Heal th Financia	al Systems		RI VERVI EW	I HOSPI	TAL		In Lie	u of Form CM	S-2552-10
This report is	s required by law (4	2 USC 1395g;	42 CFR 413.20(b)).	Failu	re to report c	an resul	t in all interim	FORM APPROV	/ED
payments made	since the beginning	of the cost	reporting period be	eing d	eemed overpaym	ents (42	USC 1395g).	OMB NO. 093	8-0050
AND SETTLEMENT	SUMMARY	COMPLEX COS	ST REPORT CERTIFICATI	I ON	Provider CCN:	150059	Period: From 01/01/2015 To 12/31/2015	Worksheet S Parts I-III Date/Time P 5/19/2016 4	repared:
PART I - COST	REPORT STATUS								
Provi der	1. [X] El ectroni ca	lly filed c	ost report				Date: 5/19/20	16 Time:	4:58 pm
use only	2. [] Manually su	ibmitted cos	t report						
			report enter the num Enter "F" for full o			ovider re	esubmitted this co	ost report	
Contractor use only	5. [1]Cost Report (1) As Submitted (2) Settled with (3) Settled with (4) Reopened (5) Amended	7 out Audit 8	. Date Received: . Contractor No. . [N]Initial Repor . [N]Final Report	t for for th	this Provider is Provider CC	11. C CCN 12. [PR Date: ontractor's Vendo O]If line 5, cc number of tim	olumn 1 is 4:	
PART II - CERT	TI FI CATI ON								
ADMI NI STRATI VE PROVI DED OR PR	ACTION, FINE AND/O	R IMPRISONME PAYMENT DIRE	FORMATION CONTAINED I ENT UNDER FEDERAL LAW ECTLY OR INDIRECTLY (MENT MAY RESULT.	N. FU	RTHERMORE, IF	SERVI CES	IDENTIFIED IN TH	IIS REPORT WI	ERE
	CERTIFICATION BY	OFFICER OR	ADMINISTRATOR OF PRO	OVI DER	(S)				

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by RIVERVIEW HOSPITAL (15059) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 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. , 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.



Officer or Administrator of Provider(s)

Title

			Title	XVIII			
	Cost Center Description	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	119, 489	74, 738	29, 690	148, 129	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	20, 701	0		-31, 392	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	11, 915	0		0	7.00
200.00	Total	0	152, 105	74, 738	29, 690	116, 737	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 valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving 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.

Dato
Date

		DENTIFICATION DA	AIA	Provi	der CCN:	150059	Period: From 01/01/	2015	Workshe Part I	et S-2	
									Date/Ti 5/19/20		
	1.00		. 00	:	3.00		4	4.00	07 17720		
00	Hospital and Hospital Health Care Co Street: 395 WESTFIELD ROAD	PO Box:									1.
00	City: NOBLESVILLE	State:	IN Z	ip Code	: 46060-	Count	ty: HAMI LTON				2.
		Component N	ame	CCN	CBSA	Provi der			nt Syst		
			N	lumber	Number	Туре	Certified		0, or	1 1	-
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	Hospital and Hospital-Based Componen			2.00	3.00	1 4.00	3.00	0.00	1.00	0.00	
00	Hospi tal	RIVERVIEW HOSPIT	TAL 1	50059	26900	1	07/07/1966	N	Р	0	3.
0	Subprovider - IPF			FTOFO	2/000	-	01/01/1004		P		4.
0	Subprovider - IRF	RIVERVIEW HOSPIT REHAB	AL I	5T059	26900	5	01/01/1994	N		0	5.
0	Subprovider - (Other)										6.
0	Swing Beds - SNF										7.
0	Swing Beds - NF				24000		10/0/ /1000	N	P	N	8.
0 00	Hospital-Based SNF Hospital-Based NF	RIVERVIEW HOSPIT	AL SNF I	55669	26900		10/26/1999	N		N	9.
00	Hospi tal -Based OLTC										111.
00	Hospital-Based HHA										12.
00	Separately Certified ASC										13
00 00	Hospital-Based Hospice Hospital-Based Health Clinic - RHC										14
00	Hospital -Based Health Clinic - FQHC										16.
00	Hospital-Based (CMHC) I										17.
00 00	Renal Dialysis Other										18
00	other						From:		То	I	19
							1.00		2. (
00	Cost Reporting Period (mm/dd/yyyy)						01/01/2		12/31/	/2015	20
00	Type of Control (see instructions)							9			21
00	Does this facility qualify and is it	currently receiv	ving pavme	nts for	di sprop	ortionate	Y		N	1	22.
	share hospital adjustment, in accord	ance with 42 CFR	§412.106?	In col	umn 1,	enter "Y"					
	for yes or "N" for no. Is this facil				2.06(c)(2) (Pi ckl e					
01	amendment hospital?) In column 2, en Did this hospital receive interim un				cost r	eportina	Y		Y		1 22
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION	DATA	Provi der		eriod: rom 01/01/ o 12/31/		Workshe Part I Date/Ti 5/19/20	me Pre	pared:
		H		Urban/Run 1.00			Geogr	
26.00 Enter your standard geographic classification (not			jinning of the	1.00	1	2.0		26.00
 cost reporting period. Enter "1" for urban or "2" 27.00 Enter your standard geographic classification (not reporting period. Enter in column 1, "1" for urban 	wage) sta or "2" fo	atus at the enc or rural. If ap			1			27.00
as. 00 enter the effective date of the geographic reclass If this is a sole community hospital (SCH), enter effect in the cost reporting period.			CH status in		0			35.00
				Begi nni 1. 00	-	Endi 2. (0	-
36.00 Enter applicable beginning and ending dates of SCH		Subscript line	36 for number			2.0		36.00
of periods in excess of one and enter subsequent of 37.00 If this is a Medicare dependent hospital (MDH), en is in effect in the cost reporting period.		umber of perioc	ls MDH status		0			37.00
38.00 If line 37 is 1, enter the beginning and ending da greater than 1, subscript this line for the number enter subsequent dates.								38.00
				Y/N 1.00		Y/ 2.0		-
39.00 Does this facility qualify for the inpatient hospi				N		2. C		39.00
hospitals in accordance with 42 CFR §412.101(b)(2) or "N" for no. Does the facility meet the mileage CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for y 40.00 Is this hospital subject to the HAC program reduct	requiremen ves or "N"	nts in accordar for no. (see i	nce with 42 nstructions)	N		Y		40.00
"N" for no in column 1, for discharges prior to Oc no in column 2, for discharges on or after October			ves or "N" for					
, · · · · · · · · · · · · · · · ·					V	XVIII	XIX	-
Prospective Payment System (PPS)-Capital					1.00) 2.00	3.00	
45.00 Does this facility qualify and receive Capital pay with 42 CFR Section §412.320? (see instructions)	ment for (di sproporti onat	e share in acc	ordance	N	Y	N	45.00
46.00 Is this facility eligible for additional payment e pursuant to 42 CFR §412.348(f)? If yes, complete W Pt. III.	exception /kst. L, P	for extraordina t. III and Wkst	ry circumstanc :. L-1, Pt. I t	es hrough	N	N	N	46.00
47.00Is this a new hospital under 42 CFR §412.300 PPS c48.00Is the facility electing full federal capital paym				10.	N N	N N	N N	47.00 48.00
Teaching Hospitals56.00Is this a hospital involved in training residents	in approv	ed GME programs	? Enter "Y" f	or yes	N			56.00
or "N" for no. 57.00 If line 56 is yes, is this the first cost reportin GME programs trained at this facility? Enter "Y"								57.00
is "Y" did residents start training in the first m for yes or "N" for no in column 2. If column 2 is	onth of tl "Y", com	his cost report plete Worksheet	ing period? E	nter "Y"				
"N", complete Wkst. D, Parts III & IV and D-2, Pt. 58.00 If line 56 is yes, did this facility elect cost re defined in CMS Pub. 15-1, chapter 21, §2148? If ye	i mbursemei	nt for physicia	ins' services a	IS	N			58.00
59.00 Are costs claimed on line 100 of Worksheet A? If	yes, comp	lete Wkst. D-2,			N			59.00
60.00 Are you claiming nursing school and/or allied heal provider-operated criteria under §413.85? Enter "				tions)	Y			60.00
	Y/N	IME	Direct GME	IME		Di rect	t GME	
	1.00	2.00	3.00	4.00		5.0		-
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)					0.00		0.00	61.00
61.01 Enter the average number of unweighted primary car FTEs from the hospital's 3 most recent cost report ending and submitted before March 23, 2010. (see		0.00	0.00					61.01
instructions) 61.02 Enter the current year total unweighted primary ca FTE count (excluding OB/GYN, general surgery FTEs,	ire	0.00	0.00					61.02
and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00					(1.02
61.03 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	r	0.00	0.00					61.03
 instructions) 61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the 		0.00	0.00					61.04
 current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (li 		O. OC	0.00					61.05
 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimar care or general surgery. (see instructions) 		0.00	0.00					61.06
	1	•	•		1			

OSPITAL AND HOSPITAL	HEALTH CARE COMPI	LEX IDENTIFICATION DA		F	eriod: rom 01/01/2015 o 12/31/2015	5/19/2016 4:5	pared:
			Program Name			Direct GME FTE Count	
	11 /4 67	<u> </u>	1.00	2.00	3.00	4.00	
special ty, if a for each new pr col umn 1, the p program code, c unweighted cour FTE unweighted 1.20 Of the FTEs in program special residents for c instructions) enter in column 3, the IME FTE	any, and the numbe ogram. (see instr program name, ente enter in column 3, it and enter in co count. line 61.05, speci ty, if any, and t each expanded prog enter in column 1, n 2, the program c	lumn 4, direct GME fy each expanded he number of FTE ram. (see the program name, ode, enter in column and enter in column			0.00		61. 1
						1.00	
ACA Provisions	Affecting the Hea	Ith Resources and Ser	vices Administratio	on (HRSA)		1.00	
		s that your hospital			od for which	0.00	62.00
		funding (see instructs that rotated from a		nton (TUC) into	vour boonital	0.00	62. 0 ⁻
during in this	cost reporting pe	s that rotated from a riod of HRSA THC prog sidents in Nonprovide	<u>jram. (see instructi</u>		your nospi tai	0.00	62.0
3.00 Has your facili	ty trained reside	nts in nonprovider se umn 1. If yes, comple	ettings during this	<u>e instructions)</u>		N	63.0
				Unweighted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col.	
				Nonprovi der Si te	Hospi tal	2))	
0				1.00	2.00	3.00	1
		r FTE Residents in No		-This base year	is your cost r	eporting	
4.00 Enter in column in the base yea resident FTEs a settings. Enter resident FTEs	n 1, if line 63 is ar period, the num attributable to ro er in column 2 the chat trained in yo	uly 1, 2009 and befor yes, or your facilit ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter ir 1 + column 2)). (see	y trained residents -primary care all nonprovider i non-primary care o column 3 the ratic instructions)	,			64.0
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
year period, th associated with FTEs for each p program in whic residents. Ente the program con col umn 3, the r unweighted prir residents attri rotations occur non-provider se col umn 4, the r unweighted prir	facility the in the base program name primary care orimary care th you trained er in column 2, de, enter in number of hary care FTE butable to rring in all ettings. Enter in number of			0.00	0.00	0. 000000	

Heal th	Financial Systems	RI VI	ERVIEW HOSPI	TAL		In Li	eu of Form CMS-2	2552-10
	AL AND HOSPITAL HEALTH CARE COMP				F	Period: From 01/01/2015 Fo 12/31/2015	Worksheet S-2 Part I	pared:
					Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	Section 5504 of the ACA Current	Vaar ETE Rasidants in	n Nonnrovi de	r Satting	1.00	2.00	3.00	
	beginning on or after July 1, 20	010	•	0				
66.00	Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	ccurring in all nonpr unweighted non-primar al. Enter in column 3	rovider sett ry care resi 3 the ratio	i ngs. dent	0.0	0 0. 0	0 0. 000000	66.00
		Program Name	Program	Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.0	0	3.00	4.00	5.00	
67.00	Enter in column 1, the program 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)				0.0	0 0.0	0 0.000000	67.00
	Inpatient Psychiatric Facility F	PPS				1.0	00 2.00 3.00	
70.00	Is this facility an Inpatient Ps	ychiatric Facility (I	PF), or doe	s it conta	ain an IPF sub	provi der? N		70.00
	Enter "Y" for yes or "N" for no If line 70 yes: Column 1: Did th recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF Column 3: If column 2 is Y, indi (see instructions) Inpatient Rehabilitation Facilit	e facility have an ap efore November 15, 20 lumn 2: Did this faci R 412.424 (d)(1)(iii) cate which program ye y PPS	D04? Enter lity train)(D)? Enter ear began du	"Y" for ye residents "Y" for ye ring this	es or "N" for in a new teac es or "N" for cost reportin	no. (see hing no. g period.	0	71.00
75.00	ls this facility an Inpatient Re subprovider? Enter "Y" for yes		y (IRF), or	does it co	ontain an IRF	Y		75.00
76.00	If line 75 yes: Column 1: Did th recent cost reporting period end no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente indicate which program year bega	e facility have an ap ing on or before Nove train residents in a r "Y" for yes or "N"	ember 15, 20 new teachin for no. Col	04? Enter g program umn 3: If	"Y" for yes o in accordance column 2 is Y	r "N" for with 42	0	76.00
							1.00	-
	Long Term Care Hospital PPS		6	II NII C				00.00
80.00 81.00	Is this a long term care hospita Is this a LTCH co-located within "Y" for yes and "N" for no. TEFRA Providers	another hospital for	r part or al	I of the o	no. cost reporting	period? Enter	N N	80.00 81.00
	Is this a new hospital under 42						N	85.00
	Did this facility establish a ne §413.40(f)(1)(ii)? Enter "Y" fo Is this hospital a "subclause (I	r yes and "N" for no.					N	86. 00 87. 00
	for yes or "N" for no.					V	XIX	
						1.00	2.00	
90.00	Title V and XIX Services Does this facility have title V	and/or XIX inpatient	hospital se	rvi ces? Er	nter "Y" for	N	Y	90.00
	yes or "N" for no in the applica Is this hospital reimbursed for	ble column.				N	Y	91.00
	full or in part? Enter "Y" for y	es or "N" for no in t	the applicab	le column.		IN IN		
92.00	Are title XIX NF patients occupy instructions) Enter "Y" for yes				ion)? (see		N	92.00
93.00	Does this facility operate an IC	F/IID facility for pu			d XIX? Enter	N	Ν	93.00
94.00	"Y" for yes or "N" for no in the Does title V or XIX reduce capit applicable column.		or yes, and	"N" for no	o in the	Ν	Ν	94.00

Health Financial Systems RIVERVIEW HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider		lr eriod: com 01/01/		of For Workshe Part I		
	Te			Date/Ti 5/19/20		
	L	V 1.00	I	XI 2	x	-
95.00 If line 94 is "Y", enter the reduction percentage in the applicable column 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no applicable column.		N	0.00	<u> </u>	0.00	95.00 96.00
97.00 If line 96 is "Y", enter the reduction percentage in the applicable column Rural Providers	n		0. 00		0.00	97.00
105.00 Does this hospital qualify as a critical access hospital (CAH)? 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive met	hod of payment	N N				105. 00 106. 00
<pre>for outpatient services? (see instructions) 107.00 If this facility qualifies as a CAH, is it eligible for cost reimbursemen training programs? Enter "Y" for yes or "N" for no in column 1. (see inst yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the p reimbursed. If yes complete Wkst. D-2, Pt. II.</pre>	ructions) lf	N				107.00
108.00 Is this a rural hospital qualifying for an exception to the CRNA fee scher CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	dul e? See 42	N				108.00
Physi cal 1.00	Occupational 2.00	Speecl 3.00		Respira 4. C		_
109.00 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		N		109.00
				1.0		
110.00 Did this hospital participate in the Rural Community Hospital Demonstration the current cost reporting period? Enter "Y" for yes or "N" for no.	on project (410	A Demo)for		N		110.00
			1.00	2.00	3.00	_
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in is yes, enter the method used (A, B, or E only) in column 2. If column 2 3 either "93" percent for short term hospital or "98" percent for long ter psychiatric, rehabilitation and long term hospitals providers) based on the	is "E", enter i rm care (includ	n column es	N		0	115. 00
Pub.15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" for yes or "N 117.00 Is this facility legally-required to carry malpractice insurance? Enter "'	" for no.		N Y			116. 00 117. 00
no. 118.00 s the malpractice insurance a claims-made or occurrence policy? Enter 1	if the policy i	s	2			118.00
claim-made. Enter 2 if the policy is occurrence.	Premi ums	Losses	6	Insura	ance	
	1.00	2.00		3. 0	0	_
118.01 List amounts of malpractice premiums and paid losses:	822, 579		5,000	5.0		118.01
		1.00		2.0	0	_
118.02 Are malpractice premiums and paid losses reported in a cost center other Administrative and General? If yes, submit supporting schedule listing ca and amounts contained therein.		N				118.02
119.00 D0 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless prov §3121 and applicable amendments? (see instructions) Enter in column 1, "Y "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see inst Enter in column 2, "Y" for you can "" for no.	" for yes or he Outpatient	N		Ν		119.00 120.00
Enter in column 2, "Y" for yes or "N" for no.						121.00
121.00 Did this facility incur and report costs for high cost implantable device: patients? Enter "Y" for yes or "N" for no. Transplant Center Information	s charged to	Y				
patients? Enter "Y" for yes or "N" for no. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N"		Y N				125. 00
patients? Enter "Y" for yes or "N" for no. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter the certification date (s) (mm/dd/yyyy) and the center of the certification date (s) (mm/dd/yyyy) below.	for no. If					125. 00 126. 00
<pre>patients? Enter "Y" for yes or "N" for no. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter the certific in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, enter the certification date is a Medicare certified heart transplant center, enter the certification date.</pre>	for no. If fication date					
 patients? Enter "Y" for yes or "N" for no. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter the certific in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, enter the certifin column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, enter the certified liver transplant center, enter the certification date, if applicable, in column 2. 	for no. If fication date ication date					126. 00
 patients? Enter "Y" for yes or "N" for no. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" yes, enter certification date(s) (mm/d/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter the certific in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, enter the certific in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, enter the certific in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, enter the certific in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified lung transplant center, enter the certific in column 1. 	for no. If fication date ication date ication date					126. 00 127. 00
 patients? Enter "Y" for yes or "N" for no. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter the certifin column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, enter the certifin column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, enter the certifin column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, enter the certific of this is a Medicare certified liver transplant center, enter the certific column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified lung transplant center, enter the certific column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, enter the certific column 2. 	for no. If fication date ication date ication date cation date in					126.00 127.00 128.00
 patients? Enter "Y" for yes or "N" for no. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter the certific in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, enter the certific in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, enter the certific in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, enter the certific in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified lung transplant center, enter the certific column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, enter the certification date, in column 1. 131.00 If this is a Medicare certified intestinal transplant center, enter the certification date, if applicable, in column 2. 	for no. If fication date ication date ication date cation date in tification					126.00 127.00 128.00 129.00
 patients? Enter "Y" for yes or "N" for no. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter the certifin column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, enter the certifin column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, enter the certifin column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, enter the certific column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified lung transplant center, enter the certific column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, enter the certific date in column 1 and termination date, if applicable, in column 2. 131.00 If this is a Medicare certified intestinal transplant center, enter the certific date in column 1 and termination date, if applicable, in column 2. 132.00 If this is a Medicare certified intestinal transplant center, enter the certific date in column 1 and termination date, if applicable, in column 2. 132.00 If this is a Medicare certified intestinal transplant center, enter the certific date in column 1 and termination date, if applicable, in column 2. 	for no. If fication date ication date ication date cation date in tification ertification					126.00 127.00 128.00 129.00 130.00
 patients? Enter "Y" for yes or "N" for no. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" yes, enter certification date(s) (mn/d/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter the certific in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, enter the certific in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, enter the certific in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified lung transplant center, enter the certific oclumn 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified lung transplant center, enter the certific column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, enter the certific column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, enter the certific date in column 1 and termination date, if applicable, in column 2. 131.00 If this is a Medicare certified intestinal transplant center, enter the certified in column 1 and termination date, if applicable, in column 2. 	for no. If fication date ication date ication date cation date in tification ertification ication date					126.00 127.00 128.00 129.00 130.00 131.00

Health Financial Systems	RI VERVI E	W HOSPI TAL			In Lieu	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX				Period: From 01/01		Worksheet S-2 Part I Date/Time Pre 5/19/2016 4:5	pared:
				1.0	0	2.00	
All Providers				1.0	10	2.00	
140.00 Are there any related organization o chapter 10? Enter "Y" for yes or "N" are claimed, enter in column 2 the h	for no in column 1. I	If yes, and home	office costs	Y			140. 00
		2. 00		3	3. 00		
If this facility is part of a chain				ame and ac	dress (of the	
home office and enter the home offic 141.00Name:	<u>e contractor name and</u> Contractor's Name:	contractor numb		or's Numbe	r.		141.00
141.00 Name: 142.00 Street:	PO Box:		Contracto	or s numbe	Γ:		141.00
143. 00 Ci ty:	State:		Zip Code:				143.00
			· ·		-		
	· · · · · · ·					1.00	111.00
144.00 Are provider based physicians' costs	Included in Workshee	t A?				Y	144.00
				1.0	0	2.00	
145.00 If costs for renal services are clai inpatient services only? Enter "Y" f no, does the dialysis facility inclu period? Enter "Y" for yes or "N" fo	or yes or "N" for no i de Medicare utilizatio r no in column 2.	in column 1. If o on for this cost	column 1 is reporting	Y			145.00
146.00 Has the cost allocation methodology Enter "Y" for yes or "N" for no in c yes, enter the approval date (mm/dd/	olumn 1. (See CMS Pub.			N			146. 00
					-	1.00	
147.00 Was there a change in the statistica	l basis? Enter "Y" for	r ves or "N" for	no.			N	147.00
148.00 Was there a change in the order of a						N	148.00
149.00 Was there a change to the simplified	cost finding method?						149.00
		Part A	Part B	Titl		Title XIX	
Does this facility contain a provide	r that qualifies for	1.00	2.00	3.0		4.00	
or charges? Enter "Y" for yes or "N"							
155.00 Hospi tal		N	N	N		N	155.00
156.00 Subprovi der – IPF		N	N	N		N	156.00
157.00 Subprovi der – IRF 158.00 SUBPROVI DER		N	N	N		N	157.00 158.00
159. 00 SNF		Ν	N	N		N	158.00
160.00 HOME HEALTH AGENCY		N	N	N		N	160.00
161.00 CMHC			N	N		N	161.00
					-	1.00	
Multicampus						1.00	
165.00 Is this hospital part of a Multicamp	us hospital that has (one or more campu	uses in diffe	rent CBSAs	?	N	165.00
Enter "Y" for yes or "N" for no.	News	Country	C+-+- 7:	- Carla	CDCA		
	Name 0	County 1.00			CBSA 4.00	FTE/Campus 5.00	
166.00 If line 165 is yes, for each		1.00	2.00	0.00	1.00		166.00
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							
Ucal th Information Tachnology (ULT)	incontivo in the Amer	i can Bacayany an	d Doi nuactman	+ Ac+		1.00	
Health Information Technology (HIT) 167.00 Is this provider a meaningful user u	nder §1886(n)? Enter	"Y" for ves or '	<u>u keinvestmen</u> 'N" for no	t ACT		Y	167.00
168.00 If this provider is a CAH (line 105	is "Y") and is a meani	ingful user (line	e 167 is "Y")	, enter th	e		168.00
reasonable cost incurred for the HIT	assets (see instructi	ions)					
168.01 If this provider is a CAH and is not				a hardshi	р		168. 01
exception under §413.70(a)(6)(ii)? E 169.00 If this provider is a meaningful use transition factor. (see instructions	r (line 167 is "Y") ar						169. 00
				Begi ni		Endi ng	
170.00 Enter in columns 1 and 2 the EHR beg period respectively (mm/dd/yyyy)	inning date and ending	g date for the re	eporting	1.0		2.00 12/29/2015	170. 00

Health Financial Systems	RI VERVI EW HOSP	TAL	In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provider CCN: 150059	From 01/01/2015	Worksheet S- Part I Date/Time Pr 5/19/2016 4:	epared:
				1.00	-
171.00 If line 167 is "Y", does this prov Medicare cost plans reported on Wk (see instructions)				N	171.00

PI L	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der		Period: From 01/01/2015 To 12/31/2015		epared
					Y/N	Date	<u>57 piii</u>
					1.00	2.00	
	General Instruction: Enter Y for all YES resp mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	oonses. Enter N for	all nu re	sponses. Ente	er all dates in t	rne	_
00	Provider Organization and Operation Has the provider changed ownership immediatel	v prior to the bea	inning of	the cost	N		1.0
,0	reporting period? If yes, enter the date of t						1. 1
				Y/N	Date	V/I	
00	Has the provider terminated participation in	the Medicare Progr	am2 lf	1.00 N	2.00	3.00	2.
.0	yes, enter in column 2 the date of terminatic voluntary or "I" for involuntary.			N			2.
00	Is the provider involved in business transact contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel of directors through ownership, control, or f	, chain home offic d to the provider o , or members of th	es, drug r its e board	N			3.
	relationships? (see instructions)			N/ (1)	-		_
				Y/N 1.00	Type 2.00	Date 3.00	
_	Financial Data and Reports			1.00	2.00	0.00	
00	Column 1: Were the financial statements prep Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or column 3. (see instructions) If no, see instr	Audited, "C" for C enter date availab	ompiled,	Y	A	03/28/2016	4.
00	Are the cost report total expenses and total			N			5.
	those on the filed financial statements? If y	<u>yes, submit reconci</u>	i i ati on.		Y/N	Legal Oper.	
					1.00	2.00	
	Approved Educational Activities		·				_ ,
0	Column 1: Are costs claimed for nursing scho the legal operator of the program?	DOI? COLUMN 2: IT	yes, is tr	ne provider is	5 N		6.
0	Are costs claimed for Allied Health Programs? Were nursing school and/or allied health prog	grams approved and/		l during the	Y Y		7. 8.
0	cost reporting period? If yes, see instructic Are costs claimed for Interns and Residents i		uate medic	al education	N		9.
0	program in the current cost report? If yes, s				N .		
00	Was an approved Intern and Resident GME progr		newed in t	he current	Ν		10.
00	cost reporting period? If yes, see instructic Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see	rs other than I & R	in an App	proved	Ν		11.
						Y/N	
	Bad Debts					1.00	-
00	Is the provider seeking reimbursement for bac					Y	12.
00	If line 12 is yes, did the provider's bad deb	ot collection polic	y change c	luring this co	ost reporting	N	13.
00	period? If yes, submit copy. If line 12 is yes, were patient deductibles a	and/or co-payments	waived? If	ves, see ins	structions.	N	14.
	Bed Complement						
00	Did total beds available change from the pric	or cost reporting p	eriod?lf			N	15.
		Descriptio	'n	Y/N	art A Date	Part B Y/N	-
		0		1.00	2.00	3.00	
~~	PS&R Data	[05 (1) (001)		
00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see			Y	05/16/2016	Y	16.
00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is			N		Ν	17.
00	yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional			N		N	18.
00	claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments			N		N	19.
	made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.						
00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N		N	20.

OSPI T	Financial Systems AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	RI VERVIEW HOS STIONNAI RE		CCN: 150059	Peri od:	Worksheet S-:	
00111					From 01/01/2015 To 12/31/2015	Part II	epared:
				F	Part A	Part B	
		Descripti	i on	Y/N	Date	Y/N	
		0		1.00	2.00	3.00	
1.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			N		N	21. 0
				•			
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPIT	ALS ONLY (EXCEPT	CHI LDRENS H	OSPI TALS)		1.00	
	Capital Related Cost					1	
	Have assets been relifed for Medicare purpose Have changes occurred in the Medicare depreci reporting period? If yes, see instructions.			als made dur	ing the cost		22. 0 23. 0
4.00	Were new leases and/or amendments to existing If yes, see instructions	g leases entered i	nto during	this cost re	eporting period?		24.0
5.00	Have there been new capitalized leases entered instructions.	ed into during the	e cost repor	ting period?	'lfyes, see		25.0
	Were assets subject to Sec. 2314 of DEFRA acquinstructions.	0	·	0.	5		26.0
7.00	Has the provider's capitalization policy char copy. Interest Expense	nged during the co	ost reportin	g period? If	yes, submit		27.0
8. 00	Were new loans, mortgage agreements or letter period? If yes, see instructions.	rs of credit enter	red into dur	ing the cost	reporting		28. (
9.00	Did the provider have a funded depreciation a treated as a funded depreciation account? If			bt Service R	Reserve Fund)		29.
0. 00	Has existing debt been replaced prior to its instructions.			debt? If yes	s, see		30.
1.00	Has debt been recalled before scheduled matur instructions.	rity without issua	ance of new	debt? If yes	s, see		31.
2. 00	Purchased Services Have changes or new agreements occurred in pa arrangements with suppliers of services? If y	atient care servio	ces furnishe	d through co	ontractual		32.
3. 00	If line 32 is yes, were the requirements of S no, see instructions.			g to competi	tive bidding? If		33.
	Provi der-Based Physi ci ans			· · · ·		1	-
	Are services furnished at the provider facili If yes, see instructions.	•	-				34.
5.00	If line 34 is yes, were there new agreements physicians during the cost reporting period?			ts with the	-		35.
					<u>Y/N</u> 1.00	Date 2.00	
	Home Office Costs				1.00	2.00	
	Were home office costs claimed on the cost re If line 36 is yes, has a home office cost sta		ared by the	home office?			36. 37.
3. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the provider? If yes, enter in column 2 the f				-		38.
9.00	If line 36 is yes, did the provider render se see instructions.				5,		39.
0. 00	If line 36 is yes, did the provider render se instructions.	ervices to the hom	me office?	lf yes, see			40.
			1.	00	2.	00	
I. 00	Cost Report Preparer Contact Information Enter the first name, last name and the title held by the cost report preparer in columns		CHAEL		ALESSANDRI NI		41.
	respectively.	i, ∠, anu 3,					
2. 00	Enter the employer/company name of the cost i	report BLI	JE AND CO				42.

Heal th	Financial Systems	RIVERVIEW H	OSPI TAL		In Lieu	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der	CCN: 150059	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part II Date/Time Pre 5/19/2016 4:5	pared:
		Part B	·		· · · · · · · · ·		
		Date					
		4.00					
	PS&R Data	05 (4 (/004 (1 4 / 00
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions)	05/16/2016					16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)						17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.						18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.						19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:						20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.						21.00
		_	3.	00	_		
	Cost Report Preparer Contact Information		J.	00			
	Enter the first name, last name and the title held by the cost report preparer in columns respectively.		ENIOR MANAGER				41.00
42.00	Enter the employer/company name of the cost	report					42.00
43.00	preparer. Enter the telephone number and email address report preparer in columns 1 and 2, respectiv						43.00

Heal th	Financial Systems	RI VERVI EW	HOSPI	TAL			In Lie	u of Form CMS-	25	52-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA		Provi der	CCN: 150059		eriod: rom 01/01/2015 o 12/31/2015	Worksheet S-3 Part I Date/Time Pre 5/19/2016 4:5	epa	
								I/P Days / O/F Visits / Trips)	
	Component	Worksheet A Line Number	No.	of Beds	Bed Days Avai I abl e		CAH Hours	Title V		
		1.00		2.00	3.00		4.00	5.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30. 00		90	32, 85	50	0.00	С)	1.00
2.00 3.00	HMO and other (see instructions) HMO IPF Subprovider									2.00 3.00
4.00 5.00 6.00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF							C		4.00 5.00 6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)			90	32, 85	50	0.00	C		7.00
8.00 9.00 10.00 11.00	INTENSI VE CARE UNI T CORONARY CARE UNI T BURN INTENSI VE CARE UNI T SURGI CAL INTENSI VE CARE UNI T	31. 00		15	5,47	75	0.00	С	1	8.00 9.00 10.00 11.00
12. 00 13. 00	OTHER SPECIAL CARE (SPECIFY) NURSERY	43.00						C		12.00 13.00
14.00 15.00 16.00	Total (see instructions) CAH visits SUBPROVIDER - IPF			105	38, 32	25	0.00	C) 1	14.00 15.00 16.00
17. 00 18. 00	SUBPROVI DER – I RF SUBPROVI DER	41.00		24	8, 76	60		C		17.00 18.00
19.00 20.00 21.00 22.00 23.00 24.00	SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE	44. 00		25	9, 12	25		C	222	19.00 20.00 21.00 22.00 23.00 24.00
24. 10 25. 00 26. 00 26. 25	HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	30. 00							2	24. 10 25. 00 26. 00 26. 25
27.00 28.00 29.00 30.00 31.00 32.00	Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions)			154		0		C) 2 2 3 3	27.00 28.00 29.00 30.00 31.00 32.00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days			0		U			3	32.00 32.01 33.00

IOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der	CCN: 150059	Perio From To	od: 01/01/2015 12/31/2015	Worksheet S-3 Part I Date/Time Pre 5/19/2016 4:5	pared
		I/P Days	/ O/P Visits	/ Trips		Full Time E	qui val ents	
	Component	Title XVIII	Title XIX	Total All Patients		tal Interns Residents	Employees On Payroll	
		6.00	7.00	8.00		9.00	10.00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	5, 420	517	13, 06	50	7.00	10.00	1. (
. 00	HMO and other (see instructions)	2,085	1, 749					2.0
. 00	HMO I PF Subprovi der	2,000	0					3.0
. 00	HMO I RF Subprovi der	295	196					4.0
. 00	Hospital Adults & Peds. Swing Bed SNF	0	0		0			5.0
. 00	Hospital Adults & Peds. Swing Bed NF	-	0		0			6.1
. 00	Total Adults and Peds. (exclude observation	5, 420	517					7.0
. 00	beds) (see instructions) INTENSIVE CARE UNIT	1, 163	0	2, 50	14			8.
. 00	CORONARY CARE UNIT	1, 103	0	2, 50	54			9.
0.00	BURN INTENSIVE CARE UNIT							10.
. 00	SURGI CAL I NTENSI VE CARE UNI T							10.
2.00	OTHER SPECIAL CARE (SPECIFY)							12.
3.00	NURSERY		0		0			13.
4.00	Total (see instructions)	6, 583	517		-	0, 00	1, 221. 75	
5.00	CAH visits	0, 505	0		0	0.00	1,221.75	15.
b. 00	SUBPROVIDER - IPF	0	0		U			16.
. 00	SUBPROVI DER – I RF	3, 901	95	5, 58	33	0.00	40.80	
3.00	SUBPROVI DER	0, 701	,0	0,00		0.00	10.00	18
00	SKILLED NURSING FACILITY	3, 431	0	5,00	01	0.00	0.00	
. 00	NURSING FACILITY	0,101	0	0,00		01.00	0.00	20.
. 00	OTHER LONG TERM CARE							21.
. 00	HOME HEALTH AGENCY							22
. 00	AMBULATORY SURGICAL CENTER (D. P.)							23
. 00	HOSPI CE							24
. 10	HOSPICE (non-distinct part)	0	0		0			24.
. 00	CMHC - CMHC							25.
. 00	RURAL HEALTH CLINIC							26.
. 25	FEDERALLY QUALIFIED HEALTH CENTER							26.
. 00	Total (sum of lines 14-26)					0.00	1, 262. 55	27
. 00	Observation Bed Days		45	1, 78	38			28
. 00	Ambul ance Trips	0						29.
. 00	Employee discount days (see instruction)				0			30
. 00	Employee discount days - IRF				0			31.
2. 00	Labor & delivery days (see instructions)	0	2		8			32.
2. 01	Total ancillary labor & delivery room outpatient days (see instructions)				0			32.
3. 00		0						33.

HOSPI T	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	<u>RIVERVIEW H</u> AL DATA	Provi der	CCN: 150059	Period: From 01/01/2015 To 12/31/2015	Worksheet S-3 Part I Date/Time Pre 5/19/2016 4:5	pared:
		Full Time Equivalents		Di s	charges	10/11/2010 110	
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1, 5.	23 80	3, 821	1.00
2.00	HMO and other (see instructions)			4	59 427		2.0
3.00	HMO I PF Subprovi der				0		3.00
4.00	HMO IRF Subprovider				20		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
5.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
3.00	INTENSIVE CARE UNIT						8.0
9.00	CORONARY CARE UNIT						9.0
0.00	BURN INTENSIVE CARE UNIT						10.0
11.00	SURGI CAL I NTENSI VE CARE UNI T						11.0
12.00	OTHER SPECIAL CARE (SPECIFY)						12.0
13.00	NURSERY						13.0
14.00	Total (see instructions)	0.00	0	1, 5	23 80	3, 821	14.0
15.00	CAH visits						15.0
16.00	SUBPROVIDER - IPF	0.00					16.0
17.00	SUBPROVIDER - IRF	0. 00	0	3.	31 7	469	
8.00	SUBPROVI DER	0.00					18.0
9.00	SKILLED NURSING FACILITY	0.00					19.0
20.00	NURSING FACILITY						20.0
1.00	OTHER LONG TERM CARE						21.0
2.00	HOME HEALTH AGENCY						22.0
3.00	AMBULATORY SURGICAL CENTER (D. P.)						23.0
4.00	HOSPICE						24.0
4.10	HOSPICE (non-distinct part)						24.1
5.00	CMHC - CMHC RURAL HEALTH CLINIC						25. C 26. C
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26.0
7.00		0, 00					20.2
28.00	Total (sum of lines 14-26)	0.00					27.0
28.00 29.00	Observation Bed Days Ambulance Trips						28.0
0.00	Employee discount days (see instruction)						30.0
1.00	Employee discount days (see fistruction) Employee discount days - IRF						30.0
	1 5						31.0
32.00 32.01	Labor & delivery days (see instructions)						32.0
>∠. UI	Total ancillary labor & delivery room						32.0
	outpatient days (see instructions) LTCH non-covered days						33.0

OSPI T.	AL WAGE INDEX INFORMATION			Provi der	F	eriod: rom 01/01/2015 o 12/31/2015		pared:
		Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	(col.2 ± col.		Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							
. 00	Total salaries (see	200.00	66, 483, 453	-593, 660	65, 889, 793	2, 626, 101. 00	25. 09	1.00
	instructions)							
. 00	Non-physician anesthetist Part		0	0	0	0.00	0.00	2.00
. 00	A Non-physician anesthetist Part		0	0	0	0.00	0.00	3.00
	В		-	_	_			
. 00	Physician-Part A -		0	0	0	0.00	0.00	4.00
. 01	Administrative Physicians – Part A – Teaching		0	0	0	0.00	0.00	4.01
.00	Physician-Part B		0	0	0	0.00		
. 00	Non-physician-Part B		0	0	0	0.00		
. 00	Interns & residents (in an	21.00	0	0	0	0.00	0.00	7.00
. 01	approved program) Contracted interns and		0	0	0	0.00	0.00	7.01
	residents (in an approved		-	_				
00	programs)		0			0.00	0.00	0.00
. 00 . 00	Home office personnel SNF	44.00	U			0.00 0.00		
D. 00	Excluded area salaries (see	111 00	25, 366, 481	112, 974	25, 479, 455			
	instructions)							
	OTHER WAGES & RELATED COSTS Contract Labor: Direct Patient		1, 716, 096	0	1, 716, 096	6, 629. 00	250 00	11.00
1.00	Care		1, 710, 090		1, 710, 090	0, 029. 00	250.00	
2. 00	Contract Labor: Top Level		0	0	0	0.00	0.00	12.00
	management and other							
	management and administrative services							
3. 00	Contract Labor: Physician-Part		583, 413	0	583, 413	1, 482. 00	393.67	13.00
4 00	A - Administrative		0			0.00	0.00	14.00
4.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00	14.00
5.00	Home office: Physician Part A		0	0	0	0.00	0.00	15.00
	- Administrative							
6. 00	Home office and Contract Physicians Part A - Teaching		0	0		0.00	0.00	16.00
	WAGE-RELATED COSTS							
7.00	Wage-related costs (core) (see		10, 814, 024	0	10, 814, 024			17.00
8. 00	instructions) Wage-related costs (other)		0	0	0			18.00
0.00	(see instructions)		0					10.00
	Excluded areas		3, 286, 600		0,200,000			19.00
0. 00	Non-physician anesthetist Part		0	0	0			20.00
1. 00	Non-physician anesthetist Part		0	0	0			21.00
	В							
2.00	Physician Part A - Administrative		0	0	0			22.00
2. 01	Physician Part A - Teaching		0	0	0			22.01
	Physician Part B		0	0	0			23.00
	Wage-related costs (RHC/FQHC)		0	-	0			24.00
5.00	Interns & residents (in an approved program)		0	0				25.00
	OVERHEAD COSTS - DIRECT SALARIE	S		1				
	Employee Benefits Department	4.00	385, 605					
	Administrative & General Administrative & General under	5.00	8, 145, 047 1, 017, 717					
5.00	contract (see inst.)		1,017,717		1,017,717	5,005.00	175.50	20.00
	Maintenance & Repairs	6.00	0	-	0	0.00		
	Operation of Plant	7.00	1, 520, 153					
1.00 2.00	Laundry & Linen Service Housekeeping	8.00 9.00	44, 012 839, 730					
	Housekeeping under contract		0	0	0	0.00		
4 95	(see instructions)							
4.00 5.00	Dietary Dietary under contract (see	10.00	975, 731 0	-	256, 248	23, 270. 00 0. 00		
5.00	instructions)		U			0.00	0.00	35.00
	Cafeteri a	11.00	0	660, 947	660, 947			
	Maintenance of Personnel	12.00	0	0		0.00		37.00
	Nursing Administration Central Services and Supply	13.00 14.00	657, 126 492, 533					38.00 39.00
		50	2, 166, 106					

Health Financial Systems		RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION			Provi der		Peri od:	Worksheet S-3	
					rom 01/01/2015		
					To 12/31/2015	Date/Time Pre 5/19/2016 4:5	
	Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
	Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
			(from	(col.2 ± col.	Salaries in	col. 5)	
			Worksheet A-6)	3)	col. 4		
	1.00	2.00	3.00	4.00	5.00	6.00	
41.00 Medical Records & Medical Records Library	16. 00	766, 671	-1, 946	764, 725	39, 128. 00	19. 54	41.00
42.00 Social Service	17.00	547,790	-1, 391	546, 399	9 15, 051. 00	36.30	42.00
43.00 Other General Service	18.00	C	0	(0.00	0.00	43.00

Heal th	Financial Systems		RI VERVI EW	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provi der		Period: From 01/01/2015 To 12/31/2015		oared.
							5/19/2016 4:5	
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		67, 501, 170	-593, 660	66, 907, 51	0 2,631,904.00	25. 42	1.00
	instructions)							
2.00	Excluded area salaries (see		25, 366, 481	112, 974	25, 479, 45	5 591, 752. 00	43.06	2.00
	instructions)							
3.00	Subtotal salaries (line 1		42, 134, 689	-706, 634	41, 428, 05	5 2,040,152.00	20. 31	3.00
	minus line 2)							
4.00	Subtotal other wages & related		2, 299, 509	0	2, 299, 50	9 8, 111. 00	283. 50	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		10, 814, 024	0	10, 814, 02	4 0.00	26. 10	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		55, 248, 222	-706, 634	54, 541, 58	8 2,048,263.00	26.63	6.00
7.00	Total overhead cost (see		17, 558, 221	134, 771	17, 692, 99	2 760, 338. 00	23. 27	7.00
	instructions)							

Heal th	Financial Systems	RI VERVI EW HOSP	PLTAL			. In Lie	u of Form CMS-2	2552-10
HOSPI 1	AL WAGE RELATED COSTS		Provider (CCN:	150059	Period: From 01/01/2015 To 12/31/2015		pared:
							Amount	
							Reported	
	PART IV - WAGE RELATED COSTS						1.00	
	Part A - Core List							
	RETIREMENT COST							
1.00	401K Employer Contributions						1, 001, 483	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribut	tion					1,001,483	
3.00	Nonqualified Defined Benefit Plan Cost (see in						0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instr						0	4.00
4.00	PLAN ADMINISTRATIVE COSTS (Paid to External Or							4.00
5.00	401K/TSA Plan Administration fees	gam zatrony					0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan						0	6.00
7.00	Employee Managed Care Program Administration F	Fees					0	7.00
	HEALTH AND INSURANCE COST						-	
8.00	Health Insurance (Purchased or Self Funded)						7, 196, 598	8.00
9.00	Prescription Drug Plan						0	
10.00	Dental, Hearing and Vision Plan						45, 626	10.00
11.00	Life Insurance (If employee is owner or benefi	ciary)					33, 472	11.00
12.00	Accident Insurance (If employee is owner or be						0	12.00
13.00	Disability Insurance (If employee is owner or	benefi ci ary)					209, 249	13.00
14.00	Long-Term Care Insurance (If employee is owner	r or beneficiary)					0	14.00
15.00	'Workers' Compensation Insurance						112, 587	15.00
16.00	Retirement Health Care Cost (Only current year	r, not the extraor	rdi nary accr	rual	requi re	d by FASB 106.	0	16.00
	Non cumulative portion)							
	TAXES							
	FICA-Employers Portion Only						4, 794, 620	
18.00	Medicare Taxes - Employers Portion Only						0	
19.00	Unemployment Insurance						32, 398	
20.00	State or Federal Unemployment Taxes						0	20.00
01 00	OTHER				4 11			01.00
21.00	Executive Deferred Compensation (Other Than Reinstructions))	etirement lost kep	ported on II	nes	i throu	gn 4 above. (see	0	21.00
22.00	Day Care Cost and Allowances						0	
23.00	Tuition Reimbursement						80, 961	
24.00	Total Wage Related cost (Sum of lines 1 -23)						13, 506, 994	24.00
	Part B - Other than Core Related Cost							
25.00	OTHER WAGE RELATED COSTS (SPECIFY)						0	25.00

Heal th	Financial Systems	RI VERVI EW HOSPI	TAL		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST		Provi der	CCN: 150059	Peri od:	Worksheet S-3	
					From 01/01/2015		
					To 12/31/2015	Date/Time Pre 5/19/2016 4:5	pared:
	Cost Center Description				Contract Labor		
	Cost center bescription				1.00	2.00	
	PART V - Contract Labor and Benefit Cost						
	Hospital and Hospital-Based Component Identifi	cati on:					
1.00	Total facility's contract labor and benefit co	st			0	0	1.00
2.00	Hospi tal				0	0	2.00
3.00	Subprovider - IPF						3.00
4.00	Subprovider - IRF				0	0	4.00
5.00	Subprovider - (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	Hospital-Based SNF				0	0	8.00
9.00	Hospital-Based NF						9.00
10.00	Hospital-Based OLTC						10.00
11.00	Hospital-Based HHA						11.00
12.00	Separately Certified ASC						12.00
13.00	Hospital-Based Hospice						13.00
14.00	Hospital-Based Health Clinic RHC						14.00
15.00	Hospital-Based Health Clinic FQHC						15.00
16.00	Hospital-Based-CMHC						16.00
17.00	Renal Dialysis				0	0	17.00
18.00	Other				0	0	18.00

