORDS & LIBRARY  01700 SOCIAL SERVICE						1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
20. 00 21. 00 22. 00 23. 00	02000 NURSING PROGRAM 02100 I&R SERVICES-SALARY & FRINGES APPRV 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECIFY)	C	0	0			20. 00 21. 00 22. 00 23. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS		0	0	0 771 220		20.00
30. 00 31. 00	03100 INTENSIVE CARE UNIT			-	8, 771, 332 1, 306, 615	0	30. 00 31. 00
40.00	04000 SUBPROVI DER - I PF	C	0	0	0	0	40.00
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	C		0	895, 501 0	0	43. 00 44. 00
00	ANCILLARY SERVICE COST CENTERS	_		-	-1		
50. 00 52. 00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	C		0	4, 507, 657 572, 125	0	50. 00 52. 00
53. 00	05300 ANESTHESI OLOGY		1	0	573, 135 619, 388	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	C	0	0	1, 827, 178	0	54.00
56. 00 57. 00	05600 RADI 0I SOTOPE 05700 CT SCAN		0	0	649, 498 837, 777	0	56. 00 57. 00
58. 00	05800 MRI	C	Ö	0	405, 867	0	58. 00
60. 00 62. 30	06000 LABORATORY 06250 BLOOD CLOTTING FOR HEMOPHILIACS	C	0	0	4, 621, 488	0	60. 00 62. 30
64. 00	06400 I NTRAVENOUS THERAPY		0	0	0	0	64.00
65. 00	06500 RESPIRATORY THERAPY	C	0	0	1, 636, 848	0	65.00
66. 00 68. 00	06600 PHYSI CAL THERAPY 06800 SPEECH PATHOLOGY	C	0	0	3, 305, 687 426, 532	0	66. 00 68. 00
	06900 ELECTROCARDI OLOGY		ő	Ö	62, 842	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	C	0	0	1, 437, 528	0	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS		0	0	428, 844 1, 613, 152	0	72. 00 73. 00
73. 01	07301 I NJECTABLE DRUGS	C	0	0	2, 818, 830	0	73. 01
76. 97 76. 98	07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY	C	0	0	0	0	76. 97 76. 98
76. 99	07699 LI THOTRI PSY	C	Ö	Ö	ō	0	76. 99
00.00	OUTPATIENT SERVICE COST CENTERS  08800 RURAL HEALTH CLINIC			l ol	2 200 444	0	88. 00
88. 00 88. 01	08800  RURAL HEALTH CLINIC		0	0	2, 290, 664 9, 989, 006	0	88.00
88. 02	08802 RURAL HEALTH CLINIC III	C	0	0	O	0	88. 02
90. 00 91. 00	09000 CLI NI C 09100 EMERGENCY	C	0	0	663, 013 3, 592, 171	0	90.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		,		3, 372, 171	0	92.00
93. 99	09399 PARTIAL HOSPITALIZATION PROGRAM	C	0	0	o	0	93. 99
95. 00	OTHER REIMBURSABLE COST CENTERS  O9500 AMBULANCE SERVI CES		1 0		ol	0	95.00
99. 10	09910 CORF	C	ő	Ö	ő	0	99. 10
99. 20	09920 OUTPATIENT PHYSICAL THERAPY	C	0	0	0	0	
	09930 OUTPATIENT OCCUPATIONAL THERAPY 09940 OUTPATIENT SPEECH PATHOLOGY			0	0	0	
	10100 HOME HEALTH AGENCY		0	0	o		101.00
116 00	SPECIAL PURPOSE COST CENTERS 11600 HOSPI CE		I	O	ol	0	116. 00
118.00		C	0		53, 280, 553		118.00

Health Finar	ncial Systems	RI CHLAND MEMOR	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	TION - GENERAL SERVICE COSTS		Provider Co	F	Period: From 01/01/2023 To 12/31/2023		pared: 42 am
		INTERNS &	RESI DENTS				
	Cost Center Description	SERVI CES-SALA RY & FRI NGES APPRV	SERVI CES-OTHE R PRGM COSTS APPRV	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown	
		21. 00	22, 00	23.00	24.00	Adjustments 25.00	
NONRE	IMBURSABLE COST CENTERS	21.00	22.00	23.00	24.00	25.00	
	PHYSICIANS' PRIVATE OFFICES	0	0	(	3, 385, 163	0	192.00
194. 00 07950	OTHER NONREIMBURSABLE	0	0	(	0	0	194. 00
	MEMORY DI SORDER	0	0	(	0		194. 01
	ASSISTED LIVING	0	0	(	3, 927, 842		194. 02
	CONTRACTED RETAIL RX	0	0	(	3, 106, 756		194. 03
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers	0	0				200. 00 201. 00
202. 00	TOTAL (sum lines 118 through 201)		0		63, 700, 314		202.00

			5/31/2024 10:	42 am
	Cost Center Description	Total		
		26. 00		
	GENERAL SERVICE COST CENTERS			
1. 00	00100 CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP			2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500 ADMINISTRATIVE & GENERAL			5.00
6. 00	00600 MAI NTENANCE & REPAI RS			6.00
7.00	00700 OPERATION OF PLANT			7.00
8. 00	00800 LAUNDRY & LI NEN SERVI CE			8.00
9.00	00900 HOUSEKEEPI NG			9.00
10.00	01000 DI ETARY			10.00
11.00	01100 CAFETERI A			11.00
12.00	01200 MAI NTENANCE OF PERSONNEL			12.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY			13. 00 14. 00
				15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY			16. 00
17. 00				17. 00
19. 00				19.00
20. 00				20.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV			21.00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV			22. 00
	02300 PARAMED ED PRGM-(SPECIFY)			23. 00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS			25.00
30 00	03000 ADULTS & PEDIATRICS	8, 771, 332		30.00
31. 00		1, 306, 615		31.00
40. 00	04000 SUBPROVI DER - I PF	1, 300, 013		40.00
43. 00	04300 NURSERY	895, 501		43. 00
44. 00	04400 SKILLED NURSING FACILITY	075, 501		44. 00
44.00	ANCILLARY SERVICE COST CENTERS	<u> </u>		1 44.00
50.00		4, 507, 657		50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	573, 135		52.00
53. 00	05300 ANESTHESI OLOGY	619, 388		53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 827, 178		54.00
56. 00	05600 RADI OI SOTOPE	649, 498		56.00
57. 00	05700 CT SCAN	837, 777		57.00
58. 00	05800 MRI	405, 867		58.00
60.00	06000 LABORATORY	4, 621, 488		60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		62. 30
64.00	06400 I NTRAVENOUS THERAPY	o		64.00
65.00	06500 RESPIRATORY THERAPY	1, 636, 848		65.00
66.00	06600 PHYSI CAL THERAPY	3, 305, 687		66.00
68.00	06800 SPEECH PATHOLOGY	426, 532		68. 00
69.00	06900 ELECTROCARDI OLOGY	62, 842		69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 437, 528		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	428, 844		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 613, 152		73.00
73. 01	07301 I NJECTABLE DRUGS	2, 818, 830		73. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	0		76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	О		76. 98
76. 99	07699 LI THOTRI PSY	0		76. 99
	OUTPATIENT SERVICE COST CENTERS			
88.00	08800 RURAL HEALTH CLINIC	2, 290, 664		88. 00
88. 01	08801 RURAL HEALTH CLINIC II	9, 989, 006		88. 01
	08802 RURAL HEALTH CLINIC III	0		88. 02
90.00	09000 CLI NI C	663, 013		90.00
	09100 EMERGENCY	3, 592, 171		91.00
92.00				92.00
93. 99	09399 PARTI AL HOSPI TALI ZATI ON PROGRAM	0		93. 99
	OTHER REIMBURSABLE COST CENTERS			
	09500 AMBULANCE SERVICES	0		95.00
	09910 CORF	0		99. 10
	09920 OUTPATIENT PHYSICAL THERAPY	0		99. 20
	09930 OUTPATIENT OCCUPATIONAL THERAPY	0		99. 30
	09940 OUTPATIENT SPEECH PATHOLOGY	0		99. 40
101.00	10100 HOME HEALTH AGENCY	0		101.00
	SPECIAL PURPOSE COST CENTERS			
	11600 HOSPI CE	0		116. 00
118.00	9 /	53, 280, 553		118. 00
40-	NONREI MBURSABLE COST CENTERS	0.000		
	19200 PHYSI CI ANS' PRI VATE OFFI CES	3, 385, 163		192.00
	07950 OTHER NONREI MBURSABLE	0		194.00
	07952 MEMORY DI SORDER	0		194. 01
	207953 ASSISTED LIVING	3, 927, 842		194. 02
	07951 CONTRACTED RETAIL RX	3, 106, 756		194. 03
200.00	Cross Foot Adjustments	0		200. 00

Health Fir	nancial Systems	RICHLAND MEMORIA	AL HOSPITAL	In Lieu of Form CMS-2552-10			
COST ALLO	CATION - GENERAL SERVICE COSTS		Provider CCN: 14-0147	From 01/01/2023 To 12/31/2023	Worksheet B Part I Date/Time Prepar 5/31/2024 10:42		
	Cost Center Description	Total					
		26. 00					
201.00	Negative Cost Centers	0			20	1.00	
202. 00	TOTAL (sum lines 118 through 201)	63, 700, 314			20:	2.00	

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | From 12/4024 | Prepared: | Provider CCN: 14-0147

					lo	12/31/2023	Date/lime Pre   5/31/2024 10:	
				CAPI TAL REI	ATED COSTS			
		Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
			Capi tal				DEPARTMENT	
			Related Costs 0	1. 00	2.00	2A	4. 00	
	GENER	AL SERVICE COST CENTERS		1.00	2.00	2/1	1. 00	
1. 00	1	CAP REL COSTS-BLDG & FIXT						1.00
2.00		CAP REL COSTS-MVBLE EQUIP		4 247		4 247	4 247	2.00
4. 00 5. 00	1	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	4, 057	4, 367 148, 448	0	4, 367 152, 505	4, 367 174	4. 00 5. 00
6. 00		MAINTENANCE & REPAIRS	4,037	22, 428		22, 428	116	6.00
7. 00		OPERATION OF PLANT	0	279	O	279	0	7. 00
8. 00	1	LAUNDRY & LINEN SERVICE	0	27, 738		27, 738	40	8. 00
9.00		HOUSEKEEPI NG DI ETARY	0	25, 267	0	25, 267	109	9.00
10. 00 11. 00	1	CAFETERIA	0	67, 581 0		67, 581 0	54 113	10. 00 11. 00
12. 00		MAINTENANCE OF PERSONNEL	Ö	0		Ö	0	12.00
13.00		NURSING ADMINISTRATION	0	2, 838		2, 838	236	13.00
14.00		CENTRAL SERVICES & SUPPLY PHARMACY	0	34, 385		34, 385	16	14.00
15. 00 16. 00		MEDICAL RECORDS & LIBRARY	5, 402	17, 756 10, 184	0	23, 158 10, 184	142	15. 00 16. 00
17. 00		SOCIAL SERVICE	l o	0, 104		0	0	17. 00
19. 00	01900	NONPHYSICIAN ANESTHETISTS	O	0	0	О	0	19. 00
20.00	1	NURSING PROGRAM	0	0	0	0	0	20.00
21. 00 22. 00		I&R SERVICES-SALARY & FRINGES APPRV   I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		0	0	21. 00 22. 00
23. 00	1	PARAMED ED PRGM-(SPECIFY)	0	0	1	0	0	23. 00
	I NPAT	IENT ROUTINE SERVICE COST CENTERS						
30.00		ADULTS & PEDIATRICS	14, 708	145, 800		160, 508	424	30.00
31. 00 40. 00		INTENSIVE CARE UNIT SUBPROVIDER - IPF	2, 175 0	28, 533 0		30, 708 0	55 0	31. 00 40. 00
43. 00	1	NURSERY	Ö	9, 039		9, 039	47	43. 00
44.00		SKILLED NURSING FACILITY	-180	0	0	-180	0	44.00
FO 00		LARY SERVICE COST CENTERS OPERATING ROOM		FO 140		FO 140	10/	F0 00
50. 00 52. 00	1	DELIVERY ROOM & LABOR ROOM	0	50, 140 0	1	50, 140 0	106 47	50. 00 52. 00
53. 00		ANESTHESI OLOGY	Ö	0	Ö	o	203	53.00
54.00		RADI OLOGY-DI AGNOSTI C	0	22, 673		22, 673	142	54.00
56.00		RADI OI SOTOPE	0	6, 349	1	6, 349	26	56.00
57. 00 58. 00	05800	CT SCAN	0	5, 371 5, 642	0	5, 371 5, 642	66 18	57. 00 58. 00
60.00		LABORATORY	Ö	31, 712		31, 712	209	60.00
62. 30		BLOOD CLOTTING FOR HEMOPHILIACS	0	0	· -	0	0	62. 30
64. 00 65. 00	1	I NTRAVENOUS THERAPY RESPIRATORY THERAPY	0 272	0 9. 118	0	0 18, 490	0	64. 00 65. 00
66. 00		PHYSICAL THERAPY	9, 372	8, 996		8, 996	122 287	66.00
68. 00		SPEECH PATHOLOGY	0	4, 183		4, 183	33	68. 00
69. 00		ELECTROCARDI OLOGY	0	0		0	0	69. 00
		MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	
73.00		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0	0		0	0	72. 00 73. 00
73. 01	1	INJECTABLE DRUGS	Ö	0	Ö	Ö	Ō	73. 01
76. 97	1	CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
76. 98 76. 99	1	HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 98
76. 99		LITHOTRIPSY TIENT SERVICE COST CENTERS	<u> </u>	0	<u> </u>	<u> </u>	U	76. 99
88. 00		RURAL HEALTH CLINIC	0	32, 079	0	32, 079	163	88. 00
88. 01		RURAL HEALTH CLINIC II	0	93, 363		93, 363	718	
88. 02 90. 00		RURAL HEALTH CLINIC III	0	0 8, 507	0	0 507	0	88. 02 90. 00
91.00	1	EMERGENCY	0	8, 507 29, 511		8, 507 29, 511	35 228	
92.00		OBSERVATION BEDS (NON-DISTINCT PART		,,		0		92.00
93. 99		PARTI AL HOSPI TALI ZATI ON PROGRAM	0	0	0	0	0	93. 99
05 00		REIMBURSABLE COST CENTERS  AMBULANCE SERVICES		0	0	ol	0	95. 00
99. 10	1	l e e e e e e e e e e e e e e e e e e e	0	0		o	0	
	1	OUTPATIENT PHYSICAL THERAPY	0	0	O	o	0	99. 20
		OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99. 30
		OUTPATIENT SPEECH PATHOLOGY HOME HEALTH AGENCY	9, 150	0	0	9, 150	0	99. 40 101. 00
101.00		AL PURPOSE COST CENTERS	7, 150	0	ı	7, 130	U	101.00
	11600	HOSPI CE	0	0		0		116. 00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	44, 684	852, 287	0	896, 971	3, 929	118. 00
192. 00		IMBURSABLE COST CENTERS PHYSICIANS' PRIVATE OFFICES	0	129, 661	0	129, 661	215	192. 00
		,	1	• •			- 1	·

Health Financial Systems	RI CHLAND MEMOR	RICHLAND MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-1			
ALLOCATION OF CAPITAL RELATED COSTS		Provi der C		Period: From 01/01/2023 Fo 12/31/2023	Worksheet B Part II Date/Time Pre 5/31/2024 10:			
		CAPI TAL RE	LATED COSTS					
Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE RENEELTS			

		CAPI TAL REI	LATED COSTS			
Cost Center Description	Di rectly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
	0	1.00	2. 00	2A	4. 00	
194. 00 07950 OTHER NONREI MBURSABLE	0	0	0	0	0	194.00
194. 01 07952 MEMORY DI SORDER	0	0	0	0	0	194. 01
194. 02 07953 ASSISTED LIVING	0	59, 232	0	59, 232	198	194. 02
194. 03 07951 CONTRACTED RETAIL RX	559	0	0	559	25	194. 03
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	45, 243	1, 041, 180	0	1, 086, 423	4, 367	202. 00

Provider CCN: 14-0147

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part II
To 12/31/2023 Date/Time Prepared: 5/31/2024 10:42 am

					0 12/31/2023	5/31/2024 10:	
	Cost Center Description	ADMINISTRATIV E & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
		5. 00	6. 00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS						
	00100 CAP REL COSTS-BLDG & FIXT						1.00
	00200 CAP REL COSTS-MVBLE EQUIP						2.00
1	DO400 EMPLOYEE BENEFITS DEPARTMENT DO500 ADMINISTRATIVE & GENERAL	152, 679					4. 00 5. 00
1	00600 MAINTENANCE & REPAIRS	4, 861	27, 405				6.00
	00700 OPERATION OF PLANT	5, 946	27,403	6, 234			7.00
	00800 LAUNDRY & LINEN SERVICE	1, 457	878				8.00
	00900 HOUSEKEEPI NG	3, 314	800	•	· ·	32, 014	9. 00
	01000 DI ETARY	2, 055	2, 139	487	549	l	10.00
11.00	01100 CAFETERI A	3, 139	0	0	0	0	11.00
	01200 MAINTENANCE OF PERSONNEL	0	0	1	0	0	12.00
1	01300 NURSING ADMINISTRATION	9, 443	90			6, 070	13.00
	01400 CENTRAL SERVICES & SUPPLY	2, 506	1, 088	1		3, 772	14.00
1	01500 PHARMACY	3, 824	562		0	1, 656	
	01600 MEDICAL RECORDS & LIBRARY	2, 534	322	1	0	0	16.00
	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	17. 00 19. 00
	02000 NURSING PROGRAM	0	0		0		20.00
1	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0		0	0	21.00
1	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	Ö		0	Ö	22.00
1	02300 PARAMED ED PRGM-(SPECIFY)	0	Ö	Ö	0	Ö	23. 00
	NPATIENT ROUTINE SERVICE COST CENTERS					•	
30.00	03000 ADULTS & PEDIATRICS	11, 891	4, 612	1, 049	13, 206	4, 416	30.00
31.00	03100 INTENSIVE CARE UNIT	1, 813	903	205	0	644	31.00
	04000 SUBPROVI DER – I PF	0	0		0	0	40.00
	04300 NURSERY	1, 332	286		531	0	43.00
	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
	NCILLARY SERVICE COST CENTERS	7 004	1 507	2/1	1 244	2 (00	   E0 00
1	D5000 OPERATING ROOM D5200 DELIVERY ROOM & LABOR ROOM	7, 904 1, 206	1, 587 0	1	1, 244 768	3, 680 644	50. 00 52. 00
	05300 ANESTHESI OLOGY	1, 206	0	1	700	0	53.00
1	05400 RADI OLOGY-DI AGNOSTI C	3, 729	718	1	642	230	54.00
1	05600 RADI OI SOTOPE	1, 414	201	•		230	56.00
	05700 CT SCAN	1, 845	170	•		230	57.00
	05800 MRI	857	179	•	0	230	58.00
1	06000 LABORATORY	10, 247	1, 004		110	l	60.00
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	1		0	62.30
	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
	06500 RESPIRATORY THERAPY	3, 635	289		567	230	65.00
	06600 PHYSI CAL THERAPY	7, 349	285	•	0	552	66. 00
	06800 SPEECH PATHOLOGY	875	132		0	552	68. 00
1	06900 ELECTROCARDI OLOGY	122	0	0	0	230	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 166	0	0	0	0	71.00
1	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	242 2, 352	0		0	0	72. 00 73. 00
	07300 DRUGS CHARGED TO PATTENTS	3, 945	0		0	0	73.00
	07697 CARDI AC REHABI LI TATI ON	3, 743	0		0	0	76. 97
	07698 HYPERBARI C OXYGEN THERAPY	0	Ö		0	Ö	76. 98
	07699 LI THOTRI PSY	0	0	Ö	0	1	76. 99
O	OUTPATIENT SERVICE COST CENTERS					•	
	08800 RURAL HEALTH CLINIC	4, 437	1, 015			,	88. 00
1	08801 RURAL HEALTH CLINIC II	20, 505	2, 955	1		1, 840	1
	08802 RURAL HEALTH CLINIC III	0	0	1			88. 02
	09000 CLI NI C	1, 204	269		732	0	90.00
	09100 EMERGENCY	5, 776	934	213	2, 268	1, 932	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART 09399 PARTIAL HOSPITALIZATION PROGRAM	0	0	0	_	0	92. 00 93. 99
	OTHER REIMBURSABLE COST CENTERS	U		0	0	0	93.99
	09500 AMBULANCE SERVICES	0	0	) 0	0	0	95. 00
	09910 CORF	0	Ö		0	ő	99. 10
99. 20 0	09920 OUTPATIENT PHYSICAL THERAPY	0	0	Ö	0	Ō	99. 20
99. 30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99. 30
	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99. 40
101.001	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
1	11600 HOSPI CE	0	0			1	116. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	134, 331	21, 427	4, 873	23, 581	29, 622	j 118. 00
	IONREI MBURSABLE COST CENTERS	F 700	4 100	004	^	4/0	102.00
	19200 PHYSICIANS' PRIVATE OFFICES 07950 OTHER NONREIMBURSABLE	5, 782 0	4, 103				192. 00 194. 00
	07950 OTHER NONKETMBURSABLE 07952 MEMORY DI SORDER		0		_		194.00
	07953 ASSISTED LIVING	5, 119	1, 875	1	6, 732		194. 01
	07951 CONTRACTED RETAIL RX	7, 447	1, 8/3				194. 02
	1			<u> </u>	<u>.                                    </u>	<u> </u>	

Н	ealth Financial Systems	RICHLAND MEMOR	AL HOSPITAL				In Lie	u of Form CMS-	2552-10
A	ILLOCATION OF CAPITAL RELATED COSTS		Provi der	CCN	: 14-0147	Per Fro To	m 01/01/2023	Date/Time Pre	
_								5/31/2024 10:	42 am
	Cost Contor Doscription	ADMINICTDATIV	MALNITENIANICE	0 0	DEDATION	ΛE.	I VIINDDA 6	HULICENEED! NO	

							5/31/2024 10:	42 am
		Cost Center Description	ADMI NI STRATI V	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
			E & GENERAL	REPAI RS	PLANT	LINEN SERVICE		
			5. 00	6. 00	7. 00	8. 00	9. 00	
200.00	)	Cross Foot Adjustments						200.00
201.00	)	Negative Cost Centers	0	0	0	0	0	201.00
202.00	)	TOTAL (sum lines 118 through 201)	152, 679	27, 405	6, 234	30, 313	32, 014	202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-0147

	Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF PERSONNEL	NURSI NG ADMI NI STRATI O N	5/31/2024 10: CENTRAL SERVI CES & SUPPLY	42 am
		10. 00	11. 00	12.00	13. 00	14. 00	
1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 19. 00 20. 00 21. 00 22. 00	GENERAL SERVICE COST CENTERS  00100 CAP REL COSTS-BLDG & FIXT  00200 CAP REL COSTS-BUDG & FIXT  00400 EMPLOYEE BENEFITS DEPARTMENT  00500 ADMINISTRATIVE & GENERAL  00600 MAINTENANCE & REPAIRS  00700 OPERATION OF PLANT  00800 LAUNDRY & LINEN SERVICE  00900 HOUSEKEEPING  01000 DIETARY  01100 CAFETERIA  01200 MAINTENANCE OF PERSONNEL  01300 NURSING ADMINISTRATION  01400 CENTRAL SERVICES & SUPPLY  01500 PHARMACY  01600 MEDICAL RECORDS & LIBRARY  01700 SOCIAL SERVICE  01900 NONPHYSICIAN ANESTHETISTS  02000 NURSING REPOGRAM  02100 I &R SERVICES-SALARY & FRINGES APPRV	72, 865 0 0 0 0 0 0	3, 252 0 181 33 100 0 0	0 0 0 0	18, 878 0 0 0 0 0	42, 560 0 0 0 0	1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 19. 00 20. 00 21. 00 22. 00
30. 00 31. 00 40. 00	O2300   PARAMED ED PRGM-(SPECIFY)     INPATIENT ROUTINE SERVICE COST CENTERS     O3000   ADULTS & PEDIATRICS     O3100   INTENSIVE CARE UNIT     O4000   SUBPROVIDER - IPF	23, 524 3, 754 0	517 55 0	0 0	7, 061 1, 134 0	1, 607 217 0	30. 00 31. 00 40. 00
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	0	49 0		,	0	43. 00 44. 00
50. 00 52. 00 53. 00 54. 00 56. 00 57. 00 58. 00 62. 30 64. 00 65. 00 66. 00 68. 00 69. 00 71. 00 72. 00 73. 01 76. 97 76. 98 76. 99	ANCILLARY SERVICE COST CENTERS  05000 OPERATING ROOM  05200 DELIVERY ROOM & LABOR ROOM  05300 ANESTHESIOLOGY  05400 RADIOLOGY-DIAGNOSTIC  05600 RADIOISOTOPE  05700 CT SCAN  05800 MRI  06000 LABORATORY  06250 BLOOD CLOTTING FOR HEMOPHILIACS  06400 INTRAVENOUS THERAPY  06600 RESPIRATORY THERAPY  06600 PHYSICAL THERAPY  06800 SPEECH PATHOLOGY  07100 MEDICAL SUPPLIES CHARGED TO PATIENT  07200 IMPL. DEV. CHARGED TO PATIENTS  07300 DRUGS CHARGED TO PATIENTS  07301 INJECTABLE DRUGS  07697 CARDIAC REHABILITATION  07698 HYPERBARIC OXYGEN THERAPY  07699 LITHOTRIPSY  00UTPATIENT SERVICE COST CENTERS	0 717 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	116 0 70 128 199 65 18 227 0 0 112 304 31 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 342 0 0 205 25 0 0 0 0 189 0 3 0 0 0 0	1, 083 0 140 2 0 79 14 20 0 0 65 0 0 28, 200 9, 721 0 0	50. 00 52. 00 53. 00 54. 00 56. 00 57. 00 58. 00 60. 00 62. 30 64. 00 65. 00 66. 00 68. 00 69. 00 71. 00 72. 00 73. 01 76. 98 76. 99
91. 00 92. 00	08800  RURAL HEALTH CLINIC 08801  RURAL HEALTH CLINIC II 08802  RURAL HEALTH CLINIC III 09000  CLINIC 09100  EMERGENCY 09200  OBSERVATION BEDS (NON-DISTINCT PART 09399  PARTIAL HOSPITALIZATION PROGRAM OTHER REIMBURSABLE COST CENTERS	0 0 0 0 0	130 550 0 30 262	0 0 0 0	_, 555	8 3 0 0 1, 159	88. 00 88. 01 88. 02 90. 00 91. 00 92. 00 93. 99
99. 10 99. 20 99. 30 99. 40	09500 AMBULANCE SERVICES 09910 CORF 09920 OUTPATIENT PHYSICAL THERAPY 09930 OUTPATIENT OCCUPATIONAL THERAPY 09940 OUTPATIENT SPEECH PATHOLOGY 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0 0 0 0 0 0	0 0 0 0 0	0 0 0 0	0 0 0 0 0	0 0 0 0 0 0	95. 00 99. 10 99. 20 99. 30 99. 40 101. 00
116. 00 118. 00	11600 HOSPI CE	0 27, 995	0 2, 997			0 42, 318	116. 00 118. 00
192. 00 194. 00 194. 01	NONRE MBURSABLE COST CENTERS 19200 PHYSI CI ANS' PRI VATE OFFI CES 07950 OTHER NONREI MBURSABLE 07952 MEMORY DI SORDER 07953 ASSI STED LI VI NG	0 0 0 0 44, 870	0 0 0 255	0 0	0 0	241 0 0	192. 00 194. 00 194. 01 194. 02

Health Financial Systems	RICHLAND MEMORIAL HOSPITAL	-	In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der	CCN: 14-0147	Peri od: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Prepared: 5/31/2024 10:42 am

						5/31/2024 10:	42 am_
	Cost Center Description	DI ETARY	CAFETERI A	MAI NTENANCE	NURSI NG	CENTRAL	
				OF PERSONNEL	ADMI NI STRATI O	SERVICES &	
					N	SUPPLY	
		10. 00	11. 00	12.00	13.00	14.00	
194. 03 0795	CONTRACTED RETAIL RX	0	0	0	0	0	194. 03
200. 00	Cross Foot Adjustments						200.00
201. 00	Negative Cost Centers	0	0	0	0	0	201.00
202. 00	TOTAL (sum lines 118 through 201)	72, 865	3, 252	0	18. 878	42, 560	202.00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | From 12/4024 | Prepared: | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-0147

				'	0 12/31/2023	Date/lime Pr 5/31/2024 10	
	Cost Center Description	PHARMACY	MEDI CAL	SOCI AL SERVI CE	NONPHYSI CI AN	NURSI NG PROGRAM	
			RECORDS & LI BRARY	SERVICE	ANESTHETI STS	PRUGRAM	
		15. 00	16. 00	17. 00	19. 00	20.00	
1. 00	GENERAL SERVICE COST CENTERS  OO100 CAP REL COSTS-BLDG & FIXT			I		I	1 00
2. 00	00200 CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
6. 00	00600 MAINTENANCE & REPAIRS						6.00
7. 00 8. 00	00700 OPERATION OF PLANT						7.00
9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG						8. 00 9. 00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A						11.00
12. 00	01200 MAI NTENANCE OF PERSONNEL						12.00
13. 00 14. 00	01300   NURSI NG   ADMI NI STRATI ON   01400   CENTRAL   SERVI CES & SUPPLY						13.00
15. 00	01500 PHARMACY	29, 570					15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	27, 370	13, 113				16.00
17. 00	01700 SOCIAL SERVICE	0	0	(			17. 00
	01900 NONPHYSI CI AN ANESTHETI STS	0	0	(	0	•	19.00
20. 00 21. 00	02000 NURSING PROGRAM 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0			(	20.00
21.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	o	0				23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	0	2, 740				30.00
31. 00 40. 00	03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0	206 0				31. 00 40. 00
43.00	04300 NURSERY	0	206	1			43.00
	04400 SKILLED NURSING FACILITY	o	0	•			44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	4, 098	•			50.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0	88 0	•			52. 00 53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	324				54.00
56. 00	05600 RADI OI SOTOPE	Ö	0	1			56.00
57.00	05700 CT SCAN	0	0	(			57. 00
58. 00	05800 MRI	0	0				58.00
60. 00 62. 30	06000   LABORATORY   06250   BLOOD   CLOTTI NG   FOR   HEMOPHI LI ACS	0	648 0				60. 00 62. 30
64. 00	06400 I NTRAVENOUS THERAPY	0	0				64.00
65. 00	06500 RESPI RATORY THERAPY	Ö	0				65.00
66. 00	06600 PHYSI CAL THERAPY	0	0	(			66. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	(			68.00
69. 00 71. 00	06900  ELECTROCARDI OLOGY   07100  MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0	(			69. 00 71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0				72.00
	07300 DRUGS CHARGED TO PATIENTS	10, 327	0	d			73.00
	07301 I NJECTABLE DRUGS	19, 176	0	C			73. 01
	07697 CARDI AC REHABI LI TATI ON	0	0	(			76. 97
	07698 HYPERBARI C OXYGEN THERAPY 07699 LI THOTRI PSY	0	0				76. 98 76. 99
70. 77	OUTPATIENT SERVICE COST CENTERS	<u> </u>			<u> </u>		70.77
	08800 RURAL HEALTH CLINIC	0	0	(	)		88. 00
	08801 RURAL HEALTH CLINIC II	0	0	(			88. 01
	08802 RURAL HEALTH CLINIC III 09000 CLINIC	0	0	(			88. 02 90. 00
	09100 EMERGENCY	67	1, 385				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	9	., 555	Ì			92.00
93. 99	09399 PARTIAL HOSPITALIZATION PROGRAM	0	0	(			93. 99
05 00	OTHER REIMBURSABLE COST CENTERS			Τ		T	05.00
	09500 AMBULANCE SERVI CES 09910 CORF	0	0	(			95. 00 99. 10
	09920 OUTPATIENT PHYSICAL THERAPY	0	0				99. 20
	09930 OUTPATIENT OCCUPATIONAL THERAPY	Ö	0				99. 30
	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	(			99. 40
101.00	10100 HOME HEALTH AGENCY	0	0		)		101.00
116 00	SPECIAL PURPOSE COST CENTERS 11600 HOSPI CE	O	0			I	116 00
118.00		29, 570	9, 695				116. 00 118. 00
	NONREI MBURSABLE COST CENTERS	27,070	,, 675			`	
	19200 PHYSICIANS' PRIVATE OFFICES	0	3, 153	1			192. 00
	07950 OTHER NONREI MBURSABLE	0	0	1			194. 00 194. 01
	07952 MEMORY DISORDER 07953 ASSISTED LIVING	٥	265				194.01
. , 52	1	<u>ا</u>	200	1	1	ı	1

Health Financial Systems	RICHLAND MEMOR	I AL HOSPI TAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der Co	CN: 14-0147	Peri od:	Worksheet B	
				From 01/01/2023		
				To 12/31/2023		
					5/31/2024 10:	42 am
Cost Center Description	PHARMACY	MEDI CAL	SOCI AL	NONPHYSI CI AN	NURSI NG	
		RECORDS &	SERVI CE	ANESTHETI STS	PROGRAM	
		LI BRARY				
	15. 00	16. 00	17. 00	19. 00	20.00	
194.03 07951 CONTRACTED RETAIL RX	0	0		0		194. 03
200.00 Cross Foot Adjustments				0	0	200.00
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	29, 570	13, 113		0 0	0	202.00

Period: Worksheet B
From 01/01/2023 Part II Provi der CCN: 14-0147

						To 12/31/2023	Date/Time Pre 5/31/2024 10:	
			INTERNS &	RESI DENTS			3/31/2024 10.	42 alli
		Cost Center Description	SERVI CES-SALA RY & FRI NGES APPRV	SERVI CES-OTHE R PRGM COSTS APPRV	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	DENED		21. 00	22. 00	23. 00	24.00	25. 00	
1 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT						1 00
1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 19. 00 20. 00 21. 00 22. 00	00200 00400 00500 00700 00700 01100 01100 01500 01600 01700 02000 02100	CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA MAINTENANCE OF PERSONNEL NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE NONPHYSICIAN ANESTHETISTS NURSING PROGRAM I&R SERVICES-SALARY & FRINGES APPRV I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 19. 00 20. 00 21. 00 22. 00
23. 00		PARAMED ED PRGM-(SPECIFY)						23.00
30. 00	_	I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS				231, 555	0	30.00
31.00		INTENSIVE CARE UNIT				39, 694 0	0	31.00
40. 00 43. 00		SUBPROVI DER - I PF   NURSERY				12, 612	0	40. 00 43. 00
44. 00		SKILLED NURSING FACILITY				-180	0	44. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM				71, 661	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM				3, 470	0	52.00
53. 00 54. 00	1	ANESTHESI OLOGY   RADI OLOGY-DI AGNOSTI C				1, 819 28, 956	0	53. 00 54. 00
56. 00	1	RADI OI SOTOPE				8, 383	0	56.00
57.00	1	CT SCAN				7, 865	0	57.00
58. 00 60. 00	05800	LABORATORY				6, 999 45, 049	0	58. 00 60. 00
62. 30	1	BLOOD CLOTTING FOR HEMOPHILIACS				0	0	62. 30
64.00		I NTRAVENOUS THERAPY				0	0	64.00
65. 00 66. 00	1	RESPI RATORY THERAPY PHYSI CAL THERAPY				23, 576 18, 027	0	65. 00 66. 00
68. 00	06800	SPEECH PATHOLOGY				5, 836	0	
69. 00 71. 00		ELECTROCARDIOLOGY   MEDICAL SUPPLIES CHARGED TO PATIENT				355 29, 366	0	
72.00	1	IMPL. DEV. CHARGED TO PATIENTS				9, 963	0	72.00
73.00		DRUGS CHARGED TO PATIENTS				12, 679	0	73.00
73. 01 76. 97		I NJECTABLE DRUGS CARDI AC REHABI LI TATI ON				23, 121	0	73. 01 76. 97
76. 98	1	HYPERBARI C OXYGEN THERAPY				o	0	76. 98
76. 99	07699	LITHOTRIPSY TIENT SERVICE COST CENTERS				0	0	76. 99
88. 00		RURAL HEALTH CLINIC				40, 469	0	88. 00
88. 01		RURAL HEALTH CLINIC II				123, 393	0	88. 01
88. 02 90. 00		RURAL HEALTH CLINIC III CLINIC				0 11, 264	0	88. 02 90. 00
91.00	1	EMERGENCY				46, 356	0	91.00
92.00	1	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
93. 99		PARTIAL HOSPITALIZATION PROGRAM REIMBURSABLE COST CENTERS				0	0	93. 99
95.00	09500	AMBULANCE SERVICES				0	0	•
99. 10 99. 20	1	CORF  OUTPATIENT PHYSICAL THERAPY				0	0	99. 10 99. 20
99. 30	09930	OUTPATIENT OCCUPATIONAL THERAPY					0	99. 30
99. 40	1	OUTPATIENT SPEECH PATHOLOGY				0 150	0	1
101.00		HOME HEALTH AGENCY AL PURPOSE COST CENTERS				9, 150	0	101. 00
	11600	HOSPI CE				0		116. 00
118. 00	기	SUBTOTALS (SUM OF LINES 1 through 117)	0	0		811, 438	0	118. 00

Health Finar	ncial Systems	RICHLAND MEMOR	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION (	OF CAPITAL RELATED COSTS		Provi der Co	CN: 14-0147	Peri od: From 01/01/2023 To 12/31/2023		
		INTERNS &	RESI DENTS				
	Cost Center Description	SERVI CES-SALA RY & FRI NGES APPRV	SERVI CES-OTHE R PRGM COSTS APPRV	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		21. 00	22. 00	23. 00	24. 00	25. 00	
	MBURSABLE COST CENTERS						
192. 00 19200	PHYSICIANS' PRIVATE OFFICES				144, 549	0	192. 00
194. 00 07950	OTHER NONREI MBURSABLE				0	0	194. 00
194. 01 07952	MEMORY DI SORDER				0		194. 01
	ASSISTED LIVING				122, 405	0	194. 02
194. 03 07951	CONTRACTED RETAIL RX				8, 031	0	194. 03
200. 00	Cross Foot Adjustments	0	0		0		200. 00
201. 00	Negative Cost Centers	0	0		0		201. 00
202. 00	TOTAL (sum lines 118 through 201)	0	0	1	0 1, 086, 423	0	202. 00

Provider CCN: 14-0147

			5/31/2024	10: 42 am
	Cost Center Description	Total	, , , , , , , , , , , , , , , , , , , ,	
	OFFICE OF	26. 00		
1 00	GENERAL SERVICE COST CENTERS			1 00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP			1. 00 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT			4.00
5. 00	00500 ADMINISTRATIVE & GENERAL			5. 00
6.00	00600 MAI NTENANCE & REPAI RS			6.00
7.00	00700 OPERATION OF PLANT			7.00
8.00	00800 LAUNDRY & LINEN SERVICE			8. 00
9. 00	00900 HOUSEKEEPI NG			9.00
10.00	01000 DI ETARY			10.00
11. 00 12. 00	01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL			11. 00 12. 00
13. 00	01300 NURSING ADMINISTRATION			13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY			14.00
15.00	01500 PHARMACY			15.00
16.00	01600 MEDICAL RECORDS & LIBRARY			16. 00
17.00				17. 00
				19.00
	02000 NURSI NG PROGRAM			20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV			21. 00 22. 00
	02200   1&R SERVICES-OTHER PRGM COSTS APPRV   02300   PARAMED ED PRGM-(SPECIFY)			23. 00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS			25.00
30.00		231, 555		30.00
		39, 694		31.00
40.00	04000 SUBPROVI DER - I PF	0		40.00
43.00	04300 NURSERY	12, 612		43.00
44. 00	04400 SKILLED NURSING FACILITY	-180		44. 00
F0 00	ANCILLARY SERVICE COST CENTERS	74 ((4		- FO 00
50.00		71, 661		50.00
52. 00 53. 00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	3, 470 1, 819		52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	28, 956		54.00
56. 00	05600 RADI OI SOTOPE	8, 383		56.00
57.00	05700 CT SCAN	7, 865		57.00
58.00	05800  MRI	6, 999		58. 00
60.00	06000 LABORATORY	45, 049		60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		62. 30
64.00	06400 I NTRAVENOUS THERAPY	0		64.00
65. 00 66. 00	06500 RESPIRATORY THERAPY	23, 576		65.00
68. 00	06600 PHYSI CAL THERAPY 06800 SPEECH PATHOLOGY	18, 027 5, 836		66. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	355		69.00
71. 00		29, 366		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	9, 963		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	12, 679		73.00
73. 01	07301 I NJECTABLE DRUGS	23, 121		73. 01
	07697 CARDI AC REHABI LI TATI ON	0		76. 97
	07698 HYPERBARI C OXYGEN THERAPY	0		76. 98
76. 99	07699 LI THOTRI PSY OUTPATI ENT SERVI CE COST CENTERS	0		76. 99
88. 00		40, 469		88.00
88. 01	08801 RURAL HEALTH CLINIC II	123, 393		88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0		88. 02
90.00	09000 CLI NI C	11, 264		90.00
91.00	09100 EMERGENCY	46, 356		91.00
92.00				92.00
93. 99		0		93. 99
95. 00	OTHER REIMBURSABLE COST CENTERS  09500 AMBULANCE SERVICES	l ol		95. 00
99. 10				99. 10
	09920 OUTPATIENT PHYSICAL THERAPY			99. 20
99. 30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0		99. 30
	09940 OUTPATIENT SPEECH PATHOLOGY	0		99. 40
101.00	10100 HOME HEALTH AGENCY	9, 150		101.00
	SPECIAL PURPOSE COST CENTERS	1		
	11600 HOSPI CE	0		116.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)   NONREIMBURSABLE COST CENTERS	811, 438		118. 00
192 00	19200 PHYSICIANS' PRIVATE OFFICES	144, 549		192. 00
	07950 OTHER NONREI MBURSABLE	144, 549		194. 00
	07952 MEMORY DI SORDER			194. 01
	07953 ASSISTED LIVING	122, 405		194. 02
	07951 CONTRACTED RETAIL RX	8, 031		194. 03
200.00	Cross Foot Adjustments	0		200. 00

Health Fi	nancial Systems	RICHLAND MEMORIA	AL HOSPITAL	In Lieu	u of Form CMS-2	2552-10
ALLOCATIO	ON OF CAPITAL RELATED COSTS		Provi der CCN: 14-0147	From 01/01/2023	Worksheet B Part II Date/Time Pre 5/31/2024 10:	
	Cost Center Description	Total				
		26. 00				
201.00	Negative Cost Centers	0				201.00
202.00	TOTAL (sum lines 118 through 201)	1, 086, 423				202.00

