Health Financial Systems	RI VERVI EW HOSPI TAL	In Lieu of Form CMS-2552-10								
This report is required by law (42 USC 1395g; 42 CF payments made since the beginning of the cost report		sult in all interim FORM APPROVED								
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPO AND SETTLEMENT SUMMARY	ORT CERTIFICATION Provider CCN: 15-0059	Period:         Worksheet S           From 01/01/2019         Parts I-III           To         12/31/2019         Date/Time Prepared:           6/8/2020         1:18 pm								
PART I - COST REPORT STATUS		0/0/2020 1. 10 pm								
Provider 1. [X] Electronically filed cost rep	port	Date: 6/8/2020 Time: 1:18 pm								
use only 2. [ ]Manually submitted cost repor 3. [ 0 ]If this is an amended report 4. [ F ]Medicare Utilization. Enter '	enter the number of times the provider	resubmitted this cost report								
Contractor use only5. [ 1 ]Cost Report Status (1) As Submitted6. Date 7. Contr (2) Settled without Audit 8. [ N ]	Recei ved: 10	NPR Date: .Contractor's Vendor Code: 4 .[0]If line 5, column 1 is 4: Enter number of times reopened = 0-9.								
PART II - CERTIFICATION										
PART 11 - CERTIFICATION         MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND         ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE         PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND         ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.         CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)         I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying         electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and         Expenses prepared by RIVERVIEW HOSPITAL (15-0059) for the cost report and statement are true, correct,         complete and prepared from the books and records of the provider in accordance with applicable instructions,         except as noted.       I further certify that I am familiar with the laws and regulations regarding the provision of										
health care services, and that the services laws and regulations.	s identified in this cost report were p	rovided in compliance with such								
[ X ]I have read and agree with the above of	certification statement. I certify that ment to be the legally binding equivale									
	(Si gned) BRENDA BAKER									
	Officer or Admi	nistrator of Provider(s)								
	CFO									
	Title									
	Date (Dated when repo	rt is electronically signed.)								
	Date									
Cost Contor Description	Title XVIII Title V Part A Part B	HIT Title XIX								
Cost Center Description	1.00 2.00 3.00	4.00 5.00								
PART III - SETTLEMENT SUMMARY										
1.00 Hospital		, 324 0 48, 692 1. 00								
2.00 Subprovider - LPF		0 0 2.00								

0 Swing bed - SNF Swing bed - NF 0 0 0 5.00 5.00 0 6.00 6.00 0 SKILLED NURSING FACILITY 7.00 0 1, 212 0 0 7.00 200.00 Total 0 155, 516 205, 738 -55 200.00 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

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.

SPI T	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX		<u>RVIEW HOS</u> TA		er CCN	N: 15-005	I	Period: From 01/01/ To 12/31/	/2019	Worksh Part I Date/1	<u>rm CMS-</u> neet S-2 ime Pre 20 1:18	2 epared
	1.00		00		3.00				4.00			
00	Hospital and Hospital Health Care Co Street: 395 WESTFIELD ROAD	PO Box:										1.0
	Ci ty: NOBLESVI LLE	State: I	N Z	Zip Code	e: 4606	60- 0	Count	y: HAMI LTON				2.
		Component Na		CCN	CBS		∕i der	Date			tem (P,	
				lumber	Numb	er   Iy	/pe	Certified	V	, 0, or XVIII		-
		1.00		2.00	3.0	0 4	00	5.00	6. 00	_		-
	Hospital and Hospital-Based Componer			2100	0.0			0.00	0.00	1 // 00	1 01 00	
00	Hospi tal	RI VERVI EW HOSPI TA	AL   1	50059	2690	00	1	07/07/1966	N	P	0	3.
)0 )0	Subprovider - IPF Subprovider - IRF	RI VERVI EW HOSPI TA REHAB	AL 1	5T059	2690	00	5	01/01/1994	N	Р	0	4. 5.
0	Subprovider - (Other) Swing Beds - SNF											6
0	Swing Beds - NF											8.
0 00	Hospital-Based SNF Hospital-Based NF	RI VERVI EW HOSPI TA	AL SNF   1	55669	2690	00		10/26/1999	N	P	N	9
00	Hospital-Based OLTC											111.
00	Hospital -Based HHA											12.
00	Separately Certified ASC											13
00	Hospi tal -Based Hospi ce											14
00 00	Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - FQHC											15
00	Hospital-Based (CMHC)											17
00	Renal Dialysis											18
00	Other							From:			o:	19
								1.00			00	1
	Cost Reporting Period (mm/dd/yyyy)							01/01/2	019	12/31	/2019	20
00	Type of Control (see instructions)							9				21
	Inpatient PPS Information					1.0	0	2.00		3.	00	
	Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fo Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting pe Enter in column 2, "Y" for yes or "N	stment, in accord r yes or "N" for 412.106(c)(2)(Pid r yes or "N" for compensated care mn 1, "Y" for yes riod occurring pr	dance with no. Is th ckle ameno no. payments s or "N" f rior to Oc	n 42 CFF nis dment for thi for no t ctober f	s for 1.	Y		Y				22.
02	reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost re Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1.	er October 1. (se requires final o port settlement? " for no, for the er 1. Enter in co e cost reporting	e instruct uncompensa (see inst e portion blumn 2, " period or	ctions) ated can truction of the 'Y" for n or af	re ns) yes ter	Ν		N				22.
03	Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no.	ds for delineatin olumn 1, "Y" for g period prior to no for the portio er October 1. (se 100 but not more	ng statist yes or "N o October on of the ee instruc than 499	tical an N" for n 1. Ente cost ctions) beds (a	reas no er as	Ν		N			Ν	22.
00	Which method is used to determine Me below? In column 1, enter 1 if date if date of discharge. Is the method reporting period different from the reporting period? In column 2, ente	of admission, 2 i of identifying th method used in th	f census ne days ir ne prior c "N" for r	days, d this d cost no.	or 3 cost			3 N				23.
			In-State Medicaid paid days 1.00	Medio	caid ble aid ys	Out-of State Medicai paid day 3.00	d M ys e		ledi ca IMO da 5.00	ys Me	Other edicaid days 6.00	_
00	If this provider is an IPPS hospital	, enter the	53		906	5.00	0	4.00		098		24.
	in-state Medicaid paid days in colum Medicaid eligible unpaid days in col out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in	n 1, in-state umn 2, olumn 3, d days in column			-				,			

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATIO	DATA	Provider CC	N: 15-0059	Period: From 01/0	1/2010	Worksh Part I	eet S-2	2
				To 12/3		Date/T	ime Pre 20 1:18	
	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medi cai d pai d days	Out-of State Medicaid eligible unpaid	Medi ca HMO da	id C ys Mee	ither di cai d days	
5.00   f this provider is an IRF, enter the in-state	1.00	2.00	3.00	4.00	5.00	41	5. 00	25.00
Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-st Medicaid eligible unpaid days in column 4, Medica HMO paid and eligible but unpaid days in column 5	tate ai d			Urban/Ri	ural S		f Geogr	
				1.0		2.		
6.00 Enter your standard geographic classification (no cost reporting period. Enter "1" for urban or "2"		at the be	ginning of	the	1			26.00
7.00 Enter your standard geographic classification (nc reporting period. Enter in column 1, "1" for urba enter the effective date of the geographic reclas	ot wage) status an or "2" for r	ural. If a		st	1			27.00
5.00 If this is a sole community hospital (SCH), enter			CH status i	n	0			35.00
effect in the cost reporting period.				Begi nn	i ng:	Endi	ng:	
6.00 Enter applicable beginning and ending dates of SC	<u>`Histatus Subs</u>	crint line	36 for num	1.C	0	2.	00	36.00
of periods in excess of one and enter subsequent	dates.	·						
7.00 If this is a Medicare dependent hospital (MDH), e is in effect in the cost reporting period.	enter the numbe	er of perio	ds MDH Stat	us	0			37.00
7.01 Is this hospital a former MDH that is eligible for accordance with FY 2016 OPPS final rule? Enter "Y instructions)								37.0
8.00 If line 37 is 1, enter the beginning and ending c greater than 1, subscript this line for the numbe enter subsequent dates.								38.00
				Y/I 1. C		۲ <i>۲</i> 2.		_
9.00 Does this facility qualify for the inpatient hosp				ume N		<u> </u>		39.00
<ul> <li>hospitals in accordance with 42 CFR §412.101(b)(2 1 "Y" for yes or "N" for no. Does the facility me accordance with 42 CFR 412.101(b)(2)(i), (ii), or or "N" for no. (see instructions)</li> <li>0.00 Is this hospital subject to the HAC program reduc "N" for no in column 1, for discharges prior to C no in column 2, for discharges on or after Octobe</li> </ul>	eet the mileage (iii)? Enter ction adjustmer October 1. Ente	e requireme in column nt? Enter " er "Y" for	nts in 2 "Y" for y Y" for yes	es or N		١	1	40.00
					V 1.00	XVIII 2.00	XI X 3.00	-
Prospective Payment System (PPS)-Capital						2.00	3.00	
5.00 Does this facility qualify and receive Capital pa with 42 CFR Section §412.320? (see instructions)	ayment for disp	proporti ona	te share in	accordance	N	Y	N	45.00
6.00 Is this facility eligible for additional payment pursuant to 42 CFR §412.348(f)? If yes, complete Pt. III.			5		N	N	N	46.00
7.00 Is this a new hospital under 42 CFR §412.300(b) F 8.00 Is the facility electing full federal capital pay Teaching Hospitals					N N	N N	N N	47.00 48.00
6.00 Is this a hospital involved in training residents	s in approved (	ME program	s? Enter "	Y" for yes	N			56.00
or "N" for no. 7.00 If line 56 is yes, is this the first cost reporti GME programs trained at this facility? Enter "Y" is "Y" did residents start training in the first for yes or "N" for no in column 2. If column 2 i "N", complete Wkst. D, Parts III & IV and D-2, Pt	'for yes or "N month of this s "Y", complet	l" for no i cost repor e Workshee	n column 1. ting period	lf column ? Enter "Y				57.00
8.00 If line 56 is yes, did this facility elect cost r defined in CMS Pub. 15-1, chapter 21, §2148? If y	reimbursement f	or physici	ans' servic	es as	N			58.00
9.00 Are costs claimed on line 100 of Worksheet A? If	<u>fyes, complete</u>	e Wkst. D-2	, Pt. I. NAHE 413.8 Y/N	35 Worksho Line		Pass-T Qualifi Crite Co	cation erion	59.00
							40	
			1.00	2.0	00	3.		

OSPI TAL	nancial Systems RIVE AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		HOSPITAL Provider CO		eriod: com 01/01/2019	u of Form CMS-2 Worksheet S-2 Part I Date/Time Pre	)
		Y/N	IME	Direct GME	IME	6/8/2020 1:18 Direct GME	pm
		1.00	2.00	3.00	4.00	5.00	1
	d your hospital receive FTE slots under ACA				0.00		61.
	ction 5503? Enter "Y" for yes or "N" for no in						
	lumn 1. (see instructions) ter the average number of unweighted primary care						61.
	Es from the hospital's 3 most recent cost reports						01.
	ding and submitted before March 23, 2010. (see						
	structions)						
	ter the current year total unweighted primary care						61.
	E count (excluding OB/GYN, general surgery FTEs, d primary care FTEs added under section 5503 of						
	A). (see instructions)						
	ter the base line FTE count for primary care						61.
	d/or general surgery residents, which is used for						
	termining compliance with the 75% test. (see structions)						
	ter the number of unweighted primary care/or						61.
	rgery allopathic and/or osteopathic FTEs in the						01.
	rrent cost reporting period. (see instructions).						
	ter the difference between the baseline primary						61.
	d/or general surgery FTEs and the current year's imary care and/or general surgery FTE counts (line						
	.04 minus line 61.03). (see instructions)						
	ter the amount of ACA §5503 award that is being						61.
	ed for cap relief and/or FTEs that are nonprimary						
Ca	re or general surgery. (see instructions)	Pro	ogram Name	Program Code	Unweighted	Unweighted	
			ogram Hamo		IME FTE Count	Direct GME	
						FTE Count	
10 00			1.00	2.00	3.00	4.00	
	the FTEs in line 61.05, specify each new program ecialty, if any, and the number of FTE residents				0.00	0.00	61.
	r each new program. (see instructions) Enter in						
	lumn 1, the program name. Enter in column 2, the						
	ogram code. Enter in column 3, the IME FTE						
	weighted count. Enter in column 4, the direct GME						
	E unweighted count. The FTEs in line 61.05, specify each expanded				0.00	0.00	61
	ogram specialty, if any, and the number of FTE				0.00	0.00	1 01.
	sidents for each expanded program. (see						
	structions) Enter in column 1, the program name.						
	ter in column 2, the program code. Enter in column the IME FTE unweighted count. Enter in column 4,						
	e direct GME FTE unweighted count.						
	V						
100	A Draviciona Affanting the Health Decourage and Co		Adminiatration			1.00	
-	A Provisions Affecting the Health Resources and Ser ter the number of FTE residents that your hospital				iod for which	0.00	62
	ur hospital received HRSA PCRE funding (see instruc			i opor tring por		0.00	1 .
	ter the number of FTE residents that rotated from a				your hospital	0.00	62.
	ring in this cost reporting period of HRSA THC prog			ons)			-
	aching Hospitals that Claim Residents in Nonprovide s your facility trained residents in nonprovider se			cost reporting	period? Enter	N	63.
	" for yes or "N" for no in column 1. If yes, comple						
				Unwei ghted	Unweighted	Ratio (col.	
				FTES	FTEs in	1/ (col . 1 +	
				Nonprovider Site	Hospi tal	col. 2))	
				1.00	2.00	3.00	1
Se	ction 5504 of the ACA Base Year FTE Residents in No	onprovi	der Settings				
ре	riod that begins on or after July 1, 2009 and befor	re June	e 30, 2010.	-	-	· ·	
	ter in column 1, if line 63 is yes, or your facilit			0.00	0.00	0. 000000	64.
	the base year period, the number of unweighted nor sident FTEs attributable to rotations occurring in						
	ttings. Enter in column 2 the number of unweighted						
	sident FTEs that trained in your hospital. Enter in	n colum	n 3 the ratio				
	(column 1 divided by (column 1 + column 2)). (see						1

	EX IDENTIFICATION D	ATA Provider C		eriod: 	Worksheet S-2 Part I	2
			To			epareo
	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	
.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column			0.00	0.00	0. 000000	, 05.
4)). (see instructions)			Unweighted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 +	
			Nonprovider Site	Hospi tal	col. 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Current beginning on or after July 1, 20		n Nonprovider Settin	gsEffective f	or cost report	ing periods	
.00 Enter in column 1 the number of u FTEs attributable to rotations or		iry care resident	0.00	0.00	0. 000000	
Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	unweighted non-prima al. Enter in column	ary care resident 3 the ratio of	Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col 4))	
Enter in column 2 the number of u FTEs that trained in your hospita	unweighted non-prima al. Enter in column column 2)). (see ir	ary care resident 3 the ratio of astructions)				
Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + 00 Enter in column 1, the program	unweighted non-prima al. Enter in column column 2)). (see ir	ary care resident 3 the ratio of astructions)	FTĔs Nonprovider	FTES in Hospital	3/ (col. 3 + col. 4)) 5.00	
Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	unweighted non-prima al. Enter in column <u>column 2)). (see ir</u> Program Name	ary care resident 3 the ratio of istructions) Program Code	FTĔs Nonprovider Site 3.00	FTES in Hospital	3/ (col. 3 + col. 4)) 5.00	
Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + .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	unweighted non-prima al. Enter in column <u>column 2)). (see ir</u> Program Name	ary care resident 3 the ratio of istructions) Program Code	FTĔs Nonprovider Site 3.00	FTES in Hospital	3/ (col. 3 + col. 4)) 5.00 0.000000	
Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + .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)	unweighted non-prima al. Enter in column <u>column 2)). (see ir</u> Program Name <u>1.00</u>	ary care resident 3 the ratio of istructions) Program Code 2.00	FTEs Nonprovi der Si te 3.00 0.00	FTES in Hospi tal 4.00 0.00	3/ (col. 3 + col. 4)) 5.00 0.000000	
Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + .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) Inpatient Psychiatric Facility Pl .00 Is this facility an Inpatient Psy Enter "Y" for yes or "N" for no. .00 If line 70 is yes: Column 1: Did recent cost report filed on or be 42 CFR 412.424(d)(1)(iii)(c)) Col program in accordance with 42 CFF Column 3: If column 2 is Y, indice	unweighted non-prima al. Enter in column <u>column 2)). (see ir</u> Program Name <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u>	ary care resident         3 the ratio of         istructions)         Program Code         2.00         2.00         (IPF), or does it contain approved GME teach         2004? Enter "Y" for the sident:         (II) Program resident:         (D)? Enter "Y" for the sident:	FTEs Nonprovi der Si te 3.00 0.00 tain an IPF subj ing program in yes or "N" for in s in a new teacl yes or "N" for i	FTES in Hospital 4.00 0.00 0.00 1.00 provider? N the most no. (see hing no.	3/ (col. 3 + col. 4)) 5.00 0.000000	0 67.
Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + .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) Inpatient Psychiatric Facility PI .00 Is this facility an Inpatient Psy Enter "Y" for yes or "N" for no. .00 If line 70 is yes: Column 1: Did recent cost report filed on or be 42 CFR 412.424(d)(1)(iii)(c)) Col program in accordance with 42 CFF	unweighted non-prima al. Enter in column <u>column 2)). (see ir</u> Program Name <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u>	ary care resident         3 the ratio of         istructions)         Program Code         2.00         2.00         (IPF), or does it contain approved GME teach         2004? Enter "Y" for the sident:         (II) Program resident:         (D)? Enter "Y" for the sident:	FTEs Nonprovi der Si te 3.00 0.00 tain an IPF subj ing program in yes or "N" for in s in a new teacl yes or "N" for i	FTES in Hospital 4.00 0.00 0.00 1.00 provider? N the most no. (see hing no.	3/ (col . 3 + col . 4)) 5.00 0.0000000	

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0059	Period: From 01/01/201 To 12/31/201	9 Date/Ti	et S-2 me Prepare <u>O 1:18 pm</u>
		1	00 2.00	3.00
6.00 If line 75 is yes: Column 1: Did the facility have an approved recent cost reporting period ending on or before November 15, 2 no. Column 2: Did this facility train residents in a new teachi CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Co indicate which program year began during this cost reporting period.	2004? Enter "Y" for yes ng program in accordan Jumn 3: If column 2 is	n the most N or "N" for ce with 42 Y,		0 76.
Long Term Care Hospital PPS			1.0	0
0.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes an 1.00 Is this a LTCH co-located within another hospital for part or a "Y" for yes and "N" for no. TEFRA Providers		ng period? Ente	r N	
<ul> <li>5.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TE</li> <li>6.00 Did this facility establish a new Other subprovider (excluded u §413.40(f)(1)(i)? Enter "Y" for yes and "N" for no.</li> </ul>	3		. N	85. 86.
7.00 Is this hospital an extended neoplastic disease care hospital c 1886(d) (1) (B) (vi)? Enter "Y" for yes or "N" for no.	lassified under sectio	n	N	87.
		V 1.00	XI X 2. 0	
Title V and XIX Services 0.00 Does this facility have title V and/or XIX inpatient hospital s	ervices? Enter "Y" for	N	Y	90.
yes or "N" for no in the applicable column. 1.00 Is this hospital reimbursed for title V and/or XIX through the		Ν	Y	91.
full or in part? Enter "Y" for yes or "N" for no in the applica 2.00 Are title XIX NF patients occupying title XVIII SNF beds (dual instructions) Enter "Y" for yes or "N" for no in the applicable	certification)? (see		N	92.
3.00 Does this facility operate an ICF/IID facility for purposes of "Y" for yes or "N" for no in the applicable column.		Ν	N	93.
4.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and applicable column.	l"N" for no in the	N	N	94.
5.00 If line 94 is "Y", enter the reduction percentage in the applic 6.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or applicable column.		0. 00 N	0.0 N	
7.00 If line 96 is "Y", enter the reduction percentage in the applic 8.00 Does title V or XIX follow Medicare (title XVIII) for the inter stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for column 1 for title V, and in column 2 for title XIX.	ns and residents post	0. 00 Y	0. 0 Y	
8.01 Does title V or XIX follow Medicare (title XVIII) for the repor C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title title XIX.			Y	98.
8.02 Does title V or XIX follow Medicare (title XVIII) for the calcu bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or " for title V, and in column 2 for title XIX.		Y	Y	98.
8.03 Does title V or XIX follow Medicare (title XVIII) for a critica reimbursed 101% of inpatient services cost? Enter "Y" for yes o for title V, and in column 2 for title XIX.			N	98.
8.04 Does title V or XIX follow Medicare (title XVIII) for a CAH rei outpatient services cost? Enter "Y" for yes or "N" for no in co in column 2 for title XIX.		d N	N	98.
8.05 Does title V or XIX follow Medicare (title XVIII) and add back Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in colu column 2 for title XIX.			Y	98.
8. 06 Does title V or XIX follow Medicare (title XVIII) when cost rei Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 column 2 for title XIX. Rural Providers		Y	Y	98.
05.00 Does this hospital qualify as a CAH? 06.00 f this facility qualifies as a CAH, has it elected the all-inc	lusive method of navma	N nt N		105. 106.
<ul> <li>00.0011 this factify qualifies as a CAH, has it elected the art-inc for outpatient services? (see instructions)</li> <li>07.001f this facility qualifies as a CAH, is it eligible for cost re training programs? Enter "Y" for yes or "N" for no in column 1. yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25</li> </ul>	imbursement for I&R (see instructions) If	N		107.
reimbursed. If yes complete Wkst. D-2, Pt. II. 08.00  s this a rural hospital qualifying for an exception to the CRN				108.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	IOSPI TAL Provi der C		eriod: rom 01/01/	2019	u of For Workshe Part I Date/Ti 6/8/202	et S-: me Pr	2 epared:
	Physi cal	Occupati onal	Speech	า	Respi r	atory	
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.	1.00 N	2.00 N	3.00 N		4. ( N		109.00
				-	1. (	00	-
110.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	'Y" for yes or	"N" for no. I	f yes,		N	1	110.00
			1.00		2. (	00	
111.00 If this facility qualifies as a CAH, did it participate in t Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ac for tele-health services.	ost reporting olumn 1 is Y, rticipating ir	period? Enter enter the column 2.	N				111.00
			-	1.00	2.00	3.00	
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percen psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y"	If column 2 nt for long te rs) based on 1 for yes or "N	is "E", enter erm care (inclu the definition W" for no.	in column des in CMS	N		0	115.00
117.00 Is this facility legally-required to carry malpractice insur no.	rance? Enter '	'Y" for yes or	"N" for	Y			117.00
118.00 Is the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	icy? Enter 1	if the policy	is	2			118.00
		Premi ums	Losses	5	Insur	ance	
		1.00	2.00		3. (		
118.01 List amounts of malpractice premiums and paid losses:		935, 894	L	0			0118.01
			1.00		2. (	00	
I18.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scheo and amounts contained therein. I19.00 D0 NOT USE THIS LINE			N				118.02
120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmer Enter in column 2, "Y" for yes or "N" for no.	ר column 1, " ualifies for ו	(" for yes or the Outpatient	N		N		120.00
121.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.	antable device	es charged to	Y				121.00
122.00 Does the cost report contain healthcare related taxes as def			N				122.00
Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.							125.0
Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for	or yes and "N'	for no. If	N				126.0
Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.	5		N				
<ul> <li>Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information</li> <li>25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>26.00 If this is a Medicare certified kidney transplant center, entin column 1 and termination date, if applicable, in column 2</li> <li>27.00 If this is a Medicare certified heart transplant center, entin center, entin column 1 and termination date.</li> </ul>	nter the certi 2. ter the certif	fication date	N				127.0
<ul> <li>Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information</li> <li>25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>26.00 If this is a Medicare certified kidney transplant center, entin column 1 and termination date, if applicable, in column 2</li> <li>27.00 If this is a Medicare certified heart transplant center, entin column 1 and termination date, if applicable, in column 2</li> <li>28.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2</li> </ul>	nter the certi 2. ter the certi1 2. ter the certi1	fication date fication date	N				
<ul> <li>Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information</li> <li>25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>26.00 If this is a Medicare certified kidney transplant center, er in column 1 and termination date, if applicable, in column 2</li> <li>27.00 If this is a Medicare certified heart transplant center, ent in column 1 and termination date, if applicable, in column 2</li> <li>28.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2</li> <li>29.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2</li> </ul>	nter the certi 2. ter the certi1 2. ter the certi1 2.	fication date fication date fication date					128.0
<ul> <li>Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information</li> <li>25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>26.00 If this is a Medicare certified kidney transplant center, entin column 1 and termination date, if applicable, in column 2</li> <li>27.00 If this is a Medicare certified heart transplant center, entin column 1 and termination date, if applicable, in column 2</li> <li>28.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2</li> <li>29.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2</li> <li>29.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2</li> <li>29.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2</li> <li>29.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.</li> <li>30.00 If this is a Medicare certified pancreas transplant center, enter</li> </ul>	nter the certi 2. ter the certif 2. ter the certif 2. er the certifi enter the cer	fication date fication date fication date cation date in					128. 0 129. 0
<ul> <li>Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information</li> <li>25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>26.00 If this is a Medicare certified kidney transplant center, ent in column 1 and termination date, if applicable, in column 2</li> <li>27.00 If this is a Medicare certified heart transplant center, ent in column 1 and termination date, if applicable, in column 2</li> <li>28.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2</li> <li>29.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.</li> <li>30.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in column 2.</li> </ul>	nter the certi 2. ter the certif 2. ter the certif er the certifi enter the cer umn 2. c, enter the cer	fication date fication date fication date cation date in tification					128.0 129.0 130.0
<ul> <li>Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information</li> <li>25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>26.00 If this is a Medicare certified kidney transplant center, er in column 1 and termination date, if applicable, in column 2</li> <li>27.00 If this is a Medicare certified heart transplant center, ent in column 1 and termination date, if applicable, in column 2</li> <li>28.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2</li> <li>29.00 If this is a Medicare certified lung transplant center, ent column 1 and termination date, if applicable, in column 2</li> <li>29.00 If this is a Medicare certified pancreas transplant center, enter column 1 and termination date, if applicable, in column 2.</li> <li>30.00 If this is a Medicare certified pancreas transplant center, enter column 1 and termination date, if applicable, in column 2.</li> <li>30.00 If this is a Medicare certified pancreas transplant center, enter column 1 and termination date, if applicable, in column 2.</li> <li>30.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in col</li> <li>31.00 If this is a Medicare certified intestinal transplant center date in column 1 and termination date, if applicable, in col</li> <li>32.00 If this is a Medicare certified intestinal transplant center date in column 1 and termination date, if applicable, in col</li> </ul>	nter the certi 2. ter the certif 2. ter the certif enter the cer umn 2. c, enter the certif umn 2. ter the certif	fication date fication date fication date cation date in rtification certification					128.0 129.0 130.0 131.0
<ul> <li>Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information</li> <li>125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>126.00 If this is a Medicare certified kidney transplant center, ent in column 1 and termination date, if applicable, in column 2</li> <li>127.00 If this is a Medicare certified heart transplant center, ent in column 1 and termination date, if applicable, in column 2</li> <li>128.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2</li> <li>128.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2</li> <li>129.00 If this is a Medicare certified lung transplant center, ente column 1 and termination date, if applicable, in column 2.</li> <li>130.00 If this is a Medicare certified pancreas transplant center, and the in column 1 and termination date, if applicable, in column 2.</li> <li>130.00 If this is a Medicare certified pancreas transplant center, and the in column 1 and termination date, if applicable, in column 2.</li> </ul>	nter the certi 2. ter the certif 2. ter the certif enter the cert umn 2. r, enter the certif ter the certif 2.	fication date fication date fication date cation date in tification certification fication date					127.00 128.00 129.00 130.00 131.00 132.00

Health Financial Systems	RI VERVI EW	HOSPI TAL			In Lieu	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provider CC	N: 15-0059		od: 1 01/01/2019 12/31/2019	Worksheet S-2 Part I Date/Time Pre 6/8/2020 1:18	epared:
		·			1.00		-
140.00 Are there any related organization chapter 10? Enter "Y" for yes or ' are claimed, enter in column 2 the	'N" for no in column 1. I	f yes, and home	office c		<u>1.00</u> Y	2.00	140.00
		00			3.00		
If this facility is part of a cha office and enter the home office	contractor name and contr		-			of the home	
141.00Name: 142.00Street:	Contractor's Name: PO Box:			actor's	Number:		141.00 142.00
143.00 Ci ty:	State:		Zip C	oue:			143.00
		1.00					
144.00 Are provider based physicians' cos	sts included in Worksheet	E A?				Y	144.00
					1.00	2.00	-
145.00 If costs for renal services are cl inpatient services only? Enter "Y" no, does the dialysis facility in period? Enter "Y" for yes or "N"	' for yes or "N" for no i clude Medicare utilizatio	n column 1. If	column 1		Y	2.00	145.00
146.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d	gy changed from the previncolumn 1. (See CMS Pub.	ously filed cos 15-2, chapter	t report? 40, §4020	) If	N		146.00
						1.00	-
147.00 Was there a change in the statisti	cal basis? Enter "Y" for	ves or "N" for	no			1.00 N	147.00
148.00 Was there a change in the order of						N	148.00
149.00 Was there a change to the simplifi	ed cost finding method?					N	149.00
		Part A 1.00	Part 2.00		Title V 3.00	Title XIX 4.00	-
Does this facility contain a prov	der that qualifies for a						
or charges? Enter "Y" for yes or						3. 13)	
155.00Hospital 156.00Subprovider - IPF		N	N		N	N	155.00
156. 00 Subprovider – TPF 157. 00 Subprovider – TRF		N	N N		N N	N N	156.00 157.00
158. 00 SUBPROVI DER							158.00
159. 00 SNF		N	N		N	N	159.00
160.00HOME HEALTH AGENCY 161.00CMHC		N	I N		N N	N N	160.00 161.00
			IN IN		IN	IN	101.00
						1.00	1
Multicampus							
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that has c	one or more camp	uses in d	ifferent	t CBSAs?	N	165.00
	Name	County	State	Zip Co	de CBSA	FTE/Campus	
	0	1.00	2.00	3.00	4.00	5.00	
166.00 If line 165 is yes, for each 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)						0.00	0166.00
						1.00	-
Health Information Technology (HI	T) incentive in the Ameri	can Recovery an	nd Reinves	stment A	ct	1.00	
167.00 Is this provider a meaningful user 168.00 If this provider is a CAH (line 10	under §1886(n)? Enter	"Y" for yes or	"N" for n	0.		Y	167.00 168.00
reasonable cost incurred for the H 168.01 If this provider is a CAH and is n	not a meaningful user, do	bes this provide			nardshi p		168. 01
exception under §413.70(a)(6)(ii)' 169.00 If this provider is a meaningful of transition factor. (see instruction	user (line 167 is "Y") ar				), enter the	9.9	9169.00
					Begi nni ng	Endi ng	
170.00 Enter in columns 1 and 2 the EHR I	peginning date and ending	g date for the r	eporti ng		1.00	2.00	170.00
period respectively (mm/dd/yyyy)							

Health Financial Systems						
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA	Provider CCN: 15-0059	Period: From 01/01/2019	Worksheet S	5-2	
			To 12/31/2019			
			1.00	2.00		
171.00 If line 167 is "Y", does this provid	er have any days for indiv	viduals enrolled in	N		0171.00	
section 1876 Medicare cost plans rep						
"Y" for yes and "N" for no in column	on					
1876 Medicare days in column 2. (see	instructions)					

OSPI T	Financial Systems RIVERVIEW F AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-0059	Period:	u of Form CMS Worksheet S-	
				From 01/01/2019 To 12/31/2019	Part II Date/Time Pr 6/8/2020 1:1	epared
				Y/N	Date	
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N	lfor all NO r	esponses. En	ter all dates in	the	
	mm/dd/yyyy format.					-
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					-
. 00	Has the provider changed ownership immediately prior to the	beginning of	the cost	N		1.0
. 00	reporting period? If yes, enter the date of the change in c	column 2. (see	instruction			
			Y/N	Date	V/I	
	1		1.00	2.00	3.00	
. 00	Has the provider terminated participation in the Medicare P yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2.0
. 00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of of directors through ownership, control, or family and othe relationships? (see instructions)	offices, drug der or its of the board	N			3. (
			Y/N	Туре	Date	
			1.00	2.00	3.00	
. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	°or Compiled,	Y	A	07/30/2020	4.0
. 00	Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		N			5.
				Y/N	Legal Oper.	_
	Approved Educational Activities			1.00	2.00	-
. 00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2:	lfves ist	he provider	is N		6.0
. 00	the legal operator of the program?	11 300, 10 1				0.1
. 00 . 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved		d during the	Y N		7. 8.
. 00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cal education	n N		9. (
0.00	Was an approved Intern and Resident GME program initiated o cost reporting period? If yes, see instructions.	or renewed in	the current	Ν		10.
1. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an Ap	proved	Ν		11.
				-	Y/N 1.00	
	Bad Debts				1.00	
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p			cost reporting	Y N	12. 13.
4.00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? I	f yes, see i	nstructions.	Ν	14.
5.00	Did total beds available change from the prior cost reporti	<u> </u>	<u>yes, see in</u> t A	structions. Par	N	15.
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
6. 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)	Ν		N		16.
7.00	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	Y	03/27/2020	) Y	03/27/2020	17.
8. 00	in columns 2 and 4. (see instructions) 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	Ν		N		18.
	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R	Ν		N		19.

	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN	: 15-0059	Period: From 01/01/20 To 12/31/20		Prepared		
		Descri p	tion	Y/N	Y/N			
		0		1.00	3.00			
0. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			Ν	N	20.0		
		Y/N	Date	Y/N	Date			
		1.00	2.00	3.00	4.00			
1.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.0		
					1.00			
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS HO	SPI TALS)					
	Capital Related Cost							
2.00	Have assets been relifed for Medicare purposes? If yes, see					22.0		
3.00	Have changes occurred in the Medicare depreciation expense	due to appraisa	ls made du	ring the cost		23.0		
	reporting period? If yes, see instructions.							
4.00	Were new leases and/or amendments to existing leases entere	ed into during t	his cost r	eporting perio	od?	24.0		
- 00	If yes, see instructions	the east ward i	Ing need of					
5.00	Have there been new capitalized leases entered into during instructions.	the cost report	ing period	r i i yes, see		25.0		
6. 00		he cost reportin	a neriod?	lfves see		26.0		
0.00	0 Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.							
7.00	Has the provider's capitalization policy changed during the	e cost reporting	period? I	fyes, submit		27.0		
	сору.		•	5				
	Interest Expense							
3.00	Were new loans, mortgage agreements or letters of credit er	ntered into duri	ng the cos	t reporting		28.		
	period? If yes, see instructions.					29.		
. 00								
0. 00	treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled mate		oht? If vo	5 500		30.		
J. 00	instructions.	unity with new u	ebt: II ye	5, 566		30.		
1.00	Has debt been recalled before scheduled maturity without is	ssuance of new d	ebt?lf ve	s. see		31.		
	instructions.		5					
	Purchased Servi ces							
2.00	Have changes or new agreements occurred in patient care ser		through c	ontractual		32.0		
0 00	arrangements with suppliers of services? If yes, see instru							
3.00	If line 32 is yes, were the requirements of Sec. 2135.2 app	piled pertaining	το compet	itive bidding?	΄ I Π	33.		
	no, see instructions. Provider-Based Physicians							
1 00	Are services furnished at the provider facility under an a	rrangement with	nrovi der-h	ased physician	15?	34.		
1. 00	If yes, see instructions.	i angemente wi th				01.		
5.00	If line 34 is yes, were there new agreements or amended exi	isting agreement	s with the	provi der-base	ed	35.		
	physicians during the cost reporting period? If yes, see in	nstructions.		<u> </u>				
				Y/N	Date			
				1.00	2.00			
	Home Office Costs				1	24		
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pu	ronarod by the b	ome office	2		36. 37.		
	If the solid yes, has a nome office cost statement been pr If yes, see instructions.	i epai eu by the h	one office	1		37.		
7.00		fice different f	rom that o	f		38		
7.00	If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year end			f		38.		
7.00 8.00	If line 36 is yes , was the fiscal year end of the home of	d of the home of	fice.					
7.00 3.00 9.00	If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions.	d of the home of er chain compone	fice. nts? If ye	S,		39.		
7.00 3.00 9.00	If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the	d of the home of er chain compone	fice. nts? If ye	S,		39.		
7.00 3.00 9.00	If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions.	d of the home of er chain compone	fice. nts? If ye	S,		39. (		
7.00 3.00 9.00	If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the	d of the home of er chain compone home office? I	fice. nts? If ye f yes, see	S,	2.00	39. (		
7.00 3.00 9.00	If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the instructions.	d of the home of er chain compone	fice. nts? If ye f yes, see	S,	2.00	39.		
7.00 3.00 9.00 0.00	If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information	d of the home of er chain compone home office? I 1.00	fice. nts? If ye f yes, see	s,	2.00	39.0		
7.00 3.00 9.00 0.00	If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information	d of the home of er chain compone home office? I	fice. nts? If ye f yes, see	S,	2.00	39.0		
7.00 3.00 9.00 0.00	If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position	d of the home of er chain compone home office? I 1.00	fice. nts? If ye f yes, see	s,	2.00	39.0		
7.00 3.00 9.00 0.00	If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	d of the home of er chain compone home office? I 1.00	fice. nts? If ye f yes, see	s,	2.00	39. ( 40. ( 41. (		
7.00 8.00 9.00	If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	d of the home of er chain compone home office? I 1.00	fice. nts? If ye f yes, see	s,	2.00	38. ( 39. ( 40. ( 41. ( 41. ( 42. (		

Health Financial Systems	RI VERVI EW	HOSPI TAL	In Lieu	In Lieu of Form CMS-2552-10		
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSE	MENT QUESTI ONNAI RE	Provider CCN: 15-0059	Period: From 01/01/2019 To 12/31/2019	Date/Time Pre	pared:	
				6/8/2020 1:18	pm	
		3.00	_			
Cost Report Preparer Contact Informa	tion					
41.00 Enter the first name, last name and		MANAGER			41.00	
held by the cost report preparer in	columns 1, 2, and 3,					
respecti vel y.						
42.00 Enter the employer/company name of t	he cost report				42.00	
preparer.						
43.00 Enter the telephone number and email					43.00	
report preparer in columns 1 and 2,	respecti vel y.					

	Financial Systems	RIVERVIEW H		CN 15 0050		u of Form CMS-2	
HUSPI	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C		Period: From 01/01/2019	Worksheet S-3 Part I	
					To 12/31/2019		
						I/P Days /	pin
						0/P Visits /	
						Tri ps	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number	2.00	Available	4.00	F 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	1.00	2.00	<u>3.00</u> 40,15	4.00	5.00	1.00
1.00	8 exclude Swing Bed, Observation Bed and	50.00	110	40,10	0.00	0	1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO I PF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation		110	40, 15	0.00	0	7.00
0 00	beds) (see instructions)	31.00	15	E 47	E 0.00	0	0.00
8.00 9.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T	31.00	15	5, 47	0.00	0	8.00 9.00
10.00	BURN I NTENSI VE CARE UNI T						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		125	45, 62	5 0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	24	8, 76	0	0	17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY	44.00	25	9, 12	5	0	19.00
20.00	NURSI NG FACI LI TY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00 23.00
23.00 24.00	AMBULATORY SURGI CAL CENTER (D. P. ) HOSPI CE						23.00
24.00	HOSPICE (non-distinct part)	30, 00					24.00
25.00	CMHC - CMHC	50.00					25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		174				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0		0		32.00
32.01	Total ancillary labor & delivery room						32.01
22.02	outpatient days (see instructions)						22.00
33.00	LTCH non-covered days						33.00
33. UI	LTCH site neutral days and discharges	I			I		33.01

Component         I/P Days / 0/P Visits / Trips         Full Time Equivalents           Title XVIII         Title XVIII         Total AII Patients         Total Interns & Residents         Employees / Payroli           1.00         Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and bospice days)(see instructions for col. 2 for the portion of LDP room available beds)         5, 172         519         12, 240         9.00         10.00           0.00         HM0 and other (see instructions)         6, 00         212         0         0         0         0           0.00         HM0 ints & Peds. Swing Bed SNF         0         0         0         0         0         0           0.00         HM0 ints & Adults & Peds. Swing Bed SNF         0 <th>PI TAL</th> <th>L AND HOSPITAL HEALTH CARE COMPLEX STATISTIC</th> <th>AL DATA</th> <th>Provider CC</th> <th>F</th> <th>eriod: rom 01/01/2019 o 12/31/2019</th> <th></th> <th>pare</th>	PI TAL	L AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	F	eriod: rom 01/01/2019 o 12/31/2019		pare
Image: Construction of the spectral adult is & Peds. (columns 5, 6, 7 and beck). (columns 6, 7, 10, 12, 240         Patients         & Residents         'Payrol 1           00         Hospital Adult is & Peds. (columns 5, 6, 7 and hospital doubles). (columns 6, 0, 2). (columns 6, 2, 10, 2). (columns 6, 2). (			I/P Days	/ O/P Visits	/ Trips	Full Time I		
6.00         7.00         8.00         9.00         10.00           0.00         Hospital Adults & Peds. (columns 5, 6, 7 and B exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LOP room available beds)         5172         519         12,240           0.01         HM0 and other (see instructions for col. 2 for the portion of LOP room available beds)         0         0         0           0.01         HM0 and other (see instructions)         4,087         1,892         0         0           0.01         HM0 IRF Subprovider         0         0         0         0         0           0.01         Hospital Adults & Peds. Swing Bed SNF         0         0         0         0         0         0           0.01         Total Adults and Peds. (exclude observation beds) (see instructions)         5,172         519         12,240         0         0         0         0         0         0         0         0         0         0         0         0         0         0         1,470         0         3,317         0         0         0         0         1,125         0         0         0         0         0         0         0         0         0         0         0         0         0		Component	Title XVIII	Title XIX				
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) 00         5,172         519         12,240           00         HM0 and other (see instructions)         4,087         1,892           00         HM0 RS Subprovider         0         0           00         HM0 IPF Subprovider         0         0           00         INTENSI WE CARE UNIT         1,470         0         3,317           00         DURGICAL INTENSIVE CARE UNIT         1,470         0         1,421           1.0         DURGICAL INTENSIVE CARE UNIT         1,470         0         1,421           1.0         SUBROVIDER - IPF         0         0         0         0           1.00         SUBPROVIDER - IRF         3,334         95 </th <th></th> <th></th> <th>6.00</th> <th>7.00</th> <th></th> <th></th> <th></th> <th></th>			6.00	7.00				
00       HW0 and other (see instructions)       4,087       1,892         00       HW0 IPF Subprovider       0       0         00       How IRF Subprovider       0       0         00       How IRF Subprovider       0       0         00       Hospital Adults & Peds. Swing Bed SNF       0       0       0         00       Hospital Adults & Peds. Swing Bed SNF       0       0       0         00       Hospital Adults and Peds. (exclude observation beds) (see instructions)       5,172       519       12,240         00       INTENSI VE CARE UNIT       1,470       0       3,317       0         00       INTENSI VE CARE UNIT       1,470       0       3,317         00       INTENSI VE CARE UNIT       1,470       0       1,421         00       NURSERY       0       1,421       0         00       NURSERY       0       0       0       0         1.00       SUBPROVIDER - IFF       0       0       0       0         1.00       SUBPROVIDER - IFF       3,334       95       5,586       0.00       24         8.00       SUBPROVIDER - IFF       3,334       95       5,586       0.00       24<	8 H	B exclude Swing Bed, Observation Bed and lospice days)(see instructions for col. 2					10.00	1
00         Hospital Adults & Peds. Swing Bed SNF         0         0           00         Hospital Adults & Peds. Swing Bed NF         0         0           00         Total Adults & Peds. (sec) Ide observation         5, 172         519         12, 240           00         INTENSIVE CARE UNIT         1, 470         0         3, 317           00         UNTENSIVE CARE UNIT         1, 470         0         3, 317           00         BURN INTENSIVE CARE UNIT         0         0         1, 421           00         OTHER SPECIAL CARE (SPECIFY)         0         1, 421           00         OTHER SPECIAL CARE (SPECIFY)         0         1, 421           00         OTHER SPECIAL CARE (SPECIFY)         0         0         1, 125           00         OTHER SPECIAL CARE (SPECIFY)         0         0         1, 125           00         OTHER SPECIAL CARE (SPECIFY)         0         0         1, 125           00         DUBROVIDER - IPF         0         0         0         24           00         SUBPROVIDER - IRF         3, 334         95         5, 586         0.00         24           00         SUBPROVIDER - IRF         3, 334         95         5, 586         0.00 <td>о  н</td> <td>MO and other (see instructions)</td> <td>4, 087 0</td> <td></td> <td></td> <td></td> <td></td> <td>2</td>	о  н	MO and other (see instructions)	4, 087 0					2
00       Hospital Adults & Peds. Swing Bed NF       0       0         00       Total Adults and Peds. (exclude observation beds) (see instructions)       5,172       519       12,240         00       INTENSI VE CARE UNIT       1,470       0       3,317         00       OCRORNARY CARE UNIT       1,470       0       3,317         00       UNTENSI VE CARE UNIT       1,470       0       1,421         00       OURSERY       0       1,421       0         00       NURSERY       0       1,421       0         00       SUBROVIDER - IPF       0       0       0         00       SUBPROVIDER - IRF       0       0       0         00       SUBPROVIDER - IRF       3,334       95       5,586       0.00       24         00       SUBROVIDER - IRF       2,172       0       3,010       0.00       0         00       SUBROVIDER       1       2,172       0       3,010       0.00       0         00       OHABULATORY SURGICAL CENTER (D.P.)       209       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0			0	212				4
00       Total Adults and Peds. (exclude observation beds) (see instructions)       5,172       519       12,240         00       INTENSIVE CARE UNIT       1,470       0       3,317         00       BURN INTENSIVE CARE UNIT       1,470       0       3,317         00       OTHER SPECIAL CARE (SPECIFY)       0       1,421         00       OTHER SPECIAL CARE (SPECIFY)       0       0       1,421         00       OTHER SPECIAL CARE (SPECIFY)       0       0       0       0         00       OTHER SPECIAL CARE (SPECIFY)       0       0       0       0         00       OTHER SPECIAL CARE (SPECIFY)       0       0       0       1,421         00       OTHER SPECIAL CARE (SPECIFY)       0       0       0       0         00       SUBPROVIDER - IPF       0       0       0       0         00       SUBPROVIDER - IRF       3,334       95       5,586       0.00       24         00       SUBPROVIDER       1,722       0       3,010       0.00       0         00       SUBPROVIDER       1,722       0       3,010       0.00       0         00       OHREALTH AGENCY       2,172       0       <	о Н	lospital Adults & Peds. Swing Bed SNF	0	-				5
00       INTENSIVE CARE UNIT       1,470       0       3,317         00       CORONARY CARE UNIT       1,470       0       3,317         00       BURN INTENSIVE CARE UNIT       1,470       0       3,317         00       SURGICAL INTENSIVE CARE UNIT       0       1,421         00       OTHER SPECIAL CARE (SPECIFY)       0       1,421         00       Total (see instructions)       6,642       519       16,978       0.00         00       SUBPROVIDER - IPF       0       0       0       0       0         00       SUBPROVIDER - IRF       3,334       95       5,586       0.00       24         00       SUBPROVIDER - IRF       3,334       95       5,586       0.00       24         00       SUBPROVIDER - IRF       3,334       95       5,586       0.00       24         00       SUBPROVIDER       3,310       0.00       0       0       0       0         00       SUBPROVIDER       3,334       95       5,586       0.00       24         00       SUBPROVIDER       3,010       0.00       0       0         00       MURALING TERCARE       0       0       0 <td>о  т</td> <td>otal Adults and Peds. (exclude observation</td> <td>5, 172</td> <td>-</td> <td>-</td> <td></td> <td></td> <td>6</td>	о  т	otal Adults and Peds. (exclude observation	5, 172	-	-			6
1.00       SURGICAL INTENSIVE CARE UNIT         2.00       OTHER SPECIAL CARE (SPECIFY)         3.00       NURSERY         4.00       Total (see instructions)         6.642       519         5.00       CAH visits         00       SUBPROVIDER - IPF         00       SUBPROVIDER - IRF         00       SUBPROVIDER - IRF         00       SUBPROVIDER - IRF         00       SUBPROVIDER         00       OTHER LONG TERM CARE         00       OHADE TERM CARE         00       OMADULATORY SURGICAL CENTER (D. P. )         00       MURAL HEALTH CLINIC         00       CMCMC - CMHC </td <td>0   I 0   C</td> <td>NTENSI VE CARE UNI T CORONARY CARE UNI T</td> <td>1, 470</td> <td>0</td> <td>3, 317</td> <td></td> <td></td> <td>8</td>	0   I 0   C	NTENSI VE CARE UNI T CORONARY CARE UNI T	1, 470	0	3, 317			8
1.00       NURSERY       0       1,421         .00       Total (see instructions)       6,642       519       16,978       0.00       1,125         .00       CAH visits       0       0       0       0       0       0         .00       SUBPROVI DER - IPF       0       0       0       0       0       0         .00       SUBPROVI DER - IRF       3,334       95       5,586       0.00       24         .00       SUBROVI DER       IRF       3,334       95       5,586       0.00       0         .00       SKI LLED NURSI NG FACI LITY       2,172       0       3,010       0.00       0         .00       SKI LLED NURSI NG FACI LITY       2,172       0       3,010       0.00       0         .00       OTHER LONG TERM CARE	00 S	SURGICAL INTENSIVE CARE UNIT						10   11   12
0.00       CAH visits       0       0       0       0         0.00       SUBPROVIDER - IFF       3,334       95       5,586       0.00       24         0.00       SUBPROVIDER       3,334       95       5,586       0.00       24         0.00       SUBPROVIDER       2,172       0       3,010       0.00       0         0.00       NURSING FACILITY       2,172       0       3,010       0.00       0         0.00       HEALTH AGENCY       2,172       0       3,010       0.00       0         0.00       HOME HEALTH AGENCY       209       209       209       209       209       209       209       209       200       200       200       200       200       200       200       200       2,702       200				0	1, 421			13
0.00       SUBPROVIDER - IPF       3,334       95       5,586       0.00       24         0.00       SUBPROVIDER       3,010       0.00       24         0.00       SKILED NURSING FACILITY       2,172       0       3,010       0.00       0.00         0.00       HOME HEALTH AGENCY       2,172       0       3,010       0.00       0.00         0.00       HOME HEALTH AGENCY       209       209       209       209       209         0.00       CMHC - CMHC       209       209       0.00       0.00       0.00       0.00         0.00       CMHC - CMHC       209       0.00       0.00       0.00       0.00       0.00       0.0							1, 125. 54	
1.00       SUBPROVIDER - IRF       3,334       95       5,586       0.00       24         1.00       SUBPROVIDER       2,172       0       3,010       0.00       0         1.00       SVILLED NURSING FACILITY       2,172       0       3,010       0.00       0         1.00       NURSING FACILITY       2,172       0       3,010       0.00       0         1.00       OTHER LONG TERM CARE			0	0	0			15
.00SUBPROVIDER.00SKILLED NURSING FACILITY2,17203,0100.00000NURSING FACILITY2,17203,0100.00000OTHER LONG TERM CARE			3 334	95	5 586	0.00	24.07	16
.00NURSING FACILITY.00OTHER LONG TERM CARE.00HOME HEALTH AGENCY.00AMBULATORY SURGICAL CENTER (D. P. ).00HOSPICE.00HOSPICE (non-distinct part).00CMHC - CMHC.00RURAL HEALTH CLINIC.25FEDERALLY QUALIFIED HEALTH CENTER.00Doservation Bed Days.00Ambulance Trips.00Employee di scount days (see instruction).00Employee di scount days (see instructions).00Labor & delivery days (see instructions).00Labor & delivery days (see instructions).00Labor & delivery days (see instructions)			5, 554	75	3, 300	0.00	24.07	18
.00OTHER LONG TERM CAREImage: Construction of the second constructio		SKILLED NURSING FACILITY	2, 172	0	3, 010	0.00	0.00	
P. 00HOME HEALTH AGENCY8. 00AMBULATORY SURGICAL CENTER (D. P. )4. 00HOSPICE4. 10HOSPICE (non-distinct part)5. 00CMHC - CMHC5. 00RURAL HEALTH CLINIC5. 00RURAL HEALTH CLINIC5. 25FEDERALLY QUALIFIED HEALTH CENTER6. 00Observation Bed Days6. 00Observation Bed Days6. 00Employee discount days (see instruction)6. 00Employee discount days (see instructions)6. 00Labor & delivery days (see instructions)6. 001277246								20
B. 00AMBULATORY SURGICAL CENTER (D. P. )4. 00HOSPICE4. 10HOSPICE (non-distinct part)5. 00CMHC - CMHC5. 00RURAL HEALTH CLINIC5. 00RURAL HEALTH CLINIC5. 25FEDERALLY QUALIFIED HEALTH CENTER6. 00Total (sum of lines 14-26)6. 00Observation Bed Days7. 00Ambulance Trips7. 00Employee discount days (see instruction)7. 00Employee discount days (see instructions)7. 00Labor & delivery days (see instructions)7. 001277. 00246								21
A. 00HOSPICE4. 10HOSPICE (non-distinct part)5. 00CMHC - CMHC5. 00RURAL HEALTH CLINIC5. 00RURAL HEALTH CLINIC5. 25FEDERALLY QUALIFIED HEALTH CENTER6. 00Total (sum of lines 14-26)7. 00Total (sum of lines 14-26)7. 00Observation Bed Days7. 00Ambulance Trips7. 00Employee discount days (see instruction)7. 00Employee discount days - IRF7. 00Labor & delivery days (see instructions)7. 001277. 246								22
10HOSPICE (non-distinct part)20900CMHC - CMHC20900RURAL HEALTH CLINIC25FEDERALLY QUALIFIED HEALTH CENTER000Total (sum of lines 14-26)000Observation Bed Days000Ambulance Trips000Employee discount days (see instruction)000Labor & delivery days (see instructions)000Labor & delivery days (see instructions)0								24
A. 00CMHC - CMHCA. 00CMHC - CMHCA. 000. 00RURAL HEALTH CLINIC00002. 25FEDERALLY QUALIFIED HEALTH CENTER00000. 00Total (sum of lines 14-26)00000. 00Observation Bed Days02,70201,1490. 00Ambulance Trips00000. 00Employee discount days (see instruction)00000Labor & delivery days (see instructions)0127246					209			24
.25FEDERALLY QUALIFIED HEALTH CENTER0000.000.00Total (sum of lines 14-26)00001,149.00Observation Bed Days002,7021.00Ambulance Trips0001.00Employee discount days (see instruction)000.00Employee discount days - IRF001.00Labor & delivery days (see instructions)0127246	00 C	CMHC - CMHC						25
Total (sum of lines 14-26)0.0000Observation Bed Days00.00Ambulance Trips00.00Employee discount days (see instruction)000Employee discount days - IRF000Labor & delivery days (see instructions)0100Labor & delivery days (see instructions)0								26
B. 00Observation Bed Days02,7020. 00Ambulance Trips000. 00Employee discount days (see instruction)0. 00Employee discount days - LRF00. 00Labor & delivery days (see instructions)0120127246			0	0	0			
0.00Ambulance Trips00.00Employee discount days (see instruction)0.00Employee discount days - LRF000Labor & delivery days (see instructions)0127246				0	0 700		1, 149. 61	
.00Employee discount days (see instruction)0.00Employee discount days - LRF0.00Labor & delivery days (see instructions)0127.246			0	0	2, 702			28
.00     Employee discount days - IRF     0       .00     Labor & delivery days (see instructions)     0     127     246		1	0		0			30
2. 00 Labor & delivery days (see instructions) 0 127 246								31
			О	127	246			32
	01   T	otal ancillary labor & delivery room						32
outpatient days (see instructions)								
3. 00     LTCH non-covered days     0       3. 01     LTCH site neutral days and discharges     0			Ű					33

	Financial Systems FAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	RIVERVIEW HO	Provi der C	CN: 15-0059	Peri od:	u of Form CMS-2 Worksheet S-3	
					From 01/01/2019 To 12/31/2019	Part I	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00 2.00	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) HMO and other (see instructions)		0		44 441	3, 995	1.00
3.00 4.00 5.00	HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF				0 20		3.00 4.00 5.00
6.00 7.00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)						6. 00 7. 00
8.00 9.00 10.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T BURN I NTENSI VE CARE UNI T						8.00 9.00 10.00
11.00 12.00 13.00	SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY) NURSERY						11.00 12.00 13.00
14.00 15.00 16.00	Total (see instructions) CAH visits SUBPROVIDER - IPF	0.00	0	1, 5	38 82	3, 995	14.00 15.00 16.00
17.00 18.00	SUBPROVI DER – I RF SUBPROVI DER	0.00	0	30	7 7	489	17.00 18.00
19.00 20.00 21.00 22.00	SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY	0.00					19.00 20.00 21.00 22.00
23.00 24.00 24.10	AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part)						23.00 23.00 24.00 24.10
25.00 26.00 26.25	CMHC – CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	0. 00					25.00 26.00 26.25
27. 00 28. 00	Total (sum of lines 14-26) Observation Bed Days	0.00					27.00 28.00
29.00 30.00 31.00 32.00 32.01	Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room						29.00 30.00 31.00 32.00 32.01
33. 00 33. 01	outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges				0		33. 00 33. 01