	Financial Systems RIVERVIEW				u of Form CMS-2	
PROSPE	CTIVE PAYMENT FOR SNF STATISTICAL DATA	Provi der	F	Period: From 01/01/2015 To 12/31/2015	Worksheet S-7 Date/Time Pre	
					5/19/2016 4:5	
				1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all pa or was there no Medicare utilization? Enter "Y" for yes in complete the rest of this worksheet.					1.00
2.00	Does this hospital have an agreement under either section swing beds? Enter "Y" for yes or "N" for no in column 1. I			N		2.00
	date (mm/dd/yyyy) in column 2.	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	1.00	2.00	3.00	4.00	
3.00 4.00		RUX RUL	C 27		0 27	3.00 4.00
5.00		RVX	c	0	0	5.00
6.00 7.00		RVL RHX			0	6.00 7.00
8.00		RHL			0	8.00
9.00		RMX	c		0	9.00
10.00		RML			0	10.00
11. 00 12. 00		RLX RUC	730	-	730	12.00
13.00		RUB	1, 331	0	1, 331	13.00
14.00		RUA RVC	521		521	
15.00 16.00		RVD	277		277 246	
17.00		RVA	66	0	66	17.00
18.00 19.00		RHC RHB	63		63 37	18.00 19.00
20.00		RHA	31		31	20.00
21.00		RMC	2	0	2	21.00
22.00 23.00		RMB RMA	7		7	22.00 23.00
23.00		RLB			4	23.00
25.00		RLA	c	0	0	25.00
26.00 27.00		ES3 ES2			0	26.00 27.00
27.00		ES1			0	27.00
29.00		HE2	c	0	0	29.00
30. 00 31. 00		HE1 HD2	C 11		0	30.00 31.00
32.00		HD1	4		4	32.00
33.00		HC2	C		0	33.00
34.00 35.00		HC1 HB2			0	34.00 35.00
36.00		HB1	1	0	1	36.00
37.00		LE2	0	-	0	37.00
38.00 39.00		LE1 LD2	12		12	38.00 39.00
40.00		LD1	6		6	40.00
41.00		LC2	0		0	41.00
42.00 43.00		LC1 LB2			0	42.00 43.00
44.00		LB1	0	0 0	0	44.00
45.00 46.00		CE2 CE1	C 1		0	45.00 46.00
48.00		CD2			0	48.00
48.00		CD1	6	0	6	48.00
49.00		CC2	0		0	49.00
50. 00 51. 00		CC1 CB2	23		23 0	50.00 51.00
52.00		CB1	10	0	10	52.00
53.00 54.00		CA2 CA1			0	53.00 54.00
55.00		SE3			0	55.00
56.00		SE2	C	0	0	56.00
57.00 58.00		SE1 SSC			0	57.00 58.00
58.00 59.00		SSB			0	59.00
60.00		SSA	C	0 0	0	60.00
61.00 62.00		I B2 I B1			0	61.00 62.00
63.00		I A2			0	63.00
64.00		I A1	C	0	0	64.00
65.00 66.00		BB2 BB1			0	65.00 66.00
67.00		BA2	C	0	0	67.00
68.00		BA1	c	0 0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA Provider CON: 150059 Period: From 01/01/2015 Period: To 12/31/2015 Worksheet S-7 69:00 67:00 SNF Days Swing Bed SNF Total (Sum of Days Col. 2 + 3) Col. 2 + 3) 69:00 100 2.00 3.00 4.00 69:00 71:00 PC2 0 0 0 69:00 71:00 PC2 0 0 0 73:00 71:00 PC2 0 0 0 73:00 75:00 PC2 0 0 0 77:00 78:00 PA2 0 0 0 78:00 79:00 PA2 0 0 0 78:00 79:00 AAA 0 0 0 78:00 79:00 PA2 0 0 0 78:00 70:00 PA2 0 0 0 78:00 79:00 PA2 0 0 0 28:00 70:00	Health Financial Systems RIVERVIEW	HOSPI TAL		In Lie	eu of Form CMS-	2552-10
Group SNF Days Swing Bed SNF Total (sum of Days) Coll (sum of Days) 69.00 1.00 2.00 3.00 4.00 70.00 PF2 0 0 0.69.00 71.00 PF1 0 0 0.69.00 72.00 PF1 0 0 0 71.00 73.00 PF2 0 0 0 73.00 74.00 PF2 0 0 0 73.00 75.00 PF2 0 0 0 75.00 70.00 PF4 0 0 75.00 77.00 70.00 PA4 0 0 0 78.00 200.00 ID14 3.431 0 0 78.00 201.00 Exper			CCN: 150059	Period: From 01/01/2015	Worksheet S-7 Date/Time Pre	pared:
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72.00 P01 5 0 5 72.00 73.00 PC2 0 0 0 73.00 74.00 PC1 4 0 4 74.00 75.00 PC1 4 0 4 74.00 75.00 PC1 4 0 4 74.00 77.00 P22 0 0 0 75.00 77.00 PA1 0 0 0 77.00 78.00 PA1 0 0 0 77.00 78.00 PA1 0 0 0 77.00 200.00 TOTAL 3.431 CBSA att EGSA	70.00	PE1		0 0	0	70.00
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1.002.003.00A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increase associated with direct patient care and related expenses for each category. (see instructions)00.00202.00202.00Staffing 000.00203.00203.00204.00Retention of employees00.00204.00205.00Training00.00205.00206.00OTHER (SPECIFY)000.00206.00					and Related	
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payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated202.00202.00Staffing00.00202.00203.00Recruitment00.00203.00204.00Retention of employees00.00204.00205.00OTraining00.00205.00206.00OTHER (SPECIFY)00.00206.00			1.00	2.00	3.00	
expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)00.00202.00202.00Staffing00.00203.00203.00203.00Recruitment00.00204.00204.00Retention of employees00.00205.00205.00OTHER (SPECIFY)00.00205.00	A notice published in the Federal Register Volume 68, No.	149 August 4, 2	003 provi ded	for an increase	in the RUG	
column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)00.00202.00202.00Staffing00.00203.00203.00203.00Recruitment00.00203.00204.00Retention of employees00.00204.00205.00OTraining00.00205.00206.00OTHER (SPECIFY)00.00206.00	payments beginning 10/01/2003. Congress expected this incre	ease to be used	for direct	patient care and	rel ated	
Line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated202.00Staffing00.00202.00203.00Recruitment00.00203.00204.00Retention of employees00.00204.00205.00OTraining00.00205.00206.00OTHER (SPECIFY)00.00206.00	expenses. For lines 202 through 207: Enter in column 1 the	amount of the	expense for	each category. Ei	nter in	
with direct patient care and related expenses for each category. (see instructions)202.00Staffing00.00202.00203.00Recruitment00.00203.00204.00Retention of employees00.00204.00205.00Training00.00205.00206.00OTHER (SPECIFY)00.00206.00						
202.00 Staffing 0 0.00 202.00 203.00 Recruitment 0 0.00 203.00 204.00 Retention of employees 0 0.00 204.00 205.00 Training 0 0.00 205.00 206.00 OTHER (SPECIFY) 0 0.00 206.00	line 7, column 3. In column 3, enter "Y" for yes or "N" for	r no if the spe	nding reflec	ts increases asso	oci ated	
203.00 Recruitment 0 0.00 203.00 204.00 Retention of employees 0 0.00 204.00 205.00 Training 0 0.00 205.00 206.00 OTHER (SPECIFY) 0 0.00 206.00		egory. (see ins	tructions)	T	1	
204.00 Retention of employees 0 0.00 204.00 205.00 Training 0 0.00 205.00 206.00 OTHER (SPECIFY) 0 0.00 206.00						1
205.00 Training 0 0.00 205.00 206.00 OTHER (SPECIFY) 0 0.00 206.00						
206.00 OTHER (ŠPECI FY) 0 0.00 206.00	204.00 Retention of employees			0 0.00		204.00
	205. 00 Trai ni ng			0 0.00		205.00
207.00 Total SNF revenue (Worksheet G-2, Part I, line 7, column 3) 2,535,210 207.00				0 0.00		
	207.00 Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	2, 535, 2	10		207.00

Heal th	Financial Systems RIVERVIEW HOSPI	ΓAL		In Lie	eu of Form CMS	-2552-10
		Provi der	CCN: 150059	Peri od:	Worksheet S-	10
				From 01/01/2015		
				To 12/31/2015	Date/Time Pr 5/19/2016 4:	
					57 197 2010 4.	<u>57 pili</u>
					1.00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid	ded by li	ne 202 colum	ı 8)	0. 32552	5 1.00
	Medicaid (see instructions for each line)	-				
2.00	Net revenue from Medicaid				5, 026, 34	9 2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental	payments	from Medicai	1?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from 1	Medi cai d				0 5.00
6.00	Medicaid charges				16, 892, 17	
7.00	Medicaid cost (line 1 times line 6)				5, 498, 82	
8.00	Difference between net revenue and costs for Medicaid program (I	ine 7 min	us sum of lir	nes 2 and 5; if	472, 47	8 8.00
	< zero then enter zero)					
	State Children's Health Insurance Program (SCHIP) (see instruction	ons for ea	ach line)		1	
9.00	Net revenue from stand-al one SCHIP					0 9.00
10.00	Stand-alone SCHIP charges					0 10.00
11. 00 12. 00	Stand-alone SCHIP cost (line 1 times line 10)	lino 11 m		if . Jong then		0 11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (lenter zero)	ine n m	inus iine 9;	TT < Zero then		0 12.00
	Other state or local government indigent care program (see instru	uctions fo	or each line`			
13.00	Net revenue from state or local indigent care program (Not includ					0 13.00
14.00	Charges for patients covered under state or local indigent care			,		0 14.00
		program (
15.00	State or local indigent care program cost (line 1 times line 14)					0 15.00
16.00	Difference between net revenue and costs for state or local indic	gent care	program (lin	ne 15 minus line		0 16.00
	13; if < zero then enter zero)	5				
	Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to fund	9	5			0 17.00
18.00	Government grants, appropriations or transfers for support of hos					0 18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local	i ndi gent	care program	ns (sum of lines	472, 47	8 19.00
	8, 12 and 16)		Lint in a constant	Lanuard	Tatal (asl)	
			Uni nsured pati ents	Insured patients	Total (col. ' + col. 2)	
			<u> </u>	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (a	at full	6, 129, 9			1 20.00
20.00	charges excluding non-reimbursable cost centers) for the entire		0, 127, 7		0,127,71	20.00
21.00	Cost of initial obligation of patients approved for charity care		1, 995, 4	19 0	1, 995, 44	9 21.00
	times line 20)					
22.00	Partial payment by patients approved for charity care			0 0		0 22.00
23.00	Cost of charity care (line 21 minus line 22)		1, 995, 4	19 0	1, 995, 44	9 23.00
					1.00	
24.00	Does the amount in line 20 column 2 include charges for patient (nd a length o	of stay limit	N	24.00
	imposed on patients covered by Medicaid or other indigent care p					_
25.00	If line 24 is "yes," charges for patient days beyond an indigen		ogram's leng	h of stay limit		0 25.00
26.00	Total bad debt expense for the entire hospital complex (see inst				8, 277, 00	
27.00	Medicare bad debts for the entire hospital complex (see instruct				177, 47	
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line				8, 099, 52	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expension	nse (line	i times line	28)	2, 636, 59	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	- 20)			4, 632, 04	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line	e 30)			5, 104, 52	4 31.00

LAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provi der		Period: From 01/01/2015	Worksheet A	
					To 12/31/2015	Date/Time Pre 5/19/2016 4:5	
	Cost Center Description	Sal ari es	Other		Reclassificati	Recl assi fi ed	
				+ col. 2)	ons (See A-6)	Trial Balance (col. 3 +-	
						col. 4)	
		1.00	2.00	3.00	4.00	5.00	
0	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT		12, 437, 007	12, 437, 00	7 -223, 591	12, 213, 416	•
0	00400 EMPLOYEE BENEFITS DEPARTMENT	385, 605	5, 925, 899			6, 816, 326	
0	00500 ADMI NI STRATI VE & GENERAL	8, 145, 047	15, 900, 339			23, 036, 736	
0	00700 OPERATION OF PLANT	1, 520, 153	4, 502, 272			6, 018, 790	
0 0	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	44, 012 839, 730	338, 949 676, 427			382, 855 1, 514, 149	
00	01000 DI ETARY	975, 731	1, 586, 898			677, 173	
00	01100 CAFETERI A	0	0		0 1, 735, 891	1, 735, 891	
00	01300 NURSI NG ADMI NI STRATI ON	657, 126	141, 459			797, 014	
00 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	492, 533 2, 166, 106	13, 725, 505 11, 163, 465			14, 860, 750 13, 123, 719	
	01600 MEDICAL RECORDS & LIBRARY	766, 671	806, 061			1, 570, 899	
00	01700 SOCIAL SERVICE	547, 790	230, 460			776, 940	
00	02300 PARAMED ED PRGM PHARMACY	0	0		0 200, 672	200, 672	23
00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	6, 104, 983	740, 929	6, 845, 91	2 580, 201	7, 426, 113	30
00	03100 I NTENSI VE CARE UNI T	1, 667, 414	185, 937			1, 881, 099	
00	04100 SUBPROVI DER - I RF	1, 186, 021	995, 777			2, 178, 962	
00	04300 NURSERY	0	0		0 0	0	1
00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	0	2, 200, 257	2, 200, 25	7 -37,681	2, 162, 576	44
00	05000 OPERATING ROOM	1, 519, 353	6, 640, 986	8, 160, 33	9 -568, 578	7, 591, 761	50
00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0,100,00	0 0	0	
00	05400 RADI OLOGY-DI AGNOSTI C	1, 539, 452	720, 625			2, 270, 496	
00	05500 RADI OLOGY-THERAPEUTI C	371, 143	507, 445			880, 455	
00 01	05700 CT SCAN 03630 ULTRA SOUND	252, 439 95, 309	37, 517 14, 932			289, 352 110, 013	
00	05800 MAGNETIC RESONANCE I MAGING (MRI)	166, 309	65, 408			231, 320	
00	05900 CARDI AC CATHETERI ZATI ON	798, 759	673, 427			1, 479, 678	
00	06000 LABORATORY	2, 214, 003	2, 809, 313	5, 023, 31		5, 072, 748	
01 00	06001 BLOOD LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	0	0 525, 879	525, 87	0 0	0 525, 879	60
00	06400 I NTRAVENOUS THERAPY	0	525, 879	525, 67	0 0	525, 879	
00	06500 RESPI RATORY THERAPY	906, 795	152, 256	1, 059, 05	1 240, 333	1, 299, 384	
00	06600 PHYSI CAL THERAPY	3, 576, 988	2, 035, 612	5, 612, 60	0 -8, 554	5, 604, 046	
00 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	0	0		0 0	0	6
00	06900 ELECTROCARDI OLOGY	632, 614	72, 757	705, 37	1 110, 578	815, 949	
00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	1
	07200 IMPL. DEV. CHARGED TO PATIENT	0	1, 287, 800	1, 287, 80		1, 287, 800	
	07300 DRUGS CHARGED TO PATIENTS	0	0	222.25	0 0		73
00 00	07400 RENAL DI ALYSI S 03020 OTHER ANCI LLARY	0	333, 354 0	333, 35	0 0	333, 354 0	
	03140 CARDI AC REHAB	648, 747	279, 856	928, 60	3 -1, 551	927, 052	
	03070 WOMEN'S CENTER	361, 206	68, 961			429, 303	
03		451, 152	84, 288	535, 44	0 31, 921	567, 361	70
00	OUTPATI ENT SERVICE COST CENTERS	1, 121, 805	560, 402	1, 682, 20	7 -62, 384	1, 619, 823	90
01	09001 OUTPATI ENT	368, 838	481, 450			855, 368	
00	09100 EMERGENCY	1, 779, 159	716, 996			2, 511, 900	9'
01	09101 SHORT STAY	0	0		0 0	0	
00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS			I			92
00	09500 AMBULANCE SERVICES	60, 396	12, 652	73, 04	8 -144	72, 904	9!
	SPECIAL PURPOSE COST CENTERS						4
. 00		42, 363, 389	89, 639, 557	132, 002, 94	6 147, 080	132, 150, 026	118
. ೧೧	NONREIMBURSABLE COST CENTERS	88, 465	146, 562	235, 02	7 -212	234, 815	190
. 00	19200 PHYSICIANS' PRIVATE OFFICES	21, 977, 152	13, 793, 443			35, 480, 415	
. 01	19201 FOUNDATI ON	144, 233	10, 498	154, 73	1 -345	154, 386	192
		1,044,134	209, 510			1, 252, 139	
	19206 HOME HEALTH PARTNERSHIP	0 419, 234	26, 223 61, 561			26, 223 479, 793	
	19207 WESTFIELD SCHOOLS	419, 234 446, 846	-160, 841			479, 793 284, 937	
	19204 MOB - NOBLESVILLE SQUARE	0	379, 650			379, 650	
. 08	19205 RIVERVIEW MEDICAL ARTS	0	162, 074			162, 074	192
	19300 NONPALD WORKERS	0	0		0 0		19:
	007950 WORKMED 07951 MEALS ON WHEELS	0	0		0 0 0 147, 232	0 147, 232	194 194
. 01	TOTAL (SUM OF LINES 118-199)	66, 483, 453	104, 268, 237	170, 751, 69		170, 751, 690	

CLASS	Financial Systems IFICATION AND ADJUSTMENTS OF TRIAL BALANCE	RI VERVI EW OF EXPENSES		Provi der	CCN: 1500		wof Form (Worksheet	
						/01/2015 /31/2015		Prepar
	Cost Center Description	Adjustments		Expenses			1 37 197 2016	-+. 57 pr
		(See A-8) 6.00		<u>llocation</u> 7.00				
C	GENERAL SERVICE COST CENTERS	0.00						
	DO100 NEW CAP REL COSTS-BLDG & FIXT	-231		2, 213, 185				1
	DO400 EMPLOYEE BENEFITS DEPARTMENT	-35, 828		6, 780, 498				4
	DO500 ADMINISTRATIVE & GENERAL	-6, 444, 286		6, 592, 450				5
	DO700 OPERATION OF PLANT	-11, 740		6, 007, 050				7
	DO800 LAUNDRY & LINEN SERVICE	0		382, 855				8
	DO900 HOUSEKEEPI NG	0		1, 514, 149				9
	D1000 DI ETARY	0		677, 173				10
		-697, 848		1,038,043				11
	D1300 NURSI NG ADMI NI STRATI ON D1400 CENTRAL SERVI CES & SUPPLY	0		797, 014 4, 860, 750				13
	D1500 PHARMACY	-						14
	D1600 MEDICAL RECORDS & LIBRARY	-4, 955, 646 -1, 208	1	8, 168, 073 1, 569, 691				16
	D1700 SOCIAL SERVICE	-1,200		776, 940				17
	D2300 PARAMED ED PRGM PHARMACY	0		200, 672				23
	NPATIENT ROUTINE SERVICE COST CENTERS		1	200, 072				
	D3000 ADULTS & PEDI ATRI CS	-594, 799		6, 831, 314				30
	D3100 I NTENSI VE CARE UNI T	-10, 903		1, 870, 196				31
	04100 SUBPROVI DER – I RF	0		2, 178, 962				41
	D4300 NURSERY	0	•	0				43
00 0	D4400 SKILLED NURSING FACILITY	-125, 211		2, 037, 365				44
	ANCILLARY SERVICE COST CENTERS							
00	D5000 OPERATING ROOM	-2, 433, 002	2	5, 158, 759				50
00 0	D5200 DELIVERY ROOM & LABOR ROOM	0		0				52
	D5400 RADI OLOGY-DI AGNOSTI C	-1, 013		2, 269, 483				54
	D5500 RADI OLOGY-THERAPEUTI C	0		880, 455				55
	D5700 CT SCAN	0		289, 352				57
	D3630 ULTRA SOUND	0		110, 013				57
	D5800 MAGNETIC RESONANCE IMAGING (MRI)	0		231, 320				58
	05900 CARDI AC CATHETERI ZATI ON	-525,000		954, 678				59
	D6000 LABORATORY	-66, 742		5, 006, 006				60
	D6001 BLOOD LABORATORY	0		0				60
	D6300 BLOOD STORING, PROCESSING & TRANS.	0		525, 879				63
	06400 I NTRAVENOUS THERAPY	0		0				64
	06500 RESPIRATORY THERAPY	-198, 334		1, 101, 050				65
	D6600 PHYSI CAL THERAPY	0		5, 604, 046				66
	06700 OCCUPATIONAL THERAPY	0		0				67
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	-225		815, 724				69
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-225		015, 724				71
	07200 IMPL. DEV. CHARGED TO PATIENT	0		0 1, 287, 800				72
	D7300 DRUGS CHARGED TO PATIENTS			1, 207, 000				73
	07400 RENAL DIALYSIS	0		333, 354				74
	D3020 OTHER ANCI LLARY	0		000,004				76
	D3140 CARDI AC REHAB	0		927, 052				76
	D3070 WOMEN'S CENTER	0		429, 303				76
	D3330 ENDOSCOPY	0		567, 361				76
	DUTPATIENT SERVICE COST CENTERS							
00 0	09000 CLINIC	-85		1, 619, 738				90
01 0	09001 OUTPATI ENT	-350	1	855, 018				90
	D9100 EMERGENCY	0		2, 511, 900				91
01 0	D9101 SHORT STAY	0		0				91
	09200 OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	09500 AMBULANCE SERVICES	-2, 975		69, 929		 		95
_	SPECIAL PURPOSE COST CENTERS							
. 00	SUBTOTALS (SUM OF LINES 1-117)	-16, 105, 426	11	6, 044, 600				118
	NONREI MBURSABLE COST CENTERS	-		004 045				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		234, 815				190
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	/ ³	5, 480, 415				192
	19201 FOUNDATION	0	1	154, 386				192
	19202 CLINICS		1	1, 252, 139				192
	19206 HOME HEALTH PARTNERSHIP	0	1	26, 223				192
	19207 WESTFIELD SCHOOLS		1	479, 793				192
	19203 PRACTICE MANAGEMENT	0		284, 937				192
	19204 MOB - NOBLESVILLE SQUARE		(379,650				192 192
	19205 RIVERVIEW MEDICAL ARTS	0		162, 074				192
	19300 NONPALD WORKERS 07950 WORKMED		(0				193
1. UUJU	D7950 WORKMED	0	(0 147, 232				194
010		0	1	147,232				200

	Financial Systems		RI VERVI EW F				eu of Form CMS	
RECLAS	SI FI CATI ONS			Provider CC	N: 150059	Period: From 01/01/201		
						To 12/31/201	5 Date/Time Pr 5/19/2016 4:	
	Cost Center	I ncreases Li ne #	Salary	Other				
	2.00	3.00	4.00	5.00				
1.00	A – CAFETERIA RECLASS CAFETERIA	11.00	660, 947	1,074,944				1.00
1.00			660, 947	1,074,944				1.00
4 9 9	B - MEALS ON WHEELS		5 (05 0	24.470				
1.00	MEALS ON WHEELS	<u> </u>	<u>56, 0</u> 59 56, 059	9 <u>1, 1</u> 73 91, 173				1.00
	C – INSURANCE RECLASS							
1.00	ADMI NI STRATI VE & GENERAL		<u>0</u> 0	<u>223, 591</u> 223, 591				1.00
	D - MED SUPPLY RECLASS			223, 371				
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	440, 016				1.00
2.00 3.00	CARDI AC CATHETERI ZATI ON	59.00 0.00	0	9, 682 0				2.00 3.00
4.00		0.00	0	0				4.00
5.00 6.00		0. 00 0. 00	0	0				5.00 6.00
7.00		0.00	0	0				7.00
			0	449, 698				_
1.00	E - RSMA RECLASS EMPLOYEE BENEFITS DEPARTMENT	4.00	0	388, 373				1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	189, 314	14, 559				2.00
3.00	OPERATING_ROOM	50.00	2, 566, 886	<u>190, 728</u> 593, 660				3.00
	F - PHYSICIAN PROFESSIONAL FE	ES	2,730,200	373,000				
1.00	ADULTS & PEDIATRICS	30.00	0	594, 800				1.00
2.00 3.00	INTENSIVE CARE UNIT OPERATING ROOM	31.00 50.00	0	31, 735 24, 000				2.00 3.00
4.00	RADI OLOGY-DI AGNOSTI C	54.00	0	14, 100				4.00
5.00 6.00	RADI OLOGY-THERAPEUTI C	55.00 60.00	0	4,400				5.00
8.00 7.00	LABORATORY RESPI RATORY THERAPY	65.00	0	54, 727 242, 501				6.00 7.00
8.00	ELECTROCARDI OLOGY	69.00	0	112, 500				8.00
9.00 10.00	ENDOSCOPY OUTPATI ENT	76. 03 90. 01	0	33, 000 6, 000				9.00 10.00
11.00	EMERGENCY	91.00	0	20, 000				11.00
12.00	PHYSICIANS' PRIVATE OFFICES	1 <u>92.</u> 00	<u>0</u>	7 <u>5,000</u> 1,212,763				12.00
	G - BONUS RECLASS		0	1,212,703				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	123, 626	0				1.00
2.00 3.00	ADMINISTRATIVE & GENERAL OPERATION OF PLANT	5.00 7.00	0	1, 200 224				2.00 3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	6				4.00
5.00 6.00	HOUSEKEEPI NG DI ETARY	9.00 10.00	0	124 144				5.00 6.00
7.00	NURSING ADMINISTRATION	13.00	0	97				7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	73				8.00
9. 00 10. 00	PHARMACY MEDI CAL RECORDS & LI BRARY	15.00 16.00	0	319 113				9.00 10.00
11.00	SOCIAL SERVICE	17.00	0	81				11.00
12.00	ADULTS & PEDIATRICS	30.00	0	900				12.00
13.00 14.00	I NTENSI VE CARE UNI T SUBPROVI DER – I RF	31.00 41.00	0	246 175				13.00 14.00
15.00	OPERATING ROOM	50.00	0	20				15.00
16.00	RADI OLOGY-DI AGNOSTI C	54.00 55.00	0	227				16.00
17.00 18.00	RADI OLOGY-THERAPEUTI C CT SCAN	57.00	0	55 37				17.00 18.00
19.00	ULTRA SOUND	57.01	0	14				19.00
20.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	25				20.00
21.00	CARDI AC CATHETERI ZATI ON	59.00	0	118				21.00
22.00	LABORATORY	60.00 65.00	0	326				22.00
23.00 24.00	RESPI RATORY THERAPY PHYSI CAL THERAPY	65.00 66.00	0	134 527				23.00 24.00
25.00	ELECTROCARDI OLOGY	69.00	0	93				25.00
26. 00 27. 00	CARDIAC REHAB WOMEN'S CENTER	76. 01 76. 02	0	96 53				26.00 27.00
27.00 28.00	ENDOSCOPY	76.02 76.03	0	53 66				27.00
29.00	CLI NI C	90.00	0	139				29.00
30. 00 31. 00	OUTPATI ENT EMERGENCY	90. 01 91. 00	0	54 262				30.00 31.00
32.00	AMBULANCE SERVICES	91.00	0	202				32.00
33.00	GIFT, FLOWER, COFFEE SHOP &	190.00	0	13				33.00
34.00	CANTEEN PHYSICIANS' PRIVATE OFFICES	192.00	О	965				34.00
		· · · · · · · · · · · · · · · · · · ·	I	1				·

Heal th	Financial Systems		RI VERVI EW	HOSPI TAL		In Lieu of Form CMS-255		
RECLAS	SEFECATIONS			Provi der	CCN: 150059	Period: From 01/01/2015	Worksheet A-	6
						To 12/31/2015	Date/Time Pr 5/19/2016 4:	epared:
		Increases					571772010 4.	
	Cost Center	Line #	Sal ary	0ther				
	2.00	3.00	4.00	5.00				
35.00	FOUNDATI ON	192.01	0	21				35.00
36.00	CLINICS	192.02	0	93				36.00
37.00	WESTFIELD SCHOOLS	192.04	0	62				37.00
38.00	PRACTICE MANAGEMENT	192.05	0	66				38.00
	0		123, 626	7, 177				
	H - PARAMED ED PHARMACY RESID	DENCY PRG						
1.00	PARAMED ED PRGM PHARMACY	23.00	81, 098	119, 574				1.00
	TOTALS		81, 098	119, 574				
500.00	Grand Total: Increases		3, 677, 930	3, 772, 580				500.00

	Financial Systems SIFICATIONS		RIVERVIEW H		CCN: 150059	Period:	u of Form CN Worksheet A	
						From 01/01/2015 To 12/31/2015	Date/Time F	Prepared:
		Decreases					5/19/2016 4	<u>4:57 pm</u>
	Cost Center	Line #	Salary		Wkst. A-7 Ref	<u>,</u>		
	6.00	7.00	8.00	9.00	10.00			
1.00	A - CAFETERI A RECLASS DI ETARY	10.00	660, 947	1,074,944		0		1.00
1.00	0		660, 947	1,074,944				1.00
	B - MEALS ON WHEELS					-		
1.00	DI ETARY	<u>10.</u> 00	<u>56, 0</u> 59 56, 059	9 <u>1, 1</u> 73 91, 173		Q		1.00
	C - INSURANCE RECLASS		30, 037	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	223, 591	1	2		1.00
	FIXT	+	₀	223, 591		-		
	D - MED SUPPLY RECLASS		-					
1.00	SKILLED NURSING FACILITY	44.00	0	37, 681		0		1.00
2.00 3.00	RADI OLOGY-THERAPEUTI C CARDI AC CATHETERI ZATI ON	55.00 59.00	0	1, 646 280		0		2.00 3.00
4.00	ELECTROCARDI OLOGY	69.00	0	409		0		4.00
5.00	CLINIC	90.00	0	60, 131		0		5.00
6.00 7.00	OUTPATIENT PHYSICIANS' PRIVATE OFFICES	90. 01 192. 00	0	38 349, 513		0		6.00 7.00
7.00	0		0	449, 698				7.00
	E - RSMA RECLASS							-
1.00 2.00	OPERATING ROOM	50.00 0.00	3, 349, 860 0	0		0		1.00
2.00 3.00		0.00	0	0		0		3.00
	0		3, 349, 860	0		1		
1 00	F - PHYSICIAN PROFESSIONAL FEE ADMINISTRATIVE & GENERAL	<u>5.00</u>	0	1 212 7/2		0		1.00
1.00 2.00	ADMINISTRATIVE & GENERAL	0.00	0 0	1, 212, 763 0		0		1.00
3.00		0.00	0	0		0		3.00
4.00		0.00	0	0		0		4.00
5.00 6.00		0.00 0.00	0	0		0		5.00 6.00
7.00		0.00	0	0		0		7.00
8.00		0.00	О	0		0		8.00
9. 00 10. 00		0.00 0.00	0	0		0		9.00 10.00
11.00		0.00	0	0		0		11.00
12.00		0.00	0	0		Q		12.00
	O G - BONUS RECLASS		0	1, 212, 763				_
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	7, 177		0		1.00
2.00	ADMI NI STRATI VE & GENERAL	5.00	20, 678	. 0		0		2.00
3.00	OPERATION OF PLANT	7.00	3, 859	0		0		3.00
4.00 5.00	LAUNDRY & LINEN SERVICE HOUSEKEEPING	8.00 9.00	112 2, 132	0		0		4.00 5.00
6.00	DI ETARY	10.00	2, 477	0		0		6.00
7.00	NURSING ADMINISTRATION	13.00	1, 668	0		0		7.00
8.00 9.00	CENTRAL SERVICES & SUPPLY PHARMACY	14.00 15.00	1, 250 5, 499	0		0		8.00 9.00
10.00	MEDICAL RECORDS & LIBRARY	16.00	1, 946	0		0		10.00
11.00	SOCI AL SERVI CE	17.00	1, 391	0		0		11.00
12.00 13.00	ADULTS & PEDIATRICS	30.00 31.00	15, 499	0		0		12.00
14.00	I NTENSI VE CARE UNI T SUBPROVI DER – I RF	41.00	4, 233 3, 011	0		0		13.00 14.00
15.00	OPERATING ROOM	50.00	352	0		0		15.00
16.00	RADI OLOGY-DI AGNOSTI C	54.00	3, 908	0		0		16.00
17.00 18.00	RADI OLOGY-THERAPEUTI C CT SCAN	55.00 57.00	942 641	0		0		17.00 18.00
19.00	ULTRA SOUND	57.01	242	0		0		19.00
20. 00	MAGNETIC RESONANCE I MAGING	58.00	422	0		0		20.00
21.00	(MRI) CARDIAC CATHETERIZATION	59.00	2, 028	0		0		21.00
21.00	LABORATORY	60.00	5, 621	0		0		21.00
23.00	RESPI RATORY THERAPY	65.00	2, 302	0		0		23.00
24.00		66.00	9, 081	0		0		24.00
25.00 26.00	ELECTROCARDI OLOGY CARDI AC REHAB	69.00 76.01	1, 606 1, 647	0		0		25.00 26.00
27.00	WOMEN' S CENTER	76.02	917	0		0		27.00
28.00	ENDOSCOPY	76.03	1, 145	0		0		28.00
29.00 30.00	CLINIC OUTPATIENT	90.00 90.01	2, 392 936	0		0		29.00 30.00
30.00	EMERGENCY	90.01	4, 517	0		ő		30.00
		95.00	153	0		0		32.00
32.00 33.00	AMBULANCE SERVICES GIFT, FLOWER, COFFEE SHOP &	190.00	225	0		0		33.00

Heal th	Financial Systems		RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS	-2552-10
RECLAS	SI FI CATI ONS			Provi der	CCN: 150059	Peri od:	Worksheet A-	6
						From 01/01/2015 To 12/31/2015		enared
						10 12/01/2010	5/19/2016 4:	<u>57 pm</u>
		Decreases						
	Cost Center	Line #	Sal ary	0ther	Wkst. A-7 Ref	₹.		
	6. 00	7.00	8.00	9.00	10.00			
34.00	PHYSICIANS' PRIVATE OFFICES	192.00	16, 632	0		0		34.00
35.00	FOUNDATI ON	192.01	366	0		0		35.00
36.00	CLINICS	192.02	1, 598	0		0		36.00
37.00	WESTFIELD SCHOOLS	192.04	1, 064	0		0		37.00
38.00	PRACTICE MANAGEMENT	1 <u>92.</u> 05	<u> </u>	0		0		38.00
	0		123, 626	7, 177				
	H - PARAMED ED PHARMACY RESID	DENCY PRG						
1.00	PHARMACY	<u> </u>	<u> </u>	<u>119, 5</u> 74		0		1.00
	TOTALS		81, 098	119, 574				
500.00	Grand Total: Decreases		4, 271, 590	3, 178, 920				500.00

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150059	Period: From 01/01/2015 To 12/31/2015		pared:
			Acquisition	S		
	Begi nni ng Bal ances	Purchases	Donati on	Total	Disposals and Retirements	
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE		2.00	0.00	4.00	3.00	
1.00 Land	15, 917, 384	0		0 0	0	1.00
2.00 Land Improvements	2, 625, 399	173, 080		0 173, 080	0	2.00
3.00 Buildings and Fixtures	98, 046, 778	1, 048, 395		0 1, 048, 395	351	3.00
4.00 Building Improvements	0	0		0 0	0	4.00
5.00 Fixed Equipment	36, 953, 557	1, 320, 844		0 1, 320, 844	0	5.00
6.00 Movable Equipment	68, 503, 087	9, 549, 667		0 9, 549, 667	2, 741, 704	6.00
7.00 HIT designated Assets	0	0		0 0		7.00
8.00 Subtotal (sum of lines 1-7)	222, 046, 205	12, 091, 986		0 12, 091, 986	2, 742, 055	
9.00 Reconciling Items	0	0		0 0		9.00
10.00 Total (line 8 minus line 9)	222, 046, 205			0 12, 091, 986	2, 742, 055	10.00
	Endi ng Bal ance					
		Depreci ated				
	(Assets				
	6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	15, 917, 384	0				1.00
2.00 Land Improvements	2, 798, 479					2.00
3.00 Buildings and Fixtures	99, 094, 822	0				3.00
4.00 Building Improvements	99, 094, 022 0	0				4.00
5.00 Fixed Equipment	38, 274, 401	0				5.00
6.00 Movable Equipment	75, 311, 050					6.00
7.00 HIT designated Assets	, 5, 511, 050					7.00
8.00 Subtotal (sum of lines 1-7)	231, 396, 136	0				8.00
9.00 Reconciling Items	0	0				9.00
10.00 Total (line 8 minus line 9)	231, 396, 136	0				10.00
		•				•

Heal th	Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der		Period:	Worksheet A-7	
					From 01/01/2015 To 12/31/2015		
			SL	JMMARY OF CAPI	TAL	571972010 4.5	
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	•	
						instructions)	
	1	9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR			nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	10, 493, 153	0	1, 545, 90	9 397, 945	0	1.00
3.00	Total (sum of lines 1-2)	10, 493, 153	0	1, 545, 90	9 397, 945	0	3.00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00]			
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	12, 437, 007				1.00
3.00	Total (sum of lines 1-2)	0	12, 437, 007				3.00

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der		Period:	Worksheet A-7	
				From 01/01/2015 To 12/31/2015		hared
					5/19/2016 4:5	
	COM	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capitalized	Gross Assets	Ratio (see	Insurance	
	01033 //33013	Leases	for Ratio	instructions)	i nisur unoc	
			(col. 1 - col			
			2)			
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00 NEW CAP REL COSTS-BLDG & FIXT	99, 094, 822		99, 094, 82			1.00
3.00 Total (sum of lines 1-2)	99, 094, 822		99, 094, 82			3.00
	ALLOCA	TION OF OTHER (CAPITAL	SUMMARY C	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
cost center bescription		Capi tal -Rel ate		Depreciation	Lease	
		d Costs	through 7)			
	6.00	7.00	8,00	9,00	10,00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0.00	7100	10100	
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	0		0 10, 493, 153	0	1.00
3.00 Total (sum of lines 1-2)	0	0		0 10, 493, 153	0	3.00
		SL	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance (see			Total (2) (sum	
		instructions)	instructions)	Capital -Relate		
				d Costs (see	through 14)	
	11.00	12.00	13.00	instructions) 14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		12.00	13.00	14.00	15.00	
1.00 NEW CAP REL COSTS-BLDG & FIXT	1, 545, 678	174, 354		0 0	12, 213, 185	1.00
3.00 Total (sum of lines 1-2)	1, 545, 678			0 0		3.00
3.00 [10tal (3am 01 11163 1-2)	1, 545, 070	174, 554	I	0	12,213,103	5.00

	Financial Systems TMENTS TO EXPENSES				Period:	u of Form CMS-2 Worksheet A-8	//
					From 01/01/2015 To 12/31/2015		
				Expense Classification or To/From Which the Amount is			/ piii
	Cost Center Description	Pasi s (Cada (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5. 00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter			NEW CAP REL COSTS-BLDG & FLXT	1.00	0	1.00
2.00	2) Investment income - CAP REL			*** Cost Center Deleted ***	2.00	0	2.00
3.00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		C		0.00	0	3.00
4.00	(chapter 2) Trade, quantity, and time		0		0.00	0	4.00
5.00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5.00
6.00	expenses (chapter 8) Rental of provider space by		O		0.00	0	6.00
7.00	suppliers (chapter 8) Telephone services (pay stations excluded) (chapter		O		0.00	0	7. OC
B. 00	21) Television and radio service (chapter 21)		0		0.00	0	8. OC
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician adjustment	A-8-2	0 -2, 822, 400		0.00	0 0	9.00 10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		C		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-366, 500			0	12.00
13.00 14.00	Laundry and linen service Cafeteria-employees and guests	В	0 -624, 617	CAFETERI A	0.00 11.00	0	13.00 14.00
15.00	Rental of quarters to employee and others		C		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	1.		C		0.00	0	17.00
18.00	Sale of medical records and abstracts		C		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		C		0.00	0	19.00
20. 00 21. 00	Vending machines Income from imposition of interest, finance or penalty		0 0		0. 00 0. 00	0 0	
22. 00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		C		0.00	0	22.00
23.00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	C	RESPI RATORY THERAPY	65.00		23.00
24.00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	C	PHYSI CAL THERAPY	66.00		24.00
25.00	limitation (chapter 14) Utilization review - physicians' compensation		O	*** Cost Center Deleted ***	114.00		25.00
26.00	(chapter 21) Depreciation - NEW CAP REL		C	NEW CAP REL COSTS-BLDG & FLXT	1.00	0	26.00
27.00	COSTS-BLDG & FIXT Depreciation - CAP REL COSTS-MVBLE EQUIP		C	*** Cost Center Deleted ***	2.00	о	27.00
8.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***			28.00
9.00 0.00	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	0 0	OCCUPATI ONAL THERAPY	0.00 67.00		29.00 30.00
80. 99	limitation (chapter 14) Hospice (non-distinct) (see		O	ADULTS & PEDIATRICS	30.00		30. 99
31. 00	instructions) Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	limitation (chapter 14) CAH HIT Adjustment for		C		0.00	0	32.00
33.00	Depreciation and Interest OTHER REV MEDICAL REPORT	В	-1, 208	MEDICAL RECORDS & LIBRARY	16.00	о	33.00

<u>Heal th</u>	Financial Systems		RI VERVI EW	HOSPITAL	In Lie	u of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES			Provider CCN: 150059	Peri od:	Worksheet A-8	
					From 01/01/2015 To 12/31/2015		
				Expense Classification o	n Warkshoot A	5/19/2016 4:5	7 pm
				To/From Which the Amount is			
					· · · · · · · · · · · · · · · · · · ·		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	OTHER REV RADIOLOGY FILM	В	-14	RADI OLOGY-DI AGNOSTI C	54.00	0	33.01
33. 02	OTHER REVENUES-OTHER	В	-6, 285	ADMI NI STRATI VE & GENERAL	5.00	0	33. 02
33. 03	REV-FI TNESS OTHER REVENUES ->PURCHASE	В	-18 330	ADMI NI STRATI VE & GENERAL	5.00	0	33. 03
33.03	DI SCOUNTS	b	- 10, 330	ADMINISTRATIVE & GENERAL	5.00	0	33.0.
33.04	OTHER REV ->VHA DI VI DENDS:	В	-54, 126	ADMINISTRATIVE & GENERAL	5.00	0	33.04
	OTHER						
33.05	EDUCATION OTHER REVENUE	В		EMPLOYEE BENEFITS DEPARTMEN		0	33.05
33.06	NON-OP EXPENSE INVESTMENT FEES			ADMI NI STRATI VE & GENERAL	5.00	0	33.06
33. 07	EMPLOYEE HEALTH/INF CONT - OTHER REV	В	-2, 126	EMPLOYEE BENEFITS DEPARTMEN	IT 4.00	0	33.07
33. 08	RADI OLOGY-OTHER REVENUE-CDS	В	-371	RADI OLOGY-DI AGNOSTI C	54.00	0	33.08
	FOR LEGA						
33.09	AMBULANCE ->OTHER REVENUE	В		AMBULANCE SERVICES	95.00	0	33.09
34.00	LABORATORY -> OTHER REVENUE	В		LABORATORY	60.00	0	34.00
36.00	EMPLOYEE WELLNESS- OTHER REVENUE	В	-13, 660	EMPLOYEE BENEFITS DEPARTMEN	IT 4.00	0	36.00
38.00	PR/MARKETING- OTHER REVENUE	В	-1, 450	ADMI NI STRATI VE & GENERAL	5.00	0	38.00
39.00	MISCELLANEOUS INTEREST INCOME	В	-41, 480	ADMI NI STRATI VE & GENERAL	5.00	0	39.00
40.00	INTEREST INCOME - BOND FUNDS	В		NEW CAP REL COSTS-BLDG & FIXT	1.00	11	40.00
41.00	RENTAL INCOME - TCU	В		SKILLED NURSING FACILITY	44.00	0	41.00
42.00	COMMUNITY RELATIONS	A	-1, 637, 019	ADMI NI STRATI VE & GENERAL	5.00	0	42.00
44.00	COMMUNITY RELATIONS BENEFITS	A	-19, 598	EMPLOYEE BENEFITS DEPARTMEN	T 4.00	0	44.00
45. 01	CRNA	A		OPERATING ROOM	50.00	0	45.01
45.03	PHYSICIAN RECRUITMENT	A		ADMI NI STRATI VE & GENERAL	5.00	0	45.03
45.06	I HA LOBBYING EXPENSE	A		ADMI NI STRATI VE & GENERAL	5.00	0	45.06
45.07	HAF EXPENSE	A		ADMINISTRATIVE & GENERAL	5.00	0	45.07
45.08 45.10	ENGINEERING - ENERGY REBATES HUMAN RESOURCES-OTHER REVENUE	B		OPERATION OF PLANT EMPLOYEE BENEFITS DEPARTMEN	7.00	0	45.08 45.10
45.10	COMM HEALTH FAIR FLU/VACS	В		ADMI NI STRATI VE & GENERAL	T 4.00 5.00	0	45.10
45.12	WOUND CARE-OTHER REVENUE	B		OUTPATI ENT	90.01	0	45.12
45.13	WORKMED WEST-OTHER REVENUE	В		CLINIC	90.00	0	45.13
45.14	DI ETARY OTHER REVENUE EXTERNAL CATER			CAFETERI A	11.00	0	45. 14
45. 15	PFS ADMIN OTHER REVENUE	В	-65	ADMI NI STRATI VE & GENERAL	5.00	0	45.15
45.16	EDUCATION OTHER REVENUE	В		ADMI NI STRATI VE & GENERAL	5.00	0	45.16
45.18	SHO/UNCLAI MED REFUNDS	В		ADMI NI STRATI VE & GENERAL	5.00	0	45.18
45.19	OP PHARMACY REVENUE	В	-4, 955, 104		15.00	0	45.19
45.20	DI ETARY SALES PR DEDUCT	В	-72, 577	CAFETERI A	11.00		
46.00			0		0.00		46.00
46. 01			0		0.00		46. 0 ⁻
46.02			0		0.00		
46.03			0		0.00	0	
50.00	TOTAL (sum of lines 1 thru 49)		-16, 105, 426				50.00
	(Transfer to Worksheet A, column 6, line 200.)						

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

(1) bescription - an chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Systems	RI VERVI EW	/ HOSPI TAL	In Lie	eu of Form CMS-2	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM	ME Provider CCN: 150059	Period:	Worksheet A-8	-1
OFFI CE	COSTS			From 01/01/2015 To 12/31/2015		
	Line 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 ADJUST	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED C	RGANI ZATI ONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	50.00	OPERATING ROOM	OPERATING ROOM	3, 371, 596	3, 738, 096	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	0		0	3, 371, 596	3, 738, 096	5.00

* 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 Ownership	Name	Percentage of Ownership				
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.

i ci indui					
6.00	В	RSMA	100.00	0.00	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.

Health Financial Systems	RI VERVI EW HOSP	I TAL	In Lieu of Form CMS-2552-10		
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATI	ONS AND HOME	Provider CCN: 150059	Period: From 01/01/2015	Worksheet A-8-1	
OFFICE COSTS				Date/Time Prepared:	

								12/31/2013		
									5/19/2016 4:	<u>57 pm</u>
	Net	Wkst. A-7 Ref.								
	Adjustments									
	(col. 4 minus									
	col. 5)*									
	6.00	7.00								
	A. COSTS INCUR	RED AND ADJUST	MENTS REQUIRED	AS A RESULT	OF TRANS	ACTIONS WITH RELATED	ORG	ANIZATIONS OR	CLAI MED	
	HOME OFFICE CO	STS:								
1.00	-366, 500	0								1.00
2.00	0	0								2.00
3.00	0	0								3.00
4.00	0	0								4.00
5.00	-366, 500									5.00

* 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

nas	not been posted to worksheet A,	corumns randzor z, the amount arrowable should be mulcated in corumni 4 or this part.	
	Rel ated Organi zati on(s)		
	and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELAT	ED 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 7.00	6.00
7.00	7.00
8.00	8.00
9.00	9.00
10.00	10.00
8. 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.

 D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.

E. Individual is director, officer, administrator, or key person of provider and related organization.

Director, officer, administrator, or key person of related organization or relative of such person has financial interest in F. provi der.