Peri od: Worksheet B-1 From 01/01/2023 Provider CCN: 14-0147

						From 01/01/2023 To 12/31/2023		pared:
			CAPITAL REL	ATED COSTS			373172024 10.	42 dili
		Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VAL UE -NEW)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	
			1.00	0.00	SALARI ES)		5.00	
	GENER	AL SERVICE COST CENTERS	1. 00	2. 00	4. 00	5A	5. 00	
1.00	00100	CAP REL COSTS-BLDG & FIXT	119, 214					1. 00
2. 00 4. 00		CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT	500	1, 028, 225 0		1		2. 00 4. 00
5. 00		ADMINISTRATIVE & GENERAL	16, 997	58, 120			51, 724, 806	5. 00
6.00	1	MAINTENANCE & REPAIRS	2, 568				1, 646, 548	6.00
7. 00 8. 00	1	OPERATION OF PLANT LAUNDRY & LINEN SERVICE	32 3, 176	0 19, 575		-	2, 014, 314 493, 572	7. 00 8. 00
9.00	00900	HOUSEKEEPI NG	2, 893	1, 063	714, 628	0	1, 122, 720	9. 00
10. 00 11. 00		DI ETARY CAFETERI A	7, 738	21, 831 0	357, 03 <sup>4</sup> 741, 530		696, 302 1, 063, 319	10. 00 11. 00
12. 00		MAINTENANCE OF PERSONNEL	0	0			1,003,317	12.00
13.00		NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	325	124, 498			3, 198, 758	13.00
14. 00 15. 00		PHARMACY	3, 937 2, 033	34, 729 1, 794			848, 756 1, 295, 278	14. 00 15. 00
16.00		MEDICAL RECORDS & LIBRARY	1, 166		(	-	858, 314	
17. 00 19. 00		SOCIAL SERVICE NONPHYSICIAN ANESTHETISTS	0	0	·	0	0	17. 00 19. 00
20.00	02000	NURSING PROGRAM	0	0		o o	0	20.00
21. 00 22. 00		I&R SERVICES-SALARY & FRINGES APPRV   I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	· ·	-	0	21. 00 22. 00
23. 00	02300	PARAMED ED PRGM-(SPECIFY)	0	0			0	23. 00
20.00		I ENT ROUTI NE SERVI CE COST CENTERS	14 404	12 004	2 702 223		4 020 015	20.00
30. 00 31. 00		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	16, 694 3, 267	12, 006 8, 324				30. 00 31. 00
40.00		SUBPROVI DER - I PF	0	0		-	0	40.00
43. 00 44. 00	1	NURSERY  SKILLED NURSING FACILITY	1, 035 0	22, 544 0			451, 290 0	43. 00 44. 00
	ANCI L	LARY SERVICE COST CENTERS						
50. 00 52. 00	1	OPERATING ROOM DELIVERY ROOM & LABOR ROOM	5, 741 0	111, 922 0			2, 677, 526 408, 378	50. 00 52. 00
53. 00		ANESTHESI OLOGY	0	45, 100			476, 237	53.00
54.00		RADI OLOGY-DI AGNOSTI C	2, 596	43, 500			1, 263, 228	54.00
56. 00 57. 00	1	RADI OI SOTOPE CT SCAN	727 615	0 2, 179	,		479, 008 624, 841	56. 00 57. 00
58.00	05800	MRI	646	0	119, 866	0	290, 318	58.00
60. 00 62. 30		LABORATORY BLOOD CLOTTING FOR HEMOPHILIACS	3, 631	58, 232 0	1, 375, 201		3, 471, 319 0	60. 00 62. 30
64.00	06400	I NTRAVENOUS THERAPY	0	0	d	o o	0	64.00
65. 00 66. 00		RESPI RATORY THERAPY PHYSI CAL THERAPY	1, 044 1, 030	10, 108 13, 464			1, 231, 468 2, 489, 483	65. 00 66. 00
68. 00		SPEECH PATHOLOGY	479					
		ELECTROCARDI OLOGY	0				41, 216	
71. 00 72. 00		MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS	0	0			394, 921 82, 009	71. 00 72. 00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	(	0	796, 879	73.00
73. 01 76. 97		I NJECTABLE DRUGS CARDI AC REHABI LI TATI ON	0	0			1, 336, 216 0	73. 01 76. 97
76. 98	07698	HYPERBARIC OXYGEN THERAPY	0	0			0	76. 98
76. 99		LITHOTRIPSY TIENT SERVICE COST CENTERS	0	0		0	0	76. 99
88. 00	08800	RURAL HEALTH CLINIC	3, 673	2, 962	1, 069, 134	1 0	1, 503, 060	88. 00
88. 01		RURAL HEALTH CLINIC II RURAL HEALTH CLINIC III	10, 690			0	6, 950, 755	88. 01 88. 02
88. 02 90. 00	1	CLINIC	0 974	0 5, 175		5 0	0 407, 759	90. 00
91.00	09100	EMERGENCY	3, 379	32, 792			1, 956, 683	91.00
92. 00 93. 99	1	OBSERVATION BEDS (NON-DISTINCT PART PARTIAL HOSPITALIZATION PROGRAM	0	0		0	0	92. 00 93. 99
	OTHER	REIMBURSABLE COST CENTERS	_					
95. 00 99. 10	09500	AMBULANCE SERVICES	0	0			0	95. 00 99. 10
99. 20	1	OUTPATIENT PHYSICAL THERAPY	0	0		o o	ő	99. 20
99. 30		OUTPATIENT OCCUPATIONAL THERAPY	0	0	(	0	0	99. 30
		OUTPATIENT SPEECH PATHOLOGY HOME HEALTH AGENCY	0	0	(	-	0	99. 40 101. 00
	SPECI	AL PURPOSE COST CENTERS		-		-		
116. 00 118. 00	1	HOSPICE  SUBTOTALS (SUM OF LINES 1 through 117)	97, 586	_				116. 00 118. 00
	•							

Health Finar	ncial Systems	RICHLAND MEMOR	IAI HOSPITAI		In lie	u of Form CMS-2	2552-10
	TION - STATISTICAL BASIS	THE OTTER WE MEMORE	Provi der CC		eri od:	Worksheet B-1	
					rom 01/01/2023 o 12/31/2023	Date/Time Pre 5/31/2024 10:	
		CAPI TAL REL	ATED COSTS				
	Cost Center Description	BLDG & FLXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VAL UE -NEW)	EMPLOYEE BENEFITS DEPARTMENT	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	
			,	(GROSS SALARI ES)		,	
		1. 00	2.00	4. 00	5A	5. 00	
	IMBURSABLE COST CENTERS						
	PHYSICIANS' PRIVATE OFFICES	14, 846	22, 005	1, 416, 141	0	1, 958, 752	
	OTHER NONREI MBURSABLE	0	0	O	0		194. 00
	MEMORY DI SORDER	0	0	0	0		194. 01
	ASSISTED LIVING	6, 782		1, 305, 061		1, 734, 037	
	CONTRACTED RETAIL RX	0	1, 048	165, 718	0	2, 522, 694	
200. 00	Cross Foot Adjustments						200.00
201. 00	Negative Cost Centers	1 041 100		1 220 104		11 075 500	201.00
202. 00	Cost to be allocated (per Wkst. B, Part I)	1, 041, 180	U	1, 230, 194		11, 975, 508	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	8. 733706	0. 000000	0. 042733		0. 231523	203.00
204. 00	Cost to be allocated (per Wkst. B, Part II)			4, 367		152, 679	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part			0. 000152		0. 002952	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS | Peri od: | Worksheet B-1 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Provider CCN: 14-0147

					To	12/31/2023	Date/Time Pre 5/31/2024 10:	
		Cost Center Description	MAINTENANCE &		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
			REPAIRS (SQUARE FEET)	PLANT (SQUARE FEET)	LINEN SERVICE (LAUNDRY PO	(HOURS OF SERVICE)	(DIETARY ME ALS SERV)	
			,		UNDS)	ŕ		
	GENED	AL SERVICE COST CENTERS	6. 00	7.00	8. 00	9. 00	10. 00	
1. 00		CAP REL COSTS-BLDG & FIXT						1.00
2.00		CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 6. 00		ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	99, 149					5. 00 6. 00
7. 00		OPERATION OF PLANT	32	l				7.00
8. 00	1	LAUNDRY & LINEN SERVICE	3, 176					8.00
9. 00	1	HOUSEKEEPI NG	2, 893	l ·		696		9. 00
10.00	1	DI ETARY	7, 738			0	11, 083	10.00
11. 00 12. 00		CAFETERIA MAINTENANCE OF PERSONNEL	0	0		0	0	11. 00 12. 00
13. 00		NURSI NG ADMI NI STRATI ON	325	325	-	132	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3, 937	ł		82	0	14. 00
15.00		PHARMACY	2, 033	l ·		36	0	15.00
16. 00 17. 00	1	MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	1, 166	1, 166 0		0	0	16. 00 17. 00
17.00		NONPHYSICIAN ANESTHETISTS	0	0	_	0	0	19.00
20. 00		NURSI NG PROGRAM	0	Ö	Ö	Ö	0	20.00
21.00		I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	O	0	21.00
22. 00		I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	- 1	0	0	22.00
23. 00		PARAMED ED PRGM-(SPECIFY) I ENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	23. 00
30. 00		ADULTS & PEDIATRICS	16, 694	16, 694	139, 538	96	3, 578	30.00
31.00		INTENSIVE CARE UNIT	3, 267	3, 267		14	571	31.00
40.00		SUBPROVI DER - I PF	0	0	_	0	0	40.00
43.00		NURSERY	1, 035 0	,		0	0	43.00
44. 00		SKILLED NURSING FACILITY LARY SERVICE COST CENTERS	U	0	<u> </u>	U	0	44.00
50.00		OPERATING ROOM	5, 741	5, 741	13, 142	80	0	50.00
52.00		DELIVERY ROOM & LABOR ROOM	0	0	8, 117	14	109	52.00
53.00	1	ANESTHESI OLOGY	0	0	0	0	0	53.00
54. 00 56. 00	1	RADI OLOGY-DI AGNOSTI C RADI OI SOTOPE	2, 596 727	2, 596 727		5 5	0	54. 00 56. 00
57.00		CT SCAN	615	615		5	0	57.00
58.00	05800		646	646	1	5	0	58. 00
60.00	1	LABORATORY	3, 631	3, 631		14	0	60.00
62. 30		BLOOD CLOTTING FOR HEMOPHILIACS	0	0	_	0	0	62.30
64. 00 65. 00	1	I NTRAVENOUS THERAPY RESPI RATORY THERAPY	1, 044	0 1, 044	-	0  5	0	64. 00 65. 00
66. 00		PHYSI CAL THERAPY	1, 030	,		12	0	66.00
68. 00	1	SPEECH PATHOLOGY	479	479	0	12	0	68. 00
69.00		ELECTROCARDI OLOGY	0	0	0	5	0	69.00
71. 00 72. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	71. 00 72. 00
73. 00		DRUGS CHARGED TO PATIENTS	0	Ö	o o	Ö	0	73.00
73. 01	07301	INJECTABLE DRUGS	0	0	0	0	0	73. 01
76. 97		CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
76. 98 76. 99	1	HYPERBARI C OXYGEN THERAPY LI THOTRI PSY	0	0	0	0	0	76. 98 76. 99
70. 77		TIENT SERVICE COST CENTERS			<u> </u>	<u> </u>		70.77
88. 00	08800	RURAL HEALTH CLINIC	3, 673	3, 673		40	0	
88. 01		RURAL HEALTH CLINIC II	10, 690	1		40	0	88. 01
88. 02 90. 00		RURAL HEALTH CLINIC III CLINIC	974	0 974	-	0	0	88. 02 90. 00
91. 00		EMERGENCY	3, 379	l .		42	0	91.00
92.00		OBSERVATION BEDS (NON-DISTINCT PART						92.00
93. 99		PARTI AL HOSPI TALI ZATI ON PROGRAM	0	0	0	0	0	93. 99
95. 00		REIMBURSABLE COST CENTERS AMBULANCE SERVICES	0		O	ol	0	95. 00
	09910		0		0	0	0	
	1	OUTPATIENT PHYSICAL THERAPY	0	0	0	o	0	
		OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99. 30
		OUTPATIENT SPEECH PATHOLOGY HOME HEALTH AGENCY	0	0	0	0	0	99. 40 101. 00
101.00		AL PURPOSE COST CENTERS	0	0	0	<u> </u>	0	101.00
	11600	HOSPI CE	0	0	0	0		116. 00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	77, 521	77, 489	249, 144	644	4, 258	118. 00
102.00		IMBURSABLE COST CENTERS	14 044	14 044	l ol	10	0	102 00
		PHYSICIANS' PRIVATE OFFICES OTHER NONREIMBURSABLE	14, 846 0	14, 846 0		10 0		192. 00 194. 00
		MEMORY DI SORDER	0	Ö		ő		194. 01
					"			

Health Financial Systems	RICHLAND MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 14-0147	Period: Worksheet B-1 From 01/01/2023
		To 12/31/2023 Date/Time Prepared:

				''	0 12/31/2023	5/31/2024 10:	
	Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		REPAI RS	PLANT	LINEN SERVICE	(HOURS OF	(DIETARY ME	
		(SQUARE FEET)	(SQUARE FEET)	(LAUNDRY PO	SERVICE)	ALS SERV)	
				UNDS)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	ASSISTED LIVING	6, 782	6, 782	71, 124	42	•	194. 02
194. 03 07951	CONTRACTED RETAIL RX	0	0	0	0	0	194. 03
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B,	2, 027, 762	2, 481, 328	752, 308	1, 572, 359	1, 223, 102	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)		l		,		1
204. 00	Cost to be allocated (per Wkst. B,	27, 405	6, 234	30, 313	32, 014	72, 865	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 276402	0. 062895	0. 094649	45. 997126	6. 574483	205. 00
	[11)						
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						[

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS RICHLAND MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 14-0147 Peri od: From 01/01/2023 To 12/31/2023 Worksheet B-1 Date/Time Prepared: 5/31/2024 10: 42 am PHARMACY CENTRAL SERVI CES & SUPPLY NURSI NG ADMI NI STRATI O Cost Center Description CAFETERI A MAI NTENANCE (PHARM COST (CAFE MEALS OF PERSONNEL SERV) (NUMBER Ν ED REQ)

		SERV)	(NUMBER HOUSED)	N (DIRECT NUR SING HO)	SUPPLY (CS COSTED REQUIS)	ED REQ)	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 10. 00 11. 00 12. 00 13. 00 15. 00 17. 00 19. 00 20. 00 21. 00 22. 00 23. 00	01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING PROGRAM 02100 I&R SERVICES-SALARY & FRINGES APPRV 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	505, 783 0 28, 136 5, 073 15, 500 0 0 0	0 0 0 0 0 0 0 0	136, 566 0 0 0 0 0 0 0	359, 065 0 0 0 0 0 0	2, 060, 386 0 0 0 0 0 0	16. 00 17. 00
30.00	1	80, 460	0		13, 558	0	1
31. 00 40. 00	03100   INTENSIVE CARE UNIT   04000   SUBPROVIDER -   IPF	8, 549 0	0		1, 832 0	0	
43.00	04300 NURSERY	7, 648	0		0	0	43.00
44. 00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	<u> </u>	0	0	0	0	44.00
50. 00 52. 00 53. 00 54. 00	+ I	18, 055 0 10, 885 19, 929	0 0 0 0	0	9, 140 0 1, 178 17	0 0 0 0	52.00
56.00	05600 RADI OI SOTOPE	2, 977	0	180	0	0	56.00
57. 00 58. 00	05700 CT SCAN 05800 MRI	10, 167 2, 777	0	0	670 116	0	57. 00 58. 00
60.00		35, 311	0	Ö	166	0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	O	0	0	0	0	62.30
64. 00 65. 00	06400   I NTRAVENOUS THERAPY 06500   RESPI RATORY THERAPY	17, 470	0	0	0 545	0	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	47, 332	0	1, 368	0	0	66.00
68.00	06800 SPEECH PATHOLOGY	4, 808	0	0	0	0	68.00
69. 00 71. 00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	23	0	23	237, 930	0	69. 00 71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	Ö	Ō	0	82, 009	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS 07301 INJECTABLE DRUGS	0	0	0	0	719, 533	1
73. 01 76. 97	07501 INJECTABLE DRUGS		0	0	0	1, 336, 216 0	1
	07698 HYPERBARI C OXYGEN THERAPY	o	0		0	0	
76. 99	07699 LI THOTRI PSY  OUTPATI ENT SERVI CE COST CENTERS	0	0	0	0	0	76. 99
88. 00	08800 RURAL HEALTH CLINIC	20, 148	0		64	0	
88. 01 88. 02	1	85, 466	0	19, 894 0	27	0	88. 01 88. 02
	09000 CLINIC	4, 672	0	2, 596	0	4, 637	1
91.00		40, 734	0	19, 444	9, 775	0	1
92. 00 93. 99	09200 OBSERVATION BEDS (NON-DISTINCT PART 09399 PARTIAL HOSPITALIZATION PROGRAM	o	0	0	o	0	92. 00 93. 99
	OTHER REIMBURSABLE COST CENTERS	9		3	9		
	09500 AMBULANCE SERVI CES 09910 CORF	0	0	0	0	0	1
	09920 OUTPATIENT PHYSICAL THERAPY		0	0	0	0	1
	09930 OUTPATIENT OCCUPATIONAL THERAPY	o	0	0	0	0	
	09940 OUTPATIENT SPEECH PATHOLOGY   10100 HOME HEALTH AGENCY		0	0	0	0	99. 40 101. 00
	SPECIAL PURPOSE COST CENTERS	<u> </u>		-	<u>ال</u>		
	0 11600 HOSPI CE	0	0		0 357,037		116.00
118. 0	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	466, 120	0	125, 719	357, 027	2, 060, 386	] 18.00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0		2, 032		192. 00
194. 0	0 07950 OTHER NONREIMBURSABLE	0	0	0	0	0	194. 00

Health Financial	Systems	RICHLAND MEMORIAL	HOSPI TAL		In Lieu	u of Form CMS-2552-10
COST ALLOCATION	- STATISTICAL BASIS		Provi der C	CCN: 14-0147	From 01/01/2023	Worksheet B-1 Date/Time Prepared:

				11	0 12/31/2023	Date/Time Pre 5/31/2024 10:	
	Cost Center Description	CAFETERI A	MAI NTENANCE	NURSI NG	CENTRAL	PHARMACY	
	•	(CAFE MEALS	OF PERSONNEL	ADMI NI STRATI O	SERVICES &	(PHARM COST	
		SERV)	(NUMBER	N	SUPPLY	ED REQ)	
			HOUSED)	(DI RECT NUR	(CS COSTED		
				SING HO)	REQUIS)		
		11. 00	12. 00	13.00	14. 00	15. 00	
	MEMORY DI SORDER	0	0	0	0		194. 01
194. 02 07953	ASSISTED LIVING	39, 663	0	10, 847	6		194. 02
194. 03 07951	CONTRACTED RETAIL RX	0	0	0	0	0	194. 03
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	1, 309, 502	0	4, 325, 177	1, 435, 437	1, 809, 097	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	2. 589059	0. 000000				1
204. 00	Cost to be allocated (per Wkst. B,	3, 252	0	18, 878	42, 560	29, 570	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 006430	0. 000000	0. 138234	0. 118530	0. 014352	205. 00
	[11]						
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						1

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-0147

					7273172023	5/31/2024 10: INTERNS &	
	Cost Center Description	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	NONPHYSI CI AN ANESTHETI STS (ASSI GNED TI ME)	NURSI NG PROGRAM (ASSI GNED TI ME)	RESI DENTS SERVI CES-SALA RY & FRI NGES APPRV (ASSI GNED TI ME)	
	OFNEDAL CEDIUSE COCT OFNEDO	16. 00	17. 00	19. 00	20.00	21. 00	
1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 19. 00 20. 00 21. 00	GENERAL SERVICE COST CENTERS  00100 CAP REL COSTS-BLDG & FIXT  00200 CAP REL COSTS-MVBLE EQUIP  00400 EMPLOYEE BENEFITS DEPARTMENT  00500 ADMINISTRATIVE & GENERAL  00600 MAINTENANCE & REPAIRS  00700 OPERATION OF PLANT  00800 LAUNDRY & LINEN SERVICE  00900 HOUSEKEEPING  01000 DIETARY  01100 CAFETERIA  01200 MAINTENANCE OF PERSONNEL  01300 NURSING ADMINISTRATION  01400 CENTRAL SERVICES & SUPPLY  01500 PHARMACY  01600 MEDICAL RECORDS & LIBRARY  01700 SOCIAL SERVICE  01900 NONPHYSICIAN ANESTHETISTS  02000 NURSING PROGRAM  02100 I&R SERVICES-SALARY & FRINGES APPRV	445 0 0 0	0 0 0 0	0	0	0	1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 19. 00 20. 00 21. 00
22. 00 23. 00	02200   1&R SERVICES-OTHER PRGM COSTS APPRV 02300   PARAMED ED PRGM-(SPECIFY)	0	0				22. 00 23. 00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	0				23.00
30. 00 31. 00 40. 00 43. 00 44. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04300 NURSERY 04400 SKILLED NURSING FACILITY	93 7 0 7 0	0 0 0 0	0 0	0 0 0 0	0	30. 00 31. 00 40. 00 43. 00 44. 00
FO 00	ANCILLARY SERVICE COST CENTERS	120		I 0			F0 00
50. 00 52. 00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	139	0 0		0		50.00 52.00
53. 00	05300 ANESTHESI OLOGY	0	Ö	1	0	_	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	11	0	-	0	0	54.00
56. 00 57. 00	05600	0	0		0	0	56. 00 57. 00
58. 00	05800 MRI	0	Ö	Ö	0	0	58. 00
60.00	06000 LABORATORY	22	0	0	0	0	60.00
62. 30 64. 00	06250 BLOOD CLOTTING FOR HEMOPHILIACS 06400 INTRAVENOUS THERAPY	0	0	0	0	0	62. 30 64. 00
65. 00	06500 RESPIRATORY THERAPY	0	Ö	Ö	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	0	0	0	66.00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	0	0	0	0	68. 00 69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0		71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73. 00 73. 01	07300 DRUGS CHARGED TO PATIENTS 07301 NJECTABLE DRUGS	0	0	0	0	0	73. 00 73. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	0	Ö	Ö	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 98
70. 99	07699 LITHOTRIPSY   OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	76. 99
	08800 RURAL HEALTH CLINIC	0	0	1	0	_	88. 00
88. 01	08801 RURAL HEALTH CLINIC II 08802 RURAL HEALTH CLINIC III	0	0	0	0	0	88. 01 88. 02
90.00	09000 CLI NI C	0	0	o o	0	0	90.00
	l l	47	0	0	0	0	91.00
92. 00 93. 99	09200 OBSERVATION BEDS (NON-DISTINCT PART 09399 PARTIAL HOSPITALIZATION PROGRAM	0	0	o	0	0	92. 00 93. 99
73. 77	OTHER REIMBURSABLE COST CENTERS			0		0	75. 77
95.00		0	0		0	_	95.00
	09910 CORF 09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99. 10 99. 20
99. 30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	O	0	0	99. 30
	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0		99.40
101.00	10100   HOME HEALTH AGENCY   SPECIAL PURPOSE COST CENTERS	. 0	0	0	0	0	101. 00
	11600 H0SPI CE	0			0		116. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	329	0	0	0	0	118. 00

Health Financial Systems	RICHLAND MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der C		Peri od: From 01/01/2023	Worksheet B-1	
					Date/Time Pre 5/31/2024 10:	
Cost Contar Doscription	MEDICAL	SOCIAL	NONDHYSLCLAN	MITDST NC	I NTERNS & RESI DENTS	

				T	o 12/31/2023	Date/Time Pre 5/31/2024 10:	
						I NTERNS &	42 alli
						RESI DENTS	
	Cost Center Description	MEDI CAL	SOCI AL	NONPHYSI CI AN	NURSI NG	SERVI CES-SALA	
		RECORDS &	SERVI CE	ANESTHETI STS	PROGRAM	RY & FRINGES	
		LI BRARY	(TIME SPENT)	(ASSI GNED	(ASSI GNED	APPRV	
		(TIME SPENT)	·	TIME)	TIME)	(ASSI GNED	
		,		ĺ	ŕ	`TIME)	
		16. 00	17. 00	19. 00	20. 00	21. 00	
	I MBURSABLE COST CENTERS						
	PHYSICIANS' PRIVATE OFFICES	107	0	0	0		192. 00
	OTHER NONREI MBURSABLE	0	0	0	0		194. 00
	MEMORY DI SORDER	0	0	0	0		194. 01
	ASSISTED LIVING	9	0	0	0		194. 02
	CONTRACTED RETAIL RX	0	0	0	0	0	194. 03
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B,	1, 110, 070	0	0	0	0	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	2, 494. 539326	0. 000000	0. 000000	0. 000000		1
204. 00	Cost to be allocated (per Wkst. B,	13, 113	0	0	0	0	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	29. 467416	0. 000000	0. 000000	0. 000000	0. 000000	205.00
224 22	[11]						
206. 00	NAHE adjustment amount to be allocated				0		206. 00
207.00	(per Wkst. B-2)				0.000000		207 00
207. 00	NAHE unit cost multiplier (Wkst. D,				0. 000000		207. 00
	Parts III and IV)	1					l

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS RICHLAND MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 14-0147

Peri od: Worksheet B-1 From 01/01/2023 To 12/31/2023 Date/Time Prepared:

						0 12/31/2023	Date/lime Prepared:   5/31/2024 10:42 am
			INTERNS &	<u> </u>			
			RESI DENTS				
		Cost Center Description	SERVI CES-OTHE	PARAMED ED			
			R PRGM COSTS APPRV	PRGM (ASSI GNED			
			(ASSI GNED	TIME)			
			TIME)	11 1112/			
			22. 00	23. 00			
		AL SERVICE COST CENTERS	1		T.		
1.00		CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP					1.00
2. 00 4. 00	1	EMPLOYEE BENEFITS DEPARTMENT					2.00
5. 00	1	ADMINISTRATIVE & GENERAL					5.00
6. 00	1	MAINTENANCE & REPAIRS					6. 00
7.00	00700	OPERATION OF PLANT					7. 00
8.00	1	LAUNDRY & LINEN SERVICE					8. 00
9.00	1	HOUSEKEEPI NG					9.00
10. 00 11. 00		DIETARY					10.00
12.00		CAFETERIA   MAINTENANCE OF PERSONNEL					11.00
13. 00		NURSING ADMINISTRATION					13. 00
14. 00		CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15. 00
16. 00	1	MEDICAL RECORDS & LIBRARY					16. 00
17. 00		SOCIAL SERVICE					17.00
19.00	1	NONPHYSI CI AN ANESTHETI STS					19.00
20. 00 21. 00	1	NURSING PROGRAM   I&R SERVICES-SALARY & FRINGES APPRV					20.00
22. 00	1	I&R SERVICES-OTHER PRGM COSTS APPRV	0				22.00
23. 00	1	PARAMED ED PRGM-(SPECIFY)		0			23.00
		IENT ROUTINE SERVICE COST CENTERS					
30.00		ADULTS & PEDIATRICS	0	0			30.00
31.00		INTENSIVE CARE UNIT	0	0			31.00
40. 00 43. 00	1	SUBPROVIDER - IPF  NURSERY	0	0			40. 00 43. 00
44.00	1	SKILLED NURSING FACILITY		0			44.00
		LARY SERVICE COST CENTERS	-1				
50.00	1	OPERATING ROOM	0	0	1		50.00
52.00	1	DELIVERY ROOM & LABOR ROOM	0	0	1		52.00
53. 00 54. 00	1	ANESTHESI OLOGY   RADI OLOGY-DI AGNOSTI C	0	0			53. 00 54. 00
56.00	1	RADI OLOGI - DI AGNOSTI C		0			56.00
57. 00	1	CT SCAN	0	0	1		57.00
58.00	05800	MRI	0	0			58.00
60.00	1	LABORATORY	0	0			60.00
62. 30		BLOOD CLOTTING FOR HEMOPHILIACS	0	0	1		62. 30 64. 00
64. 00 65. 00		I NTRAVENOUS THERAPY   RESPI RATORY THERAPY	0	0			65. 00
66. 00	1	PHYSI CAL THERAPY		0			66.00
68.00		SPEECH PATHOLOGY	0	0			68. 00
		ELECTROCARDI OLOGY	0	0			69.00
	1	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1		71.00
		IMPL. DEV. CHARGED TO PATIENTS	0	0			72.00
73. 00 73. 01	1	DRUGS CHARGED TO PATIENTS INJECTABLE DRUGS	0	0			73. 00 73. 01
	1	CARDI AC REHABI LI TATI ON		0			76. 97
76. 98	1	HYPERBARIC OXYGEN THERAPY	O	0			76. 98
76. 99		LI THOTRI PSY	0	0			76. 99
00.00		TIENT SERVICE COST CENTERS	ا				00.00
88. 00 88. 01		RURAL HEALTH CLINIC RURAL HEALTH CLINIC II	0	0	1		88. 00   88. 01
88. 02	1	RURAL HEALTH CLINIC III		0			88. 02
90.00		CLINIC	Ö	0			90.00
91.00		EMERGENCY	0	0			91.00
92. 00	1	OBSERVATION BEDS (NON-DISTINCT PART	_	_			92.00
93. 99		PARTIAL HOSPITALIZATION PROGRAM REIMBURSABLE COST CENTERS	0	0			93. 99
95. 00		AMBULANCE SERVICES		0			95. 00
99. 10				0	1		99. 10
	1	OUTPATIENT PHYSICAL THERAPY	0	0			99. 20
		OUTPATIENT OCCUPATIONAL THERAPY	0	0	1		99. 30
		OUTPATIENT SPEECH PATHOLOGY	0	0			99. 40
101.00		HOME HEALTH AGENCY AL PURPOSE COST CENTERS	0	0	1		101.00
116. 00		HOSPICE		О			116. 00
118.00	1	SUBTOTALS (SUM OF LINES 1 through 117)	o	0	1		118.00

COST ALLOCATION - STATISTICAL BASIS  Provider CCN: 14-0147 Period: From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/31/2024 10: 42 am  INTERNS & RESIDENTS SERVICES-OTHE R PRGM COSTS APPRV (ASSIGNED)  Period: From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/31/2024 10: 42 am
To 12/31/2023 Date/Time Prepared: 5/31/2024 10: 42 am  INTERNS & RESIDENTS  Cost Center Description SERVICES-OTHE R PRGM COSTS PRGM  To 12/31/2023 Date/Time Prepared: 5/31/2024 10: 42 am
RESIDENTS   SERVICES-OTHE   PARAMED ED   R PRGM COSTS   PRGM
Cost Center Description SERVICES-OTHE PARAMED ED R PRGM COSTS PRGM
R PRGM COSTS   PRGM
APPRV (ASSLGNED)
(ASSI GNED TIME)
TIME)
22.00 23.00
NONREI MBURSABLE COST CENTERS
192. 00 19200  PHYSI CI ANS' PRI VATE OFFI CES   0  0  192. 00
194. 00 07950  OTHER NONREI MBURSABLE   0  0    194. 00
194. 01 07952 MEMORY DI SORDER   0  0   194. 01
194. 02 07953  ASSI STED LI VI NG   0  0  194. 02
194. 03 07951 CONTRACTED_RETAIL_RX   0  0  194. 03
200.00   Cross Foot Adjustments   200.00

0. 000000

0. 000000

0.000000

0. 000000

0. 000000

201. 00 202. 00

203. 00 204. 00

205. 00

206.00

207. 00

201.00

202.00

203.00

204.00

205.00

206.00

207.00

Negative Cost Centers

Part I)

Part II)

Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part I)
Cost to be allocated (per Wkst. B,

NAHE adjustment amount to be allocated (per Wkst. B-2)
NAHE unit cost multiplier (Wkst. D, Parts III and IV)

Unit cost multiplier (Wkst. B, Part

Health Financial Systems	RICHLAND MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 14-0147	Period: Worksheet C From 01/01/2023 Part I
		To 12/31/2023 Date/Time Prepared:

Cost Center Description				Т	o 12/31/2023	Date/Time Pre 5/31/2024 10:	
Total Cost			Title	· XVIII	Hospi tal		42 dili
NPATIENT ROUTI NE SERVI CE COST CENTERS   1.00   2.00   3.00   4.00   5.00   3.00							
NPAT ENT ROUTINE SERVICE COST CENTERS   1.00   2.00   3.00   4.00   5.00	Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
INPATIENT ROUTINE SERVICE COST CENTERS   1.00   2.00   3.00   4.00   5.00	, , , , , , , , , , , , , , , , , , ,				Di sal I owance		
INPATIENT ROUTINE SERVICE COST CENTERS   1.00   2.00   3.00   4.00   5.00		B, Part I,					
INPATIENT ROUTINE SERVICE COST CENTERS   8,771, 332   0, 8,771, 332   0, 8,771, 332   0, 8,771, 332   0, 8,771, 332   0, 8,771, 332   0, 8,771, 332   0, 8,771, 332   0, 8,771, 332   0, 8,771, 332   0, 8,771, 332   0, 8,771, 332   0, 8,771, 332   0, 8,771, 332   0, 8,771, 332   0, 8,771, 332   0, 8,771, 332   0, 8,771, 332   0, 8,771, 332   0, 8,731, 332   0, 8,731, 332   0, 8,731, 332   0, 8,731, 332   0, 8,731, 332   0, 8,731, 332   0, 8,731, 332   0, 8,731, 332   0, 8,731, 332   0, 8,731, 332   0, 8,731, 332   0, 9, 44, 00   44, 00   44, 00   44, 00   44, 00   44, 00   44, 00   44, 00   44, 00   44, 00   44, 00   44, 00   44							
30.00   03000   ADULTS & PEDIATRICS   8, 771, 332   8, 771, 332   0, 00     31.00   03100   NITENSIN VE CARE UNIT   1, 306, 615   1, 306, 615   0, 100   0, 00   0,		1. 00	2.00	3.00	4. 00	5. 00	
31. 00   03100   INTENSIVE CARE UNIT	INPATIENT ROUTINE SERVICE COST CENTERS						
40.00   04000   04000   04000   0   0   0	30. 00   03000   ADULTS & PEDI ATRI CS	8, 771, 332		8, 771, 332	0	8, 771, 332	30.00
43.00   O4300   MURSERY   895,501   895,501   0   895,501   43.00   AMCI LLARY SERVICE COST CENTERS   Service   Se	31.00 03100 INTENSIVE CARE UNIT	1, 306, 615		1, 306, 615	0	1, 306, 615	31.00
Add   O   O   O   O   O   O   O   O   O	40. 00   04000   SUBPROVI DER - I PF	0		0	0	0	40.00
ANCILLARY SERVICE COST CENTERS   A, 507, 657   A, 507, 657   O, 4, 507, 657   So. 00   So. 00   GPEANTING ROOM   A, 507, 657   So. 00   So. 00   GPEANTING ROOM   A, 507, 657   So. 00   So. 0		895, 501		895, 501	0	895, 501	43.00
50.00   05000  0FEATI ING ROOM   4, 507, 657   4, 507, 657   0   4, 507, 657   50, 00   520, 0	44.00 04400 SKILLED NURSING FACILITY	0		0	0	0	44.00
S2.00   05200   DELLYERY ROOM & LABOR ROOM   573, 135   573, 135   0   573, 135   0   573, 135   0   52.00							
S3.0   0   0   0   0   0   0   0   0   0							
S4. 00   05400   RADIOLOGY-DIAGNOSTIC   1,827,178   1,827,178   0   1,827,178   0   6.49,498   0   6.49,498   0   6.49,498   0   6.49,498   0   6.49,498   0   6.49,498   0   6.49,498   0   6.49,498   0   0   6.49,498   0   0   6.49,498   0   0   6.49,498   0   0   6.49,498   0   0   0   0   0   0   0   0   0		573, 135		573, 135	0	573, 135	52.00
55.00   05600   RADIO I SOTOPE   649, 498   649, 498   649, 498   65.00		619, 388		619, 388	0	619, 388	
S7.00   05700   CT SCAN   837, 777   837, 777   0   837, 777   57.00	54. 00   05400 RADI OLOGY-DI AGNOSTI C	1, 827, 178		1, 827, 178	0	1, 827, 178	54.00
58.00   05800   MR    405, 867   405, 867   0 405, 867   58. 00		649, 498		649, 498	0	649, 498	56.00
60.0   06000   LABORATORY   4, 621, 488   0, 24, 621, 488   0, 0   0   0   0   0   0   0   0   0	57. 00   05700   CT   SCAN	837, 777		837, 777	0	837, 777	57.00
62.30   06250   BLOOD CLOTTING FOR HEMOPHILIACS   0   0   0   0   0   62.30   64.00   06400   INTRAVENOUS THERAPY   0   0   0   0   0   0   65.00   06500   RESPI RATORY THERAPY   1,636,848   0   1,636,848   0   1,636,848   0   66.00   06600   PRESPI RATORY THERAPY   3,305,687   0   3,305,687   0   67.00   06600   PRESPI RATORY THERAPY   3,305,687   0   3,305,687   0   68.00   06600   SPECEN PATHOLOGY   426,532   0   426,532   0   426,532   0   69.00   06900   ELECTROCARDIOLOGY   62,842   62,842   0   62,842   0   62,842   69,00   69.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT   1,437,528   1,437,528   0   1,437,528   71.00   67.00   07200   IMPL DEV. CHARGED TO PATIENTS   428,844   428,844   0   428,844   72.00   67.00   07300   DRUGS CHARGED TO PATIENTS   1,613,152   1,613,152   0   1,613,152   73.00   67.01   07301   INJECTABLE DRUGS   2,818,830   2,818,830   0   2,818,830   73.01   67.09   07697   CARDIAC REHABILITATION   0   0   0   0   0   0   76.99   67.09   07698   HYPERBERRE CONTOR THERAPY   0   0   0   0   0   0   0   76.99   67.09   07699   LITHOTRIPSY   0   0   0   0   0   0   0   0   0	58. 00   05800   MRI	405, 867		405, 867	0	405, 867	58.00
64. 00   06400   INTRAVENOUS THERAPY   0   0   0   0   0   64. 00   65. 00   06500   RESPI RATORY THERAPY   1,636,848   0   1,636,848   0   1,636,848   65. 00   66. 00   06600   PHYSI CAL THERAPY   3,305,687   0   3,305,687   0   3,305,687   0   68. 00   06600   PHYSI CAL THERAPY   3,305,687   0   3,305,687   0   69. 00   06900   ELECTROCARDI OLOGY   426,532   0   426,532   0   426,532   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   1,437,528   1,437,528   0   1,437,528   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   4,28,844   428,844   0   428,844   0   428,844   0   73. 00   07300   DRUGS CHARGED TO PATIENTS   1,613,152   1,613,152   0   1,613,152   73. 00   73. 01   07301   INJECTABLE DRUGS   2,818,830   2,818,830   0   2,818,830   0   2,818,830   0   2,818,830   0   76. 99   07697   CARDI AC REHABILITATI ON   0   0   0   0   76. 97   76. 99   07697   CARDI AC REHABILITATI ON   0   0   0   0   76. 98   76. 99   07699   LITHOTH IPSY   0   0   0   0   0   76. 99   76. 99   07699   LITHOTH IPSY   0   0   0   0   0   0   76. 99   07699   LITHOTH IPSY   0   0   0   0   0   76. 90   08000   RURAL HEALTH CLINIC   11   9,989,006   9,989,006   0   9,989,006   88. 01   79. 00   09000   CLINIC   0   0   0   0   0   79. 00   09000   CLINIC   0   0   0   0   79. 00   09000   CLINIC   0   0   0   0   79. 00   09000   CLINIC   0   0   0   0   79. 00   09000   0   0   0   0   79. 00   09000   0   0   0   0   79. 00   09000   0   0   0   0   79. 00   0   0   0   0   79. 00   0   0   0   0   79. 00   0   0   0   0   79. 00   0   0   0   0   79. 00   0   0   0   0   79. 00   0   0   0   79. 00   0   0   0   0   79. 00   0   0   0   0   79. 00   0   0   0   79. 00   0   0   0   0   79. 00   0   0   0   79. 00   0   0   0   79. 00   0   0   0   79. 00   0   0   0   79. 00   0   0   0   79. 00   0   0   0   79. 00   0   0   0   79. 00   0   0   0   79. 00   0   0   0   79. 00   0   0   0   79. 00   0   0   0   79. 00   0   0   0   79. 00   0   0   0   79. 00   0   0   0   79. 00   0   0   0   79. 00	60. 00   06000   LABORATORY	4, 621, 488		4, 621, 488	0	4, 621, 488	60.00
65.00   06500   RESPIRATORY THERAPY   1,636,848   0   1,636,848   0   3,305,687   0   426,532   0   42	62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
66.00   06600   PHYSI CAL THERAPY   3, 305, 687   0   3, 305, 687   0   3, 305, 687   0   68.00   68.00   06800   SPEECH PATHOLOGY   426, 532   0   426, 532   0   426, 532   0   69.00   06900   ELECTROCARDIOLOGY   62, 842   0   62, 842   0   62, 842   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   1, 437, 528   1, 437, 528   0   1, 437, 528   71. 00   72. 00   07200   IMPL DEV. CHARGED TO PATIENTS   428, 844   628, 844   629, 629   62	64. 00 06400 I NTRAVENOUS THERAPY	0		0	0	0	64.00
68.00   06800   SPEECH PATHOLOGY   426, 532   0   426, 532   0   62, 844   72, 90   73, 90   73, 90   73, 90   73, 90   73, 90   73, 90   73, 90   73, 90   73, 90   73, 90   74, 92   90   90, 90   90, 90   90, 90   90, 90   90, 90   90, 90   90, 90   90, 90   90, 90   90, 90   90, 90   90, 90   90, 90, 90   90, 90, 90   90, 90, 90   90, 90, 90, 90   90, 90, 90, 90   90, 90, 90, 90, 90, 90, 90, 90, 90, 90,	65. 00 06500 RESPIRATORY THERAPY	1, 636, 848	0	1, 636, 848	0	1, 636, 848	65.00
69.00   0.6900   ELECTROCARDI OLOGY	66. 00   06600 PHYSI CAL THERAPY	3, 305, 687	0	3, 305, 687	0	3, 305, 687	66.00
71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   1, 437, 528   1, 437, 528   0   1, 437, 528   71. 00   72. 00   07200   MPL. DEV. CHARGED TO PATIENTS   428, 844   428, 844   0   428, 844   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   1, 613, 152   1, 613, 152   0   1, 613, 152   0   1, 613, 152   0   1, 613, 152   0   1, 613, 152   0   1, 613, 152   0   1, 613, 152   0   1, 613, 152   0   1, 613, 152   0   1, 613, 152   0   1, 613, 152   0   1, 613, 152   0   1, 613, 152   0   1, 613, 152   0   1, 613, 152   0   1, 613, 152   0   0   0   0   0   0   0   0   0	68. 00 06800 SPEECH PATHOLOGY	426, 532	0	426, 532	0	426, 532	68.00
72. 00   07200   IMPL DEV. CHARGED TO PATIENTS   428,844   428,844   428,844   0   428,844   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   1,613,152   1,613,152   0   1,613,152   0   1,613,152   73. 00   73.01   INJECTABLE DRUGS   2,818,830   2,818,830   0   2,818,830   0   2,818,830   0   2,818,830   0   2,818,830   0   2,818,830   0   0   0   0   0   0   0   0   0	69. 00 06900 ELECTROCARDI OLOGY	62, 842		62, 842	0	62, 842	69.00
73. 00   07300   DRUGS CHARGED TO PATIENTS	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 437, 528		1, 437, 528	0	1, 437, 528	71.00
73. 01   07301   INJECTABLE DRUGS   2, 818, 830   2, 818, 830   0   2, 818, 830   73. 01   76. 97   07697   CARDI AC REHABI LI TATI ON   0   0   0   0   0   76. 98   76. 99   07699   LI THOTRI PSY   0   0   0   0   0   0   0   0   0	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	428, 844		428, 844	0	428, 844	72.00
76. 97	73.00 07300 DRUGS CHARGED TO PATIENTS	1, 613, 152		1, 613, 152	0	1, 613, 152	73.00
76. 98   07698   HYPERBARIC OXYGEN THERAPY   0   0   0   0   0   76. 98   76. 99   07699   LI THOTRI PSY   0   0   0   0   0   00   0   0   0	73. 01 07301 I NJECTABLE DRUGS	2, 818, 830		2, 818, 830	0	2, 818, 830	73. 01
76. 99	76. 97 07697 CARDI AC REHABI LI TATI ON	0		0	0	0	76. 97
SECOND   CONTROL   CONTR	76. 98 07698 HYPERBARI C OXYGEN THERAPY	0		0	0	0	76. 98
88. 00	76. 99 07699 LI THOTRI PSY	0		0	0	0	76. 99
88. 01	OUTPATIENT SERVICE COST CENTERS						
88. 02 08802 RURAL HEALTH CLINIC III 0 0 0 0 0 0 88. 02 90. 00 09000 CLINIC 663, 013 663, 013 0 663, 013 90. 00 91. 00 09100 EMERGENCY 3, 592, 171 3, 592, 171 0 3, 592, 171 0 3, 592, 171 0 3, 592, 171 0 3, 592, 171 0 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 2, 041, 638 2, 041, 638 2, 041, 638 2, 041, 638 92. 00 93. 99 074	88.00 08800 RURAL HEALTH CLINIC	2, 290, 664		2, 290, 664	0	2, 290, 664	88. 00
90. 00   09000   CLINIC   663, 013   0   663, 013   90. 00   9100   EMERGENCY   3,592,171   3,592,171   0   3,592,171   91. 00   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART   2,041,638   2,	88.01 08801 RURAL HEALTH CLINIC II	9, 989, 006		9, 989, 006	0	9, 989, 006	88. 01
91. 00	88.02 08802 RURAL HEALTH CLINIC III	0		0	0	0	88. 02
92. 00	90. 00  09000  CLI NI C	663, 013		663, 013	0	663, 013	90.00
93. 99   09399   PARTI AL HOSPI TALI ZATI ON PROGRAM   0   0   0   0   0   0     OTHER REI MBURSABLE COST CENTERS   0   0   0   0   0   95. 00     99. 10   09910   CORF   0   0   0   0   99. 10     99. 20   09920   OUTPATI ENT PHYSI CAL THERAPY   0   0   0   0   99. 20     99. 30   09930   OUTPATI ENT OCCUPATI ONAL THERAPY   0   0   0   0   99. 30     99. 40   09940   OUTPATI ENT SPEECH PATHOLOGY   0   0   0   0     101. 00   HOME HEALTH AGENCY   0   0   0   0     SPECIAL PURPOSE COST CENTERS   116. 00   116. 00     200. 00   Subtotal (see instructions)   55, 322, 191   0   55, 322, 191   0     201. 00   Less Observation Beds   2, 041, 638   2, 041, 638   201. 00	91. 00   09100   EMERGENCY	3, 592, 171		3, 592, 171	0	3, 592, 171	91.00
OTHER REIMBURSABLE COST CENTERS           95. 00         09500 AMBULANCE SERVI CES         0         0         0         95. 00           99. 10         09910 CORF         0         0         0         99. 10           99. 20         09920 OUTPATI ENT PHYSI CAL THERAPY         0         0         0         99. 20           99. 30         09930 OUTPATI ENT OCCUPATI ONAL THERAPY         0         0         0         99. 30           99. 40         09940 OUTPATI ENT SPEECH PATHOLOGY         0         0         0         99. 40           101. 00         10100 HOME HEALTH AGENCY         0         0         0         0         101. 00           SPECIAL PURPOSE COST CENTERS         0         0         0         0         1016. 00           200. 00         Subtotal (see instructions)         55, 322, 191         0         55, 322, 191         0         55, 322, 191         0         55, 322, 191         200. 00           201. 00         Less Observation Beds         2, 041, 638         2, 041, 638         2, 041, 638         201. 00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 041, 638		2, 041, 638		2, 041, 638	92.00
95. 00   09500   AMBULANCE SERVI CES   0   0   0   0   95. 00   99. 10   09910   CORF   0   0   0   0   99. 10   99. 20   09920   OUTPATI ENT PHYSI CAL THERAPY   0   0   0   0   99. 20   99. 30   09930   OUTPATI ENT OCCUPATI ONAL THERAPY   0   0   0   0   99. 30   99. 40   09940   OUTPATI ENT SPECH PATHOLOGY   0   0   0   0   0   10100   HOME HEALTH AGENCY   0   0   0   0   10100   OUTPATI ENT SPECH PATHOLOGY   0   0   0   0   1010. 00   OUTPATI ENT SPECH PATHOLOGY   0   0   0   0   1010. 00   OUTPATI ENT SPECH PATHOLOGY   0   0   0   0   1010. 00   OUTPATI ENT SPECH PATHOLOGY   0   0   0   0   1010. 00   OUTPATI ENT SPECH PATHOLOGY   0   0   0   0   1010. 00   OUTPATI ENT SPECH PATHOLOGY   0   0   0   0   0   0   OUTPATI ENT SPECH PATHOLOGY   0   0   0   0   0   0   0   0   0	93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	0		0	0	0	93. 99
99. 10							
99. 20	95. 00 09500 AMBULANCE SERVICES	0		0	0	0	95.00
99. 30	99. 10   09910   CORF	0		0		0	99. 10
99. 40   09940   OUTPATIENT SPEECH PATHOLOGY   0   0   99. 40   101. 00   10100   HOME   HEALTH   AGENCY   0   0   0   101. 00   101. 00   116. 00		0		0		0	99. 20
101. 00	99.30 09930 OUTPATIENT OCCUPATIONAL THERAPY	0		0		0	99. 30
SPECIAL PURPOSE COST CENTERS   116.00		0		0		0	99. 40
116. 00 11600 H0SPI CE 0 0 0 116. 00 200. 00 Subtotal (see instructions) 55, 322, 191 0 55, 322, 191 0 55, 322, 191 200. 00 201. 00 Less Observation Beds 2, 041, 638 2, 041, 638 201. 00		0		0		0	101. 00
200. 00     Subtotal (see instructions)     55, 322, 191     0     55, 322, 191     0     55, 322, 191       201. 00     Less Observation Beds     2, 041, 638     2, 041, 638     2, 041, 638     2, 041, 638							1
201.00 Less Observation Beds 2,041,638 2,041,638 2,041,638 201.00		_		-			
			0	,,	-		
202. 00							
	202.00   Total (see instructions)	53, 280, 553	0	53, 280, 553	0	53, 280, 553	202.00