SPI T	AL WAGE INDEX INFORMATION			Provider C		Period: From 01/01/2019 To 12/31/2019		pare
		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst. A-6)	Adj usted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	PART II - WAGE DATA	1.00	2.00	3.00	4.00	5.00	6.00	
	SALARIES							
00	Total salaries (see instructions)	200.00	81, 435, 616	225, 979	81, 661, 59	5 2, 391, 183. 00	34. 15	1
00	Non-physician anesthetist Part A		0	0	(	0.00	0.00	2
00	Non-physician anesthetist Part		0	0	(	0.00	0.00	3
0	Physician-Part A - Administrative		0	0	(	0.00	0.00	4
)1	Physicians - Part A - Teaching		0	0		0.00		
00	Physician and Non Physician-Part B		0	0		0.00		
00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0		0.00		
00	Interns & residents (in an approved program)	21.00	0	0	(	0.00	0.00	7
D1	Contracted interns and residents (in an approved programs)		0	0	(	0.00	0.00	7
00	Home office and/or related organization personnel		0	0		0.00	0.00	8
00	SNĚ	44.00	0	0	(	0.00		
00	Excluded area salaries (see instructions) OTHER WAGES & RELATED COSTS		27, 106, 951	310, 173	27, 417, 12	4 601, 784. 00	45.56	10
00	Contract Labor: Direct Patient Care		494, 193	0	494, 193	3 5, 615. 00	88. 01	11
00	Contract labor: Top level management and other management and administrative services		0	0	(	0.00	0. 00	12
00	Contract Labor: Physician-Part A - Administrative		585, 781	0	585, 78	1 4, 416. 00	132.65	13
00	Home office and/or related organization salaries and wage-related costs		0	0	(	0.00	0. 00	14
01	Home office salaries		0	0	(	0.00	0.00	14
02	Related organization salaries		0	0		0.00		
00	Home office: Physician Part A - Administrative		0	0		0.00	0.00	15
00	Home office and Contract Physicians Part A - Teaching WAGE-RELATED COSTS		0	0	(	0.00	0.00	16
00	Wage-related costs (core) (see instructions)		12, 386, 250	0	12, 386, 250	C		17
00	Wage-related costs (other) (see instructions)							18
00 00	Excluded areas Non-physician anesthetist Part		4, 912, 116 0	0	4, 912, 110	6		19 20
00	A Non-physician anesthetist Part		0	0				21
00	B Physician Part A -		0	   0		D		22
01	Administrative Physician Part A - Teaching		0			0		22
	Physician Part B		0	0		5		23
00	Wage-related costs (RHC/FQHC) Interns & residents (in an		0	0				24 25
50	approved program) Home office wage-related		0	0				25
51	(core) Related organization		0	0		c		25
52	wage-related (core) Home office: Physician Part A		0	0		c		25
53	- Administrative - wage-related (core) Home office & Contract		0	0		D		25
	Physicians Part A - Teaching - wage-related (core)		Ū					

Heal th	Financial Systems		RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider C		Period: From 01/01/2019 To 12/31/2019		pared:
		Wkst. A Line	Amount	Recl assi fi cat	Adj usted	Paid Hours	Average	
		Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from Wkst.	3)	col. 4	col. 5)	
				A-6)				
		1.00	2.00	3.00	4.00	5.00	6.00	
	OVERHEAD COSTS - DIRECT SALARI				1	1		
26.00	Employee Benefits Department	4.00	542, 325		542, 32			
27.00	Administrative & General	5.00	9, 095, 871					
28.00	Administrative & General under		669, 546	0	669, 54	6 2, 830. 00	236. 59	28.00
	contract (see inst.)							
29.00	Maintenance & Repairs	6.00	0	0		0.00		29.00
30.00	Operation of Plant	7.00	2, 124, 270	0	2, 124, 27	0 79, 499. 00	26. 72	30.00
31.00	Laundry & Linen Service	8.00	66, 038	0	66, 03	8 4, 218. 00	15.66	31.00
32.00	Housekeepi ng	9.00	1, 183, 697	0	1, 183, 69	7 85, 227. 00	13.89	32.00
33.00	Housekeeping under contract		0	0		0.00	0.00	33.00
	(see instructions)							
34.00	Dietary	10.00	1, 309, 433	-1, 021, 881	287, 55	2 29, 639. 00		34.00
35.00	Dietary under contract (see		0	0		0.00	0.00	35.00
	instructions)							
36.00	Cafeteri a	11.00	0	937, 973	937, 97	3 48, 422. 00	19.37	36.00
37.00	Maintenance of Personnel	12.00	0	0		0.00	0.00	37.00
38.00	Nursing Administration	13.00	390, 934	0	390, 93	4 8, 738. 00	44.74	38.00
39.00	Central Services and Supply	14.00	614, 474	0	614, 47	4 29, 434. 00	20. 88	39.00
40.00	Pharmacy	15.00	2, 924, 746	-226, 265	2, 698, 48	1 75, 476. 00	35.75	40.00
41.00	Medical Records & Medical	16.00	819, 036		819, 03	6 32, 923. 00	24.88	41.00
	Records Library							
42.00	Social Service	17.00	646, 305	0	646, 30	5 18, 785. 00	34.41	42.00
43.00	Other General Service	18.00	0	0		0 0.00	0.00	43.00

Heal th	Financial Systems		RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI 1	AL WAGE INDEX INFORMATION			Provider C		Period: From 01/01/2019 To 12/31/2019		pared:
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Paid Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY			_			
1.00	Net salaries (see		82, 105, 162	225, 979	82, 331, 14	1 2, 394, 013. 00	34.39	1.00
	instructions)							
2.00	Excluded area salaries (see		27, 106, 951	310, 173	27, 417, 12	4 601, 784. 00	45.56	2.00
	instructions)							
3.00	Subtotal salaries (line 1		54, 998, 211	-84, 194	54, 914, 01	7 1, 792, 229. 00	30.64	3.00
	minus line 2)							
4.00	Subtotal other wages & related		1, 079, 974	0	1, 079, 97	4 10, 031. 00	107.66	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		12, 386, 250	0	12, 386, 25	0.00	22.56	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		68, 464, 435	-84, 194	68, 380, 24	1 1, 802, 260. 00	37.94	6.00
7.00	Total overhead cost (see		20, 386, 675	-576, 284	19, 810, 39	1 749, 955. 00	26.42	7.00
	instructions)							
		·			•			•

	Financial Systems	RI VERVI EW HOSP				u of Form CMS-2	
OSPI T	AL WAGE RELATED COSTS	ſ	Provider CCN:	15-0059	Period: From 01/01/2019	Worksheet S-3 Part IV	
						Date/Time Pre	pared.
						6/8/2020 1:18	
						Amount	· · · · ·
						Reported	
						1.00	
	PART IV - WAGE RELATED COSTS						
	Part A - Core List						
	RETIREMENT COST						
. 00	401K Employer Contributions					1, 184, 503	1.00
. 00	Tax Sheltered Annuity (TSA) Employer Contribut					0	2.00
. 00	Nonqualified Defined Benefit Plan Cost (see in	nstructions)				0	3.00
. 00	Qualified Defined Benefit Plan Cost (see instr	ructions)				0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Or	rgani zati on)					
. 00	401K/TSA Plan Administration fees					0	5.00
. 00	Legal /Accounting/Management Fees-Pension Plan					0	6.0
. 00	Employee Managed Care Program Administration F	ees				0	7.0
	HEALTH AND INSURANCE COST						1
. 00	Health Insurance (Purchased or Self Funded)					0	8.0
01	Health Insurance (Self Funded without a Third	Party Administra	or)			0	8.0
. 02	Health Insurance (Self Funded with a Third Par					0	8.0
. 03	Health Insurance (Purchased)	5				9, 998, 645	8.0
. 00	Prescription Drug Plan					0	
0.00	Dental, Hearing and Vision Plan					235, 726	10.0
1.00	Life Insurance (If employee is owner or benefi	ci arv)				46, 707	
2.00	Accident Insurance (If employee is owner or be					0	
3.00	Disability Insurance (If employee is owner or					0	
4.00	Long-Term Care Insurance (If employee is owner					317, 853	
5.00	'Workers' Compensation Insurance					47,074	
6.00	Retirement Health Care Cost (Only current year	not the extraor	dinary accru	al requir	ed by FASB 106	0	
0.00	Non cumulative portion)		undig doore	ai i oqui i		Ū	
	TAXES						1
7.00	FICA-Employers Portion Only					5, 413, 888	17.0
8.00	Medicare Taxes - Employers Portion Only					0	
9.00	Unemployment Insurance					8, 193	
	State or Federal Unemployment Taxes					0,1,0	
0.00	OTHER						20.0
1 00	Executive Deferred Compensation (Other Than Re	tirement Cost Rer	orted on lir	les 1 thro	ugh 4 above (see	0	21.0
1.00	instructions))				ugii 4 ubove. (3ee	, U	21.0
2.00	Day Care Cost and Allowances					0	22.0
3.00	Tuition Reimbursement					45, 777	
	Total Wage Related cost (Sum of lines 1 -23)					17, 298, 366	
4.00	Part B - Other than Core Related Cost					17,270,300	24.0
	OTHER WAGE RELATED COSTS (SPECIFY)						25.0

Heal th	Financial Systems	RI VERVI EW HOSPI TAL	In Lieu	u of Form CMS-2	2552-10
HOSPI 1	AL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0059	Peri od:	Worksheet S-3	
			From 01/01/2019 To 12/31/2019		norod.
			To 12/31/2019	Date/Time Pre 6/8/2020 1:18	
	Cost Center Description		Contract	Benefit Cost	
	·		Labor		
			1.00	2.00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identific				
1.00	Total facility's contract labor and benefit co	st	494, 193	17, 298, 366	
2.00	Hospi tal		494, 193	17, 298, 366	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

Heal th	Financial Systems RIVERVIEW HOSP	ITAL		In Lie	u of Form CMS-	2552-10	
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CC	N: 15-0059	Period: From 01/01/2019	Worksheet S-1	0	
				To 12/31/2019			
					1.00		
	Uncompensated and indigent care cost computation				1.00	-	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	vided by li	ne 202 colum	in 8)	0. 295243	1.00	
	Medicaid (see instructions for each line)					1	
2.00	Net revenue from Medicaid				8, 130, 817	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 and/or supplement			ai d?		4.00	
5.00 6.00	If line 4 is no, then enter DSH and/or supplemental payments fi Medicaid charges	rom Medical	a		0 54, 153, 284		
7.00	Medicaid cost (line 1 times line 6)				15, 988, 378		
8.00	Difference between net revenue and costs for Medicaid program	(line 7 min	us sum of li	nes 2 and 5: if	7, 857, 561		
	< zero then enter zero)	-			, ,		
	Children's Health Insurance Program (CHIP) (see instructions fo	or each lin	e)				
9.00	Net revenue from stand-alone CHIP				0		
10.00 11.00	Stand-alone CHIP charges Stand-alone CHIP cost (line 1 times line 10)				0		
	Difference between net revenue and costs for stand-alone CHIP	(line 11 mi	nus line Q.	if < zero then		1	
12.00	enter zero)		nus rine 7,		0	12.00	
	Other state or local government indigent care program (see inst	tructions f	or each line	)		1	
13.00	Net revenue from state or local indigent care program (Not incl				0		
14.00	Charges for patients covered under state or local indigent care	e program (	Not included	in lines 6 or	0	14.00	
15.00	10) State or local indigent care program cost (line 1 times line 14	4)			0	15.00	
16.00	Difference between net revenue and costs for state or local inc		program (Li	ne 15 minus line	-		
10.00	13; if < zero then enter zero)	argent care	program (ri			10.00	
	Grants, donations and total unreimbursed cost for Medicaid, CHI	P and stat	e/local indi	gent care progra	ms (see	1	
47 00	instructions for each line)					1 4 7 66	
17.00 18.00	Private grants, donations, or endowment income restricted to fu				0		
18.00 19.00	Government grants, appropriations or transfers for support of H Total unreimbursed cost for Medicaid, CHIP and state and local			s (sum of lines	7, 857, 561		
17.00	8, 12 and 16)	i indigent			7,007,001	17.00	
			Uni nsured	Insured	Total (col. 1		
		-	patients	pati ents	+ col. 2)		
	Uncompensated Care (see instructions for each line)		1.00	2.00	3.00	-	
20.00	Charity care charges and uninsured discounts for the entire fac	cility	9, 274, 0	99 1, 970, 883	11, 244, 982	20.00	
	(see instructions)				, ,		
21.00	Cost of patients approved for charity care and uninsured discou	unts (see	2, 738, 1	13 1, 970, 883	4, 708, 996	21.00	
00.00	instructions)						
22.00	Payments received from patients for amounts previously written charity care	orr as		0 0	0	22.00	
23.00	5		2, 738, 1 <sup>-</sup>	1, 970, 883	4, 708, 996	23.00	
		I			.,		
					1.00		
24.00	Does the amount on line 20 column 2, include charges for patier		ond a length	of stay limit	N	24.00	
25.00	imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond the		cara progra	m's longth of	0	25.00	
25.00	stay limit	ne murgent	care progra	III S Tength Of	0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see ins	structions)			12, 445, 197	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex	x (see inst	ructions)		372, 205		
27.01	7.01       Medicare allowable bad debts for the entire hospital complex (see instructions)       572,623       27						
28.00	Non-Medicare bad debt expense (see instructions)			`	11, 872, 574		
29.00 30.00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp Cost of uncompensated care (line 23 column 3 plus line 29)	pense (see	Instructions	)	3, 705, 712 8, 414, 708		
	Total unreimbursed and uncompensated care cost (line 19 plus li	ine 30)			16, 272, 269		
000						1 0 00	

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	RI VERVI EW H	IOSPI TAL Provi der CO	°.N: 15-0059 ₽	In Lie eriod:	u of Form CMS-2 Worksheet A	2552-10
1120210				F	rom 01/01/2019 o 12/31/2019		
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)		
	_					col. 4)	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		20, 094, 200	20, 094, 200	-177, 179	19, 917, 021	1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	542, 325	9, 113, 124				4.00
5.00	00500 ADMINI STRATI VE & GENERAL	9,095,871	30, 884, 674			35, 636, 944	5.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	2, 124, 270 66, 038	5, 556, 852 346, 569		0	7, 681, 122 412, 607	7.00 8.00
9.00	00900 HOUSEKEEPI NG	1, 183, 697	834, 999		-		9.00
10.00	01000 DI ETARY	1, 309, 433	2, 293, 500	3, 602, 933		789, 262	
11.00 13.00	01100 CAFETERIA 01300 NURSI NG ADMI NI STRATI ON	0 390, 934	0 142, 115	0 533, 049	2, 580, 852 0		11.00 13.00
13.00	01400 CENTRAL SERVICES & SUPPLY	614, 474	929, 115			533, 049 18, 935, 699	•
15.00	01500 PHARMACY	2, 924, 746	22, 252, 750				
16.00	01600 MEDICAL RECORDS & LIBRARY	819, 036	570, 186		0	1, 389, 222	
17.00 23.00	01700 SOCI AL SERVI CE 02300 PARAMED ED PRGM PHARMACY	646, 305 0	149, 852 0	796, 157 0	0 233, 969	796, 157 233, 969	
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	0	0	233, 707	233, 707	25.00
30.00	03000 ADULTS & PEDI ATRI CS	8, 625, 510	1, 298, 051	9, 923, 561	-429, 425		
31.00	03100 I NTENSI VE CARE UNI T	2, 716, 687	567,620				
41.00 43.00	04100 SUBPROVI DER – I RF 04300 NURSERY	1, 492, 989 0	1, 203, 980 0	2, 696, 969	-92, 387	2, 604, 582 0	41.00 43.00
44.00	04400 SKILLED NURSING FACILITY	0	1, 558, 279	1, 558, 279	-34, 301	1, 523, 978	
	ANCI LLARY SERVI CE COST CENTERS						
50.00 52.00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	3, 465, 872 0	8, 275, 739 0	11, 741, 611 0	-13, 232, 990 0		50.00 52.00
52.00	05400 RADI OLOGY-DI AGNOSTI C	1, 817, 392	650, 959	2, 468, 351	-5, 219	0 2, 463, 132	
55.00	05500 RADI OLOGY-THERAPEUTI C	506, 873	563, 486	1, 070, 359		1, 131, 046	
57.00	05700 CT SCAN	374, 305	160, 456	534, 761	-99, 002		
57.01 58.00	03630 ULTRA SOUND 05800 MAGNETIC RESONANCE IMAGING (MRI)	415, 418 332, 567	40, 155 44, 168	455, 573 376, 735			
59.00	05900 CARDI AC CATHETERI ZATI ON	871, 498	1, 834, 711	2, 706, 209			
60.00	06000 LABORATORY	2, 984, 237	3, 978, 063				
60.01	06001 BLOOD LABORATORY	0	0	0	0	-	60.01
63.00 64.00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	447, 600	447,600	0	447, 600 0	63.00 64.00
65.00	06500 RESPIRATORY THERAPY	1, 409, 991	332, 882	1, 742, 873	421, 834	-	65.00
66.00	06600 PHYSI CAL THERAPY	4, 983, 219	2, 855, 851	7, 839, 070	-6, 945		66.00
67.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	0	0	0	67.00 68.00
68.00 69.00	06900 ELECTROCARDI OLOGY	544, 984	145, 217	690, 201	149, 776	0 839, 977	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	11, 712, 382	11, 712, 382	0		
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0 334, 999	0 334, 999	0 -1, 157	0 333, 842	
76.00	03020 OTHER ANCI LLARY	0	0	0	0	0	76.00
76.01	03140 CARDI AC REHAB	675, 293	1, 083, 830	1, 759, 123			
76. 02 76. 03	03070 WOMEN' S CENTER 03330 ENDOSCOPY	431, 688 0	157, 191 0	588, 879 0			
70.03	OUTPATIENT SERVICE COST CENTERS	UU	0	0	0	0	70.03
90.00	09000 CLI NI C	359, 031	204, 298				90.00
90.01		605, 915	589, 764				
90.02 91.00	09002 NEUROPSYCHOLOGY 09100 EMERGENCY	165, 426 3, 325, 630	40, 547 7, 891, 677	205, 973 11, 217, 307	0 -258, 735	205, 973 10, 958, 572	
91.01	09101 SHORT STAY	0, 020, 000	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
95.00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	49, 367	38, 476	87, 843	26, 500	114, 343	95.00
93.00	SPECIAL PURPOSE COST CENTERS	49, 307	30,470	07,043	20, 300	114, 343	95.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	55, 871, 021	139, 178, 317	195, 049, 338	-2, 283, 071	192, 766, 267	118.00
100.00	NONREIMBURSABLE COST CENTERS	165, 669	202, 567	368, 236	0	368, 236	100 00
	19200 PHYSI CLANS' PRI VATE OFFICES	21, 083, 160	9, 300, 431		2, 054, 842		
192.01	19201 FOUNDATI ON	181, 736	13, 382	195, 118	0	195, 118	192.01
	19202 CLINICS 19206 HOME HEALTH PARTNERSHIP	1, 007, 710 0	232, 184		-916		
	19200 HOME HEALTH PARTNERSHIP	1, 320, 104	2, 152 163, 053	2, 152 1, 483, 157	-570		192.03 192.04
192.05	19203 PRACTI CE MANAGEMENT	395, 465	352, 229	747, 694	0	747, 694	192.05
	19204 MOB - NOBLESVILLE SQUARE	0	33, 473	33, 473	0	33, 473	
	19208 PHYSICIANS' PRIVATE OFFICES 19205 RIVERVIEW MEDICAL ARTS	0	0 86, 657	0 86, 657	0	0 86, 657	192.07 192.08
	19209 BEHAVI OR CARE	165, 660	77, 649	243, 309	-2	243, 307	
193.00	19300 NONPAI D WORKERS	0	0	0	0	0	193.00
193.01	19301 PHYSI CI AN SERVI CES-LYONS	78, 810	16, 136	94, 946	0	94, 946	193.01

Health Financial Systems	RIVERVIEW H	OSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (	OF EXPENSES	Provider CC		Period:	Worksheet A	
				rom 01/01/2019 To 12/31/2019		
Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
			+ col. 2)	ions (See	Trial Balance	
				A-6)	(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4.00	5.00	
193. 02 19302 UNI VERSI TY HS ATHLETI CS	32, 141	3, 583	35, 724	1 0	35, 724	193.02
193.03 19303 OB/GYN SPEC NEMUNALTI	487, 916	80, 613	568, 529	9 0	568, 529	193.03
193.04 19304 OB/GYN SPEC GATHERS	1,000	880	1, 880	0 0	1, 880	193.04
193. 05 19305 OB SPECIALI STS DAVENPORT	136, 443	26, 200	162, 643	3 0	162, 643	193.05
194.0007950 WORKMED	508, 781	337, 946	846, 72	-1, 158	845, 569	194.00
194.0107951 MEALS ON WHEELS	0	0	(	230, 875	230, 875	194.01
200.00 TOTAL (SUM OF LINES 118 through 199)	81, 435, 616	150, 107, 452	231, 543, 068	3 0	231, 543, 068	200.00

CLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (	JI LAFLINGLO	Provider CCN: 1	5-0059  Period:  From 01/01/2	Worksheet A
			To 12/31/2	2019 Date/Time Prepare
Cost Center Description	Adjustments	Net Expenses		6/8/2020 1:18 pm
	(See A-8)	For		
	6.00	Allocation 7.00		
GENERAL SERVICE COST CENTERS	6.00	7.00		
00 00100 NEW CAP REL COSTS-BLDG & FIXT	-61, 912	19, 855, 109		1
00 00400 EMPLOYEE BENEFITS DEPARTMENT	-62, 249			4
00 00500 ADMI NI STRATI VE & GENERAL	-11, 787, 271	23, 849, 673		5
00 00700 OPERATION OF PLANT	-1, 201			7
00 00800 LAUNDRY & LINEN SERVICE	0			8
	0			9
. 00  01000 DI ETARY . 00  01100 CAFETERI A	-73, 874 -782, 148			10
00 01300 NURSI NG ADMI NI STRATI ON	-702, 140			13
00 01400 CENTRAL SERVICES & SUPPLY	0			14
00 01500 PHARMACY	-5, 442, 416			15
. 00 01600 MEDI CAL RECORDS & LI BRARY	-494	1, 388, 728		16
. 00 01700 SOCIAL SERVICE	0			17
. 00 02300 PARAMED ED PRGM PHARMACY	0	233, 969		23
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	-1,000	9, 493, 136		30
. 00 03100 I NTENSI VE CARE UNI T	-1,000			31
00 04100 SUBPROVI DER – I RF	0			41
00 04300 NURSERY	0			43
. 00 04400 SKILLED NURSING FACILITY	0	1, 523, 978		44
ANCILLARY SERVICE COST CENTERS		1 1		
. 00 05000 OPERATING ROOM	-3, 218, 326			50
. 00 05200 DELIVERY ROOM & LABOR ROOM . 00 05400 RADIOLOGY-DIAGNOSTIC	-3, 028	0 2, 460, 104		52
. 00 05500 RADIOLOGY-DERAPEUTIC	-3, 028			55
. 00 05700 CT SCAN	0			57
. 01 03630 ULTRA SOUND	0			57
.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	372, 485		58
. 00 05900 CARDI AC CATHETERI ZATI ON	-735, 000			59
. 00 06000 LABORATORY	-222, 462			60
01 06001 BLOOD LABORATORY	0	0		60
. 00 06300 BLOOD STORING, PROCESSING & TRANS. . 00 06400 INTRAVENOUS THERAPY	-3, 210	444, 390		63
. 00 06500 RESPIRATORY THERAPY	-460,000	-		65
. 00 06600 PHYSI CAL THERAPY	0			66
. 00 06700 OCCUPATI ONAL THERAPY	0	0		67
. 00 06800 SPEECH PATHOLOGY	0			68
. 00 06900 ELECTROCARDI OLOGY	-226, 766			69
. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	-		71
00 07200 MPL. DEV. CHARGED TO PATIENT	0			72
00 07400 RENAL DIALYSIS		-		73
00 03020 OTHER ANCI LLARY	0			76
. 01 03140 CARDI AC REHAB	0			76
. 02 03070 WOMEN' S CENTER	0	505, 199		76
. 03 03330 ENDOSCOPY	0	0		76
OUTPATIENT SERVICE COST CENTERS		505 700		
. 00   09000   CLINIC . 01   09001   OUTPATI ENT	0 -135,050	505, 729 1, 061, 832		90
02 09002 NEUROPSYCHOLOGY	-135,050	205, 973		90
00 09100 EMERGENCY	-5, 915, 678			91
01 09101 SHORT STAY	0			91
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				92
OTHER REIMBURSABLE COST CENTERS		1		
. 00 09500 AMBULANCE SERVICES	-6, 600	107, 743		95
SPECIAL PURPOSE COST CENTERS 3.00 SUBTOTALS (SUM OF LINES 1 through 117)	-29, 138, 685	163, 627, 582		118
NONREI MBURSABLE COST CENTERS	-27, 130, 003	103, 027, 302		
D. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	368, 236		190
2. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	32, 438, 433		192
2. 01 19201 FOUNDATI ON	0			192
2. 02 19202 CLINICS	0	1, 238, 978		192
2. 03 19206 HOME HEALTH PARTNERSHIP	0	2, 152		192
2. 04 19207 WESTFIELD SCHOOLS		1, 482, 587		192 192
2. 05 19203 PRACTI CE MANAGEMENT 2. 06 19204 MOB - NOBLESVI LLE SQUARE		747, 694 33, 473		192
2. 07 19204 MOB - NOBLESVILLE SQUARE 2. 07 19208 PHYSICIANS' PRIVATE OFFICES		0		192
2. 08 19205 RI VERVI EW MEDI CAL ARTS	0	86, 657		192
2. 09 19209 BEHAVI OR CARE	0	243, 307		192
3. 00 19300 NONPAI D WORKERS	0	0		193
3. 01 19301 PHYSI CLAN SERVI CES-LYONS	0	94, 946		193
3. 02 19302 UNI VERSI TY HS ATHLETI CS	0	35, 724		193

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lieu	u of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (	OF EXPENSES	Provider CC	CN: 15-0059	Period: From 01/01/2019	Worksheet A
				To 12/31/2019	Date/Time Prepared: 6/8/2020 1:18 pm
Cost Center Description	Adjustments	Net Expenses			
	(See A-8)	For			
		Allocation			
	6.00	7.00			
193. 03 19303 OB/GYN SPEC NEMUNALTI	0	568, 529			193.03
193.04 19304 OB/GYN SPEC GATHERS	0	1, 880			193.04
193. 05 19305 OB SPECIALI STS DAVENPORT	0	162, 643			193.05
194. 00 07950 WORKMED	0	845, 569			194.00
194.0107951 MEALS ON WHEELS	0	230, 875			194.01
200.00 TOTAL (SUM OF LINES 118 through 199)	-29, 138, 685	202, 404, 383			200.00

ASS	SI FI CATI ONS			Provider CCN: 15-00	059	Period: From 01/01/2019 To 12/31/2019	Worksheet A-6 Date/Time Pre	
						10 12/31/2017	6/8/2020 1: 18	3 pm
		Increases						
	Cost Center	Line #	Sal ary	Other				
	2.00	3.00	4.00	5.00				
	A – CAFETERIA RECLASS							
	CAFETERI A	<u>11.00</u>	<u> </u>	<u>1, 642, 8</u> 79				1.C
	TOTALS		937, 973	1, 642, 879				
	B - MEALS ON WHEELS RECLASS							
	MEALS ON WHEELS	194.01	83, 908	<u>146, 9</u> 67				1.0
	TOTALS		83, 908	146, 967				
	C - INSURANCE RECLASS							
	ADMI NI STRATI VE & GENERAL	5.00	0	<u>177, 1</u> 79				1.0
	TOTALS		0	177, 179				
	D - MED SUPPLY RECLASS							
	CENTRAL SERVICES & SUPPLY	14.00	0	17, 392, 110				1.0
		0.00	0	0				2.0
		0.00	0	0				3.0
		0.00	0	0				4.0
		0.00	0	0				5.
		0.00	0	0				6.
		0.00	0	0				7.
		0.00	o	0				8.
		0.00	0	Ō				9.
0		0.00	0	0				10.
0		0.00	0	Ō				11.
0		0,00	0	0				12.
o		0.00	0	Ő				13.
0		0.00	0	0				14.
o		0.00	0	0				15.
0		0.00	0	0				16.
0		0.00	0	0				10.
0		0.00	0	0				17.
0		0.00	0	0				10. 19.
0		0.00	0	0				20.
			-	0				20. 21.
0		0.00	0					
0		0.00	0	0				22.
0		0.00	0	0				23.
0		0.00	0	0				24.
0		0.00	0	0				25.
0		0.00	0	0				26.
0		0.00	0	0				27.
0		0.00	0	<u> </u>				28.
	TOTALS		0	17, 392, 110				
	E - RSMA RECLASS	!	100!					-
	OPERATING ROOM	50.00	492, 090	0				1.
			0	— — <u>0</u>				2.
	TOTALS		492, 090	0				
	F - PHYSICIAN PROFESSIONAL FE		-					
	ADMI NI STRATI VE & GENERAL	5.00	0	255, 763				1.
	OPERATING ROOM	50.00	0	970, 442				2.
	RADI OLOGY-DI AGNOSTI C	54.00	0	4, 500				3.
	RADI OLOGY-THERAPEUTI C	55.00	0	62, 400				4.
	LABORATORY	60.00	0	97, 490				5.
	RESPI RATORY THERAPY	65.00	0	500, 000				6.
	ELECTROCARDI OLOGY	69.00	0	150, 000				7.
	OUTPATI ENT	90.01	0	175, 050				8.
	EMERGENCY	91.00	0	40, 000				9.
	AMBULANCE SERVICES	95.00	0	26, 500				10.
0	PHYSICIANS PRIVATE OFFICES	<u> </u>	0	2, 494, 398				11.
	TOTALS		0	4, 776, 543				
I	G - PARAMED ED RECLASS PHARM							
	PARAMED ED PRGM PHARMACY	23.00	226, 265	7, 704				1.
	TOTALS	+	226, 265	7,704				
	H - COMMUNITY RELATIONS RECLA	ASS						
	ADMI NI STRATI VE & GENERAL	5.00	0	266, 111				1. (
	TOTALS			266, 111				

LASS	Financial Systems		RI VERVI EW H		CCN: 15-0059	Period:	u of Form CMS-2552 Worksheet A-6
						From 01/01/2019 To 12/31/2019	
						10 12/31/2019	Date/Time Prepare 6/8/2020 1:18 pm
		Decreases				. 1	
	Cost Center	Line #	Salary	Other 0	Wkst. A-7 Ref	<u>.</u>	
	6.00 A - CAFETERIA RECLASS	7.00	8.00	9.00	10.00		
	DI ETARY	10.00	937, 973	1, 642, 879		0	1
.0			937, 973	1, 642, 879		1	
	B - MEALS ON WHEELS RECLASS	I				1	
00	DI ETARY	10.00	83, 908	146, 967		0	1
	TOTALS		83, 908	146, 967			
	C - INSURANCE RECLASS				1		
	NEW CAP REL COSTS-BLDG &	1.00	0	177, 179	1	2	1
	FIXT	+				4	
	D - MED SUPPLY RECLASS		0	177, 179			
0	DI ETARY	10.00	0	1, 944	1	0	1
	PHARMACY	15.00	0	25, 549		0	2
	ADULTS & PEDIATRICS	30.00	0	429, 425		o	3
	INTENSIVE CARE UNIT	31.00	o	253, 950		0	4
	SUBPROVIDER - IRF	41.00	0	92, 387		0	5
	SKILLED NURSING FACILITY	44.00	0	34, 301		0	6
	OPERATI NG ROOM	50.00	О	14, 206, 200		0	7
0	RADI OLOGY-DI AGNOSTI C	54.00	О	9, 719		0	8
	RADI OLOGY-THERAPEUTI C	55.00	0	1, 713		o	9
	CT SCAN	57.00	0	99, 002		0	10
	ULTRA SOUND	57.01	0	3, 293		0	11
00	MAGNETIC RESONANCE IMAGING	58.00	0	4, 250		0	12
	(MRI)						
	CARDI AC CATHETERI ZATI ON	59.00	0	969, 059		0	13
		60.00	0	1, 737		0	14
		65.00	0	78, 166		0	15
	PHYSI CAL THERAPY ELECTROCARDI OLOGY	66.00 69.00	0	6, 945		0	16
			0	224		0	
	RENAL DI ALYSI S CARDI AC REHAB	74.00 76.01	0	1, 157		0	18
	WOMEN' S CENTER	76.02	0	117, 025 83, 680		0	20
	CLINIC	90.00	0	57,600		0	20
	OUTPATI ENT	90.01	0	173, 847		0	22
	EMERGENCY	91.00	0	298, 735		o	23
	PHYSICIANS' PRIVATE OFFICES	192.00	o	439, 556		o	24
	CLINICS	192.02	0	916		0	25
00	WESTFIELD SCHOOLS	192.04	0	570		0	26
00	BEHAVIOR CARE	192.09	О	2		o	27
00	WORKMED	194.00	0	<u>1, 1</u> 58		o	28
	TOTALS	T	0	17, 392, 110		1	
	E - RSMA RECLASS				1	1	
	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2, 768		0	1
0	OPERATING ROOM	<u>50.00</u>	0	489, 322		o	2
	TOTALS F - PHYSICIAN PROFESSIONAL FEI		U	492, 090	l		
0	ADMINISTRATIVE & GENERAL	<u>5.00</u>		4, 776, 543		0	1
0	CONTRACTIVE & GENERAL	0.00	0	4, 770, 543		0	2
0		0.00	0	0		0	3
0		0.00	0	0		0	4
0		0.00	ol	0		0	5
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ō		0.00	0	0		o	7
0		0.00	0	0		o	8
0		0.00	О	0		0	9
00		0.00	О	0		0	10
00		0.00	o	<u>0</u>		o	11
	TOTALS		0	4, 776, 543			
	G - PARAMED ED RECLASS PHARM I						
0	PHARMACY	<u>15.</u> 00	226, 265	7,704		이	1
	TOTALS		226, 265	7, 704			
0	H - COMMUNITY RELATIONS RECLAS		267 111	~	1	0	
0	ADMI NI STRATI VE & GENERAL	<u>5.</u> 00	<u>266, 1</u> 11 266, 111	0		0	1
	Grand Total: Decreases		1, 514, 257	24, 635, 472			500

Heal th	Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider CO		Period: From 01/01/2019 To 12/31/2019		pared:
				Acquisition			
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	BALANCES					
1.00	Land	15, 961, 384	0		0 0	0	1.00
2.00	Land Improvements	2, 979, 163	153, 987		0 153, 987	0	2.00
3.00	Buildings and Fixtures	0	0		0 0	0	3.00
4.00	Building Improvements	134, 845, 640	31, 157, 608		0 31, 157, 608	0	4.00
5.00	Fixed Equipment	42, 616, 181	3, 173, 360		0 3, 173, 360	0	5.00
6.00	Movable Equipment	140, 765, 480	0		0 0	21, 651, 559	6.00
7.00	HIT designated Assets	0	0		0 0	0	7.00
8.00	Subtotal (sum of lines 1-7)	337, 167, 848	34, 484, 955		0 34, 484, 955	21, 651, 559	8.00
9.00	Reconciling Items	0	0		0 0	0	9.00
10.00	Total (line 8 minus line 9)	337, 167, 848	34, 484, 955		0 34, 484, 955	21, 651, 559	10.00
		Endi ng	Fully				
		Bal ance	Depreciated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES					
1.00	Land	15, 961, 384	0				1.00
2.00	Land Improvements	3, 133, 150	0				2.00
3.00	Buildings and Fixtures	0	0				3.00
4.00	Building Improvements	166, 003, 248	0				4.00
5.00	Fixed Equipment	45, 789, 541	0				5.00
6.00	Movable Equipment	119, 113, 921	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	350, 001, 244	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	350, 001, 244	0				10.00

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-0059	Peri od:	Worksheet A-7	
				From 01/01/2019 To 12/31/2019	Part II Date/Time Pre	pared:
	·				6/8/2020 1:18	pm
		SL	JMMARY OF CAP	TAL		
Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
				(see instructions)	instructions)	
	9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WOR			and 2			
1.00 NEW CAP REL COSTS-BLDG & FIXT	20, 094, 200	0		0 0	0	1.00
3.00 Total (sum of lines 1-2)	20, 094, 200	0		0 0	0	3.00
	SUMMARY O	F CAPI TAL				
Cost Center Description	Other	Total (1)				
	Capi tal -Rel at	(sum of cols.				
	ed Costs (see	9 through 14)				
	instructions)					
	14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	MN 2, LINES 1 a	and 2			
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	20, 094, 200				1.00
3.00  Total (sum of lines 1-2)	0	20, 094, 200				3.00

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2019 To 12/31/2019		pared:
	COMF	PUTATION OF RA	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00 NEW CAP REL COSTS-BLDG & FIXT	166, 003, 248	0	166, 003, 24	8 1.000000	0	1.00
3.00 Total (sum of lines 1-2)	166, 003, 248		166, 003, 24			3.00
	ALLOCAT	FION OF OTHER (	CAPI TAL	SUMMARY C	OF CAPITAL	
Cost Center Description	Taxes	Other	Total (sum o	Depreciation	Lease	
		Capi tal -Rel at				
		ed Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS			- i		
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	-		0 20, 094, 200		1.00
3.00 Total (sum of lines 1-2)	0	-		0 20, 094, 200	0	3.00
		SL	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
		(see	instructions)			
		instructions)		ed Costs (see instructions)	9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00 NEW CAP REL COSTS-BLDG & FIXT	-61, 912	-177, 179		0 0	19, 855, 109	1.00
3.00  Total (sum of lines 1-2)	-61, 912	-177, 179	l	0 0	19, 855, 109	3.00

al th Financial	Systems	

	Financial Systems MENTS TO EXPENSES		RI VERVI EW	Provider CCN: 15-0059	Period:	u of Form CMS-2 Worksheet A-8	
					From 01/01/2019 To 12/31/2019		
				Expense Classification or To/From Which the Amount is		6/8/2020 1:18	pm
				TO/FION WHICH THE AMOUNT IS	to be Adjusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
		(2)	2.00	3.00	4.00	Ref. 5.00	
1.00	Investment income - NEW CAP	1.00	0	NEW CAP REL COSTS-BLDG &	1.00	0	1.00
	REL COSTS-BLDG & FIXT (chapter 2)			FIXT			
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time		0		0.00	0	4.00
5.00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5.00
6.00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6.00
7.00	suppliers (chapter 8) Telephone services (pay		0		0.00	0	7.00
7.00	stations excluded) (chapter		0		0.00	0	7.00
8.00	21) Tel evision and radio service		0		0.00	0	8.00
9.00	(chapter 21) Parking Lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-10, 594, 905			0	
11.00	Sale of scrap, waste, etc.		0		0.00	0	11.00
12.00	(chapter 23) Related organization	A-8-1	174, 198			0	12.00
13.00	transactions (chapter 10) Laundry and linen service		0		0.00	0	13.00
14.00 15.00	Cafeteria-employees and guests Rental of quarters to employee	В	-550, 740	CAFETERI A	11.00 0.00		
	and others		0				
16.00	Sale of medical and surgical supplies to other than		0		0.00	0	16.00
17.00	patients Sale of drugs to other than		0		0.00	0	17.00
18.00	patients Sale of medical records and		0		0.00		18.00
	abstracts		0				
19.00	Nursing and allied health education (tuition, fees,		0		0.00	0	19.00
20.00	books, etc.) Vending machines		0		0.00	o	20.00
21.00	Income from imposition of		0		0.00		
	interest, finance or penalty charges (chapter 21)					_	
22.00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22.00
23.00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
	therapy costs in excess of		_				
24.00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66.00		24.00
	therapy costs in excess of limitation (chapter 14)						
25.00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25.00
26 00	(chapter 21)			NEW CAD DEL COSTS DUDC .	1.00		24 00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT			NEW CAP REL COSTS-BLDG & FIXT	1.00		26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00 29.00	Non-physician Anesthetist Physicians' assistant		0	*** Cost Center Deleted ***	19.00 0.00		28.00 29.00
30.00	Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67.00		30.00
	therapy costs in excess of limitation (chapter 14)						
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

Heal th	Fi nan	ici al	Systems
AD.JUST	MENTS	TO	EXPENSES

	MENTS TO EXPENSES		RIVERVIEW		eri od:	Worksheet A-8	
AD5051	MENTS TO EXTENSES				rom 01/01/2019	Nor Kaneet A o	
				Te	o 12/31/2019	Date/Time Pre	pared:
				Expense Classification on	Worksheet A	6/8/2020 1:18	
				To/From Which the Amount is			
				To Thom will child the Amount 13	to be haj usted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
		(2)				Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
	pathology costs in excess of						
	limitation (chapter 14)						
32.00	CAH HIT Adjustment for		0		0.00	0	32.00
	Depreciation and Interest						
33.00	HAF EXPENSE	А	-9, 030, 600	ADMINISTRATIVE & GENERAL	5.00	0	33.0
33.01	PHYSICIAN RECRUITMENT OFFSET	А	-1, 825	ADMINISTRATIVE & GENERAL	5.00	0	33.0
33. 02	OTHER REV MEDICAL REPORT	В	- 494	MEDICAL RECORDS & LIBRARY	16.00	0	33.0
33. 03	OTHER REVENUE PURCHASE DISC &	В	-12, 581	ADMI NI STRATI VE & GENERAL	5.00	0	33.0
	REBATE						
33.04	RADI OLOGY OTHER REV	В	-2, 878	RADI OLOGY-DI AGNOSTI C	54.00	0	33.0
33.05	AMBULANCE OTHER REVENUE	В	-6, 600	AMBULANCE SERVICES	95.00	0	33.0
33.06	LAB OTHER REVENUE	В	-160, 972	LABORATORY	60.00	0	33.0
33.07	MATERNITY CENTER OTHER REV	В		ADULTS & PEDIATRICS	30.00	0	33.0
33.08	INFORMATION SYSTEMS OTHER REV	В	-48, 628	ADMI NI STRATI VE & GENERAL	5.00	0	33.0
33.09	ADMINISTRATION LEAN TEAM	В	3, 062	ADMI NI STRATI VE & GENERAL	5.00	0	33.0
33.10	EDUCATION OTHER REVENUE	В	-15, 307	ADMI NI STRATI VE & GENERAL	5.00	0	33.10
33.11	SHO/UNCLAI MED REFUNDS	В	-3	ADMI NI STRATI VE & GENERAL	5.00	0	33.1
33. 12	OP PHARMACY REVENUE	А	-5, 442, 416	PHARMACY	15.00	0	33.1
33.13	DIETARY SALES PR DEDUCT	В	-231, 408	CAFETERIA	11.00	0	33.1
33.14	WELLNESS SERVICES EXTERNAL	В	-33, 828	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.1
33. 15	WESTFIELD BISTRO OTHER REV	В	-73, 874	DI ETARY	10.00	0	33.1
33.16	NON OP REV MISC INTEREST	В	-61, 912	NEW CAP REL COSTS-BLDG &	1.00	11	33.10
				FLXT			
33.17	COMMUNITY RELATIONS	А	-2, 316, 385	ADMI NI STRATI VE & GENERAL	5.00	0	33.1
33. 18	COMMUNITY RELATIONS BENEFITS	А	-28, 421	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.18
33. 19	CRNA	А	-675,000	OPERATING ROOM	50.00	0	33.1
33. 20	I HA LOBBYING EXPENSE	А	-4, 525	ADMI NI STRATI VE & GENERAL	5.00	0	33.2
33. 21	OTHER REVENUE FITNESS	В	-45	ADMI NI STRATI VE & GENERAL	5.00	0	33.2
33. 22	CV SERVICES OTHER REVENUE	В	-150	RADI OLOGY-DI AGNOSTI C	54.00	0	33.2
33. 23	CT SCAN OTHER REVENUE	В	-2, 254	ELECTROCARDI OLOGY	69.00	0	33.2
33. 24	BLOOD BANK OTHER REVENUE	В	-3, 210	BLOOD STORING, PROCESSING &	63.00	0	33.24
				TRANS.			
33. 25	MATERIALS MANAGEMENT RENTAL	В	-1, 201	OPERATION OF PLANT	7.00	0	33. 25
	INCOME						
33.26	FISCAL SERVICES COMMERCE BANK	В	-14, 783	ADMI NI STRATI VE & GENERAL	5.00	0	33.20
	REBATE						
50.00	TOTAL (sum of lines 1 thru 49)		-29, 138, 685				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						1

(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-	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO	ME Provider CCN: 15-0059	Period: From 01/01/2019	Worksheet A-8	3-1
OFFICE				To 12/31/2019		
	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	ORGANI ZATI ONS OR	CLAIMED HOME	
	OFFICE COSTS:					
1.00	50.00	OPERATING ROOM	OPERATING ROOM	620, 625	446, 427	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	TOTALS (sum of lines 1-4).			620, 625	446, 427	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which not been nosted to Worksheet A columns 1 and/or 2 the amount allowable should be indicated in column A of this par

nas no	t been posted to worksneet A,	corumns r and/or 2, the a	amount allowable si	nould be indicated in colum	1 4 of this part.	
				Related Organization(s) and	d/or Home Office	
				3 ,		
	Symbol (1)	Name	Percentage of	Name	Percentage of	
			Ownershi p		Ownershi p	
	1 00	2.00	2 00	4.00	5.00	
	1.00	2.00	3.00	4.00	5.00	

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

r or mour oome					
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.

С 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 organi zati on.

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 provi der.

Health Financial Systems R	I VERVIEW HOS	SPI TAL	In Lieu	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATION OFFICE COSTS	S AND HOME	Provider CCN: 15-0059	Period: From 01/01/2019	Worksheet A-8-1
UFFICE CUSIS				Date/Time Prepared:

			6/8/2020 1: 18	
	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
	A. COSTS INCUR	RED AND ADJUSTI	MENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME	
	OFFICE COSTS:			
1.00	174, 198	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	174, 198			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,	COLUMNS I AND	01 2	, the amount	arrowabre	Shourd be	Thurcateu	TH COLUMN 4 OF	this part.	
	Related Organization(s)									
	and/or Home Office									
	Type of Business									
	6, 00									
	0.00									
	B. INTERRELATIONSHIP TO RELATIONSHIP	TED ORGANI ZATI	ON(S)	AND/OR HOME	E 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

	Sement under title Aviii.	
6.00		6.00
7.00 8.00		7.00
8.00		8.00
9.00		9.00
9.00 10.00 100.00		10.00
100.00		100.00

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

 C. Provider has financial interest in corporation, partnership, or other organization.
 D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.

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 provi der.

Health Financial Systems		RI VERVI EW	HOSPI TAL		In Lieu of Form CMS-2552-10			
PROVIDER BASED PHYSICIAN ADJUSTMENT			Provider (	CCN: 15-0059	Period: Worksheet A-8-2			
						From 01/01/2019		
						To 12/31/2019	Date/Time Pre 6/8/2020 1:18	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identifier	Remuneration	Component	Component		ider Component	
					•		Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		ADMI NI STRATI VE & GENERAL	345, 651	345, 651	(			
2.00	0.00		0		(			
3.00		OPERATING ROOM	2, 717, 524				-	3.00
4.00		CARDIAC CATHETERIZATION	735, 000	735, 000	(	-	0	4.00
5.00	60.00	LABORATORY	61, 490	61, 490	(	0 0	0	5.00
6.00	65.00	RESPI RATORY THERAPY	460, 000	460, 000	(	0 0	0	6.00
7.00	69.00	ELECTROCARDI OLOGY	224, 512	224, 512	(	0 0	0	7.00
8.00		OUTPATI ENT	135, 050		(	0 0	0	8.00
9.00		EMERGENCY	40, 000	40, 000	(	0 0	0	9.00
10.00	91.00	EMERGENCY	5, 875, 678	5, 875, 678	(	0 0	0	10.00
200.00			10, 594, 905		(	)	0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of		Physician Cost	
		l denti fi er	Limit	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Education	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		ADMINISTRATIVE & GENERAL	0	0	(		-	
2.00	0.00		0					
3.00		OPERATING ROOM	0	0	(		0	3.00
4.00		CARDIAC CATHETERIZATION	0	0	(		0	4.00
5.00		LABORATORY	0	0	(	0 0	0	5.00
6.00	65.00	RESPI RATORY THERAPY	0	0	(	0 0	0	6.00
7.00	69.00	ELECTROCARDI OLOGY	0	0	(	0 0	0	7.00
8.00	90.01	OUTPATI ENT	0	0	(	0 0	0	8.00
9.00		EMERGENCY	0	0	(	0 0	0	9.00
10.00	91.00	EMERGENCY	0	0	(	0 0	0	10100
200.00			0	0	(	0 0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
1 . 0.0	1.00	2.00	15.00	16.00	17.00	18.00		1.05
1.00		ADMI NI STRATI VE & GENERAL	0		(			1.00
2.00	0.00		0	0	(			2.00
3.00		OPERATING ROOM	0	0				3.00
4.00		CARDIAC CATHETERIZATION	0	0	(			4.00
5.00		LABORATORY	0	0				5.00
6.00		RESPI RATORY THERAPY	0	0	(			6.00
7.00		ELECTROCARDI OLOGY	0	0	(			7.00
8.00		OUTPATI ENT	0	0				8.00
9.00		EMERGENCY	0	0	(			9.00
10.00	91.00	EMERGENCY	0					10.00
200.00			0	0	(	10, 594, 905		200.00

Health Financial Systems	RI VERVI EW				u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		riod: om 01/01/2019 12/31/2019		
		CAPI TAL RELATED COSTS			6/8/2020 1:18	
Cost Center Description	Net Expenses	NEW BLDG &	EMPLOYEE	Subtotal	ADMI NI STRATI V	
	for Cost	FI XT	BENEFITS		E & GENERAL	
	Allocation (from Wkst A		DEPARTMENT			
	col. 7)					
GENERAL SERVICE COST CENTERS	0	1.00	4.00	4A	5.00	
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	19, 855, 109	19, 855, 109				1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	9, 590, 432		9, 682, 089			4.00
5. 00 00500 ADMINI STRATI VE & GENERAL 7. 00 00700 OPERATI ON OF PLANT	23, 849, 673 7, 679, 921		1, 053, 885 253, 544	26, 312, 777 15, 883, 877	26, 312, 777 2, 338, 710	5.00 7.00
8. 00 00800 LAUNDRY & LINEN SERVICE	412, 607		7, 882	467, 037	68, 766	
9. 00 00900 HOUSEKEEPI NG	2, 018, 696		141, 281	2, 197, 632	323, 575	9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	715, 388 1, 798, 704		34, 321 111, 953	853, 555 2, 172, 832	125, 676 319, 923	•
13. 00 01300 NURSING ADMINISTRATION	533, 049		46, 660	2, 172, 032	87, 117	•
14.00 01400 CENTRAL SERVICES & SUPPLY	18, 935, 699	222, 825	73, 341	19, 231, 865	2, 831, 661	14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	19, 475, 562		322, 080 97, 757	20, 075, 525	2, 955, 880 232, 801	
17. 00 01700 SOCIAL SERVICE	1, 388, 728 796, 157		77, 140	1, 581, 118 925, 860	136, 322	16.00
23.00 02300 PARAMED ED PRGM PHARMACY	233, 969		27, 006	265, 934		•
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0 402 124	2, 818, 885	1 020 504	13, 341, 527	1 064 290	20.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 I NTENSI VE CARE UNIT	9, 493, 136 3, 030, 357		1, 029, 506 324, 253	3, 804, 898	1, 964, 380 560, 226	•
41.00 04100 SUBPROVIDER - IRF	2, 604, 582		178, 197	3, 089, 359	454, 871	
43. 00 04300 NURSERY	0	0	0	0	0	
44. 00 04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	1, 523, 978	222, 057	0	1, 746, 035	257, 083	44.00
50.00 05000 OPERATING ROOM	-4, 709, 705	1, 619, 726	472, 407	-2, 617, 572	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 55. 00 05500 RADI OLOGY-THERAPEUTI C	2, 460, 104 1, 131, 046		216, 917 60, 498	2, 937, 340 1, 421, 119	432, 488 209, 243	
57. 00 05700 CT SCAN	435, 759		44, 676	545, 283	80, 286	•
57.01 03630 ULTRA SOUND	452, 280		49, 583	518, 883	76, 399	
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 59. 00 05900 CARDIAC CATHETERIZATION	372, 485 1, 002, 150		39, 694 104, 019	494, 751 1, 198, 274	72, 846 176, 431	
60. 00 06000 LABORATORY	6, 835, 591		356, 187	7, 650, 192	1, 126, 399	•
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 64. 00 06400 INTRAVENOUS THERAPY	444, 390	62, 449	0	506, 839	74, 626 0	63.00 64.00
65. 00 06500 RESPIRATORY THERAPY	1, 704, 707	34, 679	168, 291	1, 907, 677	280, 883	•
66. 00 06600 PHYSI CAL THERAPY	7, 832, 125		594, 777	8, 547, 448		•
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	0	67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY	613, 211	-	65, 047	999, 202	147, 121	•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS	11, 712, 382	0	0	11, 712, 382	1, 724, 508 0	•
74. 00 07400 RENAL DI ALYSI S	333, 842	29, 721	0	363, 563		74.00
76.00 03020 OTHER ANCI LLARY	0	0	0	0	0	76.00
76. 01 03140 CARDI AC REHAB 76. 02 03070 WOMEN' S CENTER	1, 642, 098		80, 600 51 525	1, 809, 205	266, 384	1
76. 03 03330 ENDOSCOPY	505, 199 0		51, 525 0	721, 451 0	106, 225 0	
OUTPATIENT SERVICE COST CENTERS	-					1
90. 00 09000 CLINIC	505, 729			625, 715		
90. 01 09001 0UTPATI ENT 90. 02 09002 NEUROPSYCHOLOGY	1, 061, 832 205, 973		72, 320 19, 745	1, 246, 476 355, 894	183, 529 52, 401	
91. 00 09100 EMERGENCY	5, 042, 894		396, 934	6, 118, 124	900, 820	•
91. 01 09101 SHORT STAY	0	0	0	0	0	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) OTHER REI MBURSABLE COST CENTERS				0		92.00
95. 00 09500 AMBULANCE SERVICES	107, 743	8, 734	5, 892	122, 369	18, 017	95.00
SPECIAL PURPOSE COST CENTERS	4 (0, (07, 500		( (00 771	150 704 100	00.000.001	
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	163, 627, 582	19, 014, 965	6, 620, 771	159, 726, 120	20, 028, 921	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	368, 236	193, 232	19, 774	581, 242		190.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	32, 438, 433		2, 516, 418	35, 567, 499		•
192. 01 19201 FOUNDATI ON 192. 02 19202 CLI NI CS	195, 118 1, 238, 978		21, 691 120, 276	216, 809 1, 359, 254	31, 923 200, 134	192.01 192.02
192. 03 19206 HOME HEALTH PARTNERSHIP	2, 152		120, 270	2, 152		192.02
192. 04 19207 WESTFIELD SCHOOLS	1, 482, 587	0	157, 562	1, 640, 149	241, 492	192.04
192.05 19203 PRACTICE MANAGEMENT 192.06 19204 MOB - NOBLESVILLE SQUARE	747, 694 33, 473		47, 201	794, 895 33, 473	117, 039 4 928	192.05 192.06
192. 00 19204 MOB - NOBLESVILLE SQUARE 192. 07 19208 PHYSICIANS' PRIVATE OFFICES	33, 473 0	0	0	33, 473 0		192.06
192. 08 19205 RI VERVI EW MEDI CAL ARTS	86, 657		0	86, 657		192.08
			· · · · · · · · · · · · · · · · · · ·			

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO		Period:	Worksheet B	
				From 01/01/2019 To 12/31/2019		pared:
					6/8/2020 1:18	
		CAPI TAL				
Cost Center Description		RELATED COSTS NEW BLDG &	EMPLOYEE	Subtotal	ADMI NI STRATI V	
cost center bescription	Net Expenses for Cost	FIXT	BENEFITS	Subtotal	E & GENERAL	
	Allocation	11.71	DEPARTMENT			
	(from Wkst A		DELYNCHMENT			
	col. 7)					
	0	1.00	4.00	4A	5.00	
192. 09 19209 BEHAVI OR CARE	243, 307	34, 264	19, 77	3 297, 344		
193. 00 19300 NONPALD WORKERS	0	0		0 0		193.00
193. 01 19301 PHYSI CLAN SERVI CES-LYONS	94, 946	0	9,40		15, 365	193.01
193. 02 19302 UNI VERSI TY HS ATHLETI CS	35, 724		3,83			193.02
193.03 19303 OB/GYN SPEC NEMUNALTI	568, 529		58, 23			•
193.04 19304 OB/GYN SPEC GATHERS	1, 880	0	11			193.04
193. 05 19305 OB SPECIALI STS DAVENPORT	162, 643		16, 28			
194. 00 07950  WORKMED	845, 569		60, 72	6 906, 295		•
194.0107951 MEALS ON WHEELS	230, 875	0	10, 01	5 240, 890		
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0		0 0		201.00
202.00  TOTAL (sum lines 118 through 201)	202, 404, 383	19, 855, 109	9, 682, 08	9 202, 404, 383	26, 312, 777	202.00