	Financial Syste		RI VERVI EN				eu of Form CMS-	
PROVI DE	R BASED PHYSIC	I AN ADJUSTMENT		Provi der	- CCN: 150059	Peri od:	Worksheet A-8	3-2
						From 01/01/2015 To 12/31/2015		
	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	5.00	ADMI NI STRATI VE & GENERAL	5,000	5,000)	0 179,000	0	1.00
2.00	54.00	RADI OLOGY-DI AGNOSTI C	628	628	3	0 271,900	0	2.00
3.00	50.00	OPERATING ROOM	1, 391, 502	1, 391, 502		0 239,400	0	3.00
4.00	59.00	CARDIAC CATHETERIZATION	525,000	525,000)	0 179,000	0	4.00
5.00		ADULTS & PEDIATRICS	594, 799			0 179,000		5.00
6.00		INTENSIVE CARE UNIT	10, 903			0 179,000		6.00
7.00		RESPI RATORY THERAPY	198, 334			0 179,000		7.00
8.00		PHARMACY	542			0 179,000		8.00
9.00		ELECTROCARDI OLOGY	225			0 179,000		9,00
10.00		ADMI NI STRATI VE & GENERAL	95, 467	95, 467		0 179,000		10.00
200.00	5.00		2, 822, 400			0		
200.00	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
	WKSL. A LINE #	I denti fi er	Limit	Unadjusted RCE			of Malpractice	
		rdentifier		Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12	i nisur unee	
	1.00	2.00	8,00	9.00	12.00	13.00	14.00	
1.00		ADMI NI STRATI VE & GENERAL	0			0 0		1.00
2.00		RADI OLOGY-DI AGNOSTI C	0			ol o		2.00
3.00		OPERATI NG ROOM	0			ol o	-	3.00
4.00		CARDI AC CATHETERI ZATI ON	0			ol o	-	4.00
5.00		ADULTS & PEDIATRICS					0	5.00
6.00		I NTENSI VE CARE UNI T			·	o o	0	
7.00		RESPI RATORY THERAPY						7.00
8.00		PHARMACY			·			8.00
9.00		ELECTROCARDI OLOGY		-	·			9,00
10.00		ADMI NI STRATI VE & GENERAL		-				10.00
200.00	5.00	ADMINISTRATIVE & GENERAL		-			0	
200.00	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	0	200.00
	WRSt. A EINC #	I denti fi er	Component	Limit	Di sal I owance	Aujustilient		
		raditerret	Share of col.		Di Sai i Ollanoo			
			14					
	1.00	2.00	15.00	16.00	17.00	18.00	1	
1.00	5.00	ADMI NI STRATI VE & GENERAL	0	C)	0 5,000		1.00
2.00	54.00	RADI OLOGY-DI AGNOSTI C	0	l c)	0 628		2.00
3.00	50.00	OPERATING ROOM	0			0 1, 391, 502		3.00
4.00		CARDI AC CATHETERI ZATI ON	0			0 525,000		4.00
5.00		ADULTS & PEDIATRICS	0			0 594, 799		5.00
6.00		INTENSIVE CARE UNIT	0			0 10, 903		6.00
7.00		RESPI RATORY THERAPY	0			0 198, 334		7.00
8.00		PHARMACY	0			0 542		8.00
9.00		ELECTROCARDI OLOGY	0			0 225		9,00
10.00		ADMI NI STRATI VE & GENERAL				0 95,467		10.00
200.00	0.00		0			0 2, 822, 400		200.00
	I	1			1	-1 2, 522, 100	1	

	Financial Systems NLLOCATION - GENERAL SERVICE COSTS	RI VERVI EW		CCN: 150050		eu of Form CMS-:	2552-10
CUST	LLUCATION - GENERAL SERVICE CUSIS		Provi der	1	Period: From 01/01/2015 Fo 12/31/2015	Date/Time Pre	pared:
			CAPI TAL			5/19/2016 4:5	7 pm
			RELATED COSTS				
	Cost Center Description	Net Expenses for Cost	NEW BLDG & FLXT	EMPLOYEE BENEFITS	Subtotal	ADMI NI STRATI VE & GENERAL	
		Allocation		DEPARTMENT			
		(from Wkst A					
		<u>col.7)</u>	1.00	4.00	4A	5.00	
	GENERAL SERVICE COST CENTERS	1					
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	12, 213, 185					1.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	6, 780, 498 16, 592, 450				18, 413, 267	4.00 5.00
7.00	00700 OPERATI ON OF PLANT	6, 007, 050					
8.00	00800 LAUNDRY & LINEN SERVICE	382, 855				59, 021	8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	1, 514, 149					
10.00	01100 CAFETERI A	677, 173 1, 038, 043				105, 103 170, 542	
13.00	01300 NURSI NG ADMI NI STRATI ON	797, 014					
14.00	01400 CENTRAL SERVICES & SUPPLY	14, 860, 750				2, 030, 729	
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	8, 168, 073 1, 569, 691				1, 152, 824 233, 354	
17.00	01700 SOCIAL SERVICE	776, 940					
23.00	02300 PARAMED ED PRGM PHARMACY	200, 672				28, 791	
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	(001 014	1 000 (04	(27.01)	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1 2// /14	1 20 00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	6, 831, 314 1, 870, 196				1, 266, 614 324, 780	1
41.00	04100 SUBPROVI DER – I RF	2, 178, 962				356, 336	
43.00	04300 NURSERY	C	0		0 0	0	
44.00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	2,037,365	5 230, 219	(2, 267, 584	306, 487	44.00
50.00	05000 OPERATING ROOM	5, 158, 759	710, 905	77, 019	5, 946, 683	803, 754	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	C	0	(0 0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 269, 483				368, 578	
55.00 57.00	05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN	880, 455 289, 352		38, 738 26, 348		148, 113 42, 670	
57.00	03630 ULTRA SOUND	110, 013		9,948		16, 214	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	231, 320		17, 359		33, 611	
59.00	05900 CARDI AC CATHETERI ZATI ON	954, 678					
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	5,006,006	305, 764	231, 08	7 5, 542, 857	749, 173	1
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	525, 879	44,899		570, 778	77, 146	
64.00	06400 I NTRAVENOUS THERAPY	C	0		0 0	0	64.00
65.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	1, 101, 050				167, 810	
66.00 67.00	06700 OCCUPATI ONAL THERAPY	5, 604, 046		373, 349	9 5,977,395 0 0	807, 905 0	
68.00	06800 SPEECH PATHOLOGY	C	o o		0 0	0	68.00
	06900 ELECTROCARDI OLOGY	815, 724					
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	1, 287, 800		1	0 0 1, 287, 800		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 207, 000			0 1, 207, 000	0	1
74.00	07400 RENAL DI ALYSI S	333, 354	13, 209		346, 563	46, 841	
76.00	03020 OTHER ANCI LLARY	007.050	0	(0	
76. 01 76. 02	03140 CARDIAC REHAB 03070 WOMEN'S CENTER	927, 052 429, 303		67, 713 37, 701		134, 452 90, 478	
76.03	03330 ENDOSCOPY	567, 361					
00.00	OUTPATIENT SERVICE COST CENTERS	4 / 60 755				001 751	00.05
90. 00 90. 01	09000 CLINIC 09001 0UTPATIENT	1, 619, 738 855, 018		117, 130 38, 498		234, 756 132, 353	
90.01 91.00	09100 EMERGENCY	2, 511, 900					
91.01	09101 SHORT STAY	C	0		0 0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
95.00	OTHER REI MBURSABLE COST CENTERS 09500 AMBULANCE SERVI CES	69, 929	0	6, 304	4 76, 233	10, 304	95.00
75.00	SPECIAL PURPOSE COST CENTERS	07,727	·10	0, 30	10,233	10,304	75.00
118.00	· · · · · · · · · · · · · · · · · · ·	116, 044, 600	11, 762, 698	4, 313, 873	3 113, 066, 494	12, 793, 330	118.00
100.00	NONREIMBURSABLE COST CENTERS	224.045	117 000	0.00	1 2/1 057	40.000	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	234, 815 35, 480, 415					190.00 192.00
	19201 FOUNDATI ON	154, 386					192.01
	19202 CLINICS	1, 252, 139	0	109, 09:		183, 984	
	19206 HOME HEALTH PARTNERSHIP	26, 223 479, 793		43, 758			192.03 192.04
	19207 WESTFIELD SCHOOLS	284, 937		43, 758			192.04
192.06	19204 MOB - NOBLESVILLE SQUARE	379, 650	0 0		379, 650	51, 313	192.06
	19205 RI VERVI EW MEDI CAL ARTS	162,074			162, 074	21, 906	192.08
	019300 NONPALD WORKERS 007950 WORKMED		°				193.00 194.00
174. UU			יו ^י 0	n (J U	0	1174.00

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	eu of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Period: From 01/01/2015 To 12/31/2015		
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPI TAL <u>RELATED COSTS</u> NEW BLDG & FI XT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMI NI STRATI VE & GENERAL	
	0	1.00	4.00	4A	5.00	
194.0107951 MEALS ON WHEELS	147, 232	0	5, 86	6 153, 098	20, 693	194.01
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers		0		0 0	0	201.00
202.00 TOTAL (sum lines 118-201)	154, 646, 264	12, 213, 185	6, 841, 49	2 154, 646, 264	18, 413, 267	202.00

Heal th	Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	LLOCATION - GENERAL SERVICE COSTS		Provi der		eriod: rom 01/01/2015	Worksheet B Part I	
				Te		Date/Time Pre	pared:
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	5/19/2016 4:5 CAFETERI A	
		PLANT	LI NEN SERVI CE		10.00	11 00	
	GENERAL SERVICE COST CENTERS	7.00	8.00	9.00	10.00	11.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	12, 172, 804					5.00 7.00
8.00	00800 LAUNDRY & LINEN SERVICE	90, 468					8.00
9.00	00900 HOUSEKEEPI NG	57, 051					9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	135, 313 284, 065		3, 907 54, 700	1, 021, 940 0	1, 771, 086	10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	000			0	23, 745	
14.00	01400 CENTRAL SERVICES & SUPPLY	170, 284			0	33, 255	
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	263, 997			0	91, 710 46, 846	
	01700 SOCIAL SERVICE	75, 108		9,708	0	18, 020	
	02300 PARAMED ED PRGM PHARMACY	7,086		0	0	1, 101	
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	2 404 449	183, 730	<u> </u>	499, 800	475 424	30.00
30.00 31.00	03100 I NTENSI VE CARE UNI T	3, 496, 648 659, 193			61, 081	475, 634 117, 846	
41.00	04100 SUBPROVI DER – I RF	613, 159			241, 945	101, 600	
43.00	04300 NURSERY	0	-		0	0	43.00
44.00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	423, 081	42, 512	109, 400	219, 114	0	44.00
50.00	05000 OPERATI NG ROOM	1, 306, 454	30, 745	238, 335	0	96, 846	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		-	0	0	52.00
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	545, 457 324, 614			0	93, 477 21, 855	1
57.00	05700 CT SCAN	021,011			0	12, 541	57.00
57.01	03630 ULTRA SOUND	0	-		0	6, 168	1
58.00 59.00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	131, 610	-	1, 701	0	11, 574 47, 337	58.00 59.00
60.00	06000 LABORATORY	561, 914			0	141, 492	60.00
60.01	06001 BLOOD LABORATORY	0	-	0	0	0	60.01
63.00 64.00	06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY	82, 513		0	0	0	63.00 64.00
65.00	06500 RESPI RATORY THERAPY	84, 296	-		0	59, 461	65.00
66.00	06600 PHYSI CAL THERAPY	0			0	88, 927	66.00
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0		0	0	67.00 68.00
69.00	06900 ELECTROCARDI OLOGY	489, 640	, i		0	37, 936	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C	0	0	0	71.00
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	72.00
	07400 RENAL DI ALYSI S	24, 274	0	0	0	0	1
76.00	03020 OTHER ANCI LLARY	0	C	0	0	0	76.00
76. 01 76. 02	03140 CARDIAC REHAB 03070 WOMEN'S CENTER	371, 973			0	24, 702	
	03330 ENDOSCOPY	115, 656			0	17, 330 22, 415	
	OUTPATIENT SERVICE COST CENTERS	1					
90. 00 90. 01	09000 CLINIC 09001 0UTPATIENT	157, 530			0	24, 732 14, 549	90.00 90.01
90.01 91.00	09100 EMERGENCY	732, 426			0	118, 895	1
91.01	09101 SHORT STAY	0	C	0	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
95.00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	0	C	0	0	3, 455	95.00
	SPECIAL PURPOSE COST CENTERS	-					
118.00		11, 344, 928	539, 529	1, 762, 115	1, 021, 940	1, 753, 449	118.00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	216, 500	0	5, 861	0	5 233	190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	464, 223			0		192.00
	19201 FOUNDATI ON	147, 153		0	0		192.01
	19202 CLINICS 19206 HOME HEALTH PARTNERSHIP	0	208	39, 071	0		192.02 192.03
	19207 WESTFIELD SCHOOLS			0	0		192.03
	19203 PRACTICE MANAGEMENT	0	192	0	0		192.05
	19204 MOB - NOBLESVILLE SQUARE 19205 RIVERVIEW MEDICAL ARTS	0	0	0	0		192.06 192.08
	19205 RIVERVIEW MEDICAL ARTS			0	o		192.08
194.00	07950 WORKMED	0	0	0	Ō	0	194.00
	07951 MEALS ON WHEELS	0	0	0	0	6, 037	194.01
200.00 201.00		0	a a	0	0	0	200.00
202.00		12, 172, 804	586, 166	1, 910, 586	1, 021, 940	1, 771, 086	

Heal th	Financial Systems	RI VERVI EW I	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
	ALLOCATION - GENERAL SERVICE COSTS				Period: From 01/01/2015	Worksheet B	
					To 12/31/2015	Date/Time Pre	pared:
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY		5/19/2016 4:5 SOCI AL SERVI CE	
		ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY		
		13.00	14.00	15.00	16.00	17.00	
1 00	GENERAL SERVICE COST CENTERS			1			1 1 00
1.00 4.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT						1.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00 10.00
11.00	01100 CAFETERI A						11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	1,006,342					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	17, 265, 256				14.00
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	0	10, 086, 69	9 0 2, 157, 588		15.00
17.00	01700 SOCIAL SERVICE	0	0		0 2, 137, 300	1, 086, 377	
23.00	02300 PARAMED ED PRGM PHARMACY	0	0		0 0	0	1
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	500.000			0 (50.044	050.00/	
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	588, 039 145, 698	0		0 658, 044 0 163, 514	853, 086 58, 629	1
41.00	04100 SUBPROVIDER - IRF	145, 670	0		0 0	95,809	
43.00	04300 NURSERY	0	0		0 0	0	1
44.00	04400 SKI LLED NURSI NG FACI LI TY	0	0		0 3, 988	78, 853	44.00
50.00	ANCI LLARY SERVI CE COST CENTERS	0	0		0 777, 689	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 15, 953	0	1
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 19, 941	0	
57.00 57.01	05700 CT SCAN 03630 ULTRA SOUND	0	0		0 0	0	57.00 57.01
58.00	05800 MAGNETIC RESONANCE I MAGI NG (MRI)	0	0		0 0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60.00	06000 LABORATORY	0	0		0 43, 870	0	60.00
60. 01 63. 00	06001 BLOOD LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	60.01 63.00
64.00	06400 INTRAVENOUS THERAPY	0	0		0 0	0	1
65.00	06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0 251, 253	0	
67.00 68.00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	0	0		0 0	0	67.00 68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 63, 810	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	17, 265, 256		0 0	0	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	
73.00 74.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0	10, 086, 69	9 0	0	73.00 74.00
76.00	03020 OTHER ANCI LLARY	0	0		0 0	0	
76.01	03140 CARDI AC REHAB	0	0		0 0	0	
76.02	03070 WOMEN' S CENTER	0	0		0 0	0	
76.03	03330 ENDOSCOPY OUTPATI ENT SERVICE COST CENTERS	0	0		0 0	0	76.03
90.00	09000 CLINIC	0	0		0 0	0	90.00
90.01	09001 OUTPATI ENT	0	0		0 0	0	90.01
91.00	09100 EMERGENCY	146, 994	0		0 151, 550	0	
91.01 92.00	09101 SHORT STAY 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	0	0		0 0	0	91.01 92.00
72.00	OTHER REIMBURSABLE COST CENTERS	11		I			72.00
95.00	09500 AMBULANCE SERVI CES	0	0		0 0	0	95.00
	SPECIAL PURPOSE COST CENTERS		17 0/5 05/	10.00/ /0		4 00 4 077	
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	1,006,342	17, 265, 256	10, 086, 69	9 2, 149, 612	1, 086, 377	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 0	0	192.00
	19201 FOUNDATI ON	0	0		0 0		192.01
	2 19202 CLI NI CS 3 19206 HOME HEALTH PARTNERSHI P	0	0		0 7,976		192. 02 192. 03
	19200 HOME HEALTH PARTNERSHIP	0	0		0 0		192.03
	19203 PRACTI CE MANAGEMENT	0	0		0 0		192.05
	19204 MOB - NOBLESVILLE SQUARE	0	0		0 0		192.06
	19205 RIVERVIEW MEDICAL ARTS	0	0	1	0 0		192.08
	19300 NONPALD WORKERS 07950 WORKMED		0				193.00 194.00
194.01	07951 MEALS ON WHEELS	0	0		0 0		194.00
200.00							200.00
201.00 202.00		1 004 242	0 17 365 354	10 004 40		0 1, 086, 377	201.00
202.00	I IVIAL (SUIII IIIIES IIO-201)	1,006,342	17, 265, 256	10, 086, 69	9 2, 157, 588	1,000,377	1202.00

Health Financial Systems	RI VERVI EW H	IOSPI TAL		In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	Fi	eriod: rom 01/01/2015 o 12/31/2015	Worksheet B Part I Date (Time Propagad)
			T		Date/Time Prepared: 5/19/2016 4:57 pm
Cost Center Description	PARAMED ED PRGM PHARMACY	Subtotal	Intern & Residents Cost	Total	
			& Post		
			Stepdown Adjustments		
	23.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	1				1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5. 00 00500 ADMINI STRATI VE & GENERAL					5.00
7.00 00700 OPERATION OF PLANT					7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG					8.00 9.00
10. 00 01000 DI ETARY					10.00
					11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY					13.00 14.00
15. 00 01500 PHARMACY					15.00
16.00 01600 MEDI CAL RECORDS & LI BRARY					16.00
17.00 01700 SOCIAL SERVICE 23.00 02300 PARAMED ED PRGM PHARMACY	249, 992				17.00 23.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	247,772				23.00
30. 00 03000 ADULTS & PEDI ATRI CS	0	18, 004, 276		18, 004, 276	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	4,072,230		4,072,230	31.00
41. 00 04100 SUBPROVI DER – I RF 43. 00 04300 NURSERY	0	4, 339, 733 0	0	4, 339, 733 0	41.00 43.00
44.00 04400 SKILLED NURSING FACILITY	0	3, 451, 019	0	3, 451, 019	44.00
		0.200 EQ(0.200 50/	F0.00
50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	0	9, 200, 506 0	0	9, 200, 506 0	50.00 52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	3, 816, 020	0	3, 816, 020	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	1, 624, 864	0	1, 624, 864	55.00
57. 00 05700 CT SCAN 57. 01 03630 ULTRA SOUND	0	370, 911 142, 343	0	370, 911 142, 343	57.00 57.01
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	295, 818		295, 818	58.00
59.00 05900 CARDI AC CATHETERI ZATI ON	0	1, 453, 717	0	1, 453, 717	59.00
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	0	7, 107, 681	0	7, 107, 681	60. 00 60. 01
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	730, 437	0	730, 437	63.00
64.00 06400 I NTRAVENOUS THERAPY	0	0	0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	1, 558, 995	0	1, 558, 995	65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0	7, 138, 237 0	0	7, 138, 237 0	66.00 67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	1, 968, 171	0	1, 968, 171	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	17, 265, 256 1, 461, 859		17, 265, 256 1, 461, 859	71.00 72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	249, 992	10, 336, 691	0	10, 336, 691	73.00
74.00 07400 RENAL DIALYSIS	0	417, 678	0	417, 678	74.00
76. 00 03020 OTHER ANCI LLARY 76. 01 03140 CARDI AC REHAB	0	0 1, 193, 423	0	0 1, 193, 423	76.00 76.01
76. 02 03070 WOMEN' S CENTER	0	1, 195, 095		1, 195, 095	76.02
76. 03 03330 ENDOSCOPY	0	933, 157		933, 157	76.03
00110011 ENT SERVICE COST CENTERS	0	1, 997, 155		1, 997, 155	90.00
90. 01 09000 0UTPATI ENT	0	1, 323, 035		1, 323, 035	90.00
91. 00 09100 EMERGENCY	0	4, 909, 661	0	4, 909, 661	91.00
91.01 09101 SHORT STAY	0	0	0	0	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS			0		92.00
95. 00 09500 AMBULANCE SERVICES	0	89, 992	0	89, 992	95.00
SPECIAL PURPOSE COST CENTERS	0.40,000	404 007 040		404 007 040	140.00
118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	249, 992	106, 397, 960	0	106, 397, 960	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	638, 360	0	638, 360	190. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	43, 785, 280		43, 785, 280	192.00
192. 01 19201 FOUNDATI ON 192. 02 19202 CLI NI CS	0	436, 757 1, 592, 470		436, 757 1, 592, 470	192. 01 192. 02
192. 03 19206 HOME HEALTH PARTNERSHIP	0	29, 767		29, 767	192.02
192.04 19207 WESTFIELD SCHOOLS	0	594, 314	0	594, 314	192.04
192. 05 19203 PRACTICE MANAGEMENT	0	376, 585		376, 585	192.05
192. 06 19204 MOB - NOBLESVILLE SQUARE 192. 08 19205 RIVERVIEW MEDICAL ARTS	0	430, 963 183, 980		430, 963 183, 980	192. 06 192. 08
193. 00 19300 NONPAI D WORKERS	0	03, 700	0	0	192.00
194.00 07950 WORKMED	0	0	0	0	194.00
194.0107951 MEALS ON WHEELS 200.00 Cross Foot Adjustments	0	179, 828	0	179, 828 0	194. 01 200. 00
	ן U	0	, U	U	200.00

Health Financial Systems RIVERVIEW HOSPITAL In Lie						2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 150059	Period: From 01/01/2015 To 12/31/2015		nared:
					5/19/2016 4:5	
Cost Center Description	PARAMED ED	Subtotal	Intern &	Total		
	PRGM PHARMACY		Residents Cos	st		
			& Post			
			Stepdown			
			Adjustments			
	23.00	24.00	25.00	26.00		
201.00 Negative Cost Centers	0	0)	0 0		201.00
202.00 TOTAL (sum lines 118-201)	249, 992	154, 646, 264		0 154, 646, 264		202.00

Heal th	Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	TION OF CAPITAL RELATED COSTS		Provi der	F	Period: From 01/01/2015 Fo 12/31/2015	Worksheet B Part II Date/Time Pre	pared:
			CAPI TAL			5/19/2016 4:5	7 pm
	Cost Center Description	Directly Assigned New Capital	RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	ADMI NI STRATI VE & GENERAL	
		Related Costs	1.00	2A	4.00	5.00	
	GENERAL SERVICE COST CENTERS	-	1	1			
1.00 4.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT		60, 994	60, 994	4 60, 994		1.00 4.00
4.00 5.00	00500 ADMINISTRATIVE & GENERAL					978, 255	4.00
7.00	00700 OPERATION OF PLANT	0				77,005	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	C	49, 228			3, 136	
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY) 31, 044 73, 630			11, 725 5, 584	9.00 10.00
11.00	01100 CAFETERI A		154, 574			9, 061	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	0	(612	6, 216	1
14.00	01400 CENTRAL SERVICES & SUPPLY	C	92, 660			107, 892	
15.00 16.00	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY		143, 654 76, 789			61, 249	
17.00	01700 SOCIAL SERVICE					12, 398 6, 283	1
23.00	02300 PARAMED ED PRGM PHARMACY	C				1, 530	
	INPATIENT ROUTINE SERVICE COST CENTERS		<u> </u>				
30.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0				67, 295	30.00
31.00 41.00	04100 SUBPROVIDER - IRF					17, 255 18, 932	31.00 41.00
43.00	04300 NURSERY			(0	43.00
44.00	04400 SKILLED NURSING FACILITY	0	230, 219	230, 219	9 0	16, 284	44.00
50.00	ANCI LLARY SERVICE COST CENTERS		740.005	710.005		10, 700	50.00
50.00 52.00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM			710, 905	5 687 0 0	42, 703 0	50.00 52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C		-	296, 809	- -	19, 582	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	C	176, 638	176, 638		7, 869	55.00
57.00	05700 CT SCAN	0	0	(235	2, 267	57.00
57. 01 58. 00	03630 ULTRA SOUND 05800 MAGNETIC RESONANCE IMAGING (MRI)) 89) 155	861 1, 786	57.01 58.00
59.00	05900 CARDI AC CATHETERI ZATI ON		71,615	71, 615		7, 968	
60.00	06000 LABORATORY	C	305, 764			39, 803	60.00
60.01	06001 BLOOD LABORATORY	0	0	(0	0	60.01
63.00 64.00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 I NTRAVENOUS THERAPY		44, 899	44, 899		4, 099 0	63.00 64.00
65.00	06500 RESPIRATORY THERAPY		45, 870	45, 870	844	8, 916	
66.00	06600 PHYSI CAL THERAPY	C	0	(3, 329	42, 924	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	(0	0	67.00
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY		0 266, 437	266, 437) () 7 () () () () () () () () () () () () ()	0 8, 245	68.00 69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0 200, 437	200, 437	0 0		71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	C	0	0	0 0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	(0	0	
74.00 76.00	07400 RENAL DIALYSIS 03020 OTHER ANCILLARY		13, 209	13, 209		2, 489 0	74.00 76.00
	03140 CARDI AC REHAB				604	7, 143	1
76. 02	03070 WOMEN'S CENTER	C	202, 408	202, 408		4, 807	
76.03		C	62, 934	62, 934	420	4, 864	76.03
90.00	OUTPATIENT SERVICE COST CENTERS				1,044	12, 472	90.00
90.01	09001 OUTPATI ENT		85, 719			7,032	
91.00	09100 EMERGENCY	C	398, 548	398, 548	3 1, 656	22, 233	
	09101 SHORT STAY	C	0	(0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS		<u> </u>	(92.00
95.00	09500 AMBULANCE SERVICES	0	0	(56	547	95.00
	SPECIAL PURPOSE COST CENTERS		1				1
118.00		0	11, 762, 698	11, 762, 698	3 38, 464	679, 703	118.00
190 00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		117, 808	117, 808	8 82	2 598	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES		252, 606			273,069	
	19201 FOUNDATI ON	C	80, 073	80, 073			192. 01
		0	0	(973		192.02
	19206 HOME HEALTH PARTNERSHIP 19207 WESTFIELD SCHOOLS				0 0 0 390		192. 03 192. 04
	19203 PRACTICE MANAGEMENT				2 416		192.05
192.06	19204 MOB - NOBLESVILLE SQUARE	C	0	0	0 0	2, 726	192.06
	19205 RIVERVIEW MEDICAL ARTS						192.08
	19300 NONPALD WORKERS 07950 WORKMED						193.00 194.00
	07951 MEALS ON WHEELS		o o		52		194.01

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150059		Peri od:	Worksheet B		
				From 01/01/2015 To 12/31/2015		pared:	
					5/19/2016 4:5	<u>7 pm</u>	
		CAPI TAL					
		RELATED COSTS					
Cost Center Description	Di rectl y	NEW BLDG &	Subtotal	EMPLOYEE	ADMI NI STRATI VE		
	Assigned New	FLXT		BENEFI TS	& GENERAL		
	Capi tal			DEPARTMENT			
	Related Costs						
	0	1.00	2A	4.00	5.00		
200.00 Cross Foot Adjustments				0		200.00	
201.00 Negative Cost Centers		0		0 0	0	201.00	
202.00 TOTAL (sum lines 118-201)	0	12, 213, 185	12, 213, 18	60, 994	978, 255	202.00	

	Financial Systems	RI VERVI EW				u of Form CMS-	2552-10
ALLOCAT	TION OF CAPITAL RELATED COSTS		Provi der	Fi	eriod: rom 01/01/2015	Worksheet B Part II	
				Т		5/19/2016 4:5	
	Cost Center Description	OPERATION OF PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		7.00	8.00	9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS						1.00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	4 4 24 1 20					5.00
	00800 LAUNDRY & LINEN SERVICE	4, 636, 129 34, 455					7.00 8.00
9.00	00900 HOUSEKEEPI NG	21, 728		1			9.00
	01000 DI ETARY	51, 535			131, 121	274 210	10.00
	01100 CAFETERIA 01300 NURSING ADMINISTRATION	108, 189		.,,	0	274, 310 3, 678	1
	01400 CENTRAL SERVICES & SUPPLY	64,854	-	-	0	5, 151	
	01500 PHARMACY	100, 546		.,	0	14, 204	
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	53, 746			0	7, 256 2, 791	
	02300 PARAMED ED PRGM PHARMACY	2, 699		-	0	171	
	INPATIENT ROUTINE SERVICE COST CENTERS	4 004 700	07.007		(4.407	70.445	
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	1, 331, 732			64, 127 7, 837	73, 665 18, 252	30.00
	04100 SUBPROVI DER – I RF	233, 527			31, 043	15, 736	1
	04300 NURSERY	0		-	0	0	
	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	161, 134	6, 300	3, 738	28, 114	0	44.00
	05000 OPERATI NG ROOM	497, 576	4, 556	8, 143	0	15, 000	50.00
	05200 DELIVERY ROOM & LABOR ROOM	0		-	0	0	52.00
	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	207, 742			0	14, 478	
	05700 CT SCAN	123, 632			0	3, 385 1, 942	
57.01	03630 ULTRA SOUND	0	C	, i i i i i i i i i i i i i i i i i i i	0	955	57.01
	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	-		0	1, 793	1
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	50, 125 214, 010		2, 336	0	7, 332 21, 915	
60. 01	06001 BLOOD LABORATORY	0		0	0	0	60.01
	06300 BLOOD STORING, PROCESSING & TRANS.	31, 426	0	0	0	0	63.00
	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0 32, 105		0 0 200	0	0 9, 209	64.00 65.00
	06600 PHYSI CAL THERAPY	0			Ő	13, 773	
	06700 OCCUPATI ONAL THERAPY	0		-	0	0	67.00
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	186, 484	0 745	-	0	0 5, 876	68.00 69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0 2, 330	0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	0	C	0	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	9, 245	0	0	0	0	73.00
	03020 OTHER ANCI LLARY	9,243	0	0	0	0	
76.01	03140 CARDI AC REHAB	0			0	3, 826	76.01
	03070 WOMEN' S CENTER 03330 ENDOSCOPY	141, 670			0	2, 684 3, 472	
	OUTPATIENT SERVICE COST CENTERS	44,049	3, 074	, U	0	3,472	70.03
	09000 CLINIC	0			0	3, 831	
	09001 OUTPATI ENT 09100 EMERGENCY	59, 997 278, 952			0	2, 253 18, 415	1
	09101 SHORT STAY	278, 452		0	0	18, 415	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	0	C	0	0	535	95.00
	SPECIAL PURPOSE COST CENTERS	0		/ U	0		95.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	4, 320, 824	79, 949	60, 205	131, 121	271, 578	118.00
H	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	82, 456		200	0	011	190.00
	19200 PHYSI CLANS' PRI VATE OFFICES	176, 804			0		190.00
	19201 FOUNDATI ON	56, 045		0	0		192. 01
	19202 CLINICS	0			0		192.02
	19206 HOME HEALTH PARTNERSHIP 19207 WESTFIELD SCHOOLS			-	0		192.03 192.04
	19203 PRACTI CE MANAGEMENT	0	28		0	0	192.05
	19204 MOB - NOBLESVILLE SQUARE	0	0	0	0		192.06
	19205 RIVERVIEW MEDICAL ARTS 19300 NONPAID WORKERS				0		192.08 193.00
	07950 WORKMED	0		0	0		194.00
194.01	07951 MEALS ON WHEELS	0	C	0	0		194.01
200.00 201.00	Cross Foot Adjustments Negative Cost Centers				0	0	200.00
201.00	TOTAL (sum lines 118-201)	4, 636, 129	86, 860	65, 278	131, 121	274, 310	
					• 1		•

Health Fin	ancial Systems	RI VERVI EW I	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	N OF CAPITAL RELATED COSTS				Period: From 01/01/2015	Worksheet B	
					To 12/31/2015	Date/Time Pre	pared:
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	5/19/2016 4:5 SOCI AL SERVI CE	/ pm
	'	ADMI NI STRATI ON	SERVICES &		RECORDS &		
		13.00	SUPPLY 14.00	15.00	LI BRARY 16.00	17.00	
	ERAL SERVICE COST CENTERS						
	00 NEW CAP REL COSTS-BLDG & FIXT 00 EMPLOYEE BENEFITS DEPARTMENT						1.00 4.00
	00 ADMINISTRATIVE & GENERAL						4.00 5.00
	OO OPERATION OF PLANT						7.00
	00 LAUNDRY & LINEN SERVICE						8.00
	00 HOUSEKEEPI NG 00 DI ETARY						9.00 10.00
	00 CAFETERI A						11.00
		10, 506	271 012				13.00
	00 CENTRAL SERVI CES & SUPPLY 00 PHARMACY	0	271, 912 0	323, 26	2		14.00 15.00
	00 MEDICAL RECORDS & LIBRARY	0	0		0 151, 236		16.00
	00 SOCIAL SERVICE	0	0		0 0	79, 060	
	OO PARAMED ED PRGM PHARMACY ATIENT ROUTINE SERVICE COST CENTERS	0	0		0 0	0	23.00
	00 ADULTS & PEDI ATRI CS	6, 139	0		0 46, 126	62, 083	30.00
	00 I NTENSI VE CARE UNI T	1,521	0		0 11, 462	4, 267	31.00
	00 SUBPROVI DER – I RF 00 NURSERY	1, 311	0			6, 972 0	41.00 43.00
	00 SKILLED NURSING FACILITY	0	0		280	5, 738	
	I LLARY SERVICE COST CENTERS	-				-	
	OO OPERATING ROOM OO DELIVERY ROOM & LABOR ROOM	0	0		0 54,510 0 0	0	50.00 52.00
	00 RADI OLOGY-DI AGNOSTI C	0	0		0 1, 118	0	54.00
	00 RADI OLOGY-THERAPEUTI C	0	0		0 1, 398	0	55.00
	00 CT SCAN 30 ULTRA SOUND	0	0			0	57.00 57.01
	00 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
59.00 059	00 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
		0	0		0 3,075 0 0	0	60.00
	01 BLOOD LABORATORY 00 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	60. 01 63. 00
	00 INTRAVENOUS THERAPY	0	0		0 0	0	64.00
		0	0		0 0	0	65.00
	00 PHYSI CAL THERAPY 00 OCCUPATI ONAL THERAPY	0	0		0 17,612 0 0	0	66.00 67.00
	00 SPEECH PATHOLOGY	0	0		0 0	0	68.00
		0	0		0 4, 473	0	69.00
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS 00 IMPL. DEV. CHARGED TO PATIENT	0	271, 912			0	71.00
73.00 073	OO DRUGS CHARGED TO PATIENTS	0	0	323, 26	2 0	0	73.00
	00 RENAL DI ALYSI S	0	0		0 0	0	74.00
	20 OTHER ANCI LLARY 40 CARDI AC REHAB	0	0			0	76.00 76.01
	70 WOMEN' S CENTER	0	0		0 0	0	76.02
	30 ENDOSCOPY	0	0		0 0	0	76.03
	PATIENT SERVICE COST CENTERS	0	0		0 0	0	90.00
	01 OUTPATI ENT	0	0		0 0	0	
	00 EMERGENCY	1, 535	0		0 10, 623	0	91.00
	01 SHORT STAY 00 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0	0		0 0	0	91.01 92.00
	ER REIMBURSABLE COST CENTERS	<u> </u>				L	72.00
	00 AMBULANCE SERVI CES	0	0		0 0	0	95.00
118.00	CIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)	10, 506	271, 912	323, 26	2 150, 677	70.060	118.00
	REIMBURSABLE COST CENTERS	10, 500	271, 912	525, 20	2 130, 077	79,000	118.00
190.00190	OO GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190. 00
	00 PHYSI CI ANS' PRI VATE OFFI CES 01 FOUNDATI ON	0	0		0 0		192. 00 192. 01
	02 CLINICS	0	0		559		192.01
	06 HOME HEALTH PARTNERSHIP	0	0		0 0	0	192. 03
	07 WESTFIELD SCHOOLS	0	0		0 0		192.04
	03 PRACTICE MANAGEMENT 04 MOB - NOBLESVILLE SQUARE		0				192. 05 192. 06
192.08 192	05 RIVERVIEW MEDICAL ARTS	0	0		o o	0	192.08
	00 NONPAID WORKERS	0	0		0 0		193.00
	50 WORKMED 51 MEALS ON WHEELS		0				194. 00 194. 01
200.00	Cross Foot Adjustments		0				200.00
201.00	Negative Cost Centers	0	0				201.00
202.00	TOTAL (sum lines 118-201)	10, 506	271, 912	323, 26	2 151, 236	/9,060	202.00

	Financial Systems ION OF CAPITAL RELATED COSTS	RI VERVI EW I		CCN: 150059 Pe	In Lieu riod:	u of Form CMS-2552-1 Worksheet B
ALLOCAT	TON OF CALLINE RELATED COSTS		i i ovi dei		om 01/01/2015	Part II Date/Time Prepared: 5/19/2016 4:57 pm
	Cost Center Description	PARAMED ED PRGM PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	5/17/2010 4. 57 pm
		23.00	24.00	25.00	26.00	
	SENERAL SERVICE COST CENTERS			1		
4.00 0 5.00 0 7.00 0 8.00 0 9.00 0 10.00 0	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA					1.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00
14.00 0 15.00 0	01300 NURSENG ADMENTSTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY					13.00 14.00 15.00 16.00
	01700 SOCIAL SERVICE	0.000				17.00
	02300 PARAMED ED PRGM PHARMACY NPATIENT ROUTINE SERVICE COST CENTERS	8, 332				23.00
	33000 ADULTS & PEDIATRICS		3, 607, 660	0 0	3, 607, 660	30.00
	03100 INTENSIVE CARE UNIT		681, 522		681, 522	31.00
	04100 SUBPROVIDER - IRF		653, 265		653, 265 0	41.00
	04300 NURSERY 04400 SKILLED NURSING FACILITY		451, 807	0	451, 807	43.00
	NCI LLARY SERVICE COST CENTERS		101,007		101,007	
	D5000 OPERATING ROOM		1, 334, 080		1, 334, 080	50.00
1	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC		C 547, 316	Ű	0 547, 316	52.00 54.00
	05500 RADI OLOGY-THERAPEUTI C		314, 304	-	314, 304	55.00
	D5700 CT SCAN		4,444	0	4, 444	57.00
1	03630 ULTRA SOUND		1, 905		1, 905	57.0
1	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION		3, 801 140, 024		3, 801 140, 024	58.00 59.00
	06000 LABORATORY		588, 963		588, 963	60.00
	06001 BLOOD LABORATORY		C	0 0	0	60. O ^r
	06300 BLOOD STORING, PROCESSING & TRANS.		80, 424	0	80, 424	63.00
	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY		97, 144		97, 144	64. 00 65. 00
	06600 PHYSI CAL THERAPY		78, 637		78, 637	66. 00
	06700 OCCUPATI ONAL THERAPY		C	0 0	0	67.00
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY		C 475, 185	0	475 195	68.00 69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		475, 185 271, 912	-	475, 185 271, 912	71.00
	07200 I MPL. DEV. CHARGED TO PATIENT		9, 248		9, 248	72.00
73.00 0	07300 DRUGS CHARGED TO PATIENTS		323, 262	2 0	323, 262	73.00
	07400 RENAL DI ALYSI S 03020 OTHER ANCI LLARY		24, 943		24, 943	74.00 76.00
	03140 CARDI AC REHAB		12, 972		12, 972	76.0
	03070 WOMEN' S CENTER		353, 806		353, 806	76. 02
			119, 613	8 0	119, 613	76. 03
	DUTPATIENT SERVICE COST CENTERS		17, 465	j 0	17, 465	90.00
	09001 OUTPATI ENT		158, 505		158, 505	90. 0
	09100 EMERGENCY		749, 359		749, 359	91.00
	09101 SHORT STAY 09200 OBSERVATION BEDS (NON-DISTINCT PART)		C	0	0	91. 0 ⁻ 92. 00
	THER REIMBURSABLE COST CENTERS			0		92.00
95.00 0	09500 AMBULANCE SERVI CES		1, 138	3 0	1, 138	95.00
	SPECIAL PURPOSE COST CENTERS	-1				
118.00	SUBTOTALS (SUM OF LINES 1-117) IONREI MBURSABLE COST CENTERS	0	11, 102, 704	0	11, 102, 704	118. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		203, 955	j 0	203, 955	190. 00
192.001	19200 PHYSI CLANS' PRI VATE OFFI CES		733, 352	0	733, 352	192.00
	19201 FOUNDATION		139,030		139,030	192. 0 [°]
	19202 CLINICS 19206 HOME HEALTH PARTNERSHIP		12, 673 188		12, 673 188	192. 02 192. 03
	19207 WESTFIELD SCHOOLS		4, 150		4, 150	192. 04
	19203 PRACTICE MANAGEMENT		2, 825		2, 825	192. 05
	19204 MOB - NOBLESVILLE SQUARE		2, 726		2,726	192.00
	19205 RIVERVIEW MEDICAL ARTS 19300 NONPAID WORKERS		1, 164 C		1, 164	192. 08 193. 00
	07950 WORKMED		C	0	0	194.00
	07951 MEALS ON WHEELS		2, 086		2, 086	194. 01
200.00	Cross Foot Adjustments	8, 332	8, 332	2 0	8, 332	200. 00

Health Financial Systems RIVERVIEW HOSPITAL In Lieu						u of Form CMS-	2552-10
ALLOCATI ON	OF CAPITAL RELATED COSTS		Provi der		Period: From 01/01/2015	Worksheet B Part II	
					To 12/31/2015		
	Cost Center Description	PARAMED ED	Subtotal	Intern &	Total		
		PRGM PHARMACY		Residents Cos	t		
				& Post			
				Stepdown			
				Adjustments			
		23.00	24.00	25.00	26.00		
201.00	Negative Cost Centers	0	0		0 0		201.00
202.00	TOTAL (sum lines 118-201)	8, 332	12, 213, 185		0 12, 213, 185		202.00

	Financial Systems LLOCATION - STATISTICAL BASIS	RI VERVI EW		CCN: 150059 F	In Lie Period:	u of Form CMS- Worksheet B-1	
				F	rom 01/01/2015 o 12/31/2015		pared:
	Cost Center Description	CAPI TAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	Reconciliatior	ADMI NI STRATI VE & GENERAL (ACCUM. COST)		
		1.00	4.00	5A	5.00	7.00	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT	490, 981					1.00
4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION	2, 452 39, 022 183, 224 1, 979 1, 248 2, 960 6, 214 0	65, 380, 562 8, 124, 369 1, 516, 294 43, 900 837, 598 256, 248 660, 947 655, 458	-18, 413, 267	10, 723, 426 436, 677 1, 632, 840 777, 617 1, 261, 779 865, 602	266, 283 1, 979 1, 248 2, 960 6, 214 0	4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	3, 725 5, 775	680, 597 2, 079, 509				1
16.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	3, 087 1, 643	764, 725 546, 399	i C	1, 726, 502	3, 087	16.00
23.00	02300 PARAMED ED PRGM PHARMACY	155	81, 098	c C	213, 014	155	23.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	76, 490	6, 089, 484	C	9, 371, 218	76, 490	30.00
	03100 I NTENSI VE CARE UNI T	14, 420	1, 663, 181			14, 420	
	04100 SUBPROVIDER - IRF 04300 NURSERY	13, 413	1, 183, 010 0			13, 413 0	1
	04400 SKI LLED NURSI NG FACI LI TY ANCI LLARY SERVI CE COST CENTERS	9, 255	0		-	9, 255	•
	05000 OPERATI NG ROOM	28, 579	736, 027	' C	5, 946, 683	28, 579	50.00
	05200 DELIVERY ROOM & LABOR ROOM	11 022	1 525 544		-	11 022	
	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	11, 932 7, 101	1, 535, 544 370, 201			11, 932 7, 101	
	05700 CT SCAN	0	251, 798				
	03630 ULTRA SOUND	0	95, 067			0	
	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	0 2, 879	165, 887 796, 731				
	06000 LABORATORY	12, 292	2, 208, 382			12, 292	
	06001 BLOOD LABORATORY	0	0	C	-	0	
	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	1,805	0			1, 805 0	1
	06500 RESPI RATORY THERAPY	1, 844	904, 493	-	-	1, 844	•
	06600 PHYSI CAL THERAPY	0	3, 567, 907				
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0			0	
	06900 ELECTROCARDI OLOGY	10, 711	631, 008				
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	0 0	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0	0		1, 287, 800	0	
	07400 RENAL DIALYSIS	531	0		346, 563	531	
	03020 OTHER ANCI LLARY	0	0) C	0	0	76.00
	03140 CARDIAC REHAB 03070 WOMEN'S CENTER	0 8, 137	647, 100 360, 289				
	03330 ENDOSCOPY	2, 530	450, 007				
	OUTPATIENT SERVICE COST CENTERS			1			
	09000 CLI NI C 09001 OUTPATI ENT	0 3, 446	1, 119, 413 367, 902		1, 736, 874 979, 235		
	09100 EMERGENCY	16, 022	1, 774, 642				
	09101 SHORT STAY	0	0	C		0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
95.00	09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	0	60, 243	C	76, 233	0	95.00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	472, 871	41, 225, 458	-18, 413, 267	94, 653, 227	248, 173	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	4, 736	88, 240				190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	10, 155	21, 960, 520				192.00
	19201 FOUNDATI ON 19202 CLI NI CS	3, 219 0	143, 867 1, 042, 536				192. 01 192. 02
192.03	19206 HOME HEALTH PARTNERSHIP	0	0	C	26, 223	0	192. 03
	19207 WESTFIELD SCHOOLS	0	418, 170		523, 551		192. 04 192. 05
	19203 PRACTICE MANAGEMENT 19204 MOB - NOBLESVILLE SQUARE	0	445, 712 0) 331, 577 379, 650		192.05
192.08	19205 RIVERVIEW MEDICAL ARTS	0	0		162, 074	0	192. 08
	19300 NONPALD WORKERS	0	0				193.00
194.00	07950 WORKMED	0	0) C	0	0	194.00

Health Fir	nancial Systems	RI VERVI EW	HOSPI TAL		In Lieu of Form CMS-2552-10		
COST ALLO	CATION - STATISTICAL BASIS		Provi der	CCN: 150059	Peri od:	Worksheet B-1	
					From 01/01/2015 To 12/31/2015		
		CAPI TAL					
		RELATED COSTS					
	Cost Center Description	NEW BLDG & FLXT	EMPLOYEE BENEFI TS	Reconciliati	on ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	
		(SQUARE	DEPARTMENT		(ACCUM.	(SQUARE	
		FEET)	(GROSS		COST)	FEET)	
			SALARI ES)				
		1.00	4.00	5A	5.00	7.00	
194.01079	51 MEALS ON WHEELS	0	56, 059		0 153, 098	0	194.01
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	12, 213, 185	6, 841, 492		18, 413, 267	12, 172, 804	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	24. 875066	0. 104641		0. 135160	45. 713786	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)		60, 994		978, 255	4, 636, 129	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)		0. 000933		0. 007181	17. 410533	205.00

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	RI VERVI EW		CCN: 150059	In Lie Period:	u of Form CMS-: Worksheet B-1	
			1	From 01/01/2015 To 12/31/2015		pared:
Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (HOURS OF SERVI CE)	DI ETARY (MEALS SERVED)	CAFETERI A (MAN HOURS)	NURSI NG ADMI NI STRATI ON (DI RECT NRSI NG HRS)	
	8.00	9.00	10.00	11.00	13.00	
GENERAL SERVI CE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 4.00 00400 EMPLOYEE BENEFI TS DEPARTMENT 5.00 00500 ADMI NI STRATI VE & GENERAL 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LI NEN SERVI CE 9.00 00900 HOUSEKEEPI NG	73, 174 0	978				1.00 4.00 5.00 7.00 8.00 9.00
10.00 01000 DI ETARY 11.00 01100 CAFETERIA 13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 01400 CENTRAL SERVI CES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDI CAL RECORDS & LI BRARY 17.00 01700 SOCI AL SERVI CE 23.00 02300 PARAMED ED PRGM PHARMACY	0 0 550 0 0 0 0	2 28 0 1 25 5 0 0 0		3 0 1, 479, 281 19, 833 0 27, 776 0 76, 600 0 39, 128 0 15, 051 0 920	679, 861 0 0 0 0 0 0	10.00 11.00 13.00 14.00 15.00 16.00 17.00 23.00
30. 00 03000 ADULTS & PEDI ATRI CS	22, 936	313	38, 63	8 397, 265	397, 265	30.00
31. 00 03100 I NTENSI VE CARE UNI T	5, 347	49	4, 72	2 98, 430	98, 430	31.00
41. 00 04100 SUBPROVI DER – I RF 43. 00 04300 NURSERY	5, 717	63	18, 70	4 84, 860 D 0	84, 860 0	41.00 43.00
44. 00 04400 SKI LLED NURSI NG FACI LI TY	5, 307	56	16, 93	9 0	0	
ANCI LLARY SERVI CE COST CENTERS	2 020	100			0	50.00
50.00 05000 0PERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	3,838	122		0 80, 890 0 0	0	50.00 52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	4, 285	16		0 78, 076	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C 57. 00 05700 CT SCAN	592	5		0 18, 254 0 10, 475	0	55.00 57.00
57. 01 03630 ULTRA SOUND	0	0		5 152	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1		9, 667	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	1,888	0 35		0 39, 538 0 118, 180	0	59.00 60.00
60. 01 06001 BLOOD LABORATORY	0	0		0 0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	0	0			0	64.00 65.00
66. 00 06600 PHYSI CAL THERAPY	617	4		0 49,664 0 74,275	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
	0	0			0	68.00 69.00
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	628	35 0		0 31,686 0 0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	
74. 00 07400 RENAL DI ALYSI S 76. 00 03020 OTHER ANCI LLARY	0	0		0 0	0	74.00 76.00
76. 01 03140 CARDI AC REHAB	54	20		20, 632	0	76.01
76. 02 03070 WOMEN' S CENTER 76. 03 03330 ENDOSCOPY	365	22 0		0 14,475 0 18,722	0	76.02
OUTPATIENT SERVICE COST CENTERS	3, 264	0		0 18, 722	0	76.03
90. 00 09000 CLI NI C	99	0		20, 657	0	
90. 01 09001 0UTPATI ENT 91. 00 09100 EMERGENCY	1, 988 9, 877	12 85		0 12, 152 0 99, 306	0 99, 306	90. 01 91. 00
91. 01 09101 SHORT STAY	0	0		0 0	0	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVI CES	0	0		2, 886	0	95.00
SPECIAL PURPOSE COST CENTERS	,			2,000	~	70100
118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	67, 352	902	79, 00		679, 861	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3		0 4, 371		190. 00 192. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 192. 01 19201 FOUNDATI ON	5, 772	53 0		5,318		192.00
192. 02 19202 CLI NI CS	26	20		0 0	0	192.02
192. 03 19206 HOME HEALTH PARTNERSHIP 192. 04 19207 WESTFI ELD SCHOOLS	0	0				192. 03 192. 04
192. 04 19207 WESTFIELD SCHOOLS 192. 05 19203 PRACTICE MANAGEMENT	24	0				192.04 192.05
192.06 19204 MOB - NOBLESVILLE SQUARE	0	0		0 0	0	192.06
192. 08 19205 RI VERVI EW MEDI CAL ARTS 193. 00 19300 NONPAI D WORKERS	0	0				192. 08 193. 00
193. 00 19300 NONPATD WORKERS 194. 00 07950 WORKMED	0	0				193.00 194.00
194.01 07951 MEALS ON WHEELS	0	0		5, 042		194.01
200.00 Cross Foot Adjustments						200.00