						5/31/2024 10:	42 am_
			Title	XVIII	Hospi tal	PPS	
	·		Charges		·		
	Cost Center Description	I npati ent	Outpati ent	Total (col.	Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
				' ' ' ' ' ' '		Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7.00	10.00	
20.00		F 457 (40		F 457 (4			00.00
30.00	03000 ADULTS & PEDI ATRI CS	5, 457, 640		5, 457, 64			30.00
31.00	03100 INTENSIVE CARE UNIT	1, 354, 690		1, 354, 69			31.00
40.00	04000 SUBPROVI DER - I PF	0		1	0		40.00
43.00	04300 NURSERY	322, 510		322, 51	0		43.00
44.00	04400 SKILLED NURSING FACILITY	0			0		44.00
	ANCILLARY SERVICE COST CENTERS						]
50.00	05000 OPERATING ROOM	2, 081, 704	11, 400, 353	13, 482, 05	7 0. 334345	0.000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	477, 035	308, 490	785, 52	5 0. 729620	0. 000000	52.00
53. 00	05300 ANESTHESI OLOGY	0	304, 090			0.000000	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	976, 036	12, 379, 941			0. 000000	
56. 00	05600 RADI OI SOTOPE	152, 123	2, 746, 175			0. 000000	56.00
57. 00	05700 CT SCAN	4, 663, 741	25, 103, 739			0. 000000	
	05800 MRI						
58.00		491, 700	6, 916, 234			0.000000	
60.00	06000 LABORATORY	6, 889, 689	30, 681, 953			0. 000000	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	1	0. 000000	0. 000000	62. 30
64.00	06400 I NTRAVENOUS THERAPY	0	0	1	0. 000000	0. 000000	
65.00	06500 RESPI RATORY THERAPY	4, 665, 370	1, 398, 060	6, 063, 43	0. 269954	0. 000000	
66.00	06600 PHYSI CAL THERAPY	2, 232, 205	13, 180, 511	15, 412, 71	6 0. 214478	0.000000	66.00
68.00	06800 SPEECH PATHOLOGY	187, 605	1, 105, 142	1, 292, 74	7 0. 329942	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	994, 925	9, 270, 577	10, 265, 50	2 0. 006122	0. 000000	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	744, 071	3, 510, 872			0. 000000	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	95, 721	246, 180			0.000000	
73. 00	07300 DRUGS CHARGED TO PATIENTS	5, 625, 823	3, 974, 910			0. 000000	
73. 01	07301 I NJECTABLE DRUGS	0, 020, 020	8, 284, 066			0. 000000	
76. 97	07697 CARDI AC REHABI LI TATI ON		0, 204, 000	1	0. 000000	0. 000000	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY		0		0. 000000		
76. 99		0		l .			
76. 99	07699 LI THOTRI PSY	U	0		0. 000000	0. 000000	76.99
	OUTPATIENT SERVICE COST CENTERS		0.4/4.470				
88. 00	08800 RURAL HEALTH CLINIC	0	2, 161, 178				88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	11, 663, 061				88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0	0	1	0		88. 02
90.00	09000 CLI NI C	0	711, 521	711, 52	0. 931825		
91.00	09100 EMERGENCY	3, 359, 041	26, 615, 947	29, 974, 98	8 0. 119839	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	619, 790	4, 151, 635	4, 771, 42	5 0. 427889	0.000000	92.00
93. 99	09399 PARTIAL HOSPITALIZATION PROGRAM	o	0		0. 000000	0. 000000	93. 99
	OTHER REIMBURSABLE COST CENTERS	'		•	<u>'</u>		1
95.00	09500 AMBULANCE SERVI CES	0	0		0. 000000	0.000000	95.00
99. 10	09910 CORF		0	1	0	0.00000	99. 10
99. 20	09920 OUTPATIENT PHYSICAL THERAPY		0		o		99. 20
99. 30	09930 OUTPATIENT OCCUPATIONAL THERAPY		0		0		99. 30
99. 40	09940 OUTPATIENT SPEECH PATHOLOGY		0		0		99.40
	1	0	-		-		
101.00	10100 HOME HEALTH AGENCY	] 0	0	1	0		101. 00
44/ 00	SPECIAL PURPOSE COST CENTERS						111 00
	11600 H0SPI CE	0	0	l .	0		116.00
200.00	,	41, 391, 419	176, 114, 635	217, 506, 05	4		200.00
201.00							201. 00
202.00	Total (see instructions)	41, 391, 419	176, 114, 635	217, 506, 05	4		202.00

Heal th Financial Systems RICHLAND MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0147 | Period: From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: 5/31/2024 10: 42 am

				5/31/2024 10:42 am
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00   03000   ADULTS & PEDI ATRI CS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
40. 00   04000   SUBPROVI DER - 1 PF				40.00
43. 00   04300   NURSERY				43.00
44. 00 O4400 SKILLED NURSING FACILITY				44. 00
ANCILLARY SERVICE COST CENTERS				
50. 00   05000   OPERATING ROOM	0. 334345			50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 729620			52.00
53. 00   05300   ANESTHESI OLOGY	2. 036858			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 136806			54.00
56. 00   05600   RADI 01 SOTOPE	0. 224096			56.00
57. 00   05700 CT SCAN	0. 028144			57. 00
58. 00   05800   MRI	0. 054788			58.00
60. 00   06000   LABORATORY	0. 123005			60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			62.30
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000			64.00
65. 00 06500 RESPIRATORY THERAPY	0. 269954			65.00
66. 00   06600   PHYSI CAL THERAPY	0. 214478			66.00
68. 00 06800 SPEECH PATHOLOGY	0. 329942			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 006122			69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 337849			71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	1. 254293			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 168024			73.00
73. 01 07301 I NJECTABLE DRUGS	0. 340271			73. 01
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000			76. 98
76. 99 07699 LI THOTRI PSY	0. 000000			76. 99
OUTPATIENT SERVICE COST CENTERS				00.00
88. 00 08800 RURAL HEALTH CLINIC				88.00
88. 01 08801 RURAL HEALTH CLINIC II				88. 01
88. 02 08802 RURAL HEALTH CLINIC III	0.001005			88. 02
90. 00   09000   CLI NI C	0. 931825			90.00
91. 00   09100   EMERGENCY 92. 00   09200   0BSERVATI ON BEDS (NON-DI STINCT PART	0. 119839 0. 427889			91. 00 92. 00
93. 99   09399   PARTI AL HOSPI TALI ZATI ON PROGRAM	0. 427889			93. 99
OTHER REIMBURSABLE COST CENTERS	0.000000			93. 99
95. 00 09500 AMBULANCE SERVICES	0. 000000			95.00
99. 10 09910 CORF	0.000000			99. 10
99. 20   09920   OUTPATIENT PHYSICAL THERAPY				99. 10
99. 30 09930 OUTPATIENT OCCUPATIONAL THERAPY				99. 30
99. 40 09940 OUTPATIENT SPEECH PATHOLOGY				99. 40
101.00 10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS				101.00
116. 00 11600 HOSPI CE				116. 00
200.00 Subtotal (see instructions)				200. 00
201. 00 Less Observation Beds				201.00
202.00 Total (see instructions)				202.00
202.00   10141 (300 111311 4011 0113)	1			1202.00

Health Financial Systems	RICHLAND MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 14-0147	Period: Worksheet C From 01/01/2023 Part I
		To 12/31/2023 Date/Time Prepared:

					o 12/31/2023	Date/lime Pre 5/31/2024 10:	
			Ti tl	e XIX	Hospi tal	PPS	12 4111
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	·	(from Wkst.	Adj .		Di sal I owance		
		B, Part I,	•				
		col. 26)					
		1. 00	2.00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	8, 771, 332		8, 771, 332		8, 771, 332	
31.00	03100 I NTENSI VE CARE UNI T	1, 306, 615		1, 306, 615		1, 306, 615	1
40.00	04000 SUBPROVI DER - I PF	0		0	_	0	40. 00
43.00	04300 NURSERY	895, 501		895, 501		895, 501	1
44. 00	04400 SKILLED NURSING FACILITY	0		0	0	0	44.00
	ANCILLARY SERVICE COST CENTERS		1		_		
50.00	05000 OPERATING ROOM	4, 507, 657		4, 507, 657		4, 507, 657	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	573, 135		573, 135		573, 135	1
53.00	05300 ANESTHESI OLOGY	619, 388		619, 388		619, 388	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 827, 178	l .	1, 827, 178		1, 827, 178	1
56.00	05600 RADI OI SOTOPE	649, 498		649, 498		649, 498	1
57. 00	05700 CT SCAN	837, 777		837, 777		837, 777	57.00
58.00	05800 MRI	405, 867		405, 867		405, 867	1
60.00	06000 LABORATORY	4, 621, 488		4, 621, 488		4, 621, 488	1
62. 30 64. 00	06250 BLOOD CLOTTING FOR HEMOPHILIACS 06400 INTRAVENOUS THERAPY			0	_	0	62. 30 64. 00
65.00	06500 RESPIRATORY THERAPY	1, 636, 848	C	1	_	1, 636, 848	
66.00	06600 PHYSI CAL THERAPY	3, 305, 687		1,,		3, 305, 687	66.00
68. 00	06800 SPEECH PATHOLOGY	426, 532		1		426, 532	
69. 00	06900 ELECTROCARDI OLOGY	62, 842		62, 842		62, 842	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 437, 528		1, 437, 528		1, 437, 528	1
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	428, 844		428, 844		428, 844	
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 613, 152		1, 613, 152		1, 613, 152	1
73. 01	07301 I NJECTABLE DRUGS	2, 818, 830		2, 818, 830		2, 818, 830	1
76. 97	07697 CARDI AC REHABI LI TATI ON	2,010,000		2,010,000		0,010,000	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY				_	0	76. 98
76. 99	07699 LI THOTRI PSY					0	1
, 0, , ,	OUTPATIENT SERVICE COST CENTERS				<u> </u>		1
88. 00	08800 RURAL HEALTH CLINIC	2, 290, 664		2, 290, 664	0	2, 290, 664	88.00
88. 01	08801 RURAL HEALTH CLINIC II	9, 989, 006		9, 989, 006		9, 989, 006	
88. 02	08802 RURAL HEALTH CLINIC III	0				0	88. 02
90.00	09000 CLI NI C	663, 013		663, 013	0	663, 013	90.00
91.00	09100 EMERGENCY	3, 592, 171		3, 592, 171	0	3, 592, 171	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 041, 638		2, 041, 638		2, 041, 638	92.00
93. 99	09399 PARTIAL HOSPITALIZATION PROGRAM	0		0	0	0	93. 99
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0		0	0	0	95.00
99. 10	09910 CORF	0		0		0	99. 10
99. 20	09920 OUTPATIENT PHYSICAL THERAPY	0		0		0	99. 20
99. 30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0		0		0	99. 30
	09940 OUTPATIENT SPEECH PATHOLOGY	0		0		0	99. 40
101.00	10100 HOME HEALTH AGENCY	0		0		0	101.00
	SPECIAL PURPOSE COST CENTERS	1	1		1		
	11600 HOSPI CE	0		0			116.00
200.00	,	55, 322, 191	C	1		55, 322, 191	
201.00		2, 041, 638		2, 041, 638		2, 041, 638	
202.00	Total (see instructions)	53, 280, 553	( C	53, 280, 553	0	53, 280, 553	1202.00

					To 12/31/2023	Date/Time Pre 5/31/2024 10:	pared:
			Ti tl	e XIX	Hospi tal	PPS	42 alli
			Charges	CAIA	nospi tui	110	
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	0.00	71.00	0.00	7, 00	10100	
30.00	03000 ADULTS & PEDIATRICS	0			O		30.00
31.00	03100 INTENSIVE CARE UNIT	O		(			31.00
40.00	04000 SUBPROVI DER - I PF	O		(			40.00
43.00	04300 NURSERY	O		(			43.00
44.00	04400 SKILLED NURSING FACILITY	0					44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0.000000	0.000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	)	0.000000	0.000000	52.00
53.00	05300 ANESTHESI OLOGY	0	0	1	0.000000	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	1	0.000000	0.000000	54.00
56.00	05600 RADI OI SOTOPE	0	0	1	0.000000	0.000000	56.00
57.00	05700 CT SCAN	0	0	)	0.000000	0.000000	57.00
58. 00	05800  MRI	0	0	)	0.000000	0.000000	58. 00
60.00	06000 LABORATORY	0	0	)	0.000000	0.000000	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	1	0.000000	0.000000	62. 30
64.00	06400 I NTRAVENOUS THERAPY	0	0	1	0.000000	0.000000	64.00
65.00	06500 RESPI RATORY THERAPY	0	0	1	0.000000	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	0	0	1	0.000000	0.000000	66.00
68. 00	06800 SPEECH PATHOLOGY	0	0	1	0.000000	0.000000	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	1	0.000000	0.000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1	0.000000	0.000000	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	1	0.000000	0.000000	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0.000000	0.000000	
73. 01	07301 I NJECTABLE DRUGS	0	0	1	0.000000	0.000000	
76. 97	07697   CARDI AC REHABI LI TATI ON	0	0	1	0. 000000	0.000000	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	1	0. 000000	0.000000	
76. 99	07699 LI THOTRI PSY	0	0	1	0. 000000	0. 000000	76. 99
	OUTPATIENT SERVICE COST CENTERS			T .			
88. 00	08800 RURAL HEALTH CLINIC	0	0	1	0.000000	0.000000	
88. 01	08801 RURAL HEALTH CLINIC II	0	0	1	0.000000	0.000000	1
88. 02	08802 RURAL HEALTH CLINIC III 09000 CLINIC	0	0		0.000000	0.000000	88. 02
90. 00 91. 00		0	0	1	0.000000	0.000000	
91.00	O9100   EMERGENCY   O9200   OBSERVATION   BEDS   (NON-DISTINCT   PART		0	1	0. 000000 0. 000000	0. 000000 0. 000000	
92.00	09399 PARTIAL HOSPITALIZATION PROGRAM		0	1	0.000000	0. 000000	
93. 99	OTHER REIMBURSABLE COST CENTERS	<u> </u>		'	J 0. 000000J	0.00000	93.99
95. 00	09500 AMBULANCE SERVICES	O	0	l .	0. 000000	0. 000000	95. 00
99. 10	09910 CORF		0	1	0.000000	0.000000	99. 10
99. 20	09920 OUTPATIENT PHYSICAL THERAPY		0				99. 20
99. 30	09930 OUTPATIENT OCCUPATIONAL THERAPY		0		o l		99. 30
99. 40	09940 OUTPATIENT SPEECH PATHOLOGY		0	1	o l		99. 40
	10100 HOME HEALTH AGENCY		0	1	o l		101.00
.51.50	SPECIAL PURPOSE COST CENTERS	<u> </u>		· · · · · · · · · · · · · · · · · · ·	-		1
116. 00	11600 HOSPI CE	0	0		o		116. 00
200.00		o	0	1			200.00
201.00	, ,						201.00
202.00	i i	0	0		o		202.00
		•					

Health Financial Systems RICHLAND MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0147 Period: From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/31/2024 10: 42 am

-					5/31/2024 10:42 am
			Title XIX	Hospi tal	PPS
	Cost Center Description	PPS Inpatient			
		Ratio			
		11. 00			
	INPATIENT ROUTINE SERVICE COST CENTERS				
	03000 ADULTS & PEDIATRICS				30.00
	03100 INTENSIVE CARE UNIT				31.00
	04000 SUBPROVI DER - I PF				40.00
	04300 NURSERY				43.00
44.00	04400 SKILLED NURSING FACILITY				44.00
	ANCILLARY SERVICE COST CENTERS				
	05000 OPERATING ROOM	0. 000000			50.00
	05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
	05300 ANESTHESI OLOGY	0. 000000			53.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
	05600 RADI OI SOTOPE	0. 000000			56. 00
	05700 CT SCAN	0. 000000			57.00
	05800 MRI	0. 000000			58.00
	06000 LABORATORY	0. 000000			60.00
1	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			62. 30
	06400 INTRAVENOUS THERAPY	0. 000000			64.00
	06500 RESPI RATORY THERAPY	0. 000000			65.00
	06600 PHYSI CAL THERAPY	0. 000000			66.00
1	06800 SPEECH PATHOLOGY	0. 000000			68.00
	06900 ELECTROCARDI OLOGY	0. 000000			69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71.00
	07200 MPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
1	07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
	07301 NJECTABLE DRUGS	0. 000000			73.01
	07697 CARDI AC REHABI LI TATI ON	0. 000000			76. 97
	07698 HYPERBARIC OXYGEN THERAPY	0. 000000			76. 98
	07699 LI THOTRI PSY	0. 000000			76. 99
	OUTPATIENT SERVICE COST CENTERS	0.000000			90,00
	08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC II	0. 000000 0. 000000			88. 00 88. 01
	08802 RURAL HEALTH CLINIC III	1			•
	09000 CLINIC	0. 000000 0. 000000			88. 02 90. 00
	09100 EMERGENCY	0. 000000			91.00
1	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92.00
1	09399 PARTIAL HOSPITALIZATION PROGRAM	0. 000000			93. 99
	OTHER REIMBURSABLE COST CENTERS	0.000000			73. 77
-	09500 AMBULANCE SERVICES	0. 000000			95.00
	09910 CORF	0.000000			99. 10
	09920 OUTPATIENT PHYSICAL THERAPY				99. 20
	09930 OUTPATIENT PHISTORE THERAPT				99. 30
	09940 OUTPATIENT SPEECH PATHOLOGY				99. 40
1	10100 HOME HEALTH AGENCY				101. 00
	SPECIAL PURPOSE COST CENTERS				101.00
	11600 HOSPI CE				116.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201. 00
202.00	Total (see instructions)				202. 00
_5 55	1.314. (33331. 401 013)	1			1202.00

Title XIX	REDUCTIONS FOR MEDICALD GREE			To	12/31/2023	Date/Time Pre 5/31/2024 10:	
Wisst B, Part I, col.   26   Part II, col.   27   Part II, col.   28   Part II, col.   28   Part II, col.   29   Part II, col.   29   Part III, col.   29   Part III, col.   29   Part III, col.   29   Part III, col.   20   Par				e XIX	Hospi tal		12 diii
Part 1, col.   Part 11, col.   Part 11 col.   Par	Cost Center Description	Total Cost					
ANCILLARY SERVICE COST CENTERS					Reduction		
AMCILLARY SERVICE COST CENTERS		Part I, col.	Part II col.	Capital Cost		Reducti on	
ANCILLARY SERVICE COST CENTERS		26)	26)			Amount	
ANCILLARY SERVICE COST CENTERS							
50.00   050000  050000  050000  050000  050000  050000  050000  050000  050000  050000  050000  050000  0500000  0500000  0500000  0500000000	ANCHI ADV CEDVICE COCT CENTEDS	1. 00	2. 00	3.00	4.00	5. 00	
S2.00   05200   DELIVERY ROOM & LABOR ROOM   573, 135   3, 470   569, 665   0   0   52.00     53.00   05300   ANESTHEES LOLGY   619, 388   1, 819   617, 569   0   0   53.00     54.00   05400   RADIO LOGY-DI AGNOSTI C   1, 827, 178   28, 956   1, 798, 222   0   0   54.00     55.00   05500   RADIO LOGY-DI AGNOSTI C   1, 827, 178   28, 956   1, 798, 222   0   0   54.00     55.00   05500   RADIO LOGY-DI AGNOSTI C   1, 827, 178   28, 956   1, 798, 222   0   0   56.00     55.00   05500   RADIO LOGY-DI AGNOSTI C   1, 827, 178   28, 956   1, 798, 222   0   0   57.00     55.00   05500   RADIO STORY   1, 636, 867   6, 999   398, 668   0   0   58.00     56.00   055000   LABORATORY   4, 621, 488   45, 049   4, 576, 439   0   0   0   0   0     62.30   06250   BLOOD CLOTTI NG FOR HEMOPHI LI ACS   0   0   0   0   0   0   0   0   0		4 507 457	71 441	4 425 004	٥١	^	E0 00
S3. 00   05300   AMESTHESI OLOGY   6.19, 38B   1, 819		1			O O	ů.	
S4. 00   05400   RADIO LOGY-DIAGNOSTIC   1,827,178   28,956   1,798,222   0   0   54,00   50.00   50.00   650					0	-	
56. 00   056,00   R500   RADIOI SOTOPE   649, 498   8, 38.3   641, 115   0   0   56, 00   57. 00   05700   CT SCAN   837, 777   7, 86.5   829, 912   0   0   57, 00   58. 00   05800   MRI   405, 867   6, 999   398, 868   0   0   58, 00   60. 00   06000   LABRATORY   4, 621, 488   45, 049   4, 576, 439   0   0   0   0   61. 00   06000   LABRATORY   1   1   1   1   1   62. 30   06250   BLODD CLOTTI NG FOR HEMOPHI LI ACS   0   0   0   0   0   63. 00   06500   RESPI RATORY THERAPY   0   0   0   0   0   64. 00   06400   INTRAVENUS THERAPY   1, 636, 848   23, 576   1, 613, 272   0   0   65, 00   65. 00   06600   RESPI RATORY THERAPY   3, 305, 687   18, 027   3, 287, 660   0   0   66, 00   66. 00   06600   SPECEH PATHOLOGY   426, 532   5, 836   420, 696   0   0   66, 00   69. 00   06900   ELECTROCARDI OLOGY   62, 842   355   62, 487   0   0   69, 00   69. 00   06900   ELECTROCARDI OLOGY   62, 842   355   62, 487   0   0   69, 00   71. 00   07100   MDI CIAL SUPPLIES CHARGED TO PATI ENTS   428, 844   9, 963   418, 881   0   0   72, 00   72. 00   07200   IMPL DEV. CHARGED TO PATI ENTS   428, 844   9, 963   418, 881   0   0   73, 00   73. 01   07300 DRUGS CHARGED TO PATI ENTS   1, 613, 152   12, 679   1, 600, 473   0   0   73, 00   74. 97   07697   CARDIA CREHABI LI TATI ON   0   0   0   0   0   0   75. 98   07699   HYPERBARIC COYGEN THERAPY   0   0   0   0   0   0   0   76. 99   07499   LITHOTRI PSY   0   0   0   0   0   0   0   76. 99   07499   LITHOTRI PSY   0   0   0   0   0   0   76. 99   07499   LITHOTRI PSY   0   0   0   0   0   0   76. 99   07499   LITHOTRI PSY   0   0   0   0   0   0   76. 99   07490   LIRALTH CLINIC II   9, 999,064   40, 469   2, 250, 195   0   0   88, 01   77. 00   09000   01000   01000   01000   01000   01000   01000   78. 00   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   78. 00   09000		1		· ·	0	ů.	
57.00   05700   CT SCAN   837, 777   7, 865   829, 912   0   0   57.00					0	-	1
58.00   05800   MRI				· ·	0	ŭ	
60.00   06000   LABORATORY			·		٥	-	1
62.30   06250   BLOOD CLOTTING FOR HEMOPHILIACS   0   0   0   0   0   0   0   0   0				· ·	0	ŭ	
64. 00   06400   INTRAVENOUS THERAPY   0 0 0 0 0 0 0 0 0 0 0 0 0 0 64. 00 65. 00   06500   RESPIRATORY THERAPY   1,636,848   23,576   1,613,272 0 0 0 65. 00 66. 00   06600   PHYSI CAL THERAPY   3,305,687   18,027   3,287,660 0 0 66. 00   07. 00   07. 00		4, 021, 488		4, 576, 439	0	0	1
65.00   06500   RESPIRATORY THERAPY   1,636,848   23,576   1,613,272   0   0   65.00		0	0	0	0	0	
66.00   06600   PHYSICAL THERAPY   3, 305, 687   18, 027   3, 287, 660   0   0   66.00   68.00   06800   SPEECH PATHOLOGY   426, 532   5, 836   420, 696   0   0   68.00   69.00   06900   ELECTROCARDI OLOGY   62, 842   355   62, 487   0   0   69.00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   1, 437, 528   29, 366   1, 408, 162   0   0   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   428, 844   9, 963   418, 881   0   0   72. 00   73. 01   07301   INJECTABLE DRUGS   2, 818, 830   23, 121   2, 795, 709   0   0   73. 01   73. 01   07301   INJECTABLE DRUGS   2, 818, 830   23, 121   2, 795, 709   0   0   73. 01   74. 97   07697   CARDI AC REHABI LI TATION   0   0   0   0   0   0   0   75. 98   07698   HYPERBARI C OXYGEN THERAPY   0   0   0   0   0   0   0   76. 99   07699   LITHOTIP PSY   0   0   0   0   0   0   76. 99   07699   LITHOTIP PSY   0   0   0   0   0   0   88. 01   08800   RURAL HEALTH CLINIC   1   1   9, 989, 006   123, 393   9, 865, 613   0   0   88. 01   88. 02   08802   RURAL HEALTH CLINIC   1   1   9, 989, 006   123, 393   9, 865, 613   0   0   88. 02   90. 00   09000   CLINIC   663, 013   11, 264   651, 749   0   0   0   0   90. 00   09000   CLINIC   663, 013   11, 264   651, 749   0   0   0   90. 00   09000   DISSERVATION BEDS (NON-DISTINCT PART   2, 041, 638   53, 897   1, 987, 741   0   0   92.00   90. 00   09000   DISPARVATION BEDS (NON-DISTINCT PART   2, 041, 638   53, 897   1, 987, 741   0   0   99.20   99. 10   09010   CMERCENCY   0   0   0   0   0   0   0   99. 20   09920   0UTPATIENT PHYSICAL THERAPY   0   0   0   0   0   0   99. 20   09920   0UTPATIENT PHYSICAL THERAPY   0   0   0   0   0   0   99. 20   09920   0UTPATIENT CCUPATIONAL THERAPY   0   0   0   0   0   0   99. 30   09930   0000   0000   0000   0000   0000   0000   0000   99. 40   09940   0000   0000   0000   0000   0000   0000   99. 40   00000   00000   00000   00000   00000   00000   00000   99. 40   000000000000000000000000000000000		1 424 040	22 574	1 412 272	0	0	
68.00 06800 SPEECH PATHOLOGY 426, 532 5, 836 420, 696 0 0 68.00 699.00 699.00 126. ELCTROCARDI LOGY 62, 842 355 62, 487 0 0 69.00 697.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 1, 437, 528 29, 366 1, 408, 162 0 0 71.00 72.00 07200 IMPL DEV. CHARGED TO PATI ENTS 428, 844 9, 963 418, 881 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 1, 613, 152 12, 679 1, 600, 473 0 0 73.00 173.01 INJECTABLE DRUGS 2, 818, 830 23, 121 2, 795, 709 0 0 73.01 76. 97 07697 (ARDI AC REHABI LI TATI ON 0 0 0 0 0 0 0 0 0 76. 97 76. 98 197ERRAPI C OXYGEN THERAPY 0 0 0 0 0 0 0 0 76. 98 76. 99 07699 LI THOTRI PSY 0 0 0 0 0 0 0 0 0 0 76. 98 80.00 GBSOO RURAL HEALTH CLI NI C 1 9, 989, 006 123, 393 9, 865, 613 0 0 88.00 888.01 08801 RURAL HEALTH CLI NI C 1 663, 013 11, 264 651, 749 0 0 0 0 88.00 88.01 88.02 08802 RURAL HEALTH CLI NI C 1 663, 013 11, 264 651, 749 0 0 0 0 0 0 99.00 99.00 09000 CLI NI C 663, 013 11, 264 651, 749 0 0 0 0 0 99.00 99.00 99.30 99399 PARTI AL HOSPITALI ZATI ON PROGRAM 0 0 0 0 0 0 0 0 0 99.00 0 99.30 99.30 99399 PARTI AL HOSPITALI ZATI ON PROGRAM 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					0	0	1
69. 00   06900   ELECTROCARDI OLOGY   6.2, 842   355   6.2, 487   0   0   69, 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   1, 437, 528   29, 366   1, 408, 162   0   0, 71. 00   72. 00   07200   MPL. DEV. CHARGED TO PATIENTS   428, 844   9, 963   418, 881   0   0, 72. 00   73. 01   07300   DRUGS CHARGED TO PATIENTS   1, 613, 152   12, 679   1, 600, 473   0   0, 73. 00   73. 01   07301   INJECTABLE DRUGS   2, 818, 830   23, 121   2, 795, 709   0   0, 73. 00   76. 97   07697   CARDI AC REHABI LI TATI ON   0   0   0   0   0   0   76. 99   07699   LITHOTI PSY   0   0   0   0   0   0   76. 99   07699   LITHOTI PSY   0   0   0   0   0   0   76. 99   07699   LITHOTI PSY   0   0   0   0   0   0   76. 99   07699   LITHOTI PSY   0   0   0   0   0   76. 99   07699   LITHOTI PSY   0   0   0   0   0   76. 99   07699   LITHOTI PSY   0   0   0   0   0   76. 99   07699   LITHOTI PSY   0   0   0   0   0   76. 99   07699   LITHOTI PSY   0   0   0   0   0   76. 99   07699   LITHOTI PSY   0   0   0   0   0   76. 99   07699   LITHOTI PSY   0   0   0   0   0   76. 99   07699   LITHOTI PSY   0   0   0   0   0   77. 97   07699   LITHOTI PSY   0   0   0   0   78. 00   08800   RURAL HEALTH CLINIC III   9, 989, 006   123, 393   9, 865, 613   0   0   88. 01   78. 00   08802   RURAL HEALTH CLINIC III   0   0   0   0   0   0   0   78. 00   09000   0.0   0.0   0   0   0   0   0   79. 00   09000   0.0   0.0   0   0   0   0   0   79. 00   09000   0.0   0.0   0.0   0   0   0   79. 00   09000   0.0   0.0   0   0   0   79. 00   09000   0.0   0.0   0   0   0   79. 00   0.0   0.0   0.0   0   0   79. 00   0.0   0.0   0   0   0   0   79. 00   0.0   0.0   0   0   0   0   79. 00   0.0   0.0   0   0   0   0   79. 00   0.0   0.0   0   0   0   79. 00   0.0   0.0   0   0   0   79. 00   0.0   0.0   0   0   0   79. 00   0.0   0.0   0   0   0   79. 00   0.0   0.0   0   0   79. 00   0.0   0.0   0   0   79. 00   0.0   0.0   0   0   79. 00   0.0   0.0   0   0   79. 00   0.0   0.0   0   79. 00   0.0   0.0   0   79. 00   0.0   0.0   0   79. 00   0.0					0	0	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT				· ·	0	0	1
72.00   07200   IMPL DEV. CHARGED TO PATIENTS   428,844   9,963   418,881   0   0   72.00   73.00   07300   DRUGS CHARGED TO PATIENTS   1,613,152   12,679   1,600,473   0   0   73.00   73.01   INJECTABLE DRUGS   2,818,830   23,121   2,795,709   0   0   0   0   0   0   0   0   0				· ·	0	0	
73. 00   07300   DRUGS CHARGED TO PATIENTS					O O	ů.	1
73. 01   07301   INJECTABLE DRUGS   2, 818, 830   23, 121   2, 795, 709   0   0   73. 01   76. 97   07697   CARDI AC REHABILITATION   0   0   0   0   0   0   76. 98   07698   REHABILITATION   0   0   0   0   0   76. 99   07699   LITHOTRI PSY   0   0   0   0   0   000   0   0   0				· ·	0	ů.	
76. 97   07697   CARDI AC REHABI LI TATI ON   0   0   0   0   0   0   76. 97   76. 98   07698   HYPERBARI C OXYGEN THERAPY   0   0   0   0   0   0   0   76. 98   76. 99   07699   LI THOTRI PSY   0   0   0   0   0   0   0   76. 99   00   0   0   0   0   0   0   76. 99   00   0   0   0   0   0   76. 99   00   0   0   0   0   0   76. 99   00   0   0   0   0   76. 99   00   0   0   0   0   0   88. 00   08800 RURAL HEALTH CLI NI C   2, 290, 664   40, 469   2, 250, 195   0   0   88. 00   88. 01   08801 RURAL HEALTH CLI NI C   11   9, 989, 006   123, 393   9, 865, 613   0   0   0   0   88. 02   08802 RURAL HEALTH CLI NI C   11   9, 989, 006   123, 393   9, 865, 613   0   0   0   0   90. 00   09000   CLI NI C   663, 013   11, 264   651, 749   0   0   0   91. 00   09100   EMERGENCY   3, 592, 171   46, 356   3, 545, 815   0   0   91. 00   92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART   2, 041, 638   53, 897   1, 987, 741   0   0   92. 00   93. 99   09399   PARTI AL HOSPI TALI ZATI ON PROGRAM   0   0   0   0   0   97. 00   099100   CORF   0   0   0   0   0   99. 10   099100   OUTPATI ENT PHYSI CAL THERAPY   0   0   0   0   0   99. 20   09920   OUTPATI ENT PHYSI CAL THERAPY   0   0   0   0   0   99. 40   09940   OUTPATI ENT SPEECH PATHOLOGY   0   0   0   0   99. 40   09940   OUTPATI ENT SPEECH PATHOLOGY   0   0   0   99. 40   09940   OUTPATI ENT SPEECH PATHOLOGY   0   0   0   90. 00   0   0   0   90. 00   0   0   0   90. 00   0   0   0   90. 00   0   0   0   90. 00   0   0   0   90. 00   0   0   0   90. 00   0   0   90. 00   0   0   90. 00   0   0   0   90. 00		1			O O	0	1
76. 98				2, 795, 709	O O	ů.	1
76. 99			ı	0	0	ů.	
SECOND   CONTROL   CONTR		· ·	_	0	0	-	
88. 00		] 0		U <sub>I</sub>	U <sub>I</sub>	0	76.99
88. 01		2 290 664	40 469	2 250 195	٥	0	88 00
88. 02 08802 RURAL HEALTH CLINIC III 0 0 0 0 0 0 0 0 88. 02 90. 00 09000 CLINIC 0 663, 013 11, 264 651, 749 0 0 0 90. 00 91. 00 09100 EMERGENCY 3, 592, 171 46, 356 3, 545, 815 0 0 91. 00 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART 2, 041, 638 53, 897 1, 987, 741 0 0 0 92. 00 93. 99 0399 PARTIAL HOSPITALIZATION PROGRAM 0 0 0 0 0 0 0 0 0 93. 99  OTHER REIMBURSABLE COST CENTERS  95. 00 09500 AMBULANCE SERVICES 0 0 0 0 0 0 0 0 0 95. 00 99. 10 09910 CORF 0 0 0 0 0 0 0 0 99. 10 99. 20 09920 OUTPATIENT PHYSICAL THERAPY 0 0 0 0 0 0 0 99. 10 99. 30 09930 OUTPATIENT OCCUPATIONAL THERAPY 0 0 0 0 0 0 0 99. 30 99. 40 09940 OUTPATIENT SPEECH PATHOLOGY 0 0 0 0 0 0 99. 30 99. 40 09940 OUTPATIENT SPEECH PATHOLOGY 0 0 0 0 0 0 0 0 0 1010. 00  SPECIAL PURPOSE COST CENTERS  116. 00 11600 HOSPICE 0 0 0 0 0 0 0 0 16. 00 201. 00 Less Observation Beds 2, 041, 638 53, 897 1, 987, 741 0 0 200. 00 201. 00 Less Observation Beds 2, 041, 638 53, 897 1, 987, 741 0 0 0 201. 00			·				
90. 00   09000   CLINIC   663, 013   11, 264   651, 749   0   0   90. 00   91. 00   91. 00   91. 00   92. 00   92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART   2, 041, 638   53, 897   1, 987, 741   0   0   92. 00   93. 99   09399   PARTIAL HOSPITALIZATION PROGRAM   0   0   0   0   0   0   0   0   0		1	·		0	ů.	
91. 00		· · · · · ·	Ĭ		0	0	1
92. 00   09200   OBSERVATI ON BEDS (NON-DI STINCT PART   2,041,638   53,897   1,987,741   0   0   0   93.99   OBSERVATI ON BEDS (NON-DI STINCT PART   2,041,638   53,897   1,987,741   0   0   0   93.99   OBSERVATI ON BEDS (NON-DI STINCT PART   2,041,638   53,897   1,987,741   0   0   0   0   93.99   OBSERVATI ON PROGRAM   0   0   0   0   0   0   0   0   0				· ·	0	0	
93. 99   09399   PARTI AL HOSPI TALI ZATI ON PROGRAM   0   0   0   0   0   0     0THER REIMBURSABLE COST CENTERS   0   0   0   0   0   0     95. 00   09500   AMBULANCE SERVI CES   0   0   0   0   0   0     99. 10   09910   CORF   0   0   0   0   0   0     99. 20   09920   OUTPATI ENT PHYSI CAL THERAPY   0   0   0   0   0     99. 30   09930   OUTPATI ENT OCCUPATI ONAL THERAPY   0   0   0   0   0     99. 40   09940   OUTPATI ENT SPEECH PATHOLOGY   0   0   0   0     101. 00   HOME HEALTH AGENCY   0   9, 150   -9, 150   0     101. 00   HOME HEALTH AGENCY   0   0   0   0     SPECIAL PURPOSE COST CENTERS   116. 00   116.00   HOSPI CE   0   0   0     200. 00   Subtotal (sum of lines 50 thru 199)   44, 348, 743   581, 654   43, 767, 089   0   0     201. 00   Less Observation Beds   2, 041, 638   53, 897   1, 987, 741   0   0     201. 00   0   0   0   0     0   0   0   0					0	-	
OTHER REIMBURSABLE COST CENTERS           95. 00         09500 AMBULANCE SERVICES         0         0         0         0         0         95. 00           99. 10         09910 CORF         0         0         0         0         0         99. 10           99. 20         09920 OUTPATI ENT PHYSI CAL THERAPY         0         0         0         0         0         0         99. 20           99. 30         09930 OUTPATI ENT OCCUPATI ONAL THERAPY         0         0         0         0         0         0         0         99. 30           99. 40         09940 OUTPATI ENT SPEECH PATHOLOGY         0         0         0         0         0         0         99. 40           101. 00         10100 HOME HEALTH AGENCY         0         9, 150         -9, 150         0         0         101. 00           SPECIAL PURPOSE COST CENTERS         0         0         0         0         0         0         1016. 00           200. 00         Subtotal (sum of lines 50 thru 199)         44, 348, 743         581, 654         43, 767, 089         0         0         0         200. 00           201. 00         Less Observation Beds         2, 041, 638         53, 897         1, 987, 741		1			0	ū	
95. 00   09500   AMBULANCE SERVICES   0   0   0   0   0   0   95. 00   99. 10   09910   CORF   0   0   0   0   0   0   0   99. 10   99. 20   09920   OUTPATI ENT PHYSI CAL THERAPY   0   0   0   0   0   0   0   99. 20   99. 30   09930   OUTPATI ENT OCCUPATI ONAL THERAPY   0   0   0   0   0   0   0   99. 30   99. 40   09940   OUTPATI ENT SPECH PATHOLOGY   0   0   0   0   0   0   99. 40   101.00   HOME HEALTH AGENCY   0   9, 150   -9, 150   0   0   101.00   SPECIAL PURPOSE COST CENTERS   116. 00   11600   HOSPI CE   0   0   0   0   0   116. 00   200. 00   Subtotal (sum of lines 50 thru 199)   44, 348, 743   581, 654   43, 767, 089   0   0   200. 00   201. 00   Cost of the standard of the sum of lines 50 thru 199   44, 348, 743   581, 654   43, 767, 089   0   0   0   0   0   0   0   0   0				٥	٥,		70.77
99. 10   09910   CORF   0   0   0   0   0   0   99. 10   99. 20   09920   OUTPATIENT PHYSICAL THERAPY   0   0   0   0   0   99. 20   99. 30   09930   OUTPATIENT OCCUPATIONAL THERAPY   0   0   0   0   0   0   99. 40   09940   OUTPATIENT SPECH PATHOLOGY   0   0   0   0   0   101. 00   10100   HOME HEALTH AGENCY   0   9, 150   -9, 150   0    SPECIAL PURPOSE COST CENTERS  116. 00   116.00   HOSPI CE   0   0   0   0   0   200. 00   Subtotal (sum of lines 50 thru 199)   44, 348, 743   581, 654   43, 767, 089   0   0   0   201. 00   Less Observation Beds   2, 041, 638   53, 897   1, 987, 741   0   0   201. 00		0	0	0	0	0	95.00
99. 20   09920   0UTPATIENT PHYSICAL THERAPY   0   0   0   0   0   99. 20   99. 30   09930   0UTPATIENT OCCUPATIONAL THERAPY   0   0   0   0   0   99. 40   09940   0UTPATIENT SPEECH PATHOLOGY   0   0   0   0   101.00   10100   HOME   HEALTH   AGENCY   0   9, 150   -9, 150   0    SPECIAL PURPOSE COST CENTERS  116. 00   116.00   HOSPI CE   0   0   0   0   200. 00   Subtotal (sum of lines 50 thru 199)   44, 348, 743   581, 654   43, 767, 089   0   0   201. 00   Less Observation Beds   2, 041, 638   53, 897   1, 987, 741   0   0   201. 00   099. 20   0   0   0   0   0   0   0   0   0   0   0		0	0	0	o	0	99. 10
99. 30   09930   0UTPATIENT OCCUPATIONAL THERAPY   0   0   0   0   0   99. 30   99. 40   09940   0UTPATIENT SPEECH PATHOLOGY   0   0   0   0   0   99. 40   101. 00   10100   HOME   HEALTH   AGENCY   0   9, 150   -9, 150   0   0   101. 00   101. 00   116. 0		0	0	0	0	0	1
99. 40   09940   0UTPATIENT SPEECH PATHOLOGY   0   0   0   0   99. 40   101. 00   10100   HOME   HEALTH   AGENCY   0   9, 150   -9, 150   0   0   101. 00		0	0	0	0	0	
101. 00   10100   HOME HEALTH AGENCY   0   9, 150   -9, 150   0   0   101. 0		0	0	0	o	0	1
SPECIAL PURPOSE COST CENTERS   116.00   116.00   116.00   10   0   0   0   116.00		0	9, 150	-9, 150	O	0	101.00
200.00 Subtotal (sum of lines 50 thru 199) 44,348,743 581,654 43,767,089 0 0 200.00 201.00 Less Observation Beds 2,041,638 53,897 1,987,741 0 0 0 201.00			,	,	-,		
201.00 Less Observation Beds 2,041,638 53,897 1,987,741 0 0 201.00	116. 00 11600 HOSPI CE	0	0	0	0	0	116. 00
201.00 Less Observation Beds 2,041,638 53,897 1,987,741 0 0 201.00	200.00 Subtotal (sum of lines 50 thru 199)	44, 348, 743	581, 654	43, 767, 089	o	0	200.00
202.00   Total (line 200 minus line 201)   42,307,105   527,757   41,779,348   0   0   202.00			53, 897		О	0	201.00
	202.00   Total (line 200 minus line 201)	42, 307, 105	527, 757	41, 779, 348	o	0	202.00