	Financial Systems ALLOCATION - GENERAL SERVICE COSTS	RI VERVI EW	HOSPI TAL Provi der C	Fr	eriod: com 01/01/2019	J of Form CMS- Worksheet B Part I Date (Time Dre	
				То		Date/Time Pre 6/8/2020 1:18	pm
	Cost Center Description	OPERATION OF PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		7.00	8.00	9.00	10.00	11.00	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT						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	18, 222, 587					7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	81, 531 65, 953					8.00 9.00
10.00	01000 DI ETARY	181, 890			1, 171, 428		10.00
11.00	01100 CAFETERI A	459, 207		72, 152	0	3, 024, 114	
13.00	01300 NURSI NG ADMI NI STRATI ON	20, 957		0	0	20, 648	
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	390, 284 486, 720		2, 577 64, 421	0	69, 552 178, 349	
16.00	01600 MEDICAL RECORDS & LIBRARY	165, 752		12, 884	0	77, 797	
17.00	01700 SOCI AL SERVI CE	92,066		0	0	44, 389	
23.00	02300 PARAMED ED PRGM PHARMACY	8, 685	0	0	0	5, 307	23.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	4, 937, 356	193, 501	791, 094	643, 960	601, 046	30.00
30.00	03100 I NTENSI VE CARE UNI T	4, 937, 330 788, 693			91, 501	146, 708	31.00
41.00	04100 SUBPROVI DER – I RF	536, 984			271, 488	118, 296	
43.00	04300 NURSERY	0	0	0	0	0	43.00
44.00	04400 SKI LLED NURSI NG FACI LI TY ANCI LLARY SERVI CE COST CENTERS	388, 939	44, 773	157, 188	164, 479	0	44.00
50.00	05000 OPERATING ROOM	2, 836, 997	59, 916	275, 723	0	271, 438	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0			0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	455, 957			0	136, 212	
55.00	05500 RADI OLOGY-THERAPEUTI C	402, 107			0	31, 567	55.00
57.00 57.01	05700 CT SCAN 03630 ULTRA SOUND	113, 583 29, 811		0 2, 577	0	24, 190 5, 607	57.00 57.01
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	144, 626		2, 577	0	19, 700	
59.00	05900 CARDI AC CATHETERI ZATI ON	161, 325			0	47, 919	
60.00		802, 926		90, 190	0	265, 429	60.00
60. 01 63. 00	06001 BLOOD LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	0 109, 380	-	0	0	0	60.01 63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPI RATORY THERAPY	60, 742		0	0	98, 416	
66.00	06600 PHYSI CAL THERAPY	211, 140			0	385, 771	66.00
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	0	0	0	67.00 68.00
69.00	06900 ELECTROCARDI OLOGY	562, 143	5, 298	-	0	54, 665	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 74.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0 52, 057		0	0	0	73.00 74.00
	03020 OTHER ANCI LLARY	02,007	0	0	0	0	
76.01	03140 CARDI AC REHAB	151, 519			0		76.01
	03070 WOMEN' S CENTER	288, 524			0	38, 398	
76.03	03330 ENDOSCOPY OUTPATI ENT SERVI CE COST CENTERS	0	0	0	0	0	76.03
90.00	09000 CLINIC	135, 100	835	56, 691	0	31, 522	90.00
90.01	09001 OUTPATI ENT	196, 739		20, 615	0	40, 473	
90.02	09002 NEUROPSYCHOLOGY	228,006		0	0	0	90.02
91.00 91.01	09100 EMERGENCY 09101 SHORT STAY	1, 188, 054	83, 328	219, 032	0	204, 880 0	91.00 91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		0	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS		1				
95.00	09500 AMBULANCE SERVICES	15, 298	0	0	0	4, 405	95.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	16, 751, 051	568, 217	2, 450, 587	1, 171, 428	2, 981, 619	118 00
110.00	NONREIMBURSABLE COST CENTERS	10, 731, 031	500,217	2,430,307	1, 171, 420	2, 701, 017	110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	338, 451		18, 038	0		190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	1, 073, 071	48, 696	118, 535	0		192.00
	19201 FOUNDATI ON 19202 CLI NI CS	0	219	0	0		192. 01 192. 02
	19206 HOME HEALTH PARTNERSHIP	0	0	0	0		192.02
192.04	19207 WESTFIELD SCHOOLS	0	0	0	0	0	192.04
	19203 PRACTI CE MANAGEMENT	0	202	0	0		192.05
	19204 MOB - NOBLESVILLE SQUARE	0	0	0	0		192.06 192.07
	19208 PHYSICIANS' PRIVATE OFFICES 19205 RIVERVIEW MEDICAL ARTS			0	0		192.07
	19209 BEHAVI OR CARE	60, 014	0	0	0		192.00
193.00	19300 NONPAI D WORKERS	0	0	0	0	0	193.00
	19301 PHYSI CI AN SERVI CES-LYONS	0	0	0	0		193.01
	19302 UNI VERSI TY HS ATHLETI CS 19303 OB/GYN SPEC NEMUNAI TI			0	0		193. 02 193. 03
175.00		0	1 0	, U	U	0	1. 73. 05

							2552-10	
COST ALLOCA	TION - GENERAL SERVICE COSTS		Provider C		Period:	Worksheet B		
					From 01/01/2019 To 12/31/2019	Date/Time Pre	pared:	
		_				6/8/2020 1:18	pm	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPING	DI ETARY	CAFETERI A		
		PLANT	LINEN SERVICE					
		7.00	8.00	9.00	10.00	11.00		
193.04 19304	OB/GYN SPEC GATHERS	0	0		0 0	0	193.04	
193.05 19305	OB SPECIALISTS DAVENPORT	0	0		0 0	0	193.05	
194.0007950	WORKMED	0	0		0 0	0	194.00	
194.0107951	MEALS ON WHEELS	0	0		0 0	10, 236	194.01	
200.00	Cross Foot Adjustments						200.00	
201.00	Negative Cost Centers	0	0		0 0	0	201.00	
202.00	TOTAL (sum lines 118 through 201)	18, 222, 587	617, 334	2, 587, 16	0 1, 171, 428	3, 024, 114	202.00	

Health Financial Systems	RI VERVI EW H	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	N: 15-0059	Period: From 01/01/2019	Worksheet B Part I	
				To 12/31/2019		
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	
	ADMI NI STRATI O N	SERVICES & SUPPLY		RECORDS & LI BRARY	SERVI CE	
	13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS						1 1 00
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						1.00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5.00
7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE						7.00 8.00
9. 00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERIA 13. 00 01300 NURSING ADMINISTRATION	720, 396					11.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	120, 370	22, 530, 579				14.00
15.00 01500 PHARMACY	0	0	23, 760, 89			15.00
16.00 01600 MEDICAL RECORDS & LIBRARY 17.00 01700 SOCIAL SERVICE	0	0		0 2, 070, 352 0 0	1, 198, 637	16.00 17.00
23.00 02300 PARAMED ED PRGM PHARMACY	0	0		0 0	0	1
INPATIENT ROUTINE SERVICE COST CENTERS	101.010			0 407 475	075 0/0	
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	404, 312 98, 688	0 0		0 437,675 0 103,272	975, 962 67, 800	30.00
41. 00 04100 SUBPROVI DER – I RF	79, 576	0		0 0	110, 884	1
43.00 04300 NURSERY	0	0		0 0	0	43.00
44. 00 04400 SKI LLED NURSI NG FACI LI TY ANCI LLARY SERVI CE COST CENTERS	0	0		0 9, 835	43, 991	44.00
50. 00 05000 OPERATING ROOM	0	0		0 845, 845	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 55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0 0 24, 589	0	54.00 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) 59. 00 05900 CARDIAC CATHETERIZATION	0	0		0 0 0 0	0	58.00 59.00
60. 00 06000 LABORATORY	0	0		0 44, 259	0	60.00
60. 01 06001 BLOOD LABORATORY	0	0		0 0	0	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 64.00 06400 INTRAVENOUS THERAPY	0	0		0 0 0 0	0	63.00 64.00
65. 00 06500 RESPIRATORY THERAPY	0	0		0 0	0	65.00
66.00 06600 PHYSI CAL THERAPY	0	0		0 285, 227	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY	0	0		0 0 0 0	0	67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		63, 930	0	69.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	22, 530, 579		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	23, 760, 89	0 0 5 0	0	72.00
74.00 07400 RENAL DI ALYSI S	0	0	, ,	0 0	0	
76.00 03020 OTHER ANCI LLARY	0	0		0 0	0	
76. 01 03140 CARDI AC REHAB 76. 02 03070 WOMEN' S CENTER	0	0		0 0	0	1
76. 03 03330 ENDOSCOPY	0	0		0 0	0	1
OUTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C	0	0		0 0	0	90.00
90. 01 09001 OUTPATI ENT	0	0		0 0	0	90.00
90. 02 09002 NEUROPSYCHOLOGY	0	0		0 0	0	90.02
91.00 09100 EMERGENCY 91.01 09101 SHORT STAY	137, 820	0		0 142, 613	0	91.00 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 SPECIAL PURPOSE COST CENTERS	0	0		0 0	0	95.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	720, 396	22, 530, 579	23, 760, 89	5 1, 957, 245	1, 198, 637	118.00
NONREI MBURSABLE COST CENTERS	0				0	100.00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0 0 0		190.00 192.00
192. 01 19201 FOUNDATI ON	0	0		0 0	0	192.01
192. 02 19202 CLINICS	0	0		0 113, 107		192.02
192. 03 19206 HOME HEALTH PARTNERSHIP 192. 04 19207 WESTFI ELD SCHOOLS	0	0				192.03 192.04
192. 05 19203 PRACTI CE MANAGEMENT	0	0		0 0		192.04
192. 06 19204 MOB - NOBLESVILLE SQUARE	0	0		0 0		192.06
192. 07 19208 PHYSI CLANS' PRI VATE OFFI CES 192. 08 19205 RI VERVI EW MEDI CAL ARTS	0	0				192.07 192.08
192. 09 19209 BEHAVI OR CARE	0	0		0 0		192.00
193. 00 19300 NONPALD WORKERS	0	0		0 0		193.00
	~ ~ ~	~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~				
193. 01 19301 PHYSI CI AN SERVI CES-LYONS 193. 02 19302 UNI VERSI TY HS ATHLETI CS	0	0 0		0 0		193. 01 193. 02

Health Financial Systems	RI VERVI EW I	HOSPI TAL		In Lieu of Form CMS-2552-1			
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CCN: 15-0059			Worksheet B Part I Date/Time Prepared: 6/8/2020 1:18 pm		
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL		
	ADMI NI STRATI O	SERVICES &		RECORDS &	SERVI CE		
	N	SUPPLY		LI BRARY			
	13.00	14.00	15.00	16.00	17.00		
193. 03 19303 OB/GYN SPEC NEMUNALTI	0	0		0 0	0 193. 03		
193.04 19304 OB/GYN SPEC GATHERS	0	0		0 0	0 193. 04		
193. 05 19305 OB SPECIALI STS DAVENPORT	0	0		0 0	0 193.05		
194.0007950 WORKMED	0	0		0 0	0 194.00		
194.0107951 MEALS ON WHEELS	0	0		0 0	0 194.01		
200.00 Cross Foot Adjustments					200.00		
201.00 Negative Cost Centers	0	0		0 0	0 201.00		
202.00 TOTAL (sum lines 118 through 201)	720, 396	22, 530, 579	23, 760, 89	2, 070, 352	1, 198, 637 202. 00		

Heal th	Financial Systems	RI VERVI EW H	OSPI TAL		In Lieu	u of Form CMS-2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 01/01/2019	Worksheet B Part I
				ſ	Го 12/31/2019	Date/Time Prepared: 6/8/2020 1:18 pm
	Cost Center Description	PARAMED ED PRGM PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown	Total	
		23.00	24.00	Adjustments 25.00	26.00	
	GENERAL SERVICE COST CENTERS	23.00	24.00	23.00	20.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL					4.00
7.00	00700 OPERATION OF PLANT					7.00
8.00	00800 LAUNDRY & LI NEN SERVI CE					8.00
9.00	00900 HOUSEKEEPI NG					9.00
10.00	01000 DI ETARY					10.00
11.00 13.00	01100 CAFETERIA 01300 NURSING ADMINISTRATION					11.00 13.00
	01400 CENTRAL SERVICES & SUPPLY					14.00
	01500 PHARMACY					15.00
	01600 MEDI CAL RECORDS & LI BRARY					16.00
	01700 SOCIAL SERVICE	010 000				17.00
23.00	02300 PARAMED ED PRGM PHARMACY	319, 082				23.00
30.00	03000 ADULTS & PEDIATRICS	0	24, 290, 813	(	24, 290, 813	30.00
	03100 I NTENSI VE CARE UNI T	0	5, 869, 238	(		31.00
41.00	04100 SUBPROVI DER – I RF	0	4, 872, 032	(	4, 872, 032	41.00
	04300 NURSERY	0	0	(		43.00
44.00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	0	2,812,323	(	2, 812, 323	44.00
50.00	05000 OPERATING ROOM	0	1, 672, 347	(	1, 672, 347	50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0	(		52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	4, 103, 798	(	4, 103, 798	54.00
	05500 RADI OLOGY-THERAPEUTI C	0	2, 119, 388	(	2/ 11/ 000	55.00
	05700 CT SCAN	0	763, 342		763, 342	57.00 57.01
57.01 58.00	03630 ULTRA SOUND 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	633, 277 734, 500	(	000,211	57.01
59.00	05900 CARDI AC CATHETERI ZATI ON	0	1, 599, 877	(		59.00
	06000 LABORATORY	0	9, 979, 395	(	9, 979, 395	60.00
	06001 BLOOD LABORATORY	0	0	(		60.01
63.00 64.00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	690, 845			63.00 64.00
65.00	06500 RESPIRATORY THERAPY	0	2, 347, 718	(	-	65.00
	06600 PHYSI CAL THERAPY	0	10, 693, 300	(		66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	(		67.00
	06800 SPEECH PATHOLOGY	0	0	(	5	68.00
69.00 71.00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1, 930, 279 22, 530, 579			69.00 71.00
	07200 I MPL. DEV. CHARGED TO PATIENT	0	13, 436, 890	(	13, 436, 890	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	319, 082	24,079,977	(		73.00
	07400 RENAL DIALYSIS	0	469, 150	(	469, 150	74.00
	03020 OTHER ANCI LLARY 03140 CARDI AC REHAB	0	0	(		76.00 76.01
	03070 WOMEN' S CENTER	0	2, 366, 381 1, 196, 330		2, 366, 381 1, 196, 330	76.02
	03330 ENDOSCOPY	0	0	(		76.03
	OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			1	
		0	941, 992	(		90.00
	09001 OUTPATI ENT 09002 NEUROPSYCHOLOGY	0	1, 704, 604 636, 301		0 1, 704, 604 0 636, 301	90. 01 90. 02
	09100 EMERGENCY	0	8, 994, 671	( (	8, 994, 671	90.02
	09101 SHORT STAY	0	0			91.01
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		-	(		92.00
05 05	OTHER REIMBURSABLE COST CENTERS		4/0.055			
	09500 AMBULANCE SERVICES	0	160, 089	[(	160, 089	95.00
95.00	SPECIAL PURPOSE COST CENTERS		454 (00 40)	(	151, 629, 436	118.00
95.00 118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	319, 082	151, 629, 436		, ,	
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	319, 082	151, 629, 436			
118.00 190.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	319, 082	1, 045, 103	(		190.00
118.00 190.00 192.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CIANS' PRI VATE OFFI CES	319, 082 0 0	1, 045, 103 42, 044, 682		42, 044, 682	192.00
118.00 190.00 192.00 192.01	SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CIANS' PRI VATE OFFI CES 19201 FOUNDATI ON	319, 082 0 0 0	1, 045, 103 42, 044, 682 259, 200	(	42, 044, 682 259, 200	192.00 192.01
118.00 190.00 192.00 192.01 192.02	SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CIANS' PRI VATE OFFI CES	319, 082 0 0 0 0 0 0	1, 045, 103 42, 044, 682	(	42, 044, 682	192.00
118.00 190.00 192.00 192.01 192.02 192.03 192.04	SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CI ANS' PRI VATE OFFI CES 19201 FOUNDATI ON 19202 CLI NI CS 19206 HOME HEALTH PARTNERSHI P 19207 WESTFI ELD SCHOOLS	319, 082 0 0 0 0 0 0 0 0	1, 045, 103 42, 044, 682 259, 200 1, 672, 714	(	42, 044, 682259, 2001, 672, 714	192. 00 192. 01 192. 02
118.00 190.00 192.00 192.01 192.02 192.03 192.04 192.05	SUBTOTALS (SUM OF LINES 1 through 117)         NONREI MBURSABLE COST CENTERS         19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN         19200 PHYSI CI ANS' PRI VATE OFFI CES         19201 FOUNDATI ON         19202 CLI NI CS         19200 HOME HEALTH PARTNERSHI P         19200 WESTFI ELD SCHOOLS         19203 PRACTI CE MANAGEMENT	319, 082 0 0 0 0 0 0 0 0 0 0	1, 045, 103 42, 044, 682 259, 200 1, 672, 714 2, 469 1, 881, 641 912, 136	(	42,044,682           259,200           1,672,714           2,469           1,881,641           912,136	192.00 192.01 192.02 192.03 192.03 192.04 192.05
118.00 190.00 192.00 192.01 192.02 192.03 192.04 192.05 192.06	SUBTOTALS (SUM OF LINES 1 through 117)         NONREI MBURSABLE COST CENTERS         19000       GI FT, FLOWER, COFFEE SHOP & CANTEEN         19200       PHYSI CI ANS' PRI VATE OFFI CES         19201       FOUNDATI ON         19202       CLI NI CS         19204       HOME HEALTH PARTNERSHI P         19203       PRACTI CE MANAGEMENT         19204       MOB - NOBLESVI LLE SQUARE	319, 082 0 0 0 0 0 0 0 0 0 0	1, 045, 103 42, 044, 682 259, 200 1, 672, 714 2, 469 1, 881, 641	(	42,044,682           259,200           1,672,714           2,469           1,881,641	192.00 192.01 192.02 192.03 192.03 192.04 192.05 192.06
118.00 190.00 192.00 192.01 192.03 192.03 192.04 192.05 192.06 192.07	SUBTOTALS (SUM OF LINES 1 through 117)         NONREI MBURSABLE COST CENTERS         19000       GI FT, FLOWER, COFFEE SHOP & CANTEEN         19200       PHYSI CI ANS' PRI VATE OFFI CES         19201       FOUNDATI ON         19202       CLI NI CS         19204       HOME HEALTH PARTNERSHI P         19203       PRACTI CE MANAGEMENT         19204       MOB - NOBLESVI LLE SQUARE         19208       PHYSI CI ANS' PRI VATE OFFI CES	319, 082 0 0 0 0 0 0 0 0 0 0 0 0	1, 045, 103 42, 044, 682 259, 200 1, 672, 714 2, 469 1, 881, 641 912, 136 38, 401 0	(	42,044,682           259,200           1,672,714           2,469           1,881,641           912,136           38,401           0           0	192.00 192.01 192.02 192.03 192.04 192.05 192.05 192.07
118.00 190.00 192.00 192.01 192.03 192.03 192.04 192.05 192.06 192.07 192.08	SUBTOTALS (SUM OF LINES 1 through 117)         NONREI MBURSABLE COST CENTERS         19000       GI FT, FLOWER, COFFEE SHOP & CANTEEN         19200       PHYSI CI ANS' PRI VATE OFFI CES         19201       FOUNDATI ON         19202       CLI NI CS         19204       HOME HEALTH PARTNERSHI P         19203       PRACTI CE MANAGEMENT         19204       MOB - NOBLESVI LLE SQUARE	319, 082 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 045, 103 42, 044, 682 259, 200 1, 672, 714 2, 469 1, 881, 641 912, 136		42,044,682           259,200           1,672,714           2,469           1,881,641           912,136           38,401           0           99,416	192.00 192.01 192.02 192.03 192.03 192.04 192.05 192.06

Health Financial Systems	RI VERVI EW H	IOSPI TAL	In Lie	In Lieu of Form CMS-2552-10		
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Peri od:	Worksheet B	
				From 01/01/2019 To 12/31/2019		
				10 12/31/2019	6/8/2020 1:18 pm	
Cost Center Description	PARAMED ED	Subtotal	Intern &	Total		
	PRGM PHARMACY		Resi dents			
			Cost & Post			
			Stepdown			
			Adjustments			
	23.00	24.00	25.00	26.00		
193. 01 19301 PHYSI CI AN SERVI CES-LYONS	0	119, 717		0 119, 717	193.01	
193. 02 19302 UNI VERSI TY HS ATHLETI CS	0	45, 385		0 45, 385	193.02	
193.03 19303 OB/GYN SPEC NEMUNALTI	0	719, 049		0 719, 049	193.03	
193.04 19304 OB/GYN SPEC GATHERS	0	2, 293		0 2, 293	193.04	
193.05 19305 OB SPECIALISTS DAVENPORT	0	205, 273		0 205, 273	193.05	
194. 00 07950 WORKMED	0	1, 039, 736		0 1, 039, 736	194.00	
194.0107951 MEALS ON WHEELS	0	286, 594		0 286, 594	194.01	
200.00 Cross Foot Adjustments	0	0		0 0	200.00	
201.00 Negative Cost Centers	0	0		0 0	201.00	
202.00 TOTAL (sum lines 118 through 201)	319, 082	202, 404, 383		0 202, 404, 383	202.00	

ALLOCA	Financial Systems TION OF CAPITAL RELATED COSTS	RI VERVI EW	Provi der CC	F	Period: From 01/01/2019 Fo 12/31/2019		pared:
	Cost Center Description	Directly Assigned New Capital Related Costs	CAPI TAL RELATED COSTS NEW BLDG & FI XT	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	ADMI NI STRATI V E & GENERAL	pm
		0	1.00	2A	4.00	5.00	
	GENERAL SERVICE COST CENTERS	1					
1.00 4.00 5.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	0		91,65		1 410 107	1.00 4.00 5.00
7.00	00700 OPERATION OF PLANT		.,	1, 409, 219 7, 950, 412		1, 419, 197 126, 134	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	46, 548	46, 548		3, 709	8.00
9.00	00900 HOUSEKEEPI NG	0	0,,000	37, 655		17, 451	9.00
10.00	01000 DI ETARY 01100 CAFETERI A		103, 846 262, 175	103, 846 262, 175		6, 778 17, 254	10.00
13.00	01300 NURSI NG ADMI NI STRATI ON			11, 965		4, 698	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0		222, 825		152, 720	
15.00	01500 PHARMACY	0		277, 883		159, 420	
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	,	94, 633		12, 556	
17.00 23.00	01700 SOCIAL SERVICE 02300 PARAMED ED PRGM PHARMACY			52, 563 4, 959		7, 352 2, 112	17.00 23.00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	4, 757	4, 75	230	2,112	25.00
30.00	03000 ADULTS & PEDIATRICS	0	2, 818, 885	2, 818, 885	5 9, 747	105, 945	30.00
31.00	03100 I NTENSI VE CARE UNI T	0		450, 288		30, 215	
41.00	04100 SUBPROVIDER - IRF	0		306, 580		24, 533	41.00
43.00	04300 NURSERY 04400 SKILLED NURSING FACILITY	0		( 222, 057	, i i i i i i i i i i i i i i i i i i i	0 13, 865	43.00
11.00	ANCI LLARY SERVICE COST CENTERS		222,007	222,001		10,000	1 1.00
50.00	05000 OPERATING ROOM	0		1, 619, 726	5 4, 472	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		(	, i i i i i i i i i i i i i i i i i i i	0	52.00
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C	0		260, 319		23, 325	
57.00	05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN		229, 575 64, 848	229, 575 64, 848		11, 285 4, 330	
57.01	03630 ULTRA SOUND	0		17,020		4, 120	57.0
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	82, 572	82, 572		3, 929	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	/2/100	92, 105		9, 515	59.00
60.00		0	458, 414	458, 414		60, 750	
60. 01 63. 00	06001 BLOOD LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	0	62, 449	( 62, 449		0 4, 025	60.0 <sup>°</sup> 63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	(		0	64.00
65.00	06500 RESPI RATORY THERAPY	0	34, 679	34, 679		15, 149	65.0
66.00	06600 PHYSI CAL THERAPY	0	120, 546	120, 546		67, 875	66.0
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	(		0	67.0 68.0
69.00	06900 ELECTROCARDI OLOGY		320, 944	320, 944		7, 935	
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0		(	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	(	0 0	93, 008	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	)	0	0	73.00
76.00	07400 RENAL DI ALYSI S 03020 OTHER ANCI LLARY		29, 721	29, 72		2, 887 0	74.00
76.01	03140 CARDI AC REHAB		86, 507	86, 507	7 763	14, 367	
76.02	03070 WOMEN' S CENTER	0	164, 727	164, 72		5, 729	
76.03		0	0	(	0 0	0	76.03
90 00	OUTPATI ENT SERVICE COST CENTERS	0	77, 133	77, 133	3 406	4, 969	90.00
90.00	09000 CLINIC 09001 0UTPATI ENT		112, 324	112, 324		4, 969 9, 898	
90.02	09002 NEUROPSYCHOLOGY	0	130, 176	130, 176		2, 826	
91.00	09100 EMERGENCY	0	678, 296	678, 296	5 3, 758	48, 584	91.00
91.01	09101 SHORT STAY	0	0	(	0	0	91.0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
95.00	09500 AMBULANCE SERVICES	0	8, 734	8, 734	1 56	972	95.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	19, 014, 965	19, 014, 965	62, 684	1, 080, 220	118.00
	NONREI MBURSABLE COST CENTERS	1					1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	193, 232	193, 232			190.00
	19200 PHYSICIANS' PRIVATE OFFICES 19201 FOUNDATION		612, 648	612, 648	3 23, 815 0 205	282, 510 1 722	192. 00 192. 0
	19201 FOUNDATION 19202 CLINICS			(	1,139	10, 794	
	19206 HOME HEALTH PARTNERSHIP	0	o o	(	0 0		192.0
192.04	19207 WESTFIELD SCHOOLS	0	0	(	1, 492	13, 024	192. 04
	19203 PRACTI CE MANAGEMENT	0	0	(	447	6, 312	
	19204 MOB - NOBLESVILLE SQUARE	0	0	(			192.0
	19208 PHYSICIANS' PRIVATE OFFICES 19205 RIVERVIEW MEDICAL ARTS			( r			192. 0 192. 0
197 13		. 0	- U	(	- 0	000	1 · · ∠ · U

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO	CN: 15-0059	Period: From 01/01/2019	Worksheet B Part II		
				To 12/31/2019			
		CAPI TAL					
		RELATED COSTS					
Cost Center Description	Di rectl y	NEW BLDG &	Subtotal	EMPLOYEE	ADMI NI STRATI V		
	Assigned New	FLXT		BENEFITS	E & GENERAL		
	Capi tal			DEPARTMENT			
	Related Costs						
	0	1.00	2A	4.00	5.00		
193.00 19300 NONPALD WORKERS	0	0		0 0	0	193.00	
193. 01 19301 PHYSI CLAN SERVI CES-LYONS	0	0		0 89	829	193.01	
193. 02 19302 UNI VERSI TY HS ATHLETI CS	0	0		0 36	314	193.02	
193.03 19303 OB/GYN SPEC NEMUNALTI	0	0		0 551	4, 977	193.03	
193.04 19304 OB/GYN SPEC GATHERS	0	0		0 1	16	193.04	
193. 05 19305 OB SPECIALI STS DAVENPORT	0	0		0 154	1, 421	193.05	
194. 00 07950 WORKMED	0	0		0 575	7, 197	194.00	
194.0107951 MEALS ON WHEELS	0	0		0 95	1, 913	194.01	
200.00 Cross Foot Adjustments				0		200.00	
201.00 Negative Cost Centers		0		0 0		201.00	
202.00 TOTAL (sum lines 118 through 201)	0	19, 855, 109	19, 855, 1	91, 657			

ALLOCALION OF CAPITAL RELATED OSTS	Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lieu	u of Form CMS-	2552-10
Open Construct Note (*)         Full Note (*) <t< td=""><td>ALLOCATION OF CAPITAL RELATED COSTS</td><td></td><td>Provider C</td><td>Fi</td><td>rom 01/01/2019</td><td>Part II</td><td>nared.</td></t<>	ALLOCATION OF CAPITAL RELATED COSTS		Provider C	Fi	rom 01/01/2019	Part II	nared.
PLANT         UVER: SERVICE         0         0           000         00100 KER CAP ELCOSTS BLOG A FLY         0 <t< td=""><td>Cost Costor Description</td><td></td><td></td><td></td><td></td><td>6/8/2020 1:18</td><td>pareu. pm</td></t<>	Cost Costor Description					6/8/2020 1:18	pareu. pm
Decked. Service Cost CENTERS         Image: Cost CENTERS           0.0000 LINDTEE BUILTIS OLEWARNENT         0.0000 LINDTEE BUILTIS OLEWARNENT         0.0000 LINDTEE BUILTIS OLEWARNENT           0.0000 LINDTEE BUILTIS OLEWARNENT         0.0000 LINDTEE BUILTIS OLEWARNENT         0.0000 LINDTEE BUILTIS OLEWARNENT           0.0000 LINDTEE PUILTIS OLEWARNENT         0.0000 LINDTEE BUILTIS OLEWARNENT         0.0000 LINDTEE BUILTIS OLEWARNENT           0.0000 LINDTEE PUILTIS OLEWARNENT         0.0000 LINDTEE PUILTIS OLEWARNENT         0.0000 LINDTEE PUILTIS OLEWARNENT           10.0000 LINDTEE PUILTIS OLEWARNENT         203, 568         0.2, 390         90, 486, 647           10.0000 LINDTEE PUILTIS OLEWARNENT         7, 290         0         0.0000         0.0000           10.0000 LINDTEE PUILTIS OLEWARNENT         17, 3022         666         2, 82         0.011, 188         184, 200           10.0000 LINDTEE PUILTIS OLEWARNENT         13, 924         0         0.0000         0.0000         7, 144         19, 224         12, 12, 15, 16, 000           10.0000 LINDTEE PUILTIS OLEWARNENT         20, 188, 460         2, 24, 20         12, 24, 150         10, 224, 150         10, 224, 150         10, 224, 150         10, 224, 150         10, 224, 150         10, 224, 150         10, 224, 150         10, 224, 150         10, 224, 150         10, 224, 150         10, 224, 150         10, 22	COST CENTER DESCRIPTION				DIETARY	CAFETERIA	
1.000         00100         DEC CAP FELC CASTS-BLEG & FIXT         1.00         4.00           5.00         00400         DEPARATESON         4.00           5.00         00500         DEPARATESON         4.00           5.00         00500         DEPARATESON         5.00           6.00         00500         DEPARATESON         5.00         8.00           6.00         00500         DEPARATESON         29.240         6.0         2.100         9.00           7.00         DEPARATESON         29.240         0         2.100         9.00         9.00           11.00         DITOSON MERSINE AND STRATTON         20.266         0         2.131         0         2.000         3.000		7.00	8.00	9.00	10.00	11.00	
4.00         Decoder Javie NUTRE TRUE TIS DEPARTMENT         4.00         4.00           0.000         DECODER MARTMENT TIS DEPARTMENT         8.0.29         4.00           1.000         DECODER MARTMENT TIS DEPARTMENT         9.02         4.00           0.000         DECODER MARTMENT TIS DEPARTMENT         8.0.29         4.00         5.6.64         9.00           0.000         DECODER MARTMENT TIS DEPARTMENT         2.03.886         0         2.341         19.9.00           1.000         DECODER MARTMENT TIS DEPARTMENT         2.03.886         0         2.344         19.9.00           1.000         DECODER MARTMENT         2.03.886         0         2.344         10.00         11.00							1 1 00
7.00         DOUDD GPLANTION F PLANT         B, D78, 948							
8.00         000000 (LAURDRY & LINEN SERVICE         3.0         147         8.0.479         8.0.0         950.00000         950.00000         950.00000         950.00000         950.00000         950.00000         950.00000         950.000000         950.000000         950.0000000000000         950.00000000000000000000000000000000000							1
9.00         DORODI HOUSEKETPING         9.2.20         0         BB, 644         9.00			0/ 470				1
10.00         01000         DETRAY         60. 640         0         341         191.92         10. 04           11.00         TH300         MURSL NR ARM IN STRATTON         9,297         0         0         0         3.8.1         12.00           12.00         TH300         MURSL NR ARM IN STRATTON         9,297         0         0         0         3.8.1         12.00           12.00         TH300         MURSL NR ARM IN STRATTON         9,297         0         0         0         7.8.461         17.00							1
10.100         DIADO MURSING ADMINISTRATION         9, 291         0         0         0         3.321         13.00           15.00         DIADO MURSING ADMINISTRATION         9, 291         17, 302         660         5         0         11, 88         14.00           15.00         DISAD PLANAACY         25, 786         0         2, 134         0         28         0         0         0         11, 88         14.00           15.00         DISAD MURSING ADMINISTRATION         2, 157, 786         0         0         0         0         17, 101         17, 101         17, 101         17, 101         17, 101         17, 101         17, 101         17, 101         17, 101         17, 101         14, 00         18, 37, 71         14, 44, 19         19, 97, 97, 11, 14, 14, 19         19, 97, 12, 12         14, 12, 97, 77, 12, 45, 62, 27, 52, 26         2, 64, 94         14, 102         14, 12, 97, 77, 12, 45, 62, 272         5, 266         2, 64, 94         14, 102         14, 102         14, 12, 11, 14, 14, 104         14, 12, 12, 17, 17, 14, 45, 46         14, 104         14, 12, 12, 17, 17, 14, 14, 104         14, 12, 12, 17, 17, 14, 14, 104         14, 12, 12, 17, 17, 14, 14, 104         14, 12, 12, 12, 17, 17, 14, 14, 104         14, 12, 12, 12, 17, 17, 14, 14, 104         14, 12, 12, 12, 17, 17, 14, 14, 104         14, 12, 12, 12, 12, 1			-		191, 930		1
14.00       [01400] CENTRAL SERVICES & SUPPLY       173,032       6.60       2.8       0       11,186       14,00       15,00       16,00       10,00       10,00       10,00       10,00       10,00       10,00       10,00       10,00       10,00       10,00       10,00       11,00			-		0		1
15.00         01500         PHARMACY         215, 780         0         2.134         0         226, 690         15.00           17.00         01700         SOCIAL SERVICE         0         0         0         12, 515         16.00           10.00         10700         SOCIAL SERVICE         0         0         0         0         12, 515         16.00           10.00         03000         ADULTS & PEDIATRICS         3, 481         0			-	-			
16. 00 01+00 WEBICAL BECORDS & LIBBARY       73, 486       0       422       0       71, 515       16. 00         73. 00 2000 PAAMID ID PROFILES       3, 851       0       0       0       864       71, 00         1700 01700 SOLAL SERVICE COST CENTERS       2, 188, 900       71, 07       70, 77       74, 490       72, 600       71, 00         1700 01700 SUBPROVIDER - LIFF       2, 188, 900       6, 77       74, 490       72, 600       74, 401       74, 900         1700 01700 SUBPROVIDER - LIFF       2, 88, 971       6, 777       6, 379       6, 441       17, 900       44, 60         170 00 1000 SUBPROVIDER - LIFF       0       0       0       6, 720       2, 694       0       44, 60         170 00 1000 SUBPROVIDER - LIFF       0       0       0       43, 660       5, 200       26, 694       0       44, 60         170 00 5000 SUBPROVIDER - LIFF       0       0       0       12, 517       44, 490       0       62, 694       52, 694       52, 694       52, 694       52, 694       52, 694       52, 694       52, 694       52, 694       52, 694       52, 694       52, 694       52, 694       52, 694       52, 694       52, 694       52, 694       52, 694       52, 694       52, 694					U U		1
21.00         D 20200 PRAMED D PRON PHARMARY         3, 801         0         0         0         854         21.00         0         854         21.00         0         854         21.00         95.00         71.00         26, 137         11.40         95.00         71.00         71.00         72.00         <			-		-		
INPATE INT ROUTE SERVICE COST CENTERS         Internet intern			-	-	-		
30. 00       3000 JAULTS & PEDIATRICS       2. 188, 968       27, 107       26, 199       105, 508       96, 666       30. 00         10. 00 JADDI MERSERY       238, 071       6, 757       5, 377       14, 481       19. 029       11. 00       141. 00         10. 00 JADDI MERSERY       172, 435       6, 272       5, 200       26, 949       14. 00         10. 00 JADDI MERSERY       172, 435       6, 272       5, 200       26, 949       14. 00         10. 00 JADDI MERSERY       172, 435       6, 272       5, 200       26, 949       14. 00         10. 00 JADDI MERSERY       127, 777       8, 393       9, 132       0       45, 664       50. 00         10. 00 JADDI MERSERY       128, 777       8, 393       9, 132       0       0       50. 00       50.		3, 851	0	0	0	854	23.00
31.00       03100       INTERNS USE CARE. UNIT       349, 665       6, 319       5, 377       14, 402       22, 600       31.00         43.00       04300       NURSERY       0 <t< td=""><td></td><td>2, 188, 968</td><td>27, 107</td><td>26, 199</td><td>105, 508</td><td>96, 686</td><td>30.00</td></t<>		2, 188, 968	27, 107	26, 199	105, 508	96, 686	30.00
43. 00         04300         NURSERY         0							
44.00         0.04400         SKILLED NURSING FACILITY         172,435         6,272         5,206         26,949         0         44,00           MACILLARY SERVICE COST CENTERS         -							
ARCILLARY SERVICE COST CENTERS           92.00         005000 (PERTINE ROM         1.257,77         8,333         9,132         0         45,664         50.00           52.00         05200 (PERTINE ROM & LABOR ROM         0         0         0         0         50.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00			-	-	Ű		1
50. 00         05000         0PERATING ROOM         1.257, 777         8. 393         9. 132         0         43. 664         50. 00           51. 00         05000         0PELVERY ROOM         0		172, 435	6, 272	5, 206	26, 949	0	44.00
54. 00         054.00         054.00         054.00         054.00         054.00         054.00         054.00         054.00         054.00         054.00         054.00         057.00         056.00         550.00         560.00         660.00         77.00         660.01 </td <td></td> <td>1, 257, 777</td> <td>8, 393</td> <td>9, 132</td> <td>0</td> <td>43, 664</td> <td>50.00</td>		1, 257, 777	8, 393	9, 132	0	43, 664	50.00
55. 00         0500 RADICLORY-THERAPEUTIC         178, 273         700         ests         0         5, 078         55. 00         57. 01         05. 01         57. 01         05. 01         57. 01         05. 01         57. 01         05. 01         58. 00         0.80         0.900			-	-	-		1
57. 00       657.00       0700 (CT SZAM)       50.357       0       0       9.401       57.00       58.00       9902       57.01       13.216       0       85       0       9.297       57.01       58.00       9902       57.01       77.63       0       0       9500       6900       6500       6800       0.00       67.06       59.00       6900       60.01       60001       LABORATORY       355.975       0       2.987       0       42.698       60.00       60.01       60.01       60.01       60.01       60.01       60.01       60.01       60.01       60.00					-		1
57. 01       363:01 ULTRA SOUND       13. 216       0       650       902       57. 01         58. 00       05000 CARDIAC CATHETER JATION       71, 523       2, 231       0       0       7, 708       59. 00         0.000       06001 BLOOD LABORATORY       355. 975       2, 987       0       42. 698       60. 00         0.00       06001 INTRAVENUS THERAPY       0       0       0       66. 00       66. 00         0.00       06001 INTRAVENUS THERAPY       0       0       0       64. 00       66. 00       66. 00       66. 00       66. 00       66. 00       66. 00       66. 00       66. 00       66. 00       66. 00       66. 00       66. 00       66. 00       66. 00       66. 00       66. 00       67. 00       0       0       68. 00       66. 00       66. 00       67. 00       78. 00       78. 00       78. 00       78. 00       78. 00       78. 00       78. 00       78. 00       78.					-		
58. 00         06800 (ARGRETIC RESONANCE LIVACING (MRI)         64. 120         0         88         0         3. 160         58. 00           00         00000 (ARDIA CATHETERIZATION         71, 523         2. 31         0         0, 706         59. 00           0.0000 (ARDIA CATHETERIZATION         355, 975         0         2, 987         0         42. 698         60. 00           0.0010 (AGOBI LOOD LABORATORY         0         0         0         60. 00         66. 00           0.0000 (ARDIA TEXPENDENT THERAPY         0         0         0         64. 00         64. 00           0.000 (CLIPATIONAL THERAPY         93. 608         729         0         62. 056         66. 00           0.000 (SCIPATIONAL THERAPY         93. 608         729         0         0         0         64. 00           0.000 (SCIPATIONAL THERAPY         0         0         0         0         0         0         0         67. 00         68. 00         660. 00         660. 00         660. 00         67. 00         68. 00         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0 <td></td> <td></td> <td>-</td> <td></td> <td>-</td> <td></td> <td>1</td>			-		-		1
60.00         06000         LABORATORY         355,975         0         2,987         0         42,698         60.00         66.01           63.00         06300         BLOOD LABORATORY         0         0         66.01           64.00         64.00         0         0         0         66.01           64.00         0         0         0         0         0         66.01           66.00         06600         0         0         0         0         0         66.00           0         0         0         0         0         0         0         66.00           0         0         0         0         0         0         0         66.00           0         0         0         0         0         0         66.00         6600         6600         6600         6600         6600         6600         6600         6600         6600         6600         67.00         71.00         71.00         71.00         71.00         71.00         72.00         0         0         0         72.00         72.00         72.00         0         0         72.00         72.00         72.00         72.00         72			-	85	0	3, 169	58.00
60.01         BLOOD         LABORATORY         0				-	0		
63. 00         00-300         BLOOD STORI NG, PROCESSI NG & TRANS.         48, 494         0         0         0         63. 00           64.00         06400         INTRAVENDUS THERAPY         26, 930         0         0         15. 831         65. 00           65. 00         06500         PHYSI CAL THERAPY         26, 930         0         0         0         66. 00           66.00         06000         PHYSI CAL THERAPY         93, 608         729         0         0         67. 00         66. 00         66. 00         66. 00         66. 00         66. 00         66. 00         66. 00         66. 00         66. 00         66. 00         66. 00         67. 00         0         0         0         0         68. 00         66. 00         66. 00         67. 00         0         0         0         71. 00         71. 00         71. 00         73. 00         74. 00         0         0         0         74. 00         0			0		0		
65:00         06500         PHSTCAT. HERRAPY         26,930         0         0         15,831         65.00           66:00         06700         OCUPATI (NAL. THERRAPY         93,608         729         0         0         66.00           66:00         06700         OCUPATI (NAL. THERRAPY         93,608         729         0         0         67.00         66.00         67.00         0			-	-	0		1
66.00         06600         PMSD (AL THERAPY         93.608         7.29         0         0         66.00         66.00         66.00         66.00         67.00         0         0         0         0         0         71.00         72.00         72.00         73.00         73.00         73.00         73.00         73.00         73.00         74.00         0         0         0         74.00         74.00         74.00         74.00         74.00         74.00         74.00         74.00         74.00         74.00         74.00         74.00         74.00         74.00         74.00         75.01         74.00         76.01         75.01         74.00         76.01         76.01         76.01         76.01         76.01         76.01         76.01         76.01         76.01         76.01         76.01         76.01         76.01         76.01         76.01         76.01         76.01	64.00 06400 I NTRAVENOUS THERAPY	0	-	0	0	0	64.00
67.00         06700         0CUPATIONAL THERAPY         0         0         0         0         67.00           68.00         06800         SPEECH PATHOLOGY         0         0         0         67.00           68.00         06800         SPEECH PATHOLOGY         0         0         0         67.00           71.00         07100         MEDI CAL SUPPLIES CHARGED TO PATIENTS         0         0         0         71.00           72.00         07300         RUKS CHARGED TO PATIENTS         0         0         0         73.00           74.00         07400         RENAL DIALYSIS         23,079         0         0         0         74.00           76.00         03020         OTHER ANCI LLARY         0         0         0         74.00           76.01         03020         OTHER ANCI LLARY         0         0         0         0         76.00           76.02         03070         WOURY'S CENTER         127.917         431         1.280         0         6.177         76.02           76.02         000         0         0         0         0         0         0         0         0         0         0         0         0				-			1
68. 00         668.00         69600         6900         71.00         71.00         71.00         71.00         71.00         71.00         71.00         71.00         71.00         71.00         71.00         71.00         0         0         0         0         71.00         71.00         71.00         71.00         71.00         71.00         71.00         71.00         71.00         71.00         71.00         71.00         0         0         0         0         71.00					-		1
69.00         06900         ELECTROCARD 0 LOGY         249.225         742         3,243         0         8,794         69.00           71.00         07000         MPLL BV. CHARGED TO PATIENTS         0         0         0         72.00           72.00         07300         DRUSC CHARGED TO PATIENTS         0         0         0         0         73.00           74.00         7400         RAND RANE LLARY         0         0         0         0         74.00           76.00         3020         OTHER ANCI LLARY         0         0         0         0         76.00           0         0.00         0         0         0         0         0         0         76.00           0.00         0.00         0         0         0         0         0         76.03           0.00         0.00000 CLI NIC         S9.896         117         1.878         0         6.517         90.00           0.00         0.00000 CLI NIC         S9.896         117         1.873         7.254         0         92.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00			-	-	0		
72.00         072.00         IMPL         Dev         CHARGED TO PATIENT         0         0         0         0         72.00         73.00         74.00         76.03         74.00         66.30         76.03         75.03         76.03         76.03         76.03         76.03         76.03         76.03         76.03         76.03         76.03         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.0		249, 225	742	3, 243	0	8, 794	69.00
73.00         ORUGS CHARGED TO PATIENTS         0         0         0         0         0         0         0         0         73.00           74.00         0740.00         RENAL DI AL VISI S         23,079         0         0         0         0         0         0         0         0         0         74.00         76.00         03020         OTHER ANCI LLARY         0			0	-	0		1
74.00       0 <td></td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td></td> <td>1</td>		0	0	0	0		1
76 00         0320         OTHER ANCILLARY         0		23, 079	0	0	0		1
76.02       0370       WOMEN'S CENTER       127,917       431       1,280       0       6,177       76.02         01330       ENDOSCOPY       0       0       0       0       0       0       76.03       0<		0	0	0	0	0	
76.03       0330 [ENDOSCOPY       0       0       0       0       0       0       0       76.03         00.00       OUTPATI ENT SERVICE COST CENTERS       59,896       117       1,878       0       5,071       90.00         90.01       09000 [CLINIC       87,224       2,349       683       0       6,511       90.01         90.02       09002 [NEUROPSYCHOLOGY       101,086       0       0       0       90.00       90.01       90.01       91.01       90.01       526,721       11,673       7,254       0       32,958       91.00       91.01       92.00       9200 [OSECHATION BEDS (NON-DI STINCT PART)       0       0       0       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.01       92.00       92.01       92.00       92.01 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
OUTPATLENT SERVICE COST CENTERS           90.00         09000 CLINIC         59,896         117         1,878         0         5,071         90.00           90.01         09001 OUTPATLENT         87,224         2,349         683         0         6,511         90.01           90.02         09002 NUROPSYCHOLOGY         101,086         0         0         0         0         90.02           91.00         09101 SHORT STAY         0         0         0         0         0         0         0         0         0         0         0         101         92.00         09520 085ERVATION BEDS (NON-DI STINCT PART)         0         <							
90.00         09000         CLINIC         59,896         117         1,878         0         5,071         90.00           90.01         09001         OUTPATIENT         87,224         2,349         663         0         6,511         90.00           90.02         09002         NEUROPSYCHOLOGY         101,086         0		0			0	0	/0.03
90. 02         09002         NEUROPSYCHOLOGY         101,086         0 <th< td=""><td></td><td></td><td></td><td></td><td>0</td><td></td><td></td></th<>					0		
91.00       09100       EMERGENCY       526, 721       11, 673       7, 254       0       32, 958       91.00         91.01       09101       SHORT STAY       0       0       0       0       0       91.01         92.00       OBSERVATION BEDS (NON-DISTINCT PART)       0       0       0       0       92.00         07HER       REI MBURSABLE COST CENTERS       6, 782       0       0       0       709         95.00       MONDEL MURSABLE COST CENTERS       6, 782       0       0       0       709         91.00       ISUBTOLALS (SUM OF LINES 1 through 117)       7, 426, 543       79, 598       81, 161       191, 930       479, 631         118.00       SUBTOLALS (SUM OF LINES 1 through 117)       7, 426, 543       79, 598       81, 161       191, 930       479, 631         190.00       19000       GIFT, FLOWER, COFFEE SHOP & CANTEEN       150, 052       0       597       0       3, 505       190.00         192.01       19000ATION       0       0       0       0       192.01       0010ATI ON       192.01       0       192.02       192.02       192.02       192.02       192.03       192.04       0       0       192.04       192.02					0		
91.01         09101         SHORT STAY         0         0         0         0         0         91.01         92.00         09200         DBSERVATION BEDS (NON-DISTINCT PART)         92.00         92.00         0         0         0         92.00         92.00         0         0         0         92.00         92.00         0         0         0         92.00         92.00         92.00         92.00         92.00         0         0         0         92.00         92.00         0         0         0         92.00         92.00         92.00         0         0         0         92.00         92.00         92.01         92.02         92.01 <td></td> <td></td> <td></td> <td>J J</td> <td>0</td> <td></td> <td></td>				J J	0		
OTHER         REI MBURSABLE         COST CENTERS         0         0         709           95.00         09500         AMBULANCE         SERVI CES         6, 782         0         0         709         95.00           SPECI AL         PURPOSE         COST CENTERS         6, 782         0         0         709         95.00           I18.00         SUBTOTALS         SUM OF         LINES 1         through 117)         7, 426, 543         79, 598         81, 161         191, 930         479, 631         118.00           NONREI         MBURSABLE         COST CENTERS         0         597         0         3, 505         190.00           192.00         19200         PHYSI CI ANS'         PRI VATE         OFFICES         475, 744         6, 822         3, 926         0         0         192.00           192.01         FOUDATI ON         0         0         0         0         0         192.02           192.02         CLI NI CS         0         31         0         0         192.02           192.03         19206         HOME HEALTH         PARTNERSHI P         0         0         0         0         192.02           192.04         19204         MO			0	0	0		
95.00         OP500         AMBULANCE SERVICES         6,782         0         0         709         95.00           SPECIAL PURPOSE COST CENTERS							92.00
SPECIAL PURPOSE COST CENTERS         Image: Cost centers           118.00         SUBTOTALS (SUM OF LINES 1 through 117)         7, 426, 543         79, 598         81, 161         191, 930         479, 631           190.00         GIGT, FLOWER, COFFEE SHOP & CANTEEN         150, 052         0         597         0         3, 505         190.00           192.00         PHYSI CI ANS' PRI VATE OFFI CES         475, 744         6, 822         3, 926         0         0         192.00           192.01         FOUNDATI ON         0         0         0         0         0         192.02           192.02         LI NI CS         0         31         0         0         192.02           192.03         19200         HOMME HEALTH PARTNERSHI P         0         0         0         192.02           192.04         19207         WESTFI ELD SCHOOLS         0         0         0         0         192.05           192.05         19203         PRACTI CE MANAGEMENT         0         28         0         0         192.05           192.06         19204         MOB - NOBLESVI LLE SQUARE         0         0         0         0         192.06           192.07         19208         PHYSI CI ANS' PRI VA		( 700				700	05 00
118.00         SUBTOTALS (SUM OF LINES 1 through 117)         7, 426, 543         79, 598         81, 161         191, 930         479, 631         118.00           NONREI MBURSABLE COST CENTERS         NONREI MBURSABLE COST CENTERS         0         0         597         0         3, 505         190.00         192.00         19200         PHYSI CI ANS' PRI VATE OFFI CES         475, 744         6, 822         3, 926         0         0         192.00         192.01         19201         FOUNDATI ON         0         0         0         0         192.02         192.02         CLI NI CS         0         0         0         0         192.02         192.02         CLI NI CS         0         0         0         0         192.02 <td< td=""><td></td><td>6, 782</td><td>0</td><td>0</td><td>0</td><td>/09</td><td>95.00</td></td<>		6, 782	0	0	0	/09	95.00
NORREI MBURSABLE         COST         CENTERS           190.00         19000         GI FT,         FLOWER,         COFFEE         SHOP & CANTEEN         150,052         0         597         0         3,505         190.00           192.00         19200         PHYSI CLANS'         PRI VATE OFFICES         475,744         6,822         3,926         0         0         192.00           192.01         19201         FOUNDATI ON         0         0         0         0         0         0         192.02           192.02         19202         CLI NI CS         0         31         0         0         0         192.02           192.03         19206         HOME HEALTH         PARTNERSHI P         0         0         0         0         0         192.02           192.05         19203         PRACTI CE         MANAGEMENT         0         28         0         0         192.03           192.06         19204         MOB - NOBLESVI LLE SQUARE         0         0         0         0         192.05           192.06         19204         MOB - NOBLESVI LLE SQUARE         0         0         0         0         192.07           192.07         1920		7, 426, 543	79, 598	81, 161	191, 930	479, 631	118.00
192.00       19200       PHYSI CI ANS' PRI VATE OFFICES       475, 744       6, 822       3, 926       0       0       192.00         192.01       19201       FOUNDATI ON       0       0       0       0       1, 684       192.01         192.02       19202       CLI NI CS       0       31       0       0       192.02         192.03       19206       HOME HEALTH PARTNERSHI P       0       0       0       192.03         192.04       19207       WESTFI ELD SCHOOLS       0       0       0       0       192.04         192.05       19208       PRACTI CE MANAGEMENT       0       28       0       0       0       192.05         192.06       19204       MOB - NOBLESVI LLE SQUARE       0       0       0       192.06       192.04       192.05         192.07       19208       PHYSI CI ANS' PRI VATE OFFI CES       0       0       0       0       192.07         192.08       19205       RI VERVI EW MEDI CAL ARTS       0       0       0       192.09       192.09       192.09       192.09       192.09       192.09       192.09       192.09       192.09       0       0       0       0       192.09	NONREI MBURSABLE COST CENTERS		-		• • • •		
192.01       19201       FOUNDATION       0       0       1,684       192.01         192.02       19202       CLINICS       0       31       0       0       192.02         192.03       19206       HOME HEALTH PARTNERSHIP       0       0       0       0       192.03         192.04       19207       WESTFI ELD SCHOOLS       0       0       0       0       192.04         192.05       19203       PRACTI CE MANAGEMENT       0       28       0       0       192.05         192.07       19204       MOB - NOBLESVI LLE SQUARE       0       0       0       192.05         192.07       19208       PHYSI CI ANS' PRI VATE OFFICES       0       0       0       192.07         192.08       19205       RI VERVI EW MEDI CAL ARTS       0       0       0       192.08         192.09       19209       BEHAVI OR CARE       26,607       0       0       0       192.09         193.00       19300       NOPAI D WORKERS       0       0       0       0       193.00         193.02       19302       UNI VERSI TY HS ATHLETICS       0       0       0       0       193.02         193.02			0		0		
192.02       19202       CLINICS       0       0       192.02         192.03       19206       HOME HEALTH PARTNERSHIP       0       0       0       0       192.03         192.04       19207       WESTFI ELD SCHOOLS       0       0       0       0       192.04         192.05       19203       PRACTICE MANAGEMENT       0       28       0       0       192.05         192.06       19204       MOB - NOBLESVILLE SQUARE       0       0       0       192.05         192.07       19208       PHYSI CI ANS' PRI VATE OFFICES       0       0       0       192.07         192.08       19205       RI VERVI EW MEDI CAL ARTS       0       0       0       192.08         192.09       19209       BEHAVI OR CARE       26,607       0       0       0       192.09         193.00       19300       NONPAI D WORKERS       0       0       0       193.00       193.01       193.02       193.02       193.02       193.02       193.02       193.02       193.02       0       0       0       193.02		4/5, /44	6, 822		0		
192.03       19206       HOME HEALTH PARTNERSHIP       0       0       0       192.03         192.04       19207       WESTFI ELD SCHOOLS       0       0       0       192.04         192.05       19203       PRACTI CE MANAGEMENT       0       28       0       0       192.05         192.06       19204       MOB - NOBLESVI LLE SOUARE       0       0       0       192.05         192.07       19208       PHYSI CI ANS' PRI VATE OFFI CES       0       0       0       192.07         192.08       19205       RI VERVI EW MEDI CAL ARTS       0       0       0       192.08         192.09       19209       BEHAVI OR CARE       26, 607       0       0       0       192.09         193.00       19300       NONPAI D WORKERS       0       0       0       193.01         193.02       19302       UNI VERSI TY HS ATHLETI CS       0       0       0       193.02		0	31	0	0		
192.05       19203       PRACTI CE MANAGEMENT       0       28       0       0       192.05         192.06       19204       MOB - NOBLESVI LLE SQUARE       0       0       0       192.06         192.07       19208       PHYSI CI ANS' PRI VATE OFFICES       0       0       0       192.07         192.08       19209       RI VERVI EW MEDI CAL ARTS       0       0       0       192.08         192.09       19209       BEHAVI OR CARE       26,607       0       0       192.09         193.00       19300       NOPAI D WORKERS       0       0       0       193.01         193.02       19302       UNI VERSI TY HS ATHLETI CS       0       0       0       0       193.02	192. 03 19206 HOME HEALTH PARTNERSHIP	0		0	Ō	0	192.03
192.06       19204       MOB - NOBLESVILLE SQUARE       0       0       0       192.06         192.07       19208       PHYSICIANS' PRIVATE OFFICES       0       0       0       192.07         192.08       19205       RIVERVIEW MEDICAL ARTS       0       0       0       0       192.08         192.09       19209       BEHAVI OR CARE       26,607       0       0       0       192.09         193.00       19300       NOPAI D WORKERS       0       0       0       0       193.00         193.02       19302       UNI VERSI TY HS ATHLETICS       0       0       0       0       193.02		0	0	0	0		
192.07       19208       PHYSI CI ANS' PRI VATE OFFICES       0       0       0       192.07         192.08       19205       RI VERVI EW MEDI CAL ARTS       0       0       0       192.08         192.09       19209       BEHAVI OR CARE       26,607       0       0       0       192.09         193.00       19300       NONPAI D WORKERS       0       0       0       0       193.00         193.01       19301       PHYSI CI AN SERVI CES-LYONS       0       0       0       193.01         193.02       19302       UNI VERSI TY HS ATHLETI CS       0       0       0       0       193.02		0			0		
192.08       19205       RI VERVI EW MEDI CAL ARTS       0       0       0       192.08         192.09       19209       BEHAVI OR CARE       26,607       0       0       0       192.09         193.00       19300       NONPAI D WORKERS       0       0       0       0       193.00         193.01       19301       PHYSI CI AN SERVI CES-LYONS       0       0       0       193.01         193.02       19302       UNI VERSI TY HS ATHLETI CS       0       0       0       0       193.02		0	0	0	o		
193.00       19300       NONPAI D WORKERS       0       0       0       193.00         193.01       19301       PHYSI CI AN SERVICES-LYONS       0       0       0       0       193.01         193.02       19302       UNI VERSI TY HS ATHLETICS       0       0       0       0       193.02	192. 08 19205 RI VERVI EW MEDI CAL ARTS	-	0	0	Ō	0	192.08
193.01       PHYSI CI AN SERVI CES-LYONS       0       0       0       193.01         193.02       19302       UNI VERSI TY HS ATHLETI CS       0       0       0       0       193.02		26, 607	0	0	0		
193. 02 19302 UNI VERSI TY HS ATHLETI CS 0 0 0 0 0 193. 02				0	0		
		0	0	0	0		
		0	0	0	0		