Heal th	- Financial Systems	RI VERVI EW	HOSPI TAL		In Lieu of Form CMS-2552-10		
COST AL	LOCATION - STATISTICAL BASIS		Provi der		Period:	Worksheet B-1	
					From 01/01/2015 To 12/31/2015		
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
		LINEN SERVICE	(HOURS OF	(MEALS	(MAN	ADMI NI STRATI ON	
		(POUNDS OF	SERVI CE)	SERVED)	HOURS)		
		LAUNDRY)				(DI RECT	
						NRSING HRS)	
		8.00	9.00	10.00	11.00	13.00	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	586, 166	1, 910, 586	1, 021, 94	0 1, 771, 086	1, 006, 342	202.00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	8. 010578	1, 953. 564417	12. 93545	8 1. 197261	1. 480217	203.00
204.00	Cost to be allocated (per Wkst. B,	86, 860	65, 278	131, 12	1 274, 310	10, 506	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	1. 187034	66. 746421	1.65969	6 0. 185435	0. 015453	205.00
					1		

	RI VERVI EW H		CCN: 150050			
LLUCATION - STATISTICAL DASIS		Provider	1	From 01/01/2015	Date/Time Pre	pared:
Cost Center Description	CENTRAL SERVI CES & SUPPLY (COSTED PEOULS)	PHARMACY (COSTED REQUI S.)	MEDI CAL RECORDS & LI BRARY (TI ME SDENT)	SOCI AL SERVI CE (TI ME SPENT)	PARAMED ED PRGM PHARMACY (ASSI GNED TI ME)	
	14.00	15.00	16.00	17.00	23.00	
GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	100 0 0	100 0 0				1.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 17.00
02300 PARAMED ED PRGM PHARMACY	0	0			100	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS O3000 ADULTS & PEDI ATRI CS O3100 I NTENSI VE CARE UNI T O4100 SUBPROVI DER - I RF O4300 NURSERY O4400 SKI LLED NURSI NG FACI LI TY	0 0 0 0 0	0 0 0 0 0	4	1 287	0 0 0 0 0	31.00 41.00 43.00
ANCI LLARY SERVICE COST CENTERS		0	10		0	50.00
05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC 05500 RADIOLOGY-THERAPEUTIC 05700 CT SCAN 03630 ULTRA SOUND 05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06001 BLOOD LABORATORY 06300 BLOOD STORING PROCESSING & TRANS.		0 0 0 0 0 0 0 0 0 0 0	(((1 ¹	4 0 5 0 0 0 0 0 0 0 0 0 0 0 1 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0	52.00 54.00 55.00 57.00 57.01 58.00 59.00 60.00 60.01 63.00
06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENT 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 03020 OTHER ANCI LLARY	0 0 0 0 0 100 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	((((10) (0 0 0 0 3 0 0 0 0 0 6 0 0 0	0 0 0 0 0 0 0 100 0 0 0 0	64.00 65.00 66.00 67.00 68.00 69.00 71.00 72.00 73.00 74.00 76.00
	0	0			0	
	0	0	(0 0	0	76.03
09000 CLINIC 09001 OUTPATIENT 09100 EMERGENCY 09101 SHORT STAY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0 0 0	0 0 0 0	(0 0	0 0 0 0	90. 01 91. 00
	0	0	(0 0	0	95.00
SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)	100	100	539	9 5, 318	100	118.00
19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CLANS' PRI VATE OFFI CES 19201 FOUNDATI ON 19202 CLI NI CS 19206 HOME HEALTH PARTNERSHI P 19207 WESTFI ELD SCHOOLS 19203 PRACTI CE MANAGEMENT 19204 MOB - NOBLESVI LLE SQUARE 19205 RI VERVI EW MEDI CAL ARTS 19300 NONPAI D WORKERS 07950 WORKMED 07951 MEALS ON WHEELS				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 0 0 0 0 0 0 0 0 0 0 0 0 0	190.00 192.00 192.01 192.02 192.03 192.04 192.05 192.06 192.08 193.00 194.00 194.01 200.00
	GENERAL SERVI CE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFI TS DEPARTIENT 00500 ADMI NI STRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPI NG 01100 CAFETERIA 01300 NURSI NG ADMI NI STRATI ON 01400 01400 CENTRAL SERVICE SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVICE OST CENTERS 03000 ADULTS & PEDI ATRICS 03100 INTENSIVE CARE UNIT 04100 SULLED NURSI NG FACI LI TY AMOD SUPROVI DER I RF 04400 SULLED NURSI NG FACI LI TY ANCI LLARY SERVI CE COST CENTERS 05000 DEPERATI NG <t< td=""><td>LLLOCATION - STATISTICAL BASIS Cost Center Description CENTRAL SERVICES & SUPPLY (COSTED REDUIS.) GENERAL SERVICE COST CENTERS 14.00 GOTOONEX CAP REL COSTS-BLDG & FIXT (OAGO EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00700 OPERATION OF PLANT 008000 LAUNDRY & LINEN SERVICE 009000 HOUSEKEEPING 10100 CAFETERIA 013000 NURSING ADMINISTRATION 011000 CAFETERIA 013000 NURSING ADMINISTRATION 011000 CAFETERIA 013000 NURSING ADMINISTRATION 01500 PHARMACY 00 01400 CENTRAS SERVICES SUPPLY 01000 SOCIAL SERVICE 02300 PARAMEDE DP PROM PHARMACY 0 013000 INTENDE ED PROM PHARMACY 017000 SOCIAL SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 03000 INTENVE CARE UNIT 04100 SUBPROVIDER - I RF 043000 NISERVY 00 Ad300 NISERVY 00 Ad300 NISERVY 00 Ad300 NISERVY 00 Ad300 DOPERATING ROOM 00 SOCIAL SERVICE CONT CENTERS 05000 DOPERATING ROOM 00 SOCIAL SERVICE CONT CENTERS 05000 DOPERATING ROOM 00 SOCIAD DICGY-THERAPEUTIC 00 SOCIAD DICGY-THERAPEUTIC 00 SOCIAD DICGY-THERAPEUTIC 00 SOCIAD CATHETRIZATION 00 AG300 NICT CRESONANCE I MAGING (MRI) 00 SOCIAD CATHETRIZATION 00 AG300 NICT CRESONANCE I MAGING (MRI) 00 SOCIAD CACHETRIZ RATION 00 AG300 DICGY THERAPEY 00 AG300 DICGY THERAPEY 00 AG300 DICGY THERAPY 00 AG300 DICGY THERAPY 00 AG300 DICGY TO PATIENTS 00 AG300 DICGY THERAPY 00 AG300 DICGY THERAPY 00 AG300 NICT CRESONANCE I MAGING (MRI) 00 SOCIO CARDIAC CATHETER 200 00 AG300 DICGY THERAPY 00 AG300 DIN</td><td>LLLOCATION - STATISTICAL BASIS Provider Cost Center Description SERVICES & SERVICES & COSTED REQUIS.) PHARMACY (COSTED REQUIS.) GENERAL SERVICE COST CENTERS 14.00 15.00 GENERAL SERVICE COST CENTERS 14.00 15.00 GENERAL SERVICE COST SERVICE OOTOO NEW CAP REL COSTS-BLOC & FIXT OOGOO ADMINISTRATIVE & GENERAL OOTOO DEPEATION OF PLANT OOTOO DEPEATION OF PLANT OOTOO DEPEATERIA 0 OOTOO DEPEATION OF DEPARTMENT OOTOO DEPEATERIA 0 0 OOTOO DEPEATERIA 0 0 OTOO DI ETARY 0 0 OTOO DI ETARY 0 0 OTOO DI ETARY 0 0 OTOO SOCIAL SERVICE SUPPLY 100 OTOO SOCIAL RECORDS & LIBRARY 0 0 OTOO SOCIAL SERVICE COST CENTERS 0 0 OADOO SUPTA & PEDIATICS 0 0 0 OADOO SOCIAL SERVICE COST CENTERS 0 0 0 OSOOD PHARMACY 0 0 0 0 OSOOD PHARMACY 0 0 0 0 OSOOD PHARMACY 0 0</td><td>LLICATION - STATISTICAL BASIS Provider CCN: 150059 MEDICAL Cost Center Description SERVICES & SUPPLY CONTRAL SERVICES & SUPPLY PRAMMCY (COSTED) MEDICAL CONTRAL SERVICE COST CENTERS 14.00 15.00 T6.00 ODTOO INFE CARE LOSTS - LING & FLYT (TIME COSTED) 15.00 T6.00 ODTOO INFE CARE LOSTS - LING & FLYT (COSTED) 1000 T6.00 ODTOO INFE CARE LOSTS - LING & FLYT (COSTED) 1000 T6.00 ODTOO INFE CARE LOSTS - LING & FLYT (COSTED) 1000 T6.00 ODTOO INFE CARE LOSTS - LING & FLYT (COSTED) 1000 1000 ODTOO INFE CARE A SUPPLY (COSTED) 1000 1000 ODTOO INFE CARY (COSTED) 1000 1000 ODTOO INFE CARE A SUPPLY (COSTED) 1000 1000 ODTOO INFER CARY (COSTED) 0 0 1000 ODTOO INFERCE A SUPPLY (COSTED) 1000 0 1000 ODTOO INFERCE ARY (COSTED) 0 0 1000 ODTOO INFERCE ARY (COSTED) 0 0 1000 ODTOO INFERCE ARY (COSTED) 0 0 1000</td><td>LLUCATION - STATISTICAL BASIS Provider CCN-150069 Provider CCN-15006 COSTED Provider CCN-15006 Provi</td><td>LLLCATION - STATISTICAL BASIS Provider CDC: 15009/ Period: To M23/2016 -5. SUPPLY Cost Center Description Cost Center Descript</td></t<>	LLLOCATION - STATISTICAL BASIS Cost Center Description CENTRAL SERVICES & SUPPLY (COSTED REDUIS.) GENERAL SERVICE COST CENTERS 14.00 GOTOONEX CAP REL COSTS-BLDG & FIXT (OAGO EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00700 OPERATION OF PLANT 008000 LAUNDRY & LINEN SERVICE 009000 HOUSEKEEPING 10100 CAFETERIA 013000 NURSING ADMINISTRATION 011000 CAFETERIA 013000 NURSING ADMINISTRATION 011000 CAFETERIA 013000 NURSING ADMINISTRATION 01500 PHARMACY 00 01400 CENTRAS SERVICES SUPPLY 01000 SOCIAL SERVICE 02300 PARAMEDE DP PROM PHARMACY 0 013000 INTENDE ED PROM PHARMACY 017000 SOCIAL SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 03000 INTENVE CARE UNIT 04100 SUBPROVIDER - I RF 043000 NISERVY 00 Ad300 NISERVY 00 Ad300 NISERVY 00 Ad300 NISERVY 00 Ad300 DOPERATING ROOM 00 SOCIAL SERVICE CONT CENTERS 05000 DOPERATING ROOM 00 SOCIAL SERVICE CONT CENTERS 05000 DOPERATING ROOM 00 SOCIAD DICGY-THERAPEUTIC 00 SOCIAD DICGY-THERAPEUTIC 00 SOCIAD DICGY-THERAPEUTIC 00 SOCIAD CATHETRIZATION 00 AG300 NICT CRESONANCE I MAGING (MRI) 00 SOCIAD CATHETRIZATION 00 AG300 NICT CRESONANCE I MAGING (MRI) 00 SOCIAD CACHETRIZ RATION 00 AG300 DICGY THERAPEY 00 AG300 DICGY THERAPEY 00 AG300 DICGY THERAPY 00 AG300 DICGY THERAPY 00 AG300 DICGY TO PATIENTS 00 AG300 DICGY THERAPY 00 AG300 DICGY THERAPY 00 AG300 NICT CRESONANCE I MAGING (MRI) 00 SOCIO CARDIAC CATHETER 200 00 AG300 DICGY THERAPY 00 AG300 DIN	LLLOCATION - STATISTICAL BASIS Provider Cost Center Description SERVICES & SERVICES & COSTED REQUIS.) PHARMACY (COSTED REQUIS.) GENERAL SERVICE COST CENTERS 14.00 15.00 GENERAL SERVICE COST CENTERS 14.00 15.00 GENERAL SERVICE COST SERVICE OOTOO NEW CAP REL COSTS-BLOC & FIXT OOGOO ADMINISTRATIVE & GENERAL OOTOO DEPEATION OF PLANT OOTOO DEPEATION OF PLANT OOTOO DEPEATERIA 0 OOTOO DEPEATION OF DEPARTMENT OOTOO DEPEATERIA 0 0 OOTOO DEPEATERIA 0 0 OTOO DI ETARY 0 0 OTOO DI ETARY 0 0 OTOO DI ETARY 0 0 OTOO SOCIAL SERVICE SUPPLY 100 OTOO SOCIAL RECORDS & LIBRARY 0 0 OTOO SOCIAL SERVICE COST CENTERS 0 0 OADOO SUPTA & PEDIATICS 0 0 0 OADOO SOCIAL SERVICE COST CENTERS 0 0 0 OSOOD PHARMACY 0 0 0 0 OSOOD PHARMACY 0 0 0 0 OSOOD PHARMACY 0 0	LLICATION - STATISTICAL BASIS Provider CCN: 150059 MEDICAL Cost Center Description SERVICES & SUPPLY CONTRAL SERVICES & SUPPLY PRAMMCY (COSTED) MEDICAL CONTRAL SERVICE COST CENTERS 14.00 15.00 T6.00 ODTOO INFE CARE LOSTS - LING & FLYT (TIME COSTED) 15.00 T6.00 ODTOO INFE CARE LOSTS - LING & FLYT (COSTED) 1000 T6.00 ODTOO INFE CARE LOSTS - LING & FLYT (COSTED) 1000 T6.00 ODTOO INFE CARE LOSTS - LING & FLYT (COSTED) 1000 T6.00 ODTOO INFE CARE LOSTS - LING & FLYT (COSTED) 1000 1000 ODTOO INFE CARE A SUPPLY (COSTED) 1000 1000 ODTOO INFE CARY (COSTED) 1000 1000 ODTOO INFE CARE A SUPPLY (COSTED) 1000 1000 ODTOO INFER CARY (COSTED) 0 0 1000 ODTOO INFERCE A SUPPLY (COSTED) 1000 0 1000 ODTOO INFERCE ARY (COSTED) 0 0 1000 ODTOO INFERCE ARY (COSTED) 0 0 1000 ODTOO INFERCE ARY (COSTED) 0 0 1000	LLUCATION - STATISTICAL BASIS Provider CCN-150069 Provider CCN-15006 COSTED Provider CCN-15006 Provi	LLLCATION - STATISTICAL BASIS Provider CDC: 15009/ Period: To M23/2016 -5. SUPPLY Cost Center Description Cost Center Descript

Heal th Fi	nancial Systems	RI VERVI EW HOSPI TAL			In Lieu of Form CMS-2552-10		
COST ALLO	CATION - STATISTICAL BASIS		Provider CCN: 150059		Period:	Worksheet B-1	
					From 01/01/2015 To 12/31/2015	Date/Time Pre 5/19/2016 4:5	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCI AL SERVI CE		
		SERVICES &	(COSTED	RECORDS &		PRGM PHARMACY	
		SUPPLY	REQUIS.)	LI BRARY	(TIME	(ASSI GNED	
		(COSTED		(TIME	SPENT)	TIME)	
		REQUIS.)		SPENT)		, , , , , , , , , , , , , , , , , , ,	
		14.00	15.00	16.00	17.00	23.00	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	17, 265, 256	10, 086, 699	2, 157, 58	3 1, 086, 377	249, 992	202.00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	172, 652. 560000	100, 866. 990000	3, 988. 14787	4 204. 283001	2, 499. 920000	203.00
204.00	Cost to be allocated (per Wkst. B,	271, 912	323, 262	151, 23	5 79, 060	8, 332	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	2, 719. 120000	3, 232. 620000	279. 54898	3 14. 866491	83. 320000	205.00
	11)						

	ancial Systems	RI VERVI EW				u of Form CMS-2	2552-10
COMPUTATI ON	N OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 150059	Period: From 01/01/2015	Worksheet C Part I	
					To 12/31/2015	Date/Time Pre 5/19/2016 4:5	pared:
			Ti tl	e XVIII	Hospi tal	PPS	<u>/ piii</u>
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
		(from Wkst. B, Part I, col.	Adj .		Di sal I owance		
		26)					
		1.00	2.00	3.00	4.00	5.00	
I NPA	TIENT ROUTINE SERVICE COST CENTERS						
	00 ADULTS & PEDIATRICS	18, 004, 276		18, 004, 2			
	DO INTENSIVE CARE UNIT	4, 072, 230		4, 072, 2		4, 072, 230	
	00 SUBPROVI DER – I RF	4, 339, 733		4, 339, 7		4, 339, 733	
	00 NURSERY	0		0.454.0	0 0	0	
	00 SKILLED NURSING FACILITY	3, 451, 019		3, 451, 0	19 0	3, 451, 019	44.00
	LLARY SERVICE COST CENTERS	9, 200, 506		9, 200, 5	0 0	9, 200, 506	50.00
	DO DELIVERY ROOM & LABOR ROOM	9,200,300		7,200,3	0 0	9,200,300	1
	00 RADI OLOGY-DI AGNOSTI C	3, 816, 020		3, 816, 0	-	3, 816, 020	
	00 RADI OLOGY-THERAPEUTI C	1, 624, 864		1, 624, 8		1, 624, 864	
	DO CT SCAN	370, 911		370, 9		370, 911	
57.01 0363	BO ULTRA SOUND	142, 343		142, 3	43 0	142, 343	57.01
	00 MAGNETIC RESONANCE IMAGING (MRI)	295, 818		295, 8	18 0	295, 818	58.00
	00 CARDI AC CATHETERI ZATI ON	1, 453, 717		1, 453, 7		1, 453, 717	
	00 LABORATORY	7, 107, 681		7, 107, 6		7, 107, 681	
	1 BLOOD LABORATORY	0			0 0	0	
	00 BLOOD STORING, PROCESSING & TRANS.	730, 437		730, 4		730, 437	
	00 I NTRAVENOUS THERAPY 00 RESPI RATORY THERAPY	1, 558, 995	0	1, 558, 9	0 0 95 0	0 1, 558, 995	
	00 PHYSI CAL THERAPY	7, 138, 237				7, 138, 237	•
	00 OCCUPATIONAL THERAPY	7, 138, 237			0 0	7, 130, 237	•
	O SPEECH PATHOLOGY	0	0		0 0	0	•
	O ELECTROCARDI OLOGY	1, 968, 171	-	1, 968, 1		1, 968, 171	•
	DO MEDICAL SUPPLIES CHARGED TO PATIENTS	17, 265, 256		17, 265, 2		17, 265, 256	•
72.00 0720	OO IMPL. DEV. CHARGED TO PATIENT	1, 461, 859		1, 461, 8	59 0	1, 461, 859	72.00
	DO DRUGS CHARGED TO PATIENTS	10, 336, 691		10, 336, 6	91 0	10, 336, 691	73.00
	00 RENAL DIALYSIS	417, 678		417, 6		417, 678	•
	20 OTHER ANCI LLARY	0			0 0	0	
	O CARDI AC REHAB	1, 193, 423		1, 193, 4		1, 193, 423	
	O WOMEN' S CENTER 30 ENDOSCOPY	1, 195, 095		1, 195, 0		1, 195, 095	
	ATIENT SERVICE COST CENTERS	933, 157		933, 1	0	933, 157	76.03
	DO CLINIC	1, 997, 155		1, 997, 1	55 0	1, 997, 155	90.00
	01 OUTPATI ENT	1, 323, 035		1, 323, 0		1, 323, 035	
	DO EMERGENCY	4, 909, 661		4, 909, 6		4, 909, 661	
	01 SHORT STAY	0			0 0	0	•
	O OBSERVATION BEDS (NON-DISTINCT PART)	2, 168, 075		2, 168, 0	75	2, 168, 075	92.00
	R REIMBURSABLE COST CENTERS						
	00 AMBULANCE SERVICES	89, 992		89, 9			95.00
200.00	Subtotal (see instructions)	108, 566, 035				108, 566, 035	
201.00	Less Observation Beds	2, 168, 075		2, 168, 0		2, 168, 075	•
202.00	Total (see instructions)	106, 397, 960	1 0	106, 397, 9	0 0	106, 397, 960	1202. UU

From 01/01/2015 Part 1 Dr 12/31/2015 Description Cost Center Description Inpatient Outpatient Charges Outpatient Total (col. 6 + col. 7) Cost or Other Ratio TEFRA Inpatient 0.00 0.00 7.00 8.00 9.00 10.00 30.00 0.000 (DITESN VE CARE UNIT 0.000 (DITESN VE CARE UNIT 0.0000 (DITESN VE CARE UNIT 0.0000 (DITESN VE CARE UNIT 0.0000 (DITESN VE CARE UNIT 0.00000 (DITESN VE CARE UNIT 0.000000 (DITESN VE CARE UNIT 0.00000 (DITESN VE CARE UNIT 0.00000 (DITESN VE CARE UNIT 0.000000 (DITESN VE CARE UNIT 0.00000 (DITESN VE CARE UNIT 0.000000 (DITESN	Health Financial Systems	RI VERVI EW I				u of Form CMS-	2552-10
Cost Center Description Inpatient Outpatient Cost Cost or Other Ratio TFEPA Inpatient 1000100000000000000000000000000000000	COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der		Period: From 01/01/2015 To 12/31/2015	Date/Time Pre	
Cost Center Description Inpatient Outpatient Total (col. 6) (1patient Cost or Other Ratio TEFRA Inpatient Ratio 10001 03000 AUULTS & PEDIATRICS 23,492,264 23,492,264 30.00 30.00 30.00 03000 AUULTS & PEDIATRICS 23,492,264 5,399,066 5,399,066 31.1 41.00 04100 SUBPROVIDER - I RF 5,591,161 5,591,161 5,591,161 5,591,161 30.0 30.00 05000 (PERATING ROM 20,381,579 24,107,850 44,489,429 0.206600 0.000000 50.00 05000 (PERATING ROM 20,381,579 24,107,850 44,489,429 0.206802 0.000000 55.00 51.00 05000 (DEV-ENTRENFOMA & LABOR ROM 0.02,381,579 24,107,850 44,489,429 0.286802 0.000000 55.00 51.00 05000 (DEV-ENTRY ROM & LABOR ROM 0.02,283,5710 0.000000 55.01 0.000000 55.01 0.000000 55.01 0.000000 55.01 0.000000 55.01 0.000000 55.01 0.000000 55.01 0.0000000 55.01				0 XV/111	Hospi tal		7 pm
Cost Center Description Inpatient Outpatient Total (col. 6) (sol. 7) Cost Other Ratio TEFRA Inpatient Ratio INPATIENT ROUTINE SERVICE COST CENTERS -					nospi tai	PP3	
INPATE ENT ROUTING SERVICE COST CENTERS 22. 492. 264 23. 492. 264 30. 00 44. 49. 95. 67. 77 0. 206902 0. 000000 54. 44. 49. 55. 591. 161 44. 499. 55. 67. 77 0. 281298 0. 000000 54. 55. 591. 591. 591. 591. 591. 591. 591.	Cost Center Description	I npati ent	<u> </u>			Inpati ent	
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31:00 03100 INTENSIVE CARE_UNIT 5, 399, 066 5, 399, 066 31.0 31.00 04100, 04100, SUPEROV DER - IRF 5, 591, 161 41.1 41:00 04400, NURSERV 2, 535, 210 - <t< td=""><td>INPATIENT ROUTINE SERVICE COST CENTERS</td><td></td><td></td><td></td><td></td><td></td><td></td></t<>	INPATIENT ROUTINE SERVICE COST CENTERS						
41:00 04100 SUBERROW DER - I RF 5, 591, 161 5, 591, 161 41.0 40:00 044000 SKILLED NURSING FACILITY 2, 535, 210 43. 44:00 04000 SKILLED NURSING FACILITY 2, 535, 210 44. 50:00 05000 DEXID CENTERS 0 0 0.000000 50. 51:00 05500 DELIVERY ROM & LABOR ROM 0 0 0.000000 51.0 51:00 05500 RADIOLOGY-THERAPEUTIC 16.23, 695 11.942.082 13.565, 777. 120 0.281307 0.000000 55. 50:00 05500 RADIOLOGY-THERAPEUTIC 88.493 5.687.627 5.776.120 0.281307 0.000000 55. 50:00 05500 RADIOLOGY-THERAPEUTIC 88.445 8.340.669 13.203.514 0.110110 0.000000 55. 50:00 05500 CARDIA C CATHETERI ZATI ON 4.862.845 8.340.669 13.203.514 0.110101 0.000000 60.00 60:00 06000 DADO TSCINC, PROCESSING & TRANS. 940.413 568.425 1.583.830 0.8481460 0.0000000 60.00	30. 00 03000 ADULTS & PEDIATRICS	23, 492, 264		23, 492, 26	4		30.00
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71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 26, 163, 665 20, 478, 378 46, 642, 043 0. 370165 0. 000000 71. 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 957, 207 3, 317, 732 4, 274, 939 0. 341960 0. 000000 72. 0 73.00 07300 DRUGS CHARGED TO PATIENTS 11, 899, 664 12, 781, 351 24, 681, 015 0. 418811 0. 000000 73. 0 74.00 07400 RENAL DI ALYSI S 454, 641 5, 964 460, 605 0. 906803 0. 000000 74. 0 76.01 03140 CARDI AC REHAB 304, 210 3, 422, 728 3, 726, 938 0. 3202015 0. 000000 76. 0 76.02 03070 WOMEN'S CENTER 3, 046 4, 355, 402 4, 358, 448 0. 274202 0. 000000 76. 0 76.03 03330 ENDOSCOPY 745, 491 5, 441, 106 6, 186, 597 0. 150835 0. 000000 90. 0 90. 0 90.00 OPO00 CLI NIC 26, 000 4, 357, 218 4, 383, 218 0. 455637 0. 000000 90. 0 90. 0 0. 0000000 90. 0		U U	0				•
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 957, 207 3, 317, 732 4, 274, 939 0. 341960 0.000000 72.0 73.00 07300 DRUGS CHARGED TO PATIENTS 11, 899, 664 12, 781, 351 24, 681, 015 0. 418811 0.000000 73.0 74.00 07400 RENAL DIALYSIS 454, 641 5, 964 460, 605 0.906803 0.000000 74.0 76.01 03140 CARDIAC REHAB 304, 210 3, 422, 728 3, 726, 938 0.320215 0.000000 76.0 76.02 03070 WOMEN'S CENTER 3, 046 4, 355, 402 4, 358, 448 0.274202 0.000000 76.0 76.03 03330 ENDOSCOPY 745, 491 5, 441, 106 6, 186, 597 0.150835 0.000000 76.0 70.00 09001 CLINIC 26,000 4, 357, 218 4, 383, 218 0.455637 0.000000 90.0 90.01 09100 EMERGENCY 2, 860, 106 18, 347, 015 21, 207, 121 0.231510 0.000000 90.0 91.01 09101 SHORT STAY 0 0 0							•
73.00 07300 DRUGS CHARGED TO PATIENTS 11, 899, 664 12, 781, 351 24, 681, 015 0.418811 0.000000 73.0 74.00 07400 RENAL DIALYSIS 454, 641 5, 964 460, 605 0.906803 0.000000 74.0 76.00 03020 OTHER ANCILLARY 0 0 0 0.000000 76.0 76.01 03140 CARDIAC REHAB 304, 210 3, 422, 728 3, 726, 938 0.320215 0.000000 76.0 76.02 03070 WOMEN'S CENTER 3, 046 4, 355, 402 4, 358, 448 0.274202 0.000000 76.0 76.03 03330 ENDOSCOPY 745, 491 5, 441, 106 6, 186, 597 0.150835 0.000000 76.0 70.00 09000 CLI NI C 26, 000 4, 357, 218 4, 383, 218 0.455637 0.000000 90.0 90.0 90.01 09001 UTPATIENT 210, 823 4, 472, 734 4, 683, 557 0.282485 0.000000 90.0 91.00 09101 SHORT STAY 0 0 0 0.000000 0.000000							
74.00 07400 RENAL DIALYSIS 454, 641 5, 964 460, 605 0.906803 0.000000 74.4 76.00 03020 OTHER ANCILLARY 0 0 0 0.000000 76.4 76.01 03140 CARDIAC REHAB 304, 210 3, 422, 728 3, 726, 938 0.320215 0.000000 76.4 76.02 03070 WOMEN'S CENTER 3, 046 4, 355, 402 4, 358, 448 0.274202 0.000000 76.4 76.03 03330 ENDOSCOPY 745, 491 5, 441, 106 6, 186, 597 0.150835 0.000000 76.4 70.00 09000 CLI NI C 26, 000 4, 357, 218 4, 383, 218 0.455637 0.000000 90.4 90.01 09001 OUTPATI ENT 210, 823 4, 472, 734 4, 683, 557 0.282485 0.000000 90.4 91.00 09101 SHORT STAY 0 0 0 0.000000 0.000000 91.4 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 591, 428 2, 482, 938 3, 074, 366 0.705210 0.0000000 91.							
76. 00 03020 OTHER ANCI LLARY 0 0 0 0.000000 0.000000 76. 0 76. 01 03140 CARDI AC REHAB 304, 210 3, 422, 728 3, 726, 938 0.320215 0.000000 76. 0 76. 02 03070 WOMEN'S CENTER 3, 046 4, 355, 402 4, 358, 448 0.274202 0.000000 76. 0 76. 03 03330 ENDOSCOPY 745, 491 5, 441, 106 6, 186, 597 0.150835 0.000000 76. 0 00100 CLI NI C 26,000 4, 357, 218 4, 383, 218 0.455637 0.000000 90. 0 90.01 09001 OUTPATI ENT 210, 823 4, 472, 734 4, 683, 557 0.282485 0.000000 90. 0 91.00 09100 EMERGENCY 2, 860, 106 18, 347, 015 21, 207, 121 0.231510 0.000000 91. 0 91.01 09101 SHORT STAY 0 0 0 0.000000 0.000000 91. 0 92.00 092000 OBSERVATI ON BEDS (NON-DI STI NCT PART) 591, 428 2, 482, 938 3, 074, 366 0.705210 0.							•
76. 01 03140 CARDI AC REHAB 304, 210 3, 422, 728 3, 726, 938 0. 320215 0. 000000 76. 0 76. 02 03070 WOMEN'S CENTER 3, 046 4, 355, 402 4, 358, 448 0. 274202 0. 000000 76. 0 76. 03 03330 ENDOSCOPY 745, 491 5, 441, 106 6, 186, 597 0. 150835 0. 000000 76. 0 0UTPATI ENT SERVICE COST CENTERS 26,000 4, 357, 218 4, 383, 218 0. 455637 0. 000000 90. 0 90. 01 09000 CLINIC 210, 823 4, 472, 734 4, 683, 557 0. 282485 0. 000000 90. 0 91. 00 09100 EMERGENCY 2, 860, 106 18, 347, 015 21, 207, 121 0. 231510 0. 000000 91. 0 91. 01 09101 SHORT STAY 0 0 0 0 0. 000000 0. 000000 91. 0 92.00 092000 OBSERVATI ON BEDS (NON-DI STINCT PART) 591, 428 2, 482, 938 3, 074, 366 0. 705210 0. 000000 92. 0 07HER REI MBURSABLE COST CENTERS 0 0 0. 0000000		454, 641		460, 60			
76. 02 03070 WOMEN'S CENTER 3,046 4,355,402 4,358,448 0.274202 0.000000 76.0 76. 03 03330 ENDOSCOPY 745,491 5,441,106 6,186,597 0.150835 0.000000 76.0 00100 CLINIC COST CENTERS 26,000 4,357,218 4,383,218 0.455637 0.000000 90.0 90.00 09000 CLINIC 210,823 4,472,734 4,683,557 0.282485 0.000000 90.0 91.01 09101 EMERGENCY 2,860,106 18,347,015 21,207,121 0.231510 0.000000 91.0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 591,428 2,482,938 3,074,366 0.705210 0.000000 91.0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 591,428 2,482,938 3,074,366 0.705210 0.000000 91.0 92.00 09500 AMBULANCE SERVICES 0 0 0.000000 0.000000 95.4 0.000000 0.0000000 95.4 90.00 UPSON Subtotal (see i nstructions) 137,948,984		U U	0				
76. 03 03330 ENDOSCOPY 745, 491 5, 441, 106 6, 186, 597 0. 150835 0.000000 76. 4 0UTPATI ENT SERVICE COST CENTERS 0 00000 CLINIC 26,000 4, 357,218 4, 383,218 0. 455637 0.000000 90. 90. 90. 90. 90. 90. 90. 90. 90. 90.							
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 26,000 4,357,218 4,383,218 0.455637 0.000000 90.01 90.01 09001 OUTPATI ENT 210,823 4,472,734 4,683,557 0.282485 0.000000 90.01 91.00 09100 EMERGENCY 2,860,106 18,347,015 21,207,121 0.231510 0.000000 91.01 91.01 09101 SHORT STAY 0 0 0 0.000000 91.01 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 591,428 2,482,938 3,074,366 0.705210 0.000000 92.0 95.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 591,428 2,482,938 3,074,366 0.705210 0.000000 92.0 95.00 09200 BUB TABLE COST CENTERS 0 0 0.000000 92.0 92.0 0.000000 0.0000000 92.0 92.0 0.000000 92.0 0.000000 92.0 0.000000 92.0 0.000000 92.0							
90. 00 09000 CLINIC 26,000 4,357,218 4,383,218 0.455637 0.000000 90.01 90. 01 09001 OUTPATIENT 210,823 4,472,734 4,683,557 0.282485 0.000000 90.01 91. 00 09100 EMERGENCY 2,860,106 18,347,015 21,207,121 0.231510 0.000000 91.0 91. 01 09101 SHORT STAY 0 0 0 0.000000 91.0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 591,428 2,482,938 3,074,366 0.705210 0.000000 92.0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 591,428 2,482,938 3,074,366 0.705210 0.000000 92.0 95. 00 09200 AMBULANCE SERVICES 0 0 0.000000 0.000000 92.0 200. 00 Subtotal (see instructions) 137,948,984 188,901,194 326,850,178 200.0 201.0		745, 491	5, 441, 106	6, 186, 59	0. 150835	0.00000	76.03
90.01 09001 0UTPATIENT 210,823 4,472,734 4,683,557 0.282485 0.000000 90.0 91.00 09100 EMERGENCY 2,860,106 18,347,015 21,207,121 0.231510 0.000000 91.0 91.01 09101 SHORT STAY 0 0 0 0 0.000000 91.0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 591,428 2,482,938 3,074,366 0.705210 0.000000 92.0 95.00 09500 AMBULANCE SERVICES 0 0 0 0.000000 0.000000 95.0 200.00 Subtotal (see instructions) 137,948,984 188,901,194 326,850,178 200.00 200.00 200.00		a.c.a.a.l			0 0 155 107	0.00000	
91.00 09100 EMERGENCY 2,860,106 18,347,015 21,207,121 0.231510 0.000000 91.0 91.01 09101 SHORT STAY 0 0 0 0 0.000000 91.0 92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 591,428 2,482,938 3,074,366 0.705210 0.000000 92.0 0THER REIMBURSABLE COST CENTERS 0 0 0 0.000000 95.0 0.000000 95.0 0.000000 95.0 0.000000 95.0 0.000000 95.0 0.000000 0.000000 95.0 200.00 Subtotal (see instructions) 137,948,984 188,901,194 326,850,178 0.000000 0.000000 200.0 201.00 Less Observation Beds 201.00 137,948,984 188,901,194 326,850,178 201.00							•
91. 01 09101 SHORT STAY 0 0 0 0.000000 0.000000 91. 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 591, 428 2, 482, 938 3, 074, 366 0.705210 0.000000 92. 0 0THER REI MBURSABLE COST CENTERS 0 0 0 0.000000 95. 0 95. 00 09500 AMBULANCE SERVICES 0 0 0 0.000000 95. 0 200. 00 Subtotal (see instructions) 137, 948, 984 188, 901, 194 326, 850, 178 200. 0 201. 0							•
92. 00 OTHER RELIMBURSABLE COST CENTERS 0 0 0.000000 92.4 95. 00 200. 00 09500 AMBULANCE SERVICES 0 0 0 0.000000 95.4 92. 00 09500 AMBULANCE SERVICES 0 0 0 0.000000 95.4 200. 00 Subtotal (see instructions) 137,948,984 188,901,194 326,850,178 200.4 200.4			18, 347, 015	21, 207, 12			
OTHER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVI CES 0 0 0.000000 95.0 200.00 Subtotal (see instructions) 137,948,984 188,901,194 326,850,178 200.0 200.0 201.00 Less Observation Beds 201.00			0	2 074 07			
95. 00 09500 AMBULANCE SERVICES 0 0 0 0.000000 95. 0 200. 00 Subtotal (see instructions) 137, 948, 984 188, 901, 194 326, 850, 178 200. 0		591, 428	2, 482, 938	3, 074, 36	0.705210	0.000000	92.00
200.00 Subtotal (see instructions) 137,948,984 188,901,194 326,850,178 200.0 201.00 Less Observation Beds 201.00 137,948,984 188,901,194 326,850,178 200.0					0 000000	0,000000	05 00
201.00 Less Observation Beds 201.0		-	-			0.000000	•
		137, 940, 984	100, 901, 194	320, 630, 17	U		
		137 0/8 00/	188 001 104	326 850 17	Q		•
		137, 740, 704	100, 701, 194	320, 030, 17		I	1202.00

Health Financial Systems	RI VERVI EW HOS	PI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150059	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepared: 5/19/2016 4:57 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
41.00 04100 SUBPROVIDER - IRF				41.00
43.00 04300 NURSERY				43.00
44.00 04400 SKILLED NURSING FACILITY				44.00
ANCI LLARY SERVI CE COST CENTERS				
50.00 05000 OPERATI NG ROOM	0. 206802			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 281298			54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0. 281307			55.00
57.00 05700 CT SCAN	0. 036872			57.00
57.01 03630 ULTRA SOUND	0. 060680			57.01
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 091889			58.00
59.00 05900 CARDI AC CATHETERI ZATI ON	0. 110101			59.00
60. 00 06000 LABORATORY	0. 190069			60.00
60.01 06001 BLOOD LABORATORY	0. 000000			60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS	. 0. 484106			63.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000			64.00
65. 00 06500 RESPI RATORY THERAPY	0. 266995			65.00
66.00 06600 PHYSI CAL THERAPY	0. 370544			66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000			68.00
69.00 06900 ELECTROCARDI OLOGY	0. 207461			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIE				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 341960			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 418811			73.00
74.00 07400 RENAL DIALYSIS	0. 906803			74.00
76.00 03020 OTHER ANCI LLARY	0. 000000			76.00
76. 01 03140 CARDI AC REHAB	0. 320215			76.01
76.02 03070 WOMEN' S CENTER	0. 274202			76.02
76. 03 03330 ENDOSCOPY	0. 150835			76.03
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLINIC	0. 455637			90.00
90. 01 09001 OUTPATI ENT	0. 282485			90.01
91.00 09100 EMERGENCY	0. 231510			91.00
91.01 09101 SHORT STAY	0. 000000			91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PA				92.00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0. 000000			95.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202.00
	i I			1

COMPLITATION OF	al Systems F RATIO OF COSTS TO CHARGES	RI VERVI EW		CCN: 150059	Peri od:	u of Form CMS-: Worksheet C	2552-10
	I RATIO OF COSTS TO CHARGES		riovider	CCN. 130037	From 01/01/2015	Part I	
					To 12/31/2015	Date/Time Pre 5/19/2016 4:5	pared:
				le XIX	Hospi tal	5/19/2016 4:5 Cost	/pm
					Costs	0031	
С	ost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2.00	3.00	4.00	5.00	
	INT ROUTINE SERVICE COST CENTERS	18,004,276		18,004,2	76 0	18, 004, 276	30.00
	NTENSI VE CARE UNI T	4, 072, 230		4, 072, 2			
	UBPROVIDER - IRF	4, 339, 733		4, 339, 7		4, 339, 733	
43.00 04300 N		4, 337, 733		4,007,7	0 0	4, 337, 733	43.00
	KILLED NURSING FACILITY	3, 451, 019		3, 451, 0			
ANCILLA	RY SERVICE COST CENTERS		I				1
	PERATING ROOM	9, 200, 506		9, 200, 5	06 0	9, 200, 506	50.00
52.00 05200 D	ELIVERY ROOM & LABOR ROOM	0			0 0	0	52.00
	ADI OLOGY-DI AGNOSTI C	3, 816, 020		3, 816, 0	20 0	3, 816, 020	
	ADI OLOGY-THERAPEUTI C	1, 624, 864		1, 624, 8		1, 624, 864	
57.00 05700 C		370, 911		370, 9		370, 911	
	LTRA SOUND	142, 343		142, 3		142, 343	
	AGNETIC RESONANCE IMAGING (MRI)	295, 818		295, 8		295, 818	
	ARDI AC CATHETERI ZATI ON	1, 453, 717		1, 453, 7		1, 453, 717	
	ABORATORY	7, 107, 681		7, 107, 6	81 0 0 0		
	LOOD LABORATORY LOOD STORING, PROCESSING & TRANS.	0		720 4		0	
	NTRAVENOUS THERAPY	730, 437		730, 4	0 0	730, 437 0	
	ESPIRATORY THERAPY	1, 558, 995		1, 558, 9		1, 558, 995	
	HYSI CAL THERAPY	7, 138, 237		7, 138, 2		7, 138, 237	
	CCUPATIONAL THERAPY	0		7,100,2	0 0	0	
	PEECH PATHOLOGY	0			0 0	0	
	LECTROCARDI OLOGY	1, 968, 171		1, 968, 1	71 0	1, 968, 171	
	EDICAL SUPPLIES CHARGED TO PATIENTS	17, 265, 256		17, 265, 2			
72.00 07200 1	MPL. DEV. CHARGED TO PATIENT	1, 461, 859		1, 461, 8	59 0	1, 461, 859	72.00
	RUGS CHARGED TO PATIENTS	10, 336, 691		10, 336, 6	91 0	10, 336, 691	73.00
	ENAL DIALYSIS	417, 678		417, 6	78 0	417, 678	
	THER ANCI LLARY	0			0 0	0	
	ARDI AC REHAB	1, 193, 423		1, 193, 4		1, 193, 423	
	OMEN' S CENTER	1, 195, 095		1, 195, 0			
		933, 157		933, 1	57 0	933, 157	76.03
90. 00 09000 C	ENT SERVICE COST CENTERS	1, 997, 155		1, 997, 1	55 0	1 007 155	90.00
	UTPATI ENT	1, 323, 035		1, 323, 0		1, 997, 155 1, 323, 035	
	MERGENCY	4, 909, 661		4, 909, 6		4, 909, 661	
	HORT STAY	4, 909, 001		T, 707, 0		4, 909, 001	
	BSERVATION BEDS (NON-DISTINCT PART)	2, 168, 075		2, 168, 0	-	2, 168, 075	
	REIMBURSABLE COST CENTERS	,,, _,				_,,	1
	MBULANCE SERVICES	89, 992		89, 9	92 0	89, 992	95.00
200.00 S	ubtotal (see instructions)	108, 566, 035		108, 566, 0	35 0	108, 566, 035	200.00
201.00 L	ess Observation Beds	2, 168, 075		2, 168, 0	75	2, 168, 075	201.00
202.00 T	otal (see instructions)	106, 397, 960	0	106, 397, 9	60 0	106, 397, 960	202 00

Health Financial Systems	RI VERVI EW I				u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 150059	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Pre	
			le XIX	Hospi tal	5/19/2016 4:5 Cost	7 pm
		Charges			COST	
Cost Center Description	I npati ent	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA Inpatient Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	23, 492, 264		23, 492, 26			30.00
31. 00 03100 I NTENSI VE CARE UNI T	5, 399, 066		5, 399, 06			31.00
41.00 04100 SUBPROVIDER - IRF	5, 591, 161		5, 591, 16	51		41.00
43. 00 04300 NURSERY	0			0		43.00
44. 00 04400 SKI LLED NURSI NG FACI LI TY	2, 535, 210		2, 535, 21	0		44.00
ANCI LLARY SERVI CE COST CENTERS	00.001.570	04 407 050			0.00000	
50. 00 05000 OPERATING ROOM	20, 381, 579	24, 107, 850	44, 489, 42		0.000000	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	1 ()) () [11 042 002	10 5/5 75	0 0.00000	0.000000	•
54. 00 05400 RADI OLOGY - DI AGNOSTI C	1, 623, 695	11, 942, 082			0.000000	
55. 00 05500 RADI OLOGY-THERAPEUTI C	88, 493	5, 687, 627	5, 776, 12		0.000000	•
57. 00 05700 CT SCAN	1, 612, 882	8, 446, 565			0.000000	•
57.01 03630 ULTRA SOUND 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	307, 062 340, 598	2, 038, 740 2, 878, 706			0.000000	•
					0.000000	
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	4, 862, 845 10, 868, 230	8, 340, 669 26, 526, 983			0. 000000 0. 000000	
60. 01 06001 BLOOD LABORATORY	10, 808, 230	20, 520, 963	37, 395, 21	0. 000000	0.000000	•
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	940, 413	568, 425	1, 508, 83		0.000000	•
64. 00 06400 I NTRAVENOUS THERAPY	740, 413	500, 425	1, 500, 05	0 0. 000000	0.000000	
65. 00 06500 RESPI RATORY THERAPY	4, 851, 956	987,075	5, 839, 03		0.000000	•
66. 00 06600 PHYSI CAL THERAPY	8, 953, 347	10, 310, 864			0.000000	
67. 00 06700 OCCUPATI ONAL THERAPY	0, 700, 017	0,010,001		0 0.000000	0.000000	•
68. 00 06800 SPEECH PATHOLOGY	0	0		0 0.000000	0. 000000	•
69. 00 06900 ELECTROCARDI OLOGY	1, 883, 902	7,603,042	9, 486, 94		0. 000000	•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	26, 163, 665	20, 478, 378			0.000000	•
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	957, 207	3, 317, 732			0.000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	11, 899, 664	12, 781, 351			0.000000	
74.00 07400 RENAL DIALYSIS	454, 641	5, 964			0.000000	74.00
76.00 03020 OTHER ANCI LLARY	0	0		0 0.000000	0.000000	76.00
76. 01 03140 CARDI AC REHAB	304, 210	3, 422, 728	3, 726, 93	0. 320215	0.000000	76.01
76.02 03070 WOMEN' S CENTER	3, 046	4, 355, 402	4, 358, 44	8 0. 274202	0.000000	76.02
76. 03 03330 ENDOSCOPY	745, 491	5, 441, 106	6, 186, 59	0. 150835	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	26, 000	4, 357, 218			0. 000000	•
90. 01 09001 OUTPATI ENT	210, 823	4, 472, 734			0. 000000	•
91.00 09100 EMERGENCY	2, 860, 106	18, 347, 015	21, 207, 12		0. 000000	
91.01 09101 SHORT STAY	0	0		0 0.000000	0. 000000	
92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	591, 428	2, 482, 938	3, 074, 36	0. 705210	0.00000	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	0		0 0. 000000	0.000000	•
200.00 Subtotal (see instructions)	137, 948, 984	188, 901, 194	326, 850, 17	8		200.00
201.00 Less Observation Beds	107 040 004	100 001 104	224 050 47	10		201.00
202.00 Total (see instructions)	137, 948, 984	188, 901, 194	326, 850, 17	ö		202.00

Health Financial Systems	RI VERVI EW HOSI	PI TAL	In Lie	u of Form CMS-25	52-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150059	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepa 5/19/2016 4:57	
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS				3	30. 00
31.00 03100 INTENSIVE CARE UNIT				3	31.00
41. 00 04100 SUBPROVIDER - IRF				4	41.00
43. 00 04300 NURSERY				4	43.00
44.00 04400 SKILLED NURSING FACILITY					44.00
ANCI LLARY SERVI CE COST CENTERS	1 1				
50. 00 05000 OPERATI NG ROOM	0, 000000			Ę	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000				55.00
57. 00 05700 CT SCAN	0.000000				57.00
57. 01 03630 ULTRA SOUND	0. 000000				57.00 57.01
	0.000000				57.01
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000				59.00
	0.000000				60.00
60. 01 06001 BLOOD LABORATORY	0.000000				60.01
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0.00000				63.00
64.00 06400 INTRAVENOUS THERAPY	0.000000				64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000				68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
74. 00 07400 RENAL DI ALYSI S	0. 000000			7	74.00
76.00 03020 OTHER ANCI LLARY	0. 000000			7	76.00
76. 01 03140 CARDI AC REHAB	0. 000000			7	76. 01
76.02 03070 WOMEN'S CENTER	0. 000000			7	76. 02
76. 03 03330 ENDOSCOPY	0. 000000			7	76.03
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	0. 000000			ç	90.00
90. 01 09001 OUTPATI ENT	0. 000000			ç	90. 01
91.00 09100 EMERGENCY	0. 000000			ç	91.00
91.01 09101 SHORT STAY	0. 000000			ç	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			ç	92.00
OTHER REIMBURSABLE COST CENTERS	· · ·				
95. 00 09500 AMBULANCE SERVICES	0,000000			c	95.00
200.00 Subtotal (see instructions)					00.00
201.00 Less Observation Beds					01.00
202.00 Total (see instructions)					02.00
	1			123	