Heal th Financial Systems RICHLAND MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY

REDUCTIONS FOR MEDICALD ONLY

REDUCTIONS FOR MEDICALD ONLY

REDUCTIONS FOR MEDICALD ONLY

In Lieu of Form CMS-2552-10

Worksheet C
From 01/01/2023
To 12/31/2023
To 12/31/2023

5/31/2024 10:42 am Title XIX Hospi tal PPS Total Charges Outpati ent Cost Center Description Cost Net of Capital and (Worksheet C, Cost to Operating Part I Charge Ratio Cost column 8) (col. 6 / Reducti on col. 7) 7.00 8.00 6.00 ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM 4, 507, 657 0. 334345 50 00 13, 482, 057 52.00 05200 DELIVERY ROOM & LABOR ROOM 573, 135 785, 525 0.729620 52.00 05300 ANESTHESI OLOGY 53.00 619, 388 304, 090 2.036858 53.00 05400 RADI OLOGY-DI AGNOSTI C 1, 827, 178 13, 355, 977 0.136806 54.00 54.00 05600 RADI OI SOTOPE 2, 898, 298 56.00 649, 498 0.224096 56.00 57.00 05700 CT SCAN 837, 777 29, 767, 480 0.028144 57.00 58.00 05800 MRI 405, 867 7, 407, 934 0.054788 58.00 06000 LABORATORY 4, 621, 488 37, 571, 642 60. nn 0.123005 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 0 0.000000 62.30 64.00 06400 I NTRAVENOUS THERAPY 0.000000 64.00 65.00 06500 RESPIRATORY THERAPY 1, 636, 848 6, 063, 430 0.269954 65.00 06600 PHYSI CAL THERAPY 3, 305, 687 15, 412, 716 0.214478 66.00 66.00 68.00 06800 SPEECH PATHOLOGY 426, 532 1, 292, 747 0.329942 68.00 06900 ELECTROCARDI OLOGY 69.00 62, 842 10, 265, 502 0.006122 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 4, 254, 943 1, 437, 528 0.337849 71 00 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 428, 844 341, 901 1.254293 72.00 07300 DRUGS CHARGED TO PATIENTS 1, 613, 152 9, 600, 733 0.168024 73.00 07301 I NJECTABLE DRUGS 2, 818, 830 0.340271 73.01 73.01 8, 284, 066 07697 CARDIAC REHABILITATION 76. 97 0 0.000000 76.97 76.98 07698 HYPERBARIC OXYGEN THERAPY 0 C 0.000000 76.98 07699 LI THOTRI PSY 76.99 0 0.000000 76.99 OUTPATIENT SERVICE COST CENTERS 1.059915 88.00 08800 RURAL HEALTH CLINIC 2, 290, 664 2, 161, 178 88.00 08801 RURAL HEALTH CLINIC II 9, 989, 006 11, 663, 061 0.856465 88.01 88.01 08802 RURAL HEALTH CLINIC III 88.02 0.000000 88.02 663, 013 09000 CLI NI C 90 00 711, 521 0.931825 90 00 91.00 09100 EMERGENCY 3, 592, 171 29, 974, 988 0.119839 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 2, 041, 638 4, 771, 425 0.427889 92.00 92.00 93.99 09399 PARTIAL HOSPITALIZATION PROGRAM 0.000000 93.99 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 0 0.000000 95.00 99. 10 09910 CORF 0 0.000000 99. 10 0 0 99. 20 09920 OUTPATIENT PHYSICAL THERAPY 0 0.000000 99. 20 99. 30 09930 OUTPATIENT OCCUPATIONAL THERAPY 99.30 0 0.000000 99. 40 09940 OUTPATIENT SPEECH PATHOLOGY 0 0.000000 99.40 101.00 101.00 10100 HOME HEALTH AGENCY 0.000000 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 0.000000 116.00 200.00 Subtotal (sum of lines 50 thru 199) 44, 348, 743 210, 371, 214 200.00

2, 041, 638

42, 307, 105

210, 371, 214

201.00

202.00

201.00

202.00

Less Observation Beds

Total (line 200 minus line 201)

Health Financial Systems	RICHLAND MEMOR	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITA	L COSTS	Provi der C	<u> </u>	Period: From 01/01/2023 Fo 12/31/2023	Date/Time Pre 5/31/2024 10:	pared: 42 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost	Swing Bed Adjustment	Reduced Capi tal	Total Patient Days	Per Diem (col. 3 /	
	(from Wkst. B, Part II, col. 26)		Related Cost (col. 1 - col. 2)		col. 4)	
	1. 00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
30. 00 ADULTS & PEDIATRICS	231, 555	9, 221	222, 334	4, 253	52. 28	30.00
31. 00 INTENSIVE CARE UNIT	39, 694		39, 69	·	112. 77	
40. 00 SUBPROVI DER - I PF	0	l o	(		0.00	
43. 00 NURSERY	12, 612		12, 612	312	40. 42	43.00
44.00 SKILLED NURSING FACILITY	-180		-180	0	0.00	44.00
200.00 Total (lines 30 through 199)	283, 681		274, 460	4, 917		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS	6. 00	7. 00		<u> </u>		
30. 00 ADULTS & PEDIATRICS	1, 651	86, 314				30.00
31.00 INTENSIVE CARE UNIT	176					31.00
40. 00   SUBPROVI DER - I PF	170	17,040				40.00
43. 00 NURSERY	0	1 0				43.00
44.00 SKILLED NURSING FACILITY	0	1 0				44.00
200.00 Total (lines 30 through 199)	1, 827	106, 162				200. 00

Health Financial Systems	RICHLAND MEMOF	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	TAL COSTS	Provi der C		Period: From 01/01/2023 To 12/31/2023		
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)			
	col. 26)					
	1. 00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	71, 661	13, 482, 057	0. 00531	5 576, 990	3, 067	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	3, 470	785, 525	0. 00441	7 0	0	52.00
53. 00   05300   ANESTHESI OLOGY	1, 819	304, 090	0. 00598	2 0	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	28, 956	13, 355, 977	0. 00216	8 471, 835	1, 023	54.00
56. 00   05600   RADI 0I SOTOPE	8, 383	2, 898, 298	0. 00289	2 45, 568	132	56.00
57.00 05700 CT SCAN	7, 865	29, 767, 480	0. 00026	4 2, 173, 625	574	57.00
58 00 05800 MRI	6 999	7 407 934	0 00094	5 216 280	204	58 00

45, 049

23, 576

18, 027

29, 366

12, 679

23.121

40, 469

123, 393

11, 264

46, 356

53, 897

572, 504

0

0

9, 963

5,836

355

0

37, 571, 642

6, 063, 430

1, 292, 747

15, 412, 716

10, 265, 502

4, 254, 943

9, 600, 733

8, 284, 066

2, 161, 178

711, 521

11, 663, 061

29, 974, 988

4, 771, 425

210, 371, 214

341, 901

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0.001199

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0.001321

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0.018725

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0. 015831

0.001546

0.011296

0.000000

3, 309, 640

2, 167, 176

536, 305

551, 425

244, 282

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2, 504, 280

1, 750, 030

15, 011, 696

394, 085

70, 175

3, 968

8, 426

1, 686

3, 308

627

317

19

0

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0 88.00

0 88.01

0 88.02

0 93.99

30, 509 200. 00

2,706

4, 452

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60.00

62.30

64.00

65.00

66.00

68.00

69.00

71.00

72.00

73.00

73.01

76.98

0 90 00

91.00

92.00

95.00

60. 00 | 06000 | LABORATORY

62.30

65.00

66.00

68.00

69.00

71.00

72.00

73.00

73.01

76. 97

76.98

76.99

88.00

88. 01

88.02

90 00

91.00

92.00

93.99

200.00

06250 BLOOD CLOTTING FOR HEMOPHILIACS

07100 MEDICAL SUPPLIES CHARGED TO PATIENT

09200 OBSERVATION BEDS (NON-DISTINCT PART

09399 PARTIAL HOSPITALIZATION PROGRAM

Total (lines 50 through 199)

07200 IMPL. DEV. CHARGED TO PATIENTS

07300 DRUGS CHARGED TO PATIENTS

07698 HYPERBARIC OXYGEN THERAPY

OUTPATIENT SERVICE COST CENTERS

07697 CARDIAC REHABILITATION

08800 RURAL HEALTH CLINIC

08801 RURAL HEALTH CLINIC II

08802 RURAL HEALTH CLINIC III

OTHER REIMBURSABLE COST CENTERS

06400 I NTRAVENOUS THERAPY

06500 RESPIRATORY THERAPY

06600 PHYSI CAL THERAPY

06800 SPEECH PATHOLOGY

06900 ELECTROCARDI OLOGY

07301 I NJECTABLE DRUGS

07699 LI THOTRI PSY

09000 CLI NI C

09100 EMERGENCY

95. 00 09500 AMBULANCE SERVICES

Health Financial Systems	RI CHLAND MEMOR	PLAL HOSPITAL		In lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER		STS Provi der C		Period: From 01/01/2023 To 12/31/2023	Worksheet D Part III Date/Time Pre 5/31/2024 10:	epared:
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdowr	Cost	Medi cal	
	Post-Stepdown		Adjustments		Educati on	
	Adjustments				Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	31.00
40. 00   04000   SUBPROVI DER - 1 PF	0	0		0	0	40.00
43. 00 04300 NURSERY	0	0		0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	l 0		0		44.00
200.00 Total (lines 30 through 199)	0	l o		0	l 0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem	I npati ent	
	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col. 6)		
		minus col. 4)		,		
	4. 00	5.00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	4, 25	0.00	1, 651	30.00
31.00 03100 INTENSIVE CARE UNIT		0	35	0.00	176	31.00
40. 00 04000 SUBPROVI DER - I PF	0	l o		0.00	l o	40.00
43. 00 04300 NURSERY		l o	31	0.00	l o	43.00
44.00 04400 SKILLED NURSING FACILITY		l o		0.00	l o	44.00
200.00 Total (lines 30 through 199)		0	4, 91			200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31.00 03100 INTENSIVE CARE UNIT	0					31.00
40. 00   04000   SUBPROVI DER - 1 PF	0					40.00
43. 00   04300 NURSERY	0					43.00
44.00 04400 SKILLED NURSING FACILITY	0					44.00
200.00 Total (lines 30 through 199)	0					200.00
1 (	,	1				, , , , , ,

Health Financial Systems	RI CHLAND MEMORI AI	_ HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 14-0147	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared:

Non Physician   Anesthetist   Cost Center Description   Non Physician   Anesthetist   Cost   Nursing Program						10 12/31/2023	5/31/2024 10:	eparea: 42 am
Non Physician   Name			Title	XVIII	Hospi tal		12 0111	
Anesthetist   Cost		Cost Center Description	Non Physician					
Cost				9				
ANCILLARY SERVICE COST CENTERS			Cost					
1.00   2A   2.00   3A   3.00						,		
50, 00   05000   OPERATI NG ROOM   0   0   0   0   0   0   0   0   0			1. 00		2.00	3A	3. 00	
52.00   05200   DELIVERY ROOM & LABOR ROOM   0   0   0   0   0   52.00		ANCILLARY SERVICE COST CENTERS			•			
53.00   05300   ANESTHESI OLOGY   0   0   0   0   0   0   53.00	50.00	05000 OPERATING ROOM	0	0		0 0	0	50.00
54.00   05400   RADI OLOGY-DI AGNOSTI C   0   0   0   0   0   0   54.00	52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
56. 00   05600   RADI DI SOTOPE   0   0   0   0   0   0   56. 00	53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
57. 00   05700   CT SCAN   0   0   0   0   0   0   0   57. 00   58. 00   05800   MRI   0   0   0   0   0   0   0   0   58. 00   06000   LABORATORY   0   0   0   0   0   0   0   0   0	54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
58. 00	56.00	05600 RADI OI SOTOPE	0	0		0 0	0	56.00
60.00   06000   LABORATORY   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	57.00	05700 CT SCAN	0	0		0 0	0	57.00
62. 30	58.00	05800  MRI	0	0		0 0	0	58. 00
64. 00   06400   INTRAVENOUS THERAPY   0   0   0   0   0   0   0   64. 00   65. 00   06500   RESPI RATORY THERAPY   0   0   0   0   0   0   0   65. 00   06600   PHYSI CAL THERAPY   0   0   0   0   0   0   68. 00   06600   PHYSI CAL THERAPY   0   0   0   0   0   0   68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   0   0   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   0   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   0   73. 01   07301   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   73. 01   07301   INJECTABLE DRUGS   0   0   0   0   0   74. 97   07697   CARDI AC REHABI LI TATI ON   0   0   0   0   76. 97   07697   CARDI AC REHABI LI TATI ON   0   0   0   0   0   76. 98   07698   HYPERBARI C OXYGEN THERAPY   0   0   0   0   0   76. 99   UI THOTRI PSY   0   0   0   0   0   88. 01   08801   RURAL HEALTH CLINI C   11   0   0   0   88. 01   08801   RURAL HEALTH CLINI C   11   0   0   0   88. 02   08802   RURAL HEALTH CLINI C   11   0   0   0   90. 00   09900   CLINI C   0   0   0   0   91. 00   09100   EMERGENCY   0   0   0   0   92. 00   09399   PARTI AL HOSPI TALI ZATI ON PROGRAM   0   0   0   0   0   0   0   0   0   0	60.00	06000 LABORATORY	0	0		0 0	0	60.00
65. 00	62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0	62. 30
66. 00   06600   PHYSICAL THERAPY   0   0   0   0   0   0   66. 00   68. 00   06800   SPECH PATHOLOGY   0   0   0   0   0   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   0   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   0   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   73. 01   07301   INJECTABLE DRUGS   0   0   0   0   0   76. 97   07697   CARDI AC REHABILITATION   0   0   0   0   0   76. 98   07698   HYPERBARIC OXYGEN THERAPY   0   0   0   0   0   76. 98   07699   LITHOTRI PSY   0   0   0   0   76. 98   08800   RURAL HEALTH CLINIC   1   0   0   0   88. 00   08800   RURAL HEALTH CLINIC   1   0   0   0   88. 01   08801   RURAL HEALTH CLINIC   1   0   0   0   88. 02   08802   RURAL HEALTH CLINIC   1   0   0   0   90. 00   09000   CLINIC   0   0   0   91. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART   0   0   92. 00   09399   PARTI AL HOSPI TALI ZATI ON PROGRAM   0   0   0   0   0   0   0   0   0   0	64.00	06400 I NTRAVENOUS THERAPY	0	0		0 0	0	64.00
68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   0   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   0   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   0   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   73. 01   07301   INJECTABLE DRUGS   0   0   0   0   0   76. 97   07697   CARDI AC REHABI LI TATI ON   0   0   0   0   0   76. 98   07698   HYPERBARI C OXYGEN THERAPY   0   0   0   0   0   76. 99   07699   LI THOTRI PSY   0   0   0   0   0   76. 99   0000   DURAL HEALTH CLINIC   0   0   0   0   88. 01   08801   RURAL HEALTH CLINIC   11   0   0   0   0   88. 02   08802   RURAL HEALTH CLINIC   11   0   0   0   0   88. 02   08802   RURAL HEALTH CLINIC   11   0   0   0   0   90. 00   09000   CLINIC   0   0   0   0   91. 00   09100   DEMERGENCY   0   0   0   0   92. 00   09399   PARTI AL HOSPITALIZATI ON PROGRAM   0   0   0   0   00   0   0   0   0   00   0	65.00	06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
69. 00	66.00	06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
71. 00	68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   72. 00   73. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   0   73. 00   73. 00   73. 01   07301   INJECTABLE DRUGS   0   0   0   0   0   0   0   0   73. 01   76. 97   07697   CARDI AC REHABI LITATI ON   0   0   0   0   0   0   0   0   0	69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   73. 00   73. 00   73. 01   07301   INJECTABLE DRUGS   0   0   0   0   0   0   0   0   73. 01   76. 97   076.97   076.97   076.97   076.98   HYPERBARIC OXYGEN THERAPY   0   0   0   0   0   0   0   0   0	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
73. 01   07301   INJECTABLE DRUGS   0   0   0   0   0   0   73. 01   76. 97   07697   CARDI AC REHABI LI TATI ON   0   0   0   0   0   0   0   76. 98   07698   HYPERBARI C OXYGEN THERAPY   0   0   0   0   0   0   76. 99   07699   LI THOTRI PSY   0   0   0   0   0   0   76. 99   00   0   0   0   0   0   76. 99   00   0   0   0   0   0   88. 00   08800   RURAL HEALTH CLINIC   0   0   0   0   0   88. 01   08801   RURAL HEALTH CLINIC   1   0   0   0   0   88. 02   08802   RURAL HEALTH CLINIC   1   0   0   0   0   88. 02   08802   RURAL HEALTH CLINIC   1   0   0   0   0   88. 02   09000   O9100   CLINIC   0   0   0   0   0   91. 00   09100   EMERGENCY   0   0   0   0   92. 00   09200   OBSERVATI ON BEDS (NON-DI STINCT PART   0   0   0   0   93. 99   07399   PARTI AL HOSPI TALI ZATI ON PROGRAM   0   0   0   0   0THER REI MBURSABLE COST CENTERS	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
76. 97	73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76. 98   07698   HYPERBARI C OXYGEN THERAPY   0   0   0   0   0   0   0   76. 98 76. 99   07699   LI THOTRI PSY   0   0   0   0   0   0   0   76. 99    OUTPATI ENT SERVI CE COST CENTERS	73. 01	07301 I NJECTABLE DRUGS	0	0		0 0	0	73. 01
76. 99 07699 LI THOTRI PSY 0 0 0 0 0 0 0 76. 99 0UTPATI ENT SERVI CE COST CENTERS  88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 0 88. 00 88. 01 88. 01 08801 RURAL HEALTH CLINIC III 0 0 0 0 0 0 88. 01 88. 02 08802 RURAL HEALTH CLINIC III 0 0 0 0 0 0 0 88. 02 90. 00 09000 CLINIC 0 0 0 0 0 0 0 0 0 90. 00 91. 00 09100 EMERGENCY 0 0 0 0 0 0 0 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 0 0 0 0 93. 99 0714 L HOSPI TALI ZATI ON PROGRAM 0 0 0 0 0 0 0 93. 99 0THER REIMBURSABLE COST CENTERS	76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76. 97
SECTION   SERVICE COST CENTERS   SERVICE CO	76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0	76. 98
88. 00   08800   RURAL HEALTH CLINIC   0 0 0 0 0 0 0 88. 00   88. 01   08801   RURAL HEALTH CLINIC   11 0 0 0 0 0 0 0 88. 01   88. 02   08802   RURAL HEALTH CLINIC   11 0 0 0 0 0 0 0 88. 01   88. 02   08802   RURAL HEALTH CLINIC   11 0 0 0 0 0 0 0 0 88. 02   90. 00   09000   CLINIC   0 0 0 0 0 0 0 0 0 0 0 90. 00   91. 00   09100   EMERGENCY   0 0 0 0 0 0 0 0 0 91. 00   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART   0 0 0 0 0 0 0 93. 99   93. 99   09399   PARTIAL HOSPITALIZATION PROGRAM   0 0 0 0 0 0 0 0 93. 99   0THER REIMBURSABLE COST CENTERS	76. 99		0	0		0 0	0	76. 99
88. 01 08801 RURAL HEALTH CLINIC II 0 0 0 0 0 0 88. 01 88. 02 08802 RURAL HEALTH CLINIC III 0 0 0 0 0 0 0 88. 02 90. 00 09000 CLINIC 0 0 0 0 0 0 0 0 0 90. 00 91. 00 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 0 0 0 93. 99 07399 PARTIAL HOSPITALIZATION PROGRAM 0 0 0 0 0 0 93. 99 OTHER REIMBURSABLE COST CENTERS								
88. 02   08802   RURAL HEALTH CLINIC III   0 0 0 0 0 0 0 88. 02   90. 00   09000   CLINIC   0 0 0 0 0 0 0 0 90. 00   91. 00   09100   EMERGENCY   0 0 0 0 0 0 0 91. 00   92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART   0 0 0 0 0 0 0 92. 00   93. 99   09399   PARTIAL HOSPITALIZATION PROGRAM   0 0 0 0 0 0 0 0 0 93. 99   0THER REIMBURSABLE COST CENTERS			0	0		0	0	88. 00
90. 00   09000   CLINIC   0   0   0   0   0   0   90. 00   91. 00   91. 00   92. 00   92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART   0   0   0   0   0   0   92. 00   93. 99   0THER REIMBURSABLE COST CENTERS	88. 01	08801 RURAL HEALTH CLINIC II	0	0		0 0	0	88. 01
91. 00	88. 02	08802 RURAL HEALTH CLINIC III	0	0		0 0	0	88. 02
92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART   0   0   0   0   0   93. 99   071   0   0   0   0   0   0   0   0   0	90.00	09000 CLI NI C	0	0		0 0	0	90.00
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM 0 0 0 0 0 93. 99 OTHER REIMBURSABLE COST CENTERS	91.00	09100 EMERGENCY	0	0		0 0	0	91.00
OTHER REIMBURSABLE COST CENTERS	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
	93. 99	09399 PARTIAL HOSPITALIZATION PROGRAM	0	0		0	0	93. 99
95 OO LOGSOOL AMBULLANCE SERVICES								
		09500 AMBULANCE SERVI CES						95. 00
200.00   Total (lines 50 through 199)   0   0   0   0   200.00	200.00	Total (lines 50 through 199)	0	0		0 0	0	200.00

Health Financial Systems	RI CHLAND MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-2	552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PAS	S Provider C	CN: 14-0147	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prep 5/31/2024 10:4	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Patio of Cost	

			'	0 12/31/2023	5/31/2024 10:	pared: 42 am
		Title	· XVIII	Hospi tal	PPS	12 (3
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
·	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS	_					
50.00 05000 OPERATING ROOM	0	0	C	.0, .02, 00,	0. 000000	50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0	C	785, 525	0. 000000	52.00
53. 00   05300   ANESTHESI OLOGY	0	0	C	00 17 0 70		53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	C	,	0.000000	54.00
56. 00   05600   RADI 01 SOTOPE	0	0	C	2, 898, 298		56.00
57.00  05700 CT SCAN	0	0	C	29, 767, 480		57.00
58. 00  05800 MRI	0	0	C	7, 407, 934	0.000000	58. 00
60. 00  06000 LABORATORY	0	0	C	37, 571, 642	0.000000	60.00
62.30   06250   BLOOD CLOTTING FOR HEMOPHILIACS	0	0	C	0	0.000000	62. 30
64.00   06400   I NTRAVENOUS THERAPY	0	0	C	0	0.000000	64.00
65. 00   06500   RESPI RATORY THERAPY	0	0	C	6, 063, 430	0.000000	65.00
66. 00   06600 PHYSI CAL THERAPY	0	0	C	15, 412, 716	0.000000	66.00
68.00   06800   SPEECH PATHOLOGY	0	0	C	1, 292, 747	0.000000	68. 00
69. 00   06900   ELECTROCARDI OLOGY	0	0	C	10, 265, 502	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C	4, 254, 943	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	341, 901	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	C	9, 600, 733	0.000000	73.00
73. 01   07301   I NJECTABLE DRUGS	0	0	C	8, 284, 066	0.000000	73. 01
76. 97   07697   CARDI AC REHABI LI TATI ON	0	0	C	0	0.000000	76. 97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	C	0	0.000000	76. 98
76. 99 07699 LI THOTRI PSY	0	0	C	0	0.000000	76. 99
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	C	-, ,		88. 00
88.01   08801   RURAL HEALTH CLINIC II	0	0	C	11, 663, 061	0.000000	88. 01
88.02   08802   RURAL HEALTH CLINIC III	0	0	C	0	0.000000	88. 02
90. 00  09000  CLI NI C	0	0	C	711, 521	0.000000	90.00
91. 00   09100   EMERGENCY	0	0	C	29, 974, 988	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	C	4, 771, 425	0.000000	92.00
93.99 O9399 PARTIAL HOSPITALIZATION PROGRAM	0	0	C	0	0.000000	93. 99
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES					 	95.00
200.00   Total (lines 50 through 199)	0	0	(	210, 371, 214	ļ	200. 00

Health Financial Systems  APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S	ERVICE OTHER PASS	Provi der C	CN: 14-0147 P	eri od:	Worksheet D	
THROUGH COSTS			F	rom 01/01/2023		
			T	o 12/31/2023	Date/Time Pre 5/31/2024 10:	
		Ti tl e	xVIII	Hospi tal	973172024 TO. PPS	42 alli
Cost Center Description	Outpati ent	Inpatient	Inpatient	Outpati ent	Outpati ent	
oost conten boscii pti on	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col . 6 ÷	onal ges	Costs (col. 8	onal ges	Costs (col. 9	
	col. 7)		x col. 10)		x col . 12)	
	9.00	10. 00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0. 000000	576, 990	0	3, 066, 426	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	0	o	0	52.00
53. 00   05300   ANESTHESI OLOGY	0. 000000	0	0	o	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	471, 835	0	3, 211, 910	0	54.00
56. 00   05600   RADI 0I SOTOPE	0. 000000	45, 568	0	1, 238, 880	0	56.00
57. 00 05700 CT SCAN	0. 000000	2, 173, 625	0	8, 549, 220	0	57.00
58. 00   05800   MRI	0. 000000	216, 280	0	2, 070, 580	0	58.00
60. 00 06000 LABORATORY	0. 000000	3, 309, 640	0	3, 489, 836	0	60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0	0	0	0	62.30
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	0	0	0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	2, 167, 176	0	484, 018	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	536, 305	0	50, 865	0	66.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	70, 175	0	78, 700	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	551, 425	0	1, 866, 200	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	244, 282		813, 905	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	. 0	1	77, 616	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	2, 504, 280	0	793, 235	0	73.00
73. 01 07301 I NJECTABLE DRUGS	0. 000000	0	0	4, 502, 585	0	73. 01
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0	0	0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0	0	o	0	76. 98
76. 99 07699 LI THOTRI PSY	0. 000000	0	0	0	0	76. 99
OUTPATIENT SERVICE COST CENTERS				,		
88. 00 08800 RURAL HEALTH CLINIC	0. 000000	0	0	0	0	88. 00
88.01 08801 RURAL HEALTH CLINIC II	0. 000000	0	0	o	0	88. 01
88. 02 08802 RURAL HEALTH CLINIC III	0. 000000	0	0	o	0	88. 02
90. 00 09000 CLI NI C	0. 000000	0	0	o	0	90.00
91. 00 09100 EMERGENCY	0. 000000	1, 750, 030	0	3, 815, 543	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	394, 085	0	1, 223, 350	0	92.00
03 00 00300 DADTIAL HOSDITALIZATION DDOCDAM	0.000000	0		ا م	0	1 02 00

0. 000000

15, 011, 696

0 200.00

0 93.99 95.00

35, 332, 869

93. 99 | 09399 | PARTI AL HOSPITALI ZATI ON PROGRAM |
OTHER REI MBURSABLE COST CENTERS |
95. 00 | 09500 | AMBULANCE SERVI CES |
200. 00 | Total (lines 50 through 199)

Health Financial Systems	RI CHLAND MEMORI AL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0147	Peri od: From 01/01/2023	Worksheet D Part V

				-	From 01/01/2023 Fo 12/31/2023		
			Title	2 XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	·	Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Services (see	Servi ces	Services Not	,	
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.		Ded. & Coins.	Ded. & Coins.		
		9		(see inst.)	(see inst.)		
		1. 00	2.00	3.00	4.00	5. 00	
	ANCILLARY SERVICE COST CENTERS	•	•	•			
50.00	05000 OPERATING ROOM	0. 334345	3, 066, 426		0	1, 025, 244	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 729620		,	0	0	52.00
	05300 ANESTHESI OLOGY	2. 036858		1	0	Ō	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 136806		1	0	439, 409	54.00
	05600 RADI OI SOTOPE	0. 224096		1	0	277, 628	56.00
57. 00	05700 CT SCAN	0. 028144			9	240, 609	•
58. 00	05800 MRI	0. 054788		1		113, 443	•
60. 00	06000 LABORATORY	0. 123005			-	429, 267	60.00
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 123003			٥	429, 207	62.30
			l .	1	٥	-	ł
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	l .	l .	0	0	64.00
65.00	06500 RESPI RATORY THERAPY	0. 269954			0	130, 663	65.00
	06600 PHYSI CAL THERAPY	0. 214478			0	10, 909	66.00
	06800 SPEECH PATHOLOGY	0. 329942		1	0	25, 966	1
	06900 ELECTROCARDI OLOGY	0. 006122			0	11, 425	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 337849			9	274, 977	
	07200 IMPL. DEV. CHARGED TO PATIENTS	1. 254293			0	97, 353	
	07300 DRUGS CHARGED TO PATIENTS	0. 168024			0	133, 283	73.00
	07301 I NJECTABLE DRUGS	0. 340271	4, 502, 585		3, 016	1, 532, 099	73. 01
	07697 CARDI AC REHABI LI TATI ON	0. 000000		)	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0	0	76. 98
76. 99	07699 LI THOTRI PSY	0. 000000	0	)	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC						88. 00
88. 01	08801 RURAL HEALTH CLINIC II						88. 01
88. 02	08802 RURAL HEALTH CLINIC III						88. 02
	09000 CLI NI C	0. 931825	0		0	0	90.00
	09100 EMERGENCY	0. 119839			0	457, 251	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 427889			o o	523, 458	
	09399 PARTIAL HOSPITALIZATION PROGRAM	0. 000000			o o	0 0 0	1
73. 77	OTHER REIMBURSABLE COST CENTERS	0.00000		'	51 0		75.77
95.00	09500 AMBULANCE SERVICES	0. 000000		1			95.00
200.00		0.00000	35, 332, 869	1	3, 016	5, 722, 984	
200.00		1	33, 332, 609		3,010	J, 122, 704	200.00
201.00	Only Charges	1		1			201.00
202. 00		1	35, 332, 869		3, 016	5, 722, 984	202 00
202.00	I liver charges (Title 200 - Title 201)	I	1 30, 332, 009	1	3,010	J, 122, 904	2U2.UU

Health Financial Systems	RICHLAND MEMORIA	L HOSPITAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0147	Peri od: From 01/01/2023	Worksheet D Part V Date/Time Prepared:

Cost					Т	o 12/31/2023	Date/Time Prepared: 5/31/2024 10:42 am
Cost   Cost   Cost   Cost   Rel imbursed   Servi ces Not   Subject To   Ded. & Colors   Cost   Rel imbursed   Servi ces Not   Subject To   Ded. & Colors   Cost				Ti tl e	e XVIII	Hospi tal	
Reimbursed Subject To   Ded. & Coins. (see inst.)   Ded. & Coins. (see inst.)   To   Ded. & Coins			Cos				
ANCILLARY SERVICE COST CENTERS		Cost Center Description	Cost	Cost			
ANCILLARY SERVICE COST CENTERS   Subject To   Ded. & CoIns, (see inst.)   Subject To   Ded. & CoIns, (see inst.)   O   Ded.		'	Rei mbursed	Rei mbursed			
Ded. & Coin s.   See inst.			Servi ces	Services Not			
See Inst.   See Inst.   See Inst.			Subject To	Subject To			
ANCILLARY SERVICE COST CENTERS			Ded. & Coins.	Ded. & Coins.			
ANCILLARY SERVICE COST CENTERS			(see inst.)	(see inst.)			
50.00   050000   05000   05000   05000   05000   05000   05000   05000   050000   050000   050000   05000   050000   05000   05000   05000   05000   05000   05000   05000   05000			6. 00	7. 00			
52.00   05200   05200   0521VERY ROOM & LABOR ROOM   0   0   0   0   0   0   0   0   0							
53. 00   05300   AMESTHESI OLOGY   53. 00   54. 00   54. 00   54. 00   54. 00   54. 00   54. 00   54. 00   55. 00   56. 00   56. 00   56. 00   56. 00   56. 00   56. 00   56. 00   56. 00   56. 00   56. 00   56. 00   56. 00   57. 00   57. 00   57. 00   57. 00   57. 00   57. 00   58	50. 00 05000	OPERATING ROOM	0	C	)		50.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C   0   0   0   0   0   0   0   0   0			0	C	)		52.00
56. 00   05600   RADI OI SOTOPE   0 0 0   57. 00	53.00 05300	ANESTHESI OLOGY	0	C	)		53.00
57. 00	54.00 05400	RADI OLOGY-DI AGNOSTI C	0	C	)		54.00
58. 00   05800 MRI	56.00 05600	RADI OI SOTOPE	0	C			56.00
60. 00   06000   LABORATORY   0   0   0   0   0   0   0   0   0	57. 00 05700	CT SCAN	0	C			57.00
62. 30	58. 00 05800	MRI	0	C			58.00
64. 00   06400   INTRAVENOUS THERAPY   0   0   0   0   0   0   0   0   0	60.00 06000	LABORATORY	0	C			60.00
65. 00   06500   RESPI RATORY THERAPY   0   0   0   0   0   0   0   0   0	62. 30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	C			62. 30
66. 00   06600   PHYSI CAL THERAPY   0   0   0   0   68. 00   68. 00   06800   SPECH PATHOLOGY   0   0   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   73. 01   07301   INJECTABLE DRUGS   0   1,026   73. 01   76. 97   07697   CARDI AC REHABILLITATION   0   0   0   76. 98   07699   CARDI AC REHABILLITATION   0   0   0   76. 99   07699   LITHOTRI PSY   0   0   0   88. 00   08800   RURAL HEALTH CLINIC   1   88. 00   08801   RURAL HEALTH CLINIC   1   88. 01   08802   RURAL HEALTH CLINIC   1   88. 02   09800   CLINIC   0   0   0   90. 00   09100   DEFENCING   0   0   91. 00   09100   DEFENCING   0   0   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART   0   0   0   93. 99   OP399   PARTIAL HOSPITALIZATION PROGRAM   0   0   95. 00   09500   AMBULANCE SERVICES   0   201. 00   Charges   0   0   0   0010   Charges   0   0010	64. 00 06400	INTRAVENOUS THERAPY	0	C			64.00
68. 00 06800 SPEECH PATHOLOGY 0 0 0 69.00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 69.00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 0 0 71.00 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0 0 0 72.00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 73.00 73. 01 07301 I NJECTABLE DRUGS 0 1,026 73.00 76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 76. 98 76. 99 07699 LI THOTRI PSY 0 0 0 76. 99 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	65. 00 06500	RESPI RATORY THERAPY	0	C			65.00
69.00   06900   ELECTROCARDI OLOGY   0   0   0   0   0   0   0   0   0	66.00 06600	PHYSI CAL THERAPY	0	C			66.00
71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT   0   0   0   0   0   0   0   0   0	68. 00 06800	SPEECH PATHOLOGY	0	C			68.00
72. 00 07200   IMPL. DEV. CHARGED TO PATIENTS 0 0 0 73. 00 07300   DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	69. 00 06900	ELECTROCARDI OLOGY	0	C			69.00
73. 00	71. 00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	C			71.00
73. 01   07301   INJECTABLE DRUGS   0   1,026   73. 01   76. 97   07697   CARDI AC REHABILITATION   0   0   0   0   0   0   0   0   0	72. 00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	C			72.00
76. 97 76. 97 76. 98 76. 98 76. 99 76. 98 76. 99 76. 99 76. 98 76. 99 76. 98 76. 99 76. 98 76. 99 76. 98 76. 99 76. 98 76. 99 76. 98 76. 99 76. 98 76. 99 76. 98 76. 99 76. 98 76. 99 76. 98 76. 99 76. 98 76. 99 76. 98 76. 99 76. 98 76. 99 76. 98 76. 99 76. 98 76. 99 76. 98 76. 99 76. 98 76. 99 76. 98 76. 99 76. 98 76. 98 76. 99 76. 98 76. 99 76. 98 76. 98 76. 99 76 76. 98 76. 98 76. 99 76 76. 98 76. 99 76 76. 98 76. 99	73.00 07300	DRUGS CHARGED TO PATIENTS	0	C			73.00
76. 98 76. 99 76. 90 76	73. 01   07301	INJECTABLE DRUGS	0	1, 026			73. 01
76. 99   O7699   LI THOTRI PSY   O O O	76. 97   07697	CARDIAC REHABILITATION	0	C			76. 97
SECTION   STATE   SERVICE COST CENTERS   SECTION	76. 98 07698	HYPERBARI C OXYGEN THERAPY	0	C			76. 98
88. 00  88. 01  88. 01  88. 01  88. 02  88. 01  88. 02  90. 00  90. 00  90. 00  91. 00  91. 00  92. 00  92. 00  93. 99  09399 PARTIAL HOSPITALIZATION PROGRAM  90. 00  91. 00  91. 00  91. 00  92. 00  93. 99  001HER REIMBURSABLE COST CENTERS  95. 00  95. 00  95. 00  95. 00  95. 00  95. 00  95. 00  95. 00  96. 00  96. 00  97. 00  98. 01  98. 01  98. 01  98. 01  98. 01  98. 01  98. 01  98. 01  99. 00  90. 00  91. 00  91. 00  92. 00  93. 99  01  01  01  01  01  01  01  01  01	76. 99 07699	LI THOTRI PSY	0	C			76. 99
88. 01   08801   RURAL HEALTH CLINIC II	OUTPA <sup>-</sup>	TIENT SERVICE COST CENTERS					
88. 02	88. 00 08800	RURAL HEALTH CLINIC					88.00
90. 00   09000   CLINIC   0   0   0   90. 00   91. 00   91. 00   92. 00   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART   0   0   0   0   0   0   0   0   0	88. 01 08801	RURAL HEALTH CLINIC II					88. 01
91.00   09100   EMERGENCY   0 0 0   0   0   0   0   0   0   0	88. 02 08802	RURAL HEALTH CLINIC III					88. 02
92. 00   09200   095ERVATION BEDS (NON-DISTINCT PART   0   0   0   0   0   93. 99   09399   PARTIAL HOSPITALIZATION PROGRAM   0   0   0   0   0   0   0   0   0	90.00 09000	CLINIC	0	C			90.00
93. 99 07	91.00 09100	EMERGENCY	0	C			91.00
OTHER REIMBURSABLE COST CENTERS  95.00	92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	C			92.00
95. 00	93. 99 09399	PARTIAL HOSPITALIZATION PROGRAM	0	C			93. 99
200.00   Subtotal (see instructions)	OTHER	REIMBURSABLE COST CENTERS					
201.00 Less PBP Clinic Lab. Services-Program 0 201.00 Only Charges	95. 00 09500	AMBULANCE SERVICES	0				95.00
Only Charges	200. 00	Subtotal (see instructions)	0	1, 026			200.00
Only Charges	201. 00	Less PBP Clinic Lab. Services-Program	0				201.00
202.00   Net Charges (line 200 - line 201)   0   1,026   202.00		Only Charges					
	202. 00	Net Charges (line 200 - line 201)	0	1, 026	o		202. 00

	nancial Systems MENT OF INPATIENT/OUTPATIENT ANCILLARY SE OSTS	RICHLAND MEMOR RVICE OTHER PAS	S Provider Co	CN: 14-0147	Peri Froi To		u of Form CMS-2 Worksheet D Part IV Date/Time Pre	
			Component	JCN. 14-5560	10	12/31/2023	5/31/2024 10:	42 am
			Title	XVIII	Ski	lled Nursing	PPS	
					<u></u>	Facility		
	Cost Center Description	Non Physician	Nursi ng	Nursi ng			Allied Health	
		Anesthetist	Program	Program		ost-Stepdown		
		Cost	Post-Stepdown		F	Adjustments		
		1.00	Adjustments	2.00		2.4	2.00	
ANC	CILLARY SERVICE COST CENTERS	1. 00	2A	2.00		3A	3. 00	
	DOO OPERATING ROOM	0	0		0	O	0	50.00
	200 DELIVERY ROOM & LABOR ROOM	0			0	0	0	52.00
- 1	BOO ANESTHESI OLOGY	0	0		0	0	0	53.00
	400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	0	54.00
	600 RADI OI SOTOPE	0	0		0	0	0	56.00
	700 CT SCAN	0	0		0	0	0	57.00
	BOO MRI	0	0		0	0	0	58.00
	DOO LABORATORY	0	0		0	Ö	0	60.00
	250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0	O	0	62. 30
64. 00 064	400 I NTRAVENOUS THERAPY	0	0		0	0	0	64.00
55.00 065	500 RESPIRATORY THERAPY	0	0		0	0	0	65.00
66.00 066	600 PHYSI CAL THERAPY	0	0		0	0	0	66.00
8. 00 068	BOO SPEECH PATHOLOGY	0	0		0	0	0	68.00
4	900 ELECTROCARDI OLOGY	0	0		0	0	0	69.00
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	0	71.00
	200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	72.00
	BOO DRUGS CHARGED TO PATIENTS	0	0		0	0	0	73.00
	BO1   NJECTABLE DRUGS	0	0		0	0	0	73. 0
	597 CARDI AC REHABI LI TATI ON	0	0		0	0	0	76. 97
	598 HYPERBARI C OXYGEN THERAPY	0			0	0	0	76. 98
	699 LITHOTRIPSY FPATIENT SERVICE COST CENTERS	0	0		0	0	0	76. 99
	BOO RURAL HEALTH CLINIC	0	0		0	O	0	88.00
	BOT RURAL HEALTH CLINIC	0	0		0	0	0	88.00
	302 RURAL HEALTH CLINIC III				0	0	0	88.02
	000 CLINIC	0	l 0		0	0	0	90.00
	100 EMERGENCY	1 0	1 0		0	0	0	91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	Ĭ	0	92.00
	399 PARTIAL HOSPITALIZATION PROGRAM	0	0		0	0	0	93. 99
OTH	HER REIMBURSABLE COST CENTERS					<u> </u>		1
	500 AMBULANCE SERVICES							95.00
200.00	Total (lines 50 through 199)	0	0		0	o	0	200.00

THROUGH COSTS		/ICE OTHER PAS	Component	CN: 14-0147 CCN: 14-5580	Peri od: From 01/01/2023 To 12/31/2023	Date/Time Pre 5/31/2024 10:	pared: 42 am
			Title	XVIII	Skilled Nursing Facility	PPS	
Cost Center Description		All Other	Total Cost	Total	Total Charges		
		Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Education	1, 2, 3, and	Cost (sum of		(col. 5 ÷	
		Cost	4)	col s. 2, 3,	col. 8)	col . 7)	
				and 4)		(see	
	-				7.00	instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS				ı	10 100 057	0.00000	
50. 00 05000 OPERATING ROOM		0	0		0 13, 482, 057		
52.00   05200   DELI VERY ROOM & LABOR ROOM		0	0		0 785, 525		
53. 00   05300   ANESTHESI OLOGY		0	0		0 304, 090		
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0	0		0 13, 355, 977		
56. 00   05600   RADI OI SOTOPE		0	0		0 2, 898, 298	l	1
57. 00 05700 CT SCAN		0	0		0 29, 767, 480	l	
58. 00   05800   MRI		0	0		0 7, 407, 934		
60. 00   06000   LABORATORY		0	0		0 37, 571, 642		
62. 30 06250 BLOOD CLOTTING FOR HEMOPHIL	ACS	0	0		0	0. 000000	
64. 00 06400 I NTRAVENOUS THERAPY		0	0		0 0	0. 000000	
65. 00 06500 RESPI RATORY THERAPY		0	0		0 6, 063, 430		
66. 00   06600   PHYSI CAL THERAPY		0	0		0 15, 412, 716	l e	
68. 00 06800 SPEECH PATHOLOGY		0	0		0 1, 292, 747	0. 000000	
69. 00 06900 ELECTROCARDI OLOGY		0	0		0 10, 265, 502	0.000000	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO		0	0		0 4, 254, 943		
72.00 07200 IMPL. DEV. CHARGED TO PATIE	VIS	0	0		0 341, 901	0. 000000	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0	0		0 9, 600, 733		
73. 01 07301 I NJECTABLE DRUGS		0	0		0 8, 284, 066		
76. 97 O7697 CARDI AC REHABI LI TATI ON		0	0		0	0.000000	
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0	0		0	0.000000	
76. 99 07699 LI THOTRI PSY		0	0		0 0	0. 000000	76. 99
OUTPATIENT SERVICE COST CENTERS		0			0 0 4 (4 4 70	0.00000	
88. 00 08800 RURAL HEALTH CLINIC		0	0		0 2, 161, 178		
88. 01   08801 RURAL HEALTH CLINIC II		0	0		0 11, 663, 061	0.000000	
88. 02   08802 RURAL HEALTH CLINIC III		0	0		0 711 501	0.000000	
90. 00   09000   CLI NI C		0	0		0 711, 521	0.000000	
91. 00   09100   EMERGENCY	ICT DADT	0	0		0 29, 974, 988	l e	
92. 00 09200 OBSERVATION BEDS (NON-DISTII		0	0		0 4, 771, 425		
93. 99 09399 PARTIAL HOSPITALIZATION PROC	JKAW .	U	0		0 0	0.000000	93.99
OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES							]   95. 00