Heal th Financia	In Lie	u of Form CMS-:	2552-10				
ALLOCATION OF C	CAPITAL RELATED COSTS		Provider C		Period:	Worksheet B	
					From 01/01/2019 To 12/31/2019	Part II Date/Time Pre	narod
					10 12/31/2019	6/8/2020 1: 18	_pm
Cos	st Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NO	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE				
		7.00	8.00	9.00	10.00	11.00	
193.04 19304 OB	/GYN SPEC GATHERS	0	0		0 0	0	193.04
193.05 19305 OB	SPECIALISTS DAVENPORT	0	0		0 0	0	193.05
194.0007950 WOF	RKMED	0	0		0 0	0	194.00
194.0107951 MEA	ALS ON WHEELS	0	0		0 0	1, 647	194.01
200. 00 Cro	oss Foot Adjustments						200.00
201.00 Neg	gative Cost Centers	0	0		0 0	0	201.00
202.00 TO	TAL (sum lines 118 through 201)	8, 078, 946	86, 479	85, 68	191, 930	486, 467	202.00

Heal th	Financial Systems	RI VERVI EW H	IOSPI TAL		In Lie	u of Form CMS-:	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CO	CN: 15-0059	Period: From 01/01/2019	Worksheet B Part II	
					To 12/31/2019	Date/Time Pre	epared:
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	6/8/2020 1:18 SOCI AL	
		ADMI NI STRATI O	SERVICES &		RECORDS &	SERVI CE	
		N 13.00	SUPPLY 14.00	15.00	LI BRARY 16. 00	17.00	
1 00	GENERAL SERVICE COST CENTERS						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 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG						8.00 9.00
10.00	01000 DI ETARY						10.00
11.00		20 717					11.00
13.00 14.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	29, 717 0	561, 194				13.00
15.00	01500 PHARMACY	0	0	686, 9	62		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0		0 194, 543	100 (00	16.00
17.00 23.00	01700 SOCIAL SERVICE 02300 PARAMED ED PRGM PHARMACY	0	0		0 0	108, 602 0	1
20100	INPATIENT ROUTINE SERVICE COST CENTERS						20100
30.00	03000 ADULTS & PEDIATRICS	16, 678	0		0 41, 127	88, 426	1
31.00 41.00	03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER – I RF	4, 071 3, 283	0		0 9,704 0 0	6, 143 10, 047	
43.00	04300 NURSERY	0	0		0 0	0	1
44.00	04400 SKILLED NURSING FACILITY	0	0		0 924	3, 986	44.00
50.00	ANCI LLARY SERVICE COST CENTERS	0	0		0 79, 481	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 0	0	
55.00 57.00	05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN	0	0		0 2, 310 0 0	0	
57.01	03630 ULTRA SOUND	0	0		0 0	0	1
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 0	0	1
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	0		0 0 0 4, 159	0	59.00 60.00
60.01	06001 BLOOD LABORATORY	0	0		0 0	0	1
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	0		0 0	0	
66.00	06600 PHYSI CAL THERAPY	0	0		0 26, 802	0	1
67.00	06700 OCCUPATIONAL THERAPY	0	0		0 0	0	67.00
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	0		0 0 0 6,007	0	68.00 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	561, 194		0 0	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0	(0) 0	0 0	0	
73.00 74.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0	686, 9	62 0	0	
76.00	03020 OTHER ANCI LLARY	0	0		0 0	0	
76.01	03140 CARDI AC REHAB	0	0		0 0	0	
76.02 76.03	03070 WOMEN' S CENTER 03330 ENDOSCOPY	0	0		0 0 0 0	0	
, 01 00	OUTPATIENT SERVICE COST CENTERS	· · · · ·				· · · · · · · · · · · · · · · · · · ·	10100
	09000 CLINIC	0	0		0 0 0		
90. 01 90. 02	09001 OUTPATI ENT 09002 NEUROPSYCHOLOGY	0	0		0 0 0 0	0	
91.00	09100 EMERGENCY	5, 685	0		0 13, 401	0	91.00
91.01	09101 SHORT STAY	0	0		0 0	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
95.00	09500 AMBULANCE SERVI CES	0	0		0 0	0	95.00
110.00	SPECIAL PURPOSE COST CENTERS	20 717	E(1 104	(0( 0	(2) 102 015	100 (02	110.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	29, 717	561, 194	686, 9	62 183, 915	108, 602	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00 192.01
	19201 FOUNDATI ON 219202 CLI NI CS	0	0		0 0 0 10, 628		192.01
192.03	19206 HOME HEALTH PARTNERSHIP	Ő	0		0 0	0	192.03
	19207 WESTFIELD SCHOOLS	0	0		0 0		192.04
	19203 PRACTICE MANAGEMENT 19204 MOB - NOBLESVILLE SQUARE	0	0				192.05 192.06
192.07	19208 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.07
	19205 RI VERVI EW MEDI CAL ARTS	0	0		0 0		192.08
	19209 BEHAVI OR CARE 19300 NONPAI D WORKERS	0	0		0 0		192.09 193.00
193.01	19301 PHYSI CLAN SERVI CES-LYONS	Ő	0		0 0	0	193.01
193.02	19302 UNI VERSI TY HS ATHLETI CS	0	0		0 0	0	193.02

Health Financial Systems	RI VERVI EW I	HOSPI TAL		In Lie	eu of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO	CN: 15-0059	Period: From 01/01/2019		
				To 12/31/2019	Date/Time Pre 6/8/2020 1:18	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	
	ADMI NI STRATI O	SERVICES &		RECORDS &	SERVI CE	
	N	SUPPLY		LI BRARY		
	13.00	14.00	15.00	16.00	17.00	
193. 03 19303 OB/GYN SPEC NEMUNALTI	0	0		0 0	0	193.03
193.04 19304 OB/GYN SPEC GATHERS	0	0		0 0	0	193.04
193. 05 19305 OB SPECIALI STS DAVENPORT	0	0		0 0	0	193.05
194. 00 07950 WORKMED	0	0		0 0	0	194.00
194.0107951 MEALS ON WHEELS	0	0		0 0	0	194.01
200.00 Cross Foot Adjustments	1					200.00
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	29, 717	561, 194	686, 9	62 194, 543	108, 602	202.00

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lieu	ر of Form CMS-2552	-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		riod: om 01/01/2019	Worksheet B Part II	
			To		Date/Time Prepared 6/8/2020 1:18 pm	d:
Cost Center Description	PARAMED ED PRGM PHARMACY	Subtotal	Intern & Residents	Total		
			Cost & 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.	
5. 00 00500 ADMI NI STRATI VE & GENERAL 7. 00 00700 OPERATI ON OF PLANT					5.	
8.00 00800 LAUNDRY & LI NEN SERVI CE				-	8.	00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY					9.	
11. 00 01100 CAFETERI A					11.	
13.00 01300 NURSING ADMINISTRATION					13.	
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY					14.	
16.00 01600 MEDI CAL RECORDS & LI BRARY					16.	
17.00 01700 SOCIAL SERVICE 23.00 02300 PARAMED ED PRGM PHARMACY	12, 032				17.	
INPATIENT ROUTINE SERVICE COST CENTERS	.2,002			1		
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T		5, 525, 276 903, 444	0	5, 525, 276 903, 444	30. 31.	
41. 00   04100  SUBPROVI DER - I RF		659, 845	0	659, 845	41.	
43.00 04300 NURSERY		0	0	0	43.	
44. 00 04400 SKI LLED NURSI NG FACI LI TY ANCI LLARY SERVI CE COST CENTERS		451, 694	0	451, 694	44.	00
50.00 05000 OPERATI NG ROOM		3, 022, 645	0	3, 022, 645	50.	
52. 00   05200   DELI VERY ROOM & LABOR ROOM 54. 00   05400   RADI 0LOGY-DI AGNOSTI C		0 518, 320	0	0 518, 320	52. 54.	
55. 00 05500 RADI OLOGY-THERAPEUTI C		428, 647	0	428, 647	55.	
57. 00 05700 CT SCAN		123, 849	0	123, 849	57.	
57.01  03630 ULTRA SOUND 58.00  05800 MAGNETIC RESONANCE IMAGING (MRI)		35, 812 154, 251	0	35, 812 154, 251	57. 58.	
59. 00 05900 CARDI AC CATHETERI ZATI ON		184, 067	0	184, 067	59.	00
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY		928, 355 0	0	928, 355 0	60. 60.	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		114, 968	0	114, 968	63.	
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY		04 192	0	04 192	64.	
66.00 06600 PHYSI CAL THERAPY		94, 182 377, 247	0	94, 182 377, 247	65. 66.	
67.00 06700 OCCUPATI ONAL THERAPY		0	0	0	67.	
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY		0 597, 506	0	0 597, 506	68. 69.	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		561, 194	0	561, 194	71.	00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS		93, 008 686, 962	0	93, 008 686, 962	72. 73.	
74. 00 07400 RENAL DI ALYSI S		55, 687	0	55, 687	74.	
76. 00 03020 OTHER ANCI LLARY		0	0	0	76.	
76. 01   03140   CARDI AC REHAB 76. 02   03070   WOMEN' S CENTER		181, 002 306, 749	-	181, 002 306, 749	76. 76.	
76. 03 03330 ENDOSCOPY		0	0	0	76.	03
OUTPATI ENT SERVICE COST CENTERS 90. 00 09000 CLINIC		149, 470	0	149, 470	90.	00
90. 01 09001 OUTPATI ENT		219, 674	0	219, 674	90.	01
90. 02 09002 NEUROPSYCHOLOGY 91. 00 09100 EMERGENCY		234, 275 1, 328, 330	0	234, 275 1, 328, 330	90. 91.	
91.01 09101 SHORT STAY		1, 320, 330	0	1, 320, 330	91.	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			0		92.	00
OTHER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVI CES		17, 253	0	17, 253	95.	00
SPECIAL PURPOSE COST CENTERS	-					
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	0	17, 953, 712	0	17, 953, 712	118.	00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		352, 189		352, 189	190.	
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 192. 01 19201 FOUNDATI ON		1, 405, 465 3, 611	0	1, 405, 465 3, 611	192. 192.	
192. 02 19202 CLI NI CS		22, 592	0	22, 592	192.	02
192. 03 19206 HOME HEALTH PARTNERSHIP 192. 04 19207 WESTFI ELD SCHOOLS		17 14 516	0	17 14 516	192. 192.	
192. 04 19207 WESTFIELD SCHOOLS 192. 05 19203 PRACTICE MANAGEMENT		14, 516 6, 787	0	14, 516 6, 787	192.	
192.06 19204 MOB - NOBLESVILLE SQUARE		266	0	266	192.	06
192. 07 19208 PHYSI CLANS' PRI VATE OFFI CES 192. 08 19205 RI VERVI EW MEDI CAL ARTS		0 688	0	0 688	192. 192.	
192. 09 19209 BEHAVI OR CARE		63, 419	0	63, 419	192.	09
193. 00 19300 NONPAI D WORKERS		0	0	0	193.	00

Health Financial Systems	RI VERVI EW H	IOSPI TAL		In Lie	eu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-0059	Period: From 01/01/2019	Worksheet B Part II
				To 12/31/2019	Date/Time Prepared:
					6/8/2020 1:18 pm
Cost Center Description	PARAMED ED	Subtotal	Intern &	Total	
	PRGM PHARMACY		Residents		
			Cost & Post		
			Stepdown		
			Adjustments		
	23.00	24.00	25.00	26.00	
193. 01 19301 PHYSI CLAN SERVI CES-LYONS		918		0 918	
193. 02 19302 UNI VERSI TY HS ATHLETI CS		350		0 350	193.02
193.03 19303 OB/GYN SPEC NEMUNALTI		5, 528		0 5, 528	193.03
193.04 19304 OB/GYN SPEC GATHERS		17		0 17	193.04
193. 05 19305 OB SPECIALISTS DAVENPORT		1, 575		0 1,575	193.05
194. 00 07950 WORKMED		7, 772		0 7,772	194.00
194.0107951 MEALS ON WHEELS		3, 655		0 3, 655	194.01
200.00 Cross Foot Adjustments	12, 032	12, 032		0 12,032	200.00
201.00 Negative Cost Centers	0	0		0 0	201.00
202.00 TOTAL (sum lines 118 through 201)	12, 032	19, 855, 109		0 19, 855, 109	202.00

	Financial Systems LLOCATION - STATISTICAL BASIS	RI VERVI EW I	HOSPITAL Provider C		Period:	u of Form CMS-2 Worksheet B-1	
					rom 01/01/2019 o 12/31/2019	Date/Time Pre 6/8/2020 1:18	
	Cost Center Description	CAPI TAL RELATED COSTS NEW BLDG & FI XT (SOUARE FEET)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	Reconciliatio n	ADMI NI STRATI V E & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		1.00	4.00	5A	5.00	7.00	
	GENERAL SERVICE COST CENTERS	620 626		1	1		1 1 00
1.00 4.00 5.00 7.00 8.00 9.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	620, 626 2, 865 44, 049 248, 512 1, 455 1, 177	81, 119, 270 8, 829, 760 2, 124, 270 66, 038 1, 183, 697	-26, 312, 777 C	15, 883, 877 467, 037 2, 197, 632	325, 200 1, 455 1, 177	8.00 9.00
11. 00 13. 00 14. 00 15. 00	01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	3, 246 8, 195 374 6, 965 8, 686	287, 552 937, 973 390, 934 614, 474 2, 698, 481		2, 172, 832 591, 674 19, 231, 865	3, 246 8, 195 374 6, 965 8, 686	11.00 13.00 14.00
17.00 23.00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE 02300 PARAMED ED PRGM PHARMACY INPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	2, 958 1, 643 155	819, 036 646, 305 226, 265		0 1, 581, 118 925, 860 0 265, 934	2, 958 1, 643 155	16.00 17.00 23.00
31. 00 41. 00	03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER – I RF	88, 112 14, 075 9, 583	8, 625, 510 2, 716, 687 1, 492, 989		3, 804, 898 3, 089, 359	88, 112 14, 075 9, 583	31.00 41.00
	04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY ANCI LLARY SERVI CE COST CENTERS	6, 941	0			0 6, 941	43.00 44.00
52.00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	50, 629 0	3, 957, 962 0	c c	0 0	50, 629 0	52.00
55.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	8, 137 7, 176	1, 817, 392 506, 873	C	1, 421, 119	8, 137 7, 176	•
57.01	05700 CT SCAN 03630 ULTRA SOUND	2, 027 532	374, 305 415, 418	C	518, 883	2, 027 532	•
59.00	05800 MAGNETIC RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON	2, 581 2, 879	332, 567 871, 498	C	1, 198, 274	2, 581 2, 879	59.00
60. 01	06000 LABORATORY 06001 BLOOD LABORATORY 06300 BLOOD STORI NG, PROCESSI NG & TRANS.	14, 329 0	2, 984, 237 0		0	14, 329 0	60.01
64.00	06400 I NTRAVENOUS THERAPY 06500 RESPIRATORY THERAPY	1, 952 0 1, 084	0 0 1, 409, 991	C	0 0	1, 952 0	64.00
66.00	06500 RESPERATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	3, 768	4, 983, 219 0		8, 547, 448	1, 084 3, 768 0	66.00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0 10, 032	0 544, 984	C	0	0	
72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0	0 0			0 0 0	
74.00	07400 RENAL DI ALYSI S 03020 OTHER ANCI LLARY	929 0	0	C	) 363, 563 ) 0	929 0	74.00
76.02	03140 CARDI AC REHAB 03070 WOMEN' S CENTER 03330 ENDOSCOPY	2, 704 5, 149 0	675, 293 431, 688 0	C	721, 451	2, 704 5, 149 0	76.02
90.00	OUTPATIENT SERVICE COST CENTERS	2, 411	359, 031	C	625, 715	2, 411	90.00
	09001 OUTPATI ENT 09002 NEUROPSYCHOLOGY	3, 511 4, 069	605, 915 165, 426		1, 246, 476 355, 894	3, 511 4, 069	
	09100 EMERGENCY 09101 SHORT STAY	21, 202 0	3, 325, 630 0		6, 118, 124 0 0	21, 202 0	91.00 91.01
	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
	09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	273	49, 367			273	1
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	<u>594, 365</u> 6, 040	55, 470, 767		5 136, 030, 915 581, 242	298, 939	190.00
192.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CI ANS' PRI VATE OFFI CES 19201 FOUNDATI ON	19, 150 0	21, 083, 160 181, 736	c	35, 567, 499	19, 150	190.00 192.00 192.01
192.02	19202 CLINICS 19206 HOME HEALTH PARTNERSHIP	0	1, 007, 710		1, 359, 254 2, 152	0	192.01 192.02 192.03
192.04	19200 NOME NEALTH FARTNERSHIP 19207 WESTFIELD SCHOOLS 19203 PRACTICE MANAGEMENT	0	1, 320, 104 395, 465		2, 132 1, 640, 149 794, 895	0	192.03 192.04 192.05
192.06	19203 PRACTICE MANAGEMENT 19204 MOB - NOBLESVILLE SQUARE 19208 PHYSICIANS' PRIVATE OFFICES	0	370,400 0 0		) 794, 895 ) 33, 473	0	192.05 192.06 192.07
	19208 PHYSICIANS PRIVATE OFFICES	0	0		86,657		192.07

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
				rom 01/01/2019 To 12/31/2019		
	CAPI TAL					
	RELATED COSTS				005047101105	
Cost Center Description	NEW BLDG &	EMPLOYEE		ADMI NI STRATI V		
	FI XT (SQUARE	BENEFI TS DEPARTMENT	n	E & GENERAL (ACCUM.	PLANT (SQUARE	
	FEET)	(GROSS		COST)	FEET)	
	1	SALARI ES)		(031)	1	
	1.00	4.00	5A	5.00	7.00	
192. 09 19209 BEHAVI OR CARE	1, 071	165, 660	(	297, 344	1, 071	192.09
193.00 19300 NONPALD WORKERS	0	0	(	0 0		193.00
193. 01 19301 PHYSI CLAN SERVI CES-LYONS	0	78, 810	(	104, 352		193.01
193. 02 19302 UNI VERSI TY HS ATHLETI CS	0	32, 141		39, 560		193.02
193.03 19303 OB/GYN SPEC NEMUNALTI	0	487, 916		626, 765		193.03
193.04 19304 OB/GYN SPEC GATHERS	0	1, 000		1, 999		193.04
193. 05 19305 OB SPECIALISTS DAVENPORT	0	136, 443		178, 928		193.05
194. 00 07950 WORKMED	0	508, 781		906, 295		194.00
194.01 07951 MEALS ON WHEELS	0	83, 908		240, 890	0	194.01
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	10 055 100	0 ( 00 000		2/ 212 777	10 000 507	201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	19, 855, 109	9, 682, 089		26, 312, 777	18, 222, 587	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	31, 992068	0. 119356		0, 147238	56.035015	203 00
204.00 Cost to be allocated (per Wkst. B,	01.772000	91,657		1, 419, 197		
Part II)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		.,,,	0,0,0,0,,,0	201100
205.00 Unit cost multiplier (Wkst. B, Part		0. 001130		0.007941	24.843007	205.00
206.00 NAHE adjustment amount to be allocated						206.00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,						207.00
Parts III and IV)			I	1		

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	RI VERVI EW	HOSPITAL Provider CC	CN: 15-0059 Pe	In Lie	u of Form CMS-2 Worksheet B-1	
			Fr To	om 01/01/2019 12/31/2019		
Cost Center Description	LAUNDRY & LI NEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (HOURS OF SERVI CE)	DI ETARY (MEALS SERVED)	CAFETERI A (MAN HOURS)	6/8/2020 1: 18 NURSI NG ADMI NI STRATI 0 N (DI RECT NRSI NG HRS)	pm
	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         BENEFITS         DEPARTMENT           5. 00         00500         ADMI NI STRATI VE         & GENERAL           7. 00         00700         OPERATI ON OF PLANT           8. 00         00800         LAUNDRY & LI NEN SERVI CE           9. 00         00900         HOUSEKEEPI NG           10. 00         01000         DI ETARY           11. 00         01100         CAFETERI A           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           23. 00         02300         PARAMED ED PRGM           02300         PARAMED ED PRGM         PHARMACY           INPATI ENT         ROUTI NE         SERVI CE         COST CENTERS	73, 174 0 0 0 550 0 0 0 0 0 0 0	1,004 4 28 0 1 1 25 5 0 0 0	79, 311 0 0 0 0 0 0 0 0 0	1, 279, 786 8, 738 29, 434 75, 476 32, 923 18, 785 2, 246	453, 210 0 0 0 0 0 0 0	$\begin{array}{c} 1.\ 00\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 23.\ 00 \end{array}$
30. 00 03000 ADULTS & PEDIATRICS	22, 936	307	43, 599	254, 358	254, 358	30.00
31.00       03100       I NTENSI VE CARE UNI T         41.00       04100       SUBPROVI DER - I RF         43.00       04300       NURSERY         44.00       04400       SKI LLED NURSI NG FACI LI TY	5, 347 5, 717 0 5, 307	63 63 0 61	6, 195 18, 381 0 11, 136	62, 086 50, 062 0 0	62, 086 50, 062 0 0	31.00 41.00 43.00 44.00
ANCILLARY SERVICE COST CENTERS				-		
50.00         05000         OPERATING ROOM           52.00         05200         DELIVERY ROOM & LABOR ROOM           54.00         05400         RADI OLOGY-DI AGNOSTI C           55.00         05500         RADI OLOGY-THERAPEUTI C           57.00         05700         CT SCAN           57.01         03630         ULTRA SOUND	7, 102 0 4, 285 592 0 0	107 0 41 10 0 1		114, 871 0 57, 644 13, 359 10, 237 2, 373	0 0 0 0 0	50.00 52.00 54.00 55.00 57.00 57.01
58.00       05800       MAGNETIC RESONANCE IMAGING (MRI)         59.00       05900       CARDIAC CATHETERIZATION         60.00       06000       LABORATORY         60.01       06001       BLOOD LABORATORY         63.00       06300       BLOOD STORING, PROCESSING & TRANS.         64.00       06400       INTRAVENOUS THERAPY	0 1, 888 0 0 0 0	1 0 35 0 0 0		8, 337 20, 279 112, 328 0 0 0		58.00 59.00 60.00 60.01 63.00 64.00
65.00       06500       RESPI RATORY THERAPY         66.00       06600       PHYSI CAL THERAPY         67.00       06700       OCCUPATI ONAL THERAPY         68.00       06800       SPEECH PATHOLOGY         69.00       06900       ELECTROCARDI OLOGY         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS	0 617 0 0 628 0	0 0 0 38 0	0 0 0 0 0	41, 649 163, 256 0 23, 134 0	0 0 0 0 0	65.00 66.00 67.00 68.00 69.00 71.00
72.00       07200       I MPL. DEV. CHARGED TO PATI ENT         73.00       07300       DRUGS CHARGED TO PATI ENTS         74.00       07400       RENAL DI ALYSI S         76.00       03140       CARDI AC REHAB	0 0 0 0 54	0 0 0 31	0 0 0 0 0	0 0 0 24, 941	0 0 0 0	72.00 73.00 74.00 76.00 76.01
76. 02 03070 WOMEN' S CENTER 76. 03 03330 ENDOSCOPY	365 0	15 0	0 0	16, 250 0	0	76.02 76.03
OUTPATI ENT SERVICE COST CENTERS           90.00         09000         CLINIC           90.01         09001         OUTPATI ENT           90.02         09002         NEUROPSYCHOLOGY           91.00         09100         EMERGENCY           91.01         09101         SHORT STAY           92.00         09200         OBSERVATION BEDS (NON-DISTINCT PART)	99 1, 988 0 9, 877 0	22 8 0 85 0	0 0 0 0 0	13, 340 17, 128 0 86, 704 0	0 0 86, 704 0	90.00 90.01 90.02 91.00 91.01 92.00
OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVI CES	0	0	0	1, 864	0	95.00
SPECIAL PURPOSE COST CENTERS		-				
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	67, 352	951	79, 311	1, 261, 802		
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 192. 01 19201 FOUNDATI ON 192. 02 19202 CLI NI CS 192. 03 19206 HOME HEALTH PARTNERSHI P	0 5, 772 0 26 0	7 46 0 0 0	0 0 0 0 0	9, 222 0 4, 430 0 0	0 0 0	190. 00 192. 00 192. 01 192. 02 192. 03
192. 04 19207 WESTFIELD SCHOOLS 192. 05 19203 PRACTICE MANAGEMENT 192. 06 19204 MOB - NOBLESVILLE SQUARE 192. 07 19208 PHYSICIANS' PRIVATE OFFICES 192. 08 19205 RI VERVIEW MEDICAL ARTS	0 24 0 0 0	0 0 0 0	0 0 0 0 0	0 0 0 0 0	0 0 0	192.04 192.05 192.06 192.07 192.08
192. 09 19209  BEHAVI OR CARE 193. 00 19300  NONPAI D WORKERS	0	0 0	0 0	0		192. 09 193. 00

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CO		Period: From 01/01/2019 To 12/31/2019	Date/Time Pre	pared:
Cost Center Description	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (HOURS OF SERVI CE)	DI ETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	6/8/2020 1: 18 NURSI NG ADMI NI STRATI 0 N (DI RECT NRSI NG HRS)	pm
	8.00	9,00	10.00	11.00	13.00	
193.01       193.01       PHYSICLAN SERVICES-LYONS         193.02       19302       UNIVERSITY HS ATHLETICS         193.03       19303       OB/GYN SPEC NEMUNALTI         193.04       19304       OB/GYN SPEC GATHERS         193.05       19305       OB SPECIALISTS DAVENPORT         194.00       07950       WORKMED         194.01       07951       MEALS ON WHEELS         200.00       Cross Foot Adjustments         201.00       Negative Cost Centers         202.00       Cost to be allocated (per Wkst. B, Part I)	0 0 0 0 0 0 617, 334	0 0 0 0 0 0 2, 587, 160	1, 171, 42	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 720, 396	
203.00 Unit cost multiplier (Wkst. B, Part I)	8. 436521					
204.00 Cost to be allocated (per Wkst. B, Part II)	86, 479		191, 93			204.00
205.00 Unit cost multiplier (Wkst. B, Part	1. 181827	85. 342629	2. 41996	0. 380116	0. 065570	205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	RI VERVI EW H	IOSPI TAL Provi der CO	N. 15 0050	In Lie Period:	u of Form CMS-2 Worksheet B-1	
CUST ALLOCATION - STATISTICAL BASIS		Provider CC	LN: 15-0059	From 01/01/2019 To 12/31/2019	Date/Time Pre	pared:
Cost Center Description	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	PHARMACY (COSTED REQUIS.)	MEDI CAL RECORDS & LI BRARY (TI ME SPENT)	SOCI AL SERVI CE (TI ME SPENT)	6/8/2020 1:18 PARAMED ED PRGM PHARMACY (ASSI GNED TI ME)	pm
GENERAL SERVICE COST CENTERS	14.00	15.00	16.00	17.00	23.00	
1.00       00100       NEW CAP REL COSTS-BLDG & FIXT         4.00       00400       EMPLOYEE BENEFITS DEPARTMENT         5.00       00500       ADMI NI STRATI VE & GENERAL         7.00       00700       OPERATION OF PLANT         8.00       00800       LAUNDRY & LINEN SERVICE         9.00       00900       HOUSEKEEPI NG         10.00       01000       DI ETARY         11.00       01100       CAFETERI A         13.00       01300       NURSI NG ADMI NI STRATI ON         14.00       01400       CENTRAL SERVICES & SUPPLY         15.00       01500       PHARMACY         16.00       01600       MEDI CAL RECORDS & LI BRARY         17.00       01700       SOCI AL SERVICE         23.00       D2300       PARMED ED PRGM PHARMACY         INPATI ENT ROUTI NE SERVICE COST CENTERS	100 0 0 0 0	100 0 0 0	4	21 0 5, 286 0 0	100	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 23.00
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		89 4, 304	0	30.00
31.00         03100         I NTENSI VE CARE UNI T           41.00         04100         SUBPROVI DER - I RF           43.00         04300         NURSERY           44.00         04400         SKI LLED NURSI NG FACI LI TY           ANCI LLARY SERVICE COST CENTERS         ANCI LLARY	0 0 0 0	0 0 0		21 299 0 489 0 0 2 194	0 0 0	31.00 41.00 43.00 44.00
50. 00 05000 OPERATING ROOM	0	0	1	72 0	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C 57. 00 05700 CT SCAN 57. 01 03630 ULTRA SOUND		0 0 0 0		0 0 0 0 5 0 0 0 0 0	0 0 0 0	52.00 54.00 55.00 57.00 57.01
58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	0 0 0	0 0 0		0 0 0 0 9 0	0 0 0 0	58.00 59.00 60.00 60.01
63.00         06300         BLOOD STORI NG, PROCESSI NG & TRANS.           64.00         06400         I NTRAVENOUS THERAPY           65.00         06500         RESPI RATORY THERAPY	0 0 0	0 0 0		0 0 0 0 0 0	0 0 0	63.00 64.00 65.00
66. 00         06600         PHYSI CAL THERAPY           67. 00         06700         OCCUPATI ONAL THERAPY           68. 00         06800         SPEECH PATHOLOGY           69. 00         06900         ELECTROCARDI OLOGY	0 0 0 0	0 0 0 0		58 0 0 0 0 0 13 0	0 0 0 0	66.00 67.00 68.00 69.00
71.00         07100         MEDI CAL         SUPPLI ES         CHARGED         TO         PATI ENTS           72.00         07200         I MPL.         DEV.         CHARGED         TO         PATI ENTS           73.00         07300         DRUGS         CHARGED         TO         PATI ENTS           74.00         07400         RENAL         DI ALYSI S	100 0 0 0	0 0 100 0		0 0 0 0 0 0 0 0	0 0 100 0	71.00 72.00 73.00 74.00
76.00         03020         OTHER ANCI LLARY           76.01         03140         CARDI AC REHAB           76.02         03070         WOMEN' S CENTER           76.03         03330         ENDOSCOPY	0 0 0	0 0 0		0 0 0 0 0 0 0 0	0 0 0 0	76. 01 76. 02
OUTPATI ENT SERVICE COST CENTERS           90.00         CLINIC	0	0		0 0	0	90.00
90.01         09001         0UTPATI ENT           90.02         09002         NEUROPSYCHOLOGY           91.00         09100         EMERGENCY           91.01         09101         SHORT STAY	0 0 0 0	0 0 0 0		0 0 0 0 29 0 0 0	0 0 0 0	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) OTHER REI MBURSABLE COST CENTERS						92.00
95.00 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	0	0	-	0 0		95.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	100	100	3	98 5, 286		118.00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 192. 01 19201 FOUNDATI ON 192. 02 19202 CLI NI CS	0 0 0 0	0 0 0 0		0 0 0 0 23 0	0 0 0	190. 00 192. 00 192. 01 192. 02
192. 03 19206 HOME HEALTH PARTNERSHIP 192. 04 19207 WESTFIELD SCHOOLS 192. 05 19203 PRACTICE MANAGEMENT 192. 06 19204 MOB - NOBLESVILLE SQUARE	0 0 0 0	0 0 0 0		0 0 0 0 0 0 0 0	0 0 0	192. 03 192. 04 192. 05 192. 06
192. 07 19208 PHYSI CLANS' PRI VATE OFFICES 192. 08 19205 RI VERVI EW MEDI CAL ARTS 192. 09 19209 BEHAVI OR CARE 193. 00 19300 NONPAI D WORKERS	0 0 0	0 0 0		0 0 0 0 0 0 0 0	0 0	192. 07 192. 08 192. 09 193. 00

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
				From 01/01/2019 To 12/31/2019		pared: pm
Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	PARAMED ED	
	SERVICES &	(COSTED	RECORDS &	SERVI CE	PRGM PHARMACY	
	SUPPLY	REQUIS.)	LIBRARY	(TIME	(ASSI GNED	
	(COSTED REQUIS.)		(TIME SPENT)	SPENT)	TIME)	
	14.00	15.00	16.00	17.00	23.00	
193.01 19301 PHYSI CLAN SERVI CES-LYONS	0	0		0 0		193.01
193. 02 19302 UNI VERSI TY HS ATHLETI CS	0	0		0 0	0	193.02
193.03 19303 OB/GYN SPEC NEMUNALTI	0	0		0 0	0	193.03
193.04 19304 OB/GYN SPEC GATHERS	0	0		0 0		193.04
193. 05 19305 OB SPECIALISTS DAVENPORT	0	0		0 0		193.05
194. 00 07950 WORKMED	0	0		0 0		194.00
194.0107951 MEALS ON WHEELS	0	0		0 0	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,	22, 530, 579	23, 760, 895	2, 070, 35	52 1, 198, 637	319, 082	202.00
203.00 Part I) Unit cost multiplier (Wkst. B, Part I)	225 205 70000	237, 608. 95000	4, 917. 70071	3 226. 756905	3, 190. 820000	202 00
	225, 305. 79000	237,008.95000	4,917.70071	3 220.750905	3, 190. 820000	203.00
204.00 Cost to be allocated (per Wkst. B,	561, 194	686, 962	194, 54	3 108, 602	12,032	204.00
Part II)		,				
205.00 Unit cost multiplier (Wkst. B, Part	5, 611. 940000	6, 869. 620000	462.09738	20. 545214	120. 320000	205.00
1)						
206.00 NAHE adjustment amount to be allocated					0	206.00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,					0. 000000	207.00
Parts III and IV)	I	I			l	I

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2019 To 12/31/2019		pared:
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4, 00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS	24, 290, 813		24, 290, 81	3 0	24, 290, 813	30.00
31.00 03100 INTENSIVE CARE UNIT	5, 869, 238		5, 869, 23			
41.00 04100 SUBPROVIDER - IRF	4, 872, 032		4, 872, 03			41.00
43.00 04300 NURSERY	0			0 0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	2, 812, 323		2, 812, 32	3 0	2, 812, 323	44.00
ANCI LLARY SERVICE COST CENTERS				-		
50.00 05000 OPERATING ROOM	1, 672, 347		1, 672, 34			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0			0 0	-	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	4, 103, 798		4, 103, 79		4, 103, 798	
55.00 05500 RADI OLOGY-THERAPEUTI C	2, 119, 388		2, 119, 38		2, 119, 388	
57.00 05700 CT SCAN	763, 342		763, 34			57.00
57.01 03630 ULTRA SOUND	633, 277		633, 27		633, 277	57.01
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	734, 500		734, 50		734, 500	
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 599, 877		1, 599, 87		.,,	59.00
	9, 979, 395		9, 979, 39		,,,,,,,,,,,	60.00
60. 01 06001 BLOOD LABORATORY	00.045			0 0	0	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 64.00 06400 I NTRAVENOUS THERAPY	690, 845		690, 84	5 O 0 O	690, 845 0	63.00 64.00
65. 00 06500 RESPIRATORY THERAPY	2, 347, 718	0	2, 347, 71	0	-	
66. 00 06600 PHYSICAL THERAPY	10, 693, 300					66.00
67. 00 06700 OCCUPATI ONAL THERAPY	10, 093, 300			0 0		67.00
68. 00 06800 SPEECH PATHOLOGY		0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	1, 930, 279	0	1, 930, 27	0	-	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	22, 530, 579		22, 530, 57			
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	13, 436, 890		13, 436, 89			
73. 00 07300 DRUGS CHARGED TO PATIENTS	24, 079, 977		24, 079, 97			73.00
74.00 07400 RENAL DI ALYSI S	469, 150		469, 15			74.00
76.00 03020 OTHER ANCI LLARY	0			0 0	0	76.00
76. 01 03140 CARDI AC REHAB	2, 366, 381		2, 366, 38	1 0	2, 366, 381	76.01
76.02 03070 WOMEN'S CENTER	1, 196, 330		1, 196, 33	0 0	1, 196, 330	76.02
76. 03 03330 ENDOSCOPY	0			0 0	0	76.03
OUTPATIENT SERVICE COST CENTERS				-		
90. 00 09000 CLINIC	941, 992		941, 99		, =	90.00
90. 01 09001 OUTPATI ENT	1, 704, 604		1, 704, 60		.,	90.01
90. 02 09002 NEUROPSYCHOLOGY	636, 301		636, 30		636, 301	90.02
91.00 09100 EMERGENCY	8, 994, 671		8, 994, 67		8, 994, 671	
91. 01 09101 SHORT STAY	0			0 0	0	91.01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	4, 392, 560	1	4, 392, 56	U	4, 392, 560	92.00
95.00 09500 AMBULANCE SERVICES	160, 089		160, 08	9 0	160, 089	05 00
200.00 Subtotal (see instructions)	156, 021, 996					
201.00 Less Observation Beds	4, 392, 560		4, 392, 56		4, 392, 560	
202.00 Total (see instructions)	151, 629, 436					
	1 101,027,100	. 0	1	-1 0	1	

Health Financial Systems	RI VERVI EW I				u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2019 To 12/31/2019	Date/Time Pre	epared:
			e XVIII	Hospi tal	6/8/2020 1:18 PPS	3 pm
		Charges		HOSPITAL	PP5	
Cost Center Description	I npati ent	Outpati ent	Total (col. ( + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent	
				Ratio	Ratio	
	6.00	7.00	8.00	9,00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	I					
30. 00 03000 ADULTS & PEDIATRICS	33, 609, 676		33, 609, 67	6		30.00
31.00 03100 INTENSIVE CARE UNIT	10, 028, 315		10, 028, 31	5		31.00
41.00 04100 SUBPROVIDER - IRF	7, 311, 682		7, 311, 68	2		41.00
43. 00 04300 NURSERY	0			0		43.00
44.00 04400 SKILLED NURSING FACILITY	1, 922, 404		1, 922, 40	4		44.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	28, 261, 529	59, 864, 417	88, 125, 94	6 0. 018977	0.00000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0. 000000	0. 000000	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 932, 308	11, 006, 033	12, 938, 34	0. 317181	0. 000000	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	105, 658	8, 856, 663	8, 962, 32	1 0. 236478	0. 000000	55.00
57.00 05700 CT SCAN	3, 719, 699	16, 489, 499	20, 209, 19	8 0. 037772	0. 000000	57.00
57.01 03630 ULTRA SOUND	1, 339, 529	7, 666, 820			0. 000000	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	689, 747	5,044,590			0.000000	
59.00 05900 CARDI AC CATHETERI ZATI ON	9, 362, 201	13, 162, 147			0.000000	
60. 00 06000 LABORATORY	15, 289, 558	35, 209, 188			0. 000000	
60. 01 06001 BLOOD LABORATORY	0	0		0.000000	0. 000000	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	939, 967	370, 607	1, 310, 57		0.000000	
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0.000000	0. 000000	
65. 00 06500 RESPIRATORY THERAPY	5, 308, 462	1, 821, 520	7, 129, 98		0. 000000	
66.00 06600 PHYSI CAL THERAPY	12, 663, 450	20, 255, 508			0. 000000	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0.000000	0. 000000	
68. 00 06800 SPEECH PATHOLOGY	0	0		0.000000	0. 000000	
69. 00 06900 ELECTROCARDI OLOGY	1, 924, 874	6, 648, 806			0. 000000	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	19, 343, 954	21, 143, 978			0. 000000	
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	8, 657, 899	9, 375, 589			0. 000000	
73. 00 07300 DRUGS CHARGED TO PATIENTS	15, 510, 895	44, 163, 081			0. 000000	
74. 00 07400 RENAL DI ALYSI S	678, 015	7, 793			0. 000000	
76. 00 03020 OTHER ANCI LLARY	0,0,010	0		0.000000	0. 000000	
76. 01 03140 CARDI AC REHAB	581, 710	11, 643, 935			0. 000000	
76. 02 03070 WOMEN' S CENTER	19, 416	7, 696, 671			0. 000000	
76. 03 03330 ENDOSCOPY	0	0,0,0,0		0. 000000	0.000000	
OUTPATIENT SERVICE COST CENTERS	0	0	1	0 0.000000	0.00000	/0.03
90. 00 09000 CLINIC	7, 345	5, 843, 613	5, 850, 95	8 0. 160998	0. 000000	90.00
90. 01 09001 0UTPATI ENT	346, 469	4, 761, 148				
90. 02 09002 NEUROPSYCHOLOGY	13, 960	1, 715, 363			0. 000000	
91. 00 09100 EMERGENCY	5, 621, 265	29, 434, 418			0. 000000	
91. 01 09101 SHORT STAY	5, 021, 205	29, 434, 410		0.000000	0. 000000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 154, 468	5, 049, 959			0. 000000	
OTHER REIMBURSABLE COST CENTERS	1, 154, 400	5, 047, 739	0,204,42	0.101912	0.00000	72.00
95. 00 09500 AMBULANCE SERVICES	0	0		0 0. 000000	0. 000000	95 00
200.00 Subtotal (see instructions)	186, 344, 455	327, 231, 346			0.00000	200.00
201.00 Less Observation Beds	100, 344, 433	321, 231, 340	515, 575, 80	1		200.00
202.00 Total (see instructions)	186, 344, 455	327, 231, 346	513, 575, 80	1		201.00
	100, 344, 455	321, 231, 340	g 515, 575, 80	4	I	202.00

	Financial Systems ATION OF RATIO OF COSTS TO CHARGES	RI VERVI EW HO	Provi der CCN: 15-0059	Peri od:	J of Form CMS-2552
COMPUT	ATTON OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0059	From 01/01/2019	Worksheet C Part I
				To 12/31/2019	Date/Time Prepare
			Title XVIII	Hospi tal	6/8/2020 1:18 pm PPS
	Cost Center Description	PPS Inpatient		nospi tui	110
		Ratio			
		11.00			
	INPATIENT ROUTINE SERVICE COST CENTERS	-			
	03000 ADULTS & PEDIATRICS				30
	03100 I NTENSI VE CARE UNI T				31
	04100 SUBPROVI DER – I RF				41
	04300 NURSERY				43
44.00	04400 SKILLED NURSING FACILITY				44
	ANCI LLARY SERVI CE COST CENTERS	T			
	05000 OPERATING ROOM	0. 018977			50
	05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52
	05400 RADI OLOGY-DI AGNOSTI C	0. 317181			54
	05500 RADI OLOGY-THERAPEUTI C	0. 236478			55
	05700 CT SCAN	0. 037772			57
	03630 ULTRA SOUND	0.070315			57
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 128088			58
	05900 CARDI AC CATHETERI ZATI ON	0.071029			59
		0. 197617			60
	06001 BLOOD LABORATORY	0.000000			60
	06300 BLOOD STORING, PROCESSING & TRANS.	0. 527132			63
	06400 I NTRAVENOUS THERAPY	0. 000000			64
		0. 329274			65
	06600 PHYSI CAL THERAPY	0. 324837			66
		0.000000			67
		0.000000			68
	06900 ELECTROCARDI OLOGY	0. 225140			
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 556476			71
	07200 I MPL. DEV. CHARGED TO PATIENT	0. 745108			72
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0. 403526			73
	03020 OTHER ANCI LLARY	0. 684084 0. 000000			74
	03140 CARDI AC REHAB	0. 193559			76
	03070 WOMEN' S CENTER	0. 193539			76
	03330 ENDOSCOPY	0. 000000			76
70.03	OUTPATIENT SERVICE COST CENTERS	0.000000			70
90.00	09000 CLINIC	0. 160998			90
	09001 0UTPATI ENT	0. 333738			90
	09002 NEUROPSYCHOLOGY	0. 367948			90
	09100 EMERGENCY	0. 256582			91
	09101 SHORT STAY	0. 000000			91
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 707972			92
	OTHER REIMBURSABLE COST CENTERS	0.707712			72
	09500 AMBULANCE SERVICES	0.000000			95
200.00		0.000000			200
200.00					201
202.00					202

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 01/01/2019 Fo 12/31/2019	Worksheet C Part I Date/Time Pre 6/8/2020 1:18	pared: pm
		Titl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I,	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	col . 26) 1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00 03000 ADULTS & PEDIATRICS	24, 290, 813		24, 290, 81	3 0	24, 290, 813	30.00
31.00 03100 INTENSIVE CARE UNIT	5, 869, 238		5, 869, 23			
41. 00 04100 SUBPROVI DER – I RF	4, 872, 032		4, 872, 03		-//	41.00
43. 00 04300 NURSERY	1, 0, 2, 002			0 0		43.00
44.00 04400 SKILLED NURSING FACILITY	2, 812, 323		2, 812, 32			44.00
ANCI LLARY SERVICE COST CENTERS	_/ -/ -/	I	_/ _/ _/ _/		_/ - / - / - / /	
50.00 05000 OPERATING ROOM	1, 672, 347		1, 672, 34	7 0	1, 672, 347	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0		(	0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 103, 798		4, 103, 79	3 0	4, 103, 798	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	2, 119, 388		2, 119, 38	3 0	2, 119, 388	
57.00 05700 CT SCAN	763, 342		763, 34	2 0	763, 342	57.00
57.01 03630 ULTRA SOUND	633, 277		633, 27	7 0	633, 277	57.01
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	734, 500		734, 500	0 0	734, 500	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 599, 877		1, 599, 87		.,	59.00
60. 00 06000 LABORATORY	9, 979, 395		9, 979, 39	5 0	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	60.00
60.01 06001 BLOOD LABORATORY	0			0 0	0	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	690, 845		690, 84		690, 845	63.00
64.00 06400 I NTRAVENOUS THERAPY	0		(	0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	2, 347, 718		_/ = / /			
66.00 06600 PHYSI CAL THERAPY	10, 693, 300		10, 693, 30			
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	-	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0		0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	1, 930, 279		1, 930, 27		.,	69.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	22, 530, 579		22, 530, 57		1 1 -	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS	13, 436, 890 24, 079, 977		13, 436, 890			72.00 73.00
74. 00 07400 RENAL DIALYSIS	469, 150		24, 079, 97 469, 150		,	
76.00 03020 OTHER ANCI LLARY	409, 130				409, 150	76.00
76. 01 03140 CARDI AC REHAB	2, 366, 381		2, 366, 38		2, 366, 381	76.01
76. 02 03070 WOMEN' S CENTER	1, 196, 330		1, 196, 33			
76. 03 03330 ENDOSCOPY	0			0 0	0	76.03
OUTPATIENT SERVICE COST CENTERS				<u> </u>	<u> </u>	10100
90. 00 09000 CLINIC	941, 992		941, 99	2 0	941, 992	90.00
90. 01 09001 OUTPATI ENT	1, 704, 604		1, 704, 60	4 0	1, 704, 604	90.01
90. 02 09002 NEUROPSYCHOLOGY	636, 301		636, 30	1 0	636, 301	90.02
91.00 09100 EMERGENCY	8, 994, 671		8, 994, 67		8, 994, 671	91.00
91. 01 09101 SHORT STAY	0		(	0 0	0	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 392, 560		4, 392, 560	)	4, 392, 560	92.00
OTHER REIMBURSABLE COST CENTERS				1		
95.00 09500 AMBULANCE SERVICES	160, 089		160, 08			
200.00 Subtotal (see instructions)	156, 021, 996					
201.00 Less Observation Beds	4, 392, 560		4, 392, 56		4, 392, 560	
202.00  Total (see instructions)	151, 629, 436	0	151, 629, 43	6 0	151, 629, 436	202.00

Health Financial Systems	RI VERVI EW I		01 15 0050		u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Pre	epared:
					6/8/2020 1:18	3 pm
			e XIX	Hospi tal	Cost	
Cost Center Description	Inpatient	Charges Outpatient	Total (col /	6 Cost or Other	TEFRA	
cost center bescription	inpatrent	outputrent	+ col. 7	Ratio	I npati ent	
				hatro	Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	33, 609, 676		33, 609, 67	6		30.00
31.00 03100 I NTENSI VE CARE UNI T	10, 028, 315		10, 028, 31	5		31.00
41.00 04100 SUBPROVIDER - IRF	7, 311, 682		7, 311, 68	2		41.00
43.00 04300 NURSERY	0			0		43.00
44.00 04400 SKILLED NURSING FACILITY	1, 922, 404		1, 922, 40	4		44.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	28, 261, 529	59, 864, 417			0. 000000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0. 000000	0. 000000	
54.00 05400 RADI OLOGY-DI AGNOSTI C	1, 932, 308	11, 006, 033			0. 000000	
55. 00 05500 RADI OLOGY-THERAPEUTI C	105, 658	8, 856, 663			0. 000000	
57.00 05700 CT SCAN	3, 719, 699	16, 489, 499			0. 000000	
57.01 03630 ULTRA SOUND	1, 339, 529	7, 666, 820			0. 000000	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	689, 747	5,044,590	5, 734, 33		0. 000000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	9, 362, 201	13, 162, 147			0. 000000	
60. 00 06000 LABORATORY	15, 289, 558	35, 209, 188	50, 498, 74		0. 000000	
60. 01 06001 BLOOD LABORATORY	0	0		0 0. 000000	0. 000000	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	939, 967	370, 607	1, 310, 57		0. 000000	
64.00 06400 INTRAVENOUS THERAPY	0	0		0 0. 000000	0. 000000	
65. 00 06500 RESPI RATORY THERAPY	5, 308, 462	1, 821, 520			0. 000000	
66. 00 06600 PHYSI CAL THERAPY	12, 663, 450	20, 255, 508			0. 000000	
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0. 000000	0. 000000	
68.00 06800 SPEECH PATHOLOGY	0	0		0 0. 000000	0. 000000	
69. 00 06900 ELECTROCARDI OLOGY	1, 924, 874	6, 648, 806			0. 000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	19, 343, 954	21, 143, 978			0. 000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	8, 657, 899	9, 375, 589			0. 000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	15, 510, 895	44, 163, 081			0. 000000	
74.00 07400 RENAL DI ALYSI S	678, 015	7, 793			0.00000	
76.00 03020 OTHER ANCI LLARY	0	0		0 0. 000000	0.00000	
76. 01 03140 CARDI AC REHAB	581, 710	11, 643, 935			0.00000	
76. 02 03070 WOMEN' S CENTER	19, 416	7, 696, 671			0.00000	
76. 03 03330 ENDOSCOPY	0	0		0 0.000000	0.00000	76.03
OUTPATIENT SERVICE COST CENTERS	7.045		5 050 05		0.00000	
90. 00 09000 CLINIC	7, 345	5, 843, 613			0.00000	
90. 01 09001 0UTPATI ENT	346, 469	4, 761, 148			0.00000	
90. 02 09002 NEUROPSYCHOLOGY	13, 960	1, 715, 363			0.00000	
91.00 09100 EMERGENCY	5, 621, 265	29, 434, 418			0.00000	
91. 01 09101 SHORT STAY	0	0		0 0.00000	0.00000	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	1, 154, 468	5, 049, 959	6, 204, 42	7 0. 707972	0. 000000	92.00
OTHER REI MBURSABLE COST CENTERS				0 0 000000	0.000000	
95. 00 09500 AMBULANCE SERVICES	0	0		0 0.000000	0. 000000	
200.00 Subtotal (see instructions)	186, 344, 455	327, 231, 346	513, 575, 80	1		200.00
201.00 Less Observation Beds	104 044 455	227 224 244		1		201.00
202.00  Total (see instructions)	186, 344, 455	327, 231, 346	513, 575, 80	Ц		202.00

Health Financial Sys		RI VERVI EW HO			u of Form CMS-2	:552-1
COMPUTATION OF RAIL	O OF COSTS TO CHARGES		Provider CCN: 15-0059	Period: From 01/01/2019	Worksheet C Part I	
				To 12/31/2019	Date/Time Prep	
			Title XIX	Hospi tal	6/8/2020 1:18 Cost	pm
Cost Ce	nter Description	PPS Inpatient	пцели		0031	
		Ratio				
		11.00				
I NPATI ENT ROU	TINE SERVICE COST CENTERS					
30.00 03000 ADULTS						30.0
31.00 03100 INTENSI	VE CARE UNIT					31.0
41.00 04100 SUBPROV	IDER – IRF					41.0
43.00 04300 NURSERY						43.0
44.00 04400 SKI LLED	NURSING FACILITY					44.0
ANCI LLARY SER	VICE COST CENTERS					
50.00 05000 OPERATI	NG ROOM	0. 000000				50.0
52.00 05200 DELIVER	Y ROOM & LABOR ROOM	0. 000000				52.0
54.00 05400 RADI OLO	GY-DI AGNOSTI C	0. 000000				54.0
55. 00 05500 RADI OLO	GY-THERAPEUTI C	0. 000000				55.0
57.00 05700 CT SCAN		0. 000000				57.0
57.01 03630 ULTRA S	DUND	0. 000000				57.0
58.00 05800 MAGNETI	C RESONANCE IMAGING (MRI)	0. 000000				58.0
	CATHETERI ZATI ON	0. 000000				59.0
60. 00 06000 LABORAT		0. 000000				60.0
60.01 06001 BLOOD L	ABORATORY	0. 000000				60.0
	TORING, PROCESSING & TRANS.	0. 000000				63.0
64.00 06400 INTRAVE		0. 000000				64.0
65. 00 06500 RESPI RA	TORY THERAPY	0. 000000				65.0
66. 00 06600 PHYSI CA	L THERAPY	0. 000000				66.0
67.00 06700 0CCUPAT	IONAL THERAPY	0. 000000				67.0
68.00 06800 SPEECH	PATHOLOGY	0. 000000				68.0
69.00 06900 ELECTRO	CARDI OLOGY	0. 000000				69.0
71.00 07100 MEDI CAL	SUPPLIES CHARGED TO PATIENTS	0. 000000				71.0
72.00 07200 IMPL. D	EV. CHARGED TO PATIENT	0. 000000				72.0
73.00 07300 DRUGS C	HARGED TO PATIENTS	0. 000000				73.0
74.00 07400 RENAL D	I ALYSI S	0. 000000				74.0
76.00 03020 OTHER A	NCI LLARY	0. 000000				76.0
76. 01 03140 CARDI AC	REHAB	0. 000000				76.0
76.02 03070 WOMEN' S	CENTER	0. 000000				76.0
76.03 03330 ENDOSCO		0. 000000				76.0
OUTPATIENT SE	RVICE COST CENTERS					
90.00 09000 CLINIC		0. 000000				90.0
90. 01 09001 OUTPATI	ENT	0. 000000				90.0
90. 02 09002 NEUROPS	YCHOLOGY	0. 000000				90.0
91.00 09100 EMERGEN	CY	0. 000000				91.0
91.01 09101 SHORT S	ТАҮ	0. 000000				91.0
92.00 09200 OBSERVA	TION BEDS (NON-DISTINCT PART)	0. 000000				92.0
	SABLE COST CENTERS	•				
95.00 09500 AMBULAN	CE SERVICES	0. 000000				95.0
200.00 Subtota	l (see instructions)					200. 0
201.00 Less 0b	servation Beds					201.0
202.00 Total (	see instructions)					202.0

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	_ COSTS	Provider C		Period: From 01/01/2019 To 12/31/2019		pared:
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	5, 525, 276	0	5, 525, 27	6 14, 942	369.78	30.00
31.00 INTENSIVE CARE UNIT	903, 444		903, 44	4 3, 317	272.37	31.00
41.00 SUBPROVIDER - IRF	659, 845	0	659, 84	5 5, 586	118.12	41.00
43.00 NURSERY	0			0 1, 421	0.00	43.00
44.00 SKILLED NURSING FACILITY	451, 694		451, 69	3, 010	150.06	44.00
200.00 Total (lines 30 through 199)	7, 540, 259		7, 540, 25	9 28, 276		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	5, 172	1, 912, 502				30.00
31.00 INTENSIVE CARE UNIT	1, 470	400, 384				31.00
41.00 SUBPROVIDER - IRF	3, 334	393, 812				41.00
43.00 NURSERY	0					43.00
44.00 SKILLED NURSING FACILITY	2, 172	325, 930				44.00
200.00 Total (lines 30 through 199)	12, 148	3, 032, 628				200.00

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT,	AL COSTS	Provider C	CN: 15-0059	Period: From 01/01/2019 To 12/31/2019		pared:
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II, col. 26)	col. 8)	col. 2)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
50. 00 05000 OPERATING ROOM	3, 022, 645	88, 125, 946	0.03429	13, 583, 812	465, 911	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0					•
54. 00 05400 RADI OLOGY-DI AGNOSTI C	518, 320	12, 938, 341	0.04000		35, 030	•
55. 00 05500 RADI OLOGY-THERAPEUTI C	428, 647	8, 962, 321	0.0478			•
57. 00 05700 CT SCAN	123, 849					
57.01 03630 ULTRA SOUND	35, 812					•
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	154, 251	5, 734, 337				
59. 00 05900 CARDI AC CATHETERI ZATI ON	184, 067					•
60. 00 06000 LABORATORY	928, 355					
60. 01 06001 BLOOD LABORATORY	0					•
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	114, 968	1, 310, 574				
64.00 06400 INTRAVENOUS THERAPY	0	0	0.0000			•
65. 00 06500 RESPIRATORY THERAPY	94, 182	7, 129, 982			35, 216	65.00
66. 00 06600 PHYSI CAL THERAPY	377, 247	32, 918, 958				
67.00 06700 OCCUPATI ONAL THERAPY	0					1
68.00 06800 SPEECH PATHOLOGY	0					
69. 00 06900 ELECTROCARDI OLOGY	597, 506	8, 573, 680			87, 509	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	561, 194					71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	93,008					
73.00 07300 DRUGS CHARGED TO PATIENTS	686, 962					•
74.00 07400 RENAL DIALYSIS	55, 687					•
76.00 03020 OTHER ANCI LLARY	0					•
76. 01 03140 CARDI AC REHAB	181,002	12, 225, 645			1, 868	76.01
76. 02 03070 WOMEN' S CENTER	306, 749					•
76. 03 03330 ENDOSCOPY	0			0 0	0	76.03
OUTPATIENT SERVICE COST CENTERS	1		•	- <b>I</b>		1
90. 00 09000 CLINIC	149, 470	5, 850, 958	0. 02554	6 5,064	129	90.00
90. 01 09001 0UTPATI ENT	219, 674	5, 107, 617	0.04300	78, 369	3, 371	90.01
90. 02 09002 NEUROPSYCHOLOGY	234, 275	1, 729, 323	0. 1354	4, 901	664	90.02
91.00 09100 EMERGENCY	1, 328, 330			2, 356, 947	89, 309	91.00
91.01 09101 SHORT STAY	0					91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	999, 149	6, 204, 427	0. 1610:	88 0	0	92.00
OTHER REIMBURSABLE COST CENTERS			·			1
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	11, 395, 349	460, 703, 724		49, 101, 636	1, 102, 488	200.00