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAP	PITAL COSTS			Period: From 01/01/2015 To 12/31/2015	5/19/2016 4:5	
			e XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B,	Swing Bed Adjustment	Reduced Capital Related Cost	Days	Per Diem (col. 3 / col. 4)	
	Part II, col. 26)		(col. 1 - col 2)	•		
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS		•	·			
30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT 41.00 SUBPROVIDER - IRF 43.00 NURSERY 44.00 SKILLED NURSING FACILITY 200.00 Total (lines 30-199)	3, 607, 660 681, 522 653, 265 0 451, 807 5, 394, 254	0	3, 607, 66 681, 52 653, 26 451, 80 5, 394, 25	2 2, 504 5 5, 583 0 0 7 5, 001	272. 17 117. 01 0. 00 90. 34	31.00 41.00 43.00
Cost Center Description	Inpatient Program days 6.00	Inpatient Program Capital Cost (col. 5 x col. 6) 7.00	J, 374, 23	4 27, 730		200.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT 41.00 SUBPROVIDER - IRF 43.00 NURSERY 44.00 SKILLED NURSING FACILITY 200.00 Total (lines 30-199)	5, 420 1, 163 3, 901 0 3, 431 13, 915	316, 534 456, 456 0 309, 957				30.00 31.00 41.00 43.00 44.00 200.00

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT.	AL COSTS	Provi der	CCN: 150059	Period: From 01/01/2015 To 12/31/2015		pared: 7 pm
			e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	1, 334, 080	44, 489, 429			258, 708	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C			0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	547, 316	13, 565, 777	0. 04034	45 812, 383	32, 776	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	314, 304	5, 776, 120	0. 0544	4 76, 233	4, 148	55.00
57.00 05700 CT SCAN	4, 444	10, 059, 447	0.00044	12 789, 254	349	57.00
57.01 03630 ULTRA SOUND	1, 905	2, 345, 802	0.0008	115, 480	94	57.01
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	3, 801	3, 219, 304	0. 00118	139, 256	164	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	140, 024	13, 203, 514	0. 01060	1, 315, 334	13, 949	59.00
60. 00 06000 LABORATORY	588, 963	37, 395, 213	0.0157	4, 673, 683	73, 611	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0.0000	0 0	0	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	80, 424	1, 508, 838	0.05330	291,700	15, 548	63.00
64.00 06400 INTRAVENOUS THERAPY	0	C	0.0000			64.00
65. 00 06500 RESPI RATORY THERAPY	97, 144	5, 839, 031			40, 937	65.00
66. 00 06600 PHYSI CAL THERAPY	78, 637					66,00
67. 00 06700 OCCUPATI ONAL THERAPY	0					67.00
68. 00 06800 SPEECH PATHOLOGY	0	-			0	68.00
69. 00 06900 ELECTROCARDI OLOGY	475, 185	-				69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	271, 912					71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	9, 248					
73. 00 07300 DRUGS CHARGED TO PATIENTS	323, 262					
74. 00 07400 RENAL DIALYSIS	24, 943				12, 473	
76. 00 03020 OTHER ANCI LLARY	24, 743				0	76.00
76. 01 03140 CARDI AC REHAB	12,972	-			-	76.01
76. 02 03070 WOMEN' S CENTER	353, 806				013	76.02
76. 03 03330 ENDOSCOPY	119, 613				6, 108	76.02
OUTPATIENT SERVICE COST CENTERS	117,013	0,100,377	0.0193	515, 901	0, 100	70.03
90. 00 09000 CLINIC	17, 465	4, 383, 218	0.00398	35 12,035	48	90.00
90. 01 09001 OUTPATI ENT	158, 505		1			90.00
91. 00 09100 EMERGENCY	749, 359					90.01
91.00 09100 EMERGENCY 91.01 09101 SHORT STAY	/49, 359				54, 406 0	91.00
		, i			-	91.01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	434, 435	3, 074, 366	0.14130	0	0	92.00
						05 00
	L 1 11 7 47	200 022 477		37, 926, 385	401 440	95.00
200.00 Total (lines 50-199)	6, 141, 747	289, 832, 477	I	37, 920, 385	681, 660	1200. 00

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS	TS Provi der		Period: From 01/01/2015 To 12/31/2015	Date/Time Pre 5/19/2016 4:5	
		Titl	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health	All Other	Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos		1 through 3,	
					minus col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	C	0		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	C	C		0	0	31.00
41.00 04100 SUBPROVIDER - IRF	C	0		0 0	0	41.00
43. 00 04300 NURSERY	C	0		0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	C	0		0	0	44.00
200.00 Total (lines 30-199)	C	C		0	0	200.00
Cost Center Description	Total Patient	Per Diem (col.	Inpati ent	Inpati ent		
	Days	5 ÷ col. 6)	Program Days			
				Pass-Through		
				Cost (col. 7 x		
				col. 8)		
	6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	14, 848					30.00
31.00 03100 INTENSIVE CARE UNIT	2, 504					31.00
41. 00 04100 SUBPROVI DER – I RF	5, 583					41.00
43. 00 04300 NURSERY	C			0 0		43.00
44.00 04400 SKILLED NURSING FACILITY	5, 001					44.00
200.00 Total (lines 30-199)	27, 936		13, 91	5 0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	ERVICE OTHER PASS	Provi der	CON. 1EOOEO			
			CCN: 150059	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Pre 5/19/2016 4:5	pared: 7 pm
		Ti tl	e XVIII	Hospi tal	PPS	•
Cost Center Description	Non Physician	Nursing School	Allied Healt	h All Other	Total Cost	
	Anestheti st			Medi cal	(sum of col 1	
	Cost			Education Cost		
					4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	-			-	-	
50. 00 05000 OPERATING ROOM	0	0		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00
57. 00 05700 CT SCAN	0	0		0 0	0	57.00
57. 01 03630 ULTRA SOUND	0	0		0 0	0	57.01
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60.00 06000 LABORATORY	0	0		0 0	0	60.00
60. 01 06001 BLOOD LABORATORY	0	0		0 0	0	60.01
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	63.00
64.00 06400 I NTRAVENOUS THERAPY	0	0		0 0	0	64.00 65.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67. 00 06700 0CCUPATIONAL THERAPY	0	0		0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	249, 99		249, 992	73.00
74. 00 07400 RENAL DIALYSIS	0	0	247, 7	0 0	249, 992	74.00
74. 00 07400 RENAL DIALISIS 76. 00 03020 OTHER ANCI LLARY	0	0		0 0	0	76.00
76. 01 03140 CARDI AC REHAB	0	0			0	76.01
76. 02 03070 WOMEN' S CENTER	0	0		0 0	0	76.02
76. 03 03330 ENDOSCOPY	0	0		0 0	0	76.02
OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0	70.03
90. 00 09000 CLINIC	0	0		0 0	0	90.00
90. 01 09001 0UTPATI ENT	0	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0	0			0	91.00
91. 01 09101 SHORT STAY	0	0		0 0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS	0	0	1		0	,2.00
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	0	0	249, 99	02 0	249, 992	

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PAS	S Provi der		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2015		
				To 12/31/2015	Date/Time Pre 5/19/2016 4:5	pared:
		Ti +1	e XVIII	Hospi tal	PPS	7 pili
Cost Center Description	Total	Total Charges			Inpati ent	
cost center beschiption	Outpatient	(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of		$(col. 5 \div col$		Charges	
	col. 2, 3 and		7)	$(col. 6 \div col.$	onar ges	
	4)		.,	7)		
	6.00	7.00	8.00	9.00	10, 00	
ANCI LLARY SERVI CE COST CENTERS	0.00	1.00	0100	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10100	
50. 00 05000 OPERATI NG ROOM	0	44, 489, 429	0.00000	0 0.00000	8, 627, 615	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0					52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	13, 565, 777	0.00000			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0					
57. 00 05700 CT SCAN	0					57.00
57. 01 03630 ULTRA SOUND	0					
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0					
59. 00 05900 CARDI AC CATHETERI ZATI ON	0					59.00
60. 00 06000 LABORATORY	0				4, 673, 683	
60. 01 06001 BLOOD LABORATORY	0		0.00000		0	60.01
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0				-	
64. 00 06400 I NTRAVENOUS THERAPY	0	.,,	0.00000			64.00
65. 00 06500 RESPIRATORY THERAPY	0		0.00000		2, 460, 576	
66. 00 06600 PHYSI CAL THERAPY	0		0. 00000		930, 688	•
67. 00 06700 OCCUPATI ONAL THERAPY	0		0.00000		0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0	0.00000			68.00
69. 00 06900 ELECTROCARDI OLOGY	0					
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	.,				71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0					
73. 00 07300 DRUGS CHARGED TO PATIENTS	249, 992					
74. 00 07400 RENAL DI ALYSI S	247,772				230, 331	
76. 00 03020 OTHER ANCI LLARY	0				230, 331	76.00
76. 01 03140 CARDI AC REHAB					-	
76. 02 03070 WOMEN' S CENTER						76.02
76. 03 03330 ENDOSCOPY						76.02
OUTPATIENT SERVICE COST CENTERS		0,100,377	0.00000	0.00000	515, 701	/0.03
90. 00 09000 CLINIC	0	4, 383, 218	0.00000	0 0. 000000	12,035	90.00
90. 01 09001 0UTPATI ENT		.,				
91. 00 09100 EMERGENCY						
91. 01 09101 SHORT STAY						91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS		3,014,300	0.0000	0.00000	0	,2.00
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	249, 992	289, 832, 477			37, 926, 385	
	277, 772	207,002,477	I	1	01, 720, 303	200.00

Cost Center Description Inpatient Program Pass-Through Costs (col. 8) x col. 10) Outpatient Program Pass-Through Costs (col. 9) x col. 10) Outpatient Program Pass-Through Costs (col. 9) x col. 10) Outpatient Program Pass-Through Costs (col. 9) x col. 10) State Pass-Through Costs (col. 9) x col. 12) MACILLARY SERVICE COST CENTERS 0 4, 251, 026 0 50.00 05000 (PEEATING ROM S50.00 (S500 (PEEATING ROM RADIOLOGY-THRAPEUTIC 0 3, 474, 681 0 52.00 50.00 (S500 (ARADIOLOGY-THRAPEUTIC 0 2, 145, 723 0 55.00 55.00 50.00 (S500 (ARADIOLOGY-THRAPATIC) 0 2, 796, 654 0 54.00 55.00 50.00 (S500 (ARADIOLOGY-THRAPEATIC) 0 2, 786, 654 0 57.00 56.00 56.00 56.00 50.00 (S500 (ARADIOLOGY-THRAPEATIC) 0 2, 862, 358 0 56.00 56.00 50.00 (S500 (ARADIOLOGY-THRAPATIC) 0 2, 862, 358 0 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.	Health Financial Systems	RI VERVI EW H	HOSPI TAL		In Lie	eu of Form CMS-2	552-10
Cost Center Description Inpatient Program Pass-Through Costs (col. 8) i col. 10 Outpatient Program Pass-Through Costs (col. 9) i col. 12 Hospital PPS ANCI LLARY SERVICE COST CENTERS 0 11.00 12.00 13.00 50.00 52.00 05000 OPERATI NG ROM 50.00 (52000 RADI OLCY-THEAPEUTI C 0 4.251.026 50.00 52.00 50.00 (5200 QLIVERY ROM & LABOR ROM 50.00 (5500 QLIVERY ROM & LABOR ROM 0 4.251.026 50.00 51.00 (5200 QLIVERY ROM & LABOR ROM 50.00 (5500 QLIVERY ROM & LABOR ROM 0 3.474.681 0 52.0 52.00 (5200 QLIVERY ROM & LABOR ROM 0 2.796.654 0 57.00 55.00 50.00 (5500 QLIVERX SOUND 0 3.3572 0 57.00 56.00 50.00 (5500 QLIVERX SOUND 0 3.653.359 0 60.00 0.06000 LABORATORY 0 2.862.138 0 60.00 0.00 (5000 LABORATORY 0 2.852.777 0 63.00 0.00 (5000 LABORATORY 0 2.852.778 64.00 64.00 0.00 (5000 RESPI RATORY THEAPLY 0 0	APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS	Provi der	CCN: 150059	From 01/01/2015	Part IV Date/Time Prep	oared: 7 pm
Program Pass-Through Costs (col 10) Program Charges Program Pass-Through Sol 0 Program Pass-Through Sol 0 Program Pass-Through Sol 0 Program Sol 120 Program Pass-Through Sol 0 Program Sol 0 Program Pass-Through Sol 0 Program Sol 0 Program Sol 120 Program Sol 0 Program				e XVIII	Hospi tal		
Pass-Through Costs (col. 8 x col. 10) Charges x col. 12) Pass-Through Costs (col. 9 x col. 12) 11.00 12.00 13.00 50.00 05000 OPERATING ROOM 0 4.251,026 0 50.00 05400 OPERATING ROOM 0 0 52.00 51.00 05400 OPERATING ROOM 0 0 52.00 52.00 05200 OPERATING ROOM 0 0 52.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 52.00 55.00 05500 CT SCAN 0 2.746,654 0 57.00 57.00 05600 LABORATORY 0 2.862,138 0 60.00 60.01 06001 LABORATORY 0 2.862,138 0 60.00 60.00 06000 LABORATORY 0 0 0 63.00 66.00 60.00 06000 LABORATORY 0 0 0 64.00 64.00 60.00 06000 LABORATORY 0 0 0 66.00 66.00 66.00 67.00	Cost Center Description						
Costs (col. 8 Costs (col. 9 Costs (col. 9 <thcol. 9<="" th=""> Costs (col. 9<td></td><td></td><td></td><td></td><td></td><td></td><td></td></thcol.>							
x col. 10) x col. 12) 11.00 12.00 13.00 50.00 00000 DPERATIN ROM 0 4,251,026 0 50.00 05000 DPERATIN ROM 0 4,251,026 0 50.00 05400 RADI LOGY-THERAPEUTIC 0 3,474,681 0 57.00 05700 CT SCAN 0 2,796,654 0 57.00 58.00 05600 MAGNETIC CRESONANCE IMAGING (MRI) 0 866,468 0 59.00 0.00 06000 LABORATORY 0 2,862,138 0 60.00 0.01 06001 LABORATORY 0 2,862,138 0 60.00 0.00 00000 LABORATORY 0 0 0 63.00 60.00 0.00 00000 LABORATORY 0 0 0 60.00 60.00 60.00 63.00 60.00 60.00 60.00 63.00 60.00 63.00 60.00 66.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 <t< td=""><td></td><td></td><td>Charges</td><td></td><td></td><td></td><td></td></t<>			Charges				
II.00 I2.00 I3.00 50.00 05000 OPERATING ROOM 0 0 0 52.00 05000 DELIVERY ROOM & LABOR ROOM 0 0 0 0 52.00 05000 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 0 52.00 05000 DELIVERY ROOM & LABOR ROOM 0 0 0 0 52.00 0 55.00 0.500 RADI OLGOY-THERAPEUTI C 0 2.145, 723 0 55.00 55.00 55.00 0 55.00 0 55.00					9		
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57. 01 03630 ULTRA SOUND 57. 01 383, 512 0 57. 0 58. 00 DSB00 MAGNETI C RESONANCE I MAGING (MRI) 0 866, 468 0 58. 00 50. 00 DS900 CARDIA C CATHETERI ZATI ON 0 3, 563, 359 0 60. 0 60. 01 06001 BLOOD LABORATORY 0 2, 862, 138 0 60. 0 60. 01 06001 BLOOD STORI NG, PROCESSI NG & TRANS. 285, 707 0 63. 0 64. 00 05400 INTRAVENOUS THERAPY 0 0 0 0 64. 0 65. 00 06500 RESPI RATORY THERAPY 0 318, 823 0 66. 0 66. 0 66. 00 06000 VPHSI CAL THERAPY 0 0 0 0 67. 0 68. 0 69. 00 6900 SEPECH TATIONY THERAPY 0 0 0 67. 0		0			0		
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59.00 CARDI AC CATHETERI ZATI ON 0 3, 563, 359 0 59.00 60.00 06000 LABORATORY 0 2, 862, 138 0 60.00 63.00 06000 INTRAVENDUS THERAPY 0 0 0 63.00 64.00 06400 INTRAVENDUS THERAPY 0 0 0 64.00 65.00 06500 RESPI RATORY THERAPY 0 318, 823 0 65.00 66.00 06000 PHYSI CAL THERAPY 0 318, 823 0 66.00 66.00 06000 SPEECH PATHOLOGY 0 0 0 67.00 68.00 06600 SPEECH PATHOLOGY 0 0 0 68.00 69.00 05000 RESPI RATORY HERAPY 0 0 0 68.00 69.00 71.00 07200 IMPL DEV CHARGED TO PATI ENTS 4, 841, 463 0 71.00 73.00 73.00 07300 DRUSC SHARGED TO PATI ENTS 43, 048 4, 670, 988 47, 312 73.00 76.00 03020 OTHER ANCI LLARY 0 0		0		1	0		57.01
60.00 06000 LABORATORY 0 2,862,138 0 60.00 70.00 71.00 71.00 71.00 71.00 71.00 72.00 73.00 <t< td=""><td>58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)</td><td>0</td><td>866, 468</td><td></td><td>0</td><td></td><td>58.00</td></t<>	58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	866, 468		0		58.00
60.01 06001 BLOOD LABORATORY 0 0 60.0 63.00 0 63.00 0 63.00 0 63.00 0 63.00 0 63.00 0 63.00 0 63.00 0 63.00 0 63.00 0 63.00 63.00 0 0 0 63.00 63.00 0 0 0 63.00 63.00 0 0 0 0 0 64.00 66.00 65.00 66.00 0 60.00 65.00 66.00 0		0			0		59.00
63.00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 285, 707 0 63.00 64.00 06400 INTRAVENOUS THERAPY 0 0 0 64.00 65.00 06500 RESPI RATORY THERAPY 0 318, 823 0 66.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 2,455,986 0 71.00 71.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 43,048 4,670,988 47,312 73.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 43,048 4,670,988 47,312 73.00 76.00 76.00 03020 OTHER ANCI LLARY 0 0 76.00 76.00 76.00 76.00 03140 CHARB 0 1,516,621 0 76.00 76.00 76.00 <td></td> <td>0</td> <td>2, 862, 138</td> <td></td> <td>0</td> <td></td> <td>60.00</td>		0	2, 862, 138		0		60.00
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65.00 06500 RESPI RATORY THERAPY 0 318,823 0 65.00 66.00 06000 PHYSI CAL THERAPY 0 0 0 66.00 67.00 0CCUPATI ONAL THERAPY 0 0 0 67.00 67.00 68.00 0SECH PATHOLOGY 0 0 0 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 0 2,455,986 0 71.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 4,841,463 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 0 1,440,658 0 73.00 73.00 70300 RUGS CHARGED TO PATI ENTS 43,048 4,670,988 47,312 73.00 74.00 07400 RENAL DI ALYSI S 0 0 0 74.00 76.01 03140 CARDI AC REHAB 0 1,516,621 0 76.00 76.02 03330 ENDOSCOPY 0 1,425,829 0 76.00 70.01 09000 CLINIC 0 1,167,464 <td< td=""><td>63.00 06300 BLOOD STORING, PROCESSING & TRANS.</td><td>0</td><td>285, 707</td><td></td><td>0</td><td></td><td>63.00</td></td<>	63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	285, 707		0		63.00
66.00 06600 PHYSI CAL THERAPY 0 0 0 66.00 67.00 0CCUPATI ONAL THERAPY 0 0 0 67.00 0 68.00 0SPECH PATHOLOGY 0 0 0 68.00 0 69.00 0 68.00 0 69.00 0 0 0 68.00 69.00 69.00 0 69.00 0 69.00 0 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 71.00 71.00 71.00 71.00 71.00 71.00 72.00 72.00 72.00 73.00 0RUGS CHARGED TO PATI ENTS 43.048 4, 670, 988 47, 312 73.00 73.00 74.00 74.00 74.00 74.00 74.00 74.00 76.00	64.00 06400 INTRAVENOUS THERAPY	0	0)	0		64.00
67.00 06700 0CCUPATI ONAL THERAPY 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 2,455,986 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 4,841,463 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 0 1,440,658 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENT 0 1,440,658 0 73.00 74.00 OT400 RENAL DI ALYSI S 0 0 0 74.00 76.01 03140 CARDI AC REHAB 0 1,516,621 0 76.00 76.02 03070 WOMEN'S CENTER 0 332,128 0 76.00 76.02 03300 ENDOSCOPY 0 1,167,464 0 90.00 0.01 09000 CLINIC 0 3,365,503 0 91.00 91.00 09100 EMERGENCY 0 3,365,503 0 91.00 <	65. 00 06500 RESPI RATORY THERAPY	0	318, 823		0		65.00
68.00 06800 SPEECH PATHOLOGY 0 0 0 68.00 69.00 06900 ELECTROCARDIOLOGY 0 2,455,986 0 69.00 71.00 OTOO MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 4,841,463 0 71.00 72.00 O7200 IMPL. DEV. CHARGED TO PATIENT 0 1,440,658 0 72.00 73.00 O7300 RUGS CHARGED TO PATIENTS 43,048 4,670,988 47,312 73.00 74.00 O7400 RENAL DI ALYSI S 0 0 0 74.00 76.01 03140 CARDIA CR EHAB 0 1,516,621 0 76.00 76.02 03301 ENDOSCOPY 0 1,425,829 0 76.00 70.01 09000 CLI NI C 0 1,167,464 0 90.00 90.01 09000 CLI NI C 0 3,365,503 0 91.00 91.00 09001 EMERGENCY 0 3,365,503 0 91.00 91.00 O9200 OBSERVATION BEDS (NON-DI STINCT PART) 0	66. 00 06600 PHYSI CAL THERAPY	0	0		0		66.00
69.00 06900 ELECTROCARDI OLOGY 0 2,455,986 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 4,841,463 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 1,440,658 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 43,048 4,670,988 47,312 73.00 74.00 07400 RENAL DI ALYSI S 0 0 0 74.00 76.01 03140 CARDI AC REHAB 0 1,516,621 0 76.00 76.02 03070 WOMEN'S CENTER 0 332,128 0 76.00 0 0 1,425,829 0 76.00 76.00 76.00 76.00 03330 ENDOSCOPY 0 1,425,829 0 76.00	67.00 06700 OCCUPATIONAL THERAPY	0	0		0		67.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 4, 841, 463 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 0 1, 440, 658 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 43, 048 4, 670, 988 47, 312 73.00 74.00 07400 RENAL DI ALYSI S 0 0 0 74.00 76.00 03020 OTHER ANCI LLARY 0 0 0 76.00 76.01 03140 CARDI AC REHAB 0 1, 516, 621 0 76.00 76.02 03070 WOMEN'S CENTER 0 332, 128 0 76.00 76.03 03330 ENDOSCOPY 0 1, 167, 464 0 90.00 90.00 09000 CLINIC 0 816, 447 0 90.00 91.01 09101 UTPATI ENT 0 816, 447 0 91.00 91.01 9101 SHOR STAY 0 0 0 91.00 92.00 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 761, 727 <td>68.00 06800 SPEECH PATHOLOGY</td> <td>0</td> <td>0</td> <td>)</td> <td>0</td> <td></td> <td>68.00</td>	68.00 06800 SPEECH PATHOLOGY	0	0)	0		68.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 1,440,658 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 43,048 4,670,988 47,312 73.00 74.00 07400 RENAL DI ALYSIS 0 0 0 74.00 76.00 03020 OTHER ANCILLARY 0 0 0 76.00 76.01 03140 CARDIAC REHAB 0 1,516,621 0 76.00 76.02 03070 WOMEN'S CENTER 0 332,128 0 76.00 76.03 03330 ENDOSCOPY 0 1,167,464 0 76.00 70.00 09000 CLI NI C 0 1,167,464 0 90.00 90.01 09000 CLI NI C 0 316,447 0 90.00 91.00 09100 EMERGENCY 0 3,365,503 0 91.00 91.01 SHORT STAY 0 0 0 0 91.00 92.00 0BSERVATION BEDS (NON-DI STINCT PART) 0 761,727 0 91.00	69. 00 06900 ELECTROCARDI OLOGY	0	2, 455, 986	,	0		69.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 1,440,658 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 43,048 4,670,988 47,312 73.00 74.00 07400 RENAL DI ALYSIS 0 0 0 74.00 76.00 03020 OTHER ANCILLARY 0 0 0 76.00 76.01 03140 CARDIAC REHAB 0 1,516,621 0 76.00 76.02 03070 WOMEN'S CENTER 0 332,128 0 76.00 76.03 03330 ENDOSCOPY 0 1,167,464 0 76.00 70.00 09000 CLI NI C 0 1,167,464 0 90.00 90.01 09000 CLI NI C 0 316,447 0 90.00 91.00 09100 EMERGENCY 0 3,365,503 0 91.00 91.01 SHORT STAY 0 0 0 0 91.00 92.00 0BSERVATION BEDS (NON-DI STINCT PART) 0 761,727 0 91.00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4, 841, 463		0		71.00
73.00 07300 DRUGS CHARGED TO PATIENTS 43,048 4,670,988 47,312 73.00 74.00 07400 RENAL DI ALYSI S 0 0 0 74.00 76.00 03020 OTHER ANCI LLARY 0 0 0 76.00 76.01 03140 CARDI AC REHAB 0 1,516,621 0 76.00 76.02 03070 WOMEN'S CENTER 0 332,128 0 76.00 76.03 03330 ENDOSCOPY 0 1,425,829 0 76.00 00100 CLI NI C 0 1,167,464 0 90.00 90.00 90.00 09000 CLI NI C 0 3,365,503 90.00 90.00 91.01 O9101 STAY 0 0 0 91.00 91.00 92.00 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0 761,727 0 91.00 92.00 09500 AMBULANCE SERVICES 95.00 95.00 95.00 95.00		0	1, 440, 658		0		72.00
74.00 07400 RENAL DI ALYSI S 0 0 0 74.00 76.00 03020 0THER ANCI LLARY 0 0 0 76.00 76.01 03140 CARDI AC REHAB 0 1,516,621 0 76.00 76.02 03070 WOMEN'S CENTER 0 332,128 0 76.00 76.03 03330 ENDOSCOPY 0 1,425,829 0 76.00 00000 CLI NI C 0 1,167,464 0 90.00 90.01 09000 CLI NI C 90.00 90.00 90.00 90.00 91.00 09000 ENERGENCY 0 3,365,503 90.00 91.00 91.01 SHORT STAY 0 0 0 91.00 91.00 91.00 92.00 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 761,727 0 91.00 92.00 OPSOO AMBULANCE SERVICES 95.00 95.00 95.00 95.00 95.00	73.00 07300 DRUGS CHARGED TO PATIENTS	43,048	4, 670, 988	47.3	12		73.00
76.00 03020 0THER ANCI LLARY 0 0 0 76.00 76.01 03140 CARDI AC REHAB 0 1, 516, 621 0 76.00 76.02 03070 WOMEN'S CENTER 0 332, 128 0 76.00 76.03 0330 ENDOSCOPY 0 1, 425, 829 0 76.00 0010 09000 CLI NI C 0 1, 167, 464 0 90.00 90.01 09001 OUTPATI ENT 0 816, 447 0 90.00 91.00 OP100 EMERGENCY 0 3, 365, 503 0 91.00 91.01 SHORT STAY 0 0 0 91.00 90.00 91.00 92.00 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 761, 727 0 92.00 0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00		0	0				74.00
76.01 03140 CARDIAC REHAB 0 1,516,621 0 76.0 76.02 03070 WOMEN'S CENTER 0 332,128 0 76.0 76.03 03330 ENDOSCOPY 0 1,425,829 0 76.0 0010 09000 CLINIC 0 1,167,464 0 90.0 90.00 09001 OUTPATI ENT 0 816,447 90.0 90.0 91.00 O9100 EMERGENCY 0 3,365,503 0 91.0 91.01 SHORT STAY 0 0 0 91.0 9200 00 920		0	0		0		76.00
76.02 03070 WOMEN'S CENTER 0 332,128 0 76.02 76.03 03330 ENDOSCOPY 0 1,425,829 0 76.02 0UTPATI ENT SERVICE COST CENTERS 0 1,167,464 0 90.00 90.00 09001 OUTPATI ENT 0 816,447 0 90.00 91.00 09100 EMERGENCY 0 3,365,503 0 91.00 91.01 SHORT STAY 0 0 0 91.00 92.00 05SERVATION BEDS (NON-DI STINCT PART) 0 761,727 0 92.00 95.00 09500 AMBULANCE SERVICES 95.00 95.00 95.00 95.00		0	1, 516, 621		0		76.01
76.03 03330 ENDOSCOPY 0 1,425,829 0 76.03 0UTPATI ENT SERVICE COST CENTERS 0 1,167,464 0 90.01 90.01 09001 0UTPATI ENT 0 1,167,464 0 90.01 90.01 90.01 90.01 0010 AUTPATI ENT 0 816,447 0 90.00 90.00 90.00 90.00 91.00 91.01 State 90.01 90.01 90.01 91.01 90.01 91.01 State 91.00 91.01 91.01 State 91.00 91.01 90.01 91.01 91.01 90.01 91.00 91.00 92.00 0582RVATI ON BEDS (NON-DI STI NCT PART) 0 761,727 0 91.00 91.00 92.00	76. 02 03070 WOMEN' S CENTER	0			0		76.02
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 1,167,464 0 90.00 90.01 09001 OUTPATIENT 0 816,447 0 90.00 91.00 09100 EMERGENCY 0 3,365,503 0 91.00 91.01 SHORT STAY 0 0 0 91.00 92.00 OS200 OBSERVATION BEDS (NON-DI STINCT PART) 0 761,727 0 92.00 95.00 09500 AMBULANCE SERVICES 95.00 950.00 950.00 950.00		0			-		76.03
90.00 09000 CLINIC 0 1,167,464 0 90.00 90.01 09001 0UTPATIENT 0 816,447 0 90.00 91.00 09100 EMERGENCY 0 3,365,503 0 91.00 91.01 SHORT STAY 0 0 0 0 91.00 92.00 0BSERVATION BEDS (NON-DISTINCT PART) 0 761,727 0 92.00 071HER REI MBURSABLE COST CENTERS 95.00 9500 AMBULANCE SERVICES 95.00		-1 -1	., .==, ==.	1			
90.01 09001 0UTPATIENT 0 816,447 0 90.0 91.00 09100 EMERGENCY 0 3,365,503 0 91.0 91.01 09101 SHORT STAY 0 0 0 91.0 92.00 0BSERVATION BEDS (NON-DISTINCT PART) 0 761,727 0 92.0 0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00		0	1, 167, 464		0		90.00
91.00 09100 EMERGENCY 0 3, 365, 503 0 91.00 91.01 09101 SHORT STAY 0 0 0 91.00 92.00 09SERVATI ON BEDS (NON-DI STI NCT PART) 0 761, 727 0 92.00 0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00		-					90.01
91. 01 09101 SHORT STAY 0 0 0 0 91. 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 761, 727 0 92. 00 0THER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00		-			-		91.00
92.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0 761, 727 0 92.00 0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 95.00		-	0,000		-		91.01
OTHER REI MBURSABLE COST CENTERS 95.00 95.00 09500 AMBULANCE SERVICES 95.00			761 727				92.00
95.00 09500 AMBULANCE SERVICES 95.00		V	701,721		<u> </u>		,2.00
							95.00
	200.00 Total (lines 50-199)	43, 048	43, 742, 905	47 3	12		200.00

Health Financial Systems APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provi der	CCN: 150059	Period: From 01/01/2015 To 12/31/2015		pared: 7 pm
		. Ti tl	e XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS			1		070.404	
50. 00 O5000 OPERATING ROOM	0. 206802			0 0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.00000			0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 281298			0 0	977, 421	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0. 281307			0 0	603, 607	55.00
57.00 05700 CT SCAN	0. 036872			0 0	103, 118	•
57.01 03630 ULTRA SOUND	0. 060680			0 0	23, 272	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 091889			0 125		•
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 110101			0 0	392, 329	•
60. 00 06000 LABORATORY	0. 190069		1, 33	32 0	544, 004	60.00
60.01 06001 BLOOD LABORATORY	0. 000000			0 0	0	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 484106			0 0	138, 312	63.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000			0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 266995			0 0	85, 124	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 370544			0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000			0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000			0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 207461			0 0	509, 521	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 370165			71 515	1, 792, 140	•
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 341960			0 0	492, 647	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 418811			0 14, 273	1, 956, 261	73.00
74.00 07400 RENAL DIALYSIS	0. 906803			0 0	0	74.00
76.00 03020 OTHER ANCI LLARY	0. 000000			0 0	0	76.00
76. 01 03140 CARDI AC REHAB	0. 320215			0 0	485, 645	
76.02 03070 WOMEN' S CENTER	0. 274202			0 0	91, 070	
76. 03 03330 ENDOSCOPY	0. 150835	1, 425, 829		0 0	215, 065	76.03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 455637			0 0		90.00
90. 01 09001 OUTPATI ENT	0. 282485			0 986		90.01
91. 00 09100 EMERGENCY	0. 231510			0 0	779, 148	91.00
91.01 09101 SHORT STAY	0. 000000			0 0	0	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 705210	761, 727		0 0	537, 177	92.00
OTHER REIMBURSABLE COST CENTERS		-				
95. 00 09500 AMBULANCE SERVICES	0.00000			0		95.00
200.00 Subtotal (see instructions)		43, 742, 905	1, 40	03 15, 899	11, 447, 175	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)		43, 742, 905	1,40	15, 899	11, 447, 175	202.00

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 150059	Period: From 01/01/2015	Worksheet D Part V	
				To 12/31/2015	Date/Time Pro 5/19/2016 4:	epared: 57 pm
		Titl	e XVIII	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To Ded. & Coins.	Subject To Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS	0100		<u> </u>			
50. 00 05000 OPERATI NG ROOM	0	0				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55.00
57.00 05700 CT SCAN	0	0				57.00
57.01 03630 ULTRA SOUND	0	0				57.01
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	11				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	-				59.00
60. 00 06000 LABORATORY	253					60.00
60. 01 06001 BLOOD LABORATORY	0					60.01
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 64. 00 06400 I NTRAVENOUS THERAPY	0	0				63.00 64.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68. 00 06800 SPEECH PATHOLOGY	0	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	0					69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	26	191				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	5, 978				73.00
74.00 07400 RENAL DIALYSIS	0	0				74.00
76.00 03020 OTHER ANCI LLARY	0	0				76.00
76. 01 03140 CARDI AC REHAB	0	0				76.01
76. 02 03070 WOMEN' S CENTER	0					76.02
76. 03 03330 ENDOSCOPY	0	0				76.03
90. 00 09000 CLINIC	0	0				90.00
90. 01 09001 OUTPATI ENT	0					90.00
91. 00 09100 EMERGENCY	0	0				91.00
91. 01 09101 SHORT STAY	0					91.01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES	0					95.00
200.00 Subtotal (see instructions)	279	6, 459				200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	279	6, 459				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS Provider CCN: 150597 Component CCN: 150597 Title XVIII Period Total Charges (Column 4) Period District CN: 150597 Title XVIII Period Subprovider CC: 120507 Column 4: 55 pm (Column	Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	eu of Form CMS-	2552-10
Component CCN: 15T059 To 12/31/2015 Date/Time Prepared: 50/02/06.4:57 pm Cost Center Description Capital Related cost (from Wkst. 0, Part II, col. Total Charges (and context) Ratio of Cost to Charges Inpatient (Charges) Capital Cost Center Description Solution 31 (col. 1 + col. Part II, col. Capital Cost Center Description Solution 31 (col. 1 + col. Part II, col. Capital Col. 1 + col. Part II, col. Col. 1 + col. Col. 1 + col. Col. 1 + col. Col. 1 + col. Col. 0 + 759 (col. 1 + col. Part II, col. Solution 31 (col. 1 + col. Part II, col. Col. 0 + 759 (col. 1 + col. Part II, col. Col. 0 + 759 (col. 1 + col. Part II, col. Col. 0 + 759 (col. 1 + col. Part II, col. Col. 0 + 759 (col. 1 + col. Part II, col. Col. 0 + 759 (col. 1 + col. Part II, col. Col. 0 + 759 (col. 1 + col. Part II, col. Col. 0 + 759 (col. 1 + col. Part II, col. Col. 0 + 759 (col. 0 + 750 (col. 2 + 750) Sol. 0 + 759 (col. 0 + 750) Col. 0 + 759 (col. 0 + 750) Sol. 0 + 750 (col. 0 + 750) <td>APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA</td> <td>AL COSTS</td> <td>Provi der</td> <td>CCN: 150059</td> <td></td> <td></td> <td></td>	APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der	CCN: 150059			
Cost Center Description Capital Related Cost (from WKst. C, 20) Ratio of Cost to Charges (col. 1, eol. 2) Inpertient Copital Costs (col. um 4) Copital Costs (col. um 4) ANCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05000 0PERATING ROM 05000 0PERATING ROM 50.00 1.334,080 44,489,429 0.02996 158,700 4.759 50.00 50.00 05000 0PERATING ROM 00 0 0.000000 0 0.52.00 50.00 05400 RADIOLOGYINERAPEUTIC 314,304 547,76,120 0.05414 0 0.55.00 57.00 05000 CARDIOLOGYINERAPEUTIC 314,304 57.76,120 0.05414 0 0.55.00 58.00 05600 MAGNETIC RESONANCE INAGING (MRI) 3.601 3.219,304 0.000012 8.540 7.57.01 58.00 05600 MAGNETIC RESONANCE INAGING (MRI) 3.601 3.219,304 0.010357 669,122 10.964 60.00 0.000000 0 0 0.000000 0 0.600012 8.540 7.77.11 57.01 58.00 05000 MAGN					From 01/01/2015	Part II	
Cost Center Description Capital Related cost (from Wkst. 6, Part II, col. 26) Title X/III Subprovider - Inpatient to Charges (col. 1 + col. 26) Capital Charges (col. 1 + col. 26) Capital Coum 3 × colum 3 × colum 3 × colum 4) MCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 0 05000 (PERATING ROM 0 0000 (Cost 2000 (DELVERY ROM & LABOR ROM 0 0000 (Cost 2000 (Cos			Component	t CCN: 151059	10 12/31/2015	Date/lime Pre	pared:
Cost Center Description Capital Related Cost (from Wkst. 6, Part II, col. 2) Total ent to Charges (col um 3 x col um 4) Capital Costs (col um 3 x col um 4) 4NC1LLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05000 0PERATING ROOM 1.334,000 44,489,429 0.029986 158,700 4.759 50.00 054.00 044,000 0 0.000000 0 0 55.00 51.00 054.00 PELVEPK PROW & LABOR ROOM 0 0 0.000000 0 0 55.00 51.00 054.00 CADI LOGY-THERAPEUTIC 314,304 5.776,120 0.045414 0 0 65.00 57.00 CADI LOGY-THERAPEUTIC 314,304 5.776,120 0.054414 0 0 65.50 58.00 05500 UTAR SOUND 1.33,01,323,514 0.0104057 55.00 75.70 1.33,01 75.70 1.33,01 75.70 1.33,01 75.70 1.33,01 75.70 1.33,01 75.70 1.350,50 66,00 0 0.00000 <td></td> <td></td> <td>T: +1</td> <td>a VV/111</td> <td>Cubarovi dor</td> <td></td> <td>7 pm</td>			T: +1	a VV/111	Cubarovi dor		7 pm
Cost Center Description Capital Related Cost (from Wkst. 6, Part I, col. 20) Total Charges (col. 1 + col. 2) Ratio of Cost (col. mn 3, 2) Copital Costs (col.um 3, 2) Copital Costs (col. 1 + col. 2) MACILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 0.00 05000 DEEATING ROOM 1,334,080 44,489,429 0.029996 158,700 4,759 50.00 52.00 05200 DEL/VEPY ROOM & LABOR ROOM 54,7316 13,565,777 0.040345 90,227 3,640 54,00 57.00 05700 OFADATING KONSTIC 547,316 13,565,777 0.040345 90,227 3,640 54,00 57.00 05700 OFADATING KONSTIC 547,316 13,203,514 0.00042 6,667 30 57,01 59.00 05500 MADIDLOGY-THERAPEUTIC 140,024 13,203,514 0.00181 15,503 18 58,061 3,219,304 0.01181 15,503 18 58,061 10,024 13,203,514 0.01665 96,6122 10,964 60.00 0.00 6000 CABDIACOTHETERT2ATION 140,024 13,203,514			11 (1	e XVIII		PP5	
NUCLLLARY SERVICE COST CENTERS Column 4) Column 4) 50.00 05000 OPERATING ROOM 1.00 2.00 3.00 4.00 5.00 50.00 05000 OPERATING ROOM 1.334,080 44,489,429 0.029986 158,700 4,759 50.00 50.00 05000 DELIVERY ROOM & LABOR ROOM 0 0.000000 0 0 52.00 50.00 05500 RADI DLOGY-THERAPEUTIC 547,316 13,565,777 0.044345 90,227 3,640 54.00 51.00 05500 RADI DLOGY-THERAPEUTIC 314,304 5,771 0.044345 90,227 3,640 54.00 51.00 05500 RADI DLOGY-THERAPEUTIC 314,304 5,771 0.00442 67,687 30 57.01 52.00 CASDMARCH LAR SOUND 1.905 2,345,802 0.000118 15,503 18 58.00 57.01 53.00 0500 CABON LAC CATHETER LATION 140,024 13,203,514 0.01000 10.460.00 0.000000 0	Cost Center Description	Cani tal	Total Charges	Ratio of Cos		Canital Costs	
Image: constraint of the service of the ser	Cost Center Description						
Part II. col. 8) 2) 5 6 1.00 2.00 3.00 4.00 5.00 50.00 05000 OPERATING ROM 1.334.080 44,489,429 0.029986 158,700 4,759 50.00 52.00 05200 DELIVERY ROM & LABOR ROM 0 0 0.000000 0 0 52.00 54.00 05400 RADIOLGGY-DLARNOSTIC 547,316 13,565,777 0.40434 0 0 55.00 57.00 05500 RADIOLGGY-THERAPUTIC 314,304 5,776,120 0.064414 0 0 55.00 57.00 05500 RADIOLGGY-THERAPUTIC 314,304 5,770,120 0.00424 6,867 30 57.00 59.00 05500 CARDIAC CATHETERIZATION 1.40,024 13,203,7355,213 0.01181 15,550 18 58.06 37,395,213 0.01500 59,06 60.01 60.00 60.01 60.00 60.01 60.00 60.01 60.00 60.01 60.00 60.01 60.01 60.00 60.01 60.01 <td< td=""><td></td><td></td><td></td><td>5</td><td></td><td></td><td></td></td<>				5			
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ANCI LLARY SERVICE COST CENTERS Image: Cost Centers 0.00 COSOIO OPERATINO ROOM 1, 334, 080 0 0.00 0.000000 0 0 50.00 52.00 05200 DELI VERY ROOM & LABOR ROOM 54.00 54.00 0.000000 0 0 52.00 55.00 05500 RAD LOLGY-DI ARNOSTIC 547,316 13,565,777 0.040345 90,227 3,640 54.00 57.00 05700 CT SCAN 44.444 10,059,447 0.000424 67,687 30 57.01 58.00 05800 MAGNETI C RESONANCE IMAGING (MRI) 3.801 3,219,304 0.001181 15,503 18 58.00 59.00 05900 CARDIA C CATHETERIZATI ON 140,024 13,203,514 0.010605 95,458 1,012 59,00 60.01 06000 LABDRATORY 588,963 37.395,213 0.01665 95,458 1,012 19,964 60.01 63.00 06300 BLODD DABRATORY 588,963 37.395,213 0.016657 449,237 7,474 65.00 650.00 660.00 66.00		· · · · · · · · · · · · · · · · · · ·	2 00	3 00	4 00	5.00	
50. 00 05000 DEENATING ROOM 1.334,080 44,489,429 0.029986 158,700 4,759 50.00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 0.000000 0 0 52.00 54. 00 D5400 RADIOLOGY-DIAGNOSTIC 314,304 57,777 0.040345 90,227 3,640 54.00 55. 00 OSCO0 (T SCAN 4.4444 10,059,447 0.00042 67,687 30 57.00 57. 00 OSCO0 MARCHET CRESONANCE I MAGING (MRI) 3.801 3,219,304 0.001181 15,503 18 58.00 59.00 05000 CARDIAC CATHETREI ZATI ON 140,024 13,293,514 0.016050 95,488 1,012 59.00 60.00 06000 LABORATORY 588,963 37,395,213 0.015750 696,122 10,964 60.00 61.00 IABORATORY 588,963 37,395,213 0.016637 449,237 7,474 65.00 65.00 OSCOO INTRING, RPACESSING & TRANS. 80.424 1,508.838 <td< td=""><td>ANCLULARY SERVICE COST CENTERS</td><td>1.00</td><td>2.00</td><td>0.00</td><td>1.00</td><td>0.00</td><td></td></td<>	ANCLULARY SERVICE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
52.00 OS200 DELIVERY ROM & LABOR ROM 0 0 0.000000 0 0 52.00 54.00 05400 RADIOLOGY-DIAGNOSTIC 547,316 13,565,777 0.040345 90,227 3,640 54.00 57.00 05500 RADIOLOGY-THERAPEUTIC 314,304 5,776,120 0.054414 0 0 55.00 7.00 05300 UTRA SOUND 4,444 10,059,447 0.000412 67,687 35 7.00 58.00 OSBOO CARDIA CATHETERIZATION 140,024 13,203,514 0.010605 59,458 1,012 59,00 59.00 06000 CABOLA CATHETERIZATION 140,024 13,203,514 0.010605 59,458 1,012 59,00 60.00 06001 BLODD LABORATORY 588,963 37,355,213 0.015750 696,122 10,964 60.01 61.00 06000 RESPIRATORY THERAPY 74,744 5839,031 0.016637 249,237 7,474 65.00 65.00 06000 RESPIRATORY THERAPY 78,637 19,264,211 0.000000 0 66.00		1 334 080	44 489 429	0.0299	36 158 700	4 759	50 00
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55.00 05500 RADIOLOGY-THERAPEUTIC 314, 204 5, 776, 120 0.054141 0 0 55.00 57.00 05700 CT SCAN 4, 444 10, 059, 447 0.000412 8, 540 7 57.01 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 3, 801 3, 219, 304 0.010111 15, 503 18 58.00 05900 CARDIA C. CATHETERIZION 140, 024 13, 203, 514 0.010605 95, 458 1.012 59.00 06001 D6000 LABORATORY 58.8963 37, 395, 213 0.015750 696, 122 10, 964 60.00 06101 D6000 LABORATORY 0 0.000000 0 0 60.01 06300 BLOOD STORING, PROCESSING & TRANS. 80, 424 1, 508, 838 0.053302 15, 228 812 63.00 66.00 O6000 RESPI RATORY THERAPY 97, 144 5, 839, 031 0.06633 32, 321, 952 13, 566 66.00 67.00 OCCUPATI ONAL THERAPY 78, 637 19, 264, 211 0.000000 0 67.00 68.00 OSF00E ELECT		-	-				
57.00 05700 CT SCAN 4,444 10,059,447 0.000442 67,687 30 57.01 57.01 03630 ULTRA SOUND 1,905 2,345,802 0.000812 8,540 7 57.01 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 3,801 3,219,304 0.001811 15,503 18 58.00 59.00 CARDI AC CATHETERI ZATI ON 140,024 13,203,514 0.010605 95,458 1.012 59.00 60.01 06001 BLOOD LABORATORY 0 0.000000 0 60.01 63.00 OG300 BLOOD STORI NG, PROCESSI NG & TRANS. 80,424 1,508,338 0.053302 15,228 812 63.00 64.00 OG400 ITRAVENUS THERAPY 0 0 0.000000 0 0 64.00 65.00 06500 RESPI RATORY THERAPY 71,44 5.839,031 0.016637 449,237 7,474 65.00 66.00 06600 PHYSI CAL THERAPY 78,637 19,264,211 0.000000 0 0 67.00 67.00 CACUPATI ONAL THERAP							
57. 01 0330 ULTRA SOUND 1,905 2,345,802 0.000812 8,540 7 57. 01 58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 3,801 3,219,304 0.00181 15,503 18 58. 00 60.00 06000 LABORATORY 588,963 0.015750 696,122 10,964 60. 01 60.01 06000 DSOD STORING, PROCESSING & TRANS. 80.424 1,508,838 0.053302 15,228 812 63. 00 64.00 06400 INTRAVENUS THERAPY 0 0 0.000000 0 0 64. 00 65.00 06500 RSPI RATORY THERAPY 97,144 5,839,031 0.01637 449,237 7,474 65. 00 66.00 06400 PHYSI CAL THERAPY 78,637 19,264,211 0.004082 3,321,952 13,560 66. 00 67.00 06700 CCUPATI ONAL THERAPY 0 0 0.0000000 0 68. 00 69.00 SPECT PATHOLOGY 0 0 0.0000000 0 0 68. 00 71.00 07100 MEDI CAL SU							
58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 3.801 3.219,304 0.001181 15,503 18 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 1140,024 13,203,514 0.010605 95,458 1,012 59.00 60.00 06000 LABORATORY 588,963 37,395,213 0.015750 696,122 10,964 60.00 64.00 06300 LABORATORY 0 0.000000 0 0 64.00 64.00 06400 INTRAVENOUS THERAPY 0 0.000000 0 0 64.00 65.00 06500 RESPI RATORY THERAPY 97,144 5,839,031 0.01637 449,237 7,474 65.00 66.00 06600 PHS1 CAL THERAPY 78,637 19,264,211 0.000000 0 0 67.00 67.00 06700 0 0.000000 0 0 0 68.00 6900 DEECH PATHOLGY 0 0 0.000000 0 0 68.00 71.00 OT200 INPL EXCHARGED TO PATI ENTS 271,912 46,642,043 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
59:00 OS900 CARDI AC CATHETERI ZATI ON 140,024 13,203,514 0.010605 95,458 1,012 59.00 60:00 O6000 LABORATORY 588,963 37,395,213 0.015750 696,122 10,964 60.00 63:00 O6000 DSTORI NG, PROCESSI NG & TRANS. 80,424 1,508,838 0.053302 15,228 812 63.00 64:00 O6500 RESPIRATORY THERAPY 0 0 0.000000 0 64.00 0 06500 RESPIRATORY THERAPY 97,144 5,839,031 0.016637 449,237 7,474 65.00 66:00 06600 PHYSI CAL THERAPY 78,637 19,264,211 0.04002 3,321,952 13,560 66.00 67:00 06700 CCUPATI ONAL THERAPY 0 0 0.000000 0 67.00 06800 SPECH PATHOLOGY 0 0 0.000000 0 68.00 69:00 IECTROCARDI DLOGY 475,185 9,486,944 0.05088 43,2632 2,522 71.00 71:00 MDI CAL SUPPLI ES CHARGED TO PATI E							
60.00 06000 LABORATORY 588,963 37,395,213 0.015750 696,122 10,964 60.00 60.01 06000 LABORATORY 0 0 0.000000 0 0 60.01 63.00 06300 BLODD LABORATORY 0 0 0.000000 0 0 60.01 64.00 06400 INTRAVENOUS THERAPY 0 0 0.000000 0 64.00 65.00 06500 RESPI RATORY THERAPY 97,144 5,839,031 0.016637 449,237 7,474 65.00 66.00 06500 OCCUPATI ONAL THERAPY 97,144 5,839,031 0.016637 449,237 7,474 65.00 67.00 06700 OCCUPATI ONAL THERAPY 0 0 0.000000 0 66.00 68.00 SPECH PATHOLOGY 0 0 0.0000000 0 67.00 68.00 69.00 OCCUPATI ONAL THERAPY 21,912 46,642,043 0.005830 432,632 2,522 71.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 221,924 46,642,							
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65:00 06500 RESPI RATORY THERAPY 97, 144 5, 839, 031 0.016637 449, 237 7, 474 65:00 66:00 06600 PHYSI CAL THERAPY 78, 637 19, 264, 211 0.004082 3, 321, 952 13, 560 66:00 67:00 0C0000CUPATI IONAL THERAPY 0 0 0.000000 0 68:00 69:00 06900 ELECTROCARDI OLOGY 475, 185 9, 486, 944 0.05808 46, 962 2, 352 69:00 71:00 OT200 IMPL DEV CHARGED TO PATI ENTS 271, 912 46, 642, 043 0.005830 432, 632 2, 522 71:00 73:00 07300 DRUGS CHARGED TO PATI ENTS 323, 262 24, 681, 015 0.013098 770, 808 10, 096 73:00 76:00 03020 OTHEA ANCI LLARY 0 0 0 0.000000 0 76:02 76:01 03140 CARDI AC REHAB 12, 972 3, 726, 938 0.003481 11, 956 42 76:01 76:02 03070 WOMEN'S CENTER 353, 806 4, 358, 448 0.081177 0 7							•
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76.00 03020 OTHER ANCI LLARY 0 0 0.000000 0 0 76.00 76.01 03140 CARDI AC REHAB 12,972 3,726,938 0.003481 11,956 42 76.01 76.02 03070 WOMEN'S CENTER 353,806 4,358,448 0.081177 0 0 76.02 76.03 03330 ENDOSCOPY 119,613 6,186,597 0.019334 26,214 507 76.03 0017PATI ENT SERVICE COST CENTERS 17,465 4,383,218 0.003985 2,760 11 90.00 90.00 09001 OUTPATI ENT 158,505 4,683,557 0.033843 42,121 1,426 90.01 91.00 09100 EMEGENCY 749,359 21,207,121 0.035335 51,271 1,812 91.00 91.01 09101 SHORT STAY 0 0 0.000000 0 0 91.01 92.00 092002 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 3,074,366 0.000000 0 92.00 0 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)				1			•
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76. 03 03330 ENDOSCOPY 119, 613 6, 186, 597 0.019334 26, 214 507 76. 03 OUTPATI ENT SERVICE COST CENTERS 0 09000 CLI NI C 17, 465 4, 383, 218 0.003985 2, 760 11 90. 00 90. 00 09000 UUTPATI ENT 17, 465 4, 683, 557 0.033843 42, 121 1, 426 90. 01 90. 01 09100 UMERGENCY 749, 359 21, 207, 121 0.035335 51, 271 1, 812 91. 00 91. 01 O9101 Stort STAY 0 0 0.000000 0 91. 01 92. 00 09200 DBERVATI ON BEDS (NON-DI STI NCT PART) 0 3, 074, 366 0.000000 0 0 92. 00 0 09200 DBERVATI ON BEDS (COST CENTERS 95. 00 95.00 95.00 95.00 95.00							
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OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00							
95.00 09500 AMBULANCE SERVICES 95.00		0	3,074,366	0.0000	0 00	0	92.00
200.00 Total (lines 50-199) 5, 707, 312 289, 832, 477 6, 407, 622 65, 395 200.00							
	200.00 Total (lines 50-199)	5, 707, 312	289, 832, 477		6, 407, 622	65, 395	200.00