	Financial Systems  IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RI CHLAND MEMORIA	_	CN 14 0147	In Lie	u of Form CMS-2	2552-10
	TONMENT OF INPATTENT/OUTPATTENT ANCIELARY SE H COSTS	RVICE UTHER PASS	Provider C	CN: 14-0147	From 01/01/2023	Worksheet D Part IV	
TTIKOOG	11 00313		Component	CCN: 14-5580	To 12/31/2023		pared: 42 am
			Title	e XVIII	Skilled Nursing		
					Facility		
	Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Throug		Pass-Through Costs (col. 9	
		(col. 6 ÷		Costs (col.	8		
		col . 7) 9.00	10. 00	x col. 10)	12.00	x col . 12) 13.00	
	ANCILLARY SERVICE COST CENTERS	9.00	10.00	11.00	12.00	13.00	
50.00	05000 OPERATING ROOM	0. 000000	(	7	0 0	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	(		0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 000000	(	1	0 0	0	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	0.000000	(	1		0	54.00
56.00	05600 RADI OLOGI - DI AGNOSTI C	0.000000	(	1	0 0	0	56.00
57. 00	05700 CT SCAN	0. 000000	(	1	0 0	0	57.00
58.00	05800 MRI	0. 000000	(	1	0 0	0	
60.00	06000 LABORATORY	0. 000000	(	1	0 0	0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	(	1	0	0	
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	(		0 0	Ö	
65. 00	06500 RESPI RATORY THERAPY	0. 000000	(		0 0	0	
66. 00	06600 PHYSI CAL THERAPY	0. 000000	(		0 0	0	66.00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	(	1	0 0	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	(		0	0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	(		0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	(		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	(		0	0	1
73. 01	07301   NJECTABLE DRUGS	0. 000000	(		0 0	0	
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 000000	(		0 0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 000000	(	ol	0 0	0	76. 98
76. 99	07699 LI THOTRI PSY	0. 000000	(		0 0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS	<u> </u>		•			1
88.00	08800 RURAL HEALTH CLINIC	0. 000000	(		0 0	0	88.00
88. 01	08801 RURAL HEALTH CLINIC II	0. 000000	(		0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0. 000000	(		0	0	88. 02
90.00	09000 CLI NI C	0. 000000	(	)	0 0	0	90.00
91.00	09100 EMERGENCY	0. 000000	(		0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	(		0 0	0	
93. 99	09399 PARTIAL HOSPITALIZATION PROGRAM	0. 000000	(		0 0	0	93. 99
	OTHER REIMBURSABLE COST CENTERS						1
95. 00 200. 00	09500 AMBULANCE SERVICES					_	95.00
	Total (lines 50 through 199)		(	N.	0 0	· ^	200.00

Health Financial Systems	RI CHLAND MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der Co		Period: From 01/01/2023 To 12/31/2023		epared: 42 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col . 2)			
	1. 00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	231, 555	9, 221	222, 33	4, 253	52. 28	30.00
31.00 INTENSIVE CARE UNIT	39, 694		39, 69	4 352	112. 77	31.00
40. 00 SUBPROVI DER - I PF	0	0	)	0	0.00	40.00
43. 00 NURSERY	12, 612		12, 61	2 312	40. 42	43.00
44.00 SKILLED NURSING FACILITY	-180		-18	0	0.00	44.00
200.00 Total (lines 30 through 199)	283, 681		274, 46	0 4, 917		200.00
Cost Center Description	I npati ent	Inpatient				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS	_					
30. 00 ADULTS & PEDIATRICS	158	8, 260				30.00
31.00 INTENSIVE CARE UNIT	17	1, 917				31.00
40.00 SUBPROVIDER - IPF	0	0	)			40.00
43. 00 NURSERY	15	606				43.00
44.00 SKILLED NURSING FACILITY	0	0	)			44.00
200.00 Total (lines 30 through 199)	190	10, 783				200.00

Health Financial Systems	RICHLAND MEMORIA	L HOSPITAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ANCILLARY	SERVICE CAPITAL COSTS	Provi der CCN: 14-0147		Worksheet D
			From 01/01/2023	Part II

					From 01/01/2023		
					To 12/31/2023		epared:
			T; +1	e XIX	Hospi tal	5/31/2024 10: PPS	42 am
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
	cost center bescription	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
		(from Wkst.	C. Part I.	(col. 1 ÷	Charges	column 4)	
		B, Part II,	col. 8)	col. 2)	Charges	COT dillit 4)	
		col . 26)	COI. 0)	COI. 2)			
		1.00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	11.00	2.00	0.00	1.00	0.00	
50.00	05000 OPERATING ROOM	71, 661	0	0.00000	0 0	0	50.00
	05200 DELIVERY ROOM & LABOR ROOM	3, 470	0	•		0	
53. 00	05300 ANESTHESI OLOGY	1, 819	0	0.00000		0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	28, 956	0	0.00000		0	54.00
56. 00	05600 RADI OI SOTOPE	8, 383	0			0	
57. 00	05700 CT SCAN	7, 865	0	•		0	
58. 00	05800 MRI	6, 999	0	0. 00000		0	58.00
60.00	06000 LABORATORY	45, 049	0	0. 00000		0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	•		0	1
	06400 I NTRAVENOUS THERAPY	0	0	•		0	1
65. 00	06500 RESPI RATORY THERAPY	23, 576	0	0. 00000		0	1
66. 00	06600 PHYSI CAL THERAPY	18, 027	0	0. 00000		0	66.00
68. 00	06800 SPEECH PATHOLOGY	5, 836	0			0	1
	06900 ELECTROCARDI OLOGY	355	0			0	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	29, 366	0	0. 00000		0	1
	07200 IMPL. DEV. CHARGED TO PATIENTS	9, 963	0	0.00000		0	72.00
	07300 DRUGS CHARGED TO PATIENTS	12, 679	Ó	0.00000		0	73.00
	07301 I NJECTABLE DRUGS	23, 121	0	0.00000	0	0	73. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0.00000	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0.00000	0	0	76. 98
	07699 LI THOTRI PSY	0	0	0.00000	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS	•			<del>"</del>		
88. 00	08800 RURAL HEALTH CLINIC	40, 469	0	0.00000	0 0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	123, 393	0	0.00000	0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0	0	0.00000	0	0	88. 02
90.00	09000 CLI NI C	11, 264	0	0.00000	0	0	90.00
91.00	09100 EMERGENCY	46, 356	0	0.00000	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	53, 897	0	0.00000	0	0	92.00
93. 99	09399 PARTIAL HOSPITALIZATION PROGRAM	0	0	0.00000	0	0	93. 99
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50 through 199)	572, 504	0		0	0	200.00

Health Financial Systems	RICHLAND MEMOR	RLAL HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER		STS Provi der C		Period: From 01/01/2023 To 12/31/2023	Worksheet D Part III Date/Time Pre 5/31/2024 10:	pared:
			e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng		Allied Health	All Other	
	Program	Program	Post-Stepdowr	Cost	Medi cal	
	Post-Stepdown		Adjustments		Educati on	
	Adjustments				Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				_		
30. 00 03000 ADULTS & PEDIATRICS	0	0	)	0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	31.00
40. 00   04000   SUBPROVI DER - 1 PF	0	0		0	0	40.00
43. 00 04300 NURSERY	0	0		0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0		0		44.00
200.00 Total (lines 30 through 199)	0	l 0		0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem	Inpatient	
	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col. 6)		
		minus col. 4)				
	4. 00	5.00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	4, 25	0.00	158	30.00
31.00 03100 INTENSIVE CARE UNIT		0	35	0.00	17	31.00
40. 00 04000 SUBPROVI DER - I PF	0	0		0.00	0	40.00
43. 00 04300 NURSERY		0	31.	0.00	15	43.00
44.00 04400 SKILLED NURSING FACILITY		l o		0.00	0	44.00
200.00 Total (lines 30 through 199)		l o	4, 91	7	190	200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31.00 03100 INTENSIVE CARE UNIT	0					31.00
40. 00   04000   SUBPROVI DER - I PF	0					40.00
43. 00   04300   NURSERY	0					43.00
44.00 04400 SKILLED NURSING FACILITY	0					44.00
200.00 Total (lines 30 through 199)	0					200.00
	•	'				

Health Financial Systems	RICHLAND MEMORIAI	_ HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 14-0147	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared:

					10 12/31/2023	5/31/2024 10:	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	·	Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1. 00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000  OPERATI NG ROOM	0	0		0	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	
53. 00	05300 ANESTHESI OLOGY	0	0		0	0	00.00
54. 00	05400  RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
56. 00	05600  RADI 0I SOTOPE	0	0		0	0	56.00
57. 00	05700  CT SCAN	0	0		0	0	57.00
58.00	05800  MRI	0	0		0	0	00.00
60.00	06000 LABORATORY	0	0		0	0	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0	0	62. 30
64.00	06400 I NTRAVENOUS THERAPY	0	0		0	0	64.00
65. 00	06500 RESPI RATORY THERAPY	0	0		0	0	65.00
66. 00	06600 PHYSI CAL THERAPY	0	0		0	0	66.00
68. 00	06800 SPEECH PATHOLOGY	0	0		0	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	0	0		0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73.00
73. 01	07301   NJECTABLE DRUGS	0	0		0	0	73. 01
	O7697   CARDI AC   REHABI LI TATI ON	0	0		0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0		0 0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0		0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	0		0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0	0		0	0	88. 02
90.00	09000  CLI NI C	0	0		0 0	0	90.00
91.00	09100 EMERGENCY	0	0		0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
93. 99	09399 PARTIAL HOSPITALIZATION PROGRAM	0	0		0 0	0	93. 99
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVI CES						95.00
200.00	Total (lines 50 through 199)	0	0		0	0	200.00

Health Financial Systems	RICHLAND MEMORIA	L HOSPITAL	In Lieu	ı of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 14-0147	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2023	Part IV

THROUG	in COSTS				To 12/31/2023	Date/Time Pre 5/31/2024 10:	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	·	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
		Cost	4)	col s. 2, 3,	col . 8)	col. 7)	
				and 4)		(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	(	0	0. 000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(	0	0.00000	
53.00	05300 ANESTHESI OLOGY	0	0	(	0	0.000000	53.00
54.00	05400   RADI OLOGY-DI AGNOSTI C	0	0	(	0	0.000000	
56.00	05600 RADI OI SOTOPE	0	0	(	0	0.000000	56.00
57.00	05700  CT SCAN	0	0	(	0	0.000000	57.00
58.00	05800  MRI	0	0	(	0	0.000000	58.00
60.00	06000 LABORATORY	0	0	(	0	0.000000	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	(	0	0.000000	62. 30
64.00	06400 I NTRAVENOUS THERAPY	0	0	(	0	0.000000	64.00
65.00	06500 RESPI RATORY THERAPY	0	0	(	0	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	0	0	(	0	0.000000	66.00
68.00	06800 SPEECH PATHOLOGY	0	0	(	0	0.000000	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0	(	0	0.000000	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(	0	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(	0	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	(	0	0.000000	73.00
73. 01	07301 I NJECTABLE DRUGS	0	0	(	0	0.000000	73. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	(	0	0.000000	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	(	0	0.000000	76. 98
76. 99	07699 LI THOTRI PSY	0	0	(	0	0.000000	76. 99
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	(	0	0.000000	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	0	(	0	0.000000	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0	0	(	0	0.000000	88. 02
90.00	09000 CLI NI C	0	0	(	0	0.000000	90.00
91.00	09100 EMERGENCY	0	0	(	0	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	(	0	0.000000	92.00
93. 99	09399 PARTIAL HOSPITALIZATION PROGRAM	0	0	(	0	0. 000000	93. 99
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES						95.00
200.00	Total (lines 50 through 199)	0	0	(	0		200. 00

Health Financial Systems	RI CHLAND MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILL THROUGH COSTS	ARY SERVICE OTHER PASS	Provider C		Period: From 01/01/2023 To 12/31/2023		pared: 42 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost to Charges	Program Charges	Program Pass-Through	Program Charges	Program Pass-Through	
	(col . 6 ÷		Costs (col. 8		Costs (col. 9	

						3/31/2024 10.	42 alli
				e XIX	Hospi tal	PPS	
	Cost Center Description	Outpati ent	Inpatient	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷		Costs (col. 8		Costs (col. 9	
		col. 7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11. 00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 000000	0		0	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	0	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 000000	0	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	0	0	0	0	54.00
56.00	05600 RADI OI SOTOPE	0. 000000	0	0	0	0	56.00
57.00	05700 CT SCAN	0. 000000	0	0	0	0	57.00
58.00	05800 MRI	0. 000000	0	0	0	0	58. 00
60.00	06000 LABORATORY	0. 000000	0	0	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0	0	0	0	62.30
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0. 000000	0	0	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	0	0	0	0	66.00
68.00	06800 SPEECH PATHOLOGY	0. 000000	0	0	0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	0	O	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0	o	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	0	0	0	0	73.00
73. 01	07301 I NJECTABLE DRUGS	0. 000000	0	0	0	0	73. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 000000	0	0	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0	0	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0. 000000	0	0	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						1
88.00	08800 RURAL HEALTH CLINIC	0. 000000	0	0	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0. 000000	0	O	0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0. 000000	0	O	0	0	88. 02
90.00	09000 CLI NI C	0. 000000	0	O	0	0	90.00
91.00	09100 EMERGENCY	0. 000000	0	o	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0	o	0	0	92.00
93. 99	09399 PARTI AL HOSPI TALI ŽATI ON PROGRAM	0. 000000	0	o	0	0	93. 99
	OTHER REIMBURSABLE COST CENTERS						1
95.00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)		0	0	0	0	200.00
				'	,	•	•

Health Financial Systems	RICHLAND MEMORIAL HOSPITAL	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 14-0147	Peri od: From 01/01/2023	Worksheet D-1	
			Date/Time Pre 5/31/2024 10:	pared: 42 am
	Title XVIII	Hospi tal	PPS	
Cost Center Description				
			1. 00	

APACE   ALL PROVIDER COMPONENTS			Title XVIII	Hospi tal	PPS	
BRATT   ALL PROVIDER COMPONENTS   BRATTERI DMS   BRATTERI DMS   STATE   BRATTERI DMS   ST		Cost Center Description		-	1 00	
MPATTERT DAYS   1.00		PART I - ALL PROVIDER COMPONENTS			1.00	
Inpatt and days (Including private room days, excluding swing-bed and newborn days)   1, 250   2, 00   3, 00   7, 00						
Private room days (excluding swing-bed and observation bed days). If you have only private room days. 3, 222 4, 00 do not complete this line. 4, 00 Semi-private room days (excluding swing-bed and observation bed days). 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1,	1.00				5, 724	1.00
do not complete this line.  4. 00 Sell-private room days (excluding swing-bed and observation bed days)  1. 10 Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost 1, 414 5.00 copyright period (if calendar year, enter 0 on this line)  7. 00 Total swing-bed KP type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  8. 00 Total swing-bed KP type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9. 00 Total swing-bed KP type inpatient days (including private room days) after December 31 of the cost reporting period (in patient days and including private room days) after December 31 of the cost reporting period (in patient days and including private room days) after December 31 of the cost reporting period (in patient days applicable to the Program (excluding swing-bed and newbork days) (see instructions)  10. 00 Saing-bed SW type inpatient days applicable to the Program (excluding swing-bed and newbork days) (see instructions)  11. 00 Saing-bed SW type inpatient days applicable to the Program (excluding swing-bed and newbork days) (see instructions)  12. 00 Saing-bed SW type inpatient days applicable to the Program (excluding swing-bed and newbork days) (see instructions)  13. 00 Swing-bed SW type inpatient days applicable to the Program (excluding private room days)  14. 00 Swing-bed SW type inpatient days applicable to the SW of XX only (including private room days)  15. 00 Swing-bed SW type inpatient days applicable to services after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  16. 00 Wind-bed SW type services applicable to services through December 31 of the cost reporting period (including private room days)  17. 00 Swing-bed SW type services applicable to services after December 31 of the cost reporting period (including private room days)  18. 00 Wind-bed SW						
	3. 00	,	ys). If you have only pr	ivate room days,	0	3. 00
1.01   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)   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)   Total inpatient days (including private room days) after December 31 of the cost reporting period (If calendar year, enter 0 on this line)   Total inpatient days including private room days) after December 31 of the cost reporting period (If calendar year, enter 0 on this line)   Total inpatient days including private room days)   Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)   Solid Pole SNF type inpatient days applicable to the Program (excluding swing-bed and period SNF type inpatient days applicable to describe the solid private room days)   Total inpatient days applicable to describe the solid private room days   Total SNF type inpatient days applicable to describe the solid private room days)   Total SNF type inpatient days applicable to describe the solid private room days   Total SNF type inpatient days applicable to describe the solid private room days   Total SNF type inpatient days applicable to the solid private room days   Total SNF type inpatient days applicable to describe the solid private room days   Total SNF type inpatient days applicable to describe the solid private room days   Total SNF type inpatient days applicable to the solid private room days   Total SNF type inpatient days applicable to the solid private room days   Total SNF type inpatient days applicable to the solid private room days   Total SNF type inpatient days applicable to the solid private room days   Total SNF type inpatient days applicable to the solid private room days   Total SNF type inpatient days applicable to the solid private room days   Total SNF type inpatient days   Total SNF type solid private room days   Total SNF type	4 00		ad daya)		2 222	4 00
reporting period (if calendar year, enter 0 on this line)  7.00  7				or 31 of the cost		
10tal 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)   7.00   7	5.00		on days) through becembe	i 31 of the cost	1, 414	3.00
Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost proporting period of Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost proporting period (if calendar year, enter 0 on this line) to the Program (excluding swing-bed and private room days applicable to the Program (excluding swing-bed and private room days) through December 31 of the cost reporting period (see Instructions) through December 31 of the cost reporting period (see Instructions) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) December 31 of the cost reporting period (if calendar year, enter 0 on this line) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) december 31 of the cost reporting period (if calendar year, enter 0 on this line) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) december 31 of the cost reporting period (if calendar year, enter 0 on this line) to 10 to	6.00	1	om days) after December	31 of the cost	0	6.00
reporting period  8. 00 Total swing-bed NF type inpatient days (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line)  9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)  10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 0 December 31 of the cost reporting period (see instructions)  12. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 0 December 31 of the cost reporting period (including private room days) after 1 December 31 of the cost reporting period (including private room days)  13. 00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days)  14. 00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days)  15. 00 Total nursery days (itle V or XIX only)  16. 00 Total nursery days (itle V or XIX only)  17. 00 Idea (ally necessary private room days applicable to titles V or XIX only (including private room days)  18. 00 Total nursery days (itle V or XIX only)  18. 00 Idea (ally necessary private room days applicable to services through December 31 of the cost reporting period (including nurser)  18. 00 Idea (ally necessary private room days applicable to services after December 31 of the cost reporting period (including nurser)  18. 00 Idea (all rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including reporti			•			
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line)  Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)  No Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after only through becamber 31 of the cost reporting period (see instructions)  No Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after only through becamber 31 of the cost reporting period (see instructions)  11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after only through becamber 31 of the cost reporting period (see instructions)  12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  13.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days)  14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days)  15.00 Total nursery days (title V or XIX only)  16.00 Nursery days (title V or XIX only)  17.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  18.00 Medical care rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (see instructions)  18.00 Medical care rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (see instructions)  18.71 Agriculture rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 8 x 1 including swing-bed ost applicable to SNF type services through December 31 of the cost reporting period (line 8 x 1 including swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 8 x 1 including swing-bed cost applicable to NF type services after Dec	7. 00		m days) through December	31 of the cost	57	7. 00
reporting period (if calendar year, énter 0 on this line)  10. 00 Swing-bed Swit yell upstient days applicable to the Program (excluding swing-bed and newborn days) (see instructions)  10. 00 Swing-bed SWit type lipatient days applicable to title XVIII only (including private room days)  11. 00 Swing-bed SWit type lipatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions)  12. 00 Swing-bed WE 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)  12. 00 Swing-bed WE type inpatient days applicable to title XVIII only (including private room days) on 12. 00 through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  13. 00 Swing-bed WE type inpatient days applicable to title XVIII only (including private room days) on 13. 00 through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  14. 00 Wedi Cally necessary private room days applicable to the Program (excluding swing-bed days)  15. 00 Total nursery days (title V or XIX only)  16. 00 Nursery days (title V or XIX only)  17. 00 Medicare rate for swing-bed SWF services applicable to services through December 31 of the cost reporting period (if calendar year, enter 0 wing-bed SWF services applicable to services after December 31 of the cost 24. 47 19. 00 reporting period (including swing-bed swing-bed SWF services applicable to services after December 31 of the cost 24. 47 19. 00 reporting period (including swing-bed swing-bed SWF services applicable to services after December 31 of the cost 24. 47 19. 00 reporting period (including swing-bed SWF services applicable to services after December 31 of the cost reporting period (line 3 x 11 including swing-bed cost applicable to SWF type services through December 31 of the cost reporting period (line 4 x 11 including swing-bed cost applicable to NF type services	9 00		m days) after December 3	11 of the cost	0	9 00
1.651   1.05	8.00		ili days) arter beceiliber 3	of the cost	U	8.00
newborn days) (see Instructions) 10.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SMF 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) 12.00 Swing-bed MF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed MF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Swing-bed MF type inpatient days applicable to titles V or XIX only (including private room days) 15.00 Total nursery days (title V or XIX only) 16.00 Total unserve days (title V or XIX only) 17.00 Nursery days (title V or XIX only) 18.00 Medicare rate for swing-bed SMF services applicable to services through December 31 of the cost reporting period (including SMF) 18.00 Medicare rate for swing-bed SMF services applicable to services after December 31 of the cost reporting period (including SMF) 19.00 Medicare rate for swing-bed SMF services applicable to services after December 31 of the cost reporting period (including SMF) 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including SMF) 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including SMF) 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including SMF) 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line SMF) 19.00 SWF, SMF, SMF, SMF, SMF, SMF, SMF, SMF, SM	9. 00		o the Program (excluding	swing-bed and	1, 651	9.00
through December 31 of the cost reporting period (see instructions)  1.00 Swing-bed SNF type inpatient days applicable to titlex Vill only (including private room days) after 0 pecember 31 of the cost reporting period (if calendar year, enter 0 on this line)  1.00 Swing-bed NF type inpatient days applicable to titlex V or XIX only (including private room days) 0 through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  1.00 Swing-bed NF type inpatient days applicable to titlex V or XIX only (including private room days) 0 through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.00 Medically inecessary private room days applicable to the Program (excluding swing-bed days) 0 through December 31 of the cost 1.00 New Including private room days applicable to the Program (excluding swing-bed days) 0 through December 31 of the cost 1.00 New Including Private room days applicable to services through December 31 of the cost 2.00 New Including Private Program (excluding swing-bed days) 1.00 New Including Private Program (excluding Swing-December 31 of the cost 2.00 New Including Private Program (excluding Swing-December 31 of the cost 2.00 New Including Private Program (excluding Swing-December 31 of the cost 2.00 New Including Private Program (excluding Swing-December 31 of the cost 2.00 New Including Private Program (excluding Swing-December 31 of the cost 2.00 New Including Private Program (excluding Swing-December 31 of the cost 2.00 New Including Private Program (excluding Swing-December 31 of the cost 2.00 New Including Private Program (excluding Swing-December 31 of the cost 2.00 N				,	,	
11.00 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) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 15.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 16.00 Nursery days (title V or XIX only) 17.00 Nursery days (title V or XIX only) 17.00 Nursery days (title V or XIX only) 18.00 Nursery days (title V or XIX only) 19.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost 18.00 Nedicare rate for swing-bed SNF services applicable to services after December 31 of the cost 18.00 Nedicare rate for swing-bed SNF services applicable to services after December 31 of the cost 18.00 Nedicare rate for swing-bed NF services applicable to services after December 31 of the cost 18.00 Nedicare rate for swing-bed NF services applicable to services after December 31 of the cost 18.00 Nedicare rate for swing-bed NF services applicable to services after December 31 of the cost 18.00 Nedicare rate for swing-bed NF services applicable to services after December 31 of the cost 18.00 Nedicare rate for swing-bed NF services applicable to services after December 31 of the cost 18.00 Nedicare rate for swing-bed NF services applicable to services after December 31 of the cost 18.00 Nedicare rate for swing-bed NF services after December 31 of the cost reporting period (including private room period (including services) 18.00 Nedicare rate for swing-bed NF services after December 31 of the cost reporting period (line 6 x IIIne 18) 18.00 Nedicare rate for swing-bed NF services after December 31 of the cost reporting period (line 6 x IIIne 18) 18.00 Nedica	10.00			room days)	1, 069	10.00
December 31 of the cost reporting period (if calendar year, enter 0 on this line)  12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Medical In precessary private room days applicable to the Program (excluding swing-bed days)  15.00 Total nursery days (title V or XIX only)  16.00 No Nursery days (title V or XIX only)  17.00 Medical rear test for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including private room cost differential (line of XIII only)  18.00 Medical care rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (and are rate for swing-bed NF services applicable to services after December 31 of the cost (24.47)  19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost (224.47)  20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost (224.47)  20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost (224.47)  20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost (224.47)  20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost (224.47)  20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost (224.47)  20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost (224.47)  20.00 Medical drate for swing-bed NF services after December 31 of the cost reporting period (line of X iline 17)  20.00 Medical drate for swing-bed to SNF type services after December 31 of the cost reporting period (line of X iline 17)  20.00 Medical drate for swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line of X iline 17)  20.00 Med	44 00				0	44 00
12.00 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 3.00 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 call endar year, enter 0 on this line) 4.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 5.00 Total nursery days (title V or XIX only) 5.00 Norsery days (title V or XIX only) 6.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (local drate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (local drate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (local drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (local drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line for syling-bed cost applicable to SNF type services through December 31 of the cost reporting period (line for X iline 18) 5 x line 17) 5 x line 18) 6 x line 18) 6 x line 18) 7 x line 19) 8 x line 20 x	11.00			oom days) after	Ü	11.00
through December 31 of the cost reporting period  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  15.00 Total nursery days (title V or XIX only)  16.00 Nursery days (title V or XIX only)  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18.00 Nedicare rate for swing-bed SNF services applicable to services after December 31 of the cost  19.00 reporting period  19.00 Medicader rate for swing-bed NF services applicable to services after December 31 of the cost  19.00 reporting period  20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  224.47 19.00 reporting period  20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  224.47 19.00 reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.01 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line sine 1)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line sine 1)  24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line sine 1)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line sine 1)  26.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line sine 1)  27. Willing-bed cost applicable to NF type services after December 31 of the cost reporting period (line sine 2)  28.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line sine 3)  29.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line sine 3)  29.00 Swing-bed cost applicable to NF type services after December 31 of the cost re	12 00			e room days)	n	12.00
13.00   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)   14.00   15.00	12.00		x only (mer during private	to room days)	G	12.00
14.00   Medically necessary private room days applicable to the Program (excluding swing-bed days)   0   14.00   15.	13.00		X only (including privat	e room days)	0	13.00
15.00   Total nursery days (title V or XIX only)		after December 31 of the cost reporting period (if calendar y	ear, enter 0 on this lin	ie)		
16.00 Nursery days (title V or XIX only)  Wind BED ADJUSTMENT  17.00 Modicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period reporting			am (excluding swing-bed	days)	-	
SWING BED ADJUSTMENT					-	
17. 00   Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period   18. 00   Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost   243. 34   18. 00   19. 00   Medicare rate for swing-bed NF services applicable to services through December 31 of the cost   224. 47   19. 00   20. 00   Medicald rate for swing-bed NF services applicable to services after December 31 of the cost   224. 47   20. 00   20. 00   Medicald rate for swing-bed NF services applicable to services after December 31 of the cost   224. 47   20. 00   20. 00   Medicald rate for swing-bed NF services applicable to services after December 31 of the cost   224. 47   20. 00	10.00				0	10.00
18.00   Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost   243.34   18.00	17. 00		es through December 31 o	of the cost	237. 99	17.00
reporting period  Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  2.0.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 224. 47 20.00  Total general inpatient routine service cost (see instructions)  2.0.00 Ngng-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 336.518 22.00  2.0.00 Ngng-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 17)  2.0.00 Ngng-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  2.0.00 Ngng-bed cost applicable to NF type services after December 31 of the cost reporting period (line 12.795 24.00  2.0.00 Ngng-bed cost applicable to NF type services after December 31 of the cost reporting period (line 12.795 24.00  2.0.00 Ngng-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  2.0.00 Ngng-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  2.0.00 Ngng-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  2.0.00 Ngng-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  2.0.00 Ngng-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  2.0.00 Ngng-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  2.0.00 Ngng-bed cost applicable to NF type services after December 31 of the cost reporting period (line 3 x line 20)  2.0.00 Ngng-bed cost applicable to NF type service cost net of swing-bed cost reporting period (line 3 x line 30)  2.0.00 Ngng-bed cost applicable to NF type service cost net of swing-bed cost (line 21 minus line 26)  2.00 Ngng-bed cost applicable to NF type service cost net of swing-bed cost (line 21			-			
19.00   Medical drate for swing-bed NF services applicable to services through December 31 of the cost reporting period   22.4.47   20.00   20.00   Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period   22.4.47   20.00   21.00   Total general inpatient routine service cost (see instructions)   8,771,332   21.00   22.00   Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line   336,518   22.00   Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line   32.00   x line 18)   24.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line   12,795   24.00   x line 19)   25.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line   12,795   24.00   25.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line   12,795   24.00   25.00   34.00   25.00   34.0	18. 00	1	es after December 31 of	the cost	243. 34	18. 00
reporting period  20.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 7 x line 18)  25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service cost net of swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Swing-bed cost (see instructions)  31.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32.00 Average perivate room per diem charge (line 29 + line 3)  33.00 Average perivate room per diem charge (line 29 + line 3)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room charge differential (line 34 x line 31)  37.00 General inpatient routine service cost differential (line 34 x line 31)  38.00 Average per diem private room charge differential (line 34 x line 31)  38.00 Average per diem private room charge differential (line 34 x line 31)  38.00 Average per diem private room charge differential (line 37 minus line 33)  38.00 Average per diem private room charge differential (line 37 minus line 36)  38.00 Program general inpatient routine service cost per diem (see instructions)  38.00 Average per diem private room cost differential (line 37 minus line 38)  38.00 Aver	10 00		s through Dosombor 21 of	the cost	224 47	10 00
20.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 21.00 Total general inpatient routine service cost (see instructions) 8,771,332 21.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 33.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18) 25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 349,313 26.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 8,422,019 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 300 Swing-bed charges) 300 Swing-bed cost (see charges (excluding swing-bed and observation bed charges) 300 Swing-private room charges (excluding swing-bed charges) 300 Swing-private room per diem charge (line 29 + line 3) 300 Average per inpatient routine service cost/charge ratio (line 27 + line 28) 300 Swing-private room per diem charge (line 30 + line 4) 300 Swing-private room per diem charge (line 30 + line 4) 300 Swing-private room cost differential (line 32 minus line 33)(see instructions) 300 Swing-private room cost differential (line 32 minus line 33)(see instructions) 300 Swing-private room cost differential (line 32 minus line 33) (see instructions) 300 Swing-private room cost differential (line 32 minus line 33) (see instructions) 300 Swing-private room cost differential (line 32 minus line 33) 300 Swing-private room cost differential (line 32 minus line 33) 300 Swing-bed general inpatient routine servic	17.00	1.	3 through becember 31 or	the cost	224.47	17.00
21.00   Total general inpatient routine service cost (see instructions)   8,771,332   21.00   22.00   Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)   336,518   22.00   x line 18)   336,518   22.00   x line 18)   336,518   22.00   32.00   x line 18)   336,518   22.00   32.00   x line 18)   336,518   32.00   32.00   x line 18)   336,518   32.00	20.00	, , , , , , , , , , , , , , , , , , , ,	s after December 31 of t	he cost	224. 47	20.00
22.00   Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)   23.00   Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)   24.00   Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)   25.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)   25.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)   26.00   Total swing-bed cost (see instructions)   349, 313   26.00   Total swing-bed cost (see instructions)   349, 313   27.00   PRIVATE ROOM DIFFERENTIAL ADJUSTMENT   28.00   General inpatient routine service cost net of swing-bed and observation bed charges)   0 29, 00   29.00   Private room charges (excluding swing-bed charges)   0 29, 00   31.00   General inpatient routine service cost/charge ratio (line 27 + line 28)   0,000   32.00   Average private room per diem charge (line 29 + line 3)   0,000   33.00   Average perivate room per diem charge (line 29 + line 3)   0,000   33.00   Average per diem private room cost differential (line 32 x line 31)   0,000   35.00   Average per diem private room cost differential (line 34 x line 31)   0,000   35.00   Average per diem private room cost differential (line 34 x line 35)   0,000   37.00   Private room cost differential adjustment (line 3 x line 35)   0,000   37.00   Private room cost differential adjustment (line 3 x line 35)   0,000   37.00   Program general inpatient routine service cost per diem (see instructions)   1,980,25   38.00   Adjusted general inpatient routine service cost per diem (see instructions)   1,980,25   38.00   Adjusted general inpatient routine service cost per diem (see instructions)   0,000   39.00   Program general inpatient routine service cost per diem (see instructions)   0,000   39.00   Program general inpatient routine servic						
5 x line 17)  Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00  X line 18)  25.00  Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 12,795 24.00 7 x line 19)  25.00  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 x line 20)  26.00  Total swing-bed cost (see instructions)  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and observation bed charges)  Defenral inpatient routine service cost-pate (harges)  Defenral inpatient routine service cost-pate (line 27 + line 28)  Defenral inpatient routine service cost-pate (line 27 + line 28)  Defenral inpatient routine service cost-pate (line 30 + line 4)  Defenral inpatient routine service cost-pate (line 30 + line 31)  Defenral inpatient routine service cost pate (line 30 + line 31)  Defenral inpatient routine service cost pate (line 34 x line 31)  Defenral inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 422, 019)  Defenral inpatient routine service cost per diem (see instructions)  Defenral inpatient routine service cost per diem (see instructions)  Defenral inpatient routine service cost per diem (see instructions)  Defenral inpatient routine service cost per diem (see instructions)  Defenral inpatient routine service cost per diem (see instructions)  Defenral inpatient routine service cost per diem (see instructions)  Defenral inpatient routine service cost per diem (see instructions)  Defenral inpatient routine service cost per di						
23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line of x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line of x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line of x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 PRIVATE ROOM DIFFERENTIAL ADUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room per diem charge (line 29 + line 3)  30.00 Average per diem private room charge (line 30 + line 4)  30.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 34 x line 35)  30.00 Average per diem private room cost differential (line 34 x line 35)  30.00 Average per diem private room cost differential (line 34 x line 35)  30.00 Average per diem private room cost differential (line 34 x line 35)  30.00 Average per diem private room cost differential (line 35 minus line 36)  30.00 Average per diem private room cost differential (line 35 minus line 36)  30.00 Average per diem private room cost differential (line 34 x line 35)  30.00 Average per diem private room cost differential (line 36 minus line 36)  30.00 Average per diem private room cost differential (line 36 minus line 36)  30.00 Average per diem private room cost differential (line 36 minus line 36)  30.00 Average per diem private room cost differential (line 36 min	22.00		er 31 of the cost report	ing period (iine	330, 518	22.00
x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 12,795 24.00 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 x line 20)  26.00 Total swing-bed cost (see instructions) 349,313 26.00 349,313 26.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 8,422,019 27.00 9 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 28.00 29.00 Private room charges (excluding swing-bed charges) 0 29.00 29.00 Semi-private room charges (excluding swing-bed charges) 0 30.00 Semi-private room charges (excluding swing-bed charges) 0 30.00 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 0.000000 31.00 32.00 Average per diem charge (line 29 + line 3) 0.00 32.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 0.00 34.00 Average per diem private room cost differential (line 34 x line 31) 0.00 35.00 Average per diem private room cost differential (line 34 x line 35) 0 Private room cost differential djustment (line 3 x line 35) 0 Average per diem private room cost differential (line 35 minus line 36) 9 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,980.25 38.00 0 Program general inpatient routine service cost (line 9 x line 38) 3,269,393 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	23. 00		31 of the cost reportin	na period (line 6	0	23. 00
7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32.00 Average private room per diem charge (line 29 + line 3)  33.00 Average semi-private room per diem charge (line 30 + line 4)  34.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 422, 019)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 422, 019)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00						
25.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)   25.00 x line 20   26.00   70 tal swing-bed cost (see instructions)   349,313   26.00   27.00   27.00   27.00   27.00   28.00   27.00   28.00   29.00	24. 00		r 31 of the cost reporti	ng period (line	12, 795	24.00
x line 20)  26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  9.00 Pri vate room charges (excluding swing-bed charges)  3.00 Semi-pri vate room charges (excluding swing-bed charges)  3.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  3.00 Average pri vate room per diem charge (line 29 + line 3)  3.00 Average semi-pri vate room per diem charge (line 30 + line 4)  3.00 Average per diem pri vate room charge differential (line 34 x line 31)  3.00 Average per diem pri vate room cost differential (line 34 x line 31)  3.00 Average per diem pri vate room cost differential (line 3 x line 35)  3.00 Pri vate room cost differential adjustment (line 3 x line 35)  3.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 422, 019)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  3.00 Average general inpatient routine service cost per diem (see instructions)  3.00 Average per alien private room cost differential (line 9 x line 38)  3.00 Adjusted general inpatient routine service to cost per diem (see instructions)  3.00 Adjusted general inpatient routine service cost per diem (see instructions)  3.00 Adjusted general inpatient routine service cost per diem (see instructions)  3.00 Adjusted general inpatient routine service cost (line 9 x line 38)  3.00 Adjusted general inpatient routine service cost (line 9 x line 38)  3.00 Adjusted general inpatient routine service cost (line 9 x line 38)  3.00 Adjusted general inpatient routine service cost (line 9 x line 38)  3.00 Adjusted general inpatient routine service cost (line 9 x line 38)	25 00		21 - 6 + 1 +			25 00
Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room per diem charge (line 29 ÷ line 29 + line 28)  30.00 Average private room per diem charge (line 29 ÷ line 3)  30.00 Average semi-private room per diem charge (line 30 ÷ line 4)  30.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Private room cost differential adjustment (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average	25.00	] 3	31 of the cost reporting	period (line 8	U	25.00
27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29. 00 Private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  30. 00 General inpatient routine service cost/charge ratio (line 27 ± line 28)  30. 00 Average private room per diem charge (line 29 + line 3)  30. 00 Average semi-private room per diem charge (line 30 + line 4)  30. 00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  30. 00 Average per diem private room cost differential (line 34 x line 31)  30. 00 Average per diem private room cost differential (line 34 x line 31)  30. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 ± line 28)  30. 00 Average per diem private room cost differential (line 30 ± line 30)  30. 00 Average per diem private room cost differential (line 30 ± line 30)  30. 00 Average per diem private room cost differential (line 30 ± line 30)  30. 00 Average per diem private room cost differential (line 30 ± line 30)  30. 00 Average per diem private room cost differential (line 30 ± line 30)  30. 00 Average per diem private room cost differential (line 30 ± line 30)  30. 00 Average per diem private room cost differential (line 30 ± line 30)  30. 00 Average per diem private room cost differential (line 30 ± line 30)  30. 00 Average per diem private room cost differential (line 30 ± line 30)  30. 00 Average per diem private room cost differential (line 30 ± line 30)  30. 00 Average per diem private room cost differential (line 30 ± line 30)  30. 00 Average per diem private room cost differential (line 30 ± line 30)  30. 00 Average per diem private room cost differential (line 30 ± line 30)  30. 00 Average per diem private room cost different	26. 00				349, 313	26.00
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Average private room per diem charge (line 29 ÷ line 3)  30.00 Average semi-private room per diem charge (line 29 ÷ line 3)  31.00 Average per diem private room per diem charge (line 30 ÷ line 4)  32.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 422, 019)  37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  39.00 Program general inpatient routine service cost (line 9 x line 38)  39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 28.00 29.00  29.00 29.00  30.00 30.00	27.00		(line 21 minus line 26)			
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 422, 019)  37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 3, 269, 393 3, 269, 393 3, 269, 393 3, 269, 393 3, 269, 393 3, 269, 393 3, 269, 393						
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 422, 019)  37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions) 37.00 Program general inpatient routine service cost (line 9 x line 38) 38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	28. 00	General inpatient routine service charges (excluding swing-be	d and observation bed ch	arges)	- 1	
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  32.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 422, 019)  37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  37.00 Program general inpatient routine service cost (line 9 x line 38)  38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 0.00 32.00  0.00 32.00  0.00 33.00  0.00 33.00  0.00 34.00  0.00 34.00  0.00 35.00  0.00 35.00  0.00 36.00  0.00 36.00  0.00 36.00  0.00 37.00  0.00 37.00  0.00 37.00  0.00 38.00  0.00 38.00  0.00 38.00  0.00 38.00  0.00 38.00  0.00 39.00  0.00 39.00  0.00 39.00  0.00 30.00  0.0						
32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 33.00 Average per diem private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 422, 019) 37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 37.00 Program general inpatient routine service cost (line 9 x line 38) 38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)			· Lino 20)			
33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 422, 019)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 34.00  36.00 37.00  37.00 36.00  37.00 37.00  38.00 37.00  38.00 37.00  38.00 37.00  39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)		,	- Time 20)			
Average per diem private room charge differential (line 32 minus line 33)(see instructions)  34.00 Average per diem private room cost differential (line 34 x line 31)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 422, 019)  Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 34.00 35.00 36.00 37.00 37.00 38.00 37.00						
35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 422, 019)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			nus line 33)(see instruc	tions)		
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 422, 019 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  37.00 8, 422, 019 8, 422, 019 37.00 8, 422, 019 37.00 9  37.00 8, 422, 019 8, 422, 019 37.00 9  37.00 8, 422, 019 8, 422, 0		, , ,				
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,980.25 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00					-	
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,980.25 38.00  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00	37. 00	i i	and private room cost di	fferential (line	8, 422, 019	37.00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,980.25 38.00  Program general inpatient routine service cost (line 9 x line 38)  3,269,393 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00						
38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,980.25 38.00  Program general inpatient routine service cost (line 9 x line 38)  3,269,393 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00			USTMENTS			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  3, 269, 393 39.00 0 40.00	38. 00				1, 980. 25	38. 00
		Program general inpatient routine service cost (line 9 x line	38)			
41.00   Total Program general inpatient routine service cost (line 39 + line 40) 3, 269, 393   41.00						
	41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		3, 269, 393	41.00