Health Financial Systems	RI VERVI EW				u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P	ASS THROUGH COS	STS Provider C	CN: 15-0059	Period: From 01/01/2019	Worksheet D Part III	
				To 12/31/2019	Date/Time Pre	epared:
		Ti +Lo	e XVIII	Hospi tal	6/8/2020 1:18 PPS	3 pm
Cost Center Description	Nursi ng	Nursing		h Allied Health	All Other	
	School	School	Post-Stepdow		Medi cal	
	Post-Stepdown		Adjustments		Educati on	
	Adjustments		-		Cost	
	1A	1.00	2A	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0				0	
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	0	0		0 0	0	
41. 00 04100 SUBPROVIDER - IRF	0				0	
43. 00 04300 NURSERY	0			0 0	0	
44.00 04400 SKILLED NURSING FACILITY	0	0		0 0	-	44.00
200.00 Total (lines 30 through 199)	0	0		0 0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patier		I npati ent	
	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col. 6)		
	instructions) 4.00	minus col. 4) 5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS	4.00	5.00	0.00	7.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS	0	0	14, 9	42 0.00	5, 172	30.00
31.00 03100 INTENSIVE CARE UNIT		0	3, 3	17 0.00	1, 470	31.00
41.00 04100 SUBPROVIDER - IRF	0	0	5,5			
43.00 04300 NURSERY		0	1, 4			
44.00 04400 SKI LLED NURSI NG FACI LI TY		0	3, 0			
200.00 Total (lines 30 through 199)	I npati ent	0	28, 2	/6	12, 148	200.00
Cost Center Description	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9.00					
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	-					
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 I NTENSI VE CARE UNI T	0					30.00
31. 00 03100 I NTENSI VE CARE UNI T 41. 00 04100 SUBPROVI DER – I RF						41.00
41. 00  04100  SUBPROVIDER - TRF 43. 00  04300  NURSERY						41.00
44. 00 04400 SKILLED NURSING FACILITY	0					44.00
200.00 Total (lines 30 through 199)	0					200.00
		1				

	Financial Systems	RI VERVI EW			In Lie	eu of Form CMS-2	2552-10
	FIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE GH COSTS	RVICE OTHER PAS	S Provider C	CN: 15-0059	Period: From 01/01/2019 To 12/31/2019		pared:
		_	Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursi ng School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
	ANCILLARY SERVICE 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	
60.00	06000 LABORATORY	0	0		0 0	0	•
60.01	06001 BLOOD LABORATORY	0	0		0 0	0	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	
64.00	06400 I NTRAVENOUS THERAPY	0	0		0 0	0	
65.00	06500 RESPI RATORY THERAPY	0	0		0 0	0	
66.00	06600 PHYSI CAL THERAPY	0	0		0 0	0	
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0	
69.00	06900 ELECTROCARDI OLOGY	0	0			0	
71.00		0	0			0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0			0	
73.00		0	0			319,082	
74.00	07400 RENAL DI ALYSI S	0	0			0 0	•
76.00		0				0	
76.01	03140 CARDI AC REHAB	0				0	•
76.02		0	0		0 0	0	
76.02		0	0		0 0	-	
70.05	OUTPATIENT SERVICE COST CENTERS	0	0		0 0	10	/0.03
90.00	09000 CLINIC	0	0	1	0 0	0	90.00
90.00	09001 OUTPATI ENT	0					
90.01	09001 00 PATTENT	0				0	
90.02 91.00	09100 EMERGENCY	0				0	
91.00	09101 SHORT STAY	0				0	
		0	0			0	
72.00	OTHER REIMBURSABLE COST CENTERS	0		I	<u>v</u>	0	72.00
95.00		1				1	95.00
200.00		0	0		0 0	319, 082	
200.00		0	0	I	- Ч	J 317, 002	1200.00

20RTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE 20UGH COSTS Cost Center Description	AII Other			From 01/01/2019 To 12/31/2019		
				To 12/31/2010		
Cost Center Description				10 12/31/2019	Date/Time Pre	epared:
Cost Center Description			xviii	Hospi tal	6/8/2020 1:18 PPS	3 pm
Cost Center Description		Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpatient	(from Wkst.	to Charges	
	Education	1, 2, 3, and	Cost (sum of		(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
	0001	.,	and 4)	0011 0)		
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
00 05000 OPERATING ROOM	0	0		0 88, 125, 946	0.000000	50.00
00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0. 000000	52.00
00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 12, 938, 341	0. 000000	54.00
00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 8, 962, 321	0.000000	55.00
00 05700 CT SCAN	0	0		0 20, 209, 198	0.00000	57.00
01 03630 ULTRA SOUND	0	0		9, 006, 349	0.000000	57.01
00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 5, 734, 337	0.00000	58.00
00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 22, 524, 348	0.000000	59.00
00 06000 LABORATORY	0	0		0 50, 498, 746	0.000000	60.00
01 06001 BLOOD LABORATORY	0	0		0 0	0.000000	60.01
00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 1, 310, 574	0.000000	63.00
00 06400 I NTRAVENOUS THERAPY	0	0		0 0	0.000000	
00 06500 RESPI RATORY THERAPY	0	0		0 7, 129, 982		65.00
00 06600 PHYSI CAL THERAPY	0	0		0 32, 918, 958		
00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0.000000	
00 06800 SPEECH PATHOLOGY	0	0		0 0	0.00000	
00 06900 ELECTROCARDI OLOGY	0	0		0 8, 573, 680		
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 40, 487, 932		
00 07200 I MPL. DEV. CHARGED TO PATIENT	0	0		0 18, 033, 488		
00 07300 DRUGS CHARGED TO PATIENTS	0	319, 082				
00 07400 RENAL DI ALYSI S	0	0		0 685, 808		
00 03020 OTHER ANCI LLARY	0	0		0 0		
01 03140 CARDI AC REHAB	0	0		0 12, 225, 645		
02 03070 WOMEN' S CENTER	0	0		0 7, 716, 087		
03 03330 ENDOSCOPY	0	0		0 0	0.00000	76.03
OUTPATIENT SERVICE COST CENTERS		0			0.00000	
00 09000 CLINIC	0	-		0 5, 850, 958		
	0	0		0 5, 107, 617		
02 09002 NEUROPSYCHOLOGY	0			0 1, 729, 323		
00 09100 EMERGENCY	0			0 35, 055, 683		
01 09101 SHORT STAY	0	0		0 0	0.000000	
00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 6, 204, 427	0.00000	92.00
OTHER REI MBURSABLE COST CENTERS			1		1	
00 09500 AMBULANCE SERVICES 0.00 Total (lines 50 through 199)	0	319, 082	319, 08	2 460, 703, 724		95.00 200.00

Health Financial Systems	RI VERVI EW HO	)SPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider C	CN: 15-0059	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2019	Part IV	norod.
				To 12/31/2019	Date/Time Pre 6/8/2020 1:18	pareu:
		Title	XVIII	Hospi tal	PPS	piii
Cost Center Description	Outpati ent	Inpatient	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷	5	Costs (col.		Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	13, 583, 812		0 13, 225, 427	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	874, 407		0 2, 394, 930	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	52, 633		0 3, 022, 818	0	55.00
57.00 05700 CT SCAN	0. 000000	1, 419, 209		0 4, 048, 491	0	57.00
57.01 03630 ULTRA SOUND	0. 000000	81, 116		0 647, 393	0	57.01
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	249, 675		0 1, 306, 486	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	1, 964, 179		0 5, 227, 886	0	59.00
60. 00 06000 LABORATORY	0. 000000	6, 102, 877		0 3, 731, 973	0	60.00
60.01 06001 BLOOD LABORATORY	0. 000000	0		0 0	0	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	216, 286		0 77,076	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	2, 666, 062		0 713, 921	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 598, 345		0 102, 747	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	1, 255, 669		0 2, 963, 010	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	7,023,773		0 5, 508, 192	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	3, 735, 438		0 2, 571, 081	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 005347	5, 456, 094		18, 709, 224	100, 038	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	248, 386		0 0	0	74.00
76.00 03020 OTHER ANCI LLARY	0. 000000	0		0 0	0	76.00
76. 01 03140 CARDI AC REHAB	0. 000000	126, 185		0 4, 939, 748	0	76.01
76.02 03070 WOMEN'S CENTER	0. 000000	2, 209		0 666, 628	0	76.02
76. 03 03330 ENDOSCOPY	0. 000000	0		0 0	0	76.03
OUTPATIENT SERVICE COST CENTERS	-		1	1		
90. 00 09000 CLINIC	0. 000000	5, 064		0 2, 134, 476	0	90.00
90. 01 09001 OUTPATI ENT	0. 000000	78, 369		0 2,041,621	0	90.01
90. 02 09002 NEUROPSYCHOLOGY	0. 000000	4, 901		0 568, 173	0	90.02
91.00 09100 EMERGENCY	0. 000000	2, 356, 947		0 4, 376, 636	0	91.00
91. 01 09101 SHORT STAY	0. 000000	0		0 0	0	91.01
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0. 000000	0		0 1, 051, 408	0	92.00
OTHER REIMBURSABLE COST CENTERS	1 1		1			
95. 00 09500 AMBULANCE SERVICES		10 101			100	95.00
200.00   Total (lines 50 through 199)		49, 101, 636	29, 17	80, 029, 345	100, 038	200.00

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES ANI	O VACCINE COST	Provider C		Period: From 01/01/2019 To 12/31/2019		pared:
		Title	e XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
·	Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
	From	Services (see	Servi ces	Services Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins.	Ded. & Coins.		
	9		(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 018977			0 0	250, 979	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 317181	2, 394, 930		0 0	759, 626	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 236478	3, 022, 818		0 0	714, 830	55.00
57.00 05700 CT SCAN	0. 037772	4, 048, 491		0 0	152, 920	57.00
57.01 03630 ULTRA SOUND	0. 070315	647, 393		0 0	45, 521	57.01
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 128088	1, 306, 486		0 0	167, 345	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 071029	5, 227, 886		0 0	371, 332	59.00
60. 00 06000 LABORATORY	0. 197617	3, 731, 973		0 0	737, 501	60.00
60.01 06001 BLOOD LABORATORY	0. 000000	0		0 0	0	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 527132	77,076		0 0	40, 629	63.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 329274	713, 921		0 0	235, 076	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 324837	102, 747		0 0	33, 376	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 225140	2, 963, 010		0 0	667, 092	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 556476	5, 508, 192	8	9 0	3, 065, 177	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 745108	2, 571, 081		0 0	1, 915, 733	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 403526	18, 709, 224		0 26, 782	7, 549, 658	73.00
74.00 07400 RENAL DIALYSIS	0. 684084	0		0 0	0	74.00
76.00 03020 OTHER ANCI LLARY	0. 000000	0		0 0	0	76.00
76. 01 03140 CARDI AC REHAB	0. 193559	4, 939, 748		0 0	956, 133	76.01
76.02 03070 WOMEN'S CENTER	0. 155044	666, 628		0 0	103, 357	76.02
76. 03 03330 ENDOSCOPY	0. 000000	0		0 0	0	76.03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 160998	2, 134, 476		0 0	343, 646	90.00
90. 01 09001 OUTPATI ENT	0. 333738	2, 041, 621		0 0	681, 367	90.01
90. 02 09002 NEUROPSYCHOLOGY	0. 367948	568, 173		0 0	209, 058	90.02
91.00 09100 EMERGENCY	0. 256582	4, 376, 636		0 0	1, 122, 966	91.00
91.01 09101 SHORT STAY	0. 000000	0		0 0	0	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 707972	1, 051, 408		0 0	744, 367	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0. 000000			0		95.00
200.00 Subtotal (see instructions)		80, 029, 345	8	9 26, 782	20, 867, 689	
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00  Net Charges (line 200 - line 201)		80, 029, 345	8	9 26, 782	20, 867, 689	202.00

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2552	2-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES ANI	D VACCINE COST	Provider CO	CN: 15-0059	Peri od: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Prepare 6/8/2020 1:18 pm	
		Title	XVIII	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) 6.00	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) 7.00				
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0				0. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				2.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				6.00
57.00 05700 CT SCAN	0	0				. 00
57.01 03630 ULTRA SOUND	0	0				. 01
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0				8.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				. 00
60. 00 06000 LABORATORY	0	0				. 00
60. 01 06001 BLOOD LABORATORY	0	0				0.01
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0				. 00
64.00 06400 I NTRAVENOUS THERAPY	0	0				. 00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	0				. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				o. 00 7. 00
68. 00 06800 SPEECH PATHOLOGY	0	0				. 00 3. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0				9.00 9.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	50	0				. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0				2.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	10, 807				. 00 . 00
74. 00 07400 RENAL DI ALYSI S	0	0,007				. 00
76.00 03020 OTHER ANCI LLARY	0	0				. 00
76. 01 03140 CARDI AC REHAB	0	0				0.01
76. 02 03070 WOMEN' S CENTER	0	0				. 02
76. 03 03330 ENDOSCOPY	0	0				. 03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0			90.	0. 00
90. 01 09001 OUTPATI ENT	0	0			90.	). 01
90. 02 09002 NEUROPSYCHOLOGY	0	0			90.	0. 02
91. 00 09100 EMERGENCY	0	0			91.	. 00
91.01 09101 SHORT STAY	0	0				. 01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0			92.	. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0					. 00
200.00 Subtotal (see instructions)	50	10, 807			200.	
201.00 Less PBP Clinic Lab. Services-Program	0				201.	. 00
Only Charges		10 007				
202.00  Net Charges (line 200 - line 201)	50	10, 807	l		202.	. 00

52.00         OS200         DELIVERY ROM & LABOR ROM         0         0         0.000000         0         0         52.00           54.00         D5400         RADIOLOGY-DI ACNOSTI         518,359         2,388         54.00           55.00         D5500         RADIOLOGY-THERAPEUTI C         518,352         12,388,44         0.040061         58,359         2,388         55.00           57.00         OSTOO CT SCAN         123,849         20.209,198         0.006128         69,768         4228         57.00           58.00         D5800         MARDICIC RESONANCE IMAGING (MRI )         154,251         57.734,337         0.026900         13,570         365         58.00           00.00         CADIO CARDI AC CATHETERIZATION         184,067         22,524,348         0.008172         29,627         242         59.00           60.01         D6000         LADORATORY         928,355         50.498,746         0.087723         10,438         916         63.00           63.00         D6300 RESPIRATORY         0         0         0.000000         0         64.00           64.00         ORSON RESPIRATORY         0         0         0.000000         0         64.00           65.00         D65000 RESPIRA	Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-	2552-10
Component CCN: 15-T059         To         12/31/2019         Date/Time Prepared: b/2/20200 1:18 pm (Control Control Contrelector Control Control Control Contrelecont Contro	APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provider C	CN: 15-0059			
Cost Center Description         Capital Related Cost (from Wkst. Cool. 2)         Ratio of Cost (col. um 4)         Capital Related Cost (col. m)         Ratio of Cost (col. m)         Capital Costs (col. m)         Capital Related Cost (col. m)         Capital (col. m) <thcol m)<="" th="">         Capital (col. m)&lt;</thcol>			Component	CON 15 TOED		Part II	narod
Cost Center Description         Capital Related Cost (From Wkst. B, Part I, B, Part I, B, Part I, Col. 20)         Title XVIII         Subprovider - From Kst. C, Part I, B, Part I, B, Part I, Col. 20)         Capital Costs (Col. 1 + Col. 2)           ANCILLARY SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           52.00         05200 DELUTERY ROOM 05200 CT SCAN         0.0040061         58.359         2.338         54.00           55.00         05500 RADI LOCY-IN ACMOSTIC         518.320         12.938,341         0.040061         58.359         2.338         54.00           57.01         05700 CT SCAN         123.849         20.0299         198         0.008128         69.768         428         57.00           50.00         05900 CARDI AC CATHETERI ZATI ON         184.067         2.524.348         0.008172         29.627         2242         59.00         60.00         60.00         60.00         60.00         60.00         60.00         60.01         60.01         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00			component	CCN. 13-1037	10 12/31/2019	6/8/2020 1:18	pareu. 3 pm
Cost Center Description         Capital Related Cost (from Wkst. Cost Line Program (col. 1)         Capital Cost (col. 1)         Coprant Capital Col. 1)         Coprant Coprant (col. 2)         Coprant Coprant (col. 1)         Coprant Coprant (col. 2)           MCILLARY SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           50.00         550.00         0         0.0400         0.04000         5.00         5.00           52.00         05200 DELIVERY MOM & LABOR ROM         3.022, 645         88, 125, 946         0.03299         175, 127         6.007         50.00           52.00         05400 RADI DLOGY - THEAREDUT C         518, 320         12, 938, 341         0.040061         58, 359         2.388         54.00           53.00         05500 RADI DLOGY - THEAREDUT C         428, 647         8, 962, 321         0.04788         2, 720         130.55.00         55.00           05500 LARGA C, CATHETERI ZATI ON         184, 067         2.2, 24, 348         0.008172         29, 667         24, 667         6.60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00			Title	2 XVIII	Subprovider -		, b
Rel ared Cost (from Wkst. b, Part II, col. 26)         Col Charges (col um 4)         Col um 3 x col um 4)           50.00         5000         0000         0000         0000         0000         0000         0000         0000         0000         0000         0000         0000         0000         0000         0000         00000         00000         00000         000000         000000         000000         000000         000000         000000         000000         000000         000000         000000         000000         000000         000000         000000         000000         000000         000000         000000         0000000         0000000         000000         000000         000000         00000000         00000000         0000000 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td>-</td> <td></td>						-	
Image: constraint of the service of the ser	Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
B         Part II.         col. 20         3.00         4.00         5.00           50.00         05000         0PERATING ROM         3,022,645         88,125,946         0.034299         175,127         6,007         50.00           50.00         05200         DELLVERY ROM & LABOR ROM         0         0         0.000000         0         0         52.00           50.00         05500         RADIOLOGY-THERAPEUTIC         428,647         8,962,321         0.047828         2,720         130         55.00           50.00         05500         RADIOLOGY-THERAPEUTIC         428,647         8,962,321         0.047828         2,720         130         55.00           50.00         05500         CT ACAN         123,849         9.005,349         0.033976         7,460         30         57.01           03300         ULREN SOUND         184,067         22,524,348         0.008172         29,627         242         59.00           60.00         66000         LABORATORY         928,355         50,498,746         0.133209         375,840         4,964         63.00         64.00         64.00         64.00         64.00         64.00         64.00         64.00         64.00         64.00         64.00 </td <td></td> <td>Related Cost</td> <td>(from Wkst.</td> <td>to Charges</td> <td>Program</td> <td>(column 3 x</td> <td></td>		Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
col.         260         .00         5.00           ANCI LLARY SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           52.00         05200 DELIVERY ROM & LABOR ROM         3.022.645         88,125.946         0.034209         175,127         6.007         50.07           52.00         054.00         054.00         054.00         054.00         0.040061         58.359         2.38         54.00           51.00         05500 RADI DLOGY-DI AGNOSTI C         518.320         12.938.341         0.040061         58.359         2.38         54.00           57.00         05500 CT SCAN         123.849         20.209.198         0.06128         69.768         428         57.00           58.00         05600 MAGNETI C RESONANCE IMAGING (MRI )         154.251         5.73.437         0.0264900         13.570         365         58.00           60.00         06000 LABORATORY         928.355         50.498.746         0.0133209         375.640         0.60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00 <td></td> <td>(from Wkst.</td> <td>C, Part I,</td> <td>(col. 1 ÷</td> <td>Charges</td> <td>column 4)</td> <td></td>		(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
I.00         2.00         3.00         4.00         5.00           50.00         05000         0PERATING ROM         3.022,645         88,125,946         0.034299         175,127         6.007         50.00           52.00         05200         DELIVERY ROM & LABOR ROM         0         0.000000         0         0         52.00           52.00         05200         RADI OLOGY-11 AGNOSTI C         518,320         12,938,341         0.040061         58,359         2,338         54.00         57.00         57.00         05700         CTAO         7.460         30         57.00         57.00         05700         A4.00         1.067.746         3.022,441         8.962,321         0.047828         2,720         130         55.00           57.00         05700         CTAO         135,812         9.063,349         0.00376         7,460         30         57.01         3.02         4.800         4.80         57.01         3.02         4.80         6.0037         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00		B, Part II,	col. 8)	col. 2)			
ANCILLARY SERVICE COST CENTERS         Image: Control of							
50. 00         05000         0PERATI NG ROM         3, 022, 645         88, 125, 946         0, 034299         175, 127         6, 007         50. 00           52. 00         05200         DELI VERY ROM & LABOR ROM         0         0         0,000000         0         52.00         52.00         05200         RADI OLOGY-DI AGNOSTI C         518, 320         12, 938, 341         0.040061         58, 359         2, 338         54.00         57.01         05700         13, 022, 948         0.008172         29, 627         242         59.00         <		1.00	2.00	3.00	4.00	5.00	
52.00         OS200         DELIVERY ROM & LABOR ROM         0         0         0.000000         0         55.00		1			- 1	1	
54. 00       05400       RADI DLOGY-DIAGNOSTI C       518, 320       12, 938, 341       0.0400ch       58, 359       2, 338       54, 00         55. 00       05500       RADI DLOGY-THERAPEUTI C       428, 647       8, 962, 321       0.047828       2, 720       130       55, 00         57. 01       05600       CT SCAN       123, 849       20, 209, 198       0.006128       69, 768       428       57, 01         58. 00       05600       MARCHTI C RESONANCE IMAGI NG (MRI )       154, 251       5, 734, 337       0.026900       13, 570       365       58, 00         59. 00       05900       LABDA LAC CATHETERI ZATI ON       184, 067       22, 524, 348       0.008172       29, 627       242       59, 00         60. 00       6000       LABORATORY       928, 355       50, 498, 746       0.013836       852, 275       15, 668       60, 00         60. 00       6000       INTAVENDUS THERAPY       0       0       0.000000       0       64, 00       64, 00         64.00       INTAVENDUS THERAPY       97, 727       32, 918, 958       0.011460       39, 963, 662       45, 417       66, 00       66, 00       66000       6600       6600       6600       94, 457, 932       0.03200       0			88, 125, 946				
55:00       05500       RADIOLOGY-THERAPEUTIC       428,647       8,962,321       0.047828       2,720       130       55.00         57:00       05700       CT SCAN       123,849       20,209,198       0.006128       69,768       428       57.00         57:01       03630       ULTRA SOUND       35,812       9,006,349       0.003976       7,460       30       57.01         58:00       OSB00       CATHETERIZATION       184,067       22,524,348       0.008172       29,627       242       59.00         60:01       06000       LABORATORY       928,355       50,498,746       0.013384       852,275       15,668       60.01         61:00       06000       RESPI RATORY       928,355       50,498,746       0.087723       10,438       916       63.00       64.00         64:00       06400       INTRAVENOUS THERAPY       94       129,928       0.011460       3,963,062       45,417       66.00         65:00       6500       RESPI RATORY THERAPY       94,182       7,129,928       0.0113209       375,840       4,964       65.00         66:00       06600       PHYSICAL THERAPY       94,182       7,129,928       0.013209       375,840       4,964       <			0				
57. 00       057.00       CT SCAN       123.849       20, 209, 198       0.006128       69, 768       428       57.00         57. 01       03630       ULTRA SOUND       35, 812       9, 006, 349       0.003976       7, 460       30       57.01         58.00       05800       MAGNETI C RESONANCE I MAGI NG (MRI)       154, 251       5, 734, 337       0.026900       13, 570       365       58.00         59.00       OLBORO CARDIAC CATHETERI ZATI ON       184, 067       22, 524, 348       0.008172       29, 627       242       59.00         60.00       OLOOD LABORATORY       0       0.000000       0       0.000000       0       66.00       60.00         64.00       06400       INTRAVENOUS THERAPY       94, 182       7, 129, 982       0.013209       375, 840       4, 964       65.00         65.00       06500       PESPI RATORY THERAPY       377, 247       32, 918, 958       0.011460       3, 963, 062       45, 417       66.00       66.00         66.00       066000       PESPI RATORY THERAPY       377, 247       32, 918, 958       0.011460       3, 963, 062       45, 417       66.00       67.00       0.000000       0       67.00       67.00       0.0000000       0       67.							
57. 01       03630       LTRA SOUND       35, 812       9, 006, 349       0, 003976       7, 460       30       57, 01         58. 00       05800       MAGNETI C RESONANCE I MAGI NG (MRI )       154, 251       5, 734, 337       0, 026900       13, 570       365       58, 00         60. 00       06000       LABDRATORY       928, 355       50, 498, 746       0, 018384       852, 275       15, 668       60, 00         60. 01       BLODD STORI NG, PROCESSI NG & TRANS.       114, 968       1, 310, 574       0, 087723       10, 438       916       63, 00         64. 00       06400       INTRAVENUS THERAPY       0       0       0, 000000       0       64, 00         65. 00       06500 RESPI RATORY THERAPY       94, 182       7, 129, 982       0, 013209       375, 840       4, 964       65, 00         66. 00       06600 RESPI RATORY THERAPY       97, 506       8, 573, 680       0, 000000       0       66, 00         67. 00       06600 SPEECH PATHOLOGY       0       0       0, 000000       0       68, 00         69. 00       06900 ELECTROCARDI OLOGY       597, 550       8, 573, 676       0, 069691       53, 181       3, 700       71, 00         71. 00       07100 MEDI CAL SUPPLI ES CHAR		428, 647	8, 962, 321	0. 04782	28 2, 720	130	55.00
58:00       05800       MARNETIC RESONANCE IMAGING (MRI)       154,251       5,734,337       0.026900       13,570       365       58.00         59:00       05900       CARDIA C CATHETERIZATION       184,067       22,524,348       0.008172       29,627       242       59.00         60:00       LABORATORY       928,355       50,498,746       0.018384       852,275       15,668       60.00         60:00       LABORATORY       0       0.000000       0       0.63.00       06000 LABORATORY       0       0.000000       0       64.00         64:00       O6400 INTRAVENOUS THERAPY       94,182       7,129,982       0.013209       375,840       4,964       65.00         66:00       06600 PHYSI CAL THERAPY       377,247       32,918,958       0.011460       3,963,062       45,417       66.00         67:00       06700       OCUPATI ONAL THERAPY       0       0       0.000000       0       68.00         69:00       OSPO0 ELECTROARDI OLOGY       597,506       8,573,680       0.048691       53,181       3,705       74.00         71:00       07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS       561,194       40,487,932       0.013861       842,138       11,673       71.00	57.00 05700 CT SCAN	123, 849	20, 209, 198			428	57.00
59:00         CARDI AC CATHETERI ZATION         184,067         22,524,348         0.008172         29,627         242         59.00           06:00         LABORATORY         928,355         50,498,746         0.018384         852,275         15,668         60.00           06:00         LBLOD LABORATORY         0         0.000000         0         060.00           06:01         BLOOD STORI NG, PROCESSI NG & TRANS.         114,968         1,310,574         0.087723         10,438         916         63.00           06:00         INTRAVENUS THERAPY         94,182         7,129,982         0.013209         375,840         4,964         65.00           06:00         OCCUPATI ONAL THERAPY         377,247         32,918,958         0.011460         3,963,062         45,417         66.00           0         0         0.000000         0         0         0.000000         0         0         0.000000         0         0         0.000000         0         0         67.00         68.00         0.000000         0         0         0.000000         0         0         67.00         68.00         68.00         68.00         68.00         68.00         68.00         68.00         68.00         68.00         68.00<		35, 812	9, 006, 349	0.0039	76 7,460	30	57.01
60.00         IABORATORY         928, 355         50, 498, 746         0.018344         852, 275         15, 668         60.00           06001         BLOOD LABORATORY         0         0         0.000000         0         0         60.01           63.00         06300         BLOOD STORING, PROCESSING & TRANS.         114, 968         1, 310, 574         0.087723         10, 438         916         63.00           64.00         06400         INTRAVENOUS THERAPY         0         0         0.000000         0         0         64.00           06500         RESPI RATORY THERAPY         94, 182         7, 129, 982         0.013209         375, 840         4, 964         65.00           06600         PHYSI CAL THERAPY         377, 247         32, 918, 958         0.011460         3, 963, 062         45, 417         66.00           06700         OCCUPATI ONAL THERAPY         0         0         0.000000         0         67.00           06900         ELECTROCARDI OLOGY         597, 506         8, 573, 680         0.069691         53, 181         3, 706         69.07           71.00         0700         IMEDI CAL SUPPLIES CHARGED TO PATI ENTS         561, 980         0.005158         21, 579         1111         72.00		154, 251	5, 734, 337			365	58.00
60.01       06001       BLOOD LABORATORY       0       0       0.00000       0       0       06.01         63.00       06300       BLOOD STORING, PROCESSING & TRANS.       114,968       1,310,574       0.087723       10,438       916       63.00         64.00       06400       INTRAVENUS THERAPY       0       0       0.000000       0       64.00         65.00       06500       RESPI RATORY THERAPY       377,247       32,918,958       0.011460       3,963,062       45,417       66.00         66.00       00       0.000000       0       0       0.000000       0       67.00         67.00       06700       0CCUPATI ONAL THERAPY       377,247       32,918,958       0.011460       3,963,062       45,417       66.00         68.00       06800       SPECH PATHOLOGY       0       0       0.000000       0       67.00         67.00       0700       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       561,194       40,487,932       0.013861       842,138       11,673       71.00         72.00       0700       IMPL, DEV. CHARGED TO PATI ENTS       568,962       59,673,976       0.011512       903,826       10,405       73.00         73.00       07300	59. 00 05900 CARDI AC CATHETERI ZATI ON	184, 067	22, 524, 348	0.0081	29,627	242	59.00
63.00       06300       BLOOD STORING, PROCESSING & TRANS.       114,968       1,310,574       0.087723       10,438       916       63.00         64.00       0400       INTRAVENOUS THERAPY       0       0       0.000000       0       64.00         65.00       0500       RESPIRATORY THERAPY       94,182       7,129,922       0.013209       375,840       4,964       65.00         66.00       06600       PHYSI CAL THERAPY       377,247       32,918,958       0.011460       3,963,062       45,417       66.00         67.00       0C000       0       0.000000       0       67.00       68.00       69.00       69.00       0.600000       0       68.00       69.07       73.181       3.706       71.00       71.00       71.00       MEDI CAL SUPPLIES CHARGED TO PATI ENT       56.1,194       40,487,932       0.011512       69.3,826       10,435       13.305       74.00       73.00       73.00 <td< td=""><td>60. 00 06000 LABORATORY</td><td>928, 355</td><td>50, 498, 746</td><td>0. 01838</td><td>852, 275</td><td>15, 668</td><td>60.00</td></td<>	60. 00 06000 LABORATORY	928, 355	50, 498, 746	0. 01838	852, 275	15, 668	60.00
64.00       06400       INTRAVENOUS THERAPY       0       0       0.000000       0       0       64.00         65.00       06500       RESPI RATORY THERAPY       94, 182       7, 129, 982       0.013209       375, 840       4, 964       65.00         66.00       06500       OCCUPATI ONAL THERAPY       377, 247       32, 918, 958       0.011460       3, 963, 062       45, 417       66.00         67.00       06700       OCCUPATI ONAL THERAPY       0       0       0.000000       0       67.00         68.00       OB600       EECTROCARDI OLOGY       0       0       0.000000       0       68.00         69.00       OT100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       551, 194       40, 487, 932       0.013861       842, 138       11, 673       71.00         71.00       07100       MEICAL SUPPLIES CHARGED TO PATI ENTS       554, 687       685, 808       0.081199       163, 855       13, 305       74.00       74.00       7400       REMAR LDI ALXYIS       55, 687       685, 808       0.081199       163, 855       13, 305       74.00       76.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.	60. 01 06001 BLOOD LABORATORY	0	0	0.0000	0 0	0	60.01
65.00       06500       RESPIRATORY THERAPY       94, 182       7, 129, 982       0.013209       375, 840       4, 964       65.00         66.00       06600       PHYSI CAL THERAPY       377, 247       32, 918, 958       0.011460       3, 963, 062       45, 417       66.00         67.00       0CUPATI ONAL THERAPY       0       0       0.000000       0       66.00         68.00       06800       SPECH PATHOLOGY       0       0.000000       0       66.00         69.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       551, 194       40, 487, 932       0.013861       842, 138       11, 673       71.00         72.00       0700       IMUEL DEV. CHARGED TO PATI ENTS       568, 194       40, 487, 932       0.011512       903, 826       10, 405       73.00       73.00         73.00       07300       RUGS CHARGED TO PATI ENTS       55, 687       685, 808       0.081199       163, 855       13, 305       74.00         76.00       03020       OTHER ANCI LLARY       0       0       0.000000       0       76.00         03330       ENDOSCOPY       0       0       0.000000       0       0       0.000000       0       76.00       0       0.000000	63.00 06300 BLOOD STORING, PROCESSING & TRANS.	114, 968	1, 310, 574	0. 08772	10, 438	916	63.00
66.00       06600       PHYSI CAL THERAPY       377, 247       32, 918, 958       0.011460       3, 963, 062       45, 417       66. 00         67.00       0CCUPATI ONAL THERAPY       0       0       0.000000       0       67. 00         68.00       0SPECH PATHOLOGY       0       0       0.000000       0       68. 00         69.00       06900       ELECTROCARDI OLOGY       597, 506       8, 573, 680       0.069691       53, 181       3, 706       69. 00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       561, 194       40, 487, 932       0.013861       842, 138       11, 673       71. 00         73.00       07200 I MPL       DEV. CHARGED TO PATIENT       93, 008       18, 033, 488       0.005158       21, 579       111       72. 00         74.00       07400       RENAL DI ALYSI S       55, 687       685, 808       0.081199       163, 855       13, 305       74. 00       76. 00       0       0       0       0       76. 00       76. 00       76. 00       0.03020       0THER ANCI LLARY       0       0       0       0       0       0       76. 00       76. 00       76. 00       76. 00       76. 00       0       0       0       0	64.00 06400 INTRAVENOUS THERAPY	0	0	0.0000	0 0	0	64.00
67.00       06700       OCCUPATI ONAL THERAPY       0       0       0.000000       0       67.00         68.00       06800       SPEECH       PATHOLOGY       0       0       0.000000       0       68.00         69.00       06900       ELECTROCARDI OLOGY       597, 506       8, 573, 680       0.069691       53, 181       3, 706       69.07         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       561, 194       40, 487, 932       0.013861       842, 138       11, 673       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENT       93,008       18,033,488       0.005158       21, 579       111       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       686,962       59,673,976       0.011512       903,826       10,405       73.00         74.00       03020       OTHER ANCI LLARY       0       0       0.000000       0       0       66.00         76.01       03140       CARDI AC REHAB       181,002       12,225,645       0.014805       4,194       62       76.01         76.02       03070       WOMEN'S CENTER       306,749       7,716,087       0.039754       1111       4       76.02      <	65. 00 06500 RESPI RATORY THERAPY	94, 182	7, 129, 982	0. 01320	375, 840	4, 964	65.00
68:00       06800       SPEECH PATHOLOGY       0       0       0.000000       0       0       68:00       69:00       0       06900       ELECTROCARDI OLOGY       597,506       8,573,680       0.069691       53,181       3,706       69:00       71:00       0       0       0       0       0       69:00       71:00       0       MEDI CAL SUPPLIES CHARGED TO PATIENTS       561,194       40,487,932       0.013861       842,138       11,673       71:00         72:00       07200       IMPL       DEV. CHARGED TO PATIENT       93,008       18,033,488       0.005158       21,579       1111       72:00       0       07400       RENAL DI ALYSI S       686,962       59,673,976       0.011512       903,826       10,405       73:00       74:00       0       0       0       0.000000       0       0       76:00       0       0       0       0.000000       0       0       76:00       76:00       0       0.000000       0       0       0       0       0.000000       0       0       76:00       76:00       76:00       76:00       76:00       76:00       76:00       76:00       76:00       76:00       76:00       76:00       76:00       76:00       76:00	66. 00 06600 PHYSI CAL THERAPY	377, 247	32, 918, 958	0. 01140	3, 963, 062	45, 417	66.00
69.00       06900       ELECTROCARDIOLOGY       597,506       8,573,680       0.069691       53,181       3,706       69.00         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       561,194       40,487,932       0.013861       842,138       11,673       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENT       93,008       18,033,488       0.005158       21,579       111       72.00         73.00       07300       RUGS CHARGED TO PATIENTS       686,962       59,673,976       0.011512       903,826       10,405       73.00       74.00       74.00       0.03020       OTHER ANCILLARY       0       0       0.000000       0       76.00       76.00       03040       CARDIAC REHAB       181,002       12,225,645       0.014805       4,194       62       76.00       76.00         76.02       03070       WOMEN'S CENTER       306,749       7,716,087       0.039754       111       4       76.02         70.01       090001       CLINIC       149,470       5,850,958       0.025546       1,890       48       90.00         90.01       090001       OUPATIENT       219,674       5,107,617       0.04309       49,794       2,142       90.01 <td>67.00 06700 OCCUPATI ONAL THERAPY</td> <td>0</td> <td>0</td> <td>0.0000</td> <td>0 0</td> <td>0</td> <td>67.00</td>	67.00 06700 OCCUPATI ONAL THERAPY	0	0	0.0000	0 0	0	67.00
71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       561, 194       40, 487, 932       0.013861       842, 138       11, 673       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENT       93,008       18,033,488       0.005158       21,579       111       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       686,962       59,673,976       0.011512       903,826       10,405       73.00         74.00       07400       RENAL DIALYSIS       55,687       685,808       0.081199       163,855       13,305       74.00         76.00       03020       OTHER ANCILLARY       0       0       0.000000       0       76.00         03140       CARDIAC REHAB       181,002       12,225,645       0.014805       4,194       62       76.01         03300       ENDOSCOPY       0       0       0.000000       0       0       76.02       0.03300       ENDOSCOPY       76.02       0.025546       1.890       48       90.01       90.02       90001       CUTPATIENT       219,674       5,107,617       0.43009       49,774       2,142       90.01       90.02         90.01       09000       CLINIC       24,275       1,729,323	68.00 06800 SPEECH PATHOLOGY	0	0	0.0000	0 0	0	68.00
72.00       07200       IMPL. DEV. CHARGED TO PATIENT       93,008       18,033,488       0.005158       21,579       111       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       686,962       59,673,976       0.011512       903,826       10,405       73.00         74.00       07400       RENAL DI ALYSIS       55,687       685,808       0.081199       163,855       13,305       74.00         76.00       03020       OTHER ANCI LLARY       0       0       0.000000       0       76.00         76.01       03140       CARDIAC REHAB       181,002       12,225,645       0.014805       4,194       62       76.00         76.02       03070       WOMEN'S CENTER       306,749       7,716,087       0.39754       111       4       76.02         76.03       03330       ENDOSCOPY       0       0       0.000000       0       76.02         00.00       09000       CLINIC       149,470       5,850,958       0.025546       1,890       48       90.00         90.01       09001       OUTPATIENT       219,674       5,107,617       0.043009       49,794       2,142       90.01         90.02       09002       NEUROPSYCHOLOG	69. 00 06900 ELECTROCARDI OLOGY	597, 506	8, 573, 680	0.0696	53, 181	3, 706	69.00
73.00       07300       DRUGS CHARGED TO PATIENTS       686,962       59,673,976       0.011512       903,826       10,405       73.00         74.00       07400       RENAL DI ALYSIS       55,687       685,808       0.081199       163,855       13,305       74.00         76.00       03020       OTHER ANCI LLARY       0       0       0.000000       0       0       76.00         76.01       03140       CARDI AC REHAB       181,002       12,225,645       0.014805       4,194       62       76.01         76.02       03070       WOMEN'S CENTER       306,749       7,16,087       0.039754       111       4       76.02         03330       ENDOSCOPY       0       0       0.000000       0	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	561, 194	40, 487, 932	0. 01386	842, 138	11, 673	71.00
74.00       07400       RENAL DI ALYSI S       55, 687       685, 808       0.081199       163, 855       13, 305       74.00         76.00       03020       OTHER ANCI LLARY       0       0       0.000000       0       76.00         76.01       03140       CARDI AC REHAB       181,002       12,225,645       0.014805       4,194       62       76.01         76.02       03070       WOMEN'S CENTER       306,749       7,716,087       0.039754       111       4       76.02         70.03       03330       ENDOSCOPY       0       0       0.000000       0 <td>72.00 07200 IMPL. DEV. CHARGED TO PATIENT</td> <td>93, 008</td> <td>18, 033, 488</td> <td>0.00515</td> <td>58 21, 579</td> <td>111</td> <td>72.00</td>	72.00 07200 IMPL. DEV. CHARGED TO PATIENT	93, 008	18, 033, 488	0.00515	58 21, 579	111	72.00
76.00       03020       OTHER ANCI LLARY       0       0       0.000000       0       0       76.00         76.01       03140       CARDI AC REHAB       181,002       12,225,645       0.014805       4,194       62       76.01         76.02       03070       WOMEN'S CENTER       306,749       7,716,087       0.039754       111       4       76.02         03330       ENDOSCOPY       0       0       0.000000       0 </td <td>73.00 07300 DRUGS CHARGED TO PATIENTS</td> <td>686, 962</td> <td>59, 673, 976</td> <td>0.0115</td> <td>903, 826</td> <td>10, 405</td> <td>73.00</td>	73.00 07300 DRUGS CHARGED TO PATIENTS	686, 962	59, 673, 976	0.0115	903, 826	10, 405	73.00
76.01       03140       CARDIAC REHAB       181,002       12,225,645       0.014805       4,194       62       76.01         76.02       03070       WOMEN'S CENTER       306,749       7,716,087       0.039754       111       4       76.02         03330       ENDOSCOPY       0       0       0.000000       0       0       76.03         04000       CLINIC       149,470       5,850,958       0.025546       1,890       48       90.00         90.01       09000       CLINIC       149,470       5,850,958       0.025546       1,890       48       90.00         90.02       O9000       CLINIC       149,470       5,850,958       0.025546       1,890       48       90.00         90.01       OUTPATIENT       219,674       5,107,617       0.043009       49,794       2,142       90.01         90.02       NEUROPSYCHOLOGY       234,275       1,729,323       0.135472       0       0       90.02         91.00       O9100       EMERGENCY       1,328,330       35,055,683       0.037892       32,293       1,224       91.00         92.00       OBSERVATION BEDS (NON-DISTINCT PART)       0       0       0.000000       0       <	74.00 07400 RENAL DIALYSIS	55, 687	685, 808	0. 08119	163, 855	13, 305	74.00
76.02       03070       WOMEN'S CENTER       306,749       7,716,087       0.039754       111       4       76.02         03330       ENDOSCOPY       0       0       0       0.000000       0       0       76.02         0UTPATI ENT SERVICE COST CENTERS       0       0       0.025546       1,890       48       90.00         90.00       09000       CLINIC       149,470       5,850,958       0.025546       1,890       48       90.00         90.01       09001       0UTPATI ENT       219,674       5,107,617       0.043009       49,794       2,142       90.01         90.02       09002       NEUROPSYCHOLOGY       234,275       1,729,323       0.135472       0       0       90.02         91.00       OP100       EMERGENCY       1,328,330       35,055,683       0.037892       32,293       1,224       91.00         91.01       SHORT STAY       0       0       0.000000       0       91.00       91.00         9200       0BSERVATION BEDS (NON-DISTINCT PART)       0       6,204,427       0.000000       0       91.00       92.00         07HER       REI MBURSABLE COST CENTERS       95.00       09500       AMBULANCE SERVICES	76.00 03020 OTHER ANCI LLARY	0	0	0.0000	0 0	0	76.00
76.02       03070       WOMEN'S CENTER       306,749       7,716,087       0.039754       111       4       76.02         03330       ENDOSCOPY       0       0       0       0.000000       0       0       76.02         0UTPATI ENT SERVICE COST CENTERS       0       0       0.025546       1,890       48       90.00         90.00       09000       CLINIC       149,470       5,850,958       0.025546       1,890       48       90.00         90.01       09001       0UTPATI ENT       219,674       5,107,617       0.043009       49,794       2,142       90.01         90.02       09002       NEUROPSYCHOLOGY       234,275       1,729,323       0.135472       0       0       90.02         91.00       OP100       EMERGENCY       1,328,330       35,055,683       0.037892       32,293       1,224       91.00         91.01       SHORT STAY       0       0       0.000000       0       91.00       91.00         9200       0BSERVATION BEDS (NON-DISTINCT PART)       0       6,204,427       0.000000       0       91.00       92.00         07HER       REI MBURSABLE COST CENTERS       95.00       09500       AMBULANCE SERVICES	76. 01 03140 CARDI AC REHAB	181,002	12, 225, 645	0.01480	4, 194	62	76.01
76.03         03330         ENDOSCOPY         0         0         0.000000         0         0         76.03           0UTPATI ENT SERVICE COST CENTERS         0         0         0.000000         CLINIC         149,470         5,850,958         0.025546         1,890         48         90.00           90.00         09000         CLINIC         149,470         5,850,958         0.025546         1,890         48         90.00         90.01           90.01         09001         OUTPATI ENT         219,674         5,107,617         0.043009         49,794         2,142         90.01           90.02         09002         NEUROPSYCHOLOGY         234,275         1,729,323         0.135472         0         0         90.02           91.00         EMERGENCY         11,328,330         35,055,683         0.037892         32,293         1,224         91.00           91.01         SHORT STAY         0         0         0.000000         0         91.01         91.01         91.01         91.01         91.01         91.01         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         9	76. 02 03070 WOMEN' S CENTER	306, 749					76.02
OUTPATI ENT SERVICE COST CENTERS           90.00         09000         CLINIC         149,470         5,850,958         0.025546         1,890         48         90.00           90.01         09001         0UTPATI ENT         219,674         5,107,617         0.043009         49,794         2,142         90.01           90.02         09002         NEUROPSYCHOLOGY         234,275         1,729,323         0.135472         0         0         90.02           91.00         09100         EMERGENCY         1,328,330         35,055,683         0.037892         32,293         1,224         91.00           91.01         SHORT STAY         0         0         0         0         91.01           92.00         0BSERVATI ON BEDS (NON-DI STINCT PART)         0         6,204,427         0.000000         0         91.01           92.00         OBSERVATI ON BEDS (NON-ENTERS         92.00         0         92.00		0			0 0	0	76.03
90.00       09000       CLINIC       149,470       5,850,958       0.025546       1,890       48       90.00         90.01       09001       0UTPATIENT       219,674       5,107,617       0.043009       49,794       2,142       90.01         90.02       09002       NEUROPSYCHOLOGY       234,275       1,729,323       0.135472       0       0       90.02         91.00       09101       EMERGENCY       1,328,330       35,055,683       0.037892       32,293       1,224       91.00         91.01       SHORT STAY       0       0       0.000000       0       91.01         92.00       0BSERVATION BEDS       (NON-DISTINCT PART)       0       6,204,427       0.000000       0       0       91.00         92.00       09200       AMBULANCE SERVICES       95.00       95.00       95.00       95.00       95.00       95.00       95.00							
90.01       09001       0UTPATI ENT       219, 674       5, 107, 617       0.043009       49, 794       2, 142       90.01         90.02       09002       NEUROPSYCHOLOGY       234, 275       1, 729, 323       0.135472       0       0       90.02         91.00       09100       EMERGENCY       1, 328, 330       35, 055, 683       0.037892       32, 293       1, 224       91.00         91.01       SHORT STAY       0       0       0       0.000000       0       91.01         92.00       OBSERVATION BEDS (NON-DISTINCT PART)       0       0       0.000000       0       0       91.01         95.00       09500       AMBULANCE SERVICES       95.00       95.00       95.00       95.00       95.00       95.00       95.00		149, 470	5, 850, 958	0.02554	1,890	48	90.00
90.02       09002       NEUROPSYCHOLOGY       234,275       1,729,323       0.135472       0       0       90.02         91.00       09100       EMERGENCY       1,328,330       35,055,683       0.037892       32,293       1,224       91.00         91.01       09101       SHORT STAY       0       0       0       0.000000       0       91.01         92.00       0BSERVATI ON BEDS (NON-DI STINCT PART)       0       6,204,427       0.000000       0       92.00         0THER REI MBURSABLE COST CENTERS       95.00       09500       AMBULANCE SERVICES       95.00							
91.00       09100       EMERGENCY       1,328,330       35,055,683       0.037892       32,293       1,224       91.00         91.01       09101       SHORT STAY       0       0       0.000000       0       91.01         92.00       0BSERVATI ON BEDS (NON-DI STINCT PART)       0       6,204,427       0.000000       0       92.00         0THER REI MBURSABLE COST CENTERS       95.00       09500       AMBULANCE SERVICES       95.00							
91. 01       09101       SHORT STAY       0       0       0.000000       0       91. 01         92. 00       09200       0BSERVATI ON BEDS (NON-DI STINCT PART)       0       6, 204, 427       0.000000       0       92. 00         0THER REI MBURSABLE COST CENTERS       95. 00       09500       AMBULANCE SERVICES       95. 00							
92. 00         09200         0BSERVATI ON BEDS (NON-DI STINCT PART)         0         6, 204, 427         0. 000000         0         92. 00           0THER REI MBURSABLE COST CENTERS         95.00         09500 AMBULANCE SERVICES         95.00							1
OTHER REI MBURSABLE COST CENTERS         95.00         09500 AMBULANCE SERVICES         95.00		0	6, 204, 427			0	92.00
95.00 09500 AMBULANCE SERVICES 95.00							1
							95.00
		10, 396, 200	460, 703, 724		7, 631, 107	119, 185	200.00

Health Fi	nancial Systems	RI VERVI EW	HOSPI TAL			In Lie	u of Form CMS-3	2552-10
APPORTI ON	WENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PAS	S Provider C	CN: 15-0059	Perio		Worksheet D	
THROUGH C	COSTS		Component	CCN: 15-T059	From  To	01/01/2019 12/31/2019		narod
			component	CCN. 15-1054	10	12/31/2019	6/8/2020 1:18	pareu. pm
			Title	× XVIII	Sub	provider -	PPS	
						IRF		
	Cost Center Description	Non Physician	Nursi ng	Nursi ng			Allied Health	
		Anesthetist	School	School		st-Stepdown		
		Cost	Post-Stepdown		Ac	djustments		
		1.00	Adjustments	2.00		3A	3.00	
	CILLARY SERVICE COST CENTERS	1.00	2A	2.00		3A	3.00	
	000 OPERATING ROOM	0	0		0	0	0	50.00
	200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	0	52.00
	400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	0	54.00
	500 RADI OLOGY-THERAPEUTI C	0	0		0	0	0	55.00
	700 CT SCAN	0	0		0	0	0	57.00
	630 ULTRA SOUND	0	0		0	0	0	57.01
	800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0	0	58.00
59.00 059	900 CARDI AC CATHETERI ZATI ON	0	0		0	0	0	59.00
60.00 060	000 LABORATORY	0	0		0	0	0	60.00
60.01 060	001 BLOOD LABORATORY	0	0		0	0	0	60.01
63.00 063	300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	0	63.00
	400 I NTRAVENOUS THERAPY	0	0		0	0	0	64.00
	500 RESPI RATORY THERAPY	0	0		0	0	0	65.00
	600 PHYSI CAL THERAPY	0	0		0	0	0	66.00
	700 OCCUPATI ONAL THERAPY	0	0		0	0	0	67.00
	800 SPEECH PATHOLOGY	0	0		0	0	0	68.00
		0	0		0	0	0	69.00
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS 200 IMPL. DEV. CHARGED TO PATIENT	0	0		0	0	0	71.00
	300 DRUGS CHARGED TO PATIENT	0	0		0	0	319, 082	72.00 73.00
	400 RENAL DI ALYSI S	0	0		0	0	0	74.00
	020 OTHER ANCI LLARY	0	0		0	0	0	76.00
	140 CARDI AC REHAB	0	0		0	0	0	76.01
	070 WOMEN' S CENTER	0	0		0	0	0	76.02
	330 ENDOSCOPY	0	0		0	0	0	76.03
OUT	TPATIENT SERVICE COST CENTERS	,					-	
90.00 090	000 CLINIC	0	0		0	0	0	90.00
90.01 090	001 OUTPATI ENT	0	0		0	0	0	90.01
90.02 090	002 NEUROPSYCHOLOGY	0	0		0	0	0	90.02
	100 EMERGENCY	0	0		0	0	0	91.00
	101 SHORT STAY	0	0		0	0	0	91.01
	200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0		0	92.00
	HER REIMBURSABLE COST CENTERS							
	500 AMBULANCE SERVICES		_			~	210,000	95.00
200.00	Total (lines 50 through 199)	0	0	1	0	0	319, 082	200.00