Health Financial Systems	RIVERVIEW H	IOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provi der	CCN: 150059	Period:	Worksheet D	
THROUGH COSTS		Component		From 01/01/2015 To 12/31/2015		norod.
		component	CCN: 15T059	10 12/31/2015	5/19/2016 4:5	
		Titl	e XVIII	Subprovider -	PPS	
			-	I RF		
Cost Center Description	Non Physician N	lursing School	Allied Healt	n All Other	Total Cost	
	Anesthetist			Medi cal	(sum of col 1	
	Cost			Education Cost		
					4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0	0		0 0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	
57.00 05700 CT SCAN	0	0		0 0	0	57.00
57.01 03630 ULTRA SOUND	0	0		0 0	0	•
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
60. 01 06001 BLOOD LABORATORY	0	0		0 0	0	60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	249, 99	2 0	249, 992	73.00
74. 00 07400 RENAL DI ALYSI S	0	0		0 0	0	74.00
76.00 03020 OTHER ANCI LLARY	0	0		0 0	0	76.00
76. 01 03140 CARDI AC REHAB	0	0		0 0	0	76.01
76.02 03070 WOMEN'S CENTER	0	0		0 0	0	76.02
76. 03 03330 ENDOSCOPY	0	0		0 0	0	76.03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0		0 0	0	90.00
90. 01 09001 OUTPATI ENT	0	0		0 0	0	90.01
91.00 09100 EMERGENCY	0	0		0 0	0	
91.01 09101 SHORT STAY	0	0		0 0	0	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS				_		
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	0	0	249, 99	2 0	249, 992	200.00

Health Financial Systems	RI VERVI EW				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provi der	CCN: 150059	Peri od:	Worksheet D	
THROUGH COSTS		0		From 01/01/2015	Part IV	
		Component	CCN: 15T059	To 12/31/2015	Date/Time Pre 5/19/2016 4:5	pared: 7 nm
		Ti †I	e XVIII	Subprovider -	PPS	7 pin
			C AVIII	IRF	115	
Cost Center Description	Total	Total Charges	Ratio of Cos		I npati ent	
	Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of	Part I, col.	(col. 5 ÷ col		Charges	
	col. 2, 3 and		7)	(col. 6 ÷ col.	J	
	4)	, í	, í	7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS		•	•			
50. 00 05000 OPERATI NG ROOM	0	44, 489, 429	0.0000	0. 000000	158, 700	50. OC
52.00 05200 DELIVERY ROOM & LABOR ROOM	0				0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	-			90, 227	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0				0	55.00
57. 00 05700 CT SCAN	0				67,687	57.00
57. 01 03630 ULTRA SOUND	0	2, 345, 802			8, 540	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0				15, 503	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0				95, 458	
60. 00 06000 LABORATORY	0				696, 122	60.00
60. 01 06001 BLOOD LABORATORY					0,122	60.01
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.					15, 228	
64. 00 06400 I NTRAVENOUS THERAPY		.,			13, 220	64.00
65. 00 06500 RESPI RATORY THERAPY		-			449, 237	65.00
66. 00 06600 PHYSI CAL THERAPY					3, 321, 952	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	19, 204, 211			3, 321, 332	67.00
68. 00 06800 SPEECH PATHOLOGY		-			0	
69. 00 06900 ELECTROCARDI OLOGY		-			46, 962	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS					432, 632	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS					24, 894	
73. 00 07300 DRUGS CHARGED TO PATIENTS	249, 992					
73.00 107300 DRUGS CHARGED TO PATTENTS 74.00 107400 RENAL DIALYSIS	249, 992				770, 808 79, 350	
76. 00 03020 OTHER ANCI LLARY		400, 803			19, 350	76.00
		-				
	0	3, 726, 938			11, 956	
76. 02 03070 WOMEN' S CENTER	0	.,			0	76.02
76. 03 03330 ENDOSCOPY	0	6, 186, 597	0.00000	0. 000000	26, 214	76.03
OUTPATIENT SERVICE COST CENTERS		4 000 040	0.0000		0.7/0	
90. 00 09000 CLINIC	0					
90. 01 09001 0UTPATI ENT	0				42, 121	90.01
91. 00 09100 EMERGENCY	0				51, 271	91.00
91. 01 09101 SHORT STAY	0				0	91.01
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0	3, 074, 366	0.0000	0. 000000	0	92.00
OTHER REI MBURSABLE COST CENTERS	1	1	1	1		
95.00 09500 AMBULANCE SERVICES 200.00 Total (lines 50-199)	249, 992	289, 832, 477			6, 407, 622	95.00

Heal th	Financial Systems	RIVERVIEW H	IOSPI TAL		In Li	eu of Form CMS-2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	Provi der	CCN: 150059	Peri od:	Worksheet D
THROUG	H COSTS		Component	t CCN: 15T059	From 01/01/2019 To 12/31/2019	
			component	L 00M. 191037	10 12/31/2013	5/19/2016 4:57 pm
			Ti tl	e XVIII	Subprovider -	
					I RF	
	Cost Center Description	I npati ent	Outpati ent	Outpati ent		
		Program	Program	Program		
		Pass-Through	Charges	Pass-Throug		
		Costs (col. 8		Costs (col.		
		x col. 10)	12.00	x col. 12) 13.00		
	ANCI LLARY SERVI CE COST CENTERS	11.00	12.00	13.00		
50.00	05000 OPERATING ROOM	0	0		0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	52.00
54.00	05400 RADI OLOGY - DI AGNOSTI C	0	0		0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	55.00
57.00	05700 CT SCAN	0	0		0	57.00
57.00	03630 ULTRA SOUND	0	0		0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	58.00
58.00 59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	59.00
60.00	06000 LABORATORY	0	0		0	60.00
60. 00	06001 BLOOD LABORATORY	0	0		0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0	64.00
65.00	06500 RESPI RATORY THERAPY	0	0		0	65.00
66,00	06600 PHYSI CAL THERAPY	0	0		0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0	69.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0		0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	7, 808	0		0	73.00
74.00	07400 RENAL DIALYSIS	0	0		0	74.00
76.00	03020 OTHER ANCI LLARY	0	0		0	76.00
76.01	03140 CARDI AC REHAB	0	0		0	76.01
76.02	03070 WOMEN' S CENTER	0	C		0	76.02
76.03	03330 ENDOSCOPY	0	C		0	76.03
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLI NI C	0	C)	0	90.00
90.01	09001 OUTPATI ENT	0	C		0	90.01
91.00	09100 EMERGENCY	0	C		0	91.00
91.01	09101 SHORT STAY	0	C		0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0)	0	92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVI CES					95.00
200.00	Total (lines 50-199)	7, 808	0		0	200.00

APPORT IO NUMERT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider COX: 155664 Period : To 12/31/2015 Period : Part IV Period : To 12/31/2015 Period : Part IV Part IV	Health Financial Systems	RIVERVIEW H	OSPI TAL		In Lie	u of Form CMS-	2552-10	
Component CCN: 15569 To 12/31/2015 Date/Time Prepared: 5/10/2016.4.57 pm Cost Title XVIII Skilled Nursing Pesilled Total Cost Total Cost Anesthetist Cost 1.00 2.00 3.00 4.00 5.00 50.00 05000 (PERATING ROM 05000 (PERATING ROM 05100 (PERATING ROM 00 (PERA		VICE OTHER PASS	Provi der	CCN: 150059	Peri od:			
Cost Center Description Non Physician Nursing School Allied Nursing PPS Facility Allied Nursing Cost Pracing PPS 0 AncitLLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 0 05000 (DPERATING ROM 0 0 0 0 0 5.00 0 05000 (DPERATING ROM 0	THROUGH COSTS		C	00N 1FF//0				
Cost Center Description Non Physician Nursing School Allied Health All other ANCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05000 (DELVERY ROW & LABOR ROM 0 0 0 0 50.00 50.00 054.00 DELVERY ROW & LABOR ROM 0 0 0 0 50.00 50.00 054.00 DELVERY ROW & LABOR ROM 0 0 0 0 50.00 50.00 054.00 DELVERY ROW & LABOR ROM 0 0 0 0 55.00 50.00 0550.00 DEVORT ROW & LABOR ROM 0 0 0 55.00 50.00 0550.00 DESONDALICAR'-INTERRAPEUTIC 0 0 0 0 57.00 50.00 0550.00 DESONDALICAR'-INTERRAPEUTIC 0 0 0 0 57.00 58.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 <td></td> <td></td> <td>Component</td> <td>CCN: 155669</td> <td>10 12/31/2015</td> <td>Date/IIme Pre</td> <td>parea: 7 nm</td>			Component	CCN: 155669	10 12/31/2015	Date/IIme Pre	parea: 7 nm	
Facility Facility Facility Cost Center Description Non Physician Nursing School Allied Halt Total Cost Ancillary Service Cost Cost Ancillary Service Cost Centeres Cost Allied Halt Ancillary Service Cost Centeres O O O O Solo Operation Cost O O O O O Solo Operation Cost O<			Ti †I		Skilled Nursing		7 piii	
Cost Center Description Non Physician Nursing School Allied Health All Other Medical Education Cost Total Cost (sum of col. 4) 9 05000 0PERATING ROM 0				C AVIII	5	115		
Anesthetist Cost Medical Cost (sum of col 1 Education Cost (sum of col 1 through col strong hol 50.00 NACILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 NACILLARY SERVICE COST CENTERS 0 0 0 0 5.00 50.00 0FEXIVERY ROOM & LABOR ROM 0 0 0 0 5.00 52.00 0FEXIVERY ROOM & LABOR ROM 0 0 0 0 5.00 57.00 0F500 RADIOLOCY-THERAPEUTI C 0 0 0 55.00 55.00 57.01 0330 ULTRA SOUND 0 0 0 0 0 57.00 58.00 05500 RADIOLOCY-THERAPEUTI C 0 0 0 0 57.00 59.00 05600 RADIOLOCY-THERAPEUTI C 0 0 0 0 57.00 59.00 05600 RADIOLOCY-THERAPEUTI C 0 0 0 0 57.00 58.00 05500 RADIOLOCY-THERAPEUTI C 0 0 0 0 0 57.00 58.00 05500 RADIOLOCY-THERAPEUTI C 0 0 0 <td< td=""><td>Cost Center Description</td><td>Non Physician N</td><td>ursina School</td><td>Allied Healt</td><td></td><td>Total Cost</td><td></td></td<>	Cost Center Description	Non Physician N	ursina School	Allied Healt		Total Cost		
Inclusive Inclusive <t< td=""><td></td><td></td><td>J</td><td></td><td></td><td>(sum of col 1</td><td></td></t<>			J			(sum of col 1		
Inclusive Inclusive <t< td=""><td></td><td>Cost</td><td></td><td></td><td>Education Cost</td><td>through col.</td><td></td></t<>		Cost			Education Cost	through col.		
ANCI LLARY SERVICE COST CENTERS Image: Control of Control on Control of Control of Control on Control of Control on Control of Control on Control O								
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52.00 05200 DELIVERY ROM & LABOR ROM 0 0 0 0 52.00 54.00 05400 RADIOLOGY-DIAGNOSTIC 0<	ANCI LLARY SERVI CE COST CENTERS							
54.00 05400 RADIOLOGY-DIAGNOSTLC 0 0 0 0 0 0 0 50.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 57.01 0 0 0 0 0 57.01 58.00 58.00 0 0 0 0 0 57.01 58.00 58.00 0	50. 00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00	
55.00 05500 ADIOLOGY-THERAPEUTIC 0 0 0 0 0 55.00 57.00 05700 CT SCAN 0	52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00	
57.00 CT SCAN 0 0 0 0 57.01 57.01 03630 ULTRA SOUND 0 0 0 0 57.01 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 0 0 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0	54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00	
57. 01 0330 ULTRA SOUND 0 0 0 0 0 0 57. 01 58. 00 05800 MARGNETIC RESONANCE IMAGING (MRI) 0 0 0 0 0 58. 00 60. 00 06000 LABORATORY 0<	55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00	
57. 01 0330 ULTRA SOUND 0 0 0 0 0 0 57. 01 58. 00 05800 MARGNETIC RESONANCE IMAGING (MRI) 0 0 0 0 0 58. 00 60. 00 06000 LABORATORY 0<	57.00 05700 CT SCAN	0	0		0 0	0	57.00	
58.00 05800 MARNETI C RESONANCE I MAGING (MRI) 0<		0	0		0 0	0	57.01	
59:00 CARDI AC CATHETERI ZATI ON 0 <		0	0		0 0		•	
60.00 06000 LABORATORY 0		0	0		0 0	-		
60.01 06001 BLOOD LABORATORY 0 <td></td> <td>0</td> <td>0</td> <td></td> <td></td> <td></td> <td></td>		0	0					
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 63.00 64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 64.00 65.00 06500 RESPIRATORY THERAPY 0 0 0 0 64.00 65.00 06600 PHYSI CAL THERAPY 0 0 0 0 66.00 66.00 06600 CCUPATI ONAL THERAPY 0 0 0 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 69.00 06900 0 71.00 71.00 71.00 71.00 71.00 71.00 71.00 72.00 73.00 07300 DRUCS CHARGED TO PATI ENTS 0 0 0 72.00 73.00 74.00 0 0 0 74.00 74.00 76.00 0 0 0 76.01 76.01		0	0			-		
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65.00 06500 RESPI RATORY THERAPY 0 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 66.00 67.00 0COUPATI ONAL THERAPY 0 0 0 0 66.00 67.00 0COUPATI ONAL THERAPY 0 0 0 0 67.00 68.00 06800 SPECH PATHOLOGY 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 69.00 71.00 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 71.00 72.00 O7200 IMPL. DEV. CHARGED TO PATI ENT 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 74.00 74.00 O7400 RENAL DI ALYSIS 0 0 0 74.00 76.01 03140 CARDI AC REHAB 0 0 0 76.01 76.02 03070 WOMEN'S CENTER 0 0 0 0		0	0		0			
66.00 06600 PHYSI CAL THERAPY 0 0 0 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 74.00 74.00 07400 RENAL DI ALYSIS 0 0 0 74.00 76.01 03140 CREHAB 0 0 0 76.02 76.02 03070 WOMEN'S CENTER 0 0 0 0 76.02 76.02 0370 WOMEN'S CENTER 0 0 0 0 76.02 76.03 03330 ENOSCOPY 0		0	0		0 0	-	•	
67.00 06700 0CCUPATIONAL THERAPY 0 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 69.00 GEQOD ELECTROCARDI OLOGY 0 0 0 0 0 69.00 71.00 OT100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 71.00 72.00 O7200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 72.00 73.00 O7300 DRUGS CHARGED TO PATIENTS 0 0 249,992 249,992 73.00 74.00 O7400 RENAL DI ALYSI S 0 0 0 0 74.00 76.01 03140 CARDI AL CREHAB 0 0 0 0 76.01 76.02 03070 WOMEN'S CENTER 0 0 0 0 76.02 0.03330 ENDOSCOPY 0 0 0 0 0 0 90.00 0.000 OPOOL CLINIC 0 0 0 0 0 <		0	0		0 0			
68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0		0	0		0 0	-		
69.00 06900 ELECTROCARDIOLOGY 0 0 0 0 0 0 0 71.00 71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 249,992 0 249,992 73.00 74.00 07400 RENAL DIALYSIS 0 0 0 0 74.00 76.00 03020 OTHER ANCILLARY 0 0 0 0 76.00 76.01 03140 CARDIAC REHAB 0 0 0 0 76.01 76.02 03070 WOMEN'S CENTER 0 0 0 0 76.02 76.03 03330 ENDOSCOPY 0 0 0 0 90.00 90.00 CLINIC 0 0 0 0 90.01 90.01 91.00 09001 OUTPATIENT 0 0 0 <td< td=""><td></td><td>0</td><td>0</td><td></td><td>0 0</td><td>-</td><td></td></td<>		0	0		0 0	-		
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 249,992 0 249,992 73.00 74.00 07400 RENAL DI ALYSI S 0 0 0 0 74.00 76.00 03020 OTHER ANCI LLARY 0 0 0 0 76.00 76.01 03140 CARDI AC REHAB 0 0 0 0 76.01 76.02 03070 WOMEN'S CENTER 0 0 0 0 76.02 76.03 03330 ENDOSCOPY 0 0 0 0 76.02 70.00 09000 CLI NI C 0 0 0 0 90.00 90.00 09000 CLI NI C 0 0 0 0 90.01 91.01 09010 UTPATI ENT 0 0 0 0 90.01 91.0		0	0		0 0	-		
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74.00 07400 RENAL DI ALYSI S 0 0 0 0 74.00 76.00 03020 OTHER ANCI LLARY 0 0 0 0 76.00 76.01 03140 CARDIA C. REHAB 0 0 0 0 0 76.01 76.02 03070 WOMEN'S CENTER 0 0 0 0 76.02 76.03 03330 ENDOSCOPY 0 0 0 0 0 76.02 76.03 03330 ENDOSCOPY 0 0 0 0 0 76.02 76.04 09000 CLI NI C 0 0 0 0 90.00 90.00 09001 UTPATI ENT SERVICE COST CENTERS 90.01 90.01 90.01 90.01 91.00 09001 UTPATI ENT 0 0 0 0 90.01 91.01 09001 UTPATI ENT 0 0 0 0 91.00 92.00 09200 BERGENCY 0 0 0 0 0 91.01		0	0	0.40.0		-		
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76.01 03140 CARDI AC REHAB 0 0 0 0 76.01 76.02 03070 WOMEN'S CENTER 0 0 0 0 76.02 76.03 03330 ENDOSCOPY 0 0 0 0 0 76.02 76.04 03330 ENDOSCOPY 0 0 0 0 0 76.03 0UTPATI ENT SERVICE COST CENTERS 0 0 0 0 0 90.00 90.00 09001 OUTPATI ENT 0 0 0 90.00 90.10 09100 UTPATI ENT 0 0 0 90.01 91.00 09100 EMERGENCY 0 0 0 91.01 91.01 SHORT STAY 0 0 0 0 91.01 92.00 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 92.00 0THER REI MBURSABLE COST CENTERS 0 0 0 0 92.00 95.00 09500 AMBULANCE SERVI CES 95.00 95.00 95.00 <		0	0		0 0	-		
76.02 03070 WOMEN'S CENTER 0 0 0 0 76.02 76.02 76.02 76.02 76.03 76.02 76.03 <th 70.03<<="" td=""><td></td><td>0</td><td>0</td><td></td><td>0 0</td><td></td><td></td></th>	<td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td></td> <td></td>		0	0		0 0		
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95.00 09500 AMBULANCE SERVICES 95.00		0	0		0 0	0	92.00	
		· · ·						
200.00 Total (lines 50-199) 0 0 249,992 0 249,992 200.00								
	200.00 Total (lines 50-199)	0	0	249, 9	92 0	249, 992	200.00	

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provi der	CCN: 150059	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2015	Part IV	
		Component	t CCN: 155669	To 12/31/2015	Date/Time Pre 5/19/2016 4:5	pared:
		T: +1	e XVIII	Skilled Nursing		7 рш
		11 11	e XVIII	Facility	PPS	
Cost Center Description	Total	Total Charges	Patio of Cos		Inpatient	
COST Center Description	Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of	Part I, col.	(col. 5 ÷ col		Charges	
	col. 2, 3 and		7)	(col. 6 ÷ col.	charges	
	4)	0)	()	(cor. 0 ÷ cor. 7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS	6.00	7.00	8.00	9.00	10.00	
		44 400 400	0.0000		0	
50. 00 05000 OPERATING ROOM	C					
52. 00 05200 DELIVERY ROOM & LABOR ROOM	C					
54. 00 05400 RADI OLOGY-DI AGNOSTI C	C					
55. 00 05500 RADI OLOGY-THERAPEUTI C	C				0	
57. 00 05700 CT SCAN	C				0	
57.01 03630 ULTRA SOUND	C	2, 345, 802				
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	C	3, 219, 304				
59. 00 05900 CARDI AC CATHETERI ZATI ON	C	13, 203, 514				
60. 00 06000 LABORATORY	C	37, 395, 213	0.0000	0. 000000	1, 004, 056	60.00
60. 01 06001 BLOOD LABORATORY	C	0	0.0000	0. 000000	0	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	C	1, 508, 838	0.0000	0. 000000	0	63.00
64.00 06400 INTRAVENOUS THERAPY	C	C	0.0000	0. 000000	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	5, 839, 031	0.0000	0. 000000	357, 839	65.00
66. 00 06600 PHYSI CAL THERAPY	C					
67. 00 06700 OCCUPATI ONAL THERAPY						•
68. 00 06800 SPEECH PATHOLOGY		-				
69. 00 06900 ELECTROCARDI OLOGY		-				
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			1			
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT						
73. 00 07300 DRUGS CHARGED TO PATIENTS	249, 992		1			
74. 00 07400 RENAL DIALYSIS						•
76. 00 03020 OTHER ANCI LLARY		1 °				
76. 01 03140 CARDI AC REHAB	0	3, 726, 938				
76. 02 03070 WOMEN' S CENTER	C	.,				
76. 03 03330 ENDOSCOPY	C	6, 186, 597	0.0000	0.00000	0	76.03
OUTPATIENT SERVICE COST CENTERS		1	1			-
90. 00 09000 CLINIC	C					
90. 01 09001 OUTPATI ENT	C					
91. 00 09100 EMERGENCY	C	21, 207, 121				91.00
91.01 09101 SHORT STAY	C		0.0000			91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	C	3, 074, 366	0.0000	0. 000000	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	249, 992	289, 832, 477			4, 071, 274	
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54.00 05400 RADI OLOGY-DI ACROSTIC 0 0 54. 55.00 0500 RADI OLOGY-THERAPEUTI C 0 0 0 57.00 05700 CT SCAN 0 0 0 57.01 03330 ULTRA SOUND 0 0 0 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 59. 60.01 06000 LABORATORY 0 0 0 0 60. 60.01 06000 INTRAVENUS THERAPY 0 0 0 63. 61.00 06500 RESPI RATORY THERAPY 0 0 0 64. 65.00 06500 RESPI RATORY THERAPY 0 0 0 65. 66.00 06500 RESPI RATORY THERAPY 0 0 0 64. 65.00 06500 RESPI RATORY THERAPY 0 0 0 67. 66.00 00 0 0 0 0 0 7	Heal th	Financial Systems	RIVERVIEW H	IOSPI TAL		In Li	eu of Form CMS-2552-1
AMOUNT CONTO Component CCN: 155669 To 12/31/2015 Date/Time Prepares 5/10/2016 4: 57 pm Cost Center Description Inpatient Program Pass-Through Costs (col. 10) Title XVIII Skilled Nursing Pass-Through Costs (col. 9 0utpatient Program Costs (col. 9 Program Pass-Through Costs (col. 9 0utpatient Program Costs (col. 9 <td></td> <td></td> <td>VICE OTHER PASS</td> <td>Provi der</td> <td>CCN: 150059</td> <td>Peri od:</td> <td>Worksheet D</td>			VICE OTHER PASS	Provi der	CCN: 150059	Peri od:	Worksheet D
ANCI LLARY SERVICE COST CENTERS Outpatient Program Costs (col. 8) Outpatient Program Costs (col. 8) Outpatient Program Costs (col. 10) Outpatient Program Costs (col. 10) Outpatient Program Costs (col. 12) Shill ed Nursing Pass-Through Costs (col. 20) Shill ed Nursing Program Costs (col. 20) Outpatient Program Costs (col. 20) Program Pass-Through Costs (col. 20) Outpatient Program Costs (col. 20) Program Program Costs (col. 20) Outpatient Program Costs (col. 20) </td <td>THROUG</td> <td>H COSTS</td> <td></td> <td>Componen</td> <td>+ CCN, 15540</td> <td></td> <td></td>	THROUG	H COSTS		Componen	+ CCN, 15540		
Cost Center Description Inpatient Program Pass-Through Costs (col. 8 x col. 10) Outpatient Program Costs (col. 9 x col. 10) Program Pass-Through Costs (col. 9 x col. 12) Program Pass (col. 9				componen	L CCN. 155009	10 12/31/2013	
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Program Program <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td>5</td></t<>							5
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 Nursery days (title V or XIX only) SWING BED ADJUSTMENT Medicare rate for swing-bed SNF se reporting period Medicaid rate for swing-bed SNF se reporting period Medicaid rate for swing-bed NF ser reporting period Total general inpatient routine se Swing-bed cost applicable to SNF t x line 17) Swing-bed cost applicable to SNF t x line 18) Swing-bed cost applicable to NF ty x line 19) Swing-bed cost applicable to NF ty x line 20) Total swing-bed cost (see instruct General inpatient routine service PRIVATE ROOM DIFFERENTIAL ADJUSTMEI General inpatient routine service Private room charges (excluding sw Semi-private room per diem char Average per diem private room char O Average per diem private room cost PART II - HOSPITAL AND SUBPROVIDER PROGRAM INPATIENT OPERATING COST B 		in (excluding swing-bed	uays)	0			
 Medicare rate for swing-bed SNF se reporting period Medicare rate for swing-bed SNF se reporting period Medicaid rate for swing-bed NF ser reporting period Total general inpatient routine se Swing-bed cost applicable to SNF t 5 x line 17) Swing-bed cost applicable to SNF t x line 18) Swing-bed cost applicable to NF ty 7 x line 19) Swing-bed cost applicable to NF ty x line 20) Total swing-bed cost (see instruct General inpatient routine service PRIVATE ROOM DIFFERENTIAL ADJUSTMEI General inpatient routine service PRIVATE room charges (excluding sw 200) Semi-private room per diem char Average per diem private room cost differential adj General inpatient routine service 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDER: 				0			
reporting period Medicare rate for swing-bed SNF sere reporting period Medicaid rate for swing-bed NF sere reporting period Medicaid rate for swing-bed NF sere reporting period Total general inpatient routine sec Swing-bed cost applicable to SNF t 5 x line 17) 8.00 Swing-bed cost applicable to SNF t x line 18) 1.00 Swing-bed cost applicable to NF ty 7 x line 19) 1.00 Swing-bed cost applicable to NF ty 7 x line 20) 1.00 Swing-bed cost applicable to NF ty 2.00 Total swing-bed cost (see instruct 3.00 General inpatient routine service PRIVATE ROOM DIFFERENTIAL ADJUSTMEN 3.00 General inpatient routine service PRIVATE room charges (excluding sw 3.00 Average private room per diem char 3.00 Average per diem private room cost 3.00 Average per diem private room cost 3.00 Private room cost differential adj 3.00 General inpatient routine service 3.00 Average per diem private room cost 3.00 Private room cost differential adj 3.00 PART 11 - HOSPITAL AND SUBPROVIDERS PROGRAM INPATIENT OPERATING COST BU							
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reporting period Medicaid rate for swing-bed NF ser reporting period Total general inpatient routine se Swing-bed cost applicable to SNF t 5 x line 17) 8.00 Swing-bed cost applicable to SNF t x line 18) 8.00 Swing-bed cost applicable to NF ty 7 x line 19) 9.00 Swing-bed cost applicable to NF ty x line 20) 9.00 Total swing-bed cost (see instruct 0 General inpatient routine service PRIVATE ROOM DIFFERENTIAL ADJUSTMEI 8.00 General inpatient routine service PRIVATE room charges (excluding sw 0.00 Semi-private room per diem char 8.00 Average per diem private room cost 9.00 Private room cost differential adj 9.00 General inpatient routine service 9.00 Average per diem private room cost 9.00 Private room cost differential adj 9.00 PART II - HOSPITAL AND SUBPROVIDER: PROGRAM INPATIENT OPERATING COST BI							
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reporting period Total general inpatient routine se Swing-bed cost applicable to SNF t 5 x line 17) 8.00 Swing-bed cost applicable to SNF t x line 18) 4.00 Swing-bed cost applicable to NF ty 7 x line 19) 5.00 Swing-bed cost applicable to NF ty x line 20) 5.00 Total swing-bed cost (see instruct 7.00 General inpatient routine service PRIVATE ROOM DIFFERENTIAL ADJUSTMEN 8.00 General inpatient routine service PRIVATE room charges (excluding sw 0.00 Semi-private room charges (excluding sw 0.00 Semi-private room per diem char 8.00 Average per diem private room cost 8.00 Average per diem private room cost 9.00 Private room cost differential adj 7.00 General inpatient routine service 2.00 Average per diem private room cost 3.00 Average per diem private room cost 5.00 Private room cost differential adj 7.00 General inpatient routine service 2.7 minus line 36) PART 11 - HOSPITAL AND SUBPROVIDERS PROGRAM INPATIENT OPERATING COST BU	ces applicable to services	after December 31 of t	he cost	0.00	20		
 Swing-bed cost applicable to SNF t 5 x line 17) Swing-bed cost applicable to SNF t x line 18) Swing-bed cost applicable to NF ty 7 x line 19) Swing-bed cost applicable to NF ty x line 20) Swing-bed cost applicable to NF ty x line 20) Swing-bed cost (see instruct 7.00 General inpatient routine service PRIVATE ROOM DIFFERENTIAL ADJUSTMEI Semi-private room charges (excluding sw 0.00 Semi-private room per diem char Average per diem private room charges (excluding Average per diem private room charges O Average per diem private room cost 0.00 Private room cost differential adj 0.00 General inpatient routine service O Average per diem private room cost 0.00 Private room cost differential adj 0.00 Average per diem toutine service O Average per diem toutine service O Average per diem private room cost 0.00 Private room cost differential adj 0.00 PART II - HOSPITAL AND SUBPROVIDER: PROGRAM INPATIENT OPERATING COST B 							
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 3. 00 Swing-bed cost applicable to SNF t x line 18) 4. 00 Swing-bed cost applicable to NF ty 7 x line 19) 5. 00 Swing-bed cost applicable to NF ty x line 20) 5. 00 Total swing-bed cost (see instruct General inpatient routine service PRIVATE ROOM DIFFERENTIAL ADJUSTMEI 8. 00 General inpatient routine service Private room charges (excluding sw 0.00 Semi -private room charges (excludi 0.00 General inpatient routine service 2. 00 Average private room per diem char 3. 00 Average semi -private room per diem 4. 00 Average per diem private room cost 5. 00 Private room cost differential adj 6. 00 General inpatient routine service 2. 00 Average per diem private room cost 3. 00 Average per diem private room cost 5. 00 Private room cost differential adj 7. 00 General inpatient routine service 2. 7 minus line 36) PART 11 - HOSPITAL AND SUBPROVIDERS PROGRAM INPATIENT OPERATING COST BUST 	e services through Decembe	er 31 of the cost report	ing period (line	0	22		
x line 18) 5.00 Swing-bed cost applicable to NF ty 7 x line 19) 5.00 Swing-bed cost applicable to NF ty x line 20) 5.00 Total swing-bed cost (see instruct 7.00 General inpatient routine service PRIVATE ROOM DIFFERENTIAL ADJUSTMEN 8.00 General inpatient routine service PRIVATE room charges (excluding sw 0.00 Semi-private room charges (excluding sw 0.00 Semi-private room per diem char 8.00 Average private room per diem char 8.00 Average per diem private room char 5.00 Average per diem private room cost 5.00 Private room cost differential adj 7.00 General inpatient routine service 2.00 Average per diem private room cost 5.00 Private room cost differential adj 7.00 General inpatient routine service 2.7 minus line 36) PART 11 - HOSPITAL AND SUBPROVIDERS PROGRAM INPATIENT OPERATING COST BU	e services after December	31 of the cost reportin	g period (line 6	0	23		
 7 x line 19) 5.00 Swing-bed cost applicable to NF ty x line 20) 5.00 Total swing-bed cost (see instruct 7.00 General inpatient routine service PRIVATE ROOM DIFFERENTIAL ADJUSTMEI 8.00 General inpatient routine service 9.00 Private room charges (excluding sw 0.00 Semi-private room charges (excluding sw 0.00 Semi-private room per diem char 8.00 Average per diem private room per diem char 8.00 Average per diem private room cost 0 Private room cost 1 fferential adj 7.00 General inpatient routine service 9.00 Average per diem private room cost 0 PART 11 - HOSPITAL AND SUBPROVIDER: PROGRAM INPATIENT OPERATING COST B 							
 5.00 Swing-bed cost applicable to NF ty x line 20) 5.00 Total swing-bed cost (see instruct General inpatient routine service PRIVATE ROOM DIFFERENTIAL ADJUSTMEI 8.00 General inpatient routine service 9.00 Private room charges (excluding sw) 00 General inpatient routine service 00 General inpatient routine service 00 Average private room per diem char 00 Average per diem private room charge 00 Average per diem private room cost 00 Private room cost differential adj 00 General inpatient routine service 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDER: PROGRAM INPATIENT OPERATING COST BUSILIANS 	services through December	31 of the cost reporti	ng period (line	0	24		
x line 20) Total swing-bed cost (see instruct General inpatient routine service PRIVATE ROOM DIFFERENTIAL ADJUSTMEN General inpatient routine service Private room charges (excluding sw 0.00 Semi-private room charges (excludi 0.00 General inpatient routine service 0.00 Average private room per diem char 0.00 Average semi-private room per diem 0.00 Average per diem private room char 0.00 Average per diem private room cost 0.00 Private room cost differential adj 0.00 General inpatient routine service 2.00 Average per diem private room cost 0.00 Private room cost differential adj 0.00 General inpatient routine service 2.7 minus line 36) PART II - HOSPITAL AND SUBPROVIDER: PROGRAM INPATIENT OPERATING COST BI	services after December 3	1 of the cost reporting	period (line 8	0	25		
 7.00 General inpatient routine service PRIVATE ROOM DIFFERENTIAL ADJUSTMEI 8.00 General inpatient routine service 9.00 Private room charges (excluding sw 0.00 Semi-private room charges (excluding sw 0.00 General inpatient routine service 2.00 Average private room per diem char 8.00 Average per diem private room charge 8.00 Average per diem private room char 6.00 Average per diem private room cost 9.00 Private room cost differential adj 7.00 General inpatient routine service 2.7 minus line 36) PART 11 - HOSPITAL AND SUBPROVIDER PROGRAM INPATIENT OPERATING COST BUSIL 		3					
PRI VATE ROOM DIFFERENTIAL ADJUSTMEI 8.00 General inpatient routine service 9.00 Private room ckcl uding sw 9.00 Semi-private room ckcl uding sw 9.00 Semi-private room ckcl uding sw 9.00 General inpatient routine secluding 9.00 General inpatient routine secluding 9.00 Average private room per diem 9.00 Average per diem private room char 9.00 Average per diem private room char 9.00 Average per diem private room cost 9.00 Private room cost differential adj 7.00 General inpatient routine service 27 minus line 36) <t< td=""><td>-</td><td></td><td></td><td>0</td><td></td></t<>	-			0			
 3.00 General inpatient routine service D00 Private room charges (excluding sw D00 Semi-private room charges (excludi D00 General inpatient routine service D00 Average private room per diem char D00 Average semi-private room per diem D00 Average per diem private room char D00 Average per diem private room cost D00 Private room cost differential adj C00 General inpatient routine service 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDER: PROGRAM INPATIENT OPERATING COST BUSE 		line 21 minus line 26)		18, 004, 276	27		
 Private room charges (excluding sw Semi-private room charges (excludi General inpatient routine service Average private room per diem char Average semi-private room per diem Average per diem private room char Average per diem private room cost Private room cost differential adj General inpatient routine service 27 minus line 36) PART 11 - HOSPITAL AND SUBPROVIDERS PROGRAM INPATIENT OPERATING COST BIO 		and observation bed ch	arges)	0	28		
 General inpatient routine service Average private room per diem char Average semi-private room per diem Average per diem private room char Average per diem private room cost Average per diem private room cost OO Average per diem private room co				0	29		
 Average private room per diem char Average semi-private room per diem Average per diem private room char Average per diem private room cost Private room cost differential adj General inpatient routine service 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS PROGRAM INPATIENT OPERATING COST BUSCONT 	0,00			0	30		
 .00 Average semi-private room per diem .00 Average per diem private room char .00 Average per diem private room cost .00 Private room cost differential adj .00 General inpatient routine service .27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS PROGRAM INPATIENT OPERATING COST BUSIL 		line 28)		0.000000			
 .00 Average per diem private room char .00 Average per diem private room cost .00 Private room cost differential adj .00 General inpatient routine service .27 minus line 36) PART II - HOSPITAL AND SUBPROVIDER: PROGRAM INPATIENT OPERATING COST BUDGEN 				0.00			
 .00 Average per diem private room cost .00 Private room cost differential adj .00 General inpatient routine service .27 minus line 36) PART II - HOSPITAL AND SUBPROVIDER PROGRAM INPATIENT OPERATING COST BUDGRAM 		us line 22) (can instrue	tions)	0.00 0.00			
.00 Private room cost differential adj .00 General inpatient routine service 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDER PROGRAM INPATIENT OPERATING COST B			(10113)	0.00			
2.00 General inpatient routine service 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS PROGRAM INPATIENT OPERATING COST BI	-	/		0.00			
PART II - HOSPITAL AND SUBPROVIDER PROGRAM INPATIENT OPERATING COST B		nd private room cost di	fferential (line	18, 004, 276			
PROGRAM INPATIENT OPERATING COST B					1		
		STMENTS			-		
				1, 212. 57	38		
0.00 Program general inpatient routine				6, 572, 129			
0.00 Medically necessary private room c .00 Total Program general inpatient ro				0 6, 572, 129			

JWPUT	ATION OF INPATIENT OPERATING COST		Provi der		Period: From 01/01/2015 To 12/31/2015	Date/Time Pre	epared
				e XVIII	Hospi tal	5/19/2016 4:5 PPS	57 pm
	Cost Center Description	Total Inpatient Costl	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
2.00	NURSERY (title V & XIX only)	0	0	0.0	0 0	, C) 42. C
2 00	Intensive Care Type Inpatient Hospital Units	4 072 220	2 504	1 () ()	0 1 1 (2	1 001 275	1 42 0
3.00 4.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T	4,072,230	2, 504	1, 626. 2	9 1, 163	1, 891, 375	5 43. C 44. C
5.00	BURN INTENSIVE CARE UNIT						45.0
	SURGI CAL I NTENSI VE CARE UNI T						46. C
7.00	OTHER SPECIAL CARE (SPECIFY)						47. C
	Cost Center Description					1.00	
8.00	Program inpatient ancillary service cost (Wks	at D-3 col 3	line 200)			1.00 10,668,242	2 48. C
9.00	Total Program inpatient costs (sum of lines 4			ns)		19, 131, 746	
	PASS THROUGH COST ADJUSTMENTS			10)		1 17/101/710	
D. 00	Pass through costs applicable to Program inpa	atient routine :	services (from	Wkst. D, sum	of Parts I and	1, 633, 431	i 50. C
1. 00	Pass through costs applicable to Program inpa	atient ancillar	y services (fr	om Wkst. D, si	um of Parts II	724, 708	3 51.0
2. 00	and IV) Total Program excludable cost (sum of lines {	50 and 51)				2, 358, 139	9 52.0
3.00	Total Program inpatient operating cost exclude		lated, non-phv	sician anesth	etist, and	16, 773, 607	
	medical education costs (line 49 minus line 5						
	TARGET AMOUNT AND LIMIT COMPUTATION						
4.00	Program di scharges) 54.0) 55.0
5.00 5.00	Target amount per discharge Target amount (line 54 x line 55)					0.00	
7.00	Difference between adjusted inpatient operati	ng cost and ta	rget amount (I	ine 56 minus	line 53)		
3.00	Bonus payment (see instructions)		C				
9.00	mpounded by the	0.00	59. (
	market basket						
0.00 1.00	Lesser of lines 53/54 or 55 from prior year of lines 53/54 is less than the lower of lines				the amount by	0.00	
1.00	which operating costs (line 53) are less than						01.0
	amount (line 56), otherwise enter zero (see i		3 (ITIES 54 X		the target		
2.00	Relief payment (see instructions)	,				C	62.0
3.00	Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)			C) 63.0
4.00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	to through Doop	mbor 21 of the	aget reporti	an portiod (Coo	C	64.0
4.00	instructions) (title XVIII only)	is through becer		cost reportin	ig per l'ou (see		04.0
5.00	Medicare swing-bed SNF inpatient routine cost	ts after Decemb	er 31 of the c	ost reporting	period (See	C	65.0
	instructions)(title XVIII only)						
5.00	Total Medicare swing-bed SNF inpatient routin	ne costs (line)	64 plus line 6	5)(title XVII	l only). For	C	66. (
7.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine	costs through	Decomber 21 o	f the cost rou	porting poriod		67.0
7.00	(line 12 x line 19)	e costs through	December 31 0	i the cost re	boi tring period		07.0
B. 00	Title V or XIX swing-bed NF inpatient routine	e costs after De	ecember 31 of	the cost repo	rting period	C	68. (
	(line 13 x line 20)						
9.00	Total title V or XIX swing-bed NF inpatient					C) 69. (
0. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili					1	70.
1.00	Adjusted general inpatient routine service co						71.
2.00	Program routine service cost (line 9 x line 1						72.
3.00	Medically necessary private room cost applica			ne 35)			73.
1.00	Total Program general inpatient routine servi	•			out 11'		74.
5.00	Capital-related cost allocated to inpatient r 26, line 45)	outine service	COSTS (from W	orksneet B, Pa	art II, column		75.0
5.00	Per diem capital-related costs (line 75 ÷ lin	ne 2)					76.
7.00	Program capital -related costs (line 9 x line						77.
. 00	Inpatient routine service cost (line 74 minus						78.
. 00	Aggregate charges to beneficiaries for excess	• •			10 line 70		79.
. 00 . 00	Total Program routine service costs for compa Inpatient routine service cost per diem limit		UST IIMITATION	(IINE /8 MIN	us iine 79)		80. 81.
. 00	Inpatient routine service cost per drem finm)				82.
. 00	Reasonable inpatient routine service cost frim tation (in						83.
. 00	Program inpatient ancillary services (see ins		-				84.
6.00	Utilization review - physician compensation						85.
. 00	Total Program inpatient operating costs (sum		rough 85)				86.
. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS					1, 788	3 87.
	Total observation bed days (see instructions)	1					
3.00	Adjusted general inpatient routine cost per o	diem (line 27 ∸	line 2)			1, 212. 57	7 88.