	Financial Systems ATION OF INPATIENT OPERATING COST	RI CHLAND MEMORI	AL HOSPITAL Provider C		Peri od:	u of Form CMS-2 Worksheet D-1	
					From 01/01/2023 To 12/31/2023	Date/Time Pre 5/31/2024 10:	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Hospi tal Program Days	PPS Program Cost (col. 3 x col. 4)	
	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.00
	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT		352	3, 711. 97	7 176	653, 307	43. 00
44. 00 45. 00 46. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	1, 306, 615	302	3,711.9.	176	655, 307	44. 00 45. 00 46. 00 47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3, line 200)			1. 00 2, 356, 053	48.00
49. 00	Program inpatient cellular therapy acquisiti Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS				column 1)	0 6, 278, 753	
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sum	of Parts I and	106, 162	50.00
51. 00	Pass through costs applicable to Program inp and IV)		ry services (f	rom Wkst. D, s	um of Parts II	30, 509	
53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu medical education costs (line 49 minus line	ding capital re	elated, non-ph	ysician anesth	etist, and	136, 671 6, 142, 082	
	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	] 54. 00
	Target amount per discharge					0.00	
	Permanent adjustment amount per discharge					0.00	
	Adjustment amount per discharge (contractor Target amount (line 54 x sum of lines 55, 55					0.00	1
	Difference between adjusted inpatient operat			line 56 minus	line 53)	ő	
	Bonus payment (see instructions)	o .			ŕ	0	1 00.00
	Trended costs (lesser of line 53 $\div$ line 54, updated and compounded by the market basket)		·	0 .	o .	0.00	
	Expected costs (lesser of line 53 ÷ line 54, market basket)					0.00	60.00
	Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x enter zero. (see instructions)	ser of 50% of t	he amount by	which operatin	g costs (line	0	61.00
62. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ont (soo instru	ictions)			0	
[	PROGRAM INPATIENT ROUTINE SWING BED COST	·			1 1 (0	-	
	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dece	ember 31 of th	e cost reporti	ng period (See	254, 411	64.00
	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts after Decemb	er 31 of the	cost reporting	period (See	0	65.00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH, see instructions	ne costs (line	64 plus line	65)(title XVII	I only); for	254, 411	66.00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	December 31	of the cost re	porting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after [	ecember 31 of	the cost repo	rting period	0	68. 00
69.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NI					0	69. 00
70. 00	Skilled nursing facility/other nursing facil	ity/ICF/IID rou	itine service	cost (line 37)			70.00
	Adjusted general inpatient routine service c Program routine service cost (line 9 x line	,	rne 70 ÷ rrne	2)			71.00
	Medically necessary private room cost applic	,	ı (line 14 x l	ine 35)			73.00
	Total Program general inpatient routine serv Capital-related cost allocated to inpatient				art II. column		74. 00 75. 00
	26, line 45) Per diem capital-related costs (line 75 ÷ li		`	·	·		76.00
1	Program capital-related costs (line 9 x line						77. 00
	Inpatient routine service cost (line 74 minu			-1>			78.00
1	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp			•	us line 70)		79.00
1	Inpatient routine service costs for comp		tati U	(11110 70 11111	as 11110 /7)		81.00
82. 00	Inpatient routine service cost limitation (I	ine 9 x line 81	•				82.00
	Reasonable inpatient routine service costs (		ns)				83.00
	Program inpatient ancillary services (see in Utilization review - physician compensation		ons)				84. 00 85. 00
1	or realism physician compensation						
85. 00	Total Program inpatient operating costs (sum	<u>of Lines</u> 83 th	irough 85)				] 86.00
85. 00 86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions	S THROUGH COST	rough 85)			1, 031	86. 00 87. 00

Health Financial Systems	RI CHLAND MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023		pared: 42 am_
		Title	XVIII	Hospi tal	PPS	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions	)			2, 041, 638	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	231, 555	8, 771, 332	0. 02639	9 2, 041, 638	53, 897	90.00
91.00 Nursing Program cost	0	8, 771, 332	0.00000	0 2, 041, 638	0	91.00
92.00 Allied health cost	0	8, 771, 332	0.00000	0 2, 041, 638	0	92.00
93.00 All other Medical Education	0	8, 771, 332	0.00000	0 2, 041, 638	0	93.00
	•					

Health Financial Systems	RICHLAND MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 14-0147	Peri od: From 01/01/2023	Worksheet D-1
	Component CCN: 14-5580		
	Title XVIII	Skilled Nursing	PPS
		Facility	

		TI LIE AVIII	Facility	FF3	
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
4 00	INPATIENT DAYS				4 00
1. 00 2. 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			0	1. 00 2. 00
3. 00	Private room days (excluding swing-bed and observation bed da		ivate room days,	0	3.00
	do not complete this line.		•		
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		r 21 of the cost	0	4. 00 5. 00
5.00	reporting period	on days) thi ough becembe	i 31 of the cost	U	5.00
6.00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6. 00
7 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo	m daya) through Dagambar	21 of the cost	0	7. 00
7. 00	reporting period	ill days) through becember	31 Of the Cost	U	7.00
8.00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	a the Dreamen (evaluding	owing had and	0	0.00
9. 00	Total inpatient days including private room days applicable t newborn days) (see instructions)	o the Program (excluding	Swirig-bed and	0	9. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	oom days)	0	10.00
11 00	through December 31 of the cost reporting period (see instruc				44.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (if calendar year, e		bom days) arter	0	11. 00
12.00	Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12.00
10.00	through December 31 of the cost reporting period				10.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13. 00
14. 00	Medically necessary private room days applicable to the Progr			0	14. 00
15.00	Total nursery days (title V or XIX only)			0	15. 00
16. 00	Nursery days (title V or XLX only) SWLNG BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31 o	f the cost	0. 00	17. 00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to servic reporting period	es after December 31 of	the cost	0.00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost	0. 00	19. 00
	reporting period			0.00	
20.00	Medicaid rate for swing-bed NF services applicable to service reporting period	s after December 31 of t	ne cost	0.00	20. 00
21.00	Total general inpatient routine service cost (see instruction	s)		0	21.00
22. 00	Swing-bed cost applicable to SNF type services through Decemb	er 31 of the cost report	ing period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	a period (line 6	0	23. 00
	x line 18)		]		
24. 00	Swing-bed cost applicable to NF type services through Decembe $7 \times 1$ ine 19)	r 31 of the cost reporti	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25. 00
	x line 20)	. 3	` `		
26.00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(Lino 21 minus Lino 26)		0	26. 00 27. 00
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(Trile 21 iii flus Trile 20)		0	27.00
	General inpatient routine service charges (excluding swing-be	d and observation bed ch	arges)		28. 00
	Pri vate room charges (excluding swing-bed charges)			0	29.00
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	30. 00 31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	. 11116 20)		0. 00	32. 00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	33. 00
34.00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	tions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x li		,	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	•		0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	0	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see				38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	•			39. 00
40.00	Medically necessary private room cost applicable to the Progr				40.00
41.00	Total Program general inpatient routine service cost (line 39	+ IIne 40)			41.00

	Financial Systems ATION OF INPATIENT OPERATING COST	RI CHLAND MEMOR		CN: 14-0147	Period:	u of Form CMS-: Worksheet D-1	
			Component	CCN: 14-5580	From 01/01/2023 To 12/31/2023	Date/Time Pre	epared:
			Ti †l e	e XVIII	Skilled Nursing	5/31/2024 10: PPS	42 am
					Facility		
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. ÷ col. 2)		Program Cost (col. 3 x col. 4)	
12.00	NUDCEDY (+; +1 - 1/ 0 VIV and a)	1. 00	2.00	3.00	4.00	5. 00	42.00
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Unit						42.00
43.00	INTENSIVE CARE UNIT						43.00
	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47. 00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47.00
	cost center bescription					1. 00	
	Program inpatient ancillary service cost (				1 1)		48.00
	Program inpatient cellular therapy acquisitotal Program inpatient costs (sum of lines				, column I)		48. 01 49. 00
	PASS THROUGH COST ADJUSTMENTS		,	ĺ			
50. 00	Pass through costs applicable to Program in III)	npatient routine	services (fro	m Wkst. D, su	m of Parts I and		50.00
51. 00	Pass through costs applicable to Program in and IV)	npatient ancillar	ry services (f	rom Wkst. D,	sum of Parts II		51.00
52.00	Total Program excludable cost (sum of lines						52.00
53. 00	Total Program inpatient operating cost excl medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION		erated, non-ph	ysıcıan anest	netist, and		53.00
54. 00	Program di scharges						54.00
	Target amount per discharge						55.00
	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor	use onlv)					55. 01 55. 02
56.00	Target amount (line 54 x sum of lines 55, 5	55. 01, and 55. 02)					56.00
	Difference between adjusted inpatient opera	ating cost and ta	arget amount (	line 56 minus	line 53)		57. 00 58. 00
58. 00 59. 00	Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	n the cost rep	orting period	ending 1996,		59.00
60. 00	updated and compounded by the market basket Expected costs (lesser of line 53 ÷ line 54	t)	·	0 .			60.00
61. 00	market basket) Continuous improvement bonus payment (if li						61.00
	55.01, or line 59, or line 60, enter the le 53) are less than expected costs (lines 54						
62. 00	enter zero. (see instructions) Relief payment (see instructions)						62.00
	Allowable Inpatient cost plus incentive pay PROGRAM INPATIENT ROUTINE SWING BED COST	·	,				63.00
64. 00	Medicare swing-bed SNF inpatient routine coinstructions)(title XVIII only)	osts through Dece	ember 31 of th	e cost report	ing period (See		64.00
65. 00	Medicare swing-bed SNF inpatient routine co instructions)(title XVIII only)	osts after Decemb	per 31 of the	cost reportin	g period (See		65.00
66. 00	Total Medicare swing-bed SNF inpatient rout CAH, see instructions	•			3,		66.00
	Title V or XIX swing-bed NF inpatient routi (line 12 x line 19)	_					67.00
68. 00 69. 00	Title V or XIX swing-bed NF inpatient routi (line 13 x line 20) Total title V or XIX swing-bed NF inpatient			·	orting period		68.00
	PART III - SKILLED NURSING FACILITY, OTHER	NURSING FACILITY	, AND ICF/IID	ONLY			
	Skilled nursing facility/other nursing faci				)	0 00	
	Adjusted general inpatient routine service Program routine service cost (line 9 x line	,	ine /U ÷ IIne	: ∠)		0. 00 0	1
73. 00	Medically necessary private room cost appli	cable to Program				0	73.00
74. 00 75. 00	Total Program general inpatient routine ser Capital-related cost allocated to inpatient			,	Part II, column	0	
76. 00	26, line 45) Per diem capital-related costs (line 75 $\div$ l	ine 2)				0. 00	76.00
77. 00	Program capital-related costs (line 9 x lin	ne 76)				0	77.00
	Inpatient routine service cost (line 74 mir Aggregate charges to beneficiaries for exce		provi den inecon	ds)		0	
80.00	Total Program routine service costs for cor	mparison to the o			nus line 79)	0	80.00
81.00	Inpatient routine service cost per diem lin		1)			0.00	
82. 00 83. 00	Inpatient routine service cost limitation ( Reasonable inpatient routine service costs					0	1
84.00	Program inpatient ancillary services (see i	nstructions)	•			0	84.00
	Utilization review - physician compensation Total Program inpatient operating costs (su					0	
55. 50	PART IV - COMPUTATION OF OBSERVATION BED PA		ougii 00 <i>)</i>			0	30.00
87.00	Total observation bed days (see instruction	ns)				0	87.00

Health Financial Systems	RI CHLAND MEMOR	I AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (	CCN: 14-5580	From 01/01/2023 To 12/31/2023		pared: 42 am_
		Title	XVIII	Skilled Nursing	PPS	
				Facility		
Cost Center Description						
					1. 00	
88.00 Adjusted general inpatient routine cost per					0.00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions	)			0	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	0	0	0. 00000	0 0	0	90.00
91.00 Nursing Program cost	0	0	0. 00000	00	0	91.00
92.00 Allied health cost	0	0	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	0	0. 00000	0 0	0	93.00

Health Financial Systems	RICHLAND MEMORIAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 14-0147	Peri od:	Worksheet D-1	
		From 01/01/2023		
		To 12/31/2023	Date/Time Pre	pared:
			5/31/2024 10:	42 am_
	Title XIX	Hospi tal	PPS	
Cost Center Description				
			1. 00	
PART I - ALL PROVIDER COMPONENTS				
I NPATI ENT DAYS				
1.00 Inpatient days (including private room days	and swing-bed days, excluding newborn)		5, 724	1.00

	Cost Center Description	113	
	PART I - ALL PROVIDER COMPONENTS	1. 00	
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5, 724	
2. 00 3. 00	Inpatient days (including private room days, excluding swing-bed and newborn days)  Private room days (excluding swing-bed and observation bed days). If you have only private room days,	4, 253 0	2. 00 3. 00
4. 00	do not complete this line.  Semi-private room days (excluding swing-bed and observation bed days)	3, 222	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	1, 414	
6. 00	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)	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	57	7. 00
8. 00	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)	0	8. 00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	158	9. 00
10. 00	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)	0	10.00
11. 00	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)	0	11.00
12. 00	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	0	12.00
13. 00	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)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)	312 15	1
17. 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	237. 99	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	243. 34	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	224. 47	19. 00
20. 00	reporting period Medical drate for swing-bed NF services applicable to services after December 31 of the cost	224. 47	20.00
21. 00 22. 00	reporting period Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	8, 771, 332 336, 518	
	5 x line 17)	·	
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	12, 795	
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25. 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	349, 313 8, 422, 019	
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29. 00	Pri vate room charges (excluding swing-bed charges)	0	
30. 00	Semi-private room charges (excluding swing-bed charges)	0	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0. 00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0. 00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	8, 422, 019	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1 000 05	20.00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)	1, 980. 25 312, 880	1
	Medically necessary private room cost applicable to the Program (line 14 x line 35)	312, 880	40.00
	Total Program general inpatient routine service cost (line 39 + line 40)	312, 880	

	Financial Systems ATION OF INPATIENT OPERATING COST	RI CHLAND MEMORI	Provider Co		In Lie eriod: rom 01/01/2023	u of Form CMS-2 Worksheet D-1	
				T		Date/Time Pre 5/31/2024 10:	
	Cost Center Description	Total	Ti tl Total	e XIX Average Per	Hospital Program Days	PPS Program Cost	
	COST CERTED DESCRIPTION	Inpati ent Cost	I npati ent Days	Diem (col. 1 ÷ col. 2)	Program bays	(col . 3 x col . 4)	
42. 00	NURSERY (title V & XIX only)	1. 00 895, 501	2. 00	3. 00 2, 870. 20	4. 00 15	5. 00 43, 053	42.00
42.00	Intensive Care Type Inpatient Hospital Units		312	2,870.20	15	43, 033	42.00
	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	1, 306, 615	352	3, 711. 97	17	63, 103	44. 00 45. 00 46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47. 00
10.00	·					1. 00	40.00
48. 00 48. 01 49. 00	Program inpatient ancillary service cost (Wk Program inpatient cellular therapy acquisiti Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	on cost (Worksh	neet D-6, Part		column 1)	0 0 419, 036	48. 01
50. 00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I an					10, 783	50.00
51. 00						0	51.00
52. 00	and IV) Total Program excludable cost (sum of lines 50 and 51)					10, 783	52.00
53.00	, , , , , , , , , , , , , , , , , , ,					408, 253	
54.00	Program di scharges					0	
55. 00 55. 01						0. 00 0. 00	55. 00 55. 01
55.02	Adjustment amount per discharge (contractor use only)					0. 00	55. 02
56. 00 57. 00						0	56. 00 57. 00
58.00						0	58.00
59. 00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)					0. 00	59. 00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					0. 00	60.00
61.00						0	61.00
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive payment (see instructions)					0	62.00 63.00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST						64.00
	instructions)(title XVIII only)						
	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66. 00	CAH, see instructions						66.00
67. 00	(line 12 x line 19)	· ·		·	0 .	0	
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)			•	rting period	0	
	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					0	
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c						70.00 71.00
72.00	Program routine service cost (line 9 x line	,	THE 70 : TIME	2)			72.00
73.00	Medically necessary private room cost applic		•				73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient				art II, column		74. 00 75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital related costs (line 9 x line						77.00
78.00							78.00
79. 00 80. 00							79. 00 80. 00
81. 00	Inpatient routine service costs for comp		ost rimitation	i (iiiie /o millic	13 TITIE /7)		81.00
82.00	Inpatient routine service cost limitation (I	ine 9 x line 81	•				82.00
83.00							83.00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ons)				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum						86.00
07.00	PART IV - COMPUTATION OF OBSERVATION BED PASS					4 001	07.00
	Total observation bed days (see instructions Adjusted general inpatient routine cost per		line 2)			1, 031 1, 980. 25	87. 00 88. 00

Health Financial Systems	RICHLAND MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023	Date/Time Pre 5/31/2024 10:	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions	)			2, 041, 638	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		·		(from line	(col. 3 x	
				89)	col. 4) (see	
				,	instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	231, 555	8, 771, 332	0. 02639	9 2, 041, 638	53, 897	90.00
91.00 Nursing Program cost	0	8, 771, 332	0.00000	0 2, 041, 638	0	91.00
92.00 Allied health cost	0	8, 771, 332	0.00000	0 2, 041, 638	0	92.00
93.00 All other Medical Education	0	8, 771, 332	0. 00000	0 2, 041, 638	0	93.00

INPATIENT ROUTINE SERVICE COST CENTERS		Peri od: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Prep 5/31/2024 10:4
INPATIENT ROUTINE SERVICE COST CENTERS	e XVIII	Hospi tal	PPS
00	Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
00	1.00	2. 00	3. 00
00			
00		2, 288, 620	
00		658, 790	
ANCILLARY SERVICE COST CENTERS  00 05000 OPERATI NG ROOM 00 05200 DELIVERY ROOM & LABOR ROOM 00 05300 ANESTHESI OLOGY 00 05400 RADI OLOGY-DI AGNOSTI C 00 05600 RADI OLOGY-DI AGNOSTI C 00 05700 CT SCAN 00 05800 MRI 00 06000 LABORATORY 30 06250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS 00 06400 INTRAVENOUS THERAPY 00 06500 RESPI RATORY THERAPY 00 06500 RESPI RATORY THERAPY 00 06600 PHYSI CAL THERAPY 00 06600 SPEECH PATHOLOGY 00 06900 ELECTROCARDI OLOGY 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 01 07301 INJECTABLE DRUGS 97 07697 CARDI AC REHABI LI TATI ON 080680 RURAL HEALTH CLI NI C 01 08801 RURAL HEALTH CLI NI C 01 08802 RURAL HEALTH CLI NI C 01 08802 RURAL HEALTH CLI NI C 01 09000 CLI NI C 00 09100 EMERGENCY 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART		0	
05000   05000   0PERATING ROOM   05200   DELIVERY ROOM & LABOR ROOM   05300   ANESTHESI OLOGY   05400   RADI OLOGY-DI AGNOSTI C   05400   RADI OLOGY-DI AGNOSTI C   05400   RADI OLOGY-DI AGNOSTI C   05500   RADI OLOGY-DI AGNOSTI C   05800   MRI   06000   LABORATORY   06250   BLOOD CLOTTING FOR HEMOPHILI ACS   06400   INTRAVENOUS THERAPY   06400   INTRAVENOUS THERAPY   06600   PHYSI CAL THERAPY   06600   PHYSI CAL THERAPY   06600   SPECH PATHOLOGY   06900   ELECTROCARDI OLOGY   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   07200   IMPL. DEV. CHARGED TO PATI ENTS   07300   DRUGS CHARGED TO PATI ENTS   07300   DRUGS CHARGED TO PATI ENTS   07697   CARDI AC REHABI LI TATI ON   07698   HYPERBARI C OXYGEN THERAPY   07699   LI THOTRI PSY   0017947   ENTANTI SERVI CE COST CENTERS   07697   CARDI AC REHABI LI TATI ON   07698   RURAL HEALTH CLI NI C   11   08801   RURAL HEALTH CLI NI C   11   08801   RURAL HEALTH CLI NI C   11   09000   CLI NI C   09100   EMERGENCY   00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART			
00	1		
05300   ANESTHESI OLOGY	0. 33434		192, 914
05400	0. 72962		0
05600	2. 03685		0
00         05700         CT SCAN           00         05800         MRI           00         06000         LABORATORY           30         06250         BLOOD CLOTTING FOR HEMOPHILIACS           00         06400         INTRAVENOUS THERAPY           00         06500         RESPIRATORY THERAPY           00         06600         PHYSI CAL THERAPY           00         06600         PHYSI CAL THERAPY           00         06800         SPEECH PATHOLOGY           00         06900         ELECTROCARDI OLOGY           00         07100         MEDI CAL SUPPLIES CHARGED TO PATI ENT           00         07200         IMPL. DEV. CHARGED TO PATI ENTS           00         07300         DRUGS CHARGED TO PATI ENTS           01         07301         INJECTABLE DRUGS           97         07697         CARDI AC REHABI LI TATI ON           98         07698         HYPERBARI C OXYGEN THERAPY           99         07699         LI THOTRI PSY           0UTPATI ENT SERVI CE COST CENTERS           00         08800         RURAL HEALTH CLI NI C II           01         08801         RURAL HEALTH CLI NI C III           00         09000         CLI NI C<	0. 13680		64, 550
00   05800   MRI   00   06000   LABORATORY   30   06250   BLOOD CLOTTING FOR HEMOPHILIACS   10   06400   INTRAVENOUS THERAPY   00   06500   RESPIRATORY THERAPY   00   06600   PHYSICAL THERAPY   00   06800   SPEECH PATHOLOGY   00   06900   ELECTROCARDIOLOGY   00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT   00   07200   IMPL. DEV. CHARGED TO PATIENTS   01   07300   DRUGS CHARGED TO PATIENTS   01   07301   INJECTABLE DRUGS   07   07697   CARDIAC REHABILITATION   08   07698   HYPERBARIC OXYGEN THERAPY   07699   LITHOTRIPSY   0UTPATIENT SERVICE COST CENTERS   00   08800   RURAL HEALTH CLINIC   10   08801   RURAL HEALTH CLINIC   11   08801   RURAL HEALTH CLINIC   12   08802   RURAL HEALTH CLINIC   13   09000   CLINIC   14   09100   EMERGENCY   15   09200   OBSERVATION BEDS (NON-DISTINCT PART	0. 22409		10, 212
00	0. 02814 0. 05478		61, 175
30	0. 05478		11, 850 407, 102
00	0. 00000		407, 102
00	0.00000		0
00	0. 26995		585, 038
00   06800   SPEECH PATHOLOGY   06900   ELECTROCARDI OLOGY   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   07200   IMPL. DEV. CHARGED TO PATI ENTS   07300   DRUGS CHARGED TO PATI ENTS   07301   INJECTABLE DRUGS   07497   CARDI AC REHABI LI TATI ON   07697   CARDI AC REHABI LI TATI ON   07698   HYPERBARI C OXYGEN THERAPY   07699   LI THOTRI PSY   00TPATI ENT SERVI CE COST CENTERS   00800   RURAL HEALTH CLINI C   108801   RURAL HEALTH CLINI C   11   08801   RURAL HEALTH CLINI C   11   09000   CLINI C   00000   CLINI C   00000   09100   EMERGENCY   00000   09200   OBSERVATI ON BEDS (NON-DI STINCT PART	0. 21447	· · ·	115, 026
00 06900 ELECTROCARDI OLOGY 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 00 07300 DRUGS CHARGED TO PATI ENTS 01 07301 INJECTABLE DRUGS 97 07697 CARDI AC REHABI LI TATI ON 98 07698 HYPERBARI C OXYGEN THERAPY 99 07699 LI THOTRI PSY 0UTPATI ENT SERVI CE COST CENTERS 00 08800 RURAL HEALTH CLINI C 01 08801 RURAL HEALTH CLINI C II 02 08802 RURAL HEALTH CLINI C III 03801 RURAL HEALTH CLINI C III 04 09000 CLINI C 05 09100 EMERGENCY 06 09200 OBSERVATI ON BEDS (NON-DI STINCT PART	0. 32994		23, 154
00	0.00612		3, 376
00	0. 33784		82, 530
00	1. 25429		0
97   07697   CARDI AC REHABILITATION   98   07698   HYPERBARI C OXYGEN THERAPY   99   07699   LITHOTRI PSY   00TPATIENT SERVICE COST CENTERS   00   08800   RURAL HEALTH   CLINI C   I   01   08801   RURAL HEALTH   CLINI C   I   02   08802   RURAL HEALTH   CLINI C   I   04   09000   CLINI C   05   09100   EMERGENCY   06   09200   OBSERVATION   BEDS   (NON-DISTINCT   PART	0. 16802		420, 779
97   07697   CARDIAC REHABILITATION   98   07698   HYPERBARIC OXYGEN THERAPY   99   07699   LITHOTRIPSY	0. 34027		0
99   07699   LI THOTRI PSY	0.00000	00	0
OUTPATIENT SERVICE COST CENTERS	0. 00000	00	0
00	0. 00000	00	0
01			
02   08802   RURAL HEALTH CLINIC III 00   09000   CLINIC 00   09100   EMERGENCY 00   09200   OBSERVATION   BEDS (NON-DISTINCT PART	0.00000	00	0
00   09000   CLINIC 00   09100   EMERGENCY 00   09200   OBSERVATION   BEDS   (NON-DISTINCT   PART	0.00000		0
00 09100 EMERGENCY 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.00000		0
00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 93182		0
	0. 11983		209, 722
99   09399  PARTI AL HOSPI TALI ZATI ON PROGRAM	0. 42788		168, 625
OTHER RELIBURARY E ARREST OFFITTERS	0.00000	00 0	0
OTHER REI MBURSABLE COST CENTERS			
00 09500 AMBULANCE SERVICES		45 044 (0)	0.054.050
0.00 Total (sum of lines 50 through 94 and 96 through 98)		15, 011, 696	2, 356, 053
1.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 2.00 Net charges (line 200 minus line 201)		0 15, 011, 696	

Health Financial Systems RICHLAND MEMORI INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		CCN: 14-0147	Peri od:	u of Form CMS-2 Worksheet D-3	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider		From 01/01/2023	Worksneet D-3	•
	Component	CCN: 14-U147	To 12/31/2023	5/31/2024 10:	
	Ti tl	e XVIII	Swing Beds - SNF		
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col . 1 x	
		1.00	2.00	col . 2)	-
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	
30. 00   03000   ADULTS & PEDI ATRI CS		1			30.00
31. 00   03100   NTENSI VE CARE UNIT					31.00
40. 00   04000   SUBPROVI DER -   PF					40.00
43. 00   04300   NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS					45.00
50. 00 O5000 OPERATI NG ROOM		0. 33434	5 0	0	50.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM		0. 72962		Ö	
53. 00   05300  ANESTHESI OLOGY		2. 03685		0	
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 13680		4, 427	1 00.0
56. 00   05600   RADI OI SOTOPE		0. 22409		0	1
57. 00   05700   CT   SCAN		0. 02814		85	
58. 00   05800   MRI		0. 05478		0	
60. 00   06000   LABORATORY		0. 12300		21, 742	
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.00000	· ·	0	1
64. 00 06400 I NTRAVENOUS THERAPY		0.00000		0	
65. 00 06500 RESPI RATORY THERAPY		0. 26995		167, 604	65.0
66. 00 06600 PHYSI CAL THERAPY		0. 21447	847, 455	181, 760	66.0
68. 00 06800 SPEECH PATHOLOGY		0. 32994	55, 470	18, 302	68.0
69. 00 06900 ELECTROCARDI OLOGY		0. 00612	10, 050	62	69.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 33784	9 1, 466	495	71.0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		1. 25429	0	0	72.0
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 16802	512, 030	86, 033	73.0
73. 01   07301   I NJECTABLE DRUGS		0. 34027	'1 0	0	73.0
76. 97 O7697 CARDI AC REHABI LI TATI ON		0.00000	0 0	0	76. 9
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0.00000	0 0	0	76. 9
76. 99 07699 LI THOTRI PSY		0. 00000	0 0	0	76. 9
OUTPAȚI ENT SERVI CE COST CENTERS					4
88. 00 08800 RURAL HEALTH CLINIC		0.00000		0	1 00.0
88. 01   08801   RURAL HEALTH CLINIC II		0.00000		0	
88. 02   08802   RURAL   HEALTH   CLINIC   III		0.00000		0	
90. 00   09000   CLI NI C		0. 93182		0	
91. 00   09100   EMERGENCY		0. 11983		0	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 42788	· ·	1, 609	
93. 99 09399 PARTI AL HOSPI TALI ZATI ON PROGRAM		0.00000	00 0	0	93. 9
OTHER REIMBURSABLE COST CENTERS					٠. ١
95.00 09500 AMBULANCE SERVICES 200.00 Total (sum of Lines 50 through 94 and 96 through 98)			2 263 235	/Q2 110	95.0

482, 119 200. 00 201. 00 202. 00

2, 263, 235 0 2, 263, 235

Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net charges (line 200 minus line 201)

200. 00 201. 00 202. 00

Health Financial Systems	RICHLAND MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-0147	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/31/2024 10:42 am

	Title XVIII	Hospi tal	5/31/2024 10: PPS	42 am_
			1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		1.00	
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring prior to October 'instructions')	(see	0 3, 211, 158	1. 00 1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after Octobe instructions)	er 1 (see	1, 168, 679	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring 1 (see instructions)	ng prior to October	0	1.03
1. 04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring October 1 (see instructions)	ng on or after	0	1. 04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount		0	2. 00 2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instructions) Outlier payments for discharges occurring prior to October 1 (see instructions)		7, 167	2. 03
2. 04 3. 00 4. 00	Outlier payments for discharges occurring on or after October 1 (see instructions) Managed Care Simulated Payments Bed days available divided by number of days in the cost reporting period (see inst	ructions)	0 0 40. 15	3.00
	Indirect Medical Education Adjustment			
5. 00 5. 01	FTE count for allopathic and osteopathic programs for the most recent cost reporting or before 12/31/1996. (see instructions) FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)		0.00	5. 00 5. 01
6. 00	FTE count for allopathic and osteopathic programs that meet the criteria for an addinew programs in accordance with 42 CFR 413.79(e)			•
6. 26	Rural track program FTE cap limitation adjustment after the cap-building window clothe CAA 2021 (see instructions)	osed under §127 of	0.00	6. 26
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)		0. 00 0. 00	7. 00 7. 01
7. 02	cost report straddles July 1, 2011 then see instructions.  Adjustment (increase or decrease) to the hospital's rural track program FTE limital track programs with a rural track for Medicare GME affiliated programs in accordance and 87 FR 49075 (August 10, 2022) (see instructions)		0.00	7. 02
8. 00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic paffiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26 1998), and 67 FR 50069 (August 1, 2002).		0. 00	8. 00
8. 01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the report straddles July 1, 2011, see instructions.	ne ACA. If the cos	0.00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slots from a closed tead under § 5506 of ACA. (see instructions)		0.00	8. 02
8. 21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the instructions)	•	0.00	
9. 00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 a minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions) FTE count for allopathic and osteopathic programs in the current year from your red		0.00	
	FTE count for residents in dental and podiatric programs.	or us	0.00	11.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
	Total allowable FTE count for the penultimate year if that year ended on or after sotherwise enter zero.	september 30, 1997,		14.00
16.00	Sum of lines 12 through 14 divided by 3. Adjustment for residents in initial years of the program (see instructions)		0.00	15. 00 16. 00
17. 00 18. 00			0.00	17. 00 18. 00
	Current year resident to bed ratio (line 18 divided by line 4).  Prior year resident to bed ratio (see instructions)		0. 000000 0. 000000	ı
	Enter the lesser of lines 19 or 20 (see instructions)		0. 000000	
22.00	IME payment adjustment (see instructions)		0	l
22. 01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		0	22. 01
23. 00	Number of additional allopathic and osteopathic IME FTE resident cap slots under $42(f)(1)(iv)(C)$ .	2 CFR 412. 105	0.00	
24. 00 25. 00		ne 24 (see	0. 00 0. 00	1
26. 00 27. 00	Instructions) Resident to bed ratio (divide line 25 by line 4) IME payments adjustment factor. (see instructions)		0. 000000 0. 000000	
			0.00000	28. 00
	IME add-on adjustment amount - Managed Care (see instructions)		0	•
29. 00 29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29. 00 29. 01
	<u>Disproportionate Share Adjustment</u> Percentage of SSI recipient patient days to Medicare Part A patient days (see instr	ructions)	3. 75	•
31. 00 32. 00			21. 30 25. 05	•
	Allowable disproportionate share percentage (see instructions)			33.00
			•	

Heal th	Financial Systems RICHLAND MEMORIA	AL HOSPITAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-0147	Peri od: From 01/01/2023 To 12/31/2023	Date/Time Pre	
		Title XVIII	Hospi tal	5/31/2024 10: PPS	42 am_
			, noopi tai		
34 00	Disproportionate share adjustment (see instructions)			1. 00 108, 949	34 00
011.00	per oper trionate onal o day detiment (eee rinet detrone)		Prior to 10/1		0 11 00
	Uncompensated Care Payment Adjustment		1.00	2. 00	
35. 00	Total uncompensated care amount (see instructions)		6, 874, 403, 459	5, 938, 006, 757	35.00
35. 01	Factor 3 (see instructions)		0.000029000	0. 000029236	
35. 02 35. 03	Hospital UCP, including supplemental UCP (see instructions) Pro rata share of the hospital UCP, including supplemental L	ICP (see instructions)	199, 358 149, 109	173, 601 43, 637	35. 02 35. 03
	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	or (see that detrons)	192, 746		36.00
40. 00	Additional payment for high percentage of ESRD beneficiary of Total Medicare discharges (see instructions)	lischarges (lines 40 thro	ugh 46) 0		40.00
41.00	Total ESRD Medicare discharges (see instructions)		0		41.00
41. 01	Total ESRD Medicare covered and paid discharges (see instruc		0		41.01
42. 00 43. 00	Divide line 41 by line 40 (if less than 10%, you do not qual Total Medicare ESRD inpatient days (see instructions)	ify for adjustment)	0.00		42. 00 43. 00
44. 00	Ratio of average length of stay to one week (line 43 divided	d by line 41 divided by 7	0. 000000		44. 00
45. 00	days) Average weekly cost for dialysis treatments (see instruction	ns)	0.00		45. 00
46.00	Total additional payment (line 45 times line 44 times line 4		0		46. 00
47. 00 48. 00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDH,	emall rural hoenitale	4, 688, 699 4, 708, 806		47. 00 48. 00
40.00	only. (see instructions)	Silari Turai 1103pi tars	4, 700, 000		40.00
				Amount 1.00	
49. 00	Total payment for inpatient operating costs (see instruction	ns)		4, 708, 806	49. 00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I a			327, 888	
51. 00 52. 00	Exception payment for inpatient program capital (Wkst. L, Pt Direct graduate medical education payment (from Wkst. E-4, I			0	51. 00 52. 00
53.00	Nursing and Allied Health Managed Care payment	,		0	53.00
54. 00 54. 01	Special add-on payments for new technologies Islet isolation add-on payment			32, 234 0	54. 00 54. 01
55. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	69)		0	•
55. 01	Cellular therapy acquisition cost (see instructions)			0	55. 01
56. 00 57. 00	Cost of physicians' services in a teaching hospital (see int Routine service other pass through costs (from Wkst. D, Pt.	•	through 35).	0	56. 00 57. 00
58.00	Ancillary service other pass through costs from Wkst. D, Pt.			0	58. 00
59. 00 60. 00	Total (sum of amounts on lines 49 through 58) Primary payer payments			5, 068, 928 0	59. 00 60. 00
61.00	Total amount payable for program beneficiaries (line 59 minu	us line 60)		5, 068, 928	1
62.00	Deductibles billed to program beneficiaries			700, 404	ı
63. 00 64. 00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)			0 186, 245	
65.00	Adjusted reimbursable bad debts (see instructions)			121, 059	65.00
66. 00 67. 00	Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63)	structions)		154, 900 4, 489, 583	
68. 00	Credits received from manufacturers for replaced devices for	applicable to MS-DRGs (	see instructions)	4, 469, 363	68.00
69. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96)	.(For SCH see instruction	ns)	0	69.00
70. 00 70. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons	stration) adjustment (see	instructions)	0	70. 00 70. 50
70. 75	N95 respirator payment adjustment amount (see instructions)	otration, adjustment (300	riisti doti olis)	Ö	70. 75
70.87	Demonstration payment adjustment amount before sequestration	1		0	ı
70. 88 70. 89	SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see ins	structions)		0	70. 88 70. 89
70. 90	HSP bonus payment HVBP adjustment amount (see instructions)	,		0	70. 90
70. 91 70. 92	HSP bonus payment HRR adjustment amount (see instructions)			0	70. 91 70. 92
	Bundled Model 1 discount amount (see instructions) HVBP payment adjustment amount (see instructions)			-5, 135	•
70. 94	HRR adjustment amount (see instructions)			-19, 621	70. 94
70. 95	Recovery of accelerated depreciation			0	70. 95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der C	CN: 14-0147	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Pre 5/31/2024 10:	pared:
	Title	XVIII	Hospi tal	PPS	
		FFY	(уууу)	Amount	
70.04			0	1. 00	70.0
'0.96 Low volume adjustment for federal fiscal year (yyyy) (Enter the corresponding federal year for the period prior to 10/1			2022	738, 981	70.96
0.97 Low volume adjustment for federal fiscal year (yyyy) (Enter			2023	252, 501	70. 9
the corresponding federal year for the period ending on or				,	
D. 98 Low Volume Payment-3			0	0	70. 98
0.99 HAC adjustment amount (see instructions)				0	
.00 Amount due provider (line 67 minus lines 68 plus/minus line .01 Sequestration adjustment (see instructions)	es 69 & 70)			5, 456, 309	
<ol> <li>Sequestration adjustment (see instructions)</li> <li>Demonstration payment adjustment amount after sequestration</li> </ol>	1			109, 126 0	71.0
1.03 Sequestration adjustment-PARHM pass-throughs					71.0
2.00 Interim payments				5, 599, 562	72.0
2.01   Interim payments-PARHM					72. 0°
3.00 Tentative settlement (for contractor use only)				0	
3.01 Tentative settlement-PARHM (for contractor use only)	02 72 and			252 270	73.0
4.00 Balance due provider/program (line 71 minus lines 71.01, 71 73)	. 02, 72, and			-252, 379	74.00
4.01 Balance due provider/program-PARHM (see instructions)					74.0
5.00 Protested amounts (nonallowable cost report items) in accor	dance with			249, 533	75.0
CMS Pub. 15-2, chapter 1, §115.2					
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
0.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or su plus 2.04 (see instructions)	IM OT 2.03			0	90.0
1.00 Capital outlier from Wkst. L, Pt. I, line 2				0	91.0
2.00 Operating outlier reconciliation adjustment amount (see ins	structions)			0	92.0
3.00 Capital outlier reconciliation adjustment amount (see instr				0	93.0
4.00 The rate used to calculate the time value of money (see ins					94.0
5.00 Time value of money for operating expenses (see instruction	•			0	
6.00 Time value of money for capital related expenses (see instr	uctions)		Prior to 10/1	0 0n/After 10/1	96.00
			1.00	2. 00	
HSP Bonus Payment Amount			1. 00	2. 00	
00.00 HSP bonus amount (see instructions)				2. 00	100. 0
00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment			1.00	2.00	
00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 01.00 HVBP adjustment factor (see instructions)	ons)		0. 0000000000	2.00 0 0.0000000000	101. 0
00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 01.00 HVBP adjustment factor (see instructions) 02.00 HVBP adjustment amount for HSP bonus payment (see instructi	ons)		1.00	2.00 0 0.0000000000	101. 0
00.00 HSP bonus amount (see instructions)	ons)		0. 0000000000	2.00 0 0.0000000000	102. 0
00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 01.00 HVBP adjustment factor (see instructions) 02.00 HVBP adjustment amount for HSP bonus payment (see instructi HRR Adjustment for HSP Bonus Payment 03.00 HRR adjustment factor (see instructions) 04.00 HRR adjustment amount for HSP bonus payment (see instruction)	ons)		0. 0000000000	2.00 0 0.0000000000 0	101. 0 102. 0 103. 0
00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 01.00 HVBP adjustment factor (see instructions) 02.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 03.00 HRR adjustment factor (see instructions) 04.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration)	ons) stration) Adju		0. 0000000000 0. 0000000000000000000000	2.00 0.0000000000 0.0000 0.0000 0	101. 0 102. 0 103. 0 104. 0
00.00 HSP bonus amount (see instructions)  HVBP Adjustment for HSP Bonus Payment 01.00 HVBP adjustment factor (see instructions) 02.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 03.00 HRR adjustment factor (see instructions) 04.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonson) 00.00 Is this the first year of the current 5-year demonstration	ons) stration) Adju		0. 0000000000 0. 0000000000000000000000	2.00 0.0000000000 0.0000 0.0000 0	101. 0 102. 0 103. 0 104. 0
00.00 HSP bonus amount (see instructions)  HVBP Adjustment for HSP Bonus Payment 01.00 HVBP adjustment factor (see instructions) 02.00 HVBP adjustment amount for HSP bonus payment (see instructi HRR Adjustment for HSP Bonus Payment 03.00 HRR adjustment factor (see instructions) 04.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demonson) 00.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no.	ons) stration) Adju		0. 0000000000 0. 0000000000000000000000	2.00 0.0000000000 0.0000 0.0000 0	101. 0 102. 0 103. 0 104. 0
00.00  HSP bonus amount (see instructions)  HVBP Adjustment for HSP Bonus Payment  01.00  HVBP adjustment factor (see instructions)  02.00  HVBP adjustment amount for HSP bonus payment (see instructions)  03.00  HRR Adjustment factor (see instructions)  04.00  HRR adjustment factor (see instructions)  04.00  HRR adjustment amount for HSP bonus payment (see instructions)  Rural Community Hospital Demonstration Project (§410A Demonson)  00.00  Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement	ons) stration) Adju period under		0. 0000000000 0. 0000000000000000000000	2.00 0.0000000000 0.0000 0.0000 0	101. 0 102. 0 103. 0 104. 0
00.00  HSP bonus amount (see instructions)  HVBP Adjustment for HSP Bonus Payment  01.00 HVBP adjustment factor (see instructions)  02.00 HVBP adjustment amount for HSP bonus payment (see instructions)  03.00 HRR Adjustment factor (see instructions)  04.00 HRR adjustment factor (see instructions)  04.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demonson)  00.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  01.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, I	ons) stration) Adju period under		0. 0000000000 0. 0000000000000000000000	2.00 0.0000000000 0.0000 0.0000 0	101. 0 102. 0 103. 0 104. 0 200. 0
00. 00 HSP bonus amount (see instructions)  HVBP Adjustment for HSP Bonus Payment 01. 00 HVBP adjustment factor (see instructions) 02. 00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 03. 00 HRR adjustment factor (see instructions) 04. 00 HRR adjustment amount for HSP bonus payment (see instructions) 04. 00 HRR adjustment amount for HSP bonus payment (see instructions) 06. 00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement 01. 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, I oc. 00 Medicare discharges (see instructions) 03. 00 Case-mix adjustment factor (see instructions)	ons) stration) Adju period under ine 49)	the 21st	0. 0000000000 0. 0000000000 0 0	2.00 0.0000000000 0.00000000000 0.0000 0	101. 0 102. 0 103. 0 104. 0 200. 0
00. 00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 01. 00 HVBP adjustment factor (see instructions) 02. 00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 03. 00 HRR adjustment factor (see instructions) 04. 00 HRR adjustment amount for HSP bonus payment (see instructions) 04. 00 HRR adjustment amount for HSP bonus payment (see instructions) 06. 00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement 01. 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, I over the computation of Demonstration Case-mix adjustment factor (see instructions) 03. 00 Case-mix adjustment factor (see instructions)	ons) stration) Adju period under ine 49)	the 21st	0. 0000000000 0. 0000000000 0 0	2.00 0.0000000000 0.00000000000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00
00.00 HSP bonus amount (see instructions)  HVBP Adjustment for HSP Bonus Payment 01.00 HVBP adjustment factor (see instructions) 02.00 HVBP adjustment amount for HSP bonus payment (see instructi HRR Adjustment for HSP Bonus Payment 03.00 HRR adjustment factor (see instructions) 04.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demon: 00.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 01.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, I 02.00 Medicare discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A period)	ons) stration) Adju period under ine 49)	the 21st	0. 0000000000 0. 0000000000 0 0	2.00 0.00000000000000 0.0000 0.0000	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
00. 00  HSP bonus amount (see instructions)  HVBP Adjustment for HSP Bonus Payment  01. 00  HVBP adjustment factor (see instructions)  02. 00  HVBP adjustment amount for HSP bonus payment (see instructions)  03. 00  HRR Adjustment factor (see instructions)  04. 00  HRR adjustment factor (see instructions)  04. 00  HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demonson)  00. 00  Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  01. 00  Medicare inpatient service costs (from Wkst. D-1, Pt. II, I on Medicare inpatient service costs (from Wkst. D-1, Pt. II, I on Medicare discharges (see instructions)  Computation of Demonstration Target Amount Limitation (N/A period)  04. 00  Medicare target amount	ons) stration) Adju period under ine 49)	the 21st	0. 0000000000 0. 0000000000 0 0	2.00 0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
00. 00  HSP bonus amount (see instructions)  HVBP Adjustment for HSP Bonus Payment  01. 00 HVBP adjustment factor (see instructions)  02. 00 HVBP adjustment amount for HSP bonus payment (see instructions)  HRR Adjustment for HSP Bonus Payment  HRR adjustment factor (see instructions)  04. 00  HRR adjustment factor (see instructions)  04. 00  HRR adjustment amount for HSP bonus payment (see instructions)  Rural Community Hospital Demonstration Project (§410A Demonson)  05. 00  Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  01. 00  Medicare inpatient service costs (from Wkst. D-1, Pt. II, I one)  02. 00  Medicare discharges (see instructions)  Computation of Demonstration Target Amount Limitation (N/A period)  04. 00  Medicare target amount  05. 00  Case-mix adjusted target amount (line 203 times line 204)	ins) stration) Adjuperiod under ine 49)	the 21st	0. 0000000000 0. 0000000000 0 0	2.00 0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment O1.00 HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement HOLO Medicare inpatient service costs (from Wkst. D-1, Pt. II, I bounded a see instructions) Computation of Demonstration Target Amount Limitation (N/A period) HOLO Medicare target amount HOLO Medicare inpatient routine cost cap (line 202 times line 204) HOLO Medicare inpatient routine cost cap (line 202 times line 204) HOLO Medicare inpatient routine cost cap (line 202 times line 204) HOLO Medicare inpatient routine cost cap (line 202 times line 204) HOLO Medicare Inpatient Reimbursement	ine 49) in first year	the 21st	0. 0000000000 0. 0000000000 0 0	2.00 0.00000000000000 0.0000 0.0000	101. 0 102. 0 103. 0 104. 0 200. 0 201. 0 202. 0 203. 0 204. 0 205. 0 206. 0
HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment O1.00 HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) U1.00 HRR adjustment amount for HSP bonus payment (see instructions) U2.00 U3.00 U3.00 U3.00 U4.00 U4.00 U4.00 U5.00 U6.00 U6	ine 49) in first year	the 21st	0. 0000000000 0. 0000000000 0 0	2.00 0.0000000000 0.0000 0.0000 0.tration	101. 0 102. 0 103. 0 104. 0 200. 0 201. 0 202. 0 203. 0 204. 0 205. 0 206. 0
HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment O1.00 HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR Adjustment for HSP Bonus Payment HRR adjustment for HSP Bonus Payment HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) O1.00 HSR adjustment amount for HSP bonus payment (see instructions) O2.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement O1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, I on one cost Reimbursement (see instructions) O2.00 Medicare discharges (see instructions) O3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A period) O4.00 Medicare target amount O5.00 Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 204) Adjustment to Medicare Part A Inpatient Reimbursement O7.00 Program reimbursement under the \$410A Demonstration (see in Medicare Part A Inpatient Reimbursement	ine 49) in first year	the 21st	0. 0000000000 0. 0000000000 0 0	2.00 0.00000000000000 0.0000 0.tration	101. 0 102. 0 103. 0 104. 0 200. 0 201. 0 202. 0 203. 0 204. 0 205. 0 206. 0 207. 0 208. 0
HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment  O1.00 HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment  O3.00 HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demonson)  O2.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement  O3.00 Cost Reimbursement  O4.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, I computation of Demonstration Target Amount Limitation (N/A period)  O4.00 Medicare target amount  O5.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A period)  O6.00 Medicare target amount  O7.00 Medicare inpatient routine cost cap (line 202 times line 204) Adjustment to Medicare Part A Inpatient Reimbursement  O7.00 Program reimbursement under the §410A Demonstration (see in Medicare Part A inpatient service costs (from Wkst. E, Pt. O9.00 Adjustment to Medicare IPPS payments (see instructions)	ine 49) in first year	the 21st	0. 0000000000 0. 0000000000 0 0	2.00 0.00000000000000 0.0000 0.tration	101. 0 102. 0 103. 0 104. 0 200. 0 201. 0 202. 0 203. 0 204. 0 205. 0 206. 0 207. 0 208. 0 209. 0
HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 01.00 HVBP adjustment factor (see instructions) 02.00 HVBP adjustment amount for HSP bonus payment (see instructi HRR Adjustment for HSP Bonus Payment 03.00 HRR adjustment factor (see instructions) 04.00 HRR adjustment factor (see instructions) 04.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demonsormation Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 01.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, I Medicare discharges (see instructions) 03.00 Case-mix adjustment factor (see instructions) 04.00 Medicare target amount 05.00 Case-mix adjusted target amount (line 203 times line 204) 06.00 Medicare inpatient routine cost cap (line 202 times line 204) 06.00 Medicare inpatient routine cost cap (line 202 times line 204) 07.00 Program reimbursement under the §410A Demonstration (see in 08.00 Medicare Part A Inpatient Reimbursement 07.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. 09.00 Adjustment to Medicare IPPS payments (see instructions)	ine 49) in first year  25) structions) A, line 59)	the 21st	0. 0000000000 0. 0000000000 0 0	2.00 0.0000000000 0.0000 0.0000 0	101. 0 102. 0 103. 0 104. 0 200. 0 201. 0 202. 0 203. 0 204. 0 205. 0 206. 0 207. 0 208. 0 209. 0 210. 0
HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 01.00 HVBP adjustment factor (see instructions) 02.00 HVBP adjustment amount for HSP bonus payment (see instructi HRR Adjustment for HSP Bonus Payment 03.00 HRR adjustment factor (see instructions) 04.00 HRR adjustment factor (see instructions) 04.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demonsormation Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 01.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, I Medicare discharges (see instructions) 03.00 Case-mix adjustment factor (see instructions) 04.00 Medicare target amount 05.00 Case-mix adjusted target amount (line 203 times line 204) 06.00 Medicare inpatient routine cost cap (line 202 times line 204) 06.00 Medicare inpatient routine cost cap (line 202 times line 204) 07.00 Program reimbursement under the §410A Demonstration (see in 08.00 Medicare Part A Inpatient Reimbursement 07.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. 09.00 Adjustment to Medicare IPPS payments (see instructions)	ine 49) in first year  25) structions) A, line 59)	the 21st	0. 0000000000 0. 0000000000 0 0	2.00 0.0000000000 0.0000 0.0000 0	101. 0 102. 0 103. 0 104. 0 200. 0 201. 0 202. 0 203. 0 205. 0 206. 0 207. 0 208. 0 209. 0 209. 0
OO. OO HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment OO. OO HVBP adjustment factor (see instructions) OO. OO HVBP adjustment amount for HSP bonus payment (see instructi HRR Adjustment for HSP Bonus Payment OO. OO HRR adjustment factor (see instructions) OO. OO HRR adjustment amount for HSP bonus payment (see instruction) OO. OO HRR adjustment amount for HSP bonus payment (see instruction) OO. OO Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement OO. OO Medicare inpatient service costs (from Wkst. D-1, Pt. II, I OO. OO Medicare discharges (see instructions) OO. OO Case-mix adjustment factor (see instructions) OO. OO Case-mix adjustment factor (see instructions) OO. OO Medicare target amount OO. OO Medicare inpatient routine cost cap (line 202 times line 204) OO. OO Medicare inpatient routine cost cap (line 202 times line 204) OO. OO Medicare Part A Inpatient Reimbursement OO. OO Program reimbursement under the §410A Demonstration (see in 08. OO Medicare Part A inpatient service costs (from Wkst. E, Pt. OO. OO. OO. Adjustment to Medicare IPPS payments (see instructions) OO. OO. Reserved for future use OO. OO. Total adjustment to Medicare IPPS payments (see instructions)	ine 49)  in first year  istructions) A, line 59)	the 21st	0. 0000000000 0. 0000000000 0 0	2.00 0.000000000000 0.0000 0.tration	101. 0 102. 0 103. 0 104. 0 200. 0 201. 0 202. 0 203. 0 204. 0 205. 0 206. 0 207. 0 208. 0 209. 0 211. 0
OO. OO HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment OI. OO HVBP adjustment factor (see instructions) OZ. OO HVBP adjustment amount for HSP bonus payment (see instructi HRR Adjustment for HSP Bonus Payment OI. OO HRR adjustment for HSP Bonus Payment OI. OO HRR adjustment factor (see instructions) OI. OO HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demonsor) OI. OO Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement OI. OO Medicare inpatient service costs (from Wkst. D-1, Pt. II, I or	ine 49) in first year  istructions) A, line 59) istructions)	of the curre	0. 0000000000 0. 0000000000 0 0	2.00 0.0000000000000 0.0000 0.tration	101. 0 102. 0 103. 0 104. 0 200. 0 201. 0 202. 0 203. 0 204. 0 205. 0 206. 0 207. 0 208. 0 209. 0 210. 0