Heal th	Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORT	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PAS	S Provider C		Peri od:	Worksheet D	
THROUG	GH COSTS				From 01/01/2019	Part IV	
			Component	CCN: 15-T059	To 12/31/2019		epared:
					Culture and share	6/8/2020 1:18	s pm
			IITIE	e XVIII	Subprovider - IRF	PPS	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Education	1, 2, 3, and	Cost (sum of		(col. 5 ÷	
		Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
		0001	.,	and 4)	0011 0)		
		4.00	5.00	6.00	7.00	8.00	
	ANCI LLARY SERVICE COST CENTERS		0.00	0.00	1100	0.00	
50.00	05000 OPERATING ROOM	0	0		0 88, 125, 946	0.000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 12, 938, 341	0. 000000	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 8, 962, 321	0.000000	
57.00	05700 CT SCAN	0	0		0 20, 209, 198		
57.00	03630 ULTRA SOUND	0	0		0 9,006,349		
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 5, 734, 337	0. 000000	
59.00	05900 CARDIAC CATHETERIZATION	0	0				
		0	0		0 22, 524, 348		
60.00	06000 LABORATORY	0	0		0 50, 498, 746		
60.01	06001 BLOOD LABORATORY	0	0		0 0	0.00000	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 1, 310, 574		
64.00	06400 I NTRAVENOUS THERAPY	0	0		0 0	0.000000	
65.00	06500 RESPI RATORY THERAPY	0	0		0 7, 129, 982		
66.00	06600 PHYSI CAL THERAPY	0	0		0 32, 918, 958		
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0. 000000	
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0.000000	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 8, 573, 680		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 40, 487, 932	0. 000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 18, 033, 488	0. 000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	319, 082	319, 08	2 59, 673, 976	0.005347	73.00
74.00	07400 RENAL DI ALYSI S	0	0		0 685, 808	0.000000	74.00
76.00	03020 OTHER ANCI LLARY	0	0		0 0	0. 000000	76.00
76.01	03140 CARDI AC REHAB	0	0		0 12, 225, 645	0. 000000	76.01
76.02		0	0		0 7, 716, 087	0.000000	
	03330 ENDOSCOPY	0	0		0 0		1
	OUTPATIENT SERVICE COST CENTERS	-					
90.00	09000 CLINIC	0	0		0 5, 850, 958	0.00000	90.00
90.01	09001 OUTPATIENT	0	n		0 5, 107, 617		
90.02	09002 NEUROPSYCHOLOGY	0	n		0 1, 729, 323		1
91.00	09100 EMERGENCY	0	0		0 35, 055, 683		1
91.00	09101 SHORT STAY	0	0		0 00,000,000	0.000000	1
92.00		0	0		0 6, 204, 427		1
72.00	OTHER REIMBURSABLE COST CENTERS	- V	0	1	0,204,427	0.00000	/2.00
95 00	09500 AMBULANCE SERVICES						95.00
200.00		0	319, 082	319, 08	2 460, 703, 724		200.00
200.00		, v	517,002	1 317,00		I	1-00.00

ealth Financial Systems	RIVERVIEW H				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider C	CN: 15-0059	Period:	Worksheet D	
HROUGH COSTS		Component (	CCN: 15-T059	From 01/01/2019 To 12/31/2019	Part IV Date/Time Pre	epared:
		Titlo	XVIII	Subprovider -	6/8/2020 1:18 PPS	рш
		nue	AVIII	IRF	PP3	
Cost Center Description	Outpati ent	Inpatient	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug	h Charges	Pass-Through	
	(col. 6 ÷		Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	175, 127		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	58, 359		0 0	0	54.00
5. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	2, 720	1	0 0	0	55.00
57.00 05700 CT SCAN	0. 000000	69, 768		0 0	0	57.00
57. 01 03630 ULTRA SOUND	0. 000000	7,460		0 0	0	57.01
8.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	13, 570		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	29,627		0 0	0	
00. 00 06000 LABORATORY	0. 000000	852, 275		0 0	0	
0. 01 06001 BLOOD LABORATORY	0. 000000	002,270		0 0	0	60.01
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	10, 438		0 0	0	
0. 00 06400 I NTRAVENOUS THERAPY	0. 000000	10, 430		0 0	0	64.00
55. 00 06500 RESPIRATORY THERAPY	0. 000000	375, 840		0 0	0	
6. 00 06600 PHYSI CAL THERAPY	0. 000000	3, 963, 062		0 0	0	66.00
57. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	3, 903, 002		0 0	0	
57. 00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	
		-		-	-	
99.00 06900 ELECTROCARDI OLOGY	0. 000000	53, 181		0 0	0	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	842, 138		0 0	0	1
22.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	21, 579		0 0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0.005347	903, 826	4,8		0	
4.00 07400 RENAL DIALYSIS	0. 000000	163, 855		0 0	0	1
76.00 03020 OTHER ANCI LLARY	0. 000000	0		0 0	0	
76. 01 03140 CARDI AC REHAB	0. 000000	4, 194		0 0	0	
76.02 03070 WOMEN' S CENTER	0. 000000	111		0 0	0	
76. 03 03330 ENDOSCOPY	0. 000000	0		0 0	0	76.03
OUTPATIENT SERVICE COST CENTERS			1			
20. 00 09000 CLINIC	0. 000000	1, 890		0 0	0	
20. 01 09001 OUTPATI ENT	0. 000000	49, 794		0 0	0	
0. 02 09002 NEUROPSYCHOLOGY	0. 000000	0		0 0	0	
P1. 00 09100 EMERGENCY	0. 000000	32, 293		0 1, 020	0	1
21.01 09101 SHORT STAY	0. 000000	0		0 0	0	
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
25.00 09500 AMBULANCE SERVICES 200.00 Total (lines 50 through 199)						95.00
		7,631,107	4,8	33 1, 020		200.00

	ancial Systems	RI VERVI EW				u of Form CMS-	2552-10
APPORTI ONME	ENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C	CN: 15-0059	Peri od:	Worksheet D	
			Component	CCN: 15-T059	From 01/01/2019 To 12/31/2019	Part V Date/Time Pre	epared.
			oomponone		10 12/01/2017	6/8/2020 1:18	S pm
			Title	e XVIII	Subprovider -	PPS	
					I RF		
				Charges		Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost Reimbursed	PPS Services	
		Charge Ratio From	Reimbursed Services (see	Reimbursed Services	Servi ces Not	(see inst.)	
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.	11131.)	Ded. & Coi ns	,		
		9		(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
ANCI	LLARY SERVICE COST CENTERS						
	O OPERATING ROOM	0. 018977	0	)	0 0	0	50.00
52.00 0520	O DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
54.00 0540	0 RADI OLOGY-DI AGNOSTI C	0. 317181	0		0 0	0	54.00
55.00 0550	0 RADI OLOGY-THERAPEUTI C	0. 236478	0		0 0	0	55.00
57.00 0570	O CT SCAN	0. 037772	0		0 0	0	57.00
57.01 0363	O ULTRA SOUND	0. 070315	0		0 0	0	57.01
	O MAGNETIC RESONANCE IMAGING (MRI)	0. 128088	0		0 0	0	58.00
	O CARDI AC CATHETERI ZATI ON	0. 071029	0		0 0	0	59.00
	00 LABORATORY	0. 197617	0		0 0	0	
	1 BLOOD LABORATORY	0. 000000	0		0 0	0	
	0 BLOOD STORING, PROCESSING & TRANS.	0. 527132	0		0 0	0	
	O I NTRAVENOUS THERAPY	0. 000000	0		0 0	0	
	0 RESPI RATORY THERAPY	0. 329274	0		0 0	0	
	0 PHYSI CAL THERAPY	0. 324837	0		0 0	0	
	0 OCCUPATIONAL THERAPY	0. 000000	0		0 0	0	
	0 SPEECH PATHOLOGY	0.000000			0 0	0	
		0. 225140	-		0 0	0	
	0 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 IMPL. DEV. CHARGED TO PATIENT	0. 556476			0 0	0	
	0 DRUGS CHARGED TO PATIENTS	0. 745108 0. 403526			0 2,071	0	
	0 RENAL DIALYSIS	0. 403320			0 2,071	0	•
	O OTHER ANCI LLARY	0. 000000			0 0	0	
	O CARDI AC REHAB	0. 193559			0 0	0	
	O WOMEN' S CENTER	0. 155044			0 0	0	
	O ENDOSCOPY	0. 000000			0 0	0	
	ATIENT SERVICE COST CENTERS	0.000000			0 0		10100
	DOCLINIC	0. 160998	0	)	0 0	0	90.00
	01 OUTPATI ENT	0. 333738	0		0 0	0	
	2 NEUROPSYCHOLOGY	0. 367948	0		0 0	0	
91.00 0910	DO	0. 256582	1, 020		0 0	262	91.00
91.01 0910	1 SHORT STAY	0. 000000	0		0 0	0	91.01
92.00 0920	O OBSERVATION BEDS (NON-DISTINCT PART)	0. 707972	0		0 0	0	92.00
	R REIMBURSABLE COST CENTERS						
	O AMBULANCE SERVI CES	0. 000000			0		95.00
200.00	Subtotal (see instructions)		1, 020		0 2,071	262	200.00
201.00	Less PBP Clinic Lab. Services-Program				0 0		201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	1	1, 020	1	0 2,071	262	202.00

Health Fina	ancial Systems	RI VERVI EW H	OSPI TAL		In Lieu	of Form CMS	-2552-10
APPORTI ONME	ENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C	CN: 15-0059	Peri od:	Worksheet D	
			Component	CCN: 15-T059	From 01/01/2019 To 12/31/2019	Part V Date/Time Pr 6/8/2020 1:1	epared: 8 pm
			Title	e XVIII	Subprovider - IRF	PPS	
		Cost	S			I	
	Cost Center Description	Cost	Cost	1			
	•	Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
			ed. & Coins.				
			(see inst.)				
		6.00	7.00				
	LLARY SERVICE COST CENTERS	,					
	O OPERATING ROOM	0	0				50.00
	O DELIVERY ROOM & LABOR ROOM	0	0				52.00
	0 RADI OLOGY-DI AGNOSTI C	0	0				54.00
55.00 0550	0 RADI OLOGY-THERAPEUTI C	0	0				55.00
57.00 0570	O CT SCAN	0	0				57.00
57.01 0363	OULTRA SOUND	0	0				57.01
58.00 0580	O MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.00
59.00 0590	O CARDI AC CATHETERI ZATI ON	0	0				59.00
60.00 0600	0 LABORATORY	0	0				60.00
60.01 0600	1 BLOOD LABORATORY	0	0				60.01
63.00 0630	O BLOOD STORING, PROCESSING & TRANS.	0	0				63.00
64.00 0640	O I NTRAVENOUS THERAPY	0	0				64.00
65.00 0650	0 RESPI RATORY THERAPY	0	0				65.00
66.00 0660	0 PHYSI CAL THERAPY	0	0				66.00
67.00 0670	O OCCUPATI ONAL THERAPY	0	0				67.00
68.00 0680	O SPEECH PATHOLOGY	0	0				68.00
69.00 0690	0 ELECTROCARDI OLOGY	0	0				69.00
71.00 0710	O MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00 0720	OIMPL. DEV. CHARGED TO PATIENT	0	0				72.00
73.00 0730	O DRUGS CHARGED TO PATIENTS	0	836				73.00
	0 RENAL DIALYSIS	0	0				74.00
76.00 0302	O OTHER ANCI LLARY	0	0				76.00
76.01 0314	O CARDI AC REHAB	0	0				76.01
76.02 0307	O WOMEN' S CENTER	0	0				76.02
76.03 0333	0 ENDOSCOPY	0	0				76.03
	ATIENT SERVICE COST CENTERS						
		0	0				90.00
	1 OUTPATI ENT	0	0				90.01
	2 NEUROPSYCHOLOGY	0	0				90.02
	0 EMERGENCY	0	0				91.00
	1 SHORT STAY	0	0				91.01
	0 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
	R REIMBURSABLE COST CENTERS	<u> </u>		1			
	O AMBULANCE SERVICES	0					95.00
200.00	Subtotal (see instructions)	0	836				200.00
201.00	Less PBP Clinic Lab. Services-Program	0					201.00
	Only Charges Net Charges (line 200 - line 201)						200 00
202.00		0	836	1			202.00

Heal th	Financial Systems	RI VERVI EW	HOSPI TAL			In Lie	u of Form CMS-:	2552-10
APPORTI	ONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PAS	S Provider C	CN: 15-0059	Peri		Worksheet D	
THROUGH	I COSTS		Component	CCN: 15-5669	Fron  To	n 01/01/2019 12/31/2019	Part IV Date/Time Pre	narod
			component	CCN. 15-5009	10	12/31/2019	6/8/2020 1:18	pareu. pm
			Title	e XVIII	Ski I	led Nursing		
						Facility		
	Cost Center Description	Non Physician	Nursi ng	Nursi ng			Allied Health	
		Anesthetist	School	School		st-Stepdown		
		Cost	Post-Stepdown		A	djustments		
		1.00	Adjustments	2.00		2.4	2.00	
	ANCI LLARY SERVICE COST CENTERS	1.00	2A	2.00		3A	3.00	
	05000 OPERATING ROOM	0	0		0	0	0	50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	0	52.00
	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	0	54.00
	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	0	55.00
	05700 CT SCAN	0	0		0	0	0	57.00
	03630 ULTRA SOUND	0	0		0	0	0	57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0	0	58.00
	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	0	59.00
	06000 LABORATORY	0	0		0	0	0	60.00
	06001 BLOOD LABORATORY	0	0		0	0	0	60.01
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	0	63.00
	06400 I NTRAVENOUS THERAPY	0	0		0	o	0	64.00
	06500 RESPI RATORY THERAPY	0	0		0	0	0	65.00
	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		0	0	319, 082	73.00
74.00	07400 RENAL DI ALYSI S	0	0		0	0	0	74.00
	03020 OTHER ANCI LLARY	0	0		0	0	0	76.00
	03140 CARDI AC REHAB	0	0		0	0	0	76.01
	03070 WOMEN'S CENTER	0	0		0	0	0	76.02
	03330 ENDOSCOPY	0	0		0	0	0	76.03
	DUTPATIENT SERVICE COST CENTERS	-	-	1	-	-		
	09000 CLINIC	0	0		0	0	0	90.00
	09001 OUTPATI ENT	0	0		0	0	0	90.01
	09002 NEUROPSYCHOLOGY	0	0		0	0	0	90.02
	09100 EMERGENCY	0	0		0	0	0	91.00
	09101 SHORT STAY	0	0		0	0	0	91.01
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		1	U		0	92.00
	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVI CES			1	-			95.00
200.00	Total (lines 50 through 199)	0	0		0	0	319, 082	
200.00	(Thes by through 199)	0	0	1	U	U	317,002	200.00

Heal th	Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORT	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PAS	S Provider C	CN: 15-0059	Peri od:	Worksheet D	
THROUG	GH COSTS				From 01/01/2019	Part IV	
			Component	CCN: 15-5669	To 12/31/2019	Date/Time Pre 6/8/2020 1:18	
			Title	xviii	Skilled Nursing		pili
			iiiie		Facility	FFJ	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Education	1, 2, 3, and	Cost (sum of		(col . 5 ÷	
		Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
		0001	.,	and 4)	0011 0)		
		4,00	5.00	6.00	7.00	8.00	
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0 88, 125, 946	0.000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 12, 938, 341	0. 000000	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 8, 962, 321	0. 000000	
57.00	05700 CT SCAN	0	0		0 20, 209, 198		
57.01	03630 ULTRA SOUND	0	0		0 9,006,349		
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0			0 5, 734, 337	0.000000	
59.00	05900 CARDI AC CATHETERI ZATI ON	0			0 22, 524, 348		
60.00	06000 LABORATORY	0			0 50, 498, 746		
60.00	06001 BLOOD LABORATORY	0			0 30,490,740	0. 000000	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 1, 310, 574		
64.00	06400 I NTRAVENOUS THERAPY	0	0		0 1, 310, 374	0. 000000	
65.00	06500 RESPIRATORY THERAPY	0	0		0 7, 129, 982		
66.00	06600 PHYSI CAL THERAPY	0	0		0 32, 918, 958		
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 32, 910, 930	0. 000000	
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0. 000000	
69.00		0	0				
71.00	06900 ELECTROCARDI OLOGY	0	0		0 8, 573, 680		
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0		0 40, 487, 932	0.000000	
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0	210.00	0 18, 033, 488		
73.00	07300 DRUGS CHARGED TO PATIENTS	0	319, 082				
74.00	07400 RENAL DI ALYSI S 03020 OTHER ANCI LLARY	0	0		0 685, 808		
76.00		0	0			0. 000000	
76.01	03140 CARDI AC REHAB	0	0		0 12, 225, 645		
76.02		0	0		0 7, 716, 087		1
76.03		0	0		0 0	0.000000	76.03
00.00		0	0	1		0,000000	00.00
90.00		0	0		0 5, 850, 958		
90.01		0	0		0 5, 107, 617		
90.02	09002 NEUROPSYCHOLOGY	0	0		0 1, 729, 323		
91.00	09100 EMERGENCY	0	0		0 35, 055, 683		1
91.01	09101 SHORT STAY	0	0			0.000000	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 6, 204, 427	0.000000	92.00
05 05	OTHER REIMBURSABLE COST CENTERS			1			05 00
	09500 AMBULANCE SERVICES	_	210,000	210.00	1/0 702 704		95.00
200.00	)   Total (lines 50 through 199)	0	319, 082	319, 08	2 460, 703, 724	I	200.00

Health Financial Systems	RI VERVI EW HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider C	CN: 15-0059	Peri od:	Worksheet D	
THROUGH COSTS			001 45 5440	From 01/01/2019	Part IV	
		Component	CCN: 15-5669	To 12/31/2019	Date/Time Pre 6/8/2020 1:18	epared:
		Title	XVIII	Skilled Nursing		pili
		intre		Facility	115	
Cost Center Description	Outpati ent	Inpatient	I npati ent	Outpatient	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷	J	Costs (col.	5	Costs (col. 9	
	col. 7)		x col. 10)	-	x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.000000	0		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0, 000000	0		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	38, 482		0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0, 000000	0		0 0	0	55.00
57. 00 05700 CT SCAN	0. 000000	0		0 0	0	57.00
57. 01 03630 ULTRA SOUND	0. 000000	0		0 0	0	57.01
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
60. 00 06000 LABORATORY	0. 000000	755, 400		0 0	0	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000	/ 33, 400 0		0 0	0	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	45, 981		0 0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0.000000	43, 701		0 0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	148, 606		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 134, 035		0 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	1, 134, 033		0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	231, 494		0 0	0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	231, 494		0 0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0.005347	1, 083, 096	5, 7		0	73.00
	0. 005347	1, 083, 096			0	73.00
	0. 000000	0		0 0	0	76.00
	0. 000000	0			0	
	0. 000000	0		0 0 0 0	0	76.01
		0		0 0	0	76.02 76.03
76. 03 03330 ENDOSCOPY OUTPATI ENT SERVICE COST CENTERS	0. 000000	0		0 0	0	/0.03
	0,000000	0	1	0 0	0	00.00
	0. 000000 0. 000000	0		0 0	0	90.00
		-		-	-	90.01
90. 02 09002 NEUROPSYCHOLOGY	0. 000000	0		0 0	0	90.02
91.00 09100 EMERGENCY	0. 000000	0		0 0	0	91.00
91.01 09101 SHORT STAY	0.000000	0		0 0	0	91.01
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) OTHER REI MBURSABLE COST CENTERS	0. 000000	0		0 0	0	92.00
	1		1			
		2 427 004		91 0	~	95.00 200.00
200.00  Total (lines 50 through 199)	1	3, 437, 094	5, 79	7 I U	0	200.00

OMPUT	TATION OF INPATIENT OPERATING COST	Provider CCN: 15-0059	Period:	Worksheet D-1	
			From 01/01/2019 To 12/31/2019	Date/Time Pre	
		Title XVIII	Hospi tal	6/8/2020 1:18 PPS	pm
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed da	vs. excluding newborn)		14, 942	1 1
00 00	Inpatient days (including private room days, excluding swing Private room days (excluding swing-bed and observation bed d	bed and newborn days)	vrivata room dave	14, 942	2
00	do not complete this line.	5, 5, 5,	in vate room days,	0	
00 00	Semi-private room days (excluding swing-bed and observation Total swing-bed SNF type inpatient days (including private r reporting period		er 31 of the cost	12, 240 0	
00	Total swing-bed SNF type inpatient days (including private r	room days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private ro	oom days) through Decembe	er 31 of the cost	0	7
00	Total swing-bed NF type inpatient days (including private ro	oom days) after December	31 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable	to the Program (excludir	g swing-bed and	5, 172	9
. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII		room days)	0	10
. 00	through December 31 of the cost reporting period (see instru Swing-bed SNF type inpatient days applicable to title XVIII	only (including private	room days) after	0	11
. 00	December 31 of the cost reporting period (if calendar year, Swing-bed NF type inpatient days applicable to titles V or X		te room days)	0	12
. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or X			0	13
. 00	after December 31 of the cost reporting period (if calendar Medically necessary private room days applicable to the Prog			0	14
. 00 . 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
. 00	Medicare rate for swing-bed SNF services applicable to servi reporting period	Ũ		0.00	17
. 00	Medicare rate for swing-bed SNF services applicable to servi reporting period	ces after December 31 of	the cost	0.00	18
. 00	Medicaid rate for swing-bed NF services applicable to servic reporting period	es through December 31 c	of the cost	0.00	19
. 00	Medicaid rate for swing-bed NF services applicable to servic reporting period	es after December 31 of	the cost	0.00	20
. 00	Total general inpatient routine service cost (see instructio Swing-bed cost applicable to SNF type services through Decem		ting period (line	24, 290, 813 0	
	5 x line 17)	·	0, ,		
	Swing-bed cost applicable to SNF type services after December x line 18)		-		
	Swing-bed cost applicable to NF type services through Decemb $7 \times \text{line 19}$	·	0, ,	0	
. 00	Swing-bed cost applicable to NF type services after December x line 20) $% \left( \frac{1}{2}\right) =0$	31 of the cost reportir	ng period (line 8	0	25
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 24, 290, 813	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-b			0	28
	Private room charges (excluding swing-b	ieu anu ubservatrun ded (	inai yes <i>)</i>	0	
. 00	Semi -private room charges (excluding swing-bed charges)			0	30
		'÷line 28)		0.00000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)		unti ana)	0.00	
	Average per diem private room charge differential (line 32 m		ictions)	0.00	
	Average per diem private room cost differential (line 34 x l			0.00	
	Private room cost differential adjustment (line 3 x line 35)		lifforonti -1 (1)	0	
. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost d	IIITERENTIAL (LINE	24, 290, 813	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				-
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.			1, 625. 67	38
2 00					i .30
	Adjusted general inpatient routine service cost per diem (se				
	Program general inpatient routine service cost (line 9 x lin Medically necessary private room cost applicable to the Prog	ne 38)		8, 407, 965 0	39

COMPUT	Financial Systems	RI VERVI EW H		CN: 15-0059	Period:	u of Form CMS- Worksheet D-1	
					From 01/01/2019 To 12/31/2019		
					To 12/31/2019	Date/Time Pre 6/8/2020 1:18	
				e XVIII	Hospi tal	PPS	
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. + col. 2)		(col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
12.00	NURSERY (title V & XIX only)	0	C				42.0
	Intensive Care Type Inpatient Hospital Units						
13.00	INTENSIVE CARE UNIT	5, 869, 238	3, 317	1, 769. 4	1, 470	2, 601, 077	
14.00 15.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44.0
16.00							46.0
	OTHER SPECIAL CARE (SPECIFY)						47.0
	Cost Center Description						
10 00	Program inpatient ancillary service cost (W	ket D 2 col 2	Lino 200)			<u> </u>	10 0
18.00 19.00				ons)		24, 508, 977	
F7.00	PASS THROUGH COST ADJUSTMENTS	41 through 40)(	See Thisti de ti	0113)		24, 300, 777	
50.00	Pass through costs applicable to Program in	patient routine	services (fro	m Wkst. D, su	m of Parts I and	2, 312, 886	50.0
	111)						
51.00	Pass through costs applicable to Program in	patient ancillar	y services (f	rom Wkst. D,	sum of Parts II	1, 131, 662	2 51.0
52.00	and IV) Total Program excludable cost (sum of lines	50 and 51)				3, 444, 548	52.0
53.00	Total Program inpatient operating cost exclu		lated, non-ph	ysician anest	hetist, and	21, 064, 429	
	medical education costs (line 49 minus line	52)		-			
- 4 00	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 55.00	5 5					0 0. 00	
56.00	Target amount (line 54 x line 55)					0.00	
57.00	5	ting cost and ta	rget amount (	line 56 minus	line 53)	0	
58.00	Bonus payment (see instructions)	-	-			0	58.0
59.00	Lesser of lines 53/54 or 55 from the cost re	eporting period	endi ng 1996,	updated and c	ompounded by the	0.00	59.0
50.00	market basket Lesser of lines 53/54 or 55 from prior year	cost report un	dated by the	market hasket		0.00	60.0
61.00	If line 53/54 is less than the lower of line					0.00	
	which operating costs (line 53) are less that						
	amount (line 56), otherwise enter zero (see	instructions)				_	
62.00	Relief payment (see instructions)	mant (and instru	ati ana)			0	
63.00	Allowable Inpatient cost plus incentive pays PROGRAM INPATIENT ROUTINE SWING BED COST					0	) 63. C
64.00		sts through Dece	mber 31 of th	e cost report	ing period (See	0	64. C
	instructions)(title XVIII only)	-					
65.00	Medicare swing-bed SNF inpatient routine components instructions)(title XVIII only)	sts after Decemb	er 31 of the	cost reportin	g period (See	0	65.0
66.00	Total Medicare swing-bed SNF inpatient rout	ine costs (line	64 nlus line	65)(title XVI	ll only) For	C	66.0
00.00	CAH (see instructions)				i i on y). Toi	0	
67.00		ne costs through	December 31	of the cost r	eporting period	0	67. C
	(line 12 x line 19)						
68.00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	ne costs after D	ecember 31 or	the cost rep	orting period	0	68.0
69.00	Total title V or XIX swing-bed NF inpatient	routine costs (	line 67 + lin	e 68)		C	69.0
	PART III - SKILLED NURSING FACILITY, OTHER N					-	
70.00	Skilled nursing facility/other nursing faci	2			)		70.0
71.00	Adjusted general inpatient routine service		ine 70 ÷ line	2)			71.0
72.00	Program routine service cost (line 9 x line Medically necessary private room cost appli		(line 14 v l	ine 35)			72.0
74.00	Total Program general inpatient routine services	<sup>o</sup>	•				74.0
75.00	Capital -related cost allocated to inpatient	•			Part II, column		75.0
_,	26, line 45)						
76.00	Per diem capital related costs (line 75 ÷ l						76.0
7.00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 mine)						77.0
9.00	Aggregate charges to beneficiaries for exce	,	rovider recor	ds)			79.0
0.00	Total Program routine service costs for com				nus line 79)		80.
1.00	Inpatient routine service cost per diem lim						81.
32.00	Inpatient routine service cost limitation (		· .				82.0
3.00 4.00	Reasonable inpatient routine service costs Program inpatient ancillary services (see in	•	5)				83. 84.
35.00	Utilization review - physician compensation		ns)				85.0
36.00	Total Program inpatient operating costs (su	•					86.0
	PART IV - COMPUTATION OF OBSERVATION BED PAS	SS THROUGH COST					
87.00	Total observation bed days (see instruction					2,702	
88.00	Adjusted general inpatient routine cost per	•	iine 2)			1, 625. 67 4, 392, 560	
	Observation bed cost (line 87 x line 88) (set						

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2019	Worksheet D-1	
				To 12/31/2019		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	5, 525, 276	24, 290, 813	0. 22746	4, 392, 560	999, 149	90.00
91.00 Nursing School cost	0	24, 290, 813	0.00000	4, 392, 560	0	91.00
92.00 Allied health cost	0	24, 290, 813	0.00000	4, 392, 560	0	92.00
93.00 All other Medical Education	0	24, 290, 813	0.00000	4, 392, 560	0	93.00

JIVIPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0059 Component CCN: 15-T059	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Pre	
		Title XVIII	Subprovi der -	6/8/2020 1: 18 PPS	
	Cost Center Description		I RF		
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				
00	Inpatient days (including private room days and swing-bed days			5, 586	
00 00	Inpatient days (including private room days, excluding swing-b Private room days (excluding swing-bed and observation bed day do not complete this line.	ys). If you have only p	rivate room days,	5, 586 0	
00 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo reporting period	er 31 of the cost	5, 586 0		
00	Total swing-bed SNF type inpatient days (including private roc reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6.
00	Total swing-bed NF type inpatient days (including private room reporting period	n days) through Decembe	r 31 of the cost	0	7.
00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December 3	31 of the cost	0	8.
00	Total inpatient days including private room days applicable to newborn days)	o the Program (excluding	g swing-bed and	3, 334	9.
. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct		room days)	0	10.
. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er	nly (including private nter 0 on this line)	3	0	11.
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	(only (including priva	te room days)	0	12.
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar ye			0	13
. 00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	
. 00 . 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	es through December 31 (	of the cost	0.00	17.
. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18.
. 00	reporting period Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 o	f the cost	0.00	19
. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of	the cost	0.00	20
. 00	Total general inpatient routine service cost (see instructions	5)		4, 872, 032	21
00	Swing-bed cost applicable to SNF type services through December 5 x line 17)		31 (	0	
. 00	Swing-bed cost applicable to SNF type services after December x line 18)			0	
	Swing-bed cost applicable to NF type services through December 7 x line 19)			0	
. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	g period (line 8	0	
. 00 . 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost ( PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		0 4, 872, 032	
00	General inpatient routine service charges (excluding swing-bed	d and observation bed c	narges)	0	28
. 00	Private room charges (excluding swing-bed charges)			0	29
00	Semi-private room charges (excluding swing-bed charges)			0	
00	General inpatient routine service cost/charge ratio (line 27 ÷	⊦line 28)		0.00000	
00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
00	Average per diem private room charge differential (line 32 mir		ctions)	0.00	
00	Average per diem private room cost differential (line 34 x lir	ne 31)		0.00	35
00	Private room cost differential adjustment (line 3 x line 35)			0	
. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	and private room cost d	fferential (line	4, 872, 032	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ISTMENITS			-
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			872. 19	38
00					
	Adjusted general inpatient routine service cost per diem (see				
8.00 9.00 9.00	Program general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progra	38)		2, 907, 881 0	39.

MPUTATION OF INPATIENT OPERATING COST		HOSPITAL Provider C	CN: 15-0059	Peri od:	worksheet D-1	
			CCN: 15-T059	From 01/01/2019 To 12/31/2019	Date/Time Pre	epare
		Title	e XVIII	Subprovider -	6/8/2020 1:18 PPS	8 pm
Cost Contor Description	Total	Total	Average Per	I RF	Drogram Cost	
Cost Center Description	Total I npati ent Cost	Total I npati ent Days	Diem (col. ÷ col. 2)	1	Program Cost (col. 3 x col. 4)	
2.00 NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	) 42.
Intensive Care Type Inpatient Hospital Uni			0.0			J 42
. 00 INTENSIVE CARE UNIT	0	(	0.	0 00	C	
. OO CORONARY CARE UNIT . OO BURN INTENSIVE CARE UNIT						44
. 00 SURGI CAL I NTENSI VE CARE UNI T						46
. 00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47
cost center bescription					1.00	+
.00 Program inpatient ancillary service cost (					2, 614, 034	
.00 Total Program inpatient costs (sum of line PASS THROUGH COST ADJUSTMENTS	es 41 through 48)(	see instructi	ons)		5, 521, 915	5 49
.00 Pass through costs applicable to Program i	npatient routine	services (fro	m Wkst. D, su	m of Parts I and	393, 812	2 50
.00 Pass through costs applicable to Program i and IV)	npatient ancillar	y services (f	rom wkst. D,	sum of Parts II	124, 018	51
.00 Total Program excludable cost (sum of line					517, 830	
5.00 Total Program inpatient operating cost exc		elated, non-ph	ysician anest	hetist, and	5, 004, 085	5 53
medical education costs (line 49 minus lin TARGET AMOUNT AND LIMIT COMPUTATION	ie 52)				I	
.00 Program discharges					C	
.00   Target amount per discharge .00   Target amount (line 54 x line 55)					0.00	
.00 Difference between adjusted inpatient oper	ating cost and ta	arget amount (	line 56 minus	line 53)		
.00 Bonus payment (see instructions)	0	0		,	C	
.00 Lesser of lines 53/54 or 55 from the cost market basket	reporting period	endi ng 1996,	updated and o	compounded by the	e 0.00	59
0.00 Lesser of lines 53/54 or 55 from prior yea	r cost report, up	dated by the	market basket		0.00	60
.00 If line 53/54 is less than the lower of li					C	) 61
which operating costs (line 53) are less t amount (line 56), otherwise enter zero (se		s (lines 54 x	60), or 1% c	f the target		
.00 Relief payment (see instructions)					( c	
Allowable Inpatient cost plus incentive pa PROGRAM INPATIENT ROUTINE SWING BED COST	yment (see instru	ictions)			<u> </u>	63
. 00 Medicare swing-bed SNF inpatient routine c	osts through Dece	ember 31 of th	e cost report	ing period (See	0	64
instructions)(title XVIII only)						
.00 Medicare swing-bed SNF inpatient routine c instructions)(title XVIII only)	osts after Decemb	er 31 of the	cost reportir	g period (See	C	) 65
. 00 Total Medicare swing-bed SNF inpatient rou	tine costs (line	64 plus line	65)(title XVI	II only). For	c c	66
CAH (see instructions)	· · · · · · · · · · · · · · · · · · ·	December 21	-6			
.00 Title V or XIX swing-bed NF inpatient rout (line 12 x line 19)	The costs through	December 31	or the cost r	eporting period		67
.00 Title V or XIX swing-bed NF inpatient rout	ine costs after [	ecember 31 of	the cost rep	orting period	C	68  0
(line 13 x line 20) 0.00 Total title V or XIX swing-bed NF inpatien	t routino costs (	lino 67 , lin	o 69)			) 69
PART III - SKILLED NURSING FACILITY, OTHER						107
0.00 Skilled nursing facility/other nursing fac				)		70
.00 Adjusted general inpatient routine service .00 Program routine service cost (line 9 x lin		ine 70 ÷ line	2)			71
. 00 Medically necessary private room cost appl		n (line 14 x l	ine 35)			73
.00 Total Program general inpatient routine se	•					74
<ol> <li>Conductory Control Contro</li></ol>	IL FOULT NE SERVICE	e costs (from	worksneet B,	Part II, COlumn		75
.00 Per diem capital-related costs (line 75 ÷						76
.00 Program capital-related costs (line 9 x li .00 Inpatient routine service cost (line 74 mi						77
.00 Aggregate charges to beneficiaries for exc		orovider recor	ds)			79
.00 Total Program routine service costs for co	mparison to the c			nus line 79)		80
.00  Inpatient routine service cost per diem li .00  Inpatient routine service cost limitation		)				81
.00 Reasonable inpatient routine service cost rimitation	•					83
.00 Program inpatient ancillary services (see	instructions)					84
5.00 Utilization review – physician compensation 5.00 Total Program inpatient operating costs (s						85
PART IV - COMPUTATION OF OBSERVATION BED P					I	
<ul> <li>C. 00 Total observation bed days (see instructions. 00 Adjusted general inpatient routine cost per period.)</li> </ul>					0	
8.00  Adjusted general inpatient routine cost pe	r alom (lino 27 -	1100 20			0.00	)  88

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO	CN: 15-0059	Period: From 01/01/2019	Worksheet D-1	
		Component (	CCN: 15-T059	To 12/31/2019		
		Title	XVIII	Subprovider -	PPS	
				I RF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		, í		(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	659, 845	4, 872, 032	0. 13543	35 0	0	90.00
91.00 Nursing School cost	0	4, 872, 032	0.0000	0 0	0	91.00
92.00 Allied health cost	0	4, 872, 032	0.0000	0 0	0	92.00
93.00 All other Medical Education	0	4, 872, 032			0	93.00

	Financial Systems RIVERVIEW HO			of Form CMS-2	
COMPUT	TION OF INPATIENT OPERATING COST	Provider CCN: 15-0059 Component CCN: 15-5669	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Pre	pared:
		Title XVIII	Skilled Nursing Facility	<u>6/8/2020 1: 18</u> PPS	_pm
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS				
	NPATIENT DAYS Inpatient days (including private room days and swing-bed day	vs excluding newborn)		3, 010	1.00
	Inpatient days (including private room days and swing bed day Inpatient days (including private room days, excluding swing			3, 010	2.00
	Private room days (excluding swing-bed and observation bed d	ays). If you have only p	rivate room days,	0	3.00
	do not complete this line. Semi-private room days (excluding swing-bed and observation l	hed days)		3, 010	4.00
5.00	Total swing-bed SNF type inpatient days (including private ro	5,	er 31 of the cost	3,010	5.00
( 00	reporting period				
	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 of the cost	0	6.00
	Total swing-bed NF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	0	7.00
	reporting period Tatal aving had NE type inpatient days (including private re	am dava) aftar Dacambar	21 of the east	0	0.00
	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	on days) after becenber	31 OF THE COST	0	8.00
9.00	Total inpatient days including private room days applicable	to the Program (excludin	g swing-bed and	2, 172	9.00
	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII (	only (including privato	room dave)	0	10.00
	through December 31 of the cost reporting period (see instruc		room uays)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII (	only (including private	room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, o Swing-bed NF type inpatient days applicable to titles V or X		te room dave)	0	12.00
	through December 31 of the cost reporting period			0	12.00
	Swing-bed NF type inpatient days applicable to titles V or X			0	13.00
	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Prog			0	14.00
	Total nursery days (title V or XIX only)	Tam (exer during swring bed	uays)	0	15.00
	Nursery days (title V or XIX only)			0	16.00
	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servio	ces through December 31	of the cost	0.00	17.00
18.00	reporting period Medicare rate for swing-bed SNF services applicable to servio	and often December 21 of	the east	0.00	18.00
	reporting period	Ces aiter December 31 01	the cost	0.00	18.00
	Medicaid rate for swing-bed NF services applicable to service reporting period	es through December 31 o	f the cost	0.00	19.00
	Medicaid rate for swing-bed NF services applicable to service reporting period	es after December 31 of	the cost	0.00	20.00
	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decem			2, 812, 323	
	5 x line 17)	ber 31 of the cost repor	ting period (ine	0	22.00
	Swing-bed cost applicable to SNF type services after December x line 18)	r 31 of the cost reporti	ng period (line 6	0	23.00
	Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost report	ing period (line	0	24.00
25.00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reportin	g period (line 8	0	25.00
	x line 20)			-	
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 2, 812, 323	26.00 27.00
-	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			2,012,020	27.00
	General inpatient routine service charges (excluding swing-be	ed and observation bed c	harges)	0	28.00
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29.00 30.00
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)	inus lino 22)(soo instru	ations)	0.00	
	Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li	, ,		0. 00 0. 00	
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost d	ifferential (line	2, 812, 323	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD. Adjusted general inpatient routine service cost per diem (ser				38.00
	Program general inpatient routine service cost per drem (ser	-			39.00
	FIOGLAIII GENELAL TIPALLEIL TOULTHE SELVICE COSL (TITE 7 X TITE				
39. 00 40. 00	Medically necessary private room cost applicable to the Program general inpatient routine service cost (line 3)	ram (line 14 x line 35)			40.00 41.00

Health Financial Systems COMPUTATION OF INPATIENT OPERATING COST	RI VERVI EW	HOSPITAL Provider C	CN: 15-0059	In Lie Period:	u of Form CMS-2 Worksheet D-1	
			CCN: 15-5669	From 01/01/2019 To 12/31/2019		
			XVIII	Skilled Nursing	6/8/2020 1:18	
				Facility		
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. ÷ col. 2)	0 5	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 <u>NURSERY (title V &amp; XIX only)</u> Intensive Care Type Inpatient Hospital Unit	5					42.00
43. 00 I NTENSI VE CARE UNI T	<u> </u>					43.00
44.00 CORONARY CARE UNIT 45.00 BURN INTENSIVE CARE UNIT						44.00
45. 00   BURN I NTENSI VE CARE UNI T 46. 00   SURGI CAL I NTENSI VE CARE UNI T						45.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description					1.00	
48.00 Program inpatient ancillary service cost (W	/kst. D-3, col.	3, line 200)			1.00	48.00
49.00 Total Program inpatient costs (sum of lines	5 41 through 48)	(see instructi	ons)			49.00
PASS THROUGH COST ADJUSTMENTS 50.00 Pass through costs applicable to Program in	patient routine	services (fro	n Wkst. D, si	um of Parts I and	1	50.00
51.00 Pass through costs applicable to Program in and IV)	patient ancilla	ry services (f	rom Wkst. D,	sum of Parts II		51.00
52.00 Total Program excludable cost (sum of lines						52.00
53.00 Total Program inpatient operating cost excl medical education costs (line 49 minus line	5 1	elated, non-ph	ysician anes	thetist, and		53.00
TARGET AMOUNT AND LIMIT COMPUTATION	; 52)				<u> </u>	
54.00 Program di scharges						54.00
55.00 Target amount per discharge 56.00 Target amount (line 54 x line 55)						55.00 56.00
57.00 Difference between adjusted inpatient opera	ting cost and t	arget amount (	line 56 minus	s line 53)		57.00
58.00 Bonus payment (see instructions)						58.00
59.00 Lesser of lines 53/54 or 55 from the cost r market basket	reporting period	ending 1996,	updated and o	compounded by the		59.00
60.00 Lesser of lines 53/54 or 55 from prior year	cost report, u	pdated by the	market baske <sup>.</sup>	t		60.00
61.00 If line 53/54 is less than the lower of line						61.00
which operating costs (line 53) are less th amount (line 56), otherwise enter zero (see		its (it nes 54 x	60), OF 1% (	on the target		
62.00 Relief payment (see instructions)						62.00
63.00 Allowable Inpatient cost plus incentive pay PROGRAM INPATIENT ROUTINE SWING BED COST	ment (see instr	uctions)				63.00
64.00 Medicare swing-bed SNF inpatient routine co	sts through Dec	ember 31 of th	e cost repor	ting period (See		64.00
<ul><li>instructions)(title XVIII only)</li><li>65.00 Medicare swing-bed SNF inpatient routine co</li></ul>	sts after Decem	her 31 of the	cost reportiu	na period (See		65.00
instructions)(title XVIII only)				0 1 1		
66.00 Total Medicare swing-bed SNF inpatient rout CAH (see instructions)	ine costs (line	64 plus line	65)(title XV	III only). For		66.00
67.00 Title V or XIX swing-bed NF inpatient routi	ne costs throug	h December 31	of the cost i	reporting period		67.00
(line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routi	no coste aftor	Docombor 21 of	the cost rou	porting poriod		68.00
(line 13 x line 20)	ne costs al tel	December 31 01	the cost rep	boi tring period		00.00
69.00 Total title V or XIX swing-bed NF inpatient						69.00
70.00 Skilled nursing facility/other nursing faci				7)	2, 812, 323	70.00
71.00 Adjusted general inpatient routine service	cost per diem (				934.33	71.00
72.00 Program routine service cost (line 9 x line		m (lino 14 v l	ino 25)		2, 029, 365	
73.00 Medically necessary private room cost appli 74.00 Total Program general inpatient routine ser					0 2, 029, 365	
75.00 Capital-related cost allocated to inpatient	•			Part II, column	0	
26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ l	ine 2)				0.00	76.00
77.00 Program capital-related costs (line 9 x lin	ne 76)				0	77.00
78.00 Inpatient routine service cost (line 74 min		providor rocar	de)		0	
79.00 Aggregate charges to beneficiaries for exce 80.00 Total Program routine service costs for com	•	•		nus line 79)	0	
81.00 Inpatient routine service cost per diem lim	ni tati on		(		0.00	81.00
82.00 Inpatient routine service cost limitation (	line 9 x line 8				0	
83.00 Reasonable inpatient routine service costs 84.00 Program inpatient ancillary services (see i	•	ns)			2, 029, 365 1, 168, 911	
85.00 Utilization review - physician compensation		ons)			0	
86.00 Total Program inpatient operating costs (su	m of lines 83 t	hrough 85)			3, 198, 276	
PART IV - COMPUTATION OF OBSERVATION BED PA 87.00 Total observation bed days (see instruction					0	87.00
5 (		· lino 2)				88.00
88.00 Adjusted general inpatient routine cost per		÷ TTHE Z)			0.00	00.00

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period:	Worksheet D-1	
		Component (	CCN: 15-5669	From 01/01/2019 To 12/31/2019		pared: pm
		Title	XVIII	Skilled Nursing	PPS	
				Facility		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				. 89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	0	0	0.0000	0 00	0	90.00
91.00 Nursing School cost	0	0	0. 00000	0 00	0	91.00
92.00 Allied health cost	0	0	0. 00000	0 00	0	92.00
93.00 All other Medical Education	0	0	0.00000	0 00	0	93.00

OMPUT	Financial Systems RIVERVIEW H TATION OF INPATIENT OPERATING COST	Provider CCN: 15-0059	Peri od:	Worksheet D-1	
			From 01/01/2019 To 12/31/2019	Date/Time Pre 6/8/2020 1:18	
		Title XIX	Hospi tal	Cost	, piii
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS				
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed da	ays, excluding newborn)		14, 942	1
00 00	Inpatient days (including private room days, excluding swing Private room days (excluding swing-bed and observation bed of		orivate room days,	14, 942 0	
00	do not complete this line. Semi-private room days (excluding swing-bed and observation			12, 240	
00	Total swing-bed SNF type inpatient days (including private r reporting period			0	5
00	Total swing-bed SNF type inpatient days (including private r reporting period (if calendar year, enter 0 on this line)	room days) after December	31 of the cost	0	6
00	Total swing-bed NF type inpatient days (including private reporting period	oom days) through Decembe	er 31 of the cost	0	7
00	Total swing-bed NF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 of the cost	0	8
00	Total inpatient days including private room days applicable newborn days)	to the Program (excludir	ng swing-bed and	519	9
. 00	Swing-bed SNF type inpatient days applicable to title XVIII through December 31 of the cost reporting period (see instru		room days)	0	10
. 00	Swing-bed SNF type inpatient days applicable to title XVIII December 31 of the cost reporting period (if calendar year,	only (including private	room days) after	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or > through December 31 of the cost reporting period		ite room days)	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or >			0	13
	after December 31 of the cost reporting period (if calendar Medically necessary private room days applicable to the Proc			0	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			1, 421 0	
. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servi	ices through December 31	of the cost	0.00	17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to servi	ices after December 31 of	the cost	0.00	18
. 00	reporting period Medicaid rate for swing-bed NF services applicable to servic	ces through December 31 c	of the cost	0.00	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to servic	ces after December 31 of	the cost	0.00	20
. 00	reporting period Total general inpatient routine service cost (see instruction	ons)		24, 290, 813	21
. 00	Swing-bed cost applicable to SNF type services through Decem 5 x line 17)	mber 31 of the cost repor	ting period (line		
. 00	Swing-bed cost applicable to SNF type services after December x line 18)	er 31 of the cost reporti	ng period (line 6	0	23
. 00	Swing-bed cost applicable to NF type services through Decemb 7 x line 19)	ber 31 of the cost report	ing period (line	0	24
. 00	Swing-bed cost applicable to NF type services after December x line 20)	r 31 of the cost reportir	ng period (line 8	0	25
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	t (line 21 minus line 26)		0 24, 290, 813	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-b Private room charges (excluding swing-bed charges)	bed and observation bed o	charges)	0 0	
	Semi -private room charges (excluding swing-bed charges)	7		0	
	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	/ ÷ IINE 28)		0.000000	
	Average semi-private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)	)		0.00	
	Average per diem private room charge differential (line 32 m	•	ictions)	0.00	
	Average per diem private room cost differential (line 34 x l	, ,		0.00	
	Private room cost differential adjustment (line 3 x line 35)	-		0.00	
	General inpatient routine service cost net of swing-bed cost	•	lifferential (line	-	
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD				1.
					1 20
. 00	Adjusted general inpatient routine service cost per diem (se	-		1,625.67	
8. 00 9. 00	Adjusted general inpatient routine service cost per diem (se Program general inpatient routine service cost (line 9 x lin Medically necessary private room cost applicable to the Proc	ne 38)		1, 625. 67 843, 723 0	39

	ncial Systems	RIVERVIEW H			In Lie	u of Form CMS-	2552-10
COMPUTATI ON	OF INPATIENT OPERATING COST		Provider C		Period: From 01/01/2019	Worksheet D-1	1
					To 12/31/2019	Date/Time Pre 6/8/2020 1:18	
			Ti tl	e XIX	Hospi tal	Cost	
	Cost Center Description	Total	Total	Average Per Diem (col. 1	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days	÷ col. 2)		(col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	ERY (title V & XIX only) nsive Care Type Inpatient Hospital Units	0	1, 421	0.0	0 0	0	42.00
	VSI VE CARE UNIT	5, 869, 238	3, 317	1, 769. 4	4 0	0	43.00
	NARY CARE UNIT						44.00
	INTENSIVE CARE UNIT						45.00
	I CAL I NTENSI VE CARE UNI T R SPECI AL CARE (SPECI FY)						46.00
	Cost Center Description			I	1		
48.00 Prog	ram inpatient ancillary service cost (Wk		Line 200)			1.00 265,155	48.00
	Program inpatient costs (sum of lines			ons)		1, 108, 878	
	THROUGH COST ADJUSTMENTS	······································				.,,	
	through costs applicable to Program inp	atient routine	services (fro	n Wkst. D, sur	n of Parts I and	0	50.00
51.00 Pass	through costs applicable to Program inp	atient ancillar	v services (fi	rom Wkst D 4	sum of Parts II	C	51.00
and			5 301 11 003 (11				
	Program excludable cost (sum of lines					0	
	l Program inpatient operating cost exclu cal education costs (line 49 minus line !		lated, non-phy	ysician anesti	netist, and	0	53.00
	T AMOUNT AND LIMIT COMPUTATION	52)					
	ram discharges					0	
	et amount per discharge et amount (line 54 x line 55)					0.00	
	erence between adjusted inpatient operat	ing cost and ta	raet amount (	line 56 minus	line 53)	0	
	s payment (see instructions)		ger and and (			0	
	er of lines 53/54 or 55 from the cost re	porting period	endi ng 1996, i	updated and co	ompounded by the	0.00	59.00
	et basket er of lines 53/54 or 55 from prior year o	cost report un	dated by the i	market hasket		0.00	60.00
	ine 53/54 is less than the lower of line				the amount by	0.00	
	n operating costs (line 53) are less that		s (lines 54 x	60), or 1% of	f the target		
	nt (line 56), otherwise enter zero (see ef payment (see instructions)	instructions)				C	62.00
	wable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	
	RAM INPATIENT ROUTINE SWING BED COST					-	
	care swing-bed SNF inpatient routine cos ructions)(title XVIII only)	ts through Dece	mber 31 of the	e cost reporti	ng period (See	0	64.00
	care swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the o	cost reporting	g period (See	0	65.00
	ructions)(title XVIII only)						
	Medicare swing-bed SNF inpatient routi (see instructions)	ne costs (line	64 plus line (	65)(title XVII	I only). For	0	66.00
	e V or XIX swing-bed NF inpatient routing	e costs through	December 31	of the cost re	eporting period	0	67.00
	e 12 x line 19)					_	
	e V or XIX swing-bed NF inpatient routin e 13 x line 20)	e costs after D	ecember 31 of	the cost repo	orting period	0	68.00
	title V or XIX swing-bed NF inpatient	routine costs (	line 67 + line	e 68)		0	69.00
	III - SKILLED NURSING FACILITY, OTHER NU						
	led nursing facility/other nursing facil sted general inpatient routine service c				)		70.00
, ,	ram routine service cost (line 9 x line)			2)			72.00
	cally necessary private room cost applic						73.00
	Program general inpatient routine serv tal-related cost allocated to inpatient				Part II column		74.00
	line 45)	Service	CUSIS (ITUM)	NUL NOI	art II, COLUMN		/ 5.00
76.00 Per (	diem capital-related costs (line 75 ÷ li						76.00
0	ram capital-related costs (line 9 x line						77.00
	tient routine service cost (line 74 minu: egate charges to beneficiaries for exces:		rovi der recor	ds)			78.00
55	Program routine service costs for comp	• •			nus line 79)		80.00
	tient routine service cost per diem limi		`				81.00
	tient routine service cost limitation (l onable inpatient routine service costs (						82.00
	ram inpatient ancillary services (see in:		~ /				84.00
85.00 Utili	zation review - physician compensation	(see instructio					85.00
	Program inpatient operating costs (sum		rough 85)				86.00
	IV - COMPUTATION OF OBSERVATION BED PASS observation bed days (see instructions					2, 702	87.00
	sted general inpatient routine cost per		Lino 2)			1, 625. 67	
88.00 Adj us	steu general inpatrent routine cost per i					1,025.07	00.00

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2019	Worksheet D-1	
				To 12/31/2019	Date/Time Pre 6/8/2020 1:18	
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	5, 525, 276	24, 290, 813	0. 22746	4, 392, 560	999, 149	90.00
91.00 Nursing School cost	0	24, 290, 813	0.00000	4, 392, 560	0	91.00
92.00 Allied health cost	0	24, 290, 813	0.00000	4, 392, 560	0	92.00
93.00 All other Medical Education	0	24, 290, 813	0.00000	4, 392, 560	0	93.00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0059 Component CCN: 15-T059	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Pre 6/8/2020 1:18	pare
		Title XIX	Subprovider -	Cost	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS				
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	s excluding newborn)		5, 586	1.
00	Inpatient days (including private room days, excluding swing-			5, 586	2.
00	Private room days (excluding swing-bed and observation bed da		rivate room days,	0	3.
	do not complete this line.				
00 00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		or 21 of the cost	5, 586 0	45
50	reporting period	on days) through becent		0	
00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)			_	
00	Total swing-bed NF type inpatient days (including private roo reporting period	m days) through Decembe	r 31 of the cost	0	7
00	Total swing-bed NF type inpatient days (including private roo	m days) after December :	31 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)			Ũ	
00	Total inpatient days including private room days applicable t	o the Program (excludin	g swing-bed and	95	9
00	newborn days)			-	1.0
00	Swing-bed SNF type inpatient days applicable to title XVIII o through December 31 of the cost reporting period (see instruc		room days)	0	10
00	Swing-bed SNF type inpatient days applicable to title XVIII o		room davs) after	0	11
	December 31 of the cost reporting period (if calendar year, e	nter 0 on this line)	5	-	
00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including priva	te room days)	0	12
00	through December 31 of the cost reporting period	V only (including prive	to room douc)	0	13
00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13
00	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	days)	0	14
	Total nursery days (title V or XIX only)		3 /	1, 421	15
. 00	Nursery days (title V or XIX only)			0	16
. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	es through December 31	of the cost	0.00	1 17
00	reporting period	es thi ough becember 51		0.00	
00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0.00	18
~~	reporting period		<b>C</b> 11		
00	Medicaid rate for swing-bed NF services applicable to service reporting period	es through December 31 o	f the cost	0.00	19
00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of	the cost	0.00	20
	reporting period				
00	Total general inpatient routine service cost (see instruction			4, 872, 032	
00	Swing-bed cost applicable to SNF type services through Decemb	er 31 of the cost repor	ting period (line	0	22
00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reportion	na period (line 6	0	23
	x line 18)			Ũ	20
00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost report	ing period (line	0	24
00	7 x line 19)			0	0.5
00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	g period (ine 8	0	25
00	Total swing-bed cost (see instructions)			0	26
00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		4, 872, 032	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-be	d and observation bed c	harges)	0	28
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29 30
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 mi		ctions)	0.00	
	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35)	ne 31)		0.00	35 36
	General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line	-	
	27 minus line 36)			., 5, 2, 662	]
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ			070 40	1 20
	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			872. 19 82, 858	
	Medically necessary private room cost applicable to the Progr			02,000	40
	Total Program general inpatient routine service cost (line 39			82, 858	

Health Financial Systems COMPUTATION OF INPATIENT OPERATING COST	RI VERVI EW H		CN: 15-0059	In Lie Period:	u of Form CMS- Worksheet D-1	
			CCN: 15-T059	From 01/01/2019 To 12/31/2019		epared:
		Ti tl	e XIX	Subprovider -	Cost	5 piii
Cost Center Description	Total I npati ent Cost	Total Inpatient Days	Average Per Diem (col. ÷ col. 2)	0 5	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
2.00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Un	0		0.	00 0	0	42.0
I3. 00 I NTENSI VE CARE UNI T	0	C	0.	00 00	0	
14.00 CORONARY CARE UNIT 15.00 BURN INTENSIVE CARE UNIT						44.0
6.00 SURGICAL INTENSIVE CARE UNIT						45.0
7.00 OTHER SPECIAL CARE (SPECIFY)						47.0
Cost Center Description					1.00	
8.00 Program inpatient ancillary service cost					132, 617	
9.00 Total Program inpatient costs (sum of lin PASS THROUGH COST ADJUSTMENTS	es 41 through 48)(	see instructi	ons)		215, 475	49.0
0.00 Pass through costs applicable to Program	inpatient routine	services (fro	m Wkst. D, sı	um of Parts I and	0	50.0
)	innationt anaillar		nom Wkot D	oum of Dorto II	0	E1 0
1.00 Pass through costs applicable to Program and IV)	inpatrent ancirrar	y services (i	TOM WKSL. D,	Sum of Parts II	0	51.0
52.00 Total Program excludable cost (sum of lin		1.1.1.1			0	
53.00 Total Program inpatient operating cost ex medical education costs (line 49 minus li		elated, non-ph	ysician anest	thetist, and	0	53.0
TARGET AMOUNT AND LIMIT COMPUTATION	110 02)				1	
4.00 Program discharges 5.00 Target amount per discharge					0.00	
6.00 Target amount (line 54 x line 55)					0.00	
7.00 Difference between adjusted inpatient ope	erating cost and ta	irget amount (	line 56 minus	s line 53)	0	
8.00 Bonus payment (see instructions) 9.00 Lesser of lines 53/54 or 55 from the cost	reporting period	ending 1996	undated and d	compounded by the	0.00	
market basket	reporting period	churng 1770,		compounded by the	0.00	57.0
50.00 Lesser of lines 53/54 or 55 from prior ye					0.00	
51.00 If line 53/54 is less than the lower of l which operating costs (line 53) are less					0	61.0
amount (line 56), otherwise enter zero (s				5		
52.00 Relief payment (see instructions) 53.00 Allowable Inpatient cost plus incentive p	avment (see instru	ictions)			0	
PROGRAM INPATIENT ROUTINE SWING BED COST	· ·					00.0
54.00 Medicare swing-bed SNF inpatient routine instructions)(title XVIII only)	costs through Dece	mber 31 of th	e cost report	ing period (See	0	64.0
55.00 Medicare swing-bed SNF inpatient routine	costs after Decemb	er 31 of the	cost reportir	ng period (See	0	65.0
instructions)(title XVIII only)		(A)				
66.00 Total Medicare swing-bed SNF inpatient ro CAH (see instructions)	outine costs (line	64 plus line	65)(TITIE XVI	II ONLY). FOR	0	66. C
57.00 Title V or XIX swing-bed NF inpatient rou	itine costs through	December 31	of the cost r	reporting period	0	67.0
(line 12 x line 19) 58.00  Title V or XIX swing-bed NF inpatient rou	itine costs after Γ	ecember 31 of	the cost rer	orting period	0	68.0
(line 13 x line 20)				for thig period		
59.00 Total title V or XIX swing-bed NF inpatie PART III - SKILLED NURSING FACILITY, OTHE					0	69.0
0.00 Skilled nursing facility/other nursing fa				7)		70.0
1.00 Adjusted general inpatient routine servic		ine 70 ÷ line	2)			71.0
2.00 Program routine service cost (line 9 x li 3.00 Medically necessary private room cost app		line 14 x l	ine 35)			72.0
4.00 Total Program general inpatient routine s	ervice costs (line	e 72 + line 73	)			74.0
75.00 Capital-related cost allocated to inpatie 26, line 45)	ent routine service	e costs (from	Worksheet B,	Part II, column		75.0
6.00 Per diem capital-related costs (line 75 ÷	line 2)					76.0
7.00 Program capital-related costs (line 9 x l	· · · · · · · · · · · · · · · · · · ·					77.0
8.00  Inpatient routine service cost (line 74 m 9.00  Aggregate charges to beneficiaries for ex	,	rovi der recor	ds)			78.0
0.00 Total Program routine service costs for c	comparison to the c			nus line 79)		80.0
1.00  Inpatient routine service cost per diem   2.00  Inpatient routine service cost limitation		)				81.0
32.00 Reasonable inpatient routine service cost	• .	· .				82.0
84.00 Program inpatient ancillary services (see	instructions)					84.0
35.00 Utilization review - physician compensati 36.00 Total Program inpatient operating costs (						85.0
PART IV - COMPUTATION OF OBSERVATION BED					I	30.0
87.00 Total observation bed days (see instructi					0	
88.00 Adjusted general inpatient routine cost p 89.00 Observation bed cost (line 87 x line 88)		,			0.00	88.0 89.0
					, -	

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period:	Worksheet D-1	
		Component (	CCN: 15-T059	From 01/01/2019 To 12/31/2019		pared: pm
		Ti tl	e XIX	Subprovider -	Cost	
				I RF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
				, , , , , , , , , , , , , , , , , , ,	instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	659, 845	4, 872, 032	0. 13543	35 0	0	90.00
91.00 Nursing School cost	0	4, 872, 032	0.0000	0 00	0	91.00
92.00 Allied health cost	0	4, 872, 032	0. 00000	0 00	0	92.00
93.00 All other Medical Education	0	4, 872, 032	0.0000	0 00	0	93.00