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lieu of Form CMS-255			
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period:	Worksheet D-1		
				From 01/01/2015 To 12/31/2015	Date/Time Pre 5/19/2016 4:5	pared: 7 pm	
		Titl	e XVIII	Hospi tal	PPS		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on		
		(from line 27)	column 2	Observati on	Bed Pass		
				Bed Cost (from	Through Cost		
				line 89)	(col. 3 x 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	3, 607, 660	18, 004, 276	0. 20037	8 2, 168, 075	434, 435	90.00	
91.00 Nursing School cost	0	18, 004, 276	0.00000	0 2, 168, 075	0	91.00	
92.00 Allied health cost	0	18, 004, 276	0.00000	0 2, 168, 075	0	92.00	
93.00 All other Medical Education	0	18, 004, 276	0. 00000	0 2, 168, 075	0	93.00	

		Provider CCN: 150059 Component CCN: 15T059 Title XVIII	Peri od: From 01/01/2015 To 12/31/2015 Subprovi der - I RF	Worksheet D-1 Date/Time Prep 5/19/2016 4:5 PPS	pared		
	Cost Center Description		-	1.00			
	PART I - ALL PROVIDER COMPONENTS						
1.00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days,	excluding newborn)		5, 583	1.0		
2.00	Inpatient days (including private room days, excluding swing-bed			5, 583			
3.00	Private room days (excluding swing-bed and observation bed days)	. If you have only pr	vate room days,	0	3.0		
00	do not complete this line.	dava)		5, 583			
. 00 . 00	Semi-private room days (excluding swing-bed and observation bed Total swing-bed SNF type inpatient days (including private room		r 31 of the cost	5, 583	4.0 5.0		
	reporting period			c c			
. 00	Total swing-bed SNF type inpatient days (including private room	days) after December	31 of the cost	0	6.0		
. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room d	ave) through December	31 of the cost	0	7.0		
. 00	reporting period	ays) through becember	ST OF THE COST	0	'.'		
3.00	Total swing-bed NF type inpatient days (including private room d	ays) after December 3	1 of the cost	0	8. (
9.00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to t	bo Drogram (avaluding	cwing bod and	3, 901	9.0		
. 00	newborn days)	The Program (excruating	swillig-bed allu	3, 901	9.0		
0.00	Swing-bed SNF type inpatient days applicable to title XVIII only	(including private r	oom days)	0	10.0		
4 00	through December 31 of the cost reporting period (see instructio						
1.00	Swing-bed SNF type inpatient days applicable to title XVIII only December 31 of the cost reporting period (if calendar year, ente		com days) arter	0	11.		
2.00	Swing-bed NF type inpatient days applicable to titles V or XIX o		e room days)	0	12.		
	through December 31 of the cost reporting period						
3.00	Swing-bed NF type inpatient days applicable to titles V or XIX o after December 31 of the cost reporting period (if calendar year			0	13.		
4.00	Medically necessary private room days applicable to the Program			0	14.		
5.00	Total nursery days (title V or XIX only)			0	15.		
6.00	Nursery days (title V or XIX only)			0	16.		
7.00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services	through December 31 o	f the cost	0.00	17.		
	reporting period	U U					
8.00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost	0.00	18.		
9.00	reporting period Medicaid rate for swing-bed NF services applicable to services t	hrough December 31 of	the cost	0.00	19.		
0. 00	reporting period Medicaid rate for swing-bed NF services applicable to services a	fter December 31 of t	ne cost	0.00	20		
0.00	reporting period		10 0031	0.00	20.		
1.00	Total general inpatient routine service cost (see instructions)			4, 339, 733			
2.00	Swing-bed cost applicable to SNF type services through December 5 x line 17)	31 of the cost report	ing period (line	0	22.		
3. 00	Swing-bed cost applicable to SNF type services after December 31	of the cost reporting	g period (line 6	0	23.		
4 00	x line 18)	1 - C + h + + : .		0	24		
4.00	Swing-bed cost applicable to NF type services through December 3 7×10^{-1} x line 19)	i of the cost reporting	ig period (inne	0	24.		
5.00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25.		
6. 00	x line 20) Total swing-bed cost (see instructions)			0	26.		
	General inpatient routine service cost net of swing-bed cost (li	ne 21 minus line 26)		4, 339, 733			
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT]		
	General inpatient routine service charges (excluding swing-bed a	nd observation bed ch	arges)	0			
9.00 0.00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 30.		
1.00	General inpatient routine service cost/charge ratio (line 27 ÷ l	ine 28)		0. 000000			
2. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.		
3.00	Average semi-private room per diem charge (line 30 ÷ line 4)		t:)	0.00 0.00			
4.00 5.00							
6.00	Private room cost differential adjustment (line 3 x line 35)	~.,		0. 00 0			
7.00	General inpatient routine service cost net of swing-bed cost and	private room cost di	fferential (line	4, 339, 733			
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY						
	PART IT - HOSPITAL AND SUBPROVIDERS UNLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST	MENTS			1		
8. 00	Adjusted general inpatient routine service cost per diem (see in			777. 31	38.		
9.00	Program general inpatient routine service cost (line 9 x line 38)		3, 032, 286			
	Medically necessary private room cost applicable to the Program	. ,		2 022 284			
1.00	Total Program general inpatient routine service cost (line 39 +	1110 40)	I	3, 032, 286	41.		

	Financial Systems ATION OF INPATIENT OPERATING COST	RI VERVI EW F		CCN: 150059	Peri od:	eu of Form CMS- Worksheet D-1	
			Component	t CCN: 15T059	From 01/01/2015 To 12/31/2015	Date/Time Pre	
			Ti tl	e XVIII	Subprovider - IRF	5/19/2016 4:5 PPS	57 p
	Cost Center Description	Total Inpatient Costl	Total	Average Per	Program Days	Program Cost (col. 3 x col.	
		1.00		<u>col. 2)</u> 3.00	4.00	4) 5.00	_
. 00	NURSERY (title V & XIX only)	0	2.00 0) 42
~~	Intensive Care Type Inpatient Hospital Units						
. 00 . 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	U	0.	00 0	0	4:
	BURN INTENSIVE CARE UNIT						4
. 00	SURGI CAL I NTENSI VE CARE UNI T						40
. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						4
00	Program inpatient ancillary corvice cast (Wks	t D 2 col 2	line 200)			1.00 2,169,693	
	Program inpatient ancillary service cost (Wks Total Program inpatient costs (sum of lines 4			ons)		5, 201, 979	
	PASS THROUGH COST ADJUSTMENTS						
. 00	Pass through costs applicable to Program inpa	itient routine s	services (from	n Wkst. D, su	m of Parts I and	456, 456	5
. 00	Pass through costs applicable to Program inpa	itient ancillary	y services (fr	om Wkst. D,	sum of Parts II	73, 203	3 5'
. 00	and IV) Total Program excludable cost (sum of lines 5	0 and 51)				529, 659	52
. 00 . 00	Total Program inpatient operating cost exclude		ated, non-phy	sician anest	hetist, and	4, 672, 320	
	medical education costs (line 49 minus line 5 TARGET AMOUNT AND LIMIT COMPUTATION	2)					-
. 00	Program discharges					0) 5
. 00	Target amount per discharge					0.00	
. 00 . 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operati	ng cost and tar	caet amount (l	ine 56 minus	line 53)	0	
. 00	Bonus payment (see instructions)	ing cost and tai	get unourt (i			0	
. 00	Lesser of lines 53/54 or 55 from the cost rep	orting period e	ending 1996, ι	pdated and c	ompounded by the	0.00	5
. 00	market basket Lesser of lines 53/54 or 55 from prior year of	ost report, upo	dated by the m	arket basket		0.00	6
. 00	If line 53/54 is less than the lower of lines	55, 59 or 60 e	enter the less	er of 50% of		0	6
	which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see i		s (lines 54 x	60), or 1% o	f the target		
. 00	Relief payment (see instructions)					0	6
. 00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instruc	ctions)			0) 6
. 00	Medicare swing-bed SNF inpatient routine cost	s through Decem	mber 31 of the	e cost report	ing period (See	0	6
00	instructions) (title XVIII only)	a ofter Decembr	an 21 of the c	ant reportin	a posted (Coo		
. 00	Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	s arter Decembe	er 31 of the C	ost reportin	g period (See	0) 6!
. 00	Total Medicare swing-bed SNF inpatient routir	e costs (line é	64 plus line 6	5)(title XVI	II only). For	0	6
00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine	costs through	December 31 c	of the cost r	eporting period	0	6
	(line 12 x line 19)	ocoro rin ough			opor tring por ou		
. 00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after De	ecember 31 of	the cost rep	orting period	0	68
. 00	Total title V or XIX swing-bed NF inpatient r	outine costs (I	ine 67 + line	e 68)		0	6
00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili				<u>\</u>		1 7/
. 00 . 00	Adjusted general inpatient routine service co	5)		7(7 [·]
. 00	Program routine service cost (line 9 x line 7	1)					7
. 00 . 00	Medically necessary private room cost applica Total Program general inpatient routine servi	0	•				7:
. 00	Capital-related cost allocated to inpatient r	•			Part II, column		7
. 00	26, line 45) Per diem capital-related costs (line 75 ÷ lir	ue 2)					7
. 00	Program capital -related costs (line 9 x line						7
00	Inpatient routine service cost (line 74 minus		ovidor				7
00 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa	• •			nus line 79)		8
00	Inpatient routine service cost per diem limit	ation			/		8
00 00	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (s						8
. 00	Program inpatient ancillary services (see ins		<i>>)</i>				8
. 00	Utilization review - physician compensation (see instruction					8
. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		rough 85)				86
. 00	Total observation bed days (see instructions)					0	8
	Adjusted general inpatient routine cost per o	•	line 2)			0.00	
	Observation bed cost (line 87 x line 88) (see	: INSTRUCTIONS)				1 0) 8'

Health Financial Systems	RI VERVI EW	HOSPI TAL			In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Prov	der		Period: From 01/01/2015	Worksheet D-1	
			onent	t CCN: 15T059			pared: 7 pm
			Ti tl	e XVIII	Subprovider -	PPS	
Cost Center Description	Cost	Routine (ost	column 1 ÷	Total	Observati on	
		(from line	27)	column 2	Observati on	Bed Pass	
					Bed Cost (from	Through Cost	
					line 89)	(col. 3 x 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	653, 265	4, 339	, 733	0. 15053	31 0	0	90.00
91.00 Nursing School cost	0	4, 339	, 733	0.0000	0 0	0	91.00
92.00 Allied health cost	0	4, 339	, 733	0.0000	0 0	0	92.00
93.00 All other Medical Education	0	4, 339	, 733	0.00000	0 0	0	93.00

	Financial Systems RIVERVIEW HOSPITAL In Lieu ATION OF INPATIENT OPERATING COST Provider CCN: 150059 Component CCN: 155669 Period: From 01/01/2015 To 12/31/2015 Title XVIII Skilled Nursing Facility	u of Form CMS-2 Worksheet D-1 Date/Time Prep 5/19/2016 4:5 PPS	pared:
	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
1.00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days, excluding newborn)	5, 001	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5, 001	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3.00
4 00	do not complete this line.	5,001	4.00
4.00 5.00	Semi-private room days (excluding swing-bed and observation bed days) Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	5,001	4. 00 5. 00
0.00	reporting period	J. J	0.00
6.00	Total swing-bed SNF type inpatient days (including private room 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 room days) through December 31 of the cost	0	7.00
7.00	reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8.00
0 00	reporting period (if calendar year, enter 0 on this line)	2 424	0.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	3, 431	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
11 00	through December 31 of the cost reporting period (see instructions)		11 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)	0	12.00
	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)	0	13.00
14.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
17.00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17.00
17.00	reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18.00
19.00	reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19.00
19.00	reporting period	0.00	17.00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20.00
21.00	reporting period Total general inpatient routine service cost (see instructions)	3, 451, 019	21.00
21.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line)	3, 431, 019	21.00
22.00	5 x line 17)	J. J	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23.00
24.00	x line 18) Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24.00
211 00	7 x line 19)	J. J	200
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25.00
26.00	x line 20) Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3, 451, 019	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00 29.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00 30.00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)	0	29.00 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
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	
34.00 35.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions) Average per diem private room cost differential (line 34 x line 31)	0. 00 0. 00	34.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0.00	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	3, 451, 019	37.00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
			20.00
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)		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) Medically necessary private room cost applicable to the Program (line 14 x line 35)		38.00 39.00 40.00

Health Financial Systems COMPUTATION OF INPATIENT OPERATING COST	RI VERVI EW H		CCN: 150059	In Lie Period:	eu of Form CMS-2 Worksheet D-1				
			CCN: 155669	From 01/01/2015 To 12/31/2015	Date/Time Pre	pared:			
		Ti tl	e XVIII	Skilled Nursing	5/19/2016 4:5 PPS	/pm			
Cost Center Description	Total Inpatient Costl	Total Inpatient Days	Average Per Diem (col. 1	5	Program Cost (col. 3 x col.				
	1.00	2.00	<u>col.2)</u> 3.00	4.00	4) 5.00				
42.00 NURSERY (title V & XIX only)		2.00	0.00	1.00	0.00	42.00			
43.00 INTENSIVE CARE UNIT	S					43.00			
44. 00 CORONARY CARE UNI T						44.00			
45. 00 BURN INTENSIVE CARE UNIT 46. 00 SURGICAL INTENSIVE CARE UNIT						45.00			
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00			
Cost Center Description					1.00				
48.00 Program inpatient ancillary service cost (W			``			48.00			
49.00 Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(s	see instructio	ns)			49.00			
50.00 Pass through costs applicable to Program in	patient routine s	services (from	Wkst. D, su	n of Parts I and		50.00			
51.00 Pass through costs applicable to Program in	patient ancillary	y services (fr	om Wkst. D,	sum of Parts II		51.00			
and IV) 52.00 Total Program excludable cost (sum of lines	50 and 51)	·				52.00			
53.00 Total Program inpatient operating cost excl medical education costs (line 49 minus line	uding capital rel	lated, non-phy	sician anest	netist, and		53.00			
TARGET AMOUNT AND LIMIT COMPUTATION 54.00 Program discharges						54.00			
55.00 Target amount per discharge						55.00			
56.00 Target amount (line 54 x line 55) 57.00 Difference between adjusted inpatient opera	ting cost and ta	rget amount (l	ine 56 minus	line 53)		56.00 57.00			
58.00 Bonus payment (see instructions)	0	0		·		58.00			
59.00 Lesser of lines 53/54 or 55 from the cost re market basket	eporting period (endi ng 1996, u	pdated and c	ompounded by the		59.00			
60.00 Lesser of lines 53/54 or 55 from prior year						60.00 61.00			
1.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target									
amount (line 56), otherwise enter zero (see instructions)									
62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions)									
PROGRAM INPATIENT ROUTINE SWING BED COST 64.00 Medicare swing-bed SNF inpatient routine co	sts through Docor	mbor 21 of the	cost roport	ing partial (Saa		64.00			
instructions)(title XVIII only)	5		·	51 (
65.00 Medicare swing-bed SNF inpatient routine com instructions)(title XVIII only)	sts after Decembe	er 31 of the c	ost reporting	g period (See		65.00			
66.00 Total Medicare swing-bed SNF inpatient rout	ine costs (line d	64 plus line 6	5)(title XVI	ll only). For		66.00			
CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routi	ne costs through	December 31 o	f the cost r	eporting period		67.00			
(line 12 x line 19)	na anata aftar D	acombar 21 of	the east ran	seting posied		60.00			
68.00 Title V or XIX swing-bed NF inpatient routi (line 13 x line 20)	ne costs alter De	ecember 31 01	the cost rep	bring period		68.00			
69.00 Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER 1						69.00			
70.00 Skilled nursing facility/other nursing faci	lity/ICF/IID rou [.]	tine service c	ost (line 37)	3, 451, 019				
71.00 Adjusted general inpatient routine service 72.00 Program routine service cost (line 9 x line		ine 70 ÷ line	2)		690.07 2,367,630				
73.00 Medically necessary private room cost appli	cable to Program				0	73.00			
 74.00 Total Program general inpatient routine ser 75.00 Capital -related cost allocated to inpatient 26, line 45) 	•			Part II, column	2, 367, 630 0				
76.00 Per diem capital-related costs (line 75 ÷ 1 77.00 Program capital-related costs (line 9 x lin					0.00				
78.00 Inpatient routine service cost (line 74 min	us line 77)				0	78.00			
81.00 Inpatient routine service cost per diem lim	i tati on				0.00	81.00			
82.00 Inpatient routine service cost limitation (83.00 Reasonable inpatient routine service costs					0 2, 367, 630				
84.00 Program inpatient ancillary services (see i	nstructions)				1, 342, 347	84.00			
85.00 Utilization review - physician compensation 86.00 Total Program inpatient operating costs (su					0 3, 709, 977				
PART IV - COMPUTATION OF OBSERVATION BED PAS	SS THROUGH COST				Ĩ				
87.00 Total observation bed days (see instruction 88.00 Adjusted general inpatient routine cost per					0				
00, 00 TAULUSLEU UEHELAL THUALLEHL TUULTHE COST DEL		line 2)			0.00	88.00			

Health Financial Systems RIVERVIEW HOSPITAL In Lieu of Form CI							2552-10
COMPUTATION OF INPATIENT OPERATING COST				CCN: 150059	Period: From 01/01/2015	Worksheet D-1	
		0	Component		To 12/31/2015		
			Title	e XVIII	Skilled Nursing	PPS	
					Facility		
Cost Center Description	Cost	Routi	ne Cost	column 1 ÷	Total	Observati on	
		(from	line 27)	column 2	Observati on	Bed Pass	
					Bed Cost (from	Through Cost	
					line 89)	(col. 3 x 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	D	0	0.0000	0 0	0	90.00
91.00 Nursing School cost	0)	0	0.0000	0 00	0	91.00
92.00 Allied health cost	0)	0	0.0000	0 00	0	92.00
93.00 All other Medical Education	0	D	0	0.0000	0 00	0	93.00

	Financial Systems RIVERVIEW HOS ATION OF INPATIENT OPERATING COST	Provider CCN: 150059	Period: From 01/01/2015	u of Form CMS-2 Worksheet D-1	
			To 12/31/2015	Date/Time Pre 5/19/2016 4:5	
	Cost Center Description	Title XIX	Hospi tal	Cost	
	PART I - ALL PROVIDER COMPONENTS			1.00	_
~ ~	I NPATI ENT DAYS			11.010	
00 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-b			14, 848 14, 848	
00	Private room days (excluding swing-bed and observation bed day		rivate room days,	0	
00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	d days)		13, 060	
00	Total swing-bed SNF type inpatient days (including private roc	er 31 of the cost	0		
00	reporting period Total swing-bed SNF type inpatient days (including private roc	m dave) after December	31 of the cost	0	6
50	reporting period (if calendar year, enter 0 on this line)			0	
00	Total swing-bed NF type inpatient days (including private room reporting period	days) through December	31 of the cost	0	7
00	Total swing-bed NF type inpatient days (including private room	days) after December 3	1 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line)	the Dreaman (avaluding	, owing had and	F17	Ģ
50	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	j swing-bed and	517	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII on		room days)	0	10
. 00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII or	ly (including private r	room days) after	0	1.
00	December 31 of the cost reporting period (if calendar year, en	ter 0 on this line)			1
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	only (including privat	e room days)	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13
00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra	ar, enter 0 on this lir m (excludina swina-bed	ne) davs)	0	14
00	Total nursery days (title V or XIX only)			0	
. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16
. 00	Medicare rate for swing-bed SNF services applicable to service	s through December 31 c	of the cost	0.00	17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	s after December 31 of	the cost	0.00	18
	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	through December 31 of	f the cost	0.00	19
. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20
. 00	reporting period Total general inpatient routine service cost (see instructions)		18, 004, 276	21
. 00	Swing-bed cost applicable to SNF type services through Decembe		ing period (line	0	
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reportir	na period (line 6	0	23
	x line 18)				
. 00	Swing-bed cost applicable to NF type services through December 7×1 (ine 19)	31 of the cost reporti	ng period (line	0	24
. 00	Swing-bed cost applicable to NF type services after December 3	1 of the cost reporting	period (line 8	0	25
. 00	x line 20) Total swing-bed cost (see instructions)			0	26
. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		18, 004, 276	
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	and observation bed of	arges)	0	28
	Private room charges (excluding swing-bed charges)		lui geo)	0	
. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷	line 20)		0 0. 000000	30
	Average private room per diem charge (line 29 ÷ line 3)	TTHE 20)		0.000000	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
. 00 . 00	Average per diem private room charge differential (line 32 min Average per diem private room cost differential (line 34 x lin		ctions)	0.00 0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)	-		0	36
. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	nd private room cost di	fferential (line	18, 004, 276	37
	PART I I - HOSPITÁL AND SUBPROVIDERS ONLY				
00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			1 010 57	2
	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 212. 57 626, 899	
. 00	Medically necessary private room cost applicable to the Progra	m (line 14 x line 35)		0	40
. 00	Total Program general inpatient routine service cost (line 39	+ IINE 40)		626, 899	41

OMPUT	Financial Systems TATION OF INPATIENT OPERATING COST		Provi der	CCN: 150059	Period: From 01/01/2015 To 12/31/2015	Date/Time Pre	1 epared
				le XIX	Hospi tal	5/19/2016 4:5 Cost	57 pm
	Cost Center Description	Total Inpati ent Costl 1.00	Total	Average Pe	Program Days	1	
2.00	NURSERY (title V & XIX only)	0	0) 42.0
	Intensive Care Type Inpatient Hospital Units						
3.00	INTENSIVE CARE UNIT	4, 072, 230	2, 504	1, 626.	29 0	0	
4.00 5.00	CORONARY CARE UNI T BURN INTENSIVE CARE UNI T						44.0
6.00							45.0
	OTHER SPECIAL CARE (SPECIFY)						47.0
	Cost Center Description			•			
2 00		+ D 2 2	11			1.00	10
3.00 9.00	Program inpatient ancillary service cost (Wks Total Program inpatient costs (sum of lines 4			ns)		576, 410 1, 203, 309	
7.00	PASS THROUGH COST ADJUSTMENTS			115)		1, 203, 309	47.
D. 00	Pass through costs applicable to Program inpa	atient routine s	services (from	Wkst. D, su	m of Parts I and	0	50.
1. 00	Pass through costs applicable to Program inpa	atient ancillary	/ services (fr	om Wkst. D,	sum of Parts II	0) 51.0
2.00	and IV) Total Program excludable cost (sum of lines !	50 and 51)				C	52.0
3.00	Total Program inpatient operating cost exclude		ated. non-phy	sician anest	hetist. and		
	medical education costs (line 49 minus line !						
	TARGET AMOUNT AND LIMIT COMPUTATION					1	
4.00	5 5					0	
5.00 5.00	Target amount per discharge Target amount (line 54 x line 55)					0.00) 55.) 56.
. 00 . 00	Difference between adjusted inpatient operati	ng cost and tar	rget amount (l	ine 56 minus	line 53)		
3.00	Bonus payment (see instructions)	11110 00)	0				
9.00	Lesser of lines 53/54 or 55 from the cost rep	oorting period e	ending 1996, ι	pdated and c	ompounded by the	0.00	59.
	market basket						
D. 00	Lesser of lines 53/54 or 55 from prior year of lines					0.00	
1. 00	If line 53/54 is less than the lower of lines which operating costs (line 53) are less than						61.
	amount (line 56), otherwise enter zero (see i				i the target		
2.00	1 5 (0	
3.00	Allowable Inpatient cost plus incentive payme	ent (see instruc	ctions)			0) 63.
4.00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	ts through Docom	bor 21 of the	cost roport	ing pariod (Soo	C	64.
+. 00	instructions) (title XVIII only)	is through becen		cost report	ing period (see		04.
5.00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the c	ost reportin	g period (See	C	65.
	instructions)(title XVIII only)						
6.00	Total Medicare swing-bed SNF inpatient routin	ne costs (line 6	54 plus line 6	5)(title XVI	II only). For	0) 66.
7.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	a costs through	December 31 c	f the cost r	enorting period	C	67.
7.00	(line 12 x line 19)	e costs through	December 51 C	the cost i	eporting period		07.
8. 00	Title V or XIX swing-bed NF inpatient routine	e costs after De	ecember 31 of	the cost rep	orting period	0	68.
	(line 13 x line 20)					_	
9.00	Total title V or XIX swing-bed NF inpatient N PART III - SKILLED NURSING FACILITY, OTHER NU					0) 69.
0. 00	Skilled nursing facility/other nursing facili)		70.
1.00	Adjusted general inpatient routine service co	2		•			71.
2.00	Program routine service cost (line 9 x line						72.
3.00	Medically necessary private room cost applica	0	•				73.
4.00	Total Program general inpatient routine servi	•			Dart II aalumn		74.
5.00	Capital-related cost allocated to inpatient (26, line 45)	outine service	COSTS (ITOIN W	Orksneet B,	Part II, corumn		75.
5.00	Per diem capital-related costs (line 75 ÷ lin	ne 2)					76.
7.00	Program capital-related costs (line 9 x line	76)					77.
3. 00	Inpatient routine service cost (line 74 minus						78.
. 00	Aggregate charges to beneficiaries for excess	• •			1. 70)		79.
. 00 . 00	Total Program routine service costs for compa Inpatient routine service cost per diem limit		stimitation	(ine/8 mi	nus i ne 79)		80.
. 00	Inpatient routine service cost per drem rim)				82.
. 00	Reasonable inpatient routine service costs (,					83.
. 00	Program inpatient ancillary services (see ins						84.
5.00	1 3						85.
5.00			ough 85)			L	86.
7.00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)					1, 788	8 87.
,	Adjusted general inpatient routine cost per o		line 2)			1, 212. 57	
8.00	The stee general inpatrent routine cost ber						

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period:	Worksheet D-1	
				From 01/01/2015 To 12/31/2015	Date/Time Pre 5/19/2016 4:5	
		Tit	le XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x 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	3, 607, 660	18, 004, 276	0. 20037	8 2, 168, 075	434, 435	90.00
91.00 Nursing School cost	0	18, 004, 276	0.00000	0 2, 168, 075	0	91.00
92.00 Allied health cost	0	18, 004, 276	0.00000	0 2, 168, 075	0	92.00
93.00 All other Medical Education	0	18, 004, 276	0. 00000	0 2, 168, 075	0	93.00

COMPUT		der CCN: 150059	Period: From 01/01/2015	u of Form CMS-2 Worksheet D-1			
	Сотро	onent CCN: 15T059		Date/Time Prep 5/19/2016 4:5			
		Title XIX	Subprovider -	Cost			
	Cost Center Description			1.00			
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				-		
1.00	Inpatient days (including private room days and swing-bed days, exclu			5, 583	1.0		
2.00 3.00	Inpatient days (including private room days, excluding swing-bed and Private room days (excluding swing-bed and observation bed days). If do not complete this line.	ivate room days,	5, 583 0	2.0 3.0			
1.00 5.00	Semi-private room days (excluding swing-bed and observation bed days) Total swing-bed SNF type inpatient days (including private room days)	r 31 of the cost	5, 583 0				
. 00	reporting period Total swing-bed SNF type inpatient days (including private room days) reporting period (if calendar year, enter 0 on this line)	after December	31 of the cost	0	6. (
. 00	Total swing-bed NF type inpatient days (including private room days) reporting period	-		0			
3.00	Total swing-bed NF type inpatient days (including private room days) reporting period (if calendar year, enter 0 on this line)			0			
0.00	Total inpatient days including private room days applicable to the Pr newborn days) Swing-bed SNF type inpatient days applicable to title XVIII only (inc	0 . 0	Ū į	95 0			
1. 00	through December 31 of the cost reporting period (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (inc	luding private r	5	0			
2.00	December 31 of the cost reporting period (if calendar year, enter 0 o Swing-bed NF type inpatient days applicable to titles V or XIX only (through December 31 of the cost reporting period	e room days)	0	12.			
3. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (after December 31 of the cost reporting period (if calendar year, ent			0	13.		
4.00	Medically necessary private room days applicable to the Program (excl	uding swing-bed	days)	0			
5.00 6.00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only) SWING BED ADJUSTMENT		0 0				
7.00	Medicare rate for swing-bed SNF services applicable to services throu reporting period	gh December 31 o	f the cost	0.00	17.		
8.00	Medicare rate for swing-bed SNF services applicable to services after reporting period			0.00			
9.00 0.00	Medicaid rate for swing-bed NF services applicable to services throug reporting period Medicaid rate for swing-bed NF services applicable to services after			0. 00 0. 00			
1. 00	Total general inpatient routine service cost (see instructions)			4, 339, 733			
2.00	Swing-bed cost applicable to SNF type services through December 31 of 5 x line 17)			0			
3.00 4.00	Swing-bed cost applicable to SNF type services after December 31 of t x line 18) Swing-bed cost applicable to NF type services through December 31 of			0			
5. 00	7×1 ine 19) Swing-bed cost applicable to NF type services after December 31 of th		3 T X	0	25.		
6. 00 7. 00	x line 20) Total swing-bed cost (see instructions) Comeral inpatient routine service cost net of swing bed cost (line 21	minus line 24)		0			
7.00 8.00	General inpatient routine service cost net of swing-bed cost (line 21 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and ob		arges)	4, 339, 733			
9.00	Private room charges (excluding swing-bed charges)	Servation bed Ch	u, 903)	0			
0.00	Semi -private room charges (excluding swing-bed charges)			0	30.		
1.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 2 Average private room per diem charge (line 29 ÷ line 3)	8)		0.000000			
2.00 3.00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 0.00			
1. 00	Average per diem private room charge differential (line 32 minus line	33)(see instruc	tions)	0.00			
5.00							
5.00 7.00	Private room cost differential adjustment (line 3 x line 35)						
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				37.		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS						
	Adjusted general inpatient routine service cost per diem (see instruc	tions)		777.31	38.		
			I		0		
	Program general inpatient routine service cost (line 9 x line 38)			73, 844 0			

OMPUT	Financial Systems ATION OF INPATIENT OPERATING COST		HOSPI TA		CCN: 150059	Peri od	:	eu of Form CN _ Worksheet E	
			C	omponent	CCN: 15T059		1/01/2019 2/31/2019	5 Date/Time F	
				Ti t	le XIX		ovider -	5/19/2016 Cos	
	Cost Center Description	Total Inpatient Cost		tal	Average Pe	r Prog	<u>IRF</u> Iram Days	Program Cos (col. 3 x co	
				2	col . 2)	· ·		4)	/1 .
00	NURSERY (title V & XIX only)	1.00		00 0	3.00	00	4.00	5.00 0	0 4
	Intensive Care Type Inpatient Hospital Units		1					-1	
. 00 . 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	0)	0	0.	00	(0	0 4
00	BURN INTENSIVE CARE UNIT								4
. 00	SURGI CAL INTENSIVE CARE UNIT								4
. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description								4
. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	line	200)				1.00	46 4
	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS				ns)			132, 2	
. 00	Pass through costs applicable to Program inp	atient routine	servi ce	es (from	Wkst. D, su	um of Pa	rts I and	ł	0 5
. 00	Pass through costs applicable to Program inp	atient ancillar	ry servi	ces (fr	om Wkst. D,	sum of	Parts II		0 5
. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)							0 5
. 00	Total Program inpatient operating cost exclu- medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	ding capital re	el ated,	non-phy	sician anest	hetist,	and		0 5
	Program discharges								0 5
	Target amount per discharge							0.	00 5
. 00 . 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and ta	arget ar	nount (I	ine 56 minus	line 5	3)		05
. 00	Bonus payment (see instructions)	ing obser and te	ar got a	iounie (i			0)		0 5
. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng	1996, u	pdated and c	compound	ed by the	Θ.	00 5
. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report, up	odated k	by the m	arket basket	:		0.	00 6
. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see	s 55, 59 or 60 n expected cost	enter †	the less	er of 50% of	the am			0 6
. 00 . 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST		uctions)						0 6
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 37	l of the	cost report	ing per	iod (See		0 6
. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	oer 31 d	of the c	ost reportin	ng perio	d (See		0
. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus	s line 6	5)(title XVI	II only). For		0 6
. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through	n Decemb	oer 31 o	f the cost r	eportin	g period		0
. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	-					•		0 6
	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient								0 6
	PART III - SKILLED NURSING FACILITY, OTHER NU					~			4
. 00 . 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c)			
. 00	Program routine service cost (line 9 x line	71)							
. 00 . 00	Medically necessary private room cost applic. Total Program general inpatient routine serv	0	•		ne 35)				
. 00	Capital -related cost allocated to inpatient 26, line 45)	•			orksheet B,	Part II	, column		-
00	Per diem capital-related costs (line 75 ÷ li	,							
00 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu								
. 00	Aggregate charges to beneficiaries for exces	s costs (from p							
. 00	Total Program routine service costs for comp		cost lir	ni tati on	(line 78 mi	nus lin	e 79)		8
. 00 . 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		1)						8
. 00	Reasonable inpatient routine service costs (see instructior							8
. 00	Program inpatient ancillary services (see in		ane)						8
. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum			35)					8
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST						·	
2.00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		- lin⊖ ′	2)				0	3 0 3 00
	Observation bed cost (line 87 x line 88) (se			-)				0.	00 8

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi de	r CCN: 150059	Period: From 01/01/2015	Worksheet D-1	
		Compone	nt CCN: 15T059			
		T	tle XIX	Subprovider -	Cost	
Cost Center Description	Cost	Routine Cos	column 1 ÷	Total	Observati on	
		(from line 2	') column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x 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	653, 265	4, 339, 73	0. 1505	31 0	0	90.00
91.00 Nursing School cost	0	4, 339, 73	0. 0000	0 00	0	91.00
92.00 Allied health cost	0	4, 339, 73	0. 0000	0 00	0	92.00
93.00 All other Medical Education	0	4, 339, 73	0.0000	0 00	0	93.00

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	rovi der	CCN:	150059	Peri od:	Worksheet D-3	
				From 01/01/2015		
				To 12/31/2015	Date/Time Pre 5/19/2016 4:5	pare
	Ti tl	e XVI	11	Hospi tal	PPS	. p
Cost Center Description			o of Cos		Inpati ent	
		To	Charges	5	Program Costs	
				Charges	(col. 1 x col.	
			1.00	2.00	2) 3.00	<u> </u>
INPATIENT ROUTINE SERVICE COST CENTERS		_	1.00	2.00	3.00	
D. 00 03000 ADULTS & PEDI ATRI CS				7, 895, 401		30.
1. 00 03100 I NTENSI VE CARE UNI T				2, 504, 696		31.
1.00 04100 SUBPROVIDER - IRF				0		41.
3. 00 04300 NURSERY						43.
ANCI LLARY SERVI CE COST CENTERS						
0. 00 O5000 OPERATING ROOM			0.2068		1, 784, 208	
2. 00 05200 DELIVERY ROOM & LABOR ROOM			0.0000		0	
I. 00 05400 RADI OLOGY-DI AGNOSTI C			0.2812		228, 522	
0. 00 05500 RADI OLOGY-THERAPEUTI C			0.2813		21, 445	
7. 00 05700 CT SCAN			0.0368		29, 101	
7. 01 03630 ULTRA SOUND			0.0606		7,007	
8. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)			0.0918			
. 00 05900 CARDI AC CATHETERI ZATI ON			0.1101		144, 820	
			0.1900		888, 322	
01 06001 BLOOD LABORATORY			0.0000		0	
. 00 06300 BLOOD STORING, PROCESSING & TRANS. . 00 06400 INTRAVENOUS THERAPY			0. 4841		141, 214 0	
. 00 06500 RESPIRATORY THERAPY			0. 2669		656, 961	
. 00 06600 PHYSI CAL THERAPY			0. 3705		344, 861	
00 06700 OCCUPATIONAL THERAPY			0.0000		0	
B. 00 06800 SPEECH PATHOLOGY			0.0000		0	
0. 00 06900 ELECTROCARDI OLOGY			0. 2074		-	
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			0. 3701		3, 538, 563	
00 07200 IMPL. DEV. CHARGED TO PATIENT			0.3419		190, 984	
8. 00 07300 DRUGS CHARGED TO PATIENTS			0. 4188		1, 779, 939	
. 00 07400 RENAL DIALYSIS			0.9068		208, 865	
0. 00 03020 OTHER ANCI LLARY			0.0000		0	
0. 01 03140 CARDI AC REHAB			0. 3202		56, 403	76
0. 02 03070 WOMEN' S CENTER			0.27420		0	
. 03 03330 ENDOSCOPY			0.1508	35 315, 901	47, 649	76
OUTPATIENT SERVICE COST CENTERS						4
0. 00 09000 CLINIC			0.4556		5, 484	
01 09001 OUTPATI ENT			0. 2824		23, 930	
. 00 09100 EMERGENCY			0.2315		356, 464	
. 01 09101 SHORT STAY			0.0000		0	1
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1	0.7052	10 0	0	92
OTHER REIMBURSABLE COST CENTERS 5. 00 09500 AMBULANCE SERVICES		1				1 05
				27 024 205	10 440 242	95
	no (1)			37, 926, 385	10, 668, 242	200
D1.00 Less PBP Clinic Laboratory Services-Program only charges (1 D2.00 Net Charges (line 200 minus line 201)	ne or)			27 024 205		
02.00 Net Charges (line 200 minus line 201)		I		37, 926, 385	I	202

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	ovi der	CCN: 150059	Peri od:	Worksheet D-3	
		001 457050	From 01/01/2015		
	mponent	CCN: 15T059	To 12/31/2015	Date/Time Pre 5/19/2016 4:5	parec 7 pm
	Ti tl	e XVIII	Subprovider - IRF	PPS	•
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
0.00 03000 ADULTS & PEDIATRICS			0		30.
1. 00 03100 INTENSI VE CARE UNI T			0		31.
1. 00 04100 SUBPROVIDER - IRF			3, 937, 458		41.
3. 00 04300 NURSERY			3, 937, 430		41.
ANCI LLARY SERVI CE COST CENTERS					43.
0. 00 05000 OPERATI NG ROOM		0. 2068	02 158, 700	32, 819	50.
2. 00 05200 DELIVERY ROOM & LABOR ROOM		0.0000			
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2812		25, 381	54.
5. 00 05500 RADI OLOGY-THERAPEUTI C		0. 2813		0	
7. 00 05700 CT SCAN		0. 0368		-	
7. 01 03630 ULTRA SOUND		0.0606			
B. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 0918			58.
9. 00 05900 CARDI AC CATHETERI ZATI ON		0. 1101	01 95, 458	10, 510	59.
0. 00 06000 LABORATORY		0. 1900	69 696, 122	132, 311	60.
0.01 06001 BLOOD LABORATORY		0. 0000	00 0	0	60.
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 4841	06 15, 228	7, 372	63.
4. 00 06400 I NTRAVENOUS THERAPY		0.0000	00 0	0	64.
5. 00 06500 RESPI RATORY THERAPY		0. 2669			
6. 00 06600 PHYSI CAL THERAPY		0. 3705		1, 230, 929	
7. 00 06700 OCCUPATI ONAL THERAPY		0.0000		-	
8. 00 06800 SPEECH PATHOLOGY		0.0000			
9. 00 06900 ELECTROCARDI OLOGY		0. 2074			
1. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS		0. 3701			
2.00 07200 IMPL. DEV. CHARGED TO PATIENT		0.3419			
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 4188			
4. 00 07400 RENAL DI ALYSI S		0. 9068			
6. 00 03020 OTHER ANCI LLARY		0.0000		0	
6. 01 03140 CARDI AC REHAB 6. 02 03070 WOMEN' S CENTER		0.3202			
6. 02 03070 WOMEN' S CENTER 6. 03 03330 ENDOSCOPY		0. 2742 0. 1508		0 3, 954	
OUTPATIENT SERVICE COST CENTERS		0. 1506	35 26, 214	5, 934	/0.
0. 00 09000 CLINIC		0. 4556	37 2, 760	1, 258	90.
0. 01 09001 0UTPATI ENT		0. 2824			
1. 00 09100 EMERGENCY		0. 2315			
1. 01 09101 SHORT STAY		0.0000			
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0.7052			
OTHER REIMBURSABLE COST CENTERS		0.7002	- 0		1
5. 00 09500 AMBULANCE SERVICES					95.
00.00 Total (sum of lines 50-94 and 96-98)			6, 407, 622	2, 169, 693	
01.00 Less PBP Clinic Laboratory Services-Program only charges (lin	ne 61)		0		201.
02.00 Net Charges (line 200 minus line 201)			6, 407, 622		202.

ealth Financial Systems RIVERVIEW HOSPITA NPATIENT ANCILLARY SERVICE COST APPORTIONMENT PI		CCN: 150059	Peri od:	worksheet D-3	
	o do.		From 01/01/2015		
Co	omponent	CCN: 155669	To 12/31/2015	Date/Time Pre 5/19/2016 4:5	epared
	Ti tl	e XVIII	Skilled Nursing		or pii
			Facility		
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	5	Program Costs	
			Charges	(col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1100	2.00	0100	
30. 00 03000 ADULTS & PEDIATRICS			0		30. 0
31. 00 03100 INTENSIVE CARE UNIT			0		31. (
1.00 04100 SUBPROVIDER - IRF			0		41.0
13. 00 04300 NURSERY					43.0
ANCI LLARY SERVI CE COST CENTERS				-	
50. 00 05000 OPERATING ROOM		0. 2068			
52.00 05200 DELIVERY ROOM & LABOR ROOM		0.0000		-	
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2812			
5. 00 05500 RADI OLOGY-THERAPEUTI C		0. 2813			
7. 00 05700 CT SCAN 7. 01 03630 ULTRA SOUND		0. 0368 0. 0606		-	
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.0808		-	
9. 00 05900 CARDIAC CATHETERIZATION		0. 0918		-	
0. 00 06000 LABORATORY		0. 1900			
0. 01 06001 BLOOD LABORATORY		0.0000			
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 4841			
4. 00 06400 I NTRAVENOUS THERAPY		0.0000		-	
15. 00 06500 RESPI RATORY THERAPY		0. 2669		95, 541	
6. 00 06600 PHYSI CAL THERAPY		0. 3705			
7. 00 06700 OCCUPATI ONAL THERAPY		0. 0000			
8.00 06800 SPEECH PATHOLOGY		0. 0000	00 0	0	68.
9. 00 06900 ELECTROCARDI OLOGY		0. 2074	61 0	0	69.1
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3701	65 64, 377	23, 830	71.0
2.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 3419		0	
3.00 07300 DRUGS CHARGED TO PATIENTS		0. 4188			
4. 00 07400 RENAL DI ALYSI S		0. 9068		-	
6. 00 03020 OTHER ANCI LLARY		0.0000		-	
6. 01 03140 CARDI AC REHAB		0. 3202			
16.02 03070 WOMEN'S CENTER		0.2742			
76. 03 03330 ENDOSCOPY OUTPATI ENT SERVI CE COST CENTERS		0. 1508	35 0	0	76.0
0.00 09000 CLINIC		0. 4556	37 0	0	90.0
0. 01 09000 CETNIC		0. 2824		-	
1. 00 09100 EMERGENCY		0. 2824			
1. 01 09101 SHORT STAY		0.0000		-	
22. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 7052			
OTHER REIMBURSABLE COST CENTERS		0.7002			1
95. 00 09500 AMBULANCE SERVICES					95.0
200.00 Total (sum of lines 50-94 and 96-98)			4, 071, 274	1, 342, 347	
201.00 Less PBP Clinic Laboratory Services-Program only charges (li	ne 61)		0		201. (
202.00 Net Charges (line 200 minus line 201)			4, 071, 274		202.0

ATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150059		Period:	Worksheet D-3	
				rom 01/01/2015		
				To 12/31/2015	Date/Time Pre 5/19/2016 4:5	par 7 pi
	Ti t	le XIX		Hospi tal	Cost	, p.
Cost Center Description		Ratio of (Inpati ent	
		To Charg	es	Program	Program Costs	
				Charges	(col. 1 x col.	
		1.00		2.00	2) 3.00	-
INPATIENT ROUTINE SERVICE COST CENTERS		1.00		2.00	3.00	-
00 03000 ADULTS & PEDI ATRI CS				572, 023		30
00 03100 INTENSIVE CARE UNIT				295, 550		31
00 04100 SUBPROVIDER - IRF				0		41
00 04300 NURSERY				0		43
ANCI LLARY SERVI CE COST CENTERS						
00 05000 OPERATING ROOM		0.20			42, 669	
00 05200 DELIVERY ROOM & LABOR ROOM		0.00			0	
00 05400 RADI OLOGY-DI AGNOSTI C		0.28			8, 979	
00 05500 RADI OLOGY-THERAPEUTI C		0.28			45	
00 05700 CT SCAN		0.03			1, 307	
01 03630 ULTRA SOUND		0.06			396	
00 05800 MAGNETIC RESONANCE I MAGI NG (MRI)		0.09			254	
00 05900 CARDI AC CATHETERI ZATI ON		0.11			4, 139	
00 06000 LABORATORY		0.19			55, 536	
01 06001 BLOOD LABORATORY		0.00			0	
00 06300 BLOOD STORING, PROCESSING & TRANS.		0.48			7,626	
00 06400 I NTRAVENOUS THERAPY 00 06500 RESPI RATORY THERAPY		0.00			0	
00 06600 PHYSI CAL THERAPY		0.26			57, 842 10, 907	
00 06700 OCCUPATI ONAL THERAPY		0.37			10, 907	
00 06800 SPEECH PATHOLOGY		0.00			0	
00 06900 ELECTROCARDI OLOGY		0.00			7, 369	
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.20			155, 367	
00 07200 IMPL. DEV. CHARGED TO PATIENT		0.34			0	
00 07300 DRUGS CHARGED TO PATIENTS		0.41			182, 546	
00 07400 RENAL DIALYSIS		0.90			12, 145	
00 03020 OTHER ANCI LLARY		0.00			0	
01 03140 CARDI AC REHAB		0.32			1, 691	
02 03070 WOMEN' S CENTER		0.27			0	
03 03330 ENDOSCOPY		0.15			4, 765	
OUTPATIENT SERVICE COST CENTERS				. · · · ·	· · · ·	
00 09000 CLINIC		0.45	5637	7 10, 171	4, 634	9
01 09001 0UTPATI ENT		0.28			0	1 .
00 09100 EMERGENCY		0. 23			18, 193	
01 09101 SHORT STAY		0.00			0	
00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0.70	5210	00	0	92
OTHER REI MBURSABLE COST CENTERS		1				
00 09500 AMBULANCE SERVICES				1 004 004	F7/ // A	9!
.00 Total (sum of lines 50-94 and 96-98)	(1) == (1)			1, 904, 894	576, 410	
. 00 Less PBP Clinic Laboratory Services-Program only charges	(II ne 61)			1 004 004		20
.00 Net Charges (line 200 minus line 201)				1, 904, 894		

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	L ovi der	CCN: 150059	Peri od:	eu of Form CMS-: Worksheet D-3	
NPATIENT ANGILLART SERVICE COST APPORTIONMENT	ovidei	CCN. 150059	From 01/01/2015		
Co	omponent	CCN: 15T059	To 12/31/2015	Date/Time Pre	pare
	T: +		Cubarantidara	5/19/2016 4:5	7 pm
	Πt	le XIX	Subprovider - IRF	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
0.00 03000 ADULTS & PEDI ATRI CS			0		30.
			-		
			0		31
1.00 04100 SUBPROVIDER - IRF			86, 401		41
3. 00 04300 NURSERY			0	1	43.
ANCI LLARY SERVI CE COST CENTERS 0. 00 05000 OPERATI NG ROOM		0. 2068	02 6, 324	1, 308	50.
2. 00 05200 DELIVERY ROOM & LABOR ROOM		0.2000			
		0. 2812			
5. 00 05500 RADI OLOGY-THERAPEUTI C		0.2813		0	
7. 00 05700 CT SCAN		0. 0368			
7. 01 03630 ULTRA SOUND		0.0606			
B. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0.0918			
9. 00 05900 CARDI AC CATHETERI ZATI ON		0. 1101		-	
D. 00 06000 LABORATORY		0. 1900			
D. 01 06001 BLOOD LABORATORY		0.0000			
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 4841			
4. 00 06400 I NTRAVENOUS THERAPY		0.0000		-	
5. 00 06500 RESPIRATORY THERAPY		0.2669			
5. 00 06600 PHYSI CAL THERAPY		0.3705			
7. 00 06700 OCCUPATI ONAL THERAPY		0.0000			
3. 00 06800 SPEECH PATHOLOGY		0.0000			
9. 00 06900 ELECTROCARDI OLOGY		0. 2074			
1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3701			
2.00 07200 IMPL. DEV. CHARGED TO PATIENT		0.3419		-	1
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 4188			
4. 00 07400 RENAL DIALYSIS		0. 9068			
5. 00 03020 OTHER ANCI LLARY		0.0000			
5. 01 O3140 CARDI AC REHAB		0. 3202			
5. 02 03070 WOMEN' S CENTER		0. 2742			
5. 03 03330 ENDOSCOPY		0. 1508	35 0	0	76
OUTPATIENT SERVICE COST CENTERS		0.4554	0.7		1 00
D. 00 09000 CLINIC		0.4556			
		0.2824			
1. 00 09100 EMERGENCY		0. 2315			
1.01 09101 SHORT STAY		0.0000			
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 7052	10 0	0	92
		1		1	
5. 00 09500 AMBULANCE SERVICES			174 507	F0.44	95
00.00 Total (sum of lines 50-94 and 96-98)	(4)		174, 587		
01.00 Less PBP Clinic Laboratory Services-Program only charges (lin	ne 61)		0		201
02.00 Net Charges (line 200 minus line 201)			174, 587	1	202