Peri od: Worksheet E From 01/01/2023 Part A Exhi bit 4 To 12/31/2023 Date/Time Prepared: 5/31/2024 10:42 am Provider CCN: 14-0147

		W/S E, Part A	Amounts (from		XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounte (from					
		line	E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Peri od On/After 10/01	Total (Col 2 through 4)	
		0	1. 00	2.00	3. 00	4. 00	5. 00	
1 01	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
	DRG amounts other than outlier payments for discharges	1. 01	3, 211, 158	0	3, 211, 158		3, 211, 158	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	1, 168, 679	0		1, 168, 679	1, 168, 679	1. 02
	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	0	0	0		0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0		0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2. 00						2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	0	0	0	2. 01
2. 02	Outlier payments for discharges occurring prior to	2. 03	7, 167	0	7, 167		7, 167	2. 02
2. 03	October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see	2. 04	0	0		0	0	2. 03
3. 00	instructions) Operating outlier reconciliation	2. 01	0	0	0	0	0	3. 00
4. 00	Managed care simulated payments	3. 00	0	0	0	0	0	4. 00
	Indirect Medical Education Adju	ustment	<u>l</u>					
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 000000	0. 000000	0. 000000	0. 000000		5. 00
	IME payment adjustment (see instructions)	22. 00	0	0	0	0	0	6. 00
	IME payment adjustment for managed care (see instructions)	22. 01	0	0	0	0	0	6. 01
	Indirect Medical Education Adju							
	IME payment adjustment factor (see instructions)	27. 00	0. 000000	0. 000000	0. 000000	0. 000000		7.00
	IME adjustment (see instructions)	28. 00	0	0	0	0	0	
	IME payment adjustment add on for managed care (see instructions)	28. 01	0	O	O	O	0	8. 01
	Total IME payment (sum of lines 6 and 8)	29. 00	0	0	0	0	0	9. 00
	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0	0	0	0	0	9. 01
	Disproportionate Share Adjustme		0.0005	0.0005	0.0005	0.0005		10.00
	Allowable disproportionate share percentage (see instructions)	33. 00	0. 0995	0. 0995	0. 0995	0. 0995		10.00
11. 00	Disproportionate share adjustment (see instructions)	34. 00	108, 949	0	79, 878	29, 071	108, 949	11. 00
11. 01	Uncompensated care payments	36.00	192, 746	0	149, 109	43, 637	192, 746	11. 01
	Additional payment for high per Total ESRD additional payment	centage of ES 46.00	RD beneficiary 0	di scharges 0	0	0	0	12.00
	(see instructions) Subtotal (see instructions) Hospital specific payments	47. 00 48. 00	4, 688, 699 4, 708, 806	0	3, 447, 312 3, 508, 377	1, 241, 387 1, 200, 429	4, 688, 699 4, 708, 806	
	(completed by SCH and MDH, small rural hospitals only.) (see instructions)							
	Total payment for inpatient operating costs (see instructions)	49. 00	4, 708, 806	0	3, 508, 377	1, 200, 429	4, 708, 806	15.00

Health Financial Systems	RICHLAND MEMORIAL HOSPITAL	TAL In Lieu		
LOW VOLUME CALCULATION EXHIBIT 4	Provi der CCN: 14-0147		Worksheet E Part A Exhibit 4	

12/31/2023 Date/Time Prepared: 5/31/2024 10:42 am Title XVIII Hospi tal PPS W/S E, Part A Amounts (from Pre/Post Period Prior Total (Col 2 Peri od through 4) E, Part A) Entitlement to 10/01 On/After I i ne 10/01 0 1.00 2.00 3.00 4.00 5.00 16.00 Payment for inpatient program 50.00 327, 888 237, 412 90, 476 327, 888 16.00 capital (from Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for 54.00 32, 234 0 32, 234 32, 234 17.00 0 new technologies 17.01 Net organ aquisition cost 17.01 17.02 Credits received from 68.00 0 0 0 17.02 manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation 93.00 0 18.00 adjustment amount (see instructions) 19.00 SUBTOTAL 3, 778, 023 1, 290, 905 5, 068, 928 19.00 W/S L, line (Amounts from L) 0 1. 00 2.00 3.00 4. 00 5. 00 Capital DRG other than outlier 1.00 327, 888 237, 412 90, 476 327, 888 20.00 Model 4 BPCI Capital DRG other 20.01 1. 01 0 20.01 than outlier 21.00 Capital DRG outlier payments 2.00 0 21.00 Model 4 BPCI Capital DRG 21.01 2. 01 0 0 0 21.01 outlier payments 22.00 Indirect medical education 5.00 0.0000 0.0000 22.00 0.0000 0.0000 percentage (see instructions) 23.00 Indirect medical education 6.00 23.00 adjustment (see instructions) Allowable disproportionate 0.0000 0.0000 0.0000 0.0000 24.00 10.00 24.00 share percentage (see instructions) 25.00 Disproportionate share 11.00 0 C 0 0 25.00 adjustment (see instructions) Total prospective capital 237, 412 327, 888 26.00 12.00 327, 888 90, 476 payments (see instructions) W/S E, Part A (Amounts to line Part A) 2.00 4. 00 3. 00 5.00 27.00 Low volume adjustment factor 0. 195600 0. 195600 27.00 Low volume adjustment 70.96 738, 981 738, 981 28.00 28.00 (transfer amount to Wkst. E, Pt. A, line) 29.00 Low volume adjustment 70.97 252, 501 252, 501 29.00 (transfer amount to Wkst. E, Pt. A, line) 100.00 Transfer low volume Ν 100.00 adjustments to Wkst. E, Pt. A.

Heal th Financial SystemsRICHLAND MEMORIAHOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 Provider CCN: 14-0147 Peri od: Worksheet E From 01/01/2023 Part A Exhi bit 5 To 12/31/2023 Date/Time Prepared:

				10	) 12/31/2023	5/31/2024 10:	
				XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3. 00	4. 00	
1. 00 1. 01	DRG amounts other than outlier payments DRG amounts other than outlier payments for	1. 00 1. 01	3, 211, 158	3, 211, 158		3, 211, 158	1. 00 1. 01
1. 02	discharges occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	1, 168, 679		1, 168, 679	1, 168, 679	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1. 03	O	0		0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	O		0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2. 00					2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	O	0	0	0	2. 01
2. 02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2. 03	7, 167	7, 167		7, 167	2. 02
2. 03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2. 04	0		0	0	2. 03
3. 00 4. 00	Operating outlier reconciliation Managed care simulated payments	2. 01 3. 00	0	0	0 0	0	3. 00 4. 00
5. 00	Amount from Worksheet E, Part A, line 21	21. 00	0. 000000	0. 000000	0. 000000		5. 00
6.00	(see instructions)  IME payment adjustment (see instructions)	22. 00	0	0	0	0	6.00
6. 01	IME payment adjustment for managed care (see instructions) Indirect Medical Education Adjustment for the		0	0	U	0	6. 01
7. 00	IME payment adjustment factor (see	27. 00	0. 000000	0. 000000	0. 000000		7.00
7.00	instructions)	27.00	0.00000	0.000000	0.000000		7.00
8. 00 8. 01	IME adjustment (see instructions) IME payment adjustment add on for managed	28. 00 28. 01	0	0	0	0	8. 00 8. 01
9. 00 9. 01	care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of	29. 00 29. 01	0	0	O O	0	9. 00 9. 01
	lines 6.01 and 8.01)						
10. 00	Disproportionate Share Adjustment Allowable disproportionate share percentage	33. 00	0. 0995	0. 0995	0. 0995		10.00
11. 00	(see instructions) Disproportionate share adjustment (see	34. 00	108, 949	79, 878	29, 071	108, 949	11.00
11. 01	instructions) Uncompensated care payments	36. 00	192, 746		·		11.00
11.01	Additional payment for high percentage of ES			33, 107	77, 252	134, 441	11.01
12. 00	Total ESRD additional payment (see instructions)	46. 00	0	0	0	0	12.00
13. 00 14. 00	Subtotal (see instructions)	47. 00 48. 00	4, 688, 699 4, 708, 806				
15. 00	instructions) Total payment for inpatient operating costs (see instructions)	49. 00	4, 708, 806	3, 391, 087	1, 317, 719	4, 708, 806	15. 00
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	327, 888	245, 046	82, 842	327, 888	16.00
17. 00 17. 01	Special add-on payments for new technologies Net organ acquisition cost	54. 00	32, 234	0	32, 234	32, 234	17. 00 17. 01
17. 02	Credi ts received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	0	0	0	17. 02
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	0	0	0	18. 00
19. 00	SUBTOTAL			3, 636, 133	1, 432, 795	5, 068, 928	19. 00

Hoal th	Financial Systems	RI CHLAND MEMOR	IAT IQQAH IA IQ		In lie	u of Form CMS-2	2552_10
	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA				Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Exhibi	t 5 pared:
				XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1. 00	2. 00	3. 00	4. 00	
20.00	Capital DRG other than outlier	1. 00	327, 888	244, 346	83, 542	327, 888	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	(	0	0	20. 01
21.00	Capital DRG outlier payments	2. 00	0	700	-700	0	21.00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	(	0	0	21.01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 0000	0. 0000		22.00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	(	0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0000	0. 0000	0. 0000		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	0	(	0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	327, 888	245, 046	82, 842	327, 888	26. 00
		Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt.				
			A)				
		0	1. 00	2.00	3. 00	4. 00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70. 96	738, 981	738, 98°		738, 981	28. 00
29.00	Low volume adjustment on or after October 1	70. 97	252, 501		252, 501	252, 501	29. 00
30.00	HVBP payment adjustment (see instructions)	70. 93	-5, 135	-17, 603	12, 468	-5, 135	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0	(	0	0	30. 01
31.00	HRR adjustment (see instructions)	70. 94	-19, 621	-11, 124	-8, 497	-19, 621	31.00
31. 01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0	(	0	0	31.01
	·					(Amt to	

0 70. 99

32.00 HAC Reduction Program adjustment (see instructions)
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.

1.00

2.00

0

3.00

0

(Amt. to Wkst. E, Pt. A) 4.00

32.00

100.00

Health Financial Systems	RICHLAND MEMORIAL HOSPITAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-0147	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/31/2024 10:42 am
•			

	Ti t	le XVIII	Hospi tal	PPS	42 dili
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			1, 026	
2.00	Medical and other services reimbursed under OPPS (see instructions)			5, 722, 984	
3. 00 4. 00	OPPS or REH payments Outlier payment (see instructions)			4, 333, 783 0	1
4. 01	Outlier reconciliation amount (see instructions)			0	
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0. 000	5.00
6. 00	Line 2 times line 5			0	
7. 00 8. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
9. 00	Transitional corridor payment (see instructions) Ancillary service other pass through costs including REH direct gradua	te medical educ	cation costs from		
7. 00	Wkst. D, Pt. IV, col. 13, line 200	to mour our ouu	00010 1100		7.00
10.00	Organ acqui si ti ons			0	
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			1, 026	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES  Reasonable charges				1
12. 00	Ancillary service charges			3, 016	12.00
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0	1
14.00	Total reasonable charges (sum of lines 12 and 13)			3, 016	14.00
15 00	Customary charges			0	15 00
15. 00 16. 00	Aggregate amount actually collected from patients liable for payment f Amounts that would have been realized from patients liable for payment			0	
10.00	had such payment been made in accordance with 42 CFR §413.13(e)	TOT SCI VICES (	on a chargebasi s	O	10.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00
	Total customary charges (see instructions)			3, 016	
19. 00	Excess of customary charges over reasonable cost (complete only if lin instructions)	e 18 exceeds li	ine 11) (see	1, 990	19.00
20. 00	Excess of reasonable cost over customary charges (complete only if lin	e 11 exceeds Li	ine 18) (see	0	20.00
	instructions)		(	_	
21. 00	Lesser of cost or charges (see instructions)			1, 026	21.00
	Interns and residents (see instructions)			0	
	Cost of physicians' services in a teaching hospital (see instructions) Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0 4, 333, 783	1
24.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			4, 333, 703	24.00
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)			0	25. 00
26. 00	,			833, 666	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the instructions)	sum of lines 22	2 and 23] (see	3, 501, 143	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0	28. 00
	REH facility payment amount (see instructions)				28. 50
	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)			3, 501, 143	
	Primary payer payments Subtotal (line 30 minus line 31)			0 3, 501, 143	
02.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			0,001,110	02.00
	Composite rate ESRD (from Wkst. I-5, line 11)			0	
	Allowable bad debts (see instructions)			196, 197	
	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions)			127, 528 167, 030	
37. 00	Subtotal (see instructions)			3, 628, 671	
38. 00	MSP-LCC reconciliation amount from PS&R			0	1
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	Pioneer ACO demonstration payment adjustment (see instructions)			0	39.50
39. 75 39. 97	N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration			0	
39. 98	Partial or full credits received from manufacturers for replaced device	es (see instru	ctions)	0	1
	RECOVERY OF ACCELERATED DEPRECIATION	•		0	
	Subtotal (see instructions)			3, 628, 671	1
40. 01 40. 02	Sequestration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration			72, 573 0	
	Sequestration adjustment-PARHM pass-throughs			U	40. 02
	Interim payments			3, 510, 727	
	Interim payments-PARHM				41.01
	Tentative settlement (for contractors use only)			0	
	Tentative settlement-PARHM (for contractor use only) Balance due provider/program (see instructions)			45, 371	42. 01 43. 00
43. 00	Balance due provider/program-PARHM (see instructions)			45, 5/1	43.00
44. 00	Protested amounts (nonallowable cost report items) in accordance with	CMS Pub. 15-2,	chapter 1,	0	1
	§115. 2		•		1
00.00	TO BE COMPLETED BY CONTRACTOR			^	90.00
90.00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money			0.00	
93. 00	Time Value of Money (see instructions)			0	93.00

Health Financial Systems	RICHLAND MEMORIAL	. HOSPI TAL	In Lieu	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0147	Peri od:	Worksheet E	
			From 01/01/2023		
			To 12/31/2023	Date/Time Pre	:pared:
				5/31/2024 10:	42 am
		Title XVIII	Hospi tal	PPS	
				1. 00	
94.00 Total (sum of lines 91 and 93)				0	94.00
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				0	200.00

| Peri od: | Worksheet E-1 | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Provi der CCN: 14-0147

				10 12/31/2023	5/31/2024 10: 4	
		Title	xVIII	Hospi tal	PPS	
		Inpatier	nt Part A	Par	Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		5, 599, 56	2	3, 510, 727	1.00
2.00	Interim payments payable on individual bills, either			0	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3. 00	List separately each retroactive lump sum adjustment					3.00
	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)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3. 02	ADJUSTIMENTS TO TROVIDER		1	0		3. 02
3. 03			1	Ö	l o	3. 02
3. 04				o	o o	3. 04
3. 05			1	o	Ö	3. 05
0.00	Provider to Program			<u> </u>	J	0.00
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 51				o	0	3. 51
3.52				0	0	3.52
3.53				0	0	3.53
3.54				0	0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
	3. 50-3. 98)					
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		5, 599, 56	2	3, 510, 727	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after		I			5. 00
5.00	desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5.02				0	o	5. 02
5.03				0	0	5.03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM		l .	0	0	5. 50
5. 51			l .	0	0	5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		-		45, 371	6. 01
6. 02	SETTLEMENT TO PROVIDER		252, 37	9	45, 3/1	6. 02
7. 00	Total Medicare program liability (see instructions)		5, 347, 18		3, 556, 098	7. 00
,. 50	1.01a. modi odi o program rrabiri ty (300 moti doti ons)		3, 377, 10	Contractor	NPR Date	,. 50
				Number	(Mo/Day/Yr)	
			0	1. 00	2.00	
8. 00	Name of Contractor					8. 00

Health Financial Systems RICHL ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED In Lieu of Form CMS-2552-10 RICHLAND MEMORIAL HOSPITAL Provider CCN: 14-0147

Provider CCN: 14-0147 | Period: | Worksheet E-1 | From 01/01/2023 | Part | To 12/31/2024 | 10:42 am | From 12/31/2024 | 10:42 am | F

		Component	0014: 11 0117	10 12/01/2020	5/31/2024 10:	42 am
				<u>Swing Beds - SNF</u>		
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		628, 22	25	0	1.00
2.00	Interim payments payable on individual bills, either			0	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	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)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER			0	0	
3. 02				0	0	3. 02
3. 03				0	0	3. 03
3.04				0	0	3. 04
3. 05				0	0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM			0	0	
3. 51				0	0	
3. 52				0	0	
3. 53				0	0	3. 53
3.54				0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		628, 22	25	0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
F 00	TO BE COMPLETED BY CONTRACTOR		Γ			- ^
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					1
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5. 02	TENTATIVE TO TROVIDER			0	l ől	
5. 02				0	0	
5. 05	Provider to Program			<u> </u>		3.03
5. 50	TENTATI VE TO PROGRAM			0	0	5.50
5. 51				o	l ol	
5. 52				0	0	
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	l ol	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		12, 82	22	0	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	0	
7.00	Total Medicare program liability (see instructions)		641, 04	17	0	7.00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
			)	1. 00	2.00	
				1.00	2.00	

Health Financial Systems RICHLAND MEMORIAL HOSPITAL In Lieu					u of Form CMS-	2552-10	
CALCU							
	From 01/01/2023 F To 12/31/2023 E						
					Date/Time Pre 5/31/2024 10:		
			Title XVIII	Hospi tal	PPS		
					1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDA					1	
1 00	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION					4 00	
1.00   Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14						1.00	
2.00 Medicare days (see instructions)						2.00	
3.00	Medicare HMO days from Wkst. S-3, Pt. I, co	1. 6. 11ne 2				3.00	
4.00	Total inpatient days (see instructions)					4.00	
5. 00	Total hospital charges from Wkst C, Pt. I,					5. 00	
6. 00	Total hospital charity care charges from Wk					6.00	
7. 00	CAH only - The reasonable cost incurred for	the purchase of c	certified HII technology	Wkst. S-2, Pt. I		7. 00	
0.00	line 168					0.00	
8. 00	Calculation of the HIT incentive payment (s					8.00	
9.00	Sequestration adjustment amount (see instru		( t t			9.00	
10. 00			(see Instructions)			10.00	
20.00	INPATIENT HOSPITAL SERVICES UNDER THE IPPS					20.00	
	Initial/interim HIT payment adjustment (see	instructions)				30.00	
	Other Adjustment (specify)	: 1: 20 1		>		31.00	
32.00	Balance due provider (line 8 (or line 10) m	inus iine 30 and i	ine 31) (see Instruction	ns)		32.00	

Health Financial Systems	RICHLAND MEMORIAL	. HOSPI TAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN: 14-0147	Peri od:	Worksheet E-2
			From 01/01/2023	
		Component CCN: 14-U147	To 12/31/2023	Date/Time Prepared:
				5/31/2024 10:42 am
		T1 11 \0.0111	0 1 0 1 01/5	200

	Component CCN: 14-U14/	10 12/31/2023	Date/lime Pre   5/31/2024 10:	
	Title XVIII	Swing Beds - SNF		
		Part A	Part B	
COMPUTATION OF NET COOT OF COMPDED OFFINION		1. 00	2. 00	
COMPUTATION OF NET COST OF COVERED SERVICES		670, 246	0	1 ,
00   Inpatient routine services - swing bed-SNF (see instructions) 00   Inpatient routine services - swing bed-NF (see instructions)		670, 240	U	1.0
00 Ancillary services (from Wkst. D-3, col. 3, line 200, for Pari	A and sum of Wkst D	0	0	1
Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swire			Ü	0.0
instructions)	.g pg,			
01 Nursing and allied health payment-PARHM (see instructions)				3.0
00 Per diem cost for interns and residents not in approved teachi	ng program (see		0.00	4.0
i nstructi ons)				
00 Program days		1, 069	1, 069	1
Old Interns and residents not in approved teaching program (see in	•		0	
OO Utilization review - physician compensation - SNF optional met OO Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	thod only	670, 246	0	7. 8.
00 Primary payer payments (see instructions)		070, 240	0	1
.00   Subtotal (line 8 minus line 9)		670, 246	0	1
.00 Deductibles billed to program patients (exclude amounts applic	cable to physician	0,0,2.0	0	
professional services)	or bugararan			
.00 Subtotal (line 10 minus line 11)		670, 246	0	12.
.00 Coinsurance billed to program patients (from provider records)	(exclude coinsurance	29, 200	0	13. (
for physician professional services)				
.00 80% of Part B costs (line 12 x 80%)			0	
.00 Subtotal (see instructions)		641, 046	0	1
. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	-)	0	0	16. 16.
<ul> <li>.50 Pioneer ACO demonstration payment adjustment (see instructions</li> <li>.55 Rural community hospital demonstration project (§410A Demonstration)</li> </ul>	•	0		16.
adjustment (see instructions)	atton) payment			10.
. 99 Demonstration payment adjustment amount before sequestration		0	0	16.
.00 Allowable bad debts (see instructions)		2	0	
.01 Adjusted reimbursable bad debts (see instructions)		1	0	17.
.00 Allowable bad debts for dual eligible beneficiaries (see inst	ructi ons)	1	0	18.
.00 Total (see instructions)		641, 047	0	1
.01 Sequestration adjustment (see instructions)		0	0	1
.02 Demonstration payment adjustment amount after sequestration)		0	0	
. 03   Sequestration adjustment-PARHM pass-throughs			0	19.
<ul><li>.25   Sequestration for non-claims based amounts (see instructions)</li><li>.00   Interim payments</li></ul>		628, 225	0	1
.01   Interim payments-PARHM		020, 223	U	20.
.00 Tentative settlement (for contractor use only)		0	0	
.01 Tentative settlement-PARHM (for contractor use only)				21.
.00 Balance due provider/program (line 19 minus lines 19.01, 19.02	2, 19.25, 20, and 21)	12, 822	0	22.
.01 Balance due provider/program-PARHM (see instructions)				22.
.00 Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2,	0	0	23.
chapter 1, §115.2				
Rural Community Hospital Demonstration Project (§410A Demonstr				1000
0.00 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no.	riod under the Zist			200.
Cost Reimbursement				
1.00 Medicare swing-bed SNF inpatient routine service costs (from V	Wkst. D-1. Pt. II. line			201.
66 (title XVIII hospital))				
2.00 Medicare swing-bed SNF inpatient ancillary service costs (from	n Wkst. D-3, col. 3, lir	ne		202.
200 (title XVIII swing-bed SNF))				
3.00 Total (sum of lines 201 and 202)				203.
4.00 Medicare swing-bed SNF discharges (see instructions)				204.
Computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	ent 5-year demons	tration	
period) 5.00 Medicare swing-bed SNF target amount				205
6.00 Medicare swing-bed SNF inpatient routine cost cap (line 205 ti	mes line 204)			205. 206.
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs				1200.
7.00 Program reimbursement under the §410A Demonstration (see insti				207.
8.00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2	•	1		208.
and 3)	, 121. 1, 24 3. 1.1103			- 50.
9.00 Adjustment to Medicare swing-bed SNF PPS payments (see instruc	ctions)			209.
0.00 Reserved for future use	<u>,                                      </u>			210.
Comparision of PPS versus Cost Reimbursement				
5.00 Total adjustment to Medicare swing-bed SNF PPS payment (line 2	209 plus line 210) (see			215.
instructions)	10. prus rine 210) (366			Ĺ,

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0147	Peri od: From 01/01/2023	Worksheet E-3 Part VI	
		Component CCN: 14-5580	To 12/31/2023	Date/Time Pre 5/31/2024 10:	
		Title XVIII	Skilled Nursing Facility	PPS	
				1 00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - AL	I OTHER HEALTH SERVICES FOR	TITIE YVIII DADT	1. 00 A DDS SNE	-
	SERVICES	E OTHER HEALTH SERVICES TOR	ITTLE AVITE LAKE	A II 5 SWI	
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				1
. 00	Resource Utilization Group Payment (RUGS)			0	1.
	Routine service other pass through costs			0	2
	Ancillary service other pass through costs			0	3.
. 00	Subtotal (sum of lines 1 through 3)			0	4
	COMPUTATION OF NET COST OF COVERED SERVICES				
	Medical and other services (Do not use this line as vacc	ine costs are included in li	ne 1 of W/S E,		5.
	Part B. This line is now shaded.)				
	Deducti bl e			0	
	Adjusted reimbursable bad debts (see instructions)			0	
	Utilization review			0	1
	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus li	nes 10 and 11)(see instructi	ons)	0	
	Inpatient primary payer payments			0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	Pioneer ACO demonstration payment adjustment (see instru	ctions)		0	
	Recovery of accelerated depreciation.			0	
	Demonstration payment adjustment amount before sequestra	tion		0	1
	Subtotal (see instructions			0	
	Sequestration adjustment (see instructions)			0	
	2 Demonstration payment adjustment amount after sequestration				
	Sequestration for non-claims based amounts (see instruct	i ons)		0	
	Interim payments			0	
	Tentative settlement (for contractor use only)	1E 00 1E 7E 1/ op 1 17)		0	1
	Balance due provider/program (line 15 minus lines 15.01, Protested amounts (nonallowable cost report items) in ac		0	0	1
9. OO l					

Health Financial Systems RICHLAND MEMORIAL HOSPITAL In Lieu o				u of Form CMS-2	552-10
OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT  Provider CCN: 14-0147  Period: From 01/01/2023					
	Date/Time Prep 5/31/2024 10:4	oared: 12 am			
		Title XVIII		PPS	
	1. 00				
TO BE COMPLETED BY CONTRACTOR					
1.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)					1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2			0	2.00
3.00 Operating outlier reconciliation adjustment amount (see instructions)				0	3.00
4.00 Capital outlier reconciliation adjustment amount (see instructions)					4.00
5.00 The rate used to calculate the time value of money (see instructions)				0.00	5.00
6.00 Time value of money for operating expenses (see instructions)				0	6.00
7.00 Time value of money for capital related expenses (see instructions)				0	7.00

Health Financial Systems RICHLAND MEM BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 14-0147 Period From 0

Peri od: Worksheet G From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/31/2024 10: 42 am

37		General Fund	Speci fi c	Endowment	5/31/2024 10:   Plant Fund	42 am
		1.00	Purpose Fund 2.00	Fund 3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	2, 232, 803		0	0	1.00
2. 00 3. 00	Temporary investments Notes receivable	0	0	0	0	2. 00 3. 00
4. 00	Accounts receivable	34, 589, 923	-	0	0	4.00
5. 00	Other recei vable	-7, 747, 071	Ö	o	0	5.00
6. 00	Allowances for uncollectible notes and accounts receivable		0	Ö	0	6.00
7.00	Inventory	835, 852	0	0	0	7.00
8.00	Prepai d expenses	223, 228	0	0	0	8. 00
9.00	Other current assets	0	0	0	0	9.00
10. 00 11. 00	Due from other funds	6, 810, 097	0	0	0	10.00 11.00
11.00	Total current assets (sum of lines 1-10) FIXED ASSETS	0,010,097	l o	<u> </u>	0	11.00
12. 00	Land	1, 017, 266	0	0	0	12.00
13. 00	Land improvements	688, 330		Ö	0	13.00
14.00	Accumulated depreciation	-513, 820	0	O	0	14.00
15. 00	Bui I di ngs	34, 052, 946	0	0	0	15.00
16.00	Accumulated depreciation	-22, 874, 444	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18. 00 19. 00	Accumulated depreciation Fixed equipment	0	0	0	0	18.00
20.00	Accumulated depreciation	0	0	0	0	19. 00 20. 00
21. 00	Automobiles and trucks	221, 542		0	0	21.00
22. 00	Accumulated depreciation	-154, 099		o	0	22.00
23. 00	Maj or movable equipment	30, 465, 743		O	0	23.00
24.00	Accumulated depreciation	-24, 837, 940	0	О	0	24.00
25. 00	Mi nor equi pment depreciable	0	0	0	0	25. 00
26. 00	Accumulated depreciation	0	0	0	0	26.00
27. 00	HIT designated Assets	0	0	0	0	27.00
28. 00	Accumulated depreciation	0	0	0	0	28.00
29. 00 30. 00	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	18, 065, 524	0	0	0	29. 00 30. 00
30.00	OTHER ASSETS	10,005,524		<u> </u>	0	30.00
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on Leases	0	0	o	0	32. 00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	7, 466	1	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	7, 466	1	0	0	35.00
36. 00	Total assets (sum of lines 11, 30, and 35)  CURRENT LIABILITIES	24, 883, 087	0	0	0	36.00
37. 00	Accounts payable	614, 719	0	O	0	37.00
38. 00	Salaries, wages, and fees payable	3, 752, 505		Ö	0	38.00
39.00	Payrol I taxes payable	0	0	0	0	39.00
40.00	Notes and Loans payable (short term)	0	0	0	0	40.00
41. 00	Deferred income	0	0	0	0	41.00
42.00	Accel erated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43. 00 44. 00
44. 00 45. 00	Other current liabilities Total current liabilities (sum of lines 37 thru 44)	6, 465, 305 10, 832, 529		0	0	
43.00	LONG TERM LIABILITIES	10, 032, 327	0	<u>U</u>		45.00
46. 00	Mortgage payable	0	0	o	0	46. 00
47.00	Notes payable	2, 019, 994	0	O	0	47.00
48.00	Unsecured Loans	0	0	0	0	48. 00
49. 00	Other long term liabilities	0	0	0	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2, 019, 994	1	0	0	50.00
51. 00	Total liabilities (sum of lines 45 and 50)	12, 852, 523	0	0	0	51.00
52. 00	CAPITAL ACCOUNTS  General fund balance	12, 030, 564				52. 00
53. 00	Specific purpose fund	12,030,304	0			53.00
54. 00	Donor created - endowment fund balance - restricted			o		54.00
55. 00	Donor created - endowment fund balance - unrestricted			ō		55. 00
56.00	Governing body created - endowment fund balance			О		56.00
57. 00	Plant fund balance - invested in plant				0	57.00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	12, 030, 564	0	o	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and	24, 883, 087	1	ol Ol	0	60.00
55. 55	[59]	21,000,007		٩	O	55. 55
	·	'	. '	ı		

| Period: | Worksheet G-1 | From 01/01/2023 | To 12/21/2023 | Provider CCN: 14-0147

					To 12/31/2023	Date/Time Pro 5/31/2024 10:	pared: 42 am
		General	Fund	Special F	Purpose Fund	Endowment Fund	
		1. 00	2. 00	3.00	4.00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) RECONCILING ITEM	0 0 0	22, 007, 365 -9, 976, 802 12, 030, 563		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0	5. 00 6. 00 7. 00 8. 00
9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) RECONCILING ITEM  Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0 0 0	0 12, 030, 563 0 12, 030, 563		0 0 0 0 0 0 0 0 0	0 0 0 0 0	10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00
		Endowment Fund	PI ant	Fund			
		6. 00	7. 00	8. 00			
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) RECONCILING ITEM	0	0 0 0 0 0		0		1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) RECONCILING ITEM	0 0	0 0 0 0 0		0		10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0			0		18. 00 19. 00

Health Financial Systems RI STATEMENT OF PATLENT REVENUES AND OPERATING EXPENSES Provider CCN: 14-0147