Cost Center Description           INPATIENT ROUTINE SERVICE COST CENTERS           00         03000 ADULTS & PEDIATRICS           00         03100 INTENSIVE CARE UNIT           00         04100 SUBPROVIDER - IRF           00         04300 NURSERY           ANCILLARY SERVICE COST CENTERS           00         05000 OPERATING ROOM           00         05400 RADIOLOGY-DIAGNOSTIC           00         05500 RADIOLOGY-THERAPEUTIC           00         05500 CT SCAN	Ti tl e	XVIII Ratio of Cost To Charges 1.00 0.01897 0.00000 0.31718 0.23647	Program Charges 2.00 10, 258, 916 4, 194, 496 271, 140 7 13, 583, 812 0 0 1 874, 407	6/8/2020 1: 18 PPS I npatient Program Costs (col. 1 x col. 2) 3.00 257, 780 0
INPATI ENT ROUTI NE SERVI CE COST CENTERS         00       03000 ADULTS & PEDI ATRI CS         00       03100 I NTENSI VE CARE UNI T         00       04100 SUBPROVI DER - I RF         00       04300 NURSERY         ANCI LLARY SERVI CE COST CENTERS         00       05000 OPERATI NG ROOM         00       05200 DELI VERY ROOM & LABOR ROOM         00       05400 RADI OLOGY-THERAPEUTI C	<u> </u>	Ratio of Cost To Charges 1.00 0.01897 0.00000 0.31718	I npati ent Program Charges 2.00 10,258,916 4,194,496 271,140 7 13,583,812 0 0 1 874,407	Inpatient Program Costs (col. 1 x col. 2) 3.00 257,780 0
INPATI ENT ROUTI NE SERVI CE COST CENTERS         00       03000 ADULTS & PEDI ATRI CS         00       03100 I NTENSI VE CARE UNI T         00       04100 SUBPROVI DER - I RF         00       04300 NURSERY         ANCI LLARY SERVI CE COST CENTERS         00       05000 OPERATI NG ROOM         00       05200 DELI VERY ROOM & LABOR ROOM         00       05400 RADI OLOGY-THERAPEUTI C		To Charges 1.00 0.01897 0.00000 0.31718	Program Charges 2.00 10, 258, 916 4, 194, 496 271, 140 7 13, 583, 812 0 0 1 874, 407	Program Costs (col. 1 x col. 2) 3.00 257,780 0
00         03000         ADULTS & PEDIATRICS           00         03100         INTENSIVE CARE UNIT           00         04100         SUBPROVIDER - IRF           00         04300         NURSERY           ANCILLARY SERVICE COST CENTERS           00         05000           00         DELIVERY ROOM           00         05400           01         NURSERY		0. 01897 0. 00000 0. 31718	Charges 2.00 10, 258, 916 4, 194, 496 271, 140 7 13, 583, 812 0 0 1 874, 407	(col . 1 x col . 2) 3.00 257,780 0
00         03000         ADULTS & PEDIATRICS           00         03100         INTENSIVE CARE UNIT           00         04100         SUBPROVIDER - IRF           00         04300         NURSERY           ANCILLARY SERVICE COST CENTERS           00         05000           00         DELIVERY ROOM           00         05400           01         NURSERY		0. 01897 0. 00000 0. 31718	2.00           10, 258, 916           4, 194, 496           271, 140           7           13, 583, 812           0           0           1           874, 407	<u>col. 2)</u> <u>3.00</u> <u>257,780</u> 0
00         03000         ADULTS & PEDIATRICS           00         03100         INTENSIVE CARE UNIT           00         04100         SUBPROVIDER - IRF           00         04300         NURSERY           ANCILLARY SERVICE COST CENTERS           00         05000           00         DELIVERY ROOM           00         05400           01         NURSERY		0. 01897 0. 00000 0. 31718	10, 258, 916 4, 194, 496 271, 140 7 13, 583, 812 0 0 1 874, 407	3.00 257,780 0
00         03000         ADULTS & PEDIATRICS           00         03100         INTENSIVE CARE UNIT           00         04100         SUBPROVIDER - IRF           00         04300         NURSERY           ANCILLARY SERVICE COST CENTERS           00         05000           00         DELIVERY ROOM           00         05400           01         NURSERY		0. 01897 0. 00000 0. 31718	4, 194, 496 271, 140 7 13, 583, 812 0 0 1 874, 407	257, 780 0
00         03100         I NTENSI VE CARE UNI T           00         04100         SUBPROVI DER - I RF           01         04300         NURSERY           ANCI LLARY SERVI CE COST CENTERS         00           05000         OPERATI NG ROOM           00         05200         DELI VERY ROOM & LABOR ROOM           00         05400         RADI OLOGY-THERAPEUTI C		0. 00000 0. 31718	4, 194, 496 271, 140 7 13, 583, 812 0 0 1 874, 407	257, 780 0
00         04100         SUBPROVI DER - IRF           04300         NURSERY           ANCILLARY SERVICE COST CENTERS           00         05000           00         05200           01         05200           02         05400           03         05400           04         05000           00         05400           00         05400           00         05500           00         05500           00         05500           00         05500           00         05500           00         05500		0. 00000 0. 31718	271, 140 7 13, 583, 812 0 0 1 874, 407	257, 780
00         04300         NURSERY           ANCI LLARY SERVI CE COST CENTERS           00         05000         OPERATI NG ROOM           00         05200         DELI VERY ROOM & LABOR ROOM           00         05400         RADI OLOGY-DI AGNOSTI C           00         05500         RADI OLOGY-THERAPEUTI C		0. 00000 0. 31718	7 13, 583, 812 0 0 1 874, 407	257, 780
ANCI LLARY SERVI CE COST CENTERS 00 05000 OPERATI NG ROOM 00 05200 DELI VERY ROOM & LABOR ROOM 00 05400 RADI OLOGY-DI AGNOSTI C 00 05500 RADI OLOGY-THERAPEUTI C		0. 00000 0. 31718	0 0 1 874, 407	0
00         05000         0PERATI NG ROOM           00         05200         DELI VERY ROOM & LABOR ROOM           00         05400         RADI OLOGY-DI AGNOSTI C           00         05500         RADI OLOGY-THERAPEUTI C		0. 00000 0. 31718	0 0 1 874, 407	0
0005200DELI VERYROOM & LABORROOM0005400RADI OLOGY-DI AGNOSTI C0005500RADI OLOGY-THERAPEUTI C		0. 00000 0. 31718	0 0 1 874, 407	0
00 05400 RADI OLOGY-DI AGNOSTI C 00 05500 RADI OLOGY-THERAPEUTI C		0. 31718	1 874, 407	
00 05500 RADI OLOGY-THERAPEUTI C		1		
		0.230470		
		0.037772		
01 03630 ULTRA SOUND		0. 07031		
00 05800 MAGNETIC RESONANCE I MAGI NG (MRI)		0. 12808		
00 05900 CARDI AC CATHETERI ZATI ON		0. 07102		
00 06000 LABORATORY		0. 19761		
01 06001 BLOOD LABORATORY		0.00000		1 1
00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 52713	2 216, 286	114, 011
00 06400 INTRAVENOUS THERAPY		0.00000		0
00 06500 RESPI RATORY THERAPY		0. 32927	4 2, 666, 062	877, 865
00 06600 PHYSI CAL THERAPY		0. 32483	7 1, 598, 345	519, 202
00 06700 OCCUPATI ONAL THERAPY		0.00000		
00 06800 SPEECH PATHOLOGY		0.00000		-
00 06900 ELECTROCARDI OLOGY		0. 225140		
00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		0. 55647		
00 07200 IMPL. DEV. CHARGED TO PATIENT		0.74510		
00 07300 DRUGS CHARGED TO PATIENTS		0.40352		
00 07400 RENAL DI ALYSI S 00 03020 OTHER ANCI LLARY		0. 684084		
01 03140 CARDI AC REHAB		0. 19355		
02 03070 WOMEN' S CENTER		0. 15504		
03 03330 ENDOSCOPY		0. 00000		
OUTPATIENT SERVICE COST CENTERS		0.00000	<u> </u>	
00 09000 CLINIC		0. 16099	8 5, 064	815
01 09001 OUTPATI ENT		0. 33373		
02 09002 NEUROPSYCHOLOGY		0. 36794	B 4, 901	1, 803
00 09100 EMERGENCY		0. 25658		604, 750
01 09101 SHORT STAY		0.00000		
00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 707972	2 0	0
OTHER REIMBURSABLE COST CENTERS				
00 09500 AMBULANCE SERVICES			10 101 /	10 100 000
1.00 Total (sum of lines 50 through 94 and 96 through 98)			49, 101, 636	
.00 Less PBP Clinic Laboratory Services-Program only charges 2.00 Net charges (line 200 minus line 201)	(II ne 61)		49, 101, 636	1

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT Pr	ovider C	CN: 15-0059	Period:	Worksheet D-3	}
Co	mponent (	CCN: 15-T059	From 01/01/2019 To 12/31/2019	Date/Time Pre	epare
	•			6/8/2020 1:18	
	IITIe	XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					1
D. 00 03000 ADULTS & PEDIATRICS			0		30.
1. 00 03100 I NTENSI VE CARE UNI T			0		31.
1. 00 04100 SUBPROVIDER - IRF			4, 346, 460		41.
3. 00 04300 NURSERY					43.
ANCI LLARY SERVICE COST CENTERS		0. 0189	77 175 107	3, 323	50.
2. 00 05200 DELIVERY ROOM & LABOR ROOM		0.0189		3, 323	
4. 00  05400  RADI OLOGY-DI AGNOSTI C		0. 3171		18, 510	
5. 00  05500  RADI OLOGY - DI AGNOSTI C 5. 00  05500  RADI OLOGY - THERAPEUTI C		0. 3171		643	
7. 00  05700 CT_SCAN		0. 0377		2, 635	
7. 01   03630  ULTRA SOUND		0.0703		525	
3. OO   05800   MAGNETI C RESONANCE I MAGI NG (MRI)		0. 1280			
2. 00 05900 CARDIAC CATHETERIZATION		0. 0710		2, 104	
0. 00 06000 LABORATORY		0. 1976		168, 424	
D. 01 06001 BLOOD LABORATORY		0.0000		00, 424	
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 5271		5, 502	
4. 00 06400 I NTRAVENOUS THERAPY		0.0000		0,002	
5. 00 06500 RESPIRATORY THERAPY		0. 3292		123, 754	
5. 00 06600 PHYSI CAL THERAPY		0. 3248		1, 287, 349	
7. 00 06700 OCCUPATI ONAL THERAPY		0.0000		0	
3. 00 06800 SPEECH PATHOLOGY		0.0000		0	
9. 00 06900 ELECTROCARDI OLOGY		0. 2251		11, 973	
1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 5564		468, 630	
2. 00 07200 I MPL. DEV. CHARGED TO PATI ENT		0. 7451		16, 079	
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 4035		364, 717	
1.00 07400 RENAL DIALYSIS		0.6840		112, 091	
5. 00 03020 OTHER ANCI LLARY		0.0000		0	
5. 01 03140 CARDI AC REHAB		0. 1935		812	76
5. 02 03070 WOMEN' S CENTER		0. 1550	44 111	17	76
5. 03 03330 ENDOSCOPY		0.0000	0 00	0	76
OUTPATI ENT SERVI CE COST CENTERS					1
D. 00 09000 CLINIC		0. 1609		304	90
0. 01 09001 OUTPATI ENT		0. 3337	38 49, 794	16, 618	90
0. 02 09002 NEUROPSYCHOLOGY		0. 3679		0	
. 00 09100 EMERGENCY		0. 2565		8, 286	
. 01 09101 SHORT STAY		0.0000		0	
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 7079	72 0	0	92
OTHER REIMBURSABLE COST CENTERS					
5. 00 09500 AMBULANCE SERVICES					95
00.00 Total (sum of lines 50 through 94 and 96 through 98)			7, 631, 107	2, 614, 034	
01.00 Less PBP Clinic Laboratory Services-Program only charges (I	ine 61)		0		201
02.00 Net charges (line 200 minus line 201)			7, 631, 107		202

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0059	Peri od:	Worksheet D-3	3
	Comment	CON 15 5//0	From 01/01/2019	Date (Time Dee	
	component	CCN: 15-5669	To 12/31/2019	Date/Time Pre 6/8/2020 1:18	
	Title	e XVIII	Skilled Nursing Facility		
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
			Ŭ	col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
0. 00 03000 ADULTS & PEDI ATRI CS			0		30
. 00 03100 INTENSIVE CARE UNIT			0		31
. 00 04100 SUBPROVI DER – I RF			0		41
. 00 04300 NURSERY					43
ANCI LLARY SERVICE COST CENTERS		1			
00 05000 OPERATING ROOM		0.0189		-	
. 00 05200 DELIVERY ROOM & LABOR ROOM		0.0000			
. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 31718			
. 00 05500 RADI OLOGY-THERAPEUTI C		0. 2364		-	
. 00  05700  CT_SCAN		0.0377			
01 03630 ULTRA SOUND		0.0703		-	
00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 12808		-	
00 05900 CARDI AC CATHETERI ZATI ON		0.07102			
. 00 06000 LABORATORY		0. 1976			
. 01 06001 BLOOD LABORATORY		0.0000		0	
. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 52713		24, 238	
. 00 06400 I NTRAVENOUS THERAPY		0.0000		-	
. 00 06500 RESPI RATORY THERAPY		0. 3292			
00 06600 PHYSI CAL THERAPY		0. 32483			
00 06700 OCCUPATI ONAL THERAPY		0.0000		-	
		0.0000			
00 06900 ELECTROCARDI OLOGY		0. 22514		0	
. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS		0. 5564			
. 00 07200 I MPL. DEV. CHARGED TO PATIENT		0.74510		0	
00 07300 DRUGS CHARGED TO PATIENTS		0.40352			
00 07400 RENAL DI ALYSI S		0. 68408		-	
00 03020 OTHER ANCI LLARY		0.0000			
01 03140 CARDI AC REHAB		0. 1935			
02 03070 WOMEN'S CENTER		0. 15504			
03 03330 ENDOSCOPY		0.0000	0 00	0	76
OUTPATIENT SERVICE COST CENTERS		0. 16099	98 0	0	90
. 01   09001   0UTPATI ENT		0. 33373			
02 09002 NEUROPSYCHOLOGY		0. 3337			
00 09100 EMERGENCY		0. 36794			
. 01 09100 EMERGENCY		0. 25658			
		0. 7079			
00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS		0.7079	0	0	4 72
00 09500 AMBULANCE SERVICES					95
0.00 Total (sum of lines 50 through 94 and 96 through 98)			3, 437, 094	1, 168, 911	
	(1) (4)		3, 437, 094	1, 100, 911	200
1.00 Less PBP Clinic Laboratory Services-Program only charge					

ATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0059	Period: From 01/01/2019 To 12/31/2019	Date/Time Pre	epar
			11	6/8/2020 1:18	3'pm
Cost Contor Description	11 TI	e XIX Ratio of Cos	Hospital Inpatient	Cost Inpatient	
Cost Center Description		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
			onar ges	col. 2)	
		1.00	2.00	3.00	+
INPATIENT ROUTINE SERVICE COST CENTERS					
00 03000 ADULTS & PEDI ATRI CS			1, 160, 585		30
00 03100 INTENSIVE CARE UNIT			181, 541		31
00 04100 SUBPROVIDER - IRF			0		41
00 04300 NURSERY			0		43
ANCI LLARY SERVI CE COST CENTERS		1	1		
00 05000 OPERATING ROOM		0.0189			
00 05200 DELIVERY ROOM & LABOR ROOM		0.0000		0	
00 05400 RADI OLOGY-DI AGNOSTI C		0. 31718			
00 05500 RADI OLOGY-THERAPEUTI C		0. 2364		0	
00 05700 CT SCAN		0.0377			
01 03630 ULTRA SOUND		0.0703		0	
00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 12808			
00  05900  CARDI AC CATHETERI ZATI ON 00  06000  LABORATORY		0. 07102 0. 1976		5,067	
01 06001 BLOOD LABORATORY		0. 1978			
00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 52713		e e e e e e e e e e e e e e e e e e e	
00 06400 INTRAVENOUS THERAPY		0. 00000		0	
00 06500 RESPI RATORY THERAPY		0. 3292		17,827	
00 06600 PHYSI CAL THERAPY		0. 32483			
00 06700 OCCUPATI ONAL THERAPY		0.00000			
00 06800 SPEECH PATHOLOGY		0.0000			
00 06900 ELECTROCARDI OLOGY		0. 22514			
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 5564			
00 07200 I MPL. DEV. CHARGED TO PATIENT		0.74510			
00 07300 DRUGS CHARGED TO PATIENTS		0. 40352		94, 323	7
00 07400 RENAL DIALYSIS		0. 68408	34 0	0	7
00 03020 OTHER ANCI LLARY		0.0000	0 00	0	7
01 03140 CARDI AC REHAB		0. 1935	59 6, 443	1, 247	7
02 03070 WOMEN'S CENTER		0. 15504	44 0	0	7
03 03330 ENDOSCOPY		0.0000	0 00	0	7
OUTPATI ENT SERVI CE COST CENTERS		1			
00 09000 CLINIC		0. 16099		63	
		0. 33373			
02 09002 NEUROPSYCHOLOGY		0.36794		0	
00 09100 EMERGENCY		0. 25658		21,004	
01 09101 SHORT STAY		0.0000			
00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0.7079	72 0	0	9
OTHER REIMBURSABLE COST CENTERS					9
			1, 180, 727	265, 155	
1.00Total (sum of lines 50 through 94 and 96 through 98).00Less PBP Clinic Laboratory Services-Program only charges	(line 61)		1, 180, 727		20
.00Less PBP ciffic Laboratory services-Program only charges.00Net charges (line 200 minus line 201)			1, 180, 727		20

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0059	Peri od:	Worksheet D-3	}
			From 01/01/2019		
	Component	CCN: 15-T059	To 12/31/2019	Date/Time Pre 6/8/2020 1:18	
	Ti tl	e XIX	Subprovider -	Cost	/ piii
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	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			0		1 20 0
0. 00 03000 ADULTS & PEDIATRICS 1. 00 03100 INTENSIVE CARE UNIT			0		30.0
1. 00  04100  SUBPROVIDER - IRF			523, 111		41.0
3. 00 04300 NURSERY			0		41.0
ANCI LLARY SERVI CE COST CENTERS			0		43.0
0. 00 05000 OPERATING ROOM		0.0189	77 0	0	50.0
2. 00 05200 DELIVERY ROOM & LABOR ROOM		0.0000		-	
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 3171			
5. 00 05500 RADI OLOGY-THERAPEUTI C		0. 2364		0	
7.00 05700 CT SCAN		0. 0377		0	57.
7.01 03630 ULTRA SOUND		0. 0703		0	57.
B. OO 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 1280	88 0	0	58.
9. 00 05900 CARDI AC CATHETERI ZATI ON		0. 0710	29 0	0	59.
0. 00 06000 LABORATORY		0. 1976	17 0	0	60.
0.01 06001 BLOOD LABORATORY		0.0000		0	60.
3.00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 5271			
4. 00 06400 INTRAVENOUS THERAPY		0.0000			
5. 00 06500 RESPI RATORY THERAPY		0. 3292			
6. 00 06600 PHYSI CAL THERAPY		0. 3248			
7. 00 06700 OCCUPATI ONAL THERAPY		0.0000			
8.00 06800 SPEECH PATHOLOGY		0.0000			
9. 00 06900 ELECTROCARDI OLOGY		0. 2251		-	
1. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS		0. 5564			
2. 00 07200 IMPL. DEV. CHARGED TO PATIENT		0.7451			
3. 00 07300 DRUGS CHARGED TO PATI ENTS		0.4035			
4.00 07400 RENAL DIALYSIS		0. 6840		-	1
6. 00 03020 OTHER ANCI LLARY		0.0000			
6. 01 03140 CARDI AC REHAB		0. 1935			
6. 02  03070  WOMEN' S CENTER 6. 03  03330  ENDOSCOPY		0. 1550 0. 0000			
OUTPATI ENT SERVICE COST CENTERS		0.0000	00 0	0	/0.
0. 00 09000 CLINIC		0. 1609	98 0	0	90.
0. 01 09001 0UTPATI ENT		0. 3337			
0. 02 09002 NEUROPSYCHOLOGY		0.3679			
1. 00 09100 EMERGENCY		0. 2565		-	
1. 01 09101 SHORT STAY		0.0000			
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 7079			
OTHER REI MBURSABLE COST CENTERS					1
5. 00 09500 AMBULANCE SERVI CES					95.
00.00 Total (sum of lines 50 through 94 and 96 through 98)			408, 257	132, 617	200.
01.00 Less PBP Clinic Laboratory Services-Program only charge	ges (line 61)		0		201.0
02.00 Net charges (line 200 minus line 201)		1	408, 257		202.0

	Financial Systems RIVERVIEW H ATION OF REIMBURSEMENT SETTLEMENT	HOSPITAL Provider CCN: 15-0059	In Lie Period:	u of Form CMS-2 Worksheet E	2552-10
CALCUL	AITON OF REIMBORSEMENT SETTLEMENT	Provider CCN: 15-0059	From 01/01/2019 To 12/31/2019	Part A Date/Time Pre	
		Title XVIII	Hospi tal	6/8/2020 1:18 PPS	pm
				1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00	
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occu	nring prior to October 1	(see	0 10, 972, 171	
1. 02	instructions) DRG amounts other than outlier payments for discharges occu instructions)	urring on or after October	1 (see	3, 746, 911	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI 1 (see instructions)	for discharges occurring	prior to October	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI October 1 (see instructions)	for discharges occurring	on or after	0	1.04
2.00 2.01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			0	2.00
2.01	Outlier payment for discharges for Model 4 BPCI (see instru	ucti ons)		0	2.01
2.03	Outlier payments for discharges occurring prior to October			325, 374	2.03
2.04	Outlier payments for discharges occurring on or after Octob	per 1 (see instructions)		48, 043	
3.00	Managed Care Simulated Payments			0	3.00
4.00	Bed days available divided by number of days in the cost re Indirect Medical Education Adjustment	eporting period (see instr	ructions)	117.02	4.00
5.00	FTE count for allopathic and osteopathic programs for the m or before 12/31/1996. (see instructions)	nost recent cost reporting	period ending or	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet new programs in accordance with 42 CFR 413.79(e)				
7.00 7.01	MMA Section 422 reduction amount to the LME cap as specifie ACA $\S$ 5503 reduction amount to the LME cap as specified und			0.00 0.00	
8.00	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allo affiliated programs in accordance with 42 CFR 413.75(b), 41			0.00	8.00
8. 01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap report straddles July 1, 2011, see instructions.	slots under § 5503 of the	ACA. If the cost	0.00	8.01
8. 02	The amount of increase if the hospital was awarded FTE cap under § 5506 of ACA. (see instructions)	slots from a closed teach	ing hospital	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus linestructions)			0.00	
10.00 11.00	FTE count for allopathic and osteopathic programs in the cu FTE count for residents in dental and podiatric programs.	irrent year from your reco	ras	0.00 0.00	•
12.00	Current year allowable FTE (see instructions)			0.00	
13.00	Total allowable FTE count for the prior year.			0.00	
14.00	Total allowable FTE count for the penultimate year if that otherwise enter zero.	year ended on or after Se	ptember 30, 1997,	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.				15.00
	Adjustment for residents in initial years of the program				16.00
17.00 18.00	Adjustment for residents displaced by program or hospital c Adjusted rolling average FTE count	liosui e		0.00	•
	Current year resident to bed ratio (line 18 divided by line	2 4).		0.000000	
	Prior year resident to bed ratio (see instructions)			0. 000000	
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000	
	IME payment adjustment (see instructions)			0	
22.01 23.00	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § Number of additional allopathic and osteopathic IME FTE res		CEP 412 105	0.00	1
23.00	(f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)	a a a a a a a a a a a a a a a a a a a	51 A T12. 105	0.00	
25.00	If the amount on line 24 is greater than -O-, then enter th instructions) $% \left( {{\left[ {{{\left[ {{{\left[ {{1 - 1} \right]}} \right]}_{i}}} \right]}_{i}}} \right)$	ne lower of line 23 or lin	e 24 (see	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)			0.000000	
27.00	IME payments adjustment factor. (see instructions)			0.000000	
28. 00 28. 01	IME add-on adjustment amount (see instructions) IME add-on adjustment amount - Managed Care (see instructio	ns)		0	•
29.00	Total IME payment ( sum of lines 22 and 28)			0	29.00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28 Disproportionate Share Adjustment			0	
	Percentage of SSI recipient patient days to Medicare Part A	a patient days (see instru	icti ons)	2.42	
31.00	Percentage of Medicaid patient days (see instructions)			14.74	
aa	Sum of lines 30 and 31			17 16	32.00
32.00 33.00	Allowable disproportionate share percentage (see instructio				33.00

GALCULATION OF REFUNESSENTINE SETTLEMENT         Provider CN: 15-005         Period 10/10/2016 From 01/0/2016         Decision For 1.0         Decision Period 02/00200         Decision 10/07/2016         Decision 12/07/2016         Decision 12/07/2016 <thdecision 07="" 12="" 2016<="" th="">         Decision 12/07/2016</thdecision>	Heal th	Financial Systems RI VERVI EW H03	SPI TAL	In Lie	u of Form CMS-2	2552-10
Title XVIII         Program         PPS           Incompensated Carls amount (see instructions)         0 <td>CALCUL</td> <td>ATION OF REIMBURSEMENT SETTLEMENT</td> <td>Provider CCN: 15-0059</td> <td>From 01/01/2019</td> <td>Part A Date/Time Pre</td> <td>pared:</td>	CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059	From 01/01/2019	Part A Date/Time Pre	pared:
Incomponsated Care Adjustment         1.00         2.00           35.00         Total uncompensated Care angument (see instructions)         0.00000000         0.00000000         0.00000000         0.00000000         0.00000000         0.00000000         0.00000000         0.00000000         0.00000000         0.000000000         0.00000000         0.00000000         0.00000000         0.000000000         0.00000000         0.000000000         0.000000000         0.00000000000000000000000000000000000			Title XVIII	Hospi tal		
becompensated Care Adjustment         becompensated Care Adjustment         0						
35.00       Total uncompensated care anount (see instructions)       0				1.00	2.00	
35.01       Factor 3 (see instructions)       0.00000000       0.00000000         35.02       Hospital uncompensated care payment amount (see instructions)       0.00000000       0.13.07.20         36.00       Total uncompensated care (sum of columns 1 and 2 on line 35.03)       0.118, 577       28, 641         36.00       Koat tark share of the hospital uncompensated care (sum of columns 1 and 2 on line 35.03)       1.18, 577       28, 641         36.00       Koat tark share of the hospital uncompensated care (sum of columns 1 and 2 on line 35.03)       1.18, 577       28, 644         40.00       Koat tark share of the hospital uncompensated care (sum of columns 1 and 2 on line 35.03)       1.18, 577       28, 644         41.00       Total ESN Medicare colematics of ESN Medicare colematics of ESN Medicare colematics of the 42, 652, 662, 663, 664       64       64         42.00       Divide line 41 by line 40 (f1 less than 10%, you do not qualify for adjustment)       0.00       42.00         43.00       Total ESN Medicare Covered and paid discharges culding MS-DRGs 652, 662, 663, 664       64       65         45.00       For adjust for	25 00			0	0	25 00
35.02       htsplital uncompensated care payment (if Filme 34 is zero, enter zero on this line) (see       1,096,252       1,307,420       35.02         35.03       Pro rata share of the hoping tail uncompensated care payment amount (see instructions)       819,936       38.64       35.03         36.00       Total uncompensated care (sum of colums 1 and 2 on line 35.00 line 36.00 through 460       40.00       40.00         400 Filtonal payment for high partentage of Esco beneric lary discharges for MS-DRGs       60       40.00         41.00       Total ESR0 Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685, (see       61.00         41.01       Total ESR0 Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685, (see       61.00         42.00       Divide line 41 by line 40 (if lisss than 10%, you do not qualify for adjustment)       0.00       42.00         43.00       Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7       0.000000       44.00         43.00       Average weekly cost for dialysis treatments (see instructions)       0.00       45.00         44.00       Average weekly cost for dialysis treatments (see instructions)       16.384,588       49.00         40.00       Sobiotral (see instructions)       0.00       45.00         40.00       Sobiotral (see instructions)       0.00       45.00         41.				-	-	
Instructions)         Bit         Annumber of the hospital uncompensated care payment amount (see instructions)         Bit         State          10		, , , , , , , , , , , , , , , , , , , ,	er zero on this line) (se			
35.03       Pro rate share of the hospital uncompensated care (sum of 2 on line 3.03)       1148,57       328,641       35.03       30.01       1148,57       30.00         Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)       0 <t< td=""><td>55. 02</td><td></td><td></td><td>1,070,202</td><td>1, 307, 420</td><td>55. OZ</td></t<>	55. 02			1,070,202	1, 307, 420	55. OZ
Add tional payment for high parcentage of ESRD beneficiary discharges (lines 40 through 46)           40.00         fotal Medicare discharges on Worksheet 5-3, Part 1 excluding discharges for MS-DRGs         0           652, 682, 683, 684 and 685 (see Instructions)         0         11.00           10         Total ESRD Medicare discharges excluding WS-DRGs 652, 662, 663, 664 an 665. (see         0         11.00           11.01         Total ESRD Medicare covered and paid discharges excluding WS-DRGs 652, 662, 663, 664 an 665. (see         0         42.00           43.00         Total Medicare tistories to one week (line 4.3 divided by line 41 divided by 7         0.000000         44.00           43.00         Total additional payment (line 45 times line 44 times line 41.01)         0         0         45.00           45.00         Vorsige weekly cost for dialysis treatments (see instructions)         0         0         46.00           46.00         Total additional payment for inpatient operating costs (see instructions)         0         16.384, 588         47.00           47.00         Lise to stat to one payment for Mikst L, Pt. 111, see instructions)         16.384, 588         47.00           48.00         Nursing and Allied Kee payments         10.00         16.384, 588         47.00           51.00         Kee instructions)         16.384, 583         48.00         15.00	35.03	,	ount (see instructions)	819, 936	328, 641	35.03
40.00       Total Medicare discharges on Worksheet S-3, Part L excluding discharges for MS-DRGs       0       40.00         11.00       Total ESR0 Medicare discharges excluding MS-DRGs 652, 662, 663, 664 an 665. (see Instructions)       0       41.00         11.01       Total ESR0 Medicare discharges excluding MS-DRGs 652, 662, 663, 664 an 665. (see Instructions)       0       41.00         11.00       Divide Medicare discharges excluding MS-DRGs 652, 662, 663, 664 an 665. (see Instructions)       0       41.00         12.00       Divide Medicare discharges excluding MS-DRGs 652, 662, 663, 664 an 665. (see Instructions)       0       0         44.00       Average weekly cost for dialysis treatments (see instructions)       0.00       45.00         14.00       Divide Medicare payment (in est time 1.01)       0.00       45.00         15.00       Average weekly cost for dialysis treatments (see instructions)       0.00       16.384,588         16.00       Total payment for inpatient operating costs (see instructions)       1.364,588       40.00         16.00       Total payment for inpatient program capital (Torm Wst. L. Pt. 1 and Pt. 11, see instructions).       1.364,588       40.00         16.00       Cost of physici and services in a tacching hospital (see instructions).       3.7,403,53.00       0       52.00         16.00       Cost of physici and-services in a tacaching hospital (see ins	36.00		,			36.00
652, 662, 663, 664 and 685 (see instructions)       642, 663, 664 an 665. (see instructions)       641.00         10.00 Total ESRD Medicare covered and paid discharges excluding MS-DR0s 652, 662, 663, 664 an 665. (see 0       0       41.00         20.00 Divide line 41b yline 40 (if less than 10%, you do not qualify for adjustment)       0.00       42.00         31.00 Total Medicare ESRD inpatient days excluding MS-DR0s 652, 662, 663, 664 an 665. (see 0       0       43.00         42.00 Divide line 41b yline 40 (if less than 10%, you do not qualify for adjustment)       0.000       44.00         43.00 Total Medicare ESRD inpatient days excluding KS-DR0s 652, 662, 663, 664 an 665. (see 0       0       44.00         43.00 Total additional payment (line 45 times line 41 line 11ne 41 divided by 1       0.000       44.00         45.00 Aronge weekly cost for dialysis treatments (see instructions)       0.00       45.00         46.00 Noispital specific payments (to be completed by SCH and MDH, small rural hospitals on envi, (see instructions)       1.00       40.00         47.00 Exception payment for inpatient operating costs (see instructions)       1.00       1.358,586       49.00         50.00 Payment for inpatient operating costs (see instructions)       1.00       1.358,575       55.00         51.00 Direct graduate modular elucation payment (from Wkst. L, Pt. 1 and Pt. 11, as applicable)       1.358,575       55.00       55.00         52.0						
41.00       Total ESR0 Medicare discharges excluding MS-DRGS 652, 682, 683, 684 an 685. (see intructions)       41.01         41.01       Total ESR0 Medicare covered and paid discharges excluding MS-DRGS 652, 682, 683, 684 an 685. (see intructions)       0.00         42.00       Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)       0.00       42.00         43.00       Total Medicare ESR0 inpatient days excluding MS-DRGS 652, 682, 683, 684 an 685. (see 0       43.00         43.00       Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7       0.000000       44.00         45.00       Average weekly cost for dialysis treatments (see instructions)       0.00       45.00         47.00       Divid (see instructions)       0.00       45.00         48.00       Payment for inpatient program capital (Wst. L, Pt. 11, see instructions)       0.84, 508       48.00         50.00       Payment for inpatient program capital (Wst. L, Pt. 11, see instructions)       1.00       48.00         51.00       Diverage and add-on payment       1.00, 11.345, 973, 50.00       52.00       52.00         52.00       Diverage and add-on payment       1.00, 11.345, 973, 50.00       52.00       52.00       52.00       52.00       52.00       52.00       52.00       52.00       52.00       52.00       52.00       52.00	40.00		discharges for MS-DRGs	0		40.00
Instructions)       Instructions)       41.01         Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 662, 663, 664       0       41.01         41.01       Total Medicare ESRD inpatient days excluding MS-DRGs 652, 662, 663, 664 an 665. (see       0       42.00         42.00       Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)       0.00       42.00         43.00       Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7       0.000000       44.00         45.00       Average weekly cost for dialysis treatments (see instructions)       0.00       45.00         45.00       Subtotal (see instructions)       0.00       46.00         48.00       Rosin tal specific payments (to be completed by SCH and MDH, small rural hospitals       16.384,588       47.00         49.00       Total payment for inpatient operating costs (see instructions)       16.384,588       47.00         49.00       Total payment for inpatient pogram capital (Wist, L, Pt. 1 and Pt. 11, see instructions)       16.384,588       47.00         50.00       Payment for inpatient pogram capital (from Wist, L, Pt. 1 and Pt. 11, see instructions)       37.403 33.00       55.00         51.00       Section payment for inpatient operating costs (rom Wist, D, Pt. 11, col. 11 line 200)       37.403 33.00       55.00       55.00       55.00	41 00		02 (04 (05 (			41 00
11.01       Total ESRU Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684       0       41.01         42.00       Divide Line 41 by Line 40 (if Less than 10%, you do not qualify for adjustment)       0.00       42.00         43.00       Total Medicare ESRU inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685, (see 0       0       43.00         40.00       Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7       0.000000       44.00         43.00       Total additional payment (line 45 times line 44.10.0)       0       0       46.00         47.00       Suctai (see instructions)       0.00       45.00         48.00       Heaptific payments (to be completed by SCH and MDH, small rural hospitals       0       16.384, 588       47.00         49.00       Total payment for inpatient operating costs (see instructions)       16.344, 588       47.00       1.00       48.00         49.00       Total payment for inpatient operating costs (see instructions)       16.345, 583       50.00	41.00		683, 684 an 685. (See	0		41.00
an 685. (see instructions)       42.00         200 Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)       0.00         41.00       Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)       0.000000         44.00       Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7       0.000000         45.00       Average weekly cost for dialysis treatments (see instructions)       0.00         46.00       Total additional payment (line 45 times line 41 ont)       0         47.00       Subtotal (see instructions)       16, 384, 588         48.00       Rost la specific payments (to be completed by SCH and MDH, small rural hospitals       1         49.00       Total payment for inpatient operating costs (see instructions)       16, 384, 588         49.00       Total payment for inpatient operating costs (see instructions)       1, 386, 788         51.00       Exception payment for inpatient operating costs (see instructions)       1, 386, 788         52.00       Divect graduate medical education payment for most etchnologies       37, 403         54.01       Special add-on payments for new technologies       37, 403         55.00       Average weekly cost from Wkst. D, Pt. IV, col. 11 line 200       7, 77, 718         56.00       Average average average average average average average aver	41 01	,	DRGs 652 682 683 684	0		41 01
42 00       Divide Line 41 by Line 40 (if Less than 10%, you do not quality for adjustment)       0.00       42 00         43 00       Total Medicare ESR0 inpatient days excluding MS-DRGs 652, 662, 663, 664 an 665. (see instructions)       0.000000       44.00         43 00       Total additional payment of stay to one week (line 43 divided by line 41 divided by 7 days)       0.000000       44.00         50.00       Average weekly cost for dialysis treatments (see instructions)       0.00       45.00         40.00       Total additional payment (line 45 times line 41 times line 41.01)       0       46.00         61.00       Hospital Specific payments (to be completed by SCH and MDH, small rural hospitals only, (see instructions)       16.384,588       47.00         47.00       Total payment for inpatient operating costs (see instructions)       16.384,588       49.00         61.00       Payment for inpatient program capital (from Wkst. L, Pt. 1 and Pt. II, as applicable)       1.345,973       50.00         62.00       Nursing and Allied Health Managed Care payment       37.403       53.00       55.00         63.00       Nursing and Allied Health Managed Kare payment       54.00       55.00       56.00       56.00       56.00       56.00       56.00       56.00       56.00       56.00       56.00       56.00       56.00       56.00       56.00       56.00				0		
instructions)       instructions)       44.00         40.00       Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7       0.000000         44.00       Ratio of average weekly cost for dialysis treatments (see instructions)       0.00       44.00         50.00       Verage weekly cost for dialysis treatments (see instructions)       0.00       45.00         47.00       Total additional payment (line 45 times line 44 times line 41.01)       0       46.00         47.00       Hotal (see instructions)       16.384,588       47.00         48.00       Hotal payment for inpatient operating costs (see instructions)       16.384,588       47.00         50.00       Payment for inpatient operating costs (see instructions)       1.365,973       50.00         51.00       Exception payment for inpatient program capital (from Wkst. L, Pt. 11, see instructions)       0       51.00         52.00       Nursing and Allied Healt Managed Care payment       37.403       53.00         55.00       Cost of physicians' services in a teaching hospital (see intructions)       37.403       53.00         50.01       Itslet isolation add-on payment       54.00       55.00       56.00       56.00       56.00       56.00       56.00       56.00       56.00       56.00       56.00       56.00       56.0	42.00		fy for adjustment)	0.00		42.00
44.00       Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)       0.000000       44.00         45.00       Average weekly cost for dialysis treatments (see instructions)       0.00       45.00         46.00       Total additional payment (line 45 times line 44 times line 41.01)       0       0         47.00       Subtotal (see instructions)       0.00       46.00         48.00       Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)       16.384,588       47.00         49.00       Total payment for inpatient operating costs (see instructions)       16.384,588       49.00         50.00       Payment for inpatient program capital (WKst. L, Pt. 1 and Pt. II, see pinstructions).       16.384,588       0.0         51.00       Exception payment for inpatient program capital (WKst. L, Pt. 11, see instructions).       0       51.00         52.00       Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).       0       52.00         55.00       Not organ acquisition cost (Wkst. D. 4Pt. III, col. 1, line 69)       0       54.01         55.00       Not organ acquisition cost (Wkst. D. 4Pt. III, col. 1, line 69)       17,797,135.00       59.00         56.00       Arcill ary service other pass through costs from Wkst. D. Pt. IV, col. 11 line 200)       17,797,174.59	43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 68	32, 683, 684 an 685. (see	0		43.00
days)       0.00       45.00         45.00       Average weekly cost for dialysis treatments (see instructions)       0.00         46.00       Total additional payment (line 45 times line 41.01)       0         47.00       Mototal (see instructions)       16.384,588         48.00       Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)       16.384,588         49.00       Total payment for inpatient operating costs (see instructions)       16.384,588       49.00         50.00       Payment for inpatient program capital (from Wkst. L, Pt. 111, see instructions)       10.30, 31.00         50.00       Direct graduate medical education payment (from Wkst. E.4, line 49 see instructions).       0.52.00         50.00       Special add-on payments for new technologies       37.403, 33.00         51.01       Direct graduate medical education posts from Wkst. Det 111, col. 1, line 69)       0.54.00         50.00       Routine service other pass through costs (from Wkst. Det 111, col. 11 line 200)       79.77,138,59.00         55.00       Total auduities of the program beneficiaries       17.797,138,59.00         56.00       Total auduit and-on payment Ser new technologies       17.797,138,59.00         56.00       Aroutinary payer payments on lines 49 through 58)       0.54.00         57.00       Routinary payeren		,				
45.00       Average weekly cost for dialysis treatments (see instructions)       0.00       45.00         46.00       Total additional payment (line 45 times line 44 times line 41.01)       0       0         48.00       Hospital specific payments (to be completed by SCH and MDH, small rural hospitals       0       0         49.00       Total payment for inpatient operating costs (see instructions)       16.384,588       47.00         49.00       Total payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)       16.384,588       48.00         51.00       Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)       0       11.345,973       50.00         52.00       Direct graduate medical education payment (from Wkst. E.4, Line 49 see instructions).       0       51.00         52.00       Direct graduate medical education payment (from Wkst. D, Pt. III, col. 1, line 69)       0       55.00         50.00       Cost of physicians' services in a teaching hospital (see instructions)       0       57.00         51.00       Exception payment for inpatient program beneficiaries       0       54.01         50.00       Cost of physicians' services instructions)       0       55.00         50.00       Cost of physicians' services instructions)       0       57.00         51.00       Direct g	44.00		by line 41 divided by 7	0. 000000		44.00
46.00       Total additional payment (line 45 times line 44 times line 41.01)       0       16.384.588       47.00         04.00       bubbotal (see instructions)       16.384.588       47.00         47.00       Subtotal (see instructions)       10.00       48.00         47.00       Subtotal (see instructions)       10.00       48.00         47.00       Total payment for inpatient operating costs (see instructions)       16.384.588       47.00         47.00       Total payment for inpatient operating costs (see instructions)       16.384.588       49.00         50.00       Payment for inpatient program capital (Wkst. L, Pt. 11, see instructions)       16.384.588       49.00         51.00       Exception payment for newments for new technologies       37.403       53.00         52.00       Special add-on payments for new technologies       37.403       53.00         54.01       Isle isolation cost (Wkst. D. 4 Pt. 111, col. 1, line 69)       0       54.01         56.00       Cof physicic other pass through costs (from Wkst. D, Pt. 111, col. 11 line 200)       29,174       58.00         57.00       Routine service other pass through costs (from Wkst. D, Pt. 111, col. 11 line 200)       19,184.368       23.324         59.00       Total amount payable for program beneficiaries (line 59 minus line 60)       17,742,80       17,7	45.00		-)	0.00		45 00
47.00       Subtotal (see instructions)       16,384,588       47.00         48.00       Hospital specific payments (to be completed by SCH and MDH, small rural hospitals of only. (see instructions)       16,384,588       48.00         49.00       Total payment for inpatient operating costs (see instructions)       1.00       1.00         49.00       Total payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)       16,384,588       49.00         51.00       Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)       0       1.00       52.00         52.00       Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).       37,403 53.00       53.00         54.01       Islet isolation add-on payment       60       0       54.01       0       55.00         55.00       Nursing and Allied Heal th Managed Care payment       60       0       55.00       0       55.00       0       55.00       0       55.00       0       55.00       0       0       55.00       0       55.00       0       55.00       0       0       55.00       0       0       54.01       0       54.01       0       54.01       0       55.00       0       0       55.00       0       0       56.00				0.00		
48.00       Hospital specific payments (to be completed by SCH and MDH, small rural hospitals       0       48.00         49.00       Total payment for inpatient operating costs (see instructions)       1.00         50.00       Payment for inpatient program capital (from Wkst L, Pt. II, se applicable)       1, 345, 973 50.00         51.00       Direct graduate medical education payment (from Wkst L, Pt. III, see instructions)       0       51.00         52.00       Direct graduate medical education payment (from Wkst L, Pt. III, see instructions)       0       51.00         53.00       Nursing and Allied Healt Managed Care payment       37, 403 53.00       53.00         54.01       Special add-on payments for new technologies       37, 403 55.00       54.01         55.00       Routine service other pass through costs (from Wkst. D, Pt. IV, col. 11 line 200)       57, 00       57, 00         56.00       Primary payer payments       66.00       77, 77, 138 59.00       17, 77, 138 59.00         60.00       Primary payer payments       1.04 for program beneficiaries       1.3, 59, 63.00       17, 77, 71, 73, 70, 73, 70, 70       17, 77, 73, 70, 73, 70, 70       17, 77, 73, 73, 70, 70       17, 77, 73, 70, 73, 70, 70, 70, 70, 70, 70, 70, 70, 70, 70				16 384 588		
only_(see instructions)         Amount           49.00         Total payment for inpatient operating costs (see instructions)         1.00           49.00         Total payment for inpatient program capital (from Wkst. L, Pt. II, as applicable)         16,384,588           51.00         Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)         0           52.00         Direct graduate medical education payment (from Wkst. E.4, line 49 see instructions).         0           53.00         Nursing and Allied Health Managed Care payment         37,403           54.00         Special add-on payments for new technologies         37,403           55.00         Routine service other pass through costs (from Wkst. D, Pt. III, col. 1, line 69)         56.00           56.00         Cost of physicice other pass through costs (from Wkst. D, Pt. III, col. 11 line 200)         29,174           59.00         Total (sum of amounts on lines 49 through 58)         17,797,138         59.00           61.00         Deductibles billed to program beneficiaries (line 59 minus line 60)         1,792,604         16,325,908           62.00         Oinsurance billed to program beneficiaries (line 59 minus line 60)         17,792,604         16,325,908           63.00         Coinsurance billed to program beneficiaries (see instructions)         14,336         65.00           64.00         <			small rural hospitals	0		
1.0049.00Total payment for inpatient operating costs (see instructions)1.0050.00Payment for inpatient program capital (from Wkst. L, Pt. II, and Pt. II, as applicable)16, 38, 458450.00Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)01.6, 38, 458450.00Nursing and Allied Heal th Wanaged Care payment60, 00051, 0051.00Nursing and Allied Heal th Wanaged Care payment37, 40353, 0052.00Nursing and Allied Heal th Wanaged Care payment054, 0054.01Istet isolation add-on payments for new technologies37, 40353, 0055.00Routine service other pass through costs form Wkst. D, Pt. III, column 9, lines 30 through 35).055, 0056.00Cost of physicians' services in a teaching hospital (see intructions)057, 0057.00Routiler service other pass through costs form Wkst. D, Pt. IV, column 9, lines 30 through 35).057, 0058.00Ancillary service other pass through 58)017, 797, 13859, 0050.00Total anount payable for program beneficiaries (line 59 minus line 60)1, 584, 536, 62, 0011, 584, 536, 62, 0061.00Allowable bad debts (see instructions)217, 491, 464, 00141, 386, 508, 62, 0062.00Allowable bad debts (see instructions)217, 491, 464, 0063.00Coinsurance billed to program beneficiaries (see instructions)070, 5064.00Allowable bad debts (SEE INSTRUCTIONS) (SPECIFY)141, 369, 353, 668, 7000 <tr< td=""><td></td><td></td><td>•</td><td></td><td></td><td></td></tr<>			•			
49.00Total payment for inpatient porgram capital (see instructions)16.384.58849.0050.00Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, see instructions)1.345,97350.0051.00Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)1.345,97350.0052.00Direct graduate medical education payment (from Wkst. E, 4, line 49 see instructions).052.0053.00Nursing and Allied Health Managed Care payment054.0054.01Islet isolation add-on payment054.0150.00Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)055.0050.00Ancillary service other pass through costs (from Wkst. D, Pt. III, col. 11 line 200)55.0056.0057.00Routine service other pass through costs (from Wkst. D, Pt. IV, col. 11 line 200)29,17458.0061.00Total (sum of amounts on lines 49 through 58)1.584,58640.0061.00Total (sum of amounts on lines 49 through 58)1.584,58662.0062.00Deductibles billed to program beneficiaries1.584,58662.0063.00Aljusted reimbursable bad debts (see instructions)217,49164.0064.00Aljusted reimbursable bad debts (see instructions)217,49164.0065.00Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)070.0070.50Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)070.8870.90HSP bon						
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70. 93HVBP payment adjustment amount (see instructions)-21, 44170. 9370. 94HRR adjustment amount (see instructions)-74970. 94						
					-21, 441	
70. 95  Recovery of accelerated depreciation    0    70. 95						
	70.95	Recovery of accelerated depreciation			0	70.95

ALCULATION OF REIMBURSEMENT SETTLEMENT	HOSPITAL Provider C	CN: 15-0059	Peri od:	ı of Form CMS-2 Worksheet E	
		. 10 0007	From 01/01/2019 To 12/31/2019	Part A Date/Time Pre	nare
			10 12/31/2019	6/8/2020 1:18	
	Title	e XVIII	Hospi tal	PPS	-
		FF۱	′ (уууу)	Amount	
			0	1.00	
D.96 Low volume adjustment for federal fiscal year (yyyy) (Enter			0	0	70.
the corresponding federal year for the period prior to 10/					
D.97 Low volume adjustment for federal fiscal year (yyyy) (Enter			0	0	70.
the corresponding federal year for the period ending on or	after 10/1)			-	
0.98 Low Volume Payment-3				0	
0.99 HAC adjustment amount (see instructions)	(0, 0, 70)			44, 715	
.00 Amount due provider (line 67 minus lines 68 plus/minus line	es 69 & 70)			16, 259, 003	
. 01 Sequestration adjustment (see instructions)				325, 180	
. 02 Demonstration payment adjustment amount after sequestration	n			0	
. 00 Interim payments				15, 816, 576	
8.00 Tentative settlement (for contractor use only)				0	73.
.00 Balance due provider/program (line 71 minus lines 71.01, 7	1.02, 72, and			117, 247	74
73)				407 700	
.00 Protested amounts (nonallowable cost report items) in accor	ruance with			187, 793	75
CMS Pub. 15-2, chapter 1, §115.2					-
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)		1	1	0	90
	um of 2.03			0	90
plus 2.04 (see instructions) .00 Capital outlier from Wkst. L, Pt. I, line 2				0	91
00 Capital outlier from Wkst. L, Pt. I, line 2 00 Operating outlier reconciliation adjustment amount (see ins	structions)			0	
.00 Capital outlier reconciliation adjustment amount (see inst				0	
00 The rate used to calculate the time value of money (see inst				0.00	
.00 Time value of money for operating expenses (see instruction				0.00	
.00 Time value of money for capital related expenses (see instruction				0	
the value of money for capital related expenses (see fist	i uc ti olis)		Drior to 10/1	0n/After 10/1	70
HSP Bonus Payment Amount			1.00	2.00	
HSP Bonus Payment Amount 0.00 HSP bonus amount (see instructions)				2.00	100
			1.00	2.00	100
0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment			1.00	2.00	
0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions)	i ons)		1.00	2.00 0 0.000000000	101
D. 00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions)	i ons)		0.000000000	2.00 0 0.000000000	101
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<ul> <li>0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>1.00 HVBP adjustment factor (see instructions)</li> <li>2.00 HVBP adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment for HSP bonus payment (see instructions)</li> <li>4.00 HRR adjustment for HSP bonus payment (see instructions)</li> <li>6.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, I</li> <li>2.00 Medicare discharges (see instructions)</li> <li>3.00 Case-mix adjustment factor (see instructions)</li> <li>3.00 Case-mix adjustment factor (see instructions)</li> <li>4.00 Medicare of Demonstration Target Amount Limitation (N/A period)</li> </ul>	ons) nstration) Adju period under line 49)	the 21st	1.00 0.000000000 0 0.0000 0	2.00 0 0.000000000 0 0.0000 0 tration	101 102 103 104 200 201 202 203
<ul> <li>0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>1.00 HVBP adjustment factor (see instructions)</li> <li>2.00 HVBP adjustment for HSP Bonus Payment (see instructi HRR Adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demon Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, I</li> <li>2.00 Medicare discharges (see instructions)</li> <li>3.00 Case-mix adjustment factor (see instructions)</li> <li>4.00 Medicare target amount</li> </ul>	ons) nstration) Adju period under line 49)	the 21st	1.00 0.000000000 0 0.0000 0	2.00 0.000000000 0.0000 0.0000 0 trati on	101 102 103 104 200 201 202 203
<ul> <li>0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>1.00 HVBP adjustment factor (see instructions)</li> <li>2.00 HVBP adjustment for HSP Bonus Payment (see instructi HRR Adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demor</li> <li>0.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, I</li> <li>2.00 Medicare discharges (see instructions)</li> <li>3.00 Case-mix adjustment factor (see instructions)</li> <li>4.00 Medicare target amount</li> <li>5.00 Case-mix adjusted target amount (line 203 times line 204)</li> </ul>	ons) nstration) Adju period under line 49) in first year	the 21st	1.00 0.000000000 0 0.0000 0	2.00 0.000000000 0.0000 0.0000 0 trati on	101 102 103 104 200 201 202 203 204 204 205
<ul> <li>0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>1.00 HVBP adjustment factor (see instructions)</li> <li>2.00 HVBP adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demor</li> <li>0.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no.</li> <li>Cost Reimbursement</li> <li>1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, I</li> <li>2.00 Medicare discharges (see instructions)</li> <li>3.00 Case-mix adjustment factor (see instructions)</li> <li>Computation of Demonstration Target Amount Limitation (N/A period)</li> <li>4.00 Medicare target amount</li> <li>5.00 Case-mix adjusted target amount (line 203 times line 204)</li> <li>5.00 Medicare inpatient routine cost cap (line 202 times line 204)</li> </ul>	ons) nstration) Adju period under line 49) in first year	the 21st	1.00 0.000000000 0 0.0000 0	2.00 0.000000000 0.0000 0.0000 0 trati on	101 102
<ul> <li>0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>1.00 HVBP adjustment factor (see instructions)</li> <li>2.00 HVBP adjustment for HSP Bonus Payment (see instructi HRR Adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demor</li> <li>0.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no.</li> <li>Cost Reimbursement</li> <li>1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, I</li> <li>2.00 Medicare discharges (see instructions)</li> <li>3.00 Case-mix adjustment factor (see instructions)</li> <li>3.00 Case-mix adjustment factor (see instructions)</li> <li>3.00 Case-mix adjustment factor (see instructions)</li> <li>4.00 Medicare target amount</li> <li>5.00 Case-mix adjusted target amount (line 203 times line 204)</li> <li>6.00 Medicare inpatient routine cost cap (line 202 times line 204)</li> <li>6.00 Medicare To Medicare Part A Inpatient Reimbursement</li> </ul>	ons) nstration) Adj period under line 49) in first year 05)	the 21st	1.00 0.000000000 0 0.0000 0	2.00 0.000000000 0 0.0000 0 0	101 102 103 104 200 201 202 203 204 205 206
<ul> <li>0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>1.00 HVBP adjustment factor (see instructions)</li> <li>2.00 HVBP adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demon Contury Cures Act? Enter "Y" for yes or "N" for no.</li> <li>Cost Reimbursement</li> <li>1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, I Computation of Demonstration Target Amount Limitation (N/A period)</li> <li>4.00 Medicare target amount</li> <li>5.00 Case-mix adjusted target amount (line 203 times line 204)</li> <li>5.00 Medicare inpatient routine cost cap (line 202 times line 204)</li> <li>6.00 Medicare to Medicare Part A Inpatient Reimbursement</li> <li>7.00 Program reimbursement under the §410A Demonstration (see in fraction (see information (se</li></ul>	ons) nstration) Adju period under line 49) in first year 05)	the 21st	1.00 0.000000000 0 0.0000 0	2.00 0.000000000 0 0.0000 0 0	101 102 103 104 200 201 202 203 204 205 206 206
<ul> <li>0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>1.00 HVBP adjustment factor (see instructions)</li> <li>2.00 HVBP adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demon Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, I 00 Medicare discharges (see instructions)</li> <li>3.00 Case-mix adjustment factor (see instructions)</li> <li>3.00 Case-mix adjustment factor (see instructions)</li> <li>3.00 Case-mix adjusted target amount (line 203 times line 204)</li> <li>6.00 Medicare inpatient routine cost cap (line 202 times line 204)</li> <li>6.00 Medicare Part A Inpatient Reimbursement</li> <li>7.00 Program reimbursement under the §410A Demonstration (see in 3.00 Medicare Part A inpatient service costs (from Wkst. E, Pt.</li> </ul>	ons) nstration) Adju period under line 49) in first year 05)	the 21st	1.00 0.000000000 0 0.0000 0	2.00 0 0.000000000 0 0.0000 0 tration	101 102 103 200 201 202 203 204 205 206 207 208
<ul> <li>0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>1.00 HVBP adjustment factor (see instructions)</li> <li>2.00 HVBP adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment factor (see instructions)</li> <li>6.00 HRR adjustment factor (see instructions)</li> <li>7.00 HRR adjustment factor (see instructions)</li> <li>7.00 HRR adjustment factor (see instruction Project (§410A Demor</li> <li>7.00 Nedicare inpatient service costs (from Wkst. D-1, Pt. II, I</li> <li>7.00 Medicare target amount factor (see instructions)</li> <li>7.00 Medicare target amount</li> <li>7.00 Program reimbursement under the §410A Demonstration (see in Program reimbursement under the \$410A Demonstratio</li></ul>	ons) nstration) Adju period under line 49) in first year 05)	the 21st	1.00 0.000000000 0 0.0000 0	2.00 0 0.000000000 0 0.0000 0 trati on	101 102 103 104 200 201 202 203 204 205 206 207 208 207 208 209
<ul> <li>0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>1.00 HVBP adjustment factor (see instructions)</li> <li>2.00 HVBP adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment for HSP bonus payment (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demon Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, I Computation of Demonstration Target Amount Limitation (N/A period)</li> <li>4.00 Medicare target amount</li> <li>5.00 Case-mix adjusted target amount (line 203 times line 204)</li> <li>5.00 Medicare inpatient routine cost cap (line 202 times line 204)</li> <li>5.00 Medicare Part A Inpatient service costs (from Wkst. E, Pt.</li> <li>7.00 Program reimbursement under the §410A Demonstration (see in a factor Part A Inpatient Reimbursement</li> <li>7.00 Medicare Part A inpatient service costs (from Wkst. E, Pt.</li> <li>9.00 Adjustment to Medicare IPPS payments (see instructions)</li> <li>9.00 Reserved for future use</li> </ul>	ons) nstration) Adj period under line 49) in first year 05) nstructions) A, line 59)	the 21st	1.00 0.000000000 0 0.0000 0	2.00 0.000000000 0.0000 0.0000 0 trati on	101 102 103 104 200 201 202 203 204 205 206 207 208 207 208 207 208 207
<ul> <li>0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>1.00 HVBP adjustment factor (see instructions)</li> <li>2.00 HVBP adjustment for HSP Bonus Payment (see instructi HRR Adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demor</li> <li>0.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, I</li> <li>2.00 Medicare discharges (see instructions)</li> <li>3.00 Case-mix adjustment factor (see instructions)</li> <li>3.00 Case-mix adjustment factor (see instructions)</li> <li>4.00 Medicare target amount</li> <li>5.00 Case-mix adjusted target amount (line 203 times line 204)</li> <li>6.00 Medicare inpatient routine cost cap (line 202 times line 204)</li> <li>6.00 Medicare Part A Inpatient Reimbursement</li> <li>7.00 Program reimbursement under the §410A Demonstration (see in 8.00 Medicare Part A Inpatient service costs (from Wkst. E, Pt. 9.0 Adjustment to Medicare IPPS payments (see instructions)</li> <li>0.00 Reserved for future use</li> <li>1.00 Total adjustment to Medicare IPPS payments (see instruction)</li> </ul>	ons) nstration) Adj period under line 49) in first year 05) nstructions) A, line 59)	the 21st	1.00 0.000000000 0 0.0000 0	2.00 0.000000000 0.0000 0.0000 0 trati on	101 102 103 104 200 201 202 203 204 205 206 207 208 209 210
<ul> <li>0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>1.00 HVBP adjustment factor (see instructions)</li> <li>2.00 HVBP adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demor</li> <li>0.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no.</li> <li>Cost Reimbursement</li> <li>1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, I Medicare discharges (see instructions)</li> <li>3.00 Case-mix adjustment factor (see instructions)</li> <li>3.00 Case-mix adjustment factor (see instructions)</li> <li>4.00 Medicare target amount</li> <li>5.00 Case-mix adjustment factor (see instructions)</li> <li>6.00 Medicare target amount</li> <li>6.00 Medicare target amount</li> <li>6.00 Medicare target amount</li> <li>6.00 Program reimbursement under the §410A Demonstration (see in R. 00 Medicare Part A Inpatient Reimbursement</li> <li>7.00 Program reimbursement under the §410A Demonstration (see in R. 00 Medicare Part A inpatient service costs (from Wkst. E, Pt. 200 Medicare Part A inpatient service costs (from Wkst. E, Pt. 200 Medicare Part A inpatient service costs (from Wkst. E, Pt. 200 Medicare Part A inpatient service costs (see instructions)</li> <li>0.00 Reserved for future use</li> <li>0.00 Total adjustment to Medicare IPPS payments (see instruction comparision of PPS versus Cost Reimbursement</li> </ul>	ons) nstration) Adj period under line 49) in first year 05) nstructions) A, line 59)	the 21st	1.00 0.000000000 0 0.0000 0	2.00 0.0000000000 0.0000 0.0000 0 trati on	101 102 103 200 201 202 203 204 205 206 207 208 209 210 211
<ul> <li>0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>1.00 HVBP adjustment factor (see instructions)</li> <li>2.00 HVBP adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demor</li> <li>0.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no.</li> <li>Cost Reimbursement</li> <li>1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, I Medicare discharges (see instructions)</li> <li>3.00 Case-mix adjustment factor (see instructions)</li> <li>3.00 Case-mix adjustment factor (see instructions)</li> <li>Computation of Demonstration Target Amount Limitation (N/A period)</li> <li>4.00 Medicare target amount</li> <li>5.00 Case-mix adjusted target amount (line 203 times line 204)</li> <li>6.00 Medicare part A Inpatient Reimbursement</li> <li>7.00 Program reimbursement under the §410A Demonstration (see ir 8.00 Medicare Part A inpatient service costs (from Wkst. E, Pt.</li> <li>9.00 Adjustment to Medicare IPPS payments (see instructions)</li> <li>0.00 Reserved for future use</li> <li>1.00 Total adjustment to Medicare Part A IPPS payments (from line</li> </ul>	ons) nstration) Adj period under line 49) in first year 05) nstructions) A, line 59)	the 21st	1.00 0.000000000 0 0.0000 0	2.00 0 0.000000000 0 0.0000 0 tration	101 102 103 104 201 202 203 204 205 206 207 208 209 210 211 212
<ul> <li>0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>1.00 HVBP adjustment factor (see instructions)</li> <li>2.00 HVBP adjustment for HSP Bonus Payment (see instructi HRR Adjustment for HSP Bonus Payment (see instructi HRR adjustment factor (see instructions)</li> <li>3.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demor Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, I Medicare discharges (see instructions)</li> <li>3.00 Case-mix adjustment factor (see instructions)</li> <li>Computation of Demonstration Target Amount Limitation (N/A period)</li> <li>4.00 Medicare target amount</li> <li>5.00 Case-mix adjusted target amount (line 203 times line 204)</li> <li>6.00 Medicare inpatient routine cost cap (line 202 times line 204)</li> <li>6.00 Program reimbursement under the §410A Demonstration (see in 8.00 Reserved for future use</li> <li>1.00 Reserved for future use</li> <li>1.00 Total adjustment to Medicare IPPS payments (see instructions)</li> </ul>	ons) nstration) Adj period under line 49) in first year 05) nstructions) A, line 59) ns) ne 211)	of the curr	1.00 0.000000000 0 0.0000 0	2.00 0.000000000 0.0000 0 0.0000 0	101 102 103 104 200 201 202 203 204 205 206 206