Heal th	Financial Systems RI VERVI EW HOSPI	TAL		In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der	CCN: 150059	Period: From 01/01/2015	Worksheet E Part A	
		T: +1	e XVIII	To 12/31/2015	Date/Time Pre 5/19/2016 4:5 PPS	
		11 (1		Hospi tal	· · · · · ·	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		0	1.00	2.00	
1.00 1.01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring	n pri or		0 9, 883, 116		1.00 1.01
	to October 1 (see instructions)					
1.02	DRG amounts other than outlier payments for discharges occurring after October 1 (see instructions)	g on or		3, 381, 523		1. 02
1.03	DRG for federal specific operating payment for Model 4 BPCl for discharges occurring prior to October 1 (see instructions)			0		1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for			0		1.04
2.00	discharges occurring on or after October 1 (see instructions) Outlier payments for discharges. (see instructions)			244, 487		2.00
2. 01 2. 02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instruction	nc)		0		2. 01 2. 02
3.00	Managed Care Simulated Payments			0		3.00
4.00	Bed days available divided by number of days in the cost reporti period (see instructions)	ng		100. 10		4.00
5.00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most r	racant	1	0.00		5.00
	cost reporting period ending on or before 12/31/1996. (see instru	uctions)				
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance			0.00		6.00
7.00	CFR 413.79(e) MMA Section 422 reduction amount to the IME cap as specified unc	ler 42		0.00		7.00
	CFR §412.105(f)(1)(iv)(B)(1)					
7.01	ACA Section 5503 reduction amount to the IME cap as specified ur CFR $412.105(f)(1)(iv)(B)(2)$ If the cost report straddles July 1			0.00		7.01
8.00	then see instructions. Adjustment (increase or decrease) to the FTE count for allopathi	c and		0.00		8.00
	osteopathic programs for affiliated programs in accordance with	42 CFR				
	413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 (August 1, 2002).					
8.01	The amount of increase if the hospital was awarded FTE cap slots section 5503 of the ACA. If the cost report straddles July 1, 20			0.00		8. 01
8.02	instructions. The amount of increase if the hospital was awarded FTE cap slots			0.00		8. 02
	closed teaching hospital under section 5506 of ACA. (see instruc	ctions)				
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines and 8,02) (see instructions)	(8, 8,01		0.00		9.00
10.00	FTE count for allopathic and osteopathic programs in the current from your records	t year		0.00		10.00
11.00	FTE count for residents in dental and podiatric programs.			0.00		11.00
12.00 13.00	Current year allowable FTE (see instructions) Total allowable FTE count for the prior year.			0. 00 0. 00		12.00 13.00
14.00	Total allowable FTE count for the penultimate year if that year or after September 30, 1997, otherwise enter zero.	ended on		0.00		14.00
15.00	Sum of lines 12 through 14 divided by 3.			0.00		15.00
16. 00 17. 00	Adjustment for residents in initial years of the program Adjustment for residents displaced by program or hospital closur	~e		0. 00 0. 00		16.00 17.00
18. 00 19. 00	Adjusted rolling average FTE count Current year resident to bed ratio (line 18 divided by line 4).			0.00 0.000000		18.00 19.00
20.00	Prior year resident to bed ratio (see instructions)			0. 000000		20.00
21. 00 22. 00	Enter the lesser of lines 19 or 20 (see instructions) IME payment adjustment (see instructions)			0. 000000		21.00 22.00
22. 01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for Section	1 422 of t	he MMA	0		22. 01
23.00	Number of additional allopathic and osteopathic IME FTE resident			0.00		23.00
24.00	slots under 42 Sec. 412.105 (f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)			0.00		24.00
25.00	If the amount on line 24 is greater than -O-, then enter the low line 23 or line 24 (see instructions)	ver of		0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)			0. 000000		26.00
27.00 28.00	IME payments adjustment factor. (see instructions) IME add-on adjustment amount (see instructions)			0. 000000		27.00 28.00
28. 01 29. 00	IME add-on adjustment amount - Managed Care (see instructions) Total IME payment (sum of lines 22 and 28)			0		28. 01 29. 00
29.00	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0		29.00
30.00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A pati	ent days		2.39		30.00
31.00	(see instructions) Percentage of Medicaid patient days (see instructions)	-		14.56		31.00
32.00	Sum of Lines 30 and 31			16. 95		32.00
33.00 34.00	Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions)			3. 78 125, 352		33.00 34.00

	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150059	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Date/Time Pre 5/19/2016 4:5	
		Title XVIII	Hospital Priorto October1 1.00	PPS On/After October 1 2.00	
	Uncompensated Care Adjustment				
35.00 35.01 35.02	Total uncompensated care amount (see instructions) Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero,		7, 647, 644, 885 0. 000086639 662, 586	6, 406, 145, 534 0. 000083987 538, 031	35.00 35.01 35.02
35. 03	enter zero on this line) (see instructions) Pro rata share of the hospital uncompensated care payment amount (see instructions)		495, 578	135, 243	35. 03
36. 00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		630, 821		36.00
10.00	Additional payment for high percentage of ESRD beneficiary d	ischarges (lines 40 throu			10.00
40. 00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40. OC
	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.01
42.00 43.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment) Total Medicare ESRD inpatient days excluding MS-DRGs 652,		0.00		42.00 43.00
44. 00	682, 683, 684 an 685. (see instructions) Ratio of average length of stay to one week (line 43		0. 000000		44.00
45.00	divided by line 41 divided by 7 days) Average weekly cost for dialysis treatments (see		0.00		45. OC
46.00	instructions) Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00 48.00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and		14, 265, 299 0		47.00 48.00
49.00	MDH, small rural hospitals only. (see instructions) Total payment for inpatient operating costs (see		14, 265, 299		49.00
50.00	instructions) Payment for inpatient program capital (from Wkst. L, Pt. I		1, 155, 539		50. OC
51.00	and Pt. II, as applicable) Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51. OC
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0		52. OC
54.00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies		0 8, 172		53.00 54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00 57.00	Cost of physicians' services in a teaching hospital (see intructions) Routine service other pass through costs (from Wkst. D,		0		56.00 57.00
	Pt. III, column 9, lines 30 through 35). Ancillary service other pass through costs from Wkst. D,		43, 048		58.00
59.00	Pt. IV, col. 11 line 200) Total (sum of amounts on lines 49 through 58)		15, 472, 058		59.00
50.00	Primary payer payments Total amount payable for program beneficiaries (line 59 minus line 60)		0 15, 472, 058		60. 00 61. 00
52. 00 53. 00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries		1, 484, 352 21, 105		62.00 63.00
54.00	Allowable bad debts (see instructions)		58, 200		64. OC
	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions)		37, 830 31, 818		65. 00 66. 00
57.00 58.00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices		14, 004, 431 0		67.00 68.00
69. 00	for applicable to MS-DRGs (see instructions) Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0		69. OC
70. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		о		70.00
70. 50 70. 89	RURAL DEMONSTRATION PROJECT Pioneer ACO demonstration payment adjustment amount (see		0 0		70. 50 70. 89
70. 90	instructions) HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
	HSP bonus payment HRR adjustment amount (see instructions)		0		70. 91
	Bundled Model 1 discount amount (see instructions) HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions)		0 -29, 092		70. 92 70. 93 70. 94

Heal th	Financial Systems RIVERVIEW I	HOSPI TAL	In	Lieu of Form	CMS-2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150059	Period: From 01/01/20 To 12/31/20	015 Date/Time	t E e Prepared: 6 4:57 pm
		Title XVIII	Hospi tal	F	PPS
			Prior to October 1		
		0	1.00	2.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)		0	0	70.96
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)		0	0	70.97
70. 98	Low Volume Payment-3			0	70. 98
70.99	HAC adjustment amount (see instructions)		39,	622	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		13, 935,	717	71.00
71.01	Sequestration adjustment (see instructions)		278,	714	71.01
72.00	Interim payments		13, 537,	514	72.00
73.00	Tentative settlement (for contractor use only)			0	73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		119,	489	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1, 965,	557	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)			0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2			0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0	. 00	94.00
95.00	Time value of money for operating expenses (see instructions)			0	95.00
96.00	Time value of money for capital related expenses (see instructions)			0	96.00
			Prior to 10)/1 On/After	10/1
			1.00	2.00	
	HSP Bonus Payment Amount HSP bonus amount (see instructions)			0	0 100, 00
	HVBP Adjustment for HSP Bonus Payment			0	0 100.00
	HVBP adjustment factor (see instructions)		0. 0000000		00000 101. 00
	HVBP adjustment amount for HSP bonus payment (see instructi HRR Adjustment for HSP Bonus Payment	ons)		0	0 102.00
	HRR adjustment factor (see instructions)		0.0	0.00	0000 103.00
	HRR adjustment amount for HSP bonus payment (see instructio	ns)		0	0 104.00
				•	•

	Financial Systems LUME CALCULATION EXHIBIT 4		RI VERVI EW I			eriod: rom 01/01/2015	u of Form CMS-2 Worksheet E Part A Exhibi Date/Time Pre 5/19/2016 4:5	t 4 pared:
			Amounts (from	Pre/Post	e XVIII Period Prior	Hospi tal Peri od	PPS Total (Col 2	
		line 0	<u>E, Part A)</u> 1.00	Entitlement 2.00	to 10/01 3.00	0n/After 10/01 4.00	through 4) 5.00	
1.00	DRG amounts other than outlier	1.00	0	0		4.00	0	1.00
1. 01	payments DRG amounts other than outlier payments for discharges	1.01	9, 883, 116	0	9, 883, 116	0	9, 883, 116	1. 01
1.02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	3, 381, 523	0	0	3, 381, 523	3, 381, 523	1. 02
1.03	1 DRG for Federal specific operating payment for Model 4 BPCL occurring prior to	1. 03	O	0	0	0	0	1. 03
1.04	October 1 DRG for Federal specific operating payment for Model 4 BPCL occurring on or after	1.04	O	0	0	0	0	1. 04
2.00	October 1 Outlier payments for discharges (see instructions)	2.00	244, 487	0	131, 161	113, 326	244, 487	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2. 01
3.00	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	1 1					
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0. 000000	0. 000000	0. 000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6. 01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6. 01
	Indirect Medical Education Adju	ustment for the	e Add-on for Se	ction 422 of t	he MMA			
7.00	IME payment adjustment factor	27.00	0. 000000	0. 000000	0. 000000	0. 000000		7.00
8.00	(see instructions) IME adjustment (see	28.00	0	0	0	0	0	8.00
8. 01	instructions) IME payment adjustment add on for managed care (see	28.01	0	0	0	0	0	8. 01
9.00	instructions) Total IME payment (sum of	29.00	0	0	0	0	0	9.00
9. 01	lines 6 and 8) 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		0.0070	0.0070	0.0070	0.0070		10 0
10. 00	Allowable disproportionate share percentage (see instructions)	33.00	0. 0378	0. 0378	0. 0378	0. 0378		10.00
11. 00	Disproportionate share adjustment (see instructions)	34.00	125, 352	0	93, 396	31, 956	125, 352	11.00
11. 01	Uncompensated care payments	36.00	630, 821	0	495, 578	135, 243	630, 821	11.01
12.00	Additional payment for high per Total ESRD additional payment	centage of ESF 46.00	o beneticiary o	di scharges 0	0	0	0	12.00
13. 00 14. 00	(see instructions) Subtotal (see instructions) Hospital specific payments	47.00 48.00	14, 265, 299 0	0 0	10, 603, 251 0	3, 662, 048 0	14, 265, 299 0	
15. 00	(completed by SCH and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs (see instructions)	49.00	14, 265, 299	0	10, 603, 251	3, 662, 048	14, 265, 299	15.00
16. 00	instructions) Payment for inpatient program	50.00	1, 155, 539	0	849, 288	306, 251	1, 155, 539	16.00
17.00	capital Special add-on payments for	54.00	8, 172	0	8, 172	8, 172	16, 344	17.00
17. 01 17. 02	new technologies Net organ aquisition cost Credits received from manufacturers for replaced	55.00 68.00	0 0	0 0	0	0 0	0 0	
18. 00	manufacturers for replaced devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00

Heal th	Financial Systems		RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
LOW VO	LUME CALCULATION EXHIBIT 4				-	Period: From 01/01/2015 Fo 12/31/2015	Date/Time Pre 5/19/2016 4:5	pared:
					e XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01		
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	11, 460, 71 ⁻	1 3, 976, 471	15, 437, 182	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1,061,691	0	790, 522	2 271, 169	1,061,691	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0		0	0	20. 01
21.00	Capital DRG outlier payments	2.00	56, 795	0	56, 79	5 25, 618	82, 413	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	(0	0	•
22.00	Indirect medical education	5.00	0, 0000	0, 0000	0.000	0. 0000		22.00
	percentage (see instructions)							
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	(0 0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0349	0. 0349	0.0349	9 0. 0349		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	37, 053	0	27, 589	9 9,464	37, 053	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1, 155, 539	0	849, 288	306, 251	1, 155, 539	26.00
		W/S E, Part A	(Amounts to E,					
		line	Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.00000	0. 000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96			(כ	0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

	Financial Systems AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	RIVERVIEW TION EXHIBIT 5	Provi der	CCN: 150059	Period: From 01/01/2015 To 12/31/2015	Date/Time Pre 5/19/2016 4:5	t 5 pared:
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	e XVIII Period to 10/01	Hospi tal Peri od on after 10/01	PPS Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	9, 883, 116			9, 883, 116	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3, 381, 523		3, 381, 523		1. 02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	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	1. 04
2.00	Outlier payments for discharges (see instructions)	2.00	244, 487	131, 10	61 113, 326	244, 487	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0		0 0	0	2. 01
3.00	Operating outlier reconciliation	2.01	0		0 0		3.00
4.00	Managed care simulated payments	3.00	0		0 0	0	4.00
5.00	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0.0000	0.00000		5.00
6. 00 6. 01	IME payment adjustment (see instructions) IME payment adjustment for managed care (see instructions)	22. 00 22. 01	0		0 0 0 0	-	6. 00 6. 01
	Indirect Medical Education Adjustment for the						
7.00	IME payment adjustment factor (see instructions)	27.00	0. 000000	0.0000	0. 000000		7.00
8. 00 8. 01	IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions)	28. 00 28. 01	0		0 0 0 0	0	8. 00 8. 01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0		0 0	0	9.00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0		0 0	0	9.01
10. 00	Disproportionate Share Adjustment Allowable disproportionate share percentage	33.00	0. 0378	0.03	78 0. 0378		10.00
11.00	(see instructions) Disproportionate share adjustment (see	34.00	125, 352				
11.00	Uncompensated care payments	36.00	630, 821				
01	Additional payment for high percentage of ESR			475,5	100, 240	030, 021	
12.00	Total ESRD additional payment (see instructions)	46.00	0		0 0	0	12.00
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	47.00 48.00	14, 265, 299 0		51 3, 662, 048 0 0		13. 00 14. 00
15.00	instructions) Total payment for inpatient operating costs (see instructions)	49.00	14, 265, 299	10, 603, 2	51 3, 662, 048	14, 265, 299	15.00
16.00	Payment for inpatient program capital	50.00	1, 155, 539	860, 59	294, 948	1, 155, 539	16.00
17.00	Special add-on payments for new technologies	54.00	8, 172			8, 172	
17.01	Net organ aquisition cost	55.00	0		0 0	-	
17. 02	Credits 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		I	11, 472, 0	3, 956, 997	15, 429, 010	19.00

Heal th	Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5		CCN: 150059	Period: From 01/01/2015 To 12/31/2015	Date/Time Pre 5/19/2016 4:5	pared:
				e 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	1, 061, 691	790, 5	22 271, 169	1, 061, 691	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1.01	0	1	0 0	0	20.01
21.00	Capital DRG outlier payments	2.00	56, 795	42, 4	80 14, 315	56, 795	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0		0 0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.00	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0		0 0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0349	0. 03	49 0. 0349		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	37, 053	27, 5	89 9, 464	37, 053	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1, 155, 539	860, 5	91 294, 948	1, 155, 539	26.00
		Wkst. E, Pt. A, line	(Amt. from 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	0	1	0	0	28.00
29.00	Low volume adjustment on or after October 1	70. 97	0	1	0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70. 93	-29, 092	-34, 3	26 5, 234	-29, 092	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0 0	0	30. 01
31.00	HRR adjustment (see instructions)	70.94	0		0 0	0	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99			0 39, 622		32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

	Financial Systems RIVERVIEW HOS ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150059	Peri od: From 01/01/2015 To 12/31/2015	Date/Time Pre	pared:
		Title XVIII	Hospi tal	5/19/2016 4:5 PPS	/ pm
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00 2.00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruct	tions)		6, 738 11, 399, 863	
2.00 3.00	PPS payments			10, 964, 269	•
4.00	Outlier payment (see instructions)			61, 334	•
5.00	Enter the hospital specific payment to cost ratio (see instruc	ctions)		0.000	
6.00 7.00	Line 2 times line 5 Sum of line 3 plus line 4 divided by line 6			0 0.00	
8.00	Transitional corridor payment (see instructions)			0.00	1
9.00	Ancillary service other pass through costs from Wkst. D, Pt. 1	IV, col. 13, line 200		47, 312	•
10. 00	Organ acqui si ti ons			0	
11.00	Total cost (sum of lines 1 and 10) (see instructions)			6, 738	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				1
	Ancillary service charges			17, 302	12.00
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, li	ine 69)		0	
14.00	Total reasonable charges (sum of lines 12 and 13)			17, 302	14.00
15.00	Customary charges Aggregate amount actually collected from patients liable for p	payment for services on	a charge basis	0	15.00
	Amounts that would have been realized from patients liable for			0	
	had such payment been made in accordance with 42 CFR §413.13(e)	Ũ		
	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
18.00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete onl	lvifline 18 exceeds li	ne 11) (see	17, 302 10, 564	
17.00	instructions)			10, 304	
20. 00	Excess of reasonable cost over customary charges (complete onl	ly if line 11 exceeds li	ne 18) (see	0	20.00
01 00	instructions)	- ! + + ! >		(700	01 00
	Lesser of cost or charges (line 11 minus line 20) (for CAH see Interns and residents (see instructions)	e Instructions)		6, 738 0	21.00
	Cost of physicians' services in a teaching hospital (see instr	ructions)		0	
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			11, 072, 915	24.00
25.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance (for CAH, see instructions)			14	25.00
	Deductibles and Coinsurance relating to amount on line 24 (for	r CAH, see instructions)		2, 321, 826	
	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p			8, 757, 813	
	instructions)			_	
	Direct graduate medical education payments (from Wkst. E-4, li ESRD direct medical education costs (from Wkst. E-4, line 36)	ine 50)		0	
	Subtotal (sum of lines 27 through 29)			8, 757, 813	•
	Primary payer payments			3, 518	
32.00	Subtotal (line 30 minus line 31)			8, 754, 295	32.00
22 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC Composite rate ESRD (from Wkst. 1-5, line 11)	CES)		0	33.00
	Allowable bad debts (see instructions)			212, 746	
	Adjusted reimbursable bad debts (see instructions)			138, 285	
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		162, 381	
	Subtotal (see instructions)			8, 892, 580	
	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			-42	
	Pioneer ACO demonstration payment adjustment (see instructions)	5)		0	
	Partial or full credits received from manufacturers for replace		tions)	0	
39. 99	RECOVERY OF ACCELERATED DEPRECIATION		,	0	
	Subtotal (see instructions)			8, 892, 622	
40.01				177, 852	1
	Interim payments Tentative settlement (for contractors use only)			8, 640, 032 0	41.00
	Balance due provider/program (see instructions)			74, 738	
	Protested amounts (nonallowable cost report items) in accordar	nce with CMS Pub. 15-2,	chapter 1,	0	1
	\$115.2				-
90.00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90.00
	Outlier reconciliation adjustment amount (see instructions)			0	
91.00 92.00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00 0	

VALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	CCN: 150059	Period: From 01/01/201 To 12/31/201	5 Date/Time Pre	parec
		T: +1	e XVIII	llooni tol	5/19/2016 4:5 PPS	7 pm
			t Part A	Hospi tal Pa	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider		13, 482, 0		8, 530, 331	1.
00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	0	2.
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.
	Program to Provider					
01	ADJUSTMENTS TO PROVIDER	12/31/2015	55, 5		109, 701	3.
02				0	0	
03				0	0	
04 05				0	0	
05	Provider to Program			0	0	3.
50	ADJUSTMENTS TO PROGRAM			0	0	3.
51				0	0	
52				0	0	
53				0	0	-
54				0	0	-
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		55, 5	10	109, 701	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		13, 537, 5	14	8, 640, 032	4.
	appropriate)					
~~	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after	l				1 -
00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5
~ -	Program to Provider	1				
01 02	TENTATI VE TO PROVIDER			0	0	
)2)3				0	0	
	Provider to Program	I				1
50	TENTATI VE TO PROGRAM			0	0	5
51				0	0	
52				0	0	
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
01	SETTLEMENT TO PROVIDER		119, 4	89	74, 738	
02	SETTLEMENT TO PROGRAM			0	0	-
00	Total Medicare program liability (see instructions)		13, 657, 0		8, 714, 770	7
				Contractor Number	NPR Date (Mo/Day/Yr)	
		()	1, 00	2.00	-
	Name of Contractor			1.00	2.00	8

ALYS	IS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		CCN: 150059 CCN: 15T059	Period: From 01/01/2015 To 12/31/2015		epared
		Ti tl	e XVIII	Subprovider - IRF	PPS	, pii
		I npati en	t Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		5, 545, 67	0	000	
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.
0.4	Program to Provider					
01 02	ADJUSTMENTS TO PROVIDER			0	0	
02				0	0	
04				0	0	
05				0	0	3
	Provider to Program				1	
50	ADJUSTMENTS TO PROGRAM			0	0	
51				0	0	-
52				0	0	-
53				0	0	
54				0	0	
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3
00	Total interim payments (sum of lines 1, 2, and 3.99)		5, 545, 67	73	0	4
0	(transfer to Wkst. E or Wkst. E-3, line and column as		5, 545, 0	75	0	' ⁴
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR		ı			
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none,					5
	write "NONE" or enter a zero. (1) Program to Provider					
)1	TENTATI VE TO PROVIDER			0	0	5
)2				0	0	
)3				0	0	
	Provider to Program					
0	TENTATI VE TO PROGRAM			0	0	
51				0	0	
52				0	0	
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5
0	5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1)					6
)1	SETTLEMENT TO PROVIDER		20, 70	11	0	6
)2	SETTLEMENT TO PROVIDER		20, /(0	0	
00	Total Medicare program liability (see instructions)		5, 566, 37	74	0	
-			2,000,01	Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
)	1.00	2.00	

IALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		CCN: 150059 CCN: 155669	Period: From 01/01/2015 To 12/31/2015		epare
		Ti tl	e XVIII	Skilled Nursing		or pili
		I npati er	it Part A	Facility Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1, 709, 5	74 0	000	
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.
01	Program to Provider		1	0		3.
01 02	ADJUSTMENTS TO PROVIDER			0	0	
02				0	0	
)4				0	0	
05				0	0	
	Provider to Program					
50	ADJUSTMENTS TO PROGRAM			0	0	3
51				0	0	-
52				0	0	-
53				0	0	
54				0	0	
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3
	3. 50-3. 98)		4 700 5			
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1, 709, 5	/4	0	
	TO BE COMPLETED BY CONTRACTOR		1		1	
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none,					5
	write "NONE" or enter a zero. (1)					
	Program to Provider		1		1	1 -
)1	TENTATI VE TO PROVI DER			0	0	
)2)3				0		
	Provider to Program		1	<u> </u>	1 0	1 3
50	TENTATI VE TO PROGRAM			0	0	5
51				0	0	
52				0	0	5
9	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
01	SETTLEMENT TO PROVIDER		11, 9	15	0	
02	SETTLEMENT TO PROGRAM			0	0	
00	Total Medicare program liability (see instructions)		1, 721, 48		0	7
				Contractor	NPR Date	
			0	<u>Number</u> 1.00	(Mo/Day/Yr) 2.00	
00	Name of Contractor		5	1.00	2.00	6

Heal th	Financial Systems RIVERVIEW HO	SPI TAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 150059	Peri od:	Worksheet E-1	
			From 01/01/2015 To 12/31/2015		narod.
			10 12/31/2013	5/19/2016 4:5	
		Title XVIII	Hospi tal	PPS	
		÷			
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.		14	3, 821	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	3-12		6, 583	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			2, 085	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	3-12		15, 564	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			326, 850, 178	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l			6, 129, 941	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of c	ertified HIT technology	Wkst. S-2, Pt. I	0	7.00
0.00	line 168			710 0/0	0.00
8.00	Calculation of the HIT incentive payment (see instructions)			719, 263	
9.00	Sequestration adjustment amount (see instructions)			14, 385	9.00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)		704, 878	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH			(75, 400	00.00
30.00	Initial/interim HIT payment adjustment (see instructions)			675, 188	
31.00	Other Adjustment (specify)	ing 21) (and instanting	-)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	s)	29, 690	32.00

	Financial Systems RIVERVIEW H			u of Form CMS-2	
CALCUI	LATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150059 Component CCN: 15T059	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part III Date/Time Pre	pared
		Title XVIII	Subprovider - IRF	5/19/2016 4:5 PPS	<u>/ piii</u>
	PART III - MEDICARE PART A SERVICES - IRF PPS			1.00	
. 00	Net Federal PPS Payment (see instructions)			5, 623, 218	1.0
. 00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0125	2.
. 00	Inpatient Rehabilitation LIP Payments (see instructions)			113, 027	3.
. 00	Outlier Payments			82, 430	4.
. 00	Unweighted intern and resident FTE count in the most recent	cost reporting period en	dina on or prior	0.00	5.
	to November 15, 2004 (see instructions)	5 10 10	J		
. 01	Cap increases for the unweighted intern and resident FTE cou	nt for residents that wer	e displaced by	0.00	5.
	program or hospital closure, that would not be counted witho				
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)				
b. 00	New Teaching program adjustment. (see instructions)			0.00	6.
. 00	Current year's unweighted FTE count of I&R excluding FTEs in	the new program growth p	eriod of a "new	0.00	7.
	teaching program" (see instructions)				
3. 00	Current year's unweighted I&R FTE count for residents within	the new program growth p	eriod of a "new	0.00	8.
	teaching program" (see instructions)				
. 00	Intern and resident count for IRF PPS medical education adju	stment (see instructions)		0.00	9.
0.00	Average Daily Census (see instructions)			15.295890	10.
1. 00	Teaching Adjustment Factor (see instructions)			0.00000	11.
2.00	Teaching Adjustment (see instructions)			0	12.
3.00	Total PPS Payment (see instructions)			5, 818, 675	13.
4.00	Nursing and Allied Health Managed Care payments (see instruc	tion)		0	14.
5.00	Organ acquisition (DO NOT USE THIS LINE)				15.
6. 00	Cost of physicians' services in a teaching hospital (see ins	tructions)		0	16.
7.00	Subtotal (see instructions)			5, 818, 675	17.
8.00	Primary payer payments			0	18.
9.00	Subtotal (line 17 less line 18).			5, 818, 675	19.
0. 00	Deducti bl es			129, 604	20.
1.00	Subtotal (line 19 minus line 20)			5, 689, 071	21.
2.00	Coinsurance			18, 270	22.
3.00	Subtotal (line 21 minus line 22)			5, 670, 801	23.
4.00	Allowable bad debts (exclude bad debts for professional serv	ices) (see instructions)		2, 098	24.
5.00	Adjusted reimbursable bad debts (see instructions)			1, 364	25.
6. 00	Allowable bad debts for dual eligible beneficiaries (see ins	tructions)		0	26.
7.00	Subtotal (sum of lines 23 and 25)			5, 672, 165	27.
8.00	Direct graduate medical education payments (from Wkst. E-4,	line 49)		0	28.
9.00	Other pass through costs (see instructions)			7, 808	29.
0.00	Outlier payments reconciliation			0	30.
1.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	31.
1. 50	Pioneer ACO demonstration payment adjustment (see instructio	ins)		0	31.
1. 99	Recovery of Accel erated Depreciation			0	31.
2.00	Total amount payable to the provider (see instructions)			5, 679, 973	
2. 01	Sequestration adjustment (see instructions)			113, 599	
3.00	1.5			5, 545, 673	
4.00	Tentative settlement (for contractor use only)			0	34.
5.00	1 1 5 1	· · · · · · · · · · · · · · · · · · ·		20, 701	
6. 00	Protested amounts (nonallowable cost report items) in accord §115.2	lance with CMS Pub. 15-2,	chapter 1,	110, 419	36.
	TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			82, 430	50.
51.00	Outlier reconciliation adjustment amount (see instructions)			0	51.
52.00	The rate used to calculate the Time Value of Money			0.00	52.
	Time Value of Money (see instructions)			0	53.

	· · · · J · · · ·	W HOSPITAL		u of Form CMS-2	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150059	Peri od:	Worksheet E-3	
		Component CCN: 155669	From 01/01/2015 To 12/31/2015	Part VI Date/Time Pre	narec
		component con. 133007	10 12/31/2013	5/19/2016 4:5	
		Title XVIII	Skilled Nursing	PPS	
			Facility		
				1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL	OTHER HEALTH SERVICES FOR T	ΙΤΙΕ ΧΛΙΙΙ ΡΔΡΤ Δ		
	SERVICES	offick fickerin sekvices for fi			
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				1
. 00	Resource Utilization Group Payment (RUGS)			1, 873, 613	1.
2.00	Routine service other pass through costs			0	2.0
3.00	Ancillary service other pass through costs			12, 158	
1.00	Subtotal (sum of lines 1 through 3)			1, 885, 771	4.
	COMPUTATION OF NET COST OF COVERED SERVICES				
. 00	Medical and other services (Do not use this line as vacci	ne costs are included in line	e 1 of W/S E,		5.
. 00	Part B. This line is now shaded.) Deductible			0	6.
. 00	Coi nsurance			129, 150	
. 00	Allowable bad debts (see instructions)			129, 150	
. 00	Reimbursable bad debts for dual eligible beneficiaries (se	ee instructions)		0	-
0.00	Adjusted reimbursable bad debts (see instructions)			0	
1.00	Utilization review			0	
2.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus line	es 10 and 11)(see instruction	ns)	1, 756, 621	12.
3.00	Inpatient primary payer payments	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		0	
4.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	14.
4.50	Pioneer ACO demonstration payment adjustment (see instruc	tions)		0	14.
4.99	Recovery of Accel erated Depreciation			0	14.
5.00	Subtotal (see instructions			1, 756, 621	15.
5. 01	Sequestration adjustment (see instructions)			35, 132	
	Interim payments			1, 709, 574	
7.00	Tentative settlement (for contractor use only)			0	17.
	Balance due provider/program (line 15 minus lines 15.01,	16, and 17)		11, 915	18.
	Protested amounts (nonallowable cost report items) in acc		1	0	19.

	Financial Systems RIVERVIEW HOSPI			u of Form CMS-2	
ALCUL	TION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150059	Period: From 01/01/2015		
			To 12/31/2015	Date/Time Pre 5/19/2016 4:5	
		Title XIX	Hospi tal	Cost	. թ
			Inpati ent	Outpatient	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVI			2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	ICES FUR TITLES V UR A	IX SERVICES		
. 00	Inpatient hospital/SNF/NF services		1, 203, 309		1 1.
	Medical and other services		17 2007 007	0	
00	Organ acquisition (certified transplant centers only)		0		3.
00	Subtotal (sum of lines 1, 2 and 3)		1, 203, 309	0	4.
00	Inpatient primary payer payments		0		5.
00	Outpatient primary payer payments			0	
00	Subtotal (line 4 less sum of lines 5 and 6)		1, 203, 309	0	7
	COMPUTATION OF LESSER OF COST OR CHARGES				-
	Reasonable Charges		047 574		
	Routine service charges Ancillary service charges		867, 574 1, 904, 894	0	8
	Organ acquisition charges, net of revenue		1, 904, 894	0	10
	Incentive from target amount computation		0		11
	Total reasonable charges (sum of lines 8 through 11)		2, 772, 468	0	
	CUSTOMARY CHARGES				1
3.00	Amount actually collected from patients liable for payment for s	services on a charge	0	0	13
	basi s				
. 00	Amounts that would have been realized from patients liable for		n 0	0	14
	a charge basis had such payment been made in accordance with 42	CFR §413.13(e)			
	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	
	Total customary charges (see instructions)	if line 14 exceede	2, 772, 468	0	
. 00	Excess of customary charges over reasonable cost (complete only line 4) (see instructions)	IT THE TO exceeds	1, 569, 159	0	17
3. 00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds lin	e 0	0	18
	16) (see instructions)		c c	0	
9.00	Interns and Residents (see instructions)		0	0	19
	Cost of physicians' services in a teaching hospital (see instrue		0	0	20
	Cost of covered services (enter the lesser of line 4 or line 16)		1, 203, 309	0	21
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co	ompleted for PPS provi			
	Other than outlier payments		0	0	
	Outlier payments		0	0	
	Program capital payments		0		24
	Capital exception payments (see instructions)		0	0	25
	Routine and Ancillary service other pass through costs Subtotal (sum of lines 22 through 26)		0	0	
	Customary charges (title V or XIX PPS covered services only)		0	0	
	Titles V or XIX (sum of lines 21 and 27)		1, 203, 309	0	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		172007007		1 - 1
	Excess of reasonable cost (from line 18)		0	0	30
1.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		1, 203, 309	0	31
	Deducti bl es		0	0	
	Coinsurance		0	0	
	Allowable bad debts (see instructions)		0	0	
	Utilization review	~~`	0		35
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 3	33)	1, 203, 309	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		1 202 200	0	
	Subtotal (line 36 ± line 37) Direct graduate medical education payments (from Wkst. E-4)		1, 203, 309	0	38
	Total amount payable to the provider (sum of lines 38 and 39)		1, 203, 309	0	
	Interim payments		1, 055, 180	0	40
	Balance due provider/program (line 40 minus line 41)		148, 129	0	
	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2	140, 127	0	
	chapter 1, §115.2		Ŭ	0	1.0

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150059	Period:	Worksheet E-3	
		•	From 01/01/2015 To 12/31/2015	Part VII Date/Time Pre 5/19/2016 4:5	
		Title XIX	Subprovider - IRF	Cost	
			Inpati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER COMPUTATION OF NET COST OF COVERED SERVICES	VICES FOR TITLES V OR XI	X SERVICES		-
00	Inpatient hospital/SNF/NF services		132, 290		1.
00	Medical and other services		102, 270	0	
00	Organ acquisition (certified transplant centers only)		0		
00	Subtotal (sum of lines 1, 2 and 3)		132, 290	0	4
00	Inpatient primary payer payments		0		1
00	Outpatient primary payer payments			0	
00	Subtotal (line 4 less sum of lines 5 and 6)		132, 290	0	
	COMPUTATION OF LESSER OF COST OR CHARGES				
00	Reasonable Charges Routine service charges		86, 401		1
00	Ancillary service charges		174, 587	0	
. 00	Organ acquisition charges, net of revenue		0	0	1
. 00	Incentive from target amount computation		0		1
. 00	Total reasonable charges (sum of lines 8 through 11)		260, 988	0	1:
	CUSTOMARY CHARGES				
8.00	Amount actually collected from patients liable for payment for	r services on a charge	0	0	13
~~	basi s				
. 00	Amounts that would have been realized from patients liable for	1 5	0 ו	0	1
. 00	a charge basis had such payment been made in accordance with 4 Ratio of line 13 to line 14 (not to exceed 1.000000)	12 CFR 9413. 13(e)	0. 000000	0.000000	1
. 00	Total customary charges (see instructions)		260, 988	0.000000	
. 00	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	128, 698	0	
	line 4) (see instructions)	5			
. 00	Excess of reasonable cost over customary charges (complete onl	y if line 4 exceeds line	e 0	0	18
	16) (see instructions)			_	
. 00	Interns and Residents (see instructions)		0	0	
0. 00 . 00	Cost of physicians' services in a teaching hospital (see instr Cost of covered services (enter the lesser of line 4 or line 1		0 132, 290	0	
. 00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be			0	2
. 00	Other than outlier payments		0	0	2
. 00	Outlier payments		0	0	
. 00	Program capital payments		0		2
. 00	Capital exception payments (see instructions)		0		2
. 00	Routine and Ancillary service other pass through costs		0	0	
. 00	Subtotal (sum of lines 22 through 26)		0	0	
. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
. 00	Titles V or XIX (sum of lines 21 and 27)		132, 290	0	20
. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Excess of reasonable cost (from line 18)		0	0	30
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		132, 290	0	
	Deductiblies		132, 270	0	
. 00	Coi nsurance		0	0	
. 00	Allowable bad debts (see instructions)		0	0	
. 00	Utilization review		0		3!
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	132, 290	0	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
. 00	Subtotal (line 36 ± line 37)		132, 290	0	
. 00	Direct graduate medical education payments (from Wkst. E-4)		0		3
. 00	Total amount payable to the provider (sum of lines 38 and 39)		132, 290	0	
. 00 . 00	Interim payments Balance due provider/program (line 40 minus line 41)		163, 682 -31, 392	0	
2.00 8.00	Protested amounts (nonallowable cost report items) in accordar	ace with CMS Pub 15-2	-31, 392	0	
	chapter 1, §115.2			0	⁻ `

	Financial Systems RIVERVIEW E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column onl	Provi der		Period: From 01/01/2015	u of Form CMS- Worksheet G	
unu-t	ype accounting records, comprete the general rund cordinin on	y)		To 12/31/2015	Date/Time Pre 5/19/2016 4:5	
		General Fund	Speci fi c	Endowment Fund		
		1.00	Purpose Fund 2.00	3.00	4.00	
	CURRENT ASSETS		1			
. 00	Cash on hand in banks	7, 960, 546		0 0	0	
. 00	Temporary investments Notes receivable	3, 562, 784		0 0 0 0	0	
. 00	Accounts receivable	23, 019, 068		0 0	0	
. 00	Other receivable	192, 878		0 0	0	
. 00	Allowances for uncollectible notes and accounts receivable	0		0 0	C	
. 00	Inventory	3, 895, 712		0 0	C	
. 00	Prepai d expenses	0		0 0	0	
00	Other current assets	15, 563, 200		0 0	0	
0.00 1.00	Due from other funds Total current assets (sum of lines 1-10)	54, 194, 188		0 0 0 0		
1.00	FIXED ASSETS	54, 174, 100		0 0		1 11.0
2.00	Land	15, 917, 384		0 0	C	12.0
3.00	Land improvements	0		0 0	C	13.0
4.00	Accumulated depreciation	0		0 0	C	
5.00	Buildings	0		0 0	0	
6.00 7.00	Accumulated depreciation Leasehold improvements	6, 299, 570		0 0	0	
8.00	Accumulated depreciation	0, 299, 370		0 0	0	
9.00	Fixed equipment	209, 180, 595		0 0	C	
0.00	Accumulated depreciation	-130, 989, 470		0 0	C	20.0
1.00	Automobiles and trucks	0		0 0	C	
2.00	Accumulated depreciation	0		0 0	0	
3.00	Major movable equipment Accumulated depreciation			0 0	0	
4.00 5.00	Minor equipment depreciable					
6.00	Accumulated depreciation	0		0 0	C	
7.00	HIT designated Assets	0		0 0	C	
8.00	Accumulated depreciation	0		0 0	C	28.0
9.00	Minor equipment-nondepreciable	0		0 0	0	
0.00	Total fixed assets (sum of lines 12-29)	100, 408, 079		0 0	C	30. 0
1.00	OTHER ASSETS Investments	85, 211, 677		0 0	C	31.0
2.00	Deposits on Leases	00,211,0,7		0 0	C C	
3.00	Due from owners/officers	1, 867, 431		0 0	C	33.0
4.00	Other assets	3, 886, 683		0 0	C	
5.00	Total other assets (sum of lines 31-34)	90, 965, 791		0 0	0	
6.00	Total assets (sum of lines 11, 30, and 35)	245, 568, 058		0 0	0	36.0
7.00	CURRENT LI ABI LI TI ES Accounts payable	6, 745, 516		0 0	C	37.0
8.00	Salaries, wages, and fees payable	8, 536, 142		0 0	C	
9.00	Payroll taxes payable	0		0 0	C	39.0
0.00	Notes and loans payable (short term)	5, 039, 746		0 0	C	
1.00	Deferred income	0		0 0	C	
2.00	Accel erated payments	0		0	0	42.0
3.00 4.00	Due to other funds Other current liabilities	58, 061, 619		0 0	0	
5.00	Total current liabilities (sum of lines 37 thru 44)	78, 383, 023		0 0		
	LONG TERM LI ABI LI TI ES			· [·		
6.00	Mortgage payable	0		0 0	C	46.0
7.00	Notes payable	31, 751, 311		0 0	0	
8.00	Unsecured Loans	0		0 0	0	
9.00	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49	1, 478, 960 33, 230, 271		0 0	0	
1.00	Total liabilites (sum of lines 45 and 50)	111, 613, 294		0 0	0	
1.00	CAPITAL ACCOUNTS	111,010,271	1	0 0		
2.00	General fund balance	133, 954, 764				52.0
3.00	Specific purpose fund			0		53. C
4.00	Donor created - endowment fund balance - restricted			0		54.0
5.00	Donor created - endowment fund balance - unrestricted			0		55.0
6.00 7.00	Governing body created - endowment fund balance Plant fund balance - invested in plant			0	C	56. C
7.00 8.00	Plant fund balance - reserve for plant improvement,					
5. 50	replacement, and expansion					
9.00	Total fund balances (sum of lines 52 thru 58)	133, 954, 764		0 0	C	59.0
9.00						

Heal th	Financial Systems	RI VERVI EW H	HOSPI TA	AL.			In Lie	eu of Form CMS	S-2	552-10
STATEM	ENT OF CHANGES IN FUND BALANCES		P	rovi der	CCN: 150059		eriod: com 01/01/2015 p 12/31/2015	Worksheet G Date/Time P 5/19/2016 4	rep	
		General	I Fund		Speci al	Pur	rpose Fund	Endowment Fu	nd	
		1.00	2.	00	3.00		4.00	5.00	_	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Total deductions (sum of lines 12-17) Fund balance at end of period per balance		1, 133, 133,	677, 719 277, 045 954, 764 0 954, 764 0 954, 764		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	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 19.\ 00\\ 19.\ 00\\ \end{array}$
	sheet (line 11 minus line 18)	Endowment Fund		Pl 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)	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 18. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Total deductions (sum of lines 12-17)	000		0 0 0 0 0 0		000				10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0				0				19. 00

Cos	TIENT REVENUES AND OPERATING EXPENSES	i i ovi del		Period: From 01/01/2015	Worksheet G-2	
PART I -				To 12/31/2015	Parts I & II Date/Time Pre 5/19/2016 4:5	pared: 7 pm
	t Center Description		I npati ent	Outpati ent	Total	
			1.00	2.00	3.00	
General	PATIENT REVENUES					4
	npatient Routine Services			-		
00 Hospital			23, 492, 26	4	23, 492, 264	
	DER – IPF					2.0
	DER – IRF		5, 591, 16	1	5, 591, 161	
00 SUBPROVI						4.0
00 Swing be				0	0	
00 Swing be				0	0	
	NURSING FACILITY		2, 535, 21	0	2, 535, 210	
00 NURSING						8.0
	NG TERM CARE					9.0
	neral inpatient care services (sum of lines 1-9)		31, 618, 63	5	31, 618, 635	10.0
	e Care Type Inpatient Hospital Services		_			1
	E CARE UNIT		5, 399, 06	6	5, 399, 066	
						12.0
	ENSIVE CARE UNIT					13.0
	INTENSIVE CARE UNIT					14. C
	ECIAL CARE (SPECIFY)					15.0
	tensive care type inpatient hospital services (sum	of lines	5, 399, 06	6	5, 399, 066	16.0
11-15)		4()	07 047 70		07 017 701	17.0
	patient routine care services (sum of lines 10 and	16)	37, 017, 70		37, 017, 701	
.00 Ancillar			97, 242, 92		256, 484, 215	
. 00 Outpatie			3, 688, 35		33, 348, 262	1
				0 0	0	
	Y QUALIFIED HEALTH CENTER			0 0	0	
. 00 HOME HEA						22.0
. 00 AMBULANC	E SERVICES			0 0	0	
. 00 CMHC						24.0
	RY SURGICAL CENTER (D. P.)					25.0
. 00 HOSPICE				7 47 004 000	47 070 70/	26.0
. 00 PHYSI CI A			69, 46		47, 870, 706	
	N PRO FEES		100.010.15	0 5, 999, 655	5, 999, 655	
	tient revenues (sum of lines 17-27)(transfer column	3 to Wkst.	138, 018, 45	51 242, 702, 088	380, 720, 539	28.0
G-3, lin						-
	OPERATING EXPENSES			170 751 (00		1 20 0
	g expenses (per Wkst. A, column 3, line 200)			170, 751, 690 0		29.0
. 00 ADD (SPE	JIFY)					
. 00				0		31.0
. 00				0		32.0
. 00						33.0
. 00				0		34.0
. 00				0		35.0
	ditions (sum of lines 30-35)			0		36.0
. 00 I NTEREST	EXPENSE			0		37.0
. 00				0		38.0
. 00				0		39.0
. 00				0		40.0
. 00				0		41.0
	ductions (sum of lines 37-41)			0		42.0
	erating expenses (sum of lines 29 and 36 minus line G-3, line 4)	42)(transfer		170, 751, 690		43.0

Heal th	Financial Systems RIVERVIEW HOSP	PI TAL	In Lie	u of Form CMS-2	2552-10
STATE	ENT OF REVENUES AND EXPENSES	Provider CCN: 150059	Peri od:	Worksheet G-3	
			From 01/01/2015 To 12/31/2015	Date/Time Pre	narodi
			10 12/31/2015	5/19/2016 4:5	
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line	28)		380, 720, 539	1.00
2.00	Less contractual allowances and discounts on patients' accounts	3		218, 544, 740	2.00
3.00	Net patient revenues (line 1 minus line 2)			162, 175, 799	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43	3)		170, 751, 690	
5.00	Net income from service to patients (line 3 minus line 4)			-8, 575, 891	5.00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			-563, 763	6.00
7.00	Income from investments			-1, 054, 700	7.00
8.00	Revenues from telephone and other miscellaneous communication s	servi ces		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			0	10.00
11.00				0	11.00
12.00				0	12.00
13.00				0	13.00
	Revenue from meals sold to employees and guests			0	14.00
	Revenue from rental of living quarters			0	15.00
	Revenue from sale of medical and surgical supplies to other that	an patients		0	16.00
	Revenue from sale of drugs to other than patients			0	17.00
	Revenue from sale of medical records and abstracts			0	18.00
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00				0	20.00
21.00				0	21.00
22.00				0	22.00
23.00	Governmental appropriations			0	23.00
24.00				11, 471, 399	
	Total other income (sum of lines 6-24)			9, 852, 936	
	Total (line 5 plus line 25)			1, 277, 045	
	INTEREST EXPENSE			0	27.00
	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)			1, 277, 045	29.00

ealth Financial Systems ALCULATION OF CAPITAL PAYMENT		/IEW HOSPITAL Provider CCN: 150059	Peri od:	u of Form CMS-2 Worksheet L	
			From 01/01/2015	Parts I-III	
			To 12/31/2015	Date/Time Pre 5/19/2016 4:5	
		Title XVIII	Hospi tal	PPS	/ piii
	NETLIOD			1.00	
PART I – FULLY PROSPECTIVE CAPITAL FEDERAL AMOUNT	METHOD				-
00 Capital DRG other than out	ier			1, 061, 691	1 1.
01 Model 4 BPCI Capital DRG ot				0	1.
00 Capital DRG outlier payment				56, 795	2.
01 Model 4 BPCI Capital DRG ou	utlier payments			0	2.
00 Total inpatient days divide	ed by number of days in the	cost reporting period (see instr	ructions)	42.66	3.
00 Number of interns & residen				0.00	
	percentage (see instruction			0.00	
00 Indirect medical education 1.01)(see instructions)	adjustment (multiply line 5	by the sum of lines 1 and 1.01,	columns 1 and	0	6.
00 Percentage of SSI recipient 30) (see instructions)	r patient days to Medicare P	art A patient days (Worksheet E,	part A line	2.39	7.
	ent days to total days (see	instructions)		14.56	8.
00 Sum of lines 7 and 8				16. 95	
.00 Allowable disproportionate		uctions)		3.49	
. 00 Disproportionate share adju				37, 053	
.00 Total prospective capital p	bayments (see Instructions)			1, 155, 539	12
				1.00	
PART II - PAYMENT UNDER REA	SONABLE COST				
	capital cost (see instructio			0	
3	y capital cost (see instruct			0	
	pital cost (line 1 plus line	2)		0	
00 Capital cost payment factor	. ,			0	
00 Total_inpatient_program_cap	<u>pital cost (line 3 x line 4)</u>			0	5.
				1.00	
PART III - COMPUTATION OF E Program inpatient capital c				0	1 1
5 1 1	costs for extraordinary circ	umstances (see instructions)		0	
5 1 1	tal costs (line 1 minus line			0	-
00 Applicable exception percent				0.00	-
	n to payments (line 3 x line	4)		0	
00 Percentage adjustment for e	extraordinary circumstances	(see instructions)		0.00	6
00 Adjustment to capital minim	num payment level for extrao	rdinary circumstances (line 2 x	line 6)	0	7
00 Capital minimum payment lev				0	-
	nts (from Part I, line 12, a			0	
		ei to capital payments (line 8 l		0	
.00 Current year comparison of			or year i	0	
. 00 Current year comparison of	apital minimum payment level	over capital payment (from pric	or year	0	
.00 Current year comparison of .00 Carryover of accumulated ca Worksheet L, Part III, line	apital minimum payment level e 14)		5	0	12.
 .00 Current year comparison of Carryover of accumulated ca Worksheet L, Part III, line .00 Net comparison of capital m Current year exception paym 	apital minimum payment level e 14) minimum payment level to cap ment (if line 12 is positive	over capital payment (from pric ital payments (line 10 plus line , enter the amount on this line)	e 11)	0 0	13.
 .00 Current year comparison of Carryover of accumulated ca Worksheet L, Part III, line .00 Net comparison of capital m .00 Current year exception paym .00 Carryover of accumulated ca 	apital minimum payment level e 14) minimum payment level to cap ment (if line 12 is positive apital minimum payment level	over capital payment (from pric ital payments (line 10 plus line , enter the amount on this line) over capital payment for the fo	e 11)	0	13.
 .00 Current year comparison of Carryover of accumulated ca Worksheet L, Part III, line .00 Net comparison of capital m Current year exception paym .00 Carryover of accumulated ca (if line 12 is negative, en 	apital minimum payment level e 14) minimum payment level to cap ment (if line 12 is positive apital minimum payment level nter the amount on this line	over capital payment (from pric ital payments (line 10 plus line , enter the amount on this line) over capital payment for the fo	e 11)	0 0 0	13. 14.
 0.00 Current year comparison of Carryover of accumulated ca Worksheet L, Part III, line 00 Net comparison of capital m 00 Current year exception paym 00 Carryover of accumulated ca 	apital minimum payment level e 14) minimum payment level to cap ment (if line 12 is positive apital minimum payment level nter the amount on this line rating and capital payment (over capital payment (from pric ital payments (line 10 plus line , enter the amount on this line) over capital payment for the fo) see instructions)	e 11)	0 0	13 14 15