Description   Inpatient   Outpatient   Total				'	0 12/31/2023	5/31/2024 10:	
PART I - PATIENT REVENUES		Cost Center Description		I npati ent	Outpati ent		
Supervision   1.00   Hospital   1.00							
Hospital		PART I - PATIENT REVENUES					
SUBPROVIDER		General Inpatient Routine Services					
3.00   SUBPROVIDER	1.00	Hospi tal		5, 457, 640		5, 457, 640	1.00
SUBPROVIDER	2.00	SUBPROVI DER - I PF		0		0	2.00
5.00 Swing bed - SNF	3.00	SUBPROVI DER - I RF					3.00
Section   Sect	4.00	SUBPROVI DER					4.00
SKILLÉEN NURSING FACILITY	5.00	Swing bed - SNF		0		0	5.00
8.00   NURSING FACILITY   5,457,640   5,457,640   9.00	6.00	Swing bed - NF		0		0	6. 00
O.   O.   THER LOW TERM CARE   O.   O.   D.   O.   D.   O.   O.   D.   D	7.00	SKILLED NURSING FACILITY		0		0	7.00
10. 00   Total general Inpatient care services (sum of lines 1-9)   5,457,640   10. 00   1. 354,690   11. 00   1. 354,690   11. 00   1. 354,690   11. 00   12. 00	8.00	NURSING FACILITY					8.00
Intensive Care Type Inpatient Hospital Services	9.00	OTHER LONG TERM CARE					9.00
11. 00   INTENSIVE CARE UNIT   1. 354,690   1. 354,690   1. 00   1. 354,690   1. 00	10.00	Total general inpatient care services (sum of lines 1-9)		5, 457, 640		5, 457, 640	10.00
12.00   COROMARY CARE UNIT		Intensive Care Type Inpatient Hospital Services					
13.00   BURN INTENSIVE CARE LINIT   14.00   15.00   17.85   14.00   15.00   17.85   14.00   15.00   17.85   14.00   15.00   17.85   14.00   15.00   17.85   14.00   15.00   17.85   17.00   17.85   17.00   17.85   17.00   17.85   17.00   17.85   17.00   17.15   17.00	11.00	INTENSIVE CARE UNIT		1, 354, 690		1, 354, 690	11.00
14. 00   SURGICAL INTENSIVE CARE UNIT     14. 00     15. 00     16. 00   16. 00     16. 00     16. 00     16. 00     16. 00     16. 00   16. 00     16. 00     16. 00     16. 00     16. 00     16. 00   16. 00     16. 00     16. 00     16. 00     16. 00     16. 00   16. 00     16. 00     16. 00     16. 00     16. 00     16. 00   16. 00     16. 00     16. 00     16. 00     16. 00     16. 00   16. 00     16. 00     16. 00     16. 00     16. 00     16. 00   16. 00     16. 00     16. 00     16. 00     16. 00     16. 00   16. 00     16. 00     16. 00     16. 00     16. 00     16. 00   16. 00     16. 00     16. 00     16. 00     16. 00     16. 00   16. 00     16. 00     16. 00     16. 00     16. 00     16. 00   16. 00     16. 00     16. 00     16. 00     16. 00     16. 00   16. 00     16. 00     16. 00     16. 00     16. 00     16. 00   16. 00     16. 00     16. 00     16. 00     16. 00     16. 00   16. 00     16. 00     16. 00     16. 00     16. 00     16. 00   16. 00     16. 00     16. 00     16. 00     16. 00     16. 00   16. 00     16. 00     16. 00     16. 00     16. 00     16. 00   1	12.00	CORONARY CARE UNIT					12.00
15. 00   OTHER SPECIAL CARE (SPECIFY)   16. 00   1. 354,690   1. 354,690   1. 354,690   16. 00   1. 1. 354,690   16. 00   1. 1. 150   1. 15	13.00	BURN INTENSIVE CARE UNIT					13.00
Total intensive care type inpatient hospital services (sum of lines   1, 354, 690	14.00	SURGICAL INTENSIVE CARE UNIT					14.00
11-15    17. 00   17. 00   17. 00   17. 00   18. 00   18. 00   19. 00   1	15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
17. 00   Total inpatient routine care services (sum of lines 10 and 16)   6,812,330   7.00   162,282,179   168,868,949   18. 00   19. 00   0.01   10. 00   10. 00   0.01   10. 00   0.01   10. 00   0.01   10. 00   0.01   10. 00   11. 063,061   10. 00   11. 063,061   10. 00   11. 063,061   10. 00   10. 00   0.	16.00	Total intensive care type inpatient hospital services (sum of	lines	1, 354, 690		1, 354, 690	16.00
18.00   Ancillary services   34,586,770   162,282,179   196,868,049   18.00   19.00		11-15)					
19.00     19.0	17.00	Total inpatient routine care services (sum of lines 10 and 16)		6, 812, 330		6, 812, 330	17.00
20.00   RURÂL HEALTH CLINIC   0   2, 161, 178   2, 161, 178   20.00	18.00	Ancillary services		34, 586, 770	162, 282, 179	196, 868, 949	18.00
20. 01   RURAL HEALTH CLINIC   1   0   0   11, 663, 061   11, 663, 061   20. 01	19.00	Outpati ent servi ces		0	0	0	19.00
20.02   RURAL HEALTH CLINIC III   0 0 0 0 20.02	20.00	RURAL HEALTH CLINIC		0	2, 161, 178	2, 161, 178	20.00
21.00   FEDERALLY QUALIFIED HEALTH CENTER   0   0   0   21.00     HOME HEALTH AGENCY   0   0   0   22.00     ABBULANCE SERVICES   0   0   0   0   24.00     ABBULANCE SERVICES   0   0   0   0   24.10     ABBULANCE SERVICES   0   0   0   0   0     ABBULANCE SERVICES	20. 01	RURAL HEALTH CLINIC II		0	11, 663, 061	11, 663, 061	20. 01
22.00   HOME HEALTH AGENCY   0   0   0   22.00	20.02	RURAL HEALTH CLINIC III		0	0	0	20. 02
23.00   AMBULANCE SERVICES   0 0 0 0 24.00	21.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21.00
24.00 CMHC	22.00	HOME HEALTH AGENCY			0	0	22.00
24. 10   CORF   0   0   0   24. 10   CORF   0   0   0   0   24. 10   CORF   0   0   0   0   24. 10   CORF   0   0   0   0   24. 20   CORF   COUPTATI ENT PHYSICAL THERAPY   0   0   0   0   24. 30   COUPTATI ENT OCCUPATI ONAL THERAPY   0   0   0   0   24. 40   COUPTATI ENT SPEECH PATHOLOGY   0   0   0   24. 40   COUPTATI ENT SPEECH PATHOLOGY   0   0   0   24. 40   COUPTATI ENT SPEECH PATHOLOGY   0   0   0   24. 40   COUPTATI ENT SPEECH PATHOLOGY   0   0   0   24. 40   COUPTATI ENT SPEECH PATHOLOGY   0   0   0   24. 40   COUPTATI ENT SPEECH PATHOLOGY   0   0   0   24. 40   COUPTATI ENT SPEECH PATHOLOGY   0   0   0   24. 40   COUPTATI ENT SPEECH PATHOLOGY   0   0   0   24. 40   COUPTATI ENT SPEECH PATHOLOGY   0   0   0   24. 40   COUPTATI ENT SPEECH PATHOLOGY   0   0   0   24. 40   COUPTATI ENT SPEECH PATHOLOGY   0   0   0   24. 40   COUPTATI ENT SPEECH PATHOLOGY   0   0   0   24. 40   COUPTATI ENT SPEECH PATHOLOGY   0   0   0   0   0   COUPTATI ENT SPEECH PATHOLOGY   0   0   0   0   COUPTATI ENT SPEECH PATHOLOGY   0   0   0   COUPTATI ENT SPEECH PATHOLOGY   0   0   0   COUPTATI ENT SPEECH PATHOLOGY   0   COUPTATION SPEECH PAT	23.00	AMBULANCE SERVICES		0	0	0	23.00
24. 20	24.00	CMHC					24.00
24. 20		CORF		0	o	0	24. 10
24. 40 OUTPATLENT SPEECH PATHOLOGY 25. 00 AMBULATORY SURGICAL CENTER (D. P.) 26. 00 HOSPI CE 27. 00 PHYS PRI VATE OFFI CES AND PRO FEE 28. 00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 42, 824, 255 203, 329, 034 246, 153, 289 28. 00 3. 31. 00 3. 00 31. 00 32. 00 33. 00 33. 00 33. 00 33. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 37. 00 38. 00 39. 00 40. 00 41. 00 41. 00 42. 00 Total deductions (sum of lines 37-41)  27. 00 Total additions (sum of lines 37-41)  28. 00 Total adductions (sum of lines 37-41)  29. 00 Total deductions (sum of lines 29 and 36 minus line 42) (transfer column for a co	24. 20	OUTPATIENT PHYSICAL THERAPY		0	0	0	24. 20
24. 40 OUTPATLENT SPEECH PATHOLOGY 25. 00 AMBULATORY SURGICAL CENTER (D. P.) 26. 00 HOSPI CE 27. 00 PHYS PRI VATE OFFI CES AND PRO FEE 28. 00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 42, 824, 255 203, 329, 034 246, 153, 289 28. 00 3. 31. 00 3. 00 31. 00 32. 00 33. 00 33. 00 33. 00 33. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 37. 00 38. 00 39. 00 40. 00 41. 00 41. 00 42. 00 Total deductions (sum of lines 37-41)  27. 00 Total additions (sum of lines 37-41)  28. 00 Total adductions (sum of lines 37-41)  29. 00 Total deductions (sum of lines 29 and 36 minus line 42) (transfer column for a co	24. 30	OUTPATIENT OCCUPATIONAL THERAPY		0	0	0	24. 30
25. 00				l o	o	0	24. 40
26. 00 HOSPICE							
27. 00 PHYS PRIVATE OFFICES AND PRO FEE  28. 00 Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.				0	0	0	26. 00
28.00   Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst.   42, 824, 255   203, 329, 034   246, 153, 289   28.00   29.00   30.00   30.00   31.00   32.00   33.00   34.00   33.00   34.00   35.00   37.00   36.00   37.00   38.00   37.00   38.00   39.00   40.00   41.00   42.00   Total operating expenses (sum of lines 37-41)   Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer   78, 608, 654   43.00   43.00   43.00   43.00   43.00   43.00   43.00   43.00   43.00   43.00   44		PHYS PRIVATE OFFICES AND PRO FEE		1, 425, 155	27, 222, 616	28, 647, 771	27. 00
G-3, line 1) PART II - OPERATING EXPENSES  29.00 30.00 31.00 31.00 32.00 33.00 34.00 35.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY)  DEDUCT (SPECIFY)  Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer)  74, 780, 302 29.00 31, 00 31, 00 31, 00 31, 00 32, 00 33, 828, 352 30, 00 31, 00 32, 00 33, 828, 352 36, 00 37, 00 38, 00 39, 00 40, 00 41, 00 42, 00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer)  78, 608, 654  43, 00	28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	42, 824, 255			28.00
29. 00 30. 00 30. 00 31. 00 31. 00 32. 00 33. 00 34. 00 35. 00 35. 00 36. 00 37. 00 38. 00 38. 00 39. 00 40. 00 41. 00 42. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 44. 00 44. 00 44. 00 45. 00 46. 00 47. 780, 302 39. 00 30. 00 31. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 43. 00 40. 00 41. 00 42. 00 43. 00 43. 00 44. 00 44. 00 45. 00 46. 00 47. 00 47. 00 48. 00 49. 00 49. 00 40. 00 41. 00 42. 00 43. 00 43. 00							
30.00 BAD DEBTS 3,828,352 30.00 31.00 32.00 31.00 32.00 33.0		PART II - OPERATING EXPENSES					
31.00 32.00 33.00 33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) 37.00 38.00 39.00 40.00 41.00 42.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 31.00 32.00 32.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 34.00 35.00 35.00 37.00 36.00 37.00 37.00 38.00 39.00 40.00 41.00 41.00 42.00 78.608.654	29.00	Operating expenses (per Wkst. A, column 3, line 200)			74, 780, 302		29. 00
32.00 33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY)  DEDUCT (SPECIFY)  Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer)  32.00 33.00 33.00 33.00 34.00 35.00 35.00 35.00 35.00 37.00 38.00 39.00 40.00 41.00 42.00 78,608,654	30.00	BAD DEBTS		3, 828, 352			30.00
33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY)  0 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer)  33.00 34.00 34.00 35.00 36.00 37.00 38.00 39.00 40.00 41.00 42.00 78.608.654	31.00			0			31.00
34.00 35.00 36.00 Total additions (sum of lines 30-35) 37.00 BEDUCT (SPECIFY) 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 34.00 35.00 35.00 36.00 37.00 38.00 39.00 40.00 41.00 42.00 78.608.654	32.00			0			32.00
35.00 36.00 Total additions (sum of lines 30-35) 37.00 BEDUCT (SPECIFY) 0 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 35.00 35.00 36.00 37.00 36.00 37.00 0 0 0 0 0 0 0 41.00 0 78,608,654	33.00			0			33.00
36.00 Total additions (sum of lines 30-35) 37.00 DEDUCT (SPECIFY) 0 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 38.00 0 39.00 0 40.00 41.00 78,608,654	34.00			0			34.00
37. 00 38. 00 38. 00 39. 00 40. 00 41. 00 42. 00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer  37. 00 0 37. 00 0 38. 00 0 0 40. 00 41. 00 41. 00 78, 608, 654	35.00			0			35.00
38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 78,608,654 43.00	36.00	Total additions (sum of lines 30-35)			3, 828, 352		36.00
39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 78,608,654 39.00 41.00 78,608,654 43.00	37.00	DEDUCT (SPECIFY)		0			37.00
40.00 41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 78,608,654 43.00	38.00			0			38.00
41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 78,608,654 43.00	39.00			0			39.00
42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 78,608,654 43.00				0			40.00
42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 78,608,654 43.00	41.00			0			41.00
	42.00	Total deductions (sum of lines 37-41)			0		42.00
to Wkst. G-3, line 4)	43.00	Total operating expenses (sum of lines 29 and 36 minus line 42	)(transfer		78, 608, 654		43.00
		to Wkst. G-3, line 4)					

Health Financial Systems RICHLAND MEMORIAL HOSPITAL I	In Lieu of Form CMS-2552-10
STATEMENT OF REVENUES AND EXPENSES Provider CCN: 14-0147 Period:	Worksheet G-3
From 01/01 To 12/31	1/2023 1/2023 Date/Time Prepared: 5/31/2024 10:42 am
	1.00
	1.00
1.00 Total patient revenues (from Wkst. G-2, Part I, column 3, line 28) 2.00 Less contractual allowances and discounts on patients' accounts	246, 153, 289 1. 00 178, 049, 875 2. 00
3.00 Net patient revenues (line 1 minus line 2)	178, 049, 875 2. 00 68, 103, 414 3. 00
4.00 Less total operating expenses (from Wkst. G-2, Part II, line 43)	78, 608, 654 4. 00
5.00 Net income from service to patients (line 3 minus line 4)	-10, 505, 240 5. 00
OTHER I NCOME	1 -10, 303, 240 5. 00
6.00 Contributions, donations, bequests, etc	0 6.00
7.00 Income from investments	24, 894 7. 00
8.00 Revenues from telephone and other miscellaneous communication services	0 8.00
9.00 Revenue from television and radio service	0 9.00
10.00 Purchase discounts	0 10.00
11.00 Rebates and refunds of expenses	0 11.00
12.00 Parking Lot receipts	0 12.00
13.00 Revenue from Laundry and Linen service	0 13.00
14.00 Revenue from meals sold to employees and guests	0 14.00
15.00 Revenue from rental of living quarters	0 15.00
16.00 Revenue from sale of medical and surgical supplies to other than patients	0 16.00
17.00 Revenue from sale of drugs to other than patients	0 17.00
18.00 Revenue from sale of medical records and abstracts	0 18.00
19.00 Tuition (fees, sale of textbooks, uniforms, etc.)	0 19.00
20.00 Revenue from gifts, flowers, coffee shops, and canteen	0 20.00
21.00 Rental of vending machines	0 21.00
22.00 Rental of hospital space	0 22.00
23.00 Governmental appropriations	0 23.00
24. 00 OTHER REVENUE	503, 544 24. 00
24. 50 COVI D-19 PHE Fundi ng	0 24.50
25.00 Total other income (sum of lines 6-24)	528, 438 25. 00
26.00 Total (line 5 plus line 25)	-9, 976, 802 26. 00
27. 00 OTHER EXPENSES (SPECIFY)	0 27.00
28.00 Total other expenses (sum of line 27 and subscripts)	0 28.00
29.00   Net income (or loss) for the period (line 26 minus line 28)	-9, 976, 802   29. 00

111 46	Financial Contant	NEMODIAL HOCDITAL		£ F CMC (	DEED 40
	Financial Systems RICHLAND ATION OF CAPITAL PAYMENT	D MEMORIAL HOSPITAL Provider CCN: 14-0147	Peri od:	u of Form CMS-2 Worksheet L	2552-10
CALCUL	ATION OF CALLIAL PAINLINE	110VI del CCN. 14-0147	From 01/01/2023	Parts I-III	
			To 12/31/2023		
		Title XVIII	Hospi tal	5/31/2024 10: PPS	42 am_
		II the XVIII	поѕрі таі	PF3	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			327, 888	1.00
1. 01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2.00	Capital DRG outlier payments			0	2.00
2. 01 3. 00	Model 4 BPCI Capital DRG outlier payments Total inpatient days divided by number of days in the	s cost reporting period (see inc	tructions)	0 9. 95	2. 01 3. 00
4. 00	Number of interns & residents (see instructions)	le cost reporting perrou (see mis	tructrons)	0.00	4.00
5. 00	Indirect medical education percentage (see instructi	ons)		0.00	
6. 00	Indirect medical education adjustment (multiply line		1. columns 1 and	0.00	6.00
	1.01) (see instructions)	,	, , , , , , , , , , , , , , , , , , , ,	_	
7. 00	Percentage of SSI recipient patient days to Medicare	e Part A patient days (Worksheet E	E, part A line	0. 00	7. 00
8. 00	30) (see instructions) Percentage of Medicaid patient days to total days (s	caa instructions)		0. 00	8. 00
9. 00	Sum of lines 7 and 8	see Thistructions)		0.00	
10.00	Allowable disproportionate share percentage (see ins	structions)			10.00
11. 00	Disproportionate share adjustment (see instructions)			0	11.00
12.00	Total prospective capital payments (see instructions			327, 888	12.00
	I			1. 00	
4 00	PART II - PAYMENT UNDER REASONABLE COST		T		
1. 00 2. 00	Program inpatient routine capital cost (see instruct Program inpatient ancillary capital cost (see instru			0	1. 00 2. 00
2. 00 3. 00	Total inpatient program capital cost (see Institutional Inpatient program capital cost (line 1 plus li			0	3.00
4. 00	Capital cost payment factor (see instructions)	116 2)		0	4.00
5. 00	Total inpatient program capital cost (line 3 x line	4)		0	5. 00
		,			
				1. 00	
4 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1. 00 2. 00	Program inpatient capital costs (see instructions)	roumatanass (ass i natruations)		0	1.00 2.00
2. 00 3. 00	Program inpatient capital costs for extraordinary ci Net program inpatient capital costs (line 1 minus li			0	3.00
4. 00	Applicable exception percentage (see instructions)	116 2)		0.00	
5. 00	Capital cost for comparison to payments (line 3 x li	ne 4)		0.00	5.00
6. 00	Percentage adjustment for extraordinary circumstance	,		0.00	
7.00	Adjustment to capital minimum payment level for extr	raordinary circumstances (line 2 )	x line 6)	0	7. 00
8.00	Capital minimum payment level (line 5 plus line 7)			0	8. 00
9. 00	Current year capital payments (from Part I, line 12,			0	9. 00
10.00	Current year comparison of capital minimum payment I			0	10.00
11. 00	Carryover of accumulated capital minimum payment lev Worksheet L, Part III, line 14)	vel over capital payment (from pri	or year	0	11. 00
12.00	Net comparison of capital minimum payment level to c	apital payments (line 10 plus lin	ne 11)	0	12.00
13.00	Current year exception payment (if line 12 is positi			0	13.00
14.00	Carryover of accumulated capital minimum payment lev		following period	0	14.00
	(if line 12 is negative, enter the amount on this li				
15.00	Current year allowable operating and capital payment	,		0	
16.00	Current year operating and capital costs (see instru Current year exception offset amount (see instruction			0	16. 00 17. 00
17.00	Tourrent year exception oriset amount (see instruction	nis)	I	U	17.00

Heal th	Financial Systems	RICHLAND MEMOR	LAL HOSPLTAL		In lie	u of Form CMS-:	2552-10
	SIS OF HOSPITAL-BASED RHC/FOHC COSTS	TO OTHER MEMORY	Provi der C	CN: 14-0147	Peri od:	Worksheet M-1	
7	, o c			CCN: 14-8548	From 01/01/2023 To 12/31/2023		pared:
					RHC I	Cost	
	·	Compensation	Other Costs	Total (col.	1 Reclassi fi cat	Recl assi fi ed	
		·		+ col . 2)	i ons	Trial Balance	
						(col. 3 +	
						col. 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	465, 319	70, 077			535, 396	1
2.00	Physician Assistant	132, 072	19, 890	1		151, 962	2.00
3.00	Nurse Practitioner	0	0	1	0	0	
4.00	Visiting Nurse	0	0		0 0	0	
5. 00	Other Nurse	207, 438	31, 240	238, 6	78 0	238, 678	1
6. 00	Clinical Psychologist	0	0	1	0	0	
7. 00	Clinical Social Worker	0	0	1	0	0	
7. 10	Marriage and Family Therapist						7. 10
7. 11	Mental Health Counselor						7. 11
8.00	Laboratory Technician	0	0		0	0	
9.00	Other Facility Health Care Staff Costs	0	0	00/ 0	0 0	0	
10.00	Subtotal (sum of lines 1 through 9)	804, 829	121, 207	926, 0		926, 036	
11.00	Physician Services Under Agreement	0	0	1	0 0	0	
12. 00 13. 00	Physician Supervision Under Agreement	0	0	1	0 0	0	12. 00 13. 00
	Other Costs Under Agreement	0	0		0 0	0	
14. 00 15. 00	Subtotal (sum of lines 11 through 13) Medical Supplies	0	34, 843	34, 8	9	34, 843	
16. 00	Transportation (Health Care Staff)	0	34, 643	34, 0	0 0	34, 643	
17. 00	Depreciation-Medical Equipment	0	0		0 0	0	
18. 00	Professional Liability Insurance	0	0		0 0	0	18.00
19. 00		0	0			0	
20. 00	Allowable GME Costs	J	0	1	0		20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	34, 843	34, 8	43 0	34, 843	
22. 00	Total Cost of Health Care Services (sum of	804, 829	156, 050			960, 879	
22.00	lines 10, 14, and 21)	001,027	100,000	700,0	, ,	,00,017	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0		0 0	0	23. 00
24.00	Dental	o	0		0 0	0	24.00
25.00	Optometry	0	0		0 0	0	25.00
25. 01	Tel eheal th	o	0		0 0	0	25. 01
25. 02	Chronic Care Management	0	0		0 0	0	25. 02
26.00	All other nonreimbursable costs	0	0		0 0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0	1	0 0	0	28. 00
	through 27)						
	FACILITY OVERHEAD						
29. 00	Facility Costs	0	35, 766			35, 766	
30.00	Administrative Costs	192, 866	96, 998			392, 265	
31.00	Total Facility Overhead (sum of lines 29 and	192, 866	132, 764	325, 6	30 102, 401	428, 031	31.00
	(30)	1		I			I

997, 695

1, 286, 509

102, 401

1, 388, 910 32.00

288, 814

30)

32.00 Total facility costs (sum of lines 22, 28 and 31)

Health Financial Systems	RICHLAND MEMOR	IAL HOSPITAL			In Lie	u of Form CMS-2	2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CCN: 14-0147	Peri od:		Worksheet M-1	
		C	CCN 14 0F40	From 01/			
		component	CCN: 14-8548	10 12/	31/2023	Date/Time Pre 5/31/2024 10:	
				RHC	: 1	Cost	
	Adjustments	Net Expenses					
		for					
		Allocation					

				RHC I COST	
		Adjustments	Net Expenses		
			for		
			Allocation		
			(col. 5 +		
			col. 6)		
		6. 00	7. 00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physi ci an	0	535, 396		1.00
2.00	Physician Assistant	0	151, 962		2.00
3.00	Nurse Practitioner	0	0		3. 00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	238, 678		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7. 00
7. 10	Marriage and Family Therapist				7. 10
7. 11	Mental Health Counselor				7. 11
8.00	Laboratory Techni ci an	0	0		8. 00
9. 00	Other Facility Health Care Staff Costs	0	0		9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	926, 036		10.00
11. 00	Physician Services Under Agreement	0	0		11.00
12. 00	Physician Supervision Under Agreement	0	0		12.00
13. 00	Other Costs Under Agreement	0	ĺ	•	13. 00
14. 00	Subtotal (sum of lines 11 through 13)	0			14. 00
15. 00	Medical Supplies	0	34, 843		15. 00
16.00	Transportation (Health Care Staff)	0	34, 643		16.00
17. 00	Depreciation-Medical Equipment	0			17. 00
18.00	Professional Liability Insurance	0			18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	U	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	34, 843		21.00
21.00	Total Cost of Health Care Services (sum of	0	· ·	l control of the cont	22.00
22.00	lines 10, 14, and 21)	U	900, 679		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				-
23. 00	Pharmacy	0	0		23. 00
24. 00	Dental	0			24.00
25. 00	Optometry	0	0		25. 00
25. 00	Tel eheal th	0		1	25. 00
25. 01	1	0	0	i e	25. 01
	Chronic Care Management All other nonreimbursable costs	0	0	1	26.00
26.00	4	U	U		
27. 00	Nonallowable GME costs	0			27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	Ü	0		28. 00
	through 27)				_
20.00	FACILITY OVERHEAD	0	35, 766		29. 00
29.00	Facility Costs	-			
30.00	Administrative Costs	36, 384		l e e e e e e e e e e e e e e e e e e e	30.00
31. 00	Total Facility Overhead (sum of lines 29 and	36, 384	464, 415		31.00
22.00	30)	07 204	1 405 004		22.00
32. 00	Total facility costs (sum of lines 22, 28	36, 384	1, 425, 294		32.00
	and 31)		I	I	1

	<i></i>	RI CHLAND MEMOR		ON 44 0447		u of Form CMS-	
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CN: 14-0147	Peri od: From 01/01/2023	Worksheet M-1	
			Component	CCN: 13-8584	To 12/31/2023		pared: 42 am
					RHC II	Cost	
		Compensation	Other Costs	Total (col.	1 Reclassi fi cat	Recl assi fi ed	
				+ col . 2)	i ons	Trial Balance	
						(col. 3 +	
		1.00	2.22		4 00	col . 4)	
	FACILITY HEALTH CARE CTAFE COCTO	1. 00	2. 00	3. 00	4. 00	5. 00	
1 00	FACILITY HEALTH CARE STAFF COSTS	1 450 170	107 700	1 (40 0)	20 0	1 (40 000	1 00
1.00	Physician Assistant	1, 452, 172	197, 720			, ,	
2. 00 3. 00	Physician Assistant Nurse Practitioner	480, 432 781, 469	65, 413 106, 401			545, 845 887, 870	
4. 00	Visiting Nurse	701, 409	100, 401	1	0 0	087,870	1
5. 00	Other Nurse	524, 625	71, 430		-	596, 055	
6. 00	Clinical Psychologist	524, 025	71, 430	370, 0	0	0 340,033	
7. 00	Clinical Social Worker	0	0			0	
7. 10	Marriage and Family Therapist	J	0			Ĭ	7. 10
7. 10	Mental Health Counselor						7. 10
8. 00	Laboratory Techni ci an	0	0		0	0	
9. 00	Other Facility Health Care Staff Costs	0	0		0 0	o o	
10.00	Subtotal (sum of lines 1 through 9)	3, 238, 698	440, 964	3, 679, 60	52 0	3, 679, 662	
11. 00	Physician Services Under Agreement	0	0		0 0	0	
12. 00	Physician Supervision Under Agreement	O	0		0 0	0	12.00
13.00	Other Costs Under Agreement	0	0		0 0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		0 0	0	14.00
15.00	Medical Supplies	0	203, 966	203, 90	66 0	203, 966	15.00
16.00	Transportation (Health Care Staff)	0	0		0 0	0	16.00
17.00	Depreciation-Medical Equipment	0	0		0	0	17. 00
18.00	Professional Liability Insurance	0	0	1	0	0	
19. 00		0	0	1	0	0	
20.00	Allowable GME Costs						20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	203, 966			203, 966	1
22. 00	Total Cost of Health Care Services (sum of	3, 238, 698	644, 930	3, 883, 62	28 0	3, 883, 628	22. 00
	lines 10, 14, and 21)						
23. 00	COSTS OTHER THAN RHC/FQHC SERVICES Pharmacy	O	0		0 0	0	23. 00
24. 00	Dental	0	0	l .		0	
25. 00	Optometry	0	0			0	
25. 00	Tel eheal th	0	0			0	
25. 01		0	0			0	
26. 00	All other nonreimbursable costs	0	0			Ö	
27. 00	Nonallowable GME costs	Ŭ				Ĭ	27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0	,	0 0	0	
	through 27)						
	FACILITY OVERHEAD						
29. 00	Facility Costs	0	339, 644	339, 64	14 0	339, 644	29. 00
30.00	Administrative Costs	1, 154, 582	493, 964			,	
31.00	Total Facility Overhead (sum of lines 29 and	1, 154, 582	833, 608	1, 988, 19	584, 998	2, 573, 188	31.00
	30)			1		l	

4, 393, 280

1, 478, 538

5, 871, 818

584, 998

6, 456, 816 32.00

30)

32.00 Total facility costs (sum of lines 22, 28 and 31)

Health Financial Systems	RICHLAND MEMORIAL	L HOSPI TAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider CCN: 14-0147	Peri od: From 01/01/2023	Worksheet M-1
		Component CCN: 13-8584	To 12/31/2023	Date/Time Prepared: 5/31/2024 10:42 am
			RHC II	Cost
	A -11	- + F		

						5/31/2024 10:	42 am
					RHC II	Cost	
		Adjustments	Net Expenses				
		-	for				
			Allocation				
			(col. 5 +				
			col. 6)				
		6. 00	7. 00				
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	0	1, 649, 892				1.00
2.00	Physician Assistant	0	545, 845				2.00
3.00	Nurse Practitioner	0	887, 870				3.00
4.00	Visiting Nurse	0	0				4.00
5.00	Other Nurse	0	596, 055				5.00
6.00	Clinical Psychologist	0	0				6.00
7. 00	Clinical Social Worker	0	0				7. 00
7. 10	Marriage and Family Therapist	ŭ					7. 10
7. 11	Mental Health Counselor						7. 11
8. 00	Laboratory Techni ci an	0	0				8.00
9. 00	Other Facility Health Care Staff Costs	0	0				9.00
10.00	Subtotal (sum of lines 1 through 9)	0	3, 679, 662				10.00
11. 00	Physician Services Under Agreement	0	0,077,002	1			11.00
12. 00	Physician Supervision Under Agreement	0	0				12.00
13. 00	Other Costs Under Agreement	0	0				13.00
14. 00	Subtotal (sum of lines 11 through 13)	0					14.00
15. 00	Medical Supplies	0	203, 966				15.00
16. 00	, .,	0	203, 900	1			16.00
	Transportation (Health Care Staff)	0	0				
	, · · · · · · · · · · · · · · · · · · ·	0	0				17. 00 18. 00
18.00	1	0	0				
	Other Health Care Costs	U	0				19.00
20.00	Allowable GME Costs		202 0//				20.00
21. 00	, , ,	0	203, 966				21.00
22. 00	Total Cost of Health Care Services (sum of	0	3, 883, 628				22. 00
	lines 10, 14, and 21)						_
22 00	COSTS OTHER THAN RHC/FQHC SERVICES	0					22.00
23. 00	1 ,	0	0				23.00
24. 00	Dental	0	0				24.00
25. 00	Optometry	0	0				25. 00
25. 01	Tel eheal th	0	0				25. 01
25. 02	Chronic Care Management	0	0				25. 02
26. 00	All other nonreimbursable costs	0	0				26. 00
27. 00	Nonallowable GME costs						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0				28. 00
	through 27) FACILITY OVERHEAD						-
29 00	Facility Costs	0	339, 644				29. 00
30.00	Administrative Costs	196, 353					30.00
31. 00	Total Facility Overhead (sum of lines 29 and		, , , , , , , , , , , , , , , , , , , ,	1			31.00
31.00	30)	170, 333	2,707,341				31.00
32. 00	Total facility costs (sum of lines 22, 28	196, 353	6, 653, 169				32.00
JZ. 00	and 31)	170, 333	0,000,109				32.00
	Tana OT/		1	I			I

	Financial Systems	RI CHLAND MEMOR	RIAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C	CN: 14-0147	Peri od:	Worksheet M-2	
			Component	CCN: 14-8548	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/31/2024 10:	
					RHC I	Cost	
		Number of FTE	Total Visits	Producti vi ty		Greater of	
		Personnel		Standard (1)	,	col. 2 or	
		1.00	0.00		1 x col . 3)	col . 4	
	hu ou to the propulative to	1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						-
1 00	Posi ti ons	1 00	2.755	4.20	20 4 200		1 00
1. 00 2. 00	Physi ci an Physi ci an Assi stant	1. 00 0. 00		· ·			1.00 2.00
3. 00	Nurse Practitioner	0.00					3.00
4. 00	Subtotal (sum of lines 1 through 3)	1. 92		2, 10	6, 132	6, 132	4.00
5. 00	Visiting Nurse	0.00			0, 132	0, 132	5.00
6. 00	Clinical Psychologist	0.00				0	6.00
7. 00	Clinical Social Worker	0.00				0	
7. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	7. 01
7. 02	Diabetes Self Management Training (FQHC	0.00				0	7. 02
	only)						
7.03	Marriage and Family Therapist						7.03
7.04	Mental Health Counselor						7.04
8.00	Total FTEs and Visits (sum of lines 4	1. 92	5, 291			6, 132	8. 00
	through 7)						
9. 00	Physician Services Under Agreements		0			0	9.00
						4 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	0 HOSPI TAL-BASI	ED RHC/FQHC SEI	RVICES		1. 00	
10.00	Total costs of health care services (from Wk	st. M-1, col.	7, line 22)			960, 879	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line	28)			0	11.00
12.00	Cost of all services (excluding overhead) (s					960, 879	12.00
13.00	Ratio of hospital-based RHC/FQHC services (I					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (fr			ne 31)		464, 415	
15.00	Parent provider overhead allocated to facili	ty (see instru	ctions)			865, 370	
16. 00	Total overhead (sum of lines 14 and 15)					1, 329, 785	
17. 00	Allowable GME overhead (see instructions)					0	17.00
18. 00	Enter the amount from line 16					1, 329, 785	
19.00	Overhead applicable to hospital-based RHC/FO					1, 329, 785	
20. 00	Total allowable cost of hospital-based RHC/F	UHC SERVICES (	sum of lines 10	J and 19)		2, 290, 664	J 20.00

Heal th	n Financial Systems	RI CHLAND MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	ATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der Co		Peri od:	Worksheet M-2	
			Component (		From 01/01/2023 To 12/31/2023	Date/Time Pre 5/31/2024 10:	
					RHC II	Cost	
		Number of FTE	Total Visits	Producti vi ty		Greater of	
		Personnel		Standard (1)	,	col. 2 or	
		1. 00	2. 00	3.00	1 x col . 3) 4.00	col . 4 5. 00	
	VISITS AND PRODUCTIVITY	1.00	2.00	3.00	4.00	5.00	
	Posi ti ons						
1.00	Physi ci an	3. 24	9, 587	4, 20	0 13, 608		1.00
2.00	Physician Assistant	2. 77	7, 194	2, 10	5, 817		2.00
3.00	Nurse Practitioner	4. 74	12, 320	2, 10	9, 954		3.00
4.00	Subtotal (sum of lines 1 through 3)	10. 75	29, 101		29, 379	29, 379	4.00
5.00	Visiting Nurse	0.00	0			0	
6.00	Clinical Psychologist	0.00	0			0	
7. 00	Clinical Social Worker	0.00				0	1
7. 01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	
7. 02	Diabetes Self Management Training (FQHC	0.00	0			0	7. 02
7 02	only)						7. 03
7. 03 7. 04	Marriage and Family Therapist Mental Health Counselor						7.03
8. 00	Total FTEs and Visits (sum of lines 4	10. 75	29, 101			29, 379	8.00
0.00	through 7)	10.75	29, 101			27, 377	0.00
9. 00	Physician Services Under Agreements		0			0	9. 00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T			RVICES			
10.00						3, 883, 628	
11.00						0	
12. 00 13. 00	, , ,					3, 883, 628 1, 000000	1
14. 00	,			no 21)		2, 769, 541	
15. 00				116 31)		3, 335, 837	
16. 00	·	ty (see Ilistiu	ctions)			6, 105, 378	ł
17. 00	,					0, 103, 370	1
18. 00						6, 105, 378	
19. 00		HC services (li	ine 13 x line 1	18)		6, 105, 378	
	Total allowable cost of hospital-based RHC/F				ŀ	9, 989, 006	

	Financial Systems RICHLAND MEMORIAL			u of Form CMS-2	
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 14-0147	Peri od: From 01/01/2023	Worksheet M-3	
SERVI C	£5	Component CCN: 14-8548	To 12/31/2023	Date/Time Pre	pared
				5/31/2024 10:	42 am
		Title XVIII	RHC I	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
. 00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro	m Wkst. M-2, line 20)		2, 290, 664	1. (
. 00	Cost of injections/infusions and their administration (from ${\tt W}$			96, 272	2. (
. 00	Total allowable cost excluding injections/infusions (line 1 m	ninus line 2)		2, 194, 392	3.0
. 00	Total Visits (from Wkst. M-2, column 5, line 8) Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		6, 132 0	4. 5.
. 00	Total adjusted visits (line 4 plus line 5)	11 ne 9)		6, 132	6.
. 00	Adjusted cost per visit (line 3 divided by line 6)			357. 86	7.
			Cal cul ati on	of Limit (1)	
				Rate Period 1	
			N/A	(01/01/2023	
				through 12/31/2023)	
			1. 00	2. 00	
. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	0.6 or your contractor)	348. 87	348. 87	8. (
. 00	Rate for Program covered visits (see instructions)		0.00	348. 87	9.
	CALCULATION OF SETTLEMENT			4 000	
	Program covered visits excluding mental health services (from		0	1, 833 639, 479	
2. 00	Program cost excluding costs for mental health services (line Program covered visits for mental health services (from contr	*	0	039, 479	1
3. 00	Program covered cost from mental health services (line 9 x li	•	0	0	13.
4. 00	Limit adjustment for mental health services (see instructions	•	0	0	14.
5.00	Graduate Medical Education Pass Through Cost (see instruction				15.
6.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	,	0	639, 479	
6. 01 6. 02	Total program charges (see instructions)(from contractor's re Total program preventive charges (see instructions)(from prov			524, 330 0	16. 16.
6. 03	Total program preventive costs ((line 16.02/line 16.01) times			0	16.
6. 04	Total Program non-preventive costs ((line 16 minus lines 16.0	•		478, 109	
	(Titles V and XIX see instructions.)				
6. 05	Total program cost (see instructions)		0	478, 109	
7. 00 8. 00	Primary payer amounts Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		0 41, 843	17. 18.
0.00	records)	(110m contractor		41,043	'0.
9. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction	ons) (from contractor		94, 592	19. (
	records)				
0. 00 1. 00	Net program cost excluding injections/infusions (see instruct Program cost of vaccines and their administration (from Wkst.			478, 109	
1. 50	Total program IOP OPPS payments (see instructions)	W-4, TITIE 10)		54, 525	21.
1. 55	Total program IOP Costs (see instructions)				21.
1. 60	Program IOP deductible and coinsurance (see instructions)				21.
2. 00	Total reimbursable Program cost (sum of lines 20, 21, 21.50,	minus line 21.60)		532, 634	
	Allowable bad debts (see instructions)			0	
	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
5. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	i deti ons)		0	
5. 50	Pioneer ACO demonstration payment adjustment (see instruction	ıs)		0	25.
5. 99	Demonstration payment adjustment amount before sequestration			0	25.
6.00	Net reimbursable amount (see instructions)			532, 634	
6. 01 6. 02	Sequestration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration			10, 653 0	26. 26.
	Interim payments			449, 371	
8. 00	Tentative settlement (for contractor use only)			0	28.
9. 00	Balance due component/program (line 26 minus lines 26.01, 26.			72, 610	
30.00	Protested amounts (nonallowable cost report items) in accorda	ince with CMS Pub. 15-II	.	0	

CALCUL	Financial Systems RICHLAND MEMORIAL ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC		Peri od:	u of Form CMS-2 Worksheet M-3	
SERVI C		Component CCN: 13-8584	From 01/01/2023 To 12/31/2023	Date/Time Pre	pared
		Title XVIII	RHC II	5/31/2024 10: Cost	42 am
		I the will	RHC II	'	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1. 00	
. 00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro	om Wkst. M-2. line 20)		9, 989, 006	1.0
2. 00	Cost of injections/infusions and their administration (from W			558, 006	1
. 00	Total allowable cost excluding injections/infusions (line 1 m			9, 431, 000	1
. 00	Total Visits (from Wkst. M-2, column 5, line 8)			29, 379	4.
. 00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	
. 00	Total adjusted visits (line 4 plus line 5)			29, 379	1
7. 00	Adjusted cost per visit (line 3 divided by line 6)		Cal cul ati on	321.01 of Limit (1)	7.0
			Rate Period	Rate Period 1	
			N/A	(01/01/2023	
				through	
				12/31/2023)	
			1. 00	2. 00	
. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	). 6 or your contractor)	330. 02 0. 00	330. 02	1
	Rate for Program covered visits (see instructions)  CALCULATION OF SETTLEMENT		0.00	321. 01	9.
0. 00	Program covered visits excluding mental health services (from	contractor records)	0	3, 920	10.
1. 00	Program cost excluding costs for mental health services (line		0	1, 258, 359	11.
2. 00	Program covered visits for mental health services (from contr	-	0	0	1
3. 00	Program covered cost from mental health services (line 9 x li	•	0	0	
4. 00	Limit adjustment for mental health services (see instructions		0	0	
5. 00 6. 00	Graduate Medical Education Pass Through Cost (see instruction Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	1, 258, 359	15.
6. 01	Total program charges (see instructions)(from contractor's re		0	1, 109, 600	1
6. 02	Total program preventive charges (see instructions) (from prov	•		0	1
6. 03	Total program preventive costs ((line 16.02/line 16.01) times	•		0	1
6. 04	Total Program non-preventive costs ((line 16 minus lines 16.0	03 and 18) times .80)		935, 545	16.
/ OF	(Titles V and XIX see instructions.)		0	025 545	1,
6. 05 7. 00	Total program cost (see instructions) Primary payer amounts		U	935, 545 0	
8. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		88, 928	
	records)	(			
9. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ons) (from contractor		197, 613	19. (
0. 00	Net program cost excluding injections/infusions (see instruct	ti ons)		935, 545	20.
1. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		148, 638	21.
1. 50	Total program IOP OPPS payments (see instructions)				21.
1. 55	Total program IOP Costs (see instructions)				21.
1. 60 2. 00	Program IOP deductible and coinsurance (see instructions) Total reimbursable Program cost (sum of lines 20, 21, 21.50,	minus Lino 21 60)		1, 084, 183	21.
	Allowable bad debts (see instructions)	illi ilus i i ile 21.00)		1,084,183	1
				0	
	Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		0	
5. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.
5. 50	Pioneer ACO demonstration payment adjustment (see instruction	ns)		0	
5. 99	Demonstration payment adjustment amount before sequestration			0	
6.00	Net reimbursable amount (see instructions)			1, 084, 183	1
26. 01 26. 02	Sequestration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration			21, 684 0	
7. 00	Interim payments			827, 059	
	Tentative settlement (for contractor use only)			027,007	1
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.	02, 27, and 28)		235, 440	
	Protested amounts (nonallowable cost report items) in accorda	noo with CMC Dub 1E II		0	30.

COMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der CO		Peri od: From 01/01/2023	Worksheet M-4	
		Component (	CCN: 14-8548	To 12/31/2023	Date/Time Pre 5/31/2024 10:	
			XVIII	RHC I	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2. 01	2. 02	
1. 00 2. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health	926, 036 0. 007074	926, 03 0. 00281		926, 036 0. 000000	
3. 00	care staff time Injection/infusion health care staff cost (line 1 x line 2)	6, 551	2, 61	0 2, 637	0	3.00
4. 00	Injections/infusions and related medical supplies costs (from your records)	17, 616	10, 97	0 0	0	4. 00
5. 00 6. 00	Direct cost of injections/infusions (line 3 plus line 4) Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	24, 167 960, 879	13, 58 960, 87		0 960, 879	5. 00 6. 00
7. 00 8. 00	Total overhead (from Wkst. M-2, line 19) Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	1, 329, 785 0. 025151	1, 329, 78 0. 01413	· · ·	1, 329, 785 0. 000000	
9. 00 10. 00	Overhead cost – injection/infusion (line 7 x line 8) Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	33, 445 57, 612	18, 79 32, 37		0	9. 00 10. 00
11. 00 12. 00	Total number of injections/infusions (from your records) Cost per injection/infusion (line 10/line 11)	94 612. 89	31 102. 1		0 0. 00	
13. 00	Number of injection/infusion administered to Program beneficiaries	55	17		0	
13. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees	00 700	4- 4	0	0	
14. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	33, 709	17, 46	3, 352	0	14.00
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATIO N	
				1. 00	2. 00	
15. 00	Total cost of injections/infusions and their administratio 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.	•	columns 1,		96, 272	15. 00
14 00	Total Program cost of injections/infusions and their admin		c (cum of		54, 525	16, 00

COMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der Co		Period: From 01/01/2023	Worksheet M-4	
		Component (		To 12/31/2023	Date/Time Pre 5/31/2024 10:	
			XVIII	RHC II	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2. 01	2. 02	
1. 00 2. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health	3, 679, 662 0. 007171	3, 679, 66 0. 01167		3, 679, 662 0. 000000	
3. 00	care staff time Injection/infusion health care staff cost (line 1 x line 2)	26, 387	42, 96	12, 566	0	3.00
4. 00	Injections/infusions and related medical supplies costs (from your records)	103, 820	31, 21	0	0	4. 00
5. 00 6. 00	Direct cost of injections/infusions (line 3 plus line 4) Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	130, 207 3, 883, 628	74, 17 3, 883, 62	· ·	0 3, 883, 628	5. 00 6. 00
7. 00 8. 00	Total overhead (from Wkst. M-2, line 19) Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	6, 105, 378 0. 033527	6, 105, 37 0. 01909		6, 105, 378 0. 000000	
9. 00 10. 00	Overhead cost - injection/infusion (line 7 x line 8) Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	204, 695 334, 902	116, 60 190, 78		0	9. 00 10. 00
11. 00 12. 00	Total number of injections/infusions (from your records) Cost per injection/infusion (line 10/line 11)	554 604, 52	90 211. 5		-	
13. 00	Number of injection/infusion administered to Program beneficiaries	120	29		0	
13. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. 01
14. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	72, 542	62, 39	95 13, 701	0	14. 00
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATIO N	
				1. 00	2. 00	
15. 00	Total cost of injections/infusions and their administratio 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.	•	f columns 1,		558, 006	15. 00
16.00	Total Program cost of injections/infusions and their admin		s (sum of		148, 638	16.00

Health Financial Systems	RICHLAND MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIA		Provi der CCN: 14-0147 Component CCN: 14-8548	From 01/01/2023 To 12/31/2023	
				_

		Component CCN: 14-8548	To 12/31/2023	Date/Time Prep 5/31/2024 10:4	
			RHC I	Cost	
			Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
1. 00	Total interim payments paid to hospital-based RHC/FQHC			449, 371	1. 00
2.00	Interim payments payable on individual bills, either submit	ted or to be submitted to		0	2.00
	the contractor for services rendered in the cost reporting	period. If none, write			
	"NONE" or enter a zero				
3.00	List separately each retroactive lump sum adjustment amount	based on subsequent			3.00
	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)				
	Program to Provider				
3. 01				0	3. 01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
	Provider to Program				
3.50				0	3.50
3. 51				0	3. 51
3. 52				0	3. 52
3.53				0	3.53
3.54				0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		0	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	fer to Worksheet M-3, line	е	449, 371	4.00
	27)				
	TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after des each payment. If none, write "NONE" or enter a zero. (1)	k review. Also show date o	of		5.00
	Program to Provider				
5. 01	i rogram to rrovider			0	5. 01
5. 02				0	5. 02
5. 03				0	5. 03
5. 05	Provider to Program			U	3.00
5. 50	1 TOVI GCT TO TITOGI GIII			0	5. 50
5. 51				0	5. 51
5. 52				0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	08)		0	5. 99
6. 00	Determined net settlement amount (balance due) based on the			ا	6. 00
6. 01	SETTLEMENT TO PROVIDER	. 3031 report. (1)		72, 610	6. 01
6. 02	SETTLEMENT TO PROGRAM			72,010	6. 02
7. 00	Total Medicare program liability (see instructions)			521, 981	7. 00
7.00	Tiotal medicare program traditity (see instructions)		Contractor	NPR Date	7.00
			Number	(Mo/Day/Yr)	
		0	1. 00	2. 00	

Health Financial Systems	RI CHLAND MEMORI AL	HOSPI TAL	In Lieu	u of Form CMS	5-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED F SERVICES RENDERED TO PROGRAM BENEFICIARI		Provider CCN: 1 Component CCN:	 Peri od: From 01/01/2023 To 12/31/2023		repared:

				5/31/2024 10: 4	42 a
			RHC II	Cost	
			Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
00	Total interim payments paid to hospital-based RHC/FQHC			827, 059	1.
00	Interim payments payable on individual bills, either submit	ted or to be submitted to		0	2.
	the contractor for services rendered in the cost reporting				
	"NONE" or enter a zero				
00	List separately each retroactive lump sum adjustment amount	based on subsequent			3.
	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)				
	Program to Provider				
01				0	3.
02				o	3.
03				o	3
)4				0	3
05				o	3
	Provider to Program				
50				0	3
51				l ol	3
52				l ol	3
3				l ol	3
54				l ol	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		ا ا	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans			827, 059	4
	27)				
	TO BE COMPLETED BY CONTRACTOR		-		
00	List separately each tentative settlement payment after des	sk review. Also show date o	f		5
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
)1				0	5
)2				l ol	5
)3				0	5
	Provider to Program				
50				0	5
51				0	5
2				0	5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)				6
)1	SETTLEMENT TO PROVIDER			235, 440	6
)2	SETTLEMENT TO PROGRAM			0	6
00	Total Medicare program liability (see instructions)			1, 062, 499	7
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2.00	
00	Name of Contractor				8.