ow vc	DLUME CALCULATION EXHIBIT 4			Provider C		Period: From 01/01/2019 To 12/31/2019		pared
		W/S E, Part A line	Amounts (from E, Part A)	Title Pre/Post Entitlement	e XVIII Period Prior to 10/01	Hospi tal Peri od On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
00	DRG amounts other than outlier	1.00	0	0		0 0	0	1.0
01	payments DRG amounts other than outlier payments for discharges	1.01	10, 972, 171	0	10, 972, 17	1	10, 972, 171	1. C
02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1.02	3, 746, 911	0		14, 719, 082	14, 719, 082	1.0
03	1 DRG for Federal specific operating payment for Model 4 BPCL occurring prior to	1.03	O	0		0	0	1.0
04	October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after	1.04	0	0		Ο	0	1.(
00	October 1 Outlier payments for discharges (see instructions)	2.00						2.0
01	Outlier payments for	2.02	0	0		0 0	0	2.0
02	discharges for Model 4 BPCI Outlier payments for discharges occurring prior to	2.03	325, 374	0		0	0	2.0
03	October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see	2.04	48, 043	0		373, 418	373, 418	2.0
00	instructions) Operating outlier reconciliation	2.01	0	0		o o	0	3.
00	Managed care simulated payments	3.00	0	0		0 0	0	4.
00	Indirect Medical Education Adju Amount from Worksheet E, Part	21.00	0. 000000	0.00000	0.00000	0 0.00000		5.
00	A, line 21 (see instructions) IME payment adjustment (see	22.00	0	0		o 0	0	6.
01	instructions) IME payment adjustment for managed care (see	22.01	0	0		0 0	0	6.
	instructions)	interest for the	a Add on far Sa	ation 100 of	+ba MMA			
00	Indirect Medical Education Adju IME payment adjustment factor (see instructions)	27.00	0. 000000			0 0. 000000		7.
00	IME adjustment (see instructions)	28.00	0	0		0 0	0	8.
01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0		0 0	0	8.
00	Total IME payment (sum of lines 6 and 8)	29.00	0	0		0 0	0	
01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0		0 0	0	9.
. 00	Disproportionate Share Adjustme Allowable disproportionate share percentage (see	ant 33.00	0. 0390	0. 0390	0. 039	0 0. 0390		10.
00	instructions) Disproportionate share adjustment (see instructions)	34.00	143, 512	0	106, 97	9 36, 533	143, 512	11.
. 01	Uncompensated care payments	36.00	1, 148, 577	0	819, 93	6 328, 641	1, 148, 577	11.
. 00	Additional payment for high per Total ESRD additional payment	<u>centage of ES</u> 46.00	RD beneficiary	di scharges 0		0 0	0	12.
00	(see instructions) Subtotal (see instructions) Hospital specific payments	47.00 48.00	16, 384, 588	0				13.
	(completed by SCH and MDH, small rural hospitals only.) (see instructions)							
00	Total payment for inpatient operating costs (see instructions)	49.00	16, 384, 588	0	11, 899, 08	6 4, 485, 502	16, 384, 588	15.

LOW VO	LUME CALCULATION EXHIBIT 4			Provider C	CN: 15-0059	Period: From 01/01/2019 To 12/31/2019		pared:
				Title	XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prion to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1, 345, 973	0		0 1, 345, 973	1, 345, 973	16.00
17.00 17.01	Special add-on payments for new technologies Net organ aguisition cost	54.00	0	0		0 0	0	17.00
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	O	0		0 0	0	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0		0 0	0	18.00
19.00	SUBTOTAL			0	11, 899, 08	5, 831, 475	17, 730, 561	19.00
		W/S L, line	(Amounts from L)	0.00	2.00	4.00	5.00	
20.00	Constant DDC athen then outling	0	1.00	2.00	3.00	4.00	5.00	20.00
20. 00 20. 01	Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier		1, 191, 569 0	0		0 1, 191, 569 0 0		
21. 00 21. 01	Capital DRG outlier payments Model 4 BPCI Capital DRG	2. 00 2. 01	112, 342 0	0 0		0 112, 342 0 0	112, 342 0	
22.00	outlier payments Indirect medical education percentage (see instructions)	5.00	0. 0000	0.0000	0.000	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. 0353	0. 0353	0. 035	0. 0353		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	42, 062	0		0 42, 062		
26.00	Total prospective capital payments (see instructions)	12.00	1, 345, 973	0		0 1, 345, 973	1, 345, 973	26.00
		W/S E, Part A						
		line 0	<u>E, Part A)</u> 1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor		1.00	2.00	0. 00000			27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96				0	0	
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

SPI 1	IFINANCIAL SYSTEMS TAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT S			Period: From 01/01/2019 To 12/31/2019		pared
			Title		Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
00	DRG amounts other than outlier payments	1.00					1.0
01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	10, 972, 171	10, 972, 17	1	10, 972, 171	1. (
02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3, 746, 911		3, 746, 911	3, 746, 911	1.
03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1.03	0		0	0	1.
04	DRG for Federal specific operating payment for Model 4 BPCL occurring on or after October 1	1.04	0		0	0	1.
00	Outlier payments for discharges (see instructions)	2.00					2.
01	Outlier payments for discharges for Model 4 BPCI	2. 02	0		0 0	0	2.
02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	325, 374	325, 37	74	325, 374	2.
03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	48, 043		48, 043	48, 043	2.
00	Operating outlier reconciliation	2.01	0		0 0		3.
00	Managed care simulated payments	3.00	0		0 0	0	4.
00	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, Line 21	21.00	0. 000000	0.00000	0.00000		5.
)0 )1	(see instructions) IME payment adjustment (see instructions) IME payment adjustment for managed care (see	22. 00 22. 01	0		0 0	0	6. 6.
	instructions) Indirect Medical Education Adjustment for the		Ĵ		0		0.
00	IME payment adjustment factor (see	27.00	0. 000000	0. 00000	0. 000000		7.
.0	i nstructi ons)	27.00	0.000000	0.00000	0.000000		'.
00	IME adjustment (see instructions)	28.00	0		0 0	0	8.
)1	IME payment adjustment add on for managed care (see instructions)	28.01	0		0 0	0	8.
00	Total IME payment (sum of lines 6 and 8)	29.00	0		0 0	0	9.
)1	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0		0 0	0	9.
	Disproportionate Share Adjustment						]
00	Allowable disproportionate share percentage (see instructions)	33.00	0. 0390	0. 039	0. 0390		10.
00	Disproportionate share adjustment (see instructions)	34.00	143, 512	106, 97			
01	Uncompensated care payments Additional payment for high percentage of ESI	36.00 RD beneficiarv	1, 148, 577 di scharges	819, 93	328, 641	1, 148, 577	11.
00	Total ESRD additional payment (see instructions)	46.00	0		0 0	0	12.
00	Subtotal (see instructions)	47.00	16, 384, 588	12, 224, 46	4, 160, 128	16, 384, 588	13.
00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0		0 0	0	14.
00	Total payment for inpatient operating costs (see instructions)	49.00	16, 384, 588	12, 224, 46	4, 160, 128	16, 384, 588	15.
00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1, 345, 973	1, 015, 76	330, 204	1, 345, 973	16.
00 01	Special add-on payments for new technologies Net organ acquisition cost	54.00	0		0 0	0	17. 17.
02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0		0 0	0	
00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0		0 0		
~~	SUBTOTAL		1	13, 240, 22	4, 490, 332	17, 730, 561	1 10

HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ATION EXHIBIT 5	Provider C		Period: From 01/01/2019 To 12/31/2019		pared:
			Title	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, 191, 569	892, 73	298, 837	1, 191, 569	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	112, 342	91, 52	20, 818	112, 342	21.00
	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	0.000	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. 0353	0. 035	0. 0353		24.00
25.00	Di sproporti onate share adjustment (see i nstructi ons)	11.00	42, 062	31, 51	3 10, 549	42, 062	25.00
26. 00	Total prospective capital payments (see instructions)	12.00	1, 345, 973	1, 015, 76	330, 204	1, 345, 973	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00 28.00 29.00	Low volume adjustment prior to October 1 Low volume adjustment on or after October 1	70. 96 70. 97	0		0	0	
30.00	HVBP payment adjustment (see instructions)	70, 93	-21, 441	-3, 32	-18, 112	-	1
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0 0	0	
31.00	HRR adjustment (see instructions)	70. 94	-749		0 -749	-749	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 44, 715	44, 715	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

Heal th	Financial Systems RIVERVIEW HO	SPI TAL	In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059	Period: From 01/01/2019 To 12/31/2019	Date/Time Pre	
		Title XVIII	Hospi tal	6/8/2020 1:18 PPS	pm
			illoopi tui		
				1.00	
1.00 2.00 3.00 4.00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instructions) OPPS payments Outline payments (see instructions)	ctions)		10, 857 20, 767, 651 17, 366, 613 91, 355	1.00 2.00 3.00 4.00
4.00 4.01 5.00	Outlier payment (see instructions) Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instru	uctions)		0.000	4.00 4.01 5.00
6.00 7.00	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6			0 0.00	
8.00 9.00 10.00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. Organ acquisitions	0 100, 038 0	8.00 9.00 10.00		
	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			10, 857	
10.00	Reasonabl e charges			0/ 071	
	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I Total reasonable charges (sum of lines 12 and 13)	0	12.00 13.00 14.00		
	Customary charges Aggregate amount actually collected from patients liable for Amounts that would have been realized from patients liable for had such payment been made in accordance with 42 CFR §413.13	or payment for services		0	15. 00 16. 00
	Ratio of line 15 to line 16 (not to exceed 1.00000) Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete or		ing 11) (500	0. 000000 26, 871	18.00
20.00	instructions) Excess of reasonable cost over customary charges (complete or	5	, .	16, 014	20.00
	instructions) Lesser of cost or charges (see instructions)	5		10, 857	
23.00	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see inst Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	tructions)		0 0 17, 558, 006	22.00 23.00 24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	<u>`</u>			
26.00	Deductibles and coinsurance amounts (for CAH, see instruction Deductibles and Coinsurance amounts relating to amount on lin Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	ne 24 (for CAH, see inst		18 3, 232, 941 14, 335, 904	
	instructions) Direct graduate medical education payments (from Wkst. E-4, I ESRD direct medical education costs (from Wkst. E-4, line 36)			0	28.00 29.00
30.00	Subtotal (sum of lines 27 through 29)	)		14, 335, 904	30.00
	Primary payer payments Subtotal (line 30 minus line 31)			2, 167 14, 333, 737	31.00 32.00
33.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI Composite rate ESRD (from Wkst. 1-5, line 11)	CES)		0	33.00
	Allowable bad debts (see instructions)			355, 132	34.00
35.00 36.00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		230, 836 355, 132	35.00 36.00
	Subtotal (see instructions)			14, 564, 573	
	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			32	38.00 39.00
	Pioneer ACO demonstration payment adjustment (see instruction	ns)		Ū	39.50
	Demonstration payment adjustment amount before sequestration			0	39.97
	Partial or full credits received from manufacturers for repla RECOVERY OF ACCELERATED DEPRECIATION	aced devices (see instru	ctions)	0	39.98 39.99
	Subtotal (see instructions)			14, 564, 541	40.00
	Sequestration adjustment (see instructions)			291, 291	40.01
40.02 41.00	Demonstration payment adjustment amount after sequestration Interim payments			0 14, 067, 926	40.02 41.00
42.00	Tentative settlement (for contractors use only)			0	42.00
	Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accorda §115.2	ance with CMS Pub. 15-2,	chapter 1,	205, 324 0	43.00 44.00
00.00	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money			0.00	92.00
	Time Value of Money (see instructions)			0	
<del>7</del> 4. UU	Total (sum of lines 91 and 93)			0	94.00

	Financial Systems	RI VERVI EW HOSPI TAL		u of Form CMS-2	2552-10		
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Pre	pared:		
		Title XVIII	Subprovider -	6/8/2020 1:18 PPS	pm		
			I RF				
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00			
1.00	Medical and other services (see instructions)			836	1.00		
2.00 3.00	Medical and other services reimbursed under OPPS OPPS payments	5 (see instructions)		262 385	2.00 3.00		
3.00 4.00	Outlier payment (see instructions)			0	4.00		
4.01	Outlier reconciliation amount (see instructions)			0	4.01		
5.00 6.00	Enter the hospital specific payment to cost rati Line 2 times line 5	o (see instructions)		0. 000 0	5.00 6.00		
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00			
8.00 9.00	Transitional corridor payment (see instructions)			0	8.00 9.00		
9.00 10.00	Ancillary service other pass through costs from Organ acquisitions	WKST. D, PT. TV, COL. TS, TTHE 200		0	9.00 10.00		
11.00	Total cost (sum of lines 1 and 10) (see instruct	ions)		836	11.00		
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges						
12.00	Ancillary service charges			2, 071	12.00		
13.00 14.00	Organ acquisition charges (from Wkst. D-4, Pt. I Total reasonable charges (sum of lines 12 and 13			0	13.00 14.00		
14.00	Customary charges	I	2,071	14.00			
15.00	Aggregate amount actually collected from patient		0				
16.00	Amounts that would have been realized from patie had such payment been made in accordance with 42	1 3	n a chargebasi s	0	16.00		
17.00	Ratio of line 15 to line 16 (not to exceed 1.000		0.000000	17.00			
18.00 19.00	Total customary charges (see instructions) Excess of customary charges over reasonable cost	2, 071 1, 235	18.00 19.00				
19.00	instructions)	1,230	19.00				
20.00	, , , , , , , , , , , , , , , , , , ,						
21.00	instructions) Lesser of cost or charges (see instructions)			836	21.00		
22.00	Interns and residents (see instructions)			0	22.00		
23.00 24.00	Cost of physicians' services in a teaching hospi Total prospective payment (sum of lines 3, 4, 4.		0 385	23.00 24.00			
25 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, se	a instructions)		0	25.00		
26.00	Deductibles and Coinsurance amounts (for call, se		uctions)	0	26.00		
27.00	Subtotal [(lines 21 and 24 minus the sum of line	es 25 and 26) plus the sum of lines 22	and 23] (see	1, 221	27.00		
28.00	instructions) Direct graduate medical education payments (from	n Wkst. E-4, line 50)		0	28.00		
	ESRD direct medical education costs (from Wkst.	E-4, line 36)		0	29.00		
30.00 31.00	Subtotal (sum of lines 27 through 29) Primary payer payments			1, 221 0	30.00 31.00		
32.00	Subtotal (line 30 minus line 31)			1, 221			
22.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFE	SSIONAL SERVICES)	I	0	22.00		
33.00 34.00	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			0 0	33.00 34.00		
35.00	Adjusted reimbursable bad debts (see instruction			0	35.00		
36.00 37.00	Allowable bad debts for dual eligible beneficiar Subtotal (see instructions)	les (see instructions)		0 1, 221	36.00 37.00		
38.00	MSP-LCC reconciliation amount from PS&R			0	38.00		
39.00 39.50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	o instructions)		0	39.00 39.50		
39. 50 39. 97	Pioneer ACO demonstration payment adjustment (se Demonstration payment adjustment amount before s			0			
39.98	Partial or full credits received from manufactur	ers for replaced devices (see instruc	tions)	0	39.98		
39.99 40.00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 1, 221	39.99 40.00		
40.01	Sequestration adjustment (see instructions)			24	40.01		
40. 02 41. 00	Demonstration payment adjustment amount after se Interim payments	equestration		0 783	40. 02 41. 00		
41.00	Tentative settlement (for contractors use only)			/83 0	41.00		
43.00	Balance due provider/program (see instructions)	b) in apportance with ONC Put 15 0	abaptor 1	414			
44.00	Protested amounts (nonallowable cost report item §115.2	is) in accordance with CMS Pub. 15-2, (	chapter I,	0	44.00		
00 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90.00		
	Outlier reconciliation adjustment amount (see i	nstructions)		0			
92.00	The rate used to calculate the Time Value of Mon				92.00		
93.00 94.00	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0 0	93.00 94.00		
			I	0			

	Financial Systems         RIVERVIEW           SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED         RENDERED	Provider CO	CN: 15-0059	Period: From 01/01/2019	Worksheet E-1 Part I	
				To 12/31/2019		pare pm
		Title	XVIII	Hospi tal	PPS	
		Inpati en	t Part A	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		15, 738, 2	29	13, 944, 307	1.
00	Interim payments payable on individual bills, either			0	0	2.
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
00	List separately each retroactive lump sum adjustment					3
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
01	Program to Provider ADJUSTMENTS TO PROVIDER	12/31/2019	78, 3	47 12/31/2019	123, 619	3
)1 )2	ADJUSTMENTS TU PROVIDER	12/31/2019	78, 3	0	123, 019	
)2 )3				0	0	
)4				0	0	
05				0	0	3
	Provider to Program			1		
50	ADJUSTMENTS TO PROGRAM			0	0	
51				0	0	-
52 53				0	0	-
53 54				0	0	3
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines		78, 3	-	123, 619	
	3. 50-3. 98)		7070		120,017	
00	Total interim payments (sum of lines 1, 2, and 3.99)		15, 816, 5	76	14, 067, 926	4
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after					1 5
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider			-		
)1	TENTATI VE TO PROVIDER			0	0	
)2 )3				0	0	
,5	Provider to Program			0	U	
50	TENTATI VE TO PROGRAM			0	0	15
51				0	0	5
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					6
50	the cost report. (1)					0
01	SETTLEMENT TO PROVIDER		117, 2	47	205, 324	6
02	SETTLEMENT TO PROGRAM			0	0	6
00	Total Medicare program liability (see instructions)		15, 933, 8		14, 273, 250	7
				Contractor	NPR Date	
		(	)	Number 1.00	(Mo/Day/Yr) 2.00	
		(	)	1.00	2.00	8

ALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C Component	CN: 15-0059 CCN: 15-T059	Period: From 01/01/201 To 12/31/201		pared
		Title	e XVIII	Subprovider - IRF		
		I npati en	it Part A		art B	
	-	mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
00	Total interim payments paid to provider	1.00	2.00 5,839,0	3.00	4.00	1.0
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		5, 839, 0	0	0	1. 2. 3.
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) Program to Provider					3.
D1	ADJUSTMENTS TO PROVIDER			0	0	3.
02				0	0	3.
03				0	0	3
)4 )5				0	0	3
.0	Provider to Program					
0	ADJUSTMENTS TO PROGRAM			0	0	3
51				0	0	3
52				0	0	3
53 54				0	0	3
99 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) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		5, 839, 0	07	783	4
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5
	Program to Provider					
)1	TENTATI VE TO PROVIDER			0	0	5
)2 )3				0	0	5
13	Provider to Program			0	0	1 5
50	TENTATI VE TO PROGRAM			0	0	5
51				0	0	5
52				0	0	5
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
)1	SETTLEMENT TO PROVIDER		37, 0	57	414	6
)2	SETTLEMENT TO PROGRAM			0	0	6
00	Total Medicare program liability (see instructions)		5, 876, 0		1,197 NPR Date	7
				Contractor Number	(Mo/Day/Yr)	
			0	1.00	2.00	

ALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C	CN: 15-0059 CCN: 15-5669	Period: From 01/01/20 To 12/31/20		
		 	× XVIII	Skilled Nursi	6/8/2020 1:1 ng PPS	8 pm
				Facility	19 113	
		Inpatien	it Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy		
		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, 163, 3	06 0		0 1. 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) Program to Provider					3.
01	ADJUSTMENTS TO PROVIDER			0		0 3.
02				0		0 3.
03 04				0		0 3. 0 3.
04 05				0		0 3
	Provider to Program					
50	ADJUSTMENTS TO PROGRAM			0		0 3
51				0		0 3
52				0		0 3 0 3
53 54				0		0 3 0 3
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) (transfer to Wkst. E or Wkst. E-3, line and column as		1, 163, 3	06		0 4
	appropriate) TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5
	Program to Provider		1	-		_
)1 )2	TENTATI VE TO PROVI DER			0		0 5 0 5
)2 )3				0		0 5
	Provider to Program			-		
50	TENTATI VE TO PROGRAM			0		0 5
51				0		0 5
52 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0		0 5 0 5
00	5.50-5.98) Determined net settlement amount (balance due) based on			Ŭ		6
	the cost report. (1)					
01	SETTLEMENT TO PROVIDER		1, 2	12		0 6
22	SETTLEMENT TO PROGRAM		1 144 -	0		0 6
00	Total Medicare program liability (see instructions)		1, 164, 5	Contractor		0 7
				Number	(Mo/Day/Yr)	
		(	<u>с</u>	1.00	2.00	

Heal th	Financial Systems RIVERVIEW	I HOSPI TAL	In Lie	u of Form CMS-	2552-10		
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0059 Period: WW From 01/01/2019 Di To 12/31/2019 02 6/						
	· · · · · · · · · · · · · · · · · · ·	Title XVIII	Hospi tal	PPS			
				1.00	_		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORT				_		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULA				1.00		
	1.00Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 142.00Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12						
2.00		2.00					
	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2						
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines				4.00		
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 20				5.00		
6.00	Total hospital charity care charges from Wkst. S-10, col.				6.00		
7.00	CAH only - The reasonable cost incurred for the purchase line 168	of certified HIT technology	Wkst. S-2, Pt. I		7.00		
8.00	Calculation of the HIT incentive payment (see instruction	s)			8.00		
9.00	Sequestration adjustment amount (see instructions)				9.00		
10.00	Calculation of the HIT incentive payment after sequestrat	ion (see instructions)			10.00		
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH						
30.00	30.00 Initial/interim HIT payment adjustment (see instructions)						
31.00	Other Adjustment (specify)				31.00		
32.00	32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)						

ealth Financ	ial Systems RIV	ERVIEW HOSPITAL		In Lie	u of Form CMS-2	2 <u>55</u> 2
ALCULATION (	OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15	5-0059	Period:	Worksheet E-3	
		Component CCN: 1	5-T059	From 01/01/2019 To 12/31/2019		pare
			0 1007	10 12/01/2017	6/8/2020 1:18	
		Title XVII	1	Subprovider - IRF	PPS	
					1.00	
PART I	II - MEDICARE PART A SERVICES - IRF PPS				1.00	
.00 Net Fe	deral PPS Payment (see instructions)				5, 771, 799	1
00 Medi ca	re SSI ratio (IRF PPS only) (see instructions)	)			0. 0163	2
	ent Rehabilitation LIP Payments (see instructi	i ons)			127, 557	3
	r Payments				165, 427	
	hted intern and resident FTE count in the most rember 15, 2004 (see instructions)	t recent cost reporting p	eriod en	ding on or prior	0.00	5
	creases for the unweighted intern and resident				0.00	5
1. 0	m or hospital closure, that would not be count		ip adjust	ment under 42		
	12.424(d)(1)(iii)(F)(1) or (2) (see instructi	i ons)				
	aching program adjustment. (see instructions)				0.00	
	it year's unweighted FTE count of I&R excluding	g FIES in the new program	growth p	eriod of a "new	0.00	7
	ng program" (see instructions) It year's unweighted I&R FTE count for resident	to within the new program	arowth n	oried of a "now	0.00	6
	ng program" (see instructions)	ts within the new program	growth p		0.00	
	and resident count for IRF PPS medical education	tion adjustment (see instr	uctions)		0.00	q
	e Daily Census (see instructions)		uo (1 0113)		15. 304110	
	ng Adjustment Factor (see instructions)				0.000000	
	ng Adjustment (see instructions)				0	12
	PPS Payment (see instructions)				6, 064, 783	1:
.00 Nursir	g and Allied Health Managed Care payments (see	e instruction)			0	14
5.00 Organ	acquisition (DO NOT USE THIS LINE)					1
	f physicians' services in a teaching hospital	(see instructions)			0	
	al (see instructions)				6, 064, 783	
	y payer payments				0	
	al (line 17 less line 18).				6,064,783	
0.00 Deduct					39, 532	
. 00 Subtot 2. 00 Coi nsu	al (line 19 minus line 20)				6, 025, 251 34, 100	
	al (line 21 minus line 22)				5, 991, 151	23
	ble bad debts (exclude bad debts for profession	nal sarvicas) (saa instru	ictions)		5, 991, 151	2
	ed reimbursable bad debts (see instructions)				0	25
	ble bad debts for dual eligible beneficiaries	(see instructions)			0	20
	al (sum of lines 23 and 25)	(,			5, 991, 151	2
	graduate medical education payments (from Wks	st. E-4, line 49)			0	28
0.00 Other	pass through costs (see instructions)				4, 833	29
0.00 Outlie	r payments reconciliation				0	30
. 00 OTHER	ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)				0	31
	er ACO demonstration payment adjustment (see in				0	31
	tration payment adjustment amount before seque				0	
	amount payable to the provider (see instruction	ons)			5, 995, 984	
	tration adjustment (see instructions)				119, 920	
	tration payment adjustment amount after seques	stration			E 930 007	
	m payments ive settlement (for contractor use only)				5, 839, 007	
	e due provider/program (line 32 minus lines 32	2 01 32 02 32 and 24)			0 37, 057	34
1	ted amounts (nonallowable cost report items) i		15_2	chanter 1	37,057	36
§115.2			. 13-2,		0	
	COMPLETED BY CONTRACTOR Nal outlier amount from Wkst. E-3, Pt. III, lin				165, 427	50
	er reconciliation adjustment amount (see instru				105, 427	51
	te used to calculate the Time Value of Money				0.00	
	alue of Money (see instructions)					53

	ancial Systems	RI VERVI EW HOSI			u of Form CMS-2	
CALCULATIO	N OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0059	Period: From 01/01/2019	Worksheet E-3 Part VI	
			Component CCN: 15-5669	To 12/31/2019		nare
					6/8/2020 1:18	parec
			Title XVIII	Skilled Nursing	PPS	
				Facility		
				_		
0.407					1.00	
	VI - CALCULATION OF REIMBURSEMENT SETTLEM	IEMENI - ALL OIHE	R HEALTH SERVICES FOR	ITTLE XVIII PART	A PPS SNF	
	SPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)					
	ource Utilization Group Payment (RUGS)				1, 293, 765	1.
	tine service other pass through costs				1, 293, 703	2.
	Hary service other pass through costs				5, 791	3.
						4.
	PUTATION OF NET COST OF COVERED SERVICES				1, 299, 556	
	cal and other services (Do not use this li	ne as vaccine co	osts are included in li	ne 1 of W/S E,		5.
	t B. This line is now shaded.)					
. 00 Ded	uctible				0	6.
	nsurance				106, 718	7.
	owable bad debts (see instructions)				0	8.
	mbursable bad debts for dual eligible benef		nstructions)		0	9.
	usted reimbursable bad debts (see instructi	ons)			0	10.
	ization review				0	11.
	total (sum of lines 4, 5 minus lines 6 and	7, plus lines 10	) and 11)(see instruction	ons)	1, 192, 838	
	atient primary payer payments				0	13.
	JE BASED PURCHASI NG				-4,554	
	neer ACO demonstration payment adjustment (		5)		0	14.
	onstration payment adjustment amount before	e sequestration			0	14.
	total (see instructions				1, 188, 284	
	uestration adjustment (see instructions)	ooguootroti cr			23, 766	
	onstration payment adjustment amount after	sequestration			0	15.
	erim payments				1, 163, 306	
	tative settlement (for contractor use only)		14 and $17$		0	17.
	ance due provider/program (line 15 minus li			0 -b	1, 212	18.
9.00 Pro	tested amounts (nonallowable cost report it 5.2	ems) in accordar	ICE WITH CMS 19 PUD. 15-	-2, cnapter I,	0	19.

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059	Peri od:	Worksheet E-3	3
			From 01/01/2019 To 12/31/2019		epare 8 pm
		Title XIX	Hospi tal	Cost	
			Inpatient	Outpatient	-
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEI	DVICES FOR TITLES V OR		2.00	-
	COMPUTATION OF NET COST OF COVERED SERVICES	RVICES FOR TITLES V OR A	AIA SERVICES		1
00	Inpati ent hospi tal /SNF/NF servi ces		1, 108, 878		1 1
00	Medical and other services		.,,	0	
00	Organ acquisition (certified transplant centers only)		0		3
00	Subtotal (sum of lines 1, 2 and 3)		1, 108, 878	0	4
00	Inpatient primary payer payments		0		5
00	Outpatient primary payer payments			0	6
00	Subtotal (line 4 less sum of lines 5 and 6)		1, 108, 878	0	7
	COMPUTATION OF LESSER OF COST OR CHARGES				-
~~	Reasonable Charges		1 242 127		
00 00	Routine service charges Ancillary service charges		1, 342, 127 1, 180, 727	0	8
00	Organ acquisition charges, net of revenue		1, 180, 727	0	10
1.00	Incentive from target amount computation		0		111
2.00	Total reasonable charges (sum of lines 8 through 11)		2, 522, 854	0	
	CUSTOMARY CHARGES		2,022,001		1 ' -
3.00	Amount actually collected from patients liable for payment fo	r services on a charge	0	0	13
	basi s	C			
1.00	Amounts that would have been realized from patients liable fo		on 0	0	14
	a charge basis had such payment been made in accordance with	42 CFR §413.13(e)			
5.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.00000	
. 00	Total customary charges (see instructions)		2, 522, 854	0	
7.00	Excess of customary charges over reasonable cost (complete on	ly if line 16 exceeds	1, 413, 976	0	17
	line 4) (see instructions)			0	
3.00	Excess of reasonable cost over customary charges (complete on	Ty IF TThe 4 exceeds IT	ne u	0	18
9.00	16) (see instructions) Interns and Residents (see instructions)		0	0	19
D. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)	0	0	
1.00	Cost of covered services (enter the lesser of line 4 or line	-	1, 108, 878	0	
1.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be				1 ~ '
2.00	Other than outlier payments		0	0	22
3.00	Outlier payments		0	0	23
1.00	Program capital payments		0		24
5.00	Capital exception payments (see instructions)		0		25
5.00	Routine and Ancillary service other pass through costs		0	0	26
7.00	Subtotal (sum of lines 22 through 26)		0	0	27
3.00	Customary charges (title V or XIX PPS covered services only)		0	0	
9.00	Titles V or XIX (sum of lines 21 and 27)		1, 108, 878	0	29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Excess of reasonable cost (from line 18)	<b>`</b>	0	0	
1.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	)	1, 108, 878	0	
2.00 3.00	Deducti bl es Coi nsurance		0	0 0	
s. 00 I. 00	Allowable bad debts (see instructions)		0	0	
5.00	Utilization review		0	0	35
5.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	d 33)	1, 108, 878	0	
. 00 . 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	a,	1, 100, 070	0	
3.00	Subtotal (line 36 $\pm$ line 37)		1, 108, 878	0	
9.00	Direct graduate medical education payments (from Wkst. E-4)		., 100, 070	0	39
). 00	Total amount payable to the provider (sum of lines 38 and 39)		1, 108, 878	0	
1.00	Interim payments		1, 060, 186		
2.00	Balance due provider/program (line 40 minus line 41)		48, 692	0	
3.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub 15-2,	0	0	43
	chapter 1, §115.2				1

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059	Period:	Worksheet E-3	
		Component CCN: 15-T059	From 01/01/2019 To 12/31/2019	Part VII Date/Time Pre 6/8/2020 1:18	
		Title XIX	Subprovider - IRF	Cost	
			I npati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SE COMPUTATION OF NET COST OF COVERED SERVICES	RVICES FOR TITLES V OR 2	KIX SERVICES		
00	Inpatient hospital/SNF/NF services		215, 475		1 1
00	Medical and other services		213, 473	0	
00	Organ acquisition (certified transplant centers only)		0	Ũ	
00	Subtotal (sum of lines 1, 2 and 3)		215, 475	0	4
00	Inpatient primary payer payments		0		5
00	Outpatient primary payer payments			0	6
00	Subtotal (line 4 less sum of lines 5 and 6)		215, 475	0	7
	COMPUTATION OF LESSER OF COST OR CHARGES				-
00	Reasonable Charges Routine service charges		523, 111		6
00	Ancillary service charges		408, 257	0	
0.00	Organ acquisition charges, net of revenue		400, 237	0	10
. 00	Incentive from target amount computation		0		11
. 00	Total reasonable charges (sum of lines 8 through 11)		931, 368	0	12
	CUSTOMARY CHARGES				
3.00	Amount actually collected from patients liable for payment for	or services on a charge	0	0	13
	basi s			0	
. 00	Amounts that would have been realized from patients liable for		on 0	0	14
. 00	a charge basis had such payment been made in accordance with Ratio of line 13 to line 14 (not to exceed 1.000000)	42 CFR 9413.13(e)	0, 000000	0.000000	15
b. 00	Total customary charges (see instructions)		931, 368	0.000000	
. 00	Excess of customary charges over reasonable cost (complete or	lvifline 16 exceeds	715, 893	0	17
	line 4) (see instructions)		,	-	
3. 00	Excess of reasonable cost over customary charges (complete or	nly if line 4 exceeds li	ne 0	0	18
	16) (see instructions)				
9.00	Interns and Residents (see instructions)		0	0	
0.00	Cost of physicians' services in a teaching hospital (see inst		0	0	20
1.00	Cost of covered services (enter the lesser of line 4 or line PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be		215, 475	0	21
2.00	Other than outlier payments		0	0	22
3.00	Outlier payments		0	0	
. 00	Program capital payments		0	-	24
5.00	Capital exception payments (see instructions)		0		25
6.00	Routine and Ancillary service other pass through costs		0	0	26
7.00	Subtotal (sum of lines 22 through 26)		0	0	
	Customary charges (title V or XIX PPS covered services only)		0	0	28
. 00	Titles V or XIX (sum of lines 21 and 27)		215, 475	0	29
00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Excess of reasonable cost (from line 18)		0	0	30
). 00 . 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6		215, 475	0	
	Deducti bl es	,,	215, 475	0	
B. 00	Coinsurance		0	0	
. 00	Allowable bad debts (see instructions)		0	0	
. 00	Utilization review		0		35
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 ar	nd 33)	215, 475	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37
. 00	Subtotal (line 36 ± line 37)		215, 475	0	
	Direct graduate medical education payments (from Wkst. E-4)		0	-	39
0.00	Total amount payable to the provider (sum of lines 38 and 39)		215, 475	0	
	Interim payments Balance due provider/program (line 40 minus line 41)		264, 222 -48, 747	0	
2.00 3.00	Protested amounts (nonallowable cost report items) in accorda	ance with CMS Pub 15-2	-48, 747	0	
	chapter 1, §115.2	$100$ with own tub $10^{-2}$ ,	0	0	1 40

ו y) ׂ	ype accounting records, complete the General Fund column			From 01/01/2019 To 12/31/2019	Date/Time Pre	
		General Fund	Specific Purpose Fund	Endowment Fund	6/8/2020 1:18 Plant Fund	; pm
		1.00	2.00	3.00	4.00	
00	CURRENT ASSETS Cash on hand in banks	9, 615, 828		0 0	0	1.0
00	Temporary investments	0		0 0		
00	Notes receivable	0		0 0	0	
00	Accounts receivable	37, 122, 479		0 0	0	
00	Other receivable	373, 565		0 0	0	
00 00	Allowances for uncollectible notes and accounts receivable Inventory	5, 183, 109		0 0	0	
00	Prepai d expenses	0, 103, 107		0 0	l o	
00	Other current assets	18, 323, 031		0 0	0	
0. 00	Due from other funds	0		0 0	0	10.0
	Total current assets (sum of lines 1-10)	70, 618, 012		0 0	0	11. C
	FI XED ASSETS	45 0(4 004				1 40 0
	Land Land improvements	15, 961, 384 3, 133, 150		0 0 0 0		
	Accumulated depreciation	-3, 936, 159		0 0	0	
	Buildings	164, 636, 807		0 0	0	
	Accumulated depreciation	-70, 152, 477		0 0	0	
	Leasehold improvements	1, 366, 441		0 0	0	17.0
	Accumulated depreciation	0		0 0	0	18.0
	Fixed equipment	49, 965, 068		0 0	0	
	Accumulated depreciation	-33, 480, 396		0 0	0	
	Automobiles and trucks	0		0 0	0	
	Accumulated depreciation	114 029 204		0 0	0	
	Major movable equipment Accumulated depreciation	114, 938, 394 -72, 579, 579		0 0	0	
	Minor equipment depreciable	-12, 519, 519		0 0	0	
	Accumulated depreciation	0		0 0	0	
	HIT designated Assets	0		0 0	0	
	Accumulated depreciation	0		0 0	0	28.
9.00	Mi nor equi pment-nondepreci abl e	0		0 0	0	29.
	Total fixed assets (sum of lines 12-29)	169, 852, 633		0 0	0	30.0
	OTHER ASSETS	40,000,444	1	0		1 21 4
	Investments Deposits on Leases	49, 089, 444		0 0 0 0	-	
	Due from owners/officers	344, 357		0 0		
	Other assets	6, 465, 432		0 0	l o	
	Total other assets (sum of lines 31-34)	55, 899, 233		0 0	-	
	Total assets (sum of lines 11, 30, and 35)	296, 369, 878		0 0	0	
	CURRENT LIABILITIES		1			
	Accounts payable	9, 763, 526		0 0		
	Salaries, wages, and fees payable	10, 629, 313		0 0		
	Payroll taxes payable Notes and Loans payable (short term)	0 E 11E 202		0 0		
	Deferred income	5, 115, 393		0 0	0	
	Accel erated payments	0		0 0	Ŭ	42.
	Due to other funds	0		0 0	0	
	Other current liabilities	81, 063, 433		0 0		
5.00	Total current liabilities (sum of lines 37 thru 44)	106, 571, 665		0 0	0	45.
	LONG TERM LIABILITIES					
	Mortgage payable	0		0 0		
	Notes payable	59, 727, 799		0 0	0	
	Unsecured Loans	0		0 0	0	
	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49)	796, 442 60, 524, 241		0 0 0 0	0	
	Total liabilities (sum of lines 45 and 50)	167, 095, 906		0 0		
	CAPITAL ACCOUNTS	107, 070, 700		0 0		1 01.
	General fund balance	129, 273, 972				52.
	Specific purpose fund			0	l	53.
	Donor created - endowment fund balance - restricted			0		54.
	Donor created - endowment fund balance - unrestricted			0		55.
	Governing body created - endowment fund balance			0		56.
	Plant fund balance - invested in plant				0	
3. 00	Plant fund balance - reserve for plant improvement,				0	58.
	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	129, 273, 972		0 0	0	59.
9.00		167,613,716				1 07.

Heal th F	inancial Systems	RI VERVI EW H	OSPI TAL			In Lie	u of Form CM	IS-2	552-10
STATEMEN	NT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-0059	Peri Froi To	iod: m 01/01/2019 12/31/2019	Worksheet ( Date/Time F 6/8/2020 1:	Prep	
		General	Fund	Speci al	Purp	ose Fund	Endowment Fund		
		1.00	2.00	3.00		4.00	5,00	-	
2.00 N 3.00 T 4.00 A 5.00 6 6.00 7.00 8 0.00 7 10.00 T 11.00 5 12.00 D 13.00 14.00 15 14.00 15.00 17 15.00 16.00 T 17.00 75 18.00 7 19.00 F	Total deductions (sum of lines 12-17) und balances at beginning of period let income (loss) (from Wkst. G-3, line 29) otal (sum of line 1 and line 2) dditions (credit adjustments) (specify) otal additions (sum of line 4-9) bubtotal (line 3 plus line 10) leductions (debit adjustments) (specify)		2.00 133, 916, 951 -4, 642, 979 129, 273, 972 0 129, 273, 972 0 129, 273, 972 0 129, 273, 972	3.00		4.00 0 0 0 0 0 0 0 0 0 0	3.00	0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 1,00\\ 2,00\\ 3,00\\ 4,00\\ 5,00\\ 6,00\\ 7,00\\ 8,00\\ 9,00\\ 10,00\\ 11,00\\ 12,00\\ 13,00\\ 14,00\\ 15,00\\ 16,00\\ 17,00\\ 18,00\\ 19,00\\ \end{array}$
	heet (line 11 minus line 18)	Endowment Fund	PI ant	Fund					
1 00 5		6.00	7.00	8.00					1 00
2.00 N 3.00 T	und balances at beginning of period let income (loss) (from Wkst. G–3, line 29) otal (sum of line 1 and line 2) dditions (credit adjustments) (specify)	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 T 11.00 S 12.00 D 13.00 14.00 15.00 16.00 17.00 18.00 T 19.00 F	otal additions (sum of line 4-9) Subtotal (line 3 plus line 10) Seductions (debit adjustments) (specify) Sotal deductions (sum of lines 12-17) Sund balance at end of period per balance Sheet (line 11 minus line 18)	0 0 0 0	0 0 0 0 0 0		0 0 0				10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

<u>Heal th</u>	Financial Systems RI VERVI EW HOSPI TAL		In Lie	u of Form CMS-2	2552-10
STATEN	IENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider	CCN: 15-0059	Period: From 01/01/2019 To 12/31/2019		pared:
	Cost Center Description	I npati ent	Outpati ent	Total	- Pin
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				-
1.00	General Inpatient Routine Services Hospital	27, 090, 4	70	27, 090, 470	1.00
2.00	SUBPROVIDER - IPF	27,090,4	/0	27,090,470	2.00
3.00	SUBPROVIDER - IRF	7, 311, 6	82	7, 311, 682	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF		0	0	5.00
6.00	Swing bed - NF		0	0	6.00
7.00	SKILLED NURSING FACILITY NURSING FACILITY	1, 922, 4	04	1, 922, 404	7.00
8.00 9.00	OTHER LONG TERM CARE				8.00 9.00
10.00	Total general inpatient care services (sum of lines 1-9)	36, 324, 5	56	36, 324, 556	1
	Intensive Care Type Inpatient Hospital Services	1			
11.00	I NTENSI VE CARE UNI T	10, 028, 3	15	10, 028, 315	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00 15.00	SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY)				14.00 15.00
16.00	Total intensive care type inpatient hospital services (sum of lines	10, 028, 3	15	10, 028, 315	
10.00	11-15)	10, 020, 0	10	10, 020, 010	10.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	46, 352, 8	71	46, 352, 871	17.00
18.00	Ancillary services	126, 328, 8		413, 274, 922	
	Outpatient services	7, 136, 1			
20.00	RURAL HEALTH CLINIC		0 0	0	20.00
21.00 22.00	FEDERALLY QUALIFIED HEALTH CENTER HOME HEALTH AGENCY		0 0	0	21.00 22.00
22.00	AMBULANCE SERVICES		0 0	0	22.00
24.00	CMHC		0 0	0	24.00
25.00	AMBULATORY SURGICAL CENTER (D. P. )				25.00
26.00	HOSPICE				26.00
	PHYSICIANS PRIVATE OFFICES		0 40, 402, 111		
27.01			0 1, 383, 337		1
27.02	WESTFIELD SCHOOLS BEHAVI ORAL CARE		0 30,600		1
27.03	PHYSICIAN SERVICES LYONS		0 336,630 0 3,475		
27.04	UNI VERSI TY HS ATHLETI CS		0 6,937		
27.06	OB/GYN SPEC NEMUNALTI		0 1, 373, 915		
27.07	OB/GYN SPEC GATHERS		0 65, 582	65, 582	27.07
	OB SPECIALISTS DAVENPORT		0 323, 376		
	WORKMED	0.40 /	0 1, 125, 338		
27. 10 28. 00	PRO FEES Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	342, 6 180, 160, 5			
20.00	(G-3, Line 1)	100, 100, 5	33 388, 072, 009	500, 655, 104	20.00
	PART II - OPERATING EXPENSES	<b>I</b>		I	
29.00	Operating expenses (per Wkst. A, column 3, line 200)		231, 543, 068		29.00
30.00	ADD (SPECIFY)		0		30.00
31.00			0		31.00
32.00			0		32.00 33.00
33.00 34.00			0		33.00
35.00			0		35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)		0		37.00
38.00			0		38.00
39.00			0		39.00
40.00			0		40.00
41.00 42.00	Total deductions (sum of lines 37-41)		0		41.00 42.00
42.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transf	er	231, 543, 068		42.00
	to Wkst. G-3, line 4)				

Health Financial Systems		RI VERVI EW HOSPI	TAL	In Lie	u of Form CMS-2552-10	
STATEMENT OF REVENUES AND EXPENSES		Ρ	rovider CCN: 15-0059	Peri od: From 01/01/2019 To 12/31/2019	Worksheet G-3 Date/Time Pre 6/8/2020 1:18	pared:
					1 00	
1.00	Tatal nations revenues (from Wkst ( ) Da	rt L column 2 line	28)		1.00 568,833,164	1.00
	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28) Less contractual allowances and discounts on patients' accounts					2.00
						3.00
	Less total operating expenses (from Wkst. G-2, Part II, line 43)					
	Net income from service to patients (line 3 minus line 4)				231, 543, 068 -25, 033, 511	5.00
	OTHER INCOME	5 millus illie 4)			-23, 033, 311	5.00
	Contributions, donations, bequests, etc				0	6.00
	Income from investments				9, 922, 734	7.00
	Revenues from telephone and other miscella	neous communication s	ervi ces		0	8.00
	Revenue from television and radio service				0	9.00
10.00	Purchase di scounts				0	10.00
11.00	Rebates and refunds of expenses				0	11.00
12.00	Parking lot receipts				0	12.00
13.00	Revenue from Laundry and Linen service				0	13.00
14.00	Revenue from meals sold to employees and gu	uests			0	14.00
	Revenue from rental of living quarters				0	15.00
16.00	Revenue from sale of medical and surgical s	supplies to other tha	n patients		0	16.00
17.00	Revenue from sale of drugs to other than pa	atients			0	17.00
	Revenue from sale of medical records and al				0	18.00
	Tuition (fees, sale of textbooks, uniforms,				0	19.00
	Revenue from gifts, flowers, coffee shops,	and canteen			0	20.00
	Rental of vending machines				0	21.00
						22.00
	00 Governmental appropriations					23.00
	OO NONOPERATING REVENUE AND EXPENSE					24.00
	OTHER OPERATING REVENUE				11, 751, 387	
	Total other income (sum of lines 6-24)				20, 390, 532	
	Total (line 5 plus line 25)				-4, 642, 979	
	OTHER EXPENSES (SPECIFY)				0	27.00
	Total other expenses (sum of line 27 and su	1 2			0	28.00
29.00	Net income (or loss) for the period (line 2	26 minus line 28)			-4, 642, 979	29.00

Health Financial Systems RIVERVIEW CALCULATION OF CAPITAL PAYMENT		RI VERVI EW HOSI	Provider CCN: 15-0059	Peri od:	u of Form CMS-255 Worksheet L			
				From 01/01/2019	Parts I-III			
				To 12/31/2019	Date/Time Pre 6/8/2020 1:18			
			Title XVIII	Hospi tal	PPS	piii		
	Y DROSDECTIVE METHOD				1.00			
	PART I - FULLY PROSPECTIVE METHOD CAPITAL FEDERAL AMOUNT							
	other than outlier				1, 191, 569	1.		
01 Model 4 BPCI	Model 4 BPCI Capital DRG other than outlier				0	1.		
00 Capital DRG o	Capital DRG outlier payments				112, 342	2.		
01 Model 4 BPCI	Model 4 BPCI Capital DRG outlier payments							
00 Total inpatie	Total inpatient days divided by number of days in the cost reporting period (see instructions)					3.		
00 Number of int	Number of interns & residents (see instructions)				0.00	4.		
	cal education percentage (see i				0. 00 0	5. 6.		
	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01) (concinentiation)							
	1.01) (see instructions)							
	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)							
	Percentage of Medicaid patient days to total days (see instructions)							
	Sum of Lines 7 and 8					9		
.00 Allowable dis	Allowable disproportionate share percentage (see instructions)				3. 53	10		
. 00 Disproporti or	Disproportionate share adjustment (see instructions)				42, 062	11		
00 Total prospec	tive capital payments (see ins	tructions)			1, 345, 973	12		
				-				
	MENT LINDER REASONARIE COST				1.00			
	PART II - PAYMENT UNDER REASONABLE COST Program inpatient routine capital cost (see instructions)							
	Program inpatient ancillary capital cost (see instructions)				0	1		
	Total inpatient program capital cost (line 1 plus line 2)				0	3		
	Capital cost payment factor (see instructions)				0			
	ent program capital cost (line :				0	5.		
				-	1.00			
PART III - CO	MPUTATION OF EXCEPTION PAYMENTS	5			1.00			
00 Program inpat	ient capital costs (see instru	ctions)			0	1		
	ient capital costs for extraor		s (see instructions)		0	2		
00 Net program i	npatient capital costs (line 1	minus line 2)			0	3		
	ception percentage (see instru	,			0.00			
	for comparison to payments (lin				0	-		
00 Percentage ac	ljustment for extraordinary cire				0.00			
	capital minimum payment level		circumstances (line 2 :	x line 6)	0	7		
00 Adjustment to		line 7)			0			
00 Adjustment to 00 Capital minin	num payment level (line 5 plus l				0	1 '		
00 Adjustment to 00 Capital minin 00 Current year	capital payments (from Part I,	line 12, as applic			~	10		
00 Adjustment to 00 Capital minin 00 Current year 00 Current year	capital payments (from Part I, comparison of capital minimum p	line 12, as applic payment level to ca	pital payments (line 8		0			
00Adjustment to00Capital minin00Current year.00Current year.00Carryover of	capital payments (from Part I,	line 12, as applic payment level to ca	pital payments (line 8		0			
00 Adjustment to 00 Capital minin 00 Current year 0.00 Current year .00 Carryover of Worksheet L,	capital payments (from Part I, comparison of capital minimum pa accumulated capital minimum pa	line 12, as applic payment level to ca yment level over ca	pital payments (line 8 pital payment (from pr	ior year		11		
00 Adjustment to 00 Capital minim 00 Current year 0.00 Current year 0.00 Carryover of Worksheet L, 2.00 Net compariso	capital payments (from Part I, comparison of capital minimum pa accumulated capital minimum pay Part III, line 14)	line 12, as applic payment level to ca yment level over ca evel to capital pay	pital payments (line 8 pital payment (from pr ments (line 10 plus lin	ior year ne 11)	0	11 12		
<ul> <li>Adjustment to</li> <li>Capital minin</li> <li>Current year</li> <li>Current year</li> <li>Carryover of</li> <li>Worksheet L,</li> <li>Net compariso</li> <li>Current year</li> <li>Carryover of</li> </ul>	capital payments (from Part I, comparison of capital minimum p accumulated capital minimum pay Part III, line 14) on of capital minimum payment 14 exception payment (if line 12 i accumulated capital minimum pay	line 12, as applic payment level to ca yment level over ca evel to capital pay is positive, enter yment level over ca	pital payments (line 8 pital payment (from pr ments (line 10 plus lin the amount on this line	ior year ne 11) e)	0	11 12 13		
00 Adjustment to 00 Capital minim 00 Current year 00 Current year 00 Carryover of Worksheet L, 00 Net compariso 0.00 Current year 0.00 Carryover of (if line 12 i	capital payments (from Part I, comparison of capital minimum pa accumulated capital minimum pay Part III, line 14) on of capital minimum payment I exception payment (if line 12 i accumulated capital minimum pay s negative, enter the amount of	line 12, as applic payment level to ca yment level over ca evel to capital pay is positive, enter yment level over ca n this line)	pital payments (line 8 pital payment (from pr ments (line 10 plus line the amount on this line pital payment for the	ior year ne 11) e)	0 0 0 0	11 12 13 14		
00Adjustment to00Capital minin00Current year0.00Current year1.00Carryover ofWorksheet L,2.00Net compariso3.00Current year4.00Carryover of(if line 12 i5.00Current year	capital payments (from Part I, comparison of capital minimum p accumulated capital minimum pay Part III, line 14) on of capital minimum payment 14 exception payment (if line 12 i accumulated capital minimum pay	line 12, as applic payment level to ca yment level over ca evel to capital pay is positive, enter yment level over ca n this line) I payment (see inst	pital payments (line 8 pital payment (from pr ments (line 10 plus line the amount on this line pital payment for the	ior year ne 11) e)	0 0 0	11 12 13 14		